94TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 94–1026
Part III

INDIAN HEALTH CARE IMPROVEMENT ACT

MAY 12, 1976.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

together with

MINORITY AND ADDITIONAL VIEWS

And Including the Congressional Budget Office Cost Estimate and Comparison

[To accompany H.R. 2525 which on April 9, 1976, was referred jointly to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 2525) to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

Page 31, insert "and" after "1978," in line 11, and strike out ", $2,400,000 for" in that line and all that follows through line 14 and insert in lieu thereof a period and the following:

> For fiscal years 1980, 1981, 1982, and 1983 there are authorized to be appropriated for such payments such sums as may be specifically authorized by an Act enacted after this Act.

Page 32, insert "and" after "1978," in line 12, and strike out ", $1,400,000 for fiscal year" in line 13 and all that follows through line 15 and insert in lieu thereof a period and the following:

For fiscal years 1980, 1981, 1982, and 1983 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act.

Page 32, strike out line 17 and all that follows through line 16 on page 36 and insert in lieu thereof the following:

SEC. 104. Section 225(i) of the Public Health Service Act (42 U.S.C. 234(i)) is amended (1) by inserting "(1)" after "(i)", and (2) by adding at the end the following:

"(2)(A) In addition to the sums authorized to be appropriated under paragraph (1) to carry out the Program, there are authorized to be appropriated for the fiscal year ending September 30, 1977, $5,450,000; for the fiscal year ending September 30, 1978, $6,300,000; for the fiscal year ending September 30, 1979, $7,200,000; and for fiscal years 1980, 1981, 1982, and 1983 such sums as may be specifically authorized by an Act enacted after the Indian Health Care Improvement Act, to provide scholarships under the Program to provide physicians, dentists, nurses, optometrists, podiatrists, pharmacists, public health personnel, and allied health professionals to provide services to Indians. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with this section except as provided in subparagraph (B).

"(B)(i) In making Indian Health Scholarships the Secretary shall accord priority to applicants who are Indians and shall, in consultation with the Indian Health Service, determine the distribution of the scholarships on the basis of the relative needs of Indians for additional service in specific health professions.

"(ii) The active duty service obligation prescribed by subsection (e) shall be met by the recipient of an Indian Health Scholarship by service in the Indian Health Service, in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of his profession if, as determined by the Secretary in accordance with guidelines promulgated by him, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"(C) For purposes of this paragraph, the term 'Indian' has the same meaning given that term by section 4(c) of the Indian Health Care Improvement Act and includes individuals described in clauses (1) through (4) of that section.".

Page 37, insert "and" after "1978," in line 20, and beginning in line 21 strike out ", $1,400,000 for fiscal year 1980" and all that follows through line 23 and insert in lieu thereof a period and the following:

For fiscal years 1980, 1981, 1982, and 1983 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act.

Page 38, insert "and" after "1978," in line 14, and beginning in line 15 strike out ", $300,000 for fiscal year 1980" and all that follows through line 17 and insert in lieu thereof a period and the following:

> For fiscal years 1980, 1981, 1982, and 1983 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act.

Page 38, beginning in line 23, strike out "$390,925,000 through the Service, over a seven-fiscal-year period in accordance with the schedule provided in subsection (c)" and insert in lieu thereof

> , through the Service, over the seven-fiscal-year period beginning after the date of the enactment of this Act the amounts authorized to be appropriated by subsection (c).

Page 39, line 1, insert "for" after "section".

Page 39, line 3, insert "under other Federal laws" after "Service".

Page 39, beginning in line 6 strike out "in fiscal year 1976 required to continue the programs of the Service thereafter" and insert in lieu thereof

> under this Act and such other Federal laws in the preceding fiscal year plus an amount equal to the amount required to cover pay increases and employee benefits for personnel employed under this Act and such laws and increases in the costs of serving the health needs of Indians under this Act and such laws, which increases are caused by inflation.

Page 39, beginning in line 17, strike out "and to the annual personnel levels required to continue the programs of the Service".

Page 39, line 25, insert "and" after "1978,".

Page 40, strike out ", $24,500,000" in line 1 and all that follows down through line 6 and insert in lieu thereof a period.

Page 40, line 10, insert "and" after "1978,".

Page 40, strike out ", $7,950,000" in line 11 and all that follows down through line 15 and insert in lieu thereof a period.

Page 40, line 18, insert "and" after "1978,".

Page 40, strike out ", $2,500,000" in line 19 and all that follows down through line 23 and insert in lieu thereof a period.

Page 41, line 1, insert "and" after "1978,".

Page 41, strike out the comma at the end of line 2 and insert in lieu thereof a period, and strike out lines 3 through 7.

Page 41, line 10, insert "and" after "1978,".

Page 41, strike out ", $800,000" in line 11 and all that follows down through line 15 and insert in lieu thereof a period.

Page 41, line 18, insert "and" after "1978,".

Page 41, strike out ", and" in line 19 and all that follows down through line 20 and insert in lieu thereof a period.

Page 41, line 23, insert "and" after "1978,".

Page 41, strike out ", $500,000" in line 24 and all that follows down through line 3 on page 42 and insert in lieu thereof a period.

Page 42, line 6, insert "and" after "1978,".

Page 42, strike out ", $250,000" in line 7 and all that follows down through line 9 and insert in lieu thereof a period.

Page 42, line 11, insert "and" after "1978,".

Page 42, strike out ", $9,200,000" in line 12 and all that follows down through line 14 and insert in lieu thereof a period.

Page 42, line 17, insert "and" after "1978,".

Page 42, strike out the comma at the end of line 18 and insert in lieu thereof a period, and strike out lines 19 through 22.

Page 42, insert after line 22 the following:

(7) For fiscal years 1980, 1981, 1982, and 1983 there are authorized to be appropriated for the items referred to in the preceding paragraphs such sums as may be specifically authorized by an Act enacted after this Act. For such fiscal years, positions are authorized for such items (other than the item referred to in paragraphs (4)(E) and (5)) as may be specified in an Act enacted after the date of the enactment of this Act.

Page 43, strike out lines 10 through 15 and insert in lieu thereof the following:

SEC. 301. (a) The Secretary, acting through the Service, is authorized to expend over the seven-fiscal-year period beginning after the date of the enactment of this Act the sums authorized by subsection (b) for the construction and renovation of hospitals, health centers, health stations, and other facilities of the Service.

(b) The following amounts are authorized to be appropriated for purposes of subsection (a):

Page 43, line 16, strike out "$123,880,000" and insert in lieu thereof "$67,180,000".

Page 43, line 17, strike out "$55,171,000" and insert in lieu thereof "$73,256,000".

Page 43, line 17, insert "and" after "1978,".

Page 43, line 17, strike out "$24,703,000" and insert in lieu thereof "$49,742,000".

Page 43, strike out ", $70,810,000" in line 18 and all that follows down through line 20 and insert in lieu thereof a period and the following:

For fiscal years 1980, 1981, 1982, and 1983, there are authorized to be appropriated for hospitals such sums as may be specifically authorized by an Act enacted after this Act.

Page 43, line 22, insert "and" after "1978,".

Page 43, strike out ", $4,440,000" in line 23 and all that follows down through line 2 on page 44 and insert in lieu thereof a period and the following:

For fiscal years 1980, 1981, 1982, and 1983, there are authorized to be appropriated for health centers and health stations such sums as may be specifically authorized by an Act enacted after this Act.

Page 44, line 4, insert "and" after "1978,".

Page 44, strike out ", $4,695,000" in line 5 and all that follows down through line 7 and insert in lieu thereof a period and the following:

For fiscal years 1980, 1981, 1982, and 1983, there are authorized to be appropriated for staff housing such sums as may be specifically authorized by an Act enacted after this Act.

Page 44, strike out lines 8 through 11.

Page 44, line 22, strike out "five years" and insert in lieu thereof "one year".

Page 45, strike out lines 3 through 9 and insert in lieu thereof the following:

SEC. 302. (a) During the seven-fiscal-year period beginning after the date of the enactment of this Act, the Secretary is authorized to expend under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the sums authorized under subsection (b) to supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.

Page 45, strike out lines 10 through 14 and insert in lieu thereof the following:

(b) For expenditures of the Secretary authorized by subsection (a) for facilities in existing Indian homes and communities there are authorized to be appropriated $43,000,000 for fiscal year 1977, $30,000,000 for fiscal year 1978, and $30,000,000 for fiscal year 1979. For expenditures of the Secretary authorized by subsection (a) for facilities in new Indian homes and communities there are authorized to be appropriated such sums as may be necessary for fiscal years 1977, 1978, and 1979. For fiscal years 1980, 1981, 1982, and 1983 for expenditures authorized by subsection (a) there are authorized to be appropriated such sums as may be specifically authorized in an Act enacted after this Act.

Page 45, strike out lines 15 through 21 and insert in lieu thereof the following:

"(c) Former and currently"

Page 46, line 4, strike out "(36 Stat. 861)" and insert in lieu thereof "(25 U.S.C. 47)".

Page 47, beginning in line 5, strike out "the Act of March 3, 1921 (46 Stat. 1491), as amended" and insert in lieu thereof the following: "the Act of March 3, 1931 (40 U.S.C. 276a–276a–5, known as the Davis-Bacon Act)".

Page 49, strike out lines 2 through 9 and insert in lieu thereof the following:

SEC. 402. (a) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"INDIAN HEALTH SERVICE FACILITIES"

"SEC. 1911. (a) A facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

"(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within 6 months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted."

Page 49, line 13, strike out "beneficiaries" and insert in lieu thereof "eligible for medical assistance".

Page 49, strike out line 15 and all that follows through line 5 on page 50 and insert in lieu thereof the following:

(c) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) is entitled under a State plan approved under title XIX of the Social Security Act by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of such title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.

Page 50, strike out lines 10 through 24 and insert in lieu thereof the following:

(e) Section 1905(b) of the Social Security Act is amended by inserting at the end thereof the following: "Notwithstanding the first sentence of this subsection, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).".

Page 56, strike out line 22 and all that follows down through and including line 24 on page 59 and insert in lieu thereof the following:

SEC. 601. The Secretary shall conduct a study to determine the need for, and the feasibility of, establishing a school of medicine to train Indians to provide health services for Indians. Within one year of the date of the enactment of this Act the Secretary shall complete such study and shall report to the Congress findings and recommendations based on such study.

Page 61, strike out line 25 and all that follows down through line 7 on page 62.

I. Summary of the Legislation

The purpose of the Indian Health Care Improvement Act is to establish and affirm a commitment to raise the status of health care for American Indians and Alaska Natives, over a seven-year period, to a level equal to that enjoyed by other American citizens.

H.R. 2525, as reported by the Committee on Interior and Insular Affairs, provides:

(1) A series of programs designed to increase the availability of health professionals to serve Indians, particularly in Indian Health Service (IHS) facilities, and to increase the number of Indians who enter the health professions. Title I authorizes outreach and recruitment programs, preparatory scholarships, health professions scholarships, an extern program of IHS employment for students of the health professions during the summer months, and continuing education grants for IHS health professions.

(2) A designated increase in authorizations of appropriations and staff positions over a seven-year period for direct and purchased patient care, field or preventive health programs, dental health, mental health, and alcoholism treatment and control programs.

(3) Authorizations for a systematic plan for renovation and construction over a seven-year period of Indian Health Service hospitals, health centers, health stations and staff housing, and for construction of safe water and sanitary waste disposal facilities.

(4) Payment of Medicaid and Medicare monies for services provided in IHS facilities to Indians eligible for those programs, and provisions for a title XIX Federal matching rate for Medicaid services provided to Indians in IHS facilities of 100 percent.

(5) Authorization of IHS activities in urban areas. The functions of the urban Indian health centers include outreach, identification of Indians in urban areas and their health needs, health education, assisting Indians in using the health care system, and direct delivery of services.

(6) Establishment of an American Indian medical school .

(7) Requirements for the Secretary of Health, Education, and Welfare to report to the President and the Congress on progress in achieving the purposes of the Act, to issue timely regulations, and to submit a plan for implementation of the Act for Congressional approval. The provisions of H.R. 2525, as originally reported, are explained in full in Part I of this report.

The proposal was sequentially referred to the Committee on Interstate and Foreign Commerce for consideration of those of its provisions in the Committee's jurisdiction. After hearings and mark-ups the Committee on Interstate and Foreign Commerce recommends passage of the proposal with the amendments summarized below:

(a) Limitation of specific authorizations of appropriations for the proposed programs to three fiscal years, 1977–79, with specification that authorization levels for the subsequent four fiscal years, 1980–83, will be the amounts authorized by subsequent acts. This contrasts with the present authorizations of appropriations for seven fiscal years, 1979–83, a practice inconsistent with that of the Committee on Inter-

state and Foreign Commerce. It applies to programs authorized by the proposal for identification and recruitment of Indians with a potential to become health professionals, preparatory scholarships for Indians with the capacity to become health professionals, externships for recipients of Indian health scholarships, continued education for health professionals employed by the IHS, direct health services to Indians, construction and renovation of Indian health facilities, and construction of safe water and sanitary waste disposal facilities.

(b) Elimination of the proposed separate health professions scholarship program administered by the IHS and authorization in the Public Health Service Act of Indian Health Scholarships to be made in accordance with the provisions of the existing National Health Service Corps Scholarship Program, except that:

(1) Indians will be given priority for receipt of scholarships;

(2) Scholarships will be provided to physicians, dentists, nurses and other health professionals with allocation of scholarships among the various professions according to the relative needs of Indians for the services of the various professions;

(3) Receipt of such scholarships will carry an obligation to serve in the IHS, in an urban Indian health project or in private practice in a shortage area where the Secretary of HEW determines that a substantial number of Indians will be served.

(c) Change of the authorizations for construction and renovation of hospitals from $123.9 million in fiscal 1977 to $67.2 million, $55.2 million in 1978 to $73.3 million, and from $24.7 million in 1977 to $49.7 million with provision that funds may only be expended for facilities which, where practicable, will meet the standards of the Joint Commission on Accreditation of Hospitals within one year.

(d) Clarify the conditions under which IHS facilities are eligible for medical assistance payments under Medicaid, and require the Secretary to use the sums collected from Medicaid to make improvements in IHS facilities which will bring them into compliance with Medicaid requirements for similar facilities.

(e) Strike the authorization in the original proposal for establishment of an American Indian School of Medicine and authorize a study of the feasibility of an Indian Medical School.

(f) Remove the provision in the original proposal for Congressional action on the Secretary's plan for implementation of the legislation.

II. Background to Committee Action

The Interstate and Foreign Commerce Committee has broad jurisdiction over health matters, including health services delivery, health facilities, health planning, health manpower, public health, health education, health research, programs for control of drug abuse and alcoholism, and programs of health care financing (except health care supported by payroll deductions). The Committee has enacted numerous pieces of legislation in these areas. It originally also developed legislation which transferred authority from the Department of Interior to the Department of Health, Education, and Welfare (HEW) with respect to maintenance and operation of hospital and health facilities for Indians and which authorized HEW to construct sanitation facilities and community water supplies (Public Law

83–568), and legislation which authorized HEW to provide financial assistance for construction of community hospitals which would serve Indians and non-Indians (Public Law 85–151).

H.R. 2525, as amended by the Committee on Interior and Insular Affairs, originated in the Senate as S. 522. The Senate held extensive hearings on the legislation and passed it in the 93d Congress. It passed essentially the same bill in this Congress. Initial referral was made to the Committee on Interior and Insular Affairs. When the Committee on Interior and Insular Affairs ordered H.R. 2525 reported, the bill was sequentially referred to the Committee on Interstate and Foreign Commerce for its consideration of such provisions of the bill as fell within the Committee's jurisdiction. The Committee reviewed the entire bill.

The Subcommittee on Health reported the bill with amendments by voice vote on May 5. The full Committee considered the legislation on May 6, and reported the bill with amendments by unanimous voice vote.

III. Committee Findings and Recommendations

The Committee was impressed with the evidence presented in hearings before the Committee on Interior and Insular Affairs and before its own Subcommittee on Health and the Environment concerning the lack of adequate numbers of health care personnel to serve the Indian population in the Indian Health Service, with the disturbing statistics on the generally poorer health level of the American Indian in comparison with the general population, with the deplorable state of many of the Indian Health Service facilities, and with the particular problems faced by the urban Indian in utilizing the health system and securing adequate care. This evidence is extensively documented in Part I of this report.

The need for improved health care for Indians is clear to the Committee. They endorse the concept embodied in H.R. 2525 that the Congress and the nation make a commitment to the American Indian to bring the level of Indian health, and the quality of health care facilities and health professions manpower serving Indians, to a level equal to that enjoyed by other Americans.

The Committee affirms that the programs of health service, health financing, health manpower training, and education, and all other health programs established by legislation developed by this Committee should be available to the American Indian on the same basis as all other Americans. But additionally, the Committee recognizes the need for an additional commitment to the Indian people. This is particularly true in light of the Federal Government's longstanding obligations under lawful treaties with the Indian nations for the provision to them of health services.

The amendments recommended by the Committee are designed to strengthen H.R. 2525 and make it a more effective vehicle for serving the health needs of Indians.

Amendments affecting, the time-span covered by the Act's authorizations

H.R. 2525, as reported by the Committee on Interior and Insular Affairs provided seven-year authorizations for:

(1) programs to identify and recruit Indians with a potential to become health professionals;

(2) preparatory scholarship programs for Indians who have demonstrated the capability to complete courses of study in the health professions;

(3) a health professions scholarship program;

(4) an extern program to allow recipients of a health professions scholarship to be employed by the Indian Health Service during nonacademic periods of the year;

(5) continuing education allowances for health professionals employed in the Indian Health Service;

(6) additional funds and personnel (over the fiscal year 1976 level) for programs of patient care (direct and indirect), field health, dental care, mental health, and treatment and control of alcoholism;

(7) funds for construction and renovation of hospitals, health centers, health stations, and staff housing for health professionals; and

(8) funds for construction of safe water and sanitary waste disposal facilities.

The 7-year period for authorizations was based on a plan to bring the level of health care services and facilities serving the Indian population up to the level available to the general population within a specified time period. Seven years was selected by the Interior Committee because it provided a long enough time period to make it feasible to accomplish the goal, and it was a short enough time period to enable a satisfactory commitment to the Indian people.

The Committee fully supports the concept of a time-limited, organized plan to achieve high quality health care and facilities for Indians. It agrees with the reasonableness of the seven-year plan contained in the bill as reported. The Committee is concerned, however, that provisions for specific dollar and position authorizations for seven years, up to and including fiscal year 1983, are unwise for several reasons. First, the high rate of inflation in general, and in medical care prices in particular, that has been experienced over the last several years makes it highly likely that the amounts authorized for the fiscal years in the 1980's will prove to be insufficient to accomplish the stated purposes of the Act. Inflation in the medical care area has been running at a rate which doubles the amount of dollars required to fund a static program level every five years. Inflation in construction costs has also been high. The Committee believes that the authorizing Committees of the Congress should reexamine the program before fiscal year 1980 and determine the appropriate level of authorizations to assure that the Congress is carrying out the commitment made to the Indians in H.R. 2525. Secondly, changes in medical care practices and technologies are rapid, Priorities for the allocation of dollars among the kinds of medical care services and facilities may well change over the course of a seven-year period. Again, the Committee believes that the Congress should review the allocation of funds and authorize amounts for fiscal years 1980 to 1983 after examining the progress made in the initial years of operation under H.R. 2525. Finally, the Committee believes that the authorizing Committees should make the specific

commitment for the kind of periodic oversight of the Indian health program that a three-year authorization would require. In other health legislation developed by the Committee, it has followed this formula for review every three years, and believes it has contributed to improved programs.

We remain sympathetic, however, to the intent of the Interior Committee to provide in the bill a seven-year commitment to the improved health of the American Indian that the Indian community has a right to expect. We recommend a series of amendments which we believe address our concerns, and which will also respond to the concerns of the Committee on Interior and Insular Affairs. In the manpower programs, the service programs and the construction programs, we have recommended specific dollar level authorizations for three fiscal years, for 1977, 1978, and 1979. In all cases but one, those are the same figures contained in the Interior bill. For the final four years of the seven-year plan, for fiscal years 1980–1983, we have provided for an authorization of sums to be provided in a later Act. We believe these amendments maintain the seven-year commitment, but provide for more flexibility, responsiveness and Congressional oversight than H.R. 2525, as reported by the Committee on Interior and Insular Affairs, does.

Amendment to establish Indian health scholarships under the Public Health Service Act

H.R. 2525, as reported, provides for programs designed to identify and recruit promising Indian students for a career in the health professions, and to provide them with scholarships to receive education prior to undertaking training in the health professions. Because of the unique and continuing relationship of the Indian Health Service to the Indian population, the Committee agrees that these programs should be administered by the Indian Health Service. However, the Committee is concerned that establishment and administration of a health professions scholarship program for Indians separate from the other health professions scholarship programs established by the Public Health Service Act and administered by the Department of Health, Education, and Welfare would lead to duplication, overlap, and unnecessary administrative complexity and inefficiency. The program contained in the bill as reported would seem to require, for example, that separate applications be filed for the health professions scholarship administered by the Indian Health Service, and for the National Health Service Corps scholarship established by the Public Health Service Act. Individuals would often be applying under both programs simply because of the uncertainty of their application being accepted under either one, and their desire to insure themselves the best chance for a positive response. Further, separate agencies would be making decisions on the applications. Conceivably one individual might be accepted under both programs, while another might not receive support from either. Coordination of decisions could be difficult.

Additionally, the Committee is concerned about the effect on selection of a scholarship and compliance with the service requirements that the differences in the provisions of the two scholarship

programs might have. The first concern relates to the required amount that must be repaid if the individual fails to serve as he obligated himself to do in accepting the grant. The National Health Service Corps scholarships require a payback of funds if there is a failure to fulfill the service requirement according to the formula:

$$A=2\Psi=\frac{(t-s)}{t}$$

in which "A" is the amount the United States is entitled to recover; "Ψ" is the sum of the amount paid under the scholarship program to or on behalf of the individual and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate; "t" is the total number of months in the individual's service obligation; and "s" is the number of months of such obligation that has been served.

The provision in H.R. 2525 as reported, however, requires as a payback for failure to meet the service obligation an amount equal to the following formula:

$$A=\phi=\left(\frac{t-s/2}{t}\right)$$

in which "A" is the amount the United States is entitled to recover; "Φ" is the aggregate of the amount of the scholarship grant and the sum of interest which would be payable if at the time the grant was made, it was a loan bearing interest at a rate fixed by the Secretary of the Treasury (taking into consideration private consumer rates of interest prevailing at the time the grant was made) and if the interest was compounded annually; "t" is the total number of months in the individual's service obligation; and "s" is the number of months of such obligation that has been served. The effect of the differences in the formula is to make the Indian Health Service health professional loan program relatively less stringent than the Health Service Corps scholarship program for a person who fails to meet his service obligation entirely, but relatively more stringent for a person who has met nearly all of his obligation.

Further, the amounts of the scholarship grants differ under the two programs. The National Health Service Corps scholarships pay for: (1) tuition, (2) books, supplies, equipment, medical expenses, and other educational expenses, and (3) a salary equivalent of a junior officer in the Commissioned Corps plus benefits, which would currently amount on the average to something above $10,000 under the provisions of H.R. 5546, the House-passed health manpower bill. The health professions scholarship grants established by H.R. 2525 as reported pay for: (1) tuition, plus (2) an amount *up to* $8,000 to cover costs of books, transportation, board and other expenses when combined with the individual's resources. The amount available is less, and in addition varies with the amount of the individual's own financial resources.

The Committee believes that these issues, plus the simple advantage of greater administrative simplicity, argue for making the Indian Health professions scholarships a part of the basic program of National Health Service Corps scholarships, subject to the same provisions of

law (except where otherwise specified) and administered in concert with the NHSC scholarship program. The proposed amendment accomplishes this. The Committee has retained, however, those special provisions designed to make this health professions scholarship program particularly responsive to Indians and to the manpower needs of the Indian Health Service. The amendment establishes an identifiable program of Indian Health Scholarships, which will be subject to all the provisions governing the National Health Service Corps Scholarships, except that:

(a) Indians will be given priority for receipt of the scholarships;

(b) the scholarships will be to provide physicians, dentists, nurses, optometrists, podiatrists, pharmacists, public health personnel and allied health personnel, with the allocation of scholarships among these fields determined by the relative needs of Indians for services from the specific health professions; and

(c) receipt of the scholarship will carry an obligation to serve in the Indian Health Service, in an urban Indian health project, or in private practice in a shortage area where the Secretary determines such practice serves a substantial number of Indians.

The Committee affirms its intention that the allocation of scholarships among the various health professions be made in accordance with the needs identified by the Indian Health Service for health professional personnel to serve the Indian people. Further, it expects full and complete cooperation between the Indian Health Service and the National Health Service Corps in the awarding of scholarships so that those individuals who have been recruited and identified through the recruitment program established by section 102 of H.R. 2525, and who have received health professions preparatory scholarships under the program established under section 103 of H.R. 2525 ultimately become recipients of the Indian Health scholarships. The Committee expects the Department to develop administrative procedures which will allow a single application for Indian Health scholarships and National Health Service Corps scholarships, with the individual given an opportunity to indicate his preference for the Indian Health scholarship. Further the Committee notes that the existence of the Indian Health scholarship program does not change the Department's obligation to allocate manpower from the National Health Service Corps to the Indian Health Service or other health projects serving Indians to the extent that such manpower continues to be required.

Amendment to allocate funds for hospital construction and renovation over 3-years, and to provide for meeting JCAH standards

H.R. 2525, as reported, by the Committee on Interior and Insular Affairs, provides funds for hospital construction and renovation over a 7-year period. The amounts authorized are based on a 7-year plan, included in Part I of the Report, as follows:

TITLE III—FACILITIES—7-YEAR PLAN (FISCAL YEAR 1977 THROUGH FISCAL YEAR 1983)

[In 1976 dollars]

Facilities and type and size	Previous funds	1975 appropriations	1976 President's budget	Fiscal year— 1977	1978	1979	1980	1981	1982	1983	Total known deficiencies, 1977–83
Hospital, new and replacement:											
Claremore, Okla., replacement, 70–80	200,000	8,560,000	[1] 1,280,000								
Owyhee, Nev., replacement, 15	3,200,000		[1] 350,000								
Philadelphia, Miss., replacement, 30–40	4,550,000		[1] 560,000								
Acomita, N. Mex., new, 30–40	340,000	1,000,000		5,555,000	1,100,000						
Santa Fe, N. Mex., replacement, 45–55	170,000			9,281,000	1,360,000						
Whiteriver, Ariz., replacement, 60–70	377,000			9,900,000	1,881,000						
Winslow, Ariz., replacement, 55–65		475,000		8,800,000	1,672,000						
Bethel, Alaska., replacement, 70–80	600,000			[2] 27,400,000	6,576,000						
Harlem, Mont., replacement, 15	88,000			4,800,000	816,000						
Sacaton, Ariz., replacement, 55	60,000			11,000,000	2,200,000						
Rosebud, S. Dak., replacement, 65–70	28,000			9,400,000	1,786,000						
Red Lake, Minn.,[3] replacement, 30–40				9,100,000	1,729,000						
Pawnee, Okla., replacement, 30–40				6,600,000	1,122,000						
Parker, Ariz., replacement, 30–40					6,200,000	1,054,000					
Schurz, Nev., replacement, 30–40					6,200,000	1,054,000					
Tahlequah, Okla., replacement, 60–78					11,000,000	2,200,000					
Anchorage, Alaska, replacement, 225						1,000,000	36,900,000	8,856,000			
Central, Okla. (Ada), New, 75						11,000,000	2,200,000				
Chinle, Ariz., new, 125							13,200,000	2,772,000			
Fort Yuma, Ariz., replacement, 15							4,200,000	714,000			
Crownpoint, N. Mex., replacement, 60–70								10,500,000	2,100,000		
Talihina, Okla., replacement, 60–70								10,500,000	2,100,000		
Winnebago, Nebr., replacement, 25–35									5,700,000	969,000	
Taanna, Alaska, replacement, 20–30									7,600,000	1,444,000	
Kanakanak, Alaska (equipment), replacement, 20–30										7,600,000	
										1,444,000	
Cherokee, N.C. (equipment), replacement, 30–40										6,200,000	
										1,054,000	
Total, hospital new and replacement		10,035,000	2,190,000	101,836,000	43,652,000	16,308,000	56,500,000	33,342,000	17,500,000	18,711,000	287,849,000

See footnotes at end of table.

TITLE III—FACILITIES—7-YEAR PLAN (FISCAL YEAR 1977 THROUGH FISCAL YEAR 1983)—Continued

[In 1976 dollars]

Facilities and type and size	Previous funds	1975 appropriations	1976 President's budget	Fiscal year— 1977	1978	1979	1980	1981	1982	1983	Total known deficiencies, 1977–83
Hospitals, major modernization and repair:											
Shiprock, N. Mex., modernization, 150	392,000			19,300,000	4,439,000						
Browning, Mont., modernization, 30–40	19,000			440,000	6,500,000	1,105,000					
Pine Ridge, S. Dak., modernization, 65–75				60,000	450,000	6,000,000	1,020,000				
Clinton, Okla., modernization, 25–35					40,000	320,000	3,200,000	480,000			
Fort Defiance, Ariz., modernization, 100					50,000	500,000	6,000,000	1,020,000			
Eagle Butte, S. Dak., modernization, 30–35					40,000	350,000	3,000,000	450,000			
Crow, Mont., modernization, 30–35						40,000	350,000	3,000,000	450,000		
Sisseton, S. Dak., modernization, 30–40						40,000	400,000	4,000,000	680,000		
Keams Canyon, Ariz., additions and alterations, 38						40,000	220,000	2,300,000	345,000		
San Carlos, Ariz., additions and alterations, 36							40,000	300,000	3,000,000	450,000	
Fort Yates, N. Dak., modernization, 30–40							40,000	350,000	4,050,000	680,000	
Cass Lake, Minn., modernization, 20–30							40,000	350,000	3,000,000	450,000	
Rapid City, S. Dak. (equipment), modernization, 100								60,000	650,000	{6,400,000	
Albuquerque, N. Mex., modernization, 220										{1,088,000	
										[4] 6,000,000	
Subtotal, major modernization				19,800,000	11,519,000	8,395,000	14,310,000	12,310,000	12,175,000	15,068,000	93,577,000
Minor modernization: [5]											
Rosebud, S. Dak., repairs				460,000							
Winnebago, Nebr., repairs				400,000							
Mount Edgecumbe, Alaska, miscellaneous alterations				748,000							
Tahlequah, Okla., repairs				636,000							
Subtotal, minor modernization and repair				2,244,000							2,244,000
Total, modernization and repair				22,044,000	11,519,000	8,395,000	14,310,000	12,310,000	12,175,000	15,068,000	95,821,000
Total, hospitals		10,035,000		123,880,000	55,171,000	24,703,000	70,810,000	45,652,000	29,675,000	33,779,000	383,670,000
Outpatient care facilities:											
Lame Deer, Mont., center, replacement		1,000,000									
Riverside, Calif., center, replacement		275,000									
Tohatchi, N. Mex., center, alterations		100,000									
Chemawa, Oreg.[3] center, replacement	100,000			1,860,000	(270,000)						
Tsaile, Ariz., center, new				1,900,000	(265,000)						
Torreon, N. Mex., center, new				550,000	(85,000)						

[1] Reflects prior year equipment requirements only.
[2] Includes balance of planning funds ($800,000).
[3] Master plan study completed with tribal grant funds.
[4] Includes planning funds.
[5] Includes some projects scheduled for replacement or major modernization but requiring interim measures until major project is approved.

The Committee believes that the funds authorized in fiscal year 1977 are in excess of what can be reasonably used for construction in that year. The Committee recommends an amendment that changes the authorizations for fiscal years 1977, 1978, and 1979 as follows:

	H.R. 2525, as reported	Committee amendment	Differences (H.R. 2525 over committee amendment)
Fiscal year:			
1977	$123,880,000	$67,180,000	−$56,700,000
1978	55,171,000	73,256,000	+18,085,000
1979	24,703,000	49,742,000	+25,039,000

As discussed previously, the Committee amendment limits specific authorizations to the first three fiscal years covered by H.R. 2525 (1977–1979), and authorizes such sums as will be specified in a subsequent Act for the next four fiscal years (1980–1983). The Committee affirms, however, the commitment to the seven-year construction, replacement, renovation and modernization plan, with the schedule of expenditures adjusted as follows:

TITLE III—FACILITIES—7 YR PLAN (FISCAL YEAR 1977 THROUGH FISCAL YEAR 1983)

[In 1976 dollars]

Facilities and type and size	Previous funds	1975 Appropriation	1976 President's budget	Fiscal year— 1977	1978	1979	1980	1981	1982	1983	Total known deficiencies 1977–83
Hospitals, new and replacement:											
Claremore, Okla., replacement, 70–80	200,000	8,560,000	[1] 1,280,000								
Owyhee, Nev., replacement, 15	3,200,000		[1] 350,000								
Philadelphia, Miss., replacement, 30–40	4,550,000		[1] 560,000								
Acomita, N. Mex., new, 30–40	340,000	1,000,000		3,555,000	3,110,000						
Santa Fe, N. Mex., replacement, 45–55	170,000			6,281,000	4,360,000						
Whiteriver, Ariz., replacement, 60–70	377,000			5,900,000	5,881,000						
Winslow, Ariz., replacement, 55–65		475,000		5,000,000	5,472,000						
Bethel, Alaska, replacement, 70–80	600,000		[2]	10,000,000	10,000,000	7,400,000	6,576,000				
Harlem, Mont., replacement, 15	88,000			4,800,000	816,000						
Sacaton, Ariz., replacement, 55	60,000			4,000,000	4,000,000	5,200,000					
Rosebud, S. Dak., replacement, 65–70	28,000			6,000,000	5,186,000						
Red Lake, Minn.,[3] replacement, 30–40				6,000,000	4,829,000						
Pawnee, Okla., replacement, 30–40				3,600,000	4,122,000						
Parker, Ariz., replacement, 30–40					3,200,000	4,054,000					
Schurz, Nev., replacement, 30–40					3,200,000	4,054,000					
Tahlequah, Okla., replacement, 60–78					5,000,000	8,200,000					
Anchorage, Alaska, replacement, 225						1,000,000	36,900,000	8,856,000			
Ada, Okla., new, 75						6,000,000	7,200,000				
Chinle, Ariz., new, 125							7,200,000	8,772,000			
Fort Yuma, Ariz., replacement, 15							4,200,000	714,000			
Crownpoint, N. Mex., replacement, 60–70								10,500,000	2,100,000		
Talihina, Okla., replacement, 60–70								10,500,000	2,100,000		
Winnebago, Nebr., replacement, 25–35									5,700,000	969,000	
Tanana, Alaska, replacement, 20–30									7,600,000	1,444,000	
Kanakanak, Alaska, replacement, 20–30										7,600,000	
Equipment										1,444,000	
Cherokee, N.C., replacement, 30–40										6,200,000	
Equipment										1,054,000	
Total, hospital new and replacement	10,035,000	2,190,000		55,136,000	59,176,000	35,908,000	62,076,000	39,342,000	17,500,000	18,711,000	287,849,000

See footnotes at end of table.

TITLE III—FACILITIES—7 YR PLAN (FISCAL YEAR 1977 THROUGH FISCAL YEAR 1983)—Continued

[In 1976 dollars]

Facilities and type and size	Previous funds	1975 Appropriation	1976 President's budget	Fiscal year— 1977	1978	1979	1980	1981	1982	1983	Total known deficiencies 1977–83
Hospitals, major modernization and repairs:											
Shiprock, N. Mex., modernization, 150	392,000			9,300,000	10,000,000	4,439,000					
Browning, Mont., modernization, 30–40	19,000			440,000	3,500,000	4,105,000					
Pine Ridge, S. Dak., modernization, 65–75				60,000	450,000	4,000,000	3,020,000				
Clinton, Okla., modernization, 25–35					40,000	320,000	3,200,000	480,000			
Fort Defiance, Ariz., modernization, 100					50,000	500,000	6,000,000	1,020,000			
Eagle Butte, S. Dak., modernization, 30–35					40,000	350,000	3,000,000	450,000			
Crow, Mont., modernization, 30–35						40,000	350,000	3,000,000	450,000		
Sisseton, S. Dak., modernization, 30–40						40,000	400,000	4,000,000	680,000		
Keams Canyon, Ariz., additions and alterations, 38						40,000	220,000	2,300,000	345,000		
San Carlos, Ariz., additions and alterations, 36							40,000	300,000	3,000,000	450,000	
Fort Yates, N. Dak., modernization, 30–40							40,000	350,000	4,050,000	680,000	
Cass Lake, Minn., modernization, 20–30							40,000	350,000	3,000,000	450,000	
Rapid City, S. Dak. (equipment) modernization, 100								60,000	650,000	6,400,000	
Albuquerque, N. Mex., modernization, 220										[4] 6,000,000	
Subtotal, major modernization				9,800,000	14,080,000	13,834,000	16,310,000	12,310,000	12,175,000	15,068,000	93,577,000
Minor modernization: [5]											
Rosebud, S. Dak., repairs				460,000							
Winnebago, Nebr., repairs				400,000							
Mount Edgecumbe, Alaska, miscellaneous alterations				748,000							
Tahlequah, Okla, repairs				636,000							
Subtotal, minor modernization and repair				2,244,000							2,244,000
Total, modernization and repair				12,044,000	14,080,000	13,834,000	16,310,000	12,310,000	12,175,000	15,068,000	95,821,000
Total, hospitals	10,035,000	2,190,000	67,180,000	73,256,000	49,742,000	78,386,000	51,652,000	29,675,000	33,779,000	383,670,000	

[1] Reflects prior year equipment requirements only.
[2] Includes balance of planning funds ($800,000).
[3] Master plan study completed with tribal grant funds.
[4] Includes planning funds.
[5] Includes some projects scheduled for replacement or major modernization but requiring interim measures until major project is approved.

H.R. 2525, as reported by the Committee on Interior and Insular Affairs, requires that the Secretary, prior to the expenditure of construction or renovation funds, be assured that wherever practicable, the facility affected by those funds shall meet the standards of the Joint Commission on Accreditation of Hospitals within five years. The Committee believes this represents a longer period than the Congress should allow a facility to fail to meet JCAH standards. The Secretary should act to bring all facilities into compliance as rapidly as possible. Any new facility constructed with funds authorized under section 301 of H.R. 2525 should be expected to meet JCAH standards within one year. The Committee recognizes that some expenditure of funds, particularly for renovation, may be necessary to correct life threatening conditions in facilities or parts of facilities where full compliance with JCAH standards cannot reasonably be expected within one year; and the language of the law allows the Secretary leeway to expend funds for such purposes in these situations. The objective of the Secretary, however, should parallel that of the Congress: to bring all IHS facilities up the standards applied to health facilities in general without delay.

Amendment to provide a separate authority for construction of water and sanitation facilities for new Indian housing

Part I of this Report indicates that the level of funds authorized for construction of water and sanitation facilities in H.R. 2525, as reported by the Committee on Interior and Insular Affairs, is adequate only to meet the need of existing Indian housing. It struck specific authorizations for construction of facilities for new Indian housing because:

(1) an existing agreement among the Office of Management and Budget, the Indian Health Service, the Department of Housing and Urban Development, and the Bureau of Indians Affairs provides that adequate water and sanitation facilities will automatically be provided for any new, Federally-assisted Indian housing construction and,

(2) uncertainties concerning the amount of new housing that would be built made determination of an appropriate authorization level for water and sanitation facilities for the new units difficult.

The Committee agrees that determination of a specific amount for construction of water and sanitation facilities for new as-yet-unbuilt housing units cannot easily be determined. The Committee is concerned, however, that without language in the law authorizing such sums as are necessary to build water and sanitation facilities for the new housing units, that the agreement between OMB, IHS, HUD, and BIA can be carried out only by using some of the funds intended to meet the needs of existing housing units. The Committee therefore recommends an amendment providing the general authority needed to meet the demand for water and sanitation facilities for new housing units as they are constructed.

Amendment to clarify conditions for payment of medicaid funds to Indian Health Service facilities

Under title IV of H.R. 2525, as reported by the Committee on Interior and Insular Affairs, Indian Health Service facilities (including

hospitals, skilled nursing facilities and intermediate care facilities), whether operated by the IHS or by an Indian tribe or tribal organization, would be deemed to be eligible for reimbursement under the Medicaid program for services provided to individuals eligible for medical assistance under title XIX of the Social Security Act, provided either that the facility met standards ordinarily applied to similar facilities under title XIX, or else, in the case of any facility existing at the time of enactment of H.R. 2525, that the Indian Health Service has provided an acceptable written plan to the Secretary for bringing the facility into full compliance with the standards ordinarily applied within two years from the date of acceptance of the plan by the Secretary. The provision is designed to enable Medicaid funds to flow into IHS institutions when services are provided to Indians who are eligible under the Medicaid plan of the State in which they reside (or their reservation is located). Currently, both because law has been interpreted as barring receipt of such payments by IHS facilities, and because many of those facilities cannot meet the standards required under title XIX (which, in the case of hospitals and skilled nursing facilities, parallel the standards of title XVIII), such third-party payments have not been available.

The Committee endorses the concept of making IHS facilities eligible for Medicaid payments. The Committee was concerned with several aspects of the amendment, however:

(1) it directed the Secretary to secure a plan from the IHS to bring the facility into compliance within two years; a facility out of compliance with title XIX requirements is usually required to submit a plan to come into compliance in one year;

(2) it made no provision regarding payment of funds if the plan to bring the facility into compliance within two years was not met;

(3) although it indicated the intent of Congress that IHS appropriations should not be reduced by the amount of funds received through the third-party payment programs (Medicaid and Medicare), it did not require the Secretary to use the additional revenues to improve the facilities so that they could meet the health, safety and quality standards applied to other participating facilities.

The Committee recommends an amendment which provides for:

(1) the ongoing application to IHS facilities of the health and safety standards applicable to all other similar facilities participating in Medicare,

(2) a requirement that the Secretary receive within six months of enactment a plan for achieving compliance with the applicable conditions and requirements within 12 months after the month in which the plan is submitted, and

(3) a requirement that Medicaid reimbursement funds received be earmarked for use in financing those changes needed to bring IHS facilities into compliance with Medicaid standards until such time as substantially all of the health facilities of the IHS are in compliance.

The impact of the amendment is to limit the period to a maximum time of 18 months during which a facility can receive Medicaid funds even if it fails to meet the most minimal of health and safety require-

ments. After that period, the facilities will be subject to the same requirements as are all other similar facilities participating in Medicaid. It should be noted that standards normally applied to facilities do provide some leeway. The Medicare law, for example, has authorized for a specified duration of time, the application of less rigorous standards in the case of rural hospitals where personnel scarcities and other circumstances preclude full compliance with all standards; this has been incorporated into Medicaid standards by regulation. Similarly, in the administration of Medicare, it has been recognized that in individual cases it is necessary to allow reasonable time for a facility not in full compliance to achieve that status, provided it submits an acceptable plan for taking the steps necessary to meet the standards, it is making the best use of its resources to improve quality, and it has no deficiencies which adversely affect the health and safety of patients; again, the Medicaid practice has paralleled this. The Committee reaffirms its expectation that the Secretary should hold IHS facilities to the same health, safety and quality standards generally applied to other facilities, and that he should take every step to bring the IHS facilities, into full compliance with these standards. It is not the intent of the Committee, however, to subject IHS facilities to standards more stringent or inflexible than those generally applied under the Medicaid program:

To underscore its intent that the Secretary is expected to expend the funds necessary to make those changes required to enable the IHS facilities to meet the health and safety standards, the Committee recommends an amendment requiring that Medicaid payments received by IHS facilities be earmarked for use in meeting and maintaining Medicaid standards; this use of the funds is to have priority until such time as the Secretary is able to certify in his reports to the Congress and the public that substantially all of the IHS facilities are in compliance with standards. The Committee affirms the general intent expressed in H.R. 2525, as reported by the Committee on Interior and Insular Affairs, that the receipt of Medicaid funds should not be considered justification for reductions in the IHS appropriations. These Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian.

The Committee has made a technical change in the provision for a 100 percent Federal matching rate for State Medicaid expenditures for eligible Indians receiving services in IHS facilities in order to place that provision within title XIX of the Social Security Act. The Committee approved this provision because:

(1) the Federal government has treaty obligations to provide services to Indians; it has not been a State responsibility;

(2) since the 100 percent matching is limited to services in IHS facilities, it is clearly being paid for Indians who are already IHS eligible (and therefore clearly part of the population to which the U.S. Government has an obligation) and who are already eligible for full Federal funding of their services, and

(3) States with a large IHS eligible Indian population have a limited tax base because so much of the land is public and not taxable; the higher matching rate under Medicaid simply recognizes this.

Amendment to substitute requirement for a study of the feasibility of an American Indian School of Medicine for authorization in place of establishment of such a school

H.R. 2525, as reported by the Committee on Interior and Insular Affairs, authorized $16,280,000 over a seven-year period for establishment of an American Indian School of Medicine. The Committee is concerned about both the desirability and feasibility of such a School. First, the necessary delay in planning for, developing and establishing an American Indian School of Medicine makes it doubtful that the School could contribute in any substantial way to the seven-year health improvement program set out in H.R. 2525. Secondly, there is little evidence to demonstrate that most or even a substantial number of Indian medical students would prefer to take their training at such an institution as opposed to other established medical schools. Third, the feasibility of establishing a high quality institution and of drawing adequate faculty to it needs further study. Finally, the Committee found little support for the concept among the groups that offered testimony on H.R. 2525 before the Subcommittee on Health. The Committee therefore recommends an amendment striking the authorization for establishment of the School, and instead authorizes a study of its feasibility.

Amendment to strike the requirement for congressional action on the Secretary's implementation plan

H.R. 2525, as reported, requires that the Secretary submit his plan of implementation for H.R. 2525 to the Congress. The plan becomes effective only if the Congress does not act within 60 days to disapprove it. There is no provision for resolving the problems if the Congress disapproves the plan.

The Committee believes that H.R. 2525 and the accompanying report give clear indication of the actions expected of the Secretary of HEW. Further, the changes recommended in authorization periods, if adopted, will result in extensive Congressional oversight of Departmental activities relating to implementation of the bill within a three-year period. The Committee does not agree that this oversight must be supplemented further by Congressional review of the Secretary's implementation plan, and is concerned that this will only delay the Act's timely implementation. The Committee recommends an amendment striking this requirement.

IV. Cost Differential Between H.R. 2525, as Reported by the Committee on Interior and Insular Affairs, and H.R. 2525, as Amended by the Committee on Interstate and Foreign Commerce, and Inflation Impact Statement

The amendments recommended by the Committee have the following cost impact:

(1) Reduce the authorization level for hospital construction and renovation in fiscal year 1977 by $56,700,000; increase the authorization level for hospital construction and renovation in fiscal year 1978 by $18,085,000 and in fiscal year 1979 by $25,039,000;

(2) Eliminate the authorization of $16,280,000 (spread over seven years in H.R. 2525, as reported) for the American Indian Medical School;

(3) Remove all specific authorization amounts for fiscal years 1980–1983.

The Committee notes that section 402 of H.R. 2525 will increase the Federal Medicaid budget by approximately $23 million in fiscal year 1977 and similar amounts in later years. Since the 100 percent Federal matching funds are available under Medicaid only for services for Medicaid-eligible Indians in Indian Health Service facilities (where care is already provided without cost to these Indians), the Committee notes that this represents primarily a shift in Federal expenditures from the Indian Health Service budget to the Medicaid (title XIX) budget.

The Committee affirms the findings in Part I of the Report that since the total costs of the Act are not substantial in any one sector of the country or in any one year, the inflationary impact of H.R. 2525 on prices and costs in the operation of the national economy will be minimal. While there is no appreciable change in the inflationary impact of the Act as a result of amendments recommended by the Committee, the Committee would note that authorized amounts have been reduced slightly, and authorizations for fiscal years 1980–1983 have been scheduled for later consideration. The Committee amendments involve no new budgetary authority.

The cost estimate prepared by the Congressional Budget Office follows:

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE (REVISED)

1. *Bill number:* H.R. 2525.
2. *Bill title:* The Indian Health Care Improvement Act.
3. *Purpose of bill:* To authorize additional funds for the purposes of recruiting Indians into health training programs and to provide for the training of those Indians in schools of health professions (Sections 102–105); to supplement funds available for health services (Section 201); to provide for additional support for the construction and renovation of health and environmental facilities (Sections 301–303); to extend Medicaid eligibility to Indian Health Service beneficiaries (Section 402); and to extend services being provided to urban Indians (Sections 501–505).
4. *Cost estimate:*

Budget authority/outlays	*Millions*
1977	$22.67
1978	23.80
1979	24.99
1980	26.24
1981	27.56

Section 402:

5. *Basis for estimate:* Although Sections 102–106; 201; 301–303; and 501–506 provide for additional authorization of funds, present authorizations, provided under the Snyder Act of 1921, are open-ended. Thus, H.R. 2525, while stipulating areas requiring specific attention with regard to funding, cannot be considered as increasing future budget authority or outlays, given the unlimited authorization extant under present law.

Section 402 provides for reimbursement to the Indian Health Service by the Medical Services Administration for services provided in IHS facilities to Medicaid-eligible Indians. The basis for the projected cost to Medicaid as a result of this provision is based upon estimates generated by Marco Systems in a report prepared for IHS. Their projections were based upon 1974 data and the above estimate inflates those figures to 1977 levels using the Medical Care component of the CPI. Future costs use the 1977 base inflated by 5 percent per year to account for increases in salaries and expenses in IHS facilities. The bill stipulates that funds received by IHS under this provision will be utilized to upgrade their facilities to meet Medicaid standards. Although this might represent some offset to existing appropriations to IHS for facilities improvement, there are no assurances that this will, in fact, be the case, particularly on a short-term basis. Thus, no offset is shown for the five-year period.

6. *Estimate comparison:* Not applicable.

7. *Previous CBO estimate:* An earlier estimate, dated March 24, 1976, projected Medicaid budget authority and outlays at $6.28, $19.96, $21.14, $22.51 and $23.79 million for 1977–1981. These lower estimates were based upon an assumption that the program would require a start-up period with only some sites participating initially. The present estimate assumes centralized billing and, thus, 100 percent participation at the outset of the program.

Also, the earlier estimate included authorization levels for the support of the American Indian School of Medicine. The House Interstate and Foreign Commerce Committee has removed this authorization from the bill and substituted provisions for a feasibility study to be carried out by the Secretary of HEW. No authorization is provided for this and it is assumed that existing funds will be used to carry out the purposes of that provision.

8. *Estimate prepared by:* Jeffrey C. Merrill (225–4972).

9. *Estimate approved by:* R. Scheppach for James L. Blum, Assistant Director for Budget Analysis.

V. Oversight Statement

The Committee has concluded that additional expenditures to increase the quantity and quality of health professions personnel and health facilities to improve the health of the Indian population is desirable. It has concluded that Medicaid reimbursement to Indian Health Service facilities is justified. The Subcommittee on Health and the Environment has held extensive hearings on issues related to health manpower. Additional hearings were conducted on April 27 and 28 on H.R. 2525.

The Committee has not received oversight reports from either its own Subcommittee on Investigations and Oversight or the Committee on Government Operations concerning the subject matter of H.R. 2525.

VI. Section-by-Section Analysis

The section-by-section analysis of H.R. 2525 is contained in Part I of this Report.

VII. Agency Reports

Agency reports have not been received on the amendments to H.R. 2525 recommended by the Committee. The views of the Department of Health, Education, and Welfare on the bill as reported by the Committee on Interior and Insular Affairs are included in Part I of the Report.

Changes in Existing Law Made by the Bill, As Reported

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

Section 225 of the Public Health Service Act

PUBLIC HEALTH AND NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP TRAINING PROGRAM

Sec. 225. (a) * * *

* * * * * * *

(i) (*1*) To carry out the Program, there is authorized to be appropriated $3,000,000 for the fiscal year ending June 30, 1974, and $40,000,000 for the fiscal year ending June 30, 1975.

(2)(A) In addition to the sums authorized to be appropriated under paragraph (1) to carry out the Program, there are authorized to be appropriated for the fiscal year ending September 30, 1977, $5,450,000; for the fiscal year ending September 30, 1978, $6,300,000; for the fiscal year ending September 30, 1979, $7,200,000; and for fiscal years 1980, 1981, 1982, and 1983 such sums as may be specifically authorized by an Act enacted after the Indian Health Care Improvement Act, to provide scholarships under the Program to provide physicians, dentists, nurses, optometrists, podiatrists, pharmacists, public health personnel, and allied health professionals to provide services to Indians. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with this section except as provided in subparagraph (B).

(B)(i) In making Indian Health Scholarships the Secretary shall accord priority to applicants who are Indians and shall, in consultation with the Indian Health Service, determine the distribution of the scholarships on the basis of the relative needs of Indians for additional service in specific health professions.

(ii) The active duty service obligation prescribed by subsection (e) shall be met by the recipient of an Indian Health Scholarship by service in the Indian Health Service, in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of his profession if, as determined by the Secretary in accordance with guidelines promulgated by him, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

(C) for purposes of this paragraph, the term "Indian" has the same meaning given that term by section 4(c) of the Indian Health Care Improvement Act and includes individuals described in clauses (1) through (4) of that section.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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DEFINITIONS

SEC. 1905. For purposes of this title—

(a) * * *

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(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1110(a)(8). *Notwithstanding the first sentence of this subsection, the federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).*

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INDIAN HEALTH SERVICE FACILITIES

SEC. 1911. (a) A facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within 6 months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

ACT OF DECEMBER 17, 1970

AN ACT To authorize the Secretary of the Interior to approve an agreement entered into by the Soboba Band of Mission Indians releasing a claim against the Metropolitan Water District of Southern California and Eastern Municipal Water District, California, and to provide for construction of a water distribution system and a water supply for the Soboba Indian Reservation; and to authorize long-term leases of land on the reservation.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, * * *

* * * * * * *

SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954, as amended by the Act of July 31, 1959 (73 Stat. 267).

MINORITY VIEWS ON H.R. 2525—INDIAN HEALTH CARE

We do not disagree with the contention that the health status of our Indian population is substantially inferior to that of the remainder of U.S. citizens. Statistics in numerous areas serve as a grim witness to existing problems. Testimony suggests that numerous factors contribute to this unfortunate situation, some of which are addressed in H.R. 2525. We share a desire with the authors of this bill to see substantial improvements in the health of our Indian people. Nevertheless, we fear that it offers more glitter than gold.

Amendments to H.R. 2525 by the Interstate and Foreign Commerce Committee render this bill much more realistic and its programs more accountable. In particular, authorization levels for three years only, with a clear recognition of the long-range planning needed to insure sustained progress, is far more rational than seven year authorizations which simply cannot comprehend a variety of unforeseen developments and which by-pass appropriate Congressional oversight. Likewise, a study of the need for and flexibility of an Indian School of Medicine in lieu of outright authorizations in excess of $16 million to establish a school is far more realistic than proceeding with unwarranted assumptions.

Other amendments in our Committee redistribute construction funds over the initial three years in a more realistic and acceptable manner and determine that the health professions scholarship program will be administered within the existing National Health Service Corps scholarship program. Special emphasis on Indian health manpower needs is encouraged while duplication is avoided. We approve of these provisions.

H.R. 2525, as amended, remains far from satisfactory, however. Funding levels, for instance, are kept intact far in excess of the Administration's budget. These levels are grotesque when viewed in the light of budgetary increases totaling over 200% in the past eight years, and the definite progress in improving Indian health through priorities given to these programs over many competing demands. The current bill would result in heavy additional outlays in the next fiscal year even when construction figures are redistributed. Furthermore, the extravagance of this bill is underscored by its duplication, in several areas, of Administration efforts now underway, particularly in manpower programs.

There is a risk that opposition to the approaches taken in H.R. 2525 will be viewed as a lack of concern about Indian health needs and a lack of commitment to their resolution. Our support of the goals of this bill and our Committee amendments belies any such interpretations. Modifications in the bill, in our opinion, simply do

not go far enough to insure a realistic building upon the progress that has been made in recent years.

SAMUEL L. DEVINE.
JAMES T. BROYHILL.
TIM LEE CARTER.
CLARENCE J. BROWN.
JAMES M. COLLINS.
NORMAN F. LENT.
EDWARD R. MADIGAN.

ADDITIONAL MINORITY VIEWS OF JOE SKUBITZ

While I agree with the views filed by my colleagues in the Minority, I fault them, as I do the Majority report, for not strongly emphasizing to the House that every dollar of the $136.2 million recommended by our amendments to H.R. 2525 is in addition to the $354.9 million budgeted by the President for Indian health programs. Failure to pass this bill would not, as some imply, result in no program at all for Indian health improvement.

I happen to serve on both the Interior Committee, where I am Ranking Minority Member, and the Interstate Committee. The Interior Committee acted first on this bill, and I filed dissenting views to its report. I will reprint those views following this statement.

I appreciate and support many of the amendments to H.R. 2525 recommended by the Interstate Committee. They go a long way toward meeting many of the objections I had to the bill as reported by the Interior Committee. I hope the House will adopt the changes recommended by the Interstate Committee, to wit:

(1) make no specific authorizations beyond the initial three-year period in order to force the Congress to face its responsibility to review the Indian health program periodically. Specific authorizations for seven years, as reported by the Interior Committee, are pure guesswork.

(2) reduce the first year authorizations to a level which avoids playing "chicken" with the White House and incurring a veto. While Interstate's recommended reduction of $57 million in the first year construction funds is a step in the right direction, it still leaves the fiscal year 1977 level at $118.3 million which is in addition to the $40 million in Indian health construction funds provided in the President's budget. This near 300 percent first-year increase in construction money hardly allows the Administration to "ease" into this program the first year.

(3) Interstate eliminates specific authorizations for creating an Indian School of Medicine. Interior reported H.R. 2525 with $16,280,000 for such a dreamschool. Not even the Indians embraced such a dream. In fact, the National Congress of American Indians tabled a resolution favoring such an Indian School of Medicine. I agree with Interstate's approach that such a school should be proved necessary and feasible before funds are committed to its construction.

In order that Members may know more fully the background of tenuous assumptions upon which this "Indian Health bill" was first created in the Interior Committee, I offer here my dissenting views to the Interior Committee's report of H.R. 2525:

DISSENTING VIEWS OF REPRESENTATIVE JOE SKUBITZ TO H.R. 2525

I respectfully dissent from the Majority Views and oppose the bill as reported. I do so reluctantly, because I expect that this dissent may be misinterpreted as a rejection of the responsibility the Congress has to Indian people. Nothing could be further from my motive.

The state of Indian health is deplorable. The subcommittee hearings reveal hours of testimony on higher death rates, greater disease incidence, more frequent infant deaths, and less practice of preventive medicine among Indians than non-Indians.

Of course, Indian health is not likely to improve until adequate health personnel and facilities are provided. This important upgrading will not occur until Congress initiates and commits itself to a serious program for Indian health improvement.

But H.R. 2525 is not the answer. It is not a bill for Indians only; its scholarship program is open to all health students and therefore duplicates many of HEW's on-going educational programs. In fiscal year 1977, H.R. 2525 authorizes $193 million more than the $354.9 million budgeted by the President for Indian health improvement. Such an increase is veto bait. H.R. 2525 authorizes $1.2 billion over seven years, thus passing on to the Appropriations Committee the responsibility for overseeing the legislative commitment in years ahead. Finally, H.R. 2525 authorizes construction increases of 434 percent in fiscal year 1977. This is an unrealistic and irresponsible jump in health facility construction authorizations.

UNREALISTIC PROMISES

Unfortunately, H.R. 2525 is a brightly wrapped package full of promises that can't be kept. It is an authorization made with the certain knowledge that appropriations will be considerably less. H.R. 2525 is not a commitment to improving Indian health; it is pure puffery by a legislative committee, because it ducks the real commitment of how much should actually be spent. The unrealistically high first year's authorization in H.R. 2525 gives no real guidance to the Appropriations Committee. It is a shameful way for the Interior Committee to represent its Indian clients.

For many years the House Committee on Interior and Insular Affairs has had special and nearly exclusive jurisdiction over Indian matters. Its long association with Indian problems makes it the best judge of cures and solutions. Thus, the Interior Committee has a responsibility to the Indian people to present their case for Federal funds in a wise and defensible manner. To be taken seriously, it must recommend seriously.

VETO GAME

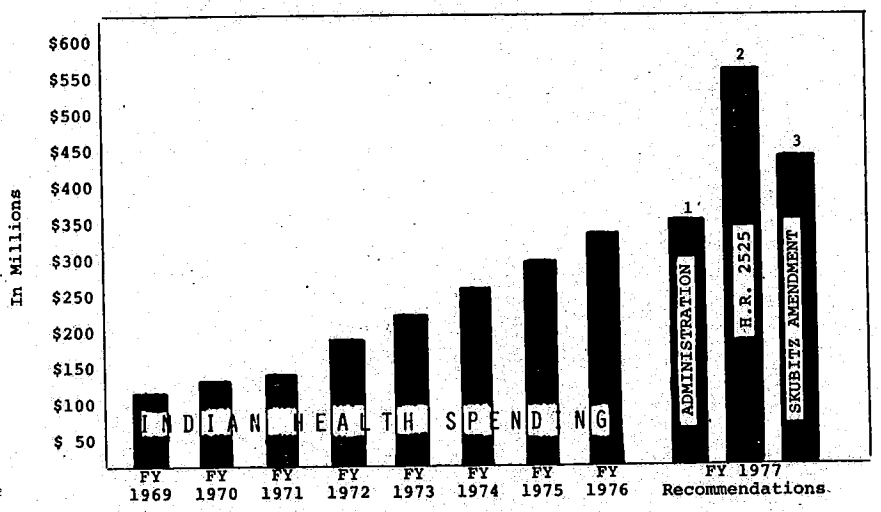
H.R. 2525 is a classic case of playing "chicken" with the White House. It authorizes, over seven years, $1.2 billion for an Indian health program. In fiscal year 1977, the first fiscal year under the bill, $193 million is authorized. This is in addition to the $354.9 million budgeted by the President for Indian health. Such a first year increase only invites a veto at a time when the President has a pretty good win record on vetoes. We gain nothing by losing an Indian health program in the veto game.

In Committee, I offered amendments which would have cut the fiscal year 1977 impact on dollar outlays to $80 million above the President's budget. I did not seek to cut a single dollar from the fiscal year 1978 or fiscal year 1979 authorizations. This first year reduction of $110 million, if successful, would have enabled the Administration to phase in, at a realistic level, the program recommended by this Committee.

H.R. 2525 as reported increases the fiscal year 1977 outlays on Indian health care programs by 62 percent over last year! Although the Administration budgeted only a 5 percent increase in fiscal year 1977, the total outlays for Indian health spending have expanded by 214 percent since fiscal year 1969. If my amendments were adopted, the recommended increase for fiscal year 1977 would have been a more reasonable 28.7 percent. (See chart)

INTERIOR COMMITTEE'S REVIEW ESSENTIAL

Perhaps the best example of an unrealistic recommendation is the seven year guess-work in H.R. 2525. Specific funding authorizations are made for 21 different programs for seven fiscal years. How can anyone know what level of spending will be appropriate to upgrade Indian health seven years from now? The figures in H.R. 2525 are



[1] 5 percent increase ($17 million) over fiscal year 1976.
[2] 62 percent increase ($210 million) over fiscal year 1976.
[3] 28.7 percent increase ($97 million) over fiscal year 1976.

simply crystal-ball predictions. I very strongly believe the Interior Committee should reexamine the Indian health program launched by this bill at least once every three years. Such a review would give us a chance to recommend realistic appropriations based on the most current data available.

I have strong suspicions that the cost projections in this bill will quickly become obsolete. Let me cite just one example. In calculating financial needs for the health professions scholarship program, the Committee produced a chart showing the tuition cost at the University of Kansas Medical School to be $1,025 per year for residents of the state and $2,025 for non-residents. I am advised that these figures have already risen to $1,500 and $3,000 respectively. The $3,500 figure for Georgetown University has already gone up to $5,000 and another raise in tuition is expected for next year. Officials don't even know yet by how much. And this bill tries to predict what will be needed seven years from now!

Future authorizations should be adjusted according to the findings of the Interior Committee, which is far more familiar with Indian problems than any other committee. A seven year authorization simply defers to the busy Appropriations Committee the truth of the Congressional commitment in years hence. The Indian citizen has a right to expect better treatment from the Interior Committee.

During Committee markup, I moved to strike authorizations beyond fiscal year 1979. I did so to force the Committee to live up to its responsibility to periodically review the programs it authorizes. I did not intend that an initial three year authorization would be a one-shot "crash" program to solve Indian health needs. In fact, I doubt that a seven year program will do the job. The Interior Committee should stick with this program until Indian health is as good as that provided non-Indians. I believe this is the kind of commitment we owe the American Indian, and can deliver to them.

434 PERCENT INCREASE IRRESPONSIBLE

Another example of a promise which can't be kept is the 434 percent in first year authorizations for construction, modernization, and replacement of hospitals, health centers and stations, staff housing, and sanitary waste disposal facilities. This is by far the lion's share of the fiscal year 1977 authorization in H.R. 2525. Out of $193 million, $175,082,000 is recommended for construction. This is in addition to the $40,345,000 in the President's budget. It is a 434 percent increase.

The President's budget request for fiscal year 1977 health construction funds is $15 million less than fiscal year 1976. I offered an amendment in Committee which would have replaced the Administration's reduction and retained $55 million of the $175 million provided in H.R. 2525. It cut the Committee's request by $105 million. Thus the amendment, if adopted, would have added $70 million in health facilities construction funds to the $40 million budgeted by the President—for a total of $110 million in fiscal year 1977. This would have left a 175 percent increase in Indian health facilities construction, but the committee insisted on the 434 percent increase—again expecting someone else to be fiscally responsible.

DUPLICATES EXISTING PROGRAMS

Although the emphasis in H.R. 2525 for fiscal year 1977 is on health facilities construction, the seven-year program authorizes $126.9 million for health professions education. The first year outlay would be $7.8 million.

The Department of Health, Education, and Welfare has repeatedly advised the Committee that this proposed program would duplicate HEW efforts already going forward under existing law. These include the National Health Service Scholarship program and the Indian Health Service training programs. These and other existing HEW programs are not exclusively for Indians, but *neither* are the programs recommended in H.R. 2525. Non-Indians can qualify and may very well dominate the H.R. 2525 scholarship proposal, but these students would either be required to serve in the Indian health field or pay back the scholarship benefits. There is no evidence that Indian students are being excluded or discriminated against under HEW's health profession programs. And an educational program exclusively for Indians (which H.R. 2525 is not) does not assure increased Indian participation.

INDIAN SCHOOL OF MEDICINE

Perhaps there is no better example of the fantasy which consumed the Committee in marking up H.R. 2525 than Title VI. This Title authorizes $16,280,000 to establish an American Indian School of Medicine. This is a package not even the Indians would endorse. The National Congress of American Indians tabled a resolution favoring such an Indian School of Medicine.

The School was added to H.R. 2525 even though no hearings were held in either the House or the Senate. It is not included in the Senate bill. It is highly doubtful that such a School could be created from the ground up in time to contribute at all to the health improvement program outlined in the seven-year authorization period. There is every reason to favor utilizing existing credited Medical Schools to train Indian health profession personnel.

CONCLUSION

The Congress owes the American Indian the kind of commitment that will launch a realistic health improvement program. The history of relations between the American Indian and the Federal Government is replete with promises from Washington that couldn't be kept. H.R. 2525 will simply add another dismal chapter to that history. It is well-intended, but it will never be lived up to. Let's be honest with the only original Americans. Let's go back to the drawing boards and report a program we know we can fund this year and as many years hereafter as are necessary to bring Indian health up to the standards of the non-Indian.

JOE SKUBITZ.

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