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Senate Committee on Indian Affairs
Hearing on the
REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

Washington, D.C.
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Written Statement of the Indian Health Service
by
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Mr. Chairman and Members of the Committee:

Good morning, I am Dr. Charles Grim, Interim Director of the Indian Health Service (IHS). Today, I am accompanied by 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. We are pleased to have this opportunity to testify on behalf of Secretary Thompson on S.556, the "Indian Health Care Improvement Act Reauthorization of 2003." And, at the Committee's request, I will report on the Secretary's One-Department Initiative as it impacts the IHS and the President's FY 04 budget proposal to consolidate automated information systems in the Department.

The IHS has the responsibility for the delivery of health services to more than 1.6 million Federally-recognized American Indians and Alaska Natives (AI/ANs) through a system of IHS, tribal, and urban (I/T/U) 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 AI/ANs 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 obligation 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 pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives (AI/ANs): The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), Public Law 94-437. 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 provided the authority for the programs of the Federal government that deliver health services to Indian people, but the IHCIA also provided additional guidance in several areas. The IHCIA contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities focused on health services for urban Indian people and addressed the construction, replacement, and repair of health care facilities.

This is an unofficial copy of Dr. Grim's written statement submitted for the record of the Senate Committee on Indian Affairs hearing of April 2, 2003, in Washington, D.C., on the Reauthorization of the Indian Health Care Improvement Act. The official copy of the written statement is contained in the Congressional Record of the hearing. Refer to Dr. Grim's oral statement for additional testimony information.

We are here today to discuss reauthorization of the IHCIA and tribal recommendations for change to the existing IHCIA in the context of the many changes that have occurred in our country's health care environment since the law was first enacted in 1976. S.556 reflects the product of an extensive tribal consultation process that took two full years and resulted in a tribally drafted reauthorization bill. The IHS staff provided technical assistance and support to the Indian tribes and urban Indian health programs through this lengthy consultation.

The Department supports the purposes of S.556 to improve the health status of AI/AN people and to raise health status the highest possible level. We do, however, continue to have concerns, as expressed previously to the Committee in the Secretary's September 27, 2001, report on S.212, regarding a number of provisions in that bill. As introduced, S.556 is identical to S.212. There are several provisions in S.556 that are inconsistent with current Medicare and Medicaid provider payment practices and could inappropriately increase costs. For example:

- Title II, Section 202, which describe a new provider type called a Qualified Indian Health Provider (QIHP**)** and Sections 212 and 221 regarding extension of the 100% Federal matching rate for Medicaid and SCHIP. These sections are further discussed below in the statement.
- In addition, Section 419 proposes to exempt patients eligible for Medicare or Medicaid from standard cost-sharing requirements such as deductibles, co-payments, and premiums. We have no concern with the current exception for Indian children exempt from premiums and co-pays in the SCHIP program.

The Department also reported in the staff analysis of its September 27, 2001, bill report some concerns with the managed care provisions in Section 423 which limits appropriate cost and utilization incentives in Medicare and Medicaid by potentially undermining capitated payments in managed care settings.

The Administration is seriously concerned about these provisions, which undermine standard practices in Medicare and Medicaid. The most pressing concerns were outlined in the Secretary's September report which I will present to you today: 1) the Qualified Indian Health Program (QIHP); 2) negotiated rule making; and, 3) extension of 100% Federal matching rate for Medicaid and SCHIP.

While the Administration continues to have serious concerns about S.556 in its current form, we are committed to working with the Committee on legislation to reauthorize this important cornerstone authority for the provision of health care to American Indians and Alaska Natives.

Qualified Indian Health Program (QIHP)

The bill would amend the Medicare statute to add various detailed provisions for a new provider type called a Qualified Indian Health Provider (QIHP) for I/T/U providers participating in the Medicare and Medicaid programs. The most problematic aspects of QIHP are the structure and operation of the payment provisions, which are not only burdensome but, more importantly, would not be feasible to administer. QIHP would require the Federal government to complete a series of complex payment computations for each I/T/U provider, for each payment period, (including rates and adjustments not available to any other provider) to identify the provider type for each that yields the highest payment amount for that period. However, such computations could only be made after services are provided, when it is too late for the providers to have known or complied with the differing conditions of participation applicable to differing provider types. In addition to the burden and feasibility issues, on a more fundamental level, this "full cost plus other costs" QIHP payment approach would be contrary to the way that Medicare generally pays providers. Moreover, it would impose disproportionately higher costs on a program that is approaching insolvency. Extending such a payment approach to Medicaid and SCHIP would raise similarly serious administrative and budgetary concerns.

Negotiated Rule Making; Tribal Consultation; Administrative Burdens

We are concerned that S. 556 would appear to broadly mandate use of negotiated rule making to develop all regulations to implement the IHCIA. Negotiated rule making is very resource-intensive for both Federal and non-Federal participants. It can be effective in appropriate circumstances, but may not be the most effective way to obtain necessary Indian

provider input in the development of IHCIA rules and regulations in a given case.

Additionally, while we appreciate the value of consultation with Tribes, we have concerns about the consultation requirements. The bill would require Tribal consultation prior to the Centers for Medicare & Medicaid Services (CMS) adopting any policy or regulation, as well as require all HHS agencies to consult with urban Indian organizations prior to taking any action, or approving any action of a State, that may affect such organizations or urban Indians. Such requirements appear to be broader than the existing Tribal consultation requirement and would be very difficult to administer, given the hundreds of regulations and policies potentially covered.

We have similar concerns about the considerable indirect adverse impact of S.556's extensive reporting requirements and other administrative burdens on IHS and CMS that would divert limited resources from other activities. One example is the proposed requirement for a detailed annual report on health care facilities construction needs and the survey of facilities it would entail. As IHS programs and both IHS and CMS administrative functions are funded by capped discretionary accounts, the imposition of additional administrative duties on IHS and CMS would have the practical effect of requiring cutbacks in current activities.

Extension of 100% Federal matching rate for Medicaid and SCHIP

We also are concerned that the bill would extend the 100% Federal matching rate to States for Medicaid and State Children's Health Insurance Program (SCHIP) services (currently applicable to such services provided through an IHS facility) to other services provided to AI/ANs, including those furnished by non-Indian health care providers. This proposed change would substantially increase Federal program and administrative costs, with no guarantee and little likelihood of any more services for Indian beneficiaries or better payments for Indian providers.

As we continue our thorough review of this far-reaching, complex legislation, we may have further comments. However, we wish to reiterate our strong commitment to reauthorization and improvement of the Indian health care programs. We will be happy to work with the Committee, the National Tribal Steering Committee, and other representatives of the American Indian and Alaska Native communities to develop a bill fully acceptable to all stakeholders in these important programs.

One-Department Initiative

In addition to our expressed concerns with S.556, I will now present an explanation of the Secretary's One-Department initiative and its benefit to the IHS.

The Secretary's One Department Initiative has been of great benefit to the IHS as well as the Native American constituents of the Department. The fundamental premise of this initiative is that the Department of Health and Human Services must speak with one, consistent voice. Nothing is more important to our success as a department. With regard to our tribal constituents the Secretary observed on his first trip to Indian Country that tribal programs were often "stove piped" and that there existed within HHS an assumption that the IHS had sole responsibility for the health issues facing tribes. In the two short years since the Secretary launched this initiative he has reestablished the Intradepartmental Council for Native American Affairs. The membership of this Council is comprised of the heads of all the HHS Operating and Staff Division with the IHS Director serving as the Vice-Chair. This Council serves as an advisory body to the Secretary and has the responsibility to assure that Indian policy is implemented across all Divisions. The Council provides the Secretary with policy guidance and budget formulation recommendations that span all Divisions of HHS. A profound impact of this Council on the IHS is the revised premise within HHS that all Agencies bear responsibility for the government's responsibility and obligation to the Native people of this country.

In addition to the Council the Secretary and Deputy Secretary have traveled widely to Indian Country with their senior staff. These trips have raised the awareness of tribal issues and have contributed greatly to our capacity to speak with one voice on behalf of tribes.

An example of a tangible benefit to the IHS is the FY '04 President's budget request for IHS of $20 million for Sanitation Facilities Program. An evaluation of the program justified an increase in the FY '04 budget for the program's most needy homes. This increase was also a result of the Secretary's visit to Alaska with his senior staff in 2002. They observed the critical need for safe drinking water and sanitation

facilities in Indian Country and acted decisively to increase the IHS budget request.

The One Department Initiative can be directly credited for this step forward for the Native people of this nation.

FY '04 Information Technology Consolidation

Also, I would like to address the Committee's request for information on the FY '04 President's budget proposal to consolidate automated information systems in the Department.

The FY '04 President's Budget for the IHS includes funding to support Departmental efforts to improve the HHS Information Technology Enterprise Infrastructure. The request includes funds to support an enterprise approach to investing in key information technology infrastructure such as security and network modernization.

These investments will enable IHS programs to carry out their missions more securely and at a lower cost. Agency funds will be combined with resources in the IT Security and Innovation Fund to promote collaboration in planning and project management and to achieve common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software.

The IHS budget request includes savings in the IT Budget from ongoing IT consolidation efforts and additional reduced spending through the streamlining or elimination of lower priority projects. As a result, the FY '04 IHS budget request proposes a decrease in spending for information technology below the FY '03 level of $9,282,000. This decrease is the result of IT savings associated with the creation of "one HHS" from the Department's disparate organization units and more efficient and effective management of the base HHS information technology system. Consolidation of IT resources will yield savings necessary to support program requirements.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act and other issues. We will be happy to answer any questions that you may have.