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INDIAN HEALTH AMENDMENTS OF 1992

JULY 1, 1992.—Ordered to be printed

Mr. MILLER of California, from the Committee on Interior and Insular Affairs, submitted the following

REPORT

[To accompany H.R. 3724 which on November 6, 1991, was referred jointly to the Committee on Interior and Insular Affairs and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Interior and Insular Affairs, to whom was referred the bill (H.R. 3724) to amend the Indian Health Care Improvement Act to authorize appropriations for Indian health programs, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Indian Health Amendments of 1992".

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

Except as otherwise specifically provided, whenever in this Act a section or other provision is amended or repealed, such amendment or repeal shall be considered to be made to that section or other provision of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

SEC. 3. FINDINGS; POLICY; AND DEFINITIONS.

(a) FINDINGS.—Section 2 of the Act (25 U.S.C. 1601) is amended—

(1) in paragraph (d), by striking out the second sentence; and

(2) by striking out paragraphs (e), (f), and (g).

(b) DECLARATION OF POLICY.—Section 3 of the Act (25 U.S.C. 1602) is amended to read as follows:

"DECLARATION OF HEALTH OBJECTIVES

"SEC. 3. (a) 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 assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.

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

"(1) Maintain coronary heart disease deaths at a level of 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) Maintain the level of cancer deaths at a rate of no more than 130 per 100,000.

"(5) Maintain the level of lung cancer deaths at a rate of no more than 42 per 100,000.

"(6) Maintain the level of chronic obstructive pulmonary disease related deaths at 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 suicide among men to no more than 12.8 per 100,000.

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

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

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

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

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

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

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

"(19) 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.

"(20) 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 70 percent among adolescents aged 15.

"(21) Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 35 percent among children aged 6 through 8 and no more than 40 percent among adolescents aged 15.

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

"(23) Reduce the prevalence of gingivitis aged 35–44 to no more than 50 percent.

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

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

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

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

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

"(29) 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.

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

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

"(32) Reduce colorectal cancer deaths to no more than 13.2 per 100,000.

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

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

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

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

"(37) 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.

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

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

"(B) Blindness, 1.4 per 1000.

"(C) Lower extremity amputation, 4.9 per 1000.

"(D) Perinatal mortality, 2 percent.

"(E) Major congenital malformations, 4 percent.

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

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

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

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

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

"(44) 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.

"(45) Reduce viral hepatitis B infection to no more than 40 per 100,000 cases.

"(46) 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.

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

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

"(49) Reduce tuberculosis to an incidence of no more than 5 cases per 100,000.

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

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

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

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

"(54) 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.

"(55) 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.

"(56) 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.

"(57) 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.

"(58) 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.

"(59) 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.

"(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).".

(c) DEFINITIONS.—Section 4 of the Act (25 U.S.C. 1603) is amended by adding at the end the following new subsections:

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

"(n) 'Substance abuse' includes inhalant abuse.".

TITLE I—INDIAN HEALTH PROFESSIONALS

SEC. 101. PURPOSE.

Section 101 of the Act (25 U.S.C. 1611) is amended to read as follows:

"PURPOSE

"SEC. 101. The purpose of this title is to increase the number of Indians entering the health professions and to assure an adequate supply of health professionals to the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health care to Indian people.".

SEC. 102. HEALTH PROFESSIONS.

(a) RECRUITMENT PROGRAM.—Section 102(a) of the Act (25 U.S.C. 1612(a)) is amended—

(1) by amending paragraph (1) to read as follows:

"(1) identifying Indians with a potential for education or training in the health professions; including, but not limited to, family medicine, internal medicine, pediatrics, obstetrics and gynecology, podiatric medicine, nursing, dentistry, mental health, osteopathy, optometry, pharmacy, psychology, public health, social work, and environmental health and engineering; 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) in paragraph (2)—

(A) by striking out "school" both places it appears and inserting in lieu thereof the following: "course of study"; and

(B) by striking out "clause (1)(A)" and inserting in lieu thereof the following: "paragraph (1)"; and

(3) in paragraph (3)—

(A) by striking out "Indians," and inserting in lieu thereof "Indians in,";

(B) by inserting a comma before "courses";

(C) by striking out ", in any school"; and

(D) by striking out "clause (1)(A)" and inserting in lieu thereof the following: "paragraph (1)".

(b) PREPARATORY SCHOLARSHIP PROGRAM.—Section 103 of the Act (25 U.S.C. 1613) is amended—

(1) by amending subsection (a)(2) to read as follows:

"(2) have demonstrated the capability to successfully complete courses of study in the health professions, including, but not limited to, family medicine, internal medicine, pediatrics, obstetrics and gynecology, podiatric medicine, nursing, dentistry, mental health, osteopathy, optometry, pharmacy, psychology, public health, social work, or environmental health and engineering.";

(2) in subsection (b)(1), by inserting before the period at the end the following: "on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary)";

(3) by amending subsection (b)(2) to read as follows:

"(2) Pregraduate education of any grantee leading to a baccalaureate degree in an approved course of study preparatory to a field of study specified in subsection (a)(2), such scholarship not to exceed 4 years (or the part-time equivalent thereof, as determined by the Secretary).";

(4) in subsection (c), by striking out "full time"; and

(5) by striking out subsection (e).

(c) HEALTH PROFESSIONS SCHOLARSHIPS.—Section 104 of the Act (25 U.S.C. 1613a) is amended—

(1) in subsection (a)—

(A) by striking out "Indian communities" and inserting in lieu thereof the following: "Indians, Indian tribes, tribal organizations, and urban Indian organizations";

(B) by striking out "full time" and inserting in lieu thereof the following: "full or part time"; and

(C) by striking out "of medicine" and all that follows through "social work" and inserting in lieu thereof the following: "and pursuing courses of study in the health professions, with an emphasis on family medicine, internal medicine, podiatric medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, osteopathy, optometry, pharmacy, psychology, public health, social work, or environmental health and engineering";

(2) in subsection (b)—

(A) in paragraph (2)—

(i) by striking out "full time" and inserting in lieu thereof "full or part time"; and

(ii) by striking out "health profession school" and inserting in lieu thereof "course of study";

(B) in paragraph (3)—

(i) by striking "(3)" and inserting "(3)(A)";

(ii) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively; and

(iii) by inserting at the end the following new subparagraph:

"(B) A recipient of an Indian Health Scholarship may, at the election of the recipient, meet the requirements of subparagraph (A) by service in a program specified in such subparagraph that—

"(i) is located on the reservation of the tribe in which the recipient is enrolled; or

"(ii) serves the tribe in which the recipient is enrolled."; and

(C) by adding at the end the following new paragraph:

"(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 (42 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.";

(3) by amending subsection (c) to read as follows:

"(c) 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."; and

(4) by striking out subsection (d).

(d) EFFECTIVE DATE.—The amendments made by subsection (c)(1)(C) and subsection (c)(2)(B) shall apply with respect to scholarships granted under section 104 of the Indian Health Care Improvement Act after the date of the enactment of this Act.

(e) EXTERN PROGRAM.—Section 105 of the Act (25 U.S.C. 1614) is amended—

(1) in subsection (a), by striking out "section 757 of the Public Health Service Act" and inserting in lieu thereof "section 104"; and

(2) in subsection (b), by striking out "school of medicine" and all that follows through "health professions" and inserting in lieu thereof "course of study in the health professions, with an emphasis on family medicine, internal medicine, podiatric medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering, or other health profession".

SEC. 103. BREACH OF CONTRACT PROVISIONS RELATING TO INDIAN HEALTH SCHOLARSHIPS.

Section 104(b) of the Act (25 U.S.C. 1613a(b)) (as amended by section 102(c) of this Act) is amended by adding at the end the following new paragraph:

"(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.".

SEC. 104. NURSING.

(a) CONTINUING EDUCATION ALLOWANCES.—Section 106(a) of the Act (25 U.S.C. 1615(a)) is amended by inserting "nurses," after "dentists,".

(b) TRAINING FOR NURSE MIDWIVES, NURSE ANESTHETISTS, AND NURSE PRACTITIONERS.—Section 112 of the Act (25 U.S.C. 1616e) is amended—

(1) in subsection (b)—

(A) at the end of paragraph (4), by striking out "or";

(B) in paragraph (5), by striking out the period at the end and inserting in lieu thereof ", or"; and

(C) by adding at the end the following new paragraph:

"(6) establish and develop clinics operated by nurses, nurse midwives, nurse anesthetists, or nurse practitioners to provide primary health care services to Indians.".

(2) by amending subsection (f) to read as follows:

"(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, nurse anesthetists, and nurse practitioners.".

(c) RETENTION BONUS FOR NURSES.—Section 117 (25 U.S.C. 1616j) of the Act is amended—

(1) by redesignating subsections (b) through (e) as subsections (c) through (f), respectively;

(2) by adding after subsection (a) the following new subsection (b):

"(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."; and

(3) by amending subsection (f) (as amended by paragraph (1)) to read as follows:

"(f) 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 or retention is difficult; and

"(2) necessary for providing health care services to Indians.".

(d) RESIDENCY PROGRAM.—Title I of the Act is amended by adding at the end the following new section:

"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 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 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 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 (l) of section 108 in the manner provided for in such subsection.".

SEC. 105. MAINTENANCE OF COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

Section 107(b) of the Act (25 U.S.C. 1616(b)) is amended—

(1) in paragraph (2), in the material preceding subparagraph (A), by inserting "and maintain" after "develop";

(2) in paragraph (2)(B), by adding at the end the following: "with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty,";

(3) in paragraphs (3) and (5), by striking out "develop" each place it appears and inserting in lieu thereof "maintain"; and

(4) in paragraph (4), by striking out "develop and".

SEC. 106. CHANGES TO INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

(a) ELIGIBILITY REQUIREMENTS.—Section 108 of the Act (25 U.S.C. 1616a(b)) is amended—

(1) in subsection (a)(1), by striking out "physicians," and all that follows through "professionals" and inserting in lieu thereof the following: "health professionals in family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering and other health professions"; and

(2) in subsection (b)—

(A) in paragraph (1)(A)—

(i) by amending clause (i) to read as follows:

"(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"; and

(ii) in clause (ii), by striking out "medicine" and all that follows through "dentistry," and inserting in lieu thereof the following: "family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering,";

(B) in paragraph (1)(B)—

(i) by inserting "and" at the end of clause (i), by striking out clause (ii), and by redesignating clause (iii) as clause (ii);

(ii) in clause (i), by striking out "medicine, osteopathy, dentistry," and inserting in lieu thereof the following: "family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering,"; and

(iii) in clause (ii) (as redesignated by clause (i) of this subparagraph), by striking out "medicine, osteopathy, dentistry," and inserting in lieu thereof the following: "family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering,"; and

(C) in paragraph (2), by inserting "and" at the end of subparagraph (D), by striking out paragraphs (3) and (4), and by inserting after paragraph (2) the following:

"(3) submit to the Secretary an application for a contract described in subsection (f).".

(b) BECOMING A PARTICIPANT.—Paragraph (1) of section 108(e) (25 U.S.C. 1616a(e)) is amended to read as follows:

"(1) An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in subsection (f).".

(c) EXTENSION OF OBLIGATED SERVICE.—Paragraph (2)(A) of section 108(e) (25 U.S.C. 1616a(e)) is amended by inserting before the semicolon the following: ", including extensions resulting in an aggregate period of obligated service in excess of 4 years".

(d) CLARIFICATION REGARDING UNDERGRADUATE LOANS.—Paragraph (1) of section 108(g) (25 U.S.C. 1616a(g)) is amended in the matter preceding subparagraph (A) by striking out "loans received by the individual for—" and inserting in lieu thereof "loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—".

(e) PAYMENT.—Subparagraph (A) of section 108(g)(2) (25 U.S.C. 1616a(g)(2)) is amended to read as follows:

"(A) 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 shortages of health professionals; and

"(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.".

(f) TAX LIABILITY.—(1) Paragraph (3) of section 108(g) (25 U.S.C. 1616a(g)) is amended to read as follows:

"(3) 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, may make payments to the individual in an amount not to exceed 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.".

(2) The amendment made by paragraph (1) shall apply only with respect to contracts under section 108 of the Indian Health Care Improvement Act entered into on or after the date of enactment of this Act.

(g) ANNUAL REPORT.—Subsection (n) of section 108 is amended to read as follows:

"(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.".

SEC. 107. RECRUITMENT ACTIVITIES.

Section 109 of the Act (25 U.S.C. 1616b) is amended—

(1) by amending the heading to read as follows:

"RECRUITMENT ACTIVITIES"; AND

(2) by amending subsection (b) to read as follows:

"(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.".

SEC. 108. ADVANCED TRAINING AND RESEARCH.

Section 111 of the Act (25 U.S.C. 1616d) is amended—

(1) in subsection (b), by amending the last sentence to read as follows: "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 (l) of section 108 in the manner provided for in such subsection."; and

(2) by striking out subsection (d).

SEC. 109. INMED PROGRAM.

Section 114(b) of the Act (25 U.S.C. 1616g(b)) is amended—

(1) by striking out "(b)" and inserting in lieu thereof "(b)(1)"; and

(2) by adding at the end the following new paragraphs:

"(2) 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 nursing profession.

"(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.".

SEC. 110. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY.

Title I of the Act is amended by inserting after section 108 the following new 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) Amounts in the Fund and available pursuant to appropriation Acts may be expended by the Secretary, acting through the Service—

"(1) to make scholarship grants under section 104; and

"(2) 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 professional to provide health care services as a result of an individual having breached a contract entered into under section 104 or section 108.".

SEC. 111. COMMUNITY HEALTH AIDE PROGRAM.

Title I of the Act (as amended by section 104 of this Act) is amended by adding at the end the following new section:

"COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA

"SEC. 119. (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 management of clinic pharmacies, supplies, equipment, and facilities; and

"(C) promotes the achievement of the health status objectives specified in section 3(b);

"(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.".

SEC. 112. TRIBAL HEALTH PROGRAM ADMINISTRATION.

Title I of the Act (as amended by section 111 of this Act) is amended by adding at the end the following new section:

"TRIBAL HEALTH PROGRAM ADMINISTRATION

"SEC. 120. The Secretary shall, by contract or otherwise, provide training for individuals in the administration and planning of tribal health programs.".

SEC. 113. HEALTH PROFESSIONAL PRIORITIES IN RELATED PROGRAM.

Section 333A(a) of the Public Health Service Act (42 U.S.C. 254f-1(a)) is amended—

(1) in paragraph (2), by striking "and" after the semicolon at the end;

(2) in paragraph (3), by striking the period at the end and inserting "; and";

(3) by adding at the end the following paragraph:

"(4) subject to paragraphs (1) through (3), give priority to meeting the needs of the Indian Health Service and the needs of health programs or facilities operated by tribes or tribal organizations under the Indian Self-Determination Act, except to the extent not practicable.".

SEC. 114. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION.—Title I of the Act (as amended by section 112 of this Act) is amended by adding at the end the following new section:

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 121. There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.".

(b) CONFORMING AMENDMENTS.—Title I of the Act is amended—

(1) in section 102, by striking out subsection (c);

(2) in section 105, by striking out subsection (d);

(3) in section 106 (as amended by section 104(a) of this Act), by striking out "(a)" and by striking out subsection (b);

(4) in section 108, by striking out subsection (o);

(5) in section 110, by striking out subsection (c);

(6) in section 113, by striking out subsection (c);

(7) in section 114, by striking out subsection (e);

(8) in section 115, by striking out subsection (f); and

(9) in section 116, by striking out subsection (e).

TITLE II—HEALTH SERVICES

SEC. 201. HEALTH STATUS AND RESOURCE DEFICIENCY STATUS.

(a) IN GENERAL.—Section 201 of the Act (25 U.S.C. 1621) is amended—

(1) in subsection (a)—

(A) in the material preceding paragraph (1), by striking out "subsection (h)" and inserting in lieu thereof "this section";

(B) by amending paragraph (1) to read as follows:

"(1) eliminating the deficiencies in health status and resources of all Indian tribes,"; and

(C) in paragraph (4), in the material preceding subparagraph (A)—

(i) by inserting after "responsibilities" the following: ", either through direct or contract care or through contracts entered into pursuant to the Indian Self-Determination Act,"; and

(ii) by striking out "resources deficiency" and inserting in lieu thereof the following: "status and resource deficiencies";

(2) in subsection (b)—

(A) in paragraph (1), by striking out "subsection (h)" and inserting in lieu thereof "this section";

(B) by striking out paragraph (2) and redesignating paragraph (3) as paragraph (2); and

(C) in paragraph (2)(A) (as redesignated by subparagraph (B))—

(i) by striking out "subsection (h)" and inserting in lieu thereof "this section";

(ii) in the first sentence, by striking out "but such allocation" through "met";

(iii) in the second sentence—

(I) by striking out "(in accordance with paragraph (2))"; and

(II) by striking out "raise the deficiency level" and inserting in lieu thereof the following: "reduce the health status and resource deficiency"; and

(D) in paragraph (2)(B) (as redesignated by subparagraph (B)), by inserting after "consultation with" the following: ", and with the active participation of,";

(3) in subsection (c)—

(A) by striking out paragraph (1) and redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively;

(B) by amending paragraph (1) (as redesignated by subparagraph (A) above) to read as follows:

"(1) The term 'health status and resource deficiency' means the extent to which—

"(A) the health status objectives set forth in section 3(b) are not being achieved; and

"(B) the Indian tribe does not have available to it the health resources it needs."; and

(C) in paragraph (3) (as redesignated by subparagraph (B) above)—

(i) by striking out "Under regulations, the" and inserting in lieu thereof "The"; and

(ii) by striking out "health resources deficiency level" and inserting in lieu thereof "extent of the health status and resource deficiency";

(4) in subsection (d)(1), by striking out "subsection (h)" and inserting in lieu thereof "this section";

(5) in subsection (e)—

(A) in the material preceding paragraph (1)—

(i) by striking out "60 days" and inserting in lieu thereof "3 years";

(ii) by striking out "Indian Health Care Amendments of 1988" and inserting in lieu thereof "Indian Health Amendments of 1992"; and

(iii) by striking out "health services priority system" and inserting in lieu thereof "health status and resource deficiency";

(B) in paragraph (1), by striking out "health resources deficiencies" and inserting in lieu thereof "health status and resource deficiencies";

(C) in paragraph (2), by striking out "the level of health resources deficiency for" and inserting in lieu thereof the following: "the extent of the health status and resource deficiency of";

(D) in paragraph (3), by striking "raise all" and all that follows through the semicolon and insert in lieu thereof the following: "eliminate the health status and resource deficiencies of all Indian tribes served by the Service; and"; and

(E) by striking out paragraphs (4) and (5) and redesignating paragraph (6) as paragraph (4); and

(6) in subsection (f), by striking out "(f)(1)" and all that follows through the paragraph designation for paragraph (2) and inserting in lieu thereof "(f)".

(b) EFFECTIVE DATE.—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.

SEC. 202. HEALTH PROMOTION AND DISEASE PREVENTION.

Section 203 of the Act (25 U.S.C. 1621b) is amended—

(1) in subsection (a), by inserting before the period at the end the following: "so as to achieve the health objectives set forth in section 3(b)";

(2) in subsection (b), in the material preceding paragraph (1), by striking out "section 201(f)" and inserting in lieu thereof "section 801"; and

(3) by striking out subsection (c).

SEC. 203. DIABETES PREVENTION, TREATMENT, AND CONTROL.

Section 204 of the Act (25 U.S.C. 1621c) is amended—

(1) by amending subsection (c) to read as follows:

"(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 to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes on those Indian reservations where the Secretary determines that diabetes is a major health problem."; and

(2) in subsection (d)—

(A) in paragraph (2), by striking out "and" after the semicolon;

(B) in paragraph (3), by striking out the period and inserting in lieu thereof the following: "; and"; and

(C) by adding at the end the following new paragraph:

"(4) evaluate the effectiveness of services provided through model diabetes projects established under this section.".

SEC. 204. MENTAL HEALTH PREVENTION AND TREATMENT SERVICES.

Section 209 of the Act (25 U.S.C. 1621h) is amended—

(1) in subsection (j) (as redesignated by section 902(3)(B) of this Act), by striking out "submit to the Congress an annual report" and inserting in lieu thereof the following: "submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report"; and

(2) by adding at the end the following new subsections:

"(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—

"(1) in the case of a person employed as a psychologist, be licensed as a clinical psychologist or working under the direct supervision of a licensed clinical psychologist;

"(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; or

"(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 tribal organization.

"(4) The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this section.

"(5) There are authorized to be appropriated $10,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000 to carry out the purposes of this section.".

SEC. 205. NEW STUDIES.

(a) HOSPICE CARE.—Title II of the Act is amended by inserting after section 204 the following:

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

"(3) the term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)).".

(b) MANAGED CARE.—Title II of the Act is amended by adding at the end the following new section:

"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 in circumstances where such tribe—

"(1) does not have an inpatient hospital located on the tribal reservation; and

"(2) is not located within close proximity to a Service hospital.

"(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 findings and conclusions of such study.".

(c) CONTRACT CARE.—Title II of the Act (as amended by subsection (b) of this Act) is amended by adding at the end the following new section:

"CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM

"SEC. 211. (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 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 purposes of this section.".

SEC. 206. COVERAGE OF SCREENING MAMMOGRAPHY.

(a) IN GENERAL.—Title II of the Act (as amended by section 205(c) of this Act) is amended by adding at the end the following new section:

"COVERAGE OF SCREENING MAMMOGRAPHY

"SEC. 212. The Secretary, 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.".

(b) CONFORMING AMENDMENT.—Section 201(a)(4)(B) of the Indian Health Care Improvement Act (25 U.S.C. 1621(a)(4)(B)) is amended by striking the semicolon at the end and inserting the following: ", including screening mammography in accordance with section 212;".

SEC. 207. PATIENT TRAVEL COSTS.

Title II of the Act (as amended by section 206 of this Act) is amended by adding at the end the following new section:

"PATIENT TRAVEL COSTS

"SEC. 213. (a) The Secretary, acting through the Service, shall provide funds for patient travel costs associated with receiving health care services provided (either directly or through contract care) under this Act.

"(b) There are authorized to be appropriated to carry out this section $15,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.".

SEC. 208. THIRD PARTY REIMBURSEMENT.

Section 206 of the Act (25 U.S.C. 1621e) is amended—

(1) by inserting ", an Indian tribe, or a tribal organization" after "United States" each place it appears;

(2) in subsection (a), by inserting ", an Indian tribe, or a tribal organization" after "Service"; and

(3) in subsection (a) and subsection (e)(1)(A), by inserting ", an Indian tribe, or a tribal organization" immediately after "Secretary" each place it appears.

SEC. 209. EPIDEMIOLOGY CENTERS.

Title II of the Act (as amended by section 207 of this Act) is amended by adding at the end the following new section:

"EPIDEMIOLOGY CENTERS

"SEC. 214. (a) The Secretary shall establish an epidemiology center in each Service area to carry out the requirements of subsection (b).

"(b) In consultation with the Service, Indian tribes, and urban Indian communities, each area epidemiology center established under this section shall—

"(1) establish a methodology to define baseline data for each of the health objectives specified in section 3(b);

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

"(3) identify the 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 the improvement of Indian health and the resources available to deliver, monitor, or evaluate those systems;

"(5) develop methods to obtain, for the purpose of assessing Indian health, data on services provided to Indians—

"(A) by the Service;

"(B) under State plans for medical assistance under title XIX of the Social Security Act;

"(C) under title XVIII of the Social Security Act;

"(D) under medical programs of the Department of Veterans Affairs; and

"(E) under private insurance systems;

"(6) assist tribes and urban Indian communities in the identification of priority service needs, based on epidemiological data;

"(7) make recommendations for the targeting of services needed by tribal, urban, and other Indian communities; and

"(8) make recommendations to improve health care delivery systems.

"(c) The Secretary shall ensure that each area epidemiology center works cooperatively with Indian tribes and tribal providers of health and social services in order to avoid duplication of existing services. Each epidemiology center shall provide technical assistance to Indian tribes and urban Indian organizations located in the service area in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community.

"(d) The director of the Centers for Disease Control and the director of the National Center for Health Statistics shall provide technical assistance to the centers in carrying out the requirements of this section.

"(e) The Service shall assign one epidemiologist from each of its area offices to each area epidemiology center to provide such center with technical assistance necessary to carry out this section.

"(f)(1) Not later than March 1, 1994, the Secretary shall transmit an initial report to the Congress describing the actions taken to carry out the purposes of this section.

"(2) Beginning September 1, 1994, the Secretary shall report to the Congress biannually on the extent to which the area epidemiology centers established under this section have aided in assessing the progress made towards meeting the health objectives specified in section 3(b).".

SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

Title II of the Act (as amended by section 209 of this Act) is amended by adding at the end the following new section:

"COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS

"SEC. 215. (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 grade 12 in schools 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 health promotion 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 dissemination 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 schools served;

"(2) the number of students served;

"(3) any new curricula established with funds provided under this section;

"(4) the number of teachers trained in the 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 Indian Affairs and in cooperation with the Secretary, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools 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; and

"(C) encourage healthy, tobacco-free school environments.

"(g) There are authorized to be appropriated to carry out this section $15,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.".

SEC. 211. INDIAN YOUTH GRANT PROGRAM.

Title II of the Act (as amended by section 210 of this Act) is amended by adding at the end the following new section:

"INDIAN YOUTH GRANT PROGRAM

"SEC. 216. (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 preadolescent 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 $5,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.".

SEC. 212. THIRD PARTY REIMBURSEMENT.

Section 206 of the Act (25 U.S.C. 1621e) is amended—

(1) by striking "(a) The" and inserting the following: "(a) Except as provided in subsection (f), the"; and

(2) by adding at the end the following new subsection:

"(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.".

SEC. 213. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION.—Title II of the Act (as amended by section 211 of this Act) is amended by adding at the end the following new section:

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 217. Except as provided in sections 209(m), 211, 213, 215, and 216, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.".

(b) CONFORMING AMENDMENTS.—Title II of the Act is amended—

(1) in section 201(h), by striking out the first sentence and striking out "subsection" and inserting in lieu thereof "section".

(2) in section 202—

(A) by striking out subsection (e);

(B) in subsection (a)(1)(B), by striking out "under subsection (e)" and inserting "to the Fund under this section"; and

(C) in subsection (c), by striking out "Funds appropriated under subsection (e)" and inserting "Amounts appropriated to the Fund under this section";

(3) in section 204(e), by striking out the first sentence and striking out "subsection (c)" and inserting in lieu thereof "this section"; and

(4) in section 209 (as amended by section 902(3)(B) of this Act)—

(A) by striking out subsections (c)(5), (d)(6), (f)(4), and (g)(5);

(B) in subsection (h)—

(i) by striking out paragraph (2) and by striking out "(1)";

(ii) by redesignating subparagraphs (A) and (B) as paragraphs (1) and (2), respectively;

(iii) by striking out "subparagraph (A)" and inserting "paragraph (1)"; and

(iv) by striking out "subparagraph (B)" and inserting "paragraph (2)";

(C) in subsection (i), by striking out paragraph (2) and by striking out "(1)";

(D) in subsection (d)(3)(B), by striking out "this subsection" and inserting in lieu thereof "this section"; and

(E) in subsection (k)(6), by striking out the first sentence and in the second sentence by striking out "subsection" and inserting in lieu thereof "section".

TITLE III—HEALTH FACILITIES

SEC. 301. HEALTH FACILITIES CLOSURE AND PRIORITIES.

Section 301 of the Act (25 U.S.C. 1631) is amended—

(1) in subsection (b)(1)—

(A) in the material preceding subparagraph (A), by striking out "other" before "outpatient";

(B) by striking out "and" at the end of subparagraph (D);

(C) by striking out the period at the end of subparagraph (E) and inserting in lieu thereof a semicolon; and

(D) by adding at the end the following new subparagraphs:

"(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) by striking out subsection (c) and redesignating subsections (d) and (e) as subsections (c) and (d), respectively;

(3) in subsection (c)(1) (as redesignated by paragraph (2) of this subsection), by amending the material preceding subparagraph (A) to read as follows—

"(c)(1) 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—"; and

(4) by striking out paragraph (2) of subsection (c) (as redesignated by paragraph (2)) and redesignating paragraphs (3), (4), and (5) of such subsection as paragraphs (2), (3), and (4), respectively.

SEC. 302. SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES.

Section 302 of the Act (25 U.S.C. 1632) is amended—

(1) by amending subsection (e) to read as follows:

"(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.";

(2) in subsection (f)(1), by striking out "subsection (h)" and inserting in lieu thereof "this section"; and

(3) in subsection (g)—

(A) in paragraph (1), by striking out "The Secretary" through "report" and inserting in lieu thereof the following: "The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report"; and

(B) by striking out paragraph (2) and redesignating paragraphs (3), (4), (5), and (6) as paragraphs (2), (3), (4), and (5), respectively.

SEC. 303. AMBULATORY CARE FACILITIES GRANT PROGRAM.

Section 306 of the Act (25 U.S.C. 1636) is amended to read as follows:

"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 operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred 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 noneligible 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. 304. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

(a) AWARDING OF GRANTS.—Section 307 of the Act (25 U.S.C. 1637) is amended—

(1) in subsection (a), by striking "The Secretary" and inserting "Subject to subsection (c)(3), the Secretary"; and

(2) in subsection (c)(3), by amending subparagraph (B) to read as follows:

"(B) Beginning October 1, 1994, the Secretary may enter into contracts or award grants under this section taking into consideration applications received under this section from all service areas. In entering into such contracts and awarding such grants, the Secretary shall give priority to service units identified in subparagraph (A) that meet the criteria specified in paragraph (1) and that have not received funding under this section. 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).".

(b) REPORTS.—Section 307(h) of the Act (25 U.S.C. 1637(h)) is amended to read as follows:

"(h)(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.".

SEC. 305. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION.—Title III of the Act is amended by adding at the end the following new section:

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 308. There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.".

(b) CONFORMING AMENDMENTS.—Title III of the Act is amended—

(1) in section 302, by striking out subsection (h); and

(2) in section 307, by striking out subsection (i).

TITLE IV—ACCESS TO HEALTH SERVICES

SECTION 401. TREATMENT OF PAYMENTS TO INDIAN HEALTH SERVICE FACILITIES UNDER MEDICARE AND MEDICAID PROGRAMS.

(a) MEDICARE PROGRAM.—(1) Section 401 of the Act (42 U.S.C. 1395qq note) is amended to read as follows:

"TREATMENT OF PAYMENTS 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 or tribal 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.".

(2) Section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c) is amended by striking out the last sentence.

(b) MEDICAID PROGRAM.—(1) Section 402 of the Act is amended to read as follows:

"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 appropriation 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.

"(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.

SEC. 402. REPORT.

Section 403 of the Act (25 U.S.C. 1671 note) is amended by striking out "The Secretary" and all that follows through "section 701" and inserting in lieu thereof the following: "The Secretary shall submit to the President, for inclusion in the report required to be transmitted to the Congress under section 801,".

SEC. 403. GRANTS TO AND CONTRACTS WITH TRIBAL ORGANIZATIONS.

Section 404(b)(4) of the Act (25 U.S.C. 1622) is amended to read as follows:

"(4) develop and implement—

"(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.".

SEC. 404. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION.—Title IV of the Act is amended by adding at the end the following new section:

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 406. There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.".

(b) CONFORMING AMENDMENTS.—Section 404 of the Act is amended by striking out subsection (c).

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

SEC. 501. GRANT AUTHORITY.

(a) IN GENERAL.—Section 502 of the Act (25 U.S.C. 1652) is amended—

(1) by striking "contracts with" and inserting the following: "contracts with, or make grants to,";

(2) by inserting after "enters into with" the following: ", or in any grant the Secretary makes to,"; and

(3) by amending the heading to read as follows:

"CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS".

(b) CONFORMING AMENDMENTS.—(1) Section 503 of the Act (25 U.S.C. 1653) is amended—

(A) in subsection (a), in the material preceding paragraph (1)—

(i) by inserting ", or make grants to," after "contracts with"; and

(ii) by inserting "or grant" after "such contract";

(B) in subsection (b)—

(i) in the material preceding paragraph (1), by inserting "or receive grants" after "enter into contracts"; and

(ii) in paragraph (5), by inserting "or to meet the requirements for receiving a grant" after "Secretary";

(C) in subsection (c)(1), by inserting before the period at the end the following: "or receiving grants under subsection (a)";

(D) in subsection (d)(1), by inserting before the period at the end the following: "or receiving grants under subsection (a)";

(E) in subsection (e)(1), by inserting before the period at the end the following: "or receiving grants under subsection (a)";

(F) in subsection (f), by inserting "or receiving grants under subsection (a)" after "this section"; and

(G) by amending the heading to read as follows:

"CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES".

(2) Section 504 of the Act (25 U.S.C. 1654) is amended—

(A) by striking "SEC. 504." and all that follows through the end of subsection (a) and inserting the following:

"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) in subsection (b)—

(i) in the material preceding paragraph (1), by inserting ", or grant made," after "contract entered into"; and

(ii) in paragraph (2), by striking "within one year" and all that follows through the period at the end and inserting the following: ", 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) in subsection (c), by inserting ", or grant made," after "entered into"; and

(D) by amending the heading to read as follows:

"CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS".

(3) Section 505 of the Act (25 U.S.C. 1655) is amended—

(A) in subsection (a), by inserting "compliance with grant requirements under this title and" before "compliance with,";

(B) in subsection (b)—

(i) by inserting "or received a grant" after "entered into a contract"; and

(ii) by inserting before the period at the end the following: "or the terms of such grant";

(C) in subsection (c)—

(i) by inserting "the requirements of a grant or complied with" after "complied with";

(ii) by inserting "or grant" after "such contract" each place it appears";

(iii) by inserting "or make a grant" after "enter into a contract"; and
(iv) by inserting "or grant" after "whose contract";
(D) in subsection (d), by inserting "or grant" after "a contract" each place it appears; and
(E) by amending the heading to read as follows:

"EVALUATIONS; RENEWALS".

(4) Section 506 of the Act (25 U.S.C. 1656) is amended—
(A) in subsection (b), by inserting "or grants" after "any contracts";
(B) in subsection (d), by inserting "or grant" after "contract" each place it appears;
(C) in subsection (e)—
(i) by inserting ", or grants to," after "Contracts with"; and
(ii) by inserting "or grants" after "such contracts"; and
(D) by amending the heading to read as follows:

"OTHER CONTRACT AND GRANT REQUIREMENTS".

(5) Section 507 of the Act (25 U.S.C. 1657) is amended—
(A) in subsection (a)—
(i) in the material preceding paragraph (1), by inserting ", or a grant received," after "entered into"; and
(ii) in paragraphs (1) and (2), by inserting "or grant" after "contract" each place it appears; and
(B) in subsections (b) and (c), by inserting "or grant" after "contract" each place it appears.
(6) Section 509 of the Act (25 U.S.C. 1659) (as amended by section 902(5)(A) of this Act) is amended by inserting "or grant recipients" after "contractors" each place it appears.

SEC. 502. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION.—Title V of the Act is amended by inserting after section 510 (as redesignated by section 902(5)(B) of this Act) the following new section:

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 511. There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.".
(b) CONFORMING AMENDMENTS.—Title V of the Act (25 U.S.C. 1650 et seq.) is amended—
(1) in section 503—
(A) in subsection (c), by striking out "(c)(1)" and inserting "(c)" and by striking out paragraph (2);
(B) in subsection (d), by striking out paragraph (4);
(C) in subsection (e), by striking out paragraph (4); and
(D) in subsection (f), by striking out paragraph (5); and
(2) in section 509 (as redesignated by section 902(5)(A) of this Act), by striking out the last sentence.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

SEC. 601. INDIAN HEALTH SERVICE.

Section 601(c) of the Act (15 U.S.C. 1661(c)) is amended—
(1) in paragraph (2), by striking out "and" after the semicolon;
(2) in paragraph (3), by striking out the period at the end and inserting in lieu thereof "; and"; and
(3) by adding at the end the following new paragraph:
"(4) all scholarship and loan functions carried out under title I.".

SEC. 602. AUTHORIZATION OF APPROPRIATIONS.

Title VI of the Act (25 U.S.C. 1661 et seq.) is amended by adding at the end the following new section:

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 603. There are 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—SUBSTANCE ABUSE PROGRAMS

SEC. 701. REDESIGNATION OF EXISTING TITLE VII.

(a) TITLE HEADING.—Title VII of the Act (25 U.S.C. 1671 et seq.) is redesignated as title VIII and the title heading is amended to read as follows:

"TITLE VIII—MISCELLANEOUS"

(b) REDESIGNATION OF SECTIONS.—Sections 701 through 720 of the Act (25 U.S.C. 1671 et seq.) are hereby redesignated as sections 801 through 820, respectively.

(c) CONFORMING AMENDMENTS.—The Act is amended—

(1) in section 207(a), by striking out "section 713" and inserting in lieu thereof "section 813";

(2) in section 307(e), by striking out "section 713" and inserting in lieu thereof "section 813"; and

(3) in section 405(b)—

(A) in paragraph (1), by striking out "sections 402(c) and 713(b)(2)(A)" and inserting in lieu thereof "sections 402(a) and 813(b)(2)(A)"; and

(B) in paragraph (4), by striking out "section 402(c)" each place it appears and inserting in lieu thereof "section 402(a)".

(d) REFERENCES.—Any reference in a provision of law other than the Indian Health Care Improvement Act to sections redesignated by subsection (b) shall be deemed to refer to the section as so redesignated.

SEC. 702. SUBSTANCE ABUSE PROGRAMS.

(a) IN GENERAL.—The Act is amended by inserting after title VI the following new title:

"TITLE VII—SUBSTANCE ABUSE PROGRAMS

"INDIAN HEALTH SERVICE RESPONSIBILITIES

"SEC. 701. The Memorandum of Agreement entered into pursuant to section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) shall include specific provisions pursuant to which the Service shall assume responsibility for—

"(1) the determination of the scope of the problem of alcohol and substance abuse among Indian people, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

"(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

"(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

"INDIAN HEALTH SERVICE PROGRAM

"SEC. 702. (a) COMPREHENSIVE PREVENTION AND TREATMENT PROGRAM.—The Secretary, acting through the Service, shall provide a program of comprehensive alcohol and substance abuse prevention and treatment which shall include—

"(1) prevention, through educational intervention, in Indian communities;

"(2) acute detoxification and treatment;

"(3) community-based rehabilitation;

"(4) community education and involvement, including extensive training of health care, educational, and community-based personnel; and

"(5) residential treatment programs for pregnant and post partum women and their children.

The target population of such a program shall be the members of Indian tribes. Additionally, efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

"(b) CONTRACT HEALTH SERVICES.—(1) The Secretary, acting through the Service, may enter into contracts with public or private providers of alcohol and substance abuse treatment services for the purpose of assisting the Service in carrying out the program required under subsection (a).

"(2) In carrying out this subsection, the Secretary shall provide assistance to Indian tribes to develop criteria for the certification of alcohol and substance abuse service providers and accreditation of service facilities which meet minimum standards for such services and facilities as may be determined pursuant to section 4205(a)(3) of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411(a)(3)).

"INDIAN WOMEN TREATMENT PROGRAMS

"SEC. 703. (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)(1) There are authorized to be appropriated $10,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000 for the purpose of carrying out this section.

"(2) Twenty percent of the funds appropriated pursuant to this subsection shall be used to make grants to urban Indian organizations funded under title V.

INDIAN HEALTH SERVICE YOUTH PROGRAM

"SEC. 704. (a) DETOXIFICATION AND REHABILITATION.—The Secretary shall develop and implement a program for acute detoxification and treatment for Indian youth who are alcohol and substance abusers. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis. These regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

"(b) TREATMENT CENTERS OR FACILITIES.—(1) The Secretary shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, a youth regional treatment center in each area under the jurisdiction of an area office. For the purposes of this subsection, the area offices of the Service in Tucson and Phoenix, Arizona, shall be considered one area office and the area office in California shall be considered to be two area offices, one office whose jurisdiction shall be considered to encompass the northern area of the State of California, and one office whose jurisdiction shall be considered to encompass the remainder of the State of California.

"(2) For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

"(3) Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

"(A) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

"(B) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility.

"(4) A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the tribes to be served by such center.

"(c) FEDERALLY OWNED STRUCTURES.—

"(1) The Secretary, acting through the Service, shall, in consultation with Indian tribes—

"(A) identify and use, where appropriate, federally owned structures suitable as local residential or regional alcohol and substance abuse treatment centers for Indian youth; and

"(B) establish guidelines for determining the suitability of any such federally owned structure to be used as a local residential or regional alcohol and substance abuse treatment center for Indian youth.

"(2) Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure.

"(d) REHABILITATION AND AFTERCARE SERVICES.—

"(1) The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement within each Service service unit community-based rehabilitation and follow-up services for Indian youth who are alcohol or substance abusers which are designed to integrate long-term treatment and to monitor and support the Indian youth after their return to their home community.

"(2) Services under paragraph (1) shall be administered within each service unit by trained staff within the community who can assist the Indian youth in continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff shall include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

"(e) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youth authorized by this section, the Secretary shall provide for the inclusion of family members of such youth in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (d) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

"(f) MULTIDRUG ABUSE STUDY.—(1) The Secretary shall conduct a study to determine the incidence and prevalence of the abuse of multiple forms of drugs, including alcohol, among Indian youth residing on Indian reservations and in urban areas and the interrelationship of such abuse with the incidence of mental illness among such youth.

"(2) The Secretary shall submit a report detailing the findings of such study, together with recommendations based on such findings, to the Congress no later than two years after the date of the enactment of this section.

"TRAINING AND COMMUNITY EDUCATION

"SEC. 705. (a) COMMUNITY EDUCATION.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement within each service unit a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education in alcohol and substance abuse to political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, and other critical members of each tribal community.

"(b) TRAINING.—The Secretary shall, either directly or by contract, provide instruction in the area of alcohol and substance abuse, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol syndrome to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

"(c) COMMUNITY-BASED TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, acting through the Service and in consultation with tribes and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

"(1) the elevated risk of alcohol and substance abuse faced by children of alcoholics;

"(2) the cultural and multigenerational aspects of alcohol and substance abuse prevention and recovery; and

"(3) community-based and multidisciplinary strategies for preventing and treating alcohol and substance abuse.

"GALLUP ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER

"SEC. 706. (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 adolescent members of the Navajo Nation and neighboring tribes.

"(b) PURPOSES OF GRANTS.—Grants made pursuant to this section shall (to the extent appropriations are made available) 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.

"REPORTS

"SEC. 707. (a) COMPILATION OF DATA.—The Secretary, with respect to the administration of any health program by a Service service unit, directly or through contract, including a contract under the Indian Self-Determination Act, shall require the compilation of data relating to the number of cases or incidents which any of the Service personnel or services were involved and which were related, either directly or indirectly, to alcohol or substance abuse. Such report shall include the type of assistance provided and the disposition of these cases.

"(b) REFERRAL OF DATA.—The data compiled under subsection (a) shall be provided annually to the affected Indian tribe and Tribal Coordinating Committee to assist them in developing or modifying a Tribal Action Plan under section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2471 et seq.).

"(c) COMPREHENSIVE REPORT.—Each service unit director shall be responsible for assembling the data compiled under this section and section 4214 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2434)

into an annual tribal comprehensive report. Such report shall be provided to the affected tribe and to the Director of the Service who shall develop and publish a biennial national report based on such tribal comprehensive reports.

"URBAN INDIAN PROGRAM

"SEC. 708. (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).

"FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT GRANTS

"SEC. 709. (a) The Secretary may make grants to Indian tribes and tribal organizations to establish fetal alcohol syndrome (hereafter in this section, section 710, section 711, and section 712 referred to as 'FAS') and fetal alcohol effect (hereafter in this section, section 710, section 711, and section 712 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)(1) There are authorized to be appropriated $10,000,000 for each of the fiscal years 1993, 1994, and 1995, and $15,000,000 for each of the fiscal years 1996, 1997, 1998, 1999, and 2000, for the purpose of carrying out this section.

"(2) 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. 710. (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.

"(d)(1) There are authorized to be appropriated $5,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000 to carry out the purposes of subsections (a) and (b).

"(2) There are authorized to be appropriated $3,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000 to carry out the purposes of subsection (c).

"REPORT

"SEC. 711. (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.

"(c) There are authorized to be appropriated $1,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000 to carry out the purposes of this section.

"ADOLESCENT AND ADULT FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT

"SEC. 712. (a) 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 and Indian communities.

"(b) For the purposes of carrying out the provisions of this section, there are authorized to be appropriated $2,000,000 for fiscal year 1993 and such sums as may be necessary for each of fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

"CLEARINGHOUSE

"SEC. 713. (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.

"(c) For the purposes of carrying out the provisions of this section, there are authorized to be appropriated $1,000,000 for 1993 and such sums as may be necessary for each of fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

"PUEBLO SUBSTANCE ABUSE TREATMENT PROJECT FOR SAN JUAN PUEBLO, NEW MEXICO

"SEC. 714. 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.

"THUNDER CHILD TREATMENT CENTER

"SEC. 715. (a) The Secretary, acting through the Service, shall make a grant to the Intertribal Addictions Recovery Organization, Inc. (commonly known as the Thunder Child Treatment Center) at Sheridan, Wyoming, 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.

"(b) For the purposes of carrying out subsection (a), there are authorized to be appropriated $2,000,000 for fiscal years 1993 and 1994. No funding shall be available for staffing or operation of this facility. None of the funding appropriated to carry out subsection (a) shall be used for administrative purposes.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 716. Except as provided in sections 703, 706, 709, 710, 711, 712, 713, and 715, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out the provisions of this title.".

(b) REDESIGNATION AND REPEAL OF EXISTING PROVISIONS.—

(1) REDESIGNATION.—The Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.) is amended by redesignating section 4224 as section 4208A.

(2) REPEAL.—Part 6 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2471 et seq.), as amended by paragraph (1), is hereby repealed.

SEC. 703. INDIAN ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND TREATMENT ACT OF 1986 AMENDMENTS.

The Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.) is amended—

(1) in section 4206—

(A) in subsection (c)—

(i) in paragraph (2)—

(I) by striking "(2) the" and inserting "(B) the";

(II) by striking "(3) the" and inserting "(C) the";

(III) by striking "(4) the" and inserting "(D) the";

(IV) in subparagraph (D) (as redesignated by subclause (III)), by striking "and" at the end;

(V) in subparagraph (E), by striking the period at the end and inserting ", and"; and

(VI) by adding at the end the following new subparagraph:

"(F) an evaluation component to measure the success of efforts made."; and

(ii) by adding at the end the following new paragraph:

"(3) All Tribal Action Plans shall be updated every 2 years."; and

(B) in subsection (d), by amending paragraph (2) to read as follows:

"(2) There are authorized to be appropriated not more than $2,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000 for grants under this subsection."; and

(C) by adding at the end the following new subsection:

"(f)(1) The Secretary of the Interior may make grants to Indian tribes adopting a resolution pursuant to subsection (a) to implement and develop community and in-school training, education, and prevention programs on alcohol and substance abuse, fetal alcohol syndrome and fetal alcohol effect.

"(2) Funds provided under this section may be used for, but are not limited to, the development and implementation of tribal programs for—

"(A) youth employment;
"(B) youth recreation;
"(C) youth cultural activities;
"(D) community awareness programs; and
"(E) community training and education programs.

"(3) There are authorized to be appropriated to carry out the provisions of this subsection $5,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000.";

(2) in section 4207(b), by amending paragraph (3) to read as follows:

"(3) The Assistant Secretary of the Interior for Indian Affairs shall appoint such employees to work in the Office of Alcohol and Substance Abuse, and shall provide such funding, services, and equipment as may be necessary to enable the Office of Alcohol and Substance Abuse to carry out its responsibilities.";

(3) in section 4210, by amending subsection (b) to read as follows:

"(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $500,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000 to carry out the provisions of this section.";

(4) in section 4212(a), by striking out "1989, 1990, 1991, and 1992" and inserting in lieu thereof "1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000";

(5) in section 4213(e), by amending paragraphs (1) and (2) to read as follows:

"(1) For the planning and design, construction, and renovation of, or purchase or lease of land or facilities for, emergency shelters and half-way houses to provide emergency care for Indian youth, there are authorized to be appropriated $10,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

"(2) For the staffing and operation of emergency shelters and half-way houses, there are authorized to be appropriated $5,000,000 for fiscal year 1993 and $7,000,000 for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.";

(6) in section 4216(a)(1)—

(A) in subparagraph (A), by striking "and" at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(C) the Makah Indian Tribe of Washington for the investigation and control of illegal narcotic traffic on the Makah Indian Reservation arising from its proximity to international waters.";

(7) by amending section 4216(a)(3) to read as follows:

"(3) For the purpose of providing the assistance required by this subsection, there are authorized to be appropriated—

"(A) $500,000 under paragraph (1)(A) for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000,

"(B) $500,000 under paragraph (1)(B) for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000, and

"(C) $500,000 under paragraph (1)(C) for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000.";

(8) by amending section 4216(b) to read as follows:

"(b)(1) MARIJUANA ERADICATION AND INTERDICTION.—The Secretary of the Interior, in cooperation with appropriate Federal, tribal, and State and local law enforcement agencies, shall establish and implement a program for the eradication of marijuana cultivation, and interdiction, investigation, and control of illegal narcotics trafficking within Indian country as defined in section 1152 of title 18, United States Code. The Secretary shall establish a priority for the use of funds appropriated under paragraph (2) for those Indian reservations where the scope of the problem is most critical, and such funds shall be available for contracting by Indian tribes pursuant to the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

"(2) For the purpose of establishing the program required by paragraph (1), there are authorized to be appropriated $2,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000.";

(9) in section 4218, by amending subsection (b) to read as follows:

"(b) AUTHORIZATION.—For the purposes of providing the training required by subsection (a), there are authorized to be appropriated $2,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999 and 2000."; and

(10) in section 4220(b), by amending paragraphs (1) and (2) to read as follows:

"(1) For the purpose of constructing or renovating juvenile detention centers as provided in subsection (a), there are authorized to be appropriated $10,000,000 for each of the fiscal years 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

"CHILD SEXUAL ABUSE TREATMENT PROGRAMS

"SEC. 819. (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.

"(b) Beginning October 1, 1995, the Secretary and the Secretary of the Interior may establish, in any service area, demonstration programs involving treatment for child sexual abuse, except that 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.".

SEC. 807. TRIBAL LEASING.

Section 820 of the Act (25 U.S.C. 1680j) (as redesignated by section 701(b) of this Act) is amended to read as follows:

"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.".

SEC. 808. EXTENSION OF TRIBAL MANAGEMENT DEMONSTRATION PROJECT TERMINATION DATE IN CERTAIN CASES.

Section 818(d) of the Act (25 U.S.C. 1680h(d)) (as redesignated by section 701(b) of this Act) is amended—

(1) in paragraph (1), by inserting before the period at the end the following: ", 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"; and

(2) in paragraph (2), by striking "1994" and inserting "1996".

SEC. 809. LONG-TERM CARE DEMONSTRATION PROJECT.

Title VIII of the Act (as redesignated by subsections (a) and (b) of section 701 of this Act) is amended by adding at the end the following new section:

"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 the 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 to 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 applica-

tion 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) 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 of 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 or tribal organization.

"(i) 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 this section. Such sums shall remain available until expended.".

SEC. 810. RESULTS OF DEMONSTRATION PROJECTS.

Title VIII of the Act (as redesignated by subsections (a) and (b) of section 701 and amended by section 809 of this Act) is amended by adding at the end the following new section:

"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.".

SEC. 811. SUBSTANCE ABUSE COUNSELOR EDUCATION DEMONSTRATION PROJECT.

Title VIII of the Act (as redesignated by subsections (a) and (b) of section 701 of this Act and amended by section 810 of this Act) is amended by adding at the end the following new section:

"SUBSTANCE ABUSE COUNSELOR EDUCATION DEMONSTRATION PROJECT

"SEC. 823. (a) The Secretary, acting through the Service, may enter into contracts with, or make grants to, 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 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 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.

"(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 purposes of this section. Such sums shall remain available until expended.".

SEC. 812. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION.—Title VIII of the Act (as redesignated by subsections (a) and (b) of section 701 and amended by section 811 of this Act) is amended by adding at the end the following new section:

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 824. Except as provided in sections 821 and 823, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.".

(b) CONFORMING AMENDMENTS.—Title VIII of the Act (25 U.S.C. 1671 et seq.) (as redesignated by subsections (a) and (b) of section 701 of this Act) is amended—

(1) in section 807 (as redesignated by section 701(b) of this Act), by striking out subsection (f); and

(2) in section 818 (as redesignated by section 701(b) of this Act), by striking out subsection (e).

SEC. 813. TRIBAL SELF-GOVERNANCE PROJECT.

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.".

TITLE IX—TECHNICAL CORRECTIONS

SEC. 901. REPEAL OF EXPIRED REPORTING REQUIREMENTS.

The Act is amended—

(1) in section 116, by striking out subsection (d);

(2) in section 204(a)—

(A) by striking out paragraph (2);

(B) by striking out "(a)(1)" and inserting in lieu thereof "(a)";

(C) by redesignating subparagraphs (A) and (B) as paragraphs (1) and (2), respectively; and

(D) in paragraph (2) (as redesignated by subparagraph (C)), by striking out "subparagraph (A)" and inserting in lieu thereof "paragraph (1)";

(3) in section 602, by striking out subsection (a)(3); and

(4) by striking out section 803 (as redesignated by section 701(b) of this Act).

SEC. 902. OTHER TECHNICAL CORRECTIONS.

The Act is amended—

(1) in section 4(c), by striking out "sections 102, 103, and 201(c)(5)," and inserting in lieu thereof the following: "sections 102 and 103,";

(2) in title I—

(A) in section 102(b)(1), by striking ": *Provided*, That the" and inserting in lieu thereof ". The";

(B) in section 105(c), by striking out "Department of Health, Education, and Welfare" and inserting in lieu thereof "Department of Health and Human Services";

(C) in section 108(d)(1)(A), by striking out "Indian Health" and inserting in lieu thereof "Indian health"; and

(D) in section 108(i), by striking out "Service manpower programs" and inserting in lieu thereof "health professional programs of the Service".

(3) in title II—

(A) by striking out "**SEC. 209. MENTAL HEALTH PREVENTION AND TREATMENT SERVICES.**" and inserting in lieu thereof the following:

"MENTAL HEALTH PREVENTION AND TREATMENT SERVICES

"SEC. 209."; and

(B) in section 209, by redesignating subsections (c) through (l) as subsections (b) through (k), respectively;

(4) in title III—

(A) by striking out "**SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.**" and inserting in lieu thereof the following:

"INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT

"SEC. 307."; and

(B) in section 301(d) (as redesignated by section 301(2) of this Act), by striking out "sections 102 and 103(b)" and inserting in lieu thereof "section 102";

(5) in title V—

(A) by striking out "**SEC. 409. FACITITIES RENOVATION.**" and inserting in lieu thereof the following:

"FACILITIES RENOVATION

"SEC. 509."; and

(B) by striking out "**SEC. 511. URBAN HEALTH PROGRAMS BRANCH.**" and inserting in lieu thereof the following:

"URBAN HEALTH PROGRAMS BRANCH

"SEC. 510.";

(6) in section 601(c)(3)(D), by striking out "(25 U.S.C. 2005, et seq.)" and inserting in lieu thereof "(42 U.S.C. 2005 et seq.)";

(7) in section 601(d)(1)(C), by striking out "appropriate" and inserting in lieu thereof "appropriated";

(8) in section 813(b)(2)(A) of the Act (25 U.S.C. 1680c(b)(2)(A)) (as redesignated by section 701(b) of this Act), by striking out "section 402(c)" and inserting in lieu thereof "section 402(a)"; and

(9) by amending the heading for section 816 of the Act (25 U.S.C. 1680f) (as redesignated by section 701(b)) to read as follows:

"INDIAN HEALTH SERVICE AND DEPARTMENT OF VETERANS AFFAIRS HEALTH FACILITIES AND SERVICES SHARING".

PURPOSE

The purpose of H.R. 3724 is to amend the Indian Health Care Improvement Act to authorize appropriations for Indian health programs, and for other purposes.

BACKGROUND AND NEED

The Federal responsibility to provide health services to Indian people has been expressed in numerous treaties with Indian tribes in which the United States agreed to provide such services. This responsibility has been further delineated and defined by numerous statutes 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. It was not until 1921,

however, with the enactment of the Snyder Act (25 U.S.C. 13), that a formal authorization for Indian health appropriations was enacted into law. This legislation 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 U.S. 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, the Congress, in 1976, enacted the Indian Health Care Improvement Act (P.L. 94-437). This legislation authorized additional funds for Indian health care, to reduce unmet needs under existing programs, and to establish specific 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 FY 1984, to a level comparable to that of the general U.S. population. The Indian Health Care Improvement Act was revised and extended in 1988 (P.L. 100-713) and the Act requires reauthorization for fiscal year 1993 and beyond.

According to the Indian Health Service, the mortality rates of American Indians and Alaska Natives continues 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 shown percentages:

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

In spite of the efforts of the Indian Health Service, the general health status of American Indian people remains poor.

On November 6, 1991, Chairman Miller introduced H.R. 3724, the Indian Health Amendments of 1991. Six days later, a joint hearing with the full Interior and Insular Affairs Committee and the Subcommittee on Health and the Environment was held on H.R. 3724. On December 19, 1991, Chairman Miller held a general oversight hearing on Indian health issues in Bismarck, North Dakota, and took testimony from several tribes. On March 5, 1992, Chairman Miller held a hearing on Fetal Alcohol Syndrome in Indian communities. Finally, on March 24, 1991 the last hearing on H.R. 3724 was held with an emphasis on Indian adolescent health. On April 29, 1992 the Committee considered H.R. 3724 and Chairman Miller offered an amendment in the nature of a substitute which reflected the wealth of testimony received from Indian country. The Committee adopted the amendment.

COMMITTEE AMENDMENT

DECLARATION OF HEALTH OBJECTIVES

The Committee Amendment reinstates the policy declaration from the original 1976 Act. The Committee strongly agrees that it is the legal obligation of the United States to assure the highest possible health status for all American Indians, including urban Indians, and to provide the necessary resources to carry out this policy. In an effort to better implement his policy, the Committee included in the amendment 59 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 in the year 2000, and (2) beginning three years from enactment, the health status objective will serve as a resource driving mechanism for the Indian Health Care Improvement Fund.

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 health objectives for the general population and specific ethnic groups for the year 2000. The Committee Amendment includes some of the goals for the general population and most of the health status objectives specific to the Native American population from the *Health People 2000* report. The health status objectives will be utilized as a yardstick for the reauthorization of the Act in the year 2000. It is the intent of the Committee that the Indian Health Service will submit a substantial and well documented report on these objectives at the time of the reauthorization pursuant to Section 801 of the Committee Amendment. 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 regulations 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 tribes and persons in the field. The Committee suggests a minimum burden on Community Health Representatives to execute these duties and a maximum burden of the Area epidemiology centers authorized under the Amendment.

TITLE I—INDIAN HEALTH PROFESSIONALS

The Committee Amendment amends Title I of the Act to provide for increased opportunities for American Indians and Alaska Natives in the health professions. The Committee amendments are 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 health professions.

The Committee intends the language in 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 their 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 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 Committee Amendment also includes language which allows a scholarship recipient to return to their own reservation and complete their service obligation to the Indian Health Service by working in a health program on their own reservation or that serves their tribe. The intent of this language is to provide further incentives to American Indians to get into the health professions in order to go to work for their tribes. 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 also expands the list of health professions eligible to participate in the externship programs established under the Act. The Committee intends this language to be interpreted broadly by the Indian Health Service so that a wide range of health professionals may participate in the externship program.

The Committee Amendment includes additional programs to improve the ability of the Indian Health Service to recruit and retain nurses within the Indian Health Service. The Amendment provides specific set-asides for training of nurses, nurse midwives, nurse anesthetists, and nurse practitioners. The Amendment also includes a provision to require that 25% of all retention bonuses awarded by the Indian Health Service be awarded to nurses. The Committee has included language which authorizes the Secretary to award retention bonuses to any nurse or physician employed by an Indian tribe under a Indian Self-Determination Act contract. This language will allow tribally employed physicians and nurses to be eligible for retention bonuses. The Committee is aware of the problems experienced by Indian tribes and tribal contractors because of their difficulty 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 Committee intends these provisions to provide a variety of incentives to nurses

employed in Indian health programs to help address the national shortage of nurses within the Indian Health Service.

The Committee Amendment also includes a provision which establishes an INMED 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 professions will serve as a great incentive and recruitment tool of the Indian Health Service. These programs will help 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 which incorporates multidisciplinary approaches and includes a strong emphasis on tribal traditional healing and cultural practices. The Committee believes that an understanding of tribal traditions and cultural values is a necessary component to health care delivery to American Indians.

The Committee Amendments have included a broad description of health professionals eligible to participate in the loan repayment program. The Committee intends this language to be interpreted broadly to include a wide range of health professionals. The original language of H.R. 3724 placed special emphasis on primary care health professionals. The Committee reconsidered this special emphasis and amended the language in H.R. 3724 to be more inclusive. The Committee received testimony from several Indian tribes expressing concerns regarding the limitations 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 is also concerned that any limitation of the ability of the Indian Health Service to utilize the loan repayment program to attract health professionals into the Indian Health Service would have potentially serious consequences for the effective delivery of health care to American Indians. For example, if the Indian Health Service loan repayment program was limited to primary care health professionals than the Indian Health Service would not be able to offer loan repayment to anesthetists, podiatrists, or pharmacists despite a documented need for these health professionals throughout the Indian Health Service. In addition, limiting the loan repayment program to direct care professionals would not allow the Indian Health Service the flexibility necessary to fill local vacancies in each service area. The Committee does not intend such a result. It is the Committee's intention that this language be interpreted broadly so that the Indian Health Service will have a degree of flexibility to respond to local recruitment needs through the loan repayment program.

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 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 which would create a critical situation 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.

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 Amendment creates the Indian Health Scholarship and Loan Repayment Recovery Fund which shall 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 indents 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.

The Committee strongly supports the continued growth and expansion of the Community Health Aid program nationally. The Committee Amendment includes a provision which expands the efforts of the community health aide programs for Alaska Natives. The Community Health Aide program in Alaska is an integral link between very remote rural locations and health facilities and programs throughout the state. In most areas, the community health aide serves as the sole contact between the native community and the health care system. The Committee believes it is vitally important to the health status of American Indians and Alaska Natives that community health aide receive adequate resources and training on acute care, emergency care, health promotion and disease prevention.

TITLE II—HEALTH SERVICES

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 action suit against IHS alleging the illegal denial of health care services which were provided to all other American Indians. Specifically, California Indians comprised 10% of the national IHS service population and yet, received approximately 2% 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). Consequently, Appropriations Committees established the Equity Health Care Fund through most of the 1980s to provide resource allocations to areas and tribes with deficiency levels.

In an effort to establish a more permanent method to deal with the resource deficiency problem, Congress in 1988 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. Five levels were established for tribes.

(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.

Funds were to be allocated pursuant to these levels with the goal of "zero deficiency."

The Committee Amendment provides that this system of allocating the Fund shall remain in place for another three years. However, during that three year interim the Committee expects the Service to begin, through its Epidemiology centers, the collection of data required under the 59 health status objectives. 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 asserts that true equity funding should be based on addressing health status deficiencies as well as evaluating historical funding deficiencies. The Committee's position is that equity funding needs to target areas substantially below several or all health status objectives. The Committee asserts that it is manifest that all Indians are entitled to comparable health care and this amendment is based on the premise. The Fund will be utilized in three years to address the true health needs of Indian country and provide equity to historically underfunded areas.

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 to 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%), Albuquerque (14%), Aberdeen (14%), Phoenix (13%), and Bemidji (13%). The Navajo and Oklahoma areas had the largest numbers of diabetes patients 6,546 and 10,775 respectively. According to the 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 amputations 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 treatment for end stage renal disease. Access for treatment is equally 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 replicated on other Indian reservations where diabetes is a major health problem.

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 tribe 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. The Committee believes this amendment will help ensure that Indian patients receive the highest quality heath care and services.

The Committee Amendment establishes the Intermediate Adolescent Mental Health program to provide grants to Indian tribes 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, suicidal, or acting 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 crisis. The Committee is very concerned that it has become a standard practice on some reservations to place suicidal children and adolescents in detention facilities without adequate supervision or treatment. It is very important that these children and adolescents be treated in a safe and well-supervised setting.

This program would allow Indian tribes to provide a variety of treatment options to Indian health care providers such as inpatient or outpatient services, emergency care, suicide prevention and crisis intervention to children and adolescents. It would allow Indian tribes 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.

The Committee Amendment provides for a Hospice Care Feasibility Study to assess the feasibility of furnishing care to terminally ill Indians. The Committee notes the inclusion of the amendment was specifically to 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 enactment.

The Committee Amendment also provides for a "managed care feasibility study" for Indian tribes without inpatient hospitals or access to service hospitals. Within 12 months of enactment, the Secretary is to submit to Congress a study on the feasibility of allowing Indian tribes to purchase managed care coverage.

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 Secretary is to agree to reimburse CRIHB for costs in providing contract care. 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 on the Demonstration Project. Four of the representatives shall 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 that 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 currently going unchecked.

The Committee is very concerned about a growing problem in the delivery of health care to Indian and Alaska Native peoples. Each year a greater percentage of Indian Health Service funding must be allocated to cover patient travel costs. In some areas, patient travel costs have grown so large that the area experienced severe funding shortfalls because of these costs. In particular, the Alaska area has identified an unmet need of $3,200,000 million for patient travel costs for FY 1993. The Phoenix area office has an unmet need of $219,201 for FY 1992, the Billings area has an estimated unmet need of $33,973, and the Aberdeen area has an estimated unmet need of $1,200,000 for patient travel costs. Patient travel is necessary for those IHS patients who suffer critical injuries in car accidents, are in need of radiation or chemotherapy treatments, or must receive regular dialysis treatments. In many cases, the lack of patient travel funds has caused individuals to forego badly needed treatments or placed the costs of transportation on the shoulders of the patient or their family. Some areas of the IHS have been forced to shift funds from other health programs to cover transportation costs for some patients. The Committee Amendment sets out a specific authorization to provide for patient travel costs so that other health programs will not need to be cut back, de-funded, or curtailed in order to cover costs associated with patient travel. In addition, separate authority for patient travel costs would allow Indian tribes in areas where there has been severe funding shortfalls for patient travel costs to seek increased appropriations to cover these projected and actual funding shortfalls.

Tribal health contractors have informed the Committee that certain insurance companies refuse to reimburse the contractors for services provided to Indian and Alaska 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; this right to extend to tribal contractors as well as the Secretary. The Committee has been informed of insurance companies refusing to pay tribal contractors for services and officials within the Indian Health Service questioning the contractor's right to recover in the absence of legislation. Therefore, the Committee Amendment includes language which clarifies that tribal health contractors have the same right to recover against private insurance companies that IHS enjoys. The Committee has received reports from several tribes and tribal organizations regarding the refusal of some states and political subdivisions of states refusing 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 encom-

passes all expenses which arose under a program administered by the tribal health contractor. The Committee intends that collections made by the tribal health contractors shall remain with the contractor, to provide 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.

The Committee Amendment establishes Epidemiology Centers in each service area of the IHS to assist tribes in monitoring and evaluating the health status objectives established under the Act. The Committee intends that the burden for gathering, monitoring, coordinating, organizing and summarizing the data on the health care objectives is the responsibility of the IHS and that the Epidemiology Centers are to have the primary responsibility to maintain accurate data for Indian tribes in each area. The Committee intends that a minimal burden is to fall on the tribes and Community Health Representatives 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 Indian tribes in each area. They will establish methods to monitor the health objectives, identify health priorities for surveillance, evaluate the delivery systems, develop better methods to obtain data from other agencies, and make recommendations on targeting health care services. The Centers shall provide technical assistance to Indian tribes and urban Indian organizations. The Committee Amendment authorizes the Centers for Disease Control and the National Center for Health Statistics to provide technical assistance to the Centers and to Indian tribes.

These Centers would have great utility not simply as monitoring units for Indian tribes, but the data developed could be useful for scientific and other purposes.

In March 1992, Dr. Robert Blum of the University of Minnesota published the report, "The State of Native American Youth Health." Dr. Blum presented the findings of this report to the Committee at the March 24, 1992 hearing on H.R. 3724. This report was based on a survey of 14,000 American Indian/Alaska Native adolescents living on or near reservations. The report represents 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/Alaska 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 av-

erage. 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. In testimony before the Committee. Dr. Blum and Dr. Resnick indicated that there is a window of opportunity between the sixth and eighth grades to have a positive impact on health and lifestyles 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 has developed the Comprehensive School Health Education program which provides grants to Indian tribes 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 children 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. The Committee intends these programs to encourage the development of multidisciplinary approaches to health promotion and education efforts in schools. It is the Committee's intention that these programs utilize to the fullest extent possible existing services and programs within the community to develop and implement programs on nutrition education, personal health, mental health wellness, chronic disease prevention, substance abuse prevention and safety education. The Committee strongly encourages Indian tribes, 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 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 Indian tribes or Alaska Native organizations that are directly served by those schools. The Committee is aware of several very successful efforts of Indian communities establishing 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 tribes will be instrumental in elevating the health status of Indian youth across the country.

The Committee Amendment includes a provision which authorizes the Secretary make grants to Indian tribes, 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 Committee intends these programs to help Indian communities to develop programs which target Indian preadolescents and adolescents and which includes the active participation of the community, the family, and traditional healers. 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. The Committee is hopeful that grants made available under this section will improve the health status of Indian youth.

TITLE III—HEALTH FACILITIES

The Committee is concerned with the impact on Indians and Native Alaskans when health service facilities are closed. The Committee Amendment provides that when the Secretary reports to Congress evaluating the impact of a proposed IHS facility closure, the report must include (1) the level of use of such hospital or facility and (2) the distance between such hospital or facility and the nearest IHS hospital.

The Committee is concerned with 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 facilities in remote areas, and that the distance to "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 which contract care providers cannot provide. 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.

The Committee Amendment authorizes the Secretary to provide financial assistance 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 which current-

ly 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 proposed federal standards. The Indian Health Service has indicated that IHS constructed landfills will meet proposed federal standards and at the time of construction, IHS constructed landfills did not meet existing federal standards. However, the Committee is concerned that upon completion of landfills, Indian tribes are unable to operate these landfills because of insufficient revenues to meet the costs of operation and maintenance. The Committee is very concerned that the IHS upon completion of the construction 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 a continuing responsibility of the Indian Health Service to assist Indian tribes to maintain 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 country of over $1.7 billion. As required by P.L. 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 plan calls for $99 million to be appropriated for each of the next ten years. The Committee is very concerned that the administration has disregarded this plan in requesting $43 million in the 1993 fiscal year budget. The Committee is mindful of the need to balance construction needs with the need to bring existing facilities into compliance with proposed federal standards. The Committee is also aware of the need of Indian tribes to develop sufficient revenues 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 tribes 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 tribe which creates 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 by providing in kind property including equipment, office space, tribal services, etc. The Committee intends this language to be interpreted very broadly in order to allow smaller communities to receive the assistance provided under the Act. In many situations, these smaller communities are the ones most in need of the federal assistance.

The Committee Amendment also includes language to authorize the Secretary to make grants to Indian tribes 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 Tribes or tribal organizations which 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 without access to existing hospitals to develop ambulatory care facilities and therefore to dramatically improve tribal member's 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 basis without diminishing the quality or quantity of services provided to eligible persons.

The Committee amends the Indian Health Care Delivery Demonstration Project to authorize the Secretary to enter into contracts or award grants for demonstration projects on October 1, 1994. 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 the 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 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 is required to submit. 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 tribes and non-Indian communities under this program could benefit health care delivery in rural areas in general. The Committee supports cooperative agreements between the tribes and other communities and views this projects as a creative solution to the problems that have arisen pursuant to the Indian Health Service's Facilities Priority list. This demonstration program would allow tribes to maintain facilities and possible serve a wider community function.

TITLE IV—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 the Indian Health Service to inflate 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 Indian tribes and tribal facilities to become more aggressive in pursuing collections under Medicare and Medicaid programs. The Committee is also concerned that all Indians receive adequate health services under the Act without regard to whether the individual is covered under the Medicare program. The Committee Amendment includes language which would prevent such a preference for health services.

The Committee Amendment also includes language to ensure that at least 80 percent of the amounts collected under the Medicaid program remain at the point of collection. The committee is concerned that funds collected by one facility may be transferred to another facility and thereby create a disincentive for vigilant collections by Indian health facilities under the Medicaid program. The Committee believes that allowing facilities to retain 80 percent of the Medicaid collections will provide incentive to pursue Medicaid collections and allow collecting facilities to directly benefit from their collections policy. The Committee Amendment also deleted language which would allow the Secretary to terminate the authority to utilize these 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 in 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 for under this Act. The Committee intends these funds to continue to be used to make these necessary improvements to meet these changing conditions.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Title V authorizes appropriations through the year 2000 to carry out health services for urban Indians and makes a conforming amendment to include "grants" along with "contracts" as methods to provide services to urban Indians.

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.

TITLE VII SUBSTANCE ABUSE PROGRAMS

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 Ameri-

can 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 Amendment authorizes the Secretary to provide a comprehensive program of alcohol and substance abuse prevention and treatment. These programs include prevention and educational intervention, acute detoxification, community-based rehabilitation, community education and involvement, training of health care personnel, and residential treatment programs for pregnant and post-partum women and their children. The Committee is concerned that current program efforts have not effectively provided community-based services. In some cases, alcohol and substance abuse intervention and treatment efforts do not address underlying problems in the home or with the family. In other cases, an individual is removed from the community as part of residential treatment efforts only to be placed back into the same home situation upon completion of the residential treatment. This practice invites relapse. Programs established under this section should include aftercare components, follow-up counselling, and family and community involvement in the treatment and prevention for alcohol and substance abuse. The Committee is also concerned that many programs established under the Act do not meet the special needs of Indian women.

Alcoholism is also a major health problem for American 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. 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 associated with alcohol and substance abuse among Indian women include fetal alcohol syndrome, fetal alcohol effect, and other related birth defects.

Many alcohol and substance abuse programs are not structured to accept 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 during the pendency of their treatment. Residential treatment facilities should have the ability to accept women with children.

The Committee Amendment includes a provision to authorize the Secretary to make grants to Indian tribes and tribal organizations 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 Indian tribes to develop programs specifically tailored to meet 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. In addition, the Committee believes that this program will help reduce the numbers of Indian children born with fetal alcohol syndrome and fetal alcohol effect through the community education and counselling and advocacy components in tribal prevention and treatment programs established under the Act.

In April 1991, the Inspector General published a report on the "Indian Health Service Youth Alcohol and Substance Abuse Programs." The Committee is very concerned regarding the findings of the Inspector General's report. The report indicated that the Indian Health Service has failed to finalize regulations establishing operating standards for Indian Youth Alcoholism programs. Because of the failure to develop standards of operation for the Indian Youth Alcoholism Programs, the Indian Health Service has been unable to effectively monitor youth alcoholism programs in order to ensure compliance with the statutory requirements. In addition, the lack of standards of operation have left many programs little guidance in their development and operations. This failure has had a direct impact on the effectiveness of programs established under the Act and the quality of services provided to Indian youth. The Committee directs the Secretary to promulgate standards of operation expeditiously and to begin a comprehensive program to determine the effectiveness and quality of services provided under the Act.

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 very concerned that the Indian Health Service has made very little progress towards meeting this goal. The Committee has included 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 directs the Indian Health Service to take immediate steps to increase the number of counselors who have been certified.

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 inhalant abuse is included in the definition of "substance abuse". The Committee is very concerned

about the increasing incidence of inhalant abuse on Indian reservations and in Alaska Native villages. Because of the significant health impacts related to inhalant 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 inhalant abuse in Indian communities.

There needs to be increased coordination between the alcohol and substance programs of the Indian Health Service and the mental health programs of the Indian Health Service. In many instances, individuals with alcohol or substance abuse problems have other associated problems which require specific counselling from properly trained mental health professionals. It is very important to the success of an intervention that there is coordination between the alcohol and substance abuse counselors and the mental health professionals. In addition, there is need for increased communication and cooperation between the Indian Health Service and the Bureau of Indian Affairs. Many times there is significant overlap between services provided by the IHS and services provided by BIA social services. In order to avoid individuals falling through the cracks, it is very important that services to individuals and their families are coordinated. The Inspector General's report indicated that there is a general lack of coordination between the BIA and IHS in conducting medical assessments of juveniles taken into custody. It is very important that specific procedures and protocols are established on each reservation to require that medical assessments are conducted for juveniles taken into custody. The Committee directs the IHS and the BIA to ensure that there are established protocols and procedures to ensure that anytime a juvenile is taken into custody that juvenile has received a medical assessment.

The Committee Amendment includes a provision that authorizes the establishment of regional treatment centers for Indian youth who are alcohol and substance abusers. The Committee included language that would allow for the establishment of two regional treatment centers in the State of California. This provision would make treatment more accessible to Indian youth in the state of California. The Committee was concerned that under the existing provisions, youth in California would be forced to travel great distances in order to receive treatment from these centers. Given the large population in the State of California, and the distances involved, the Committee felt that the objectives of this Act would be best served by the creation of two regional treatment centers, one to serve Indian youth in Northern California and one to serve Indian youth in Southern California. Each of the regional treatment centers shall be constructed or purchased at a location agreed to by a simple majority of the Indian tribes served in each area office. The Committee Amendment also includes language which authorizes the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility.

The Committee is very concerned by the inability of the Indian Health Service to site regional treatment facilities for Indian youth in each area. The failure of the Indian Health Service to establish these regional treatment facilities has forced many Indian commu-

nities to contract for expensive residential treatment for Indian youth off the reservation. In many instances, these youth do not receive culturally sensitive and relevant treatment and can be alienated in the treatment process. In many cases, residential settings for treatment of alcohol and substance abuse do not address underlying problems in the home or with the family. It is very important that regional treatment facilities coordinate treatment plans and services with service providers located on the reservation to provide aftercare and follow-up services to the juvenile. The Committee Amendment includes language which would allow the Indian Health Service to site regional treatment centers at locations which are agreed upon by tribal resolution by a majority of Indian tribes to be served by such center. The Committee intends this language to help eliminate the obstacles to the establishment of regional treatment facilities in each area of the IHS.

The Committee Amendment also includes language which would require the Secretary to develop programs which involve the family in the treatment of Indian youth. The Amendment sets aside 10 percent of the funds to provide resources to develop outpatient care to family members of Indian youths receiving treatment under the Act. In providing these services, it is very important that these services are coordinated with other services available through the Indian Health Service and the Bureau of Indian Affairs, including any social services, mental health or counselling services. The Committee expects the IHS and the BIA to develop a comprehensive cooperative approach to address alcohol and substance abuse problems of Indian youth. The Committee Amendment also includes language to authorize the Secretary to study the problems of multi-drug abuse among Indian youth. The findings of the University of Minnesota indicate that Indian youth have experienced alcohol and other drugs at an earlier age than other Americans. The Committee is very concerned about these findings and directs the Secretary to study and report to the Congress his findings regarding the incidence and prevalence of the abuse of multiple forms of drugs and its relationship to mental illness. The Committee is aware of the prevalence of sniffing gas and paint among many Indian and Alaska Native youth. This study should include a component on inhalant abuse among American Indian and Alaska Native youth.

The Committee Amendment includes a provision requiring the Secretary in cooperation with the Secretary of the Interior to develop and implement a program of community education in each area office. The Committee intends the IHS and the BIA to develop training and community education programs for tribal leaders, tribal judges, law enforcement personnel, tribal health and education personnel. It is very important for the Indian Health Service to develop training on alcohol and substance abuse for all health personnel. The Committee directs the Secretary to ensure that all physicians, mental health professionals and nurses have had training in alcohol and substance abuse treatment and prevention including the problems of fetal alcohol syndrome and fetal alcohol effect. This training is critical to an effective response to the growing problem of FAS and FAE in Indian communities. The Indian Health Service must develop diagnostic instruments to identify

high risk women in order to provide counselling and support to prevent FAS and FAE. Each area should administer 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.

It very important that the BIA train teachers, teaching assistants and other education personnel on alcohol and substance abuse issues, including FAS and FAE. In many cases, due to an ineffective identification program, many children with FAS and FAE are not identified until they are in schools. The BIA and tribal education systems must develop the ability to identify and provide support and assistance to children afflicted with FAS or FAE. The Committee directs the Indian Health Service to work cooperatively with the BIA and Indian tribes to ensure that education personnel are trained in alcohol and substance abuse prevention and treatment including specific training on FAS and FAE. It is also very important that judicial and law enforcement personnel receive this training, especially court counselors, juvenile counselors, juvenile detention personnel and probation officers.

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 regarding 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 cord 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 treatment needs of Indian clients, to provide 12 beds for an adolescent shelter bed program. The Committee believes 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 Inspector General's report on Indian Youth Alcohol Programs sited the information management system of the IHS Youth Alcohol and Substance Abuse Programs as outmoded and obsolete. The report stated that the information management system currently in place was unable to effectively track data on program treatment efforts. The Committee is very concerned regarding the findings of the Inspector General and directs the Indian Health Service to take steps to improve the information management sys-

tems of the Youth Alcohol and Substance Abuse Programs. The Committee Amendment includes a provision regarding reporting requirements of the Indian Health Service on the number of cases or incidents involving IHS personnel which were related directly or indirectly to alcohol and substance abuse. The information that will be developed pursuant to this section is vital to provide the Congress and the Administration with a clear and accurate picture of the problems of alcohol and substance abuse among American Indians and Alaska Natives. The actual scope of the problem of alcohol and substance abuse among American Indians and Alaska Natives and resource needs to address the problem are unknown. The Indian Health Service with the cooperation and active participation of Indian tribes and the Bureau of Indian Affairs must develop reliable statistics on the cases involving alcohol and substance abuse among the Indians and Alaska Natives.

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (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 mother 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 have problems in school with learning, attention, memory and problem solving skills. These difficulties often continue throughout their adult life.

The Committee held a hearing on March 5, 1992 on the problem of Fetal Alcohol Syndrome among American Indians, at which time the Committee received testimony which indicated that the rate of prevalence of FAS in the general population to be 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% of the mothers who gave birth to children with FAS had previously given birth to a child with FAS.

In hearings before the Committee, witnesses testified that many individuals with FAS do not live with their natural parents. One study reports that 64% of children with FAS were no longer with their biological mother by the age of 3. It has been estimated that the annual cost of treating the birth defects caused by FAS was $1.6 billion in 1985. This study indicated that 80% of the costs associated with FAS treatment is for residential care and support services for mentally retarded persons over the age of 21.

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. 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 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. The Indian Health Service must 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 Indian tribes to establish FAS and FAE programs on the reservation. These programs may include components which develop and provide in-school training on FAS and FAE, to identify and to provide alcohol and substance abuse treatment to high risk women, to 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 segment 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 Indian tribes 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 Indian tribes to develop programs that provide meaningful life opportunities for individuals with FAS or FAE.

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. It also authorizes the Secretary to develop and implement culturally sensitive assessment and diagnostic tools on FAS and FAE for Indian communities. It also authorizes the Secretary to make research grants to Indian tribes, tribal organizations, or to universities working with Indian tribes on cooperative projects on the prevention, treatment, and intervention for persons affected by 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. In order to develop appropriate solutions to address the problem of FAS and FAE, it is important to understand its scope. Although persons afflicted by FAS have easily distinguishable physical characteristics and features, in most instances persons who are FAE do not have the same characteristics or features and are therefore more diffi-

cult to identify. More information is necessary for the Indian Health Service, Indian tribes and the Congress to improve prevention efforts in 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 Indian tribes. 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 communities. Although the task force will be comprised of representatives of various entities, the Committee expects that the deliberations of the task force shall 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 authorizes the Secretary to conduct a study of the special educational, vocational, and independent living needs of adolescents and adults afflicted with FAS or FAE. The Committee is concerned that many Indian communities have significant numbers of individuals who have FAS or FAE and are in need of these special services. Given the cost estimates the Committee received during the March 5th hearing, the annual cost of treating the birth defects associated with FAS and FAE exceeds $1.6 billion, it is clear that there are significant needs for individuals with FAS or FAE. It is important to develop these model tribal programs and support services to provide meaningful life opportunities to individuals with FAS and FAE.

The Committee Amendment also requires the Secretary to establish a clearinghouse for prevention and treatment materials and other information regarding fetal alcohol syndrome and fetal alcohol effect. The Committee intends that the Secretary establish and maintain this clearinghouse to provide materials and handouts to Indian tribes, tribal organizations, urban Indian organizations to assist in the prevention and educational efforts on FAS and FAE. In addition, it is the Committee's intention that these materials shall be made available to any Indian tribe, tribal organization, and urban Indian organization as part of a national campaign against fetal alcohol syndrome and fetal alcohol effect. 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 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. 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 building under lease which will expire shortly. The Committee is aware of the substantial fundraising efforts of the Center to finance the construction and relocation of the Center to a new site. In order to continue these 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 used 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.

The Committee has included provisions to reauthorize the programs of the Bureau of Indian Affairs which were established under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986. The Committee is very concerned regarding the failure of the Bureau of Indian Affairs to effectively implement several of the programs established under this Act. Under the Act, there were approximately 166 tribal action plans developed to address problems of alcohol and substance abuse on the reservation. Despite the development of tribal action plans, there were no resources provided to Indian tribes to implement the action plans. Most Indian tribes were unable to effectively implement the tribal action plans and establish the community programs called for under the tribal action plans. After the initial efforts of the Bureau of Indian Affairs to develop tribal action plans there was no follow up by the BIA to assist in their implementation. The Committee Amendments include language to require the BIA to follow-up and evaluate the efforts of Indian tribes to implement the tribal action plans. In addition, the Committee Amendment includes a requirement to update the tribal action plans every two years. Finally, the Committee Amendment authorizes the Secretary of the Interior to make grants to Indian tribes to implement the tribal action plans and to develop tribal programs for youth employment, youth recreation, cultural activities, and community training and education programs. This program will allow Indian tribes to implement their tribal action plans and develop community-based programs to address alcohol and substance abuse prevention and treatment.

The Committee Amendment also authorizes the Secretary of the Interior to appoint employees to work in the Office of Alcohol and Substance Abuse and to provide funding, services, and equipment to carry out its responsibilities under the Act. The Committee is very concerned regarding the inadequate staffing of the Office of Alcohol and Substance Abuse and lack of coherent policies in each of the BIA areas. The Committee directs the BIA to establish full-time alcohol and substance abuse coordinators in each of the BIA area offices to ensure there is effective coordination and follow-up in the implementation of the provisions of this Act. It would allow for greater coordination between the efforts of Indian tribes and the BIA in developing alcohol and substance abuse prevention and treatment programs. Full-time coordinators would be responsible for reviewing area policies and conducting training programs on alcohol and substance abuse. The Committee Amendment would reauthorize the alcohol and substance abuse newsletter through the year 2000 in order to provide greater communication between the various BIA and IHS areas and Indian tribes across the country.

The Committee Amendment reauthorizes the Indian Education Programs under the Indian Alcohol and Substance Abuse Prevention and Treatment Act through the year 2000. The Committee is extremely concerned that the BIA has not fully implemented the

terms of the Act despite receiving annual appropriations to establish these very important programs. Since its enactment in 1986, the BIA has yet to establish any summer youth programs called for under the Indian Alcohol and Substance Abuse Prevention and Treatment Act. The Committee directs the Bureau of Indian Affairs to establish summer youth programs which include community education components on alcohol and substance abuse. Although the Bureau of Indian Affairs has established some alcohol and substance abuse in schools, they have not developed a more comprehensive approach to cover more of the schools serving Indian children. The current efforts of the BIA are focused only on BIA schools as part of the Drug-Free schools programs. These schools only serve 10 to 12 percent of all Indian students. The Committee expects the BIA to direct more of its efforts under this section to serving more of the total population of Indian students. This effort will require the cooperation and active participation of Indian tribes. The Committee Amendment includes a provision for the Secretary to make grants to Indian tribes to establish in-school training and education programs on alcohol and substance abuse prevention and treatment. The Committee intends the provisions of subsection (f) to provide Indian tribes with the resources to establish these in-school programs to make educational materials and programs available to a greater number of Indian students.

The Committee Amendment reauthorizes the funding for planning and design, construction and renovation of emergency shelters and halfway houses through the year 2000. In addition, the amendment provides funds for the staffing and operation of emergency shelters and halfway houses. The Inspector General's report included findings regarding the Bureau of Indian Affairs' inability to construct emergency shelters and halfway houses despite the overwhelming need for these facilities. Since enactment of the Indian Alcohol and Substance Abuse Prevention and Treatment Act, BIA has approved 31 emergency shelters and halfway houses. To date, only 16 emergency shelters and halfway houses have been constructed and only 11 are operational. The Committee is very concerned that the BIA has not yet developed and implemented shelter care program standards. Without national shelter care program standards, the BIA will not be able to monitor and evaluate each programs effectiveness and compliance. The Committee directs the BIA to develop and implement national shelter care program standards. The report also indicated a lack of coordination between the shelter care services provided and long term care programs. The development of emergency shelters and halfway houses on the reservation must be effectively integrated into an overall continuum of care. It is very important to coordinate residential treatment available at emergency shelters and halfway houses with follow-up outpatient services and aftercare. It is also important that emergency shelter programs coordinate referral services with other residential treatment facilities to provide a smooth transition for services. This coordination will require the cooperation of the Indian Health Service and Indian tribes.

The Committee Amendment reauthorizes the special law enforcement initiatives on the Tohono O'odham reservation in Arizona and the St. Regis Mohawk reservation in New York. The Commit-

tee Amendment also includes language which establishes a similar law enforcement initiative on the Makah Indian reservation in Washington. Each of these reservations has evidenced special law enforcement needs to combat extensive drug trafficking on and across their reservations. Each of these reservations serves as a major port of entry for illegal drugs into the United States. This program would provide additional funding to the tribes to support the special funding, staffing, and training needs of the tribal law enforcement programs on the reservation. The Committee Amendment also reauthorizes the Marijuana Eradication and Interdiction programs of the BIA through the year 2000. The Committee intends these funds to be available for contracting pursuant to the Indian Self-Determination Act. The Committee further intends that these funds shall be eligible to be included in self-governance compacts entered into pursuant to the Indian Self-Governance Demonstration Act. The Committee Amendment reauthorizes the training programs for law enforcement and judicial personnel on the investigation and prosecution of drug offenses and on alcohol and substance abuse prevention and treatment.

The Committee is very concerned regarding the failure of the Bureau of Indian Affairs to adequately develop the Indian Police Law Enforcement Management System (IPLEMS). Currently, the IPLEMS does not have the capacity to develop accurate national statistics on alcohol related offenses and incidents. The BIA has failed to develop these statistics from police arrest records, incident reports and the tribal court records of cases involving alcohol and substance abuse. The Committee is similarly concerned with the inability to develop national statistics on cases of child abuse and neglect cases which have been handled by tribal courts. The problems associated with the lack of reliable data has been declared a material weakness by the Office of Management and Budget. The Committee directs the BIA to develop and implement procedures to improve the management of information and develop national statistics on alcohol related offenses and incidents of child abuse and neglect. The failure to develop national statistics on these important issues prevents the Administration and the Congress from accurately determining the scope of these problems in Indian country.

The Committee is very concerned about the significant delays in the construction of juvenile detention facilities by the BIA pursuant to the Indian Alcohol and Substance Abuse Prevention and Treatment Act. Since enactment of the Act, the BIA has not constructed any juvenile detention facilities despite receiving appropriated funds for those purposes. The BIA has routinely reprogrammed funds set aside for construction and renovation of juvenile detention facilities despite the overwhelming needs of Indian tribes for these facilities and programs. The Committee is dismayed by the inaction of the Office of Construction Management and their continuing failure to construct Indian juvenile detention facilities. Several Indian tribes have contacted the Committee regarding the need for resources to renovate aging and poorly constructed facilities. Indian tribes have also indicated concerns regarding the safety of existing facilities for juveniles. Finally, several tribes have indicated that several of the facilities used to house juveniles are in violation of existing federal standards due to a lack of resources.

The Committee intends the funds provided under this section to be used in a comprehensive effort of the BIA to upgrade existing juvenile facilities to bring them within compliance of federal standards and to construct new facilities for those reservations in need of a juvenile detention facility. In addition, the Committee Amendment provides funds for staffing and operational needs of juvenile detention facilities. Currently, most Indian juvenile detention facilities lack any program components so that juveniles housed in the facilities do not have access to educational and counselling programs and health services. In some cases, Indian juveniles who are sentenced for three months in a detention facility do not have access to teachers and therefore are up to three months behind in their schooling. For some Indian youth, a sentence of more than a month results in falling a year behind in school. The Committee directs the Bureau of Indian Affairs to ensure that any Indian youth housed in a juvenile detention facility has access to educational programs, counselling programs and health services. The Committee expects these funds to help develop these essential programs in juvenile detention facilities on Indian reservations.

TITLE VIII—MISCELLANEOUS

The Committee asserts 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 main reason for the inclusion of the health objectives is to provide for a realistic mechanism for monitoring the health status of Native Americans to ensure that resources may be allocated accordingly. 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 milestone, which will mark the progress of the IHS in improving the health status of Native Americans.

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. The Committee received testimony regarding the many complicating factors of treating 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 victim of sexual abuse into a perpetrator of others. The Committee also received testimony regarding the phenomena of multi-genera-

tional sexual abuse within the family. 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 tribes, particularly in the State of California, regarding the leasing of permanent structures for the provision of health care services. Section 807 provides that Indian tribes and tribal organizations may lease permanent structures without obtaining advance approval in appropriations acts. This provision is necessary because of the difficulty experienced by 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 Amendment provides for the continuation of treating the State of Arizona as a contract health delivery area by the service. The Committee also provides for the extension of the Tribal Management Demonstration Project. Under this project, Indian tribes develop and test a phased approach to allow a tribe to assume a health delivery system which utilizes federal, tribal and private resources. A single grant is provided to Indian tribes in the demonstration and the Secretary has the discretion to waive procurement federal 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 Indian tribes a fair opportunity to fully develop and demonstrate their programs. The Committee Amendment also requires that the results of all demonstration projects under this section be disseminated to Indian tribes.

The Committee Amendment provides for a Long Term Care Demonstration Project. 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 Secretary is to establish not more than 24 of these demonstration projects and the establishment of a greater number of projects in one service area is prohibited 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 1999 on these Projects. The

Committee notes that under this provision, Indian tribes and tribal organizations provide the definition for the term "functionally disabled" based upon an assessment by the tribe of "who is determined to require home and community based services."

The Committee received testimony requesting the establishment of long term care facilities which would provide residential and custodial care for tribal elders. The Committee found this testimony compelling and the need to be genuine. However, the Committee inquired of the Indian Health Service the need for long term health care for American Indians, and received the following response:

> Several tribes are requesting that IHS fund the construction and operation of long term care facilities. The IHS does not have explicit statutory or budget authority to fund nursing home care for the elderly. If the IHS were required to provide funding support out of the existing resource base, a determination would have to be made as to what services would be discontinued or reduced. The IHS cannot meet the current demand for acute care, prevention, and/or rehabilitative care. Almost 30% of the need for acute care, and 60–70% of the need for community based mental health, alcohol, environmental health, health education, and public health nursing care is going unmet. Consequently, the IHS must ration health care in accordance with medical priorities.
>
> Long Term Care is a continuum of care ranging from community based services designed to keep the elderly at home to residential and custodial care provided through nursing homes. Examples of community based care include targeted prevention programs, home health care, day care, respite care, caregiver support programs, homemaker services, case management, transportation, and shopping services. Intermediate levels of care include skilled nursing care provided through acute care hospitals or intermediate level nursing homes and supervised housing arrangements which may include access to outpatient care on the premises. In the absence of any definition, we assume that the requests are for support of custodial care provided through a nursing home.
>
> 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 budget resources 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 *Health People 2000* objective to maintain 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. We believe that this is consistent with the Indian elders preference to remain in their home and with the IHS mission to improve the health status of American Indians and Alaska Natives.

Tribes should avail themselves of the technical knowledge and assistance of their state Medicaid office and the 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 bonafide [sic] residents of the states and are entitled to a share of federally funded programs administered by the states. They should also seek advise [sic] and council [sic] 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.

Hence, the Committee will await the results of this demonstration project and take the issue of funding for tribal nursing home facilities under advisement until more information on the need is gathered.

In 1987, the Congress considered, as part of the amendments to P.L. 93-638, the Indian Self-Determination Act, the Self-Governance Project. The Tribal Self-Governance Project was authorized by the Congress under Title III of P.L. 100-472. The Self-Governance Project allows participating Indian tribes 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 Indian tribes are currently authorized to participate in the project.

The Committee Amendment authorizes the Indian tribes 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 the annual funding agreements are allocated out of all of

the funds available to the Indian Health Service and are provided to the Indian tribe 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 directs the Secretary of Health and Human Services to make planning and negotiation grants to the participating tribes. 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 tribal participants in order to enter into compact negotiations with the Indian Health Service. Completion of a planning grant will help ensure that the groundwork necessary for an Indian tribe to negotiate a self-governance compact is in place. The Committee believes that planning grants are essential for Indian tribes 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 Self-Governance Demonstration Project is an experiment and that the Indian Health Service and the Secretary should seek to allow the Project its fullest and broadest implementation. If there is a question as to whether a particular activity, program, service or function is eligible to 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.

Other Considerations

The Committee adopted an amendment offered by Congressman Johnson which would amend the Public Health Service Act to give a priority to applications for assignment of Native Health Service Corps personnel to meet the needs of the Indian Health Service and tribal health programs. This amendment will restore language in the Public Health Service Act to help place Corps personnel with Indian Health Service or tribal health programs. The Committee is very concerned about the severe shortage of IHS physicians and nurses in some areas of the Indian Health Service. These shortages have had a dramatic impact on the delivery of health services to patients living in these service areas. In particular, the Aberdeen area of the Indian Health Service has had a very diffi-

cult time recruiting and retaining physicians. In some cases, vacancies have remained unfilled for several years. In the ten years preceding the 1990 amendments to the Public Health Service Act, which eliminated the priority for assignments to IHS and tribal programs, there was an average of 97 National Health Service Corps scholars annually assigned to Indian Health Service facilities. In the two years after the 1990 amendments, the Indian Health Service has received a total of eight National Health Service Corps scholars. The Committee believes this amendment will help address the shortages of physicians in the Indian Health Service and restore access to National Health Service Corps scholars for the Indian Health Service.

The Committee adopted an amendment offered by Congressman Richardson which precludes the Indian Health Service from seeking reimbursement from an Indian tribe or tribal organization which maintains a self-insurance plan for health services provided to eligible Indians. The Committee is concerned that, in an effort to increase recovery from third parties, the Indian Health Service has begun billing Indian tribes for health care provided to tribal members who are entitled to the services of the IHS without charge. The Committee does not intend this result. The Committee does not intend 25 U.S.C. section 1621e to be interpreted to authorize the Indian Health Service to seek reimbursement from tribally operated self-insurance plans. This would result in shifting the legal obligation to pay for Indian health services for tribal members to the tribes themselves. The Committee Amendment includes language to exempt tribally funded self-insurance plans from the collection efforts of the Indian Health Service. The Committee has heard from several Indian tribes and tribal organizations that maintain self-insurance medical plans for their employees expressing their concerns regarding the IHS policy which requires reimbursement from these self-insurance plans. Under these plans, the Indian tribe sets aside funds and pays covered employee claims for health services that are not provided by the Indian Health Service. The Committee intends that tribally funded self-insurance plans shall be specifically exempt from the collection efforts of the Indian Health Service.

The Committee also adopted an amendment offered by Congressman Williams which would allow the Secretary to make grants to tribally controlled community colleges to establish demonstration programs to develop education curricula for substance abuse counselling. The Committee is very concerned regarding the findings of the Inspector General's report on the Indian Health Service Youth Alcohol and Substance Abuse Programs issued in April 1991. One primary criticism of the Indian Health Service alcohol and substance abuse programs was the overwhelming lack of certified substance abuse counselors. The Committee intends this section to provide a mechanism for many of the uncertified counselors employed by the Indian Health Service, Indian tribes and tribal organizations to receive training from programs operated by tribally controlled community colleges in order to receive their certification. The Committee is hopeful that demonstration projects established under this section will provide substance abuse counselors the opportunity to actively pursue their counseling certification as well

as providing an opportunity for advanced training and education for those counselors who are already certified. The Committee notes the dire need for these counselors on Indian reservations and in Alaska Native Villages and asserts that no educational institution can better provide the culturally specific education required of these counselors than the tribal community colleges. The section is authorized through 1997 and the Committee notes that funds are to remain available until expended.

SECTION-BY-SECTION ANALYSIS

Section 1

Section 1 cites the short title of the Act as the "Indian Health Amendments of 1992."

Section 2

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

Section 3

Section 3 amends the findings section of the Act and Section 3, the Declaration of Policy of the Indian Health Care Improvement Act. Section 3 is amended to provide that it is the intent of the Congress that the health status of American Indians meet minimum national health standards by the year 2000. It further requires the Secretary to report to the President and the Congress on the progress made towards meeting the national health objectives for American Indians. It amends Section 4 of the Act to include definitions of the term "service area" and "substance abuse".

TITLE I—INDIAN HEALTH MANPOWER

Section 101—Purpose

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

Section 102—Health Professions

Subsection (a)

Section 102 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. This section provides grants for education and training in family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, podiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering and other health professions. This section is further amended to emphasize enrollment in a "course of study" rather than enrollment in a school.

Subsection (b)

Subsection (b) of this section amends section 103 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. This subsection prioritizes education and training in family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, podiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering and other health professions.

It also provides that scholarship grants can be used for compensatory preprofessional education and such grant shall not exceed two years on a full-time basis or the part time equivalent thereof as determined by the Secretary. Scholarship grants can be used for the pregraduate education leading to a baccalaureate degree in an approved course of study and cannot exceed 4 years or the part time equivalent thereof as determined by the Secretary. This section is amended to allow scholarship grants to Indians who are enrolled in school on a part time basis.

Subsection (c)

Subsection (a) of Section 104 of the Act is amended to expand the provision of health professionals to include Indians, Indian tribes, tribal organizations, and urban Indian organizations. It further amends this subsection to allow the Secretary to make scholarship grants to Indians who are enrolled full or part time in an accredited school. It also prioritizes individuals pursuing courses of study in family medicine, internal medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, podiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering and other health professions.

Subsection (b) of the Act is amended to allow Indians enrolled part time in an approved course of study to receive a scholarship for a period not to exceed the part time equivalent of 4 years as determined by the Secretary. It further provides that the service obligation of a scholarship recipient shall be either the part time equivalent of one year for each year the individual received a scholarship or two years and the amount of the individual's monthly stipend shall be subject to pro rata reduction based on enrolled credit hours.

It further amends subsection (d) 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 (d)

This subsection provides that the scholarships provision of section 104 of the Indian Health Care Improvement Act shall be effective upon enactment of this Act.

Subsection (e)

Section 105 of the Act is amended to provide that individuals enrolled in a course of study in family medicine, internal medicine,

pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, podiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering and other health professions are eligible for employment by the IHS during any nonacademic period of the year.

Section 103—Breach of Contract

Section 104 of the Act is amended to provide that an individual who has entered into a written contract with the Secretary and fails to maintain an acceptable level of academic standing, is dismissed for disciplinary reasons, voluntarily terminates the training before completion, or fails to accept the scholarship in whole or in part, shall be liable to the U.S. for the amount paid under the contract. If an individual breaches the contract by failure to begin or to complete his service obligation under this section, then such individual shall be liable to the U.S. for an amount as determined in accordance with the formula under subsection (l) of section 108 of the Act.

Section 104—Nursing

Subsection (a) amends section 106 of the Act to allow nurses employed in the IHS to receive continuing education allowances.

Subsection (b) amends section 112 of the Act to authorize the Secretary to provide grants to establish and develop clinics operated by nurses, nurse midwives, nurse anesthetists or nurse practitioners to provide primary health care to Indians. It authorizes not less than $1,000,000 to be used to provide training for nurse midwives, nurse anesthetists and nurse practitioners beginning in FY 1992 and each year thereafter.

Subsection (c) amends section 117 of the Act to provide that not less than 25% of the retention bonuses awarded each year shall be awarded to nurses. It also provides that nurses employed by Indian tribes or tribal organizations under P.L. 93-638 contracts shall be eligible for retention bonuses.

Subsection (d) amends Title I of the Act by adding section 118 to the Act. Section 118 establishes the Nurse Residency Program to enable nurses working in an Indian Health Program to pursue advanced training. This program can include education and work study components. A participant in this program shall incur a service obligation equal to at least three times the period of time during which they participated in the program. If a participant fails to complete such obligation, the U.S. shall be entitled to recover an amount determined pursuant to Section 108 of the Act.

Section 105—Community health representative

Section 105 amends section 107(b) of the Act to provide for the continuing maintenance of the community health representative system. 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 (a) amends section 108 of the Act to establish a program priority for health professionals in family medicine, internal

medicine, pediatrics, obstetrics and gynecology, nursing, dentistry, mental health, podiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, environmental health and engineering and other health professions. This section is further amended to allow individuals enrolled part time to participate in the program so long as they are scheduled to complete the course of study the same year.

Subsection (d) amends section 108(e) of the Act to require the Secretary to provide written notice to the applicant where an extension of obligated service exceeds four years.

Subsection (e) clarifies section 108(g) of the Act to ensure that undergraduate loans are included in the loan repayment program.

Subsection (f) amends section 108(g) 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 needs and to continue serving in the Indian health program after completion of the obligation.

Subsection (g) amends section 109(g) of the Act to provide that the Secretary may reimburse a participant for tax liability in an amount up 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.

Subsection (h) amends section 108 of the Act to require the Secretary to make 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 scholarship grants under section 104, and the number of health care providers needed by location and profession for the following three fiscal years.

Section 107—Recruitment activities

This section amends section 109 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

This section amends section 111 of the Act to provide that an individual participating in an advanced research and training program after 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—INMED program

This section amends section 114 of the Act to authorize the Secretary to provide a grant to establish an 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 110—Scholarship and Loan Repayment Recovery Fund

This section 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. It 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 Scholarship and Loan Repayment Recovery Fund. Funds in the Scholarship and Loan Repayment Recovery Fund shall be available to make scholarship awards pursuant to section 104 and loan repayment awards under section 108 of the Act.

Section 111—Community Health Aid Program

This section amends Title I of the Act to create a new section 120 which establishes a Community Health Aid program in Alaska. This program will provide training to Alaska Natives as health aides, assist in the provision of health care and health promotion in rural Alaskan villages and create the capacity for teleconferencing in local health clinics. In developing training for Community Health Aides the Secretary shall establish a certification board for community health aides and a system to identify continuing education needs and to assure quality health care is provided.

Section 112—Tribal health program administration

This section 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 113—Health professional priorities in related program

This section amends section 333(a) of the Public Health Service Act to give a priority to applications for assignment of National Health Service Corps personnel to meet the needs of the Indian Health Service and tribal health programs operated under the Indian Self-Determination Act.

Section 114—Authorization of appropriations

This section amends Title I of the Act by creating a new section 122 which authorizes appropriations through fiscal year 2000.

TITLE II—HEALTH SERVICES

Section 201—Health status and resource deficiency status

This section amends section 201 of the Act to provide that the Secretary is authorized to expend funds to eliminate deficiencies in health status and resources of all tribes. This section amends the definitions to include health status and resource deficiency which means the extent to which national health objectives are not being achieved and a tribe lacks the health resources it needs.

Subsection (b) provides that the current definitions of health status and resource deficiency shall remain in effect for three years for the date of enactment at which time the amendments under this section shall become effective.

It amends subsection (e) of the Act to require the Secretary to report to the Congress on the current health status and resource

deficiency within 3 years of the date of the enactment of these Amendments. The report shall include the extent of health status and resource deficiencies for each tribe as well as the amount of funds necessary to eliminate the health status and resource deficiencies of all tribes.

Section 202—Health promotion and disease prevention

Section 203 of the Act is amended to state that the provision of health promotion and disease prevention services through the IHS shall be designed to achieve the national health objectives under this Act.

Section 203—Diabetes prevention, treatment and control

Section 204 of the Act is amended to require the Secretary to continue to maintain through the year 2000 each model diabetes project currently in existence. The Secretary is authorized to establish new model diabetes projects and to evaluate the effectiveness of the services provided by the model diabetes projects.

Section 204—Mental health prevention and treatment services

Section 204 amends section 209 of the Act to include a new subsection which provides that any person employed as a psychologist must be licensed as a clinical psychologist or working under the direct supervision of a licensed clinical 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 licensed social worker. It 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 (m) provides that the Secretary is authorized to make grants to Indian tribes and tribal organizations to provide intermediate mental health services to Indian children and adolescents. These services may include inpatient and outpatient services, emergency care, suicide prevention and crisis intervention. 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 services are being provided. This subsection also requires grant recipients to coordinate intermediate mental health services with existing services on the reservation. There are authorized to be appropriated $10,000,000 for each of the fiscal years 1993–2000 to carry out the provisions of this section.

Section 205—New studies

This section amends section 205 of the Act to authorize the Secretary to conduct a study to determine the feasibility of providing hospice care to terminally ill Indians and to determine the most efficient means of providing such care. The Secretary shall report to the Congress within 12 months from the date of enactment the findings of such study.

Subsection (b) of this section amends Title II of the Act by creating a new subsection 210 which authorizes the Secretary to conduct a study to determine the feasibility of allowing an Indian tribe to contract for managed care coverage where the tribe does not have an impatient facility and is not in close proximity to an IHS hospital. The Secretary shall report the findings of such study to the Congress within 12 months from the date of enactment of this Act.

Subsection (c) of this section amends Title II of the Act by adding a new section 211 which authorizes the Secretary to establish a demonstration program to evaluate the use of a contract care intermediary to improve the access to health care for the California Indians. It provides that the Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs in providing contract health care to California Indians. It limits the reimbursement of the Board's administrative expenses to 5 percent of the annual budget for the program.

It provides for the establishment of an advisory board to the California Rural Indian Health Board in carrying out this demonstration project. The Board shall be composed of representatives of not less than 8 tribal health programs to be served by the demonstration project, at least half of whom are not affiliated with the California Rural Indian Health Board. The demonstration program shall begin on January 1, 1993 and end on September 30, 1997. The California Rural Indian Health Board shall submit a report no later than July 1, 1998 on the demonstration program which shall include a statement of findings.

Section 206—Coverage of screening mammography

This section amends Title II of the Act by establishing a new section 212 which authorizes the Secretary to provide screening mammography for Indian and urban Indian women 35 years or older consistent with safety and accuracy standards established by the Secretary under Title XVIII of the Social Security Act.

Section 207—Patient travel costs

This section amends Title II of the Act by adding a new section 213 which authorizes the Secretary to provide funds to meet the costs of patient travel to receive medical services, which shall include direct health care services and contract health care services. $15,000,000 are authorized to be appropriated for fiscal year 1993 and such sums as are necessary for each fiscal year thereafter through FY 2000.

Section 208—Third party reimbursement

Section 206 of the Act is amended by this section to allow Indian tribes and tribal organizations the same rights as the Secretary to recover reasonable expenses incurred for the provision of health services to any individual through third party reimbursement.

Section 209—Epidemiology centers

This section amends Title II of the Act by adding a new section 214 which authorizes the Secretary to establish an epidemiology center in each area office of the IHS. Each epidemiology center established under this Act shall establish a methodology to define

baseline data for the health objectives specified in section 3 of the Act, assist Indian tribes in the identification of priority health care service needs, and make recommendations for the targeting of health care service needs within the service area and within each Indian tribe in the area.

Subsection (c) provides that the Secretary shall ensure that each epidemiology center will work cooperatively with Indian tribes, and tribal health and social services programs to avoid duplication of services. It also provides that the centers will provide technical assistance to Indian tribes and urban Indian organizations in the service area to develop local priorities, local incidence and prevalence rates of disease and other illness.

Subsection (e) sets out the reporting requirements under this section.

Section 210—Comprehensive school health education programs

This section amends Title II of the Act by adding a new section 215 that provides that the Secretary is authorized to award grants to Indian tribes to develop comprehensive school health education programs in cooperation with the Secretary 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 the reservation.

Subsection (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; and to develop programs on nutrition, personal health, mental health wellness, substance abuse prevention, accident prevention and safety education.

Subsection (e) provides that grant recipients shall prepare annual reports to the Secretary which shall include the number of schools served, the number of students served, the numbers of teachers trained and the involvement of parents, community members and health workers in the schools program.

Subsection (f) requires the Secretary of the Interior to develop a comprehensive school education program in schools operated by the Bureau of Indian Affairs. The programs established by the Secretary under this section shall include programs from preschool through grade 12 on nutrition, personal health, mental health wellness, chronic disease prevention, substance abuse prevention, accident prevention and safety education.

Subsection (g) provides that $15,000,000 are authorized to be appropriated for fiscal year 1993 and such sums as may be necessary for each fiscal year thereafter through 2000.

Section 211—Indian youth grant program

This section amends Title II of the Act by adding a new section 216 which authorizes the Secretary to make grants to Indian tribes, tribal organizations and urban Indian organizations for innovative mental and physical disease prevention and treatment and health promotion programs for Indian pre-adolescent and adolescent youths.

Subsection (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 to provide community training and education.

Subsection (c) authorizes the Secretary to disseminate information regarding model programs and technical assistance to Indian tribes.

Subsection (e) provides that $5,000,000 are authorized to be appropriated for fiscal year 1993 and such sums as may be necessary thereafter through fiscal year 2000.

Section 212—Third party reimbursement

The section amends section 206 of the Act to provide that the United States Government shall not have a right to recover against a tribally funded self-insurance plan for health services provided to an eligible individual.

Section 213—Authorization of appropriations

This section amends Title II of the Act to create a new section 217 which authorizes such sums as may be necessary to be appropriated through fiscal year 2000 to carry out the provisions of this title with the exception of section 211. Subsection (b) of this section sets out the conforming amendments for this title.

TITLE III—HEALTH FACILITIES

Section 301—Health facilities closure and priorities

This section amends section 301 of the Act to require the Secretary to report on the potential impacts of a proposed closure of an IHS facility. This report shall include the level of utilization of such facility and the distance between the facility and the nearest IHS hospital.

Subsection (c) is amended by this section to require the Secretary to include the program information documents for the construction of the demonstration health facilities authorized under this section, in the report to the Congress authorized under section 801.

Section 302—Safe water and sanitary waste disposal facilities

Section 302 of the Act is amended to authorize the Secretary to provide 80 percent of the costs of operating, managing, and maintaining safe water and sanitary waste disposal facilities. It further provides that Indian tribes with fewer than 1,000 members can meet the 20 percent non-federal match through in-kind property. This section also requires the Secretary to include information on Indian sanitation deficiencies and facility needs in the report to the Congress authorized under section 801 of the Act.

Section 303—Ambulatory care facilities

This Section amends section 306 of the Act to require the Secretary to make grants to Indian tribes and tribal organizations to construct or renovate facilities to provide ambulatory care services. Only Indian tribes or tribal organizations operating an Indian health facility pursuant to the Indian Self-Determination Act are eligible for grant awards.

Subsection (b) provides that an ambulatory care facility must be located apart from a hospital and cannot be funded under sections

301 and 307 of this Act. Upon completion, ambulatory care facilities funded under this Act, shall have a total capacity appropriate to its projected service population, serve no less than 500 Indians annually and have a service population of not less than 2,000 Indians.

Subsection (b) also exempts Indian tribes located on an island and more than 75 miles from the nearest Indian tribe from the service population requirements under this subsection.

Subsection (c) provides that the Secretary require that a grant recipient demonstrate adequate financial support and can provide services without regard to the patients ability to pay. It also provides that the Secretary shall give priority to an Indian tribe or tribal organizations that demonstrate a need for increased ambulatory care services and insufficient capacity to deliver such services.

Subsection (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 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

This section amends section 307 of the Act to require Indian tribes to have completed an application for a demonstration project grant on or before September 30, 1995. It provides that, beginning on October 1, 1994, the Secretary may award grants to applicants from all service areas. The Secretary shall give priority to service units identified in subparagraph (A) who have met the criteria specified under the Act. It further provides that the Secretary shall ensure that there is an equal number of contracts or grants awarded in all IHS service areas during the application period in order to provide geographic distribution of projects.

Subsection (b) amends section 307 to require the Secretary to include in the report to Congress for fiscal year 1997 under section 801 an interim report on the findings and conclusions from the demonstration projects established under this action. The Secretary shall submit a final report of findings and conclusions to Congress for fiscal year 1999.

Section 305—Authorization of appropriations

This section amends Title III of the Act to create a new section 308 which authorizes such sums as may be necessary to be appropriated through fiscal year 2000 to carry out the provisions of this title. Subsection (b) sets out the conforming amendments of this Title.

TITLE IV—ACCESS TO HEALTH SERVICES

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

Subsection (a) amends section 401 of the Act by providing that any payments received by a hospital or skilled nursing facility whether operated by the IHS, an Indian tribe or tribal organization for services provided to Indians eligible for Medicare shall not be considered in determining appropriations for health care services to Indians. It further provides that this section shall not create a

preference for Medicare eligible Indians for health care services. Section 401 of the Act is amended by eliminating the provision that would terminate the use of Medicare payments for improvements when the Secretary determined and certified that all hospitals and facilities are in compliance with applicable conditions and requirements under the Act.

Subsection (b) amends section 402 of the Act to provide that payments received by an IHS facility under the Medicaid program shall be placed in a fund to make improvements necessary to achieve compliance with the requirements of Title XIX of the Social Security Act. The Secretary shall ensure each service unit receives at least 80 percent of the amounts to which the facilities are entitled under section 1911 of the Social Security Act.

Finally, this section provides that any payments received for services provided to Indians eligible for Medicaid shall not be considered in determining appropriations for health care services to Indians.

Section 402—Report

This section amends section 403 to require the Secretary to include an accounting on the amount and use of the reimbursement funds under Medicaid in his report to the Congress under section 801.

Section 403—Grants to and contracts with tribal organizations

This section revises section 404 of the Act to provide for the development and implementation of a schedule of income levels and methods to improve Indian participation in the program.

Section 404—Authorization of appropriations

This section amends Title IV of the Act to create a new section 406 which authorizes such sums as may be necessary to be appropriated through fiscal year 2000 to carry out the provisions of the Title and to make conforming amendments to the Title.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Section 501—Grant authority

This section amends sections 502, 503, 504, 505, 506, 507 and 509 of the Act to authorize the Secretary to make grants to Urban Indian organizations for purposes of this title.

Section 502—Authorization of appropriations

This section amends Title V of the Act to create a new section 511 which authorizes such sums as may be necessary to be appropriated through fiscal year 2000 to carry out this Title. Subsection (b) of this section sets out the conforming amendments for this title.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Section 601—Indian health service

This section 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.

Section 602—Authorization of appropriations

This section amends Title VI of the Act to create a new section 603 which authorizes such sums as may be necessary to be appropriated through fiscal year 2000 to carry out this Title.

TITLE VII—SUBSTANCE ABUSE PROGRAMS

Section 701—Redesignation of existing Title VII

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

Section 702—Substance abuse programs

This section amends the Act by creating a new Title VII which is titled "Substance Abuse Programs."

IHS RESPONSIBILITIES

Section 701 of this Title provides that the IHS assume responsibility for a determination of the scope of the problem of alcohol and substance abuse among Indian people, an assessment of the resources necessary for the prevention and treatment of alcohol and substance abuse, and an estimate of the funding necessary to support a program of prevention and treatment of alcohol and substance abuse.

IHS PROGRAM

Section 702 of this Title provides that the IHS shall provide a program of comprehensive alcohol and substance abuse prevention and treatment. The program shall include prevention education, acute detoxification and treatment, community-based rehabilitation, community education and involvement, residential treatment programs for pregnant and post-partum women and their children.

Subsection (b) of this section authorizes the IHS to enter into contracts with public or private providers of alcohol and substance abuse treatment services. It provides that the Secretary shall assist Indian tribes to develop certification of alcohol and substance abuse service providers and facilities.

INDIAN WOMEN'S TREATMENT PROGRAMS

Section 703 of this Title authorizes the Secretary to make grants to Indian tribes and tribal organizations to develop and implement a comprehensive program of prevention, intervention, treatment, and relapse prevention services to specifically address the cultural, historic, social and child care needs of Indian women, regardless of age. Grants under this section may be used for community educa-

tion and training on alcohol and substance abuse issues including FAS/FAE, to provide appropriate counseling advocacy and support to Indian women and their families, and to develop prevention and intervention models that incorporate traditional healers and cultural values and family involvement. There are $10,000,000 authorized to be appropriated for each of the fiscal years 1993—2000 for the purpose of this section. Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations.

IHS YOUTH PROGRAM

Section 704 of this Title authorizes the Secretary to develop and implement a program for acute detoxification and treatment for Indian youths. This program shall include the establishment of youth regional treatment centers in each area of the IHS. The Secretary is authorized to make funds available for establishing a youth treatment facility in Fairbanks, Alaska. It also provides that a youth treatment center shall be constructed in each area at a location agreed upon by resolution by a majority of the Indian tribes to be served by such center.

Subsection (c) of this section authorizes the IHS in consultation with Indian tribes to identify and use where appropriate federal facilities for youth regional treatment centers.

Subsection (d) of this section authorizes the Secretary, in cooperation with the Department of Interior, to establish a community based rehabilitation and follow-up program for Indian youth in each service unit.

Subsection (e) requires the Secretary to include family members in the treatment of Indian youth for alcohol and substance abuse. It provides that not less than 10 percent of the funds appropriated for this section shall be used for this purpose.

Subsection (f) authorizes the Secretary to conduct a study to determine the incidence and prevalence of multiple substance abuse among Indian youth and its interrelationship with mental illness. The Secretary is required to report his findings to the Congress in 2 years.

TRAINING AND COMMUNITY EDUCATION

Section 705 of this Title authorizes the Secretary, in cooperation with the Department of Interior, to develop a community education program within each service unit to provide timely information to tribal leaders, tribal judges, and other community members. The Secretary is authorized to provide training on crisis intervention, family relations, fetal alcohol syndrome, to employees of the BIA and the IHS, school personnel and others.

Subsection (c) provides that the Secretary shall develop and provide community-based training models in consultation with Indian tribes and Indian alcohol and substance abuse prevention experts. These models should address the elevated risk of alcohol and substance abuse of children of alcoholics, community-based and multidisciplinary strategies for prevention and treatment, and cultural and multi-generational aspects of alcohol and substance abuse prevention and recovery.

GALLUP ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER

Section 706 of this Title authorizes the Secretary to make grants to the Navajo Nation to provide residential treatment for alcohol and substance abuse for Navajos and neighboring tribes. Grants shall be used to provide 15 residential beds for adult long term treatment, to establish clinical assessment teams to determine appropriate treatment for patients, to provide 12 beds for an adolescent shelter bed program in Gallup, to develop a relapse program which provides vocational training and job retention services, and to provide continuing education and training to treatment staff.

Subsection (c) of this section authorizes the Navajo Nation to enter into a contract with an accredited institution in Gallup, New Mexico, to provide comprehensive alcohol and drug treatment.

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

REPORTS

Section 707 of this Title authorizes the Secretary to require any service unit health program to compile data on the number of cases handled, the type of services provided and any incidents which were related directly or indirectly to alcohol or substance abuse.

Subsection (b) of this section provides that the data collected under subsection (a) shall be provided annually to the affected Indian tribe.

Subsection (c) of this section requires each service unit director to prepare an annual comprehensive report for each affected Indian tribe. The Director of IHS shall prepare and publish a biennial national report based on the comprehensive reports.

URBAN INDIAN PROGRAM

Section 708 of this Title authorizes the Secretary to make grants to urban Indian organizations to provide prevention and treatment services for alcohol and substance abuse.

Subsection (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 and satisfactory performance standards to meet the goals of the grant.

Subsection (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).

FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT GRANTS

Section 709 of this Title authorizes the Secretary to make grants to Indian tribes and tribal organizations to establish Fetal Alcohol Syndrome and Fetal Alcohol Effect programs. Funds provided under this section may be used to provide community and in-school training and 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. There are authorized to be appropriated $10,000,000 for each of the fiscal years 1993–1995 and $15,000,000 for each of the fiscal years 1996–2000. Ten percent of the funds shall be used to make grants to urban Indian organizations for purposes of this section.

FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT EDUCATION

Section 710 of this Title authorizes the Secretary to provide assistance to Indian tribes and tribal organizations in the development and printing of education and prevention materials on FAS/FAE. A task force of representatives of the Institutes of NIDA, NIAAA, OSAP, NIMH, IHS, Office of Minority Health, BIA, and representatives of Indian tribes, tribal organizations, urban Indian communities, and FAS/FAE experts to examine the needs of Indian tribes and Indian communities. There are authorized to be appropriated $5,000,000 to carry out the provisions of this subsection for each of the fiscal years 1993–2000.

The Secretary is also authorized to 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. There are authorized to be appropriated $3,000,000 to carry out the provisions of this subsection for each of the fiscal years 1993–2000.

REPORT

Section 711 sets out the reporting requirements under the Act regarding the status of Fetal Alcohol Syndrome and Fetal Alcohol Effect in the Indian population, including the incidence rates of Indian FAS/FAE babies born in reservation and urban communities and the prevalence of FAS/FAE affected Indian persons in Indian communities. There is authorized to be appropriated $1,000,000 for each of the fiscal years 1993–2000 to carry out the provisions of this subsection.

ADOLESCENT AND ADULT FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT

Section 712 authorize the Secretary to conduct a study of the special educational, vocational and independent living needs of adolescent and adult Indians and Alaska Natives with FAS or FAE. There are authorized to be appropriated $2,000,000 for fiscal year 1993 and such sums as may be necessary thereafter through fiscal year 2000.

CLEARINGHOUSE

Section 713 authorizes the Secretary to establish a national clearinghouse for prevention and educational materials on FAS and FAE in American Indian and Alaska Native Communities. It provides that the Secretary shall ensure access to clearinghouse materials for any Indian tribe, Alaska native organization, and urban Indian organization to assist in the development of culturally sensitive educational and training materials. There are authorized to be appropriated $1,000,000 for fiscal year 1993 and such sums as may be necessary thereafter through fiscal year 2000.

PUEBLO SUBSTANCE ABUSE TREATMENT PROJECT FOR SAN JUAN

Section 714 continues the authorization for the substance abuse treatment project at San Juan Pueblo through fiscal year 1995.

THUNDER CHILD TREATMENT CENTER

Section 715 authorizes the Secretary to make a grant to the Intertribal Addictions Recovery Organization, Inc. at Sheridan, Wyoming for the completion of the construction of the Thunder Child substance abuse treatment center for American Indians. There are authorized to be appropriated $2,000,000 for fiscal years 1993 and 1994.

AUTHORIZATION OF APPROPRIATIONS

Section 716 authorizes to be appropriated such sums as may be necessary to carry out the provisions of this title, excluding sections 705(d), 709, 710, 711, 712, 713, and 715. Subsection (b) of this section set out the conforming amendments for this title.

Section 703—Indian alcohol and substance abuse prevention and treatment act amendments

This section amends the provisions the Indian Alcohol and Substance Abuse Prevention and Treatment Act (25 U.S.C. 2401 et seq.) and reauthorizes certain programs administered by the BIA under the Act.

Subsection (f) of this section provides that the Secretary of the Interior may make grants to Indian tribes to implement and develop community and in-school training, education, and prevention programs on alcohol and substance abuse, fetal alcohol syndrome and fetal alcohol effect. Funds provided under this section may be used for youth employment projects, youth recreation programs, cultural activities, and community awareness programs. There are authorized to be appropriated $5,000,000 for each of the fiscal years 1993-2000.

TITLE VIII—MISCELLANEOUS

Section 801—Reports

This section is amended to provide that the President shall transmit to the Congress a report on the progress made in meeting the objectives of this Act, a statement specifying the amount of funds requested under section 201, a statement of the total amount obligated to achieve objectives related to infant mortality and fetal alcohol syndrome and such other reports as are required under this Act.

Section 802—Regulations

This section is amended to provide that the Secretary shall consult with national and regional Indian organizations prior to any revision of or amendment to regulations promulgated pursuant to this Act and provide opportunity for adequate notice to comments from other interested parties.

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

This section extends the treatment of Arizona as a contract health service delivery area through fiscal year 2000.

Section 804—Infant and material mortality; fetal alcohol syndrome

This section amends section 814 of the Act by striking subsection (b).

Section 805—Reallocation of base resources

This section amends section 817 of the Act to require that the Secretary shall submit a report on a proposed funding cut of greater than 5 percent from the previous year for any program to be included in the President's report to the Congress under Section 801, prior to said cut becoming effective.

Section—Child sexual abuse treatment programs

This section amends section 819 of the Act to continue the authorization for the demonstration child sexual abuse treatment programs on the Hopi and Fort Peck Indian reservations through fiscal year 1995. This section authorizes the Secretary of the Interior to establish a child sexual abuse demonstration program in any service area beginning in October 1, 1995. It provides that the Secretaries shall ensure that there is an equal number of programs in all IHS service areas in order to provide for a geographic distribution of projects.

Section 807—Tribal leasing

Section 820 of the Act is amended to provide that an Indian tribe providing health care services under an Indian Self-Determination Act contract may lease permanent structures without obtaining advance approval appropriations Acts.

Section 808—Tribal management demonstration project

Section 818 of the Act is amended to provide for the extension of the termination date for tribal management projects for which a grant is made after September 30, 1990 for three years from the award date.

Section 809—Long-term care demonstration project

This section amends Title VIII of the Act by creating a new section 821, which provides that the Secretary shall enter into make contracts or make grants to Indian tribes to establish demonstration projects for the delivery of home and community-based services to functionally disabled Indians.

Subsection (b) provides that funds provided under this section may not be used to make case payments to disabled Indians, to provide room and board for the construction of facilities, for the purchase of equipment or for the provision of nursing facility services.

Subsection (c) provides that within 180 days from the date of enactment the Secretary shall develop criteria for the approval of grant applications. Such criteria shall promote the delivery of high quality culturally appropriate home and community-based services.

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

Subsection (d) provides that an Indian tribe or tribal organization may provide long term care services to persons otherwise ineligible for health care services from IHS.

Subsection (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 service areas to provide an adequate geographic distribution.

Subsection (g) provides that the Secretary shall include findings and conclusions derived from the demonstration projects in the FY 1999 report required under section 801.

Subsection (h) sets out the definitions used in this section.

Subsection (i) authorizes to be appropriated such sums as are necessary to carry out this section for each of the fiscal years 1993–1997.

Section 810—Results of demonstration projects

This section amends Title VIII of the Act 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—Substance abuse counselor education demonstration project

This section amends Title VIII of the Act by adding a new section 823 which provides that the Secretary is authorized to make grants to tribally controlled community colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.

Subsection (b) provides that funds provided under this section may only be used for developing and providing an educational curricula for substance abuse counseling.

Subsection (c) provides that the Secretary shall consult with Indian tribes and tribally controlled community college administrators in the development of criteria for the review and approval of grant applications. The criteria established shall promote the development of the capacity of tribally controlled community colleges to educate substance abuse counselors.

Subsection (d) provides that the Secretary shall provide technical assistance to enable grant recipients to comply with this section.

Subsection (e) requires the Secretary to report to the President the findings and conclusions derived from the demonstration projects established under this section which shall be included in the report required under section 801 of this Act.

Subsection (f) defines the term "educational curricula" for purposes of this section.

Subsection (g) authorizes such sums as are necessary to be appropriated for each fiscal year 1993 through 1997, to carry out the purposes of this section. It provides that sums appropriated shall remain available until expended.

Section 812—Authorization of appropriations

This section amends section 820 of the Act to authorize such sums as may be necessary to be appropriated to carry out the provisions of this title through fiscal year 2000. Subsection (b) of this section sets out the conforming amendments for this title.

Section 813—Tribal self-governance project

This section 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 negotiation 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.

TITLE IX—TECHNICAL CORRECTIONS

Section 901—Repeal of expired reporting requirements

This section amends the Act to repeal all of the expired reporting requirements.

Section 902—Other technical corrections

This section makes additional technical corrections to the Act.

Legislative History and Committee Recommendations

On November 6, 1991, Chairman Miller introduced H.R. 3724, which was cosponsored by Representatives Waxman, Richardson, Sikorski, Faleomavaega, and Kostmeyer. The Committee on Interior and Insular Affairs held two hearings on H.R. 3724 on November 12, 1991 and on March 24, 1992.

On April 29, 1992, the Committee considered H.R. 3724 and approved the bill with amendments by a voice vote. It was ordered reported and the Committee recommends its enactment by the House.

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):