

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS AND

THE HOUSE RESOURCES COMMITTEE,

OFFICE OF NATIVE AMERICAN AND INSULAR AFFAIRS

ON S. 556, A BILL TO REAUTHORIZE THE INDIAN HEALTH CARE
IMPROVEMENT ACT AND H.R. 2440, INDIAN HEALTH CARE IMPROVEMENT
ACT AMENDMENTS OF 2003

July 16, 2003

STATEMENT OF THE INDIAN HEALTH SERVICE
HEARING ON THE
REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

July 16, 2003

Mr. Chairmen and Members of the Committees:

Good morning, I am Dr. Charles Grim, Interim Director of the Indian Health Service (IHS). Today, I am accompanied by Mr. Gary Hartz, Acting Director of the Office of Public Health; Dr. Richard Olson, Acting Director, Division of Clinical and Preventive Services, Office of Public Health; and Rae Snyder, Acting Director of the Urban Health Office. 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 discuss the health disparities, Indian health facilities and urban Indian health concerns.

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), P.L.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.

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. IHS staff provided technical assistance and support to the Indian Tribes and urban Indian health programs through this lengthy consultation. However, we recognize that our programs overlap and have implications for other Federal agencies and their programs, and we are working with them to develop a comprehensive Administration position on this legislation.

Health Disparities

While the mortality rates of Indian people have improved dramatically over the past ten years, Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population:

- C Alcoholism – 770% higher
- C Diabetes – 420% higher
- C Accidents – 280% higher
- C Suicide – 190% higher
- C Homicide – 210% higher

Those statistics are startling, yet they are so often repeated that some view them as insurmountable facts. But every one of them is influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates, and even eliminating them, can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices.

A primary area of focus that I have identified based on these statistics is a renewed emphasis on health promotion and disease prevention. I believe this will be our strongest front in our ongoing battle to eliminate health disparities plaguing our people for far too long. Although we have long been an organization that emphasizes prevention, I am calling on the Agency to undertake a major revitalization of its public health efforts in health promotion and disease prevention. Both field and tribal participation in the initial stages of planning and implementation is critical.

Fortunately, the incidence and prevalence of many infectious diseases, once the leading cause of death and disability among American Indians and Alaska Natives, have dramatically decreased due to increased medical care and public health efforts that included massive vaccination and sanitation facilities construction programs. Unfortunately, as the population lives longer and adopts more of a western diet and sedentary lifestyle, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population with the increasing rates of cardiovascular disease, Hepatitis C virus, and diabetes.

Cardiovascular disease is now the leading cause of mortality among Indian people, with a

rising rate that is significantly higher than that of the U.S. general population. This is a health disparity rate that the President, the Secretary of Health and Human Services, and the IHS are committed to eliminating. The IHS is working with other HHS programs, including the Centers for Disease Control and Prevention and the National Institutes of Health's National Heart Lung and Blood Institute, to develop a Native American Cardiovascular Disease Prevention Program. Also contributing to the effort is the IHS Diabetes Program, the IHS Disease Prevention Task Force, and the American Heart Association. The primary focus is on the development of more effective prevention programs for AI/AN communities. The IHS has also begun several programs to encourage employees and our tribal and urban Indian health program partners to lose weight and exercise, such as "Walk the Talk" and "Take Charge Challenge" programs.

Diabetes mortality rates have been increasing at almost epidemic proportions. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world. The incidence of type 2 diabetes is rising faster among American Indians and Alaska Native children and young adults than in any other ethnic population, and is 2.6 times the national average. As diabetes develops at younger ages, so do related complications such as blindness, amputations, and end stage renal disease. Today I want to report to you that we may be seeing a change in this pattern however. In CY 2000 we have observed for the first time ever a decline in mortality. I must note that this is preliminary mortality data that needs to be thoroughly examined.

What is most distressing however about these statistics is that type 2 diabetes is largely preventable. Lifestyle changes, such as changes in diet, exercise patterns, and weight can significantly reduce the chances of developing type 2 diabetes. Focusing on prevention not only reduces the disease burden for a suffering population, but also lessens and sometimes eliminates the need for costly treatment options. The cost-effectiveness of a preventative approach to diabetes management is an important consideration, since the cost of caring of diabetes patients is staggering. Managed care estimates for treating diabetics range from \$5000-\$9000 per year. Since the Indian health system currently cares for approximately 100,000 people with diagnosed diabetes, this comes out to a conservative estimate of \$500 million just to treat this one condition.

Another area of concern is in behavioral health, specifically the identification and treatment of depression and strategies for prevention of depression. A recent study from Washington University in St. Louis has revealed that untreated depression doubles the risk for chronic diseases like diabetes and cardiovascular disease, not to mention the risks for alcoholism, suicide, and other violent events. This study also showed that of those individuals with chronic disease, unrecognized and untreated depression doubles the risk for complications of the chronic disease (e.g., amputations and renal disease in diabetics). We must find the best practices that will allow us to prevent depression primarily, or at the least recognize and treat it early if we are to reduce the disparities that affect Indian communities.

In summary, preventing disease and injury is a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute

care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. This is the path we must follow if we are to reduce and eliminated the disparities in health that so clearly affect AI/AN people.

Health Care Facilities

Title III authorizes the Facilities programs which construct, renovate, maintain, and improve facilities where Indian health services are provided. Sanitation facilities construction is conducted in 38 States with Federally recognized Tribes where ownership of the facilities is turned over to the Tribes to operate and maintain them once completed. The IHS health care facilities program including the tribal programs, specifically, is responsible for managing and maintaining the largest inventory of real property in the Department of Health and Human Services, with over 9 million square feet (850 gross square meters) of space. There are 49 hospitals, 231 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics which support the delivery of health care to our people. These facilities authorizations put in place the foundation on which health care delivery is provided to American Indians and Alaska Natives.

Health Care Facilities Needs Assessment & Report

Proposed provisions in the IH CIA reauthorization bills require IHS to report annually, after consultation with Tribes, on the needs for health care facilities construction, including the renovation and expansion needs. In fact, efforts are currently underway to develop a complete description of need similar to what would be required by the Bill. While not all the resource issues have been resolved, the process is in progress and 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.

Using Sanitation Facilities Construction Funds to Serve HUD Homes

Section 302(b)(3)(C) specifically proposes that IHS sanitation facilities construction funds will not be used to support service of sanitation facilities to Department of Housing and Urban Development (HUD) homes. The IHS is concerned that homes constructed using HUD funds include the necessary infrastructure to make a home complete, including safe water and sewer and wastewater disposal.

As you know, the Administration is actively reviewing S. 556 and will provide you with specific details of our analysis very shortly. We are committed to working with Tribes and other agencies to ensure that adequate facilities are planned for and funded in

conjunction with new home construction, and we appreciate HUD's and other Federal agencies' willingness to work with us in this regard.

Classifying Long Term Leases as Operating Leases

Proposed provisions of the bills would make it possible to classify a lease for health care space as an operating lease and allow for long term leases for space (capital leases) to be scored against the budget in the first year of the lease. The intent of the proposed section is to make it possible for Tribes to acquire a facility and enter into a long term lease with the Government without having the full cost of the lease scored against a single year's budget. While this may make it possible for Tribes to more easily acquire needed space to house health care services, there is concern that leasing capital space in this manner will commit future Congresses and Administrations to funding without the opportunity for review.

Retroactive funding of Joint Venture Construction Projects

Changes proposed by the bills 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 been party to 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 and/or ineffective to operate.

Sanitation Facilities Deficiency Definitions

Proposed new language in the bills, which provides definitions of sanitation deficiencies used to identify and prioritize water and sewer projects in Indian Country, is ambiguous. As written deficiency level III could be interpreted to mean all methods of service delivery are adequate to level III requirements (including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home) and only the operating condition, for example frequent service interruptions, make that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe that there should be a distinction.

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.

Tribal Management of Federally-owned Quarters

The bills reiterate authorization already provided in the Indian Self Determination and Education Act (P.L.93-638, as amended). We are concerned that slight differences in wording in the two bills either as written or in amendments could cause confusion. We believe that this proposed addition of unnecessary language should be deleted.

Threshold Criteria for Small Ambulatory Program

The Small Ambulatory Care Facility section contains proposed language that limits participation in the Small Ambulatory Program to facilities that provide more than 500 visits to eligible users and that provide ambulatory care in a service area with a population of more than 1,500 eligible Indians. These criteria are both lower limits and would apply to many facilities including all large health centers, most of which also qualify for priority evaluation and possible funding under Section 301 of the two bills. We are concerned that some facilities that meet these criteria may be of a lower priority than those on the Priority List submitted to Congress and could receive construction funding before higher priority construction needs. We do, however, see a need for a Small Ambulatory Program that addresses the needs Tribes with smaller facilities that do not meet the threshold to compete for placement on the Section 301 Priority Lists. For that reason we recommend that this section set an upper threshold criterion of 4,400 primary care provider visits for participation in the Small Ambulatory Program. The lower limit should be 500 primary care provider visits. The Small Ambulatory Program is to address the needs of small tribal facilities that are not competitive under the Section 301 Priority System because of their size.

Urban Indian Health

The Title V of the IHCA provides specific authority focused on the provision of health services for urban Indian people with funds appropriated to IHS. IHS currently funds 34 urban Indian programs nationally and these programs provide a range of services in three broad categories: comprehensive clinical programs; limited clinical programs; and outreach and referral programs.

In addition to the 34 urban Indian health programs currently in operation, the Congress has also authorized and funded the Oklahoma City Clinic and Tulsa Clinic Demonstration Programs. Both the Oklahoma City Indian Clinic and the Tulsa Indian Clinic (now the Indian Health Care Resource Center of Tulsa) were established in the early 1970's to serve the health and social needs of the urban Indian populations of Oklahoma. With the passage of the Indian Health Care Improvement Act in September 1976, these two programs were funded by the Indian Health Service (IHS) under Title V of that law as urban programs.

In 1978, the entire State of Oklahoma was designated as a Contract Health Service Delivery Area (CHSDA) by regulation (42CFR 36.22(a) (3)). As a statewide CHSDA Indian beneficiaries could reside anywhere in the state and maintain their eligibility for

both direct services and contract health services. As a result of this change, the Oklahoma Indian population count for services was inclusive of all Indians residing in the state and counted as IHS beneficiaries in the IHS calculation for resource requirements and allocations.

The 1992 amendments to IHClA provided for the establishment of two demonstration projects with the Tulsa and Oklahoma City clinics, "to be treated as service units in the allocation of resources and coordination of care." In establishing these demonstration projects Congress undertook a new and innovative approach to ensuring health services were accessible to all eligible populations in Oklahoma.

These demonstration projects have now established a "hybrid" system within the IHS and have a unique status. The projects are not operated strictly as an IHS facility or tribal contracted or compacted program or an urban program. Each program maintains its status under the Title V as an "urban Indian organization." Contracts are signed by the projects with the IHS, under Title V and the Buy Indian Act authority, yet the programs function like other IHS service units and report on the Resources and Patient Management System of the IHS with data utilized for inclusion in the allocation of resources. This unique status has allowed for a substantive increase in funds to the projects from the IHS based upon workload data and increases derived from substantial line-item funding increases directed by Congress in fiscal year 1994 addressing facility problems at each site. Both service population and overall utilization of services has dramatically increased since these programs became demonstration projects and as a result of the line item funds. They have been able to use the best of both urban and IHS structures to build a community controlled, high quality health system in a state designated as a contract health service delivery area.

On the other hand this hybrid system has raised a few concerns with some Oklahoma Tribes that operate their own health programs under the Indian Self Determination and Education Assistance Act, P. L. 93-638, as amended. The issue in most basic terms is allocation of resources for tribally administered services and urban provided services for closely located beneficiary populations. In an environment of resources reduced by a growing population and greater health need, the perception of a unique or special status may cause more concern than has been observed in the past.

While the challenges for the urban Indian health programs are many, they are much the same as those faced by the Tribes and the federal operations. Our work is to assure that we all are working to fulfill our roles in the I/T/U partnership and in collaboration to raise the health status of our Indian people.

Negotiated Rule Making; Tribal Consultation; Administrative Burdens

While the Administration continues to have serious concerns about the proposed bills in their current forms, we are committed to working with the Committees on legislation to reauthorize this important cornerstone authority for the provision of health care to American Indians and Alaska Natives.

We are concerned that both bills would appear to broadly mandate use of negotiated rule making to develop all regulations to implement the IHCA. 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 IHCA 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 bills 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 the proposed new extensive reporting requirements and other administrative burdens on IHS and CMS would divert limited resources from other activities. 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.

As we continue our thorough review of this far-reaching, complex legislation, we may have further comments on other provisions, particularly in Title IV. 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 Committees, 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.

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.