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INDIAN HEALTH CARE AMENDMENTS OF 1987

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

REPORT

[To accompany S. 129]

The Select Committee on Indian Affairs, to which was referred the bill (S. 129) to authorize and amend the Indian Health Care Improvement Act, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill, as amended, do pass.

PURPOSE

The purpose of S. 129, the Indian Health Care Amendments of 1987, is to reauthorize the Indian Health Care Improvement Act of 1976 through fiscal year 1991, to make amendments to the Indian Health Care Improvement Act, and to authorize appropriations to carry out the provisions of the Indian Health Care Improvement Act.

BACKGROUND AND NEED

The Indian Health Care Improvement Act of 1976 (25 U.S.C. 1601, et seq.) and the Snyder Act of 1921 (25 U.S.C. 13) comprise the basic legislative authority for the health care programs that are administered by the Indian Health Service (IHS), an agency of the Public Health Service within the Department of Health and Human Services (DHHS). The Indian Health Care Improvement Act was enacted into law in 1976 based upon findings that the health status of American Indians and Alaska Natives continued to rank far below that of the general population, and that all other Federal services and programs were jeopardized by the low health status of American Indian people. The Act was amended and ex-

19-010

tended in 1980, continuing authority for appropriations for the provision of health care services to Indian and Alaska Native people through September 30, 1984.

Legislation to reauthorize the Act (S. 2166) was introduced in the 98th Congress, but was vetoed by the President following the sine die adjournment of the 98th Congress. Reauthorization legislation was again introduced in the Senate (S. 277) in the beginning of the 99th Congress. A companion House bill (H.R. 1426) was passed by the House on September 18, 1986, and was passed by the Senate by the Senate on October 8, 1986 with an amendment. The House concurred in the Senate amendment with amendments on October 10, 1986, and the Senate concurred in the House amendments to the Senate amendment with an amendment on October 18, 1986. The bill was not acted upon again by the House of Representatives before the sine die adjournment of the 99th Congress. The programs authorized in the Indian Health Care Improvement Act have been extended by appropriations acts of the Congress through fiscal year 1989.

Although significant gains have been realized in improving the health status of Indian and Alaska Native people since the passage of the Act of 1976, health status parity with that of the general United States population has yet to be achieved. The age-adjusted mortality rate among American Indians is 330 percent higher than the general U.S. population, all races, for all forms of tuberculosis; 300 percent higher for chronic liver disease and cirrhosis; 210 percent higher for diabetes mellitus; and 170 percent higher for pneumonia and influenza. And, although the Indian population is the fastest growing population in the United States in numbers of births, the postneonatal mortality rate among native infants is 170 percent higher than the rate for the U.S. all races. Deaths attributable to accidents exceed national averages by 250 percent.

In exchange for lands ceded to the United States by Indian tribes under the provisions of treaties, executive orders, and various acts of the Congress, the Federal government has provided health care services to Native Americans since the early nineteenth century. Federal programs for the benefit of American Indians were first administered by the U.S. War Department, but in 1849, the responsibility for the provision of health care services to Indian people was transferred, along with the Bureau of Indian Affairs, to the Department of the Interior. In 1921, Congress enacted the Snyder Act, establishing the first legislative authorization for appropriations for the "relief of distress and conservation of health" of Indian people. Later, in 1955, the responsibility for the provision of health care services to Indian people was again transferred, this time to the Division of Health in the Department of Health, Education and Welfare, under the authority of an Act to Transfer the Maintenance and Operation of Hospital and Health Facilities for Indians to the Public Health Service (42 U.S.C. 2001, et seq.). The Division of Health subsequently came to be known as the Indian Health Service within the reorganized Department of Health and Human Services, where the responsibility for Indian health care continues to be vested.

The early focus of the Indian Health Service (IHS) was on the elimination of the infectious diseases that were widespread in the

Indian population and on chronic care for the large numbers of Indian people suffering from tuberculosis. Currently, the mission of the IHS, in carrying out the policy established by the Congress in the Indian Health Care Improvement Act, is to raise the health status of American Indians and Alaska Natives to the highest possible level. IHS defines its service delivery responsibilities to include a comprehensive range of inpatient and ambulatory medical services, dental care, mental health and alcoholism services, preventive health (immunizations and environmental services such as sanitation and water safety), health education, and Indian health manpower development programs. A broader definition of IHS responsibilities is applied in isolated rural areas on or near Indian reservations, because the infrastructure of roads, utilities, and public services that support health care delivery to non-Indian rural residents is often lacking on Indian reservations. IHS also operates a health facilities construction component that provides hospitals, clinics, and living quarters for IHS facility staff for reservation-based IHS services. Programs for Indians residing in urban areas do not directly provide hospital care, but do offer a range of ambulatory medical, dental, mental health, alcoholism treatment, support and referral services.

The Indian Health Service operates the largest direct health care delivery system within the Department of Health and Human Services, with over 11,400 permanent employee positions. IHS administers health care programs to Indians and Alaska Natives through eight area offices and four program offices, each of which has the responsibility for the provision of health care services within its respective geographic area. The area offices and program offices also have responsibility for overseeing the administration of IHS service units, the most local administrative entity, through which services are provided directly or by contract to the eligible Indian population. Each service unit may include one or more IHS hospitals, health centers, school health centers, health stations, or health locations. A health center is a facility that is open a minimum of forty hours per week and offers acute and chronic care services on an outpatient basis. A health station is a facility that may be mobile and which provides outpatient services on less than a forty hour per week basis. A health location is a site for the periodic provision of outpatient health services often provided by traveling health care professionals. In areas in which there are no IHS facilities or where an IHS facility lacks the capacity to provide certain types of health care services, the IHS contracts with private health care providers for the provision of health care services to Indian patients. IHS also provides technical assistance in the construction and operation of sewage treatment and clean water facilities.

With the enactment of the Indian Self-Determination and Education Assistance Act in 1975, Indian tribal governments, tribal organizations, Alaska Native communities, and Alaska Native regional health and village corporations have begun to assume the responsibility for the provision of health care under contract with the Indian Health Service. In addition, IHS programs, such as the Community Health Representative program, that are administered directly by Indian tribal governments, have done much to heighten

awareness of the importance of preventive health care and health education in Indian communities.

A report released by the U.S. Congress Office of Technology Assessment (OTA) in February, 1987, projects that IHS will experience serious physician shortages in the near future. In past years, the Indian Health Service physician supply has come primarily from the National Health Service Corps, a scholarship program operated by the Public Health Service that requires a service payback obligation as an exchange for scholarship assistance in medical school and residency training. National Health Service Corps obligees can elect to fulfill their obligations through service in the Indian Health Service. However, because of the phased elimination of the scholarship program, there will be only two obligees available for service in 1992. Recognizing the need for additional manpower, IHS has proposed to initiate a program that would recruit volunteers into the Service, but the Office of Technology Assessment projects that the IHS initiative will not be sufficient to meet the need, given the low salaries that IHS must offer and unattractive working and living conditions that are associated with the provision of health care on Indian reservations. For the past two years, the President's Budget has also proposed the phased elimination of the Indian Health Service scholarship program—the last remaining source of health care professional supply to the Indian Health Service.

To ascertain the need to reauthorize the Indian Health Care Improvement Act of 1976, the Select Committee on Indian Affairs held six hearings in the 98th Congress. Hearings were held in conjunction with the House Interior and Insular Affairs Committee in Phoenix, Arizona on March 31, 1983. The Senate Select Committee on Indian Affairs held further hearings on the need for reauthorization of the Act in Grand Forks, North Dakota on June 2, 1983; in Anchorage, Alaska on June 3, 1983; in Seattle, Washington on June 8, 1983; in Billings, Montana on July 8, 1983; and in Washington, D.C. on July 28, 1983. The Committee received testimony from Indian tribes, urban Indian health care programs, tribal organizations, physicians and other health care professional employees of the Indian Health Service, representatives of the Department of Health and Human Services, as well as physicians and health care professionals from the private sector. Testimony received by the Committee strongly supported the need to reauthorize the Indian Health Care Improvement Act, given the outstanding unmet health care needs of Indians and Alaska Natives that were documented in the hearing process.

On November 18, 1983, Senator Mark Andrews, Chairman of the Senate Indian Affairs Committee, introduced S. 2166, a bill to reauthorize the Indian Health Care Improvement Act of 1976 through fiscal year 1988. The Committee held two hearings on the bill in Washington, D.C. on February 29, 1984, and in Denver, Colorado on March 17, 1984. In response to testimony received from national Indian organizations, professional medical associations, Indian tribes, urban Indian health care organizations, professional medical associations, and Administration representatives, the Committee made several changes to the bill as introduced, and an amendment in the nature of a substitute to S. 2166 was unanimously approved

by the members of the Select Committee on Indian Affairs in a May 9, 1984 mark-up of the bill to reauthorize the Indian Health Care Improvement Act. S. 2166 was passed by both houses of the Congress in the 98th session of the Congress, but was vetoed by the President on October 19, 1984, following the sine die adjournment of the 98th Congress.

Recognizing that the unmet health care needs of Native Americans were continuing to worsen, the Chairman of the Indian Affairs Committee introduced a bill to reauthorize the Act (S. 277) at the beginning of the 99th session of the Congress. Largely due to the efforts of tribal leaders seeking a dialogue between the Administration and the Congress to avoid the possibility of another veto, the Office of the Secretary of the Department of Health and Human Services agreed to enter into discussions with Select Committee representatives. Several months of discussions yielded a version of the reauthorization bill to which the Administration was not opposed. Following two additional hearings in the 99th Congress, the Committee reported S. 277 on May 16, 1985.

Legislative History

On January 6, 1987, Senator Inouye introduced the Indian Health Care Amendments of 1987 (S. 129) for himself and Senators DeConcini, Matsunaga, Kennedy, Evans, Murkowski, Bingaman, Stevens, McCain, Melcher, Pressler, Evans, Cranston, Durenberger, Cochran, Nickles, Hatfield, Baucus and Domenici. S. 129 was referred to the Select Committee on Indian Affairs. Given the thorough hearing record established in the two previous sessions of the Congress, and the results of discussions with the representatives of the Department of Health and Human Services, the Chairman requested that the Committee proceed to consideration of S. 129 without further hearings. S. 129 was ordered reported with an amendment in the nature of a substitute on January 23, 1987, and further amendments to the amendment in the nature of a substitute were ordered reported on March 19, 1987. A bill to authorize and amend the Indian Health Care Improvement Act (H.R. 2290) was introduced in the House of Representatives on May 5, 1987 by Congressman Udall, for himself and Congressmen Richardson, Campbell, Johnson of South Dakota, Lowry of Washington, Lewis of Georgia, Vento, Young of Alaska, Lagomarsino, Bereuter, and Rhodes. H.R. 2290 was jointly referred to the Committee on Energy and Commerce, and to the House Interior and Insular Affairs Committee. The bill was ordered reported by the House Interior and Insular Affairs Committee on June 3, 1987 with amendments, and by the Subcommittee on Health and the Environment of the House Energy and Commerce Committee on October 9, 1987, with amendments.

Summary of Major Provisions

TITLE I

Indian health manpower programs and scholarship assistance

In its total workforce of approximately 11,400 (1985 estimates), the Indian Health Service employs approximately 750 physicians,

including physicians in administrative roles at IHS headquarters and area offices, nearly 2,000 professional nurses, 800 practical nurses, 300 pharmacists, and 275 dentists. A recent report of the U.S. Congress Office of Technology Assessment evaluated clinical staffing needs in the Indian Health Service, and found that unless current policies change, there will no physicians available from the National Health Service Corps (NHSC) scholarship program by 1992. The National Health Service Corps scholarship program has served as a major source of physician supply to the Indian Health Service in past years. The scholarship program requires one year of obligated service in the Indian Health Service for each year of scholarship assistance received by an NHSC program participant. The Office of Technology Assessment report states, "Arguing that the growing surplus of physicians nationally will diffuse to underserved areas, thus eliminating the need for the NHSC, the Administration has sought to phase out the program by restricting new scholarship awards. Recently, IHS has been able to recruit 40 to 50 voluntary physicians annually; but its ability to recruit enough volunteers to replace lost NHSC physicians has not been tested. The PHS (Public Health Service) Commissioned Corps, which has made valuable contributions to IHS professional staffing over the years, like the NHSC, has been targeted by the current Administration for reduction or elimination." The OTA report concludes that, "Thus a national physician surplus will improve medical manpower and services for Indians only if it greatly increases recruiting of voluntary physicians into IHS, which does not seem likely in the near future, given the other organized practice alternatives available to physicians, the undesirability of many IHS sites, and uncompetitive IHS salaries and benefits."

Title I reauthorizes programs that provide for the recruitment, training and professional development of Indian people to serve in the Indian Health Service. Funding is authorized for the continuation of the health professions recruitment program for Indians and for the health professions preparatory scholarship program through fiscal year 1991. The recruitment program is designed to provide information to junior and senior high school students that are interested in entering the health professions, and the preparatory scholarship program is aimed at assisting students that display an aptitude for subjects relevant to training in the health professions training.

Based upon prior actions of the Department that denied scholarship assistance to applicants on grounds that were not intended by the Congress to be the basis for such denials, language in the bill makes clear that the Secretary is not to deny scholarship assistance to an applicant otherwise eligible to participate in the preparatory scholarship program, solely on the basis of the applicant's scholastic achievement if the applicant has been admitted to, or has maintained good standing at an accredited institution.

The bill also provides authorization for funding for the continuation of the Indian Health Service extern program, a program that enables health professions students to work in Indian Health Service facilities during non-academic periods.

The bill further provides for the extension of the Indian health professions scholarship program, a program that requires one year

of obligated service in the Indian Health Service in exchange for each year of scholarship assistance received by a student pursuing a degree in the health professions. The active duty service obligation associated with such scholarship assistance can be satisfied by service in the Indian Health Service, in a program conducted under a contract entered into under the authority of the Indian Self-Determination and Education Assistance Act, in an urban Indian health care program, or in the private practice of a health profession if the practice is located in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians. The bill also makes clear that students in schools of psychology, social work, and osteopathy are eligible to participate in the scholarship assistance program.

In addition, recognizing the importance to the overall retention of personnel within the IHS, the bill provides authority for appropriations for the continuing education of IHS health care professionals.

Although not to be administered by the Indian Health Service, the bill also authorizes a health professions scholarship program for Native Hawaiians. The Native Hawaiian scholarship program is authorized in response to findings of a 1986 report of the Department of Health and Human Services which documented shortages of health care professionals available to serve the Native Hawaiian patient population. To participate in the Native Hawaiian scholarship assistance program, an applicant must be a citizen of the United States, a resident of the State of Hawaii, and a descendent of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the state of Hawaii.

Community health representatives

In many isolated Indian and Alaska Native communities, Community Health Representatives (CHRs) are the only trained health care personnel within close proximity to the reservation or community, and thus often are the only source of health care available in a medical emergency. Community health representatives administer emergency treatment, and often provide emergency transportation to the nearest Indian Health Service facility. Community health representatives provide home health care services to elderly and non-ambulatory patients, and provide health education to members of the community. The reduction of the incidence of fetal alcohol syndrome and the reduction in the rate of infant mortality in Indian and Alaska Native communities can be attributed in part to the efforts of CHRs in providing health care education to pregnant women and mothers. Several years ago, in response to an Administration proposal that the Community Health Representative program be eliminated, over 300 Indian Health Service physicians signed a petition expressing their support for the CHR program and emphasizing the importance of CHRs to the overall health care delivery system. CHRs are typically Indian men and women from the local community, that speak the tribe's native language, and are thus able to facilitate the acceptance of modern medical technology amongst members of the community that are accustomed to relying upon traditional medicine practitioners. Although the program has been in existence for almost twenty years, the program

has never been allocated enough funding to enable cost of living increases to CHRs, nor any of the other benefits that are customarily associated with employment. CHRs often serve as volunteers when funding is short, and upon retirement, receive no severance pay or retirement benefits.

In order to insure a greater stability of funding for the CHR program, Title I expresses the intent of the Congress that the Community Health Representative is to be funded under the authority of the Snyder Act of 1921, 25 U.S.C. 13, as a permanent part of the IHS health care delivery system, and directs the Secretary to maintain a Community Health Representative program that provides for the training of Indian people as health paraprofessionals, and which uses Indian paraprofessionals in the provision of health care to Indian communities. In order to assure that a high standard of paraprofessional training is provided to Community Health Representatives, Title I directs the Secretary to develop a curriculum that combines education in the theory of health care with supervised practical experience in the provision of health care; which provides instruction and practical experience in health promotion and disease prevention activities, and which provides instruction in the latest and most effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits. The Secretary is further directed to develop a system that identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and to develop programs that meet the needs for such continuing education.

Title I also directs the Secretary to maintain a system under which the work of the Community Health Representatives is closely monitored, reviewed and evaluated, and the Secretary is further directed to ensure that the provision of health care, health program, and disease prevention activities is consistent with the traditional health care practices and cultural values of the Indian tribes served by the Community Health Representative program.

TITLE II

Indian health care improvement fund

Based upon the documented backlog of services and waiting lists for surgeries that in some areas are as long as three to four years, Title II establishes an Indian Health Care Improvement Fund and authorizes the Secretary to expend amounts appropriated to that fund for the purposes of: raising the health status of Indian people to a zero level of deficiency; eliminating backlogs in the provision of health care services to Indians; meeting the health needs of Indians in an efficient and equitable manner; and augmenting the ability of the Indian Health Service to meet the health service responsibilities of providing clinical care, both direct and indirect, including clinical eye and vision care; preventive health care; direct and indirect dental care; mental health care, including community mental health services, inpatent mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners; emergency medical services; treatment and control of and rehabilitative care

related to alcoholism and drug abuse including fetal alcohol syndrome; home health care; community health representatives, and maintenance and repair.

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

To assure that amounts appropriated to the Fund are to be used first for those tribes that have the greatest levels of health resources deficiencies, Title II provides that funds may be allocated or used for the benefit of an Indian tribe which has a health resources deficiency level of Level I or II, only if as sufficient amount of funds have been appropriated to raise all Indian tribes to a health resources deficiency Level II.

In an effort to assure that funds are distributed according to level of deficiency within a service unit, the Title also provides that funds may be allocated on a service unit basis provided that the funds are used to raise each tribe within the service unit to a Level II, and that funds not be expended within a service unit on a tribe that has a deficiency level of less than Level II unless all other tribes within the service unit have been raised to a Level II. And to assure that the manner in which funds are allocated is based upon tribal priorities in consultation with the Indian Health Service, the bill provides that the allocation of funds to a service unit and to what purposes such funds should be applied, is to be determined by the Indian Health Service in consultation with the affected tribes.

The term "health resources deficiency" means a percentage that is determined by dividing the excess, if any, of the value of the health resources that an Indian tribe needs over the value of the health resources available to the tribe, by the value of the health resources that the tribe needs. The health resources available to a tribe include health resources provided by the Indian Health Service as well as health resources used by the Indian tribe, including services and financing systems provided by any Federal programs, private insurance, and programs of state or local governments.

Title II directs the Secretary to establish procedures that will allow a tribe to petition the Secretary for a review of any determination of the health resources deficiency level of the tribe. Title II makes clear that programs administered by a tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act are to be eligible on an equal basis with programs that are administered directly by the Indian Health Service.

Health services priority system report to Congress

It is the intent of the Committee that the Federal government should identify health services deficiencies among Indian tribes, and over a four-year period, raise all Indian tribes to a zero level of health resources deficiency. Although the Congress has consistently recognized the serious levels of unmet health needs among Indian tribes, resources have never been sufficient to eliminate the identi-

fied health deficiencies. Congress seeks through Title II to develop a procedure for identifying the amounts of resources that would be needed to eliminate those deficiencies. The Committee believes that the approach established in Title II would create a rational basis for the consideration of the annual budget for Indian Health services. This annual budget would be based upon identified health resources deficiencies, and calculations of the amounts of resources that would be needed to raise tribes to a level II, to a level I, and to a zero level of resources deficiencies. This would allow the Congress to rationally balance the need to address unmet Indian health needs, within the context of federal budget constraints. Over the past several years, Administration budgets for Indian health have not reflected the realities of delivering health services on Indian lands, or the continued commitment of the Congress to maintain the Federal responsibility in the delivery of those health services. While Title II does not guarantee that Administration budget requests will reflect these realities, it does mandate a set of objective criteria against which to compare the President's annual budget requests.

In order that the Congress and the tribes may be better informed on the status of outstanding health service requirements, unmet health care needs, the necessity for increased appropriations to reduce health resource deficiency levels, and in order that the Department of Health and Human Services may be better informed of tribal health care priorities and to consider such priorities in the development of the Department's annual budget request, Title II further directs the Secretary to submit a report to the Congress on the current IHS health services priority system for each tribe or service unit including newly recognized or acknowledged tribes. The report is to contain the methodology currently in use by the Service for determining tribal health resources deficiencies; as well as the most recent application of the methodology; the level of health resources deficiency for each tribe served by the Service; 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; 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; the amount of funds necessary to raise all tribes served by the Service to zero health resources deficiency; and an estimate of the amount of health service funds appropriated under the authority of the Indian Health Care Improvement Act or any other Act including the amount of any funds transferred to the Service for the preceding fiscal year that is allocated to each service unit, Indian tribe, or comparable entity, the number of Indians eligible for health services in each service unit or Indian tribe, and the number of Indians using the Service resources made available to each service unit or Indian tribe. The Secretary is further directed to annually update the tribal specific health plans which were developed as part of the plan required under section 703 of the Act.

It is the Committee's intent that the annual report to the Congress on the health services priority system be based upon annual updates of the tribal specific health plans that were orignally authorized by the Indian Health Care Improvement Act. Tribal spe-

cific health plans represent a substantial repository of data about the history, geography, population, demographics and heath needs of each Indian tribe, as identified by the tribal community in consultation with the Indian Health Service. The Committee believes that these tribal specific health plans should be used as a basis for further planning, and that the plans should be updated to reflect new developments in the roles of Indian tribal governments in the provision of health care services. Tribal governments now perform complex, multifaceted roles in the provision of health care on Indian tribes, regulating environmental matters on Indian lands, and interacting with federal, state and county governments. In addition, there have been new institutional developments in the fuctional roles of Indian tribes. Fewer tribal governments now rely upon the advisory health board system, and instead, communicate and interact directly with other governmental entities on consumer, management planning, and policy matters. These changes in the roles of tribal governments need to be taken into account in the updating of tribal specific health plans. It is the Committee's intent that the Indian Health Service work cooperatively and in consultation with Indian tribal governments to identify health needs, to jointly plan for the provision of health care services to address those needs, and to allocate resources based upon a rational identication of needs.

Indian catastrophic health emergency fund

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

Title II provides that a service unit will not be eligible for reimbursement from the Fund for the cost of treatment until its costs of treating any victim of a catastrophic illness or disaster has reached a certain threshold cost which the Secretary is to establish at not less than $10,000 or not more than $20,000. No payment is to be made from the Fund to the extent that a provider is eligible to receive payment for the treatment from any other Federal, state, local, or private source of reimbursement for which the patient is eligible.

Health promotion and disease prevention services

Finding that health promotion and disease prevention activities will improve the health and well being of Indians and will reduce the expenses for medical care of Indians; that health promotion and disease prevention activities should be undertaken by the coordinated efforts of Federal, state, and tribal governments; and that in addition to the provision of primary health care, the Indian Health Service should provide health promotion and disease prevention services to Indians, Title II directs the Secretary to provide health promotion and disease prevention services to Indians, and to submit an annual report to the Congress which evaluates the health promotion and disease prevention needs of Indians as identified in tribal specific health plans. The Secretary is further directed to require that each tribe include within any tribal specific health plan, a comprehensive plan developed by the tribe for health promotion and disease prevention among tribal members.

Title II directs the Secretary to establish at least one, but not more than four, demonstration projects to determine the most effective and cost efficient means of: providing health promotion and disease prevention services; encouraging Indian people to adopt good health habits; reducing health risks to Indians; reducing medical expenses of Indian people through health promotion and disease prevention activities; establishing a program which trains Indians in the provision of health promotion and disease prevention services to tribal members and under which Indian people receiving such training are available on a contract basis to provide health promotion and disease prevention services to other tribes; and providing training and continuing education to employees of the Indian Health Service, and to paraprofessionals participating in the Community Health Representative program in the delivery of health promotion and disease prevention services. The demonstration program is to be conducted in association with at least one health professional school, allied health profession or nurse training institution or public or private entity that provides health care.

Health promotion is defined to include the cessation of tobacco smoking, reduction in the misuse of alcohol and drugs, improvement of nutrition, improvement in physical fitness, family planning, and control of stress. Disease prevention is defined to include immunizations, control of high blood pressure, control of sexually tansmittable diseases, prevention and control of diabetes, pregnancy and infant care including prevention of fetal alcohol syndrome, control of toxic agents, occupational safety and health, accident prevention, fluoridation of water, and control of infectious agents. Federal regulations governing the activities of the Indian Health

Service promulgated in 1982 (cite) prohibit the use of Federal funds for the purpose of providing abortion services except where the life of the mother is endangered. Nothing in the definitions contained in this Act is intended to alter or in any way affect the status or application of the 1982 regulations.

Native Hawaiian health promotion and disease prevention demonstration program

The Secretary if further directed to establish within the Public Health Service, a Native Hawaiian demonstration program for health promotion and disease prevention in the State of Hawaii for the purpose of exploring ways to meet the unique health care needs of Native Hawaiians. This demonstration program is proposed in response to the findings of a study commissioned by the Department of the Health and Human Services at the direction of the Congress and conducted by the Native Hawaiian Health research Consortium.

The data gathered by the Consortium was compared with national health data by the Office of Technology Assessment and the findings indicate that amongst Native Hawaiians, preventible illnesses and diseases far exceed national averages. Age-adjusted mortality rates in the Native Hawaiian population from parasitic and infectious diseases are five hundred and nineteen times the national average; from diabetes mellitus, the age-adjusted mortality rates for Native Hawaiians are three hundred and twenty two times the national average; age-adjusted mortality rates associated with cerebrovascular disease are one hundred and thirty one times the national average, for diseases of the heart, one hundred and forty four times the national average, and for other diseases of the arteries, arterioles and capillaries, one hundred and eighty one times the national average; mortality rates associated with pneumonia and influenza are one hundred and fifty nine percent of the rates for the United States, all races; and for nepritis, nephrotic syndrome and nephrosis, one hundred and twenty times the national average.

To address the alarmingly high incidence of such preventible illnesses and diseases, the demonstration program would provide for preventive-oriented health services, including health education and mental health care, and would assure that a comprehensive effort is undertaken to reduce the high incidence of diabetes among Native Hawaiians. The program would also provide for the development of innovative training and research projects, and establish cooperative relationships with the leadership of the Native Hawaiian community.

Native Hawaiian diabetes initiative

Under the demonstration program, the Secretary would be authorized to enter into contracts with Native Hawaiian organizations to meet the objectives of the demonstration program, and specifically, to conduct a study to determine the incidence of diabetes among Native Hawaiians and activities which could be undertaken to reduce the incidence of diabetes in the Native Hawaiian population, provide early diagnosis of diabetes, and ensure proper continuing health care to those Native Hawaiians diagnosed as diabet-

ic. The Secretary is further authorized to enter into a contract with a Native Hawaiian organization for the purposes of preparing an inventory of all public and private health care programs within the State of Hawaii that are available for the treatment, prevention, or control of diabetes among Native Hawaiians. The Native Hawaiian organization (or organizations) with whom the Secretary contracts for these purposes, is to submit a report to the Secretary within two years of the date of enactment of the Act which describes the required determinations, contains the inventory of public and private health care programs, and which describes the research activities conducted. The Secretary , in turn, is required to submit the report to the Congress and the President.

Within three years of the date of enactment of the Act, the Secretary is directed to enter into a contract with a Native Hawaiian organization for the purpose of implementing a program designed to establish a diabetes control program; to screen those Native Hawaiian individuals that have been identified as having a high risk of becoming diabetic; to effectively threat newly-diagnosed diabetic in order to reduce further complications from diabetes, individuals who have high risk of becoming diabetic in order to reduce the incidence of diabetes, and short-term and long-term complications of diabetes; 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; to determine the appropriate delivery to Native Hawaiians of health care services relating to diabetes; to develop and present health education information to Native Hawaiian communities and schools concerning the prevention, treatment, and control of diabetes; and to ensure that proper continuing health care is provided to Native Hawaiians who are diagnosed as being diabetic.

The Secretary is directed to enter into a contract with a Native Hawaiian organization for the purpose of promoting coordination and cooperation between all health care providers in the delivery of diabetes-related services to Native Hawaiians; and 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.

The Secretary is also required to 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. The Secretary is further directed to enter into a contract with a Native Hawaiian organization for the purpose of developing and implementing an outreach program to ensure that the achievements and benefits derived from the activities of the model diabetes program are applied in Native Hawaiian communities to assure the diagnosis, prevention, and treatment of diabetes among Native Hawaiians. The Secretary is required to submit an annual report to the Congress outlining the activities, achievements, needs, and goals of the Native Hawaiian diabetes care program.

The Secretary is further directed to 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. The system is to be designed to facilitate the dissemination of the best available information on diabetes to Native Hawaiian communities and health care professionals.

The Secretary is also directed to enter into a contract with a Native Hawaiian organization for the purpose of conducting research concerning the causes, diagnosis, treatment, and prevention of diabetes and related complications among Native Hawaiians, and coordinating such research with all other relevant agencies and units of the government of the State of Hawaii and the U.S. Department of Health and Human Services which conduct research relating to diabetes and related complications. The Secretary is required to submit an annual report to the Congress on the status and accomplishments of the projects described above during each of the fiscal years 1989, 1990, and 1991. Reporting requirements, program evaluation requirements, requirements for contractual relationships between the Secretary and Native Hawaiian organizations, and auditing requirements are mandated to carry out the functions outlined above.

Third-Party reimbursement for cost of health services

Although eligible for IHS services, some Indian people carry private health care insurance, often as a function of an employment-related requirement. In addition, tribal governments often purchase health care insurance policies for all tribal government employees. However, most standard insurance contracts provide for a waiver of the insurance coverage or an exemption from liability under the contract, if care is provided at a Federal facility at no cost to the patient, or if the patient is not primarily financially liable for the services rendered. Thus, while the health care services provided to an Indian patient in a private hospital would be covered by the patient's private insurance, the same services provided to the patient by the Indian Health Service would not be reimbursed by the insurance company. The effect of such coverage waivers or liability exemptions is that insurers that collect premium payments from IHS-eligible Indian individuals or from tribal governments for coverage of IHS-eligible employees are being paid for insurance coverage which they are not providing. Given the well-documented insufficiency of resources that are available to tribal governments and Indian citizens, expenditures for insurance coverage that provides no benefits to the insured constitute an obvious waste of scarce resources.

In order to address this problem, Title II establishes a right of recovery in the United States for the recovery of the reasonable expenses incurred by the Secretary in providing health services through the Indian Health Service to any individual, to the same extent that such an individual or any nongovernmental provider of such services would be eligible to receive reimbursement or indemnification for such expenses, if the services had been provided by a non-governmental provider and the individual had been required to pay the expenses and did pay the expenses. Title II further provides for 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 workers' compensa-

tion laws, or a no-fault automobile accident insurance plan or program. The title also provides that no law of any state, or any political subdivision of a state, and no provision of any contract entered into or renewed after the date of enactment of the Act (the Indian Health Care Amendments of 1987), shall prevent or hinder the right of recovery established in the Act, and that no action taken by the United States to enforce the right of recovery established in the Act is to affect the right of any person to any damages, other than damages for the cost of health services provided by the Secretary through the Indian Health Service.

Title II authorizes the United States to enforce the right of recovery established in the Act by intervening or joining in any civil action or proceeding brought by an individual for whom health services were provided by the Secretary or by any representative or heirs of such an individual; or by instituting a separate civil action, after providing to the individual, or to the representative or heirs of such an individual, notice of the intention of the United States to institute a separate civil action.

Crediting of reimbursements

Title II further provides that notwithstanding any provision of law other than this section of the Act, all funds received into the Treasury of the United States by reason of the provision of health services by the Indian Health Service, including amounts paid under section 713(b)(2)(B) of the Act, and recoveries made under either section 204 of the Act, or under the Medical Care Recovery Act, 42 U.S.C. 2651, et seq., shall be credited to the reimbursable account of the Indian Health Service in the Treasury of the United States and are to remain available until expended, except that such requirements shall not apply to any amounts described in section 202(d) of the Act.

TITLE III

Tribal consultation in the planning, design, construction, and renovation of IHS facilities

Title III provides that prior to the expenditure of any funds, and prior to the making of any firm commitment to expend any funds appropriated under the authority of the Snyder Act of 1921, 25 U.S.C. 13, for the planning, design, construction, or renovation of facilities, the Secretary, acting through the Indian Health Service, shall consult with any Indian tribe that would be significantly affected by the 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 an expenditure is to be made; and shall ensure whenever practicable, that the facility meets the standards of the Joint Commission on Accreditation of Hospitals by no later than one year after the date on which the construction or renovation of the facility is completed.

Closure of Indian health service facilities

The Committee is concerned with the practice that has been followed in past years in which IHS facilities have been closed with-

out notice to patients, without adequate preparation to assure that patients are advised of alternative health care providers, and without an evaluation of the impact a proposed closure may be expected to have. Thus, Title III provides that notwithstanding any provision of law other than this subsection of the Act, no IHS hospital or other IHS outpatient health care facility, or any portion of an IHS hospital or facility, may be closed unless the Secretary has submitted to the Congress at least one year prior to the date the hospital, facility, or portion thereof is proposed for closure, an evaluation of the impact of the proposed closure which specifies in addition to other considerations, the accessibility of alternative health care resources for the population services by the hospital or facility; the cost effectiveness of the proposed closure; the quality of health care to be provided to the population served by the hospital or facility following the proposed closure; the availability of contract care funds to maintain existing levels of service; and the views of the Indian tribes served by the hospital or facility concerning the closure. These requirements are not to apply to any temporary closure of a facility or any portion of a facility if the closure is necessary for medical, environmental, or safety reasons.

Facilities construction program justification documents

Over the past several years, despite identified needs for such facilities, the President's budget has requested no funds for the construction of IHS hospitals and clinics. In addition, funds appropriated by the Congress for this purpose have been the subject of rescission proposals each year. Many IHS facilities are in a deteriorating state of disrepair, and the backlog of essential maintenance and repair projects as of December 31, 1987 amounts to over $92,000,000. The condition of IHS facilities has a direct effect on patient visits—low utilization rates correspond with facilities in poor condition. In turn, a reduction in the number of patient visits is often used as a justification for the Administration's refusal to request funds for the construction of IHS facilities. Recognizing that if facilities were in better condition, Indian patients would be more inclined to seek health care services in IHS facilities, the Congress continues to appropriate funds for the maintenance and repair of IHS facilities and for the construction of new IHS hospitals and clinics.

Program Justification Documents represent the Department's certification that all activities which are necessary to assure that facilities construction may proceed once funds are appropriated, have been completed. Therefore, in order to assist the Congress in determining whether funds should be appropriated for the construction of IHS facilities, Title III requires the inclusion of program justification documents for the construction of ten IHS facilities in the President's annual budget request which comply with applicable construction standards, and which have been approved by the Secretary.

The Secretary is also required to submit an annual report to the Congress setting forth the the current health facility priority system; the planning, design, construction, and renovation needs for the ten top-priority inpatient care facilities and the ten top-priority ambulatory care facilities (together with required staff quar-

ters); the justification for the order of priority; the projected cost of each project; and the methodology adopted by the IHS in establishing priorities under its health facility priority system. The first report is to be submitted no later than the 180 days following the enactment of the Act, and beginning in 1989, each subsequent annual report is to be submitted 60 days after the submission of the President's budget request to the Congress.

In preparing the report, the Secretary is directed to consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under contract with the IHS pursuant to the Indian Self-Determination and Education Assistance Act, and to review the needs of such tribes and tribal organizations for inpatient and outpatient facilities, including their needs for renovation and expansion of existing facilities.

The Secretary is further directed to fully and equitably integrate the planning, design, construction, and renovation needs of IHS and non-IHS facilities which are the subject of a self-determination contract into the development of the health facility priority system, and to use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the IHS, for facilities that are operated under self-determination contract.

Title III further provides that all funds appropriated under the authority of the Snyder Act of 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, are to be subject to the provisions of sections 103 and 104(b) of the Indian Self-Determination and Education Assistance Act.

Safe water and sanitary waste disposal facilities

It is estimated that there are over 60,000 Indian homes for which safe water and sanitation facilities have never been provided, and new homes for which no funds have been provided for water and sanitation facilities. An interagency agreement is supposed to provide for the transfer of appropriated funds allocated to the Department of Housing and Urban Development to the Indian Health Service for the provision of water and sanitation services to Indian homes and communities, but for several years, no funds have been requested in the President's budget for this purpose, and those funds that are appropriated by the Congress have not been expeditiously transferred to the Indian Health Service. In the interim, the incidence of diseases such as gastroenteritis, and other illnesses related to unsafe water supplies and a lack of sanitation facilities continues to rise.

In an effort to address this continuing problem, the Congress finds and declares that the provision of safe water supply systems and sanitary sewage and solid waste disposal systems is primarily a health consideration and function; the Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such systems; that the long-term cost to the Federal government of treating and curing such disease, injury, and illness is substantially greater than the short-term costs of providing such systems and other preventive health measures; that many Indian homes and communities still

lack safe water supply systems and sanitary sewage and solid waste disposal systems; and that 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. In furtherance of such findings and declarations, the Congress reaffirms the primary responsibility and authority of the Indian Health Service to provide the necessary sanitation facilities and services as provided in the Act which transferred responsibility for Indian health care to the Federal agency which is now the Department of Health and Human Services.

Title III authorizes the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to provide 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; to provide ongoing technical assistance and training in the management of utility organizations that operate and maintain sanitation facilities; to provide 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.

Title III also provides that notwithstanding any other provision of law, the Secretary of the Department of Housing and Urban Development is authorized to transfer funds appropriated under the Housing and Community Development Act of 1974 to the Secretary of the Department of Health and Human Services. Title III further creates authority for the Secretary of Health and Human Services to accept and use such funds for the purpose of providing sanitation facilities and services for Indians.

Further, in order to assure that the Congress and the Secretary have a long-range plan for addressing water supply and sanitation facility needs, Title III provides that beginning in fiscal year 1989, the Secretary of Health and Human Services, acting through the Indian Health Service, is directed to develop and begin implementation of a ten-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. Because Indian communities have been denied these facilities in the past on the grounds that the community is not capable of operating and maintaining safe water supplies and sanitation sewage and solid waste disposal facilities, Title III provides that 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. Title III also makes clear that the foregoing requirements are not to be construed as intending to diminish the primary responsibility of an Indian family, community or tribe to establish, collect, and utilize reasonable user fees, or otherwise set aside funding for the purpose of operating and maintaining sanitation facilities. To assure that programs operated by tribes or tribal organizations under the authority of the Indian Self-Determination Act are not denied safe water and sanitation facilities because such facili-

ties are not operated directly by the Indian Health Service, Title III provides that programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act are to be eligible for any funds appropriated for the purpose of providing sanitation facilities and services, and 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 Indian Health Service.

Reporting requirements

In order to assure that the Congress has full and accurate information as to the need for safe water supplies, sanitation sewage and solid waste disposal facilities when considering the amounts to be appropriated to address such needs, Title III directs the Health and Human Services Secretary to submit an annual report to the Congress which sets forth the current IHS Indian sanitation facility priority system; the methodology for determining sanitation deficiencies; the level of sanitation deficiency for each sanitation facilities project of each Indian tribe or community; the amount of funds necessary to raise all Indian tribes and communities to a level I sanitation deficiency; and the amount of funds necessary to raise all Indian tribes and communities to a level in which there are no santitation deficiencies. The first report is to be submitted no later than 180 days after the date of the Act's enactment, and beginning in 1989, each subsequent annual report is to be submitted 60 days after the date on which the President submits the budget to the Congress. In preparing each report other than the initial report, the Secretary is directed to consult with Indian tribes and tribal organizations including those tribes operating health care programs or facilities under the authrity of the Indian Self-Determination Act. To determine the sanitation needs of each tribe. The methodology used by the Secretary in determining sanitation deficiencies is to be applied uniformly to all Indian tribes and communities.

Sanitation deficiency levels are defined in Title III in the following manner: Level I is an Indian tribe or community with a sanitation system that complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to routine placement, repair or maintenance needs; Level II is an Indian tribe or community with a sanitation system that complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to capital improvements that are necessary to improve the facilities in order to meet the needs of the tribe or community for domestic sanitation facilities; Level III is an Indian tribe or community with a sanitation system that has an adequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or has no solid waste disposal facility; Level IV is an Indian tribe or community with a sanitation system that lacks either a safe water supply system or a sewage disposal system; and Level V is an Indian tribe or community that lacks safe water supply and a sewage disposal system. For purposes of these definitions, any Indian tribe or community that lacks the operation and mainte-

nance capability to enable its sanitation system to meet pollution control laws, may not be treated as having a Level I or Level II sanitation deficiency. Three million dollars each of fiscal years 1989, 1990, and 1991 are authorized for appropriation to carry out the Secretary's responsibilities, and $850,000 in fiscal years 1989, 1990, and 1991 is authorized for appropriation to provide 30 new full-time equivalent positions to carry out the Secretary's responsibilities.

Expenditure of non-IHS funds for renovation of IHS facilities

In prior years, when there have not been sufficient funds available through the Indian Health Service for the renovation or repair of IHS facilities, or facilities operated under self-determination contract by Indian tribes or tribal organizations, tribes have sought and secured funds from competitive grant programs administered by other Federal agencies. Such funds have at times been interpreted to constitute an augmentation of the IHS appropriation, and thus, not allowable. Because the Committee believe that tribes should not be penalized for such resourcefulness or initiative, and that successful tribal efforts to coordinate resources for the repair of health facilities represents true Indian self-determination, and is in keeping with the spirit of the Indian Self-Determination Act, Title III provides that notwithstanding any other provision of law, the Secretary is authorized to accept any major renovation or modernization by any Indian tribe of any IHS facility, or of any other Indian health facility operated pursuant to a contract under the authority of the Indian Self-Determination Act, including any plans or designs for renovation or modernization, and any renovation or modernization for which funds appropriated under any Federal law were lawfully expended, but only if the following requirements are met. The renovation or modernization must not require or obligate the Secretary to provide any additional employees or equipment, must be approved by the appropriate IHS area director, and must be administered by the Indian tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of IHS facilities. Further, the renovation or modernization will not be authorized if the renovation or modernization would require the diversion of funds appropriated to the IHS from any project which has a higher priority under the IHS health facility priority system. If an IHS facility which has been renovated or modernized by an Indian tribe with non-IHS funds ceases to be used as an IHS facility during the twenty-year period beginning on the date the renovation or modernization is completed, the Indian tribe will be entitled to recover from the United States, an amount which bears the same ratio to the value of the facility at the time of cessation of use as the value the renovation or modernization bore to the value of the facility at the time of the completion of renovation or modernization, less the total amount of any funds that were expended for the renovation or modernization provided specifically for the facility under any Federal program, and subject to the availability of funds provided by appropriation Acts of the Congress. Duplicate authority provided for in a previous appropriation act is repealed.

Bethel, Alaska Hospital

The Bethel Native Corporation, a profit corporation organized by the Alaska Natives of Bethel, Alaska, under the authority of the Alaska Native Claims Settlement Act, selected certain lands as their entitlement under the Act. Subsequently, in 1979, the Indian Health Service constructed a hospital on the land selected by the corporation. The Bureau of Land Management determined in 1983, and again in 1984, that the Bethel Native Corporation was entitled to conveyance of the land upon which the hospital was built. An administrative appeal of the Bureau's determination by the Department of Health and Human Services is currently pending. In an effort to expedite a resolution of the land dispute without precluding an administrative solution, the Committee encourages the HHS Secretary to enter into negotiations with the Bethel Native Corporation for an exchange of land. Title III provides that if a land exchange is not entered into within ninety days of the administrative ruling, the Secretary of Health and Human Services is directed to purchase the lands on which the hospital is located, at fair market value.

TITLE IV

Grants and contracts with tribal organizations

In past years, Indian people were advised that in order to become eligible for the Federal Medicaid or Medicare programs, it would be necesary to divest themselves of any trust property. As a consequence of this misinformation, otherwise eligible Indian patients refused to enroll in the Medicaid or Medicare programs. In an effort to correct these misunderstandings, grants and contracts with tribal organizations were authorized in the original Act for the development of an educational outreach effort to eliminate these misconceptions and to explain the benefits of enrolling under the appropriate sections of the Medicaid or Medicare programs.

Amendments to the Medicare provisions of the Social Security Act

Title IV amends section 1880 of the Social Security Act to designate additional IHS facilities and tribally-operated IHS facilities as eligible providers under the Federal Medicare program. The expanded designation authorizes IHS facilities and tribally-operated facilities to provide care to Medicare-eligible patients, and to receive reimbursement for the health care services provided to such patients from the Federal Medicare program. The extension of authority to facilities not presently covered by the Federal Medicare program is intended to enable the Indian Health Service to fully utilize all third party resources in the provision of health care to Indian people.

Given past Administration attempts to offset IHS program decreases with amounts collected from Medicare and Medicaid reimbursement, the Committee wishes to make clear that the authority to collect reimbursements from the Medicare and Medicaid programs is conditioned upon such funds being used only for the purposes authorized in the Act, that is to achieve and maintain compliance with accreditation standards. The Committee also wishes to make clear that the amendments to the Medicaid and Medicare

provisions of the Act are for the purpose of allowing the Indian Health Service to increase the number of Indian patients served through the use of third party resources to which they are entitled, and not as an offset for new budget authority.

Amendments to the Medicaid provisions of the Social Security Act

Title IV also amends section 1911 of the Social Security Act to include any other type of IHS facility that provides services of a type otherwise covered under a state Medicaid plan. Consistent with the amendments to the Medicare provisions of the Social Security Act, this amendment is intended to expand the designation of IHS facilities and tribally-operated facilities which are authorized to provide care to Medicaid-eligible patients, and to receive reimbursement for the health care services provided to such patients from the Federal Medicaid program. The extension of authority to facilities not presently covered by the Federal Medicare program is intended to enable the Indian Health Service to fully utilize all third party resources in the provision of health care to Indian people.

Amendments to section 1911 of the Social Security Act also provide authority for the Secretary to enter into agreements with a state agency for the purpose of reimbursing that agency for health care and services provided in IHS facilities to Indians who are eligible for medical assistance under the state plan. The amendments further provide that all payments to which any IHS facility is entitled under a state plan approved under title XIX section 1911 are to placed in a special fund to be held by the Secretary and used (to such extent or in such amounts as are provided in appropriations Acts) exclusively for the purpose of making any improvements in IHS facility which may be necessary to achieve compliance with the applicable conditions and requirements of title XIX. The amendments provide that in making payments from the fund, the Secretary is to ensure that each IHS service unit receives at least fifty percent of the amounts to which IHS facilities are entitled and which are collected by the service unit, if that amount is necessary for the purpose of making improvements in facilities in order to achieve compliance with the conditions and requirements of title XIX. However, the requirements that such funds be used to achieve compliance, are to cease to apply when the Secretary determines and certifies that substantially all of the IHS health facilities are in compliance with such conditions and requirements. These amendments are intended to apply to services performed on or after the date of enactment of this Act.

Demonstration program for direct billing by tribal contractors

A new provision of Title IV authorizes the establishment of a demonstration project which would permit Indian tribes and tribal organizations that operate IHS facilities to directly bill for and retain 100 percent of the Medicare and Medicaid reimbursements which they collect as a result of health care services that are provided to Medicare- and Medicaid-eligible patients in those facilities.

The Committee has received numerous comments from Indian tribes and tribal organizations that contract the operation and administration of IHS facilities under the authority of the Indian

Self-Determination and Education Assistance Act, that should they be allowed to retain all of the funds they collect from Medicaid and Medicare reimbursements and third party insurers, they could better control their own cost accounting systems and accounts receivable, and that they could thereby maximize and increase the amounts collected form such sources. Tribes and tribal organizations believe that the policy of self-determination dictates this step toward a degree of financial autonomy that will better equip them to one day assume the full range of responsibilities that are associated with the provision of health care. Evidence submitted by tribal contractors in Alaska would indicate that because of certain legal impediments that exist to the collection of third party resources by the Indian Health Service, tribal contractors can in fact collect amounts from third party sources far in excess of the amounts that the Indian Health Service is able to collect.

The demonstration program is designed to provide tribal contractors with a greater incentive to maximize their Medicare and Medicaid collections. Funds so collected are to be used for the improvement of health care by directly supporting the maintenance and operation of the health care facility in which the health care services are provided. This contrasts with current IHS policy, that redistributes funds collected from one facility to another facility, without regard to any incentives that might be inherent in allowing a facility to retain the funds collected from third party sources. To assure equity to nonparticipating facilities, amounts collected by participants in the demonstration program will offset against any amounts they would otherwise receive under the present redistribution of third party resource policy. The duration of the demonstration project is limited so that the Indian Health Service and the Congress will have the opportunity to monitor and evaluate the performance of participants, and to make an informed decision as to whether all tribal contractors should be afforded the opportunity to elect the option of retaining 100 percent of collections from third party sources.

TITLE V

Health care services for urban Indians

The amendments to Title V establish the intent of the Congress that henceforth, urban Indian health care programs are to be a permanent part of the IHS health care delivery system, and are to be funded under the authority of the Snyder Act of 1921, 25 U.S.C. 13. The Secretary is authorized to inter into contracts with existing urban Indian organizations so that such organizations can conduct a needs assessment of the health care status and needs of Indian people residing in the urban area in which the urban Indian organization is located. The needs assessment is also to evaluate the health care services that are available to urban Indians, and the need to supplement such services with the provison of direct health care services by urban Indian organizations. Where sufficient health care services exist in an urban area, the role of the urban Indian organizations is to provide referral services, pursuant to contracts with the Secretary, so that Indians residing in urban areas are better apprised of where they can receive health care

services from existing providers. However, in many areas, needs assessments have found that existing health care providers do not have the resources or facilities to expand their service population to include urban Indians. In those areas, where unmet health care needs can be documented to the satisfaction of the Secretary, urban Indian organizations may enter into contracts with the Secretary to provide direct health care services to the urban Indian population.

Over the past seven years, there have been continued efforts to eliminate all funding for the urban Indian health care programs on the grounds that there are other health care providers in an urban area that can serve the urban Indian population. However, repeated requests from the Congress to document the existence and capacity of such health care providers to serve the urban Indian population have met with no response, and to date, the Administration has failed to provide any documentation or evidence that would assure members of Congress that withdrawal of funding for the urban Indian health care programs will not result in the diminishment of health care services and a related decline in the health care status of Indian people residing in urban areas. Because it is estimated that over fifty percent of the Indian population now resides in urban settings, in part due to government efforts and policy which sought to relocate Indians to urban areas, it is critically important that the health care needs of this significant segment of the Indian population be addressed. The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land does not end at the borders of an Indian reservation. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not which to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there.

TITLE VI

Organizational improvements

Like other populations in the United States, the Indian population is increasingly becoming a more mobile population, with Indian people from one part of Indian country seeking employment and settling on reservations that may be far from their reservation of origin. In order to accomodate the needs of this increasingly mobile population, the health care system must be able to respond to a patient's needs, particularly in emergencies, no matter where in the system the patient chooses access. In recent years, the Indian Health Service, like the Veterans Administration and Department of Defense health care systems, has sought to develop an automated patient care information system, as well as uniform nationwide financial management and cost accounting systems. Such systems enhance the ability of the Service to provide quality health care to Indian patients, in part through automated access to patient records and patient history, and in part through better administration of limited health care funding.

Title VI directs the Secretary to establish an automated management information system for the Service which should be designed to include a financial management system, a patient care information system for each area served by the Service, a privacy component that protects the privacy of patient information held by or on behalf of the Service, and a services-based cost accounting component that can provide estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service. Included in the development of such systems, are automated management information systems for tribes and tribal organizations that operate IHS health care programs through contract with the IHS under the authority of the Indian Self-Determination and Education Assistance Act.

TITLE VII

Leasing and other contracts

An amendment to existing leasing authority allows the Secretary to enter into leases, contracts, or other legal agreements with Indian tribes or tribal organizations that hold legal title to, a leasehold interest in, or other beneficial interest in facilities used for the administration and delivery of health care services, and authorizes the Secretary to compensate such tribes or tribal organizations for the costs associated with the use of such facilities for the provision of health care services. Costs may include rent, depreciation, principal and interest paid or accrued, operation and maintenance and expenses, and other expenses determined by regulations to be allowable.

Health education

Statistics which document the incidence of preventable disease and illness in the Indian population support the national emphasis on health education that focuses on the promotion of health and the prevention of disease. A new provision authorizes the Secretary of the Department of Health and Human Services and the Secretary of the Department of the Interior to enter into an agreement to coordinate the efforts of the two departments in health promotion, disease prevention, and health education among Indian youth. The agreement is to provide for the establishment of minimum health outcome objectives for schools operated directly by the Bureau of Indian Affairs and for schools operated under contract with the Bureau of Indian Affairs. The agreement is also to provide for special emphasis on the identification and coordination of available resources and programs to combat alcohol and drug abuse among Indian youth through education, counselling and referral services. The rising incidence of drug and alcohol abuse in all segments of the Indian population makes it particularly important that alcohol and drug abuse prevention initiatives be undertaken at the earliest possible time. The agreement is to provide authority for IHS personnel to conduct training seminars on health promotion, disease prevention, and health education for teachers in BIA schools or tribal contract schools. Finally, the agreement is to recognize the role of tribally controlled community colleges, departments of health education at universities and colleges, and schools

of health professions in providing training on health promotion, disease prevention and health education to teachers in BIA and tribal contract schools, and is to provide for the inclusion of tribal representatives in such training.

The health outcome objectives required in the agreement are intended to serve as guidelines for the development of health education programs in BIA and tribal contract schools, and the health outcome objectives and guidelines are to prescribe the minimum objectives that such programs are to achieve. In an effort to assure that such objectives are incorporated into BIA and tribal contract school curricula, the Secretary of the Interior is authorized to establish critical job elements for Interior Department personnel which condition the continued employment of such personnel on achievement of specific objectives that the Secretary of the Interior determines to be necessary to assure that health education programs are designed to meet, at a minimum, the health outcome objectives established under the agreement. The Secretary of Health and Human Services is charged with the responsibility of encouraging the involvement of parents of Indian youth, and other interested members of Indian tribes, in training seminars on health promotion, disease prevention, and health education that are conducted by the Secretary pursuant to the agreement, by providing timely notice of such seminars to BIA schools and tribal contract schools. The HHS Secretary may elect to include in contracts the Secretary enters into with urban Indian health care programs or tribal organizations under the authority of the Indian Self-Determination Act, a requirement that urban Indian health care programs or tribal organizations provide health promotion, disease prevention, and health education to the communities service by the program or organization. A new definition of "health education" is added to the Act, a term which includes but is not limited to personal health, mental and emotional health, consumer health, enviromental health, community health, dental health, and education in: the cessastion and hazards of smoking, the hazards of alcohol and drug abuse, nutrition, safety and the prevention of accidents, the prevention and control of disease and family life matters.

Arizona as a contract health service delivery area

Section 703 amends section 708 to extend the designation of the state of Arizona as a contract heatlh service delivery area through 1990, and further amends the section to provide that the designation is for the purpose of authorizing the delivery of contract health care services to members of Federally-recognized Indian tribes of Arizona.

Eligibility of California Indians

Section 709 of the Committee bil, as modified by an amendment offered by Senator McCain during the Committee's consideration of the legislation, would codify existing IHS policy and practice with respect to the eligibility of California Indians for IHS services. Specifically, section 709 would provide that, until such time as a subsequent law provides otherwise, the following California Indians are eligible for care from the IHS: (1) any members of a Fedreally-recognized tribe; (2) any descendant of an Indian who was residing in

California on June 1, 1852, if the descendant is living in California, is a member of the Indian community served by a local IHS program, and is regraded as an Indian by the community in which he or she lives; (3) any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California; and (4) any Indian who is listed on the plans for and distribution of assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619) and any descendant of such Indian. To ensure that the provisions describing these categories are not interpreted so as to provide any new eligibility, the Committee bill also provides that nothing in section 709 is intended to expand California Indian IHS eligibility criteria beyond the scope of eligibility that applied on May 1, 1986.

Section 709 would also require the Secretary of Health and Human Services, in consultation with the Secretary of the Interior and with the assistance of all California tribal health programs serving Indians described in categories (2) and (3) above who are not members of Federally-recognized tribes, and tribal governments or their designees to prepare and submit to the Congress within three years following the date of enactment, a report to provide the Congress with sufficient data to determine which California Indians should be eligible for IHS services. The report is to contain (a) the HHS Secretary's determination of the number of Indians described in categories (2) and (3) above who are not members of Federally-recognized tribes, (b) a list of geographic locations of such Indians, (c) a list of the Indian tribes of which such Indians are members, (d) an assessment of the current health status of those Indians, and (e) an assessment of the actual availability and accessibility of alternative resources of health care on which those Indians would have to rely if IHS did not provide for their health care. According to the Office of Technology Assessment's April 1986 report entitled to "Indian Health Care", information about the health of Indians in California is practically nonexistent, primarily because of the loss of reservation lands as a consequence of changing and diverse Federal policies applied to California Indians and the difficulty in identifying Indians.

The purpose of this section is to codify existing IHS policy and practice with respect to the eligibility of California Indians for IHS services. There are currently approximately 215,000 Indians in California. About 75,000 are eligible for IHS services. Under current practice and policy, California Indians who fall into one of the four categories listed above are eligible for IHS care. These categories reflect the complex history of California Indians. In the 1850s, the President of the United States entered into treaties with over 100 Indian tribes in California. However, those treaties were never ratified. Members of tribes whose treaties were not ratified were eventually recognized in Federal law as individual "Indians of California" and were given allotments on public lands instead of tribal status. Others were belatedly recognized with the creation of rancherieas for homeless Indians in the 1930s, although their status was terminated two decades later. Other Indians were placed on reservations and their descendants are today memberts of Federally-recognized tribes.

The Committee provision identifies each of these categories of California Indians for the purpose of determining eligibility for IHS services. As previously noted, it is the Committee's intent that these provisions not be construed to increase the IHS eligibility criteria. The provision is intended, however, to protect members of the current service population from any loss of eligibility through administrative policy changes, including specifically the amendments proposed by the Department of Health and Human Services that were published in the *Federal Register* on June 10, 1986, on pages 21118 *et seq*.

California as a contract health service delivery area

The bill also provides for the designation of the state of California as a contract health service delivery area for the purpose of providing contract health services to Indians in that state with the exception of certain named counties in California (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).

Contract health facilities

The Act is further amended to make clear that the Indian Health Service is to provide funds for health care programs and facilities operated by tribe and tribal organizations under contracts with IHS entered into under the authority of the Indian Self-Determination and Education Assistance Act on the same basis as such funds are provided to programs and facilities operated directly by the Service for the purposes of maintenance and repair of clinics owned or leased by such tribes or tribal organizations, employee training, cost-of-living increases for employees, and for any other expenses relating to the provision of health services.

National Health Service Corps

In the past, National Health Service Corps personnel have been removed from programs operated by a tribe or tribal organization under contract with the IHS without advance notice to the tribal health care provider. This practice not only interrupts the continuity of care that can be provided by the tribal health care system, and can serve as a major obstacle to service delivery planning, but often, it is many months before the tribal provider can locate and hire a replacement physician or other health care personnel. An amendment to the Act provides that the HHS Secretary may only remove a member of the National Health Service Corps from a health facility operated by a tribe or tribal organizations under a contract with IHS entered into under the authority of the Indian Self-Determination and Education Assistance Act if the Secretary has provided written notice of the removal or withdrawal to such tribe or tribal organization at least sixty days before the date on which the contract is entered into or renewed.

Health services for ineligible persons

These amendments define those persons that will be eligible to receive services from the Indian Health Service although they

would otherwise be ineligible for such care. Under the amendments, services are to be extended to any individual under the age of nineteen who is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian and who is not otherwise eligible for the health care services provided by the Indian Health Service. Such persons are to be eligible for all health services provided by IHS on the same basis and subject to the same rules that apply to eligible Indians until they reach nineteen years of age. The existing and potential health needs of such individuals are to be taken into consideration by IHS in determining the need for or the allocation of IHS health resources. If an individual in this category is determined to be legally incompetent prior to attaining nineteen years of age, that individual is to remain eligible for services until one year after the date such disability has been removed.

Also eligible is the spouse of an eligible Indian who is not an Indian, or who may be of Indian descent but does not otherwise qualify as eligible for IHS services, provided that all such spouses are made eligible to receive services, as a class, by an appropriate resolution of the governing body of the tribe of which the eligible Indian spouse is a member. In contrast with those otherwise ineligible persons served by the IHS that are under nineteen years of age, the health needs of otherwise ineligible spouses are not to be taken into consideration by IHS in determining the need for or allocation of IHS health resources.

As to otherwise ineligible persons not falling within the two categories described above, the Secretary is authorized to provide services to such persons in those facilities operated directly by IHS who reside within the service area of an IHS service unit if: (1) an Indian tribe, or in the case of a multi-tribal service area, all the Indian tribes in the service area served by the IHS service unit requests provision of health services to such individuals; and (2) the Secretary and the Indian tribe or tribes have jointly determined that the provision of health services to such persons will not result in a denial or diminution of health services to eligible Indians, and if there is no reasonable alternative health facility or services, either inside or outside of the IHS service unit, available to meet the health needs of such individuals.

In the case of health facilities that are operated under a contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, the governing body of the tribe or tribal organization providing health services under contract is authorized to determine whether health services should be provided under the contract to individuals who are not otherwise eligible for such health services under any of the categories described above. In making such determinations, the tribal governing body of the tribe or tribal organization is to take into consideration whether the provision of health services to such persons would result in a denial or diminution of health services to such individuals, and whether there are any reasonable alternative health facilities or services either inside or outside the service unit services area available to meet the health needs of such individuals. In the case of a service area which serves only one Indian tribe, if the governing body of the Indian tribe revokes its concur-

rence to the provision of health services, the authority of the Secretary to provide health services shall terminate at the end of the fiscal year succeeding the fiscal year in which the tribe revokes its concurrence. In the case of a multi-tribal service area, the Secretary's authority to provide services to indigent persons would terminate at the end of the fiscal year succeeding the fiscal year in which at least fifty-one percent of the number of Indian tribes in the services area revoke their concurrence to the provision of such health services. Persons receiving care under the authority of this provision will be liable for payment for such services received under a fee schedule prescribed by the Secretary which in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Further, notwithstanding sections 1180(c) or 1911(d) of the Social Security Act or any other provision of law, fees collected under the authority of this section, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act are to be credited to the account of the facility providing the services and are to be used solely for the provision of health services within that facility, although such fees are to be available for expenditure within the facility for a period not to exceed one fiscal year after the fiscal year in which the fees were collected.

As to indigent persons, the Secretary is authorized to provide health care services to such persons who would not otherwise be eligible for such care except for this section if (but 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 IHS for the expenses incurred by the IHS in providing health services to indigent persons.

In addition to the categories of otherwise ineligible persons described above, the IHS may provide health services to otherwise ineligible individuals authorized under any provision of law in order to: (1) achieve stability in a medical emergency; (2) prevent the spread of a communicable disease or otherwise deal with a public health hazard; (3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post part; 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.

Hospital privileges for non-IHS physicians

The amendments to the Act authorize the extension of hospital privileges to non-IHS health care practitioners in IHS-operated facilities or in facilities operated under contract with the IHS under the authority of the Indian Self-Determination and Education Assistance Act when such practitioners are providing services to those otherwise ineligible and nonindigent persons described above. For such purposes, non-IHS health care practitioners may be regarded as employees of the Federal government for purposes of Federal Tort Claim Liability Act coverage only with respect to acts or omissions which occur in the course or providing services to eligible persons as part of the conditions under which such hospital privileges are extended.

Infant and maternal mortality and fetal alcohol syndrome

The amendments to the Act provide a new standard for the reducton of Indian infant mortality, Indian maternal mortality, and fetal alcohol syndrome directing the Secretary to develop and begin implementation of a plan by no later than January 1, 1989 to achieve the following objectives by January 1, 1993: (1) the reduction of the rate of Indian infant mortality in IHS area to the lower of twelve deaths per one thousand live births, or the rate of infant mortality applicable to the U.S. population as a whole; (2) reduction of the rate of maternal mortality in each IHS area to the lower of five deaths per one hundred thousand live births or the rate of maternal morality applicable to the U.S. 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 one per thousand live births, or the rate of fetal alcohol syndrome and fetal alcohol effect applicable to the U.S. population as a whole. The President of the United States is charged with including in his annual budget request for each fiscal year, a separate statement which specified the total amount obligated or expended in the most recently completed fiscal year to achieve each of these objectives.

Contract health services for the Trenton service area

This section clarifies that contract health services will continue to be provided to the Trenton service area. The Trenton service area was created because of the unique land ownership patterns of the Turtle Mountain Band of Chippewa Indians. When the 1904 allotment act set forth allotments for members of the Turtle Mountain Band, there was an inadequate land base on the Turtle Mountain Reservation for all of the members of the tribe that were to be issued allotment. Enrolled tribal members who did not receive land on the reservation were allowed to select lands in the public domain. The allotment act specified that the public lands selected by tribal members are held in trust and tribal members residing on those lands have the status of resident members of a Federally-recognized tribe, including the provision of Federal services. As a result of the allotment act, the Turtle Mountain Band of Chippewas control approximately 85,000 acres of land outside of the reservation, much of which is located in the counties of Divide, McKenzie and Williams in North Dakota, and the adjoining counties of Richland, Roosevelt, and Sheridan in the state of Montana.

By resolution of the Turtle Mountain Band Tribal Council, the Trenton service area was created as an extension of the tribal council to provide services to the off-reservation tribal members residing in the Trenton service area. The Trenton service area is administered by an elected Board of enrolled tribal members which has been delegated authority from the tribal council to contract with the IHS to provide health care services to tribal members residing in the Trenton service area. Health care services are provided through a community clinic located in Trenton and also through contract health care services provided by local hospitals. Nothing in the section is intended to enable the Trenton service area to expand services to non-tribal members or to members of other Fed-

erally-recognized tribes residing outside the Trenton service area. The number of eligible members of the Turtle Mountain Band who resided in the Trenton service area on May 1, 1986 is estimated to be approximately 1,500 persons.

Sharing of facilities and services between the Indian Health Service and the Veterans Administration.

The amendments to the Act also authorize the Secretary to 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 (VA) and to prepare a report on the feasibility of such an arrangement and submit that report to the Congress by no later than September 30, 1990.

The amendment further provides that the Secretary shall not take any action subchapter IV of part VI of title 38, U.S.C., which would impair the priority access of any Indian to health care provided through the IHS; the quality of health care services provided to any Indian through IHS; the priority access of any veteran to health care services provided by the VA; the quality of health care services provided to any veteran by the VA; the eligibility of any Indian to receive health services through the IHS; or the eligibility of any Indian who is a veteran to receive health services through the VA. The amendment also provides that nothing in this section is to construed as creating any right of a veteran to obtain health services from the Indian Health Service.

Reallocation of base resources

Because of the strong tribal opposition to the IHS initiative which has reallocated the base resources of the Indian Health Service, the amendments to the Act provide that notwithstanding any other provisions of law, any allocation of the IHS base resources for fiscal year 1987 that differs from the allocation of the IHS base resources that was made in fiscal year 1985 and affects more than five percent of the IHS base resources for fiscal year 1987, may be implemented only after the Secretary has met the following requirements: (1) the Secretary must submit to the Congress a written statement certifying that the Secretary has held consultations regarding the proposed reallocation of base resources with affected Indian tribes and tribal organizations; and (2) the Secretary must submit to the Congress a report on the proposed change in allocation of base resources, including the reasons for the change and its likely effects.

Demonstration projects for tribal management of health care services

The amendments to the Act also provide demonstration authority for tribes to develop and test a phased approach to the assumption of the IHS health care delivery system for members of the tribe living on or near the tribe's reservation through the use of IHS grants, tribal and private sector resources. The Secretary may award a grant only upon his determination that the tribe has the administrative and financial capabilities necessary to conduct a demonstration project. During the period in which a demonstration program is being conducted, the Secretary is authorized to award

all health care contracts, including community, behavioral, and preventive health care contracts to the tribe in the form of a single grant to which regulations prescribed under part A of title XIX of the Public Health Service Act shall apply, except as modified as necessary by any agreement entered into between the Secretary and the tribe to achieve the purposes of the demonstration project. The Secretary is authorized to waive any provisions of Federal procurement law as may be necessary to enable a tribe to develop and test administrative systems under the demonstration project, but only if the waiver does not diminish or endanger the delivery of health care services to Indians. The demonstration project is to terminate on September 30, 1991. By no later than September 30, 1991, the Secretary is to evaluate the performance of each tribe that has participated in the demonstration project and is to submit a report on the evaluations and demonstration project and is to submit a report on the evaluations and demonstration projects to the Congress.

TITLE VIII

Diabetes prevention and control

The objective of the Native American Diabetes Prevention and Control initiative is to broaden the research for diabetes and to strengthen the efforts of the Indian Health Service in the prevention and treatment of diabetes and its complications in order to raise the health status of Native Americans to the highest possible level.

Title VIII requires the Indian Health Service to improve and expand its activities to prevent and control diabetes among the Native American population. The goal is to reduce the incidence of diabetes among American Indians (estimated to be 40%) to a rate comparable with that of the general U.S. population.

Title VIII is based on investigative work conducted by the Select Committee on Indian Affairs, including site visits to the Navajo and Pima Reservations, which documented the lack of field resources to prevent and control diabetes. Further, a comprehensive telephone survey of tribal health directors and IHS field personnel was conducted to determine the extent of the disease and the capabilities for treatment and prevention on each reservation. Numerous problems were cited including: a lack of adequate medical facilities for treatment; patient overcrowding in existing facilities; the dispensing of expired drugs; the lack of a systematic diabetes education and prevention program; a prevalence of diabetes averaging 40%; hypertension; and associated mental health and drug and alcohol problems. The general consensus of the Indian community and health care providers was that diabetes is a primary health problem for American Indians and that the Indian Health Service was not effectively addressing the problem on systematic basis. The tribes advocate prioritizing the diabetes problem within IHS to enable IHS and tribal health care providers to more effectively deal with the disease.

There are 51 IHS hospitals and several hundred clinics providing health care services to approximately 1,000,000 Native Americans. There are seven model IHS diabetes clinics in Oklahoma, North

Dakota, Nebraska, New Mexico, Arizona, Maine and Washington, but these programs serve only 10% of the Native population. Statistics indicate that as much as 40% of the Native American population is afflicted by the disease and document that it is the second leading cause of outpatient visits to IHS facilities. Statistics show a continuous rise of diabetes in the Native American population. The diabetes mortality rate for Native Americans is 19% at an average age of 45–65 years, compared with an average 9% mortality rate for other ethnic groups. Seventy five percent of the lower extremity amputation and 78% of dialysis patients among Native Americans are attributed to diabetes.

Epidemiologists and researchers are still working to ascertain the primary cause of diabetes mellitus and in particular to determine why the disease is significantly more prevalent among Native Americans than other ethnic groups. Diet and lifestyle (particularly high fat foods and lack of exercise) are thought to contribute to the disease. In addition, some Native American diabetics with the problem of obesity have developed "insulin resistance" which poses a great challenge for treatment.

Committee Recommendations and Tabulation of Vote

The Select Committee on Indian Affairs, in open business session on March 19, 1987, by a unanimous vote of a quorum present, recommends that the Senate pass S. 129, as amended.

Section-by-Section Analysis of S. 129, as Amended

Section 1 provide that S. 129 is to be referred to as the Indian Health Care Amendments of 1987.

Section 2 contains the Table of Contents for the bill.

Section 3 states that whenever a reference to an amendment or repeal of a section or provision is cited in S. 129, the reference is to be considered to be made a section or provision of the Indian Health Care Improvement Act.

TITLE I—INDIAN HEALTH MANPOWER

Section 101 amends section 102 of the Act to extend authority for the health professions recruitment program for Indians, and authorizes appropriations in the amount of $550,000 for fiscal year 1988; $600,000 for fiscal year 1989; $650,000 for fiscal year 1990; and $700,000 for fiscal year 1991.

Section 102 amends section 103 of the Act to extend authority for the health professions preparatory scholarship program, and provides that the Secretary shall not deny scholarship assistance to an applicant who is otherwise eligible for a health professions preparatory scholarship solely on the basis of the applicant's scholastic achievement if the applicant has been admitted to an accredited institution or if the applicant has maintained good standing at an accredited institution. Good standing at an accredited institution is a determination made by the relevant institution. Section 102 authorizes appropriations in the amount of $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. Section 102 further amends section 103(c) of the Act to make clear that scholarship grants may

cover the costs of tuition, books, transportation, board and other necessary related expenses of a grantee only while the grantee is attending school full time.

Section 103 amends section 105 of the Act to authorize appropriations in the amount of $300,000 for fiscal year 1988, $350,000,000 for fiscal year 1989, $400,000 for fiscal year 1990, and $450,000 for fiscal year 1991 for the Indian Health Service extern program.

Section 104 extends authority for the Indian health professions scholarships program, and authorizes appropriations in the amount of $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. Section 104 provides that the Secretary, acting through the Service, 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 as Indian Health Scholarships, and shall be made in accordance with section 338A of the Public Health Service Act, except that the Secretary, acting through the Service, shall determine who shall receive Indian Health Scholarships, and shall determine the distribution of such scholarships among such health professionals on the basis of the relative needs of Indians for additional service in such professions. Section 104 provides that an individual shall be eligible for an Indian Health Scholarship in any year in which such individual is enrolled full time in a health profession school. Section 104 provides that the active duty obligation may be met by service in the Indian Health Service, in a program conducted under a contract entered into under the Indian Self-Determination and Education Assistance Act, in a program assisted under Title V of the Indian Health Care Improvement Act; or 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. Section 104 also amends section ? of the Public Health Service Act to define the term "Indian" to conform to the meaning govern the term "Indian" by section 4(c) of the Indian Health Care Improvement Act and to include the individuals described in clauses (1) through (4) of section 4(c) of the Indian Health Care Improvement Act. Section 104 also repeals section 338G of the Public Health Service Act.

Section 105 amends section 106 of the Act to authorize appropriations in the amount of $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 of the Act amends the Public Health Service Act by inserting a new section 338H to establish a Native Hawaiian health scholarship program. Such scholarships shall be made, subject to the availability of funds appropriated under this section, to students who meet the requirements of section 338A of the Public Health Service Act, and who are Native Hawaiians 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 of the Public Health Service Act. Section 106

additionally amends the Public Health Service Act to define the term "Native Hawaiian" to mean any individual who is a citizen of the United States, and who has any ancestors that were natives, prior to 1778, of the area which now comprises the State of Hawaii. Section 106 authorizes appropriations in the amount of $1,800,000 for fiscal year 1988, and for such fiscal year thereafter for Native Hawaiian health profession scholarships.

Section 107 amends Title I to add a new section 107 which authorizes the Secretary of the Department of Health and Human Services, under the authority of the Snyder Act of 1921 (25 U.S.C. 13), to maintain a community health representative program, the Indian Health Service is to provide for the training of Indians as health paraprofessionals, and is to use such paraprofessionals in the provision of health care to Indian communities. The Secretary, acting through the Service, shall provide a high standard of paraprofessionals training to Community Health Representatives to ensure that the community Health Representative provide quality health care to the Indian communities served by such program. In order to provide training, the Indian Health Service shall develop a curriculum that combines education in the theory of health care with supervised practical experience in the provision of health care. This training shall also provide instruction and practical experience in health promotion and disease prevention activities, particularly; nutrition, physical fitness, weight control, cessation of tobacco smoking, stress management, control of alcohol and drug abuse (including prevention of fetal alcohol syndrome), control of high blood presssure, prevention of lifestyle-related accidents, prevention and management of hearing and vision problems, and prevention of diabetes. This training shall also provide instruction in the latest and most effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits.

Section 107 also authorizes the Secretary of Health and Human Services to develop a system which identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and to develop programs that meet the needs for continuing education that have been identified by the system. The Secretary is further authorized to develop and maintain a system that provides close supervision of community health representatives, and to develop a system under which the work of Community Health Representatives is reviewed and evaluated. The Secretary is also authorized to ensure 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 the Community Health Representatives program.

TITLE II—HEALTH SERVICES

Section 201 amends Section 201 of the Indian Health Care Improvement Act to authorize the Secretary of the Department of Health and Human Services to expend funds that are appropriated under the authority of subsection (j) of section 201, through the Indian Health Service, for the purposes of: raising the health

status of Indians to a zero level of deficiency; eliminating backlogs in the provision of health services to Indians; meeting the health needs of Indians in an efficient and equitable manner; and augmenting the ability of the Indian Health Service to meet the health service responsibilities of; direct and indirect clinical care, including clinical eye and vision care; preventive health, direct and indirect dental care, 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; emergency medical services; treatment of control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians; home health care; community health representatives; and maintenance and repair. Section 201 provides that any funds appropriated under the authority of section 201(j) are not to be used to offset or limit any appropriations made to the Indian Health Service under the authority of the Snyder Act of 1921 (25 U.S.C. 13) or any other provision of law.

Section 201 further provides that funds that are appropriated under the authority of section 201(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 under the authority of section 201(j) to raise all other Indian tribes to a Level II of health resources deficiency. Section 201 also provides that funds appropriated under the authority of section 201(j) may be allocated on a service unit basis, but with the proviso that such funds must be used by each service unit in accordance with the requirements of section 201(b)(2) to raise the deficiency level of each tribe served by the service unit. Section 210 provides that the apportionment of funds allocated to a service unit under section 201(b)(3)(A) are to be determined jointly by the the Indian Health Service and the affected Indian tribes. Section 201 defines the health resources deficiency levels of Indian tribes and provides that Level I means to zero to twenty percent deficiency, Level II mans to twenty-one of forth percent deficiency; Level III means a forth-one to sixty percent deficiency, Level IV means a sixty-one to eighty percent deficiency, and Level V means an eighty-one to one-hundred percent deficiency.

Section 201 defines the term "health resources deficiency" to mean a percentage that is derived by first dividing the value of the health resources an Indian tribe needs by the value of health resources available to the tribe, then dividing that quotient by the value of the health resources that the Indian tribe needs. Section 201 states that the health resources available to an Indian tribe includes health resources provided by the Indian Health Service, as well as health resources used by the Indian tribe, which include services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments. The Secretary of the Department of Health and Human Services shall promulgate regulations which provide procedure to allow any Indian tribe to petition the Secretary for a review of any determination of the health resources deficiency level of such tribe. Section 201 provides that programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determi-

nation and Education Assistance Act are to be eligible for funds appropriated under the authority of section 201(j) on an equal basis with programs that are administered directly by the Indian Health Service.

Section 201 provides that if funds are allocated to a tribe or service unit under the authority of section 201 are used for a contract entered into under the Indian Self-Determination and Education Assistance Act, a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions. A reasonable portion means any percentage of such funds that does not exceed the negotiated indirect cost rate of the relevant tribe. Section 102 authorizes the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to expend directly or by contract, including contracts entered into under the authority of the Indian Self-Determination and Education Assistance Act, not less than one percent of the funds appropriated under the authority of section 201(j) for research in the area of Indian Health Service health responsibilities set forth in section 201(a)(4) (A) through (H).

Section 201 requires the Secretary of the Department of Health and Human Services to submit to the Congress by no later than the date that is sixty days after the enactment of the Indian Health Care Amendments of 1987, the current health services priority system report of the Indian Health Service for each Indian tribe or service unit, including newly recognized or acknowledged tribe. The health services priority system report required by section 201 shall set out: a description of methodology for determining tribal health resources deficiencies, including the most recent application of that methodology; the level of health resources deficiency for each Indian tribe served by the Indian Health Service; the amount of funds necessary to raise all Indian tribes served by the Indian Health Service below health resources deficiency level II to health resources deficiency level II; the amount of funds necessary to raise all tribes served by the Indian Health Service to zero health resources deficiency. The health services priority system report required by section 201 shall also include an estimate of: the amount of health service fund appropriated under the authority of the Indian Health Care Improvement Act, or any other Act, including the amount of any funds transferred to the Indian Health Service, for the preceding fiscal year which is allocated to each service unit, Indian tribe or comparable entity; the number of Indians eligible for health services in each service unit or Indian tribe; and the number of Indians using the Indian Health Service resources made available to each service unit or Indian tribe.

Section 201 requires the Secretary of the Department of Health and Human Services, acting through the Indian Health Service and in conjunction with each Indian tribe, to annually update the tribal specific health plans that were developed as part of the plan required under section 703 of the Indian Health Care Improvement Act. The updating of the tribal specific health plans is to be carried out in accordance with the methodology submitted to the Congress as part of the current health services priority system report re-

quired by section 201, as modified through consultation with the Indian tribe to which such tribal specific health plan relates.

Section 201 also requires the Secretary of the Department of Health and Human Services to submit to the Congress an annual report on the health services priority system of the Indian Health Service by no later than sixty days after the date the President submits to the Congress the budget required under section 1105 of Title 31 of the United States Code, for any fiscal year beginning after fiscal year 1988. The report is to be based on the updated tribal specific health plans required by section 201. The report shall include information on any changes in the methodology used by the Indian Health Service to develop the health services priority system report. Section 201 directs the President to include in the budget submitted under section 1105 of title 31 of the United States Code for each fiscal year, a separate statement that specifies the amount of funds requested to carry out the provisions of section 201 for the relevant fiscal year, and that specifies the total amount of funds obligated or expended in the most recently completed fiscal year to carry out section 201(g) and the total amount obligated or expended in the most recently completed fiscal year to carry out each of the subparagraphs of section 201(a)(4). Section 201 provides that funds appropriated under the authority of section 201 for any fiscal year are to be included in the base budget of the Indian Health Service for the purpose of determining appropriations under the authority of section 201 in subsequent fiscal years. Section 201 further provides that nothing in section 201 is intended to diminish the primary responsibility of the Indian Health Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of section 201 intended to discourage the Indian Health Service from undertaking additional efforts to achieve parity among Indian tribes and Indian Health Service service units.

Section 201(j) authorizes appropriations for the purpose of carrying out the provisions of section 201 in the amount of $18,000,000 for fiscal year 1988; $19,000,000 for fiscal year 1989; $19,000,000 for fiscal year 1990; and $20,000,000 for fiscal year 1991. Section 201 provides that any funds appropriated under the authority of section 201(j) are to be designated as the Indian Health Care Improvement Fund. Section 201 also amends section 4 of the Indian Health Care Improvement Act by striking out subsection (i), (j), and (k), and by inserting in lieu thereof, new subsections (i) and (j) to provide a definition of the term "area office" which means an administrative entity including an Indian Health Service program office, within the Indian Health Service, through which services and funds are provided to the service units within a defined geographical area. Section 201 also defines "service unit" to mean an administrative entity within the Indian Health Service, or a tribe or tribal organization operating health care programs or facilities with funds from the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

Section 202 amends Title II of the Act to add a new section 202 of the Indian Health Care Improvement Act establishing an Indian

Catastrophic Health Emergency Fund. The Fund is to consist of the amounts deposited to the Fund under the authority of section 202(d), and the amounts appropriated under the authority of section 202(e). The Fund is to be administered by the Secretary of the Department of Health and Human Services, acting through the central office of the Indian Health Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Indian Health Service. The Fund is not to be allocated, apportioned, or delegated on a service unit, area office, or any other basis. No part of the Fund or its administration is to be subject to a contract or grant under any law, including the Indian Self-Determination and Education Assistance Act.

Section 202 requires the Secretary of the Department of Health and Human Service, through the promulgation of regulations consistent with the provisions of section 202, to establish a definition of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the Fund; and to provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the Fund until the service unit's cost of treating any victim of a catastrophic illness or disaster has reached a certain threshold cost.

The Secretary is to establish the threshold cost at not less than $10,000 and not more than $20,000. The Secretary is further directed to establish a procedure for the reimbursement of the portion of the cost incurred by Indian Health Service service units or facilities; and to establish a procedure for the reimbursement of the portion of costs incurred by non-Indian Health Service facilities or provides in rendering treatment that exceeds the threshold cost whenever such treatment is otherwise authorized by the Indian Health Service. The Secretary is directed to establish a procedure for payment from the Fund in cases where the exigencies of the medial circumstances warrant treatment prior to the authorization of such treatment by the Indian Health Service. The Secretary is also directed to establish a procedure that will assure that no payment is to be made from the Fund to any provider of treatment, to the extent that the provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient receiving such treatment is eligible. Section 202 requires that funds appropriated under the authority of section 202(e) are not to be used to offset or limit appropriations made to the Indian Health Service under the authority of the Snyder Act of 1921 (25 U.S.C. 13) or any other law.

Section 202 authorizes the deposit into the Fund of all reimbursements to which the Indian Health 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 Indian Health Service. Section 202 authorizes appropriations in the amount of $10,000,000 for fiscal year 1988, and such sums as may be necesary to restore the Fund to a level of $10,000,000 for fiscal years 1989, 1990, and 1991, for the purpose of carrying out the provisions of section 202. Funds appropriated under section 202(e) are

to remain available until expended. It is the intent of the Committee that the Secretary shall expend any amounts from the Fund in any fiscal year for the purposes authorized, and that within any fiscal year, the Secretary is not to maintain the fund at the level of $10,000,000 following such expenditures. The Committee intends that any depletion in the Fund associated with such expenditures will be addressed by the appropriations actions of the Congress in the succeeding fiscal year, so that at the beginning of each fiscal year, the Fund can be restored to the $10,000,000 level.

Section 203 sets forth Congressional findings that health promotion and disease prevention activities will improve the health and well being of Indians and will reduce the long range expenses for medical care of Indians; that health promotion and disease prevention activities should be undertaken by coordinated efforts of Federal, State, local, and tribal governments; and that in addition to the provision of primary health care, the Indian Health Service has a responsibility to provide health promotion and disease prevention services to Indians. Section 203 amends section 4 of the Indian Health Care Improvement Act, as further amended by section 201(b) of S. 129, to add new subsections (k) and (l) which define the meanings given the terms "health promotion" and "disease prevention". The amendments made to section 4 of the Act by section 203 provide that the term "health promotion" includes cessation of tobacco smoking, reduction in the misuse of alcohol and drugs, improvement of nutrition, improvement in physical fitness, family planning, and control of stress. The term "disease prevention" includes immunizations, control of high blood pressure, control of sexually transmittable diseases, prevention and control of diabetes, pregnancy and infant care (including prevention of fetal alcohol syndrome), control of toxic agents, occupational safety and health, accident prevention, fluoridation of water, and control of infectious agents.

Section 203 amends Title II of the Indian Health Care Improvement Act, as amended by section 202 of S. 129, to add a new section 203, which directs the Secretary of the Department of Health and Human Services, acting through the Indian Health Service, to provide health promotion and disease prevention services to Indians. The Secretary is directed to include in each report which is required under section 201(g) an evaluation of; the health promotion and disease prevention needs of Indians identified in tribal specific health plans and the annual updates of those plans; the health promotion and disease prevention activities which would best meet such needs; and the resources which would be required to enable the Indian Health Service to undertake the health promotion and disease prevention activities necessary to meet such needs.

Section 203 requires the Secretary of the Department of Health and Human Services to promulgate regulations which would 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 that tribe. The Secretary is directed to develop from all the tribal specific health plans a comprehensive plan for the provision by the Indian Health service of health promotion and disease prevention services to Indians,

and to establish a schedule for the provision of these services to Indians. This comprehensive plan and schedule for the provision of health promotion and disease prevention services shall be completed by the date that is one (1) year after the date of enactment of the Indian Health Care Amendments of 1987.

Section 203 requires the Secretary of the Department of Health and Human Services to establish at least one, but not more than four, demonstration projects to determine the most effective and cost-efficient means of providing health promotion and disease prevention services, encouraging Indians to adopt good health habits, reducing health risks to Indians, particularly the risks of heart disease, chancer, stroke, diabetes, anxiety, depression and lifestyle-related accidents, reducing medical expenses of Indians through health promotion and disease prevention activities. These projects shall also demonstrate effective means of training Indians in the provision of health promotion and disease prevention services to members of their tribe, and shall demonstrate means of having such Indians available on a contract basis to provide such services to other tribes. These projects shall demonstrate means of providing training and continuing education to employees of the Indian Health Service, and to paraprofessionals participating in the Community Health Representatives program, in the delivery of health promotion and disease prevention services. The demonstration project shall include an analysis of the cost effectiveness of organizational structures and of social and educational programs that may be useful in achieving the objerctives described in paragraph (1) of subsection 203(e). The demonstration project shall be conducted in association with at least one health profession school, allied health profession or nurse training institution, or public or private entity that provides health care. The Secretary of the Department of Health and Human Services 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. For purposes of the demonstration project, 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)). The Secretary shall submit to Congress a final report on the demonstration project within sixty (60) days after the termination of such project. The demonstration project 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. Section 203 authorizes $500,000 for the purpose of carrying out the demonstration project, such sum to remain available without fiscal year limitation.

Section 203 amends Title II of the Indian Health Care Improvement Act to require the Secretary of the Department of Health and Human Services, acting through the Public Health Service, to 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. This demonstration program shall provide necessary preventive-oriented health services, including health education and mental health care; develop innovative training and

research projects; establish cooperative relationship with the leadership of the Native Hawaiian community; ensure that a continuous effort is made to establish programs which can be of direct benefit to other Native American people; and assure a comprehensive effort to reduce the incidence of diabetes among Native Hawaiians. The Secretary of the Department of Health and Human Services 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.

In fulfillment of the objective to assure a comprehensive effort to reduce the incidence of diabetes among Native Hawaiians, the Secretary of the Department of Health and Human Services shall enter into a contract with a Native Hawaiian organization to conduct a study to determine the incidence of diabetes among Native Hawaiians. This study shall also determine activities which should be undertaken to reduce the incidence of diabetes among Native Hawaiians; to provide Native Hawaiians with guidance in the prevention, treatment, and control of diabetes; to provide early diagnosis of diabetes among Native Hawaiians; and to ensure that proper continuing health care is provided to Native Hawaiians who are diagnosed as diabetic. The Secretary of the Department of Health and Human Services is directed to enter into a contract with a Native Hawaiian organization for the purposes of preparing an inventory of all health care programs, both public and private, within the State of Hawaii that are available for the treatment, prevention, or control of diabetes among Native Hawaiians. By no later than the date that is two (2) years after the date of enactment of the Indian Health Care Amendments of 1987, 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 the study of diabetes among Native Hawaiians required by subsection 203(f)(2)(A), the inventory of resources, and the research activities conducted under this subsection. The Secretary shall submit the report to the Congress and the President.

By no later than the date that is three (3) years after the date of enactment of the Indian Health Care Amendments of 1987, the Secretary of the Department of Health and Human Services shall enter into a contract with a Native Hawaiian organization for the purpose of implementing a program designed to establish a diabetes control program; to screen those Native Hawaiian individuals that have been identified as having a high risk of becoming diabetic; to effectively treat newly diagnosed diabetics in order to reduce further complications from diabetes, individuals who have a risk of becoming diabetic in order to reduce the incidence of diabetes, and short-term and long-term complications of diabetes; 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; to determine the appropriate delivery to Native Hawaiians of health care services relating to diabetes; to develop and present health education information to Native Hawaiian communities and schools concerning the prevention, treatment and

control of diabetes; and to ensure that proper continuing health care is provided to Native Hawaiians who are diagnosed as diabetic. The Secretary shall enter into a contract with a Native Hawaiian organization for the purpose of promoting coordination and cooperation between all health care providers in the delivery of diabetes related services to Native Hawaiians, and 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. The Secretary shall enter into a contract with a Native Hawaiian organization for the purpose of developing and implementing an outreach program to ensure that the achievements and benefits derived from the activities of the model diabetes program are applied in Native Hawaiian communities to assure the diagnosis, prevention and treatment of diabetes among Native Hawaiians. 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.

The Secretary of the Department of Health and Human Services 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. This system shall be designed to facilitate dissemination of the best available information on diabetes to Native Hawaiian communities and health care professionals.

The Secretary of Health and Human Services shall enter into a contract with a Native Hawaiian organization for the purpose of conducting research concerning the causes, diagnosis, treatment, and prevention of diabetes and related complications among Native Hawaiians, and 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.

The Secretary of Health and Human Services shall submit to the Congress an annual report on the status and accomplishments of the projects established under subsection 203(f) of the Indian Health Care Amendments of 1987 during each of the fiscal years 1989, 1990, and 1991.

The Secretary of Health and Human Services shall include in any contract which the Secretary enters into with any Native Hawaiian organization under subsection 203(f) such conditions as the Secretary considers necessary to ensure that the objectives of such contract are achieved. The Secretary shall develop procedures to evaluate compliance with, and performance of, contracts entered into by Native Hawaiian organizations under subsection 203(f) of the Indian Health Care Amendments of 1987. The Secretary shall conduct an annual onsite evaluation of each Native Hawaiian organization which has entered into a contract under subsection 203(f) for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract. If, as a result of these evaluations, the Secretary determines that a Native Hawaiian organization has not complied with or satisfactorily performed a contract, 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 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 these evaluations and attempts to resolve noncompliance or unsatisfactory performance. In determining whether to renew a contract entered into with a Native Hawaiian organization under this subsection 203(f), the Secretary shall review the records of the Native Hawaiian organization, and shall consider the results of the onsite evaluations conducted under subparagraph (C) of subsection 203(f)(7). All contracts entered into by the Secretary under subsection 203(f) 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.)* Payments made under any contract entered into under subsection 2039(f) 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 subsection 203(f). Notwithstanding any other provision of law, the Secretary may, at the request, or with the consent of a Native Hawaiian organization, revise or amend any contract entered into by the Secretary with such organization as necessary to carry out the purposes of subsection 203(f), except that whenever such organizations requests retrocession of any contract entered into subsection 203(f), such retrocession shall become effective upon a date specified by the Secretary that is not more than 120 days after the date of the request by such organization, or at such later date as may be mutually agreed to by the Secretary and such organization. For each fiscal year during which a Native Hawaiian organization receives or expends funds puruant to a contract entered into under subsection 203(f), such organization shall submit to the Secretary a quarterly report on activities conducted by the organization under the contract, the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of any Native Hawaiian organization which concern any contract entered into under subsection 203(f) shall be subject to audit by the Secretary and Comptroller General of the United States. The Secretary shall allow as a cost of any contract entered into under subsection 203(f) the cost of an annual private audit conducted by a certified public accountant. The authority of the Secretary to enter into contracts under subsection 203(f) shall be to the extent, and in amounts, provided for in appropriations Acts.

For purposes of subsection 203(f) of the Indian Health Care Amendments of 1987, the term 'Native Hawaiian' is defined to mean any individual who is a citizen of the United States, who is a resident of the State of Hawaii, and who is a descendant of the aboriginal people who occupied and exercised sovereignty in the area

that now constitutes the State of Hawaii prior to 1778. The term 'Native Hawaiian organization' is defined to mean any organization which serves and represents the interests of Native Hawaiians, 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 portions of programs) authorized under the Indian Health Care Amendments of 1987 for Native Hawaiians, and in which Native Hawaiian health professionals significantly participate in the planning, management, monitoring and evaluation of health services.

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 Section 203(f).

Section 204 amends Title II of the Indian Health Care Improvement Act by adding a new section 204. Subsection 204(a) establishes that the United States shall have the right to recover the reasonable expenses incurred by the Secretary of Health and Human Services in providing health services, through the Indian Health Service, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if such services had been provided by a nongovernmental provider, and such individual has been required to pay such expenses and did pay such expenses. Subsection 102(b) 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 workers' compensation laws, or a no-fault automobile accident insurance plan or program. 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 204(a). No action taken by the United States to enforce the right of recovery provided under subsection 204(a) shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary of Health and Human Services through the Indian Health Service). The United States may enforce the right of recovery provided under subsection 204(a) by intervening or joining in any civil action or proceeding brought by the individual for whom health services were provided by the Secretary of Health and Human Services, or by any representative or heirs of such individual, or by instituting a separate civil action, after providing to such individual, or the representative or heirs of such individual, notice of the intention of the United States to institute a separate civil action.

Section 204 of the Indian Health Care Amendments of 1987 adds a new section 205 to the Indian Health Care Improvement Act which provides that notwithstanding any provision of law other than this section 204, all funds received into the Treasury of the United States by reason of the provision of health services by the Service, including amounts paid under section 713(b)(1)(B) of the Health Care Amendments of 1987, recoveries under section 204, or recoveries under Public Law 87-693 (42 U.S.C. 2651, *et. seq.*) shall be credited to the reimbursable account of the Indian Health Serv-

ice in the Treasury of the United States and shall remain available until expended. Subsection 204(a) shall not apply to any amounts described in section 202(d), relating to the catastrophic health care fund.

TITLE III—HEALTH FACILITIES

Section 301 amends Title III of the Indian Health Care Improvement Act to require the Secretary of Health and Human Services, acting through the Indian Health Service, prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or rennovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13), to 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 ensure, whenever practicable, that such facility meets the standards of the Joint Commission on Accreditation of Hospitals by not later than one (1) year after the date on which the construction or rennovation of such facility is completed.

Section 301 directs that notwithstanding any other provision of law, no Indian Health Service hospital or 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 one (1) year prior to the date such hospital or facility, or portion thereof, is proposed to be closed, an evaluation of the impact of such proposed closure. Such evaluation shall specify, in addition to other considerations, the accessability of alternative health care resources for the population served by such hospital or facility; the cost effectiveness of such closure; the quality of health care to be provided to the population served by such hospital or facility under such closure; the availability of contract health care funds to maintain existing levels of service; and the views of the Indian tribes served by such hospital or facility concerning such closure. The Secretary of Health and Human Services is authorized to temporarily close a facility or any portion of a facility if such closure is necessary for medical, environmental or safety reasons.

Section 301 requires the President to 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 ten (10) Indian health facilities which comply with applicable construction standards, and which have been approved by the Secretary.

Section 301 directs the Secretary of Health and Human Services to submit to the Congress an annual report which sets forth the current health facility priority system of the Indian Health Service; the planning, design, construction, and rennovation needs for the ten (10) top-priority inpatient care facilities and the ten (10) top-priority ambulatory care facilities (together with required staff quarters); the justification for such order of priority; the projected cost of such projects; and the methodology adopted by the Indian Health Service in establishing priorities under its health facility

priority system. The first annual report to Congress 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. Other than the initial report, in preparing each subsequent report, the Secretary is directed to consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any contract entered into with the Service under the Indian Self-Determination and Education Assistance Act, and the Secretary shall review the needs of such tribes and tribal organization for inpatient and outpatient facilities, including their needs for rennovation and expansion of existing facilities.

In evaluating the needs of facilities operated under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, the Secretary is required to use the same criteria that the Secretary uses in evaluating the needs of facilities that are operated directly by the Indian Health Service. Section 301 directs the Secretary to ensure that the planning, design, construction, and rennovation needs of the Indian Health Service and non-Indian Health Service facilities that are operated under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the development of the health facility priority system. The Committee intends that facilities that are operated under contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act are to be integrated into the health facility priority system on the same basis that directly-operated Indian Health Service facilities are integrated into the health facility priority system. It is the intent of the Committee that all funds appropriated under the authority of the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or rennovation of health facilities for the benefit of an Indian tribe or tribes shall be subect to the provisions of sections 103 and 104(b) of the Indian Self-Determination Act.

Section 302 amends section 302 of the Indian Health Care Improvement Act to set forth Congressional findings that: the provision of safe water supply systems and sanitary sewage and solid waste disposal systems is primarily a health consideration and function; Indian people suffer an inordinately high incidence of disease, injury and illness directly attributable to the absence of inadequacy of such systems; 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; many Indian homes and communities still lack safe water supply systems and sanitary sewage and solid waste disposal systems; and 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 disposal systems as soon as possible.

In furtherance of the findings and declarations made set forth in section 302, Congress reaffirms the primary responsibility and authority of the Indian Health Service to provide the necessary sanitation facilities and service as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a). Section 302 authorizes the Secretary of Health and Human Services, acting through the Indian Health Service, to provide under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a); 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; ongoing technical assistance and training in the management of utility organizations which operate and maintain sanitation facilities; and 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. Notwithstanding any other provision of law, the Secretary of Housing and Urban Affairs is authorized to transfer funds appropriated under the Housing and Community Development Act of 1974 (42 U.S.C. 5301, *et seq.*) to the Secretary of Health and Human Services, and the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indian under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

Section 302 directs the Secretary of Health and Human Services, acting through the Indian Health Service, to begin in fiscal year 1989 to develop and begin implementing a ten-year plan to provide safe water supply facilities, and sanitary sewage and solid waste disposal facilities, to existing Indian homes and communities and to new and renovated Indian homes.

Section 302 provides that the financial or technical capability of an Indian tribe or community to safety operate and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary. Section 302 further provides that the provisions of section 302 are not to be construed as diminishing the primary responsibility of the Indian family, community, or tribe to establish, collect, and utilize reasonable user fees, or otherwise set aside funding, for the purpose of operating and maintaining sanitation facilities.

Section 302 provides that programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for any funds appropriated pursuant to subsection 302(h) of the Indian Health Care Amendments of 1987, and 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 Indian Health Service.

Section 302 requires the Secretary of Health and Human Services to submit to the Congress an annual report which sets forth: the current Indian sanitation facility priority system of the Indian Health Service; the methodology for determining sanitation deficiencies; the level of sanitation deficiency for each sanitation facilities project of each Indian tribe or community; the amount of funds necessary to raise all Indian tribes and communities to a Level I

sanitation deficiency; and the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency. The first annual report to Congress required by section 302(g) 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. Other than the initial report, the Secretary is required to consult with Indian tribes and Indian organizations (including those tribes or tribal organizations operating health care programs or facilities under any contract entered into with the Indian Health Service under the Indian Self-Determination and Education Assistance Act) to determine the sanitation needs of each tribe. The methodology used by the Secretary in determining sanitation deficiencies shall be uniformly applied to all Indian tribes and communities.

For purposes of section 302(g), the sanitation deficiency levels for an Indian tribe or community are defined as follows. Level I means an Indian tribe or community with a sanitation system which complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to route replacement, repair, or maintenance needs. Level II means an Indian tribe or community with a sanitation system which complies with all applicable water supply and pollution control laws, and 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. Level III means an Indian tribe or community with a sanitation system which has an inadequate or partial water supply and pollution control laws, or has no solid waste disposal facility. Level IV means an Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system. Level V means an Indian tribe or community that lacks a safe water supply and a sewage disposal system. For the purposes of section 302(g), 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.

Section 302 authorizes appropriations for each of the fiscal years 1989, 1990, and 1991, in the amounts for $3,000,000 for the purpose of providing funds necessary to implement the responsibilities of the Indian Health Service described in subsection 302(b)(2). Section 302 also authorizes appropriations in the amount of $850,000 for fiscal year 1989; $850,000 for fiscal year 1990; and $850,000 for fiscal year 1991, for the purpose of providing 30 new full-time equivalents for the Indian Health Service which shall be used to carry out the responsibilities of the Indian Health Service described in subsection 302(b)(2).

Section 303 amends section 305 of the Indian Health Care Improvement Act to provide that notwithstanding any other provision of law, the Secretary is authorized to accept any major renovation or modernization by any Indian tribe of any Indian Health Service facility, or of any other Indian health facility operated pursuant to

a contract entered into under the Indian Self-Determination and Education Assistance Act, including any plans or designs for such renovation or modernization, and any renovation or modernization for which funds appropriated under any Federal law were lawfully expended, but only if the requirements of subsection 305(b), as amended by section 303 of the Indian Health Care Amendments of 1987, are met. Section 305(b) provides that the requirements of this subsection are met with respect to any renovation or modernization if the renovation or modernization does not require or obligate the Secretary of Health and Human Services to provide any additional employees or equipment, is approved by the appropriate area director of the Indian Health Service, and 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. A renovation or modernization is not to be authorized by section 305 if the renovation or modernization would require the diversion of funds appropriated to the Indian Health Service from any project that has a higher priority under the Indian Health Service from any project that has a higher priority under the Indian Health Service health facility priority system. Section 305 further provides that if any Indian Health Service facility that has been renovated or modernized by an Indian tribe under the authority of section 305 ceases to be used as an Indian Health Service facility during the twenty-year period beginning on the date the renovation or modernization is completed, the Indian tribe will be entitled to recover from the United States an amount which bears the same ratio to the value of the facility at the time of the cessation of its use as a health facility, as the value of the renovation or modernization bore to the value of the facility at the time of completion of the renovation or modernization, less the total amount of funds provided specifically for the facility under any Federal program that was expended for the renovation or modernization. Section 305 also deletes duplicative language in Public Law 98-473, the law which authorizes appropriations for fiscal year 1985.

TITLE IV—ACCESS TO HEALTH SERVICES

Section 401 amends section 404 of the Indian Health Care Improvement Act to provide that the Secretary of Health and Human Services shall make grants to, or enter into contracts, including contracts under the Indian Self-Determination and Education Assistance Act, with tribe or tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native Villages to assist individual Indians to: enroll under section 1818 of part A and sections 1836 and 1837 of part B of title XVIII of the Social Security Act; pay monthly premiums for coverage due to financial (or medical) need of such individual; or apply for medical assistance provided pursuant to title XIX of the Social Security Act. Section 401 also amends section 404(b) of the Act to authorize the Secretary of Health and Human Services to place conditions as deemed necessary to effect the purpose of section 404 and that such conditions may include, as appropriate, requirements that the orga-

nization successfully undertake to: determine the population of Indians to be served that could be recipients of benefits under titles XVIII and XIX of the Social Security Act; assist individual Indians in becoming familiar with and utilizing such benefits; provide transportation to such individual Indians to the appropriate offices for enrollment or application for medical assistance, or develop and implement a schedule of income levels to determine the extent of payment of premiums by such organization for coverage of needy individuals, and methods of improving participation of Indians in receiving benefits provided pursuant to titles XVIII and XIX of the Social Security Act. Methods of improving participation of Indians may include health financing and delivery policy research for Indian tribal governments, and improving intergovernmental relations between tribal, federal, state and county governments. Section 401 further amends section 404 of the Act to authorize appropriations in the amount of $2,000,000 for fiscal year 1989; $500,000 for fiscal year 1990; and $500,000 for fiscal year 1991 for the purpose of making grants or contracts with tribes or tribal organizations, including contracts under the Indian Self-Determination and Education Act, to carry out the provisions of section 404.

Section 402 amends section 1880 of the Social Security Act by expanding the kinds of Indian Health Service facilities that are eligible for reimbursements from the Federal Medicare program on the basis of services rendered by the Indian Health Service to Medicare-eligible Indian patients. The terms "providers of services or a rural health clinic" are intended to include Indian Health Service hospitals, skilled nursing facilities, outpatient facilities, health centers and health stations, and home health care services, and to include facilities and services that are operated by a tribe or tribal organization under a contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, and tribally-owned nursing homes, hospitals and outpatient facilities. Section 402 further amends section 1880(c) of the Social Security Act to direct that the Secretary of Health and Human Services is to return to the service unit responsible for the collection of Medicare reimbursements, at least fifty percent of the amounts collected by the service unit, provided that such amounts are used exclusively for the purpose of making any improvements in Indian Health Service facilities which may be necessary to achieve compliance with conditions and requirements of the Medicare program. Section 402 requires the Secretary to make the return payments to each service unit from the special fund that is established exclusively for the purpose of making any improvements in Indian Health Service facilities that may be necessary to achieve compliance with the conditions and requirements of the Medicare program. Section 402 provides that the amendments made by section 402 are to apply to services performed on or after the date of enactment of the Indian Health Care Amendments of 1987.

Section 403 amends section 1911 of the Social Security Act to expand the kinds of Indian Health Service facilities that are eligible for reimbursements from the Federal Medicaid Program on the basis of services rendered by the Indian Health Service to Medicaid-eligible patients. The terms "skilled nursing facility, or any

other type of facility which provides services of a type otherwise covered under the State plan" are intended to include Indian Health Service hospitals, skilled nursing facilities, outpatient facilities, health centers and health stations, and to include facilities and services that are operated by a tribe or tribal organization under a contract with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, and tribally-owned nursing homes, hospitals and outpatient facilities. Section 403 further amends section 1911 of the Social Security Act to authorize the Secretary of Health and Human Services to enter into agreements with State agencies for the purpose of reimbursing those agencies for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan, and for which the State agencies have made Medicaid payments to the Indian Health Service facilities.

Section 403 also amends section 1911 of the Social Security Act to direct the Secretary of Health and Human Services to establish a special fund, to be held by the Secretary and used by the Secretary, to such extent or in such amounts as are provided in appropriations acts of Congress, exclusively for the purpose of making any improvements in the facilities of the Indian Health Service which may be necessary to achieve compliance with the applicable conditions and requirements of title XIX of the Social Security Act. The Secretary is directed to return to the service unit responsible for the collection of Medicaid reimbursements, at least fifty percent (50%) of the amounts collected by the service unit, provided that such amounts are used exclusively for the purpose of making any improvements in Indian Health Service facilities which may be necessary to achieve compliance with the conditions and requirements of title XIX of the Social Security Act. The Secretarial requirements authorized by the section 403 amendments to section 1911 of the Social Security Act are to cease to apply when the Secretary determines and certifies that substantially all of the health facilities of the Indian Health Service in the United States are in compliance with the conditions and requirements of title XIX of the Social Security Act. Section 403 also amends section 402 of the Indian Health Care Improvement Act by repealing sections 402(b) and 402(c). The amendments made by section 403 are to apply to services performed on or after the date of enactment of the Indian Health Care Amendments of 1987.

Section 404 amends Title IV of the Indian Health Care Improvement Act by adding a new section 405, to establish a demonstration program for direct billing of Medicare, Medicaid and other third party payors. Section 405 authorizes the Secretary of Health and Human Services to establish a demonstration program under which Indian tribes, tribal organizations and Alaska Native health organizations, which are contracting the entire operation of an entire hospital or clinic of the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, shall directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security (medicare), under a State plan for medical assistance approved under title XIX of the

Social Security Act (medicaid), or from any other third-party payor. The federal medical assistance percentage under the medicaid program shall continue to be 100 percent for purposes of the demonstration program. It is intended that bills generated by demonstration program participants may include a portion of the cost incurred by such participants for equipment and facilities as part of the rate structure, consistent with financial management practices and billing procedures that are employed by private sector health care facilities.

Section 405 provides that each hospital or clinic participating in the demonstration program is to be reimbursed directly under the Medicare and Medicaid programs for services rendered, without regard to the provisions of section 1880(c) and 1911(d) of the Social Security Act, but that all funds so reimbursed are first to be used by the hospital or clinic which may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of the same type under the Medicare and Medicaid programs. Any funds reimbursed from the Medicare and Medicaid programs that are in excess of the amount that is necessary to achieve or maintain the conditions or requirements referred to above are to be used solely for improving the health resources deficiency level of the Indian tribe and in accordance with the Indian Health Service regulations applicable to funds provided by the Indian Health Service under any contract entered into under the authority of the Indian Self-Determination and Education Assistance Act. Section 405 provides that amounts paid to the hospitals and clinics participating in the demonstration program are to be subject to all auditing requirements applicable to program administered directly by the Indian Health Service and to facilities participating in the Medicare and Medicaid programs. Section 405 directs the Secretary of Health and Human Services to monitor the performance of hospitals and clinics participating in the demonstration program and to require the participating hospitals and clinics to submit reports on the demonstration program on a quarterly basis, or on a more frequent basis if the Secretary deems more frequent reports to be necessary.

Section 405 further provides that no payment is to be made out of the special fund described in sections 1990(c) and 1911(d) of the Social Security Act for the benefit of any hospital or clinic that is participating in the demonstration program, notwithstanding sections 1880(c) and 1911(d) of the Social Security Act, during the period of such participation. The proscription on payments from the special fund is to assure that participating hospitals and clinics do not receive more than one reimbursement for services rendered to Medicare- or Medicaid-eligible patients from Medicare or Medicaid sources. Section 405 provides that in order to be considered for participation in the demonstration program, a hospital or clinic must submit an application to the Secretary of Health and Human Services which establishes to the satisfaction of the Secretary that: the Indian tribe or Alaska Native health organization contracts the entire operation of an Indian Health Service facility; the facility is eligible to participate in the Medicare and Medicaid programs under sections 1880 and 1911 of the Social Security Act; the facility meets any requirements that apply to programs operated directly

by the Indian Health Service; and the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan which has been approved by the Secretary for achieving such accreditation prior to October 1, 1989. Section 405 directs the Secretary to select no more than four facilities to participate in the demonstration program from among the qualified applicants prior to October 1, 1988. The demonstration program is to begin by no later than October 1, 1990 and end on September 30, 1994. Section 405 further provides that upon enactment of the Indian Health Care Amendments of 1987, the Secretary of Health and Human Services, acting through the Indian Health Service, is to commence an examination of any administrative changes that may be necessary to allow direct billing and reimbursement under the demonstration program, including any agreements with states which may be necessary to provide for direct billing under the Medicaid program; and any changes that may be necessary to enable demonstration program participants to provide medical records information on patients served under the demonstration program to the Indian Health Service that is consistent with the medical records information system of the Indian Health Service.

Prior to the commencement of the demonstration program, the Secretary is directed to implement all changes that may be required as a result of the examination of changes conducted by the Secretary. Prior to October 1, 1989, the Secretary is directed to determine any accounting information that a demonstration program participant would be required to report. At the end of fiscal year 1994, the Secretary is directed to submit a final report on the activities carried out under the demonstration program, which is to include an evaluation of whether such activities have fulfilled the objectives of the program. In the final report, the Secretary is to provide a recommendation based upon the results of the demonstration program, as to whether direct billing of and reimbursement by the Medicare and Medicaid programs and other third-party payors should be authorized for all Indian tribes and Alaska Native health organizations that are contracting the entire operation of an Indian Health Service facility. It is the intent that such report shall also include recommendations regarding cost-accounting, direct billing and reimbursement, assisting patients with applications for benefits, and intergovernmental agreements which might be applicable to Indian Health Service operated hospitals and clinics. Section 405 further directs the Secretary to provide for the retrocession of any contract entered into between a demonstration program participant and the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority is to be retroceded to the Secretary upon the Secretary's acceptance of a retroceded contract.

TITLE V—URBAN INDIAN HEALTH SERVICES

Section 502 of the Indian Health Care Amendments of 1987 amends subsection (h) of section 4 of the Indian Health Care Improvement Act to clarify the meaning of an "urban Indian organi-

zation" to mean a nonprofit corporate body situation in an urban center, governed by an urban Indian controlled board of directors.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Section 601 directs the Secretary of Health and Human Sevices to establish an automated management information system for the Indian Health Service. The management information system is to include a financial management system; a patient care information system for each area served by the Indian Health Service; a privacy component that protects the privacy of patient information held by, or on behalf of, the Indian Health Service; and a service-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 Indian Health Service. It is the intent that, as far as is practicable, the cost accounting component shall provide accurate data on the cost per inpatient day at each inpatient facility, and the cost per outpatient visit at each outpatient facility. It is also the intent that the financial management component, the patient care information system, and the cost accounting system shall be used to improve the management of health care facilities in each service unit and in local facilities operated by tribes or tribal organizations under contracts with the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act. It is the intent that the Secretary, in planning and designing the management information system, shall utilize the expertise and experience of service unit directors and tribal health personnel, as well as the expertise and experience of health care managers in the private sector (particularly those which expertise in the financial management of rural health facilities).

Section 601 requires the Secretary of Health and Human Services to submit a report to Congress by no later than September 30, 1988, which describes the activities which have been undertaken to establish an automated management information system; the activities, if any, which remain to be undertaken to complete the implementation of an automated management information system; and the amount of funds which will be needed to complete the implementation of a management information system in the succeeding fiscal years. It is the intent that this report will specify the degree to which, if any, this management information system will be used to improve the financial management of service units, including the ability to generate data on cost per inpatient day, and cost per outpatient visit; and the degree to which service unit directors and tribal health personnel have been involved in the planning and design of this management information system, and its implementation at local service unit and tribal facilities.

Section 601 requires the Secretary of Health and Human Service to provide to each Indian tribal government and tribal organization that provides health services under a contract entered into with the Indian Health Service under the Indian Self-Determination and Education Assistance Act, automated management information systems which: meet the management information needs of such Indian tribes or tribal organizations with respect to the treatment

by the Indian tribe or tribal organizations of patients of the Indian Health Service; and meet the management information needs of the Indian Health Service. It is the intent of the Committee that the Secretary of Health and Human services will work cooperatively with Indian tribal governments and Indian organizations in planning and designing these systems, including joint tribal and Indian Health Service efforts to determine management information needs and capabilities. The Secretary is required to reimburse each Indian tribal government or Indian organizations for the part of the cost of the operation of the management information system which is attributable to the treatment by such Indian tribe or tribal organization of patients of the Indian Health Service. The Indian Health Service shall provide management information systems to Indian tribe and tribal organizations provided health services in California by no later than September 30, 1989. Notwithstanding any other provision of law, each patient of the Indian Health Service shall have reasonable access to the medical or health records of such patient which are held by, or on hehalf of, the Indian Health Service. It is the intent of the Committee, that a privacy component shall be included in the management information system of the Indian Health Service, of tribal health programs, of the Patient Registration System, and that a description of this privacy component shall be included in the plans for Indian Health Service and tribal management information systems. Section 601 shall become effective upon the date of enactment of the Indian Health Care Amendments of 1987.

TITLE VII—MISCELLANEOUS PROVISIONS

Section 701 amends section 704 of the Indian Health Care Improvement Act to add a new section 704(b) which provides that the Secretary of Health and Human Services may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold: title to; a leasehold interest in; or 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 Indian Health 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.

Section 702 amends section 706 to strengthen health education efforts of the Indian Health Service. Section 702 directs the Secretary of the Interior and the Secretary of Health and Human Services to enter into an agreement to coordinate the efforts of the Department of the Interior and the Department of Health and Human Services in health promotion, disease prevention, and health education among Indian youth by no later than the date that is one (1) year after the date of enactment of the Indian Health Care Amendments of 1987. The agreement between the Secretary of the Interior and the Secretary of Health and Human Services shall: establish minimum health outcome objectives for

schools operated by the Bureau of Indian Affairs and schools operated under contract with the Bureau of Indian Affairs; provide for special emphasis on the identification and coordination of available resources and programs to combat alcohol and drug abuse among Indian youth through education, counseling, and referral services; provide authority for personnel of the Indian Health Service to conduct training seminars on health promotion, disease prevention, and health education for teachers in such schools; recognize the role of tribally controlled community colleges, departments of health education at universities and colleges, and schools of health professions in providing training on health promotion, disease prevention, and health education to teachers in such schools; and provide for inclusion of tribal representatives in such training. By no later than 30 days after the Secretary of the Interior and the Secretary of Health and Human Services have entered into the agreement, a memorandum of the agreement shall be published in the Federal Register.

The health outcome objectives that are required to be established under the health education agreement shall serve as guidelines for the development of health education programs in schools operated by the Bureau of Indian Affairs and in schools operated under contract with the Bureau of Indian Affairs. Such health outcome objectives and guidelines shall prescribe the minimum objectives that such health education programs must achieve. The Secretary of Interior may establish critical job elements for personnel employed by the Department of the Interior which condition the continued employment of such personnel on achievement of specific objectives the Secretary of Interior determines to be necessary to assure that health education programs designed to meet, at a minimum, the health outcome objectives established under the agreement are incorporated into the curricula of schools operated by the Bureau of Indian Affairs and schools operated under contract with the Bureau of Indian Affairs.

Section 702 requires the Secretary of Health and Human Services to encourage the involvement of parents of Indian youth, and other interested members of Indian tribes, in training seminars on health promotion, disease prevention, and health education that are conducted by the Secretary of Health and Human Services pursuant to the health education agreement, by providing timely notices of such seminars to schools operated by the Bureau of Indian Affairs and to schools operated under contract with the Bureau of Indian Affairs. The Secretary of Health and Human Services may elect to include in contracts the Secretary of Health and Human Services enters into with urban Indian health care programs a requirement that such programs provide health promotion, disease prevention, and health education to the Indian communities served by such programs. The Secretary of Health and Human Services may elect to include in contracts the Secretary of Health and Human Services enters into with any tribal organization under the authority of the Indian Self-Determination and Education Assistance Act, a requirement that the tribal organization provide health promotion, disease prevention, and health education to the communities served by the tribal organization. Section 702 defines "Health Education" to include, but not limited to personnel health;

mental and emotional health; consumer health; environmental health; community health; dental health; and education in the cessation of smoking, the hazards of smoking, the hazards of alcohol and drug abuse; nutrition; safety and the prevention of accidents; the prevention and control of disease; and family life matters.

Section 703 amends section 708(a) of the Indian Health Care Improvement Act to provide that, for the fiscal years beginning with the fiscal year ending September 30, 1982, and ending with the fiscal year ending September 30, 1990, the State of Arizona shall be designated as a contract health service delivery area by the Indian Health Service for the purpose of providing contract health services to members of federally recognized Indian tribes of Arizona. Section 703 repeals section 708(c) of the Indian Health Care Improvement Act, which authorized appropriations to carry out section 708.

Section 704 amends section 709 of the Indian Health Care Improvement Act to define the specific categories of Indians in California that will be eligible for health services provided by the Indian Health Service; any member of a federally recongized Indian tribe; any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant is living in California, is a member of the Indian community served by a local program of the Service, and is regarded as an Indian by the community in which such descendant lives; any Indian who holds trust interest in public domain, national forest, or Indian reservation allotments in California; and 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. Nothing in section 704 may be construed as expanding the eligibility of California Indians for health services provided by the Indian Health Service beyond the scope of eligibilty for such services that applies on May 2, 1986. Section 709(a)(4), which provides for health services for Indians in California who are 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 their descendants, shall cease to apply after September 30, 1988.

Section 705 amends section 710 of the Indian Health Care Improvement Act to provide that 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 Indian Health Service for the purpose of providing contract health services to eligible Indians in California. This provision is not intended to expand the numbers of people in California who are eligible for Contract Health Services, but rather to remove administrative obstacles to providing Contract Health services to eligible Indians in California.

Section 706 amends Title VII f the Indian Health Care Improvmeent Act by adding a new section 711. This new section provides that for health care programs and facilities operated by tribes and tribal organizations under contracts with the Indian Health Service

entered into under the Indian Self-Determination and Education Assistance Act, the Secretary of Health and Human Services shall provide funds for the maintenance and repair of clinics owned or leased by tribes and tribal organizations; for employee training; for cost-of-living increases for employees; and for any other expenses relating to the provision of health services. These funds shall be provided to tribes and tribal organizations on the same basis as such funds are provided to programs and facilities operated by the Indian Health Service.

Section 707 amends Title VII of the Indian Health Care Improvement Act by adding a new section 712, which provides that 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 conract with the Indian Health Service entered into under the Indian Self-Determination and Education Assistance 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 and renewed.

Section 708 amends Title VII of the Indian Health Care Improvement Act by adding a new section 713. Section 713(a) provides that any individual who has not attained 19 years of age; is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible Indian Health Service; shall be eligible for all health services provided by the Indian Health 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 Indian Health Service in determining the need for, or the allocation of, the health resources of the Indian Health 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 (1) year after the date such disability has been removed.

Section 713 provides that 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 Indian Health Service, shall be eligible for such health services if all of such spouses are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe of the eligible Indian. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Indian Health Service in determining the need for, or allocation of its health resources.

Section 713(b) authorizes the Secretary of Health and Human Services to provide health services under section 713 through health facilities operated directly by the Indian Health 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 section 713 or any other provision of law only under the following conditions. First, the Indian tribal government (or, in the case of a multi-tribal service area, all the Indian tribal governments) served by such service unit requests such provision of health services to such individuals. Secondly, the Secretary of Health and Human Services and the Indian tribe or tribes have

jointly determined that the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and there is no reasonable alterative health facility or service, within or without the service area of such service unit, available to meet the health needs of such individuals. In the case of health facilities operated under a contract entered into under the Indian Self-Determination and Education Assistance 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 section 713 or any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the considerations described in subparagraph (A)(ii) of section 713(b). Persons receiving health services provided by the Indian Health Service by reason of subsection 713(b) be liable for payment of such health services under a fee schedule prescribed by the Secretary of Health and Human Services which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. It is the intent of the Committee that the management information system established under section 601 be used to determine actual costs per inpatient day for inpatient facilities, and costs per outpatient visit for outpatient facilities, such costs data to be used for purposes of section 713. It is the intent of the Committee that the Secretary of Health and Human Services use, to the extent feasible, modern inpatient and outpatient financial management practices, including on-site cost finding studies, to develop and implement the fee schedule required under section 713. Notwithstanding section 1880(c) or 1911(d) of the Social Security Act or any other provision of law, fees collected under subsection 713(b), 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 services 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.

Health services may be provided by the Secretary of Health and Human Services through the Indian Health Service under subsection 713(b) to an indigent person who would not be eligible for such health services but for the provisions of paragraph (1) of subsection 713(B), 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 Indian Health Service for the expenses incurred by the Indian Health Service in providing such health services to such indigent person. It is the intent of the Committee that health services may be provided to indigent persons or any other class of ineligible persons for the specific purpose of responding to a medical emergency, as described in section 713(c).

In the case of a service area which serves only one Indian tribe, the authority of the Secretary of Health and Human Services to provide health services under paragraph (1)(A) of section 713(b) 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. In the case of a multi-tribal service area, the authority of the Secretary of Health and Human Services to provide health services under paragraph (1)(A) of section 713(b) shall terminate at the end of the fiscal year succeding 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.

Section 713 provides that the Indian Health Service may provide health services under subsection 713(c) to individuals who are eligible for health services provided by the Indian Health Service under any other subsection of section 713 or under any other provision of law in order to achieve stability in a medical emergency; prevent the spread of a communicable disease or otherwise deal with a public health hazard; provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum; or provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

Section 713(d) provides that hospital privileges in health facilities operated and maintained by the Indian Health Service or operated under a contract entered into under the Indian Self-Determination and Education Assistance Act may be extended to non-Service health care practitioners who provide services to person described in subsection 713(a) and subsection 713(b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1345(b) and chapter 171 of title 23, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing service to eligible Indians as a part of the conditions under such hospital; privileges are extended.

For purposes of section 713, the term "eligible Indian" is defined to mean any Indian who is eligible for health services provided by the Indian Health Service without regard to the provisions of section 713.

Section 709 amends Title VII of the Indian Health Care Improvement Act to add a new section 714 relating to infant and maternal mortality, and fetal alcohol syndrome. Section 714 provides that by no later than January 1, 1989, the Secretary shall develop and begin to implement a plan to achieve the following three objectives by January 1, 1993. First, a reduction in the rate of Indian infant mortality in each area office of the Indian Health Service to the lower of twelve deaths per one thousand live births, or the rate of infant mortality applicable to the United States population as a whole. Second, a reduction in the rate of maternal mortality in each area office of the Indian Health Service to the lower of five deaths per one hundred thousand live births, or the rate of maternal mortality applicable to the United States population as a whole. Third, a reduction in the rate of fetal alcohol syndrome and fetal alcohol effect associated with maternal consumption of alcohol to the lower of one per thousand live births, or the rate of fetal alcohol syndrome and such fetal alcohol effect applicable to the United States population as a whole. The President is directed to 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 the three objectives.

Section 710 amends title VII of the Indian Health Care Improvement Act by adding a new section 715 to direct the Secretary of Health and Human Services, acting through the Indian Health Service, 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. Nothing in Section 715 shall be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Indian Health Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

Section 711 amends Title VII of the Indian Health Care Improvement Act by adding a new section 716 relating to Indian Health Service and Veterans' Administration health facilities and services sharing. Section 716 directs the Secretary of Health and Human Services to 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. In examining the feasibility of such an arrangement, the Secretary shall not take any action under subchapter IV of part VI of title 38, United States Code, which would impair the priority access of any Indian to health care services provided through the Indian Health Service; the quality of health care services provided to any Indian through the Indian Health Service; the priority access of any veteran to health care services provided by the Veterans' Administration; the quality of health care services provided to any veteran by the Veterans' Administration; the eligibility of any Indian to receive health services through the Indian Health Service; or the eligibility of any Indian who is a veteran to receive health services through the Veterans' Administration. Taking these constraints into consideration, the Secretary shall prepare a report on the feasibility of such an arrangement and submit such report to the Congress by no later than September 30, 1990. Nothing in section 716 shall be construed as creating any right of a veteran to obtain health services from the Indian Health Service.

Provision of reallocation of base resources

The amendments to the Act provide that notwithstanding any other provision of law, any allocation of the base resources of the IHS, in fiscal year 1987 that differs from fiscal year 1985 and would affect more than five percent of the base resources of fiscal year 1987, will only be allowed if the Secretary of the Department of Health and Human Services can meet the following requirements:

(1) Submission of a written statement that the Secretary has held consultations regarding resource reallocation with the tribes and Indian organizations; and

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

Provision of services in Montana

This amendment to the Act provides that the Secretary of the Department of Health and Human Services, through the Indian Health Service, shall continue to provide services and benefits to Indians in a manner consistent with current policy.

The provisions of this section shall not be considered to be an expression of the sense of Congress on the merits of the District Court decision regarding the *McNabb* case.

Provision related to demonstration projects for tribal management of health care services

The amendments to the Act provide that a new section is added to Title VII, as amended, to include provision of grants for demonstration projects for Tribal management of health care services. The Secretary shall make grants to Indian tribes to establish demonstrations projects to allow tribes to develop and test a phased approach to assume responsibility for health care services utilizing IHS, Tribal and Private resources.

The grants may be awarded only if the Secretary determines that the Tribe has the administrative and financial capabilities necessary to conduct such demonstration projects.

Under the demonstration project, the Secretary shall award all health care contracts, including community, behavioral and preventive health contracts, to the Tribes in the form of a single grant meeting the conditions of Part A of Title XIX of the Public Health Service Act.

The Secretary may waive such provisions of Federal procurement law as are necessary to enable Indian tribes to develop and test administrative systems under these demonstration projects but only if such waiver does not diminish or endanger health care service to Indian people.

The demonstration projects established under this subsection will be terminated on September 30, 1991, at which time the Secretary shall evaluate the performance of each Indian tribe who participates in the demonstration project and shall submit to the Congress a report on such evaluation and projects.

Such sums as are necessary to carry out the purposes of this section are authorized to be appropriated.

TITLE VIII—DIABETES PREVENTION AND CONTROL

Section 801 contains Congressional findings that the incidence of diabetes among Indians is significantly higher than in other population groups within the United States; in several Indian tribes over 40 percent of the adults have diabetes compared with approximately 3 percent of the overall U.S. adult population; diabetes has become the second leading reason for outpatient visits by Indians to IHS facilities nationwide; serious complications of diabetes, such as kidney failure, hypertension, amputation, and blindness, are increasing in frequency among Indians; health care costs for treatment of diabetes and related complication among Indians will increase significantly in the long term unless the Department of Health and Human Services determines the cause of diabetes among Indians, develops early diagnosis, treatment, and prevention

programs to reduce the incidence of diabetes among Indians, and trains, or provides for the training of Federal and Indian health care providers in the diagnosis, treatment, and control of diabetes and related complications; a Model Diabetes Control Program exists within IHS consisting of seven project sites which serve only ten percent of IHS patients; and outreach services and the conveyance of effective treatment strategies from the model project sites need to be implemented. Section 801 also delineates the purposes of the title, which include broadening the research program of the Department of Health and Human Services relating to diabetes and related complications among Indians; strengthening IHS efforts 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 achieving a reduction in the incidence of diabetes among Indian populations to a rate comparable to that of the general U.S. population.

Section 802 authorizes the Secretary to determine the incidence of diabetes among Indians; to provide Indians with guidance in the prevention, treatment, and control of diabetes; to provide early diagnosis of diabetes among Indians; and to ensure that proper continuing health care is provided to Indians who are diagnosed as diabetic; and 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. The section also directs the Secretary to prepare an inventory of all health care programs and resources, both public and private, within the United States that are available for the treatment, prevention, or control of diabetes among Indians. The section further directs the Secretary to prepare and submit to the President and the Congress a report describing the determinations outlined above, the inventory conducted pursuant to the authority outlined above, as well as description of research activities conducted under the title, within eighteen months following the date of enactment of the Indian Health Care Amendments of 1987.

Section 803 provides that within eighteen months following the date of enactment of the Indian Health Care Amendments of 1987, the Secretary is to implement a program designed to strengthen and expand the IHS diabetes control program; to screen each individual who receives IHS services for diabetes and for conditions which indicate a high risk that the individual will become diabetic; to enable all IHS service units to effectively treat newly diagnosed diabetics in order to reduce future complications from diabetes, individuals who have a high risk of becoming diabetic in order to reduce the incidence of diabetes, and short-term and long-term complications of diabetes. The program must also be designed to conduct training programs concerning current methods of prevention, diagnosis, and treatment of diabetes and related complications among Indians for Federal, tribal and other Indian health care providers including community health representatives; to determine the appropriate delivery of health care services relating to diabetes treatment to Indians; to develop and present health education information to Indian communities and schools concerning the prevention, treatment, and control of diabetes; and to ensure that

proper continuing health care is provided to Indians who are diagnosed as diabetic. The section further directs the Secretary to promote coordination and cooperation between all health care providers in the delivery of diabetes-related services, and encourage and fund joint projects between Federal and tribal health care facilities and Indian communities for the prevention and treatment of diabetes.

Section 803 also directs the Secretary to 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: Claremore Indian Hospital in Oklahoma; Fort Totten Health Center in North Dakota; Sacaton Indian Hospital in Arizona; Winnebago Indian Hospital in Nebraska; Albuquerque Indian Hospital in New Mexico; Terry, Princeton and Old Town Health Centers in Maines; and Bellingham Health Center in Washington State. Section 803 directs the Secretary to establish and maintain a model diabetes clinic in the following locations within two years following the date of enactment of the Indian Health Care Amendments of 1987: the Navajo reservation, the Papago (Tohono O'odham) reservation, the states of Montana, Minnesota and Alaska. The Secretary is to develop and implement an outreach program to ensure that the achievements and benefits derived from the activities of the model diabetes clinics maintained under the authority of section 803 are used by all IHS service units in the diagnosis, prevention, and treatment of diabetes among Indians. The Secretary is to maintain appropriate IHS personnel to develop and implement the provisions of Title VIII and to manage and coordinate the IHS diabetes care program. The Secretary is authorized to employ in each IHS area office at least one diabetes control officer who is to coordinate and manage on a full-time basis, the IHS diabetes care program in the area served by the area office. In addition, the Secretary is to submit to the Congress an annual report outlining the activities, achievements, needs and future goals of the IHS diabetes care program.

Section 804 directs the Secretary to develop and maintain a comprehensive standardized system with IHS to collect, analyze, and report data regarding diabetes and related complications among Indians. The system is to be designed to facilitate dissemination of the best available information on diabetes to Indian communities and health care professionals. The system is to operational with two years following the date of enactment of the Indian Health Care Amendments of 1987.

Section 805 authorizes the Secretary to require of each agency and unit within the Department of Health and Human Services that conducts research relating to diabetes to give special attention to research concerning the causes, diagnosis, treatment, and prevention of diabetes and related complications among Indians; and to coordinate such research with all other agencies and units of the Department which conduct research relating to diabetes and related complications.

Section 806 authorizes the Secretary to prescribe regulations that may be necessary to carry out the provisions of Title VIII.

Section 807 authorizes appropriations of the sums that may be necessary to carry out the provisions of Title VIII.

TITLE IX

Section 901 provides that if any provision of the Act, or any amendment made by the Act, or the application of any provision or amendment to any person or circumstances is held to be invalid, the remainder of the Act, the remaining amendments made by the Act, and the application of any other provision or amendment to persons or circumstances other than those to which it is held invalid, shall not be affected.

COST AND BUDGETARY CONSIDERATIONS

The cost estimate for S. 129, as amended, as evaluated by the Congressional Budget Office, is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, February 17, 1987.

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

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 129, the Indian Health Care Amendments of 1987, as ordered reported by the Senate Select Committee on Indian Affairs on January 23, 1987.

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

With best wishes,
Sincerely,

JAMES BLUM,
(for Rudolph G. Penner).

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 129
2. Bill Title: Indian Health Care Amendment of 1987.
3. Bill status: As ordered reported by the Senate Select Committee on Indian Affairs on January 23, 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
Amounts subject of appropriations action:					
Estimated authorization levels:					
Health Professions Recruitment Program for indians	0.6	0.6	0.7	0.7	.....
Health professions scholarship	3.0	3.7	4.4	5.1	.....
Indian Health Scholarship Program	5.1	6.0	7.1	8.2	.....
Indian Health Services Extern Program	.3	.4	.4	.5	.....
Continuing education allowance	.5	.5	.6	.6	.....
Native Hawaiian scholarships	1.8	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	18.0	19.0	19.0	20.0	.....
Indian catastrophic health emergency fund	10.0	10.0	10.0	10.0	.....
Demonstration project	.5	.....	.....	.....	.....

[BY fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
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
Diabetes prevention	5.8	7.2	7.3	7.5	7.7
Total estimated authorization levels	82.5	94.0	96.0	100.3	52.4
Total estimated outlays	64.4	86.1	94.2	98.9	66.8
Direct spending provisions:					
Medicare					
Budget Authority	.2	.2	.1	.1	
Outlays	.8	.8	.8	.8	.8
Grand total:					
Budget authority authorization levels	82.7	94.2	96.1	100.4	52.4
Estimated outlays	65.2	86.9	95.0	99.7	67.6

Basis of estimate: This bill would expand the types of Indian health facilities eligible for Medicare reimbursement, resulting in direct spending from the Medicare Trust Fund. Medicare facilities would be expanded to include health centers, health stations, and home health agencies. Most facilities are already covered by Medicare, resulting in small estimated additional costs to the federal government of $800,000 each year.

Most authorization levels are stated in the bill. CBO assumes that all authorized amunts 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 $10 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 $10 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 will limit aggregate annual appropriations to the Fund to $10 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 four new model diabetes clinics in areas specified in the bill. The Indian Health Service (IHS) currently supports seven such clinics at a cost of about $200,000 for each clinic a year. If the four new clinics provide the same level of services as the current clinics, additional costs to the federal government could be about $800,000 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 areas. 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 (HHS) 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 authorized development of 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 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 Snyder 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 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 reling 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 would be between $2.3 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.

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 payers. Costs to the federal government are estimated to be about $1 million in 1988 through 1991 for both activities.

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: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Carmela Dyer.

10. Estimate approved by: C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

Executive Communications

Although the Committee requested the views of the U.S. Department of Health and Human Services on S. 129, the Committee did not receive any communication from that Department or other agencies of the Federal government.

Regulatory Impact Statement

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evalute the regulatory and paperwork impact that would be incurred in carrying out the provisions of the bill. The Committee believes that S. 129, as amended, will have some impact on regulatory and paperwork requirements.

Changes in Existing Law

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee notes the following changes in existing law: