DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

JOHN J. CALLAHAN

ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

HEARING

ON

S. 2526

THE INDIAN HEALTH CARE IMPROVEMENT ACT
REAUTHORIZATION BILL

July 26, 2000

STATEMENT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON
S. 2526 – TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT
TO REVISE AND EXTEND SUCH ACT

July 26, 2000

Mr. Chairman and Members of the Committee:

Good afternoon, I am pleased to testify today on behalf of the Secretary of the Department of Health and Human Services on this historic legislation, S.2526, the Indian Health Care Improvement Act Reauthorization of 2000. Today, I am accompanied by Dr. Michael Trujillo, Director of the Indian Health Service (HIS), Mr. Michel Lincoln, Deputy Director, Mr. Gary Hartz, Acting Director of the Office of Public Health, and Dr. Craig Vanderwagen, Director, Division of Clinical and Preventive Services, Office of Public Health.

Since Dr. Trujillo last testified before this Committee, the Department has continued to review and analyze this complex and expansive proposal as reflected in S. 2526. The Indian Health Care Improvement Act (IHCIA) was originally enacted in 1976 to provide additional guidance and authority for the programs of the federal government that deliver health services to American Indian/Alaska Natives. The reauthorization of this cornerstone authority provides an opportunity for all of us to revisit the original intent of this legislation, and examine the Act in light of the many changes that have occurred in the health care environment during the past 24 years.

The IHS has the responsibility for the delivery of health services to Federally recognized

American Indian and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (ITU)-operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level, in partnership with the population served. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. And, the Department's responsibility is to uphold the Federal government's obligation to promote healthy AI/AN people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

The Tribal Steering Committee Draft bill, upon which S. 2526 was based, was submitted to Congress by tribes directly and does not necessarily represent the Administration's views on policies. The Tribal and urban Indian health care proposals now contained in this bill recommend the most sweeping changes in the history of the IHCIA. S. 2526 contains recommendations that require careful analysis to determine the full impact of the bill's many recommendations.

In drafting the bill, tribal and urban Indian representatives placed no parameters or limitations on changes that they might consider or recommend for the reauthorization of IHCIA. This bill includes new requirements for IHS by establishing new and expanded authorities, which will increase expectations and place additional pressures on IHS' ability to operate programs within its limited appropriation. We have concerns that these expansions would detract from IHS' ability to carry out its mission of providing basic health care services to AI/ANs. Also, since many of the new provisions convert grants into programs available for tribal Self-Determination contracts and

compacts, the associated Contract Support Costs could increase proportionately. The FY 2001 Budget included a historic $230 million increase for IHS. Even though this is the largest funding increase ever requested, IHS would not be able to implement these expanded authorities.

S. 2526 contains eight (8) titles that encompass most of the health related provisions in the existing IHCIA: Title I, Indian Health, Human Resources and Development; Title II, Health Services; Title III, Facilities; Title IV, Access to Health Services, Title V, Health Services for Urban Indians; Title VI, Organizational Improvements; Title VII, Behavioral Health Programs; and Title VIII, Miscellaneous**.** The Administration is in the process of reviewing the many new provisions proposed in the tribal draft legislation in the context of the President's Budget. We are not prepared today to provide the Committee with a formal position on this expansive legislation without completing a thorough review. We will share with you today our views to date on some of the provisions contained in S.2526.

Title I – Indian Health, Human Resources and Development

The purpose of this title is to ensure that Indian health programs have an adequate supply of trained professionals able to provide culturally appropriate care. In order to achieve this goal, Title I includes provisions for the education and training of health care professionals. Many provisions in the existing statute are proposed to be amended to accommodate the rapid pace of change in the health fields in future years. We note that Sec. 105 – Indian Health Professions - combines two separate scholarship programs into one section. Under the existing statute, Sec. 104 contains the Indian Health Service Scholarship Program and Sec. 120 contains the Matching Grants program. These two programs are separate in their administration and we would

recommend they remain separate in the reauthorization of this provision.

Title II: Health Services

A number of provisions in Title II of the bill will assist in our efforts to reduce unnecessary disease and injury and raise Indian health to the highest possible level. There are many health care priorities in Indian Country, but effective prevention and treatment of diabetes and its related complications must rank among the highest. Sec. 204 of the bill would institutionalize the progress we are making with the diabetes program funded under the Balanced Budget Act of 1997, by establishing an ongoing national program within the IHCIA. This would be comparable to the President's proposal to amend the diabetes program in the Balanced Budget Act to continue funding for this important program. Sec. 212 would update and expand our tuberculosis program to focus more broadly on all communicable and infectious diseases.

Section 224(a) clarifies that patients receiving contract health services (CHS) authorized by the Service will not be liable for payment of charges or costs associated with provision of those services. This protection, together with additional protections in Title IV, would provide greater peace of mind for Indian patients who worry about dunning letters and damage to their credit because of CHS provider attempts to recover payments from them as well as from the Service.

Title III: Facilities

Sec. 301(a)(2) provides for newly constructed or renovated facilities, whenever practicable, to meet the construction standards of any nationally recognized accrediting bodies, not just JCAHO. This provision recognizes the expanding number of accrediting bodies; however, the Secretary

does not recognize all of them for the various provider types they accredit. Because it appears as though the intent is to assure that construction and renovation funds maximize the likelihood of the facility being able to collect Medicare and Medicaid payments, it may be more appropriate to revise this provision of the bill to reflect that intent.

S. 2526 greatly expands agency program reporting requirements. We have general concerns about the overall reporting burden placed on IHS because it could require the diversion of resources from other much needed programs, including patient care, facility maintenance and other critical areas of the IHS programs. In addition, of concern is the new provision in Sec. 301(c) that would require the Secretary to report annually on the needs for health care facilities construction, including the renovation and expansion needs of existing facilities. While the first year report to Congress does not require consultation with Tribes, IHS would need to develop a baseline description of existing facilities and determine the need based on existing programs, facility conditions, facility efficiency and other factors.

Section 303(b) eliminates applicability of Davis Bacon wage rates for construction of Indian Health Service facilities. The Administration has significant concerns about this provision. The Administration is firmly committed to maintaining the important worker protections provided by the Davis-Bacon Act which applies to workers employed by contractors and subcontractors performing on Federal or Federally-assisted construction projects.

Sec. 310 provides new authority for joint ventures between IHS and Tribes as an alternative to the long wait on the IHS facilities construction priority list. This proposed authority could assist

the IHS and Tribal health programs in meeting the construction needs of facilities, which average 30 years of age, and maintenance and repair of many of the facilities in Indian country.

Before moving ahead on any new Joint Venture projects in the future, IHS will need to examine the following issues: a) find a way to integrate and prioritize joint ventures with the IHS Facilities Construction Priority Lists; b) ensure that long term costs associated with staffing and operations are consistent with IHS standards for providing health care facilities and services to Federally Recognized American Indians and Alaska Natives can be accommodated by future funding levels; and, c) assure the funding committed to Joint Venture projects addresses priority needs for health care facilities and the delivery of health care services with the highest relative need.

Title IV: Access to Health Services and Conforming Amendments to the Social Security Act

In many respects, the changes in Title IV are the most far-reaching changes in the bill, both for the IHCIA and for the Social Security Act. We currently do not have cost estimates for this bill. In addition, we have not thoroughly assessed every provision for administrative feasibility and consistency with the President's Budget. I will highlight some provisions in this title.

Many of the changes in Title IV and conforming amendments to the Social Security Act focus on provider payment issues. Previous amendments to the IHCIA and the Social Security Act allow I/T/Us to bill Medicare and Medicaid in certain, limited ways and were intended to provide access to additional funds to supplement, not replace the IHS appropriation. Since those earlier amendments, both the general health system and Indian health have changed dramatically.

It is important to remember that there are fundamental differences between public health programs like IHS and many other HHS health programs, and health insurance programs like Medicare and Medicaid. Public health programs generally have limited funds, but they have broad discretion on how those funds may be used. Exactly the opposite is the case with Medicare and Medicaid, which are health insurance programs that guarantee payment with unlimited Federal funds, but place their limits on both the type of benefits and the categories of individuals for which those funds can pay. It is not surprising that IHS and HCFA programs, starting with such basic differences, have developed some incompatibilities.

Title II, sec. 203 adds a number of detailed provisions for a new provider type called a Qualified Indian Health Program (QIHP), for I/T/Us that want to participate in Medicare and Medicaid. The QIHP provisions contain a number of exceptions to the usual coverage, payment, and other rules for those programs. While creation of an Indian-specific provider type could address problems Indian providers face, the proposed QIHP is extremely complex and would present a number of difficulties in its administration.

Similarly, sec. 423 sets out a series of managed care payment rules and exceptions which may have unintended adverse consequences. In a growing number of States, health is dominated by managed care. Exempting Indian health from such systems could leave Indian providers and their patients without access to the significant advantages of increased benefits and care coordination common to such managed care systems. A simpler and more effective approach needs to be developed to address these issues.

Some proposed solutions in the bill are broader than necessary to address the underlying problems. For example-we understand that some people have read the current Emergency Medical Treatment and Active Labor Act (EMTALA) to require that Indian clinics transport emergency patients to their parent hospital even when an appropriate transfer to a closer hospital is warranted. As HCFA stated in its recent regulation concerning provider-based status, HCFA does not actually read EMTALA this way. We believe the problem could be addressed by some targeted technical assistance to Indian facilities on their responsibilities under EMTALA. In any case, it is unnecessary and perhaps unwise to exempt Indian clinics from the very important EMTALA patient protections, as Title II, sec. 202(e) proposes.

We have concerns with several other provisions in Title IV, including the following issues.

100% Reimbursement to States

Several provisions of the bill would extend the 100% Federal matching rate to States for

additional Medicaid and SCHIP services to AI/ANs. This would increase Federal program and related administrative costs.

Requirement on Medicare to reimburse for all non facility-based services

This provision would require Medicare to reimburse for all non facility-based services (e.g., home health, community-based care, ambulance services, physicians, DME, lab) provided by IHS providers. Currently, the Medicare statute requires HCFA to reimburse IHS for facility-based services (e.g., hospitals and SNFs). This would add significant new costs to the Medicare

program.

Improving Access of Indian Beneficiaries to Medicare, Medicaid, and SCHIP

Sec. 419 proposes to waive Medicaid and SCHIP premiums and Medicare, Medicaid, and SCHIP cost sharing. The Administration is on record supporting waiver of premiums and cost sharing for Indian beneficiaries in SCHIP. The Medicare late enrollment penalty is necessary for an insurance program like Medicare to avoid the negative economic consequences of "adverse selection" where individuals do not enroll or pay premiums until they are ill with costly health conditions. A statutory waiver of the Medicare late enrollment penalty, therefore, is undesirable and unnecessary given administrative actions, and provisions elsewhere in the bill, that will encourage low-income Indian elders and persons with disabilities to enroll in Medicaid, which will pay Medicare premiums for them.

Consultation

Many sections of S. 2526 have tribal consultation requirements. We are concerned that these added responsibilities would stretch our resources at the expense of other programmatic responsibilities. Tribal consultation has been an important priority for this Administration. In HHS, we appreciate the value of consultation and are increasingly involved with Tribes in this process. However, we have some concerns about the specific manner in which Section 414(a) of S. 2526 would require consultation to occur. This provision requires consultation**,** as defined in Executive Order 13084 of May 14, 1998, to be held with Indian Health Service, Tribes and Urban Indian Health Programs (I/T/U's) prior to HCFA adopting *any* policy or regulation. Similar language in section 514 requires all Health and Human Services agencies to consult with urban

Indian organizations prior to taking any action, or approving any action of a state, that may affect urban Indians or urban Indian organizations. While we value meaningful consultation on matters relevant to tribes and ITU providers, we believe these sections of the bill could be improved by providing for a process that more specifically identifies regulations and policies relevant to Tribes, I/T/U providers and urban Indians. In addition, reference to a particular Executive Order may be impractical if it is superseded or rescinded. It may be more effective to use language in the current Department of Health and Human Services (HHS) consultation policy.

Negotiated Rule Making

HHS agencies have had first-hand experience with the positive contributions of negotiated rule making. Section 553 of 5 U.S.C. Negotiated Rule Making, lists factors to be considered in determining whether or not to use the negotiated rule making procedure. These factors include: a limited number of identifiable interests that will be significantly affected by the rule as well as reasonable likelihood that a committee can be convened with a balanced representation of persons who are willing to negotiate in good faith to reach agreement by consensus on the proposed rule within a fixed period of time. Where such factors are present, negotiated rule making can be very helpful in structuring a process through which relevant stakeholders participate constructively in developing a recommended rule. However, S. 2526 would require negotiated rule making in many of its provisions. For example, Section 414 (b) would require HCFA to use the negotiated rule making for the development of all regulations to implement provisions contained in Title IV that would amend the Social Security Act, and section 802 would require the Secretary to use negotiated rule making for all regulations to implement this Act.

Negotiated rule making is very resource intensive for both Federal and non-Federal participants, and may not be the most effective way to obtain necessary I/T/U provider input in the development IHCIA rules and regulations. We would recommend instead utilizing the consultation to identify areas in the reauthorization legislation where the negotiated rule making process would be appropriate for the development of regulations.

Additionally, Section 802(b) of the bill limits membership on negotiated rule making committees to Federal and Tribal representatives. For committees to implement provisions related to Medicare, Medicaid and State Children's Health Insurance Program (SCHIP), it would be important to include representatives of State agencies charged with implementing these programs, as well as other key provider and beneficiary interests. This would increase opportunities for Tribal and other Indian representatives to build consensus and support in the development of final rules to implement the bill's various provisions.

Other General Comments

In a number of sections in the bill, for example Section 103(a), the word "grant" is stricken and replaced by "make funds available." Deleting the word "grant raises" the concern that the Department's regulations at 45 CFR might not apply to any funding agreements under this bill. We suggest using the term "grant" where appropriate throughout the bill.

There are also several sections, for example section 516(a), where the Secretary is directed to pay for services that are not presently provided. In the absence of additional appropriations, complying with these provisions would require funding reductions for existing services that are

no less necessary. We suggest that any requirement for the provision of new services be subject to the availability of appropriations.

We have not had an opportunity to field cross-agency concerns over many exemptions for tribes, tribal organizations, and urban organizations on broader long-standing Federal policies, including the Davis-Bacon Act, the Buy American Act, Section 117 of the Internal Revenue Code of 1986, the Federal Reports Elimination Act of 1998, and the Anti-Deficiency Act.

Title V: Health Services for Urban Indians

Title V authorizes the IHS to assist in meeting the health care needs of American Indians and Alaska Natives living in urban areas. Currently, urban Indian health programs serve approximately 149,000 urban Indians in 34 cities through the country. We estimate that over 350,000 urban Indians are eligible for services. With a few exceptions, funding authority for urban Indian health is specifically limited to Title IV and Title V. All other references to urban Indian health found in the other titles of the bill address areas such as consultation, rule making planning or reporting only.

S. 2526 would streamline the process for contracting and making grants to urban Indian organizations. While we support a streamlined process for contracting and grant making, we do have concerns with the elimination of certain criteria in the existing statute in S. 2526. In the existing IHCIA, Sec. 503 of Title V requires that the urban organization successfully undertake certain activities as a condition to entering into a contract with IHS for the provision of health care and referral services for urban Indians residing in the particular urban center. The elimination

of these criteria would be appropriate for on-going urban Indian contractors, but for new contractors, it would be important to retain those requirements as conditions for awarding a contract or grant.

Title V also contains new authority for the establishment of an Urban Indian Health Care Facility Revolving Loan Fund to provide guaranteed loans to urban Indian health contractors and grant recipients for construction, renovation, expansion, or purchase of health care facilities. In addition, Title V authorizes the extension of Federal Tort Claims Act coverage for urban Indian health programs. These new provisions could assist urban Indian health programs, however, they would require additional resources and we would need to assess how these new provisions fit into the Administration's priorities for Indian health.

Title VI: Organizational Improvements

Sec. 601(a)(2) provides for the elevation of the Director of the IHS to Assistant Secretary for Indian Health. The Administration has presented testimony before this committee in support of S. 299, the stand-alone bill that contains the identical provisions of Sec. 601. We believe this provision would provide a stronger coordination and advocacy role in budget and policy matter related to Indian health.

In addition, Sec. 602 (d) would authorize the Secretary, acting through the Assistant Secretary for Indian Health to enter into contracts, agreements, and joint ventures with other Federal agencies, States, and private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities. The Administration promotes the

partnership and collaboration with our sister Federal agencies in a variety of areas related to Indian health in order to maximize our resources and involvement with other Federal programs in the provision of health related services to AI/ANs.

Title VII: Behavioral Health Programs

Title VII includes many sections that were transferred from Title II, Health Services, in the existing IHCIA. This title includes major revisions, specifically to integrate Alcohol and Substance Abuse provisions with Mental Health and Social Service authorities. Where appropriate, the term tribes, tribal organizations and Indian organizations are referenced in addition to IHS.

A broad range of behavioral health services is described under "continuum of care." Several related sections were moved from Title VIII in the existing IHCIA, including the section related to Fetal Alcohol Syndrome and Child Sexual Abuse. Demonstration programs were eliminated and replaced with language authorizing programs for Indian tribes and tribal organizations. A new section would authorize the establishment of at least one inpatient psychiatric treatment facility per IHS Area. These new centers would be funded on a similar basis as the Regional Youth Treatment Centers authorized in the existing IHCIA We are concerned about the feasibility of establishing at least one inpatient psychiatric treatment facility per Area. The cost could be prohibitive and there could be difficulties in recruiting and retaining specialized staff, as well as the complexities of starting a new provider type.

Title VIII: Miscellaneous

Section 813 would deem tribal contractors and compactors as ordering agents of the Indian Health Service. We recommend that this language be revised to be consistent with the language in H.R. 1167 that authorizes tribal access to Federal sources of supply only for the purposes of carrying out an agreement under the Indian Self-Determination and Education Act.

This title establishes a National Bi-Partisan Commission on Indian Health Care Entitlement. This commission would be comprised of members of Congress, Tribal leaders, and Urban Indian health leaders to study the desirability and feasibility of making Indian health an entitlement. While many Tribal leaders and Indian people believe that the provision of health care to them should be a legal entitlement, there are many questions regarding the ramifications, including the costs, of such an entitlement.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to discuss the reauthorization of the Indian Health Care Improvement Act. We will continue to analyze the implications of this expansive legislation and will be happy to work with the committee and the Indian Health Care National Tribal Steering Committee to address the Administration's concerns. As we move into the new millennium, we must acknowledge and fulfill the long overdue obligation to advance the health status of Indian people to the highest possible level. We will be happy to answer any questions that you may have.