

STATEMENT  
BEFORE THE  
U.S. SENATE  
COMMITTEE ON INDIAN AFFAIRS

TOMMY G. THOMPSON  
SECRETARY  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JULY 21, 2004

Good afternoon, Mr. Chairman, Senator Inouye and members of the Committee. 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 is Dr. Charles Grim, Director of the Indian Health Service (IHS). This landmark legislation forms the backbone of the system through which numerous Federal health programs serve American Indians and Alaska Natives (AI/ANs) and encourages participation of eligible AI/ANs in these programs. Legislation pending before this Committee and over in the House has been given the highest degree of consideration by the Department. My staff has worked tirelessly to respond to this Committee's and the House Resource Committee's request for our views on H.R.2440. I am pleased to share with you today the result of our efforts to improve services provided by the Indian Health Service, Tribes, Tribal Organizations, Alaska Native Villages and Urban Health Programs.

As Secretary of the Department of Health and Human Services (HHS), it has been my goal to improve coordination to the maximum extent possible among the operating and staff divisions at the Department and to encourage collaboration between the Department and Tribes on the many programs impacting their members. As you know, upon my arrival at HHS, I reactivated the Intradepartmental Council on Native American Affairs (ICNAA) to provide a consistent HHS policy when working with the more than 560 Federally recognized Tribes.

I am also proud of the many achievements over that past three years in the areas of access, consultation, collaboration, organization, education, sanitation facilities construction and Medicare reform. And, I have traveled widely to Indian country over the past three years and

visited with Tribes from the Chippewa Indians and Oglala Sioux Tribe, to Alaska Native Villages including Point Hope and Kwethluk. I just arrived back from a visit with the Navajo Nation and will return again to Alaska later this month to meet with Native leaders in Anchorage and representatives of Southeast Alaska Rural Health Consortium in Juneau. Through my travels, I have recognized the need for improvements in facilities that provide the base from which so many health care needs are met. In this area, I would like to work closely with Congress to continue to address this need.

### ***HHS Accomplishments***

The Department has improved Tribal access to HHS resources in both appropriated funding as well as to non-earmarked funds and increases in discretionary set asides. Between FY 2001 and FY 2003, HHS resources provided to Tribes or expended for the benefit of Tribes increased from \$3.9 billion in 2001 to \$4.4 billion in 2003. This reflects an 11% increase in access to HHS funding for Tribes during just a two-year period.

In response to Tribal leader comments at the regional Tribal consultation session, we have honored many requests including:

- Establishing a Center for Medicare and Medicaid Services (CMS) -Technical Tribal Advisory Group (TTAG), which held its first formal meeting at the Department on February 10, 2004;
- Revising the existing HHS Tribal consultation policy and involving Tribal leaders in this process;

- Helping to bridge tribal/state relations for HHS programs administered through States: HHS, the National Congress of American Indians (NCAI) and the American Public Human Services Association (APHSA) have now entered into a Federal /State/Tribal collaborative project to work together on health and human services provided to Indian Tribes and Native organizations. HHS is forming a workgroup to focus on key areas of priorities identified by Tribes (TANF, Child Welfare, Information Systems, etc.);
- Improving outcomes of Indian children and families with Diabetes by increasing education and physical activity programs; and,
- Recommending that funding be increased for the IHS Sanitation Facilities Construction (SFC): The President's FY 2005 Budget request for IHS includes an increase of \$10 million for SFC.

Moreover, I am pleased that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), passed by Congress last year, included two provisions identified by Indian health programs as high priorities. First, the MMA allows Indian health programs to use Medicare's bargaining power when purchasing care from Medicare participating hospitals for their non-Medicare patients, thus stretching contract health and Urban Indian health funding further. Second, the MMA allows IHS and Tribal hospitals and clinics to bill for additional Medicare Part B services for the period 2005-2008. Finally, we are pleased that the MMA includes special provisions designed to help assure that pharmacies operated by Indian health programs, as well as other pharmacies, can participate in the temporary drug discount card and the permanent Part D drug benefit programs.

### *HHS Views and Comments*

The Department is strongly committed to the reauthorization of the IHCIA during this Congress in order to improve the health status of American Indian people and to increase the availability of health services for them. We believe that reauthorizing legislation should provide increased flexibility to enable the Department to work with Tribes to improve the quality of health care for American Indian people, to better empower the Tribes to provide quality health care, to increase the availability of health care, including new approaches to delivering care, and to expand the scope of health services available to eligible American Indians and Alaska Natives.

Accordingly, I commend Congress for including in H.R. 2440 various changes that respond to concerns raised in our September 27, 2001 bill report to the Senate Committee on Indian Affairs on S. 212, a similar IHCIA reauthorization bill in the 107<sup>th</sup> Congress. Moreover, I would like to note our particular interest in, and support for, certain provisions of H.R. 2440. I am impressed with the strengthening of provisions in all program areas including:

- 1) improving recruitment and retention of qualified providers, which are the foundation upon which all services are provided by the IHS, Tribes and Tribal Organizations and Urban Health Programs (ITUs);
- 2) providing for improved health services to eligible Indians;
- 3) exempting Indians from cost sharing in the Medicaid and SCHIP programs, consistent with our current treatment of eligible Indian children under SCHIP; and,
- 4) expanding behavioral health programs to provide for much needed prevention and

treatment in the areas of child sexual abuse, family violence, mental health, and other problems.

In addition, we believe that H.R. 2440, by proposing to protect eligible Indians from cost-sharing under the Medicaid and SCHIP programs, reflects the unique government-to-government relationship of the United States to Federally-recognized Indian Tribes. We would support such a proposal as consistent with current HHS policy to exempt eligible Indian children in SCHIP from premiums and cost-sharing. The proposed policy on cost-sharing would go far toward addressing the continuing underenrollment of eligible Indian individuals and families in Medicaid.

In the area of behavioral health, H.R.2440 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 we recommend you permit the Secretary the flexibility to provide for these important programs in a manner that supports the local control and priorities of Tribes to address their specific need.

The Department does have concerns about provisions affecting the Medicare statute. Given the magnitude of the changes and new programs required by the recently enacted MMA and the challenges in implementing these changes by the statutory deadlines, we do not believe it is feasible to make additional modifications to Medicare at this time. We also have concerns about provisions impacting the Medicare trust funds, which, as you know, face significant

financial challenges in the future. Finally, we have several serious concerns about the impact of H.R. 2440 on the Medicaid and SCHIP programs. Specifically, we do not believe that requiring access to unused SCHIP allotments is appropriate because it would set a precedent within SCHIP of prioritizing a population that is already eligible for services under current law, within a fixed amount of funds.

Additionally, the Department is concerned with several provisions included in the bill related to consultation requirements. H.R. 2440 proposes requirements for Federal agencies to consult with Federally-recognized Indian Tribes and Tribal organizations into statute. As exemplified by the successful outcomes of the Department's consultative process with the Tribes, the Administration remains strongly committed to consultation with Tribes as provided in Presidential Executive Order 13175. Furthermore, consultation with Tribes is provided for in the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA). We, therefore, recommend striking all language regarding consultation requirements.

I reiterate our strong commitment to reauthorization and improvement of Indian health care programs, and 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. To this end, my staff will be communicating with your staff in the near future to share additional comments and suggestions regarding reauthorization.