NATIONAL INDIAN HEALTH BOARD

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Statement of H. Sally Smith, Chairman

National Indian Health Board

Oversight Hearing on

American Indian and Alaska Native Health

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Senate Russell Building, Room 485

Chairman McCain, Vice-Chairman Dorgan, and distinguished members of the Senate Indian Affairs Committee, I am H. Sally Smith, Chairman of the National Indian Health Board (NIHB). I am Yupik from Alaska and also represent the Bristol Bay Area Health Corporation in southwestern Alaska. On behalf of NIHB, it is an honor and pleasure to provide a broad overview of health needs, in terms of access to care, health disparities and public health issues, throughout Indian Country.

The NIHB serves Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives, as well as upholding the federal government's trust responsibility to American Indian and Alaska Native Tribal governments. We strive to advance both the level and quality of health care and the adequacy of funding for health services that are operated by the Indian Health Service (IHS), programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their area.

Historical and Current Context

On September 11, 2001, the United States changed forever. We always knew the threats of terrorist attacks were real and looming, but as a nation we did not collectively confront the issue and make necessary, sweeping changes until after the events of September 11 occurred. We are now facing a similar dilemma in

Indian Country. Nowhere is the need for urgent action more poignantly articulated than in the tragedy that recently occurred on the Red Lake Reservation. It has left Indian Country with a heavy heart. However, it also brought to light the collective resolve and ability of American Indian and Alaska Native communities to respond to tragedy in a supportive and awe-inspiring manner. Tribes all across this nation quietly delivered support and aid to the Red Lake community. And while we all recognize that this type of violence and tragedy can happen anywhere, we must learn that unanswered need can foster unimaginable tragedy. As a part of surveying the status of the health care delivery system in Indian Country, it is clear that we cannot afford to allow the behavioral and mental health infrastructure crisis in Indian Country to continue, unaddressed.

Similarly, across Indian Country the crisis in health care is well documented and well known to both policy makers and the Indian Communities for which they are tasked with addressing basic human health care need and assuring access to adequate health care services. For example, several times before today, we have testified that the United States invests nearly twice the funds for the health care of a federal prisoner as it does or an American Indian or Alaska Native. We have testified that the life expectancy of AIs/ANs is nearly six years less than any other race or ethnic group in America. We have demonstrated that 13 percent of AI/AN deaths occur in those younger than 25, a rate three times higher than the average US population. The US Commission on Civil Rights reported in 2003 that "American Indian youths are twice as likely to commit suicide…Native Americans are 630 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental death compared with other groups." None of this information is new and the statistics have not worsened since 2003. Despite this, the health care disparities in Indian Country remain. The Red Lake tragedy should serve as a decisive indicator, like the canary in the mine shaft, that the health care crisis in Indian Country is real, tangible and, left unanswered, capable of tragedy. Today, let us begin again and do as the great Lakota leader, Sitting Bull, said: "Let us put our minds together and see what life we can make for our children."

Health Promotion/Disease Prevention Issues and Needs of Indian Country

In Indian country, we recognize we have a public health epidemic. As stated, our disease and mortality rates are higher than the rest of the U.S. population. We live on the average six years less than our fellow Americans. Our youth are more likely to commit suicide. Rates of cardiovascular disease among American Indians and Alaska Natives are twice the amount for the general public, and continue to

increase, while rates for the general public are actually decreasing. The prevalence of diabetes in our communities as we have come to rely on Western foods instead of our traditional diets is causing us to lose vital community members at earlier ages.

There is a growing body of empirical evidence in the Americas, as well as across Europe, Asia and other continents, that very clearly demonstrates the effectiveness of prevention. Prevention works. It's much easier and less costly to prevent disease, disability, injury, and premature death than to treat poor health conditions once present. But all too often, too many communities are left behind, and suffer from very poor health status. Today we will also share with you some compelling stories about pockets of documented progress and success stories. Despite these successes and progress, Native Americans continue bear some of the highest disease burdens of any society on earth.

According to the Indian Health Service (IHS), life expectancy of American Indians and Alaska Natives is 70.6 years compared to the U.S. population of 76.5 years, and the vast majority of illnesses and deaths are from diseases and conditions that are preventable. Despite America's vast resources, these inequities in health status continue to increase. We have already provided a statistical snapshot of just a few of these disparities. In addition, the prevalence of obesity in Native populations has increased dramatically over the past 30 years and obesity is a risk factor for diabetes that now affects over one quarter of the adult Indian population. About 40 percent of Native children are overweight and the number of Indian people with diabetes has doubled in the past five years.

Clearly, these statistics are staggering. Our young people across this great are crying out. Their cries are heard in these statistics. All of us at the National Indian Health Board are deeply saddened by the tragedy at Red Lake Chippewa Nation. We stand in unity with the entire Red Lake community and offer our deepest sympathy to Tribal members and all of those impacted. Such deeply unfortunate events give witness to nationwide statistics that demonstrate the tremendous need to increase our prevention efforts. While history shows that shootings can occur in any community, the significant disparities in available prevention funding are contributing to a growing epidemic; American Indians and Alaska Natives suffer from 70 percent higher suicide and more than double homicide rates, compared with non-Indian populations. Suicidal and violent behavior in our young people is an indicator of a larger problem related to the looming mental health crisis America faces. In fact, according the Substance Abuse and Mental Health

Services Administration, American Indians and Alaska Natives have the highest prevalence of severe mental illness of any racial or ethnic group in the nation.[i] The research study clearly documents the co-occurrence of serious mental illness and substance abuse disorders. So incidents like Red Lake, albeit sad, should be no surprise to us. Deeper budget cuts promulgated by poor public policy will simply exacerbate these challenges. We are facing a crisis of enormous proportions.

As we enter the 21st century, America remains the World's only sustained superpower. Yet, it is not among the industrialized nations' top ten for protecting and promoting the public's health. Recent data show the U.S. ranked 24th (down from 19th in 1989) among industrialized nations in infant mortality, the single most common public health indicator.[ii] We have all learned that poverty and other social and economic pressures are known contributors to the entire U.S. population's health status. According to a 2002 paper by the National Association of County and City Health Officials, entitled "Creating Health Equity through Social Justice," the "inequalities in health status in the U.S. are large, persistent, and increasing. Research documents that poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic status are the major risk factors for ill health and health inequalities. Great social costs arise from these inequities, including threats to economic development, democracy, and the social health of the nation." Certainly, this is the situation we currently face in Indian country."[iii]

Certainly we have made some advances. Where we do see progress in health indicators, what makes the difference? Resources make the difference. But, not resources alone; rather, those specifically targeted to population health improvements work. According to the Institute of Medicine, public health practice is what "…we as a society do collectively to assure the conditions in which people can be healthy." Every one of us in this room benefited this morning from a strong public health system, or prevention infrastructure. It may be invisible to many of us, but think about it. When you awoke this morning, you probably showered, and brushed your teeth. You had running water. Water that is tested continually to be sure it is safe for human ingestion. Prevention capacity is not about medical care, but it targets entire populations and is extremely cost effective.

There is also a growing body of evidence that clearly shows the benefits of what The Robert Wood Johnson Foundation calls *Active Living by Design*. This impacts not only structures, but also the culture of entire communities. Research shows that children excel in these environments, and are less likely to abuse drugs, to

miss school, to loose sleep, and consequently, they perform better in school. Tribes are no strangers to this knowledge; many Tribes are building their own Wellness Centers. But these efforts require resources, training, and support, and too many communities cannot afford the buildings, staff, and equipment because all available funds are going to treat disease, injuries, substance abuse, and other health problems that are easily prevented.

The health disparities movement in the U.S. and abroad has helped shed light on these dramatic inequities in health status. While we know a great deal about these disparities, little action has been taken to address the inequity in available prevention capacity for all communities and governments. To fulfill its important leadership role in Indian country, NIHB hopes to change this by working with Congress, the US Department of Health and Human Services (DHHS), private partners, Area Indian Health Boards, and Tribes to strengthen their ability to protect and improve health.

However, little is known about the capacity for preventing disease and reducing mortality throughout Indian country. By leveraging IHS shares, other public sources, and private revenues, many Tribal governments make substantial contributions to prevention investments, but these investments are not to scale in order to address adequately the need for an improved prevention infrastructure. Tribes are increasingly developing ideas on new programs, services, capacities, and approaches needed to help improve the health of Indian country. Additionally, Indian country is learning about changes in communities that impact, both positively or negatively, the health of Native populations. But these programs are grossly under funded, and, relative to state and county governments, Tribes do not benefit equally from federal and state resources intended for public good.

According to the Institute of Medicine, the U.S. spends approximately $1.62 trillion dollars annually for medical care costs, and approximately 2 percent of these funds, or $32 billion dollars, are spent on prevention capacity. These funds are leveraged to strengthen public health capacity in counties, cities and states in areas of communications, disease surveillance, reporting, rapid response and mobilization, workforce development and training, and information technology. Indian communities have been largely overlooked despite our growing populations and health challenges. Indian country is going to experience our population health status falling even further behind if we do not take bold action to build our own culturally appropriate approaches to address health at a population level. Relative to our county and state counterparts, the prevention infrastructure available to

Tribes is sorely lacking in capacity. I appeal to Congress to earmark prevention dollars so that collectively we can build a more equitable prevention infrastructure throughout Indian country.

With decreasing public funds at state and county levels, Tribal public health agencies will be increasingly overlooked for funding opportunities made available by the DHHS agencies as well as numerous philanthropic organizations that specialize in improving health and quality of life for all peoples. Congressionally earmarked funding for states with AI/A populations living within state borders often fails to reach Tribes[iv], and state legislatures are increasingly pressured to divert tobacco settlement and other funds previously allotted for public health programs to building and maintaining roads and other basic services.

There are bright spots, and in some areas, DHHS agencies have made progress in ensuring Tribal government eligibility to compete for funding opportunities. Many Tribes recognize and appreciate this progress, but ensuring all public resources are equally available to Tribal governments and organizations and that application processes appropriately accommodate population health status needs of Indian country requires significantly more improvement. NIHB is working closely with new partners to ensure these improvements occur.

Public Health Workforce

Tribes face significant challenges with respect to preparing and sustaining a well-trained public health workforce. Using a virtual training center framework, NIHB is working with CDC and other partners to increase the number of American Indians/Alaska Natives in public health careers. Historically, we all know IHS is grossly under-funded to provide resources dedicated to direct primary, secondary, and tertiary health care services, leaving little resources for prevention activities. But we must assure that every community has access to the basic building blocks of public health systems, including assessment and epidemiologic capacity, a trained workforce, strong emergency preparedness systems, communications infrastructure, and program implementation capacity to improve health status. These capacities will enable Tribes to advance chronic disease prevention and health promotion, HIV/AIDS, STD and TB prevention, diabetes, injury prevention and control, non-ceremonial tobacco use, and nutrition, physical activity, obesity, etc. We also need to build strong partnerships outside of the health systems to address the myriad social factors such as a high unemployment rates that cause the poor health status of American Indian/Alaska Native populations. These functions require new partnership approaches outside the realm of health organizations, and

access to training and technical expertise. Despite the challenges inherent in such an undertaking, it is within our reach if we work together on developing national policy and funding that supports such innovation.

Additionally, rising health care costs coupled with the growing AI/AN population, the prevention investments are not keeping pace need. And in Indian Country, investments remain drastically behind county and city expenditures. We must act now to put better prevention systems in place. These funds can be wisely allocated to support comprehensive public health service delivery systems operated by Tribal Public Health Departments and Wellness Centers that can recruit and train staff in:

- establishment of Tribal public health departments and wellness centers
- community health assessment systems, which require trained epidemiologists
- communicable disease management systems (STDs, etc.)
- preventive health screening services (cardiovascular screening programs, etc.)
- occupational safety/injury prevention programs
- healthy worksite initiatives
- parent education programs
- substance abuse prevention (tobacco, alcohol, methamphetamines, and other drugs)
- domestic violence prevention
- suicide prevention
- teen health promotion
- restaurant and facility inspections, and animal/livestock control, which requires trained sanitarians

These capacities will enable Tribes to advance chronic disease prevention and health promotion efforts targeting HIV/AIDS, STD and TB prevention, diabetes, injury prevention and control, non-ceremonial tobacco use, cancer, fetal alcohol syndrome, and nutrition, physical activity, obesity, and other critical ingredients needed to grow and sustain healthy communities.

American Indians and Alaska Natives have rich cultural histories grounded in community harmony and well-being. Since 1978, through Public Law (P.L.) 93-638 programs, we have seen that facilitating culturally appropriate interventions through local control of delivery systems can produce powerful outcomes. An important element that must not be overlooked in helping our communities create

health is the importance of our traditional medicine. This is a great source of strength for our people. More recently, with the Federal government no longer outlawing the practice of our traditional beliefs and customs, there has been a widespread awareness and an increased desire to resume cultural practices. For many communities, the practice of traditional Tribal medicine and spiritual ceremony may be an important component of the overall approach to achieving good health and eliminating disease. The prevention and intervention concepts embedded in traditional ceremonies (such as sweat lodge and other ceremonies) reinforce and strengthen the family and community. Using the Native cultural approach addresses the concern that many Indian youth are growing up having never been exposed to the beliefs of their ancestors that coming into adolescence with increased experience, and knowledge of their culture may help in the self-identity process.

To address the impending shortage of public health workers nationwide, in March 2005, Senator Hagel introduced a Bill to "amend the Public Health Service Act to establish a scholarship and loan repayment program for public health preparedness workforce development to eliminate critical public health preparedness workforce shortages in Federal, State, local, and tribal public health agencies." NIHB is working with Senator Hagel's staff to ensure Tribal eligibility is clearly stated in the Bill, and we greatly appreciate this opportunity. As currently drafted, the Bill would require the Secretary to provide direct funding only to states, who would then have discretion over the engagement of Tribes: "The head of the State or local office that receives a grant under subsection (a) shall be responsible for contracting and operating the loan repayment program under the grant." Tribal governments work closely with state governments on a variety of programs. But history clearly shows that funding Tribes directly results in better outcomes. The federal government has a long history of funding Tribes, and through P.L. 93-638, Tribes have demonstrated success in operating effective, efficient, and culturally-relevant programs. Enticing our young people to the pursue careers in public health is important work, and will be 100 percent more effective if leadership from Tribal governments and organizations are stewards of this recruitment. Funding only the states and not the Tribes for loan repayment programs will predictably diminish the likelihood that Native American students will pursue public health careers.

Many things change, but an old adage still holds: *an ounce of prevention is worth a pound of cure*. It's time we made the same investments in prevention delivery systems. Relative to county and state counterparts, the prevention infrastructure available to Tribes is sorely lacking in capacity. It's time we worked together to

change this scenario. Science has taught us that prevention works. I am confident that we are all here today because we believe in the power of democracy. When it comes to public health, disease has no borders. America is only as healthy as our least healthy communities. I am urging Congress to work with Indian Country to create policy and provide funding that strengthens our prevention capacity. Let this be our legacy for tomorrow's children.

Contract Support Costs

In light of the recent United States Supreme Court in the Cherokee Nation and Shoshone Paiute Tribes of the Duck Valley Reservation Contract Support Costs case, it is an appropriate invest time in taking a hard look at the amount of funding appropriated each year for Tribal governments that elect to operate their own health care delivery systems through compacting/contracting with the Indian Health Service (IHS). The Court ruled unanimously in favor of the Tribes, requiring the Federal Government to pay money damages for failing to pay contract support costs to these tribes for Fiscal Years 1994 through 1997.

This funding is critical to supporting tribal efforts to develop the administrative infrastructure gravely necessary to successfully operate IHS programs. An increase in Contract Support Costs is necessary because as Tribal governments continue to assume control of new programs, services, functions, and activities under Self-Determination and Self-Governance, the costs associated with those responsibilities increase. Tribal programs have clearly increased the quality and level of services in their health systems fairly significantly over federally operated programs. Failure to adequately fund Contract Support Costs is defeating the very programs that appear to be helping improve health conditions for American Indians and Alaska Natives. Inadequate funding requires Tribes to scale back services and programs in order to cover the necessary administrative costs under the contract/compact.

We strongly urge reconsideration of this line item in the proposed budget. As Tribes increasingly turn to new Self Determination contracts or Self Governance compacts, or as they expand the services they have contracted or compacted, funding necessary to adequately support these functions will exceed the proposed budgeted amount. We ask you to fund contract support costs at a level that is adequate to meet the needs of the Tribes and to further the important Trust responsibility charged to the federal government. Specifically, NIHB recommends an additional $100 million to meet the shortfall for current contracting and compacting; further, we recommend that funds additional to this increase be sufficient to support 20-25 new Tribal programs anticipated this Fiscal Year.

Department of Health and Human Services Tribal Consultation Policy

As one of his final actions as Secretary of Health and Human Services (HHS), on January 14, 2005, Secretary Tommy G. Thompson signed the U.S. Department of Health and Human Services - Tribal Consultation Policy. His signature concluded several months of hard work by the Tribal Consultation Policy Revision Workgroup (TCPRW), the Office of Intergovernmental Affairs, and federal participants from the various operating and staff divisions of the Department.

With the continued support of HHS Secretary Michael Leavitt, the policy will prove to be a valuable tool to institutionalize Tribal consultation throughout the Department. More importantly, it will provide the foundation for American Indian and Alaska Native Tribal governments to solidify working relationships with all operating divisions within the Department, which has previously not occurred. In the coming years, we look forward to increasing access to resources available at agencies in addition to those received from the Indian Health Service.

Health Facility Construction

The FY 2006 budget request includes a staggering decrease in excess of $85 million for health care facilities construction (HCFC), leaving only $3.32 million in the entire health care facilities budget. The remaining funds will be used for the construction of staff quarters at Fort Belknap, Montana. While the facilities at Fort Belknap are sorely needed, the rest of Indian country has equally critical facility construction needs.

This section of the budget includes construction of new facilities, such as inpatient hospitals, outpatient hospitals, staff quarters for health professionals, regional treatment centers and joint venture construction programs. It also includes the small ambulatory program and the construction of dental facilities. These elements constitute the entire physical infrastructure of the health care delivery system in American Indian and Alaska Native communities. The President's budget proposes a desire to institute a "one year pause in new health care facilities construction starts in order to focus resources on fully staffing facilities that have been constructed and are opening in Fiscal Years 05 and 06." While the goal of achieving full staffing in American Indian and Alaska Native clinics and hospitals is commendable, and one we support, disease processes and illnesses do not take a "pause." Funding to provide adequate facilities to address disease and illness for Native Peoples cannot afford to take a "pause." Stalling health care construction for one year, if it indeed is only for one year, will achieve a setback from which it

will take Indian Country a decade to recover. Additionally, the Program Assessment Rating Tool (PART) for FY 2006 measured the IHS HCFC program as "effective," which is an indication that the HCFC program is an efficient use of federal resources, in other words, it works. The Indian Health Service has taken many steps to operate in an efficient manner and cutting programs that utilize federal dollars responsibly serves as a disincentive.

Diabetes

The July 2003 United States Commission on Office of Civil Rights report, A Quiet Crisis, found that American Indians and Alaska Natives have the highest prevalence of Type 2 diabetes in the world, and rates are increasing at "almost epidemic proportions." Type 2 diabetes is largely preventable and can be managed with healthy eating, physical activity, oral medication, and/or injected insulin.

The leading cause of mortality for American Indians and Alaska Natives is heart disease. However, hidden in that statistic is the fact that the largest percentage of deaths from heart disease is caused by diabetes. Thus, diabetes is both devastating the community in terms of quality of life and "maiming and killing" American Indians and Alaska Natives.

Another startling fact regarding the prevalence of Type 2 diabetes is that it has recently become a significant threat to American Indian and Alaska Native children. Its incidence is rising faster among AI/AN children and young adults than any other ethnic population.

The Special Diabetes Program for Indians is growing into a success story. It's developing a community spirit and Tribal governments and communities are working together in a proactive approach to combat diabetes. The recently-submitted report on the Special Diabetes Program for Indians to Congress shares many of the advancements Indian Country has made in the areas of: Increased prevention activities; Increased treatment; Integrated prevention and treatment activities in culturally appropriate methods and by a multidisciplinary approach; Improved Data; Information Sharing and Best Practices; Utilizing Tribal Consultation; and Developing partnerships with the non-Indian community to combat diabetes.

The Special Diabetes Program is currently funded at $150 million annually through FY 2008. Congress and IHS worked with Tribal Leaders to make this program possible and we stand committed to seeing it permanently authorized and made a permanent fixture in American Indian and Alaska Native Communities.

Government Performance and Results Act (GPRA) and the Program Assessment Rating Tool (PART)

The Government Performance and Results Act (GPRA) addresses an array of concerns regarding government accountability and performance. The Indian Health Service and related programs have embraced the performance measures and have made vast improvements in several areas.

Here are a few success stories.

Whiteriver Service Unit

In 2001, the WRSU (Whiteriver Service Unit) of the Indian Health Service made a commitment to improving pneumococcal vaccination rates in persons aged 65 years or older. Additional funds were procured to improve data quality and carry out a campaign to vaccinate those who had not yet been vaccinated. According to GPRA analysis, the WRSU pneumococcal vaccination rate in American Indians 65 years or older increased from 58% in 2001 to 77% in 2002, 88% in 2003, and is presently at 93.4% for the first quarter of 2004. WRSU has met the pneumococcal vaccination rate goals set by IHS, Healthy People 2000 and Healthy People 2010. Additionally, this service unit met the Healthy People 2010 overarching goal of eliminating disparity for pneumococcal vaccination in this American Indian community. WRSU appears to have the highest community pneumococcal vaccination rate among IHS facilities or any state/territory of the United States.

Influenza vaccination is another success story. Using a multi-disciplinary approach, WRSU has increased influenza vaccination rates among those 65 years or older from 51% in 2001, to 60% in 2002, 74% in 2003, and 81.5% for the first quarter of 2004 by GPRA analysis. Again, WRSU has met IHS and Healthy People 2000 influenza vaccination rate goals for persons over 65 years, and has met the Healthy People 2010 goal of eliminating disparity for influenza vaccination rates in this American Indian community.

WRSU has improved rates in 15 of 17 indicators reported for the first quarter of 2004, and is presently evaluating the use of 12 additional Health Plan Employer Data and Information Set (HEDIS) or developmental indicators for upcoming reports.

Colville Service Unit

Colville is an excellent example of an overall success. Previously, they had met only 1 of the 7 GPRA indicators. The Colville Chief Executive Officer noticed the poor performance indicators and pledged to make GPRA clinical indicators a priority. He enlisted the help and guidance of a locally developed clinical quality team. Each member of the team (which included representatives from each section of the clinic) was involved in developing appropriate ways to highlight and improve indicators. Their success stemmed his leadership, as well as the involvement of the entire staff. By the end of that year, they had met 6/7 of their indicators.

The intended purpose of the Program Assessment Rating Tool (PART), developed by the Office of Management and Budget (OMB) is to evaluate programs and link performance to appropriations. The Indian Health Service has been an active participant and has scored very well, especially in comparison to other federal agencies. The question consistently raised by Tribal leadership is why does the Indian Health Service continue to be under funded, despite scoring well according to OMB criteria? The answer provided by OMB when confronted with such a question is that while PART is a tool that measures performance, it is not the only criteria utilized to determine appropriations. While Tribal leadership does not dispute such a response, we feel strongly that effective and cost efficient programs should be maintained and properly funded in order to carry out the essential functions of government.

The Hidden Epidemic: Dental Health Care for Alaska Natives

The combination of Alaska Native populations doubling since 1970, the dearth of dental health care providers in Alaska and the number of Alaska Native children suffering from tooth decay at 2 1/2 times the national rate, there is an epidemic of tooth disease and decay in Alaska Native villages. While most mainland Americans have no idea that this crisis is occurring, this epidemic is not really hidden; rather, it is unveiled with every smile that reveals missing or decayed teeth in the mouths of Alaska Natives of all ages.

In 1991, a dental manpower study was conducted in Alaska. The study concluded that if the IHS/Tribal health system doubled the number of dentists in Alaska**, it would take 10 years to eliminate the unmet need for dental services**. Despite this modest recommendation, there have been no funding increases to pursue this effort, nor has the dental community provided funding to address the issue or offered a viable solution.

For the 85,000 Alaska Natives who live in the 200 villages without road access, the only time dental services are available is when a dentist flies in to conduct a dental clinic. Alaska Tribal Health Programs experience a 25 percent vacancy rate among dentists and a 30 percent average annual turnover rate. Tribal health programs have increased their dental budgets above the IHS allocation of funds so that they could increase salaries. Despite these measures, dentists do not choose to live in remote, isolated communities or to travel via small prop-planes on a weekly to even more remote villages to conduct clinics in buildings that do not even have running water. Volunteers cannot fill this gap: if they could, the need already would have been addressed. Instead, a new solution was needed.

Community Health Aide Program (CHAP)

In order to address this need, the Alaska Native Health Board took the proactive step of endorsing the Dental Health Aide Program as a means to begin planning, certification, and drafting standards for the establishment of the Dental Aide program. The board that carried out this process included experienced Public Health Dentists, local community members, Community Health Aide Practitioner Directors and Aides, attorneys and other experts as necessary. National funders have provided an extensive financial support to move this program into the implementation stage. The first class of Dental Health Aides has been trained and are now in their preceptorship training, with dentists, in regional hospitals.

The CHAP concept was developed by IHS in the 1950s in response to the tuberculosis epidemic, high infant mortality, and the high rate of injuries in remote villages of Alaska. CHAP was authorized, exclusively for Alaska, by Congress in the Indian Health Care Improvement Act in the 1970s. CHAP has become the backbone of health care for Alaska Natives who live in traditional villages that are inaccessible by road. Today there are 5000 Chas in Alaska providing over 300,000 patient visits each year. Community Health Aides (Chas) are mostly Alaska Native people chosen by their villages. They are thoroughly trained, carefully supervised and supported. Chas work under the supervision and standing orders of physicians who closely monitor and assess their skills and performance. The work of the CHAs, therefore, alleviates mid-level practitioners and physicians from some lower level duties thereby allowing them to focus limited health care resources on more demanding tasks.

CHAs are certified (and recertified every two years) by a federally appointed Board of health professionals from the IHS, State Department of Health and Social

Services, and Tribal health programs. They must participate in continuing education annually and have their work observed by a supervising dentist. The Community Health Aide Program has been a model for the world. President Bush used the program as a template for South Africa and Afghanistan. The Dental Health Aide Program (DHAP) is a local solution to a local crisis. Alaska Native people, through representation on the Alaska Native Health Board, endorsed this solution for the dental crisis. It will be as successful as the Community Health Aide Provider Program because local residents receive training and employment, and provide high quality care to their community. The Dental Health Aides will have had as many hours of educational clinical experience in the limited number of procedures they are permitted to do as most dentists receive during their educational program and be closely monitored by licensed dentists. They will be supported by telemedicine access to the dentist who will be able to actually view the same tooth and x-rays that the Aide is examining and be subject to biannual recertification and continuing education requirements. It is our expectation that Dental Aides will be the latest addition to the mid-level health care providers in America that have proven to be successful in delivering cost effective and safe health care services within their scope of practice.

Medicare and Medicaid

Preserving the Medicaid Program

NIHB is working with over 150 other organizations to save the Medicaid program from substantial cuts during the creation of the House and Senate Budget Resolutions and to realize the establishment of a Bipartisan Commission on the Future of Medicaid.

The purpose of the proposed Commission is to provide a one-year window of opportunity for this panel to produce a studied and thorough examination of the Medicaid program. Through this product, the Commission would offer Congress an informed blueprint for reform, rather than adopting the approach suggested in the President's budget: cut Medicaid to achieve savings. NIHB supports both bills and each enjoys strong bipartisan support. HR 985 has 135 Cosponsors (59 Republicans and 76 Democrats) and S. 338 has 32 Cosponsors (20 Republicans, 11 Democrats and 1 Independent.) Efforts to establish this Commission include urging both bill sponsors to amend their proposals to stipulate that at least on Commissioner be an American Indian with experience in the delivery of health care in Indian Country. In sum, the Bipartisan Commission on the Future of

Medicaid would offer a studied response and appropriate policy recommendations to Medicaid growth.

NIHB also opposes the proposed cuts that Congress currently is considering to the Medicaid program. We understand the costs of the Medicaid program are growing at an alarming rate; however, as the payer of last resort for million's of American's health care, the increase in costs is more indicative with underlying socioeconomic issues than with the Medicaid program, itself. A disproportionate number of American Indians and Alaska Natives comprise the Medicaid population. In Alaska, alone, 40 percent of Medicaid recipients are Alaska Natives. Therefore, cuts to the Medicaid program will have the unintended consequence of further limiting AI/AN access to critically needed health care services. During the Senate budget resolution debate, Senators Gordon Smith (R-OR) and Jeff Bingaman (D-NM) sponsored an amendment which sought to zero-out the Medicaid cuts and replace them with a reserve fund to operate the proposed Bipartisan Commission. While their effort was successful, a similar provision did not pass the House of Representatives. We are very hopeful, for the sake of the tens of thousands of AIs and ANs who benefit from the Medicaid program, that the proposal of Senators Smith and Bingaman will prevail.

Medicare Modernization Act

In comments recently-submitted to the Administrator for the Centers for Medicare and Medicaid Services (CMS), NIHB demonstrated that the Medicare Modernization Act of 2003 (MMA) contains provisions that will have serious and potentially negative impacts on the Indian health care system. Subsequently, in evaluating the Act and the proposed regulations to implement Parts C and D, we identified that a significant adverse impact of lost Medicaid revenue to the Indian health care system, or IHS/Tribal and Urban (I/T/U) health service programs, will occur. We estimate these to be between $25-50 million effective January 1, 2006, with the roll out of provisions of the Act that affect the so-called "dual eligible" Medicare/Medicaid enrollee. (*An I/T/U pharmacy is one operated by an Indian health program such as a Tribe, the Indian Health Service, a Tribal organization or an urban Indian health clinic. I/T/U pharmacies provide or reduced cost prescription drugs to people with Medicare who are American Indian or Alaska Native*).

On January 1, 2006, I/T/U pharmacies will lose the ability to collect from state Medicaid program payments for drugs for dual eligible enrollees who will then

have to enroll in a private sector Medicare drug benefit plan as the Medicaid drug coverage they previously enjoyed will be precluded by the MMA. This will result in an immediate loss to the I/T/U of $25-50 million Medicaid revenue which will not soon be recovered, or even recovered in whole at some later date, with the roll out of Part C and D Medicare plans. This lost revenue to the I/T/U, which supplements an already under-funded Indian health care system, will undoubtedly exacerbate the well known health disparities that already exist between American Indians/Alaska Natives (AI/AN) and the general U.S. population (reference is made to the recently released report by the U.S. Commission on Civil Rights entitled, Broken Promises: Evaluating the Native American Health Care System.)

Our evaluation of the proposed regulations for Parts C and D raises the concern that if private sector plans are not required to engage with I/T/U's, through either network or out-of-network arrangements, the bulk of the lost Medicaid revenue to the I/T/U's on January 1, 2006, will never be recovered under the MMA, and the Indian health care system will sustain a damaging set back. Congress recognized in 1976, the shortcomings of funding to the Indian health care system and legislated access to Medicare and Medicaid benefits for all eligible AI/AN's, and to the Indian Health Service and Tribal programs that serve them. We do not believe the implementation of the new MMA provisions are intended to do harm to these already grossly under-funded Indian programs. It remains our concern that, short of a legislative correction in the MMA the Indian health care system will suffer an adverse impact as a result of the roll out of MMA programs that affect the status of dual eligibles ("dual eligibles" are individuals who are eligible to receive care under both the Medicaid and Medicare programs). CMS has not corrected this problem with in the Regulations published earlier this year.

Because most Indian health facilities are located in remote areas far distant from the mainstream health system, they must also operate pharmacies so their patients can access needed medications. I/T/U organizations operate 235 pharmacies throughout Indian Country. IHS and tribes dispense pharmaceuticals to their Indian beneficiaries without charge, as is the case for all health services they offer.

A sizeable portion of the patient base for I/T/U pharmacies consists of dual eligibles. IHS estimates that there are between 25,963[1] and 30,544[2] individuals in the IHS patient database who are receiving both Medicare and Medicaid. Since this database does not include information from some tribally-operated facilities

[1] This number represents 85 percent of the three-year total of active users.
[2] This is the number of active users, defined as at least one visit in the past three years.

(those that do not use the IHS computerized data system) or information about Indians served by urban Indian clinics, the number of dual eligibles is even greater than the IHS database reveals.

While there is no comprehensive data on the per-capita drug costs for dual eligibles in the Indian health system, we have been able to make some rough estimates by examining average state per-capita spending for this population. In 2002, the average per-capita spending for dual eligibles was $918.[3] We believe this is a very conservative figure for Indian Country, in view of the higher rates of illness that have expensive drugs associated with their treatment, including diabetes and mental illness. Furthermore, the IHS calculates that the cost of pharmaceuticals has increased by 17.6 percent per year between FY 2000 and FY 2003. This includes the cost of new drugs, increases in drug costs and population growth. Thus, if we trend the average out to the year 2006, the expected average per capita spending on drugs for dual eligibles would be $1,756.

Using these population and per-capita spending data, we estimate that the Medicaid recovery for dual eligible drug costs in the Indian health system ranges between **$23.8 million**[4] **and $53.6 million**.[5] It is vital that these revenues, so critical to the Indian health system, not be interrupted or reduced when dual eligibles are removed from the Medicaid rolls for prescription drugs with the inauguration of Medicare Part D in 2006. In their present form, however, the proposed Part D rules would jeopardize the ability of I/T/U pharmacies to maintain this level of dual eligible reimbursements.

Barriers to Part D access of Indian Dual Eligibles

There are several reasons why the intended conversion of dual eligibles from Medicaid to Medicare could be extremely problematic in the Indian health system:

- Switching payment sources from Medicaid to Prescription Drug Plans (PDPs) under Part D will hurt AI/AN consumers and Indian health providers because most tribes are located in extremely rural areas where market forces do not make it advantageous for private plans to establish networks. Dual

[3] From Table 2, "Full" Dual Eligible Enrollment and Prescription Drug Spending, by State, 2002, in "The 'Clawback:' State Financing of Medicare Drug Coverage" by Andy Schneider, published by the Kaiser Commission on Medicaid and the Uninsured, June 2004.

[4] This low number was calculated using the 25,963 figure for dual eligibles in 2003 and the $918 per capita spending in 2002. It is probably unrealistically low for 2006 given the increase in aging population in Indian Country and the increase in drug prices.

[5] This higher number uses the 30,544 number of dual eligibles in 2003 and the $1,756 estimated spending in 2006.

eligibles in those areas will have difficulty accessing the Part D benefit unless they use an Indian health pharmacy admitted to PDP networks.

- Medicaid revenues have been an important source of income for Indian health facilities. **As drug coverage for AI/AN dual eligibles is removed from Medicaid and placed under Medicare, the amount of revenue in jeopardy is estimated to be between $23.8 million and $53.6 million.** Reductions in reimbursements for pharmaceuticals cannot be absorbed by raising rates for other services, as Indian patients are served without charge.

- The level of revenue an I/T/U would collect under Part D will very likely be less than it currently collects under Medicaid for dual eligible drug coverage. Therefore a "wrap around" payment from Medicare, consisting of the difference between the PDP/Medicare Advantage Prescription Drug Plan (MA-PD) contract amount and the amount the I/T/U would have received under Medicaid, must be utilized to "hold harmless" I/T/Us, if an I/T/U contracts with a PDP/MA-PD.

- If private prescription drug plans are not <u>required</u> to contract with I/T/U pharmacies, there will be little incentive for them to do so, as the service population of these pharmacies is comparatively small and the Indian population tends to be sicker. Without network status or payment for off plan services, an I/T/U pharmacy will not be able to collect for drugs dispensed to any AI/AN enrolled in a Part D plan. This would produce three negative results: (1) a loss of revenue to the I/T/U pharmacy; (2) no meaningful opportunity for the enrolled Indian to use his Part D benefit; and (3) a windfall for the PDP who collects premiums from CMS for a dual eligible, but pays no claims.

- Even if private plans are required to contract with I/T/U pharmacies, this command will be meaningless unless the regulations set out terms specifically drafted to address the unique circumstances of the IHS, tribal and urban Indian pharmacies.

- Even if an Indian beneficiary is enrolled in a Part D plan, the I/T/U pharmacy may not know what PDP or MA-PD to bill. Particularly with automatic enrollments, the AI/AN dual eligible may not know what PDP/MA-PD he or she has been enrolled in and it may be difficult for the I/T/U pharmacy to get this information. There may be additional delay in

accessing the benefit if the individual has to disenroll and then enroll in a PDP/MA-PD for which the I/T/U pharmacy is a network provider. This situation mirrors the disastrous consequences suffered by the I/T/Us when State mandatory Medicaid managed care enrollment programs were implemented.

- If delays in implementation occur, it is not clear how the I/T/U pharmacies will recoup payment for expenditures made during the period between when the AI/AN is switched from Medicaid to Medicare pharmacy benefits and when the I/T/U pharmacy is an established network provider or able to bill for out of network services. Even if the I/T/U pharmacy is allowed to bill for services provided from the beginning of 2006, they may not have the staff to deal with a backlog of billing. Confusion and lack of information could result in not billing for covered services.

The Part D program will also impact AI/AN Medicare beneficiaries who are not dual eligibles and must pay a premium for Part D participation. Since these individuals receive drugs at Indian Health Service and tribal health pharmacies without charge, there is no incentive for them to pay premiums to enroll in a Part D plan. In order to be able to collect reimbursements for drugs dispensed to those patients, CMS must facilitate group payer options for tribes who wish to pay premiums for these beneficiaries in order for their pharmacy to be reimbursed for drugs dispensed.

The Secretary of Health and Human Services, as the principal steward of Indian health, has a responsibility to assure that the MMA, which was intended to benefit *all* Medicare beneficiaries, does not produce the opposite result for *Indian* Medicare beneficiaries who use the Indian health care system. He can guard against such an outcome by exercising the broad authority granted to the Secretary by Section 1860D-4(b)(1)(C)(iv) of the MMA which authorizes him to establish standards to assure access to Part D for I/T/U pharmacies. By this provision, Congress recognized that access for Indian beneficiaries means the ability to utilize that benefit through I/T/U pharmacies.

AI/AN Medicare beneficiaries who are not eligible for low-income cost-sharing subsidies may receive drug coverage directly from I/T/U pharmacies or under CHS referrals. While these payments will count toward the AI/AN beneficiary's annual deductible, they will not count as incurred cost toward meeting the out-of-pocket threshold ($3,600 in 2006). The reason, in brief, is that "incurred costs" are defined

by section 1860D-2(b)(4)(C)(ii) of the Social Security Act to exclude payments by "insurance or otherwise." But this statutory provision does not expressly include the I/T/U programs in this term. Rather, it is CMS, not the law that has defined what is encompassed by the term "insurance or otherwise". The agency has chosen to include I/T/U health programs as "insurance or otherwise," – but has not explained the basis for that decision, nor analyzed the impacts of it on the IHS-funded system and affected Indian Medicare beneficiaries, nor acknowledged that failing to count I/T/U pharmacy contributions toward "incurred costs" would be a windfall to the PDP in which an affected Indian is enrolled. Perhaps CMS recognized that this matter requires additional thought, as it asks for comments on "how … IHS beneficiaries will achieve maximized participation in Part D benefits."

The effect of CMS's decision to treat I/T/U programs as "insurance or otherwise" is to minimize, not maximize, participation of IHS beneficiaries in Part D benefits. As CMS itself acknowledges, "most IHS beneficiaries would almost never incur costs above the out-of-pocket limit." (69 FR at 46657). And, as CMS further recognizes, this policy "would likely provide plans with additional cost-savings." We do not believe that Congress intended Part D to be administered to minimize participation by AI/AN beneficiaries and to increase revenues for PDP and MA-PD plans at the expense of I/T/U programs. Yet that is precisely the result that the proposed rule achieves.

This is not required by the statute. Section 1860D-2(b)(4)(C)(ii) does not expressly prohibit payments by I/T/U programs from being treated as "incurred costs." By using the phrase "not reimbursed by insurance or otherwise," Congress intended to give CMS discretion to fashion a sensible definition consistent with federal policy. AI/ANs are not "reimbursed" by their IHS or tribal health care providers or by any insurance. Rather in the case of AI/AN beneficiaries, that federal policy is the trust responsibility of the United States to provide health care to AI/ANs pursuant to laws and treaties. And, as CMS acknowledges in the Preamble at p. 46651, the I.H.S. "fulfills the Secretary's unique relationship to provide health services to AI/ANs based on the government-to-government relationship between the United States and tribes." In other words, AI/AN Medicare beneficiaries have a different legal standing than other Medicare beneficiaries.

The final rule, however, does not recognize this "unique" legal relationship. Instead, the proposed rule would require those AI/ANs who are Medicare

beneficiaries, but not eligible for the low-income subsidy program, to pay substantial amounts out of pocket for their Medicare prescription drug coverage in order to meet the out-of-pocket threshold. In this way, the proposed rule violates the federal trust responsibility, under which AI/ANs are entitled to needed health care services, including prescription drugs, at the federal government's expense.

Section 1860D-2(b)(4)(C)(ii) specifies that costs shall be treated as incurred if they are paid "by another person, *such as* a family member, on behalf of the individual." (*emphasis added*). In the "unique relationship" between the federal government and AI/ANs, the I/T/Us are the functional equivalent of a "family member." Their mission, on behalf of the federal government, is to pay for prescription drugs and other health care services needed by AI/ANs. In terms of paying for prescription drugs, there is no functional difference between I/T/Us fulfilling their obligations to AI/ANs and family members fulfilling their obligations to one other. Again, there is nothing in the concept of family members paying incurred costs to suggest that Congress somehow intended that payments by I/T/Us on behalf of AI/ANs not be treated as incurred costs.

In the preamble of the rule, CMS explains that contributions made by charities would be considered "incurred costs" and describes in detail the reasons for a desirable objectives achieved by this decision. Many of the considerations recited there apply to the I/T/U system, particularly the outcome that Medicare beneficiaries who are not eligible for the low-income subsidy would be able to qualify sooner for the catastrophic coverage level. In other words, these beneficiaries would have a better opportunity to fully utilize their Part D benefit.

The outcome is just the reverse with regard to an Indian not eligible for subsidy who is served by an I/T/U pharmacy. That Medicare beneficiary would have to pay the same premium for Part D coverage (or have it paid on his behalf by the I/T/U program as CMS suggests at p. 46651), but the benefit received for that premium would be only slightly more than $1000 -- far lower than that of a non-Indian beneficiary. This is so because this Indian patient would never get out of the "donut hole" and thus would never be able to utilize the catastrophic coverage feature of the Part D benefit.

Access to Specialty Care

In many cases, health care facilities in Indian Country are found in remote or isolated locations and they suffer from severe chronic lack of adequate funding.

Many of these facilities have a "skeleton" healthcare staff and most do not benefit from specialized care such as gastroenterology, opthalmology, oncology, or dermatology. In order to receive health care by a specialist, many American Indians and Alaska Natives (AI/AN) must travel great distances, and many do so at great personal expense. While an adequate supply of specialists and primary care physicians in Indian Country remains elusive, effectively addressing this challenge will require innovation, imagination and funding.

Graduate Medical Education

Some innovations already exist. Graduate medical education (GME) is the period of training a physician (MD/DO) undergoes once he or she graduates from medical school. This residency training usually takes place in a hospital, academic medical centers or ambulatory care settings that possess a clinical base and provide health care services. GME funds are provided directly to the institutions where training takes place through Part A of the Medicare program and, to a lesser extent, from the Medicaid program. GME is an entitlement program. Payments to hospitals where residency training takes place are divided into two streams, Direct Costs, which, as implied, apply to the costs directly associated with Resident training, such as salary and benefits, stipends, housing and instructors while the Indirect Cost is provided to hospitals to cover costs such as heat and lights, malpractice insurance, patient care, etc. In 1995, the Medicare program spent $7.1 billion for residency training. According to the Centers for Medicare and Medicaid Services (CMS), the United States currently invests approximately $9 billion from Medicare and $2 billion from Medicaid in educating medical residents each year.

Hospitals in Indian Country are not benefiting from this $11 billion per year investment into health care facilities and physician manpower supply because GME isn't happening in Indian Country. The Omnibus Budget Reconciliation Act of 1997 created a national cap on the number of residency training positions that can exist in America. Two of the limited exceptions under which new residency training programs can be established are rural and underserved areas and in facilities where no such training has never before taken place. In sum, Indian Country is well-positioned to establish residency training programs at its hospitals. While the Federal government does not require teaching programs receiving public funds to be accountable to achieve any physician workforce goals, either in terms of the medical specialty the trainee enters or where he or she will practice medicine, should GME training commence in Indian Country the presence of the training programs and residents involved with bolster access to physicians substantially. In addition, health facilities in Indian country would have the

opportunity to benefit from the GME indirect funding enjoyed by other hospitals in America, both public and private. Hospitals where GME takes place receive, on average, approximately $100,000 per resident per year.

Support for further examination and establishment of GME training sites in Indian Country would be expedited if Congress would support NIHB's efforts to launch a demonstration project devoted to GME development in Indian Country

Telehealth

Telehealth, the practice of licensed health care providers providing health care using electronic forms of communication, is an innovation whose market has arrived: Indian Country. While there are few telehealth projects operating in Indian Country, some already are proving viable and effective. For example, it is utilized in Oklahoma by the UT Southwestern Medical Center is working with the Choctaw Nation with patients suffering from Alzheimer's disease. Once the patient is diagnosed, there need regular face-to-face periodic check-ups is alleviated. The tribe benefited from existing satellite connectivity because Tribal members can visit one of the local patient care centers and receive treatment from the UT Southwestern Medical Center via telehealth. This reduces staff and patient travel time, and allows physicians to assist a greater number of patients. With this added modality of care, physicians can better monitor both the medications they prescribe and any progress in the disease. Telehealth can be used to treat a variety of diseases from mental health care to oncology.

Senators Daniel K. Inouye (D-HI) and Maria Cantwell (D-WA) recently introduced legislation, S. 535, "The Native American Connectivity Act," which seeks to address the telehealth issue. Hopefully, S. 535, will achieve its stated purpose to "enhance the health of Indian tribal members through the availability and use of telemedicine and telehealth." NIHB supports the concept of this legislation.

End of Life Care and Assisted Living Services

Throughout Indian Country there remains a severe lack of End of Life facilities and assisted living facilities. In many cases American Indians and Alaska Natives must travel great distances to benefit from the services provided by nursing home, hospice and assisted living facilities. Those who do receive such care are often uprooted from their families and communities, cared for by strangers and die in this environment. Local facilities would end this scenario.

It is a benefit that the Native population in the United States is becoming increasingly healthier. Programs such as NIHB's Just Move It! Campaign seeks to further increase the health of our native populations. Many Native communities are unaware that they can use CMS-sponsored programs to create nursing home and assisted living facilities near their homes. In 2004, the Cheyenne River Sioux Tribe received a grant for over $200,000 to build a culturally appropriate nursing home facility on their reservation. NIHB believes that this type of assistance should be expanded for other communities.

NIHB recommends that any iteration of the Indian Health Care Improvement Act Reauthorization during the 109th Congress include authority for tribes to provide health care services, such as home health care, nursing care and hospice and assisted living care. We believe that these services are essential to the long term health care of all Native Americans, irrespective of age.

Conclusion

In closing, and on behalf of the National Indian Health Board, we thank the Senate Committee on Indian Affairs for its investment of time, expertise and action into investigating and improving the health care delivery systems used by American Indians and Alaska Natives. Thank you for considering our testimony and the recommendations that it contains. As the Committee works toward achieving the reauthorization of the Indian Health Care Improvement Act, NIHB is committed to assisting you in any way that we can. We will end this testimony as we began it:

Let us begin again and do as the great Lakota leader, Sitting Bull, said: "Let us put our minds together and see what life we can make for our children."

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[i] Epstein, Barker, Vorburger, & Murtha. *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders*, Substance Abuse and Mental Health Services Agency, Office of Applied Studies, 2002.
[ii] *Differentials, Income Distribution and Trends in Poverty*. Journal of Social Policy 18(3), 1989: p. 307-335; Norman Daniels, Bruce Kennedy and Ichiro Kawachi.
and, Justice is Good for Our Health: How Greater Economic Equality Would Promote Public Health, Boston Review (February/March, 2000): p. 4-9.
[iii] *Creating Health Equity Through Social Justice*. National Association of County and City Health Officials, September 2002.
[iv] *Public Health Infrastructure in American Indian and Alaska Native Communities*, Indian Health Service Roundtable, Rockville, MD, May 2002.