

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT
OF
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ASSISTANT SURGEON GENERAL, DIRECTOR
INDIAN HEALTH SERVICE
BEFORE THE
UNITED STATES HOUSE
COMMITTEE ON NATURAL RESOURCES
ON
THE REAUTHORIZATION OF
THE INDIAN HEALTH CARE IMPROVEMENT ACT

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Statement of the Indian Health Service
on the Reauthorization of the Indian Health Care Improvement Act

Mr. Chairman and Members of the Committee:

Good Morning. I am Dr. Charles W. Grim, Director of the Indian Health Service. Today I am accompanied by Mr. Robert McSwain, Deputy Director of the IHS, Mr. Gary Hartz, Director, Environmental Health and Engineering, and Dr. Richard Olson, Director, Office of Clinical and Preventive Services. We are pleased to have the opportunity to testify on the reauthorization of the Indian Health Care Improvement Act.

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 Indians/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 governed by 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 duty 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, Congress has substantially expanded the statutory authority for programs and activities in order 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's vice chairperson is the IHS Director, giving us a highly visible role within the Department on Indian policy.

In January of 2005 the Department completed work ushering through a revised HHS Tribal consultation policy and involving Tribal leaders in the process. This 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 the Department's 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. For FY 2008, Tribes identified population growth and increases in the cost of providing health care as their top budget priorities and IHS's FY 2008 budget request included an increase of \$88 million for these items.

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 for 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. In addition, a Tribal Leaders Diabetes Committee continues to meet several times a year at the direction of the IHS Director to review information on the progress of the Special Diabetes Program for Indians activities and to provide general recommendations to IHS.

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, cardiovascular disease, 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 IHCA was enacted to provide primary and preventive services in recognition of the Federal government's unique relationship with members of Federally recognized Tribes. Members of Federally recognized Tribes and their descendants 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 our attention to reauthorization of the "Indian Health Care Improvement Act."

Reauthorization

We are here today to discuss reauthorization of the IHCIA, and its impact on programs and services provided for in current law. In December of 2006, the Department submitted to the Senate Indian Affairs Committee comments on proposed legislation under consideration by the 109th Congress (S.1057). Those comments also reflected concerns in the House bill (H.R.5312) and are the basis for our testimony today. Any changes introduced by the bill under review in the 110th Congress (H.R.1328) will be considered once we have had an opportunity to fully review the newly introduced legislation. Improving access to healthcare for all eligible American Indians and Alaska Natives is a priority for all those involved in the administration of the IHS program. We have worked with this Committee in the past and we have made progress in moving toward a program supportive of existing authority while maintaining the Secretary's flexibility to effectively manage the IHS program. However, in the last bill, H.R. 5312, there continued to be provisions which could negatively impact our ability to provide needed access to services. Such provisions established program mandates and burdensome requirements that could, or would, divert resources from important services. To the extent that those provisions are included in the new legislation, we hope to work with you to continue to address these concerns.

The Department is supportive of reauthorization of the IHCIA and supports provisions that maintain or increase the Secretary's flexibility to work with Tribes, and to increase the availability of health care. Committee leadership previously responded to some concerns raised about certain provisions and some of the changes went a long way toward improving the Secretary's ability to effectively manage the program within current budgetary resources.

I would like to note for you today our particular interest in provisions previously reported out of this Committee.

Overarching Concerns

We have a number of general objections to previous language, including, expanded requirements for negotiated rulemaking and consultation; new requirements using "shall" instead of "may"; use of the term "funding" in place of "grant"; expansion of authorities for Urban Indian Organizations; new permissive authorities; provisions governing traditional health care practices; new reporting requirements; establishment of the Bipartisan Commission on Indian Health Care; 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). In addition, we noted concerns in previous language about modifying current law with respect to Medicaid and the State Children's Health Insurance Program (SCHIP) and, in some cases, we believe maintaining the current structure of Medicaid and the State Children's Health Insurance Program (SCHIP) preserves access, delivery, efficiency, and quality of services to American Indians.

We also have some more specific comments on proposals we have previously reviewed for comment.

In the area of behavioral health, proposed title VII provisions provided 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.

Reporting Requirements

The last version of H.R. 5312 that we reviewed contained various new requirements for reporting to Congress, including requirements for specific information to be included within the President's Budget and a new annual report to Congress by the Centers for Medicare & Medicaid Services and the IHS on Indians served by Social Security Act health benefit programs. The IHS, CMS, and HHS will work with Congress to provide the most complete and relevant information on IHS programs, activities, and performance and other Indian health matters. However, we recommend striking language that requires additional specificity about what should be included in the President's budget request and new requirements for annual reports.

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. IHS and Tribes operate 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

One provision in last year's bill, section 301(d) (1), required 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 have been required by the bill. The IHS 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.

Retroactive funding of Joint Venture Construction Projects

In last year's bill, section 311(a)(1) would permit a tribe that has "begun but not completed" the process of acquisition or construction of a facility to participate in the Joint Venture Program,

regardless of government involvement or lack thereof in the facility acquisition. A Joint Venture Program 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. We, therefore, would oppose such a provision.

Sanitation Facilities Deficiency Definitions

Another section 302(h) (4) would provide ambiguous definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country. As previously 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 to distinguish the various levels of deficiencies which determine the allocation of existing resources.

Threshold Criteria for Small Ambulatory Program

Yet another Section 305(b) (1) would amend current law to set two minimum thresholds for the Small Ambulatory Program - one for number of patient visits and another for the number of eligible Indians. In order to be eligible for the Small Ambulatory Program under the previously proposed criteria, 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 proposed provisions would make 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.

New Negotiated Rulemaking and Consultation Requirements

In addition, we are concerned about the 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 under current Executive Orders, as well as using the authority of Chapter V of title 5, United States Code (commonly known as the Administrative Procedures Act) to promulgate regulations where necessary to carry out IHCIA.

The comments expressed today in this testimony do not represent a comprehensive list of our current concerns. And, we will be reviewing H.R.1328 for any provisions that might be addressed in the future.

I reiterate our commitment to working with you to reauthorize the Indian Health Care Improvement Act, and the strengthening of Indian health care programs. And we will continue to work with the Committee, other Committees of Congress, and 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 reauthorization of the “Indian Health Care Improvement Act” and I will answer any questions that you may have at this time. Thank you.