STATEMENT

OF

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

UNITED STATES SENATE

COMMITTEE ON INDIAN AFFAIRS

AND

HEALTH, EDUCATION, LABOR, AND PENSIONS COMMITTEE

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ON

S. 1057

“INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2005"

JULY 14, 2005

Statement of the Department Of Health and Human Services

On S. 1057, - A Bill to Amend the “Indian Health Care Improvement Act Amendments of 2005"

Mr. Chairmen and Members of the Committees:

I am honored to testify before you today on the important issue of reauthorization of the Indian Health Care Improvement Act (IHCIA). Accompanying me today are Robert McSwain, Deputy Director, Craig Vanderwagen, M.D., Acting Chief Medical Officer, and Gary Hartz, Director, Office of Environmental Health and Engineering.

This landmark legislation forms the backbone of the system through which Federal health programs serve American Indians/Alaska Natives and encourages participation of eligible American Indian/Alaska Natives in these and other programs.

The IHS has the responsibility for the delivery of health services to more than 1.8 million Federally-recognized American Indians/Alaska Natives through a system of IHS, tribal, and urban (I/T/U) health programs based on judicial decisions and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indian/Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal government's responsibility to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major statutes are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L. 94-437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "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." Like the Snyder Act, the IHCIA provides the authority for the Federal government programs that deliver health services to Indian people, but it also provides additional guidance in several areas. The IHCIA contains specific language addressing the recruitment and retention of health professionals serving Indian communities; the provision of health services; the construction, replacement, and repair of health care facilities; access to health services; and, the provision of health services for urban Indian people.

DHHS Activities

Since enactment of the IHCIA in 1976, statutory authority has substantially expanded programs and activities to keep pace with changes in healthcare services and administration. Federal funding for the IHCIA has contributed billions of dollars to improve the health status of American Indians/Alaska Natives. And, much progress has been made particularly in the areas of infant and maternal mortality.

The Department under this Administration's leadership reactivated the Intradepartmental Council on Native American Affairs (ICNAA) to provide for a consistent HHS policy when working with the more than 560 Federally recognized Tribes. This Council gives the IHS Director a highly visible role within the Department on Indian policy where he serves as vice chairperson of the Council.

The Department has also recently completed work ushering through a revised HHS Tribal consultation policy and involving Tribal leaders in the process. This new policy further emphasizes the unique government-to-government relationship between Indian Tribes and the Federal government and assists in improving services to the Indian community through better communications. Consultation may take place at many different levels. To ensure the active participation of Tribes in the development of its budget request, an HHS-wide budget consultation session is held annually. This meeting provides Tribes with an opportunity to meet directly with leadership from all Department agencies and identify their priorities for upcoming program requests. Last year, Tribes identified inflation and population growth as their top budget priorities and IHS's FY 2006 budget request included an increase of $80 million for these items. Both the House and the Senate have included these increases in FY 2006 appropriations action, and we appreciate their efforts in this regard.

Through the Centers for Medicare & Medicaid Services (CMS), a Technical Tribal Advisory Group was established which provides Tribes with a vehicle for communicating concerns and comments to CMS on Medicare, Medicaid and SCHIP policies impacting their members. And,

the IHS has been vigilant about improving outcomes of Indian children and families with diabetes by increasing education and physical activity programs aimed at preventing and addressing the needs of those susceptible to, or struggling with, this potentially disabling disease.

It is clear the Department has not been a passive observer of the health needs of eligible American Indians/Alaska Natives. Yet, we recognize that health disparities among this population do exist and are among some of the highest in the Nation for certain diseases (e.g., alcoholism, tuberculosis, diabetes, and injuries), and that improvements in access to IHS and other Federal and private sector programs will result in improved health status for Indian people.

The IHCIA was enacted to provide basic primary and preventive services in recognition of the Federal government's unique relationship with members of Federally recognized Tribes. Members of Federally recognized Tribes are also eligible for other Federal health programs (such as Medicare, Medicaid and SCHIP), on the same basis as other Americans, and many also receive health care through employer-sponsored or other healthcare coverage.

It is within the context of current law and programs, that we turn out attention to S.1057.

S.1057

We are here today to discuss reauthorization of the IHCIA, and its impact on programs and services provided for in current law. Improving access to healthcare for all eligible American Indians and Alaska Natives is critical to the Department and a priority for all of those involved in

the administration of these important programs. We, therefore, commend your interest and will note positive provisions in S.1057. However, we will also note concern on provisions which may negatively impact our ability to provide needed access to services by establishing program mandates and burdensome requirements that may divert resources from important services. We hope to work with you to address these issues.

The Department brings a keen awareness of the health care needs of Indian country and is supportive of reauthorization of the IHCIA. We support provisions that increase the flexibility of the Department to work with Tribes, to increase the availability of health care, including new approaches to delivering care, and to expand the range of options of health services available to eligible American Indians and Alaska Natives. Accordingly, I commend Congress for including in S. 1057 various changes that respond to concerns raised in previous proposals. Some of these changes go a long way toward improving the ability of the Secretary to effectively manage the program within current budgetary resources.

Moreover, I would like to note our particular interest in other provisions of S. 1057.

In the area of behavioral health, title VII of S. 1057 provides for the needs of Indian women and youth and expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. The Department supports this effort, but opposes language in Sections 704, 706, 711(b) and 712 that requires the establishment or expansion of specific additional services. The Department should be given the flexibility to provide for all Behavioral

Health Programs in a manner that supports the local control and priorities of Tribes, and to address their specific needs within IHS overall budgetary levels.

Provisions Related to Medicare and Medicaid

In general, we believe the provisions of the bill that relate to the Medicaid and State Children's Health Insurance (SCHIP) programs should be considered by the authorizing committees and in a framework consistent with the FY 2006 Budget Resolution and the Reconciliation process. As part of the larger Resolution and Reconciliation process, a Medicaid Commission was established to examine many aspects of that program. The Commission is charged with advising the Secretary on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way. Tribes are represented on the Commission through Secretary Leavitt's recent appointment of the Chair of the Centers for Medicaid and Medicaid Services Tribal Technical Advisory Group.

Reporting Requirements

S.1057 includes new requirements for reporting to Congress within the President's Budget. The IHS and HHS will work with Congress to provide the most complete and relevant information on IHS programs, activities, and performance. However, we recommend striking language that provides additional specificity about what should be included in the President's budget request.

Indian Health Professions Scholarships

Currently, the scholarship program regularly consults with the I/T/U's to determine the

priorities. Each year, the program sends letters to all tribal chairmen, tribal health directors, urban program directors, IHS clinical directors, and IHS headquarters offices. Through this communication, scholarship program staff will update the relevant parties regarding the health professions for which awards were made in the current year and ask for their recommendations for the professions for which awards should be made in the coming year. Recommendations are aggregated and reviewed with the Office of Public Health and the Office of Management Support to determine which professions will be funded for the coming year.

New section 104(a) (2) proposes to allocate the program funding by formula to the twelve IHS areas. If allocation by formula is authorized Indian, students will not be given an opportunity to apply for a scholarship if their area does not receive adequate allocation and if their profession is not considered a priority in their area e.g., dental hygienist, physical therapist, medical technology. This would even impact a medical student who has identified general surgery or general psychiatry as a specialty. They will not receive the scholarship, because it is not a priority or there are no positions available for these disciplines/specialties.

We are concerned that the large areas will receive the greatest amount of appropriated funds, leaving the smaller areas with amounts sufficient to fund only a small portion of their health professional needs. If an area chooses to allocate the funds among the tribes within the area, funds available to many will be insufficient to support even one student.

We recommend retaining the provision in current law which would maintain the national focus

of the scholarship program to more appropriately meet the health professions needs of Indian country.

Diabetes Evaluation and Coordination

The bill has eliminated the current requirement for an evaluation of the 20 model diabetes programs for effectiveness and for each Area to employ at least one diabetes control officer, commonly now known as the Area Diabetes Consultant/Coordinator, to coordinate and manage on a full-time basis activities within the Area Office for the prevention, treatment, and control of diabetes. Area Diabetes Consultants/Coordinators are critical to the ability of the Service to provide support to the local Indian health programs as they implement the Special Diabetes for Indians Program formula and competitive grants programs. The evaluation provision for the model diabetes programs also is important to ensure that this program's effectiveness is assessed to make sure it maintains a productive role in the context of the implementation of the Special Diabetes for Indians Program at the local level. Both the National Diabetes Program and the Tribal Leaders Diabetes Committee (TLDC) have advocated for Area Diabetes Consultant/Coordinators.

We recommend that the requirement to employ at least one diabetes control officer in each of the 12 areas, as well as the requirement to evaluate the effectiveness of services provided through model diabetes projects established under this section, be retained.

Health Care Facilities

Sanitation facilities construction is conducted in 38 States with Federally recognized Tribes who take ownership of the facilities to operate and maintain them once completed. There are 49 hospitals, 247 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics supporting the delivery of health care to Indian people.

Health Care Facilities Needs Assessment & Report

New section 301(d)(1) authorizes Government Accountability Office (GAO) to complete a report, after consultation with Tribes, on the needs for health care facilities construction, including renovation and expansion needs. However, efforts are currently underway to develop a complete description of need similar to what would be required by the bill. The plan is to base our future facilities construction priority system methodology application on a more complete listing of tribal and Federal facilities needs for delivery of health care services funded through the IHS. We will continue to explore with the Tribes less resource intensive means for acquiring and updating the information that would be required in these reports.

We recommend the deletion of the reference to the Government Accountability Office undertaking the report because it would be redundant of and a setback for IHS's current efforts to develop an improved facilities construction methodology. This would allow the IHS to complete its new priority construction methodology which will address the future federal and tribal health facility needs.

Retroactive funding of Joint Venture Construction Projects

New section 311(a)(1) would permit a tribe that has "begun or substantially completed" the process of acquisition of a facility to participate in the Joint Venture Program, regardless of government involvement or lack thereof in the facility acquisition. An agreement implies that all parties have participated in the development of a plan and have arrived at some kind of consensus regarding the actions to be taken. By permitting a tribe that has "begun or substantially completed" the process of acquisition or construction, the proposed provisions could force IHS to commit the government to support already completed actions that have not included the government in the review and approval process. We are concerned that this language could put the government in the position of accepting space that is inefficient or ineffective to operate and recommend that it be deleted.

Sanitation Facilities Deficiency Definitions

New section 302(h)(4) provides definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country, which are ambiguous. As proposed deficiency level III could be interpreted to mean all methods of service delivery (including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home) are adequate to meet the level III requirements and only the operating condition, such as frequent service interruptions, makes that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe it is important to distinguish between the two.

In addition, the definition for deficiency level V and deficiency level IV, though phrased differently, have essentially the same meaning. Level IV should refer to an individual home or community lacking either water or wastewater facilities, whereas, level V should refer to an individual home or community lacking both water and wastewater facilities.

We recommend retaining current law as more appropriate for distinguishing the various levels of deficiencies which determine the allocation of existing resources.

Threshold Criteria for Small Ambulatory Program

New Section 305(b) (1) amends current law to set two minimum thresholds - one for number of patient visits and another for the number of eligible Indians. In order to be eligible under the criteria of S. 1057, a facility must provide at least 150 patient visits annually in a service area with no fewer than 1500 eligible Indians. Aside from the fact that these are both minimum thresholds and so somewhat contradictory, the new makes implementation difficult. First, the IHS cannot validate patient visits unless the applicant participates in the Resource Patient Management System (RPMS). Since some tribes do not participate in the RPMS, it is difficult to ensure a fair evaluation of all applicants. Second, the term "eligible Indians" refers to the census population figures, which cannot be verified, since they are based on the individual's statement regarding ethnicity. In order to make the language clear and equitable, the provision should provide one minimum threshold that can be validated.

New Negotiated Rulemaking and Consultation Requirements

We are concerned about the remaining requirements for negotiated rulemaking and increased requirements for consultation in the bill because of the high cost and staff time associated with this approach. We are committed to our on-going consultation with Tribes and urban Indian organizations under current Executive Orders, as well as promulgating regulations where necessary to carry out IHCIA using the procedures required by Chapter V of title 6, United States Code (commonly known as the Administrative Procedures Act).

We have other objections to S.1057, including, for example: new requirements using "shall" instead of "may" in provisions that will create budget pressures on current program activity; expansion of the scope of Federal Torts Claim Coverage for services provided to otherwise ineligible non-Indians; expansion of authorities for Urban Indian Organizations; elimination of the term "grant" and replacement with the term "funding"; and new provisions that contemplate the Secretary exercising authority through the Service, Tribes and Tribal Organizations which is not tied to agreements entered into under the Indian Self-Determination and Education Assistance Act (ISDEAA). The Administration may also have additional views on this legislation.

I reiterate our commitment to working with you to reauthorize of the Indian Health Care Improvement Act, and the strengthening of Indian health care programs. I hope to work with this Committee and other Committees of the Congress, the National Tribal Steering Committee, and other representatives of Indian country to develop a bill that all stakeholders in these

important programs can support. Again, I appreciate the opportunity to appear before you today to discuss this important legislative proposal. I will be pleased to try to answer any questions that you may have. Thank you.