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INDIAN HEALTH CARE IMPROVEMENT ACT OF 1992

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Mr. INOUYE from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 2481]

The Select Committee on Indian Affairs, to which was referred the bill (S. 2481) having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

PURPOSE

The purpose of S. 2481 is to reauthorize the Indian Health Care Improvement Act. The Indian Health Care Improvement Act defines, in terms of authorizations, the programmatic structure for the Indian Health Service. S. 2481 would seek to stabilize the programs authorized by the Indian Health Care Improvement Act through the year 2000, in the same manner as the reauthorization initiatives for the National Health Service Corps and Maternal/Child Health Block Grant. Specific health care objectives set forth in S. 2481 are drawn from the Surgeon General's "Healthy People 2000 Report" of the Department of Health and Human Services which set national health promotion and disease prevention objectives. The reauthorization would set more stringent standards by which to measure progress toward the goal of raising the health status of American Indians and Alaska Natives to the highest possible level.

59-010

BACKGROUND

The United States' responsibility to Indian tribal governments and their members for the provision of health care was established in numerous treaties with Indian tribes in which the United States agreed to provide such services. For example, in Article 2 of the 1854 Treaty with the Rogue River Indians (10 Stat. 1119), the United States agreed that "* * * provision shall be made * * * for a hospital, medicines, and a physician." The responsibility has been further delineated and defined by numerous status and administrative regulations. Based upon the Constitution, historical development, treaties, and statutes, the United States has assumed a legal and moral obligation to provide adequate health care and services to Indian tribes and their members.

The Federal government has provided health care services to American Indians since the 19th century. As early as 1802, U.S. Army doctors worked to cure smallpox outbreaks among the Indians living near military posts. In 1849, the responsibility for providing health care shifted from the military to civilian authority, when the Bureau of Indian Affairs was transferred from the War Department to the Department of Interior.

With the enactment of the Snyder Act (25 U.S.C. 13) in 1921, formal authorization for Indian health appropriations became public law. The Snyder Act authorized the Bureau of Indian Affairs to provide certain services, including those for "relief of distress and conservation of health." Under this general authority, Indian health programs were administered by the Department of Interior until 1955, when they were transferred to the Division of Indian Health (now the Indian Health Service) in the Department of Health, Education and Welfare (now the U.S. Department of Health and Human Services), pursuant to the Transfer Act (42 U.S.C. 2001).

In response to documented deficiencies in the health status of American Indians and Alaska Natives, the Congress, in 1976, enacted the Indian Health Care Improvement Act (P.L. 94-437). This legislation authorized additional funds for Indian health care, in part to reduce unmet needs under existing programs, and in part to establish new program efforts, such as manpower training and urban health clinics. A major purpose of the 1976 Act was to raise the health status of American Indians and Alaska Natives over a seven year period, ending in fiscal year 1984, to a level comparable to that of the general population. Since the 1976 Act provided only a three-year authorization, the Congress, in 1980, revised and extended the legislation through September 30, 1984 (P.L. 96-537). The Act was again revised and extended in 1988 (P.L. 100-713).

In the concluding days of the 101st Congress, three major health bills which amend the Indian Health Care Improvement Act were enacted into law (P.L. 101-630). These amendments provide statutory authorization for a comprehensive and community based mental health program, authorization for demonstration of innovative health care delivery systems and expansion of the urban Indian health programs. Unfortunately the funding to implement these new programs authorized under P.L. 100-713 and P.L. 101-630, in

the amount of $55 million, has not been proposed in the fiscal year 1993 President's budget request for the IHS.

Health Status of American Indians and Alaska Natives

The Federal government has a unique historical and legal relationship with the Indian people, whose health status is substantially inferior to that of the general U.S. population. There are approximately 1.6 million American Indians and Alaska Natives, of whom about one third live on reservations or historic trust lands, and about half live in urban areas. The Indian population is diverse, encompassing over 550 tribal governments and Alaska Native villages, each with its own traditions and cultural heritage.

When the Indian Health Care Improvement Act was first enacted in 1976, the overall goal was to improve the health status of Indians. While the health status of the Indian people has improved since 1976, it remains inferior to that of the U.S. population as a whole, as documented by the Office of Technology Assessment in "Indian Health Care" (1986).

According to the Indian Health Service, the mortality rates of American Indians and Alaska Natives continue to exceed that of the U.S. All Races group. For example, in 1987, the Indian age-adjusted mortality rates for the following causes exceeded those for the U.S. All races population by the following percentages:

	Percent
Tuberculosis	400
Alcoholism	332
Diabetes mellitus	139
Accidents	139
Homicide	64
Pneumonia and influenza	44
Suicide	28

In 1990 the Department of Health and Human Services issued "Healthy People 2000," a statement of health promotion and disease prevention objectives for the nation for the coming decade. The Department notes that, relative to other populations, the American Indian and Alaska Native population is young and impoverished, with more than 1 in 4 living below the poverty level. The Department goes on to explain: "One reason for the youthfulness of the population is the large proportion of the population who die before age 45. Most of the excess deaths—those that would not have occurred if American Indian death rates were comparable to those of the total population—can be traced to 6 causes: unintentional injuries, cirrhosis, homicide, suicide, pneumonia, and complications of diabetes." The Department's 1991 report, "Health Status of Minorities and Low-Income Groups: Third Edition," documents the higher death rates and shorter life expectancies of American Indians and Alaska Natives vis-a-vis the U.S. Caucasian population.

A March 1992 report entitled "The State of Native American Youth Health", drawn from a survey of 14,000 Indian youth, reported that suicide has emerged as a way for native youth to deal with emotional distress and hopelessness that is characteristic of many of their lives. The University of Minnesota report further found that regular use of tobacco and heavy use of substances, par-

ticularly, alcohol and marijuana, is linked to every single risk behavior found in the survey. In addition, the survey found that 20 percent of the youth felt their health is only fair to poor.

The Indian Health Care Improvement Act is administered by the Indian Health Service (IHS) within the Public Health Service of the Department of Health and Human Services. The IHS considers itself responsible for providing care to "approximately one and one half million" American Indians and Alaska Natives living on or near reservations in 33 States. In FY 1992, appropriations to the IHS totalled $1,701,017,000. This included $1,426,666,000 for health services (both direct and contract care) and $274,351,000 for health facilities construction. The President's budget for fiscal year 1993 proposes a total of $1,651,452,000 for the IHS in budget authority, a decrease of $49.5 million or 3 percent under the fiscal year 1992 budget in actual budget authority.

The IHS delivers health care to eligible Indians through three different mechanisms. It does so directly through its own facilities, including (as of January 25, 1992) 42 hospitals, 65 health centers, 4 school health centers, and 52 smaller health stations. The tribal health delivery system administered by tribal governments and tribal groups through contracts with IHS operates 8 hospitals, 93 health centers, 3 school health centers, 63 smaller health stations and satellite clinics, and 173 Alaska village clinics. In addition, the IHS funds 34 urban Indian organizations operating programs in 41 sites to deliver outpatient health and referral services to urban Indians. Where services are not offered directly through IHS or tribal facilities, limited funds are available in each area for the purchase of care on a contract basis from non-federal, non-tribal hospitals, clinics physicians and dentists.

The Committee recognizes that the task of improving the health status of American Indians and Alaska Natives, begun with enactment of the Indian Health Care Improvement Act in 1976, is not yet complete. The Department's "Healthy People 2000" sets forth 85 health status objectives for the U.S. population generally, including 31 targeted specifically at American Indians and Alaska Natives. The Committee Amendment would revise and reauthorize the Indian Health Care Improvement Act through FY 2000 to enable the IHS and the tribal governments to achieve both the targeted and some non-targeted objectives over the next 8 years.

Legislative History

S. 2481 was introduced on March 25, 1992 by Chairman Inouye for himself, Vice-Chairman McCain, Senators Daschle, Domenici, Burdick, Murkowski, Simon, Cochran, Stevens, Akaka, DeConcini, Kassebaum, Wellstone, Reid, and Kennedy, and was referred to the Select Committee on Indian Affairs. The first hearing on S. 2481 was held in Washington, D.C. on April 1, 1992. Four field hearings were held in: Lower Brule, South Dakota (April 16, 1992); Anchorage, Alaska (May 23, 1992); Bethel, Alaska (May 24, 1992), and Phoenix, Arizona (May 29, 1992). The House companion bill, H.R. 3724, has been the subject of two Washington D.C. hearings and one field hearing in North Dakota. The House Energy and Commerce Committee's Subcommittee on Health and Environment re-

ported H.R. 3724 to full committee on March 25th, 1992 and the bill was considered for report in full Committee on April 7, 1992. The House Interior and Insular Affairs Committee favorably reported on H.R. 3725 on April 29, 1992. (H. Rept. 102-643).

SUMMARY OF MAJOR PROVISIONS OF THE EXISTING ACT

Title I of the IHCIA was designed to accomplish two related goals: (1) to increase the number of Indians trained in the health professions and (2) to provide a larger pool of health professionals to serve Indian people. To accomplish these goals, the title establishes several programs: (a) a recruitment program to encourage young Indians to pursue medical careers; (b) a preparatory scholarship program to assist Indian students to orient toward a medical career; (c) a scholarship program to support Indian students in graduate schools of medicine; (d) an extern program to provide summer experience in IHS for Indian medical students; and (e) a program for continuing education of IHS personnel among others. A special nursing program and incentives for health professionals are also included.

Title II of the IHCIA is a congressional mandate to IHS to begin an incremental program to raise the health status of Indians to a level equal to the rest of the Nation. Health services includes direct and indirect patient care, dental care, mental health, alcoholism treatment, and maintenance and repair. A Catastrophic Health Emergency Fund; a Diabetes Prevention, Treatment and Control Program; and a Mental Health Program are also included in the Act.

Title III of the IHCIA pertains to the construction of health facilities, including hospitals, clinics, and health stations including necessary staff quarters, and to the construction of sanitation facilities for Indian communities and homes.

Title IV of the Act relates to the collection and use of Medicare/Medicaid reimbursements by the Indian Health Service. The Act establishes a program of grants and contracts with tribal organizations to assist eligible Indians in obtaining Medicare or Medicaid benefits.

Title V of the Act, as amended by the 1980 amendments, authorizes grants to urban Indian organizations to provide outreach and referral services to Indians in urban and other areas.

Title VI provides for organizational improvements in the Indian Health Service.

Title VII requires the Secretary to report to the Congress on the status of Indian health and also provides for Miscellaneous programs including eligibility provisions for California Indians.

SUMMARY OF MAJOR PROVISIONS OF S. 2481

DECLARARTION OF HEALTH OBJECTIVES

The Committee Amendment amends section 2 to include an additional finding regarding the unmet needs of tribal programs operating under Indian Self-Determination contracts and notes that these Public Law 93-638 contract resources are varied, yet should be provided in a fashion which allows for maximum flexibility for

tribal governments in carrying out health programs to address their respective local needs.

The Committee Amendment reinstates the declaration of policy language to underscore the fundamental legal obligation of the United States government to raise the health status of American Indians and Alaska Natives, including urban Indians, to the highest possible level, and to provide the necessary resources to carry out this policy. The policy further provides that the Indian health Service, including tribal health care programs, is responsible for providing comprehensive health care delivery at all developmental stages of life and must assure access to the same fundamental health care benefits for all eligible Indian patients. In an effort to better implement this policy, the Committee included in the amendment 69 health status objectives. These objectives serve two goals: (1) they provide a measuring device for comparing the current health status of Native Americans to their health status and the health status of other Americans in the year 2000, and (2) beginning three years from the date of enactment of the Act, the health status objectives will serve as a resource driving mechanism for the Indian Health Care Improvement Fund and other resource allocation methods.

The health status objectives were derived from a publication of the U.S. Department of Health and Human Services, Public Health Services, entitled "Healthy People 2000: National Health Promotion and Disease Prevention Objectives" (DHHS Publication No. (PHS) 91-50212). This report was released in 1990 and involved 22 expert working groups, 300 national health organizations, and all state health departments in its development. The report recommends numerous health objectives for the general population and only 22 health status objectives specific to the Native American population. In an effort to more comprehensively address all developmental stages of life and the complete array of diseases most prevalent among the Native American population, the Committee adopted additional health status objectives from the Surgeon General's report.

It is the intent of the Committee that the Indian Health Service submit a substantial and well documented report on the progress toward achieving these objectives annually. The health status objectives will be utilized to assess the need for the resources required to allocate the Indian Health Care Improvement Fund. The Amendment provides that the Indian Health Service will be allowed a three year period to implement this new method of allocating the Fund. While the Committee expects that regulations will be developed by the agency to implement the gathering of this information, it expects that these regulations will not be overly complex or overly burdensome for Indian tribal governments and those who are involved in the provision of health care services or the operation of health care programs. The Committee suggests a minimum burden be placed on Community Health Representatives and other health care providers in the field in executing duties and that the development and updating of epidemiological data be the responsibility of the Area epidemiology centers authorized under the Amendment. Finally, because health problems and their degree of severity vary among tribal communities nationwide, each tribal

government should determine the appropriate tribal-specific health promotion and disease prevention goals that address a particular tribe's needs.

Four new definitions have been added to the Act, including "Service area", "Health profession", "Health professional", and "Substance abuse". It is the Committee's desire to clarify Title I of the Act, by defining "Health Profession" to include those professions eligible for scholarship assistance under the 1988 Amendments and to add the following new professions: Podiatric medicine, geriatric medicine, marriage and family therapy, and chiropractic medicine. "Substance abuse" is defined to include inhalant abuse.

TITLE I—INDIAN HEALTH MANPOWER

Indian health manpower programs and scholarship assistance

The Committee considers the acute shortage of health professionals available to Indian and Alaska native communities, and in particular the acute shortage of Native health professionals, to be a priority policy issue. The ability of tribal governments to provide accessible and acceptable health care for their citizens is an important part of achieving self-determination. In working to accomplish this goal, tribal governments and tribal organizations have made clear to the Committee their strong desire that health manpower programs, to the extent possible, emphasize community-based training, recruitment and retention of tribal people. Health care must be available, accessible, and more importantly, acceptable. Witness testimony noted that health care provided by people of one's own culture is the most appropriate, and results in better utilization of health care services.

Indian and Alaska Native people lag far behind the general population in achieving parity in terms of their representation in the primary health professions. While the numbers of Native people employed as nursing aides, orderlies, attendants, licensed practical nurses, and physicians attendants are consistent with their percentage in the population, Indian and Alaska Native people are severely under represented in many of the primary health professions including positions for physicians, registered nurses, dentists, optometrists, pharmacists, podiatrists, dental hygiene, and speech therapists. (Source: "Minorities and Women in the Health Fields," 1990 Edition, U.S. Department of Health and Human Services.)

Tribal governments and tribal organizations have voiced concern that more opportunities must be developed for Native people to enter into the health professions. Many of the current federal or state programs which enhance opportunities for students to enter the health professions are not specifically directed at meeting the needs of Native students. The Indian Health Service also experiences constraints in this area due to limited resources and lack of sufficient recruiting personnel. The Committee believes that if the problems of clinical staffing shortages are to be addressed on a long term basis it is vital that concentrated efforts be made to draw more Native people into service in the IHS.

A study assessing the supply, geographic and specialty distribution of American Indian physicians was conducted by the Universi-

ty of Oklahoma, in conjunction with the Association of American Indian Physicians, in 1988. According to the findings there were approximately 300 Indian physicians in the U.S. At least 60 percent or 180 physicians were actively providing direct clinical or contract care in an IHS, tribal or urban Indian health facility or may have been providing indirect services in a consulting capacity or serving on tribal or urban Indian health boards. However, it must be noted that only 20 of these Indian physicians were actually working for the Indian Health Service.

More recently, the fiscal year 1993 IHS budget justification states that 75 percent of its loan repayment program funds are allocated to physicians and nurses. While the Committee does not dispute the emphasis on utilizing the program largely for physicians and nurses, the fact is that at this time the pool of Indian and Alaska Native people in these professions, and in particular physician professions, is small, and much of the loan repayment program funds are provided to non-Native people. The loan repayment program is an illustration of why the Committee wants to strengthen manpower programs to reach Indian and Alaska Native people. Thus, the Committee intends to enhance those programs which will (1) provide an incentive for Native people to seek education in the health fields, (2) make available the necessary financial resources to allow Native people to successfully complete school, and (3) ensure that Native people will ultimately serve their tribal communities, whether on reservations or in urban Indian health clinics. The Committee Amendment contains revisions in the loan and scholarship programs so that financial assistance is more closely coordinated with the needs for certain health care professionals in IHS and tribal programs.

The Committee is encouraged by the efforts of tribal colleges that are developing curricula in the health fields and have the potential to play a larger role in the training of Indian health professionals. Five of the tribal colleges have degreed nursing programs, and other colleges provide training and certification for substance abuse counsellors, and have curricula for dentistry-related professions, medical recordkeeping, nursing aides, pre-nursing, physical therapy, pre-optometry and optical technology.

The Committee Amendment amends Title I of the Act to provide for increased opportunities for American Indians and Alaska Natives in the health professions as defined in Section 4. The Committee amendment is intended to ensure that preparatory and health professions scholarships are available to American Indians and Alaska Natives across a wide range of disciplines. The Committee is concerned that statutory language limiting the courses of study eligible for scholarship assistance to only primary care services will unnecessarily reduce the number of scholarships awarded to Indian students and serve as a barrier to the effective recruitment of Indian students into the full range of health professions.

The Committee intends the provisions of this title to be interpreted broadly by the Indian Health Service. The Committee believes that the amendment will provide the Indian Health Service with the flexibility to target the recruitment efforts on health professions that are in demand throughout Indian country. The Committee recognizes the need to provide scholarship assistance to

Indian students who are enrolled in a course of study on a part-time basis. This change in the scholarship program will help provide badly needed assistance to single parents and those who are unable to go to school on a full-time basis. The Committee understands that part-time nursing students are often in need of scholarship assistance in order to continue their education. The Amendment further provides that the IHS shall not deny scholarship assistance to eligible applicants solely because they receive benefits or assistance from other federal programs.

Health Professional Placement Office

The Committee Amendment requires the Indian Health Service to establish a placement office within its headquarters office to develop and implement a national policy for the placement of health professionals in fulfillment of their scholarship obligations. Much concern has been expressed over the failure of the IHS to effectively place scholarship recipients, thereby fostering greater shortage of health professionals. The Committee anticipates that establishment of a placement office for scholarship recipients will ensure immediate placement of scholarship obligees in the areas of greatest need for their services without regard to any competitive personnel system, agency personnel limitation, or Indian preference policy.

The Committee Amendment also expands the list of health professions eligible to participate in the externship programs established under the Act during nonacademic periods. The Committee intends this provision to be interpreted broadly by the Indian Health Service so that a wide range of health professionals may participate in the externship program as defined under section 4.

The Committee has amended the IHS Health Professional Scholarship program to add breach of contract provisions. The amendment provides that an individual who signed a contract under this program and either fails to maintain an acceptable level of academic standing, is dismissed for disciplinary reasons, voluntarily ends the training before completion, or fails to accept the scholarship in whole or in part, shall be liable to the Federal government for the amount paid under the contract. The amendment further provides that an individual who breaches the contract by failing to begin or complete the service obligation shall be liable to the Federal government for an amount determined by a specified formula.

Recruitment and retention of nurses

The Committee Amendment includes a variety of programs to improve the ability of the Indian Health Service to recruit and retain nurses within the Indian Health Service. The Nursing program is amended to allow nurses employed by the IHS to receive continuing education allowances. This amendment includes nurse anesthetists in addition to nurses, nurse midwives, and nurse practitioners in Nursing Programs, and authorizes grants to establish and develop clinics operated by these professions to provide primary health care to eligible patients. The Nursing program authorization provides that not less than $1,000,000 of the annual appropriation be used to carry out the nursing program for the training of nurse midwives and nurse practitioners.

The Amendment also includes a provision to require that 25 percent of all retention bonuses awarded by the Indian Health Service be awarded to nurses. The Committee has included a provision which authorizes the Secretary to award retention bonuses to any nurse or physician employed by an Indian tribe under an Indian Self-Determination Act contract. This provision will assure that physicians and nurses employed by self-determination contractors will be eligible for retention bonuses if their positions are necessary and recruitment or retention is difficult. The Committee is aware of the problems experienced by Indian tribal governments and tribal contractors because of the difficulty in retaining health professionals. The Committee intends this language to help address the problem of retaining qualified health professionals in tribal health programs.

The Committee Amendment also includes language to allow nurses employed in Indian health programs to participate in advanced training programs in order to obtain an advanced degree. The Amendment includes a new section to award grants to public or private schools of nursing to provide primary care services in medically underserved rural areas. These clinics shall be designed to provide nursing students with a structured clinical experience that is similar in nature to physician residency training programs.

The Committee desires to make clear that it intends that all categories of nurse practioners, including nurse anesthetists, be included in recruitment provisions such as those for nursing educational grants, wherever the term nurse practioner appears in the Act. Specific mention of nurse anesthetists in the Act is intended to highlight the role that nurse anesthetists play in clinics which provide critical services to Indian populations, and is not intended to limit IHS's ability to include nurse anesthetists in the grants awarded within the Nursing program.

The Committee intends these provisions to provide a variety of incentives to nurses employed in Indian health programs in an effort to address the national shortage of nurses within the Indian Health Service.

The Committee Amendment provides for the continuation of the Community Health Representative training program and provides for the consideration of lifestyle factors (i.e. alcoholism, family dysfunction, and poverty) affecting Indian health in developing health promotion and disease prevention training curricula.

Loan Repayment Program

The Committee Amendment includes a broad description of health professionals eligible to participate in the loan repayment program as defined under section 4. Changes to the loan repayment program would allow part-time students to be eligible for the loan repayment program. The Amendment would set a minimum of 25 percent for the provision of financial assistance for nurses, nurse practitioners or nurse midwives and a 10 percent minimum for mental health professions. The setting of a minimum percentage for nurses and mental health professionals is based on the significant shortage of both professions in the Indian Health Service. Nursing vacancies typically range from 14 to 20 percent in all areas of the IHS. Further in 1990, the Office of Technology Assess-

ment found that only 17 trained mental health providers were available to address the mental health needs of children and adolescents. To remedy this discrepancy, the 1990 amendments to the Indian Health Care Improvements Act required the IHS to designate resources over the next five years to hire at least 500 more mental health professionals. The Committee believes that the term "mental health providers" should include those health professionals with training in the fields of psychology, social work, psychiatry, psychiatric nursing and marriage and family therapy.

Amendments to the Loan Repayment program redefine program participation as: entering into a contract; requiring written notice of service extensions beyond four years; and clarifying that undergraduate and graduate loans are covered by the program. The maximum loan repayment amount is increased to $35,000 per year and the amendment establishes criteria for determining the repayment amount.

The Committee received testimony from several Indian tribes expressing concerns regarding the limitation of the loan repayment program. Tribal testimony indicated a need for more flexibility in the loan repayment program to be more responsive to local needs for health professionals. The Committee shares these views.

The Committee Amendment allows the Secretary to make additional payments to loan repayment recipients to offset any additional tax liability of loan repayment recipients in amounts up to 39 percent of an individual's loan repayment. The Amendment also allows the Secretary to make such additional payments to loan repayment recipients as may be required.

The Committee notes that the Loan Repayment program has proven to be a beneficial incentive for recruiting and retaining dentists in the Indian Health Service. Since 1989, 66 dentists have joined the program and in fiscal year 1992, the IHS received 5 applications for every available loan repayment position in hard-to-fill sites. However, the Committee notes that unfortunately there is no consistency in the number of dentists enrolled from year to year. These numbers have ranged from a high of 50 in 1989 to a low of 0 in 1990. The Committee is concerned that the lack of consistency will create manpower shortages which could result in the delivery of IHS dental services falling below current levels. The Committee urges IHS to establish a consistent number of positions for dentists in the loan repayment program from year to year, using fiscal year 1992 as a base from which to begin.

The Committee is concerned about the very serious problems the Indian Health Service is having in the recruitment of health professionals. In some areas of the Indian Health Service, there is a severe shortage of IHS physicians and nurses. These shortages have had a dramatic impact on the quality of health care offered to patients living in these service areas. The Committee is aware of several situations where physicians have threatened to leave a service unit if they did not receive loan repayments, thereby creating critical situations for the Indian Health Service. The Committee is concerned that the loan repayment program is now viewed as a salary supplement by many IHS physicians. It is the intent of the Committee that the loan repayment program be used as an incentive to recruit health professionals to work in service areas where,

historically vacancies have been hard to fill. Finally, the content of the Secretary's annual report on Loan Repayment activities is redefined and is to be submitted along with the President's Budget Request.

Recruitment of health professionals

The Committee directs the Secretary through the Indian Health Service to establish a full-time position in each area office to conduct recruitment activities. The Committee intends each area office recruiter to closely coordinate their activities with the national recruitment efforts and priorities of the Indian Health Service. This program will allow each area office to conduct specific recruitment activities to address local staffing needs of the Indian Health Service. The Committee intends that each area office recruiter closely coordinate their activities with the priorities for health professionals determined by both IHS Area personnel and area tribal governments, as well as the national recruitment efforts and priorities of the Indian Health Service.

The Committee intends to allow tribally controlled postsecondary vocational institutions to participate in the nursing program grants authorized under section 112 and the Tribal Culture and History Program authorized under section 113 of the Act. The amendment will allow the United Tribes Technical Center and the Navajo Community College to participate in these programs along with other Tribally Controlled Community Colleges.

The Committee Amendment also includes a provision that establishes an Indians into Medicine program for Indian Health Service nurses and mental health professionals. The Committee is concerned that INMED programs established under existing law have operated to exclude nurses and mental health professionals. The Committee believes that INMED programs specifically geared to nursing and mental health professionals will serve as a beneficial incentive and recruitment tool of the Indian Health Service. These programs will help to significantly increase the number of nurses and mental health professionals working in the Indian Health Service. The Committee intends any INMED programs established under this section to offer education and training that incorporates multidisciplinary approaches and to include a strong emphasis on tribal traditional healing and cultural practices. It is well-established that an understanding of tribal traditions and cultural values is a necessary component to health care delivery to American Indians.

Indian health scholarship and loan repayment recovery fund

The Committee Amendment establishes the Indian Health Scholarship and Loan Repayment Recovery Fund to be used to make additional scholarships and loan repayment awards. The fund shall consist of appropriated funds equal to the amount of funds collected by the Indian Health Service from individuals who have breached their service obligations under the scholarship and loan repayment programs. The Committee intends for this fund to be used to make additional scholarship and loan repayment awards so that the Indian Health Service will not lose both the scholarship recipient and the scholarship funds when an individual breaches

their contract. The Committee is also concerned that a service unit of the Indian Health Service may be faced with a crisis situation if an individual breaches their service obligation and the service unit is unable to fill the vacancy. The Committee has included language which requires the Secretary to prioritize the replacement of an individual who has breached their service obligation after they have been assigned to a service unit or other health program. The Committee believes this fund will allow the Indian Health Service to begin to make substantial progress in addressing the severe shortages of health professionals working in Indian health programs.

A new section has been added to enable tribal governments to provide matching grants in a new category of scholarship assistance to assist Indians pursuing education in the health professions. The Amendment provides that the matching grants pay 80 percent of the scholarship costs and non-Federal contributions pay the remaining 20 percent. The Amendment establishes conditions for the scholarships, service obligations, uses of scholarship funds, monthly stipends, and academic and licensing requirements. The Amendment prohibits a scholarship recipient from discriminating against anyone seeking health care on the basis of ability to pay or from discriminating on the grounds that payment will be provided by Medicare or Medicaid. Requirements and penalties are set forth regarding any breach of contract by the scholarship recipient.

Community Health Aide Program

The Committee Amendment includes a new section to statutorily authorize the Community Health Aide Program in Alaska to train and use Alaska Natives as community health aides to provide health care, health promotion, and disease prevention services in the villages. The Community Health Aide Program is an integral link between remote rural villages and health facilities and programs throughout Alaska. In most areas, the community health aide serves as the sole contact between the native community and health care system. The Committee Amendment provides for a teleconferencing capacity in village health clinics. Further, the amendment requires training for aides, curriculum development, a certification board, and a system to supervise aides and identify their continuing education needs.

The Committee Amendment includes a new requirement titled Tribal Health Program Administration under which the Secretary is to provide training for individuals in the administration and planning of tribal health programs.

A new section has been added which requires the IHS to consider an individual's ties to their tribal community in fulfilling their obligated service requirements under the loan repayment program or other scholarship obligations. The intent of this language is to provide further incentives to American Indians to enter into the health professions so that upon completing their education they may work in their home communities. Currently, the Indian Health Service does not consider the home reservation of a scholarship recipient in making service placements. The Committee believes that scholarship recipients should be encouraged to return to their home reservations to fulfill their service obligation to the Indian Health Service.

The Committee Amendment includes a new section to provide grants to public or private colleges, universities and tribally controlled community colleges to promote the development of interdisciplinary training in two or more schools or programs in optometry, pharmacy, psychology, public health, or social work.

An Amendment is included to allow the Secretary to provide grants to any college, university, or consortium, that is located in any of the three service areas determined to have the most acute health manpower shortages. The purpose of these grants is to provide for training of health professionals using the resources of grant recipients, including students and faculty, to serve in service areas with noted shortages. Grant recipients shall be required to enter into formal agreements with the tribal governments of those service areas in which training is taking place.

TITLE II—HEALTH SERVICE

Health status and resources deficiency

In 1988, the Congress established the Indian Health Care Improvement Fund. The origins of this fund can be traced back to 1974 when California Indians tribes filed a class suit against IHS alleging a denial of health care services which were provided to all other eligible American Indians. At that time, California Indians comprised 10 percent of the national IHS service population and yet, received approximately 2 percent of the funds. The District Court ruled that IHS was required to provide health care to California Indians comparable to services offered by IHS to Indians elsewhere in the United States. The ruling was upheld in the Ninth Circuit. *Rincon Band of Missions Indians* v. *Harris,* 618 F.2d 569 (9th Cir. 1980). As a result, the Appropriations Committees of the House of Representatives and Senate established the Equity Health Care Fund through most of the 1980s to provide resource allocations to areas and tribes with deficient levels of health care services.

In an effort to establish a more permanent means of dealing with the resource deficiency problem, in 1988, the Congress established in subsection 201 of the Act, the Indian Health Care Improvement Fund which was to take the place of the "Equity Fund." The Fund was to be allocated based on the level of resource deficiency.

The Committee Amendment provides that this system of allocating the Fund shall remain in place for another three years. However, during that three years interim the Committee expects the Service to begin, through its Epidemiology centers, the collection of data required under the 69 health status objectives. Amendments to the IHCIA would require that IHS program activities remain consistent with the stated health objectives established in Section 3. The Committee Amendment will require the IHS to terminate its current system of allocating the Indian Health Care Improvement Fund since the allocation was based only on historical funding rather than addressing actual health care needs. The Committee believe that true equity funding should be based on addressing health status deficiencies as well as evaluating historical funding deficiencies. Language is included to require the IHS to determine health needs based on the actual costs of providing health care

taking local conditions into account. The Committee's believes that equity funding needs to be targeted to areas where health status is the poorest. It is manifest that all Indians are entitled to comparable health care and the Committee amendment is based on that premise. The Fund will be utilized in three years to address the true health needs of Indian country and to provide equity in achieving health status objectives.

Based upon the documented backlog of services and waiting lists for surgeries that in some areas are as long as three to four years, Title II establishes an Indian Health Care Improvement Fund and authorizes the Secretary to expend amounts appropriated to that fund for the purposes of: eliminating the deficiencies in health status and resources of all Indian tribes; eliminating backlogs in the provision of health care services to Indians; meeting the health needs of Indians in an efficient and equitable manner; and augmenting the ability of the Indian Health Service to meet the health service responsibilities, either directly or through contract care, of providing clinical care, both direct and indirect, including clinical eye and vision care; preventive health care; direct and indirect dental care; mental health care, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners; emergency medical services; treatment and control of and rehabilitative care related to alcoholism and drug abuse including fetal alcohol syndrome; home health care; community health representatives, and maintenance and repair.

Because in the past there have been attempts to offset amounts that have been appropriated to address backlogs against amounts that are requested to address current health care needs, Title II makes clear that any amounts appropriated to the Fund are not to be used to offset or limit any appropriations made to the Indian Health Service under the authority of the Snyder Act of 1921 or any other provision of law.

In an effort to assure that funds are distributed to reduce the health status and resource deficiency within a service unit, the Title also provides that funds may be allocated on a service unit basis provided that the funds are used to reduce the health status and resource deficiency of each tribal community served by such service unit. And to assure that the manner in which funds are allocated is based upon tribal priorities in consultation with the Indian Health Service, the bill provides that the allocation of funds to a service unit and to what purposes such funds should be applied, is to be determined by the Indian Health Service in consultation with the affected tribal governments.

The term "health status and resource deficiency" means the extent to which (1) the health objectives set forth in section 3(a) of the Act (as amended by the bill) are not being achieved and (2) the Indian tribe lacks the health resources it needs. The health resources available to an Indian tribe are limited to local health resources used by an Indian tribe, including services and financing systems provided by other Federal programs, provided that the IHS in determining available resources shall also take into account the actual availability of local alternative sources of health care.

Title II directs the Secretary to establish procedures that will allow a tribal government to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency level of the tribe. Title II makes clear that programs administered by a tribal government or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act are to be eligible on an equal basis with programs that are administered directly by the Indian Health Service. If any funds allocated to a tribal government or service unit are used under an Indian Self-Determination contract, a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions.

The Committee Amendment requires that, within three years of enactment of the Amendment, the Secretary is to report to the Congress on the extent of health status and resource deficiency for each Indian tribe, and the methodology by which this was determined. The report shall set out the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the IHS. In addition, the report shall include an estimate of the amount of health service funding appropriated under the authority of the Indian Health Care Improvement Act or any other Act including the amount of any funds transferred to the Service for the preceding fiscal year that is allocated to each service unit, Indian tribe, or comparable entity, the number of Indians eligible for health services in each service unit or tribal community, and the number of Indians using the Service resources made available to each service unit or tribal government. The Committee recognizes that data on health status may not be available for all Indian tribes immediately. Therefore, the Committee expects that, until the necessary data becomes available, the IHS will continue to target the amounts in the Fund on those areas most deficient in health resources.

The Committee intends that funds appropriated under the authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years. The Committee also contends that nothing in this section is intended to diminish the primary responsibility of the IHS to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the IHS from undertaking additional efforts to achieve parity among Indian tribes. Any funds appropriated under the authority of section 201 shall be designated at the "Indian Health Care Improvement Fund".

Over the past several years, Administration budgets for Indian health have not reflected the realities of delivering health services on Indian lands, or the continued commitment of the Congress to maintain the Federal responsibility in the delivery of those health services. While Title II does not guarantee that Administration budget requests will reflect these realities, it does mandate a set of objective criteria against which to evaluate the adequacy of the President's annual budget requests.

Indian catastrophic health emergency fund

A significant problem in the administration of limited contract health care resources has been consistently documented. While presently each IHS area office is authorized to administer its contract health care funds in any manner the office may elect, in practice, contract health care funds are generally paid out in reimbursement of claims from contract care providers for authorized care provided to Indian patients, as claims are submitted. In the event of a catastrophic illness or injury with which extraordinary costs for care are associated, the entire annual contract care budget of an IHS area office can be exhausted with the costs associated with one catastrophic illness or injury. Examples of high costs cases include traumas associated with automobile accidents, and complications of pregnancies and childbirth, including fetal alcohol syndrome. Given limited contract health care funds, a single incident involving a motor vehicle accident in which the victim suffers a spinal cord injury and requires intensive care, can exhaust a local service unit's annual allocation of contract care funds. To address this problem, Title II establishes an Indian Catastrophic Health Emergency Fund to be administered by the Secretary, acting through the central office of the Indian Health Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses whose care is the responsibility of the Indian Health Service. The Fund is not to be allocated, apportioned, or delegated on a service unit, area office, or any other basis, and no part of the Fund or its administration is to be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act.

Originally, Title II provided that a service unit would not be eligible for reimbursement from the Fund for the cost of treatment until its costs of treating any victim of a catastrophic illness or disaster had reached a certain threshold cost which the Secretary is to establish at not less than $10,000 or not more than $20,000. The Committee amendment raises the initial threshold for reimbursement under the Catastrophic Health Emergency Fund to $15,000. No payment is to be made from the Fund to the extent that a provider is eligible to receive payment for the treatment from any other Federal, state, local, or private source of reimbursement for which the patient is eligible.

Health promotion and disease prevention services

The Committee Amendment directs the Secretary to provide health promotion and disease prevention services to Indians to achieve the health status objectives under the Act, as amended. The Secretary shall submit an annual report to the Congress which evaluates the health promotion and disease prevention needs of Indians as a part of the President's Budget Request. The report shall include an evaluation by the IHS of: (1) the health promotion and disease prevention needs of Indians; (2) the health promotion and disease prevention activities which would best meet such needs; (3) the internal capacity of the Service to meet such needs; and (4) the resources required to assist the IHS to undertake the health pro-

motion and disease prevention activities necessary to meet such needs. The Committee Amendment deletes the expired demonstration project authority.

Diabetes

The Committee Amendment includes a provision to continue the model diabetes projects established at the Claremore Indian Hospital, the Fort Totten Health Center, the Sacaton Indian Hospital, the Winnebago Indian Hospital, the Albuquerque Indian Hospital, the Perry Health Center, the Princeton Health Center, the Old Town Health Center, the Bellingham Health Center, the Fort Berthold Reservation, the Navajo Reservation, the Tohono O'odham Reservation, the Zuni Reservation, and other projects in the states of Alaska, California, Minnesota, Montana, Oregon, and Utah through the year 2000. The Amendment also authorizes the Secretary to establish new diabetes projects on any Indian reservation where it is determined that diabetes is a major health problem. The Committee intends that this language provide flexibility to the Secretary to address the problem of diabetes on Indian reservations by establishing projects on those reservations where diabetes is a major health problem without regard to the geographic distribution of the projects.

Diabetes remains a major health problem for many American Indians across the country. According to the FY 1990 outpatient data, the areas of the Indian Health Service with the highest rates for diabetes are Tucson (21 percent), Albuquerque (14 percent), Aberdeen (14 percent), Phoenix (13 percent), and Bemidji (13 percent). The Navajo and Oklahoma areas had the largest numbers of diabetes patients—6,546 and 10,775 respectively. According to Indian Health Service, as of December 1991, there were only 18 dialysis units on Indian reservations. The Committee is very concerned about the high incidence rates for diabetes among many of the IHS areas. The Committee is also troubled by the high incidence of end stage renal disease among Indian diabetes patients. Another troubling aspect of diabetes among American Indians is the high rate of amputation among certain populations of American Indians due to circulatory problems associated with diabetes. Many American Indian diabetic patients who are in need of dialysis treatment do not have access to such treatment and access is even more difficult for patients living in remote areas of Indian reservations.

The Committee intends the language in this section to provide the authority to establish diabetes projects that can provide greater access to dialysis treatment; to podiatrists and physical therapists, who can treat foot complications due to diabetes; and to develop preventative components as part of a comprehensive treatment program for diabetes. The Committee is hopeful that through the provisions of this section the Indian Health Service can address the shortage of podiatrists in the Indian Health Service by providing for the staffing of podiatrists as part of the diabetes projects established under this section. The Committee expects that the information developed by the programs funded under this section will assist in the continued development of diabetes projects to serve other reservations where diabetes is a major health problem. Successful diabetes projects should provide model programs to be repli-

cated on other Indian reservations where diabetes is a major health problem. The Committee Amendment also requires each area-office diabetes control officer to evaluate the services provided by the model diabetes projects in anticipation that such evaluations will enhance the replication of these important projects.

Mental health services

The Committee Amendment includes a provision which requires any person employed as a psychologist, social worker, or marriage or family therapist by the Indian Health Service or an Indian tribal government or tribal organization under the Indian Self-Determination Act to be licensed or to be under the direct supervision of a person who is properly licensed within a one year period. The Committee believes this amendment will help ensure that Indian patients receive the highest quality health care and services.

The Committee has amended this section to include marriage and family therapists in the delivery of Mental Health Services to widen the pool of eligible mental health providers. Marriage and family therapists are inherently family- and community-oriented. By nature of their training and practice, they diagnose and treat mental and nervous disorders by treating individuals within the context of their families and communities in which they live. Marriage and family therapists recognize that an individual's behavior is the product of many varied forces, including one's cultural background, and that these forces can be the means to successful intervention.

The Committee Amendment establishes the Intermediate Adolescent Mental Health program to provide grants to Indian tribal governments and tribal organizations to provide intermediate mental health services to Indian children and adolescents. The Committee is very concerned about the overall lack of available mental health treatment services for Indian children and adolescents. It has come to the Committee's attention that many Indian tribes do not have adequate mental health services for Indian children and adolescents. Some tribes are forced to place children and adolescents who are in crisis, acting out or suicidal, out in juvenile detention facilities because there are no alternatives. In many cases hospitals and shelters are not equipped or willing to accept an adolescent in crises. The Committee is very concerned that it has become a standard practice on some reservations to place suicidal children and adolescents in detention without adequate supervision or treatment. It is very important that these children and adolescents receive treatment in a safe and well-supervised setting.

This program would allow Indian tribal governments to provide a variety of treatment options for Indian health care providers such as inpatient and outpatient services, emergency care, suicide prevention and crises intervention to children and adolescents. It would allow tribal governments to remodel or renovate existing facilities to provide intermediate mental health services in the community without having to remove the child from the reservation for off-reservation residential treatment. It allows the health care providers to work with the family to directly address situations in the home as part of the treatment of an adolescent in crisis. The Committee intends these services to be coordinated with existing

services in the community in order to provide a fully coordinated approach to the treatment of an adolescent in crisis.

It is the Committee's desire to develop and provide an educational pipeline commencing at the secondary educational level and concluding at the doctoral level that would recruit, retain, and train American Indians in the field and profession of psychology. A new section is included to allow three colleges or universities to develop and maintain American Indian psychology careers recruitment programs as a means to encourage more Indians to enter the mental health field. The Secretary shall provide one of the grants to develop and maintain an American Indians Into Psychology program at the University of North Dakota. Applicants for grants must agree to provide at a minimum: (1) Outreach and recruitment of participants on Indian reservations through elementary, secondary and community colleges; (2) incorporate a program advisory board comprised of tribal representatives; (3) provide summer enrichment programs to expose Indian students to the field of psychology; (4) provide stipends to undergraduate and graduate students in careers of psychology; (5) develop affiliation agreements with tribal community colleges, the IHS, university affiliated programs, and other appropriate entities to enhancement educational experience of Indian students; (6) utilize existing university support systems, and (7) to the extent feasible, employ qualified Indians in the program.

Hospice and managed care feasibility studies

The Committee Amendment provides for a Hospice Care Feasibility Study to assess the feasibility of furnishing care to terminally ill Indian patients. The Committee notes the inclusion of the amendment is intended to specifically study the unique needs of Indian people who are terminally ill and have a cultural view of death and dying which is different from those views in mainstream hospice facilities. The study requires a report from the Secretary to the Congress within 12 months of the date enactment of the Act.

The Committee Amendment also provides for a "managed care feasibility study" for Indian tribes that do not have inpatient hospitals or access to service hospitals. The Committee anticipates that this study will examine both group contract health plans and other managed care arrangements as determined by the tribal government that participate in the study. Within 12 months of enactment, the Secretary is to submit to Congress a study on the feasibility of authorizing tribal governments to purchase managed care coverage.

Tribal right of recovery

Tribal health contractors have informed the Committee that certain insurance companies refuse to reimburse the contractors for services provided to Indian and Alaskan Native policyholders. Under the Indian Health Care Improvement Amendments of 1988, there is a right of recovery against private insurers with respect to expenses incurred by the Secretary in providing health services. Congress intended this right to include tribal governments that contract with the government to provide health care as well as the Secretary. However, some insurance companies are refusing to pay

tribal governments for services rendered, and certain officials within the Indian Health Service have questioned the contractor's right to recover in the absence of further legislation. Therefore, the Committee Amendment includes language which clarifies that tribal government health contractors or tribal contractors have the same right to recover against private insurance companies that IHS enjoys. The Committee has received reports from several tribal governments and tribal organizations regarding the refusal of some states and political subdivisions of states to pay for health care provided by tribal contractors. The Committee intends this right of recovery to extend to all private insurers, including self-insurance plans developed and maintained by states or political subdivisions of states. The tribal right to recover encompasses all expenses which are associated with a program administered by the tribal health contractor. The Committee Amendment provides that the U.S. shall not have a right of recovery if the condition for which health services were provided is covered under a tribal government or tribal organization's self-insurance plan. Thus, the Committee intends that collections made by tribal health contractors shall remain with the contractor, in order to assure the availability of adequate funds to address unmet Indian health care needs. The Committee further intends that the tribal right to recover shall be subject to the same statute of limitations which would apply if the federal government was initiating an action.

Epidemiology centers

The Committee Amendment establishes Epidemiology Centers in each service area of the IHS to assist tribal health providers in monitoring and evaluating the health status objectives established under the Act in section 3. The Committee intends that the burden for gathering, monitoring, coordinating, organizing and summarizing the data on the health care objectives is the primary responsibility of the Epidemiology Centers. With the assistance of the Indian Health Service, the Epidemiology Centers shall assist the tribal health care programs and urban Indian health care programs in the identification of priority service areas, based on epidemiological data, and advocate for the targeting of services needed by tribal, urban and other Indian communities and make recommendations to improve health care delivery systems. The Committee intends that a minimal burden is to be placed on tribal governments for the gathering of local data and recognizes the necessity for tribal assistance, participation and consultation.

The Epidemiology Centers are to become nerve centers for health statistics of tribal communities in each area. They will establish methods to monitor the health objectives, identify health priorities for surveillance, evaluate the delivery systems, and develop better methods to obtain data from other agencies. The centers shall provide technical assistance to tribal governments, tribal and urban Indian organizations to accommodate the gathering of such data.

The Committee Amendment specifies that area Indian Health Boards in each area, intertribal consortia, Indian organizations, and are eligible to apply for a grant to establish and develop an area epidemiology center. The amendment establishes selection criteria, requires at least one grant in each IHS area, prescribes that

grants shall be at least $250,000 a year per center, and requires the IHS to provide technical assistance by assigning an epidemiologist from each area office to each center. The amendment requires the Secretary to transmit an initial report to the Congress by March 1, 1994, describing the actions taken to implement the Area Epidemiology Centers and a biannual report to the Congress on the progress made towards meeting the health objectives noted in Section 3. Finally, the amendment directs the Centers for Disease Control and the National Center for Health Statistics to provide technical assistance to the Epidemiology Grant Programs.

California Contract Health Services Demonstration Program

The Committee Amendment also provides for a California Contract Health Services Demonstration Program. The provision authorizes the Secretary to enter into an agreement with the California Rural Indian Health Board (CRIHB) to evaluate the use of a contract care intermediary to improve the access to health care for the Indians of California. The California Rural Indian Health Board was founded in 1969 by a consortium of nine California tribes for the purpose of working for the return of the federal Indian Health Service and federal health programs to California. These services were withdrawn by the Congress during the termination period in 1954. In 1973, a direct line item appropriation to CRIHB restored IHS services in California. Today, CRIHB operates as a statewide training and technical assistance resource and as a tribal organization under the Indian Self-Determination Act providing comprehensive health care services in twelve counties thorough resolutions from twenty-two federally recognized tribes. Additionally, affiliated with CRIHB are four Indian controlled local health programs that contract individually with IHS to provide services in six counties for ten federally recognized tribes. Collectively, CRIHB member health programs in fiscal year 1990 provided over 31 percent of all IHS-funded health care services in the California Area.

Under the Committee Amendment, the Secretary is to agree to reimburse CRIHB for costs in providing contract care. The purpose of the demonstration project would be twofold. First, the fund established under this amendment would act as a tribally-managed regional reinsurance program to the existing tribally-operated health programs much in the same way that the Catastrophic Health Emergency Fund operates on a national scale. This is possible because all of the California Area, consisting of 37 counties, is a single Contract Health Service Delivery Area (CHSDA). The immediate impact of the intermediate reinsurance program would be to expand access to medically necessary services to Contract Health Service (CHS) eligible individuals with the CHSDA. The Committee notes that centralization of this service would not change the local health program's responsibility to set eligibility criteria and to establish eligibility for individual users, it would, however, limit their liability for all costs over $1,000 per incident.

The second purpose of the demonstration project is to concentrate in a single contract enough purchasing power to generate interest in meaningful rate negotiation and quality review activities. Through the demonstration project CRIHB would seek to establish

contract discounts for inpatient health services, specialty services and supply services with existing providers including large health maintenance organization (HMO) systems, the Veterans Administration and other large health care providers.

The amendment notes that administrative expenses by CRIHB are limited to 5 percent of the annual budget. Eight tribal representatives are to serve on an advisory board to advise CRIHB for purposes of overseeing the Demonstration Project. Four of the representatives are to come from Indian tribes not affiliated with CRIHB. The Committee notes that the Indians of California are the largest group in need of contract care and the CRIHB has been providing these services for two decades. Hence, it is entirely appropriate that the demonstration project be handled in this manner.

The Committee included a provision in the amendment to provide screening mammography for Indian women over the age of 35 to address the relatively high rates of breast cancer for which screening is not currently available.

Native American youth health

In March 1992, Dr. Blum of the University of Minnesota published the report, "The State of Native American Youth Health." This report was based on a survey of 14,000 American Indian/Alaskan Native adolescents living on or near reservations. The report represents a survey of approximately one out of every eleven Indian youths. However, this report does not include information regarding those Indian youths who are most at risk, those who have dropped out of school. According to estimates in the report, approximately 40 percent of school-aged Indian youths have dropped out of school. This report found that the death rate for American Indian/Alaskan Native adolescents is twice the national average. The death rate for Indian males is nearly three times the national average. The nutritional health of Indian youth remains largely unknown although several Indian tribes have reported rates of obesity among adolescents ranging from 30 to 66 percent. One Indian youth in four has indicated that they believe their health status is not very good or poor.

Among Indian and Alaska Native youth, suicide is the second leading cause of death. The suicide mortality rates for Indian youth aged 15–19 is 2.5 times higher than the national average, for Indian youth aged 10–14 is four times higher than the national average. The report indicates that American Indians begin abusing substances at a younger age than non-Indian youth. The high rates of mortality associated with suicide and accidents can be attributable to alcohol and substance abuse. Finally, the report concludes that the Native American youth have far less access to health care services than the rest of Nation's youth. The findings of the study do note that there is a window of opportunity between the sixth and eighth grades to have a positive impact on health and lifestyle of Indian youth by the promotion of healthy lifestyles before children begin high risk behaviors. The report recommends the development of innovative Native American youth-specific programs, community-based health services, and integrated physical and mental health services in schools.

In response to this report the Committee Amendment amends the Act to authorize the Comprehensive School Health Education program which provides grants to tribal governments to develop comprehensive school health education programs for children from preschool through grade 12 in schools located on Indian reservations. The Committee intends these programs to fully integrate the provision of community health services into the schools to improve the health status of Indian and adolescents. The findings of the report on the "State of Native American Youth Health" clearly establish the interrelationship between poor health and school failure. The Committee Amendment would establish in each school a comprehensive health education program to work with Indian youth in the schools. This program would provide training to teachers on comprehensive school health education curricula to help identify risk behaviors and to more fully involve the community in health promotion and education efforts in the schools. It is the Committee's intention that these programs utilize to the fullest extent possible existing services and programs on nutrition education, personal health mental health wellness, chronic disease prevention, substance abuse prevention and safety education. The Committee Amendment directs the Secretary to provide technical assistance in development and dissemination of health education materials, and to establish criteria for approval of grant applications. The amendment also requires that grant recipients prepare annual reports and specified information to be included in the reports. The Committee strongly encourages tribal governments, school authorities, the Bureau of Indian Affairs and the Indian Health Service to enter into active partnerships to fully integrate health education programs in schools.

The Committee Amendment directs the Secretary of the Interior to develop and implement in each Bureau of Indian Affairs school, including all boarding and residential schools operated by the Bureau of Indian Affairs, comprehensive school health education programs. The Committee intends that the Secretary of Health and Human Services shall assist in the development and implementation of these programs. The programs established in BIA schools should be accomplished through the cooperative planning efforts of the BIA, the IHS, and those tribal or Alaska Native communities that are directly served by those schools. The Committee recognizes the several very successful efforts of Indian communities to establish community health education programs in the schools to promote the health, education, and welfare of Indian students. The Committee believes that a national comprehensive school education program for Indian tribal communities will be instrumental in elevating the health status of Indian youth across the country.

The Committee Amendment establishes the Indian Youth Grant Program which authorizes the Secretary to make grants to Indian tribal governments, tribal organizations, and urban Indian organizations to develop innovative mental and physical health programs for preadolescent and adolescent Indian youths. These programs should include components which promote mental and physical health, and involve cultural values, community and family participation, and traditional healers. The amendment authorizes the Secretary to disseminate information on models of health care services

delivery and to encourage and provide technical assistance in the implementation of such models. The Committee intends programs established under this section to, in part, respond to the problems identified in the University of Minnesota report entitled, "The State of Native American Youth Health." In that report, Dr. Blum and Dr. Resnick emphasized the importance of programs specifically targeting Indian youth and programs that are community-based which involve the family. Grants made available under this section are designed to improve the health status of Indian youth.

The Indian Health Care Amendments include a provision to authorize a grant program, available to tribal governments and tribal organizations, to evaluate different measures to prevent and eliminate tuberculosis (TB) on Indian reservations. Grants may be used to train health care staff, conduct screenings of residents on Indian reservations to detect or monitor TB, educate the community about TB, create and maintain a registry of persons with TB, develop coordination efforts, and treat those afflicted with TB. The Secretary is authorized to make at least one grant to a tribal government or tribal organization in each area. Grant recipients are required to cooperate with the Centers for Disease Control, the IHS, state health programs and local health agencies and to report annually on activities conducted.

The Committee is very concerned about a growing problem in the delivery of health care to Alaska Native people. Each year a greater percentage of Indian Health Service funding must be allocated to cover patient travel costs in Alaska. In fiscal year 1993, the Alaska area has identified an unmet need of $3,200,000 million for patient travel costs. Without resources to cover these high travel costs, the Committee is concerned that individuals living in remote areas of Alaska will be forced to forego badly needed treatments or will bear the burden of paying for the exorbitant costs of transportation. The Committee Amendment authorizes the IHS to provide funds to address and meet the high costs of patient travel in remote areas of Alaska.

TITLE III—HEALTH FACILITIES

Closure of Indian Health Service facilities

The Committee is concerned with the impact on Indians and Alaska Natives when health service facilities are closed. The Committee Amendment requires the IHS to report to the Congress in each President's Budget Request on the closure of IHS facilities including (1) new information on the level of utilization by all eligible Indians and (2) the distance between a hospital or facility and the nearest operating IHS hospital.

The Committee understands that there is an IHS proposal to close "under-used" inpatient care units. Twenty-nine facilities could be closed under this plan which targets small rural hospitals. The Committee insists on strict compliance with the requirements of the Act by the IHS which shall include the submission of the five current considerations for closure contained in the Act and the two additional considerations included in this amendment. It should be noted that the Committee intends that the term "level of use" is to be construed liberally in favor of retaining tribal facili-

ties in remote areas, and that the distance to the "the nearest IHS facility" is to be afforded great weight when considering closure because of the important cultural sensitivity and depth of knowledge the IHS can provide to the health needs of Indians and Alaska Natives that contact care providers cannot provide. The reference to Joint Commission on Accreditation of Hospitals has been revised to reflect the renaming of the Joint Commission to the Joint Commission on Accreditation on Health Care Organizations. In addition, the Amendment requires that the annual health facility priority system report be included with the report the President is mandated to submit to the Congress pursuant to section 801 of the Amendment.

In the instance of the Wagner, South Dakota outpatient facility, the Committee does not view the Program Justification Document which suggests closure, as adequate in demonstrating compliance with the requirement of one year's advance notice of closure. In addition, the Committee does not believe that closure of this facility can be justified given that the inpatient facility to be utilized in its place does not have equal accreditation which is equal to that of the existing IHS facility. Until funding for contract services proves more adequate, greater dependence upon contract care services, does not insure that levels of health care previously obtained will be sustained in the future.

Safe water and sanitary waste disposal facilities

The Committee Amendment authorizes the Secretary under the safe water and sanitary waste disposal facilities program to provide financial assistance covering up to 80 percent of operation, management, and maintenance costs to Indian tribes and communities for the operation and maintenance of safe water and sanitary waste facilities. The Committee is very concerned about the large numbers of open dumps and sanitary landfills on Indian reservations that currently do not meet proposed federal standards. The Indian Health Service has stated that based on their information, none of the landfills located on Indian reservations currently meet all of the federal standards. The Indian Health Service has indicated that IHS constructed landfills did meet federal standards at the time of construction, by IHS constructed landfills do not meet more recently enacted federal standards. In addition, the Committee is concerned that following construction of landfills, Indian tribal governments are unable to operate these landfills because of insufficient revenues to meet the costs of operation and maintenance. The Committee is very concerned that upon completion of the construction the IHS does not currently provide any assistance to maintain these facilities and ensure compliance with proposed federal standards. The Committee intends this language to clearly establish the continuing responsibility of the Indian Health Service to assist Indian tribal governments in maintaining these facilities in compliance with the proposed federal standards. These problems are especially difficult for Alaska Natives where the costs associated with the construction of sanitation facilities may make some projects not feasible.

The Indian Health Service has identified and reported an unmet need for sanitation facilities in Indian county of over $1.7 billion.

As required by Public Law 100-713, the Indian Health Care Improvement Act Amendments, the Indian Health Service has developed a 10 year plan to address the backlog of need for sanitation facilities as well as new construction. That plans call for $99 million to be appropriated for each of the next ten years. In contrast, the President's Budget Request for fiscal year 1993 requests only $43 million. The Committee is mindful of the need to balance construction needs with the need to bring existing facilities into compliance with proposed federal standards. However, the Committee is also aware of the need that Indian tribal governments have to develop sufficient resources to meet the fiscal demands of operating a landfill in compliance with proposed federal standards. Therefore, the Committee intends this language to allow the Indian Health Service to provide financial assistance to Indian tribal governments to bring their facilities into compliance in those situations where the costs of operating and maintaining the sanitation facility routinely exceeds the revenues generated by the fees imposed by the Indian tribal government, thereby posing a health and safety risk to the reservation population. The Committee Amendment also includes language which allows smaller Indian communities to meet the tribal match requirements under the Act. In many situations, these small communities are the ones most in need of the federal assistance. The IHS will be required to report on Safe Water and Sanitary Waste Disposal facilities in each budget request.

The Committee Amendment repeals Section 306 pertaining to the executed Bethel, Alaska study and establishes the Ambulatory Care Facilities Grant Program. The Committee Amendment includes language to authorize the Secretary to make grants to Indian tribal governments or tribal organizations to construct, renovate, or modernize an Indian health facility to provide ambulatory care services to eligible Indians. The Committee intends these grants to be awarded to those Indian tribal governments or tribal organizations that do not have access to an existing Indian hospital. Under the Committee Amendment, this facility must not have been constructed by the Indian Health Service but must have been tribally-constructed and must be tribally-owned. The Committee believes that this program will help those Indian communities lacking access to existing hospitals to develop ambulatory care facilities and therefore to dramatically improve patient access to health care. The Committee amendment includes language to allow the Gayhead Wampanoag Community in Massachusetts, and other similarly situated Indian communities, to be eligible for grants provided under this section. The Committee recognizes the need to allow Indian ambulatory care facilities constructed under this section to provide services to non-eligible persons on a cost-reimbursable basis provided that the provision of such services does not diminish the quality or quantity of services provided to eligible persons. Finally, the Amendment provides that title to such facilities shall transfer to the U.S. if the facilities cease to be used for ambulatory care to Indians.

The Committee Amendment amends the Indian Health Care Delivery Demonstration Project to extend the dates for receipt of completed applications for demonstration projects, such that a contract

or grant could be awarded on or before September 30, 1995. Subject to the availability of appropriations, applications from all areas are to be taken into consideration after this date. The Secretary is to give priority to the 9 original projects in the Demonstration Project that have not yet received funding under this program. The provision prohibits the award of a greater number of programs and grants in one service area than another until an equal number are awarded to all areas for which applications are received. The provision requires the President to submit to the Congress pursuant to section 801 of the Amendment (1) an interim report on the demonstration projects in 1997 and (2) a final report in 1999. These reports are to be included in the budget the President submits annually for the Congress. The Committee is supportive of this approach to rural health care delivery and regrets that none of the projects have received adequate funding since the 1990 establishment of the Project. The Committee notes that the potential for agreements between tribal governments and non-Indian communities under this program could benefit health care delivery in rural areas in general. The Committee supports cooperative agreements between tribal governments and other communities and views this approach as a creative solution to the problems associated with the limited reserves of the Indian Health Service. This demonstration program would allow tribal governments to maintain facilities and to serve a wider community function.

The Committee Amendment authorizes the Secretary to accept expenditure of non-IHS funds for renovation or modernization of IHS facilities, or of self-determination contract Indian health facilities. The IHS is required to establish a separate priority list of such facilities' needs for personnel or equipment. The Amendment eliminates requirements that such a renovation may not require either (1) additional IHS personnel or equipment or (2) diversion of funds appropriated for higher-priority health facilities. Further the Amendment requires the tribe or tribal organization to provide notice of its intent to renovate and to apply to be placed on the Secretary's priority list of such facilities' needs for personnel or equipment.

TITLE V—ACCESS TO HEALTH SERVICES

The Committee Amendment exempts payments received by a hospital or skilled nursing facility operated by the Indian Health Service, an Indian tribe, or tribal organization from consideration in determining appropriations for services to Indians. The Committee is concerned about the continuing practice of inflating projected collections under the Medicare and Medicaid programs to unrealistic levels. The Committee is also concerned about the practice of Indian hospitals and clinics severely underreporting collections under the Medicare and Medicaid programs so that these collections won't be charged against the facility in determining the amount of funding the facility should receive from appropriated funds. Because the amounts collected from Medicare and Medicaid are considered in determining the amount of appropriated funds the facility should receive, there is a very significant incentive to underreport collections in order to qualify for more appropriated

funds. The Committee Amendment would exempt these collections from consideration in order to stop this practice of underreporting Medicare and Medicaid collections. The Committee believes this change will serve as an incentive to tribal health programs to become more aggressive in pursuing collections under Medicare and Medicaid programs. The Committee is also concerned that all Indian people receive adequate health services under this Act without regard to whether the individual is covered under the Medicare program. The Committee Amendment includes language which discourages discrimination in the provision of health services.

A new subsection amends the Social Security Act to provide that IHS facilities or a facility of an Indian tribe or tribal organization under a self-determination contract shall be eligible for Medicare payments under this title. This amendment clarifies that the Indian Health Service and tribes or tribal organizations carrying out contracts, grants or cooperative agreements under the Indian Self-Determination Act shall be eligible for Medicare payments for services provided in clinics operated by them, as well as in hospitals and skilled nursing facilities. This amendment eliminates an inadvertent inequity that presently exists between tribal clinics that operate in conjunction with an Indian Health Service hospital and those that do not. This section also clarifies that any payments received from Medicare shall not be considered in determining appropriations for health care and services to Indians.

The Committee Amendment also includes language to ensure that at least 80 percent of the amounts collected under the Medicaid program remain at the facility responsible for collection. The Committee Amendment provides that the increase in percentage shall take effect beginning with payments made on January 1, 1993. The Committee is concerned that funds collected by one facility may be transferred to another facility and thereby create a disincentive for effective collection activities by Indian health facilities under the Medicaid program. The Committee believes that allowing facilities to retain 80 percent of the Medicaid collections will provide an incentive to pursue Medicaid collections and allow collecting facilities to directly benefit from their collections policy. The Committee Amendment also deletes language which authorizes the Secretary to terminate the use of funds to make improvements to Indian health facilities in order to maintain their accreditation by making a determination that substantially all of the health facilities meet the accreditation standards. The Committee believes that there is no need for this authority because the number of Indian health facilities continues to increase each year, the standards for accreditation are not static and will continue to change, and with each year, the facilities will age and deteriorate without the improvements provided under this Act. The Committee intends these funds to continue to be used to make these necessary improvements to meet these changing conditions.

The Committee Amendment requires the Secretary to include an accounting of the amount and use of reimbursement funds under Medicaid in his report to the President for transmission to the Congress.

The Committee Amendment amends Section 405 of the Act to continue the Demonstration Program for Direct Billing of Medi-

care, Medicaid, and other third party payors and extends the date that the demonstration will end from September 30, 1995 to September 30, 1996.

A new section is added to authorize the Secretary to enter into an agreement with any tribal or urban Indian organization to provide for the receipt and processing of applications for medical assistance under the Medicaid or Medicare programs at tribal or IHS contract health services facilities. This section also provides that the Secretary may pay Medicare Part B premiums, deductibles and copayments for low-income Indians in the Medicare Part A program. This subsection would allow payment for those beneficiaries who are between 100 to 200 percent of the federal poverty level. A new subsection is added to require the Secretary to not deny contract health services coverage to Indian recipients of medical care if they are 65 or older, or disabled. This provision will apply if the recipient has received emergency care within 30 days after beginning admission or treatment, has requested contract health services, applied to Medicaid coverage within these months and is otherwise eligible for contract health services.

Thousands of requests for Contract Health Services coverage are denied each year for failure of Indian patients to report emergency health care to the Contract Health Services program within 72 hours of receiving emergency care. In enacting a statutory modification of the Indian Health Service 72-hour emergency care rule for older or disabled American Indians and Alaska Natives, the Committee does not with to appear to approve or disapprove the 72-hour rule as applied to younger and non-disabled Indian people, or to preclude any well-focused challenge to that rule.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Only a few substantive changes are proposed to Title V as many improvements were authorized under P.L. 101–630. The Committee has provided a number of conforming amendments to include "grants" to, as well as contracts with, urban Indian organizations for health care and referral services for urban Indians. Unlike tribes, urban Indian health programs are funded primarily through grant systems except for Title V funding. The grant system will provide for a more uniform management of Title V programs through the IHS Headquarters Office. Testimony provided to the Committee indicates that Urban Indian health care programs are often treated with indifference, if not hostility, at Area Office levels. It is the Committee's hope that a centralized urban Indian program operated under the granting authority of headquarters will eliminate many of the obstacles that have thwarted the effectiveness of urban Indian health care programs.

The Committee has included language to clarify the responsibilities of the Urban Programs Branch authorized under Section 511(a). The thirty-four urban programs seek to have the Project Officer oversight responsibility centralized in IHS headquarters in Rockville, Maryland. The Committee remains concerned that appropriate support for and attention to the implementation of the 1990 Amendments to the Indian Health Care Improvement Act has not been forthcoming at the highest levels of the Indian Health

Service and that this lack of support extends to the Area Offices. The Committee will continue to monitor the implementation of this program to ensure that the needs of the urban Indian population are being addressed.

The Committee Amendment has included a new section to protect and continue the demonstration projects under Title V which are administered through the Hospitals and Clinics program. Presently, two urban Indian programs located in Oklahoma City and Tulsa, Oklahoma are participating in a special demonstration effort to examine the viability of operating as quasi-Service Units under the Hospitals and Clinics program. The Committee has provided language to exempt these programs from a change in governance resulting from possible Public Law 93-638 takeover by local tribes during the demonstration period. This provision is intended to provide for the stability of these programs necessary to evaluate the effectiveness of these demonstration efforts through the fiscal year 2000.

The Committee Amendment includes language to provide Federal Tort Claims Act coverage to Urban Indian programs as defined in the Act. Urban Indian programs have experienced an increase in medical malpractice premiums which they must pay or place in reserve, in many instances increasing by 300 percent to 500 percent in the past five to ten years. Despite the increased cost of medical malpractice premiums, funding has not kept pace with these exorbitant costs. Many urban programs, such as the Tuscon, Arizona clinic, were forced to reduce or eliminate direct medical care due solely to the prohibitive cost of medical malpractice insurance. The amendment provides urban Indian programs with the same benefit of coverage under the Federal Tort Claims Act as is provided to tribal governments and the Indian Health Service programs.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Title VI reauthorizes appropriations through the year 2000 to carry out IHS organizational improvements. Section 601 requires the Secretary to carry out through the IHS Director all scholarship and loan functions under the Act.

The Committee Amendment provides new language to abolish the position of Director of the Indian Health Service effective January 1, 1993. A new position is to then be established for which the President will appoint a person to serve as Interim Director from January 1, 1993 until a new Director is appointed and confirmed with the advice and consent of the Senate. The new amendment requires the IHS Director to serve a term of 4 years. A Director may be appointed by and with the advice and consent of the Senate for more than 1 term.

TITLE VII—SUBSTANCE ABUSE PROGRAMS

Title VII is redesignated as Title VIII and the IHS sections of Public Law 99-570 and Public Law 100-690, the Indian Anti-Drug Abuse Act programs, are included in the Act.

Alcoholism remains a major health problem among American Indian people. According to health statistics provided by the Indian Health Service, the alcoholism rate among American Indians is six

times the national average. The alcoholism death rate for American Indians is four times the national average. Alcohol use is implicated in approximately 50 percent of all crimes on Indian reservations. According to 1987 health statistics, American Indian men were five times more likely to die in an alcohol-related motor vehicle crash than other Americans. American Indians are nearly three times more likely to die of cirrhosis than other Americans. The Committee is very concerned that the programs authorized under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 have not been effectively implemented by the Indian Health Service and the Bureau of Indian Affairs.

The Committee was concerned about the findings of the Department of Interior and the Department of Health and Human Services Inspectors General Reports regarding the implementation of these programs by the S. 2481. Accordingly, upon reporting S. 2481 the Committee withheld action on all substance abuse provisions until the IHS, BIA and Inspectors General could appear before the Committee to review the findings of the two Inspectors General reports. The Committee held a hearing on July 30, 1992 to review and discuss these findings with the IHS and BIA in order to clarify and highlight expectations from Congress. In summary, the Inspectors General found that the BIA had not fully complied with the direction and guidance in the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986. Further, the IHS and BIA are working from different stated missions, lack coordination, experience high turn-over in the substance abuse field, and lack a continuum of care for Indian people requiring substance abuse services. These substance abuse provisions will be included in S. 2841, when the bill is considered in the Senate.

The Committee is concerned that the Indian Health Service is narrowly interpreting the term "substance abuse" under the Act. The Committee Amendment includes a provision in the definition section which provides that inhalent abuse is included in the definition of "substance abuse". The Committee is very concerned about the increasing incidence of inhalent abuse in Indian communities and in Alaska Native villages. Because of the significant health impacts related to inhalent abuse and the increasing numbers of young children sniffing paint, gas, and other substances, it is very important that the programs authorized under this section be flexible enough to address the problems of inhalent abuse in Indian communities.

The Committee Amendment includes a provision to address the special problems of the City of Gallup in the prevention and treatment of alcohol and substance abuse among adult and adolescent members of the Navajo Nation and surrounding Indian communities. The Committee is very concerned about the significant problems of alcohol and substance abuse among American Indians residing near the City of Gallup. The Committee has received evidence of American Indians that have died of exposure, or have been run over by cars, or involved in fatal car accidents on the roads on the Navajo reservation leading to Gallup. Each weekend, local jail facilities are overloaded to the point where individuals are stacked like wood in the holding cells. There has been a renewed effort by the city of Gallup, the State of New Mexico and

the Navajo Nation and other Indian tribes in the area to address this very tragic situation. The Committee intends this section to lend federal assistance to these efforts by providing resources to establish comprehensive alcohol and substance abuse programs in and around Gallup, New Mexico. The Committee Amendment would authorize grants to the Navajo Nation to provide 15 residential beds for adult long term treatment, to establish a clinical assessment team to determine the treatment needs of Indian clients, to provide 12 beds for an adolescent shelter bed program. The Committee believes that the problem of alcohol and substance abuse in the Gallup area is so severe as to require the full cooperation and intensive efforts of the Indian Health Service, the city of Gallup, the State of New Mexico, the Navajo Nation, and the other surrounding Indian communities.

The Committee has included language which continues the Pueblo Substance Abuse Treatment Project on the San Juan Pueblo in New Mexico to provide substance abuse treatment services to the Indians of the eight Northern Pueblos. It is intended that these resources will continue much needed access to substance abuse treatment.

The Committee has added a provision for the establishment of a regional youth alcohol and substance abuse prevention and treatment center located in Sacaton, Arizona on the Gila River Indian Reservation. This center shall be operated in a facility owned by the Gila River Indian community and leased to the Indian Health Service. This provision also provides for a unit of this regional treatment center to be operated in Schurz, Nevada to serve American Indians in that area.

The Committee has added a provision for the Alaska Native Drug and Alcohol Abuse Demonstration project to reduce alcohol and drug abuse among Alaska Natives and their families. The Alaska Native Health Board is charged with carrying out this demonstration project working in close collaboration and cooperation with Native villages.

The Committee Amendment authorizes the Secretary to make a grant to the Thunderchild Treatment Center in Sheridan, Wyoming. The Thunderchild Treatment Center has been operating out of a building under lease which will expire shortly. The Committee is aware of the substantial fundraising efforts of the Center to finance construction and relocation of the Center to a new site. In order to continue the valuable services provided to American Indians in Wyoming and surrounding states, the Committee has authorized a grant to complete the construction of the Thunderchild Treatment Center. The Committee does not intend any of the funds provided to be sued for staffing, or operation of the facility, or for administrative purposes. The Committee Amendment has a two year authorization in order to allow the Thunderchild Treatment Center additional time to utilize the funds to complete construction of the new facility.

Fetal alcohol syndrome and fetal alcohol effect

The Committee Amendment includes new authority to address the devastating problem of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE). While more data is needed nationally,

it is known that FAS and FAE are problems of dramatic proportions on many Indian reservations. Fetal Alcohol Syndrome is recognized as the leading cause of mental retardation in the United States. Fetal Alcohol Syndrome is entirely preventable. Fetal Alcohol Syndrome and Fetal Alcohol Effect are terms used to describe a series of birth defects observed in children who were born to alcoholic mothers or mothers who used alcohol during their pregnancy. These characteristics include: prenatal and postnatal growth retardation, central nervous system dysfunction, and abnormal facial features. Children with FAS often exhibit hyperactivity, mental handicaps increased irritability, lack of inhibitions, impulsiveness, speech or hearing impairments, and delays in gross motor and fine motor skill development. Children with FAS or FAE have problems in school with learning, attention, memory and problem solving skills. These difficulties continue throughout their adult life.

The House Interior and Insular Affairs Committee held a special hearing specifically to address the problem of Fetal Alcohol Syndrome among American Indians, at which time testimony was provided which indicated that the rate of prevalence of FAS in the general population is 1.3 cases per 1,000 live births. Several witnesses testified that the incidence rates among American Indians indicated an overall incidence rate of 6.1 per 1,000 live births. They also indicated that incidence rates ranged between various Indian reservations and Alaska Native villages from 1.3 per 1,000 live births to 12.2 per 1,000 live births. Testimony before the Committee indicated that 25 percent of the mothers who gave birth to children with FAS had previously given birth to a child with FAS.

Pursuant to these findings, the Committee Amendment amends Title VII and adds a new section to authorize the Secretary to make Fetal Alcohol Syndrome and Fetal Alcohol Effect Grants. These funds may be sued to provide community and in-school training and education on FAS/FAE, to provide educational and vocational support and counselling to FAS/FAE affected persons, and to develop prevention and intervention models. Recognizing the large number of American Indians and Alaska Natives residing in urban areas, this section requires 10 percent of the funds to be used to make grants to urban Indian organizations.

The Committee is concerned that there is currently no uniform FAS/FAE assessment and diagnostic system in place to measure the extent of the problem and provide early intervention to families. American Indians who are afflicted by FAS will remain a part of the Indian community and yet most Indian communities cannot provide life opportunities for them due to high rates of unemployment and lack of services. The Committee finds that most Indian communities do not have the resources to develop effective prevention and treatment programs. Many Indian communities do not have mechanisms in place for effective prenatal counselling and prenatal care. There is no current data available to accurately determine the incidence rates among American Indians in the United States. The Committee is very concerned that there has not been a comprehensive effort by the IHS or the BIA to identify high risk mothers or to identify Indian children with FAS in order to provide services to them. It is imperative that the Indian Health Service develop diagnostic instruments to identify high risk women in

order to provide counselling and support to prevent FAS and FAE. Further, the Indian Health Service must ensure that each service unit administers a standard diagnostic questionnaire to Indian women as part of their prenatal care in order to identify women at risk of having an FAS or FAE baby.

The Committee Amendment includes provisions to authorize the Secretary to make grants to tribal governments to establish FAS and FAE programs in reservation communities. These programs may include components which develop and provide in-school training on FAS and FAE, identify and provide alcohol and substance abuse treatment to high risk women, identify and provide appropriate education and vocational support and counselling to FAS and FAE affected persons, their families or caregivers, and to develop and implement counselling and support programs in schools for FAS and FAE affected children. The Committee is very concerned that there is a significant number of Indian children on Indian reservations who are afflicted with FAS and FAE. It is extremely important that these children be given every opportunity to achieve in school. These funds will assist tribal governments in developing support structures for children in schools so that they may achieve in school. This program will provide support and education to the family so that they may better care for an FAS or FAE child. It would allow tribal governments to develop programs that provide meaningful life opportunities for individuals with FAS or FAE.

The Committee has added a new section to Title VII to authorize the Secretary to assist tribes and tribal organizations in FAS and FAE education, including development, printing, and dissemination of education and prevention materials. Pursuant to this section, the Secretary is to convene an FAS/FAE Task Force to examine Indian needs and federal resources. The section also specifies the membership of the task force. The Committee also seeks to establish grants for cooperative and applied research projects for the development of FAS/FAE prevention, treatment, and aftercare programs which are conceived and implemented at the community level. The Committee has provided a section which sets out report requirements from the Indian Health Service regarding the status of FAS/FAE in the Indian population. The Committee Amendment also authorizes the Secretary to provide assistance to Indian tribes for the development and dissemination of education and prevention materials on FAS and FAE. The Committee is very concerned that there is very little information regarding the actual scope of the problem of FAS and FAE among Indian communities. The information provided to the Committee indicates a great variety in the prevalence and incidence of FAS and FAE among Indian communities.

The Committee intends the training and education materials developed under this section to be developed in consultation with, and with the full participation of tribal governments and Indian communities. Special attention to the cultural appropriateness of training and education materials is required. This section also establishes a task force to examine the needs of Indian tribes and Indian communities to address the problems of FAS and FAE. The Committee intends this task force to develop a plan and begin to define scope of the problem of FAS and FAE in Indian communi-

ties. Although the task force will be comprised of representatives of various entities, the Committee expects that the deliberations of the task force will be open to all interested parties and that interested Indian tribes will be active participants in the proceedings of the task force.

The Committee Amendment proposes the inclusion of a new section in Title VII which directs the Secretary to conduct a study of the educational, vocational, and independent living needs of adolescent and adult FAS/FAE Indians and Alaska Natives. The Committee Amendment also adds a new section which directs the Secretary to establish a national clearinghouse for prevention and education materials on Indian and Alaska Native FAS/FAE, so that standard information can be made available to tribal governments and Indian communities, and to assist with the development of local models. The Committee intends these materials to be developed in cooperation with Indian tribes to ensure that the educational and training materials are culturally sensitive and relevant. The Committee Amendment requires the Secretary to ensure access to all clearinghouse materials by any tribe or urban Indian organization to assist in the development of culturally sensitive materials.

Alcoholism is a major health problem for American Indian women. The Committee recognizes that it will be impossible to make any impact on FAS and FAE until adequate treatment resources are available for substance abusing Indian women. According to IHS health statistics for the Aberdeen area, American Indian women are nearly 12 times more likely to die of cirrhosis than other Americans. In the Billings Area, Indian women are nearly 15 times more likely to die of cirrhosis than other Americans. Indian women represented one-half of all Indian deaths from cirrhosis of the liver in 1990. Indian women develop alcohol-related liver problems faster than Indian men. Almost one in four American Indian families is maintained by a woman. Alcohol and substance abuse among American Indian women must be a major focus of the Indian Health Service in providing prevention and treatment services. Other health problems are associated with fetal alcohol syndrome, fetal alcohol effect, and other related birth defects. Most alcohol and substance abuse programs are not structured to meet the needs of American Indian women in a residential setting. Indian women are faced with very difficult decisions about whether to seek treatment for their substance abuse problems. In many cases, Indian women are the sole head of the household caring for several children. These women are faced with the prospect of losing their children to foster care if they seek treatment. Under these circumstances, most Indian women will refuse to seek treatment for fear of losing their children. There must be treatment options for Indian women where they can still care for their children while they are involved in treatment. Residential treatment facilities should have the capacity to accept women with children.

The Committee Amendment includes a provision to authorize the Secretary to make grants to Indian tribes, tribal organizations and urban Indian health providers, to develop and implement a comprehensive treatment program to specifically address the cultural,

historical, social, and child care needs of Indian women regardless of age. The Committee intends these grants to allow tribal governments to develop programs specially tailored to meeting the special needs of Indian women and to incorporate traditional healing and cultural values into an overall treatment program. These programs should involve the community and family in providing treatment, counselling and support to Indian women. The Committee believes this program will help encourage Indian women to seek treatment of their alcohol and substance abuse problems and help increase the success rate for treatment efforts among Indian women.

The Inspector General's report found that over two-thirds of all alcohol counselors in Indian Youth Alcoholism programs are not certified. In response to the report, the Indian Health Service projected that 80% of their alcohol and substance abuse counselors would be certified by the end of 1991. The Committee is concerned that the Indian Health Service has made very little progress towards meeting this goal. The Committee Amendment includes a provision which would create a demonstration project to make grants to tribally controlled community colleges to develop education curricula on substance abuse counselling. The Committee Amendment directs the Indian Health Service to take immediate steps to increase the number of counselors who have been certified.

A new section is added in Title VII to develop Substance Abuse Counselor Education Demonstration Projects in colleges, universities, and tribally controlled community colleges to develop educational curricula for substance abuse counseling, which include classroom education, clinical work experience and continuing education workshops. This provision directs the Secretary, in consultation with tribal governments, colleges, universities and administrators of tribally controlled community colleges, to develop criteria for the approval of grant applications to enhance the capacity of these educational institutions to train and educate substance abuse counselors. The Secretary is authorized to provide technical assistance to grant recipients to comply with the provisions of this section. The Secretary is also required to submit a report to the President, as required under section 801 of this Act, on the findings and recommendations from these projects.

TITLE VII—MISCELLANEOUS

The Committee Amendment requires the President, at the time he submits his request for funding for the Indian Health Service for each fiscal year, to report on the activities of the IHS in meeting certain requirements of this Act. The President's Budget should report on the progress made in meeting the objectives of this Act, statements specifying the amount requested to eliminate deficiencies in tribal health status and resources and the amount obligated to achieve certain objectives related to infant and maternal mortality and Fetal Alcohol Syndrome. Each year the President's Budget Request will be required to report on whether, and to what extent, new health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of the Act, and any steps the Secretary may have taken to consult with Indian tribal governments to address those impacts.

The Committee believes that the Report required pursuant to this Title, on the progress being made by the Indian Health Service in meeting the objectives of this Act, is among the most important provisions of the Committee Amendment. The principal reason for the inclusion of the health objectives is to assure a realistic mechanism for the monitoring of the health status of Native Americans and to ensure that resources may be allocated on the basis of meeting these objectives. Of paramount importance is the requirement of a separate statement specifying the amount of funds required to carry out the equity-based goals of the Indian Health Care Improvement Fund. The Committee envisions the annual Presidential submission on the health status of Native Americans as a yearly programs report on the efforts of the IHS in improving the health status of Native Americans.

In the interest of enhancing tribal consultation, the Committee Amendment requires the Secretary to consult with Indian tribal governments and appropriate national or regional Indian organizations prior to any revision of, or amendment to, rules or regulations made pursuant to this Act. The Secretary is directed to publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.

The Committee Amendment extends to the end of fiscal year 2000 the time during which Arizona is treated as a contract health delivery area by the Indian Health Service.

The Committee Amendment also provides for the continuation of the plan to be developed by the IHS to reduce Infant Mortality, Maternal Mortality, and Fetal Alcohol Syndrome rates in each Area of the IHS. This plan should be developed by January 1, 1994.

The Committee Amendment provides that notwithstanding any other provision of law, any allocation of the IHS base resources for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, or activity of a service unit, that allocation may be implemented only after the Secretary has submitted to the President, for inclusion in the President's annual budget request required to be submitted to the Congress, a report on the proposed change in allocation of funding. The 1988 Amendments to the Act, formerly required that any change in allocations of funding proposed by the Secretary had to be submitted to the Congress directly. In effect, the Amendment will require the IHS to submit any proposed reallocation changes, the reasons for the change and its likely effects at the time that the President submits his annual budget request for the IHS.

The Committee Amendment includes language which would continue the child sexual abuse treatment programs on the Hopi and Fort Peck Indian reservations through the year 1995. The Committee Amendment also includes language which would authorize the Secretary to establish child sexual abuse treatment programs in each service area of the Indian Health Service. The Committee has held several hearings on the problem of child sexual abuse on Indian reservations and received testimony from many tribes regarding the lack of resources to provide treatment to the victims of child sexual abuse. The Committee is extremely concerned about the

lack of available services on Indian reservations to effectively treat and counsel victims of child sexual abuse and the need for a comprehensive therapy program for victims. Several witnesses testified regarding the cycle of victimization, which if left untreated, transforms the victims of sexual abuse into a perpetrator of others. The Committee also received testimony regarding the phenomena of multi-generational sexual abuse within families. This is a problem on many Indian reservations and there is a significant need to establish comprehensive treatment programs to serve each of the Indian Health Service areas. The Committee is aware of the special needs of certain Indian communities for effective treatment programs to counsel significant victim populations within those communities. The Committee intends this language to allow the Secretary the flexibility to provide resources to those Indian communities with a significant victim population in order to stop the cycle of abuse. The Committee is very concerned about the growing problem of juvenile perpetrators on Indian reservations and intends resources available under this section to provide treatment to juvenile perpetrators who are victims of child sexual abuse.

The Committee has learned of the difficulty and frequent delays experienced by Indian tribal governments regarding the leasing of permanent structures for the provision of health care services. Section 807 provides that Indian tribal governments and tribal organizations may lease permanent structures without obtaining advance approval in appropriations acts. This provision is necessary because of the difficulty experienced by self-determination contractors operating small programs in large rural areas, who cannot otherwise respond to unanticipated changes. It would allow tribal contractors additional flexibility in leasing program facilities. The eight to twelve months required for leasing approval under the IHS lease priority system coupled with the additional time for appropriations act approval makes new leasing impossible. This section does not affect the advance leasing approval in appropriations acts required of Indian Health Service leases.

The Committee also provides for the extension of the Tribal Management Demonstration Project. Under this project, tribal governments develop and test a phased approach to assuming a health delivery system which utilizes federal, tribal and private resources. A single grant is provided to tribal governments in the demonstration program and the Secretary has the discretion to waive federal procurement laws. The demonstration was supposed to terminate in 1993, however, the Committee notes that funding and administrative delays require that the project be extended to 1996 to allow tribal governments a fair opportunity to fully develop and demonstrate their programs.

Long-term care of the elderly and disabled

The Committee Amendment directs the Secretary to disseminate to tribal governments the findings and results of demonstration projects conducted under the Act.

The Committee received substantial testimony concerning the need for long-term care of the elderly and disabled. It is understood that there is no one agency responsible for the long-term care of the Indian elderly. Some agencies, such as the Indian Health Serv-

ice, the Bureau of Indian Affairs, the Administration on Aging, and some state agencies, provide services; however, no one agency is the lead or main agency identified as the primary provider for long-term care. While Medicare has a role in serving as the lead agency responsible for services in long-term care, its focus has shifted over the past three decades since the program's inception.

Long-term care is increasingly becoming a priority for many states and many tribal governments. The impact of illness and disability on the lives of Indian elderly in particular is enormous. There are an estimated 200,000 American Indians over the age of 60. Older Indian people live in poverty at a rate estimated to be over 60 percent, have a life expectancy between three to four years less than the general population, and frequently live in substandard and over-crowded housing. Adding to these problems, the long-term care of the elderly Indian is compounded by cultural language barriers. They consequently suffer poor health, at a rate that is greater than do older non-Indians. For instance, Indian people are at particularly high risk for obesity, gall bladder disease, diabetes, hypertension, several types of cardiovascular and cerebrovascular disease, cataracts and other problems affecting vision. Elderly Indian people also have problems applying for and receiving public benefits which relates to their underutilization of the health care system.

The most commonly held perception of long-term care is one of institutional services. Long-term care involves not only institutional services, but a wide range of social as well as health services provided to elderly people in a variety of settings. The Committee understands that there is a need for institutional facilities as well as independent living facilities for the elderly Indian population. While it is understood that for some severely impaired individuals, nursing home care is the best or only solution and that skilled nursing facilities are the most effective way to provide 24-hour nursing care, the Committee understands that nursing home care may not be the preferred environment for many Indian elderly. Many of the Indian elderly and disabled would prefer to live more independently in their homes if some support could be provided there.

The Committee has reviewed the statement developed by the Indian Health Service regarding the need for long term health care for American Indians. Much of this information was considered by the IHS Workgroup on Aging and Long Term Care Roundtable, as follows:

> On a very limited basis, IHS does provide post-acute skilled nursing care if it falls within the parameters and availability of funds of the Contract Health Services Medical Priority System. It is time-limited and determined by the clinical situation and requirements for rehabilitation. While this care is provided to all eligible Indians, it is principally the elderly who require such care. All eligible Indian elders share the same right of access to the care provided by the IHS along with all other age groups. The IHS also provides medical coverage for elders in private and tribally operated nursing homes and will continue to do so. Medicaid regulations and statutory language governing the IHS use of Medicare and Medicaid collections

prohibit the IHS from being reimbursed by Medicaid for the medical care provided in these settings. IHS resources are the only resources available to support this care.

The IHS recognizes that the elderly population is increasing at an accelerated rate and that care for this population has evolved into geriatric specialty care. Accordingly, the IHS is now assessing the need for a defined elderly health program that is in keeping with the Healthy People 2000 objectives of maintaining health and functional independence. Targeted prevention and treatment can reduce the likelihood of disability and reduce the percentage of elders who have difficulty performing two or more activities of daily living thus reducing the necessity for custodial nursing home care. The Committee believes that this is consistent with the preference of most Indian elders to remain in their homes as well as consistent with the IHS mission to improve the health status of American Indians and Alaska Natives.

Tribal governments should avail themselves of the technical knowledge and assistance of their state Medicaid office and State Unit on Aging. Medicaid is the major financier of nursing home care in this country and the State Units on Aging are legislatively mandated to implement the federally funded programs under the authority of the Older Americans Act. Indians are residents of the states and are entitled to a share of Federally funded programs administered by the states. They should also seek advice and counsel from the sixteen tribes who are operating nursing homes, which were established without IHS financing. Some of these nursing homes appear to be successful, while some are not financially sound and require infusion of tribal resources to continue operating. They should also explore Medicaid and Medicare waivers for support of demonstration projects, especially home health care which could alleviate the need for nursing home care.

To initiate a response to the needs of Indian elderly and the disabled, the Committee amendment authorizes the IHS to make grants or enter into contracts for long-term care demonstration projects, through self-determination contracts with tribal governments for health-care services. Under this Project, funds are to be used only for home and community based services for functionally disabled Indians. Funds are not to be used for cash payments or room and board, facility construction or renovation, purchase of medical equipment, or nursing facility services. The Committee Amendment directs the Secretary to develop, after consultation with tribal governments and tribal organizations, criteria for approval of applications for such projects within 180 days after the date of enactment of this Act. The Secretary shall provide technical and other assistance to enable applicants to comply with the provisions of this Amendment. The Secretary is to establish not more than 24 of these demonstration projects. The establishment of a great number of projects in one service area is precluded until there are an equal number in all areas which have submitted qualified applications. The Secretary is required to submit a report to the President in fiscal year 1999, for transmission to Congress, on findings derived from the demonstration projects.

On a limited basis, the Secretary is authorized to enter into a shared services agreement with a health facility operated by a tribe or tribal organization that receives assistance under this section and that provides long-term care to older Indians. The Secretary, acting through the IHS, shall place conditions and terms on such shared service agreements necessary to carry out this section. At the request of a tribal government or tribal organizations, the Secretary shall delegate to the tribal government or tribal organizations powers of supervision and control over such local service employees as are necessary to carry out this section. Salaries for such staff and payments for such services shall be proportionally allocable to the service facility or health facility pursuant to such agreement. The Committee Amendment defines "shared service agreement" to mean a contractual agreement between the IHS and an Indian tribe or tribal organization whereby the IHS agrees to share staff and other services with a facility operated by such tribal government or tribal organization.

The term "home- and community-based services" means one or more of the following: homemaker/home health aide services, chore services, personal care services, nursing care services provided outside of a nursing facility, respite care, training for family members in managing a functionally disabled individual, adult day care, and such other home- and community-based services as the Secretary may approve. The Committee notes that under this provision, Indian tribal governments and tribal organizations provide the definition for the term "functionally disabled" based upon an assessment by the tribal government of "who is determined to require home and community based services."

Tribal self-governance project

In 1987, the Congress considered, as part of the amendments to Public Law 93-638, the Indian Self-Determination Act, the Congress authorized the Self-Governance Project under Title III of Public Law 100–472. The Self-Governance Project allows participating tribal governments to enter into an annual funding agreement with the Secretary of the Interior to plan, consolidate, and administer programs, services, and functions administered by the Bureau of Indian Affairs. Thirty tribal governments are currently authorized to participate in the project.

The Committee is persuaded that many of these tribal governments are now ready to expand their Self-Governance programs to include programs, services and functions of the Indian Health Service. For example, the Mille Lacs Band of Ojibwe Indians, has experienced great on-reservation economic and population growth in recent years that has critically overburdened its IHS on-reservation clinic and strained the tribal government's capacity to deliver essential health care and rural ambulance services. When Mille Lacs has requested increases in IHS funding to meet this new need, the IHS has claimed an inability to respond because the new need does not show up on the IHS historical needs-based formula. Such a situation is ready-made for the planning and administrative flexibility of a tribal self-governance health program in which a tribal government like Mille Lacs is authorized to obtain planning funds

and to negotiate for its fair share of IHS agency-wide resources to meet its modern needs.

The Committee Amendment now authorizes the tribal governments participating in the Self-Governance Project to plan, consolidate, redesign and administer programs, activities, services, and functions administered by the Indian Health Service pursuant to an annual funding agreement with the Secretary of Health and Human Services. Funds for annual funding agreements are allocated out of all of the funds available to the Indian Health Service and are provided to a tribal government on the basis of what the particular tribe would have received in funds and services in the absence of the annual funding agreement.

The Committee Amendment directs the Secretary of Health and Human Services to make planning and negotiation grants to participating tribal governments. The Committee is aware of the negotiations between several tribal participants and the Indian Health Service for the development of self-governance compacts. The Committee strongly supports the establishment of an Office of Self-Governance in the Indian Health Service in order to facilitate the development of the research and data necessary to the development of self-governance compacts. The Committee expects the same level of commitment and support from the Secretary of Health and Human Services and the Director of the IHS that has been demonstrated by the Secretary of the Interior and the Assistant Secretary of Indian Affairs.

Successful completion of at least one year of planning under a planning grant is a condition precedent for each of the thirty participating tribal governments in order to enter into compact negotiations with the Indian Health Service. Successful completion of a planning process will help ensure that the framework necessary for a tribal government to negotiate a self-governance compact is in place. The Committee believes that planning grants are essential for tribal governments to undertake the internal governmental planning, the budgetary and legal research, necessary for the self-governance negotiation process. The Committee views the planning process as a crucial prerequisite to successful project participation. The Committee expects the Indian Health Service to expeditiously process these grants so as not to adversely impact or unnecessarily delay the negotiation process.

Finally, the Committee notes that the Indian Health Service and the Secretary should seek to allow the self-governance demonstration project its fullest and broadest implementation. If there is a question as to whether a particular activity, program, service, or function is eligible inclusion in the project it shall be resolved in favor of inclusion. The Committee intends this section to be interpreted by the Department in a way that facilitates the inclusion of a program or activity in the project and effectuates the full implementation of the project.

The Committee Amendment includes a new section which provides for a waiver of the Paperwork Reduction Act in carrying out any study or survey authorized or required under the Indian Health Care Improvement Act.

Joint venture demonstration projects

The Committee Amendment adds a new section to provide authorization for the Indian Health Service to establish Joint Venture Demonstration Projects under which Indian tribal governments may expend tribal, private or other available non-tribal funds for acquisition or construction of a health facility for a minimum of twenty years, under a no-lease. In return, IHS will provide the equipment, supplies and staffing for the operation and maintenance for such health centers. The provision authorizes tribal governments to utilize tribal funds, private sector or other available resources, including loan guarantees to fulfill the tribal commitment under this provision.

Awards are to be made on a competitive basis only if the Secretary determines that a tribal government has the administrative and financial capabilities necessary to complete acquisition and construction of the health facility. A tribal government or tribal organization that has entered into a written agreement with the Secretary under this subsection, and that breeches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the tribe, or paid to a third party on the tribe's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. However, the Secretary has no right of recovery for funds expended for the delivery of health care services, or for personnel or staffing.

Under this Joint Venture partnership, Congress expects tribal governments to invest and commit their own resources to construct or otherwise acquire health facilities which will be staffed to provide a basic health team servicing acute and ambulatory health care services and to act as a referral center for other levels of care. The IHS is directed to remove existing obstacles and establish rules and approve waivers for IHS space planning methodologies to permit tribal governments to minimize their initial investment and permit future expansion to meet increasing workloads. The Committee expects this Joint Venture to enable the leveraging of tribal funds to expand the level of health care services available to participating tribal governments.

Although launched initially through existing IHS facilities construction appropriations authority, inclusion of this amendment in the Act now provides IHS with a statutory directive to implement and expand this innovative concept. The Committee directs the IHS to implement this program expansion expeditiously, and to increase the number of participating tribal governments. To date, tribal interest in utilizing this Joint Venture Program has far exceeded its current limited availability, and the Committee expects IHS to implement this provision creatively and in a timely and responsive fashion.

The Committee Amendment includes a provision to develop and implement a demonstration project to automate the eligibility determination and claims processing of Contract Health Services. This project would use telecommunications and computer processing to improve the information exchange between IHS health cen-

ters, private contract health care providers, the IHS Area Office and the IHS Fiscal Intermediary. The Committee anticipates that this pilot project will be established by June 15, 1993 and may involve the awarding of an outside contract.

TITLE IX—TECHNICAL CORRECTIONS

Title IX repeals expired reporting requirements and makes other technical corrections as specified.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

In open business session on June 16, 1992, the Select Committee on Indian Affairs, by a unanimous vote of a quorum present, ordered the bill, as amended, reported with the recommendation that the Senate pass the bill.

SECTION-BY-SECTION ANALYSIS OF S. 2481

Section 1. Short title

Section 1 provides that the Act may be cited as the "Indian Health Care Amendments Act of 1992."

Section 2. Amendments to Indian Health Care Improvement Act

Section 2 provides that wherever a section or other provision is amended or repealed in this Act, such amendment shall be considered made to the referenced section or provision of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

Section 3. Findings; policy; definitions

Subsection 3(a) amends subsection 2(e) of the Act to include an additional finding that the unmet needs of tribal groups or local populations are sufficiently varied that resources under the authority of the Indian Self-Determination Act should provide maximum flexibility in tribal use of these funds.

Subsection 3(b) amends section 3 of the Act by establishing a new section 3 with subsections (a), (b), (c), (d) and (e). Subsection (a) underscores the special responsibilities and legal obligation of the United States to the American Indian and Alaska Native People, to (1) meet the national goal of providing the highest possible health status to Indians and to provide existing health services with all resources necessary to effect that policy; (2) raise the health status of American Indian and Alaska Native people to the highest possible level; (3) assure that all persons eligible for the services provided by the Indian Health Service have access to the same fundamental health care benefits; and (4) assure the development of a comprehensive health care system, that will meet the health care needs of American Indian and Alaska Native people in each developmental stage of life.

Subsection (b) declares the intent of Congress that the Nation meet 69 specified health objectives by the year 2000. Subsection (c) directs the Secretary to include in the report required by section 801, to the President, a report on the progress made in each area of the Service toward meeting each of the objectives described in subsection (b). Subsection (d) declares that the objectives set forth in

subsection (b) include an emphasis on preventative, community-based services for those aged 55 or older or who are functionally impaired. Subsection (e) provides that the Secretary may revise the health objectives set forth in subsection (b) to reflect the findings of the Surgeon General related to American Indians and Alaska Natives in the "Healthy People 2000" report.

Subsection 3(c) makes technical amendments to subsection 4(c) of the Act and subsection 4(c) and adds provisions defining "service area", "health profession", "health professional", and including inhalant abuse within the definition of "substance abuse". Subsection (m) defines "service area" as the geographical area served by each Area office. Subsection (n) defines "health profession" to mean medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatric medicine, geriatric medicine, psychology, social work, marriage and family therapy, environmental health and engineering, public health nursing, chiropractic, or an allied health profession.

TITLE I—INDIAN HEALTH MANPOWER

Section 101. Purpose

Section 101 amends the Purpose section of the Act to provide that the purpose of Title I is to increase the number of Indians entering the health professions and to assure an adequate supply of health professionals to provide primary health care to Indian people.

Section 102. Health professions

Subsection 102(a) amends section 102 of the Act to authorize the Secretary to make grants to educational institutions and Indian tribes or tribal organizations to assist in identifying Indians with potential for health education and training in the health profession, as defined by subsection 4(n). It also amends section 102 to emphasize enrollment in a "course of study" rather than enrollment in a school.

Subsection 102(b) amends section 103(a) of the Act to authorize the Secretary to make grants to Indians who have demonstrated capability to successfully complete courses of study in the health professions as defined by subsection 4(n). This section also amends subsection 103(b) to provide that scholarship grants can be used for (1) compensatory preprofessional education, for a period not to exceed two years if a student is enrolled on a full-time basis or the part time equivalent thereof, and (2) pregraduate education leading to a baccalaureate degree in an approved course of study and for a period not to exceed 4 years or the part time equivalent thereof. The part time equivalent is to be determined by the Secretary. This subsection further amends subsection 103(e) to provide that the Secretary shall not deny scholarship assistance solely by reason of an applicant's eligibility for other federal assistance or benefits.

Section 102(c) makes technical amendments to subsection 104(a) of the Act and amends 104(a) to allow the Secretary to make scholarship grants to Indians who are enrolled on a part time basis; emphasizing courses of study in the health professions as defined by section 4(n). Subsection 104(b) is amended to add provisions con-

cerning the length of enrollment, period of obligated service under the Public Health Service Act, and the amount of the monthly stipend under the Public Health Service Act, with regard to individuals enrolled part time. Subsection 104(c) is amended to provide that the Secretary shall not deny scholarship assistance solely by reason of an applicant's eligibility for other federal assistance or benefits. Subsection 104(d) is amended to direct the Secretary to establish a placement office to develop and implement a national policy for the placement of health professionals within the Indian Health Service. Placements shall be made without regard to any competitive personnel system, agency personnel limitation, or Indian preference policy.

Subsection 102(d) provides that the scholarships provision of section 104 of the Indian Health Care Improvement Act shall be effective upon enactment of this Act.

Subsection 102(e) makes technical amendments to subsections 105 (a) and (b) of the Act to incorporate the health professions defined by subsection 4(n).

Section 103. Breach of contract

Section 103 amends subsection 104(b) (as amended by this Act) by adding a new paragraph 5 which contains provisions regarding breach of contracts entered into between individuals and the Secretary. Paragraph 5(A) provides that an individual who has entered into a written contract with the Secretary and (1) fails to maintain an acceptable level of academic standing, (2) is dismissed for disciplinary reasons, (3) voluntarily terminates the training before completion, or (4) fails to accept the scholarship in whole or in part, shall be liable to the United States for the amount paid to him or on his behalf under the contract. Under paragraph 5(B), if an individual breaches the contract for reasons other than those specified in 5(A), by failure to begin or to complete his service obligation under this section, then such individual shall be liable to the United States for an amount as determined in accordance with the formula under subsection 108(l) of the Act.

Section 104. Nursing

Subsection 104(a) amends subsection 106(a) of the Act to allow nurses to receive continuing education allowances.

Subsection 104(b) makes technical amendments to Section 112 of the Act and amends subsection 112(b) to authorize the Secretary to provide grants to establish and develop clinics operated by nurses, nurse midwives, or nurse practitioners to provide primary health care services to Indians. Section 112(f) is amended to require that, beginning with fiscal year 1992, not less than $1,000,000 of the amounts appropriated for each fiscal year shall be used to provide grants under this subsection (a) to train nurse midwives, nurse anesthetists, and nurse practitioners.

Subsection 104(c) amends Section 117 of the Act by redesignating subsections (b) through (e) and amends subsection (b) to provide that, beginning with fiscal year 1992, not less than 25 percent of the retention bonuses awarded each year under subsection (a) shall be awarded to nurses. Subsection (f) is amended to authorize the Secretary to pay retention bonuses to physicians and nurses em-

ployed by Indian Self-Determination Act contractors if the Secretary determines that (1) recruitment or retention for their positions is difficult, and (2), they are necessary for providing health care services to Indians.

Subsection 104(d) adds a new Section 118 to Title I of the Act which directs the Secretary to establish a program to enable licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian health program to pursue advanced training. Subsection 118(b) (as amended) requires that the program include a combination of education and work study in an Indian health program leading to an associate or bachelor's degree. Subsection (c) provides, where the educational costs are provided by the Service, such individuals shall incur an obligation to serve in an Indian health program for a period equal to at least 3 times the length of time spent in the program.

Subsection 104(e) amends Title I of the Act by adding Section 112A, which authorizes the Secretary to establish Nursing School Clinics. Subsection 112A (a) (as amended) authorizes the Secretary to provide grants to public or private schools of nursing to establish and develop clinics to address the health care needs of Indians; provide primary health care services to Indians who reside on or within 50 miles of Indian country, or in medically underserved rural areas. Subsection (b) provides that grants under subsection (a) may be used to (1) provide for all aspects of clinical training program development, (2) enhance the clinical faculty of any school receiving a grant (for example, by increasing faculty salaries and recruiting new faculty); and (3) provide scholarships to students who participate in clinics established or developed pursuant to this section.

Subsection 104(f) amends Part C of Title VII of the Public Health Service Act (42 U.S.C. 294, et. seq.) by adding a new Subpart VII entitled "Provision of Primary Care Services in Rural Areas." Subsection 765(a) (as amended) authorizes the Secretary to use up to $5,000,000 of amounts appropriated, in each of fiscal years 1993 through 1995 to award grants to public or private schools of nursing for the establishment of clinics. Subsection 756(b) provides for applications for grants under subsection (a). Subsection 756 (c) provides that grants awarded under subsection (a) shall be used to (1) establish health clinics, to be run and staffed by the faculty and students of grantee schools, (2) provide for all aspects of clinical training program development, faculty enhancement and student scholarships, and (3) carry out other activities determined appropriate by the Secretary. Subsection (d) provides that the clinics established under subsection (c) shall be designed to provide nursing students with a structured clinical experience that is similar to residency training programs for physicians.

Section 105. Community health representative

Section 105 amends section 107(b) of the Act to provide for the continuing authorization of the community health representative program. It also provides for appropriate consideration for lifestyle factors such as alcoholism, family dysfunction, and poverty that impact on Indian health status.

Section 106. IHS Loan Repayment Program

Subsection 106(a) amends the loan repayment program authorized in section 108 of the Act to provide that the loan repayment program is intended to assure an adequate supply of trained health professionals necessary to maintain accreditation of and provide health care servers to Indians. This subsection also amends subsection 108(b) to allow individuals enrolled on a part time to participate in the program so long as they are scheduled to complete the course of study the same year.

Subsection 106(b) amends section 108(d) of the Act to require that not less than 25 percent of the funds for loan repayment contracts be awarded to nurses, nurse practitioners, or nurse midwives and not less than 10 percent be provided to mental health professionals.

Subsection 106(c) makes technical amendments to subsection 108(e) of the Act.

Subsection 106(d) amends subsection 108(e)(2) to include extensions of obligated service which exceed four years.

Section 106(e) amends subsection 108(g) of the Act to provide that a loan repayment contract may include payment for undergraduate loans.

Section 106(f) amends subparagraph 108(g)(1)(A) of the Act to provide that the Secretary may pay up to $35,000 for loan repayment for each year of obligated service. In determining how much to pay, the Secretary shall consider the extent to which he can maximize the number of contracts provided, and the extent to which the contract serves as an incentive to serve in the programs with the greatest health manpower shortages and to continue serving in the Indian health program after completion of the obligation.

Subsection 106(g) amends paragraph 108(g)(3) of the Act to provide that the Secretary may reimburse a participant for tax liability in an amount equal to 39 percent of the total amount of loan repayments made for that taxable year. This authority only applies to contracts entered into on or after the date of enactment of amendments to the Act.

Subsection 106(h) amends subsection 108(n) of the Act to require the Secretary to submit an annual report to the Congress which includes the following information: the health positions for which recruitment or retention is difficult, the number of applications filed in each health profession, the number of loan repayment contracts entered into in each health profession, the amount of loan repayments, the number and amount of scholarships grants under section 104, the number of health care providers needed by location and profession for the following three fiscal years, and the planned measures to fill difficult recruitment and retention positions.

Section 107. Recruitment activities

Section 107 of the bill amends subsection 109(b) of the Act to require the Secretary to assign an individual in each area office to recruitment activities on a full time basis.

Section 108. Advanced training and research

Section 108 of the bill amends subsection 111(b) of the Act to provide that an individual participating in an advanced research and

training program following enactment of this Act who fails to complete their obligated service shall be liable to the U.S. in an amount determined pursuant to section 108 of the Act.

Section 109. Tribally controlled postsecondary vocational institutions

Subsection 109(a) amends section 112(a)(2) of the Act to authorize the Secretary to provide grants to tribally controlled postsecondary vocational institutions for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians.

Subsection 108(b) amends subsection 113(b)(1) of the Act to provide that the program designed to educate appropriate employees of the Indian Health Service about the culture and history of tribes may also be carried out in tribally controlled postsecondary vocational institutions.

Section 110. Immed Program

Section 110 amends subsection 114(b) of the Act to authorize the Secretary to provide a grant to establish an Indians into Medicine (INMED) program for the nursing profession at a college or university. In addition, the Secretary is authorized to establish an INMED program for the mental health profession at a college or university.

Section 111. Scholarship and loan repayment recovery fund

Section 111 amends Title I of the Act by adding a new section 108A, which provides for the establishment of a scholarship and loan repayment recovery fund. Subsection 108A (a) establishes in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Recovery Repayment Fund. Subsection (b) provides that an amount equal to the amounts collected by the Federal government pursuant to an individual's breach of their service obligations under section 104 or section 108 of the Act shall be appropriated to be deposited in the Recovery Fund. Subsection (c) provides that amounts in the Fund may be expended by the Secretary to make scholarship awards pursuant to section 104 and loan repayment awards under section 108 of the Act. Subsection (d) directs the Secretary to of the Treasury to invest in interest bearing obligations of the United States only such amounts of funds as are not required to meet current withdrawals from the Fund. Subsection (e) provides that the Secretary shall give priority to assigning an individual (for the purpose of the individual's obligated service requirements) to an Indian health program that has need for a health professional to provide health care services as a result of an individual having breached a contract entered into under S. 104 or S. 108.

Section 112. Matching grants to tribes

Section 112 amends Title I of the Act to establish a new section 119 to provide matching grants to Indian tribes to establish tribal scholarship programs for Indians pursuing education in the health professions. Subsection (b) provides that grants awarded to tribes or tribal organizations shall cover 20 percent of the costs of the tribal

scholarship. The remaining 80 percent of the costs shall be paid from non-federal contributions. Tribes or tribal organizations may use public or private donations as part of the non-federal contribution.

Subsection (c) provides that tribes or tribal organizations shall provide scholarships only to Indians enrolled or accepted for enrollment in an approved course of study in the health professions as defined in section 4(n).

Subsection (d) requires tribes or tribal organizations to enter into contracts with each scholarship recipient. The contract shall require the recipient to serve in an Indian health program in the same service area where the tribe is located. The term of obligated service shall be the number of years for which the scholarship is provided or two years whichever is greater or a longer period of time if the parties agree. The contract shall provide restrictions on the use of such scholarship funds, require the recipient to maintain an acceptable level of academic standing and require the recipient to meet the educational and license requirements to be a physician, certified nurse practitioner, certified nurse midwife, or physician assistant.

Subsection (e) provides that a scholarship recipient shall agree not to discriminate against an individual seeking health care based on their ability to pay, or on the basis that payment for care will be made from the Medicare or Medicaid program. This subsection further requires that the recipient of a scholarship agree to accept assignment under the Social Security Act for all services for which payment may be made under Title XVIII, Part B of the Social Security Act, and enter into an agreement with the State agency that administers the State plan for medical assistance under the Title XIX of the Social Security Act to provide service to individuals entitled to medical assistance under the plan.

Subsection (f) requires the Secretary to determine if there has been an initial breach of the contract by the scholarship recipient prior to making a grant award to a tribe. Where the Secretary has determined that a breach has occurred, he shall reduce the amount of the tribal grant by the sum of (A) an amount equal to the expenditures of federal funds made regarding the federal contracts, and (B) an amount representing interest on the amount of such expenditures, determined on the basis of the maximum legal rate prevailing for loans made during the time amounts were paid under the contract. If a tribe is not receiving a grant award for that fiscal year then the Secretary is authorized to reduce other payments to the tribe under other grants, cooperative agreements or contracts.

Subsection (g) provides that the Secretary may not make any payments under subsection (a) unless he determines that the tribe has complied with the requirements of this section.

Section 113. Community Health Aide Program

Section 113 amends Title I of the Act to create a new section 120 which establishes a Community Health Aide program in Alaska. Subsection (a) provides that, under the authority of the Snyder Act (25 U.S.C. 13), the Secretary shall maintain a Community Health Aide Program in Alaska which provides for the training of Alaska

Natives as health aides; use aides in the provision of health care, health promotion and disease prevention in rural Alaskan villages; and provide for the establishment of teleconferencing capacity in local health clinics.

Subsection (b) directs the Secretary to do the following through the Program: (1) provide a high standard of training to community health aides to ensure that they provide quality health care, health promotion, and disease prevention services to the villages served by the program; (2) develop a curriculum that combines instruction with supervised practical experience in acute care, emergency care, health promotion, disease prevention, and the management of clinic pharmacies supplies, equipment and facilities, and promotes achievement of health objectives in Section 3(a); (3) establish and maintain a Community Health Aide Certification Board to certify individuals who successfully complete the training in (b)(1) or can demonstrate equivalent experience; (4) develop and maintain a system which identifies continuing education needs; (5) develop and maintain a system that provides close supervision of community health aides; and (6) develop an evaluation system.

Section 114. Tribal Health Program Administration

Section (114) amends Title I of the Act to add a new section 121 which provides that the Secretary shall provide training in the administration and planning of tribal health programs.

Section 115. Placement of participants in scholarship and loan repayment programs

Section 115 amends Title I of the Act to add a new section 123 which allows the Secretary to consider an individual's ties to any Indian tribe in placing an individual for the purpose of fulfilling the individual's obligated service requirements under sections 104 or 108 of the Act.

Section 116. Interdisciplinary training grants

Section 116 amends Title I of the Act by adding a new section 123 which authorizes the Secretary to provide grants to public or private colleges or universities, tribally controlled community colleges, and schools or programs in optometry, pharmacy, psychology, public health, or social work for the interdisciplinary training of health professionals.

Subsection (a) provides that the purpose of this section is to increase the number of health professionals who deliver health care services to Indians.

Subsection (b) provides that the Secretary shall give priority in providing grants to applications submitted jointly by 2 or more institutions.

Subsection (c) provides that grants under this section may be used to (1) recruit health professionals for programs that train individuals in the health professions listed in subsection (a), (2) provide scholarships to individuals enrolled in such programs for tuition and other related expenses, (3) establish or maintain a program that encourages these health professionals to provide health care services to Indians, and (4) establish or maintain a program that

increases the skills of, and provides continuing education to, these health care professionals.

Subsection (d) provides that not more than $1 million may be used annually to establish postdoctoral training programs in psychology or pharmacy.

Subsection (e) provides that each applicant for a grant under this section shall include such information as the Secretary may require, including a demonstration of the connection between the applicant and a health care facility that primarily serves Indians.

Subsection (f) requires that each individual who receives training or assistance funded by a grant under this program meet the active service obligation prescribed under section 338c of the Public Health Service Act. This obligation may be met by service in the Indian Health Service, in a program contacted under the Indian Self-Determination Act, or in a program assisted under Title V of the Act.

Section 117. Manpower shortages

Section 117 amends Title I of the Act by adding a new section 124. Section 124(a) authorizes the Secretary to provide grants to any college, university or consortiums thereof, that is located in the three service areas which the Secretary determines to have the most acute health manpower shortages. Subsection 124(b) provides that a grant under this section shall be used for the purpose of training health professionals to serve in the those service areas that the Secretary determines to have the greatest difficulty in recruiting and retaining.

Subsection 124(c) provides that a grant recipient under this section shall enter into an agreement with the appropriate tribal government or organization of those service areas in which the training is taking place.

Subsection 124(d) requires the Secretary to establish procedures for submission and review of applications for grants under this section. Subsection (e) provides that the Secretary shall give preference in making grants to those applicants who most comprehensively address area health manpower shortages, coordinate their programs with other relevant programs in this title, and have entered into agreements with Indian Health facilities, whether operated by the Service or by Indian tribes under the Indian Self-Determination And Education Assistance Act.

Section 118. Authorization of appropriations

Section 118 amends Title I of the Act by adding a new section 125 which authorizes appropriations for fiscal year and each fiscal year through 2000 to carry out this title, and to carry out the Native Hawaiian Health Scholarships program under section 338K of the Public Health Service Act (42 U.S.C. 254s). Subsection 125(b) makes conforming amendments to various sections throughout Title I.

Section 201. Health status and resource deficiency status

Subsection 201(a) amends section 201(a) of the Act to provide that the Secretary is authorized to expend funds to eliminate deficiencies in health status and resources of all Indian tribes. Section 201(a) of the Act is also amended to augment the ability of the IHS to meet health service responsibilities, either directly or through contract care, with respect to those Indian tribes with the highest levels of health status and resource deficiencies. The variety of health service responsibilities under section 201(a) of the Act is amended to include the provision of screening mammography in accordance with section 213 of the bill.

Section 201(b)(1) of the Act is amended by section 201(a)(2) of the bill to provide that any funds appropriated under the authority of this section shall not be used to offset or limit any appropriations made to the IHS under the authority of the Snyder Act, or any other provision of law. Paragraph 201(b)(2) of the Act is deleted by Subsection 201(a)(2) of the bill and paragraph 201(b)(3) is redesignated as paragraph 201(b)(2). Paragraph 201(b)(2) of the Act, as amended, provides that funds allocated to each service unit shall be used to reduce the health status and resource deficiency of each tribe. Paragraph 201(b)(2) of the Act, as amended, also provides that apportionment of funds allocated to a service unit shall be determined by the IHS in consultation with and with the active participation of the affected Indian tribal governments.

Subsection 201(c) of the Act is amended by subsection 201(a)(3) of the bill which strikes paragraph (1) and redesignates paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively. Subsection 201(c)(1) of the Act as amended provides a definition for the term "health status and resource deficiency". The definition of "health status and resource deficiency" means the extent to which national health objectives set forth in section 3(a) are not being achieved taking into account the actual cost of providing health care services given local geographic, climatic, rural or other circumstances, and the extent to which a tribe lacks the health resources it needs. Subsection 201(c)(2) of the Act as amended is replaced with a new paragraph which provides that the health resources available to an Indian tribe are limited to local health resources provided by the IHS, and health resources used by the Indian tribe, including services and financing systems provided by any other Federal programs, provided that in determining available resources the IHS shall also take into account actual availability of local alternative sources of health care. Subsection 201(c)(3) of the Act as amended makes conforming amendments to provide that the Secretary shall establish procedures which allow any Indian tribe to petition the Secretary for a review of any determination of the extent of health status and resource deficiency of such tribe.

Subsection 201(d)(1) of the Act is amended by Subsection 201(a)(4) of the bill by striking "subsection (h)" and inserting "this section". Subsection 201(e) of the Act is amended so as to require the Secretary to report to the Congress on the current health status and resource deficiency of each tribe within 3 years of the date of the en-

actment of these Amendments, other conforming amendments are made as well. Subsection 201(f) of the Act is technically amended to provide that funds appropriated under authority of this section for any fiscal year shall be included in the base budget of the IHS for the purpose of determining appropriations under this section in subsequent fiscal years.

Subsection 201(b) of the bill provides that except with respect to the amendments made by subsection (a)(5), the amendments made by subsection (a) shall take effect three years after the date of the enactment of this Act. The amendments made by subsection (a)(5) shall take effect upon the date of the enactment of this Act.

Section 202. Catastrophic health emergency fund

Subsection 202 technically amends section 202(a)(1)(B) of the Act by striking "under subsection (e)" and inserting "to the Fund under this section". Subsection 202(b)(2) of the Act is amended so that the Secretary shall, through the promulgation of regulations consistent with the provisions of this section, provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the fund until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at not less than $15,000 for 1992; and for any subsequent year, the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year. Subsection 202(c) is technically amended to provide that amounts appropriated to the Fund under this section shall not be used to offset or limit appropriations made to the Service under authority of the Act of November 2, 1991, known as the Snyder Act, or any other law.

Section 203. Health promotion and disease prevention

Subsection 203 amends section 203(a) of the Act so as to provide that the provision of health promotion and disease prevention services through the IHS shall be designed to achieve the national health objectives set forth in section 3(a) of the Amendments to the Act. Subsection 203(b) is amended by striking "section 201(f)" and inserting section 801. Subsection 203(c) of the Act is struck out by the Committee Amendment.

Section 204. Diabetes prevention, treatment and control

Subsection 204 amends section 204(c) of the Act by striking subsection (c) and replacing it with a new subsection (c). Subsection 204(c)(1) as amended requires the Secretary to continue to maintain through fiscal year 2000 each model diabetes project currently in existence. Subsection 204(c)(2) as amended authorizes the IHS to establish new model diabetes projects and provides that the IHS may not establish a greater number of such projects in one service area of the IHS until there is an equal number of projects in all service areas. Subsection 204(d) as amended provides conforming amendments and provides that the IHS evaluate the effectiveness of the services provided by the model diabetes projects established under this section.

Section 205. Mental health prevention and treatment services

Subsection 205 amends section 209(j) of the Act (as redesignated by section 902(3)(B) of this Act) by striking out "submit to the Congress an annual report" and inserting "submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report". The following new subsections are also added:

Subsection 209(l) as amended provides that within 1 year of employment, any person employed as a psychologist must be licensed as a clinical psychologist or working under the direct supervision of a licensed psychologist to provide mental health services under this Act. It further provides that any person employed as a social worker must be licensed as a social worker or under the direct supervision of a social worker. The Amendment also provides that any person employed as a marriage and family therapist must be licensed as a marriage and family therapist or under the direct supervision of a licensed marriage and family therapist.

Subsection 209(m) as amended provides that the IHS may make grants to Indian tribes and tribal organizations to provide intermediate mental health services to Indian children and adolescents, including: Inpatient and outpatient services, emergency care, suicide prevention and crisis intervention, and prevention and treatment of mental illness, and dysfunctional and self-destructive behavior, including child abuse and family violence. Funds provided under this section may be used to construct or renovate an existing health facility, to hire mental health professionals, and to staff and operate an intermediate mental health facility, group home, or youth shelter where intermediate mental health service are being provided, and to make renovations and hire appropriate staff to convert existing hospital beds into adolescent units. This subsection also requires grant recipients to coordinate intermediate adolescent mental health services with existing services on the reservation. The section further requires the Secretary to establish criteria for the review and approval of applications for grants made pursuant to this section.

Subsection 209(n)(1) as amended authorizes the IHS to provide grants to at least three colleges and universities to develop and maintain American Indian psychology careers recruitment programs as a means to encourage more Indians to enter the mental health field. Subsection 209(n)(2) as amended authorizes the IHS to provide one of the grants authorized under paragraph (1) to develop and maintain an American Indians Into Psychology program at the University of North Dakota. Subsection 209(n)(3)(A) as amended provides that the IHS shall issue regulations for the competitive awarding of the grants provided under this subsection. Subsection 209(n)(3)(B) as amended requires applicants for grants under this section to provide a program which, at a minimum—(i) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and community colleges located on Indian reservations that will be served by the program, (ii) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program, (iii) provides summer enrichment programs to expose

Indian students to the varied fields of psychology through research and experiential activities, (iv) provides stipends to undergraduate and graduate students to pursue a career in psychology, (v) develops affiliation agreements with tribal community colleges, the Indian Health Service, university affiliated programs, and other appropriate entities to enhance the education of American students, (vi) to the maximum extent feasible, employs qualified Indians in the program.

Subsection 209(n)(4) as amended requires the American Indians Into Psychology program at the University of North Dakota, to the maximum extent feasible, to coordinate with the INMED program authorized by section 114 of this Act, and existing university research and communications networks.

Section 206. New studies

Subsection 206(a) amends section 205(a) of the Act to provide that the Secretary, acting through the IHS and in consultation with representatives of Indian tribes, tribal organizations, Indian Health Service personnel, and hospice providers shall conduct a study to, (1) assess the feasibility and desirability of providing hospice care to terminally ill Indians, and (2) to determine the most efficient and effective means of furnishing such care.

Subsection 205(b) as amended requires the study to: (1) assess the impact of Indian culture and beliefs concerning death and dying on the provision of hospice care to Indians; (2) estimate the number of Indians for whom hospice care may be appropriate and determine the geographic distribution of such individuals; (3) determine the most appropriate means to facilitate the participation of Indian tribes and tribal organizations in providing hospice care; (4) identify and evaluate various means for providing hospice care, including, the provision of such care by the personnel of a service hospital pursuant to a hospice program established by the Secretary at such hospital; and the provision of such care by a community-based hospice program under contract to the Service; and (5) identify and assess any difficulties in furnishing such care and the actions needed to resolve such difficulties.

Subsection 205(c) as amended provides that the Secretary, not later than 12 months after this section is enacted, shall transmit to Congress a report containing: (1) a detailed description of the study conducted pursuant to this section; and (2) a discussion of the findings and conclusions of such study.

Subsection 205(d) as amended provides that for the purposes of this section the following definitions are applicable:

(1) "terminally ill" means any Indian who has a medical prognosis (as certified by a physician) of a life expectancy of six months or less;

(2) "hospice care" means the care, items, and services as defined in section 1861 (dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)); and

(3) "hospice program" means any program which satisfies the requirements of section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395(dd)(2)).

Subsection 206(b) amends Title II of the Act by creating a new subsection 210. Subsection 210(a) as amended provides that the IHS

shall conduct a study to determine the feasibility of allowing an Indian tribe to purchase directly, or through the Service, managed care coverage for Indian tribes, which desire to participate in group contract health plans or other managed care arrangements instead of operating an inpatient hospital or ambulatory facility, and which offer the same plan to all eligible members of the community.

Subsection 210(b) as amended requires that the Secretary shall report the findings of such study to the Congress within 12 months from the date of enactment of this Act. The report shall contain a detailed description of the study conducted pursuant to this section, and a discussion of the findings and conclusions of such study.

Section 207. Right of recovery

Section 207 amends section 206 of the Act (U.S.C. 1621e) to provide that "a tribe or tribal organization" is to be inserted immediately after "United States" each place it appears. Subsection 206(a) makes conforming amendments to provide that "a tribe, or a tribal organization," immediately after the word "Service." Subsection 206(e)(1)(a) is amended by inserting "a tribe, or tribal organization," is inserted immediately after the word "Secretary". Section 206 is further amended to providethat the word "The" in subsection (a) is struck and replaced by "Except as provided in subsection (f), the". Subsection 206(b) of the Act is amended by striking "or any political subdivision of a State" and by adding a new subsection (f) which provides that the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization.

Section 208. Epidemiology Grant Program

Section 208 amends Title II of the Act by adding a new section 211. The new subsection 211(a) provides that the IHS shall provide grants to eligible recipients for the purpose of establishing area epidemiology centers to conduct the activities set forth in this section.

The new subsection 211(b) provides that in consultation with the IHS, Indian tribes and urban Indian Communities, an area epidemiology established under this section shall:

(1) establish a methodology to define baseline data for monitoring the health objectives as specified in section 3;

(2) determine the most effective way to maintain a surveillance system for health objectives;

(3) identify such health objectives that are the highest priority for monitoring, surveillance, and attention, based on an initial assessment of the epidemiology of the area and each of the communities served;

(4) evaluate existing delivery systems, data systems, and other systems that impact on the improvement of Indian health and the resources available to deliver, monitor or evaluate those services;

(5) develop methods to obtain data on Indian health from the IHS, State Medicaid systems, Federal Medicare, and Veterans Affairs systems, and private insurance systems;

(6) to assist tribes and urban Indian communities in the identification of priority service areas based on epidemiological data, and advocate for the targeting of services needed by tribal, urban and other Indian communities and make recommendations to improve health care delivery systems.

The new subsection 211(c) describes who may be eligible to receive grants to establish and develop area epidemiology centers under this section. Subsection 211(c)(1)(A) provides that the Secretary may provide grants to area Indian health boards for the establishment and development of area epidemiology centers. Subsection 211(c)(1)(B) provides a definition of an "area Indian health board". Subsection 211(c)(2) authorizes the Secretary to provide grants to intertribal Consortia or Indian organizations that are incorporated for the primary purpose of improving Indian Health, and are representative of the tribes and urban Indian communities in which they are located. Subsection 211(c)(3) provides that the IHS may provide grants directly to a tribe for the purpose of establishing and developing an area epidemiology center.

The new subsection 211(d) provides that the IHS may provide grants to the entities described in subsection 211(c) that submit an application in such manner and at such time as the Secretary shall prescribe and which meet the following minimum criteria:

(1) Applicants for grants shall ensure that the area epidemiology center will be established and operated for the primary purpose of addressing Indian health issues and will consult with the tribes or urban Indian communities that will be served by the area epidemiology center.

(2) Applicants shall demonstrate the technical, administrative, and financial expertise necessary to conduct eligible activities described in subsection (b).

(3) Applicants shall ensure that the area epidemiology center will consult and cooperate with providers of related health and social services in order to avoid duplication of existing services, and demonstrate cooperation from the tribes or urban Indian organizations in the area.

The new subsection 211(e) requires the IHS to provide at least one grant in each of the IHS areas.

The new subsection 211(f) provides that the IHS may provide a grant in such an amount as the IHS determines appropriate to carry out the purposes of this section, which shall not be less than $250,000 a year for each area epidemiology center.

The new subsection 211(g) requires the IHS to assign one epidemiologist from each of its area offices to each area epidemiology center to provide such center with technical assistance to carry out this section.

The new subsection 211(h)(1) requires the IHS to submit an initial report to the Congress by March 1, 1994, on its actions to carry out this section. Subsection 211(h)(2) requires that after the initial report, the IHS shall report to the Congress every two years on the extent to which the area epidemiology centers have helped to assess progress made towards meeting the health objectives specified under section 3 of this Act.

Section 209. California Contract Health Services Demonstration Program

Section 209 amends Title II of the Act to create a new section 212. The new subsection 212(a) requires the IHS to establish a demonstration program to evaluate the use of a contract care intermediary to improve the accessibility of health services to California Indians.

The new subsection 212(b)(1) requires the IHS, in establishing such a program, to 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 809(b) throughout the California contract health services delivery area described in section 810 with respect to high-cost care cases. The new subsection 212(b)(2) provides that 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. The new subsection 212(b)(3) provides that 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 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

The new subsection 212(c) establishes 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 eight 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.

The new subsection 212(d) requires the demonstration program described in this section to begin on January 1st 1993, and to terminate on September 30th 1997.

The new subsection 212(e) requires the California Rural Indian Health Board, not later than July 1st 1998, to submit to the IHS 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.

The new subsection 212(f) defines the term "high contract care cases" while subsection 212(g) authorizes there to be appropriated for the fiscal years 1993 through 1997 such sums as may be necessary to carry out the purposes of this section.

Section 210. Coverage of screening mammography

Subsection 210(a) amends Title II of the Act by establishing a new section 213 which authorizes the IHS provide screening mammography (as defined in section 1861(jj) of the Social Security Act) for Indian and urban Indian women 35 years or older at a frequen-

cy, determined by the IHS (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 IHS to assure the safety and accuracy of screening mammography under part B of Title XVIII of the Social Security Act.

Subsection 210(b) makes a conforming amendment to the Act.

Section 211. Comprehensive school health education programs

Section 211 amends Title II of the Act by adding a new section 214. The new subsection 214(a) provides that the IHS is authorized to award grants to Indian tribes to develop comprehensive school health education programs in cooperation with the IHS of the Interior. Funds provided under this program shall be used to provide a continuum of health education programs from preschool through grade 12 for children in schools located on Indian reservations.

The new subsection 214(b) provides that School Health Education grants may be used to develop health education curricula, to train teachers: to integrate community-based health promotion efforts; to encourage healthy; tobacco free environments; to coordinate school-based health programs with existing services; to develop programs on nutrition, personal health, mental health wellness, chronic disease prevention, substance abuse prevention, accident prevention and safety education; to develop activities for the prevention and control of communicable diseases; and to develop community and environmental health education programs.

The new subsection 214(c) provides that the IHS may provide technical assistance to Indian tribes in the development of health education plans, and the dissemination of health education materials and information on existing health programs and resources.

The new subsection 214(d) provides that the IHS establish criteria for the review and approval of applications for grants made pursuant to this section.

The new subsection 214(e) provides that grant recipients shall prepare annual reports to the IHS on activities undertaken with funds provided under this section. Such reports shall include a statement of the number of preschools, elementary and secondary schools served, any new curricula established with funds under this section, the number of students served, the numbers of teachers trained in the health curricula, and the involvement of parents, community members and health workers in programs established with funds provided under this section.

The new subsection 214(f)(1) requires the Secretary of the Interior to develop a comprehensive school education program for children from preschool through grade 12 in schools operated by the Bureau of Indian Affairs. The new subsection 214(f)(2) requires the programs established by the BIA under this section to include school programs on nutrition education, personal health, mental health wellness, chronic disease prevention, substance abuse prevention, accident prevention, safety education, and activities for the prevention and control of communicable diseases. The new subsection 214(f)(3) requires the Secretary of Interior to provide training for teachers in comprehensive school health education curricula, ensure the integration and coordination of school-based pro-

grams with existing services and health programs available in the community, and encourage healthy tobacco-free environments.

The new subsection 214(g) provides that such sums as are necessary to carry out this section are authorized to be appropriated for each of the fiscal years 1993 through fiscal year 2000.

Section 212. Indian Youth Grant Program

Section 212 amends Title II of the Act by adding a new section 215. The new subsection 215(a) provides that the IHS may make grants to Indian tribes, tribal organizations and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian pre-adolescent and adolescent youths. The new subsection 215(b) provides that grants made pursuant to this section may be used to develop prevention and treatment models for Indian youth to promote mental and physical health and incorporate cultural values, community and family involvement, and traditional healers; and develop and provide community training and education. The new subsection 215(c) authorizes the IHS to (1) disseminate information regarding models for the delivery of comprehensive health care services to Indian and Urban Indian adolescents, (2) to encourage the implementation of such models, and (3) at the request of an Indian tribe, provide technical assistance in the implementation of such models. The new subsection 215(d) establishes criteria for the review and approval of applications under this section and the new subsection 215(e) provides that such sums as are necessary to carry out this section are authorized to be appropriated for fiscal year 1993 and thereafter through fiscal year 2000.

Section 213. Tuberculosis Prevention Demonstration Program

Section 213 amends Title II of the Act by adding a new section 216. The new subsection 216(a) authorizes the IHS to make grants to Indian tribes and tribal organizations to evaluate different measures to prevent and eliminate tuberculosis (TB) on Indian reservations. The new subsection 216(b) provides that grants may used to:

(1) train health care staff in methods to eliminate TB;

(2) to conduct screenings of residents on Indian reservations to detect the presence or monitor the condition of persons who are at risk for contracting TB who already have the disease;

(3) educate the community about the nature and prevention of TB;

(4) create and maintain a registry of persons with TB, including information obtained from screenings conducted pursuant to paragraph (2);

(5) to develop methods, such as use of a TB control team, to coordinate all TB prevention and eliminate activities on a reservation; and

(6) treat those afflicted with TB.

The new subsection 216(c) directs the IHS to make at least one grant under this section to an Indian tribe or tribal organization located in each Area office, establish criteria for the review and approval of applications for grants under this section, and provide at the request of a grant applicant or recipient, technical assistance to accomplish the purposes of this section.

The new subsection 216(d) provides that grant recipients under this section, cooperate with the Centers for Disease Control, the IHS, State health programs and local health agencies to coordinate and conduct activities authorized under this section, and submit to the IHS an annual report on activities conducted with funds provided under this section.

Section 214. Patient travel costs

Section 214 amends Title II of the Act by adding at the end a new section 217 which provides that the IHS shall provide funds to meet the high costs of patient travel in remote areas of Alaska when there is no reasonable alternative for the patient.

Section 215. Authorization of appropriations

Subsection 215(a) amends Title II of the Act by adding a new section 218 which authorizes there to be appropriated such sums as may be necessary through fiscal year 2000 to carry out the provisions of this title.

Subsection 215(b) contains conforming amendments.

TITLE III—HEALTH FACILITIES

Section 301. Health facilities closure and priorities

Section 301 amends section 301(a)(2) of the Act to conform with the current nomenclature of the Joint Commission on Accreditation of Health Care Organizations. Subsection 301(b)(1) of the Act includes Service outpatient health care facilities in addition to Service hospitals in the requirement that no Service facility shall be closed without an evaluation of the impact of such closure. Subsection 301(b)(1) is further amended by stipulating two additional considerations in the Secretary's report on the potential impacts of any proposed closures of an IHS facility: the level of utilization of such hospital or facility by all eligible Indians, and the distance between the hospital or facility and the nearest operating Service hospital. Subsection 301(c) of the Act is struck and the section redesignates subsections (d) and (e) as subsections (c) and (d) respectively.

Subsection 301(c)(1) of the Act requires the Secretary to submit to the President, for inclusion in each report required to be transmitted to Congress, a report which sets forth the current health facility priority system of the Service; the planning, design, construction, and renovation needs for the 10 top-priority ambulatory care facilities; the justification for the order of priority; the projected cost of such projects; and the methodology adopted by the Service in establishing priorities under its health facility priority system. The section further amends subsection (c) by eliminating the 180-day requirement for the first report, as well as the post-1990 annual report timeline under section 1105 of title 31, United States Code. Paragraphs (3) (4) and (5) are re-numbered to conform with the Act.

Section 302. Safe water and sanitary waste disposal facilities

Section 302 amends section 302(e) of the Act to authorize the Secretary to provide financial assistance to Indian tribes and commu-

nities in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the Secretary's 10-year plan to provide safe water supply and sanitation sewage and solid waste disposal to Indian homes and communities. Subsection 302(e)(2) defines the term 'Federal share' in this Act to mean 80 percent of the costs of operating, managing, and maintaining safe water and sanitary waste disposal facilities. **Section 302** further amends Section 302(e) of the Act to allow Indian tribes with fewer than 1,000 members to meet the 20 percent non-federal match through cash donations or in-kind property, fairly evaluated. A conforming change applicable to subsection (f)(1) is included.

Section 302 also amends Section 302(g)(1) of the Act by mandating that the Secretary submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801 of this Act, a report detailing the current Indian sanitation facility priority system, the methodology for determining sanitation deficiencies, the level of sanitation deficiency for each sanitation facilities project of each Indian tribe or community, the amount of funds necessary to rise all Indian tribes and communities to a level I sanitation deficiency, and the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency.

The Section also eliminates the timing guidelines to Congress that are set forth under paragraph (2) of subsection (g), and renumbers paragraphs (3), (4), (5), and (6) as paragraphs (2), (3), (4), and (5), respectively.

Section 303. Ambulatory care facilities

Section 303 amends section 306 of the Act by striking the current Bethel, Alaska section and establishing a new section authorizing a grant program for the construction, expansion and modernization of small ambulatory care facilities.

Subsection 306(a)(1) requires the Secretary to make grants to Indian tribes and tribal organizations to construct, expand or renovate facilities to provide ambulatory care services to eligible Indians. A grant made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. for the purposes of this section, the term "construction" includes the replacement of an existing facility. Subsection 306(a)(2) provides that only Indian tribes or tribal organizations operating an Indian health facility pursuant to the Indian Self-Determination Act are eligible for grant awards.

Subsection 306(b)(1) limits the use of a grant awarded under this section to the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility:

(1) located apart from a hospital;

(2) not funded under sections 301 and 307 of this Act; and

(3) which, upon completion, will (i) have a total capacity appropriate to its projected service population; (ii) serve no less than 500 Indians annually; and (iii) provide ambulatory care in a service area with a population of not less than 2,000 eligible Indians. Subsection 306(b)(2) provides that the requirements of

clauses (ii) and (iii) shall not apply to a tribe or tribal organization applying for a grant under this section whose tribal government offices are located (A) on an island and (B) more than 75 miles from tribal government offices of the nearest other Indian tribe.

Subsection 306(c)(1) provides that no grant may be made under this section unless an application for such a grant has been submitted to and approved by the Secretary. Applications for grants under this section shall be submitted in such form and manner as the Secretary shall by regulation prescribe and the applicant shall provide reasonable assurances that, at all times after construction, expansion or modernization of a facility carried out pursuant to a grant received under this section:

(1) adequate financial support will be available for the provision of services at such facility;

(2) such facility will be available to eligible persons without regard to ability to pay, or source of payment; and

(3) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible persons, serve non-eligible persons on a cost basis.

Subsection 306(c)(2) requires that, in awarding grants under this section, the Secretary shall give priority to an Indian tribe or tribal organizations that demonstrate (1) a need for increased ambulatory care services and (2) insufficient capacity to deliver such services.

Subsection 306(d) provides that if a facility constructed or renovated with funds provided under this section ceases to be utilized to provide ambulatory care services to eligible Indians, then all right, title and interest in the facility shall be transferred to the United States.

Section 304. Indian health care delivery demonstration project

Subsection 304(a) amends section 307(c) of the Act, the Indian health care delivery authority in 25 U.S.C. 1637(c)(3). Subsection (3)(A) requires Indian tribes to complete an application for a demonstration project grant on or before September 30, 1995. Subsection 307(3)(B) is revised by inclusion of a new subparagraph which provides that, subject to the availability of appropriations, the Secretary shall also enter into contracts or award grants under this section taking into consideration applications received under this section from all service areas. The Secretary may not award a greater number of such contracts or grants in one service area than in any other service area until there is an equal number of such contracts or grants awarded with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria specified in paragraph (1).

Subsection 304(b) amends section 307(h) of the Act (25 U.S.C. 1637(h)) as follows. Subsection (h)(1) requires the Secretary to submit to the President, for inclusion in the report required under section 801 for fiscal year 1997, an interim report on the findings and conclusions from the demonstration projects established under this section. Subsection (h)(2) further requires the Secretary to submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 801 for fiscal

year 1999, a final report of findings and conclusions derived from the demonstration projects established under this section, together with legislative recommendations.

Section 305. Expenditure of nonservice funds for renovation

Section 305 amends section 305 of the Act (25 U.S.C. 1634) by striking the current statutory language and amending the section as follows. Subsection 305(a)(1) authorizes the Secretary, notwithstanding any other provision of law, to accept any major renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated under the Indian Self-Determination Act, including (1) any plans or designs for such renovation or modernization; and (2) any renovation or modernization for which funds appropriated under any Federal law were lawfully expended, provided the requirements of subsection 305(b) are met.

Subsection 305(a)(2) further directs the Secretary to maintain a separate priority list to address the needs of such identified facilities for personnel or equipment. Subsection 305(a)(3) directs the Secretary to plan for and seek funding to address the needs of these facilities pursuant to paragraph (2).

Subsection 305(b) mandates that the requirements of this section are met if the tribe or tribal organization provides notice to the Secretary of its intent to renovate or modernize and the tribe applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for personnel or equipment. In addition, the renovation or modernization must be approved by the appropriate area director of the Service and administered by the tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of service facilities.

Subsection 305(c) provides that if any Service facility which has been renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20 year period beginning on the date such renovation or modernization is completed, such tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such renovation or modernization) bore to the value of such facility at the time of the completion of such renovation or modernization.

Section 306. Authorization of appropriations

Subsection 306(a) amends Title III of the Act to create a new section 308 relating to the authorization of appropriations.

The new subsection 308 authorizes the appropriation of such sums as may be necessary for fiscal years 1993 through fiscal year 2000 to carry out the provisions of this title.

Subsection 306(b) sets out the conforming amendments of this Title.

Section 401. Treatment of payments to IHS facilities under Medicare and Medicaid programs

Section 401(a)(1) amends section 401(a) of the Act to provide that any payments received by a hospital or skilled nursing facility of the IHS (whether operated by the IHS or by an Indian tribal government or tribal organization under the Indian Self-Determination Act) for services provided to Indians eligible for benefits under title XVIII of the Social Security Act shall not be considered in determining appropriations for health care services to Indians. Section 401(a)(1) amends section 401(b) of the Act to provide that nothing in this Act authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

Section 401(a)(2) amends subsection (a) of section 1880 of the Social Security Act to provide that a facility of the Indian Health Service or of an Indian tribe or tribal organization under a Self-Determination contract shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d) of this title, if it meets all of the conditions and requirements for such payments under this title, provided that this provision shall not apply to any facility owned or operated by an Indian tribal government or tribal organization which is otherwise eligible for payments under this title.

Section 401(a)(3) amends section 1880(c) of the Social Security Act by striking out the last sentence.

Section 401(b)(1) amends section 402(a) of the Act to provide that notwithstanding any other provision of law, payments to which any facility of the IHS (including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act) is entitled under a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements necessary to achieve compliance with the requirements of title XIX of the Social Security Act. In making payments from such fund, the Secretary shall ensure that each service unit of the IHS receives at least 80 percent of the amounts to which the facilities of the IHS, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act, if such amount is necessary for the purpose of making improvements in such facilities in order to achieve compliance with the conditions and requirements of title XIX of the Social Security Act, shall not be considered in determining appropriations for health care services to Indians. Section 401(b)(1) also amends section 402(b) of the Act to provides that any payments received by such facility for services provided to Indians eligible for benefits under title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians.

Section 401(b)(2) amends section 402 to provide that the increase (from 50 percent) in the percentage of payments from the fund to be made to each service unit of the IHS specified in the amendment made by paragraph (1) shall take effect beginning with payments made on January 1, 1993.

Section 402. Report

Secton 402 of the bill amends section 403 of the Act to provide that the Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, an accounting on the amount and use of the funds made available to the IHS under this Title as a result of reimbursements through title XVIII and XIX of the Social Security Act.

Section 403. Grants and contracts with tribal organizations

Section 403 of the bill amends section 404(b)(4) of the Act to provide for the development and implementation of a schedule of a schedule of income levels to determine the extent of payments of premiums by such organizations for coverage of needy individuals, and the methods to improve participation of Indians in receiving the benefits provided under titles XVIII and XIX of the Social Security Act.

Section 404. Extension of Demonstration Program

Section 404 amends Section 405 of the Act to continue the Demonstration Program for Direct Billing of Medicare, Medicaid, and Other Third Party Payers and extends the date that the demonstration will end from September 30, 1995 to September 30, 1996.

Section 405. Additional authority

Section 405 amends Title IV of the Act by adding a new section 406(a) to provide that the Secretary may enter into an agreement with any tribal or urban Indian organization which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act and benefits under title XVIII of the Social Security Act at tribal or IHS contract health services facilities.

The new section 406(b) provides that the Secretary may pay premiums, deductibles and copayments under part B of title XVIII of the Social Security Act for beneficiaries under part A of title XVIII of the Social Security Act who are not qualified medicare beneficiaries (as described in section 1905(p) of such Act) due to income, but whose family income is not more than 200 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1991).

The new section 406(c) provides that the Secretary shall not deny contract health services coverage to Indian recipients of medical care if such recipients have: (1) attained age 65, or are disabled; (2) received emergency health care and have given notice of the receipt of such health care to the contract health services program within 30 days after receiving such health care, or have demonstrated good cause for not doing so; (3) upon the request of the administrator of the contract health services program, applied for

coverage under title XIX of the Social Security Act within 90 days of the provision of such emergency health care (in accordance with section 1902(a)(34) of the Social Security Act); and (4) are otherwise eligible for contract health services coverage.

Section 406. Authorization of appropriations

Section 406 of the bill amends Title IV of the Act by adding a new section 407 to authorize to be appropriated such sums as may be necessary for fiscal year 1993 and each fiscal year thereafter through fiscal year 2000 to carry out the provisions of the Title.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Section 501. Authorization of appropriations

Section 501 of the bill amends Title V of the Act by adding a new section 512 which authorizes such sums as may be necessary for fiscal year 1993 to be appropriated and each year through fiscal year 2000 to carry out this Title. Subsection (b) of this section sets out the conforming amendments for various sections throughout this Title.

Section 502. Grant authority

Section 502 of the bill amends sections 502, 503, 504, 505, 506, 507, 509, and 510(a) of the Act to authorize the Secretary to make grants to urban Indian organizations for health care and referral services for urban Indians.

Section 503. Federal Tort Claims Act coverage

Section 503 of the bill amends Title V of the Act by establishing a new section 511 which states that for the purposes of section 224 of the Public Health Service Act (42 U.S.C. 233(a)), with respect to claims for personal injury, including death, resulting from the performance of medical surgical, dental or related functions, an urban Indian health program carrying out a contract or agreement under Section 503(a) for the benefit of urban Indians, is deemed part of the Public Health Service in the Department of Health and Human Services while carrying out such contracts or agreements. In addition, the employees of an urban Indian program (including those acting on behalf of the organization as provided in section 2671 of title 28, United States Code) are deemed employees of the Public Health Service while acting within the scope of their employment in carrying out the contract or agreement.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Section 601. Indian Health Service

Section 601 of the bill amends section 601 of the Act to provide that the Secretary shall carry out through the Director of the IHS all scholarship and loan functions under Title I of the Act.

Section 602. Authorization of appropriations

Section 602 amends Title VI of the Act to create a new section 603 to authorize such sums as may be necessary to be appropriated

in fiscal year 1993 and each year through fiscal year 2000 to carry out this Title.

Section 603. Director of Indian Health Service

Section 603(a) abolishes the current position of Director of the Indian Health Service effective January 1, 1993. Section 603(b) establishes a new position of Director of the Indian Health Service effective January 1, 1993. Section 603(c) amends Section 601(a) of the Act by requiring the Director to be appointed by the President with the advice and consent of the Senate. Section 603(d) provides that the President may appoint a person to serve as an Interim Director from January 1, 1993 until a Director is appointed and confirmed as provided for by the amended section 601(a) of this Act. Section 601(e) amends Section 601(a) of the Act to provide that the Director shall serve a term of four years and may, with the advice and consent of the Senate, serve for more than 1 term.

TITLE VII—SUBSTANCE ABUSE PROGRAMS

Section 701. Redesignation of existing title VII

Section 701 redesignates Title VII of the Act as Title VIII and amends Title VIII to read "Miscellaneous". Section 701 also renumbers sections 701 through 720 as sections 801 through 820. Section 701(c) sets out the conforming amendments for various sections throughout this Act.

Section 702. Substance abuse programs

Subsection 702(a) of the bill amends the Act by creating a new Title VII titled "Substance Abuse Programs."

Gallup Alcohol and Substance Abuse Treatment Center

The new section 701(a) authorizes the Secretary to make grants to the Navajo Nation to provide residential treatment for alcohol and substance abuse for Navajos and neighboring tribes.

Section 701(b) sets out the purposes of grants which shall be used to provide 15 residential beds for adult long term treatment, establish clinical assessment teams to determine appropriate treatment for patients, provides 12 beds for an adolescent shelter bed program in Gallup, New Mexico, develops a relapse program which provides vocational training and job retention services, and provides continuing education and training to treatment staff.

Section 701(c) authorizes the Navajo Nation to enter into a contract with an accredited institution in Gallup, New Mexico, to provide comprehensive alcohol and drug treatment as authorized in Section 701(b).

Section 701(d) sets out the authorization of appropriations through fiscal year 1995 for this section.

Urban Indian Program

The new section 702(a) authorizes the Secretary to make grants to urban Indian organizations to provide prevention and treatment services for alcohol and substance abuse.

Section 702(b) provides that each grant made under subsection (a) shall set forth the goals to be accomplished pursuant to the grant.

Section 702(c) provides that the Secretary shall establish grant criteria which shall include the size of the urban Indian population, the health resources available, duplication of existing services or other Federal grants or contracts, capability of the organization to adequate perform the activities required and satisfactory performance standards to meet the goals of the grant. Section 702(c) also provides that the Secretary shall develop a methodology for allocating grants made pursuant to this section based on Section 701(c).

Section 702(d) provides that funds received by urban Indian organizations for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria under subsection (c).

Pueblo substance abuse treatment project for San Juan

The new Section 703 continues the authorization for the substance abuse treatment project at San Juan Pueblo, New Mexico through fiscal year 1995.

Alcohol and substance abuse treatment facility

The new Section 704(a) establishes a regional youth alcohol and substance abuse prevention and treatment center in Sacaton, Arizona, on the Gila River Indian Reservation. The center shall be established within facilities leased, with the consent of the Gila River Indian Tribe, by the Indian Health Service.

Section 704(b) The center established under Section 704(a) shall be known as the "Regional Youth Alcohol and Substance Abuse Prevention and Treatment Center".

Section 704(c) provides that the Secretary, acting through the IHS, shall establish, as a unit of the regional center, a youth alcohol and substance abuse prevention and treatment facility in Schurz, Nevada.

Alaska Native drug and alcohol abuse demonstration project

The new Section 705(a) authorizes the Secretary, acting through the IHS, to make grants to the Alaska Native Health Board to conduct a two-part demonstration project to reduce drug and alcohol abuse in Alaska Native villages and to rehabilitate families afflicted by such abuse. Sixty percent of such grant funds are to be awarded to initiate coordinated community development programs to address alcohol and drug abuse. Forty percent of such grants are to be transferred to a nonprofit corporation in the village of St. Mary's, Alaska, to expand and strengthen family rehabilitation services.

Section 705(b) provides that the Secretary, acting through the IHS, shall evaluate these programs established under 705(a) and to submit a report to be reported to the Congress by January 1, 1994.

Wyoming Treatment Center

The new Section 706(a) provides that the Secretary, acting through the IHS, shall make a grant to the Thunderchild Treatment Center at Sheridan, Wyoming, to match funds already received through private contributions for the completion of construction of a multiple approach substance abuse treatment center.

Section 706(b) provides an authorization for an appropriation of $2,000,000 in fiscal year 1994. No funding is to be made available for staffing or operation of this facility and none of the funding appropriated to carry out this section is to be used for administrative purposes.

Fetal alcohol syndrome and fetal alcohol effect grants

The new Section 707(a) of this Title authorizes the Secretary to make grants to Indian tribes and tribal organizations to establish Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) programs for the purpose of meeting the health status objectives noted in Section 3(b).

Section 707(b) provides that grants made under Section 704(a) may be used to provide community and in-school training on education on FAS/FAE, to identify and provide alcohol and substance abuse treatment to high risk women, to provide educational and vocational support and counselling to FAS/FAE affected persons, and to develop prevention and intervention models.

Section 707(c) provides that the Secretary shall establish criteria for the review and approval of grants under this section.

Section 707(d) provides that ten percent of the funds appropriated under this section shall be used to make grants to urban Indian organizations founded under Title V.

Fetal alcohol syndrome and fetal alcohol effect education

The new Section 708(a) of this Title provides that the Secretary shall provide assistance to Indian tribes and tribal organizations in the development and printing of education and prevention materials on FAS/FAE. Section 708(a) also provides that the Secretary shall provide assistance in the development and implementation of culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities. Such materials shall be developed with tribal input.

Section 708(b) provides that the Secretary shall convene a task force on FAS/FAE of representatives of the Institutes of NIDA, NIAAA, OSAP, NIMH, IHS, Office of Minority Health, BIA, and representatives of Indian tribal governments, tribal organizations, urban Indian communities, and FAS/FAE experts to examine the needs of Indian tribes and Indian communities. The Secretary shall develop an annual plan for the prevention, intervention and treatment and aftercare of those affected by FAS and FAE in Indian communities.

Section 708(c) provides that the Secretary shall make grants for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide aftercare for persons affected by FAS or FAE.

Report

The new Section 709(a) provides that the Secretary shall, not later than March 31st of each fiscal year, transmit a report to the Congress on the status of Fetal Alcohol Syndrome and Fetal Alcohol Effect in the Indian population. This report shall include the following: (1) The progress of implementing a uniform assessment and diagnostic methodology in the IHS and tribally based health

delivery systems; (2) the incidence rates of Indian FAS/FAE babies born in reservation and urban communities; (3) the prevalence of FAS/FAE affected Indian persons in Indian communities, their primary means of support, and recommendations to improve the support system for these individuals and their families or caretakers; (4) the level of support received from the entities specified in Section 710(b); (5) the number of inpatient and outpatient substance abuse treatment resources geared to meet the needs of Indian women, and the volume of care provided to Indian women; and (6) recommendations regarding prevention, intervention and appropriate vocational, educational and other support services for FAS/FAE affected individuals.

Section 709(b) provides that the Secretary may contract the production of this report to a national organization specifically addressing FAS and FAE in Indian communities.

Adolescent and adult fetal alcohol syndrome and fetal alcohol effect

The new Section 710 provides that the Secretary, acting through the IHS, shall conduct a study of the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians and Alaska Natives with FAS or FAE. In carrying out this section, the Secretary is authorized to enter into a contract or other agreement with any organization, entity, or institution of higher education with significant knowledge of FAS and FAE in Indian communities.

Clearinghouse

The new Section 711(a) provides that the Secretary, acting through the IHS, shall establish a national clearinghouse for prevention and educational materials on FAS and FAE in American Indian and Alaska Native Communities.

Section 711(b) provides that the Secretary shall ensure access to all clearinghouse materials by any Indian tribe, Alaska native organization, and urban Indian organization to assist in the development of culturally sensitive educational and training materials and to assist in community education and prevention of FAS/FAE.

Indian women's treatment programs

The new Section 712(a) of this Title provides that the Secretary may make grants to tribal governments and tribal organizations for Indian Women Treatment Programs, to include prevention, intervention and treatment services that address the cultural, historical, social, and childcare needs of Indian women, regardless of age.

Section 712(b) sets forth the uses of the grants made under this section, including: (1) development and provision of community training, education, and prevention for Indian women relating to alcohol and substance abuse and FAS/FAE; (2) identification and provision of appropriate counseling, advocacy, support and relapse prevention to Indian women and their families; (3) development of prevention and intervention models for Indian women which incorporates traditional healers, cultural values, and community and family involvement.

Section 712(c) provides that the Secretary shall establish criteria for the review and approval of grant applications.

Section 712(d) provides that twenty percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations funded under Title V.

Substance abuse counselor education demonstration project

The new Section 713(a) provides that the Secretary, acting through the IHS, may enter into contracts with, or make grants to colleges, universities, and tribally controlled community colleges as defined in section 2(a)(4) of the Tribally Controlled Community College Assistance Act of 1978 (25 U.S.C. 1801 et seq.) to establish Substance Abuse Counselor Education Demonstration Projects to develope educational curricula for substance abuse counseling.

Section 713(b) provides that funding under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors).

Section 713(c) provides that not later than 180 days after the date of enactment of this section, the Secretary, after consulation with colleges, universities, and with Indian Tribes and administrators of tribally controlled community colleges, shall develop and issue criteria for the review and approval of grant applications authorized under this section.

Section 713(d) provides that the Secretary shall provide technical and other assistance as may be necessary to enable grants recipients to comply with provisions of this section.

Section 713(e) provides that the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section, along with legislative recommendations.

Section 713(f) defines "educational curricula" to mean one or more of the following: (1) Classroom education; (2) Clinical work experience; and (3) Continuing education workshops.

Authorization of appropriations

The new Section 714 provides that except as provided in Sections 701, 706 and 713, there are authorized to be appropriated such sums as may be necessary for fiscal year 1993 and each fiscal year through fiscal year 2000 to carry out the provisions of this title.

Subsection 702(b) of the bill redesignates section 4224 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1989 (25 U.S.C.) as section 4208 A and provides that Part 6 of the same Act as amended by this subsection is repealed.

TITLE VIII—MISCELLANEOUS

Section 801. Reports

Section 801 of the Act as redesignated by section 701(b) of this bill is amended to provide that the President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to the Congress a report which contains the following: (1) the progress made in meeting the objec-

tives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which are at parity with the health services available to and the health status, of the general population; (2) a statement specifying the amount of funds requested to carry out the provisions under section 201; (3) a statement of the total amount obligated or expended to achieve each of the objectives under section 814 related to infant and maternal mortality and fetal alcohol syndrome; (4) reports required under sections 3(b), 108(n), 203(b), 209(k), 301(c), 302(g), 403, and 817(a); (5) for fiscal year 1997, the interim report required under section 307(h)(1); (6) for fiscal year 1999, the report required under section 307(h)(2); and (7) a report on whether, and to what extent, new health care programs and initiatives have had an impact on the purposes of this Act, and any steps the Secretary may have taken to consult with Indian tribes to address such impact.

Section 802. Regulations

Section 802 of the Act as redesignated by section 701 of this bill is amended so as to provide that the Secretary shall consult with national and regional Indian organizations prior to any revision of or amendment to regulations promulgated under this Act and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice, and receive comments, other interested parties.

Section 803. Extension of treatment of Arizona as a contract health service delivery area

Section 803 of the bill amends Section 808 of the Act as redesignated by section 701(b) of this bill to extend the treatment of Arizona as a contract health service delivery area through fiscal year 2000.

Section 804. Infant and maternal mortality; fetal alcohol syndrome

Section 804 of the bill amends section 814 of the Act as redesignated by 701(b) of this bill by striking section (a) and by striking subsection (b).

Section 805. Reallocation of base resources

Section 805 amends 817(a) of the Act as redesignated by section 701(b) of this bill by striking "Secretary has submitted to the Congress" and inserting "Secretary has submitted to the President, for inclusion in the report required to be transmitted to the Congress under section 801,".

Section 806. Child sexual abuse treatment programs

Section 806 amends section 819 of the Act as redesignated by section 701(b) of this bill. The new Section 819(a) provides that the Secretary and the Secretary of the Interior shall, for each fiscal year through fiscal year 1995, continue the Hopi Tribe and Assiniboine and Sioux Tribes of the Fort Peck Reservation child sexual

abuse demonstration programs and directs the Secretary to encourage the development of demonstration programs in other tribes. Section 819(b) provides that beginning October 1, 1995, the Secretary and the Secretary of Interior may establish demonstration programs involving treatment for child sexual abuse, except that the Secretaries may not establish a greater number of programs in one area until there is an equal number of demonstration programs in all IHS service areas.

Section 807. Tribal leasing

Section 820 of the Act as redesignated by section 701(b) of this bill is amended to provide that an Indian tribe providing health care services under an Indian Self-Determination Act contract may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriations Acts.

Section 808. Extension of tribal management demonstration project termination date in certain cases

Section 808 amends Section 818 of the Act as redesignated by Section 701(b) of this bill provides that in the case of a tribal management demonstration project for which a grant is made after September 30, 1990, the termination date may be three years after the date on which such grant is made.

Section 809. Long-term care demonstration project

Section 809 amends Title VIII of the Act as redesignated by subsections (a) and (b) of section 701 of this bill by creating a new section 821. Section 821(a) provides that the Secretary, acting through the IHS, is authorized to enter into contracts with, or make grants, to Indian tribal governments or tribal organizations providing health care services pursuant to a contract entered into under the Indian Self-Determination Act, to establish demonstration projects for the delivery of home and community-based services to functionally disabled Indians.

Section 821(b) provides that funds provided for a demonstration project under this section shall be used only for the delivery of home and community-based services (including transportation services) to functionally disabled Indians. Such funds under this section may not be used to make cash payments to functionally disabled Indians, to provide room and board, for the construction or renovation of facilities, for the purchase of equipment or for the provision of nursing facility services.

Section 821(c) provides that within 180 days from the date of enactment of this section, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and issue criteria for the approval of grant applications under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of tribes and tribal organizations to deliver, or arrange for the delivery of, high quality, culturally appropriate home and community-based services to functionally disabled Indians.

Section 821(d) provides that the Secretary shall provide technical assistance to enable applicants to comply with the provisions of this section.

Section 821(e) provides that an Indian tribe or tribal organizations providing services under a demonstration project may provide, on a cost basis, such services to persons otherwise ineligible for health care services from IHS.

Section 821(f) provides that the Secretary shall establish not more than 24 demonstration projects and shall ensure that there is an equal number of projects in all services areas to provide adequate geographic distribution.

Section 821(g) provide that the Secretary shall include findings and conclusions derived from the demonstration projects, together with legislative recommendations in the FY 1999 report required under section 801 of this bill.

Section 821(h) authorizes the Secretary to enter into a shared services agreement with a health facility operated by a tribe or tribal organization that receives assistance under this section and that provides long-term care to older Indians. The Secretary, acting through the IHS, shall place conditions and terms on such shared services agreements necessary to carry out this section. At the request of the tribe or tribal organization, the Secretary shall delegate to the tribe or tribal organizations powers of supervision and control over such local service employees as are necessary to carry out this section. For the purpose of this subsection, the term shared services agreement means a contractual agreement between the IHS and an Indian tribal government or tribal organization whereby the IHS agrees to share staff and other services with a health facility operated by such Indian tribal government or tribal organization. Salaries for such staff and payments for such services shall be proportionately allocable to the service facility and health facility under such agreement.

Section 821(i) sets out the definitions for "home- and community-based services" and "functionally diabled".

Section 821(j) authorizes to be appropriated such sums as are necessary to carry out this section for each of the fiscal years 1993 through fiscal year 1997. Such sums shall remain available until expended.

Section 810. Results of demonstration projects

Section 810 amends Title VIII of the Act as redesignated by subsections (a) and (b) of section 701 by adding a new section 822 which provides that the Secretary shall provide the findings and results of the demonstration projects conducted under this Act for dissemination to Indian tribes.

Section 811. Authorization of appropriations

Section 811(a) amends Section 820 of the Act as redesignated by section 701(b) of the bill and authorizes to be appropriated such sums as may be necessary for fiscal year 1993 and each fiscal year thereafter through the fiscal year 2000 to carry out the provisions of this title.

Section 811(b) amends Title VIII of the Act as redesignated by subsections (a) and (b) of section 701 of this bill to set out the conforming amendments for this title.

Section 812. Tribal self-governance project

Section 812 amends the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f note) to expand the Tribal Self-Governance Project to include the Indian Health Service programs. It provides that self-governance projects tribes shall be eligible for one year planning and negotiations grants to study the programs, activities, functions, or services of the Indian Health Service. It also authorizes such sums as are necessary to carry out the purposes of this section.

Section 813. Waiver or paperwork reduction

Section 813 amends Title VIII of the Act as redesignated by section 701(a) of the bill by adding a new Section 824 which provides that Chapter 35 of title 44, United States Code, shall not apply to information required to carry out any study or survey authorized or required by this Act.

Section 814. Joint venture demonstration projects

Section 814 amends section 818 of the Act, as redesignated by section 701(b) and amended by section 811(b)(2) of the bill, by adding after subsection (d) a new subsection (e). Paragraph (e)(1) provides that the Secretary, acting through the IHS, shall make arrangements with Indian tribes to establish joint venture demonstration projects under which an Indian tribe may expend funds for the acquisition or construction of a health facility for a minimum of 20 years, under a no cost lease, in exchange for the Service's agreement to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. A tribe may use tribal funds, private sector, or other available resources to fulfill their commitment under this subsection. Paragraph (3)(2) of provides that the Secretary may only enter into such agreements after determining that the Indian tribe has the administrative and financial capabilities necessary to fulfill the requirements in paragraph (1). Paragraph (e)(3) provides that an Indian tribe or tribal organization that enters into a written agreement under this subsection and that breaches or terminates without cause such agreement shall be liable to the United States for the amount that has been paid to the tribe under the agreement. The Secretary has a right to recover tangible property and equipment and any funds expended for operation and maintenance under this section. This does not apply to any funds expended for the delivery of health care services, or for personnel or staffing.

Section 815. Demonstration of electronic data submission

Section 815(a) provides that the Secretary shall develop and implement a project to demonstrate how current telecommunications and computer processing can be used to improve the effectiveness of the information exchange between the IHS health centers, private Contract Health Service providers, the IHS Area office and the IHS Fiscal Intermediary. Section 815(b) provides that the dem-

onstration project shall be established effective June 15, 1993, and may involve the awarding of an outside contract.

TITLE IX—TECHNICAL CORRECTIONS

Section 901. Repeal of expired reporting requirements

Section 901 amends the Act to delete reporting requirements contained in sections 116(d), 204(a), 602(a)(3), and 803 as redesignated by section 701(b).

Section 902. Other technical corrections

Section 902 amends the Act to revise certain sections as specified.

COST AND BUDGETARY CONSIDERATION

The Cost estimate for S. 2481, as provided by the Congressional Budget Office is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 7, 1992.

Hon. DANIEL K. INOUYE,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN. The Congressional Budget Office has prepared the enclosed cost estimate of S. 2481, the Indian Health Care Amendments Act of 1992, as ordered reported by the Select Committee on Indian Affairs on June 16, 1992. Enactment of S. 2481 would result in changes in direct spending in the Indian Health Service, and fees and expenses of witness programs. Therefore, pay-as-you-go procedures would apply to this bill.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER,
Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 2481.
2. Bill title: Indian Health Care Amendments Act of 1992.
3. Bill status: As ordered reported by the Senate Indian Affairs Committee on June 16, 1992.
4. Bill purpose: To amend the Indian Health Care Improvement Act to authorize appropriations for Indian health programs, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
AUTHORIZATION OF APPROPRIATIONS					
Estimated authorization levels:					
Recruitment	1	1	1	1	1

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Health professions preparatory scholarships	4	4	4	4	5
Health professions scholarships	9	9	10	10	11
Extern program	1	1	1	1	2
Continuing education	2	2	2	3	3
Nursing program	3	3	3	3	3
Retention bonuses	(1)	(1)	(1)	(1)	(1)
Nursing residency	1	1	1	1	1
Primary care in Indian country	7	7	7	2	2
Community health representative	41	42	44	46	48
IHS loan repayment	10	11	11	12	12
Advanced training and research	1	1	1	1	1
INMED	(1)	(1)	(1)	(1)	(1)
Scholarship and loan repayment recovery fund	(1)	(1)	(1)	(1)	(1)
Matching grants	1	1	1	1	1
Community health aide	21	21	22	23	24
Tribal Health Administration	6	6	6	6	7
Interdisciplinary training	2	2	2	2	2
Manpower shortages	2	2	2	2	2
Catastrophic health emergency fund	13	13	14	15	15
Health promotion/disease prevention	3	3	3	4	4
Diabetes	6	6	6	6	7
Mental health	31	32	34	35	36
Hospice study	(1)	.....	.....	.....	.....
Managed care study	(1)	.....	.....	.....	.....
Epidemiology grants	3	3	4	4	4
California contract health service demonstration	1	1	1	1	1
Screening mammographies	2	2	2	2	3
School health education	14	15	15	16	16
Indian youth grants	2	2	2	2	2
TB prevention demonstration	1	1	1	1	1
Patient travel	6	6	6	6	6
Safe water and sanitary waste	158	164	171	178	185
Ambulatory care facilities	52	54	56	59	61
IHS demonstration project	0	0	16	53	40
Medicaid/Medicare collections	101	105	109	114	119
Federal Tort Claims Act coverage	(1)	(1)	(1)	(1)	(1)
Gallup centers	1	1	1	.....	.....
Urban Substance Abuse Program	(1)	(1)	1	1	1
Pueblo substance abuse	(1)	(1)	(1)	.....	.....
Arizona substance abuse treatment facility	3	3	3	3	3
Alaska substance abuse demonstration	1	1	1	1	1
Thunder Child Center	2	.....	.....	.....	.....
Fetal alcohol syndrome grants	7	8	8	8	9
FAS/FAE education	1	1	1	1	1
FAS/FAE reports	(1)	(1)	(1)	(1)	(1)
FAS/FAE study	(1)	.....	.....	.....	.....
Clearinghouse	(1)	(1)	(1)	(1)	(1)
Indian Women Treatment Program	19	9	9	10	10
Substance abuse counselor education	1	1	1	1	1
Arizona-contract health provider	25	35	45	55	65
Fetal alcohol syndrome	318	330	343	357	372
Child sexual abuse treatment	1	1	1	1	2
Tribal management demonstration projects	1	1	2	2	2
Long-term care demonstration	6	3	116	121	126
Tribal self-governance	17	18	19	19	20
Joint venture demonstration	6	8	11	13	16
Electronic data submission	1	(1)	(1)	(1)	(1)
Total estimated authorization	915	944	1,122	1,207	1,254
Estimated outlays:					
Recruitment	1	1	1	1	1
Health professions preparatory scholarships	3	4	4	4	5

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Health professions scholarships	7	9	10	10	10
Extern program	1	1	1	1	1
Continuing education	2	2	2	3	3
Nursing program	2	3	3	3	3
Retention bonuses	(1)	(1)	(1)	(1)	(1)
Nursing residency	1	1	1	1	1
Primary care in Indian country	5	6	7	3	2
Community health representative	31	40	43	45	47
IHS loan repayment	8	10	11	11	12
Advanced training and research	1	1	1	1	1
INMED	(1)	(1)	(1)	(1)	(1)
Scholarship and loan repayment recovery fund	(1)	(1)	(1)	(1)	(1)
Matching grants	(1)	(1)	1	1	1
Community health aide	16	20	22	23	24
Tribal Health Administration	4	5	6	6	7
Interdisciplinary training	2	2	2	2	2
Manpower shortages	1	2	2	2	2
Catastrophic health emergency fund	10	13	14	14	15
Health promotion/disease prevention	2	3	3	3	4
Diabetes	4	6	6	6	6
Mental health	24	30	33	35	36
Hospice study	(1)	.....	.....	.....	.....
Managed care study	(1)	.....	.....	.....	.....
Screening mammographies	2	2	2	2	3
School health education	11	14	15	16	16
Indian youth grants	2	2	2	2	2
TB prevention demonstration	(1)	(1)	1	1	1
Patient travel	4	5	6	6	6
Safe water and sanitary waste	52	102	133	163	176
Ambulatory care facilities	17	34	44	54	58
IHS demonstration project	0	0	15	44	41
Medicaid/Medicare collections	77	99	108	113	117
Federal Tort Claims Act coverage	(1)	(1)	(1)	(1)	(1)
Gallup centers	1	1	1	(1)	(1)
Urban Substance Abuse Program	(1)	(1)	(1)	(1)	1
Pueblo substance abuse	(1)	(1)	(1)	(1)	(1)
Arizona substance abuse treatment facility	2	3	3	3	3
Alaska substance abuse demonstration	1	1	1	1	1
Thunder Child Center	2	(1)	(1)	.....	.....
Fetal alcohol syndrome grants	6	7	8	8	9
FAS/FAE education	1	1	1	1	1
FAS/FAE report	(1)	(1)	(1)	(1)	(1)
FAS/FAE study	(1)	.....	.....	.....	.....
Clearinghouse	(1)	(1)	(1)	(1)	(1)
Indian women treatment	14	10	10	9	10
Substance abuse counselor education	1	1	1	1	1
Arizona-contract health provider	19	31	42	52	62
Fetal alcohol syndrome	241	311	339	353	368
Child sexual abuse treatment	(1)	1	1	1	1
Tribal management demonstration projects	1	1	2	2	2
Long-term care demonstration	5	4	89	114	125
Tribal self-governance	13	17	18	19	20
Joint venture demonstration	5	7	10	13	16
Electronic data submission	(1)	(1)	(1)	(1)	(1)
Total estimated outlays	605	820	1,029	1,161	1,229
DIRECT SPENDING					
Estimated budget authority	(1)	(1)	(1)	1	1
Estimated outlays	(1)	(1)	(1)	1	1

[1] Less than $500,000.

Note.—Estimates may not add to totals due to rounding.

This cost estimate an implementation date of October 1, 1992.

The costs of this bill fall within budget function 550.

Basis of Estimate: The following sections describe the individual programs. Unless otherwise indicated, the bill authorizes appropriations of such sums as may be necessary for each of fiscal years 1993 through 2000 for these programs.

Health Professions Recruitment: S. 2481 would reauthorize funding for the Health Professions Recruitment Program, which identifies and assists Indians with a potential for success in the health professions. This program was funded at $.5 million in fiscal year 1992. The bill also would require each Indian Health Service (IHS) area office to assign one individual to be responsible on a full-time basis for recruitment activities. The additional cost of salaries to fulfill this requirement would be $.4 million in fiscal year 1993, increasing to $.6 million in fiscal year 1997. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adding the estimated cost of the new provision to the 1992 appropriation, and adjusting the total for projected inflation.

Health Professions Preparatory Scholarships: S. 2481 would reauthorize funding for the Health Professions Preparatory Scholarship Program, which awards scholarship grants for college pre-medical study. This program funded 227 scholarships in fiscal year 1992 for full-time study, with an appropriation of $3.2 million. The bill also would allow grants for part-time students. Assuming that the IHS receives half as many applications for part-time as for full-time study, and the same percentage of applications are awarded, the additional cost of part-time scholarships would be $600,000 in fiscal year 1993, increasing to $700,000 in fiscal year 1997. The bill authorizes appropriations of such sums as may be necessary through fiscal year 2000 for this program. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adding the estimated cost of scholarships for part-time students to the 1992 appropriation amount, and adjusting the total for projected inflation.

Health Professions Scholarships: The bill would reauthorize funding for Indian Health Professions Scholarships, which are given to Indians in health professions schools in exchange for service in the IHS upon graduation. This program funded 451 scholarships in fiscal year 1992, with an appropriation of $8 million. The bill also would allow scholarships for part-time students, and would add a placement office. Assuming that the IHS receives held as many applications for part-time as for full-time study, and the same percentage of applications are awarded, the additional cost of part-time scholarships would be $400,000 in fiscal year 1993. Assuming that the placement office would be run by a director and four support staff, the placement office would cost $200,000 in fiscal year 1993. The bill authorizes appropriations of such sums as may be necessary through fiscal year 2000 for this program. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adding the estimated cost of scholarships for part-time students and of the placement office to the 1992 appropriation amount, and adjusting the total for projected inflation.

Extern Program: S. 2481 would reauthorize funding for the IHS Extern Program, which provides employment to scholarship recipients during the nonacademic period of the year. This program was

funded at $1.2 million in fiscal year 1992. The bill authorizes appropriations of such sums as may be necessary through fiscal year 2000 for this program. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the 1992 appropriation for projected inflation.

Continuing Education Allowances: The bill would reauthorize funding for Continuing Education Allowances, which enable IHS health professionals employed in remote areas to take leave from their duty stations for professional consultation and training courses. In fiscal year 1992, $.8 million in continuing education allowances was appropriated for physicians, $.6 million for dentists, and $.7 million for nurses. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the total 1992 appropriation for projected inflation.

Nursing Program: The bill would reauthorize funding for the Nursing Program, which provides grants to programs and schools of nursing in order to increase the number of nurses who deliver health care services to Indians. This program was funded at $1 million in fiscal year 1992. The bill also would authorize the establishment and development of clinics operated by nurses, midwives, nurse anesthetists, or nurse practitioners to provide primary health care to Indians. Assuming the establishment and development of several clinics, this provision would cost $1.6 million in fiscal year 1993, increasing to $1.8 million in fiscal year 1997. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adding the estimated costs of the new provisions to the fiscal year 1992 appropriation, and adjusting the total for projected inflation. Of these amounts, the bill requires that not less than $1 million is used to provide grants for training of nurse midwives, nurse anesthetists, and nurse practitioners.

Retention Bonuses: The bill would authorize funding for retention bonuses for physicians or nurses serving in a position for which recruitment or retention of personnel is difficult. The bill also would require that not less than 25 percent of the retention bonuses awarded each year be awarded to nurses. This program was not funded in fiscal year 1992. Based on information from the IHS, this program would cost $.4 million in fiscal year 1993, increasing to $.5 million in fiscal year 1997.

Nursing Residency: S. 2481 would authorize establishment of a program to enable nurses working in an Indian health program to pursue advanced training in exchange for obligated service in an Indian health program. According to the IHS, this program already exists and was funded at $1.1 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

Primary Care Services on or near Indian Country: The bill would authorize funding for the establishment of clinics to provide primary health care services to Indians who live within 50 miles of Indian country or in medically underserved rural areas. Assuming the establishment of 4 clinics, this provision would cost $2 million in each of fiscal years 1993 through 1997. The bill also would authorize funding for clinics designed to provide nursing students with a structured clinical experience similar to residency training programs for physicians. The bill authorizes appropriations of $5

million, out of amounts appropriated for this provision for each of the fiscal years 1993 through 1995, for this purpose. CBO estimated the total cost of the provisions by adding the authorization amount for the structured clinical program to the estimated cost of primary care clinics, and adjusting the total amount of projected inflation.

Primary Care Services on or near Indian Country: The bill would authorize funding for the establishment of clinics to provide primary health care services to Indians who live within 50 miles of Indian country or in medically underserved rural areas. Assuming the establishment of 4 clinics, this provision would cost $2 million in each of fiscal years 1993 through 1997. The bill also would authorize funding for clinics designed to provide nursing students with a structured clinical experience similar to residency training programs for physicians. The bill authorizes appropriations of $5 million, out of amounts appropriated for this provision for each of the fiscal years 1993 through 1995, for this purpose. CBO estimated the total cost of the provisions by adding the authorization amount for the structured clinical program to the estimated cost of primary care clinics, and adjusting the total amount for projected inflation.

Community Health Representative: S. 2481 would reauthorize funding for the Community Health Representative Program, which trains Indians as health paraprofessionals in order to provide health care to Indian communities. This program was funded at $39 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

IHS Loan Repayment: The bill would reauthorize funding for the IHS Loan Repayment Program for health professionals, which makes payments on educational loans in exchange for service in the IHS. This program was funded at $5.9 million in fiscal year 1992. The bill would raise the loan repayment limit from $25,000 to $35,000 for each year of obligated service. In addition, the bill would require payments to the health professionals for tax expenses resulting from the loan repayment. The bill also would add podiatric medicine to the list of specialties covered by the program. According to information from the IHS, these changes would increase the cost of the loan repayment program by $4.1 million in fiscal year 1993, increasing to $4.8 million in fiscal year 1997. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the 1992 appropriation for projected inflation, and adding the estimated cost of the new provision.

Advanced Training and Research: S. 2481 would reauthorize funding for Advanced Training and Research, which enables health professionals who have worked in an Indian health program to pursue advanced training or reserve in areas of study for which a need exists. The program requires participants to serve in an Indian health program after completing the training or research program. This program was not funded in fiscal year 1992. Based on information from the IHS, CBO estimates that this program would cost $1 million in fiscal year 1993, increasing to $1.2 million in fiscal year 1997.

INMED: S. 2481 would reauthorize funding for the Indians into Medicine program (INMED), which provides grants to colleges and universities in order to attract Indians to the medical profession.

The INMED program was funded at $.4 million in fiscal year 1992. The bill also would require that one of the grants be provided to a nursing program, and one of the grants be provided to a mental health program. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

Scholarship and Loan Repayment Recovery Fund: S. 2481 would authorize establishment of a fund to make loans and provide health professions scholarships. The bill authorizes annual appropriations to the fund equal to the amounts collected from individuals who breached their scholarship or loan repayment contracts with the IHS, and the amount of interest accruing during the preceding fiscal year on obligations held in the fund. According to the IHS, $189,000 was collected from individuals who had breached their scholarship or loan repayment contract. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1991 amount for projected inflation, and adding estimated interest accruing on the obligations held in the fund.

Matching Grants to Tribes: The bill would authorize assistance to Indian tribes and tribal organizations for educating Indians to serve as health professionals in Indian communities. Grants to tribes would cover 20 percent of the cost of scholarships given to eligible Indians. Based on information from the IHS, CBO estimates that the federal share of the cost of these scholarships would be $.5 million in fiscal year 1993, increasing to $.6 million in fiscal year 1997.

Community Health Aid Program: S. 2481 would authorize funding of a program to train Alaska Natives as health aides, and use such aides in the provision of health services to Alaska Natives living in villages in rural Alaska. According to the IHS, this program already exists, and was funded at $20 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

Tribal Health Program Administration: The bill would authorize the Secretary of Health and Human Services (HHS) to provide training in the administration and planning of tribal health programs. According to the IHS, these activities are being carried out through the Tribal Grant Management Program. This program was funded at $5.4 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

Interdisciplinary Training Grants: S. 2481 would authorize funding for grants to fund the interdisciplinary training of health professionals who deliver health care services to Indians. Based on information from IHS, CBO estimates that these grants would cost $2 million in each of fiscal years 1993 through 1997. The bill states that of the amount appropriated for these grants, not more than $1 million may be used annually to establish postdoctoral training programs in psychology or pharmacy.

Manpower Shortages: The bill would authorize funding for grants to train health professionals in any of the 3 IHF service areas with the most acute health manpower shortages. Based on information from IHF, CBO estimated that three grants of $.55 mil-

lion each would cost $2 million in each of fiscal years 1993 through 1997.

Catastrophic Health Emergency Fund: S. 2481 would reauthorize funding for the Catastrophic Health Emergency Fund, which meets the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses. Currently, victims who would otherwise be eligible for payments from the fund must accrue $10,000 of medical costs per year before receiving assistance. The bill would increase the minimum level of medical costs from $10,000 to $15,000, thus decreasing the number of eligible cases. According to the IHS, there were 807 cases with cost of greater than $15,000. Assuming that 800 cases are funded per year, and that the average cost per case is $16,000 this provision would cost $13 million in fiscal year 1993, increasing to $15 million in fiscal year 1997.

Health Promotion and Disease Prevention: The bill would reauthorize funding for Health Promotion and Disease Prevention Services. These services were funded at $3 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

Diabetes Prevention, Treatment, and Control: S. 2481 would reauthorize funding for Diabetes Prevention, Treatment and Control. These activities were funded at $5.5 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

Mental Health Prevention And Treatment: The bill would reauthorize funding for Mental Health Prevention and Treatment Services. These services were funded at $27.5 million in fiscal year 1992. The bill would authorize funding for intermediate mental health services to Indian children and adolescents. Based on information from IHS, construction and renovation of facilities and staffing for these facilities would cost $2 million in fiscal year 1993, increasing to $3 million in fiscal year 1997. The bill also would authorize funding for three American Indian psychology careers recruitment programs. Based on information from IHS, CBO estimates that these programs would cost less than $500,000 in each of fiscal years 1993 through 1997. CBO estimated the fiscal year 1993, through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation and adding the cost of the additional provisions.

Hospice Care Feasibility Study: S. 2481 would authorize funding for a study to assess the feasibility of providing hospice care to terminally ill Indians and to determine the most efficient means of providing such care. Based on information from the IHS, this study would cost $.3 million in fiscal year 1993.

Managed Care Feasibility Study: The bill would authorize funding for a study to assess the feasibility of allowing Indian tribes in certain circumstances to purchase managed care coverage. Based on information from the IHS, this study would cost $.1 million in fiscal year 1993.

Epidemiology Grants: S. 2481 would authorize grants of at least $250,000 each for the establishment of an epidemiology center in

each IHS service area. Assuming that the average grant amount for each area is $275,000, the grants would cost $3 million in fiscal year 1993, increasing to $4 million in fiscal year 1997.

California Contract Health Services Demonstration Program. S. 2481 would authorize establishment of a demonstration program to evaluate the use of a contract care intermediary to provide health services to high-cost cases. Based on information from the IHS, this program would cost $.6 million in fiscal year 1993, increasing to $.7 million in fiscal year 1997.

Coverage of Screening Mammography: The bill would authorize funding to provide screening mammographies to Indian women 35 years of age or older. Based on information from the IHS on the number of eligible women, this provision would cost $2.2 million in fiscal year 1993, increasing to $2.6 million in fiscal year 1997.

School Health Education: S. 2481 would authorize funding for the development of comprehensive school health education programs for children from preschool through grade 12 in schools located on Indian reservations. Based on information from IHS, these programs would cost $14 million in fiscal year 1993, increasing to $16 million in fiscal year 1997.

Indian Youth Grant Program: The bill would authorize funding for innovative mental and physical disease prevention and health promotion and treatment programs for Indian pre-adolescent and adolescent youths. Based on information from IHS, this program would cost $2 million in each of fiscal years 1993 through 1997.

Tuberculosis Prevention Demonstration: S. 2481 would authorize grants to Indian tribes and tribal organizations to evaluate measures used to prevent and eliminate tuberculosis on Indian reservations. Based on information from IHS, personnel, equipment and other expenses for demonstration projects in each IHS service area would cost $1 million in each of fiscal years 1993 through 1997.

Patient Travel Costs: S. 2481 would authorize funding to pay for the costs of patient travel in remote areas of Alaska when there is no reasonable alternative for the patient. Based on a study by the Alaska Native Health Board, in 1990 unmet need for patient travel totaled $5 million. CBO estimated the fiscal year 1993 through 1997 cost by adjusting the fiscal year 1990 estimate for projected inflation.

Safe Water and Sanitary Waste Disposal Facilities: S. 2481 would reauthorize funding for assistance in providing safe water and sanitary waste facilities to Indian communities. The bill also would authorize federal funding for 80% of the costs of operating, managing and maintaining the facilities. In fiscal year 1992, $75 million was appropriated for construction of safe water and sanitary waste disposal facilities. Based on information from the IHS, the federal share of the cost of operating, managing, and maintaining the facilities would be approximately $80 million in fiscal year 1993, increasing to $94 million in fiscal year 1997. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation, and adding the estimated cost of the new provision.

Ambulatory Care Facilities Grant Program: The bill would authorize funding for construction, expansion, or modernization of IHS ambulatory care facilities. Based on information from the IHS,

this program would cost $52 million in fiscal year 1993, increasing to $61 million in fiscal year 1997.

Indian Health Care Delivery Demonstration Project: The bill would reauthorize funding for Indian Health Care Delivery Demonstration Projects to test alternative means of delivering health care and services through health facilities to Indians. The bill would authorize the Secretary of HHS to make grants for demonstration projects which would begin in fiscal year 1995 and end in fiscal year 1997. Based on information from the IHS, these grants would cost $16 million in fiscal year 1995, $53 million in fiscal year 1996, and $40 million in fiscal year 1997.

Treatment of Payments under Medicaid and Medicare Programs: S. 2481 would reauthorize the use of Medicaid and Medicare payments to improve IHS facilities. According to the IHS, Medicaid and Medicare payments to IHS facilities totaled $97.2 million in fiscal year 1991. Assuming that authorizations will equal the amounts collected in each year, CBO estimated fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1991 collections for projected inflation.

Coverage under the Federal Tort Claims Act: The bill would extend malpractice coverage under the Federal Tort Claims Act to health care professionals working for urban Indian health programs. The cost of extending coverage under the Federal Tort Claims Act would involve both mandatory and discretionary costs. Discretionary costs would include administrative costs to the Public Health Service (PHS), the federal judiciary, and the Department of Justice (DOJ). Mandatory costs would include payments to expert witnesses by the DOJ, indemnity payments, and payments to plaintiffs. Based on the number of health care professionals working for urban Indian health programs, CBO estimated that discretionary costs would be less than $500,000 in each of fiscal years 1993 through 1997, and that mandatory costs would be less than $500,000 in fiscal year 1993, increasing to $1 million in fiscal year 1997.

Gallup Alcohol and Substance Abuse Treatment Center: S. 2481 would authorize funding for grants to the Navajo Nation to provide residential alcohol and substance abuse treatment for adult and adolescent members of the Navajo Nation and neighboring tribes. The bill specifies authorization levels for each of fiscal years 1993 through 1995 for these grants. The following sections discuss the grants and their corresponding funding levels.

The bill would authorize funding for residential beds for adult long-term treatment at $.4 million in fiscal year 1993, $.4 million in fiscal year 1994, and $.5 million in fiscal year 1995.

The bill would authorize funding for establishment of clinical assessment teams to conduct individual assessments in order to match Indian clients with appropriate treatments. The bill authorizes appropriations of $100,000 in fiscal year 1993, $125,000 in fiscal year 1994, and $150,000 in fiscal year 1995 for these activities.

The bill would authorize funding for an adolescent shelterbed program for emergency crisis services, assessments, and family intervention. The bill authorizes appropriations of $75,000 in fiscal year 1993, $85,000 in fiscal year 1994, and $100,000 in fiscal year 1995 for this program.

The bill would authorize funding for a relapse program to identify sources of job training and opportunity, and provide vocational training, job placement and job retention services to recovering substance abusers. The bill authorizes appropriations of $150,000 in each of fiscal years 1993 through 1997 for this program.

The bill would authorize funding for continuing education of treatment staff in intensive outpatient services, development of family support systems, and case management in cooperation with regional colleges, community colleges, and universities. The bill authorizes appropriations of $75,000 in fiscal year 1993, $90,000 in fiscal year 1994, and $100,000 fiscal year 1995.

Urban Substance Abuse Program: S. 2481 would authorize funding for health-related services in prevention, treatment, or rehabilitation of, or education in alcohol and substance abuse to urban Indian organizations. This program was funded at $.4 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation

Pueblo Substance Abuse Treatment Project: The bill would authorize funding for continuation of grants to the 8 Northern Indian Pueblos Council to provide substance abuse treatment services to Indians through fiscal year 1995. These grants were funded at $.2 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

Alcohol and Substance Abuse Treatment Facility in Arizona: S. 2481 would reauthorize funding for a regional youth alcohol and substance abuse prevention and treatment center in Sacaton, Arizona. According to the IHS, this center was funded at $2.8 million in fiscal year 1992. CBO estimated the fiscal year 1993 through 1997 cost by adjusting the fiscal year 1992 cost for projected inflation.

Alaska Native Drug and Alcohol Abuse Demonstration: The bill would authorize funding for a community-based demonstration project to reduce drug and alcohol abuse in Alaska Native villages and to rehabilitate families afflicted by such abuse. Based on information from IHS, start-up costs and subsequent operational costs for this project would total $1 million in each of fiscal years 1993 through 1997.

Thunder Child Treatment Center: S. 2481 would authorize funding for the completion of construction of a multiple approach substance abuse treatment center which specializes in the treatment of alcohol and drug abuse of Indians. The bill authorizes an appropriations of $2 million in fiscal year 1993 for this purpose.

Fetal Alcohol Syndrome and Fetal Alcohol Effect Grants: The bill would authorize establishment of grants for fetal alcohol syndrome (FAS) and fetal alcohol effect (FAE) programs. The authorized programs include community and in-school training, education and prevention programs, and alcohol and substance abuse treatment programs for high-risk women. According to the IHS, community and in-school training, education and prevention would cost $2.2 million in fiscal year 1993 for staffed programs in each of eleven service areas. Based on information from HIS, treatment programs for high-risk women would cost $7 million in fiscal year

1993. CBO estimated the total cost in fiscal year 1993 through 1997 by adjusting the sum of costs for the grant programs by projected inflation. The bill also specifies that 10 percent of appropriations for FAS and FAE grants be used to make grants to urban Indian organizations.

FAS and FEA Education: S. 2481 would authorize funding for assistance to Indian tribes and tribal organizations for the production of education and prevention materials on FAS and FAE, and the development of culturally sensitive diagnostic tools. CBO estimates that production of these materials would cost $100,000 in fiscal year 1993. The bill also would authorize funding for applied research projects on methods of prevention, intervention, treatment or after care for persons affected by FAS or FAE. Based on information from IHS, these projects would cost approximately $300,000 each. Assuming that three projects are funded, the total cost of the applied research projects would be $900,000 in fiscal year 1993. CBO estimated the fiscal year 1994 through 1997 costs for this provision by adjusting the sum of the fiscal year 1993 estimates for projected inflation.

FAS/EAE Reports: S. 2481 would authorize funding for annual reports about the status of FAS and FEA in the Indian population. CBO estimates that these reports would cost less than $500,000 in each of fiscal yeas 1993 through 1997.

Adolescent and Adult FAS and FAE Study: The bill would authorize funding for a study of the special needs of adolsecent and adult Indians and Alaska Natives with FAS or FAE. Based on information from IHS, this tudy would cost $200,000 in fiscal year 1993.

Clearinghouse: H.R. 3724 would authorize establishment of a national clearinghouse for information on FAS and FAE in Indian and Alaska Native communities. The cost of the clearinghouse would include funding for staff, utilities, computers and materials. Based on information from IHS, CO estimates that these costs would be less than $500,000 in each of fiscal years 1993 through 1997.

Indian Women Treatment Program: The bill would authorize funding for development and implementation of a comprehensive program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the needs of Indian women. According to the IHS, establishment of this program in fiscal year 1993 would involve initial construction and renovation costs averaging $1 million per area, as well as initial start-up costs of $.5 million per area. Thus the program would cost $19 million in fiscal year 1993. In fiscal years 1994 through 1997 the cost of operation centers in each area and the cost of running projects would total $9 million in fiscal year 1994, increasing to $10 million in fiscal year 1997. The bill also specifies that 20 percent of appropriations for this program be used to make grants to urban Indian organizations.

Substance Abuse Counselor Education: The bill would authorize funding for the establishment of demonstration projects in tribally controlled community colleges to develop educational curricula for substance abuse counseling. The bill authorizes appropriations of such sums as may be necessary in each of fiscal years 1993 through

1997 for these projects. Based on information from an association of tribally controlled community colleges, the costs of establishing five demonstration projects would be approximately $1 million in fiscal year 1993. CBO estimated the fiscal year 1994 through 1997 authorization levels by adjusting the fiscal year 1993 estimate for projected inflation.

Arizona-Contract Health Provider: The bill would reauthorize funding for the designation of Arizona as a contract health service delivery area through fiscal year 2000. According to the IHS, because this provision was only partially funded, only urgent or emergency care services were provided. Also, only about 60 percent of those eligible under this designation were covered in the past due to funding constraints. If the program is fully funded to cover all eligible Indians, and if the increase is phased in over five years, this provision would cost $25 million in fiscal year 1993, increasing to $65 million in fiscal year 1997.

Infant and Maternal Mortality; Fetal Alcohol Syndrome: S. 2481 would reauthorize funding for programs to reduce the rate of infant mortality, maternal mortality, and fetal alcohol syndrome among Indians. According to the IHS, these programs were funded at $305 million in fiscal year 1992. CBO estimated to the fiscal year 1993 through 1997 authorization amounts by adjusting the fiscal year 1992 appropriation for projected inflation.

Child Sexual Abuse Treatment Programs: S. 2481 would reauthorize funding for Child Sexual Abuse Treatment Programs. The bill would authorize continuation of the demonstration programs involving treatment of children who have been sexually abused. The treatment would continue to be provided through certain tribes, through fiscal year 1995. Based on information from the IHS these continuations would cost $.6 million in fiscal year 1993, increasing to $.7 million in fiscal year 1995. The bill also would authorize establishment in any service area of demonstration programs involving treatments for child sexual abuse beginning in fiscal year 1996. Based on information from the IHS, this program would cost $1.4 million in fiscal year 1996, and $1.5 million in fiscal year 1997.

Tribal Management Demonstration Projects: The bill would reauthorize funding for demonstration projects for tribal management of health care services, and would extend the funding for certain projects. Information from the IHS indicates that these provisions would cost $1.2 million in fiscal year 1993, increasing to $1.9 million in fiscal year 1997.

Long-Term Care Demonstration Project: S. 2481 would authorize establishment of not more than 24 demonstration projects for the delivery of home and community-based services to functionally disabled Indians. According to an IHS survey, approximately 8% of the Indian population is functionally disabled. Assuming that 250,000 Indians are included in demonstration projects, there would be 20,000 functionally disabled people served by these projects. Accordingly to the IHS, the projects should be phased in over several years. In the first year, functional assessments, training, and technical assistance would cost a total of $6 million in fiscal year 1993. In the second year, planning and feasibility studies, training, and technical assistance would cost a total of $3 mil-

lion in fiscal year 1994. In the third through fifth years, services to the functionally disabled, administration costs, and technical assistance would cost $116 million in fiscal year 1995, increasing to $126 million in fiscal year 1997.

Tribal Self-Governance Project: S. 2481 would reauthorize funding for a research and demonstration project in which participating tribes plan, conduct, and administer programs and services. This project was funded at $16 million in fiscal year 1992. The bill also would authorize funding for one-year planning and negotiation grants to tribes participating in the demonstration project. For these grants, the bill authorizes appropriations of such sums as may be necessary. CBO estimates that these grants would require funding of less than $500,000 in each of fiscal years 1993 through 1997. CBO estimated fiscal year 1993 through 1997 authorization levels by adjusting the fiscal year 1992 appropriation for projected inflation, and adding the estimated cost of the planning grants.

Joint Venture Demonstration Projects: The bill would authorize funding for demonstration projects in which an Indian tribe would fund the acquisition or construction of a health facility, and the IHS would provide the equipment, supplies, and staffing to operate and maintain the facility. According to the IHS, the equipment, supplies and staffing would cost $2 million per facility. Assuming that 3 facilities are funded initially, and one is added per year, these projects would cost $6 million in fiscal year 1993, increasing to $16 million in fiscal year 1997.

Demonstration of Electronic Data Submission: S. 2481 would authorize funding for a project to demonstrate the accuracy and effectiveness of telecommunications and computer processing technology in data submission. Based on information from IHS, start-up costs would be $1 million in fiscal year 1993, and operating costs would be less than $.5 million per year thereafter.

This estimates assumes that all authorizations are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

6. Pay-as-you-go considerations: The Budget Enforcement Act of 1990 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1995. The enactment of S. 2481 would result in changes in direct spending in the IHS, and fees and expenses of witness programs. Therefore, the bill would have the following pay-as-you-go impact:

[By fiscal year, in millions of dollars]

	1993	1994	1995
Outlay	(1)	(1)	(1)
Receipts	(2)	(2)	(2)

[1] Less than $500,000.
[2] Not applicable.

7. Estimated cost to State and local government: The Safe Water and Sanitary Waste Program and the Matching Grants Program both require non-federal matching funds. Grant recipients are required to make non-federal contributions at the rates detailed in

the estimate. Non-federal contributions could come from state and local governments. The Joint Venture Demonstration projects require that tribes or tribal organizations fund the acquisition or construction of facilities from tribal funds, private sector, or other available resources. These contributions could come from state and local governments.

8. Estimate comparison: None.

9. Previous CBO estimate: None.

10. Estimate prepared by: Connie Takata.

11. Estimate approved by: C.G. Nuckols, Assistant Director for Budget Analysis.

Regulatory Impact Statement

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 2481 will have minimal regulatory or paperwork impact.

Executive Communications

The Committee received the following testimony from the U.S. Department of Health and Human Services on S. 2481.

Statement of Everett R. Rhoades, M.D., Director, Indian Health Service, Department of Health and Human Services

Mr. Chairman and Members of the Committee, I am Dr. Everett R. Rhoades, Director of the Indian Health Service (IHS). Accompanying me today is Mr. George Buzzard, Associate Director, Office of Administration and Management; Mr. Bill Pearson, Associate Director, Office of Environmental Health and Engineering (OEHE); Ms. Luana Reyes, Associate Director, Office of Planning, Evaluation and Legislation (OPEL); and Dr. Phillip Smith, Associate Director, Office of Health Programs (OHP). I am very pleased to be here today to discuss with you S. 2481, The Indian Health Care Amendments of 1992.

The Indian Health Care Improvement Act has been very instrumental in supporting our efforts to meet the goals of improving the health status of American Indians and Alaska Natives (AI/AN). It was responsible for reinforcing the continuing goal of achieving parity for Indian people with that of the rest of the Nation. The Act also required that the identify steps necessary to ensure that parity is achieved. We strongly support the goals of the Indian Health Care Improvement Act.

We consider this Act to be the cornerstone of our efforts to maintain a health care system which provides high quality health services to AI/AN people. As a result of this Act and accompanying increases in financial and human resources over the past fifteen years, we have made major

strides in accomplishing our primary goal of improving the health status of Indian people.

Additionally, activities authorized by this Act, in conjunction with the Indian Self-Determination and Education Assistance Act Public Law (P.L.) 93-638 represents a continuous, long-term effort to establish a framework within which AI/AN people can effectively participate in deciding their role in health programs developed to serve their communities. P.L. 93-638 provides the mechanism and the Indian Health Care Improvement Act authorizes resources to make self-determination a reality.

The IHS, in keeping with the principles of these two major Acts, continues to be guided by three key principles:

1. Continued improvement of health programs for AI/AN in ways which lend themselves to successful local management.

2. Maximum AI/AN participation in all available health programs for which they are eligible; and promoting awareness of the efforts needed to make other health programs available and accessible to those Indian people who qualify for their assistance.

3. Strengthen Indian community capabilities in the management of their own health programs, to the extent they choose.

Significant improvements in the health status of AI/AN have been accomplished. The life expectancy of AI/AN continues to increase at a rate faster than that for U.S. All Races. For example, in 1980, the life expectancy at birth for AI/AN had increased to 71.1 years (67.1 years for males and 75.1 for females), an increase of 19 percent since 1950, during which period the increase for the U.S. White population was 8 percent. Despite these gains, life expectancy at birth for AI/AN lagged behind that for the U.S. White population in 1980 (74.4 years for both sexes, 70.7 years for males, and 78.1 years for females).

Even though these unparalleled improvements are very gratifying, for a number of causes, the mortality rates for AI/AN continues to exceed that of the U.S. All Races group. For example, in 1988, the Indian (Reservation State) age-adjusted mortality rates (per 100,000 population) for the following causes exceeded those for the U.S. All Races population as shown in the following table:

Cause	Percent difference	Indian deaths		U.S. deaths	
		Rate	Number	Rate	Number
Alcoholism	438	33.9	389	6.3	16,882
Tuberculosis	400	2.5	30	0.5	1,921
Diabetes mellitus	155	25.8	304	10.1	40,368
Accidents	131	80.8	1,177	25.0	97,100
Homicide	57	14.1	214	9.0—	22,032
Pneumonia and Influenza	32	18.7	266	14.2	77,662
Suicide	27	14.5	221	11.4	30,407

Turning to future directions for IHS efforts to better serve AI/AN, we would note that IHS provides a comprehensive delivery system that is structured to include both primary and preventive services. I would like to emphasize that as a valuable supplement to this already comprehensive program, we fully expect to adhere to the objectives of the Administration's "Healthy People 2000" targets. As we move toward the next century, we must balance our emphasis on the need for increased health promotion and disease prevention services with the comprehensive nature of our program. However, our emphasis will continue to be the direct delivery of health care services.

Indian communities, as is true of the rest of the nation, are subject to changes in health care delivery. Specifically, as knowledge and availability of different treatment and services become available, and community health care needs fluctuate based on population growth and change, present methods and strategies for care may not be appropriate to specific community circumstances in two, five or more years from today.

Economic conditions in Indian country is also a factor in health care delivery. The high unemployment that has always existed in most Indian communities, which is many areas exceeds 40 percent according to the Bureau of Indian Affairs statistics, is subject to unpredictable fluctuations. Any increase in unemployment rates of the general population can result in a sharp influx of AI/AN people to their home communities and would place a strain on the health care system. The IHS always needs to be prepared for volatility in the demand for its services both in volume and types of services required. It is important for us to consider how we may maintain the most flexibility in addressing present and future demands. One key to the solution, we believe is to continue our policy of integrating more closely the multi-disciplinary activities which characterize our program.

Generally, S. 2481 continues to provide the flexibility that is required of a health care delivery system, and we support the reauthorization of the Act through the year 2000. This longer authorization period would allow the Department time to fully implement the Act as intended by Congress and would allow for more long range planning by the IHS. For example, we could expand our initiatives in managed care or think more broadly in terms of the importance of having the capability to shape our system of care to complement any larger charges in health care delivery and financing.

Although we have some concerns about certain sections of the bill, its major provisions are consistent with our perception of what the Indian Health Care Improvement Act should seek to accomplish. We look forward to continuing to work with the Committee on this important legislation.

This concludes my remarks. I will be pleased to answer any questions that you may have. Thank you.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by S. 2481 are shown as follows (existing law proposed to be omitted is enclosed in brackets, new matter is printed in italic, and existing law in which no change is proposed in shown in roman print):

INDIAN HEALTH CARE IMPROVEMENT ACT

(Public Law 94-437; approved September 30, 1976; 25 U.S.C. 1601 et seq.; amended Public Law 100-713; approved November 23, 1988)

AN ACT To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the [''Indian Health Care Improvement Act''. [25 U.S.C. 1601 note]]

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Indian Health Care Amendments Act of 1992''.

(b) TABLE OF CONTENTS.—

Sec. 1. Short Title; table of contents.
Sec. 2. Amendments to Indian Health Care Improvement Act.
Sec. 3. Findings; policy; definitions.

TITLE I—INDIAN HEALTH MANPOWER

Sec. 101. Purpose.
Sec. 102. Health professions.
Sec. 103. Breach of contract provisions relating to Indian health scholarships.
Sec. 104. Nursing.
Sec. 105. Maintenance of community health representative program.
Sec. 106. Changes to Indian health service loan repayment program.
Sec. 107. Recruitment activities.
Sec. 108. Advanced training and research.
Sec. 109. Tribally controlled postsecondary vocational institutions.
Sec. 110. INMED program.
Sec. 111. Scholarship and loan repayment recovery.
Sec. 112. Matching grants to tribes.
Sec. 113. Community health aid program.
Sec. 114. Tribal health program administration.
Sec. 115. Placement of participants in scholarship and loan repayment programs.
Sec. 116. Interdisciplinary training grants.
Sec. 117. Manpower shortages.
Sec. 118. Authorization of appropriations.

TITLE II—HEALTH SERVICES

Sec. 201. Health status and resource deficiency.
Sec. 202. Catastrophic health emergency fund.
Sec. 203. Health promotion and disease prevention.
Sec. 204. Diabetes prevention, treatment, and control.
Sec. 205. Mental health prevention and treatment services.
Sec. 206. New studies.
Sec. 207. Right of recovery.
Sec. 208. Epidemiology grant program.
Sec. 209. California contract health services demonstration program.
Sec. 210. Coverage of screening mammography.
Sec. 211. Comprehensive school health education programs.
Sec. 212. Indian youth grant program.

Sec. 213. Tuberculosis prevention demonstration project.
Sec. 214. Patient travel costs.
Sec. 215. Authorization of appropriations.

TITLE III—HEALTH FACILITIES

Sec. 301. Health facilities closure and priorities.
Sec. 302. Safe water and sanitary waste disposal facilities.
Sec. 303. Ambulatory care facilities grant program.
Sec. 304. Indian health care delivery demonstration project.
Sec. 305. Expenditure of nonservice funds for renovation.
Sec. 306. Authorization of appropriations.

TITLE IV—ACCESS TO HEALTH SERVICES

Sec. 401. Treatment of payments to Indian Health Service facilities under medicare and medicaid programs.
Sec. 402. Report.
Sec. 403. Grants to and contracts with tribal organizations.
Sec. 404. Extension of demonstration program.
Sec. 405. Additional authority.
Sec. 406. Authorization of appropriations.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Sec. 501. Authorization of appropriations.
Sec. 502. Grant authority.
Sec. 503. Federal Tort Claims Act coverage.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Sec. 601. Indian Health Service.
Sec. 602. Authorization of appropriations.
Sec. 603. Director of Indian Health Service.

TITLE VII—SUBSTANCE ABUSE PROGRAMS

Sec. 701. Redesignation of existing title VII.
Sec. 702. Substance abuse programs.

TITLE VIII—MISCELLANEOUS

Sec. 801. Reports.
Sec. 802. Regulations.
Sec. 803. Extension of treatment of Arizona as a contract health service delivery area.
Sec. 804. Infant and maternal mortality; fetal alcohol syndrome.
Sec. 805. Reallocation of base resources.
Sec. 806. Child sexual abuse treatment programs.
Sec. 807. Tribal leasing.
Sec. 808. Extension of tribal management demonstration project termination date in certain cases.
Sec. 809. Long-term care demonstration project.
Sec. 810. Results of demonstration projects.
Sec. 811. Authorization of appropriations.
Sec. 812. Tribal self-governance project.
Sec. 813. Waiver of paperwork reduction.
Sec. 814. Joint venture demonstration projects.
Sec. 815. Demonstration of electronic data submission.

TITLE IX—TECHNICAL CORRECTIONS

Sec. 901. Repeal of expired reporting requirements.
Sec. 902. Other technical corrections.

SEC. 2. AMENDMENTS TO INDIAN HEALTH CARE IMPROVEMENT ACT.

Whenever in this Act a section or other provision is amended or repealed, such amendment or repeal shall be considered to be made to that section or other provision of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.)

FINDINGS

SEC. 2. [25 U.S.C. 1601] The Congress finds that—

(a) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

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

(d) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States. [For example, for Indians compared to all Americans in 1971, the tuberculosis death rate was over four and one-half times greater, the influenza and pneumonia death rate over one and one-half times greater, and the infant death rate approximately 20 per centum greater.

[(e) All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.]

(e) The unmet needs of tribal groups or local populations are sufficiently varied that resources provided for contracts under the authority of the Indian Self-Determination Act should provide maximum flexibility for tribal use of these funds in meeting local priorities.

[(f) Further improvement in Indian health is imperiled by—

[(1) inadequate, outdated, inefficient, and undermanned facilities. For example, only twenty-four of fifty-one Indian Health Service hospitals are accredited by the Joint Commission on Accreditation of Hospitals; only thirty-one meet national fire and safety codes; and fifty-two locations with Indian populations have been identified as requiring either new or replacement health centers and stations, or clinics remodeled for improved or additional services;

[(2) shortage of personnel. For example, about one-half of the Service hospitals, four-fifths of the Service hospital outpatient clinics, and one-half of the Service health clinics meet only 80 per centum of staffing standards for their respective services;

[(3) insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and mental health services, and services available through contracts with private physicians, clinics, and agencies. For example, about 90 per centum of the surgical operations needed for otitis media have not been performed, over 57 per centum of required dental services remain to be provided, and about 98 per centum of hearing aid requirements are unmet;

[(4) related support factors. For example, over seven hundred housing units are needed for staff at remote Service facilities;

[(5) lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climate conditions; and

[(6) lack of safe water and sanitary waste disposal services. For example, over thirty-seven thousand four hundred existing and forty-eight thousand nine hundred and sixty planned replacement and renovated Indian housing units need new or upgraded water and sanitation facilities.

[(g) The Indian people's growth of confidence in Federal Indian health services is revealed by their increasingly heavy use of such services. Progress toward the goal of better Indian health is dependent on this continued growth of confidence. Both such progress and such confidence are dependent on improved Federal Indian health services.]

[DECLARATION OF POLICY

[SEC. 3. [25 U.S.C. 1602] The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.]

DECLARATION OF HEALTH OBJECTIVES

SEC. 3. (a) The Congress declares that it is the policy of the United States—

"(1) in fulfillment of its special responsibilities and legal obligations to the American Indian and Alaska Native people residing throughout the United States, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

"(2) to raise the health status of American Indian and Alaska Native people to the highest possible level;

"(3) to assure that all persons who are eligible for the health care services provided by the Indian Health Service have access to the same fundamental health care benefits; and

"(4) to assure the development of a comprehensive health care system, including tribal health care programs, that will meet the health care needs of American Indian and Alaska Native people in each of the developmental stages of life.

"(b) It is the intent of the Congress that the Nation meet the following health status objectives with respect to Indians by the year 2000;

(1) Reduce coronary heart disease deaths to no more than 100 per 100,000.

(2) Reduce the prevalence of overweight individuals to no more than 30 percent.

(3) Reduce the prevalence of anemia to less than 10 percent among children aged 1 through 5.

(4) Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000.

(5) Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000.

(6) Slow the rise in deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 25 per 100,000.

(7) Reduce deaths among men caused by alcohol-related motor vehicle crashes to no more than 44.8 per 100,000.

(8) Reduce cirrhosis deaths to no more than 13 per 100,000.

(9) Reduce drug-related deaths to no more than 3 per 100,000.

(10) Reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000 adolescents.

(11) Reduce to no more than 30 percent the proportion of pregnancies that are unintended.

(12) Reduce suicide among men to no more than 12.8 per 100,000.

(13) Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17.

(14) Reduce to less than 10 percent the prevalence of mental disorders among children and adolescents.

(15) Reduce homicides to nor more than 11.3 per 100,000.

(16) Reduce the incidence of child abuse or neglect to less than 25.2 per 1,000 under age 18.

(17) Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples.

(18) Reduce rape and attempted rape of women aged 12 and older to no more than 107 per 100,000 women.

(19) Increase years of healthy life to at least 65 years.

(20) Reduce deaths caused by unintentional injuries to no more than 66.1 per 100,000.

(21) Reduce deaths caused by motor vehicle crashes to no more than 39.2 per 100,000.

(22) Among children aged 6 months through 5 years, reduce the prevalence of blood lead levels exceeding 15 ug/dL and reduce to zero the prevalence of blood lead levels exceeding 25 ug/dl.

(23) Reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 45 percent among children aged 6 through 8 and no more than 60 percent among adolescents aged 15.

(24) Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 20 percent among children aged 6 through 8 and no more than 70 percent among adolescents aged 15.

(25) Reduce to no more than 20 percent the proportion of individuals aged 65 and older who have lost all of their natural teeth.

(26) Reduce the prevalence of gingivitis aged 35-44 to no more than 50 percent.

(27) Increase to at least 45 percent the proportion of individuals aged 35 to 44 who have never lost a permanent tooth due to dental caries or periodontal disease.

(28) Reduce destructive periodontal diseases to a prevalence of no more than 15 percent among individuals aged 35 to 44.

(29) Increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth.

(30) Increases to at least 65 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay.

(31) Reduce the infant mortality rate to no more than 8.5 per 1,000 live births.

(32) Reduce the fetal death rate (20 or more weeks of gestation) to no more than 4 per 1,000 live births plus fetal deaths..

(33) Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births.

(34) Reduce the incidence of fetal alcohol syndrome to no more than 2 per 1,000 live births.

(35) Reduce stroke deaths to no more than 20 per 100,000.

(36) Reverse the increase in end-stage renal disease (requiring maintenance dialysis or transplantation) to attain an incidence of no more than 13 per 100,000.

(37) Reduce breast cancer deaths to no more than 20.6 per 100,000 women.

(38) Reduce deaths from cancer of the uterine cervix to no more than 1.3 per 100,000 women.

(39) Reduce colectoral cancer deaths to no more than 13.2 per 100,000.

(40) Reduce to no more than 11 percent the proportion of individuals who experience a limitation in major activity due to chronic conditions.

(41) Reduce significant hearing impairment to a prevalence of no more than 82 per 1,000.

(42) Reduce significant visual impairment to a prevalence of no more than 30 per 1,000.

(43) Reduce diabetes-related deaths to no more than 48 per 100,000.

(44) Reduce diabetes to an incidence of no more than 2.5 per 1,000 and a prevalence of no more than 62 per 1,000.

(45) Reduce the most severe complications of diabetes as follows:

(A) End-stage renal disease, 1.9 per 1000.

(B) Blindness, 1.4 per 1,000.

(C) Lower extremity amputation, 4.9 per 1,000.

(D) Perinatal mortality, 2 percent.

(E) Major congenital mortality, 4 percent.

(46) Confine annual incidence of diagnosed AIDS cases to no more than 1,000 cases.

(47) Confine the prevalence of HIV infection to no more than 100 per 100,000.

(48) Reduce gonorrhea to an incidence of no more than 225 cases per 100,000.

(49) Reduce Chlamydia trachomatis infections, as measured by a decrease in the incidence of nongonococcal urethritis to no more than 170 cases per 100,000.

(50) Reduce primary and secondary syphilis to an incidence of no more than 10 cases per 100,000.

(51) Reduce the incidence of pelvic inflammatory disease, as measured by a reduction in hospitalization for pelvic inflammatory disease to no more than 250 per 100,000 women aged 15 through 44.

(52) Reduce sexually transmitted hepatitis B infection to no more than 30,500 cases.

(53) Reduce indigenous cases of vaccine-preventable diseases as follows:

(A) Diphtheria among individuals aged 25 and younger, 0.

(B) Tetanus among individuals aged 25 and younger, 0.

(C) Polio (wild-type virus), 0.

(D) Measles, 0.

(E) Rubella, 0.

(F) Congenital Rubella Syndrome, 0.

(G) Mumps, 500.

(H) Pertussis, 1000.

(54) Reduce epidemic-related pneumonia and influenza deaths among individuals aged 65 and older to no more than 7.3 per 100,000.

(55) Reduce the numbers of new carriers of viral hepatitis B among Alaska Natives to no more than 1 case.

(56) Reduce tuberculosis to an incidence of no more than 15 cases per 100,000.

(57) Reduce bacterial meningitis to no more than 8 cases per 100,000.

(58) Reduce infectious diarrhea by at least 25 percent among children.

(59) Reduce acute middle ear infections among children aged 4 and younger, as measured by days of restricted activity or school absenteeism, to no more than 105 days per 100 children.

(60) Reduce pneumonia-related days of restricted activity as follows:

(A) Individuals aged 65 and older (per 100 people), 38 days.

(B) Children aged 4 and younger (per 100 children), 24 days.

(61) Reduce cigarette smoking to a prevalence of no more than 20 percent.

(62) Reduce smokeless tobacco use by Indian and Alaska Native youth to a prevalence of no more than 10 percent.

(63) Increase to at least 65 percent the proportion of Indian and Alaska Native parents and caregivers who use feeding practices that prevent baby bottle tooth decay.

(64) Increase to at least 75 percent the proportion of Indian and Alaska Native mothers who breast feed their babies in the early postpartum period, and to at least 50 percent the proportion who continue breast feeding until their babies are 5 to 6 months old.

(65) Increase to at least 90 percent the proportion of pregnant Indian and Alaska Native women who receive prenatal care in the first trimester of pregnancy.

(66) Increase to at least 70 percent the proportion of Indians and Alaska Natives who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the United States Preventive Services Task Force.

(67) Increase the proportion of degrees awarded to Indians and Alaska Natives in the health professions and allied and associated health profession fields to 0.6 percent.

(68) Develop and implement a national process to identify significant gaps in the disease prevention and health promotion data for Indians and Alaska Natives and establish mechanisms to meet these needs.

(69) Increase services to older individuals who are in need of medical care, personal care, or chore services in their home.

"(c) The Secretary shall submit, to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report on the progress made in each area of the Service toward meeting each of the objectives described in subsection (b).

"(d) The objectives set forth in subsection (b) should include an emphasis on preventive, community-based services including, well-child and well-elder clinics, emphasis on family rather than individual treatment, and emphasis on in-home and community-based services for Indians who are aged 65 and older or who are functionally impaired.

"(e) The Secretary may revise the health objectives set forth in subsection (b) to reflect the findings of the Surgeon General related to American Indians and Alaska Natives contained in the "Healthy People 2000" report."

[(b) The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report on the program made in each area of the Service toward meeting each of the objectives described in subsection (a).]

DEFINITIONS

SEC. 4. [25 U.S.C. 1603] For purposes of this ACT—

"(a) "Secretary", unless otherwise designated, means the Secretary of Health Human Services.

(b) "Service" means the Indian Health Service.

(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of [sections 102, 103, and 201(c)(5)] *sections 102 and 103,* such terms shall mean any individual who (1), [irrespective of whether he or she lives on or near a reservation,] is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, *irrespective of whether he or she lives on or near a reservation,* or (2) is an Eskimo and Aleut or

other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organizations of Indians which is controlled by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection (c)(1) through (4) of this section.

(g) "Urban center" means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

(i) "Area office" means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

(j) "Service unit" means—

(1) an administrative entity within the Indian Health Service, or

(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act,

through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

(k) "Health promotion" includes—

(1) cessation of tobacco smoking,
(2) reduction in the misuse of alcohol and drugs,
(3) improvement of nutrition,
(4) improvement in physical fitness,
(5) family planning,
(6) control of stress, and
(7) pregnancy and infant care (including prevention of fetal alcohol syndrome),

(l) "Disease prevention" includes—

(1) immunizations,
(2) control of high blood pressure,

(3) control of sexually transmittable diseases,
(4) prevention and control of diabetes,
(5) control of toxic agents,
(6) occupational safety and health,
(7) accident prevention,
(8) fluoridation of water, and
(9) control of infectious agents.

(m) "Service area" means the geographical area served by each Area office.

(n) "Health profession" means medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatric medicine, geriatric medicine, psychology, social work, marriage and family therapy, environmental health and engineering, public health, nursing, public health nursing, chirpractic medicine, or an allied health profession.

(o) "Health professional" means an individual with a degree in a health profession.

(p) "Substance abuse" includes inhalant abuse.

TITLE I—INDIAN HEALTH MANPOWER

PURPOSE

SEC. 101. [25 U.S.C. 1611] The purpose of this title is [to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the Service and private practice among Indians,] *to increase the number of Indians entering the health professions and to assure an adequate supply of health professionals to Indians, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of primary health care to Indian people.*

9HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS9

HEALTH PROFESSIONS

Sec. 102. [25 U.S.C. 1612] (a) The Secretary, acting through the Service, shall make grants to public or nonprofit private health, or educational entities, or Indian tribes or tribal organizations to assist such entities in meeting the costs of—

(1) identifying Indians with a potential for education or training in the health profession, as defined in section 4(n), and encouraging and assisting them—[and encouraging and assisting them (A) to enroll in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health nursing, or allied health professions; or (B), if they are not qualified to enroll in any such school, or undertake such post-secondary education or training as may be required to qualify them for enrollment; especially family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, and mental health; and encouraging and assisting them—]

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

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

(2) publicizing existing sources of financial aid available to Indians enrolled in any [school] *course of study* referred to in [clause (1)(A)] *paragraph (1)* of this subsection or who are undertaking training necessary to qualify them to enroll in any such [school] *course of study;* or

(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of [Indians] *Indians in,* and the subsequent pursuit and completion by them of, courses of study, [in any school] referred to in [clause (1)(A)] *paragraph (1)* of this subsection.

(b)(1) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe [: *Provided,* That the]. *The* Secretary shall give a preference to applications submitted by Indian tribes or tribal organizations.

(2) The amount of any grant under this section shall be determined by the Secretary. Payments pursuant to grants under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as the Secretary finds necessary.

[(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

[(1) $600,000 for fiscal year 1989,

[(2) $650,000 for fiscal year 1990,

[(3) $700,000 for fiscal year 1991, and

[(4) $750,000 for fiscal year 1992.]

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS

SEC. 103. [25 U.S.C. 1613] (a) The Secretary, acting through the Service, shall make scholarship grants to Indians who—

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

(2) have demonstrated the capability to successfully complete courses of study in the health professions, as defined in section 4(n). [in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health nursing, or allied health professions, in the health professions, especially family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, or mental health.]

(b) Scholarship grants made pursuant to this section shall be for the following purposes:

(1) Compensatory preprofessional education of any grantee, such scholarship not to exceed two years *on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary).*

(2) Pregraduate education of any grantee leading to a baccalaureate degree in an approved [premedicine, predentistry, preosteopathy, preveterinary medicine, preoptometry, or prepodiatry curriculum, such scholarship not to exceed four years.] *course of study preparatory to a field of study specified in sub-*

section (a)(2), such scholarship not to exceed 4 years (or the part-time equivalent thereof, as determined by the Secretary).

(c) Scholarship grants made under this section may cover costs of tuition, books, transportation, board, and other necessary related expenses of a grantee while attending school [full time].

(d) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution.

(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

[(1) $3,000,000 for fiscal year 1989,

[(2) $3,700,000 for fiscal year 1990,

[(3) $4,400,000 for fiscal year 1991, and

[(4) $5,100,000 for fiscal year 1992.]

(e) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

SEC. 104. [25 U.S.C. 1613a] (a) In order to provide health professionals to [Indian communities] *Indians, Indian tribes, tribal organizations, and urban Indian organizations,* the Secretary, acting through the Service and in accordance with this section, shall make scholarship grants to Indians who are enrolled [full time] *full or part time* in appropriately accredited schools [of medicine, osteopathy, podiatry, psychology, dentistry, environmental health and engineering, nursing, optometry, public health, allied health professions, and social work] *and pursuing courses of study in the health professions, as defined in section 4(n).* Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254), except as provided in subsection (b) of this section.

(b)(1) The Secretary, acting through the Service, shall determine who shall receive scholarships under subsection (a) and shall determine the distribution of such scholarships among such health professions on the basis of the relative needs of Indians for additional service in such health professions.

(2) An individual shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled [full time] *full or part time* in a [health profession school] *course of study* referred to in subsection (a).

(3) The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by a recipient of an Indian Health Scholarship by service—

(A) in the Indian Health Service;

(B) in a program conducted under a contract entered into under the Indian Self-Determination Act;

(C) in a program assisted under title V of this Act; or

(D) in the private practice of the applicable profession, if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a

physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

(4) In the case of an individual receiving a scholarship under this section who is enrolled part time in an approved course of study—

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

(B) the period of obligated service specified in section 338A(f)(1)(B)(iv) of the Public Health Service Act (42 U.S.C. 254m(f)(1)(B)(iv)) shall be equal to the greater of—

(i) the part-time equivalent of one year for each year for which the individual was provided a scholarship (as determined by the Secretary); or

(ii) two years; and

(C) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act (41 U.S.C. 254m(g)(1)(B) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

[(c) For purposes of this section, the term "Indian" has the same meaning given that term by subsection (c) of section 4 of this Act, including all individuals described in clauses (1) through (4) of that subsection.]

(c) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

[(d) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

[(1) $5,100,000 for fiscal year 1989,

[(2) $6,000,000 for fiscal year 1990,

[(3) $7,100,000 for fiscal year 1991, and

[(4) $8,234,000 for fiscal year 1992.]

(d) The Secretary shall, acting through the Service, establish a Placement Office to develop and implement a national policy for the placement, to available vacancies within the Service, of health professionals required to meet the active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) without regard to any competitive personnel system, agency personnel limitation, or Indian preference policy.

(5)(A) An individual who has, on or after the date of the enactment of this paragraph, entered into a written contract with the Secretary under this section and who—

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

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

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

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

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

(B) If for any reason not specified in subparagraph (A) an individual breaches his written contract by failing either to begin such individual's service obligation under this section or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 108 in the manner provided for in such subsection.

NATIVE HAWAIIAN HEALTH SCHOLARSHIPS [1]

SEC. [42 U.S.C. 254s] Subject to the availability of funds appropriated under the authority of subsection (d) of this section, the Secretary shall provide funds to Kamehameha Schools/Bishop Estate for the purpose of providing scholarship assistance to students who—

(1) meet the requirements of section 254l(b) of this title, and

(2) are Native Hawaiians.

(b) TERMS AND CONDITIONS.—(1) The scholarship assistance provided under subsection (a) of this section shall be provided under the same terms and subject to the same conditions, regulations, and rules that apply to scholarship assistance provided under section 254l of this title.

(2) The Native Hawaiian Health Scholarship program shall not be administered by or through the Indian Health Service.

(c) "NATIVE HAWAIIAN" DEFINED.—For purposes of this section, the term "Native Hawaiian" means any individual who is—

(1) a citizen of the United States,

(2) a resident of the State of Hawaii, and

(3) a descendant of the aboriginal people, who prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawaii, as evidenced by—

(A) genealogical records,

(B) Kupuna (elders) or Kama'aina (long-term community residents) verification, or,

(C) birth records of the State of Hawaii.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,800,000 for each of the fiscal years 1990, 1991, and 1992 for the purpose of funding the scholarship assistance provided under subsection (a) of this section.

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 105 [25 U.S.C. 1614] (a) Any individual who receives a scholarship grant pursuant to [section 757 of the Public Health Service Act] *section 104* shall be entitled to employment in the service during any nonacademic period of the year. Periods of employment

[1] This section was originally included in the 1988 Amendments to the Indian Health Care Improvement Act, Public Law 100-713, as an amendment to the Public Health Service Act.

pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship grant.

(b) Any individual enrolled in a [school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions] *course of study in the health professions, as defined in section 4(n)* may be employed by the Service during any nonacademic period of the year. Any such employment shall not exceed one hundred and twenty days during any calendar year.

(c) Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the [Department of Health, Education, and Welfare] *Department of Health and Human Services.*

[(d) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

[(1) $300,000 for fiscal year 1989,
[(2) $350,000 for fiscal year 1990,
[(3) $400,000 for fiscal year 1991, and
[(4) $450,000 for fiscal year 1992.]

CONTINUING EDUCATION ALLOWANCES

SEC. 106. [25 U.S.C. 1615] [(a)] In order to encourage physicians, dentists, *nurses,* and other health professionals to join or continue in the Service and to provide their services in the rural and remote areas where a significant portion of the Indian people resides, the Secretary, acting through the Service, may provide allowances to health professionals employed in the Service to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

[(b) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

[(1) $500,000 for fiscal year 1989,
[(2) $526,300 for fiscal year 1990,
[(3) $553,800 for fiscal year 1991, and
[(4) $582,500 for fiscal year 1992.]

COMMUNITY HEALTH REPRESENTATIVE PROGRAM

SEC. 107. [25 U.S.C. 1616] (a) Under the authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary shall maintain a Community Health Representative Program under which the Service—

(1) provides for the training of Indians as health paraprofessionals, and

(2) uses such paraprofessionals in the provision of health care, health promotion, and disease prevention services to Indian communities.

(b) The Secretary, acting through the Community Health Representative Program of the Service, shall—

(1) provide a high standard of training for paraprofessionals to Community Health Representatives to ensure that the Community Health Representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by such Program,

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

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

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

(3) [develop] *maintain* a system which identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for such continuing education.

(4) [develop and] *maintain* a system that provides close supervision of Community Health Representatives,

(5) [develop] maintain a system under which the work of Community Health Representatives is reviewed and evaluated, and

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

INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM

SEC. 108. [25 U.S.C. 1616a] (a)(1) The Secretary, acting through the Service, shall establish a program to be known as the Indian Health Service Loan Repayment Program (hereinafter referred to as the "Loan Repayment Program") in order to assure an adequate supply of training [physicians, dentists, nurses, nurse practitioners, physician assistants, clinical and counseling psychologists, graduates of schools of public health, graduates of schools of social work, and other health professionals] *health professionals, as defined in section 4(n)* necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

(2) For the purposes of this section—

(A) the term "Indian health program" means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

(i) directly by the Service;

(ii) by any Indian tribe or tribal or Indian organization pursuant to a contract under—

(I) the Indian Self-Determination Act, or

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

(iii) by an urban Indian organization pursuant to title V of this Act; and

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

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

(1)(A) be enrolled—

[(i) as a full-time student in the final year of a course of study or program in an accredited institution, as determined by the Secretary, within any State; or]

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

(ii) in an approved graduate training program in [medicine, osteopathy, dentistry, family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, or other health profession;] *a health profession, as defined in section 4(n); or*

(B) have—

(i) a degree in [medicine, osteopathy, dentistry, family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, or other health profession;] *a health profession, as defined in section 4(n); and*

[(ii) completed an approved graduate training program in medicine, osteopathy, dentistry, or other health profession in a State, except that the Secretary may waive the completion requirement of this cause for good cause; and]

[(iii)] *(ii)* a license to practice [medicine, osteopathy, dentistry, family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, or other health profession] *a health profession, as defined in section 4(n)* in a State;

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

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

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

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

[(3) submit an application to participate in the Loan Repayment Program; and

[(4) sign and submit to the Secretary, at the time of submission of such application, a written contract (described in subsection (f) to accept repayment of educational loans and to

serve (in accordance with this section) for the applicable period of obligated service in an Indian health program.]

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

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

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

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

(d)(1) [The] *Consistent with paragraph (3), the* Secretary, acting through the Service and in accordance with subsection (k), shall annually—

(A) identify the positions in each [Indian Health] *Indian health* program for which there is a need or a vacancy, and

(B) rank those positions in order of priority.

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

(A) Indians; and

(B) individuals recruited through the efforts of Indian tribes or tribal or Indian organizations.

(3)(A) Subject to subparagraph (B), beginning with fiscal year 1992, of the total amounts appropriated for each fiscal year for loan repayment contracts under this section, the Secretary shall provide that—

(i) not less than 25 percent be provided to applicants who are nurses, nurse practitioners, or nurse midwives; and

(ii) not less than 10 percent be provided to applicants who are mental health professionals (other than applicants described in clause (i)).

(B) The requirements specified in clause (i) or clause (ii) of subparagraph (A) shall not apply if the Secretary does not receive the number of applications from the individuals described in clause (i) or clause (ii), respectively, necessary to meet such requirements.

(e)(1) An individual becomes a participant in the Loan Repayment Program only upon [the Secretary's approval of the individ-

ual's application submitted under subsection (b)(3) and the Secretary's acceptance of the contract submitted by the individual under subsection (b)(4).] *the Secretary and the individual entering into a written contract described in subsection (f).*

(2) The Secretary shall provide written notice to an individual promptly on—

(A) the Secretary's approving, under paragraph (1), of the individual's participation in the Loan Repayment Program, *including extensions resulting in an aggregate period of obligated service in excess of 4 years;* or

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

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

(1) an agreement under which—

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

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

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

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

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

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

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

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

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

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

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

(4) a statement of the damages to which the United States is entitled under subsection (1) for the individual's breach of the contract; and

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

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

(A) tuition expenses;

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

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

(2)(A) [Except as provided in subparagraph (B) and paragraph (3), for each year of obligated service for which an individual contracts to serve under subsection (f), the Secretary may pay up to $25,000 on behalf of the individual for loans described in paragraph (1).] *For each year of obligated service that an individual contracts to serve under subsection (f) the Secretary may pay up to $35,000 on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—*

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

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

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

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

(3) [In addition to payments made under paragraph (2), in any case in which payments on behalf of an individual under the Loan Repayment Program result in an increase in Federal, State, or local income tax liability for such individual, the Secretary may, on the request of such individual, make payments to such individual in a reasonable amount, as determined by the Secretary, to reimburse such individual for all or part of the increased tax liability of the individual.] *For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary—*

(A) in addition to such payments, shall make payments to the individual in an amount equal to 39 percent of the total amount of loan repayments made for the taxable year involved; and

(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

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

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

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

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

(k) The Secretary shall ensure that the staffing needs of Indian health programs administered by any Indian tribe or tribal or Indian organization receive consideration on an equal basis with programs that are administered directly by the Service.

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

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

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

(ii) voluntarily terminates such enrollment; or

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

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

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

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

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

in which—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(n)(1) By not later than the first of March of each year, the Secretary shall, beginning with fiscal year 1990, submit to the Congress an annual report for the preceding fiscal year setting out—

[(A) the number of such applications filed with respect to each type of health profession;

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

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

[(D) the amount of loan payments made in total and by health profession.

[(2) Not later than the first of July of each year, beginning in 1989, the Secretary shall submit to Congress a report on—

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

[(B) the measures the Secretary plans to take to fill the health professional positions maintained by the Service or by tribes or tribal or Indian organizations for which recruitment or retention is difficult.]

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

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

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

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

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

(5) the number of scholarship grants that are provided under section 104 with respect to each health profession;

(6) the amount of scholarship grants provided under section 104, in total and by health profession;

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

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

[(o) There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the provisions of this section.]

SCHOLARSHIP AND LOAN REPAYMENT RECOVERY

SEC. 108A (a) There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and

Loan Repayment Recovery Fund (hereafter in this section referred to as the "Fund"). The Fund shall consist of such amounts as may be appropriated to the Fund under subsection (b). Amounts appropriated for the Fund shall remain available until expended.

(b) For each fiscal year, there is authorized to be appropriated to the Fund an amount equal to the sum of—

(1) the amount collected during the preceding fiscal year by the Federal government pursuant to—

(A) the liability of individuals under subparagraph (A) or (B) of section 104(b)(5) for the breach of contracts entered into under section 104; and

(B) the liability of individuals under section 108(l) for the breach of contracts entered into under section 108; and

(2) the aggregate amount of interest accruing during the preceding fiscal year on obligations held in the Fund pursuant to subsection (d) and the amount of proceeds from the sale or redemption of such obligations during such fiscal year.

(c)(1) Amounts in the Fund and available pursuant to appropriation Acts may be expended by the Secretary, acting through the Service—

(A) to make scholarship grants under section 104; and

(B) to provide loans under section 108.

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

(2) Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

(e) The Secretary, acting through the Service, shall give priority to assigning an individual (for the purpose of such individual's obligated service requirements under section 104 or section 108) to an Indian health program (as defined in section 108(a)(2)) that has a need for a health care professional to provide health care services as a result of an individual having breached a contract entered into under section 104 or section 108.

9TRAVEL EXPENSES FOR RECRUITMENT

RECRUITMENT ACTIVITIES

SEC. 109. [25 U.S.C. 161b] (a) The Secretary may reimburse health professionals seeking positions in the Service, including individuals considering entering into a contract under section 108, and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

[(b) There are authorized to be appropriated $100,000 for each of the fiscal years 1990, 1991, and 1992, for the purpose of carrying out the provisions of this section.]

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

TRIBAL RECRUITMENT AND RETENTION PROGRAM

SEC. 110. [25 U.S.C. 1616c] (a) The Secretary, acting through the Service, shall fund, on a competitive basis, projects to enable Indian tribes and tribal and Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs (as defined in section 108(a)(2)).

(b)(1) Any Indian tribe or tribal or Indian organization may submit an application for funding of a project pursuant to this section.

(2) Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Determination Act shall be given an equal opportunity with programs that are administered directly by the Service to compete for, and receive, grants under subsection (a) for such projects.

[(c) There are authorized to be appropriated $1,000,000 for each of the fiscal years 1990, 1991, and 1992, for the purpose of Carrying out the provisions of this section.]

ADVANCED TRAINING AND RESEARCH

SEC. 111. [25 U.S.C. 1616d] (a) The Secretary, acting through the Service, shall establish a program to enable health professionals who have worked in an Indian health program (as defined in section 108(a)(2) for a substantial period of time to pursue advanced training or research in areas of study for which the Secretary determines a need exists.

(b) An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. [The Secretary shall develop standards for appropriate recoupment for such remaining service.] *In such event, with respect to individuals entering the program after the date of the enactment of the Indian Health Amendments of 1991, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (1) of section 108 in the manner provided for in such subsection.*

(c) Health professionals from Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Determination Act shall be given an equal opportunity to participate in the program under subsection (a).

[(d) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.]

NURSING PROGRAM

SEC. 112 [25 U.S.C. 1616e] (a) The Secretary, acting through the Service, shall provide grants to—

(1) public or private schools of nursing,

(2) tribally controlled community colleges *and tribally controlled postsecondary vocational institutions, as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 239h(2),* and

(3) nurse midwife programs, and nurse practitioner programs, that are provided by any public or private institution, for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians.

(b) Grants provided under subsection (a) may be used to—

(1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or nurse practitioners.

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

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

(4) provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and nurse practitioners, **[**or**]**

(5) provide any program that is designed to achieve the purpose described in subsection (a)**[**.**]**, *or*

(6) establish and develop clinics operated by nurses, nurse midwives, or nurse practitioners to provide primary health care services to Indians.

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

(d) In providing grants under subsection (a), the Secretary shall extend a preference to—

(1) programs that provide a preference to Indians,

(2) programs that train nurse midwives or nurse practitioners,

(3) programs that are interdisciplinary, and

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

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

(A) in the Indian Health Service;

(B) in a program conducted under a contract entered into under the Indian Self-Determination Act;

(C) in a program assisted under title V of this Act; or

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

[(f)(1) There are authorized to be appropriated for each of the fiscal years 1990, 1991, and 1992, $5,000,000 for the purpose of carrying out the provision of this section.

[(2) Of the amounts appropriated under the authority of paragraph (1) for each fiscal year, the Secretary shall use at least $1,000,000 to provide grants under subsection (a) for the training of nurse midwives.]

(f) Beginning with fiscal year 1992, of the amounts appropriated under the authority of this title for each fiscal year to be used to carry out this section, not less than $1,000,000 shall be used to provide grants under subsection (a) for the training of nurse midwives and nurse practitioners.

NURSING SCHOOL CLINICS

SEC. 112A. (a) GRANTS.—In addition to the authority of the Secretary under Section 112(a)(1), the Secretary, acting through the Service, is authorized to provide grants to public or private schools of nursing for the purpose of establishing and developing clinics to address the health care needs of Indians, and to provide primary health care services to Indians who reside on or within 50 miles of Indian country, as defined in section 1151 of title 18, United States Code, or in medically underserved rural areas. A school of nursing receiving a grant pursuant to this section shall utilize the services of its students and faculty in operating such clinics.

(b) PURPOSES.—Grants provided under subsection (a) of this section may be used to—

(1) provide for all aspects of clinical training program development;

(2) enhance the clinical faculty of any school receiving a grant pursuant to this section, by means such as increasing faculty salaries and recruiting new faculty; and

(3) provide scholarships to students who participate in clinics established or developed pursuant to this section.

(c) AMOUNT AND CONDITIONS.—The Secretary may award grants under this section in such amounts and subject to such conditions as the Secretary deems appropriate.

(d) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

(f) PROVISION OF PRIMARY CARE SERVICES IN RURAL AREAS.—Part C of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end thereof the following new subpart:

"Subpart VII—Provision of Primary Care Services in Rural Areas

"SEC. 765. PROVISION OF PRIMARY CARE SERVICES IN RURAL AREAS.

(a) AUTHORIZATION TO USE AMOUNTS.—The Secretary may not use to exceed $5,000,000, out of amounts appropriated to carry out programs under this part, in each of the fiscal years 1993 through 1995 to award grants to public or private schools of nursing for the establishment of clinics that shall be administered by such schools.

(b) APPLICATION.—A school desiring to receive a grant under subsection (a) shall prepare and submit to the Secretary, an application at such time, in such form, and containing such information as the Secretary may require.

(c) USE OF GRANTS.—Amounts received under grants awarded under subsection (a) shall be used to—

(1) establish clinics, to be run and staffed by the faculty and students of such grantee school, to provide primary care services in medically understaffed rural areas or in areas on or within 50 miles of Indian country (as defined in section 1151 of title 18, United State Code),

(2) provide for all aspects of clinical training program development, faculty enhancement and student scholarships in a manner that would benefit the clinic established under paragraph (1), and

(3) carry out any other activities determined appropriate by the Secretary.

(d) DESIGN.—The clinics established under subsection (c)(1) shall be designed to provide nursing students with a structured clinical experience that is similar in nature to that provided by residency training programs for physicians.

TRIBAL CULTURE AND HISTORY

SEC. 113. [25 U.S.C. 1616f] (a) The Secretary, acting through the Service, shall establish a program under which appropriate employees of the Service who serve particular Indian tribes shall receive educational instruction in the history and culture of such tribes and in the history of the Service.

(b) To the extent feasible, the program established under subsection (a) shall—

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

(2) be developed in consultation with the affected tribal government, and

(3) include instruction in Native American studies.

[(c) There are authorized to be appropriated for each of the fiscal year 1990, 1991, and 1992, $1,000,000 to carry out the provisions of this section.]

INMED PROGRAM

SEC. 114. [25 U.S.C. 1616g] (a) The Secretary is authorized to provide grants to at least 3 colleges and universities for the purpose of maintaining and expanding the Native American health careers recruitment program known as the "Indians into Medicine Program" (hereinafter in this section referred to as "INMED") as a means of encouraging Indians to enter the health professions.

[(b)] *(b)(1)* The Secretary shall provide one of the grants authorized under subsection (a) to maintain the INMED program at the University of North Dakota, unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section.

(2) The Secretary shall provide one of the grants authorized under subsection (a) to a college or university to establish and maintain a program similar to the INMED program for the nursing profession, including postdoctoral nursing.

(3) The Secretary shall provide one of the grants authorized under subsection (a) to a college or university to establish and maintain a program parallel to the INMED program for the mental health profession.

(c)(1) The Secretary shall develop regulations for the competitive awarding of the grants provided under this section.

(2) Applicants for grants provided under this section shall agree to provide a program which—

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

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

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

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

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

(d) By no later than the date that is 3 years after the date of enactment of the Indian Health Care Amendments of 1988, the Secretary shall submit a report to the Congress on the program established under this section including recommendations for expansion or changes to the program.

[(e) There are authorized to be appropriated for each of the fiscal years 1990, 1991, and 1992, $1,000,000 to carry out the provisions of this section.]

HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES

SEC. 115 [25 U.S.C. 1616h] (a)(1) The Secretary, acting through the Service, shall award grants to community colleges for the purpose of assisting the community college in the establishment of programs which provide education in a health profession leading to a

degree or diploma in a health profession for individuals who desire to practice such profession on an Indian reservation or in a tribal clinic.

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

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

(2) Grants may only be made under this section to a community college which—

(A) is accredited,

(B) has access to a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals,

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

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

(ii) stipulate certifications necessary to approve internship and field placement opportunities at service unit facilities of the Service or at tribal health facilities,

(D) has a qualified staff which has the appropriate certifications, and

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

(c) The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

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

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

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

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

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

Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

(e) for purposes of this section—

(1) The term "community college" means—

(A) a tribally controlled community college, or

(B) a junior or community college.

(2) The term "tribally controlled community college" has the meaning given to such term by section 2(4) of the Tribally Controlled Community College Assistance Act of 1978.

(3) The term "junior or community college" has the meaning given to such term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

[(f) There are authorized to be appropriated for each of the fiscal years 1990, 1991, and 1992, $1,500,000 to carry out the provisions of this section.]

ADDITIONAL INCENTIVES FOR HEALTH PROFESSIONALS

SEC. 116 [25 U.S.C. 1616i] (a) The Secretary may provide the incentive special pay authorized under section 302(b) of title 37, United States Code, to civilian medical officers of the Indian Health Service who are assigned to, and serving in, positions included in the list established under subsection (b)(1) for which recruitment or retention of personnel is difficult.

(b)(1) The Secretary shall establish and update on an annual basis a list of positions of health care professionals employed by, or assigned to, the Service for which recruitment or retention is difficult.

(2)(a) The Secretary may pay a bonus to any commissioned officer or civil service employee, other than a commissioned medical officer, dental officer, optometrist, and veterinarian, who is employed in or assigned to, and serving in, a position in the Service included in the list established by the Secretary under paragraph (1).

(b) The total amount of bonus payments made by the Secretary under this paragraph to any employee during any 1-year period shall not exceed $2,000.

(c) The Secretary may establish programs to allow the use of flexible work schedules, and compressed work schedules, in accordance with the provisions of subchapter II of chapter 61 of title 5, United States Code, for health professionals employed by, or assigned to, the Service.

[(d) By no later than the date that is 6 months after the date of enactment of the Indian Health Care Amendments of 1988, the Secretary shall submit a report to the Congress on the limitation imposed on amounts of premium pay for overtime to any individual employed by, or assigned to, the Service. The report shall include an explanation of existing overtime pay policy, an estimate of the budget impact of removing limitations on overtime pay, a summary of problems associated with overtime pay limitations, and recommendations for changes to the overtime pay policy.

[(e) There are authorized to be appropriated $600,000 for each of the fiscal years 1990, 1991, and 1992 to carry out the provisions of this section.]

RETENTION BONUS

SEC. 117. [25 U.S.C. 1616j] (a) The Secretary may pay a retention bonus to any physician or nurse employed by, or assigned to, and serving in, the Service either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

(1) is assigned to, and serving in, a position included in the list established under section 116(b)(1) for which recruitment or retention of personnel is difficult,

(2) the Secretary is needed by the Service,
(3) has—
(A) completed 3 years of employment with the Service, or
(B) completed any service obligations incurred as a requirement of—
(i) any Federal scholarship program, or
(ii) any Federal education loan repayment program, and
(4) enters into an agreement with the Service for continued employment for a period of not less than 1 year.

(b) Beginning with fiscal year 1992, not less than 25 percent of the retention bonuses awarded each year under subsection (a) shall be awarded to nurses.

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

[(c)] *(d)* The retention bonus for the entire period covered by the agreement described in subsection (a)(4) shall be paid at the beginning of the agreed upon term of service.

[(d)] *(e)* Any physician or nurse failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus of the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 108(1)(2)(B).

[(e)] *(f)* [There are authorized to be appropriated $3,200,000 for each of the fiscal years 1990, 1991, and 1992 to carry out the provisions of this section.] The Secretary may pay a retention bonus to any physician or nurse employed by an organization providing health care services to Indians pursuant to a contract under the Indian Self-Determination Act if such physician or nurse is serving in a position which the Secretary determines is—
(1) a position for which recruitment is difficult; and
(2) necessary for providing health care services to Indians.

NURSING RESIDENCY PROGRAM

SEC. 118. (a) The Secretary, acting through the Service, shall establish a program to enable licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian health program (as defined in section 108(a)(2)), and have an Indian health program (as defined in section 108(a)(2)), and have done so for a period of not less than one year, to pursue advanced training.

(b) Such program shall include a combination of education and work study in an Indian health program (as defined in section 108(a)(2)) leading up to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse) or a bachelor's degree (in the case of a registered nurse).

(c) An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian health program for a period of

obligated service equal to at least three times the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (1) of section 108 in the manner provided for in such subsection.

MATCHING GRANTS TO TRIBES FOR SCHOLARSHIP PROGRAMS

SEC. 119. (a)(1) The Secretary shall make grants to Indian tribes and tribal organizations for the purpose of assisting such tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.

(2) An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as the Secretary determines is necessary to carry out this section.

(b)(1) An Indian tribe or tribal organization receiving a grant under subsection (a) shall agree to provide scholarships to Indians pursuing education in the health professions in accordance with the requirements of this section.

(2) With respect to the costs of providing any scholarship pursuant to paragraph (1)—

(A) 20 percent of the costs of the scholarship shall be paid from the grant made under subsection (a) to the Indian tribe or tribal organization; and

(B) 80 percent of such costs shall be paid from non-Federal contributions made in cash by the Indian tribe or tribal organization through which the scholarship is provided.

(3) In determining the amount of non-Federal contributions that have been provided for purposes of subparagraph (B) of paragraph (2), any amounts provided by the Federal Government to the Indian tribe or tribal organization involved or to any other entity shall not be included.

(4) Non-Federal contributions required by subparagraph (B) of paragraph (1) may be provided directly by the Indian tribe or tribal organization involved or through donations from public and private entities.

(c) An Indian tribe or tribal organization shall provide scholarships under subsection (b) only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in the health professions, as defined in section 4(n).

(d) In providing scholarships under subsection (b), the Indian tribe or tribal organization shall enter into a contract with each recipient of such scholarship. Such contract shall—

(1) require such recipient to provide service in an Indian health program (as defined in section 108(a)(2)(A)), in the same service area where the Indian tribe or tribal organization providing the scholarship is located, for—

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

(B) such greater period of time as the recipient and the Indian tribe or tribal organization may agree;

(2) provide that the amount of such scholarship—

(A) may be expended only for—

(i) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the school; and

(ii) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B), such amount to be reduced pro rata (such amount to be determined by the Secretary) based on the number of hours such student is enrolled; and

(B) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in subparagraph (A);

(3) require the recipient of such scholarship to maintain an acceptable level of academic standing (as determined by the school in accordance with regulations issued by the Secretary); and

(4) require the recipient of such scholarship to meet the educational and licensure requirements necessary to be a physician, certified nurse practitioner, certified nurse midwife, or physician assistant.

(e) The recipient of a scholarship under subsection (b) shall agree, in providing health care pursuant to the requirements of subsection (d)(1)—

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

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

(f)(1) Before making a grant under subsection (a) to an Indian tribe or tribal organization for a fiscal year, the Secretary shall determine the number of scholarship contracts provided under subsection (b) with respect to which there has been an initial breach by the scholarship recipient involved during the fiscal year preceding the fiscal year for which the Indian tribe or tribal organization is applying to receive the grant.

(2) In the case of an Indian tribe or tribal organization with 1 or more initial breaches for purposes of paragraph (1), the Secretary shall reduce the amount of a grant under subsection (a) to the Indian tribe or tribal organization for the fiscal year involved by an amount equal to the sum of—

(A) an amount equal to the expenditures of Federal funds made regarding the contracts involved; and

(B) an amount representing interest on the amount of such expenditures, determined with respect to each contract on the basis of the maximum legal rate prevailing for loans made during the time amounts were paid under the contract, as determined by the Secretary of the Treasury.

(3) If an Indian tribe or tribal organization is not receiving a grant under subsection (a) for a fiscal year for which a reduction under paragraph (2) would have been made in the event that the tribe or tribal organization had received such a grant, the Secretary shall reduce the amount of payments due to the tribe or tribal organization under other grants, cooperative agreements, or contracts under this Act by the amount specified in such paragraph.

(4) The Secretary may carry out this subsection on the basis of information submitted by the tribes or tribal organizations involved, or on the basis of information collected through such other means as the Secretary determines to be appropriate.

(g) The Secretary may not make any payments under subsection (a) to an Indian tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Indian tribe or tribal organization has complied with requirements of this section.

COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA

SEC. 120. (a) Under the authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary shall maintain a Community Health Aide Program in Alaska under which the Service—

(1) provides for the training of Alaska Natives as health aides;

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

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

(b) The Secretary, acting through the Community Health Aide Program of the Service, shall—

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

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

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

(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective manage-

ment of clinic pharmacies, supplies, equipment, and facilities; and

(C) promotes the achievement of the health status objectives specified in section 3(a);

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

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

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

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

TRIBAL HEALTH PROGRAM ADMINISTRATION

SEC. 121. The Secretary shall, by contract or otherwise, provide training for individuals in the administration and planning of tribal health programs.

PLACEMENT OF PARTICIPANTS IN SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS

SEC. 122. In placing an individual for the purpose of fulfilling the individual's obligated service requirement under sections 104 or 108, the Secretary shall, to the extent consistent with the provisions of this Act and title III of the Public Health Service Act, consider the individual's ties to any Indian tribe.

INTERDISCIPLINARY TRAINING GRANTS

SEC. 123. (a) The Secretary, acting through the Service, shall provide grants to—

(1) public or private colleges or universities;

(2) tribally controlled community colleges and

(3) schools or programs in optometry, pharmacy, psychology, public health, or social work, for the interdisciplinary training of health professionals for the purpose of increasing the number of these health professionals who deliver health care services to Indians.

(b) The Secretary shall give priority in providing grants under this section to applications submitted jointly by 2 or more institutions.

(c) Grants provided under this section may be used—

(1) to recruit health professionals for programs that train individuals in one or more of the health professions described in subsection (a);

(2) to provide scholarships to individuals enrolled in such programs to pay tuition for such programs and other expenses

incurred in connection with such programs, including books, fees, room and board, and other living expenses.

(3) to establish or maintain a program that encourages these health professionals to provide, or continue to provide, health care services to Indians and

(4) to establish or maintain a program that increases the skills of, and provides continuing education to, these health care professionals, including faculty enhancement activities.

(d) Of the amount appropriated to carry out this section, not more than $1,000,000 may be used annually to establish postdoctoral training programs in psychology or pharmacy.

(e) Each applicant for a grant under this section shall include such information as the Secretary may require, including a demonstration of the connection between the applicant and a health care facility that primarily serves Indians.

(f) The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assistance funded by a grant under this section. Such obligations shall be met by service—

(1) in the Indian Health Service;

(2) in a program conducted under a contract entered into under the Indian Self-Determination Act; or

(3) in a program assisted under title V of this Act.

MANPOWER SHORTAGES

SEC. 124. (a) IN GENERAL.—The Secretary is authorized to provide grants to any college, university, or consortium thereof, that is located in any of the 3 Service areas that the Secretary determines to have the most acute health manpower shortages.

(b) PURPOSE.—A grant under this section shall be used for the purpose of training health professionals, including in the field of mental health, and using the training resources of grant recipients, including students and faculty, to provide services through Indian health facilities, to serve in those Service areas that the Secretary determines to have the greatest difficulty in recruiting and retaining such health professionals.

(c) AGREEMENTS.—A grant recipient under this section shall enter into a formal agreement with the appropriate tribal government or governments, or tribal organization, or organizations, of those Service areas in which training under this section is taking place.

(d) PROCEDURES.—The Secretary shall establish procedures for the submission and review of application for the submission and review of applications for grants under this section.

(e) PREFERENCE.—The Secretary shall give preference in making grants under this section to those applicants that—

(1) most comprehensively address area health manpower shortages;

(2) coordinate their programs with other relevant programs in this title; and

(3) have entered into agreements with Indian health facilities, whether operated by the Service or by Indian tribes under the Indian Self-Determination and Education Assistance Act.

AUTHORIZATION OF APPROPRIATIONS

SEC. 125. There are authorized to be appropriated such sums as may be necessary for fiscal year 1993 and each fiscal year thereafter through fiscal year 2000 to carry out this title, and to carry out the Native Hawaiian Health scholarships under section 338K of the Public Health Service Act (42 U.S.C. 254s).

TITLE II—HEALTH SERVICES

IMPROVEMENT OF INDIAN HEALTH STATUS

SEC. 201. [25 U.S.C. 1621] (a) The Secretary is authorized to expend funds which are appropriated under the authority of [subsection (h)] this section, through the Service, for the purpose of—

(1) [raising the health status of Indians to zero deficiency,] *eliminating the deficiencies in health status and resources of all Indian tribes,*

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

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

(4) augmenting the ability of the Service to meet the following health service responsibilities, *either directly or through contract care,* with respect to those Indian tribes with the highest levels of health [resources deficiency] *status and resource deficiencies:*

(A) clinical care (direct and indirect) including clinical eye and vision care;

(B) preventive health *including screening mammography in accordance with section 213;*

(C) dental care (direct and indirect);

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

(E) emergency medical services;

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

(G) accident prevention programs;

(H) home health care;

(I) community health representatives; and

(J) maintenance and repair.

(b)(1) Any funds appropriated under the authority of [subsection (h)] *this section* shall not be used to offset or limit any appropriations made to the Service under the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, or any other provision of law.

[(2) Funds which are appropriated under the authority of subsection (h) may be allocated to, or used for the benefit of, any Indian tribe which has a health resources deficiency level at level I or II only if a sufficient amount of funds have been appropriated under the authority of subsection (h) to raise all Indian tribes to health resources deficiency level II.]

[(3)] *(2)*(A) Funds appropriated under the authority of [subsection (h)] *this section* may be allocated on a service unit basis [but such allocation shall be made in a manner which ensures that the requirement of paragraph (2) is met]. The funds allocated to each service unit under this subparagraph shall be used by the service unit [in accordance with paragraph (2)] to [raise the deficiency level] *reduce the health status and resource deficiency* of each tribe served by such service unit.

(B) The apportionment of funds allocated to a service unit under subparagraph (A) among the health service responsibilities described in subsection (a)(4) shall be determined by the Service in consultation with *and with the active participation* of the affected Indian tribes.

(c) For purposes of this section—

[(1) The health resources deficiency levels of an Indian tribe are as follows:

[(A) level I—0 to 20 percent health resources deficiency;

[(B) level II—21 to 40 percent health resources deficiency;

[(C) level III—41 to 60 percent health resources deficiency;

[(D) level IV—61 to 80 percent health resources deficiency; and

[(E) level V—81 to 100 percent health resources deficiency.

[(2)(1) The term 'health resources deficiency' means a percentage determined dividing—

[(A) the excess, if any, of—

[(i) the value of the health resources that the Indian tribe needs, over

[(ii) the value of the health resources available to the Indian tribe, by

[(B) the value of the health resources that the Indian tribes needs.]

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

(A) the health status objectives set forth in section 3(a) are not being achieved, taking into account the actual cost of providing health care services given local geographic, climatic, rural or other circumstances; and

(B) the Indian tribe does not have available to it the health resources it needs.

[(3)] *(2)* [The health resources available to an Indian tribe include health resources provided by the Service as well as health resources used by the Indian tribe, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.] *The health resources available to an Indian tribe are limited to local health resources used by the Indian tribe, including services and financing systems provided by any other Federal programs, provided that in determining available resources the Service shall also take into account actual availability of local alternative sources of health care.*

[(4)] *(3)* [Under regulations, the] *The* Secretary shall establish procedures which allow any Indian tribe to petition the Secretary for a review of any determination of the [health resources deficiency level] *extent of the health status and resource deficiency* of such tribe.

(d)(1) Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination Act shall be eligible for funds appropriated under the authority of [subsection (h)] *this section* on an equal basis with programs that are administered directly by the Service.

(2) If any funds allocated to a tribe or service unit under the authority of this section are used for a contract entered into under the Indian Self-Determination Act, a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions.

(e) By no later than the date that is [60 days] *3 years* after the date of enactment of the [Indian Health Care Amendments of 1988] *Indian Health Care Amendments Act of 1992,* the Secretary shall submit to the Congress the current [health services priority system] *health status and resource deficiency* report of the Service for each Indian tribe or service unit, including newly recognized or acknowledged tribes. Such report shall set out—

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

(2) [the level of health resources deficiency for] *the extent of the health status and resource deficiency of* each Indian tribe served by the Service;

(3) the amount of funds necessary to [raise all Indian tribes served by the Service below health resources deficiency level II to health resources deficiency level II] *eliminate the health status and resource deficiencies of all Indian tribes served by the Service;*

[(4) the amount of funds necessary to raise all tribes served by the Service below health resources deficiency level I to health resources deficiency level I;

[(5) the amount of funds necessary to raise all tribes served by the Service to zero health resources deficiency; and

[(6)] *(4)* an estimate of—

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

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

(C) the number of Indians using the Service resources made available to each service unit or Indian tribe.

[(f)(1) The President shall include with the budget submitted to the Congress under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the amount of funds requested to carry out the provisions of this section for such fiscal year.]

[(2)] *(f)* Funds appropriated under authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

(g) Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve parity among Indian tribes.

[(h) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

[(1) $19,000,000 for fiscal year 1990,

[(2) $19,000,000 for fiscal year 1991, and

[(3) $20,000,00 for fiscal year 1992.]

(h) Any funds appropriated under the authority of *this* [subsection] *section* shall be designated as the "Indian Health Care Improvement Fund".

CATASTROPHIC HEALTH EMERGENCY FUND

SEC. 202. [25 U.S.C. 1621a] (a)(1). There is hereby established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the "Fund") consisting of—

(A) the amounts deposited under subsection (d), and

(B) the amounts appropriated [under subsection (e)] *to the Fund under this section.*

(2) The Fund shall be administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

(3) The Fund shall not be allocated, apportioned, or delegated on a service unit, area office, or any other basis.

(4) No part of the Fund or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination Act.

(b) The Secretary shall, through the promulgation of regulations consistent with the provision of this section—

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

(2) provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the Fund until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at [not less than $10,000 or not more than $20,000;] *not less than—*

(A) $15,000 for 1992; and

(B) for any subsequent year, the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

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

(A) service units or facilities of the Service, or

(B) whenever otherwise authorized by the Service, non-Service facilities or providers, in rendering treatment that exceeds such threshold cost;

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

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

(c) [Funds appropriated under subsection (e)] *Amounts appropriated to the Fund under this section* shall not be sued to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, or any other law.

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

[(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

[(1) $12,000,000 for fiscal year 1989, and

[(2) for each of the fiscal years 1990, 1991, and 1992, such sums as may be necessary to restore the Fund to a level of $12,000,000 for such fiscal year.

[Funds appropriated under the authority of this subsection shall remain available until expended.]

HEALTH PROMOTION AND DISEASE PREVENTION SERVICES

SEC. 203. [25 U.S.C. 1621b] (a) The Secretary, acting through the Service, shall provide health promotion and disease prevention services to Indians *so as to achieve the health objectives set forth in section 3(a).*

(b) The Secretary shall submit to the President for inclusion in each statement which is required to be submitted to the Congress under [section 201(f)] *section 801* an evaluation of—

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

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

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

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

[(c)(1) The Secretary shall establish at least 1 demonstration project (but no more than 4 demonstration projects) to determine the most effective and cost-efficient means of—

[(A) providing health promotion and disease prevention services,

[(B) encouraging Indians to adopt good health habits,

[(C) reducing health risks to Indians, particularly the risks of heart disease, cancer, stroke, diabetes, anxiety, depression, and lifestyle-related accidents,

[(D) reducing medical expenses of Indians through health promotion and disease prevention activities,

[(E) establishing a program—

[(i) which trains Indians in the provision of health promotion and disease prevention services to members of their tribe, and

[(ii) under which such Indians are available on a contract basis to provide such services to other tribes, and

[(F) providing training and continuing education to employees of the Service, and to paraprofessionals participating in the Community Health Representative Program, in the delivery of health promotion and disease prevention services.

[(2) The demonstration project described in paragraph (1) shall include an analysis of the cost effectiveness of organizational structures and of social and educational programs that may be useful in achieving the objectives described in paragraph (1).

[(3)(A) The demonstration project described in paragraph (1) shall be conducted in association with at least one—

[(i) health profession school,

[(ii) allied health profession or nurse training institution, or

[(iii) public or private entity that provides health care.

[(B) The Secretary is authorized to enter into contracts with, or make grants to, any school of medicine or school of osteopathy for the purpose of carrying out the demonstration project described in paragraph (1).

[(C) For purposes of this paragraph, the term 'school of medicine' and 'school of osteopathy' have the respective meaning given to such terms by section 701(4) of the Public Health Service Act (42 U.S.C. 292a(4)).

[(4) The Secretary shall submit to Congress a final report on the demonstration project described in paragraph (1) within 60 days after the termination of such project.

[(5) The demonstration project described in paragraph (1) shall be established by no later than the date that is 12 months after the date of enactment of the Indian Health Care Amendments of 1988 and shall terminate on the date that is 30 months after the date of enactment of such amendments.

[(6) There are authorized to be appropriated $500,000 for the purpose of carrying out the provisions of this subsection, such sum to remain available without fiscal year limitation.]

DIABETES PREVENTION, TREATMENT, CONTROL

SEC. 204. [25 U.S.C. 1621c] [(a)(1)] *(a)* The Secretary, in consultation with the tribes, shall determine—

[(A)] *(1)* by tribe and by service unit of the Service, the incidence of, and the types of complications resulting from, diabetes among Indians; and

[(B)] *(2)* based on [subparagraph (A)]*paragraph (1),* the measures (including patient education) each Service unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among tribes within that service unit.

[(2) Within 18 months after the date of enactment of the Indian Health Care Amendments of 1988, the Secretary shall prepare and transmit to the President and the Congress a report describing the determinations made and measures taken under paragraph (1) and making recommendations for additional funding to prevent, treat, and control diabetes among Indians.]

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

[(c)(1) The Secretary shall continue to maintain during fiscal years 1988 through 1991 each of the following model diabetes projects which are in existence on the date of enactment of the Indian Health Care Amendments of 1988.

[(A) Claremore Indian Hospital in Oklahoma;

[(B) Fort Totten Health Center in North Dakota;

[(C) Sacaton Indian Hospital in Arizona;

[(D) Winnebago Indian Hospital in Nebraska;

[(E) Albuquerque Indian Hospital in New Mexico;

[(F) Perry, Princeton, and Old Town Health Centers in Maine; and

[(G) Bellingham Health Center in Washington.

[(2) The Secretary shall establish in fiscal year 1989, and maintain during fiscal years 1989 through 1991, a model diabetes project in each of the following locations:

[(A) Fort Berthold Reservation;

[(B) the Navajo Reservation;

[(C) the Papago Reservation;

[(D) the Zuni Reservation; and

[(E) the States of Alaska, California, Minnesota, Montana, Oregon, and Utah.]

(c)(1) The Secretary shall continue to maintain through fiscal year 2000 each model diabetes project in existence on the date of the enactment of the Indian Health Amendments of 1992 and located—

(A) at the Claremore Indian Hospital in Oklahoma;

(B) at the Fort Totten Health Center in North Dakota;

(C) at the Sacaton Indian Hospital in Arizona;

(D) at the Winnebago Indian Hospital in Nebraska;

(E) at the Albuquerque Indian Hospital in New Mexico;

(F) at the Perry, Princeton, and Old Town Health Centers in Maine;

(G) at the Bellingham Health Center in Washington;

(H) at the Fort Berthold Reservation;

(I) at the Navajo Reservation;

(J) at the Tohono O'odham Reservation;
(K) at the Zuni Reservation; or
(L) in the States of Alaska, California, Minnesota, Montana, Oregon, or Utah.

(2) The Secretary may establish new model diabetes projects under this section, except that the Secretary may not establish a greater number of such projects in one service area than in any other service area until there is an equal number of such projects established with respect to all service areas.

(d) The Secretary shall—

(1) employ in each area office of the Service at least one diabetes control officer who shall coordinate and manage on a full-time basis activities within that area office for the prevention, treatment, and control of diabetes;

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

(3) ensure that data collected in each area office regarding diabetes and related complications among Indians is disseminated to all other area offices[.]*; and*

(4) evaluate the effectiveness of services provided through model diabetes projects established under this section.

(e) [There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.] Funds appropriated under [subsection (c)] *this section* in any fiscal year shall be in addition to base resources appropriated to the Service for that Year.

[NATIVE HAWAIIAN HEALTH PROMOTION AND DISEASE PREVENTION

[SEC. 205. [25 U.S.C. 1621d] Section 205 of the Indian Health Care Amendments of 1988 was repealed by P.L. 100-579 (102 Stat. 2923) and by P.L. 100-690 (102 Stat. 4229).]

HOSPICE CARE FEASIBILITY STUDY

SEC. 205. (a) The Secretary, acting through the Service and in consultation with representatives of Indian tribes, tribal organizations, Indian Health Service personnel, and hospice providers, shall conduct a study—

(1) to assess the feasibility and desirability of furnishing hospice care to terminally ill Indians; and

(2) to determine the most efficient and effective means of furnishing such care.

(b) Such study shall—

(1) assess the impact of Indian culture and beliefs concerning death and dying on the provision of hospice care to Indians;

(2) estimate the number of Indians for whom hospice care may be appropriate and determine the geographic distribution of such individuals;

(3) determine the most appropriate means to facilitate the participation of Indian tribes and tribal organizations in providing hospice care;

(4) identify and evaluate various means for providing hospice care, including—

(A) the provision of such care by the personnel of a Service hospital pursuant to a hospice program established by the Secretary at such hospital; and

(B) the provision of such care by a community-based hospice program under contract to the Service; and

(5) identify and assess any difficulties in furnishing such care and the actions needed to resolve such difficulties.

(c) Not later than the date which is 12 months after the date of the enactment of this section, the Secretary shall transmit to the Congress a report containing—

(1) a detailed description of the study conducted pursuant to this section; and

(2) a discussion of the findings and conclusions of such study.

(d) For the purposes of this section—

(1) the term 'terminally ill' means any Indian who has a medical prognosis (as certified by a physician) of a life expectancy of six months or less; and

(2) the term 'hospice care' means the care, items, services as defined in section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)); and

(3) The term 'hospice program' means any program which satisfies the requirements of section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395(dd)(2)).

REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES

SEC. 206. [25 U.S.C. 1621e] (a) [The] *Except as provided in subsection (f), the* United States, *a tribe, or a tribal organization,* shall have the right to recover the reasonable expenses incurred by the Secretary in providing health services, through the Service, *a tribe, or a tribal organization* to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if—

(1) such services had been provided by a nongovernmental provider, and

(2) such individual had been required to pay such expenses and did pay such expenses.

(b) Subsection (a) shall provide a right of recovery against any State, [or any political subdivision of a State,] only if the injury, illness, or disability for which health services were provided is covered under—

(1) workers' compensation laws, or

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

(c) No law of any State, or of any political subdivision of a State, and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, *a tribe, or a tribal organization* under subsection (a).

(d) No action taken by the United States, *a tribe, or a tribal organization* to enforce the right of recovery provided under subsection (a) shall affect the right of any person to any damages (other than

damages for the cost of health services provided by the Secretary through the Service).

(e) The United States, *a tribe, or a tribal organization* may enforce the right of recovery provided under subsection (a) by—

(1) intervening or joining in any civil action or proceeding brought—

(A) by the individual for whom health services were provided by the Secretary, *a tribe, or a tribal organization* or

(B) by any representative or heirs of such individual, or

(2) instituting a separate civil action, after providing to such individual, or to the representative or heirs of such individual, notice of the intention of the United States, *a tribe, or a tribal organization* to institute a separate civil action.

(f) The United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization.

CREDITING OF REIMBURSEMENTS

SEC. 207. [25 U.S.C. 1621f] (a) Except as provided in section 202(d), title IV, and [section 713] *section 813* of this Act, all reimbursements received or recovered, under authority of this Act, Public Law 87-693 (42 U.S.C. 2651, et seq.), or any other provision of law, by reason of the provision of health services by the Service or by a tribe or tribal organization under a contract pursuant to the Indian Self-Determination Act shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

(b) The Service may not offset or limit the amount of funds obligated to any service unit or any entity under contract with the Service because of the receipt of reimbursements under subsection (a).

HEALTH SERVICES RESEARCH

SEC. 208. [25 U.S.C. 1621g] Of the amount appropriated for the Service in any fiscal year, other than amounts made available for the Indian Health Care Improvement Fund, not less than $200,000 shall be available only for research to further the performance of the health service responsibilities of the Service. Indian tribes and tribal organizations contracting with the Service under the authority of the Indian Self-Determination Act shall be given an equal opportunity to compete for, and receive, research funds under this section.

[SEC. 209. [25 U.S.C. 1621h] MENTAL HEALTH PREVENTION AND TREATMENT SERVICES.]

MENTAL HEALTH PREVENTION AND TREATMENT SERVICES

SEC. 209. [25 U.S.C. 1621h] (a) NATIONAL PLAN FOR INDIAN MENTAL HEALTH SERVICES.—(1) Not later than 120 days after the date of enactment of this section, the Secretary, acting through the Service, shall develop and publish in the Federal Register a final

national plan for Indian Mental Health Services. The plan shall include—

(A) an assessment of the scope of the problem of a mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians, including—

(i) the number of Indians served by the Service who are directly or indirectly affected by such illness or behavior, and

(ii) an estimate of the financial and human cost attributable to such illness or behavior;

(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior; and

(C) an estimate of the additional funding needed by the Service to meet its responsibilities under the plan.

(2) The Secretary shall submit a copy of the national plan to the Congress.

[c**]** *(b)* MEMORANDUM OF AGREEMENT.—Not later than 180 days after the date of enactment of this section, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement under which the Secretaries shall, among other things—

(1) determine and define the scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians;

(2) make an assessment of the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;

(3) make an initial determination of the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);

(4)(A) ensure that Indians, as citizens of the United States and of the States in which they reside, have access to mental health services to which all citizens have access;

(B) determine the right of Indians to participate in, and receive the benefit of, such services; and

(C) take actions necessary to protect the exercise of such right;

(5) delineate the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

(6) provide a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with the mental health initiatives pursuant to this Act,

particularly with respect to the referral and treatment of dually-diagnosed individuals requiring mental health and substance abuse treatment; and

(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to subsection (d); and

(8) provide for an annual review of such agreement by the two Secretaries.

[(d)] *(c)* COMMUNITY MENTAL HEALTH PLAN.—(1) The governing body of any Indian tribe may, at its discretion, adopt a resolution for the establishment of a community mental health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members.

(2) In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the tribe in the development of such plan. Upon the establishment of such a plan and at the request of the tribe, such officials, as directed by the memorandum of agreement developed pursuant to subsection (c), shall cooperate with the tribe in the implementation of such plan.

(3) Two or more Indian tribes may form a coalition for the adoption of resolutions and the establishment and development of a joint community mental health plan under this subsection.

(4) The Secretary, acting through the Service, may make grants to Indian tribes adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community mental health plan to provide administrative support in the implementation of such plan.

[(5) There is hereby authorized to be appropriated $500,000 for fiscal year 1991 and $1,000,000 for fiscal year 1992 to carry out this subsection.]

[(e)] *(d)* MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.—(1) The Secretary and the Secretary of the Interior, in consultation with representatives of Indian tribes, shall conduct a study and compile a list of the types of staff positions specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness or dysfunctional and self-destructive behavior.

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

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

(i) elementary and secondary education;

(ii) social services and family and child welfare;

(iii) law enforcement and judicial services; and
(iv) alcohol and substance abuse;
(B) staff positions with the Service; and
(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes, including positions established in contracts entered into under the Indian Self-Determination Act.

(3)(A) The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraph (2)(A) and ensure that appropriate training has been, or will be, provided to any individual in any such position. With respect to any such individual in a position identified pursuant to paragraph (2)(C), the respective Secretaries shall provide appropriate training to, or provide funds to an Indian tribe for the training of, such individual. In the case of positions funded under a contract entered into under the Indian Self-Determination Act, the appropriate Secretary shall ensure that such training costs are included in the contract, if necessary.

(B) Funds authorized to be appropriated pursuant to [this subsection] *this section* may be used to provide training authorized by this paragraph for community education programs described in paragraph (5) if a plan adopted pursuant to subsection (d) identifies individuals or employment categories, other than those identified pursuant to paragraph (1), for which such training or community education is deemed necessary or desirable.

(4) Position-specific training criteria described in paragraph (3) shall be culturally relevant to Indian tribes and shall ensure that appropriate information regarding traditional Indian healing and treatment practices is provided.

(5) The Service shall develop and implement or, upon the request of an Indian tribe, assist such tribe to develop and implement, a program of community education on mental illness and dysfunctional and self-destructive behavior for individuals, as determined in a plan adopted pursuant to subsection (d). In carrying out this paragraph, the service shall provide, upon the request of an Indian tribe, technical assistance to the Indian tribe to obtain or develop community education and training materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

[(6) There is hereby authorized to be appropriated—

[(A) $500,000 for fiscal year 1991 to carry out this subsection, of which $100,000 shall be allocated for community education under paragraph (5); and

[(B) $5,000,000 for fiscal year 1992 to carry out this subsection, of which $1,200,000 shall be allocated for community education under paragraph (5).]

[(f)] *(e)* STAFFING.—(1) Within 90 days after the date of enactment of this section, the Secretary shall develop a plan under which the Service will increase the health care staff providing mental health services by at least 500 positions within five years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. Such additional staff shall be primarily assigned to the service unit level

for services which shall include outpatient, emergency, aftercare and follow-up, and prevention and education services.

(2) The plan developed under paragraph (1) shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) popularly known as the "Snyder Act".

[(g)] *(f)* STAFF RECRUITMENT AND RETENTION.—(1) The Secretary shall provide for the recruitment of the additional personnel required by subsection (f) and the retention of all Service personnel providing mental health services. In carrying out this subsection, the Secretary shall give priority to practitioners providing mental health services to children and adolescents with mental health problems.

(2) In carrying out paragraph (1), the Secretary shall develop a program providing for—

(A) the payment of bonuses (which shall not be more favorable than those provided for under sections 116 and 117) for service in hardship posts;

(B) the repayment of loans (for which the provisions of repayment contracts shall not be more favorable than the repayment contracts under section 108) for health professions education as a recruitment incentive; and

(C) a system of postgraduate rotations as a retention incentive.

(3) This subsection shall be carried out in coordination with the recruitment and retention programs under title I.

[(4) There are authorized to be appropriated $1,200,000 for the fiscal year 1992 to carry out this subsection.]

[(h)] *(g)* MENTAL HEALTH TECHNICIAN PROGRAM.—(1) Under the authority of the Snyder Act of November 2, 1921 (25 U.S.C. 13), the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

(A) provides for the training of Indians as mental health technicians; and

(B) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

(2) In carrying out paragraph (1)(A), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

(3) The Secretary shall supervise and evaluate the mental health technicians in the training program.

(4) The Secretary shall ensure that the program established pursuant to this subsection involves the utilization and promotion of the traditional Indian health care and treatment practices of the Indian tribes to be served.

[(5) For purposes of providing the training required under this subsection, there are authorized to be appropriated $1,000,000 for the fiscal year 1992, which shall remain available until expended.]

[(i)] *(h)* MENTAL HEALTH RESEARCH.—[(1)] The Secretary, acting through the Service and in consultation with the National

Institute of Mental Health, shall enter into contracts with, or make grants to, appropriate institutions for the conduct of research on the incidence and prevalence of mental disorders among Indians on Indian reservations and in urban areas. Research priorities under this subsection shall include—

[(A)] *(1)* the inter-relationship and inter-dependence of mental disorders with alcoholism, suicide, homicides, accidents, and the incidence of family violence, and

[(B)] *(2)* the development of models of prevention techniques. The effect of the inter-relationships and interdependencies referred to in [sub]paragraph [(A)] *(1)* on children, and the development of prevention techniques under [sub]paragraph [(B)] *(2)* applicable to children, shall be emphasized.

[(2) For purposes of carrying out this subsection, there are authorized to be appropriated $2,000,000 for the fiscal year 1992, which shall remain available until expended.]

[(j)] *(i)* FACILITIES ASSESSMENT.—[(1)] Within one year after the date of enactment of this section, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

[(2) There are authorized to be appropriated $500,000 for the fiscal year 1992 to make the assessment required by this subsection.]

[(k)] *(j)* ANNUAL REPORT.—The Service shall develop methods for analyzing and evaluating the overall status of mental health programs and services for Indians and shall [submit to the Congress an annual report] *submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report* on the mental health status of Indians which shall describe the progress being made to address mental health problems of Indian communities.

[(l)] *(k)* MENTAL HEALTH DEMONSTRATION GRANT PROGRAM.—(1) The Secretary, acting through the Service, is authorized to make grants to Indian tribes and inter-tribal consortia to pay 75 percent of the cost of planning, developing, and implementing programs to deliver innovative community-based mental health services to Indians. The 25 percent tribal share of such cost may be provided in cash or through the provision of property or services.

(2) The Secretary may award a grant for a project under paragraph (1) to an Indian tribe or inter-tribal consortium which meets the following criteria:

(A) The project will address significant unmet mental health needs among Indians.

(B) The project will serve a significant number of Indians.

(C) The project has the potential to deliver services in an efficient and effective manner.

(D) The tribe or consortium has the administrative and financial capability to administer the project.

(E) The project will deliver services in a manner consistent with traditional Indian healing and treatment practices.

(F) The project is coordinated with, and avoids duplication of, existing services.

(3) For purposes of this subsection, the Secretary shall, in evaluating applications for grants for projects to be operated under any contract entered into with the Service under the Indian Self-Determination Act, use the same criteria that the Secretary uses in evaluating any other application for such a grant.

(4) The Secretary may only award one grant under this subsection with respect to a service area until the Secretary has awarded grants for all service areas with respect to which the Secretary receives applications during the application period, as determined by the Secretary, which meet the criteria specified in paragraph (2).

(5) Not later than 180 days after the close of the term of the last grant awarded pursuant to this subsection, the Secretary shall submit to the Congress a report evaluating the effectiveness of the innovative community-based projects demonstrated pursuant to this subsection. Such report shall include findings and recommendations, if any, relating to the reorganization of the programs of the Service for delivery of mental health services to Indians.

(b) [There is authorized to be appropriated $2,000,000 for fiscal year 1991 and $3,000,000 for fiscal year 1992 to carry out the purposes of this subsection.] Grants made pursuant to this [subsection] *section* may be expended over a period of three years and no grant may exceed $1,000,000 for the fiscal years involved.

(l) LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.—Any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this Act or through a contract pursuant to the Indian Self-Determination Act shall, within 1 year from the date of employment—

(1) in the case of a person employed as a psychologist, be licensed as a psychologist or working under the direct supervision of a licensed psychologist; or

(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker;

(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

(m) INTERMEDIATE ADOLESCENT MENTAL HEALTH SERVICES.—(1) The Secretary, acting through the Service, may make grants to Indian tribes and tribal organizations to provide intermediate mental health services to Indian children and adolescents, including—

(A) inpatient and outpatient services;

(B) emergency care;

(C) suicide prevention and crisis intervention; and

(D) prevention and treatment of mental illness, and dysfunctional and self-destructive behavior, including child abuse and family violence.

(2) Funds provided under this section may be used—

(A) to construct or renovate an existing health facility to provide intermediate mental health services;

(B) to hire mental health professionals;

(C) to staff, operate, and maintain an intermediate mental health facility, group home, or youth shelter where intermediate mental health services are being provided; and

(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units.

(3) An Indian tribe or tribal organization receiving a grant under this section shall ensure that intermediate adolescent mental health services are coordinated with other tribal, service, and Bureau of Indian Affairs mental health, alcohol and substance abuse, and social services programs on the reservation of such tribe or organization.

(4) The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this section.

(n)(1) The Secretary is authorized to provide grants to at least 3 colleges and universities for the purpose of developing and maintaining American Indian psychology careers recruitment programs as a means of encouraging American Indians to enter the mental health field.

(2) The Secretary shall provide one of the grants authorized under paragraph (1) to develop and maintain an American Indians Into Psychology program at the University of North Dakota.

(3)(A) The Secretary shall issue regulations for the competitive awarding of the grants provided under this subsection.

(B) Applicants for grants under this subsection shall agree to provide a program which, at a minimum—

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

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

(iii) provides summer enrichment programs to expose Indian students to the varied fields of psychology through research and experiential activities;

(iv) provides stipends to undergranduate and graduate students to pursue a career in psychology;

(v) develops affiliation agreements with tribal community colleges, the Indian Health Service, university affiliated programs, and other appropriate entities to enhance the education of American Indian students;

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

(vii) to the maximum extent possible, employs qualified Indians in the program.

(4) The American Indians Into Psychology program at the University of North Dakota shall, to the maximum extent feasible, coordinate with the INMED program authorized by section 114 of this Act, and existing university research and communications networks.

MANAGED CARE FEASIBILITY STUDY

SEC. 210. (a) The Secretary, acting through the Service, shall conduct a study to assess the feasibility of allowing for an Indian tribe to purchase, directly or through the Service, managed care coverage for Indian tribes—

(1) which desire to participate in group contract health plans or other managed care arrangements instead of operating an inpatient hospital or ambulatory facility; and

(2) which offer the same plan to all eligible members of the facility.

(b) Not later than the date which is 12 months after the date of the enactment of this section, the Secretary shall transmit to the Congress a report containing—

(1) a detailed description of the study conducted pursuant to this section; and

(2) a discussion of the finding and conclusions of such study.

[AUTHORIZATION OF APPROPRIATIONS

[SEC. 211. There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.]

EPIDEMIOLOGY GRANT PROGRAM

SEC. 211.(a) IN GENERAL.—The Secretary shall provide grants to eligible recipients for the purpose of establishing area epidemiology centers to conduct the activities set forth in this section.

(b) ELIGIBLE ACTIVITIES.—In consultation with the Indian Health Service, Indian tribes, and urban Indian communities, an area epidemiology center established under this section shall—

(1) establish a methodology to define baseline data from the health objectives specified in section 3;

(2) determine the most effective way to establish and maintain a surveillance system for health objectives;

(3) identify such health objectives that are the highest priority for monitoring surveillance, and attention, based on an initial assessment of the epidemiology of the area and each of the communities served;

(4) evaluate existing delivery systems, data systems, and other systems that impact on the improvement of Indian health and the resources available to deliver, monitor, or evaluate those services;

(5) develop methods to obtain data on Indian health from the Indian Health Service, State Medicaid Systems, Federal Medicare and Veterans Affairs systems, and private insurance systems, and;

(6) assist tribes and urban Indian communities in the identification of priority service areas, based on epidemiologic data, and advocate for the targeting of services needed by tribal, urban, and other Indian communities and make recommendations to improve health care delivery systems.

(c) ELIGIBLE RECIPIENTS.—The following entities are eligible to receive grants to establish and develop an area epidemiology center under this section:

(1) AREA INDIAN HEALTH BOARDS.—

(A) IN GENERAL.—The Secretary may provide grants to area Indian health boards, as defined in subparagraph (B), for the establishment and development of area epidemiology centers.

(B) DEFINITION OF AREA INDIAN HEALTH BOARDS.—For the purposes of this section, the term 'area Indian health board' means an organization that—

(i) provides information to and consults with tribal leaders, urban Indian community leaders, and related health staff, on health care and health services management issues; and

(ii) provides, in collaboration with tribes and urban Indian communities, the Indian Health Service with information on ways to improve the health status of Indian people.

(2) INTERTRIBAL CONSORTIA; INDIAN ORGANIZATIONS.—The Secretary may provide grants to intertribal consortia or Indian organizations that—

(A) are incorporated for the primary purpose of improving Indian health; and

(B) are representative of the tribes and urban Indian communities in which they are located.

(3) TRIBES.—The Secretary may provide grants directly to a tribe for the purpose of establishing and developing an area epidemiology center.

(d) SELECTION CRITERIA.—The Secretary may provide grants to the entities described in subsection (c) that submit an application in such a manner and at such a time as the Secretary shall prescribe and that meet the following minimum criteria:

(1) PRIMARY PURPOSE.—Applicants for grants shall ensure that the area epidemiology center will be established and operated for the primary purpose of addressing Indian health issues and will consult with the tribes or urban Indian communities that will be served by the area epidemiology center.

(2) EXPERTISE.—Applicants shall demonstrate the technical, administrative, and financial expertise necessary to conduct the eligible activities described in subsection (b).

(3) COOPERATION.—Applicants shall ensure that the area epidemiology center will consult and cooperate with providers of related health and social services in order to avoid duplication of existing services, and demonstrate cooperation from the tribes or urban Indian organizations in the area.

(e) DISTRIBUTION OF GRANTS.—The Secretary shall provide at least 1 grant to an eligible recipient, as prescribed in subsection (c), located in each Indian Health Service area.

(f) AMOUNT OF GRANTS.—The Secretary may provide a grant in such an amount as the Secretary determines appropriate to carry out the purposes of this section, but such amount shall not be less than $250,000 a year for each area epidemiology center.

(g) TECHNICAL ASSISTANCE.—The Indian Health Service shall assign 1 epidemiologist from each of its area offices to each area epidemiology center to provide such center with technical assistance to carry out this section.

(h) REPORTS TO CONGRESS.—

(1) INITIAL REPORT.—Not later than March 1, 1994, the Secretary shall transmit an initial report to the Congress describing the actions that the Secretary has taken to carry out the purposes of this section.

(2) SUBSECTION REPORTS.—After the initial report, the Secretary shall report to the Congress biannually on the extent to which the area epidemiology centers established under this section have helped assess progress made towards meeting the health objectives specified in section 3.

CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM

SEC. 212. (a) The Secretary shall establish a demonstration program to evaluate the use of a contract care intermediary to improve the accessibility of health services to California Indians.

(b)(1) In establishing such a 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 809(b) throughout the California contract health services delivery area described in section 810 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 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

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

(e) 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) 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 202, except that the cost of such treatment does not meet the threshold cost requirement established pursuant to section 202(b)(2); and

(2) exceeds $1,000.

(g) There are authorized to be appropriated for each of the fiscal years 1993, 1994, 1995, 1996, and 1997 such sums as may be necessary to carry out the purpose of this section.

COVERAGE OF SCREENING MAMMOGRAPHY

SEC. 213. The Secretary, acting through the Service, shall provide for screening mammography (as defined in section 1861(jj) of the Social Security Act) 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.

COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS

SEC. 214. (a) The Secretary, acting through the Service and in consultation with the Secretary of the Interior, may award grants to Indian tribes to develop comprehensive school health education programs for children from preschool through grand 12 in school located on Indian reservations.

(b) Grants awarded under this section may be used to—

(1) develop health education curricula;

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

(3) integrate school-based, community-based, and other public and private heath promotive efforts;

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

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

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

(7) develop mental health wellness programs;

(8) develop chronic disease prevention programs;

(9) develop substance abuse prevention programs;

(10) develop accident prevention and safety education programs;

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

(12) develop community and environmental health education programs.

(c) The Secretary shall provide technical assistance to Indian tribes in the development of health education plans, and the dis-

semination of health education materials and information on existing health programs and resources.

(d) The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this section.

(e) Recipients of grants under this section shall submit to the Secretary an annual report on activities undertaken with funds provided under this section. Such reports shall include a statement of—

(1) The number of preschools, elementary schools, and secondary school served;

(2) the number of students served;

(3) any new curricula established with funds provided for under this section;

(4) the number of teachers trained in health curricula; and

(5) the involvement of parents, members of the community, and community health workers in programs established with funds provided under this section.

(f)(1) The Secretary of the Interior, acting through the Bureau of Affairs and in cooperation with the Secretary, shall develop a comprehensive school health education program for children from preschool grade 12 in school operated by the Bureau of Indian Affairs.

(2) Such program shall include—

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

(B) mental health wellness programs;

(C) chronic disease prevention programs;

(D) substance abuse prevention programs;

(E) accident prevention and safety education programs; and

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

(3) The Secretary of the Interior shall—

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

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

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

(g) There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

INDIAN YOUTH GRANT PROGRAM

SEC. 215. (a) The Secretary, acting through the Service, is authorized to make grants to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian pre-adolescent and adolescent youths.

(b) Grants made pursuant to this section may be used to—

(1) develop prevention and treatment models for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional healers; and

(2) develop and provide community training and education.

(c) The Secretary shall—

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

(2) encourage the implementation of such models; and

(3) at the request of an Indian tribe, provide technical assistance in the implementation of such models.

(d) The Secretary shall establish criteria for the review and approval of applications under this section.

(e) There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

TUBERCULOSIS PREVENTION DEMONSTRATION PROGRAM

SEC. 216. (a) The Secretary, acting through the Service, may make grants to Indian tribes and Indian organizations to evaluate different measures used to prevent and eliminate tuberculosis (hereafter referred in this section as "TB") on Indian reservations.

(b) A grant awarded under this section may be used to—

(1) train health care staff in methods to prevent and eliminate TB;

(2) conduct screenings of residents of Indian reservations to detect the presence, or monitor the condition, of persons who are at risk for contracting TB or who already have the disease;

(3) educate the community about the nature and prevention of TB;

(4) create and maintain a registry of persons with TB, including information obtained from screenings conducted pursuant to paragraph (2);

(5) develop methods, such as use of a TB control team, to coordinate all TB prevention and elimination activities on a reservation; and

(6) treat those afflicted with TB.

(c) The Secretary shall—

(1) make at least 1 grant under this section to an Indian tribe or tribal organization located in each Area office;

(2) establish criteria for the review and approval of applications for grants under this section, and

(3) provide, at the request of a grant applicant or recipient, technical assistance to accomplish the purposes of this section.

(d) A grant recipient under this section shall—

(1) cooperate with—

(A) The Centers for Disease Control;

(B) The Service;

(C) State health agencies; and

(D) local health agencies

to coordinate and conduct activities under this section; and

(2) submit to the Secretary an annual report on activities conducted with funds provided under this section.

PATIENT TRAVEL COSTS

SEC. 217. The Secretary, acting through the Service, shall provide funds to address and meet the high costs of patient travel in remote

areas of Alaska when there is no reasonable alternative for the patient.

AUTHORIZATION OF APPROPRIATIONS

SEC. 218. There are authorized to be appropriated such sums as may be necessary for fiscal year 1993 and each fiscal year thereafter through fiscal year 2000 to carry out this title.

TITLE III—HEALTH FACILITIES

CONSULTATION; CLOSURE OF FACILITIES; REPORTS

SEC. 301 [25 U.S.C. 1631] (a) Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, acting through the Service, shall—

(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made, and

(2) ensure, whenever practicable, that such facility meets the standards of the Joint Commission on Accreditation of [Hospitals] *Health Care Organizations* by not later than 1 year after the date on which the construction or renovation of such facility is completed.

(b)(1) Notwithstanding any provision of law other than this subsection, no Service hospital or [other] outpatient health care facility of the Service, or any portion of such a hospital or facility may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such hospital or facility (or portion thereof) is proposed to be closed an evaluation of the impact of such proposed closure which specifies, in addition to other considerations—

(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

(B) the cost of effectiveness of such closure;

(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

(D) the availability of contract health care funds to maintain existing levels of service; [and]

(E) the views of the Indian tribes served by such hospital or facility concerning such closure[.]*; and*

(F) the level of utilization of such hospital or facility by all eligible Indians; and

(G) the distance between such hospital or facility and the nearest operating Service hospital.

(2) Paragraph (1) shall not apply to any temporary closure of a facility or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

[(c) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each of the

fiscal years 1990, 1991, and 1992, program information documents for the construction of 10 Indian health facilities which—

[(1) comply with applicable construction standards, and

(2) have been approved by the Secretary.]

[(d)] *(c)(1)* [The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each of the fiscal years 1990, 1991, and 1992, program information documents for the construction of 10 Indian health facilities which—] *The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report which sets forth—*

(A) the current health facility priority system of the Service,

(B) the planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority ambulatory care facilities (together with required staff quarters),

(C) the justification for such order or priority,

(D) the projected cost of such projects, and

(E) the methodology adopted by the Service in establishing priorities under its health facility priority system.

[(2) The first report required under paragraph (1) shall be submitted by no later than the date that is 180 days after the date of enactment of the Indian Health Care Amendments of 1988 and, beginning in 1990, each subsequent annual report shall be submitted by the date that is 60 days after the date on which the President submits the budget to the Congress under section 1105 of title 31, United States Code.]

[(3)] *(2)* In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall—

(A) consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any contract entered into with the Service under the Indian Self-Determination Act, and

(B) review the needs of such tribes and tribal organizations for inpatient and outpatient facilities, including their needs for renovation and expansion of existing facilities.

[(4)] *(3)* For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any contract entered into with the Service under the Indian Self-Determination Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

[(5)] *(4)* The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities which are the subject of a contract for health services entered into with the Service under the Indian Self-Determination Act are fully and equitably integrated into the development of the health facility priority system.

[(e)] *(d)* All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of section 102 of the Indian Self-Determination Act.

SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 302. [25 U.S.C. 1632] (a) The Congress hereby finds and declares that—

(1) the provision of safe water supply systems and sanitary sewage and solid waste disposal systems is primarily a health consideration and function;

(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such systems;

(3) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such systems and other preventive health measures;

(4) many Indian homes and communities still lack safe water supply systems and sanitary sewage and solid waste disposal systems; and

(5) it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible.

(b)(1) In furtherance of the findings and declarations made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

(2) The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a)—

(A) financial and technical assistance to Indian tribes and communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities;

(B) ongoing technical assistance and training in the management of utility organizations which operate and maintain sanitation facilities; and

(C) operation and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities.

(3) Notwithstanding any other provision of law—

(A) the Secretary of Housing and Urban Affairs is authorized to transfer funds appropriated under the Housing and Community Development Act of 1974 (42 U.S.C. 5301, et seq.) to the Secretary of Health and Human Services, and

(B) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

(c) Beginning in fiscal year 1990, the Secretary, acting through the Service, shall develop and begin implementation of a 10-year plan to provide safe water supply and sanitation sewage and solid

waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.

(d) The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

[(e) The provisions of this section shall not diminish the primary responsibility of the Indian family, community, or tribe to establish, collect, and utilize reasonable user fees, or otherwise set aside funding, for the purpose of operating and maintaining sanitation facilities.]

(e)(1) The Secretary is authorized to provide financial assistance to Indian tribes and communities in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (c).

(2) For the purposes of paragraph (1), the term 'Federal share' means 80 percent of the costs described in paragraph (1).

(3) With respect to Indian tribes with fewer than 1,000 enrolled members, the non-Federal portion of the costs of operating, managing, and maintaining such facilities may be provided, in part, through cash donations or in kind property, fairly evaluated."

(f) Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination Act shall be eligible for—

(1) any funds appropriated pursuant to [subsection (h)] this section, and

(2) any funds appropriated for the purpose of providing water supply or sewage disposal services,

on an equal basis with programs that are administered directly by the Service.

(g)(1) [The Secretary shall submit to the Congress an annual report] *The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report* which sets forth—

(A) the current Indian sanitation facility priority system of the Service;

(B) the methodology for determining sanitation deficiencies;

(C) the level of sanitation deficiency for each sanitation facilities project of each Indian tribe or community;

(D) the amount of funds necessary to raise all Indian tribes and communities to a level I sanitation deficiency; and

(E) the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency.

[(2) The first report required under paragraph (1) shall be submitted by no later than the date that is 180 days after the date of enactment of the Indian Health Care Amendments of 1988 and, beginning in 1990, each subsequent annual report shall be submitted by the date that is 60 days after the date on which the President submits the budget to the Congress under section 1105 of title 31, United States Code.]

[(3)] *(2)* In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities

under any contract entered into with the Service under the Indian Self-Determination Act) to determine the sanitation needs of each tribe.

[(4)] *(3)* The methodology used by the Secretary in determining sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian tribes and communities.

[(5)] *(4)* For purposes of this subsection, the sanitation deficiency levels for an Indian tribe or community are as follows:

(A) level I is an Indian tribe or community with a sanitation system—

(i) which complies with all applicable water supply and pollution control laws, and

(ii) in which the deficiencies relate to routine replacement, repair, or maintenance needs;

(B) level II is an Indian tribe or community with a sanitation system—

(i) which complies with all applicable water supply and pollution control laws, and

(ii) in which the deficiencies relate to capital improvements that are necessary to improve the facilities in order to meet the needs of such tribe or community for domestic sanitation facilities;

(C) level III is an Indian tribe or community with a sanitation system which—

(i) has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or

(ii) has no solid waste disposal facility;

(D) level IV is an Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system; and

(E) level V is an Indian tribe or community that lacks a safe water supply and a sewage disposal system.

[(6)] *(5)* For purposes of this subsection, any Indian tribe or community that lacks the operation and maintenance capability to enable its sanitation system to meet pollution control laws may not be treated as having a level I or II sanitation deficiency.

[(h)(1) There are authorized to be appropriated for each of the fiscal years 1990, 1991, and 1992, $3,000,000 for the purpose of providing funds necessary to implement the responsibilities of the Service described in subsection (b)(2).

[(2) In addition to the amount authorized under paragraph (1), there are authorized to be appropriated for each of the fiscal years 1990, 1991, and 1992, $850,000 for the sanitation service account of the Service which shall be used to carry out the responsibilities of the Service described in subsection (b)(2).]

PREFERENCE TO INDIANS AND INDIAN FIRMS

SEC. 303. [25 U.S.C. 1633] (a) The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including

former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as an "Indian firm") in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless he finds, pursuant to rules and regulations promulgated by him, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at his finding, shall consider whether the Indian or Indian firm will be deficient with respect to (1) ownership and control by Indians, (2) equipment, (3) bookkeeping and accounting procedures, (4) substantive knowledge of the project or function to be contracted for, (5) adequately trained personnel, or (6) other necessary components of contract performance.

(b) For the purpose of implementing the provisions of this title, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities, constructed or renovated in whole or in part by funds made available pursuant to this title are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act).

SOBOBA SANITATION FACILITIES

SEC. 304. The Act of December 17, 1970 (84 Stat. 1465), is hereby amended by adding the following new section 9 at the end thereof:

"SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat 674), as amended by the Act of July 31, 1959 (73 Stat. 267)."

EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION

[SEC. 305. [25 U.S.C. 1634] (a) Notwithstanding any other provision of law, the Secretary is authorized to accept any major renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a contract entered into under the Indian Self-Determination Act, including—

[(1) any plans or designs for such renovation or modernization, and

[(2) any renovation or modernization for which funds appropriated under any Federal law were lawfully expended,

but only if the requirements of subsection (b) are met.

[(b) The requirements of this subsection are met with respect to any renovation or modernization if the renovation or modernization—

[(1) does not require or obligate the Secretary to provide any additional employees or equipment,

[(2) is approved by the appropriate area director of the Service, and

[(3) is administered by the Indian tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

[(c) A renovation or modernization shall not be authorized by this section if such renovation or modernization would require the diversion of funds appropriated to the Service from any project which has a high priority under the health facility priority system of the Service.

[(d) If any Service facility which has been renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20-year period beginning on the date such renovation or modernization is completed, such Indian tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such renovation or modernization) bore to the value of such facility at the time of the completion of such renovation or modernization.]

SEC. 305. (a)(1) Notwithstanding any other provision of law, the Secretary is authorized to accept any major renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a contract entered into under the Indian Self-Determination Act, including—

(A) any plans or designs for such renovation or modernization, and

(B) any renovation or modernization for which funds appropriated under any Federal law were lawfully expended,

but only if the requirements of subsection (b) are met.

(2) The Secretary shall maintain a separate priority list to address the needs of such facilities for personnel or equipment.

(3) The Secretary shall plan for and shall seek funding to address the needs of facilities identified pursuant to paragraph (2).

(b) The requirements of this subsection are met with respect to any renovation or modernization if—

(1) the tribe or tribal organization—

(A) provides notice to the Secretary of its intent to renovate or modernize; and

(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for personnel or equipment; and

(2) the renovation or modernization—

(A) is approved by the appropriate area director of the Service; and

(B) is administered by the tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

(c) If any Service facility which has been renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20-year period beginning on the date such renovation and modernization is completed, such Indian tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such renovation or

modernization bore to the value of such facility at the time of the completion of such renovation or modernization.

[BETHEL, ALASKA, HOSPITAL

[SEC. 306. [25 U.S.C. 1636] (a) If a final administrative ruling by the Department of the Interior holds that the Bethel Native Corporation is entitled to conveyance under the Alaska Native Claims Settlement Act of the title to the real property described in subsection (d)(1), such ruling shall be subject to judicial review.

[(b) The Secretary is authorized to enter into an agreement with Bethel Native Corporation for an exchange of the real property described in subsection (d)(1) for—

[(1) the lands described in subsection (d)(2), or

[(2) any other Federal property which Bethel Native Corporation would have been able to select under the Alaska Native Claims Settlement Act.

[(c) If an agreement for the exchange of land is not entered into under subsection (b) before the date that is 90 days after the date on which a ruling described in subsection (a) becomes final and is no longer appealable, the Secretary shall, subject to the availability of funds provided by Appropriations Acts, purchase the lands described in subsection (d)(1) at fair market value.

[(d)(1) The real property referred to in subsection (a) is United States Survey Numbered 4000, other than the lands described in paragraph (2).

[(2) The lands referred to in subsection (b)(1) are the lands identified as tracts A and B in the determination AA-18959 of the Bureau of Land management issued on September 30, 1983, pursuant to the Alaska Native Claims Settlement Act.]

GRANT PROGRAM FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES

SEC. 306.(a)(1) The Secretary, acting through the Service, shall make grants to tribes and tribal organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians. A grant made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term "construction" includes the replacement of an existing facility.

(2) A grant under paragraph (1) may only be made to a tribe or tribal organization pursuant to a contract entered into under the Indian Self-Determination Act.

(b)(1) A grant provided under this section may be used only for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

(A) located apart from a hospital;

(B) not funded under section 301 or section 307; and

(C) which, upon completion of such construction, expansion, or modernization will—

(i) have a total capacity appropriate to its projected service population;

(ii) serve no less than 500 eligible Indians annually; and

(iii) provide ambulatory care in a service area (specified in the contract entered into under the Indian Self-Determination Act) with a population of not less than 2,000 eligible Indians.

(2) The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to a tribe or tribal organization applying for a grant under this section whose tribal government offices are located—

(A) on an island; and

(B) more than 75 miles from the tribal government offices of the nearest other Indian tribe.

(c)(1) No grant may be made under this section unless an application for such a grant has been submitted to and approved by the Secretary. An application for a grant under this section shall be submitted in such form and manner as the Secretary shall by regulation prescribe and shall set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to a grant received under this section—

(A) adequate financial support will be available for the provision of services at such facility;

(B) such facility will be available to eligible persons without regard to ability to pay or source of payment; and

(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible persons, serve non-eligible persons on a cost basis.

(2) In awarding grants under this section, the Secretary shall give priority to tribes and tribal organizations that demonstrate—

(A) a need for increased ambulatory care services; and

(B) insufficient capacity to deliver such services.

(d) If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, at any time after completion of the construction, expansion, or modernization carried out with such funds, to be utilized for the purposes of providing ambulatory care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States.

[SEC. 307. [25 U.S.C. 1637] INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.]

INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT

SEC. 307. [25 U.S.C. 1637] (a) HEALTH CARE DELIVERY DEMONSTRATION PROJECT.—The Secretary, acting through the Service, is authorized to enter into contracts with, or make grants to, Indian tribes or tribal organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services through health facilities to Indians.

(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

(1) waive any leasing prohibition;

(2) permit carryover of funds appropriated for the provision of health care services;

(3) permit the use of non-Service Federal funds and non-Federal funds;

(4) permit the use of funds or property donated from any source for project purposes; and

(5) provide for the reversion of donated real or personal property to the donor.

(c) CRITERIA.—(1) Within 180 days after the date of enactment of this section, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and publish in the Federal Register criteria for the review and approval of applications submitted under this section. The Secretary may enter into a contract or award a grant under this section for projects which meet the following criteria;

(A) There is a need for a new facility *or program* or the reorientation of an existing facility.

(B) A significant number of Indians, including those with low health status, will be served by the project.

(C) The project has the potential to address the health needs of Indians in an innovative manner.

(D) The project has the potential to deliver services in an efficient and effective manner.

(E) The project is economically viable.

(F) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

(G) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

(2) The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and to advise the Secretary regarding such applications using the criteria developed pursuant to paragraph (1).

(3)(1) [The] *On or before September 30, 1995, the* Secretary shall enter into contracts or award grants under this section for a demonstration project in each of the following service units which meets the criteria specified in paragraph (1) *and for which a completed application has been received by the Secretary:*

(i) Cass Lake, Minnesota.

(ii) Clinton, Oklahoma.

(iii) Harlem, Montana.

(iv) Mescalero, New Mexico.

(v) Owyhee, Nevada.

(vi) Parker, Arizona.

(vii) Schurz, Nevada.

(viii) Winnebago, Nebraska.

(ix) Ft. Yuma, California.

[(B) After entering into contracts or awarding grants in according with subparagraph (A), and taking into account contracts entered into and grants awarded under such subparagraph, the Secretary may only enter into one contract or award one grant under this subsection with respect to a service area until the Secretary has entered into contracts or awarded grants for all service areas with respect to which the Secretary receives applications during

the application period, as determined by the Secretary, which meet the criteria developed under paragraph (1).]

(B) Subject to the availability of appropriations, the Secretary shall also enter into contracts or award grants under this section taking into consideration applications received under this section from all service areas. The Secretary may not award a greater number of such contracts or grants in one service area than in any other service area until there is an equal number of such contracts or grants awarded with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria specified in paragraph (1).

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

(e) SERVICE TO INELIGIBLE PERSONS.—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in service facilities to non-Service health care practitioners as provided in [section 713] *section 813* may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

(f) EQUITABLE TREATMENT.—For purposes of subsection (c)(1)(A), the Secretary shall, in evaluating facilities operated under any contract entered into with the Service under the Indian Self-Determination Act, use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities which are the subject of a contract for health services entered into with the Service under the Indian Self-Determination Act, are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

[(h) REPORT TO CONGRESS.—Within 90 days after the end of the period set out in subsection (a), the Secretary shall prepare and submit to Congress a report, together with legislative recommendations, on the findings and conclusions derived from the demonstration projects.]

(h) REPORTS. (1) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 801 for fiscal year 1997, an interim report on the findings and conclusions derived from the demonstration projects established under this section.

(2) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 801 for fiscal year 1999, a final report on the findings and conclusions derived from the demonstration projects established under this section, together with legislative recommendations.

[(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary for fiscal years 1991 and 1992 for the purpose of carrying out this section, which are authorized to remain available until expended.]

AUTHORIZATION OF APPROPRIATIONS

SEC. 308. There is authorized to be appropriated such sums as may be necessary for fiscal year 1993 and each fiscal year thereafter through fiscal year 2000 to carry out this title.

TITLE IV—ACCESS TO HEALTH SERVICES

[ELIGIBILITY OF INDIAN HEALTH SERVICE FACILITIES UNDER MEDICARE PROGRAM]

SEC. 401. TREATMENT OF PAYMENTS UNDER MEDICARE PROGRAM.

[SEC. 401. (a) Sections 1814(c) and 1835(d) of the Social Security Act are each amended by striking out "No payment" and inserting in lieu thereof "Subject to section 1880, no payment".

[(b) Part C of title XVIII of such Act is amended by adding at the end thereof the following new section:

["INDIAN HEALTH SERVICE FACILITIES

["SEC. 1880 [42 U.S.C. 1395qq] (a) A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding section 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this title.

["(b) Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this title which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

["(c) Notwithstanding any other provision of this title, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

["(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 403 of such Act) a

detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise toward the achievement of such compliance."

[(c) Any payments received for services provided to beneficiaries hereunder shall not be considered in determining appropriations for health care and services to Indians.

[(d) Nothing herein authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage. [42 U.S.C. 1395qq note]]

TREATMENT OF PAYMENT UNDER MEDICARE PROGRAM

SEC. 401. (a) Any payments received by a hospital or skilled nursing facility of the Service (whether operated by the Service or by an Indian tribe organization pursuant to a contract under the Indian Self-Determination Act) for services provided to Indians eligible for benefits under title XVIII of the Social Security Act shall not be considered in determining appropriations for health care and services to Indians.

(b) Nothing in this Act authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

[*SERVICES PROVIDED TO MEDICAID ELIGIBLE INDIANS*

[SEC. 402. (a) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

[*"INDIAN HEALTH SERVICE FACILITIES*

["SEC. 1991. [42 U.S.C. 1396j] (a) A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

["(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be demed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and require-

ments, during the first twelve months after the month in which such plan is submitted.

[“(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.”

[(c) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, skilled nursing facility, or any other type of facility which provides services of a type otherwise under title XIX of the Social Security Act is entitled under such a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation or in such amounts as are provided in appropriations Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of such title. In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the facilities of the Indian Health Service, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act, if such amount is necessary for the purpose of making improvements in such facilities in order to achieve compliance with the conditions and requirements of title XIX of the Social Security Act. This subsection shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.

[(d) Any payments received for services provided recipients hereunder shall not be considered in determining appropriations for the provision of health care and services to Indians.

[(e) Section 1905(b) of the Social Security Act is amended by inserting at the end thereof the following: “Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amount expended as medical assistance for service which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).”.[42 U.S.C. 1396j note]]

TREATMENT OF PAYMENTS UNDER MEDICAID PROGRAM

SEC. 402. (a) Notwithstanding any other provision of law, payments to which any facility of the Service (including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act) is entitled under a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appro-

priation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of such title. In making payments from such fund, the Secretary shall ensure that each service unit of the Service receives at least 80 percent of the amounts to which the facilities of the Service, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act, if such amount is necessary for the purpose of making improvements in such facilities in order to achieve compliance with the conditions and requirements of title XIX of the Social Security Act. This subsection shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.

(b) Any payments received by such facility for services provided to Indians eligible for benefits under title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians.

(2) The increase (from 50 percent) in the percentage of the payments from the fund to be made to each service unit of the Service specified in the amendment made by paragraph (1) shall take effect beginning with payments made on January 1, 1993.

REPORT

SEC. 403. [25 U.S.C. 1671 note] [The Secretary shall include in his annual report required by section 701] *The Secretary shall submit to the president, for inclusion in the report required to be transmitted to the Congress under section 801,* an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements through title XVIII and XIX of the Social Security Act, as amended.

GRANTS TO AND CONTRACTS WITH TRIBAL ORGANIZATIONS

SEC. 404. [25 U.S.C. 1622] (a) The Secretary, acting through the Service, shall make grants to or enter into contracts with tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

(1) enroll under section 1818 of part A and sections 1836 and 1837 of part B of title XVIII of the Social Security Act;

(2) pay monthly premiums for coverage due to financial need of such individual; and

(3) apply for medical assistance provided pursuant to title XIX of the Social Security Act,

(b) The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any contract of grant which the Secretary makes with any tribal organization pursuant to this section. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

(1) determine the population of Indians to be served that are or could be recipients of benefits under titles XVIII and XIX of the Social Security Act;

(2) assist individual Indians in becoming familiar with and utilizing such benefits;

(3) provide transportation to such individual Indians to the appropriate offices for enrollment or application for medical assistance;

(4) develop and implement [a schedule of income levels to determine the extent of payment of premiums by such organizations for coverage of needy individuals; and methods of improving the participation of Indians in receiving the benefits provided pursuant to titles XVIII and XIX of the Social Security Act.—]—

(A) a schedule of income levels to determine the extent of payments of premiums by such organizations for coverage of needy individuals; and

(B) methods of improving the participation of Indians in receiving the benefits provided under titles XVIII and XIX of the Social Security Act.

[(c) There are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1981, $5,750,000 for the fiscal year ending September 30, 1982, $6,615,000 for the fiscal year ending September 30, 1983, and $7,610,000 for the fiscal year ending September 30, 1984.]

DEMONSTRATION PROGRAM FOR DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS

SEC. 405. [42 U.S.C. 1395qq note] (a) The Secretary shall establish a demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations, which are contracting the entire operation of an entire hospital or clinic of the Service under the authority of the Indian Self-Determination Act, shall directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (medicare), under a State plan for medical assistance approved under title XIX of the Social Security Act (medicaid), or from any other third-party payor. The last sentence of section 1905(b) of the Social Security Act shall apply for purposes of the demonstration program.

(b)(1) Each hospital or clinic participating in the demonstration program described in subsection (a) shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act and [sections 402(c) and 713(b)(2)(A)] *sections 402(a) and 813(b)(2)(A)* of this Act, but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used—

(A) solely for improving the health resources deficiency level of the Indian tribe, and

(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act.

(2) The amounts paid to the hospitals and clinics participating in the demonstration program described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs.

(3) The Secretary shall monitor the performance of hospitals and clinics participating in the demonstration program described in subsection (a), and shall require such hospitals and clinics to submit reports on the program to the Secretary on a quarterly basis (or more frequently if the Secretary deems it to be necessary).

(4) Notwithstanding section 1880(c) of the Social Security Act or [section 402(c)] *section 402(a)* of this Act, no payment may be made out of the special fund described in section 1880(c) of the Social Security Act, or [section 402(c)] *section 402(a)* of this Act, for the benefit of any hospital or clinic participating in the demonstration program described in subsection (a) during the period of such participation.

(c)(1) In order to be considered for participation in the demonstration program described in subsection (a), a hospital or clinic must submit an application to the Secretary which establishes to the satisfaction of the Secretary that—

(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts the entire operation of the Service facility;

(B) the facility is eligible to participate in the medicare and medicaid programs under sections 1880 and 1911 of the Social Security Act;

(C) the facility meets any requirements which apply to programs operated directly by the Service; and

(D) the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan, which has been approved by the Secretary, for achieving such accreditation prior to October 1, 1990.

(2) From among the qualified applicants, the Secretary shall, prior to October 1, 1989, select no more than 4 facilities to participate in the demonstration program described in subsection (a). The demonstration program described in subsection (a) shall begin by no later than October 1, 1991, and end on September 30, [1995] *1996*.

(d)(1) Upon the enactment of the Indian Health Care Amendments of 1988, the Secretary, acting through the Service, shall commence an examination of—

(A) any administrative changes which may be necessary to allow direct billing and reimbursement under the demonstration program described in subsection (a), including any agreements with States which may be necessary to provide for such direct billing under the medicaid program; and

(B) any changes which may be necessary to enable participants in such demonstration program to provide to the Service

medical records information on patients served under such demonstration program which is consistent with the medical records information system of the Service.

(2) Prior to the commencement of the demonstration program described in subsection (a), the Secretary shall implement all changes required as a result of the examinations conducted under paragraph (1).

(3) Prior to October 1, 1990, the Secretary shall determine any accounting information which a participant in the demonstration program described in subsection (a) would be required to report.

(e) The Secretary shall submit a final report at the end of fiscal year [1995] *1996*, on the activities carried out under the demonstration program described in subsection (a) which shall include an evaluation of whether such activities have fulfilled the objectives of such program. In such report the Secretary shall provide a recommendation, based upon the results of such demonstration program, as to whether direct billing of, and reimbursement by, the medicare and medicaid programs and other third-party payors should be authorized for all Indian tribes and Alaska Native health organizations which are contracting the entire operation of a facility of the Service.

(f) The Secretary shall provide for the retrocession of any contract entered into between a participant in the demonstration program described in subsection (a) and the Service under the authority of the Indian Self-Determination Act. All cost accounting and billing authority shall be retroceded to the Secretary upon the Secretary's acceptance of a retroceded contract.

ADDITIONAL AUTHORITY

SEC. 406. (a) The Secretary may enter into an agreement with any tribal or urban Indian organization which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act and benefits under title XVIII of the Social Security Act at tribal or Indian Health Service contract health services facilities.

(b) The Secretary may pay premiums, deductibles, and copayments under part B of title XVIII of the Social Security Act for beneficiaries under Part A of title XVIII of such Act who are not qualified medicare beneficiaries (as described in section 1905(p) of such Act) due to income, but whose family income is not more than 200 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981).

(c) The Secretary shall not deny contract health services coverage to Indian recipients of medical care if such recipients—

(1) have attained age 65, or are disabled;

(2) have received emergency health care and have given notice of receipt of such health care to the contract health services program within 30 days after receiving such health care, or have demonstrated good cause for not so doing;

(3) have, upon the request of the administrator of the contract health services program, applied for coverage under title XIX of the Social Security Act within 90 days of the provision of such

emergency health care (in accordance with section 1902(a)(34) of such Act); and

(4) are otherwise eligible for contract health services coverage.

AUTHORIZATION OF APPROPRIATIONS

SEC. 407. There are authorized to be appropriated such funds as may be necessary for fiscal year 1993 and each fiscal year thereafter through fiscal year 2000 to carry out this title.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

PURPOSE

SEC. 501. [25 U.S.C. 1651] The purpose of this title is to establish programs in urban centers to make health services more accessible to urban Indians.

[CONTRACTS WITH URBAN INDIAN ORGANIZATIONS]

CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS

SEC. 502. [25 U.S.C. 1652] Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into [contracts with] *contracts with, or make grants to* urban Indian organizations to assist such organizations in the establishment and administration, within the urban centers in which such organizations are situated, of programs which meet the requirements set forth in this title. The Secretary, through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with, *or in any grant the Secretary makes to,* any urban Indian organization pursuant to this title.

CONTRACTS *AND GRANTS* FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES

SEC. 503. [25 U.S.C. 1653] (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into contracts, *or make grants to,* with urban Indian organizations for the provision of health care and referral services for urban Indians residing in the urban centers in which such organizations are situated. Any such contract *or grant* shall include requirements that the urban Indian organization successfully undertake to—

(1) estimate the population of urban Indians residing in the urban center in which such organization is situated who are or could be recipients of health care or referral services;

(2) estimate the current health status of urban Indians residing in such urban center;

(3) estimate the current health care needs of urban Indians residing in such urban center;

(4) identify all public and private health services resources within such urban center which are or may be available to urban Indians;

(5) determine the use of public and health services resources by the urban Indians residing in such urban center;

(6) assist such health services resources in providing services to urban Indians;

(7) assist urban Indians in becoming familiar with and utilizing such health services resources;

(8) provide basic health education, including health promotion and disease prevention education, to urban Indians;

(9) establish and implement training programs to accomplish the referral and education tasks set forth in paragraphs (6) through (8) of this subsection;

(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

(11) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

(12) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

(b) The Secretary, through the Service, shall by regulation prescribe the criteria for selecting urban Indian organizations to enter into contracts *or receive grants* under this section. Such criteria shall, among other factors, include—

(1) the extent of unmet health care needs of urban Indians in the urban center involved;

(2) the size of the urban Indian population in the urban center involved;

(3) the accessibility to, and utilization of, health care services (other than services provided under this title) by urban Indians in the urban center involved;

(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate—

(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this title; or

(B) any project funded under this title;

(5) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary *or to meet the requirements for receiving a grant* under this section;

(6) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

(7) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center; and

(8) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

[(c)(1)] *(c)* The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section *or receiving grants under subsection (a).*

[(2) There is authorized to be appropriated $1,000,000 for fiscal year 1992 to carry out this subsection.]

(d)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section *or receiving grants under subsection (a).*

(2) In making any grant to carry out this subsection, the Secretary shall take into consideration—

(A) the size of the urban Indian population to be served;

(B) the immunization levels of the urban Indian population, particularly the immunization levels of infants, children, and the elderly;

(C) the utilization by the urban Indians of alternative resources from State and local governments for no-cost or low-cost immunization services to the general population; and

(D) the capability of the urban Indian organization to carry out services pursuant to this subsection.

(3) For purposes of this subsection, the term "immunization services" means services to provide without charge immunizations against vaccine-preventable diseases.

[(4) There are authorized to be appropriated $1,000,000 for fiscal year 1992 to carry out this subsection.]

(e)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section *or receiving grants under subsection (a).*

(2) A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.

(3) Grants may be made under this subsection—

(A) to prepare assessments required under paragraph (2);

(B) to provide outreach, educational, and referral services to urban Indians regarding the availability of direct mental health services, to educate urban Indians about mental health issues and services, and effect coordination with existing mental health providers in order to improve services to urban Indians;

(C) to provide outpatient mental health services to urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment; and

(D) to develop innovative mental health service delivery models which incorporate Indian cultural support systems and resources.

[(4) There is authorized to be appropriated $500,000 for fiscal year 1991 and $2,000,000 for fiscal year 1992 to carry out this subsection.]

(f)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to urban Indian organizations administering contracts entered into pursuant to this section *or receiving grants under subsection (a)* to prevent and treat child abuse (including sexual abuse) among urban Indians.

(2) A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

(3) Grants may be made under this subsection—

(A) to prepare assessments required under paragraph (2);

(B) for the development of prevention, training, and education programs for urban Indian populations, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

(C) to provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to urban Indian perpetrators of child abuse (including sexual abuse).

(4) In making grants to carry out this subsection, the Secretary shall take into consideration—

(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

(C) the assessment required under paragraph (2).

[(5) There is authorized to be appropriated $500,000 for fiscal year 1991 and $2,000,000 for fiscal year 1992 to carry out this subsection.]

CONTRACTS *AND GRANTS* FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS

[SEC. 504 [25 U.S.C. 1654] (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, may enter into contracts with urban Indian organizations situated in urban centers for which contracts have not been entered into under section 503. The purpose of a contract under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract under section

503 with the urban Indian organization with which the Secretary has entered into a contract under this section.]

SEC. 504. (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, may enter into contracts with, or make grants to, urban Indian organizations situated in urban centers for which contracts have not been entered into, or grants have not been made, under section 503. The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization which the Secretary has entered into a contract with, or made a grant to, under this section.

(b) Any contract entered into, *or grant made,* by the Secretary under this section shall include requirements that—

(1) the urban Indian organization successfully undertake to—

(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

(B) with respect to urban Indians in the urban center involved, determine the matters described in clauses (2), (3), (4), and (8) of section 503(b); and

(2) the urban Indian organization complete performance of the contract [within one year after the date on which the Secretary and such organization enter into such contract.], *or carry out the requirements of the grant, within one year after the date on which the Secretary and such organization enter into such contract, or within one year after such organization receives such grant, whichever is applicable.*

(c) The Secretary may not renew any contract entered into, *or grant made,* under this section.

EVALUATIONS; [CONTRACT] RENEWALS

SEC. 505 [25 U.S.C. 1655] (a) The Secretary, through the Service, shall develop procedures to evaluate *compliance with grant requirements under this title and* compliance with, and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

(b) The Secretary, through the Service, shall conduct an annual on-site evaluation of each urban Indian organization which has entered into a contract *or received a grant* under section 503 for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract *or the terms of such grant.*

(c) If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied *with the requirements of a grant or complied with* or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract *or grant,* attempt to resolve with such organization the areas of noncompliance or unsatisfac-

tory performance and modify such contract *or grant* to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract *or grant* with such organization and is authorized to enter into a contract *or make a grant* under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract *or grant* is not renewed under this section.

(d) In determining whether to renew a contract *or grant* with an urban Indian organization under section 503 which has completed performance of a contract *or grant* under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract *or grant* under section 503, shall consider the results of the onsite evaluations conducted under subsection (b).

OTHER CONTRACT *AND GRANT* REQUIREMENTS

SEC. 506 [25 U.S.C. 1656] (a) Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (40 U.S.C. 270a, et seq.).

(b) Payments under any contracts *or grants* pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

(d) In connection with any contract *or grant* entered into pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract *or grant,* existing facilities owned by the Federal government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.

(e) Contracts with, *or grants to,* urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts *or grants* by such organizations.

(f) Urban Indians, as defined in section 49(f) of this Act, shall be eligible for health care or referral services provided pursuant to this title.

(g) Notwithstanding any other provision of law, organizations receiving grants or contracts under this title, including urban Indian demonstration projects, shall meet the definition of an urban Indian organization as defined in section 4(h).

REPORTS AND RECORDS

SEC. 507. [25 U.S.C. 1657] (a) For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into, *or a grant received,* pursuant to this title, such organization shall submit to the Secretary a quarterly report including—

(1) in the case of a contract *or grant* under section 503, information gathered pursuant to clauses (10) and (11) of subsection (a) of such section;

(2) information on activities conducted by the organization pursuant to the contract *or grant;*

(3) an accounting of the amounts and purposes for which Federal funds were expended; and

(4) such other information as the Secretary may request.

(b) The reports and records of the urban Indian organization with respect to a contract *or grant* under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

(c) The Secretary shall allow as a cost of any contract *or grant* entered into under section 503 the cost of an annual private audit conducted by a certified public accountant.

(d)(1) The Secretary, acting through the Service, shall submit a report to the Congress not later than March 31, 1992, evaluating—

(A) the health status of urban Indians;

(B) the services provided to Indians through this title;

(C) areas of unmet needs in urban areas not served under this title; and

(D) areas of unmet needs in urban areas not served under this title.

(2) In preparing the report under paragraph (1), the Secretary shall consult with urban Indian health providers and may contract with a national organization representing urban Indian health concerns to conduct any aspect of the report.

(3) The Secretary and the Secretary of the Interior shall—

(A) assess the status of the welfare of urban Indian children, including the volume of child protection cases, the prevalence of child sexual abuse, and the extent of urban Indian coordination with tribal authorities with respect to child sexual abuse; and

(B) submit a report on the assessment required under subparagaph (A), together with recommended legislation to improve Indian child protection in urban Indian populations, to the Congress no later than March 31, 1992.

LIMITATION ON CONTRACT AUTHORITY

SEC. 508 [25 U.S.C. 1658] The authority of the Secretary to enter into contracts under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

[SEC. 409 509 [25 U.S.C. 1659] facilities renovation.]

FACILITIES RENOVATION

SEC. 509. The Secretary may make funds available to contractors *or grant recipients* under this title for minor renovations to facilities, including leased facilities, to assist such contractors *or grant recipients* in meeting or maintaining the Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards. [There is authorized to be appropriated $1,000,000 for fiscal year 1992 to carry out this section.]

[SEC. 511 510 [25 U.S.C. 1660] URBAN HEALTH PROGRAMS BRANCH]

URBAN HEALTH PROGRAMS BRANCH

SEC. 510. (a) ESTABLISHMENT.—There is hereby established within the Service a Branch of Urban Health Programs which shall be responsible for carrying out the provisions of this title[.], *and for providing central oversight of the programs and services authorized under this title.*

(b) STAFF, SERVICES, AND EQUIPMENT.—The Secretary shall appoint such employees to work in the branch, including a program director, and shall provide such services and equipment, as may be necessary for it to carry out its responsibilities. The Secretary shall also analyze the need to provide at least one urban health program analyst for each area office of the Indian Health Service and shall submit his findings to the Congress as a part of the Department's fiscal year 1993 budget request.

FEDERAL TORT CLAIMS ACT COVERAGE

SEC. 511. For the purposes of section 224 of the Public Health Service Act (42 U.S.C. 233(a)), with respect to claims for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, an urban Indian health program carrying out contract or agreement under section 503(a) for the benefit of urban Indians, is deemed to be part of the Public Health Service in the Department of Health and Human Services while carrying out any such contract or agreement, and its employees (including those acting on behalf of the organization as provided in section 2671 of title 28, United States Code) are deemed employees of the Public Health Service while acting within the scope of their employment in carrying out the contract or agreement.

AUTHORIZATION OF APPROPRIATIONS

SEC. 512. There are authorized to be appropriated such sums as may be necessary for fiscal year 1993 and each fiscal year thereafter through fiscal year 2000 to carry out this title.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

SEC. 601 [25 U.S.C. 1661] (a) In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of

the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service. The Indian Health Service shall be administered by a Director, who shall be appointed by the *President, by and with the advice and consent of the Senate.* The Director of the Indian Health Service shall report to the Secretary through the Assistant Secretary for Health of the Department of Health and Human Services. *The Director of the Indian Health Service shall serve a term of 4 years. A Director may be appointment, by and with the advice and consent of the Senate, for more than 1 term.*

(b) The Indian Health Service shall be an agency within the Public Health Service of the Department of Health and Human Services, and shall not be an office, component, or unit of any other agency of the Department.

(c) The Secretary shall carry out through the Director of the Indian Health Service—

(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Indian Health Service on such day;

(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians; [and]

(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including (but not limited to) programs under—

(A) this Act;

(B) the Act of November 2, 1921 (25 U.S.C. 13);

(C) the Act of August 5, 1954 (42 U.S.C. 2001, et seq.);

(D) the Act of August 16, 1957 [(25 U.S.C. 2005, et seq.)] *(42 U.S.C. 2005 et seq.);* and

(E) the Indian Self-determination Act (25 U.S.C. 450f, et seq.) [.]*; and*

(4) all scholarship and loan functions carried out under title I.

(d)(1) The Secretary, acting through the Director of the Indian Health Service, shall have the authority—

(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

(C) to manage, expend, and obligate all funds [appropriate] *appropriated* for the Service.

(2) Notwithstanding any other law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

AUTOMATED MANAGEMENT INFORMATION SYSTEM

SEC. 602. [25 U.S.C. 1662] (a)(1) The Secretary shall establish an automated management information system for the Service.

(2) The information system established under paragraph (1) shall include—

(A) a financial management system,

(B) a patient care information system for each area served by the Service,

(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service, and

(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service.

[(3) By no later than September 30, 1989, the Secretary shall submit a report to Congress setting forth—

[(A) the activities which have been undertaken to establish an automated management information system,

[(B) the activities, if any, which remain to be undertaken to complete the implementation of an automated management information system, and

[(C) the amount of funds which will be needed to complete the implementation of a management information system in the succeeding fiscal years.]

(b)(1) The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act automated management information systems which—

(A) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service, and

(B) meet the management information needs of the Service.

(2) The Secretary shall reimburse each Indian tribe or tribal organization for the part of the cost of the operation of a system provided under paragraph (1) which is attributable to the treatment by such Indian tribe or tribal organization of patients of the Service.

(3) The Secretary shall provide systems under paragraph (1) to Indian tribes and tribal organizations providing health services in California by no later than September 30, 1990.

(c) Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

AUTHORIZATION OF APPROPRIATIONS

SEC. 603. There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.

[TITLE VII—MISCELLANEOUS]

TITLE VII—SUBSTANCE ABUSE PROGRAMS

GALLUP ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER

SEC. 701. (a) GRANTS FOR RESIDENTIAL TREATMENT.—The Secretary shall make grants to the Navajo Nation for the purpose of providing residential treatment for alcohol and substance abuse for adult and residential treatment for alcohol and substance abuse for adult and adolescent members of the Navajo Nation and neighboring tribes.

(b) PURPOSES OF GRANTS.—Grants made pursuant to this section shall be used to—

(1) provide at least 15 residential beds each year for adult long-term treatment, including beds for specialized services such as polydrug abusers, dual diagnosis, and specialized services for women with fetal alcohol syndrome children;

(2) establish clinical assessment teams consisting of a clinical psychologist, a part-time addictionologist, a master's level assessment counselor, and a certified medical records technician which shall be responsible for conducting individual assessments and matching Indian clients with the appropriate available treatment;

(3) provide at least 12 beds for an adolescent shelterbed program in the city of Gallup, New Mexico, which shall serve as a satellite facility to the Acoma/Canoncito/Laguna Hospital and the adolescent center located in Shiprock, New Mexico, for emergency crisis services, assessment, and family intervention;

(4) develop a relapse program for the purposes of identifying sources of job training and job opportunity in the Gallup area and providing vocational training, job placement, and job retention services to recovering substance abusers; and

(5) provide continuing education and training of treatment staff in the areas of intensive outpatient services, development of family support systems, and case management in cooperation with regional colleges, community colleges, and universities.

(c) CONTRACT FOR RESIDENTIAL TREATMENT.—The Navajo Nation, in carrying out the purposes of this section, shall enter into a contract with an institution in the Gallup, New Mexico, area which is accredited by the Joint Commission of the Accreditation of Health Care Organizations to provide comprehensive alcohol and drug treatment as authorized in subsection (b).

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

(1) to carry out the purposes of subsection (b)(1)—
(A) $400,000 for fiscal year 1993;
(B) $400,000 for fiscal year 1994; and
(C) $500,000 for fiscal year 1995;

(2) to carry out the purposes of subsection (b)(2)—
(A) $100,000 for fiscal year 1993;
(B) $125,000 for fiscal year 1994; and
(C) $150,000 for fiscal year 1995;

(3) to carry out the purposes of subsection (b)(3)—
(A) $75,000 for fiscal year 1993;

(B) $85,000 for fiscal year 1994; and
(C) $100,000 for fiscal year 1995;
(4) to carry out the purposes of subsection (b)(4), $150,000 for each of fiscal years 1993, 1994, and 1995; and
(5) to carry out the purposes of subsection (b)(5)—
(A) $75,000 for fiscal year 1993;
(B) $90,000 for fiscal year 1994; and
(C) $100,000 for fiscal year 1995.

URBAN INDIAN PROGRAM

SEC. 702. (a) GRANTS.—The Secretary may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education in alcohol and substance abuse in urban centers to those urban Indian organizations with whom the Secretary has entered into a contract under Title V of this Act.

(b) GOALS OF GRANT.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the—
(1) size of the urban Indian population;
(2) accessibility to, and utilization of, other health resources available to such population;
(3) duplication of existing Service or other Federal grants or contracts;
(4) capability of the organization to adequately perform the activities required under the grant;
(5) satisfactory performance standards for the organization in meeting the goals set forth in such grant, which standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis; and
(6) identification of need for services.

the Secretary shall develop a methodology for allocating grants made pursuant to this section based on such criteria.

(d) TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS.—Any funds received by an urban Indian organization under this or any other Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

PUEBLO SUBSTANCE ABUSE TREATMENT PROJECT FOR SAN JUAN PUEBLO, NEW MEXICO

SEC. 703. The Secretary, acting through the Service, shall continue to make grants, through fiscal year 1995, to the 8 Northern Indian Pueblos Council, San Juan Pueblo, New Mexico, for the purpose of providing substance abuse treatment services to Indians in need of such services.

ALCOHOL AND SUBSTANCE ABUSE TREATMENT FACILITY

SEC. 704. (a) The Secretary, acting through the Service, shall establish a regional youth alcohol and substance abuse prevention

and treatment center in Sacaton, Arizona, on the Gila River Indian Reservation. The center shall be established within facilities leased, with the consent of the Gila River Indian tribe, by the Indian health Service from such Tribe.

(b) The center established pursuant to this section shall be known as the "Regional Youth Alcohol and Substance Abuse Prevention and Treatment Center".

(c) The Secretary, acting through the Service, shall establish, as a unit of the regional center, a youth alcohol and substance abuse prevention and treatment facility in Schurz, Nevada.

ALASKA NATIVE DRUG AND ALCOHOL ABUSE DEMONSTRATION PROJECT

SEC. 705. (a) The Secretary, acting through the Service, shall make grants to the Alaska Native Health Board for the conduct of a two-part community-based demonstration project to reduce drug and alcohol abuse in Alaska Native villages and to rehabilitate families afflicted by such abuse. Sixty percent of such grant funds shall be employed by the Health Board to stimulate coordinated community development programs in villages seeking to organize to combat alcohol and drug use. Forty percent of such grant funds shall be transferred to a qualified nonprofit corporation providing alcohol recovery services in the village of St. Mary's, Alaska, to enlarge and strengthen a family life demonstration program of rehabilitation for families that have been or are afflicted by alcoholism.

(b) The Secretary, acting through the Service, shall evaluate the program established under subsection (a) of this section and submit a report on such evaluation to the appropriate committees of Congress by January 1, 1993.

TREATMENT CENTER

SEC. 706. (a) The Secretary, acting through the Service, shall make a grant to the Thunderchild Treatment Center at Sheridan, Wyoming, to match funds already received by the Thunderchild Treatment Center through private contributions for the completion of construction of a multiple approach substance abuse treatment center which specializes in the treatment of alcohol and drug abuse of American Indians.

(b) To carry out subsection (a), there is authorized to be appropriated, the sum of $2,000,000 for fiscal year 1994. No funding made available under this title for the purposes of carrying out this section shall be used for the staffing or operation of this facility. None of the funding appropriated to carry out subsection (a) shall be used for administrative purposes.

FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT GRANTS

SEC. 707. (a) The Secretary may make grants to Indian tribes and tribal organizations to establish fetal alcohol syndrome (hereafter in this title referred to as "FAS") and fetal alcohol effect (hereafter in title referred to as "FAE") programs as provided in this section for the purposes of meeting the health status objectives specified in section 3(b).

(b) Grants made pursuant to this section shall be used to—

(1) develop and provide community and in-school training, education, and prevention programs relating to FAS and FAE;

(2) identify and provide alcohol and substance abuse treatment to high-risk women;

(3) identify and provide appropriate educational and vocational support, counseling, advocacy, and information to FAS and FAE affected persons and their families or caretakers;

(4) develop and implement counseling and support programs in schools for FAS and FAE affected children; and

(5) develop prevention and intervention models which incorporate traditional healers, cultural values and community involvement.

(c) The Secretary shall establish criteria for the review and approval of applications for grants under this section.

(d) Ten percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations funded under title V.

FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT EDUCATION

SEC. 708. (a) The Secretary shall provide assistance to Indian tribes and tribal organizations for the development, printing, and dissemination of education and prevention materials on FAS and FAE and in the development and implementation of culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities. Such materials shall be developed through the tribal consultation process.

(b) The Secretary shall—

(1) convene a FAS/FAE Task Force, composed of representatives from the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, the Office of Substance Abuse Prevention, the National Institute of Mental Health, the Service, the Office of Minority Health of the Department of Health and Human Services, the Administration for Native Americans, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian FAS/FAE experts to examine the needs of Indian tribes and Indian communities and available Federal resources; and

(2) develop an annual plan for the prevention, intervention, treatment and aftercare for those affected by FAS and FAE in Indian communities.

(c) The Secretary shall make grants to Indian tribes, tribal organizations, universities working with Indian tribes on cooperative projects, and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide aftercare for persons affected by FAS or FAE.

REPORT

SEC. 709. (a) The Secretary shall, not later than March 31 of each fiscal year, transmit a report to the Congress on the status of FAS and FAE in the Indian population. Such report shall include the following:

(1) The progress of implementing a uniform assessment and diagnostic methodology in Service and tribally based service delivery systems.

(2) The incidence of FAS and FAE babies born for all births by reservation and urban-based sites.

(3) The prevalence of FAS and FAE affected Indian persons in Indian communities, their primary means of support, and recommendations to improve the support system for these individuals and their families or caretakers.

(4) The level of support received from the entities specified in section 710(b) in the area of FAS and FAE.

(5) The number of inpatient and outpatient substance abuse treatment resources which are specifically geared to meet the unique needs of Indian women, and the volume of care provided to Indian women through these means.

(6) Recommendations regarding the prevention, intervention, and appropriate vocational, educational and other support services for FAS and FAE affected individuals in Indian communities.

(b) The Secretary may contract the production of this report to a national organization specifically addressing FAS and FAE in Indian communities.

ADOLESCENT AND ADULT FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT

SEC. 710. The Secretary, acting through the Service, shall conduct a study of the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians and Alaska Natives with FAS or FAE. In carrying out this section, the Secretary is authorized to enter into a contract or other agreement with any organization entity, or institution of higher education with significant knowledge of FAS and FAE in Indian communities.

CLEARINGHOUSE

SEC. 711. (a) The Secretary, acting through the Service, shall establish a national clearinghouse for prevention and educational materials and other information on fetal alcohol syndrome and fetal alcohol effect in Indian and Alaska native communities.

(b) The Secretary shall ensure access to all clearinghouse materials by any Indian tribe or urban Indian organization to assist in the development of culturally sensitive education and training materials and to assist in community education and prevention of fetal alcohol syndrome and fetal alcohol effect in Indian and Alaska Native communities.

INDIAN WOMEN TREATMENT PROGRAMS

SEC. 712. (a) The Secretary may make grants to Indian tribes and tribal organizations to develop and implement a comprehensive program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social and child care needs of Indian women, regardless of age.

(b) Grants made pursuant to this section may be used to—

(1) develop and provide community training, education, and prevention programs for Indian women relating to alcohol and substance abuse issues, including fetal alcohol syndrome and fetal alcohol effect;

(2) identify and provide appropriate counseling, advocacy, support, and relapse prevention to Indian women and their families; and

(3) develop prevention and intervention models for Indian women which incorporate traditional healers, cultural values, and community and family involvement.

(c) The Secretary shall establish criteria for the review and approval of applications for grants under this section.

(d) Twenty percent of the funds appropriated pursuant to the authorization provided by subsection (d) shall be used to make grants to urban Indian organizations funded under title V.

SUBSTANCE ABUSE COUNSELOR EDUCATION DEMONSTRATION PROJECT

SEC. 713. (a) The Secretary, acting through the Service, may enter into contracts with, or make grants to colleges, universities, and tribally controlled community colleges as defined in section 2(a)(4) of the Tribally Controlled Community College Assistance Act of 1978 (25 U.S.C. 1801 et seq.) to establish demonstration projects to develop educational curricula for substance abuse counseling.

(b) Funds provided under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors).

(c) Not later than 180 days after the date of the enactment of this section, the Secretary, after consultation with colleges, universities, and with Indian tribes and administrators of tribally controlled community colleges, shall develop and issue criteria for the review and approval of applications for funding under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of colleges, universities, and tribally controlled community colleges to educate substance abuse counselors.

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

(e) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section, together with legislative recommendations.

(f) For the purposes of this section, the term "educational curriculum" means one or more of the following:

(1) Classroom education.

(2) Clinical work experience.

(3) Continuing education workshops.

AUTHORIZATION OF APPROPRIATIONS

SEC. 714. Except as provided in sections 701, 706, and 713, there are authorized to be appropriated such sums as may be necessary for

fiscal year 1993 and each fiscal year thereafter through fiscal year 2000 to carry out this title.

TITLE VIII—MISCELLANEOUS

REPORTS

[SEC. 701.] *SEC. 801.* [25 U.S.C. 1671] [The Secretary shall report annually to the President and the Congress on progress made in effecting the purposes of this Act. Within three months after the end of fiscal year 1979, the Secretary shall review expenditures and progress made under this Act and make recommendations to the Congress concerning any additional authorizations for fiscal years 1981 through 1984 for programs authorized under this Act which he deems appropriate. In the event the Congress enacts legislation authorizing appropriations for programs under this Act for fiscal years 1981 through 1984, within three months after the end of fiscal year 1983, the Secretary shall review programs established or assisted pursuant to this Act and shall submit to the Congress his assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and insure a health status for Indians, which are at a parity with the health services available to and the health status of the general population.] *The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to the Congress a report containing—*

(1) a report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which are at a parity with the health services available to and the health status of, the general population;

(2) a separate statement which specifies the amount of funds requested to carry out the provisions of section 201;

(3) a separate statement of the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in section 814, relating to infant and maternal mortality and fetal alcohol syndrome;

(4) reports required pursuant to sections (3)(b), 108(n), 203(b), 209(k), 301(c), 302(g), 403, and 817(a);

(5) for fiscal year 1997, the interim report required pursuant to section 307(h)(1);

(6) for fiscal year 1999, the report required pursuant to section 307(h)(2); and

(7) a report on whether, and to what extent, new health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of the Act, and any steps that the Secretary may have taken to consult with Indian tribes to address such impact.".

REGULATIONS

[SEC. 702.] *SEC. 802.* [25 U.S.C. 1672] [(a)(1) Within six months from the date of enactment of this Act, the Secretary shall, to the extent practicable, consult with national and regional Indian organizations to consider and formulate appropriate rules and regulations to implement the provisions of this Act.

[(2) Within eight months after the date of enactment of this Act, the Secretary shall publish proposed rules and regulations in the Federal Register for the purpose of receiving comments from interested parties.

[(3) Within ten months from the date of enactment of this Act, the Secretary shall promulgate rules and regulations to implement the provisions of this Act.

[(b) The Secretary is authorized to revise and amend any rules or regulations promulgated pursuant to this Act: Provided, That, prior to any revision of or amendment to such rules or regulations, the Secretary shall, to the extent practicable, consult, with appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.] *Prior to any revision of or amendment to rules or regulations promulgated pursuant to this Act, the Secretary shall consult with Indian tribes and appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.*

PLAN OF IMPLEMENTATION

[SEC. 703.] *SEC. 803.* [25 U.S.C. 1673] [Within two hundred and forty days after enactment of this Act, a plan will be prepared by the Secretary and will be submitted to the Congress. The plan will explain the manner and schedule (including a schedule of appropriation requests), by title and section, by which the Secretary will implement the provisions of this Act.] *Section 803 of the Act (25 U.S.C. 1673) is repealed.*

LEASES WITH INDIAN TRIBES

[SEC. 704.] *SEC. 804.* [25 U.S.C. 1674] (a) Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes for periods not in excess of twenty years. Property leased by the Secretary from an Indian tribe may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe.

(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

(1) title to;

(2) a leasehold interest in; or

(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable.

AVAILABILITY OF FUNDS

[SEC. 705.] *SEC. 805.* [25 U.S.C. 1675] The funds appropriated pursuant to this Act shall remain available until expended.

LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE

[SEC. 706.] *SEC. 806.* [25 U.S.C. 1676] Any limitation on the use of funds contained in an Act providing appropriations for the Department of Health and Human Services for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Indian Health Service.

NUCLEAR RESOURCE DEVELOPMENT HEALTH HAZARDS

[Sec. 707.] *SEC. 807.* [25 U.S.C. 1677] (a) The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with other concerned Indian tribes and organizations, a study of the health hazards to Indian communities as a result of nuclear resource development. Such study shall include—

(1) an evaluation of the nature and extent of nuclear resource development related health problems currently currently exhibited among Indians and the causes of such health problems;

(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear powerplants operation and construction, and nuclear waste disposal;

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

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

(b) Upon completion of such study the Secretary and the Service shall take into account the results of such study and develop a health care plan to address the health problems studied under subsection (a). The plan shall include—

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

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

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

(c) The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than the date eighteen months after the date of enactment of this section. The health care plan prepared under subsection (b) shall be submitted in a report no later than the date one year after the date that the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the service to address such health problems.

(d)(1) There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees): the Secretary of Energy, the Administrator of the Environmental Protection Agency, the Director of the Bureau of Mines, the Assistant Secretary for Occupational Safety and Health, and the Secretary of the Interior.

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

(3) The Secretary shall be Chairman of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

(e) In the case of any Indian who—

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

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

(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator; the Service shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may recover the costs of any medical care so rendered to which such Indian is entitled at the expense of such operator from such operator. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such costs paid to the Service from the employer for such illness or condition.

[(f) There is authorized to be appropriated $300,000 to carry out the study as provided in subsection (a), such amount to be expended by the date eighteen months after the date of the enactment of this section.]

ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

[SEC. 708.] *SEC. 808.* [25 U.S.C. 1678] (a) For the fiscal years beginning with the fiscal year ending September 30, 1982, and ending with the fiscal year ending September 30, [1991] *2000,* the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of Arizona.

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

ELIGIBILITY OF CALIFORNIA INDIANS

[SEC. 709.] *SEC. 809.* [25 U.S.C. 1679] (a)(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after the date of enactment of the Indian Health Care Amendments of 1988, prepare and submit to the Congress a report which sets forth—

(A) a determination by the Secretary of the number of Indians described in subsection (b)(2), and the number of Indians described in subsection (b)(3), who are not members of an Indian tribe recognized by the Federal Government,

(B) the geogrpahic location of such Indians,

(C) the Indian tribes of which such Indians are members,

(D) an assessment of the current health status, and health care needs, of such Indians, and

(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.

(2) The report required under paragraph (1) shall be prepared by the Secretary

(A) in consultation with the Secretary of the Interior, and

(B) with the assistance of the tribal health programs providing services to the Indians described in paragraphs (2) and (3) of subsection (b) who are not members of any Indian tribe recognized by the Federal Government.

(b) Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

(1) Any member of a federally recognized Indian tribe.

(2) Any descedent of an Indian who was residing in California on June 1, 1852, but only if such descendant—

(A) is living in California,

(B) is a member of the Indian community served by a local program of the Service, and

(C) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(c) Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

[SEC. 710.] *SEC. 810.* [25 U.S.C. 1680] The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura shall be designed as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State.

CONTRACT HEALTH FACILITIES

[SEC. 711.] *SEC. 811.* [25 U.S.C. 1680a] The Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Service entered into under the Indian Self-Determination Act—

(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,

(2) for employee training,

(3) for cost-of-living increases for employees, and

(4) for any other expenses relating to the provision of health services, on the same basis as such funds are provided to programs and facilities operated directly by the Service.

NATIONAL HEALTH SERVICE CORPS

[SEC. 712.] *SEC. 812.* [25 U.S.C. 1680b] The Secretary of Health and Human Resources shall not—

(1) remove a member of the National Health Service Corps from a health facility operated by the Indian Health Service or by a tribe or tribal organization under contract with the Indian Health Service under the Indian Self-Determination Act, or

(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.

HEALTH SERVICES FOR INELIGIBLE PERSONS

[SEC. 713.] *SEC. 813.* [25 U.S.C. 1680c] (a)(1) Any individual who—

(A) has not attained 19 years of age,

(B) is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible Indian, and

(C) is not otherwise eligible for the health services provided by the Service, shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

(2) Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe of the eligible Indian. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

(b)(1)(A) The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other subsection of this section or under any other provision of law if—

(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals, and

(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

(I) the provision of such health services will not result in a denial or diminution of health services to eligible Indians, and

(II) there is no reasonable alternative health facility or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

(B) In the case of health facilities operated under a contract entered into under the Indian Self-Determination Act, the governing body of the Indian tribe or tribal organization providing health services under such contract is authorized to determine whether health services should be provided under such contract to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the considerations described in subparagraph (A)(ii).

(2)(A) Persons receiving health services provided by the Service by reason of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, [section 402(c)] *section 402(a)* of this Act, or any other provision of law, amounts collected under this subsection, including medicare or medicaid reimbursement under title XVIII and XIX of the Social Security Act, shall be credited to the account of the facility providing the service and shall be used solely for the provision of health services within that facility. Amounts collected under this subsection shall be available for expenditure within such facility for not to exceed one fiscal year after the fiscal year in which collected.

(B) Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent person.

(3)(A) In the case of a service area which serves only one Indian tribe, the authority of the Secretary to provide health services under paragraph (a)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian tribe revokes its concurrence to the provision of such health services.

(B) In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

(c) The service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other subsection of this section or under any other provision of law in order to—

(1) achieve stability in a medical emergency,

(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard,

(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum, or

(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

(d) Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Govern-

ment for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

(e) For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

INFANT AND MATERNAL MORTALITY; FETAL ALCOHOL SYNDROME

[SEC. 714.] *SEC. 814.* [25 U.S.C. 1680d] [(a)] By no later than January 1, 1990, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1994:

(1) reduction of the rate of Indian infant mortality in each area office of the Service to the lower of—

(A) twelve deaths per one thousand live births, or

(B) the rate of infant mortality applicable to the United States population as a whole;

(2) reduction of the rate of maternal mortality in each area office of the Service to the lower of—

(A) five deaths per one hundred thousand live births, or

(B) the rate of maternal mortality applicable to the United States population as a whole; and

(3) reduction of the rate of fetal alcohol syndrome among Indians served by, or on behalf of, the Service to one per one thousand live births.

[(b) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in subsection (a).]

CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

[SEC. 715.] *SEC. 815.* [25 U.S.C. 1680e] (a) The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

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

[INDIAN HEALTH SERVICE AND VETERANS' ADMINISTRATION HEALTH FACILITIES AND SERVICES SHARING]

INDIAN HEALTH SERVICE AND DEPARTMENT OF VETERANS AFFAIRS HEALTH FACILITIES AND SERVICES SHARING

[SEC. 716.] *SEC. 816.* [25 U.S.C. 1680f] (a) The Secretary shall examine the feasibility of entering into an arrangement for the sharing of medical facilities and services between the Indian Health Service and the Veteran's Administration and shall, in accordance with subsection (b), prepare a report to the Congress by no later than September 30, 1990.

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

(1) the priority access of any Indian to health care services provided through the Indian Health Service;

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

(3) the priority access of any veteran to health care services provided by the Veterans' Administration;

(4) the quality of health care services provided to any veteran by the Veterans' Administration;

(5) the eligibility of any Indian to receive health services through the Indian Health Service; or

(6) the eligibility of any Indian who is a veteran to receive health services through the Veterans' Administration.

(c)(1) Within 30 days after the date of enactment of this section, the Director of the Indian Health Service and the Administrator of Veterans' Affairs are authorized and directed to implement an agreement under which—

(A) individuals in the vicinity of Roosevelt, Utah, who are eligible for health care from the Veterans' Administration could obtain health care services at the facilities of the Indian Health Service located at Fort Duchesne, Utah; and

(B) individuals eligible for health care from the Indian Health Service at Fort Duchesne, Utah, could obtain health care services at the Veterans' Administration medical center located in Salt Lake City, Utah.

(2) Not later than 2 years after the date of enactment of this section, the Secretary and the Administrator of Veterans' Affairs shall jointly submit a report to the Congress on the health care services provided as a result of paragraph (1).

(d) Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Indian Health Service except as provided in an agreement under subsection (c).

REALLOCATION OF BASE RESOURCES

[SEC. 717.] *SEC. 817.* [25 U.S.C. 1680g] (a) Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a service unit may be implemented only after the [Secretary has submitted to the Congress] *Secretary has submitted to the Presi-*

dent, for inclusion in the report required to be transmitted to the Congress under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

(b) Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is less than the amount appropriated to the Service for previous fiscal year.

DEMONSTRATION PROJECTS FOR TRIBAL MANAGEMENT OF HEALTH CARE SERVICES

[SEC. 718.] *SEC. 818.* [25 U.S.C. 1680h] (a)(1) The Secretary, acting through the Service, shall make grants to Indian tribes to establish demonstration projects under which the Indian tribe will develop and test a phased approach to assumption by the Indian tribe of the health care delivery system of the Service for members of the Indian tribe living on or near the reservations of the Indian tribe through the use of Service, tribal, and private sector resources.

(2) A grant may be awarded to an Indian tribe under paragraph (1) only if the Secretary determines that the Indian tribe has the administrative and financial capabilities necessary to conduct a demonstration project described in paragraph (1).

(b) During the period in which a demonstration project established under subsection (a) is being conducted by an Indian tribe, the Secretary shall award all health care contracts, including community, behavioral, and preventive health care contracts, to the Indian tribe in the form of a single grant to which the regulations prescribed under part A of title XIX of the Public Health Service Act (as modified as necessary by any agreement entered into between the Secretary and the Indian tribe to achieve the purposes of the demonstration project established under subsection (a)) shall apply.

(c) The Secretary may waive such provisions of Federal procurement law as are necessary to enable any Indian tribe to develop and test administrative systems under the demonstration project established under subsection (a), but only if such waiver does not dimish or endanger the delivery of health care services to Indians.

(d)(1) The demonstration project established under subsection (a) shall terminate on September 30, 1993, *or in the case of a demonstration project for which a grant is made after September 30, 1990, three years after the date on which such grant is made.*

(2) By no later than September 30, [1994] *1996,* the Secretary shall evaluate the performance of each Indian tribe that has participated in a demonstration project established under subsection (a) and shall submit to the Congress a report on such evaluations and demonstration projects.

(e)(1) The Secretary, acting through the Service, shall make arrangements with Indian tribes to establish joint venture demonstration projects under which an Indian tribe shall expend tribal, private, or other available nontribal funds, for the acquisition or construction of a health facility for a minimum of 20 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance

of such a health facility. A tribe may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

(2) The Secretary shall make such an arrangement with an Indian tribe only if the Secretary first determines that the Indian tribe has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility describes in paragraph (1).

(3) An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this subsection, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the tribe, or paid to a third party on the tribe's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, or for personnel or staffing, shall be recoverable.

[(f)[(e) There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.]

CHILD SEXUAL ABUSE TREATMENT PROGRAMS

[SEC. 719.] *SEC. 819.* [25 U.S.C. 1680i] [(a) The Secretary and the Secretary of the Interior shall, for each of the fiscal years 1989, 1990, and 1991, continue to provide through the Hopi Tribe and the Asiniboine and Sioux Tribes of the Fort Peck Reservation the demonstration programs involving treatment for child abuse that were conducted during fiscal year 1988 through such tribes.

[(b) There are authorized to be appropriated for each of the fiscal years 1989, 1990, and 1991 such sums as may be necessary to carry out the provisions of this section.] *(a) The Secretary and the Secretary of the Interior shall, for each fiscal year through fiscal year 1995, continue the demonstration programs involving treatment for child sexual abuse provided through the Hopi Tribe and the Asiniboine and Sioux Tribes of the Fort Peck Reservation, and shall encourage the development of demonstration programs in other tribes.*

(b) Beginning October 1, 1995, the Secretary of the Interior may establish, in any service area, demonstration programs involving treatment for child sexual abuse, except the Secretaries may not establish a greater number of such programs in one service area than in any other service area until there is an equal number of such programs established with respect to all service areas.

[PUEBLO SUBSTANCE ABUSE TREATMENT PROJECT FOR SAN JUAN PUEBLO, NEW MEXICO]

TRIBAL LEASING

SEC. 820. Indian tribes providing health care services pursuant to a contract entered into under the Indian Self-Determination Act may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.

LONG-TERM CARE DEMONSTRATION PROJECT

SEC. 821. (a) The Secretary, acting through the Service, is authorized to enter into contracts with, or make grants to, Indian tribes or tribal organizations providing health care services pursuant to a contract entered into under the Indian Self-Determination Act, to establish demonstration projects for the delivery of home- and community-based services to functionally disabled Indians.

(b)(1) Funds provided for a demonstration project under this section shall be used only for delivery of home- and community-based services (including transportation services) to functionally disabled Indians.

(2) Such funds may not be used—

(A) to make cash payments to functionally disabled Indians;

(B) to provide room and board for functionally disabled Indians;

(C) for the construction or renovation of facilities or the purchase of medical equipment; or

(D) for the provision of nursing facility services.

(c) Not later than 180 days after the date of the enactment of this section, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and issue criteria for the approval of applications submitted under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of tribes and tribal organizations to deliver, or arrange for the delivery of, high quality, culturally appropriate home- and community-based services of functionally disabled Indians.

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

(e) At the discretion of the tribe or tribal organization, services provided under a demonstration project established under this section may be provided (on a cost basis) to persons otherwise ineligible for the health care benefits of the Service.

(f) The Secretary shall establish not more than 24 demonstration projects under this section. The Secretary may not establish a greater number of demonstration projects under this section in one service area than in any other service area until there is an equal number of such demonstration projects established with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria issued pursuant to subsection (c).

(g) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section, together with legislative recommendations.

(h) The Secretary is authorized to enter into a shared services agreement with a health facility operated by a tribe or tribal organization that receives assistance under this section and that provides long-term care to older Indians. The Secretary, acting through the Service, shall place conditions and terms on such shared service agreements necessary to carry out this section. At the request of the

tribe or tribal organizations powers of supervision and control over such local service employees as are necessary to carry out this section. For the purpose of this subsection, the term "shared services agreement" means a contractual agreement between the Service and an Indian tribe or tribal organization whereby the Service agrees to share staff and other services with a health facility operated by such Indian tribe or tribal organization. Salaries for such staff and payments for such services shall be proportionately allocable to the service facility and health facility pursuant to such agreement.

(i) For the purposes of this section, the following definitions shall apply:

(1) The term "home and community-based services" means one or more of the following:

(A) Homemaker/home health aide services.

(B) Chore Services.

(C) Personal care services.

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

(E) Respite care.

(F) Training for family members in managing a functionally disabled individual.

(G) Adult day care.

(H) Such other home- and community-based services as the Secretary may approve.

(2) The term "functionally disabled" means an individual who is determined to require home- and community-based services based on an assessment that uses criteria (including, at the discretion of the tribe or tribal organization, activities of daily living) developed by the tribe and tribal organization.

(j) There are authorized to be appropriated for each of the fiscal years 1993, 1994, 1995, 1996 and 1997 such sums as are necessary to carry out this section. Such sums shall remain available until expended.

RESULTS OF DEMONSTRATION PROJECTS

SEC. 822. The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

AUTHORIZATION OF APPROPRIATIONS

[SEC. 720.] *SEC. 823.* [25 U.S.C. 1680j] [(a) The Secretary, through the Service, shall make grants to the Eight Northern Indian Pueblos Council, San Juan Pueblo, New Mexico, for the purpose of providing substance abuse treatment services to Indians in need of such services.

[(b) There are authorized to be appropriated to carry out this section $250,000 for each of the fiscal years 1990 and 1991.] *There are authorized to be appropriated such sums as may be necessary for fiscal year 1993 and each fiscal year thereafter through fiscal year 2000 to carry out this title.*

DEMONSTRATION OF ELECTRICAL DATA SUBMISSION

SEC. 824. (a) IN GENERAL.—The Secretary shall develop and implement a project to demonstrate in a pilot setting how current telecommunications and computer processing technology can be used to improve the turnaround, accuracy, and effectiveness of the information exchange between Indian Health Service health centers, private Contract Health Service providers, the Indian Health Service Area office and the Indian Health Service Fiscal Intermediary.

(b) EFFECTIVE DATE.—The project described in subsection (a) shall be established effective June 15, 1993, and may involve the awarding of an outside contract.

WAIVER OF PAPERWORK REDUCTION

SEC. 825. (a) Chapter 35 of title 44, United States Code, shall not apply to information required to carry out any study or survey authorized or required by this Act.

TRIBAL SELF-GOVERNANCE PROJECT [2]

The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450F note) is amended—

(1) in section 301, by inserting after "Interior" the following: "and the Secretary of Health and Human Services (hereafter in this title referred to as the 'Secretaries') each";

(2) in sections 302, 303, 304, and 305, by striking "Secretary" each place it appears and inserting in lieu thereof "Secretaries";

(3) in section 303(a)(1), by inserting after "Interior" the following: "and the Indian Health Service of the Department of Health and Human Services"; and

(4) by adding after section 309 the following new section:

"SEC. 310. For the purposes of providing one year planning and negotiations grants to the Indian tribes identified by section 302, with respect to the programs, activities, functions or services of the Indian Health Service, there are authorized to be appropriated such sums as may be necessary to carry out such purposes."

○

[2] *This section amends the Indian Self-Determination Act Amendments of 1991, P.L. 101–184.*