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

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Oral Statement of the Indian Health Service

by

Charles W. Grim, D.D.S., M.H.S.A.

Assistant Surgeon General
Interim Director, Indian Health Service

Mr. Chairman and Members of the Committee: Good morning. I am Dr. Charles W. Grim, Interim Director of the Indian Health Service. I am accompanied today by Michel E. Lincoln, Deputy Director of the Indian Health Service; Dr. Craig Vanderwagen, Director of Clinical and Preventive Service, Office of Public Health; and Gary Hartz, Acting Director of the Office of Public Health.

There is no single piece of legislation that will affect the future health status of American Indians and Alaska Natives more than the "Indian Health Care Improvement Act Reauthorization of 2003," S.556. In the intervening 28 years since it was first authorized; achievements in Tribal self-determination, decisions by this Committee and other authorizing and appropriations committees of Congress, and the Indian Health Service programs have improved the health status of Indian people. To continue the momentum of improvement and to achieve the goal shared by Indian Country, this committee, and the Administration to eliminate health disparities between all Americans – it is critical that the Indian Health Care Improvement Act reflect the health and world realities of today and not those of 28 years ago.

From the beginning of the tribal-federal relationship, the provision of health care services to Indians has been a key component of the federal government's trust responsibility. Two major pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians and Alaska Natives. The Snyder Act of 1921, P.L. 67-85, and the Indian Health Care Improvement Act (IHCIA), Public Law 94-437.

The Snyder Act authorized regular appropriations for the relief of distress and conservation of health of American Indians and Alaska Natives and remains the basic authority for appropriations for major Indian programs. The Indian Health Care Improvement Act was originally authorized in 1976 and was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs."

Like the Snyder Act, the IHCIA provided the authority for the programs of the Federal government that deliver health services to Indian people, but the IHCIA also provided additional guidance in several areas. The IHCIA contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities, focused on health services for urban Indian people, and addressed the construction, replacement, and repair of health care facilities.

S.556 is the product of extensive consultation that the Indian Health Service undertook during 1999 with Indian country. In anticipation of the reauthorization of the Act and the changes in the health care environment of the country, the Indian Health Service wanted to consult with Indian country to ascertain how these changes have impacted on the ability of tribes and urban Indian health programs to delivery high quality and much needed services. During consultation with Indian country, we learned that tribes were anxious to discuss the impact of managed care and other changes in the health care field that affected their ability to administer quality health programs and services. Based on this consultation, the tribes and urban Indian health programs determined they would draft a legislative proposal reflecting their concerns and issues. S.556 contains a variety of new, expanded, and strengthened provisions, activities, and services.

The Department supports the reauthorization of this cornerstone legislative authority and Secretary Thompson has made Indian health care a priority of the Department. In the Department's review of the proposed language – to ascertain its relationship to its policies and budget priorities during this time in our nation's history – there are certain provisions in S.556 that generate some concern.

The Department's review identified proposed provisions in S. 556 that are inconsistent with current Medicare and Medicaid provider payment practices and could inappropriately increase costs. For example:

The Qualified Indian Health Provider (QIHP): The bill proposes a new provider type called QIHP for IHS, Tribal and Urban Indian providers participating in Medicare and Medicaid programs. The most problematic aspects of QIHP are the structure and operation of the payment provisions, which are not only burdensome but more importantly, would not be feasible to administer. In addition to the burden and feasibility issues, on a more fundamental level, the "full cost plus other costs" QIHP payment approach would be contrary to the way that Medicare generally pays providers.

Another example is the proposed extension of 100% Federal matching rate for Medicaid and SCHIP: The bill expands the current 100% Federal matching rate to States for Medicare and SCHIP services provided through IHS facilities to include services provided to American Indians and Alaska Natives by non-Indian health care providers. The proposed change would substantially increase Federal program and administrative costs, with no guarantee and little likelihood of increasing access to services for Indian beneficiaries or better payments to Indian providers.

Additionally, the proposed provision for Negotiated Rule Making: The concern is that S.556 would appear to broadly mandate use of negotiated rule making to develop all regulations to implement the IHCIA. Negotiated rule making is very resource-intensive for both Federal and non-Federal participants. It can be effective in appropriate circumstances, but may not be the most effective way to obtain necessary Indian provider input in the development of IHCIA rules and regulations in a given case.

A hallmark of Secretary Thompson's vision for the Department is his "One-Department" initiative. I would like to share with you some of the benefits of that initiative for raising the health status of American Indian and Alaska Native people.

The fundamental premise of this initiative is that the Department of Health and Human Services must speak with one, consistent voice. Nothing is more important to our success as a department. With regard to our tribal constituents the Secretary observed on his first trip to Indian Country that tribal programs were often "stove piped" and that there existed within HHS an assumption that the IHS had sole responsibility for the health issues facing tribes.

In the two short years since the Secretary launched this initiative he has reestablished the Intradepartmental Council for Native American Affairs. The membership of this Council is comprised of the heads of all the HHS Operating and Staff Division with the IHS Director serving as the Vice-Chair. This Council serves as an advisory body to the Secretary and has the responsibility to assure that Indian policy is implemented across all Divisions. The Council provides the Secretary with policy guidance and budget formulation recommendations that span all Divisions of HHS. A profound impact of this Council on the IHS is the revised premise within HHS that all Agencies bear responsibility for the government's responsibility and obligation to the Native people of this country.

We are committed to working with the committee to ensure the reauthorization of this key legislative authority. We will be happy to answer any questions that you may have regarding the Department's views on S.556. Thank you.