

## THE INDIAN HEALTH CARE AMENDMENTS OF 1987

JULY 15, 1987.—Ordered to be printed

Mr. UDALL, from the Committee on Interior and Insular Affairs,  
submitted the following

### REPORT

together with

### ADDITIONAL VIEWS

[To accompany H.R. 2290, which on May 5, 1987, was referred jointly to the  
Committees on Energy and Commerce and Interior and Insular Affairs]

[Including cost estimate of the Congressional Budget Office]

The Committee on Interior and Insular Affairs, to whom was referred the bill (H.R. 2290) entitled, the "Indian Health Care Amendments of 1987", having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

Strike out all after the enacting clause and insert the following:

#### SHORT TITLE

SEC. 1. This Act may be cited as the "Indian Health Care Amendments of 1987".

#### TABLE OF CONTENTS

- Sec. 1. Short title and Table of Contents.
- Sec. 2. References.
- Sec. 3. Appropriations; Availability.

#### TITLE I—INDIAN HEALTH MANPOWER

- Sec. 101. Health professions recruitment program for Indians.
- Sec. 102. Health professions preparatory scholarship program.
- Sec. 103. Indian Health Service extern programs.
- Sec. 104. Indian health professions scholarship program.
- Sec. 105. Continuing education allowances.
- Sec. 106. Native Hawaiian health professions scholarship program.
- Sec. 107. Community health representatives.

#### TITLE II—HEALTH SERVICES

- Sec. 201. Improvement of Indian health status.
- Sec. 202. Catastrophic health program.
- Sec. 203. Health promotion and disease prevention.

- Sec. 204. Reimbursement of certain expenses.  
 Sec. 205. Crediting of reimbursements.

#### TITLE III—HEALTH FACILITIES

- Sec. 301. Consultation; closure of facilities; reports.  
 Sec. 302. Safe water and sanitary waste disposal facilities.  
 Sec. 303. Use of non-Service funds for renovation.  
 Sec. 304. Bethel, Alaska, hospital.

#### TITLE IV—ACCESS TO HEALTH SERVICES

- Sec. 401. Grants and contracts with tribal organizations.

#### TITLE V—URBAN INDIAN HEALTH SERVICES

- Sec. 501. Revision of program.  
 Sec. 502. Urban Indian organization.

#### TITLE VI—ORGANIZATIONAL IMPROVEMENTS

- Sec. 601. Establishment of the Indian Health Service as an agency of the Public Health Service.

#### TITLE VII—MISCELLANEOUS PROVISIONS

- Sec. 701. Leasing and other contracts.  
 Sec. 702. Arizona as a contract health service delivery area.  
 Sec. 703. Eligibility of California Indians.  
 Sec. 704. California as a contract health service delivery area.  
 Sec. 705. Contract health facilities.  
 Sec. 706. National Health Service Corps.  
 Sec. 707. Health services for ineligible persons.  
 Sec. 708. Infant and maternal mortality; fetal alcohol syndrome.  
 Sec. 709. Contract health services for the Trenton Service Area.  
 Sec. 710. Indian Health Service and Veterans' Administration health facilities and services sharing.  
 Sec. 711. Reallocation of base resources.  
 Sec. 712. Provision of services in Montana.  
 Sec. 713. Tohono O'odham demonstration project.

#### TITLE VIII—DIABETES PREVENTION AND CONTROL

- Sec. 801. Diabetes Program.

#### TITLE IX—SEVERABILITY PROVISION

- Sec. 901. Severability.

#### REFERENCES

SEC. 2. Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Indian Health Care Improvement Act (25 U.S.C. 1601, et seq.).

SEC. 3. Any new spending authority described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974 which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

#### TITLE I—INDIAN HEALTH MANPOWER

##### HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 101. Subsection (c) of section 102 (25 U.S.C. 1612(c)) is amended to read as follows:

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

- "(1) \$550,000 for fiscal year 1988,
- "(2) \$600,000 for fiscal year 1989,
- "(3) \$650,000 for fiscal year 1990, and
- "(4) \$700,000 for fiscal year 1991."

##### HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM

SEC. 102. (a) Section 103 (25 U.S.C. 1613) is amended by striking out subsection (d) and inserting in lieu thereof the following:

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

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

- "(1) \$3,000,000 for fiscal year 1988,

- "(2) \$3,700,000 for fiscal year 1989,
- "(3) \$4,400,000 for fiscal year 1990, and
- "(4) \$5,100,000 for fiscal year 1991."

(b) Subsection (c) of section 103 is amended by striking out "expenses" and inserting in lieu thereof "expenses of a grantee while attending school full time."

#### INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 103. Subsection (b) of section 105 (25 U.S.C. 1614) is amended to read as follows:

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

- "(1) \$300,000 for fiscal year 1988,
- "(2) \$350,000 for fiscal year 1989,
- "(3) \$400,000 for fiscal year 1990, and
- "(4) \$450,000 for fiscal year 1991."

#### INDIAN HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

SEC. 104. (a) Section 104 is amended to read as follows:

##### "INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

"SEC. 104. (a) In order to provide health professionals to Indian communities, the Secretary, acting through the Service and in accordance with this section, shall make scholarship grants to Indians who are enrolled full time in schools of medicine, osteopathy, podiatry, psychology, dentistry, veterinary medicine, nursing, optometry, public health, and allied health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254(1)), except as provided in subsection (b) of this section.

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

"(2) An individual shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled full time in a health profession school referred to in subsection (a).

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

"(A) in the Indian Health Service;

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

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

"(D) in the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

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

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

- "(1) \$5,100,000 for fiscal year 1988,
- "(2) \$6,000,000 for fiscal year 1989,
- "(3) \$7,100,000 for fiscal year 1990, and
- "(4) \$8,234,000 for fiscal year 1991."

"(b) Section 338G of the Public Health Service Act (42 U.S.C. 254r) is repealed.

#### CONTINUING EDUCATION ALLOWANCES

SEC. 105. Subsection (b) of section 106 (25 U.S.C. 1615(b)) is amended to read as follows:

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

- "(1) \$500,000 for fiscal year 1988,
- "(2) \$526,300 for fiscal year 1989,
- "(3) \$553,800 for fiscal year 1990, and

"(4) \$582,500 for fiscal year 1991."

#### NATIVE HAWAIIAN HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

SEC. 106. The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 104(b) of this Act, is further amended by inserting section 338G as follows:

##### "SEC. 338G. NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.

"(a) Subject to the availability of funds appropriated under the authority of subsection (d), the Secretary shall provide scholarship assistance to students who—

"(1) meet the requirements of section 338A(b), and

"(2) are Native Hawaiians.

"(b)(1) The scholarship assistance provided under subsection (a) shall be provided under the same terms and subject to the same conditions, regulations, and rules that apply to scholarship assistance provided under section 338A.

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

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

"(1) a citizen of the United States, and

"(2) a descendant of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawaii.

"(d) There are authorized to be appropriated \$1,800,000 for fiscal years 1988, 1989, 1990, and 1991, for the purpose of funding the scholarship assistance provided under subsection (a)."

#### COMMUNITY HEALTH REPRESENTATIVES

SEC. 107. Title I is amended by adding at the end thereof the following new section:

##### "COMMUNITY HEALTH REPRESENTATIVE PROGRAM

"SEC. 107. (a) Under the authority of the Act of November 2, 1921, (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary shall maintain a Community Health Representative Program under which the Service—

"(1) provides for the training of Indians as health paraprofessionals, and

"(2) uses such paraprofessionals in the provision of health care to Indian communities.

"(b) The Secretary, acting through the Community Health Representative Program of the Service, shall—

"(1) provide a high standard of paraprofessional training to Community Health Representatives to ensure that the Community Health Representatives provide quality health care to the Indian communities served by such 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 health promotion and disease prevention activities, particularly—

"(i) nutrition,

"(ii) physical fitness,

"(iii) weight control,

"(iv) cessation of tobacco smoking,

"(v) stress management,

"(vi) control of alcohol and substance abuse (including prevention of fetal alcohol syndrome),

"(vii) control of high blood pressure,

"(viii) prevention of lifestyle-related accidents,

"(ix) prevention and management of hearing and vision problems,

and

"(x) prevention of diabetes, and

"(C) provides instruction in the latest and most effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits.

"(3) develop a system which identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for such continuing education,

"(4) develop and maintain a system that provides close supervision of Community Health Representatives,

"(5) develop a system under which the work of Community Health Representatives is reviewed and evaluated, and

"(6) ensure that the provision of health care, health promotion, and disease prevention activities are consistent with the traditional health care practices and cultural values of the Indian tribes served by such Program."

## TITLE II—HEALTH SERVICES

### IMPROVEMENT OF INDIAN HEALTH STATUS

SEC. 201. (a) Section 201 (25 U.S.C. 1621) is amended to read as follows:

#### "IMPROVEMENT OF INDIAN HEALTH STATUS

"SEC. 201. (a) The Secretary is authorized to expend funds which are appropriated pursuant to subsection (j), through the Service, for the purposes of—

"(1) raising the health status of Indians to zero deficiency,

"(2) eliminating backlogs in the provision of health care services to Indians,

"(3) meeting the health needs of Indians in an efficient and equitable manner, and

"(4) augmenting the ability of the Service to meet the following health service responsibilities:

"(A) clinical care (direct and indirect) including clinical eye and vision care;

"(B) preventive health;

"(C) dental care (direct and indirect);

"(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners;

"(E) emergency medical services;

"(F) treatment and control of, and rehabilitative care related to, alcoholism and substance abuse (including fetal alcohol syndrome) among Indians;

"(G) accident prevention programs;

"(H) home health care;

"(I) community health representatives; and

"(J) maintenance and repair.

"(b)(1) Any funds appropriated pursuant to subsection (j) shall not be used to offset or limit any appropriations made to the Service under the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, or any other provision of law.

"(2) Funds which are appropriated pursuant to subsection (j) may be allocated to, or used for the benefit of, any Indian tribe which has a health resources deficiency level at level I or II only if a sufficient amount of funds have been appropriated pursuant to subsection (j) to raise all Indian tribes to health resources deficiency level II.

"(3)(A) Funds appropriated pursuant to subsection (j) may be allocated on a service unit basis but such allocation shall be made in a manner which ensures that the requirement of paragraph (2) is met. The funds allocated to each service unit under this subparagraph shall be used by the service unit (in accordance with paragraph (2)) to raise the deficiency level of each tribe served by such service unit.

"(B) The apportionment of funds allocated to a service unit under subparagraph (A) among the health service responsibilities described in subsection (a)(4) shall be determined by the Service in consultation with the affected Indian tribes.

"(c) For purposes of this section—

"(1) The health resources deficiency levels of an Indian tribe are as follows:

"(A) level I—0 to 20 percent health resources deficiency;

"(B) level II—21 to 40 percent health resources deficiency;

"(C) level III—41 to 60 percent health resources deficiency;

"(D) level IV—61 to 80 percent health resources deficiency;

"(E) level V—81 to 100 percent health resources deficiency.

"(2) Under regulations, the Secretary shall establish procedures which allow any Indian tribe to petition the Secretary for a review of any determination of the health resources deficiency level of such tribe.

"(d)(1) Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination Act shall be eligible for funds appropriated pursuant to subsection (j) on an equal basis with programs that are administered directly by the Service.

"(2) In any funds allocated to a tribe or service unit under the authority of this section are used for a contract entered into under the Indian Self-Determination Act, a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions.

"(e) The Secretary, acting through the Service, shall expend directly or by contract not less than 1 percent of the funds appropriated pursuant to subsection (j) for research in the areas of health service responsibilities set out in paragraph (A) through (H) of subsection (a)(4). Indian tribes and tribal organizations contracting with Service under the authority of the Indian Self-Determination Act shall be given an equal opportunity to compete for, and receive, such research funds.

"(f) By no later than the date that is 60 days after the date of enactment of the Indian Health Care Amendments of 1987, the Secretary shall submit to the Congress the current health services priority system report of the Service for each Indian tribe or service unit, including newly recognized or acknowledged tribes. Such report shall set out—

"(1) the methodology then in use by the Service for determining tribal health resources deficiencies, as well as the most recent application of that methodology;

"(2) the level of health resources deficiency for each Indian tribe served by the Service;

"(3) the amount of funds necessary to raise all Indian tribes served by the Service below health resources deficiency level II to health resources deficiency level II;

"(4) the amount of funds necessary to raise all tribes served by the Service below health resources deficiency level I to health resources deficiency level I;

"(5) the amount of funds necessary to raise all tribes served by the Service to zero health resources deficiency; and

"(6) an estimate of—

"(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service, for the preceding fiscal year which is allocated to each service unit;

"(B) the number of Indians eligible for health services in each service unit; and

"(C) the number of Indians using the Service resources made available to each service unit.

"(g) Upon enactment of the Indian Health Care Amendments of 1987, the Secretary, acting through the Service, shall take all necessary action, in cooperation with each Indian tribe, to bring current the tribal specific health plans which were developed as a part of the plan required by section 703 of this Act and which formed the basis for such plan in response to the requirements of section 701 of this Act. These plans shall be based upon the methodology submitted under subsection (f), as may be further modified through tribal consultation, and shall form the basis for the health services priority system report to be submitted by the Secretary for fiscal years 1989, 1990, and 1991. Such reports shall be submitted to the Congress not more than 30 days after the submissions of the annual budget for such fiscal years to the Congress by the President.

"(h)(1) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which—

"(A) specifies the amount of funds requested to carry out the provisions of this section for such fiscal year, and

"(B) specifies the total amount obligated or expended in the most recently completed fiscal year to carry out subsection (g) and to carry out each of the subparagraphs of subsection (a)(4).

"(2) Funds appropriated under authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

"(i) Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve parity among Indian tribes.

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

- "(1) \$19,000,000 for fiscal year 1989,
- "(2) \$19,000,000 for fiscal year 1990, and
- "(3) \$20,000,000 for fiscal year 1991.

Any funds appropriated under the authority of this subsection shall be designated as the 'Indian Health Care Improvement Fund'."

(b) Section 4 (25 U.S.C. 1603) is amended by striking out subsections (i), (j), and (k), and by inserting in lieu thereof the following new subsections:

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

"(j) 'Service unit' means—

- "(1) an administrative entity within the Indian Health Service, or
- "(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area."

#### CATASTROPHIC HEALTH PROGRAM

SEC. 202. Title II is amended by adding at the end thereof the following new section:

#### "CATASTROPHIC HEALTH EMERGENCY FUND

"SEC. 202. (a)(1) There is hereby established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the 'Fund') consisting of—

"(A) the amounts deposited under subsection (d), and

"(B) the amounts appropriated under subsection (e).

"(2) The Fund shall be administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

"(3) The Fund shall not be allocated, apportioned, or delegated on a service unit, area office, or any other basis.

"(4) No part of the Fund or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination Act.

"(b) The Secretary shall, through the promulgation of regulations consistent with the provisions of this section—

"(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the Fund;

"(2) provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the Fund until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at not less than \$10,000 or not more than \$20,000;

"(3) establish a procedure for the reimbursement of the costs incurred by—

"(A) service units or facilities of the Service, or

"(B) Whenever otherwise authorized by the Service, non-service facilities or providers,

in rendering treatment that exceeds such threshold cost;

"(4) establish a procedure for payment from the Fund in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

"(5) establish a procedure that will ensure that no payment shall be made from the Fund to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement.

"(c) Funds appropriated under subsection (e) shall not be used to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, or any other law.

"(d) There shall be deposited into the Fund—

"(1) all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness who is within the responsibility of the Service, and

"(2) all funds recovered under the authority of Public Law 87-693 (42 U.S.C. 2651, et seq.), popularly known as the Medical Care Recovery Act, by reason of such treatment.

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

"(1) \$12,000,000 for fiscal year 1988, and

"(2) for each of the fiscal years 1989, 1990, and 1991, such sums as may be necessary to restore the Fund to a level of \$12,000,000 for such fiscal year. Funds appropriated under the authority of this subsection shall remain available until expended."

#### HEALTH PROMOTION AND DISEASE PREVENTION

Sec. 203. (a) The Congress finds that—

(1) health promotion and disease prevention activities will—

(A) improve the health and well being of Indians, and

(B) reduce the expenses for medical care of Indians,

(2) health promotion and disease prevention activities should be undertaken by the coordinated efforts of Federal, State, local, and tribal governments, and

(3) in addition to the provision of primary health care, the Indian Health Service should provide health promotion and disease prevention services to Indians.

(b) Section 4 (25 U.S.C. 1603), as amended by section 201(b) of this Act, is further amended by adding at the end thereof the following new subsections:

"(k) 'Health promotion' includes—

"(1) cessation of tobacco smoking,

"(2) reduction in the misuse of alcohol and substances,

"(3) improvement of nutrition,

"(4) improvement in physical fitness,

"(5) family planning, and

"(6) control of stress.

"(l) 'Disease prevention' includes—

"(1) immunizations,

"(2) control of high blood pressure,

"(3) control of sexually transmittable diseases,

"(4) prevention and control of diabetes,

"(5) pregnancy and infant care (including prevention of fetal alcohol syndrome),

"(6) control of toxic agents,

"(7) occupational safety and health,

"(8) accident prevention,

"(9) fluoridation of water, and

"(10) control of infectious agents."

(c) Title II (25 U.S.C. 1621, et seq.), as amended by section 202 of this Act, is further amended by adding at the end thereof the following new section:

#### "HEALTH PROMOTION AND DISEASE PREVENTION SERVICES

"Sec. 203. (a) The Secretary, acting through the Service, shall provide health promotion and disease prevention services to Indians.

"(b) The Secretary shall include in each report which is required under section 201(g) an evaluation of—

"(1) the health promotion and disease prevention needs of Indians identified in tribal specific health plans,

"(2) the health promotion and disease prevention activities which would best meet such needs,

"(3) the internal capacity of the Service to meet such needs, and

"(4) the resources which would be required to enable the Service to undertake the health promotion and disease prevention activities necessary to meet such needs.

"(c) Under regulations, the Secretary shall require that each Indian tribe include within any tribal specific health plan that such tribe is required to submit to the Secretary a comprehensive plan developed by such tribe for health promotion and disease prevention among members of such tribe.

"(d) By no later than the date that is 1 year after the date of enactment of the Indian Health Care Amendments of 1987, the Secretary, acting through the Service, shall—

"(1) develop from tribal specific health plans a comprehensive plan for the provision by the Service of health promotion and disease prevention services to Indians, and



"(2) establish a schedule for the provision of health promotion and disease prevention services by the Service.

"(e)(1) The Secretary shall establish at least 1 demonstration project (but no more than 4 demonstration projects) to determine the most effective and cost-efficient means of—

"(A) providing health promotion and disease prevention services,

"(B) encouraging Indians to adopt good health habits,

"(C) reducing health risks to Indians, particularly the risks of heart disease, cancer, stroke, diabetes, anxiety, depression, and lifestyle-related accidents,

"(D) reducing medical expenses of Indians through health promotion and disease prevention activities,

"(E) establishing a program—

"(i) which trains Indians in the provision of health promotion and disease prevention services to members of their tribe, and

"(ii) under which such Indians are available on a contract basis to provide such services to other tribes, and

"(F) providing training and continuing education to employees of the Service, and to paraprofessionals participating in the Community Health Representative Program, in the delivery of health promotion and disease prevention services.

"(2) The demonstration project described in paragraph (1) shall include an analysis of the cost effectiveness of organizational structures and of social and educational programs that may be useful in achieving the objectives described in paragraph (1).

"(3)(A) The demonstration project described in paragraph (1) shall be conducted in association with at least one—

"(i) health profession school,

"(ii) allied health profession or nurse training institution, or

"(iii) public or private entity that provides health care.

"(B) The Secretary is authorized to enter into contracts with, or make grants to, any school of medicine or school of osteopathy for the purpose of carrying out the demonstration project described in paragraph (1).

"(C) For purposes of this paragraph, the term 'school of medicine' and 'school of osteopathy' have the respective meaning given to such terms by section 701(4) of the Public Health Service Act (42 U.S.C. 292a(4)).

"(4) The Secretary shall submit to Congress a final report on the demonstration project described in paragraph (1) within 60 days after the termination of such project.

"(5) The demonstration project described in paragraph (1) shall be established by no later than the date that is 12 months after the date of enactment of the Indian Health Care Amendments of 1987 and shall terminate on the date that is 30 months after the date of enactment of such Amendments.

"(6) There are authorized to be appropriated \$500,000 for the purposes of carrying out the provisions of this subsection, such sum to remain available without fiscal year limitation.

"(f)(1)(A) The Secretary shall, acting through the Public Health Service, establish in the State of Hawaii, as a demonstration project, a Native Hawaiian Program for Health Promotion and Disease Prevention for the purpose of exploring ways to meet the unique health care needs of Native Hawaiians.

"(B) The demonstration program that is to be established under subparagraph (A) shall—

"(i) provide necessary preventive-oriented health services, including health education and mental health care,

"(ii) develop innovative training and research projects,

"(iii) establish cooperative relationships with the leadership of the Native Hawaiian community,

"(iv) ensure that a continuous effort is made to establish programs which can be of direct benefit to other Native American people, and

"(v) assure a comprehensive effort to reduce the incidence of diabetes among Native Hawaiians.

"(C) The Secretary is authorized to enter into contracts with Native Hawaiian organizations for the purpose of assisting the Secretary in meeting the objectives of the demonstration program that is to be established under subparagraph (A).

"(2)(A) In fulfillment of the objective set forth in paragraph (1)(B)(v), the Secretary shall enter into a contract with a Native Hawaiian organization to conduct a study to determine—

"(i) the incidence of diabetes among Native Hawaiians;

"(ii) activities which should be undertaken—

"(I) to reduce the incidence of diabetes among Native Hawaiians,

"(II) to provide Native Hawaiians with guidance in the prevention, treatment, and control of diabetes,

"(III) to provide early diagnosis of diabetes among Native Hawaiians, and

"(IV) to ensure that proper continuing health care is provided to Native Hawaiians who are diagnosed as diabetic.

"(B) The Secretary shall enter into a contract with a Native Hawaiian organization for the purpose of preparing an inventory of all health care programs (public and private) within the State of Hawaii that are available for the treatment, prevention, or control of diabetes among Native Hawaiians.

"(C) By no later than the date that is 2 years after the date of enactment of this section, the Native Hawaiian organization with whom the Secretary has entered into a contract, shall prepare and transmit to the Secretary a report describing the determinations made under subparagraph (A), containing the inventory prepared under subparagraph (B), and describing the research activities conducted under this subsection. The Secretary shall submit the report to the Congress and the President.

"(3)(A) By no later than the date that is 3 years after the date of enactment of this section, the Secretary shall enter into a contract with a Native Hawaiian organization for the purpose of implementing a program designed—

"(i) to establish a diabetes control program;

"(ii) to screen those Native Hawaiian individuals that have been identified as having a high risk of becoming diabetic;

"(iii) to effectively treat—

"(I) individuals diagnosed diabetics in order to reduce further complications from diabetes,

"(II) individuals who have a high risk of becoming diabetic in order to reduce the incidence of diabetes, and

"(III) short-term and long-term complications of diabetes;

"(iv) to conduct for Federal, State, and other Native Hawaiian health care providers (including Native Hawaiian community health outreach workers), training programs concerning current methods of prevention, diagnosis, and treatment of diabetes and related complications among Native Hawaiians;

"(v) to determine the appropriate delivery to Native Hawaiians of health care services relating to diabetes;

"(vi) to develop and present health education information to Native Hawaiian communities and schools concerning the prevention, treatment, and control of diabetes; and

"(vii) to ensure that proper continuing health care is provided to Native Hawaiians who are diagnosed as being diabetic.

"(B) The Secretary shall enter into a contract with a Native Hawaiian organization for the purposes of—

"(i) promoting coordination and cooperation between all health care providers in the delivery of diabetes related services to Native Hawaiians; and

"(ii) encouraging and funding joint projects between Federal programs, State health care facilities, community health centers, and Native Hawaiian communities for the prevention and treatment of diabetes.

"(C)(i) The Secretary shall enter into a contract with a Native Hawaiian organization for the purpose of establishing a model diabetes program to serve Native Hawaiians in the State of Hawaii.

"(ii) The Secretary shall enter into a contract with a Native Hawaiian organization for the purpose of developing an implementing an outreach program to ensure that the achievements and benefits derived from the activities of the model diabetes program established under clause (1) are applied in Native Hawaiian communities to assure the diagnosis, prevention, and treatment of diabetes among Native Hawaiians.

"(D) The Secretary shall submit to the Congress an annual report outlining the activities, achievements, needs, and goals of the Native Hawaiian diabetes care program established under this paragraph.

"(4) The Secretary shall enter into a contract with a Native Hawaiian organization, for the purpose of developing a standardized system to collect, analyze, and report data regarding diabetes and related complications among Native Hawaiians. Such system shall be designed to facilitate dissemination of the best available information on diabetes to Native Hawaiian communities and health care professionals.

"(5) The Secretary shall enter into a contract with a Native Hawaiian organization for the purpose of—

"(A) conducting research concerning the causes, diagnosis, treatment, and prevention of diabetes and related complications among Native Hawaiians, and

"(B) coordinating such research with all other relevant agencies and units of the government of the State of Hawaii and the Department of Health and Human Services which conduct research relating to diabetes and related complications.

"(6) The Secretary shall submit to the Congress an annual report on the status and accomplishments of the progress established under this subsection during each of the fiscal years 1989, 1990, and 1991.

"(7)(A) The Secretary shall include in any contract which the Secretary enters into with any Native Hawaiian organization under this subsection such conditions as the Secretary considers necessary to ensure that the objectives of such contract are achieved.

"(B) The Secretary shall develop procedures to evaluate compliance with, and performance of, contracts entered into by Native Hawaiian organizations under this subsection.

"(C) The Secretary shall conduct an annual onsite evaluation of each Native Hawaiian organization which has entered into a contract under this subsection for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract.

"(D) If, as a result of the evaluations conducted under subparagraph (C), the Secretary determines that a Native Hawaiian organization has not complied with or satisfactorily performed a contract entered into under this subsection, the Secretary shall, prior to renewing such contract, attempt to resolve the areas of noncompliance or unsatisfactory performance and modify such contract to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract with such organization and is authorized to enter into a contract under this subsection with another Native Hawaiian organization that serves the same population of Native Hawaiians which is served by the Native Hawaiian organization whose contract is not renewed by reason of this subparagraph.

"(E) In determining whether to renew a contract entered into with a Native Hawaiian organization under this subsection, the Secretary shall—

"(i) review the records of the Native Hawaiian organization, and

"(ii) shall consider the results of the onsite evaluations conducted under subparagraph (C).

"(F) All contracts entered into by the Secretary under this subsection shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provision of the Act of August 24, 1935 (40 U.S.C. 270a, et seq.).

"(G) Payments made under any contract entered into under this subsection may be made in advance, by means of reimbursement, or in installments and shall be made on such conditions as the Secretary deems necessary to carry out the purposes of this subsection.

"(H) Notwithstanding any other provision of law, the Secretary may, at the request or consent of a Native Hawaiian organization, revise or amend any contract entered into by the Secretary with such organization under this subsection as necessary to carry out the purposes of this subsection.

"(I)(i) For each fiscal year during which a Native Hawaiian organization receives or expends funds pursuant to a contract entered into under this subsection, such organization shall submit to the Secretary a quarterly report on—

"(I) activities conducted by the organization under the contract,

"(I) the amounts and purposes for which Federal funds were expended, and

"(III) such other information as the Secretary may request.

"(ii) The reports and records of any Native Hawaiian organization which concern any contract entered into under this subsection shall be subject to audit by the Secretary and the Comptroller General of the United States.

"(J) The Secretary shall allow as a cost of any contract entered into under this subsection the cost of an annual private audit conducted by a certified public accountant.

"(K) The authority of the Secretary to enter into contracts under this subsection shall be to the extent, and in amounts, provided for in appropriation Acts.

"(8) For purposes of this subsection—

"(A) The term 'Native Hawaiian' means any individual who—

"(i) is a citizen of the United States,

"(ii) is a resident of the State of Hawaii, and

"(iii) is a descendant of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawaii.

"(B) The term 'Native Hawaiian organization' means any organization—

"(i) which serves and represents the interests of Native Hawaiians,

"(ii) which is recognized by the Office of Hawaiian Affairs of the State of Hawaii and E Ola Mau for the purpose of planning, conducting, or administering programs (or portion of programs) authorized under this Act for Native Hawaiians, and

"(iii) in which Native Hawaiian health professionals significantly participate in the planning, management, monitoring, and evaluation of health services.

"(9) There are authorized to be appropriated \$750,000 for each of the fiscal year 1989, 1990, 1991, and 1992, for the purpose of carrying out the provisions of this subsection.

"(10) The programs and services established by this subsection shall not be administered by or through the Indian Health Service nor shall any funds appropriated to the Indian Health Service be used to supplement funding of such programs and services."

#### REIMBURSEMENT OF CERTAIN EXPENSES

SEC. 204. Title II, as amended by section 203(c), is further amended by adding at the end thereof the following new sections:

##### "REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES

"SEC. 204. (a) The United States shall have the right to recover the reasonable expenses incurred by the Secretary in providing health services, through the Service, to any individual to the same extent that such individual, or any non-governmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if—

"(1) such services had been provided by a nongovernmental provider, and

"(2) such individual had been required to pay such expenses and did pay such expenses.

"(b) Subsection (a) shall provide a right of recovery against any State, or any political subdivision of a State, only if the injury, illness, or disability for which health services were provided is covered under—

"(1) workers' compensation laws, or

"(2) a no-fault automobile accident insurance plan or program.

"(c) No law of any State, or of any political subdivision of a State, and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1987, shall prevent or hinder the right of recovery of the United States under subsection (a).

"(d) No action taken by the United States to enforce the right of recovery provided under subsection (a) shall affect the right of any person to any damages other than damages for the cost of health services provided by the Secretary through the Service.

"(e) The United States may enforce the right of recovery provided under subsection (a) by—

"(1) intervening or joining in any civil action or proceeding brought—

"(A) by the individual for whom health services were provided by the Secretary, or

"(B) by any representative or heirs of such individual, or

"(2) instituting a separate civil action, after providing to such individual, or to the representative or heirs of such individual, notice of the intention of the United States to institute a separate civil action.

##### "CREDITING OF REIMBURSEMENTS

"SEC. 205. (a) Notwithstanding any provision of law other than this section, all funds received into the Treasury of the United States by reason of the provision of health services by the Service, including—

"(1) amounts paid under section 713(b)(2)(B), and

"(2) recoveries made under—

"(A) section 204, or

"(B) Public Law 87-693 (42 U.S.C. 2651, et seq.), popularly known as the Medical Care Recovery Act, shall be credited to the reimburseable account

of the Indian Health Service in the Treasury of the United States and shall remain available until expended.

"(b) Subsection (a) shall not apply to any amounts described in section 202(d)."

### TITLE III—HEALTH FACILITIES

#### CONSULTATION; CLOSURE OF FACILITIES; REPORTS

"Sec. 301. Section 301 (25 U.S.C. 1631) is amended to read as follows:

#### CONSULTATION; CLOSURE OF FACILITIES; REPORTS

"Sec. 301. (a) Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, acting through the Service, shall—

"(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made, and

"(2) ensure, whenever practicable, that such facility meets the standards of the Joint Commission on Accreditation of Hospitals by not later than 1 year after the date on which the construction or renovation of such facility is completed.

"(b)(1) Notwithstanding any provision of law other than this subsection, no Service hospital or other outpatient health care facility of the Service, or any portion of such a hospital or facility, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such hospital or facility (or portion thereof) is proposed to be closed an evaluation of the impact of such proposed which specifies, in addition to other considerations—

"(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

"(B) the cost effectiveness of such closure;

"(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

"(D) the availability of contract health care funds to maintain existing levels of service; and

"(E) the views of the Indian tribes served by such hospital or facility concerning such closure.

"(2) Paragraph (1) shall not apply to any temporary closure of a facilities or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

"(c) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each of the fiscal years 1989, 1990, and 1991, program information documents for the construction of 10 Indian health facilities which—

"(1) comply with applicable construction standards, and

"(2) have been approved by the Secretary.

"(d)(1) The Secretary shall submit to the Congress an annual report which sets forth—

"(A) the current health facility priority system of the Service,

"(B) the planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority ambulatory care facilities (together with required staff quarters),

"(C) the justification for such order of priority,

"(D) the projected cost of such projects, and

"(E) the methodology adopted by the Service in establishing priorities under its health facility priority system.

"(2) The first report required under paragraph (1) shall be submitted by no later than the date that is 180 days after the date of enactment of the Indian Health Care Amendments of 1987 and, beginning in 1989, each subsequent annual report shall be submitted by the date that is 60 days after the date on which the President submits the budget to the Congress under section 1105 of title 31, United States Code.

"(3) In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall—

"(A) consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any con-

tract entered into with the Service under the Indian Self-Determination Act, and

"(B) review the needs of such tribes and tribal organizations for inpatient and outpatient facilities, including their needs for renovation and expansion of existing facilities.

"(4) For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any contract entered into with the Service under the Indian Self-Determination Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

"(5) The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities which are the subject of a contract for health services entered into with the Service under the Indian Self-Determination Act are fully and equitably integrated into the development of the health facility priority system.

"(e) All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of sections 103 and 104(b) of the Indian Self-Determination Act."

#### SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

Sec. 302. Section 302 (25 U.S.C. 1632) is amended to read as follows:

#### "SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

"Sec. 302. (a) The Congress hereby finds and declares that—

"(1) the provision of safe water supply systems and sanitary sewage and solid waste disposal systems is primarily a health consideration and function;

"(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such systems;

"(3) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such systems and other preventive health measures;

"(4) many Indian homes and communities still lack safe water supply systems and sanitary sewage and solid waste disposal systems; and

"(5) it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible.

"(b)(1) In furtherance of the findings and declarations made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

"(2) The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a)—

"(A) financial and technical assistance to Indian tribes and communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities;

"(B) ongoing technical assistance and training in the management of utility organizations which operate and maintain sanitation facilities; and

"(C) operation and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities.

"(c) Beginning in fiscal year 1989, the Secretary, acting through the Service, shall develop and begin implementation of a 10-year plan to provide safe water supply and sanitation sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.

"(d) The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

"(e) The provisions of this section shall not diminish the primary responsibility of the Indian tribe or community to establish, collect, and utilize reasonable user fees, or otherwise set aside funding, for the purpose of operating and maintaining sanitation facilities.

"(f) Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination Act shall be eligible for—

"(1) any funds appropriated pursuant to subsection (h), and

"(2) any funds appropriated for the purpose of providing water supply or sewage disposal services, on an equal basis with programs that are administered directly by the Service.

"(g)(1) The Secretary shall submit to the Congress an annual report which sets forth—

"(A) the current Indian sanitation facility priority system of the Service;

"(B) the methodology for determining sanitation deficiencies;

"(C) the level of sanitation deficiency for each sanitation facilities project of each Indian tribe or community;

"(D) the amount of funds necessary to raise all Indian tribes and communities to a level I sanitation deficiency; and

"(E) the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency.

"(2) The first report required under paragraph (1) shall be submitted by no later than the date that is 180 days after the date of enactment of the Indian Health Care Amendments of 1987 and, beginning in 1989, each subsequent annual report shall be submitted by the date that is 60 days after the date on which the President submits the budget to the Congress under section 1105 of title 31, United States Code.

"(3) In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any contract entered into with the Service under the Indian Self-Determination Act) to determine the sanitation needs of each tribe.

"(4) The methodology used by the Secretary in determining sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian tribes and communities.

"(5) For purposes of this subsection, the sanitation deficiency levels for an Indian tribe or community are as follows:

"(A) level I is an Indian tribe or community with a sanitation system—

"(i) which complies with all applicable water supply and pollution control laws, and

"(ii) in which the deficiencies relate to routine replacement, repair, or maintenance needs;

"(B) level II is an Indian tribe or community with a sanitation system—

"(i) which complies with all applicable water supply and pollution control laws, and

"(ii) in which the deficiencies relate to capital improvements that are necessary to improve the facilities in order to meet the needs of such tribe or community for domestic sanitation facilities;

"(C) level III is an Indian tribe or community with a sanitation system which—

"(i) has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or

"(ii) has no solid waste disposal facility;

"(D) level IV is an Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system; and

"(E) level V is an Indian tribe or community that lacks a safe water supply and a sewage disposal system.

"(6) For purposes of this subsection, any Indian tribe or community that lacks the operation and maintenance capability to enable its sanitation system to meet pollution control laws may not be treated as having a level I or II sanitation deficiency.

"(h)(1) There are authorized to be appropriated for each of the fiscal years 1989, 1990, and 1991, \$3,000,000 for the purpose of providing funds necessary to implement the responsibilities of the Service described in subsection (b)(2).

"(2) In addition to the amount authorized under paragraph (1) there are authorized to be appropriated for each of the fiscal years 1989, 1990, and 1991, \$850,000 for the purpose of providing 30 new Full-Time Equivalents (FTE) for the Service which shall be used to carry out the responsibilities of the Service described in subsection (b)(2).

"(3) The new FTE positions authorized under this subsection will be in addition to the existing 350 FTE positions which are presently funded in the Sanitation Facilities account and which level was the minimum FTE level required for the adequate operation of this program."

#### USE OF NON-SERVICE FUNDS FOR RENOVATION

SEC. 303. (a) Section 305 (25 U.S.C. 1634) is amended to read as follows:

"EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION

"SEC. 305. (a) Notwithstanding any other provision of law, the Secretary is authorized to accept any major renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a contract entered into under the Indian Self-Determination Act, including—

"(1) any plans or designs for such renovation or modernization, and

"(2) any renovation or modernization for which funds appropriated under any Federal law were lawfully expended, but only if the requirements of subsection (b) are met.

"(b) The requirements of this subsection are met with respect to any renovation or modernization if the renovation or modernization—

"(1) does not require or obligate the Secretary to provide any additional employees or equipment,

"(2) is approved by the appropriate area director of the Service, and

"(3) is administered by the Indian tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

"(c) A renovation or modernization shall not be authorized by this section if such renovation or modernization would require the diversion of funds appropriated to the Service from any project which has a higher priority under the health facility priority system of the Service.

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

"(b) The paragraph relating to administrative provisions of the Health Services Administration under the heading "Department of Health and Human Services" in title II of the matter contained in section 101(c) of Public Law 98-473 (98 Stat. 1864) is amended by striking out the sixth proviso.

BETHEL, ALASKA, HOSPITAL

SEC. 304. Title III is amended by adding at the end thereof the following new section:

"BETHEL, ALASKA, HOSPITAL

"SEC. 306. (a) If a final administrative ruling by the Department of the Interior holds that the Bethel Native Corporation is entitled to conveyance under the Alaska Native Claims Settlement Act of the title to the real property described in subsection (d)(1), such ruling shall not be subject to judicial review.

"(b) The Secretary is authorized to enter into an agreement with Bethel Native Corporation for an exchange of the real property described in subsection (d)(1) for—

"(1) the lands described in subsection (d)(2), or

"(2) any other Federal property which Bethel Native Corporation would have been able to select under the Alaska Native Claims Settlement Act.

"(c) If an agreement for the exchange of land is not entered into under subsection (b) by the date that is 90 days after the date of the ruling described in subsection (a), the Secretary shall purchase the lands described in subsection (d)(1) at fair market value.

"(d)(1) The real property referred to in subsection (a) is United States Survey Numbered 4000, other than the lands described in paragraph (2).

"(2) The lands referred to in subsection (b)(1) are the lands identified as tracts A and B in the determination AA-18959 of the Bureau of Land Management issued on September 30, 1983, pursuant to the Alaska Native Claims Settlement Act."

TITLE IV—ACCESS TO HEALTH SERVICES

GRANTS AND CONTRACTS WITH TRIBAL ORGANIZATIONS

SEC. 401. (a) Section 404 (25 U.S.C. 1622) is amended—

(1) by striking out "and" at the end of subsection (a)(2) and inserting in lieu thereof "or", and



"(2) by striking out "shall include, but are not limited to," in subsection (b) and inserting in lieu thereof "may include, as appropriate," and

"(3) by adding "or" at the end of subsection (b)(3).

(b) Subsection (c) of section 404 (25 U.S.C. 1622(c)) is amended to read as follows:

"(c) There are authorized to be appropriated for the purpose of carrying out the provision of this subsection—

"(1) \$2,000,000 for fiscal year 1989,

"(2) \$500,000 for fiscal year 1990, and

"(3) \$500,000 for fiscal year 1991."

## TITLE V—URBAN INDIAN HEALTH SERVICES

### REVISION OF PROGRAM

SEC. 501. Title V (25 U.S.C. 1651 *et seq.*) is amended to read as follows:

### "TITLE V—HEALTH SERVICES FOR URBAN INDIANS

#### "PURPOSE

"SEC. 501. The purpose of this title is to encourage the establish of program in urban centers to make health services more accessible to urban Indians.

#### "CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

"SEC. 502 Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into contracts with urban Indian organizations to assist such organizations in the establishment and administration, within the urban centers in which such organizations are situated, of programs which meet the requirements set forth in this title. The Secretary, through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with any urban Indian organization pursuant to this title.

#### "CONTRACTS FOR THE PROVISION OF HEALTH CARE OR REFERRAL SERVICES

"SEC. 503. (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into contracts with urban Indian organizations for the provision of health care or referral services for urban Indians residing in the urban centers in which such organizations are situated. Any such contract shall include requirements that the urban Indian organization successfully undertake to—

"(1) determine the population of urban Indians residing in the urban center in which such organization is situated who are or could be recipients of health care or referral services;

"(2) determine the current health status of urban Indian residing in such urban center;

"(3) determine the current health care needs of urban Indians residing in such urban center;

"(4) identify all public and private health services resources within such urban center which are or may be available to urban Indians;

"(5) determine the use of public and private health services resources by the urban Indians residing in such urban center;

"(6) assist such health services resources in providing services to urban Indians;

"(7) assist urban Indians in becoming familiar with and utilizing such health services resources;

"(8) provide basic health education, including health promotion and disease prevention education, to urban Indians;

"(9) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (6) through (8) of this subsection;

"(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

"(11) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

"(12) where necessary, provide, or enter into contracts for the provisions of, health care services for urban Indians.

"(b) The Secretary, through the Service, shall by regulation prescribe the criteria for selecting urban Indians organizations to enter into contracts under this section. Such criteria shall, among other factors, include—

"(1) the extent of unmet health care needs of urban Indians in the urban center involved;

"(2) the size of the urban Indian population in the urban center involved;

"(3) the accessibility to, and utilization of, health care services (other than services provided under this title) by urban Indians in the urban center involved;

"(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate—

"(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this title; or

"(B) any project funded under this title;

"(5) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary under this section;

"(6) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

"(7) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center; and

"(8) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

#### "CONTRACTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS

"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 urban Indian organizations situated in urban centers for which contracts have not been entered into under section 503. The purpose of a contract under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract under section 503 with the urban Indian organization with which the Secretary has entered into a contract under this section.

"(b) Any contract entered into by the Secretary under this section shall include requirements that—

"(1) the urban Indian organization successfully undertake to—

"(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

"(B) with respect to urban Indians in the urban center involved, determine the matters described in clauses (2), (3), (4), and (8) of section 503(b); and

"(2) the urban Indian organization complete performance of the contract within one year after the date on which the Secretary and such organization enter into such contract.

"(c) The Secretary may not renew any contract entered into under this section.

#### "EVALUATIONS; CONTRACT RENEWALS

"SEC. 505. (a) The Secretary, through the Service, shall develop procedures to evaluate compliance with, and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

"(b) The Secretary, through the Service, shall conduct an annual onsite evaluation of each urban Indian organization which has entered into a contract under section 503 for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract.

"(c) If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract with such

organization and is authorized to enter into a contract under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract is not renewed under this section.

"(d) In determining whether to renew a contract with an urban Indian organization under section 503 which has completed performance of a contract under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract under section 503, shall consider the results of the onsite evaluations conducted under subsection (b).

#### "OTHER CONTRACT REQUIREMENTS

"SEC. 506. (a) Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (40 U.S.C. 270a. et seq.).

"(b) Payments under any contracts pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

"(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

"(d) In connection with any contract entered into pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.

"(e) Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts by such organizations.

#### "REPORTS AND RECORDS

"SEC. 507. (a) For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into pursuant to this title, such organization shall submit to the Secretary a quarterly report including—

"(1) in the case of a contract under section 503, information gathered pursuant to clauses (10) and (11) of subsection (a) of such section;

"(2) information on activities conducted by the organization pursuant to the contract;

"(3) an accounting of the amounts and purposes for which Federal funds were expended; and

"(4) such other information as the Secretary may request.

"(b) The reports and records of the urban Indian organization with respect to a contract under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

"(c) The Secretary shall allow as a cost of any contract entered into under section 503 the cost of an annual private audit conducted by a certified public accountant.

#### "LIMITATION ON CONTRACT AUTHORITY

"SEC. 508. The authority of the Secretary to enter into contracts under this title shall be to the extent, and in an amount, provided for in appropriation Acts."

#### URBAN INDIAN ORGANIZATION

Sec. 502. Subsection (h) of section 4 (25 U.S.C. 1603(h)) is amended by inserting "urban" after "governed by an".

#### TITLE VI—ORGANIZATIONAL IMPROVEMENTS

##### SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

(a) AMENDMENT.—Title VI (25 U.S.C. 1661) is amended to read as follows:

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

"ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

"SEC. 601. (a) In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service. The Indian Health Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director of the Indian Health Service shall report to the Secretary through the Assistant Secretary for Health, of the Department of Health and Human Services, and shall not report to, or be under the supervision of, any other officer or employee of such Department.

"(b) The Indian Health Service shall be an agency within the Public Health Service of the Department of Health and Human Services, and shall not be an office, component, or unit of any other agency of the Department.

"(c) The Secretary shall carry out through the Director of the Indian Health Service—

"(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1987, carried out by or under the direction of the individual serving as Director of the Indian Health Service on such day;

"(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians; and

"(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including (but not limited to) programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (68 Stat. 674);

"(D) the Act of August 16, 1957 (71 Stat. 370); and

"(E) the Indian Self-Determination Act (Public Law 93-638).

"(d)(1) Notwithstanding any other provision of law, the Secretary may not reorganize, alter, or discontinue the Indian Health Service or allocate or reallocate any function which this section specifies shall be performed by the Director of the Indian Health Service or by the Secretary of Health and Human Services through the Director of the Indian Health Service.

"(2) Paragraph (1) shall not apply to any action taken by the Director of the Indian Health Service which the Director of the Indian Health Service determines to be appropriate.

"(e)(1) The Director of the Indian Health Service shall have the authority—

"(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

"(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

"(C) to manage, expend, and obligate all funds appropriate for the Service.

"(2) Notwithstanding any other law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472) shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

"SEC. 602. (a)(1) The Secretary shall establish an automated management information system for the Service.

"(2) The information system established under paragraph (1) shall include—

"(A) a financial management system,

"(B) a patient care information system for each area served by the Service,

"(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service, and

"(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service.

"(3) By no later than September 30, 1988, the Secretary shall submit a report to Congress setting forth—

"(A) the activities which have been undertaken to establish an automated management information system,

"(B) the activities, if any, which remain to be undertaken to complete the implementation of an automated management information system, and

"(C) the amount of funds which will be needed to complete the implementation of a management information system in the succeeding fiscal years.

"(b)(1) The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act automated management information systems which—

"(A) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service, and

"(B) meet the management information needs of the Service.

"(2) The Secretary shall reimburse each Indian tribe or tribal organization for the part of the cost of the operation of a system provided under paragraph (1) which is attributable to the treatment by such Indian tribe or tribal organization of patients of the Service.

"(3) The Secretary shall provide systems under paragraph (1) to Indian tribes and tribal organizations providing health services in California by no later than September 30, 1989.

"(c) Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service."

(b) TRANSFERS.—All personnel, records, equipment, facilities, and interests in property that are administered by the Indian Health Service on the day before the date on which the amendments made by this section take effect shall be transferred to the Indian Health Service established by the amendment made by subsection (a) of this section. All transfers must be accomplished within 9 months of the date of enactment of this section. The Secretary is authorized to waive the Indian preference laws on a case-by-case basis for temporary transfers involved in implementing this section during such 9-month period.

(c) EFFECTIVE DATE.—Section 601 of the Indian Health Care Improvement act added by subsection (a) of this section shall take effect 9 months from the date of the enactment of this section."

(d) Section 5316 of title 5 of the United States Code is amended by adding, at the end thereof, the following: "Director, Indian Health Service, Department of Health and Human Services."

## TITLE VII—MISCELLANEOUS PROVISIONS

### LEASING AND OTHER CONTRACTS

SEC. 701. Section 704 (25 U.S.C. 1674) is amended—

(1) by striking out "Notwithstanding", and inserting in lieu thereof "(a) Notwithstanding", and

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

"(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organization which hold—

"(1) title to;

"(2) a leasehold interest in; or

"(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable."

### ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 702. (a) Subsection (a) of Section 708 (25 U.S.C. 1678(a)) is amended—

(1) by striking out "1984" and inserting in lieu thereof "1990", and

(2) by striking out "Indians in such State" and inserting in lieu thereof "members of federally recognized Indian tribes of Arizona".

(b) Section 708 (25 U.S.C. 1678(c)) is amended by striking out subsection (c).

### ELIGIBILITY OF CALIFORNIA INDIANS

SEC. 703. Section 709 (25 U.S.C. 1679) is amended to read as follows:

"ELIGIBILITY OF CALIFORNIA INDIANS

"Sec. 709. (a)(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after the date of enactment of this Act, prepare and submit to the Congress a report which sets forth—

"(A) a determination by the Secretary of the number of Indians described in subsection (b)(2), and the number of Indians described in subsection (b)(3), who are not members of an Indian tribe recognized by the Federal Government.

"(B) the geographic location of such Indians,

"(C) the Indian tribes of which such Indians are members,

"(D) an assessment of the current health status, and health care needs, of such Indians, and

"(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.

"(2) The report required under paragraph (1) shall be prepared by the Secretary—

"(A) in consultation with the Secretary of the Interior, and

"(B) with the assistance of the tribal health programs providing services to the Indians described in paragraph (2) or (3) of subsection (b) who are not members of any Indian tribe recognized by the Federal Government.

"(b) Until such time as the Congress by any subsequent amendment to this Act may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

"(1) Any member of a federally recognized Indian tribe.

"(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

"(A) is living in California,

"(B) is a member of the Indian community served by a local program of the Service, and

"(C) is regarded as an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

"(c) Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986."

"CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

"Sec. 704 Section 710 (25 U.S.C. 1680) is amended to read as follows:

"CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

"Sec. 710. The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State."

CONTRACT HEALTH FACILITIES

"Sec. 705. Title VII is amended by adding at the end thereof the following new section:

"CONTRACT HEALTH FACILITIES

"Sec. 711. The Service shall provide funds for health care programs and facilities operated by the tribes and tribal organizations under contracts with the Service entered into under the Indian Self-Determination Act—

"(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,

"(2) for employee training,

"(3) for cost-of-living increases for employees, and

"(4) for any other expenses relating to the provision of health services,

on the same basis as such funds are provided to programs and facilities operated directly by the Service."

#### NATIONAL HEALTH SERVICE CORPS

"SEC. 706. Title VII, as amended by section 705 of this Act, is further amended by adding at the end thereof the following new section:

#### "NATIONAL HEALTH SERVICE CORPS

"SEC. 712. The Secretary of Health and Human Services may remove a member of the National Health Service Corps from a health facility operated by a tribe or tribal organization under a contract with the Service entered into under the Indian Self-Determination Act only if the Secretary has provided written notice of such removal or withdrawal to such tribe or tribal organization at least 60 days before the date on which such contract is entered into or renewed."

#### HEALTH SERVICES FOR INELIGIBLE PERSONS

SEC. 707. (a) Title VII, as amended by section 706 of this Act, is further amended by adding at the end thereof the following new section:

#### "HEALTH SERVICES FOR INELIGIBLE PERSONS

"SEC. 713. (a)(1) Any individual who—

"(A) has not attained 19 years of age,

"(B) is the natural or adopted child, step-child, foster child, legal ward, or orphan of an eligible Indian, and

"(C) is not otherwise eligible for the health services provided by the Service. shall be eligible for all health services provided by the Service, on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

"(2) Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe of the eligible Indian. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

"(b)(1)(A) The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other subsection of this section or under any other provision of law if—

"(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals, and

"(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

"(I) the provision of such health services will not result in a denial or diminution of health services to eligible Indians, and

"(II) there is no reasonable alternative health facility or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

"(B) In the case of health facilities operated under a contract entered into under the Indian Self-Determination Act, the governing body of the Indian tribe or tribal organization providing health services under such contract is authorized to determine whether health services should be provided under such contract to individuals who are not eligible for such health services under any other subsection of this section or under any other provisions of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the considerations described in subparagraph (A)(ii).

"(2)(A) Persons receiving health services provided by the Service by reason of this subsection shall be liable for payment for such health services under a fee schedule prescribed by the Secretary which, in the judgment of the Secretary, results in reim-

bursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) or 1911(d) of the Social Security Act or any other provision of law, fees collected under this subsection, including Medicare or Medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the account of the facility providing the service and shall be used solely for the provision of health services within that facility. Fees collected under this subsection shall be available for expenditure within such facility for not to exceed one fiscal year after the fiscal year in which collected.

"(B) Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service providing such health services to such indigent person.

"(3)(A) In the case of a service area which serves only one Indian tribe, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian tribe revokes its concurrence to the provision of such health services.

"(B) In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

"(c) The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

"(1) achieve stability in a medical emergency,

"(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard.

"(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum, or

"(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

"(d) Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

"(e) For purposes of this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section."

#### INFANT AND MATERNAL MORTALITY; FETAL ALCOHOL SYNDROME

SEC. 708. Title VII, as amended by Section 707 of this Act, is further amended by adding at the end thereof the following new section:

#### "INFANT AND MATERNAL MORTALITY; FETAL ALCOHOL SYNDROME

SEC. 714. (a) By no later than January 1, 1989, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1993:

"(1) reduction of the rate of Indian infant mortality in each area office of the Service to the lower of—

"(A) twelve deaths per one thousand live births, or

"(B) the rate of infant mortality applicable to the United States population as a whole;

"(2) reduction of the rate of maternal mortality in each area office of the Service to the lower of—

"(A) five deaths per one hundred thousand live births, or

"(B) the rate of maternal mortality applicable to the United States population as a whole; and



"(3) reduction of the rate of fetal alcohol syndrome and fetal alcohol effect associated with maternal consumption of alcohol to the lower of—

"(A) one per one thousand live births, or

"(B) the rate of fetal alcohol syndrome and such fetal alcohol effect applicable to the United States population as a whole.

"(b) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in subsection (a)."

#### CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

SEC. 709. Title VII, as amended by section 708 of this Act, is further amended by adding at the end thereof the following new section:

#### "CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

"SEC. 715. (a) The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

"(b) Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986."

#### INDIAN HEALTH SERVICE AND VETERANS' ADMINISTRATION HEALTH FACILITIES AND SERVICES SHARING

SEC. 710. Title VII, as amended by section 709 of this Act, is further amended by adding at the end thereof the following new section:

#### "INDIAN HEALTH SERVICE AND VETERANS' ADMINISTRATION HEALTH FACILITIES AND SERVICES SHARING

"SEC. 716. (a) The Secretary shall examine the feasibility of entering into an arrangement for the sharing of medical facilities and services between the Indian Health Service and the Veterans' Administration and shall, in accordance with subsection (b), prepare a report on the feasibility of such an arrangement and submit such report to the Congress by no later than September 30, 1990.

"(b) The Secretary shall not take any action under subchapter IV of part VI of title 38, United States Code, which would impair—

"(1) the priority access of any Indian to health care services provided through the Indian Health Service;

"(2) the quality of health care services provided to any Indian through the Indian Health Service;

"(3) the priority access of any veteran to health care services provided by the Veteran's Administration;

"(4) the quality of health care services provided to any veteran by the Veteran's Administration;

"(5) the eligibility of any Indian to receive health services through the Indian Health Service; or

"(6) the eligibility of any Indian who is a veteran to receive health services through the Veteran's Administration.

"(c) Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Indian Health Service."

#### REALLOCATION OF BASE RESOURCES

SEC. 711. (a) Notwithstanding any other provision of law, any allocation of the base resources of the Indian Health Service for fiscal year 1988 that—

(1) differs from the allocation of the base resources of the Indian Health Service that was made for fiscal years 1987, and

(2) affects more than 5 percent of the base resources of the Indian Health Service for fiscal year 1988, may be implemented only after the Secretary of Health and Human Services has met the requirements of subsection (b) with respect to such reallocation.

(b) The Secretary of Health and Human Services meets the requirements of this subsection with respect to any reallocation of base resources described in subsection

(a) when the Secretary of Health and Human Services has submitted to the Congress—

(1) a written statement certifying that the Secretary of Health and Human Services has held consultations regarding such reallocation of base resources with the Indian tribes and tribal organizations affected by such reallocation; and

(2) a report on the proposed change in allocation of base resources, including the reasons for the change and its likely effects.

#### PROVISION OF SERVICES IN MONTANA

SEC. 712. (a) The Secretary of Health and Human Services, through the Indian Health Service, shall provide services and benefits for Indians in Montana in a manner consistent with the current policy as allowed by the stay during the pending litigation in *McNabb v. Heckler*, 628 F. Supp. 544 (D. Mont. 1986).

(b) The provisions of this section shall not be considered to be an expression of the sense of the Congress on the merits of the district court decision described in subsection (a).

#### TOHONO O'ODHAM DEMONSTRATION PROJECT

SEC. 713. (a) The Secretary, acting through the Service, shall make grants to the Tohono O'odham Tribe of Arizona to establish a demonstration project under which such tribe may develop and test a phased approach to assumption by such tribe of the health care delivery system of the Service for members of such tribe living on or near the reservations of such tribe through the use of Service, tribal, and private sector resources.

(b) During the period in which the demonstration project established under subsection (a) is being conducted, the Secretary shall award health care contracts, including community, behavioral and preventive health care contracts, to the tribe in the form of a single grant to which the regulations prescribed under part A of title XIX of the Public Health Service Act (as modified as necessary for agreement entered into between the Secretary and such tribe to achieve the purposes of the demonstration project under subsection (a)) shall apply.

(c) The Secretary may waive such provisions of Federal procurement law as are necessary to enable the Tohono O'odham tribe to develop and test administrative systems under the demonstration project, but only if such waiver does not diminish or endanger the delivery of health care services to Indians.

(d) The demonstration project established under subsection (a) shall terminate four years after the date it is established. Within a reasonable time thereafter, the Secretary shall submit a report to the Congress evaluating the performance of the tribe under such project.

(e) There is authorized to be appropriated \$275,000 for each of the fiscal years 1988, 1989, and 1990, and \$75,000 for fiscal year 1991 for the purposes of this section.

SEC. 714. (a) The Secretary of Health and Human Services (acting through the Director of the Indian Health Service), the Secretary of the Interior (acting through the Bureau of Indian Affairs), and the Secretary of Energy shall jointly conduct a study for the purpose of determining—

(1) the number of active nuclear resource development sites on Indian lands in the United States;

(2) the Federal agencies that carry out Federal responsibilities with respect to each such site;

(3) the health hazards that exist as a result of such sites;

(4) the remedial actions which have been undertaken with respect to such health hazards;

(5) remedial actions that are needed with respect to such health hazards; and

(6) the amount of funds that would be necessary each year to implement and maintain such needed remedial actions and the date by which the remedial actions would be implemented if sufficient funds were to provide for the remedial actions.

(b) Not later than two years after the date of the enactment of this Act, a report shall be submitted to the Congress describing the findings and conclusions made as a result of carrying out the study required in subsection (a).

#### TITLE VIII—DIABETES PREVENTION AND CONTROL

SEC. 801. The Indian Health Care Improvement Act is amended by adding at the end thereof the following new title:

# "TITLE VIII—DIABETES PREVENTION AND CONTROL

## "FINDINGS AND PURPOSE

"Sec. 801. (a) The Congress finds that—

"(1) the incidence of diabetes among Indians is significantly higher than in other population groups within the United States;

"(2) in several Indian tribes over 40 percent of the adults have diabetes compared with approximately 3 percent of the overall United States adult population;

"(3) diabetes has become the second leading reason for outpatient visits by Indians to Service facilities nationwide;

"(4) serious complications of diabetes, such as kidney failure, hypertension, amputation, and blindness, are increasing in frequency among Indians;

"(5) health care costs for treatment of diabetes and related complications among Indians will increase significantly in the long term unless the Department of Health and Human Services—

"(A) determines the cause of diabetes among Indians,

"(B) develops early diagnosis, treatment, and prevention programs to reduce the incidence of diabetes among Indians, and

"(C) trains, or provides for the training of, Federal and Indian health care providers in the diagnosis, treatment, and control of diabetes and related complications;

"(6) a Model Diabetes Control Program exists within the Service, consisting of seven project sites which serve only 10 percent of the Service patients; and

"(7) outreach services and the conveyances of effective treatment strategies from the model project sites need to be implemented.

"(b) The purposes of this title are—

"(1) to broaden the research program of the Department of Health and Human Services relating to diabetes and related complications among Indians;

"(2) to strengthen the efforts of the Service for the treatment of diabetes through the implementation of a program for the prevention and control of diabetes and related complications on each Indian Reservation and for each Alaska Native Village; and

"(3) to achieve a reduction in the incidence of diabetes among Indian populations to rate comparable to that of the general United States population.

## "STUDY OF DIABETES AMONG INDIANS

"Sec. 802. (a) The Secretary shall determine—

"(1) the incidence of diabetes among Indians;

"(2) activities the Service should take—

"(A) to reduce the incidence of diabetes among Indians,

"(B) to provide Indians with guidance in the prevention, treatment, and control of diabetes,

"(C) to provide early diagnosis of diabetes among Indians, and

"(D) to ensure that proper continuing health care is provided to Indians who are diagnosed as diabetic; and

"(3) the fiscal impact to the Federal Government of treating the long-term complications of diabetes based upon the existing prevalence and incidence of diabetes among Indians.

"(b) The Secretary shall prepare an inventory of all health care programs and resources (public and private) within the United States that are available for the treatment, prevention, or control of diabetes among Indians.

"(c) Within 18 months after the date of enactment of the Indian Health Care Amendments of 1987, the Secretary shall prepare and transmit to the President and the Congress a report describing the determinations made under subsection (a), containing the inventory prepared under subsection (b), and describing the research activities conducted under this title.

## "DIABETES CARE PROGRAM

"Sec. 803. (a) Within 18 months after the date of enactment of the Indian Health Care Amendments of 1987, the Secretary shall implement a program designed—

"(1) to strengthen and expand the diabetes control program of the Service;

"(2) to screen each individual who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic;

"(3) to enable all service units of the Service to treat effectively—

"(A) newly diagnosed diabetics in order to reduce future complications from diabetes,

"(B) individuals who have a high risk of becoming diabetic in order to reduce the incidence of diabetes, and

"(C) short-term and long-term complications of diabetes;

"(4) to conduct, for Federal, tribal, and other Indian health care providers (including community health representatives), training programs concerning current methods of prevention, diagnosis, and treatment of diabetes and related complications among Indians;

"(5) to determine the appropriate delivery to Indians of health care services relating to diabetes;

"(6) to develop and present health education information to Indian communities and schools concerning the prevention, treatment, and control of diabetes; and

"(7) to ensure that proper continuing health care is provided to Indians who are diagnosed as diabetic.

"(b) The Secretary shall—

"(1) promote coordination and cooperation between all health care providers in the delivery of diabetes related services; and

"(2) encourage and fund joint projects between Federal and tribal health care facilities and Indian communities for the prevention and treatment of diabetes.

"(c)(1) The Secretary shall continue to maintain each of the following model diabetes clinics which are in existence on the date of enactment of the Indian Health Care Amendments of 1987:

"(A) Claremore Indian Hospital in Oklahoma;

"(B) Fort Totten Health Center in North Dakota;

"(C) Sacaton Indian Hospital in Arizona;

"(D) Winnebago Indian Hospital in Nebraska;

"(E) Albuquerque Indian Hospital in New Mexico;

"(F) Perry, Princeton, Old Town and Houlton Health Centers in Maine; and

"(G) Bellingham Health Center in Washington.

"(2) Within 2 years after the date of enactment of the Indian Health Care Amendments of 1987, the Secretary shall establish and maintain a model diabetes clinic in each of the following locations:

"(A) the Navajo Reservation;

"(B) the Papago Reservation;

"(C) the States of Alaska, Minnesota, and Montana; and

"(D) the Zuni Reservation.

"(3) The Secretary shall develop and implement an outreach program to ensure that the achievements and benefits derived from the activities of the model diabetes clinics maintained under this section are used by all service units of the Service in the diagnosis, prevention, and treatment of diabetes among Indians.

"(d)(1) The Secretary shall maintain appropriate personnel within the Service to develop and implement the provisions of this title and to manage and coordinate the diabetes care program of the Service.

"(2) The Secretary shall employ in each area office of the Service at least one diabetes control officer who shall coordinate and manage on a full-time basis the diabetes care program of the Service in the area served by such area office.

"(e) The Secretary shall submit to the Congress an annual report outlining the activities, achievements, needs, and future goals of the diabetes care program of the Service.

#### "DATA COLLECTION AND ANALYSIS

"Sec. 804. The Secretary shall develop and maintain a comprehensive standardized system within the Service to collect, analyze, and report data regarding diabetes and related complications among Indians. Such system shall be designed to facilitate dissemination of the best available information on diabetes to Indian communities and health care professionals. Such system shall be operational within 2 years after the date of enactment of the Indian Health Care Amendments of 1987.

**"RESEARCH"**

"Sec. 805. The Secretary shall require each agency and unit of the Department of Health and Human Services which conducts research relating to diabetes—

"(1) to give special attention to research concerning the causes, diagnosis, treatment, and prevention of diabetes and related complications among Indians; and

"(2) to coordinate such research with all other agencies and units of the Department of Health and Human Services which conduct research relating to diabetes and related complications.

**"REGULATIONS"**

"Sec. 806. The Secretary may prescribe such regulations as may be necessary to carry out the provisions of this title.

**"AUTHORIZATION OF APPROPRIATIONS"**

"Sec. 807. There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this title."

**TITLE IX—SEVERABILITY PROVISION**

SEC. 901. If any provision of this Act, any amendment made by this Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provision or amendment to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

Amend the title so as to read:

To reauthorize and amend the Indian Health Care Improvement Act, and for other purposes.

**PURPOSE**

The purpose of H.R. 2290, by Mr. Udall and others, is to reauthorize the programs established by the Indian Health Care Improvement Act and to make sundry amendments thereto.

**BACKGROUND**

The Federal government has a historical and unique legal relationship with, and a resulting responsibility to, Indian tribes and their members. This relationship is founded upon section 8 of Article I of the United States Constitution which provides that: "The Congress shall have power \* \* \* To regulate commerce with foreign Nations, and among the several States, and with the Indian Tribes \* \* \*" The responsibility for health services has been expressed in numerous treaties with Indian tribes in which the United States agreed to provide such services. For example, in Article 2 of the 1854 Treaty with the Rogue River Indians (10 Stat. 1119), the United States agreed that " \* \* \* provision shall be made \* \* \* for a hospital, medicines, and a physician." The responsibility has been further delineated and defined by numerous 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 the Indian tribes and their members. It is the stated purpose of the Indian Health Care Improvement Act that this obligation shall be met in a manner that will insure a health status for Indians at a parity with the rest of the Nation.

## EVOLUTION OF THE FEDERAL ROLE

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

The provision of medical care to American Indians by the Federal government gradually expanded through 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 Department of Health, Education and Welfare (now the 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, in part to reduce unmet needs under existing programs, and in part 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 Indian and Alaska Natives over a seven-year period, ending in FY 1984, to a level comparable to that of the general U.S. population. Since the 1976 Act provided only a three-year authorization, the Congress, in 1980, revised and extended the legislation through September 30, 1984 (P.L. 96-537).

## THE NATIVE AMERICAN POPULATION

According to the Indian Health Service (IHS), there are currently an estimated 1.5 million American Indians and Alaska Natives in the United States. Of that total, approximately 1.4 million live in the 33 "Reservation States." These are the States in which the Indian Health Service has the responsibility to provide health care to eligible Indian and Alaska Natives on reservations or in traditional Indian communities. Approximately 909,000 eligible persons of the 1.4 million Indians and Alaska Native's living in the 33 Reservation States constitute what the IHS considers its "service" population.

The remaining 442,000 individuals are considered a "non-service" population. Some of this "non-service" population is located in areas served by urban health clinics funded under Title V of the Indian Health Care Improvement Act. In such cases, individuals may receive services from those clinics. Otherwise, these Indians must obtain services from other sources.

## HEALTH STATUS OF INDIANS

In general, the health status of Indians is poorer than that of the general U.S. population. The Congressional findings set forth in the Indian Health Care Improvement Act include several examples of the disparity between the health status of Indians compared with that of the general U.S. population: " \* \* \* for Indians compared to all Americans in 1971, the tuberculosis death rate was over four and one-half times greater, the influenza and pneumonia death rate over one and one-half times greater and the infant death rate approximately 20 percentum greater."

Data supplied in January 1987, by the IHS shows little improvement or decline in two of these areas. The age-adjusted tuberculosis death rate for American Indians and Alaska Natives in 1984 was 3.6 times greater than that for the general U.S. population. In the same year, the influenza and pneumonia death rate was 1.5 times as great. With respect to infant mortality, the rate has fallen among the Indian population since 1971, and the gap between the Indian and the general U.S. population has nearly disappeared. For 1983, the infant mortality rate for Indians was 10.2 deaths per thousand live births compared with 11.2 for the U.S. population. However, the postneonatal (28 days—11 months) death rate for Indians was 5.6 per thousand live births as compared with only 3.9 for the U.S. population.

Table 1 compares the Indian and the U.S. general population in age-adjusted mortality rates from selected causes in 1976, when the Indian Health Care Improvement Act was enacted, and in 1984, the most recent year for which such comparative data are available. These data show that there has been an improvement, but that the health status of the Indian and Native Alaska population remains below that of the general U.S. population. Indians still die of tuberculosis at a rate 3.6 times that of other U.S. citizens, and of alcoholism at a rate of 4.8 times as great.

Morbidity rates are also higher among Indians than among the U.S. general population. For example, in 1982, according to the IHS, the incidence of tuberculosis in the general population was 11.0 per 100,000. Among Indians and Alaska Natives, the incidence was 36.6 per 100,000, or more than 3 times as great.

TABLE 1.—AGE ADJUSTED MORTALITY RATES FOR INDIANS AND ALASKA NATIVES AND UNITED STATES, ALL RACES FOR SELECTED CAUSES—1976 AND 1984

[Deaths per 100,000 population]			
Year	Indians and Alaska Natives	United States, all races	Ratio of Indian and Alaska Natives, to United States, all races
Alcoholism:			
1976.....	69.8	8.6	8
1984.....	30.0	6.2	4.8
Diabetes:			
1976.....	23.3	11.1	2.1
1984.....	20.6	9.5	2.2
Gastro-Intestinal:			
1976.....	4.4	2.1	2.1
1984.....	3.6	2.8	1.2





with the construction and operation of sewage treatment and clean water facilities. The presence of sanitary water and sewer systems can have a major positive impact on the health status of the Indian and Alaska Native people, and particularly among infants.

In total, the IHS owns and operates 45 hospitals, 65 health centers, and 138 smaller health stations and satellite clinics. In addition, 6 hospitals and over 294 outpatient facilities are operated by various tribes under contract with the IHS, pursuant to the Indian Self-Determination Act (P.L. 93-638). The IHS also devotes a substantial portion of its resources to purchase "contract care" services outside of its direct delivery system from private and public health care providers.

The IHS hospital system includes 51 hospitals, most of which are located in rural areas, with bed capacities ranging from fewer than 25 beds to more than 100 beds. At least 40 of these hospitals have fewer than 100 beds; at least 10 hospitals have fewer than 25 beds. Nearly half of the 51 hospitals are more than 30 years old; 18 were built between 1912 and 1933, and 3 were built between 1940 and 1954. By way of comparison, the average size of community hospitals in the U.S. in 1982 as 174 beds, up from 153 beds in 1972. In 1982, only 235 of the 5,801 community hospitals in the U.S. had fewer than 25 beds.

The leading causes of admission to IHS hospitals are (1) child-birth (including normal deliveries) and complication of pregnancy; (2) injuries and poisonings; (3) respiratory system diseases; and (4) digestive system diseases.

#### IHS HOSPITAL ACCREDITATION

In the 1976 Indian Health Care Improvement Act, Congress found that only 24 of 51 hospitals were accredited by the Joint Commission on Accreditation of Hospitals (JCAH), and that only 31 met national fire and safety standards.

The JCAH is a private organization that has established standards for the delivery of quality medical care by hospitals and other institutions. Hospitals that meet JCAH accreditation standards are deemed to have met Medicare conditions of participation. Title IV of P.L. 94-437 contains two provisions designed to help the IHS to upgrade its facilities and improve this record. The IHS was made eligible to receive reimbursements from the Medicare and Medicaid programs for services rendered to Indians covered under those two programs. Title IV also required the surveying of all IHS facilities and the preparation of plans for the correction of deficiencies.

Currently, 43 of the 51 hospitals operated by the IHS or tribal organizations are accredited by the JCAH. The 8 non-accredited hospitals are all certified by the Health Care Financing Administration of the Department of Health and Human Services for participation in the Medicare program. Therefore, all 51 IHS/Tribal contract hospitals are currently eligible to participate in Medicare and Medicaid. Forth-three of the 51 IHS/Tribal-contract hospitals currently meet national fire and safety standards.

## IHS STAFFING

Recently, the Office of Technology Assessment (OTA) issued a report on IHS's clinical staffing problems. That report, dated February 1987, identified the major issues and barriers confronting the IHS in its efforts to recruit and retain physicians in particular and other health professionals in general. The report's purpose was to identify the current sources of health manpower for IHS, review means of improving recruitment and retention of personnel, and examine these activities and other methods for ensuring an adequate supply of health services to American Indians and Alaska Natives.

OTA's report not only underscored the reasons for the staffing shortages currently experienced by IHS, but also provided specific, grim projections on the staffing shortages which IHS would begin to experience as early as 1987. IHS presently provides direct health care services to eligible Indians through 51 hospitals, 124 full-time outpatient health centers and numerous tribally contracted health programs. IHS has relied on 130 to 150 new physicians annually from the National Health Service Corp (NHSC) program to meet the annually vacated 200 physician positions. After 1987, the total NHSC physician pool, which IHS and other federal agencies rely on for their health manpower needs, will drop from 1,000 to 500. After 1988, no more than 320 physicians will remain in the NHSC pipeline. The NHSC also provides IHS with other health professionals through this same program. As a result, IHS's ability to recruit adequate personnel from this severely diminished pool will be drastically impaired. The effects of reduced recruitment will have an immediate impact on the IHS's ability to adequately maintain the operation of many of its facilities. It is possible that the IHS may have to close, temporarily or intermittently, several of its facilities.

With the demise of the National Health Service Corp (NHSC) as a scholarship grant program, IHS will be without a primary source for its recruitment of health personnel. Originally, this program funded medical students through a grant, in return for a service payback obligation by the recipient in one of several federal agencies, such as IHS. This program's new scholarship grant assistance funds by the NHSC had also been steadily reduced prior to the program termination. The end result is a major decrease in the number of individuals available to serve in IHS or other areas of health manpower shortages.

The Indian Health Service employed in 1985, according to OTA, approximately 726 physicians, 2,766 nurses, and 4,452 other clinical staff throughout its system. IHS is unable to accurately identify the actual staffing shortages it presently experiences since its staffing projections are based on maintaining its present level of operation, without regard to total community needs. While the IHS utilizes the Joint Commission on Accreditation of Hospitals (JCAH) standard for its facility staffing requirements, these are minimum standards which do not incorporate criteria reflecting the staffing levels needed to meet a certain health care status among its service population. IHS's present annual estimate of staffing needs also in-

cluded their estimates of staffing levels required to operate all newly constructed facilities.

IHS staffing requirements should be, but are not, based on a methodology which would estimate what levels should be obtained by IHS to raise the health status of Indian people to a level comparable with the rest of this country. The OTA was unable to accurately portray the clinical staffing shortages IHS will be experiencing. However, OTA was able to provide an estimate of these shortages based on its review as a minimum projection, in which estimate the Committee concurs. OTA estimated that the IHS's staffing shortages are approximately 10 to 15 percent of its total staff. Since IHS's staff in 1985, in total, is 10,394, 10 to 15 percent would equal a 1,000 to 1,500 staff shortfall.

Since IHS personnel actions are presently administered through the Health Resources and Services Administration (HRSA), the agency which oversees the IHS, the process of recruitment, placement and retention is further complicated. Additionally, there exists two separate personnel systems affecting IHS. One system is the standard civil service system which is controlled through HRSA. The other is the Commission Corps system which is under the direct supervision of the Assistant Secretary's Office. Both systems complement one another in ensuring that the staffing needs of IHS's health care delivery system are provided for. However, this process is cumbersome, and does not promote IHS accountability nor tribal involvement in either recruitment or retention.

Table 2 shows the IHS staffing levels for a six year period by professional category. This table was prepared by the OTA staff as part of its IHS Clinical Staffing report. The IHS staffing requirements are very diverse, particularly since the agency is responsible for comprehensive, direct health care services to Indian people across the country.

TABLE 2—IHS FULL TIME PERMANENT STAFF, BY PROFESSIONAL CATEGORY, WITH PERCENT INDIAN, FISCAL YEAR 1980-85

Professional category	1980 <sup>1</sup>		1981 <sup>2</sup>		1982		1983		1984		1985	
	Numbers	Percent Indian	Numbers	Percent Indian	Numbers	Percent Indian	Numbers	Percent Indian	Numbers	Percent Indian	Numbers	Percent Indian
1. Professional Patient (direct patient care and support) .....	9,783	59.5	7,709	53.8	7,179	53.6	7,335	54.5	8,038	55.3	7,944	55.1
a. Physicians .....	612	2.0	656	2.0	619	3.1	645	2.9	711	3.2	726	3.0
b. Dentists .....	270	.4	269	2.2	190	2.1	254	2.8	269	3.3	275	2.9
c. Physicians assistant .....	85	100.0	84	78.6	78	83.3	81	85.2	83	86.7	83	12.0
d. Graduate nurses .....	1,498	21.8	1,731	23.1	1,646	25.7	1,725	26.5	1,895	27.1	1,952	28.6
e. Practical nurses .....	550	78.4	921	90.8	834	91.7	833	92.9	867	93.2	814	93.5
f. Pharmacists .....	253	.4	275	7.3	280	8.6	284	9.5	295	8.8	307	8.8
g. Social workers .....	124	52.4	110	37.3	105	41.9	100	49.0	112	54.5	111	59.5
h. Health educators, dietitians .....	138	22.5	122	34.4	132	31.1	100	14.0	107	17.8	109	24.8
i. Medical clerks <sup>3</sup> and records staff .....	43	39.5	552	91.7	462	90.5	504	91.3	582	93.3	585	93.7
j. Medical auxiliary <sup>3</sup> .....	419	72.3	676	58.6	640	54.1	648	54.8	694	54.0	709	54.2
k. Dental auxiliary <sup>3</sup> .....			343	92.7	329	93.0	350	92.0	366	93.7	371	93.3
l. Sanitarians .....	348	10.3	210	18.6	201	19.9	139	25.2	147	22.4	153	24.8
m. All others .....	5,443	82.9	1,760	83.2	1,663	81.5	1,672	84.1	1,910	84.6	1,749	86.8
2. Administrative (HQ and area offices) .....	1,461	66.1	2,688	71.9	2,321	71.3	2,297	72.3	2,304	73.6	2,450	73.9
IHS Total staff .....	11,244	60.4	10,397	58.5	9,500	58.0	9,632	58.7	10,342	59.3	10,394	59.5

<sup>1</sup> Fiscal year 1980 data reflect staff as of Dec. 31, 1979. As of August 1980, staff was 10,620 (57.6 percent Indian).

<sup>2</sup> For fiscal years 1981-85, data reflect staff as of Sept. 30 of each year.

<sup>3</sup> Dental auxiliaries were not listed separately for fiscal year 1980 and are assumed to be included in "all others." In 1980, the "all others" category included medical clerks, records librarians and technicians, and medical technicians/auxiliaries categories, reported separately in subsequent years.

Source: Adapted by OTA from U.S. DHHS, PHS, HRSA, IHS, "Annual Report to Congress on the Indian Civil Service Retirement Act," Public Law 96-135," for fiscal years 1980-85.

As the data in Table 2 reflects, the majority of Indian personnel are concentrated in the administrative functions. IHS's manpower programs are targeted, primarily, to addressing the recruitment of Indians into those health profession which are identified by IHS as shortage categories. While the Manpower program is authorized to fund scholarships to eligible Indians, with a required service pay-back obligation to IHS, it is inadequately funded to meet all of IHS's staffing needs. IHS will, for the foreseeable future, continue to rely on other federal manpower programs to help meet its needs and responsibilities. IHS's Manpower Program efforts, however, are still critical in assisting Indians into health careers where Indians, as a group, are extremely underrepresented.

#### IHS FUNDING LEVELS

Table 3 presents IHS health service appropriations levels from fiscal year 1980 through the President's fiscal year 1988 budget proposal. The President's request is lower than both the previous year's appropriation and the amount that would be necessary to maintain purchasing power at the fiscal year 1980 level.

Table 3.—Indian Health Service appropriations, fiscal years 1980-1988

[In millions of dollars]	
1980.....	621
1981.....	690
1982.....	676
1983.....	753
1984.....	824
1985.....	793
1986.....	821
1987.....	860
1988 (proposed).....	800

NOTE.—These totals exclude Facilities Construction.

Source: Indian Health Service, June 1987.

The IHS allocates its funding among 6 major activities: clinical services; preventive health (sanitation, public health nursing, and health education); urban health projects; health manpower; tribal management; and administrative. By far the largest of these activities, representing over 80 percent of the IHS's fiscal year 1987 budget, is "clinical services". This refers to the medical care, including hospital and outpatient clinic services, dental care, mental health and alcoholism services provided by the IHS facilities and the tribal health contractors. This activity also includes "contract care" expenditures by the IHS on behalf of the eligible individuals for services received outside the IHS or tribal care system. Table 4 shows the level of funding for clinical service for fiscal years 1983-1987.

TABLE 4.—OBLIGATIONS FOR IHS CLINICAL SERVICES, 1983-1987

[In thousands of dollars]					
	1983	1984	1985	1986	1987
Indian Health Delivery Systems.....	365,917	405,603	385,968	394,337	444,014
Tribal Delivery Systems.....	63,295	81,127	112,901	119,609	129,000
Total.....	429,212	486,730	498,869	513,946	573,014

TABLE 4.—OBLIGATIONS FOR IHS CLINICAL SERVICES, 1983-1987—Continued

(In thousands of dollars)

	1983	1984	1985	1986	1987
Contract Care.....	139,905	157,771	163,953	172,319	<sup>1</sup> 173,007
Total Clinical Services.....	569,117	644,501	662,822	686,265	746,021
Total IHS Obligations <sup>2</sup> .....	691,229	788,682	810,985	836,754	860,000

<sup>1</sup> Excludes \$10,000,000 Catastrophic Emergency Fund.<sup>2</sup> Excludes Facilities Construction.

Source: Indian Health Service, June 1987.

IHS funds are appropriated under a number of different authorities, including the Snyder Act, the Transfer Act, the Self-Determination Act and the Indian Health Care Improvement Act. According to the IHS, appropriations spend under the authority of the Indian Health Care Improvement Act will total \$128.6 million in fiscal year 1986, or about 15 percent of the total IHS appropriation for that year.

Table 5 indicates the funds spent under the Indian Health Care Improvement Act, by major title, between fiscal year 1982 and fiscal year 1987. During this period, appropriations for the authorities contained in the Indian Health Care Improvement Act increased by nearly 50 percent—from \$110.5 million to \$163.4 million. Appropriations for health manpower and health services increased slightly. Funding for health facilities have fluctuated up and down over the five-year period. The only significant increases in funding has been in the area of health services, from \$43.2 million in fiscal year 1982 to \$81.8 million in fiscal year 1987.

TABLE 5.—APPROPRIATIONS UNDER INDIAN HEALTH CARE IMPROVEMENT ACT AUTHORITIES

(In thousands of dollars)

	1982	1983	1984	1985	1986	1987
Manpower.....	5,760	5,760	6,000	6,499	6,395	7,018
Services.....	43,171	55,088	66,069	72,981	71,981	81,797
Facility.....	58,352	73,700	53,595	61,634	46,198	71,055
Urban services.....	3,250	3,250	3,250	3,250	3,218	3,250
Totals.....	110,533	137,798	128,914	143,465	128,575	163,390

Source: Indian Health Service, June 1987.

### CONTRACT CARE

The purchase of medical care services from non-service providers (predominately the private sector) is an essential component of the IHS and tribal patient care delivery systems. These contract health services under governing regulations at 42 CFR 36 Subpart C are used to supplement other health care resources available to Indian people. Approximately 1,300 contracts exist with health care providers for services on a daily basis. Numerous additional purchase orders are issued during the course of a year for limited services, such as emergency care, from providers generally not utilized on a regular basis.

The Contract Health Service (CHS) program includes the purchase of General Medical and Surgical Hospitalization such as hospital, physician and other services incidental to inpatient care. Ambulatory care services, including services such as outpatient physician care, laboratory, x-ray and pharmacy are also included within the program. Limited patient and escort travel and dental services are provided. Other costs are incurred to support the direct delivery of care, such as medical referrals, diagnostic services, and needed specialist consultations.

Following the signing of P.L. 99-222 (Sec. 2116) on April 4, 1986, which allows the IHS to contract with a fiscal agent, the CHS program developed a new payment policy which was published in the *FEDERAL REGISTER*, June 30, 1986. This policy caps payments to contract providers at the Medicare allowable rate. Cost savings from the implementation of the policy are projected to allow IHS to purchase additional health services for eligible American Indians and Alaska Natives.

In order to achieve the goal of raising the health status of American Indians and Alaska Natives, funds used in the CHS program must be utilized with certain priorities in mind. The IHS funds are primarily used for urgent and emergency care priorities.

Contract health services funds will be expended for emergency services, only to the extent that a non-IHS facility is the nearest available provider capable of providing the necessary services. Guidelines have been developed and implemented to increase the effective and efficient use of IHS contract health service funds. The guidelines established specific responsibilities for administration of CHS, including medical priorities for use of the funds, authorization and fund control procedures and specific criteria identifying persons to whom CHS will be provided. Under these guidelines, CHS funds are not to be expended for services that are reasonably accessible and available at an IHS facility or from alternate resources such as Medicare/Medicaid, state and local programs, and private insurance.

These guidelines provide that non-emergency services are not to be authorized for payment for patients considered to have reasonable access to IHS direct services. Patients residing within 90 minutes surface transportation time to an IHS facility capable of providing the required services are considered to have reasonable access to direct service.

The inpatient activity consumes approximately 50 percent of the total CHS funding. Ambulatory care is projected to increase at a rate of approximately 10 percent in cost per visit in FY 1988. Dental service costs are expected to rise by 6 percent, which is expected to provide services in FY 1988 at a level that is less than in FY 1987.

#### ACCOMPLISHMENTS

Acting on the recommendations of the IHS Director's 1985 Task Force on Contract Health Care Service, the IHS undertook the procurement of a Fiscal Intermediary (FI) for the processing and payment of CHS claims. A contract for these services was signed with Blue Cross and Blue Shield of New Mexico on September 17, 1986

and on October 1, 1986, CHS claims from providers began to be submitted to the FI for processing and payment.

Improvement in the methodology utilized in the allocation of resources has resulted in a more effective use of IHS clinical funds including a more equitable distribution of the overall resources, including contract care funds.

Although the implementation of the CHS payment policy is expected to result in cost savings, it is very difficult to project a reasonable estimate of FY 1987 cost savings since IHS has just begun negotiating contracts with provider hospitals under their new requirements, and the initial input from the field is mixed. The payment options available are: (1) medicare DRG rates or lower rates; (2) a percentage of billed charges or; (3) a flat per diem rate. All options are being used with contract hospitals, however some providers have refused to deal with IHS on any reduced flat basis. Additionally, there are previously existing contracts with many provider hospitals that still require renegotiation.

Included in the FY 1987 Appropriation for the CHS activity is \$10 million, to be available until expended, for a new Catastrophic Health Emergency Fund. Obligation of these funds has been deferred pending development of administrative guidelines. At the same time that the IHS is preparing these guidelines, the IHS has also been working with the Area Offices to identify the extent of the need for such funds by each area. IHS expects to fully implement this program in FY 1987. Table 6 shows the level of CHS funding from fiscal year 1982 through 1987.

Table 6.—IHS contract care expenditures, fiscal year 1982-87

[In thousands of dollars]	
1982.....	122,938
1983.....	139,907
1984.....	157,771
1985.....	163,953
1986.....	172,319
1987 (estimated) <sup>1</sup> .....	173,007

<sup>1</sup> Excludes \$10,000,000 Catastrophic Health Emergency Fund.

Source: Indian Health Service, June 1987.

Table 7 shows that a significant part of this overall increase in contract care outlays is attributable to the use of an increasingly larger proportion of available funds for hospitalization and ambulatory care with only a slight increase for other lower priority services.

TABLE 7.—CONTRACT CARE OBLIGATIONS BY TYPE OF EXPENDITURE

[In thousands of dollars]			
	1985 actual	1986 (revised)	1987 (estimate)
Hospitalization:			
ADPL.....	290,000	263,000	266,000
Per diem.....	773,000	894,000	920,000
Total.....	81,814,000	85,814,000	89,500,000
Ambulatory care.....	30,902,000	32,398,000	35,500,000
Patient and escort travel.....	5,372,000	5,686,000	5,732,000
Dental services.....	7,656,000	8,981,000	9,139,000
Other.....	38,953,000	39,440,000	33,842,000
Total amount.....	163,953,000	172,319,000	173,713,000

Source: Fiscal year 1987 IHS appropriations justification, p. 74.



## URBAN HEALTH SERVICES

Indians began to relocate from reservations and tribal communities into cities during the 1950's. By 1980, 49 percent of the Indian population in the 33 Reservation States lived in urban areas. Many of these Indians experienced difficulty in gaining access to health care and other services because of language, cultural, and economic barriers. Some Indian groups established free health clinics in cities with significant Indian population, such as Oklahoma City, Seattle, and Los Angeles, to meet the need of these individuals.

In 1976, Congress established, through Title V of the Indian Health Care Improvement Act, a program to make health services available to medically underserved Indians living in urban (and rural) areas. With funds appropriated under this authority, the IHS contracts with urban Indian organizations to support 35 programs in cities throughout the U.S. These programs provide outreach and referral services and comprehensive ambulatory health care services, including outpatient medical and dental services, and related services such as family planning, mental health, nutrition and health education, alcoholism counseling, and home health care.

In addition to grant support from IHS, the 35 urban Indian projects receive funding support from other sources, including third party reimbursements (Medicare, Medicaid, and private insurance), patient out-of-pocket payments, and grants from the private sector, such as foundations, corporations, and church groups. In addition, physicians and dentists sometimes volunteer their services to the projects.

The urban health projects do not provide inpatient hospital care, but they do provide referral services for their patients needing such care. If a patient is eligible for coverage under Medicare or Medicaid or private health insurance, he might be referred to a local hospital. If not eligible under any such third-party reimbursement program, but eligible for care from the Indian Health Service, he might be referred to the IHS facility in his home reservation or community for inpatient care.

In FY 1986, approximately 160,000 medical services were provided along with 50,000 dental, 110,000 community services and 190,000 other health related services. Over \$9 million was generated from other non-IHS sources by the 35 programs. Experience has shown that the IHS funding support enhances the ability of the programs to generate other sources of funding.

## MEDICARE AND MEDICAID

Prior to the enactment of the Indian Health Care Improvement Act in 1976, IHS facilities, like all other Federal health facilities, were not eligible for payment for services they provided to Medicare or Medicaid beneficiaries. In order to assure eligible Indians had access to the same quality of care that other Medicare and Medicaid beneficiaries had, Congress, in Title IV of the Act, made qualified IHS (or tribally operated) facilities eligible for Medicare and Medicaid reimbursement.

With respect to Medicare, the Federal program for elderly and disabled, the act specified that IHS (or tribally operated) hospitals or skilled nursing facilities (SNF) could receive Medicare reimbursement for serving eligible beneficiaries. Medicare payments must be placed in a special fund to be used (as provided in appropriations acts) exclusively for the purpose of bringing all IHS hospitals or SNFs into compliance with Medicare conditions of participation.

With respect to Medicaid, Title IV provides that qualified IHS (or tribally-operated) hospitals, skilled nursing facilities, or intermediate care facilities can receive Medicaid reimbursement for covered services provided to eligible Indians. The Federal Medicaid matching rate in the case of these services is 100 percent; that is, the Federal government pays the entire cost of services provided to Medicaid-eligible Indians by IHS facilities. As in the case of Medicare payments, the Secretary is to hold Medicaid reimbursements in a special fund for bringing IHS facilities into compliance with program standards.

The reimbursements received by IHS from Medicare and Medicaid have, by and large, been used to correct deficiencies through (1) the hiring of temporary staff to correct shortages, (2) the purchase of necessary equipment, and (3) routine maintenance and repair. In fiscal year 1986, approximately \$42 million in Medicare and Medicaid funds collected by IHS were used to correct deficiencies cited by JCAH or Medicare surveys.

The IHS began an automated billing system in 1984 for both Medicare and Medicaid. All outpatient Medicare claims are automated. Approximately 60 percent of the Medicaid outpatient claims have been automated. Currently, IHS is developing an automated inpatient Medicare and Medicaid billing system that should be implemented during FY 1988.

### COMPARISONS OF HEALTH EXPENDITURES FOR INDIANS AND THE GENERAL U.S. POPULATION

Table 8 compares per capita health expenditures for Indians and the U.S. resident population (excluding overseas military personnel) from 1977 to the President's proposed FY 1988 Budget. Table 8 compares such expenditures by real dollars in the first column while the second column uses constant dollars adjusted for inflation.

The real dollar comparison indicates that per capita health care spending for Indians increased by about 33 percent over the period from 1977 to 1988 while during the same period the per capita expenditure for the U.S. resident population increased 145 percent.

Table 8 also indicates that when per capita health expenditures are adjusted for the high rates of inflation in the health care sector, spending for Indians decreased by nearly 40 percent, while for the U.S. resident population, it increased by about 13 percent.

TABLE 8.—PER CAPITA HEALTH CARE EXPENDITURES FOR INDIAN HEALTH SERVICE (EXCLUDING ALASKA) AND U.S. RESIDENT POPULATION, FISCAL YEARS 1978–88

Fiscal year	IHS (excluding Alaska) <sup>1</sup>		U.S. Resident <sup>2</sup>	
	Current dollars	Constant (1986) dollars <sup>3</sup>	Current dollars	Constant (1986) dollars
1988.....	\$708.56	\$604.79	\$1,707.83	\$1,554.21
1987.....	767.95	740.30	1,612.54	1,554.40
1986.....	765.38	765.38	1,511.57	1,511.57
1985.....	765.95	823.40	1,408.64	1,514.19
1984.....	760.07	868.00	1,307.42	1,493.05
1983.....	698.19	835.98	1,218.17	1,477.69
1982.....	651.39	859.18	1,119.84	1,477.18
1981.....	651.71	959.31	1,005.06	1,479.29
1980.....	601.20	979.96	876.98	1,429.67
1979.....	569.43	1,030.11	782.82	1,416.18
1978.....	531.51	1,050.27	697.89	1,378.83

<sup>1</sup> Indian Health Service expenditures (obligations) excluding reimbursements, research, and sanitation. Expenditures for 1981–85 includes supplemental appropriations. Expenditures for 1987–88 are estimated. IHS expenditures do not include care American Indian and Alaska Native people receive from non-IHS funded sources.

<sup>2</sup> U.S. resident expenditures exclude nursing home care, program administration and net cost of health insurance, research, construction of medical facilities and governmental public health activities. U.S. resident expenditures for 1986–88 are based on a linear regression technique applied to 1978–85 data. Data for 1977–79 and 1981 are published in Health Care Financing Review, Health Care Financing Administration, DHHS, Winter, 1984, table 2, p. 7. Data for 1980 and 1982–84 are published in Health Care Financing Review, Health Care Financing Administration, DHHS, Fall 1985, table 2, p. 9.

<sup>3</sup> Constant 1986 dollars for each year 1978–86 are derived by dividing the calendar year 1986 Consumer Price Index (CPI) for medical care (annual average) by the corresponding medical care CPI for each respective year and multiplying the resultant ratio by the expenditure figure(s) for each year. The base year for the CPI is 1967 (i.e., calendar year 1967 CPI equals 100). Constant dollar expenditures for fiscal year 1987 and 1988 "back down" the effects of inflation used to prepare the estimated CPI for these years (6.0 percent for fiscal year 1987 and 3.7 percent for fiscal year 1988).

Source: Indian Health Service, January 1987.

## EXPLANATION

### LEGISLATIVE HISTORY AND OVERSIGHT STATEMENT

H.R. 2290 is based upon the extensive oversight and legislative record made by the Committee in the 98th and 99th Congress on similar legislation. In the 98th Congress, H.R. 4567 and S. 2166 were passed by the House and the Senate. S. 2166 was vetoed by the President on October 19, 1984.

In the 99th Congress, H.R. 1426 was introduced by Mr. Udall for himself and numerous other members. The bill passed the House and was subsequently passed by the Senate, with several amendments, but the differences were not resolved prior to adjournment of the 99th Congress.

H.R. 2290 was introduced on May 5, 1987, by Mr. Udall for himself and others. Because of the extensive hearings and record made by the Committee in the 98th and 99th Congress, the Committee held no hearings on the legislation. However, it did hold an oversight hearing on a report of the Office of Technology Assessment on clinical staffing problems of the Indian Health Service. The Committee will continue to maintain oversight with regard to these programs. The Committee ordered H.R. 2290 reported with an

amendment in the nature of a substitute on June 3, 1987 by a voice vote.

#### MAJOR BILL PROVISIONS

The bill, as amended by the substitute, amends, supplements, or repeals various provisions of the Indian Health Care Improvement Act. Its major provisions are as follows:

#### TITLE I

Title I of the IHCA was designed to accomplish two related goals: (1) to increase the number of Indians trained in the health professions and (2) to provide a larger pool of health professionals to serve Indian people. To accomplish these goals, the title established five programs. (a) a recruitment program to encourage young Indians to pursue medical careers; (b) a preparatory scholarship program to assist Indian students to re-orient to a medical career; (c) a scholarship program to support Indian students in graduate medical schools; (d) an extern program to provide summer experience in IHS for Indian medical students; and (e) a program for continuing education of IHS personnel.

Because of the remoteness and isolation of most Indian reservations and other undesirable working conditions, it is extremely difficult to recruit and retain health professionals to work in the Indian Health Service or on Indian reservations. Because of this difficulty, IHS suffers chronic staff shortages in critical health fields, particularly with respect to physicians and nurses. Table 9 shows the physician shortages in IHS for June, 1987. However, Table 10 reflects the future uncertainty and problems for IHS as they continue attempting to fill new and vacant physician positions without a substantial pool of NHSC physicians to select from. Equally debilitating is the anticipated nursing shortage for fiscal year 1988 shown in Table 11.

TABLE 9.—IHS PHYSICIAN SHORTAGE BY AREA—JUNE 1987

Area	Number of vacancies	Number of positions	Percent of total physician positions
Aberdeen .....	12	71	16.9
Alaska .....	5	108	4.6
Billings .....	5	49	10.2
Navajo .....	9	182	4.9
Oklahoma .....	9	112	8.0
Phoenix .....	2	122	1.2

Source: Indian Health Service, June 1987.

TABLE 10.—PROJECTED IHS PHYSICIANS NEEDED AND SHORTFALLS

	1987	1988	1989	1990	1991
Total physician positions .....	830	845	863	879	897
Physicians need to be recruited .....	219	198	208	220	234
NHSC scholars available .....	(900)	(489)	(60)		
IHS recruited NHSC scholars .....	142	100	20		
Projected IHS physician shortfall .....	<sup>1</sup> 44	98	188		

<sup>1</sup> IHS recruited 28 nonobligated physicians.

Source: Indian Health Service, June 1987.

TABLE 11.—IHS NURSE SHORTAGE, JUNE 1987

Type	Available nursing positions	Shortage	Percentage
Inpatient.....	3,385	372	11
Public Health.....	568	232	59
	3,953	604	15

Source: Indian Health Service, June 1987.

While significant numbers of Indians have been trained in the health professions during the seven-year implementation of title I and while many of these graduates have been placed with the IHS or are otherwise serving Indian people in the practice of their professions, a wide gap still exists between the ratio of Indian trained professionals to Indian population as compared to the Nation-wide ratio. In addition, IHS still suffers from chronic shortages of trained health personnel.

H.R. 2290, as amended, reauthorizes appropriations for the health manpower programs for fiscal years 1988 through 1991 and makes minor amendments to the title.

## TITLE II

Title II of the IHCLA was a congressional mandate to IHS to begin an incremental program in the area of health services to raise the health status of Indians to a par with the rest of the Nation. Health services included direct and indirect patient care, field health dental care, mental health, alcoholism treatment, and maintenance and repair. Amounts authorized for fiscal years 1978 through 1984 were to be incremental with respect to the base year funding of fiscal year 1977.

Substantial progress has been made in raising the health standards of the Indian people since the transfer of the health responsibility in 1955. With the enactment of the IHCLA, this progress has been accelerated. Table 12 shows some of this progress in selected health areas. However, it is clear that Indians still lag far behind the rest of the Nation in many health areas and that there are still substantial unmet health care needs among the Indian tribes. This is no more evident than in a comparison of the per capita health expenditure by IHS for Indians with the per capita health expenditure for all other citizens. As shown in Table 8, *infra.*, using constant 1987 dollars, the per capita expenditure for Indians was \$740.30 as compared to \$1,554.40 for the Nation. When one considers that the IHS Indian service population is almost solely dependent upon IHS for health care, this disparity is of critical proportions.

Table 12.—Program accomplishments since IHS established (1955)

Percent decrease in mortality thru 1982-84:

Infants.....	84
Under 28 days.....	80
28 days-11 months.....	86
Maternal.....	91
Pneumonia and influenza.....	82
Gastrointestinal.....	92
Accidents.....	48

Certain diseases originating in the perinatal period.....	86
Tuberculosis, all forms .....	97
Congenital malformations .....	64
Percent increase in services provided thru 1986:	
Hospital admissions .....	117
Outpatient visits .....	944
Dental services.....	1,003

In large part, the result of this disparity are borne by Indian infants. While neonatal (under 28 days) mortality rates have declined, the post-neonatal (28 days—11 months) mortality rate is still at an intolerable level. Chart 1, showing infant mortality rates by age for Indians and the general population, graphically depicts this problem.

## Infant Mortality Rates by Age

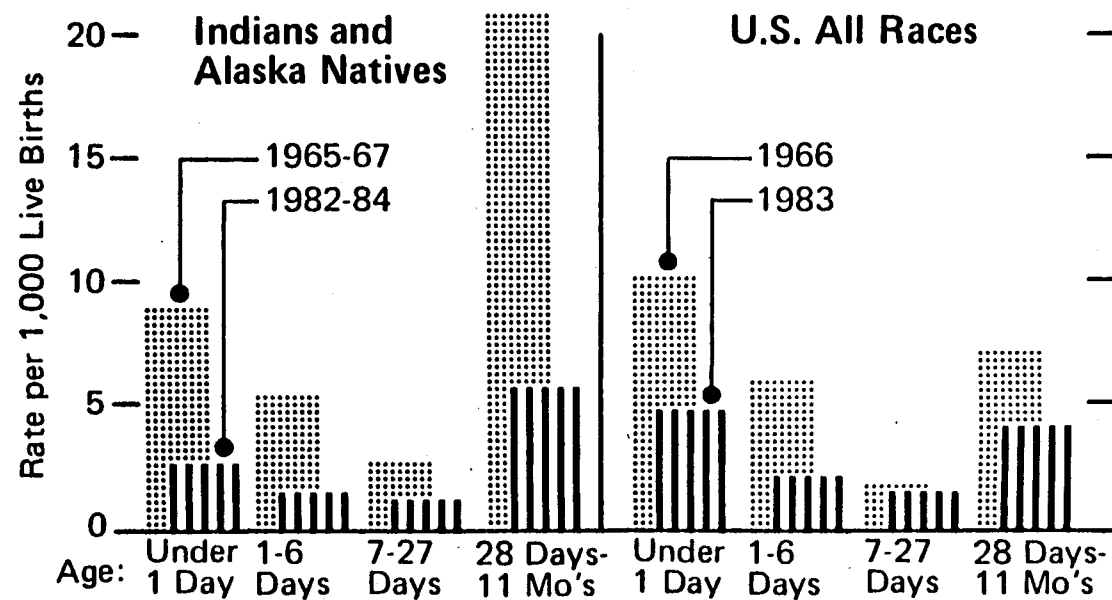


CHART 1

Alcoholism and alcohol-related deaths continue to be the primary health problem of the Indian tribes and their members. While there is still considerable debate on whether alcoholism itself is a disease and on what the causes of alcoholism are, there is no debate on the health and medical impact it has on Indian people. Indian alcoholism and its costs in terms of Federal appropriations and human suffering are of crisis proportions. The toll which alcoholism takes upon the Indian population is shown in the following series of charts. Charts 2 and 3 show the incidence of alcoholism deaths among Indians by age and sex, and as adjusted for age. Most homicides, suicides, and accidental deaths on Indian reservations are alcohol related. Chart 4 through 7 set out the incidence of homicides and suicides on Indian reservations by age and sex, and as adjusted for age. Chart 8 depicts the age adjusted accident rate for the Indian population. In Charts 3, 4, 5, 7 and 8, the Indian rate is compared with the rate for the rest of the Nation.



## Alcoholism Death Rates by Age and Sex

### Indians and Alaska Natives (1982-84)

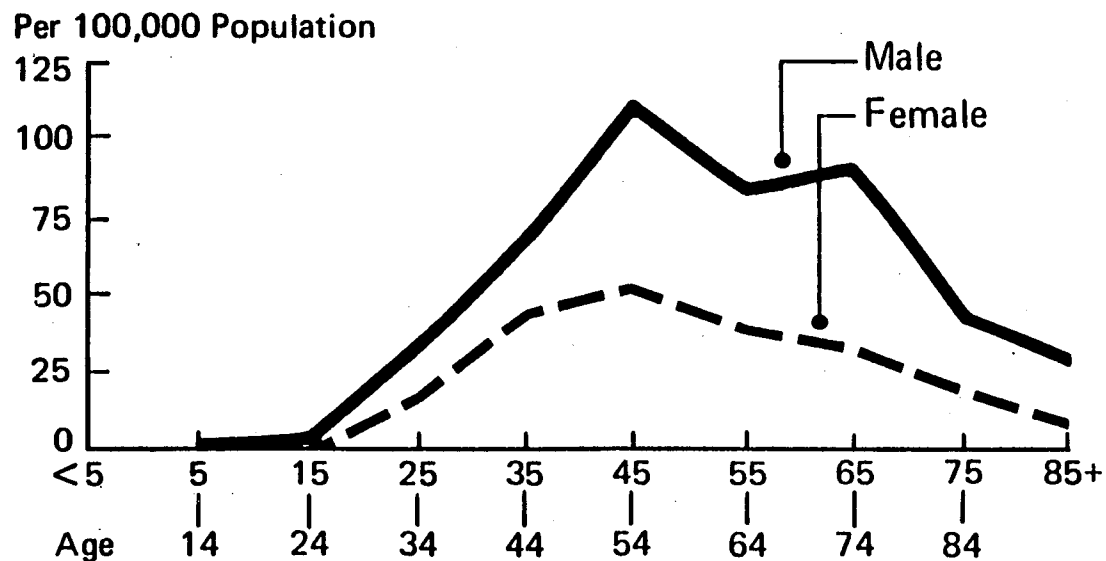
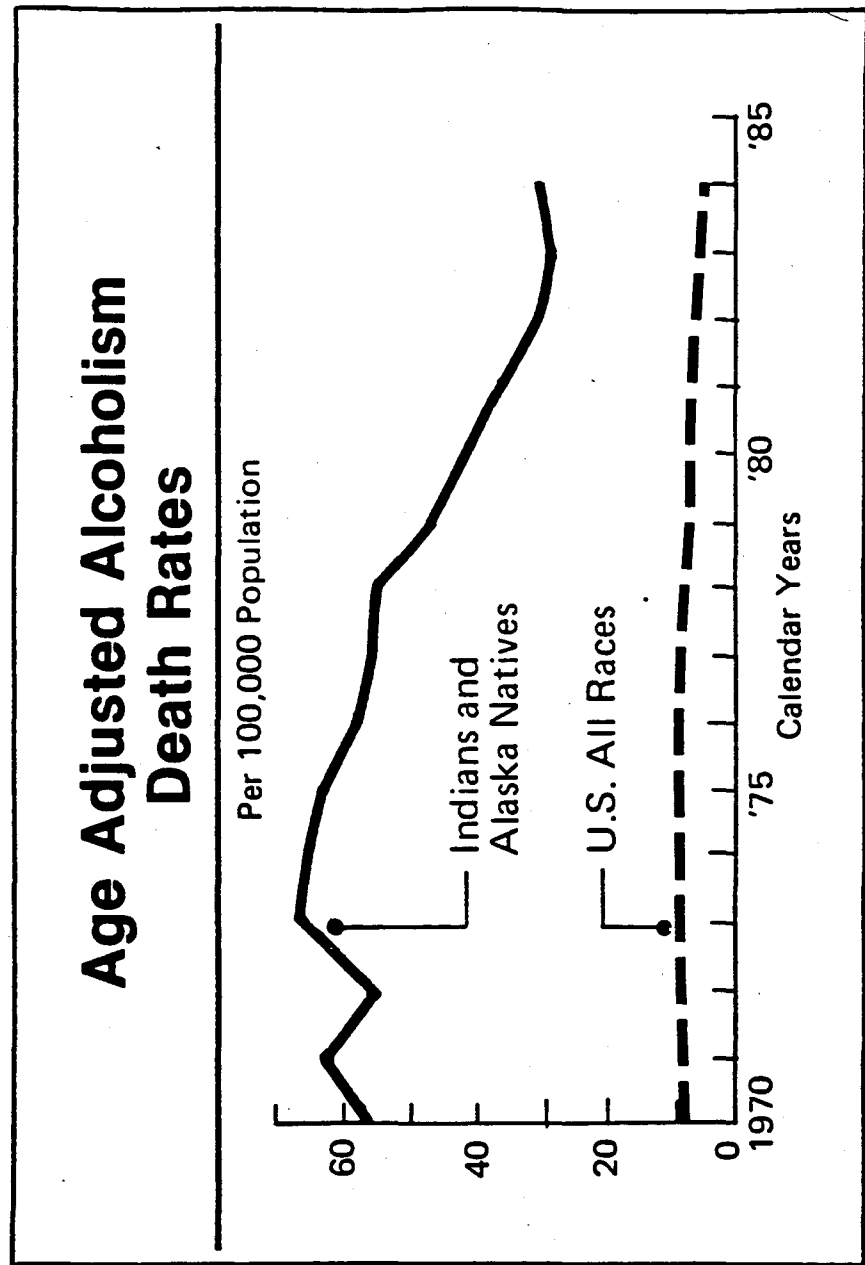


CHART 2

CHART 3



## Homicide Death Rates by Age and Sex Indians and Alaska Natives (1982-84)

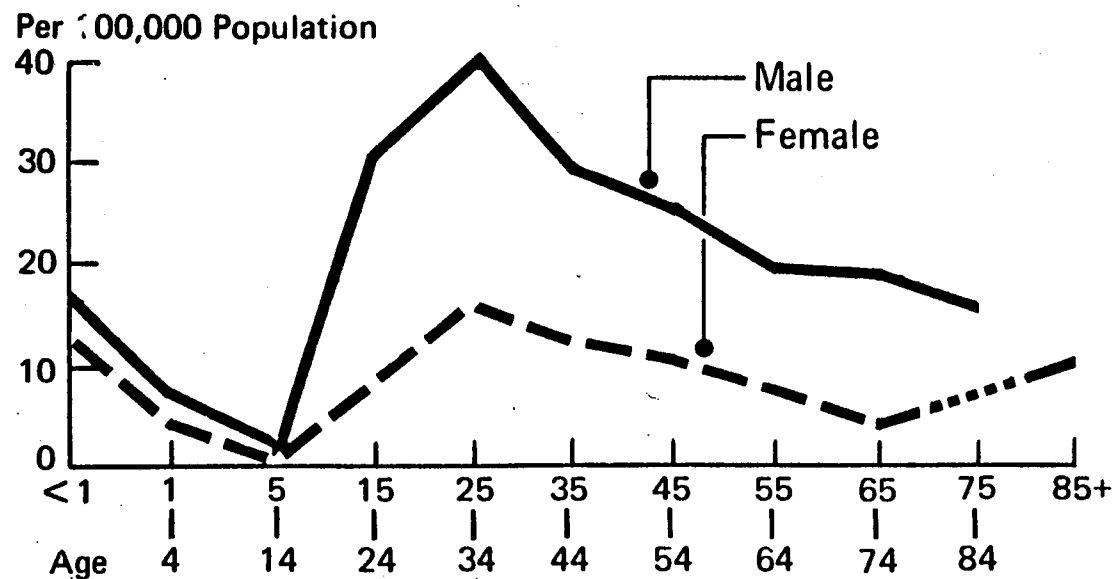
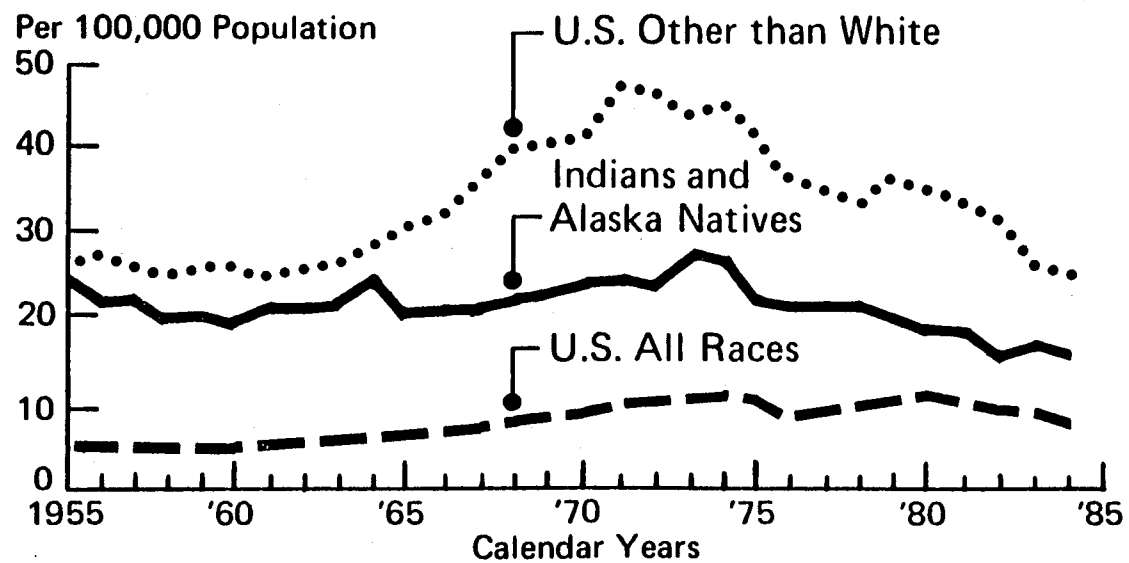


CHART 4

## Age Adjusted Homicide Death Rates



## Suicide Death Rates by Age and Sex Indians and Alaska Natives (1982-84)

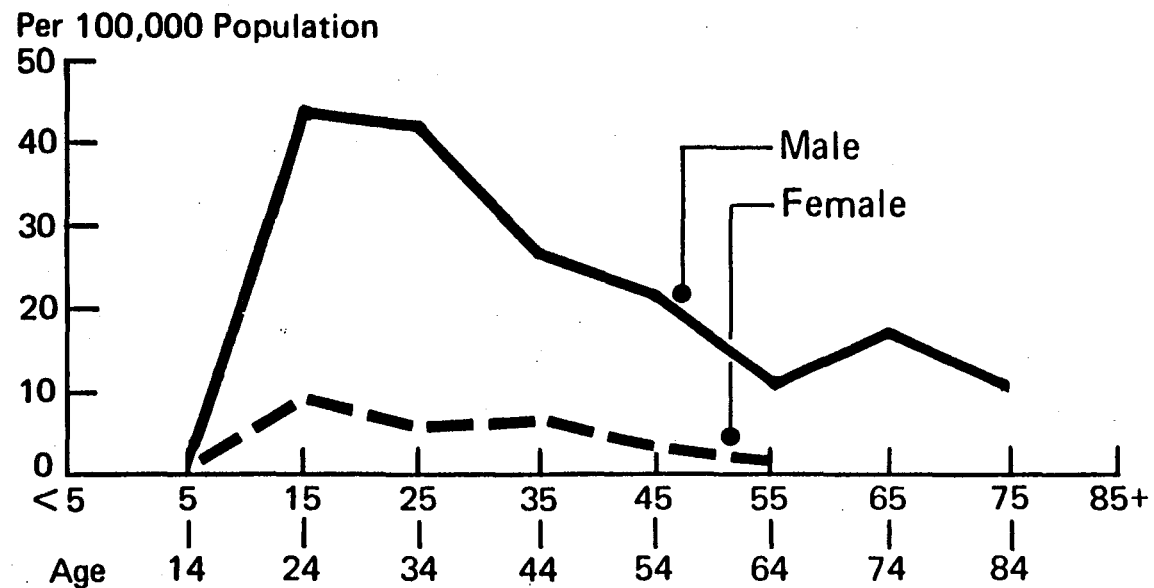
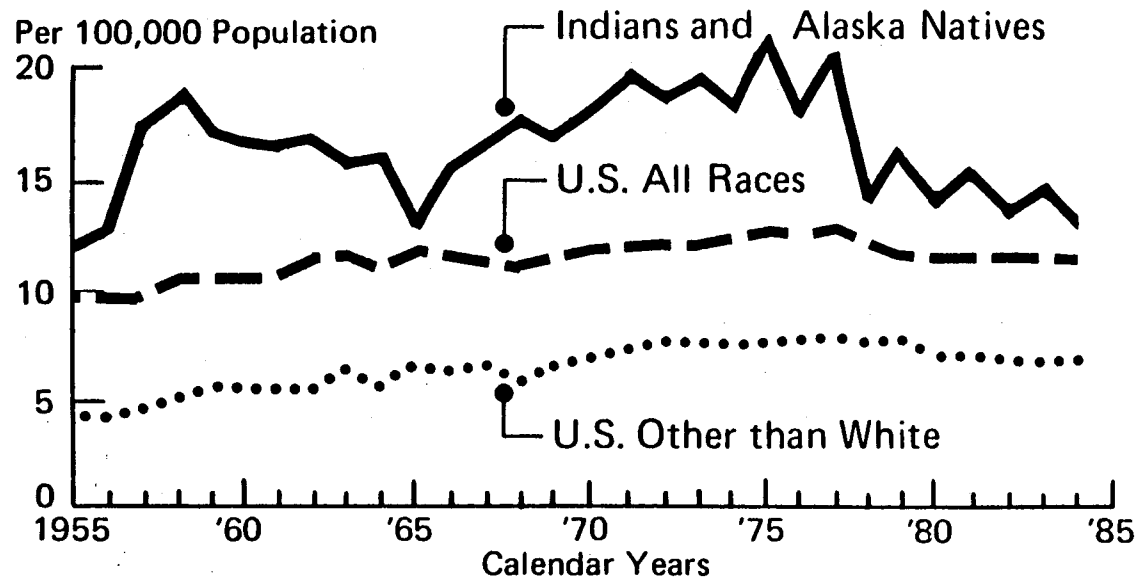
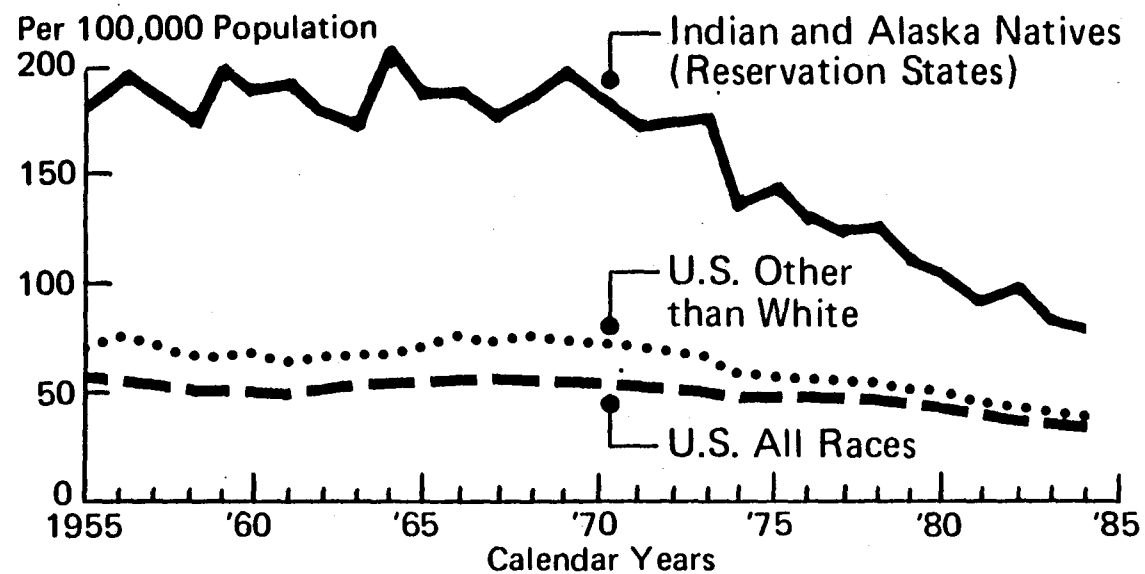


CHART 6

## Age Adjusted Suicide Death Rates



## Age Adjusted Accident Death Rates



In addition, Indians continue to suffer from various illnesses and diseases which have traditionally plagued the tribes at a rate higher than the rest of the population. Chart 9 shows selected age-adjusted death rates for Indians from various diseases as compared with the U.S. population. The chart tends to show that Indians suffer less from the diseases of affluence and more from diseases associated with poverty and poor environment.



## Selected Age-Adjusted Death Rates

### Ratio of Indians & Alaska Natives to U.S. All Races (CY '84)

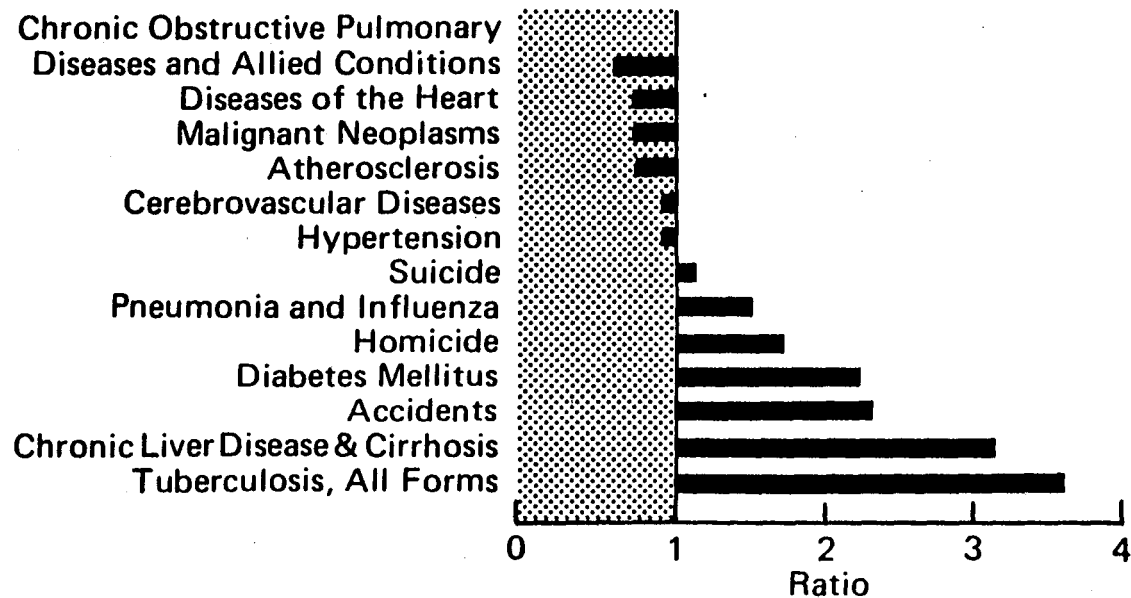


CHART 9

In view of the significant progress that has been made in closing the health care gap, H.R. 2290 amends title I of the IHCA to refocus its purpose toward achieving some degree of parity among tribes in terms of deficiencies in health resources. It establishes and authorizes appropriations for a fund to make new resources available to such tribes for that purpose. Secondly, it creates a catastrophic illness fund to meet the extraordinary costs of IHS associated with catastrophic illnesses and medical disasters.

#### TITLE III

Title III of the IHCA related to the construction of health facilities, including hospitals, clinics, and health stations including necessary staff quarters, and of sanitation facilities for Indian communities and homes. H.R. 2290 amends this title by eliminating specific appropriations authority since authority already exists under the Act of November 2, 1921 (42 Stat. 208).

In addition, it adopts a new approach for both facilities and sanitation construction. With respect to facilities, the bill requires the Secretary to submit to the Congress a report on the top ten priority hospital projects together with necessary staff quarters and the top ten priority ambulatory facilities together with needed staff quarters. The report must also include the methodology used to determine priority, the justification for the priority ranking, and the estimated costs for the submitted projects.

The bill also requires the Secretary submit a report with respect to needed sanitation facilities for Indian communities and homes.

The report must rank the tribes on the basis of sanitation facilities deficiencies from Level V through I. It must also set out the amount of funds which would be needed, over a ten-year period, to raise all tribes below a Level II to such level. The bill further amends the law to provide authority for IHS to make operation and maintenance assistance available to Indian tribes operating sanitation facilities.

A new section 305 is added to title III of the IHCA authorizing the expenditure of non-Service fund for the renovation or modernization of IHS facilities. Finally, a new section 306 providing for the settlement of a dispute between IHS and the Bethel Native Corporation over the ownership of the Bethel hospital.

#### TITLE IV

Title IV of the Act relates to the collection and use of Medicare/Medicaid reimbursements by the Indian Health Service. H.R. 2290 reauthorizes funding for section 401 which established a program of grants and contracts with tribal organizations to assist eligible Indians in obtaining Medicare or Medicaid benefits.

#### TITLE V

Title V of the Act, as amended by the 1980 amendments, authorized grants to urban and rural Indian organizations to provide outreach and referral services to Indians in urban and rural areas who are not eligible for IHS services. It also permits direct health services to these Indian populations when other care is not available. The bill rewrites the title to strike out all reference to rural

programs, since it was determined that these kinds of programs were not feasible. The bill also authorizes funding for the urban Indian health programs under the Snyder Act (25 U.S.C. 13).

#### TITLE VI

Title VI of the Act required the Secretary to conduct feasibility study on the creation and funding of an American Indian School of Medicine. The report has been submitted and the title is obsolete. The bill strikes all of the title and inserts in lieu a new title. As amended, title VI creates, in the Public Health Service, an Office of Indian Health Service to which all of the Indian health responsibilities, personnel, and other related Indian health functions within the Department are to be transferred. The title also provides for the establishment of Director, to be appointed by the President with the advice and consent of the Senate, to administer the new office.

Finally, a new section is added to the title requiring the Secretary to establish a management information system within IHS.

#### TITLE VII

Title VII of the Act, as amended, contained several miscellaneous Indian health provisions.

#### TITLE VIII

Title VIII adds a new title VIII to the IHCIA providing for a comprehensive program within the Indian Health Service with respect to diabetes detection and control among Indian people.

#### COMMITTEE AMENDMENT AND SECTION-BY-SECTION ANALYSIS

The Committee adopted an amendment in the nature of a substitute. A section-by-section analysis of the bill and an explanation of the amendment follows:

#### SECTION-BY-SECTION ANALYSIS OF H.R. 2290

##### *Section 1*

Section 1 cites the Act as the "Indian Health Care Amendments of 1987" and contains a Table of Contents.

##### *Section 2*

Section 2 provides that, unless otherwise stated, sections or provisions amended or repealed are understood to be sections or provisions of the Indian Health Care Improvement Act (IHCA), as amended.

##### *Section 3*

Section 3 provides that any new spending authority provided in this Act shall be effective in any fiscal year only to the extent or in amounts made available by appropriations Acts.

#### TITLE I

Title I amends and reauthorizes the Indian Health Manpower programs of title I of the IHCA.

*Section 101*

Section 101 reauthorizes funding for section 102 (Health Professions Recruitment Program) at \$550,000 for fiscal year 1988, \$600,000 fiscal year 1989, \$650,000 for fiscal year 1990, and \$700,000 for fiscal year 1991.

*Section 102*

Subsection (a) amends section 103 (Health Professions Preparatory Scholarship Program) by (1) providing that the Secretary may not deny aid to an eligible applicant based solely on the applicant's scholastic achievement if the applicant has been admitted to or maintains good standing in an accredited institution and (2) by reauthorizing funding at \$3,000,000 for fiscal year 1988, \$3,700,000 for fiscal year 1989, \$4,400,000 for fiscal year 1990, and \$5,100,000 for fiscal year 1991.

Subsection (b) amends subsection (c) of section 103 to provide that payments made under this program may be made to persons only while attending school full-time.

*Section 103*

Section 103 amends section 105 (Indian Health Service Extern Program) to reauthorize funding for the program at \$300,000 for fiscal year 1988, \$350,000 for fiscal year 1989, \$400,000 for fiscal year 1990, and \$450,000 for fiscal year 1991.

*Section 104*

Section 104 amends section 104 of the IHCA (Indian Health Professions Scholarship Program) by striking the section in its entirety and rewriting it. The section currently amends the Public Health Service Act by including in the National Health Service Corps scholarship program a special program for Indian Health scholarships. The amendment takes the Indian program out of the national program and establishes it as a free-standing program within the Indian Health Service. It also reauthorizes funding for the program at \$5,100,000 for fiscal year 1988, \$6,000,000 for fiscal year 1989, \$7,100,000 for fiscal year 1990, and \$8,234,000 for fiscal year 1991. It also makes two substantive changes in the program: first, by limiting scholarships to Indian applicants and, second, by making clear that scholarship assistance is tied to the number of years required by the course of study of the educational institution involved.

*Section 105*

Section 105 amends section 106 of the IHCA (Continuing Education Allowances) by reauthorizing funding for the program at \$500,000 for fiscal year 1988, \$526,300 for fiscal year 1989, \$553,800 for fiscal year 1990, and \$582,500 for fiscal year 1991.

*Section 106*

Section 106 amends the Public Health Service Act (42 U.S.C. 201 *et seq.*) by adding a new section 338G establishing a Native Hawaiian Health Professions Scholarship program. An analysis of the new section 338G follows:

Subsection (a) provides that the Secretary of HHS, subject to the availability of appropriations, shall provide scholarship assistance to Native Hawaiians who meet the requirements of section 338A of the Public Health Service Act.

Subsection (b) provides that such assistance shall be provided under the same criteria that apply to scholarship assistance under section 338A. It also provides that the assistance shall not be administered by or through the Indian Health Service.

Subsection (c) defines the term "Native Hawaiian" to mean any person who is a citizen of the United States and is a descendant of the aboriginal people who inhabited the State of Hawaii prior to 1778.

Subsection (d) authorizes to be appropriated \$1,800,000 for each of the fiscal years 1988, 1989, 1990, and 1991, for the purpose of providing such scholarship assistance.

#### *Section 107*

Section 107 amends the IHCLA by adding a new section 107 as follows:

Subsection (a) provides that, under authority of the Snyder Act (25 U.S.C. 13), the Secretary shall maintain a Community Health Representative program (CHR) under which the Indian Health Service shall provide training to Indians as health paraprofessionals and use such personnel in the provision of health care to Indian communities.

Subsection (b) provides that the Secretary, using the CHR program, shall (1) provide a high standard of paraprofessional training to CHRs; (2) develop a curriculum for such training under defined criteria; (3) develop a system for identifying the need for further CHR training; (4) develop a system for supervision of CHRs; (5) develop a system for evaluation and review of CHRs; and (6) ensure that the CHR program is operated in a manner consistent with the traditional health care practices and cultural values of the Indian tribes.

It is the intent of the Committee that all terms contained in this Act are to be construed consistent with Title 42 Code of Federal Regulations Part 36 subpart f, until such time as the provisions of that regulation may be amended, revoked or revised by Administrative action, or changed by a subsequent act of the Congress.

#### **TITLE II—HEALTH SERVICES**

Title II of H.R. 2290 substantially modifies title II (Health Services) of the IHCLA. As amended by H.R. 2290, section 201 of the IHCLA refocuses the section toward an effort to raise the health status of Indian tribes having a greater deficiency in health resources. In addition, the title adds three new sections to title II of the IHCLA. The section-by-section analysis of the title, as amended, follows:

#### *Section 201*

Section 201(a) amends section 201 of the IHCLA by rewriting it as follows:

Subsection (a) provides that the Secretary is authorized to expend funds appropriated pursuant to subsection (j) for the purposes of (1) raising the health status of Indians to a zero deficiency; (2) eliminating backlogs in the provision of health care to Indians; (3) meeting health needs of Indians in an efficient and equitable manner; and (4) augmenting the ability of IHS to meet its health care responsibilities in ten specified areas.

Subsection (b)(1) provides that funds appropriated pursuant to this section shall not be used to offset or limit appropriations under the Snyder Act or any other law.

Subsection (b)(2) provides that any funds appropriated under this section may be allocated for the benefit of tribes at a level I or II deficiency level only if a sufficient amount of funds have been appropriated to raise all tribes to a level II.

Subsection (b)(3) establishes criteria for the allocation of funds among service units of IHS and requires such allocation to be determined by IHS in consultation with affected tribes.

Subsection (c) defines five deficiency levels (I-V) based upon a percentage of need of Indian tribes for health resources and requires the Secretary to establish a procedure for tribes to petition for a review of a deficiency level established by the Secretary for that tribe.

Subsection (d) provides that programs administered by tribes under the Indian Self-Determination Act shall be eligible for funding under this section equally with programs operated directly by IHS and that a reasonable portion of any such funds allocated to a tribe under the Indian Self-Determination Act may be used for health planning, training, technical assistance and other administrative support functions.

Subsection (e) provides that not less than 1% of the funds appropriated pursuant to this section shall be used by the Secretary for health research in defined areas and that tribes or tribal organizations contracting for health services under the Indian Self-Determination Act shall have an equal right to compete for such research funds.

Subsection (f) requires the Secretary of HHS to submit, no later than 60 days after enactment, the IHS current health services priority system report for each Indian tribe or service unit. The report must set out (1) the methodology used by IHS for determining tribal health resource deficiencies; (2) the deficiency level of each tribe; (3) the amount of funds necessary to raise all tribes to a level II deficiency level; (4) the amount of funds necessary to raise all tribes to a level I; (5) the amount of funds necessary to raise all tribes to a zero deficiency; and (6) an estimate of the amount of funds from all sources allocated to each IHS service unit and the number of eligible Indians and number of Indians using the resources of each service unit.

Subsection (g) requires the Secretary to take all necessary action to bring current the tribal specific health plans developed pursuant to section 701 and 703 of the IHCA. These updated tribal specific health plans are to form the basis for the health services priority system reports to be filed with Congress for fiscal years 1989, 1990, and 1991. Such reports must be submitted no later than 30 days

after the submission of the President's budget for those fiscal years.

Subsection (h)(1) provides that the President shall include within his budget for each fiscal year a separate statement showing the amount of funds being requested to carry out this section and the total amount obligated or expended in the prior fiscal year to carry out subsection (g) and each of the subparagraphs of subsection (a)(4).

Subsection (h)(2) provides that funds appropriated pursuant to this section for any fiscal year shall be included in the base budget of IHS for the purpose of determining appropriations for this section in subsequent fiscal years.

Subsection (i) provides that nothing in this section is intended to diminish the primary responsibility of IHS to eliminate existing backlogs in unmet health care needs or to discourage IHS from taking additional steps to achieve parity of funding among Indian tribes.

Subsection (j) authorizes appropriations to carry out this section of \$19,000,000 for fiscal year 1989, \$19,000,000 for fiscal year 1990, and \$20,000,000 for fiscal year 1991. It provides that funds appropriated pursuant to the subsection shall be designated as the "Indian Health Care Improvement Fund".

Subsection (b) of section 201 of H.R. 2290 amends section 4 of the IHCA by striking three definitions relating to rural Indian health care programs and inserting, in lieu, a definition of IHS area offices and services units.

#### *Section 202*

Section 202 amends title II of the IHCA by adding a new section 202 creating a Catastrophic Health Emergency Fund. The section-by-section analysis of the section is as follows:

Subsection (a) provides for the establishment of an Indian Catastrophic Health Emergency Fund consisting of amounts deposited under subsection (d) and appropriated under subsection (e). The subsection provides that the Fund shall be administered through the central office of the IHS solely for the purpose of meeting the extraordinary medical costs associated with disasters or catastrophic illnesses; shall not be allocated, apportioned, or delegated below the central office; and shall not be subject to any contract or grant, including contracts under the Indian Self-Determination Act.

Subsection (b) requires the Secretary to promulgate regulations for the administration of the Fund, including a definition of catastrophic illnesses or disasters qualifying for payment from the fund and the establishment of a service unit threshold cost level for each such event necessary for reimbursement from the fund.

Subsection (c) provides that funds appropriated under this section shall not be used to offset or limit appropriations to IHS under other authorities.

Subsection (d) provides that all reimbursements to the IHS from any source, including third party insurance, to which the IHS is entitled for treatment of a victim of a catastrophic illness or disaster and any funds recovered under the Medical Care Recovery Act (42 U.S.C. 2651 *et seq.*) shall be deposited into the Fund.





Subsection (e)(6) authorizes the appropriation of \$500,000, without fiscal year limitation, for the purpose of carrying out this subsection.

Subsection (f)(1) provides that the Secretary, acting through the Public Health Service, shall establish in the State of Hawaii a demonstration project for a Native Hawaiian Program for Health Promotion and Disease Prevention. The subsection establishes performance criteria for such demonstration project and authorizes the Secretary to enter into contracts with Native Hawaiian organizations to carry out the demonstration project.

Paragraphs (2), (3), (4), and (5) of subsection (f) authorize the Secretary to enter into a series of contracts with Native Hawaiian organizations encompassing a comprehensive approach to the problem of diabetes among Hawaiian Natives. These contracts would have a multi-purpose range, including determining the incidence of diabetes, an inventory of existing health care programs for treatment of diabetes, designing and implementing a program for the treatment and prevention of diabetes, promoting coordination, cooperation, and joint funding of programs by Federal, State, and private organizations, establishing a model diabetes program for Native Hawaiians, developing a diabetes outreach program, developing a standardized data system relating to diabetes and related complications, and the conduct and coordination of research in the area of Native Hawaiian diabetes.

Subsection (f)(6) requires the Secretary to submit an annual report to Congress on the status and accomplishments of efforts established under this subsection during each of fiscal year 1989, 1990, and 1991.

Subsection (f)(7) establishes detailed criteria for any contract entered into by the Secretary under this subsection relating to evaluation, compliance, renewal, payments under the contract, revision and amendment, and reporting. This criteria is modeled upon the contract provisions established in the IHClA for urban Indian health contracts.

Subsection (f)(8) defines, for purposes of this subsection, "Native Hawaiian" as any person who is a citizen of the United States, a resident of Hawaii, and a descendent of the aboriginal people of Hawaii prior to 1778, and "Native Hawaiian organization" as any organization serving Native Hawaiians, recognized by the Office of Hawaiian Affairs of the State of Hawaii or E Ola Mau, a Native organization, and which include Native Hawaiian health professional's participation.

Subsection (f)(9) authorizes the appropriation of \$750,000 for each of the fiscal years 1989, 1990, 1991, and 1992 for the purposes of this subsection.

Subsection (f)(10) provides that programs and services established by this subsection shall not be administered by or through the Indian Health Service nor shall any funds appropriated to IHS be used to supplement funding of such programs or services.

#### *Section 204*

Section 204 of the bill amends the Act by adding two new sections. A section-by-section analysis of those new sections follows:

*Section 204*

Subsection (a) provides that the United States shall have the right to recover reasonable expenses incurred by the Secretary in providing health services through IHS to an individual from third party insurers as if such services had been provided by a nongovernmental provider and such individual had been required to pay for such services.

Subsection (b) provides that subsection (a) shall provide a right of recovery against a State or political subdivision only for health services covered under workers' compensation laws or a non-fault automobile insurance plan or program.

Subsection (c) provides that no State or local law and no provision of any contract entered into after the date of enactment of these amendments shall prevent recovery by the United States under subsection (a).

Subsection (d) provides that no recovery action taken by the United States under subsection (a) shall affect the right of a person to damages other than damages for the cost of the health services provided by the Secretary through IHS.

Subsection (e) provides that the United States may enforce its right of recovery either by intervening in a civil action or proceeding brought by an individual or the representative or heirs of such individual for recovery or by instituting its own action after notice to the individual or the representatives or heirs of such individual.

*Section 205*

Subsection (a) provides that, notwithstanding any other provision of law, all funds paid into the U.S. Treasury by reason of the provision of health services by IHS, including amounts paid under section 712(b)(2)(B) and recoveries made under section 204 or the Medical Recovery Act, shall be credited to the reimbursable account of IHS in the Treasury and shall remain available until expended.

Subsection (b) provides that subsection (a) shall not apply to amounts described in section 202(d).

**TITLE III—HEALTH FACILITIES**

Title III amends title III of the IHCA by striking all of the existing language relating to health facilities and sanitation construction and inserting new language. No authorization is included for construction since the Snyder Act (25 U.S.C. 13) contains sufficient authorization for appropriations for such construction. Certain other amendments are made to the title.

*Section 301*

Section 301 amends section 301 of the IHCA in its entirety.

Subsection (a) requires the Secretary to consult with the affected tribe or tribes before expending funds for the construction of health facilities with respect to the size, location, type, and other characteristics of such facility and to ensure that such facility meets the standards of the Joint Commission on Accreditation of Hospitals within one year of construction.

Subsection (b) provides that no IHS hospital or other outpatient facility, or any portion thereof, may be closed if the Secretary has

not submitted to Congress, at least one year before such proposed closure, an evaluation of the impact of such closure. The prohibition shall not apply to any temporary closure necessary for medical, environmental, or safety reasons.

Subsection (c) provides that the President shall submit with his annual budget for fiscal years 1989, 1990, and 1991, program information documents for the construction of ten IHS facilities which comply with construction standards and which have been approved by the Secretary.

Subsection (d)(1) provides that the Secretary shall submit to Congress an annual report which will include the current IHS health facility priority system; facility needs for the ten top-priority inpatient facilities and ten top-priority ambulatory facilities together with needed staff quarters; the justification and projected cost of each such facility; and the methodology adopted by IHS in establishing priorities.

Subsection (d)(2) provides that the first report shall be submitted no later than 180 days after enactment of these amendments and that reports for subsequent years will be submitted no later than 60 days after the submission of the President's annual budget.

Subsection (d)(3) provides that the Secretary, in preparing such reports, must consult with, and review the facility needs of, tribes or tribal organizations operating health programs or facilities under contract entered into under the Indian Self-Determination Act.

Subsection (d)(4) provides that the Secretary, in evaluating the needs of facilities operated by tribes or tribal organizations under the Indian Self-Determination Act, shall use the same criteria as is used in evaluating the needs of facilities operated directly by IHS.

Subsection (d)(5) provides that the Secretary shall ensure that the needs of IHS and non-IHS facilities which are subject to a contract under the Indian Self-Determination Act are fully integrated into IHS's health facility priority system.

Subsection (e) provides that all funds appropriated under the Snyder Act for health facilities construction shall be subject to contract under the Indian Self-Determination Act.

#### *Section 302*

Section 302 of H.R. 2290 amends section 302 of the IHCA, relating to sanitation facilities, by rewriting it in its entirety. A section-by-section analysis of the amended section follows:

Subsection (a) contains congressional findings relating to the importance of safe water supply systems and sanitary sewage and solid waste disposals systems to the improvement of health conditions on Indian reservations and the policy of the United States to ensure that all Indian communities are provided with such systems.

Subsection (b)(1) contains a congressional reaffirmation of the primary responsibility of the Indian Health Service in this area as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

Subsection (b)(2) provides that the Secretary is authorized to provide certain financial and technical assistance, including operation and maintenance assistance, to Indian tribes and communities operating and maintaining sanitation facilities.

Subsection (c) provides that the Secretary, beginning in fiscal year 1989, shall develop and begin implementation of a 10 year plan to provide adequate water and sanitation systems to Indian homes and communities.

Subsection (d) provides that the capability of an Indian tribe or community to operate and maintain a sanitation facility shall not be a prerequisite to the provision or construction of such facilities by the Secretary.

Subsection (e) provides that this section shall not diminish the primary responsibility of an Indian tribe or community to collect reasonable users fees or otherwise set aside funds to operate and maintain sanitation facilities.

Subsection (f) provides that tribes or tribal organizations contracting under the Indian Self-Determination Act shall be equally eligible for funds under this section or any funds appropriated for water supply or sewage disposal services.

Subsection (g)(1) provides that the Secretary shall submit an annual report to the Congress setting forth the current Indian sanitation facility priority system of IHS; the methodology used in establishing priorities; the deficiency levels of Indian tribes or communities; and the amount of funds needed to raise all tribes or communities to a level I and a zero level of deficiency.

Subsection (g)(2) provides that the first report shall be submitted no later than 180 days after enactment and, thereafter, within 60 days after submission of the President's annual budget.

Subsection (g)(3) provides that the Secretary, in preparing such reports, shall consult with Indian tribes and tribal organizations, including those contracting under the Indian Self-Determination Act.

Subsection (g)(4) provides that the Secretary shall uniformly apply the methodology used to determine sanitation deficiencies.

Subsection (g)(5) establishes the criteria for the determination of the five levels of sanitation deficiencies.

Subsection (g)(6) provides that any tribe which lacks operation and maintenance capability to enable it to meet pollution control laws may not be regarded as having a level I or II deficiency.

Subsection (h) authorizes the appropriation of \$3,000,000 for each of the fiscal years 1989, 1990, and 1991 to carry out the functions of subsection (b)(2). It also authorizes the appropriation of \$850,000 for those years to provide 30 new sanitation positions in the IHS and provides that those positions will be in addition to existing sanitation positions in IHS.

### *Section 303*

Section 303(a) amends section 305 of the IHCLA to give Indian tribes the right to use funds acquired from sources other than from IHS to renovate or modernize IHS facilities. However, any renovation or modernization will not obligate IHS to provide additional staff or equipment; the project must be approved by the IHS area director involved; the tribe must comply with applicable rules and regulations of the Secretary governing construction or renovation of such facilities; and such project may not result in a diversion of funds from facilities having a higher ranking on IHS's priority list. It also would permit the tribe to recover from the United States, in

the event the renovated or modernized IHS facility ceases to be used as an IHS facility within 20 years of the renovation or modernization, a proportionate amount of the cost of such improvement.

Section 303(b) repeals a provision of section 101(c) of P.L. 98-473 containing a similar provision to the new language of section 303 as amended by this section.

#### *Section 304*

Section 304 adds a new section 306 to title III of the IHCA.

Subsection (a) provides that, if there is a final administrative ruling by the Interior Department that the Bethel Native Corporation is entitled to a conveyance under the Alaska Native Claims Settlement Act to the property described in subsection (d)(1), such ruling shall not be subject to judicial review.

Subsection (b) provides that the Secretary may enter into an agreement with the Native Corporation for an exchange of such real property for property described in subsection (d)(2) or any other Federal property which the Corporation would be entitled to select under the Settlement Act.

Subsection (c) provides that, if no agreement is entered into for such land exchange within 90 days of the administrative ruling, the Secretary shall purchase the property described in subsection (d)(1) at fair market value.

Subsection (d)(1) describes property which the Bethel Native Corporation selected under the Alaska Native Claims Settlement Act and upon which, they allege, the IHS wrongfully constructed the Bethel IHS hospital. This land is identified as all lands in U.S. Survey Numbered 4000, except those lands described in paragraph (2).

Subsection (d)(2) identifies lands within U.S. Survey Numbered 4000 which would be available for exchange as tracts A and B in BLM determination AA-18959 issued on September 30, 1983.

#### TITLE IV—ACCESS TO HEALTH SERVICES

#### *Section 401*

Section 401 amends section 404 of the title IV of the IHCA, which provides grants to, or contracts with, tribal organizations to assist individual Indians to exercise their eligibility under Medicare/Medicaid, by making certain technical amendments and by reauthorizing funding for such program at \$2,000,000 for fiscal year 1989, \$500,000 for fiscal year 1990, and \$500,000 for fiscal year 1991.

#### TITLE V—URBAN INDIAN HEALTH SERVICES

#### *Section 501*

Section 501 of H.R. 2290 strikes all of title V of the IHCA which provides grant funds for urban and rural Indian health programs and rewrites the title. The rewrite of title V makes only four substantive changes in existing law as follows:

- (1) all reference to rural programs and the authorization of appropriations for rural programs is stricken;

- (2) separate one-year contracts are authorized to determine unmet health care needs of Indians in urban areas;
- (3) a new provision is added requiring the Secretary to evaluate annually the performance of urban Indian health care grants; and
- (4) the specific authorization for the urban programs is stricken and the authority for appropriations for such program is placed under the Snyder Act.

#### *Section 502*

Section 502 of H.R. 2290 makes a technical amendment to the definition of "urban Indian organization" in section 4 of the IHCIA.

#### TITLE VI—ORGANIZATION IMPROVEMENTS

Title VI strikes all of the existing title VI of the IHCIA which is an obsolete provision providing for a feasibility study on the creation and funding of an American Indian School of Medicine. The amended title provides for the establishment of an independent Indian Health Service within the Public Health Service of the Department of Health and Human Services and for the development of a Management Information System for IHS.

#### *Section 601*

Subsection (a) amends title VI by rewriting section 601 of the IHCIA and by adding a new section 602.

#### *Section 601*

Subsection (a) provides for the establishment of the Indian Health Service within the Public Health Service of the Department of Health and Human Services to carry out the responsibility of the United States to provide health care services to Indian tribes and people. It provides that IHS shall be administered by a Director who shall be appointed by the President, with the advice and consent of the Senate. It further provides that the Director shall report to the Secretary through the Assistant Secretary for Health and no one else.

Subsection (b) provides that IHS shall be an agency or PHS and shall not be an office, component, or unit or any other agency of the Department.

Subsection (c) provides that all the functions, powers, authorities and responsibilities of the Secretary for Indian health care shall be carried out through the Indian Health Service.

Subsection (d) provides that the Secretary may not reorganize, alter or discontinue IHS or allocate or reallocate any functions vested in IHS by this section. This prohibition shall not apply to action taken by the Director of IHS.

Subsection (e)(1) vests in the Director of IHS authority to appoint and compensate personnel, enter into procurement contracts, and expend or obligate funds.

Subsection (e)(2) makes the Indian preference laws in Federal employment applicable to new positions created in IHS as a result of its establishment under this section.

*Section 602*

Subsection (a) provides for the establishment of an automated management information system within IHS and establishes criteria for such system. It requires the Secretary to submit a report to Congress no later than September 30, 1988, on the establishment of the system.

Subsection (b)(1) provides that the Secretary shall provide each Indian tribe or tribal organization providing health care pursuant to a contract entered into under the Indian Self-Determination Act an automated management information system which meets both the tribe's needs and IHS's needs.

Subsection (b)(2) provides that the IHS shall reimburse each tribe or organization for the cost of a system which is attributable to the treatment of patients of the IHS.

Subsection (b)(3) provides that the Secretary shall provide such systems to tribes or organizations providing health care in California not later than September 30, 1989.

Subsection (c) provides that patients shall have reasonable access to any of their health records held by, or on behalf of, the IHS.

Section 601(b) of H.R. 2290 provides for the transfer of all relevant records, personnel, and property to the newly established IHS within 9 months after enactment and permits a waiver of Indian preference laws, on a case-by-case basis, during that 9 month period.

Subsection (c) of section 601 of H.R. 2290 provides that the effective date of the amended section 601 of the IHCA shall be within 9 months of enactment of the amendment.

Subsection (d) of section 601 amends section 5316 of title 5, U.S.C., establishing positions within level V of the Executive Schedule, by adding the Director of the Indian Health Service.

**TITLE VII—MISCELLANEOUS PROVISIONS**

Title VII of H.R. 2290 makes various amendments to existing provisions and adds new provisions to title VII of the IHCA, containing miscellaneous provisions.

*Section 701*

Section 701 amends section 704 of the IHCA, authorizing IHS to lease tribal facilities, by clarifying the authority of IHS to enter into such leases and by providing guidelines for the type of costs which can be included in lease rentals.

*Section 702*

Section 702 amends section 708 of the IHCA which designated the State of Arizona as a contract health service delivery area by extending that designation until 1990; by limiting eligibility for service under the designation to members of Federally-recognized Indian tribes in Arizona; and by striking subsection (c) authorizing appropriations.

*Section 703*

Section 703 amends section 709 of the IHCA relating to the eligibility of Indians of California for IHS services.

Subsection (a)(1) requires the Secretary to submit a report to Congress, no later than three years after enactment, on the general status of California Indians identified in subsections (b) (2) and (3) and their health condition and needs.

Subsection (a)(2) provides that such report shall be prepared by the Secretary in consultation with the Secretary of the Interior and with the assistance of tribal health programs providing services to such Indians who are not members of Federally-recognized tribes.

Subsection (b) provides that, unless otherwise provided by Congress, California Indians who (1) are members of a Federally-recognized tribe; (2) are descendants of Indians living in California on June 1, 1852, and who are residents of California regarded as Indians by the community in which they live; (3) hold a trust interest in Indian allotments in California; or (4) are persons or descendants of a person listed on the judgment distribution roll prepared pursuant to the Act of August 18, 1958, shall be eligible for the health services of IHS.

Subsection (c) provides that nothing in this section shall be construed as expanding the eligibility of California Indians beyond the scope of eligibility as of May 1, 1986.

#### *Section 704*

Section 704 amends section 710 of the IHCA by striking an obsolete provision relating to a personnel ceiling demonstration project and inserting a provision which designates the State of California, except for certain named counties, as an IHS contract health service delivery area.

#### *Section 705*

Section 705 amends VII of the IHCA by adding a new section 711 as follows:

Section 711 makes clear that IHS must provide funds under the Indian Self-Determination Act contracts with tribes and tribal organizations for maintenance and repair, employee training, cost-of-living increases, and other similar expenses on the same basis as is provided for programs directly operated by IHS.

#### *Section 706*

Section 706 amends title VII of the IHCA by adding a new section 712 as follows:

Section 712 provides that the Secretary may remove a member of the National Health Service Corps from a health facility operated by a tribe or tribal organization under an Indian Self-Determination Act contract only if he provides written notice of such action 60 days before the date on which the contract is to be entered into or renewed.

#### *Section 707*

Section 707 further amends title VII of the IHCA by adding a new section 713 as follows:

Subsection (a)(1) provides that minor children of Indians eligible for IHS services, including adopted children, step-children, foster children, wards, or orphans, who are not themselves eligible for such services shall be eligible until their 19th birthday. It provides



that their health needs shall be taken into consideration by IHS in its budget development and allocation process. It also provides that legal incompetents shall remain eligible beyond their 19th birthday until the disability is removed.

Subsection (a)(2) provides that the ineligible spouses of eligible Indians shall not be eligible for IHS services unless all such spouse are made eligible by action of the appropriate Indian tribes. It further provides that the health needs of such spouses shall not be taken into consideration by IHS in its budget process.

Subsection (b)(1), subparagraph (A), would permit the Secretary to provide health services to any other ineligible person, including non-Indians, within the service area of an IHS service unit if the Indian tribe or tribes request that such service be provided and if the Secretary and the tribes jointly agree that service to eligible Indians will not be impaired and that there is no alternative health resource for such persons.

Subparagraph (B) provides that Indian tribes operating IHS health facilities under an Indian Self-Determination Act contract may authorize health service to such ineligible persons under the same conditions.

Subsection (b)(1), subparagraph (A), provides that such persons must pay a fee for such service in an amount to be established by the Secretary at not less than the actual cost. Such collections shall be used by the facility collecting them for the provision of health service, but shall not be available for such expenditure beyond two fiscal years.

Subparagraph (B) provides that such services can be provided to indigent persons only if the State or local government agrees to reimburse IHS for the cost of such service.

Subsection (b)(3) provides that any service provided to ineligible persons under paragraph (1)(A) shall terminate the fiscal year after the fiscal year in which the Indian tribe revokes its consent. For multi-tribal service units, such termination requires revocation of consent by 51% of the tribes in the service unit.

Subsection (c) provides that IHS can provide health services to persons who are not eligible under any other provision of law in order to (1) achieve stability in a medical emergency; (2) prevent the spread of a communicable disease or deal with a public health hazard; (3) provide care to non-Indian women pregnant with an eligible Indian's child through post-partum; or (4) to members of the immediate family of an eligible Indian if directly related to the treatment of such Indian.

Subsection (d) authorizes the Secretary to grant hospital privileges to non-IHS health care practitioners to provide services to persons described in subsection (a) or (b). Such persons would be regarded as Federal employees for purposes of the Federal Tort Claim Act only with respect to acts or omissions relating to their treatment of eligible Indians.

Subsection (e) provides that "eligible Indian" means for purposes of this section, any Indian who is eligible for IHS services without regard to this section.

### *Section 708*

Section 708 amends title VII of the IHCA by adding a new section 714 as follows:

Section 714 provides that the Secretary, by no later than January 1, 1989, shall develop and begin implementation of a plan to reduce the rate of infant mortality, maternal mortality, and fetal alcohol syndrome among Indians to a level comparable with national rates by January 1, 1993. It also requires the President to include with his annual budget a separate statement setting forth the amount of funds obligated or expended for this effort in the past fiscal year.

### *Section 709*

Section 709 adds a new section 715 to title VII of the IHCA as follows:

Section 715 directs the Secretary to make contract health services available to Turtle Mountain Band of Chippewa Indians in certain counties of North Dakota and Montana. However, this is not to be construed as expanding eligibility of such members beyond the scope of such eligibility as of May 1, 1986.

### *Section 710*

Section 710 amends title VII of the IHCA by adding a new sections 716 as follows:

Subsection (a) provides that the Secretary shall examine the feasibility of entering into an arrangement for the sharing of facilities and services between the IHS and the Veterans' Administration. The Secretary must submit a report to Congress in that regard by September 30, 1990.

Subsection (b) provides that the Secretary may not take any action under subchapter IV of Part VI of title 38, U.S.C., which would impair either the rights of Indians to receive health services from IHS or the rights of veterans, including Indian veterans, to receive health care from the Veterans' Administration.

Subsection (c) provides that nothing in this section is to be construed as creating any right of a veteran to obtain health services from IHS.

### *Section 711*

Subsection (a) provides that the Secretary may allocate the base resources of the IHS service in fiscal year 1988 in a manner which differs from the allocation in fiscal year 1987 and which affects more than 5% of the base resources for fiscal year 1988 only if the requirement of subsection (b) are met.

Subsection (b) provides that the Secretary may make such reallocation of base resources for fiscal year 1988 if he submits to the Congress a written statement certifying that he has consulted with Indian tribes and tribal organizations about such reallocation and a report on the proposed changes in allocation.

### *Section 712*

Subsection (a) provides that the Secretary shall provide services and benefits of IHS for Indians in Montana in a manner consistent

with current policy as allowed by the stay during the pending litigation in *McNabb v. Heckler*, 628 F. Supp. 544 (D. Mont. 1986).

Subsection (b) provides that this section shall not represent any expression of the sense of Congress on the merits of the district court decision.

#### *Section 713*

Subsection (a) provides that the Secretary shall make grants to the Tohono O'odham Tribe of Arizona for a demonstration project to develop and test a phased approach for the assumption by the tribe of the IHS health care delivery system for its members through the use of IHS, tribal and private resources.

Subsection (b) provides that, during the period of the demonstration project, the Secretary shall award health care contracts to the tribe in the form of a single grant to which regulations prescribed in Part A of title XIX of the Public Health Service act, as may be modified by agreement of the Secretary and the tribe, shall apply.

Subsection (c) authorizes the Secretary to waive such Federal procurement laws as may be necessary to the effective conduct of the demonstration project, but not if such waiver would adversely affect the delivery of health care.

Subsection (d) provides that the demonstration project shall terminate four years after it is established and, within a reasonable time thereafter, the Secretary shall submit a report to Congress.

Subsection (e) authorizes the appropriation of \$275,000 for each of the fiscal years 1988, 1989, and 1990, and \$75,000 for fiscal year 1991 for this purpose.

#### *Section 714*

Subsection (a) requires the Secretary of Health and Human Services, the Secretary of the Interior, and the Secretary of Energy to jointly conduct a study of health hazards posed by active nuclear development sites on Indian lands, the remedial actions which have been taken or should be taken with respect to such hazards, and the amount of funds which would be necessary to deal with such health hazards.

Subsection (b) requires that a report be submitted to Congress not later than two years after the date of enactment of this Act.

The Committee notes that a similar report was required by the 1980 amendments to the IHCA and a completely inadequate report was submitted to Congress on April 27, 1983. This report was prepared at a cost of \$10,175 and amounted only to secondary research of sparse original information on the subject of nuclear radiation health hazards on Indian reservations. That report notes that the \$300,000 authorized by Congress for the study was not appropriated, but does not note that the Administration failed to request any funding for that report. It is the Committee's intent that the Administration conduct a somewhat more exhaustive study on this very real health hazard to Indian people.

## TITLE VIII—DIABETES PREVENTION AND CONTROL

*Section 801*

Section 801 of H.R. 2290 adds a new title VIII to the IHCA on diabetes prevention and control.

*Section 801*

Subsection (a) contains congressional findings about the severe impact of diabetes on the Indian population and the need for efforts and programs to deal with that problem.

Subsection (b) provides that the purposes of this title is to broaden research into this program, strengthen the efforts of IHS to deal with it, and to achieve a reduction of the incidence of diabetes among Indian people to a rate comparable with rest of the Nation.

*Section 802*

Subsection (a) provides that the Secretary shall determine the incidence of diabetes among Indians, activities of IHS needed to deal with the problem, and the fiscal impact to the Federal Government of treating diabetes among Indians.

Subsection (b) provides that the Secretary shall prepare an inventory of public and private programs and resources available for the treatment, prevention and control of diabetes among Indians.

Subsection (c) requires a report from the Secretary to the Congress within 18 months of enactment on his findings.

*Section 803*

Subsection (a) requires the Secretary, within 18 months of enactment, to develop and implement a comprehensive program relating to the treatment, prevention, and control of diabetes among Indian people.

Subsection (b) provides that the Secretary shall promote coordination and cooperation between all health care providers in the delivery of diabetes related services to Indians and to encourage and fund joint project in that respect.

Subsection (c)(1) provides that the Secretary will continue to maintain named model diabetes clinics in existence on the date of enactment in the states of Oklahoma, North Dakota, Arizona, Nebraska, New Mexico, Maine, and Washington.

Subsection (c)(2) provides that, within 2 years of enactment, the Secretary will establish and maintain model diabetes clinics on the Navajo Reservation, the Papago Reservation, the Zuni Reservation and in the states of Alaska, Minnesota, and Montana.

Subsection (c)(3) provides that the Secretary will establish an outreach program to ensure that the results achieved in the model clinics will be replicated in other IHS service units.

Subsection (d) provides that the Secretary shall maintain appropriate personnel in IHS to implement the diabetes effort, including at least one diabetes control officer in each area office of IHS, and shall submit an annual report to the Congress.

*Section 804*

Section 804 provides that the Secretary shall develop and maintain, within 2 years of enactment, a comprehensive standardized system to collect, analyze, and report diabetes data among Indians.

*Section 805*

Section 805 provides that the Secretary shall require each agency or unit of the Department of Health and Human Services, which conducts research relating to diabetes to give special attention to that problem among Indian people and to coordinate research with all other agencies and units in that respect.

*Section 806*

Section 806 provides that the Secretary may prescribe such regulations as may be necessary to carry out the title.

*Section 807*

Section 807 authorizes the appropriation of such sums as may be necessary to carry out the provisions of the title.

## TITLE IX—SEVERABILITY PROVISION

*Section 901*

Section 901 of H.R. 2290 contains a severability provision with respect to any holding that any provision of H.R. 2290 is determined to be unconstitutional.

## COMMITTEE RECOMMENDATIONS

The Committee on Interior and Insular Affairs, by voice vote on June 3, 1987, ordered H.R. 2290 reported favorably to the House, with an amendment.

## COST AND BUDGET ACT COMPLIANCE

The cost of H.R. 2290, over a five fiscal year period is \$68,900,000 for fiscal year 1988, \$96,700,000 for fiscal year 1989, \$98,700,000 for fiscal year 1990, \$102,800,000 for fiscal year 1991, and \$51,100,000 for fiscal year 1992. The Committee notes that the authorization level for the IHCA for the last year of authorization, fiscal year 1984, was \$202,215,000 and the actual fiscal year 1984 appropriation under the Act was \$134,215,000. The fiscal year 1988 authorization, as contained in H.R. 2290, is \$67,900,000 or \$151,315,000 less than the fiscal year 1984 appropriation level. The analysis of the Congressional Budget Office follows:

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
Washington, DC, June 15, 1987.

Hon. MORRIS K. UDALL,  
Chairman, Committee on Interior and Insular Affairs,  
U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 2290, the Indian Health

Care Amendments of 1987, as ordered reported by the House Committee on Interior and Insular Affairs on June 3, 1987.

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

With best wishes,  
Sincerely,

EDWARD M. GRAMLICH,  
*Acting Director.*

#### CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2290.
2. Bill title: Indian Health Care Amendments of 1987.
3. Bill status: As ordered reported by the House Committee on Interior and Insular Affairs on June 3, 1987.
4. Bill purpose: This bill would authorize and amend the Indian Health Care Improvement Act.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
<b>Estimated Authorization Levels</b>					
Health Professions Recruitment Program for Indians .....	0.6	0.6	0.7	0.7	.....
Health professions prep scholarship .....	3.0	3.7	4.4	5.1	.....
Indian Health Scholarship Program .....	5.1	6.0	7.1	8.2	.....
Indian Health Service Extern Program .....	.3	.4	.4	.5	.....
Continuing education allowance .....	.5	.5	.6	.6	.....
Native Hawaiian scholarships .....	1.8	1.8	1.8	1.8	.....
Community health representatives .....	27.3	28.2	29.2	30.1	31.1
Indian health care improvement fund .....	.....	19.0	19.0	20.0	.....
Indian catastrophic health emergency fund .....	12.0	12.0	12.0	12.0	.....
Demonstration project .....	.5	.....	.....	.....	.....
Health promotion .....	.....	.8	.8	.8	.8
Water and sanitation .....	.....	3.9	3.9	3.9	.....
Grants and contracts with tribal organizations .....	.....	2.0	.5	.5	.....
Health services for urban Indians .....	9.6	9.9	10.3	10.6	11.0
Tohono O'odham demonstration project .....	.3	.3	.3	.1	.....
Diabetes prevention .....	7.9	7.6	7.7	7.9	8.2
Total estimated authorization levels .....	68.9	96.7	98.7	102.8	51.1
Total estimated outlays .....	53.7	85.8	96.3	101.5	66.4

**Basis of Estimate:** Most authorization levels are stated in the bill. CBO assumes that all authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of historical spending data.

The bill authorizes \$12 million in fiscal year 1988 for the Indian Catastrophic Health Emergency Fund. It authorizes such sums as may be necessary in fiscal years 1989, 1990 and 1991 to return the Fund to a level of \$12 million. CBO assumes that this authorization would not allow repeated draining and refilling of the Fund during any one fiscal year. Rather the authorization simply would limit aggregate annual appropriations to the Fund to \$12 million.

The bill also authorizes such sums as may be necessary to provide diabetes prevention and control services to Indians through a

diabetes care program. Diabetes screening would be provided at an estimated cost of about \$200,000 each year. Training on diabetes prevention, diagnosis and treatment would be given to health care providers and to community health representatives at an estimated cost of \$2 million each year. The bill would also establish six new model diabetes clinics in areas specified in the bill. The Indian Health Service currently supports seven such clinics at a cost of about \$200,000 for each clinic a year. If the six new clinics provide the same level of services as the current clinics, additional costs to the federal government could be about \$1.2 million each year. An additional 15 full-time equivalents (FTE's) could be required to administer the diabetes care program. The alcoholism program currently operated by IHS is managed by 5 FTE's at the agency office and by about 10 FTE's in the service area. If a similar level of program administration is used for the diabetes care program, an additional 15 FTE's would be needed at a cost of about \$800,000 each year.

There are several aspects of the diabetes care program mentioned in the bill for which CBO has shown no costs in this estimate. For example, the bill states that the diabetes care program shall be designed to enable all service units of the IHS to effectively treat diabetes and to ensure proper continuing health care. The bill also states that the Secretary of Health and Human Services shall fund joint projects concerning diabetes involving federal and tribal health care facilities and Native American communities. CBO has no basis to estimate the cost of these activities mentioned in the bill or the level of federal involvement that might be undertaken to comply with the bill language.

The bill authorizes an 18 month study on the incidence of diabetes among Native Americans and how to reduce it. Costs of the study are expected to be about \$300,000 for the 18 months. The bill would also provide diabetes educational materials for Native American communities and schools. If \$1,000 were spent for materials at each Bureau of Indian Affairs contract school and at public schools with significant Native American populations, the cost would be about \$500,000. Salary and overhead for at least one full-time diabetes control officer in each area office would also be authorized. CBO estimates the cost of this provision to be about \$1 million in each year.

The bill also authorizes development of a data collection and analysis system relating to diabetes. The federal government currently operates a similar system that collects data on smoking at a cost of about \$2 million each year. Similar costs could be expected for a diabetes data collection system.

Under the bill, each agency conducting research on diabetes would be required to give special attention to research concerning Native Americans and to coordinate that research with HHS. This could be accomplished by hiring a coordinator to monitor the department's efforts at a cost of less than \$100,000 each year.

The bill would establish two current Indian Health Service (IHS) activities as permanent programs authorized under the Snyder Act of 1921. The Snyder Act of 1921 is a permanent, open-end authorization "for relief of distress and conservation of health" for Indians and provides the basic authority for the Indian Health Service.

Under the bill, the Community Health Representative program and health services for urban Indians would be permanently authorized. Specific reauthorizations of these programs would no longer be necessary. The authorization levels shown in the table for these programs reflect the permanent addition to the current level of IHS services. These levels were estimated by increasing the 1987 appropriation levels for these activities by the appropriate inflator.

Several other activities are authorized in the bill but no authorization levels are specified. Some of these activities have not been previously authorized by the Indian Health Care Improvement Act. Such activities might be carried out today under the general authorization of the Synder Act, but have never been funded. Since it is not clear whether the bill newly authorizes some of these activities, we have estimated authorization levels that might be needed, but have not included them in the table. These additional activities, if funded, could increase the fiscal year 1988 costs of this bill by \$13 million to \$33 million. All authorization levels would be subject to subsequent appropriations action.

The bill authorizes the Secretary of Health and Human Services (HHS) to enter into an agreement with the Bethel Native Corporation (BNC) for the settlement of a land dispute. If the Department of the Interior makes a final administrative ruling that entitles the BNC to the property in question, the Secretary would have 90 days to negotiate an exchange of that property for other specified land. If an agreement could not be reached within 90 days, the Secretary would purchase the property from the BNC. A final ruling has not yet been made. The cost to the federal government of a land exchange cannot be estimated until the property to be exchanged is determined. If the Secretary were to purchase the land, the cost to the federal government would be about \$9 million. This estimate is based on a 1985 appraisal by the United States Fish and Wildlife Service.

The bill would extend through 1990 Arizona's designation as a contract health service delivery area. This activity was authorized in the 1980 extension of the Indian Health Care Improvement Act at \$2 million for fiscal years 1982 through 1984. No authorization level is stated in this bill. If a similar level of resources were allocated to Arizona in fiscal years 1988 through 1990, costs could be between \$2.3 and \$2.5 million each year.

The bill would newly designate parts of the state of California as contract health service delivery areas. No specific authorization level appears in the bill. This provision could make an additional 40,000 Indians eligible for contract care. It is not clear how many would actually require contract health services. In 1985, \$534,000 was allocated for contract health care in California. About 70,000 people are currently eligible for service in California. The number of people actually using contract care services is unknown. Providing a similar level of services to an additional 40,000 eligible persons could require an extra \$300,000 each year. The bill would also authorize a three year study for these newly eligible Indians at an estimated cost to the federal government of \$100,000 in each fiscal year 1988 through 1990.



Contract health services would also be provided to the Turtle Mountain Band of Chippewa Indians who live in counties not currently included in the Trenton service area. An estimated 1,600 people would be made newly eligible by this provision. \$282,000 was allocated to the Trenton area in 1985 for contract health to serve an eligible population of about 11,000. Providing the current level of services to the newly eligible could require an additional \$40,000 each year.

The bill would authorize the Secretary of HHS to provide management information systems to all tribes, tribal organizations, and urban Indian organizations that provide health services. The federal government would pay for the portion of the system's operation attributable to patients of the Indian Health Service. Costs to the federal government could range from \$2 million to \$20 million in each year depending on the type of system developed. This cost range assumes that a management information system could be as simple as a personal computer provided for each tribal operated facility or as sophisticated as the Medicaid Management Information System (MMIS) used for claims processing and information retrieval.

The bill would authorize the Secretary of HHS to conduct a three year study on IHS and Veteran's Administration facilities and services sharing, as well as a four year demonstration project allowing direct billing of third party payors. Costs to the Federal government are estimated to be about \$1 million in 1988 through 1991 for both activities. The bill would also authorize the Secretary of HHS to conduct a two year study of health hazards to Indians resulting from nuclear resources development. CBO estimates this study could cost \$100,000 in each fiscal year 1988 and 1989.

The bill would authorize payments to tribal owned or operated clinics for maintenance and repair, employee training, and cost-of-living adjustments for employees on the same basis as funds for these activities are provided to facilities operated by IHS. CBO has no basis on which to estimate the possible cost of this provision.

CBO estimates that no additional cost to the federal government would result from enactment of the bill language relating to preventive health services and infant and maternal mortality as the IHS currently conducts similar activities in these areas.

6. Estimated cost to State and local government: The budgets of state and local governments would not be affected directly by the enactment of this bill.

7. Estimate comparison: On February 17, 1987, CBO prepared an estimate for S. 129, the Indian Health Care Amendments of 1987 as ordered reported by the Senate Select Committee on Indian Affairs. Authorization levels and certain provisions differ in these bills.

8. Previous CBO estimate: None.

9. Estimate prepared by: Carmela Dyer.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

#### INFLATIONARY IMPACT STATEMENT

The Committee finds that the new authorizations, if appropriated, would have some undetermined inflationary impact on the

national economy; however, a failure to meet the Nation's responsibility to provide adequate health care to Indian tribes would have a greater impact on a significant segment of the population which could cause adverse ramifications on the economy and inflation.

#### CHANGES IN EXISTING LAW

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 laws proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

## ADDITIONAL VIEWS

In April of 1985, Republican Members of this Committee wrote the President about the elevation of the Indian Health Service. In that letter we stated, "we are firmly committed to our shared goals of making federal programs more streamlined, responsive, and free of bureaucratic obstacles. We strongly believe the structural change of the Indian Health Service within the Department of Health and Human Services would further those goals." It remains our position that the Indian Health Service should become a full agency of the Public Health Service, as provided in title VI of H.R. 2290.

The current administrative structure of the Indian Health Service, as a subagency of the Health Resources and Services Administration of the Public Health Service, does not adequately reflect the importance of the Indian Health Service. The elevation of the IHS would simply make Indian health programs more efficient, and more responsive to the needs of the individuals for whom the programs are intended.

The recent report of the Office of Technology Assessment on the impending crisis in the Indian Health Service concerning the recruiting and retaining health professionals, cited the current Indian Health Service status as a major problem. The Indian Health Service does not currently control its personnel and procurement operations, nor does it have much input into its budget requests. We strongly believe that for the Indian Health Service to remain a viable agency, it must be given the authority, like other agencies, to control vital functions of administration. Therefore, title VI of H.R. 2290 is an essential element to the fulfillment of our commitment to Indian tribes and their members.

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