

**Testimony on Proposed Legislation to Reauthorize the
Indian Health Care Improvement Act P.L. 94-437**

**Senate Committee on Indian Affairs
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**Presented by
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Thank you for the opportunity to present the Navajo Nation's position on the proposed legislation reauthorizing the Indian Health Care Act of 1976 also known as Public Law 94-437. As a former surgeon on the Navajo Nation, it gives me great pleasure to outline recommendations for the reauthorization of this important piece of legislation. In early 1999, Indian Health Service (I H S) sponsored a series of regional meetings between health care providers from tribal and urban Indian healthcare programs to discuss specific healthcare concerns in Native communities and make recommendations regarding the reauthorization of the Indian Health Care Improvement Act, due to expire in September of this year. In June representatives from tribes, tribal organizations and urban Indian organizations (I/T/Us) formed the National 437 Steering Committee. Charged with addressing the recommendations and conflicts from the regional meetings, the committee drafted the proposed reauthorization legislation being considered today. The following areas of the proposed legislation are supported by the Navajo Nation:
Scholarships - Title I - Sections 2 and 3

The Navajo Nation concurs with assertions made in this Section that the United States government has a responsibility to ensure that the health of Native Americans is up the standards outlined for the rest of the population in its "Healthy People 2000" declaration. The Navajo Nation supports this section in recognizing the need for more Native American healthcare providers and the stipulations of this section that provide for equal funding for tribally operated healthcare facilities as is provided for I H S facilities. Title I of 94-437 gives a higher degree of autonomy to ITUs in that it provides for funding for I H S scholarships to Indians as described in Section 4 of this legislation to be funded through area offices. That individual service areas will award scholarships and service contracts will be fulfilled in the areas providing the scholarship unless otherwise agreed to, gives a higher level of control to ITUs in being able to plan for their healthcare needs and select their providers. It also means that more scholarships will be provided for federally recognized Native Americans, thus ensuring a higher degree of commitment from health care providers under these scholarships. Title I also provides for scholarships for a wider range of healthcare professionals. The Navajo Nation in recognition of the wide variety of health care providers ranging from physicians and nurses to community health representatives and pharmacists to drug and alcohol counselors and health educators, supports this increase in healthcare opportunities for Indian people. Navajo Nation also recognizes the need for a higher degree of cultural relevance in services provided to Indians. Section 117 of Title 3 requires tribal consultation in the design and delivery of training in the culture and history of the tribe scholarship recipients are to serve as an important step in ensuring that Native Americans receive care from

Indians who are aware of cultural ramifications that might affect the quality of care given and the patient's receptivity to both the provider and the health solutions he or she offers.

Environmental Health/ Title II - Section 215

Section 215 calls for study and monitoring programs to determine trends that exist in health hazards posed to Indian miners and Indians on or near reservations and in Indian communities as a result of environmental hazards that may result in chronic and or life threatening diseases. The Navajo Nation supports consultation with tribes and tribal organizations regarding these trends and stresses the importance of consultation as it allows tribes to take part in their destinies and is a true step toward self determination. The Navajo Nation also supports the inclusion of studies with summaries of findings, reports and plans of action. A task force comprised of leadership from pertinent agencies will administer the plan. The Navajo Nation approves of the defined composition of this panel due to its ability to scrutinize data accurately and make educated determinations regarding Navajos affected by environmental hazards while in employment situations. According to this facet of the reauthorization of P.L. 94-437, Indians who suffer work related illnesses or conditions as a result of uranium mining or milling will be eligible to receive diagnosis and treatment from an I H S facility. Medical care will be paid for by the owner of the facility responsible for the environmental hazard. The I H S can request reimbursement from such entity. This section does not nullify the right to recover damages other than medical expenses. The Navajo Nation supports this section because it provides for the compilation of accurate data regarding environmental health issues among Navajos along with components for education, prevention and treatment while requiring the entities charged with causing the health problems to take responsibility and rectify the damages.

Contract Health Service - Title II - Section 216

Another area of concern to the Navajo Nation is the retention of Arizona as a contract health service delivery area. At present time, the State of Arizona is designated as a contract health service delivery area by the I H S. Arizona must continue as a contract health service area until the end of Fiscal Year 2012, providing services to members of federally recognized tribes within the state. Services to Indians on reservations in Arizona will not be curtailed under this section. The Navajo Nation supports Section 216 because of the large numbers of Navajos living in urban areas such as Flagstaff, Phoenix, Tucson and other non-reservation areas. I H S facilities are often difficult for Navajos living in these areas to access. This is especially true in critical care situations.

Facilities - Title III

This Title concerns monies spent on construction and or renovation of I H S facilities. Title III stipulates that the Secretary of HHS acting through I H S shall consult with the tribe that will be significantly affected by the facilities expenditure for the purpose of determining and honoring tribal preferences concerning that facility. The Secretary and I H S are to ensure that the proposed facility meets the construction standards of a nationally recognized accrediting body not later than a year after construction/renovation. The Navajo Nation supports this Title and

acknowledges the importance of local input regarding federally run facilities in related areas. Without tribal input regarding construction and renovation of facilities, there exists a concern that monies earmarked for such construction costs will not be spent in ways consistent with tribal needs or preferences and that additional expenses will be incurred when efforts to correct these issues are undertaken. The hiring of Navajos in the building trades is also an important issue in the Navajo Nation. Tribes must be consulted prior to the undertaking of any construction or renovation projects situated on tribal land and or servicing a majority Native population. This is consistent with the principles of self determination and is often a term of the funding provided for the facility.

Priority System - Section 301(c)

I H S has never been fully funded and therefore, must prioritize projects to ensure eventual completions. This section of the Indian Health Care Reauthorization Act establishes a health care priority system along with tribes and tribal organizations. Under this title, highest priority will be based on the needs of tribes. A list of the planning, design, construction and renovation needs will be established. The top ten priority inpatient care facilities, outpatient facilities and specialized care facilities will be listed along with justifications for the order of the priorities, the projected costs and the methodologies used will also be listed. The above-described methodology will include consultations with tribal governments and tribal organizations and a review of total unmet needs. This Section is important to the Navajo Nation because it requires more consultation with tribal governments prior to establishing priorities that affect Indian communities, an important component of self determination. While outlining a priority system designed to address critical healthcare needs in Indian Country, there exists nothing in this section that stipulates a time period in which Indian healthcare needs will be met with the goal of ensuring that all communities in need will have facilities built and in operation by a specified date, the Navajo Nation encourages Congress to appropriate additional funding to build and or renovate health facilities serving a majority Indian constituency and to establish dates of completion so communities can project patient numbers, staffing needs, etc.

Comprehensive Behavioral Health Program

The Navajo Nation is in full support of the new provisions under Title VI to develop and operate a comprehensive behavioral health prevention and treatment program which places emphasis on collaboration among alcohol and substance abuse, social services and mental health programs. Revisions clarify that the Indian tribes and tribal organizations have responsibilities to develop plans which provide for a wider range of behavioral health services for families and individuals. These services can include but are not limited to community based prevention, early intervention, outpatient and behavioral health aftercare, acute hospitalization, transitional living, traditional health care practices, parenting education, youth programs, etc. Data suggests a link between substance abuse, domestic violence, accidental death and a variety of other health issues present in reservation communities. The unification of programs under one banner is not only consistent with Navajo cultural practices, but will streamline the assessment process and enable mental health providers to better serve their clients in a more cost effective way.

Non-Service Funds for Renovation - Section 305

Section 305 requires that the Secretary of Health maintain a separate priority list for increased funding for staff, equipment or other operating expenses supported by the tribal government. The Navajo Nation recognizes that an important component of the building of I H S facilities is the inclusion of funding for staff quarters, infrastructure and administrative costs for I H S facilities and or tribally run health care facilities. Medical facilities in Indian Country are often located in rural areas with few if any rental properties, either residential or commercial available. This is a strong concern in the recruitment and retention of qualified medical providers and support staff.

Joint Ventures - Section 312

The Navajo Nation supports Section 312 of the proposed legislation, which provides for I.H.S./Tribal Joint Venture Programs. Under this section, tribes can enter into joint ventures where tribes lease the facility for ten years to I.H.S., at no cost, and I.H.S. provides monies for staffing and equipment. Given the difficulty in finding funding for health care facilities and the enormous backlog on the I H S list of priorities, the Navajo Nation is in support of Section 312 as an innovative way to meet the healthcare facility needs of the Navajo Nation. However, there are instances where tribal governments are not in the financial position to provide matching funds to I H S projects. The Navajo Nation supports additional congressional funding to match these funds in instances where the tribal government is not in the position to do so.

Third Party Payors - Title IV

Many Native Americans are eligible for programs that provide healthcare to Indians under other federal and or state programs. In many I H S facilities, the operating budget consists of 50 to 60 percent funding from third party payors. Efforts to enhance collections enable these facilities to better plan for and provide services to clients. Title IV of 94-437 enables I H S, tribes, tribal organizations and urban Indian Organizations to bill Medicare, Medicaid and Children's Health Insurance Program for services provided to Indians under the Social Security Act. These monies are not considered in determining appropriations for Indian health care and shall be paid for eligible services regardless of location. Outpatient facilities are eligible if they collaborate with a hospital or other inpatient facility. Yet at the same time, it is important to recall that health care for tribal members is ultimately a trust responsibility. In keeping with this, the Nation objects to the language added to the proposed section 408(f), which provides an exception and would under certain circumstances allow IHS to bill Tribes for services provided to members. While it is understandable that IHS may need money, it is inconsistent with the federal trust responsibility to bill the beneficiary for services. In subsection (h) "tribal" should be added to "Federal or State law" as neither state law, nor state court may have jurisdiction over a claim an individual may bring against an insurer for services provided at an on-reservation facility. Section 410(b) allows recovery from managed care plans for services, for the same reasoning noted above opposing the additional language in 408(f), the Nation proposes that tribally self-funded managed care plans be excluded from the sources of recovery.

Tuba City Demonstration Project - Section 412

Specific to the Navajo Reservation is Section 412, which addresses the Tuba City Demonstration Project. Under this section, the I.H.S. will act as a Medicaid managed care organization in Arizona for people who use the Tuba City service unit. I.H.S will provide Medicaid services in return for a uniform per capita payment from the State of Arizona. Of course the provisions in the proposed legislation relating to the development of the Navajo Nation "Tri-State Medicaid Agency" are particularly important to the Navajo Nation. This provision would provide the authorization for the Health Care Financing Administration to work with the Nation to provide a uniform rate for medicaid reimbursement eligible services. Currently on the Navajo Nation there are three sets of rules with respect to medicaid reimbursable services - one for each of the states. Having one set of procedures should improve the processing of reimbursements. Additionally, since the Navajo Nation will operate this Medicaid system, we anticipate that the services can be more culturally relevant to the Navajo population. While the language as proposed sets up this opportunity, upon further reflection some minor revisions to the proposed language will enhance the ability of the Navajo Nation, and perhaps eventually other Tribe to be more self-determining in this critical area: Section 401(d) as drafted, creates the Qualified Indian Health Program (a new Sec. 1880A), in subsection (c)(5) of the proposed sec. 1880A the full cost recovery rate is to be determined by "the Health Care Financing Administration or by a State Medicaid agency..." To allow for the development of the Navajo Nation Medicare Agency, this language should be changed to read: "the Health Care Financing Administration or by a Medicaid agency recognized by the Health Care Financing Administration..." Similarly under section (d)(4) there is a reference to a "State Medicaid plan," this should be changed to "operative Medicaid plan" or other such similar language to allow for the development of tribal Medicaid plans. Section 402(c) amends sec. 1911, which makes substantial reference to "state plans" unless a "catch all" provision is included in the Navajo Nation Medicaid demonstration project section, this should also reference "tribal plans." Section 404(c) adds language to allow IHS to enter into agreements with a state to facilitate eligibility determinations for M&M recoveries. Given that some states have eligibility determinations made at county or local levels, it would seem appropriate to insert "county and local governments" after "State." On a similar level, this whole section seems unfortunately complex. Under subsection (a) IHS can enter into funding agreements with tribes and tribal organizations for eligibility determinations and enrollment in a state plan.

In practice on the Arizona portion of the Navajo Nation, what happens is that IHS gives the Nation these funds, and the Nation then contracts with the county governments for the counties to hire eligibility workers, since otherwise, the Office of General Counsel for IHS has determined that an Intergovernmental Personnel Agreement is required. While this arrangement works, it seems unnecessarily cumbersome; subsection (c) may help address this if "including funding agreements" is inserted after "agreements" in the added language. Otherwise the contracting authority in subsection (a) could be expanded. Section 405(b)(1) provides that a '638 contractor reimbursed for M&M or CHIP services. Further, "Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used to provide additional health services or improvements in its health care facilities." This statement may conflict with the sections in '638 regarding the use of program income, which can be used to provide additional services under the contract scope of work. While in most cases there will be

no conflict - the "additional health services" would be consistent with any given scope of work, it is possible that there might be an inconsistency. Add "consistent with the Indian tribe or tribal organization's contract pursuant to the Indian Self-Determination and Education Assistance Act" at the end of the sentence.

Funding of Unmet Needs and Level of Need Funding

Native American communities have never had their healthcare needs fully met. The Indian Health Service Level of Need Funded resource allocation methodology has outlined a more effective way to address Indian healthcare needs on a national basis. This methodology should be used to address unmet healthcare needs in the Native American/Alaska Native communities. According to the LNF study, I H S is serving only 1.24 million of a total 2.4 million population of Native Americans. The cost is about \$2 billion annually. The Navajo Nation is in support of the recommended \$7.4 billion yearly budget for adequately serving the Native American/Alaska Native population. This \$2,980 per person per year is still beneath the federal and or state healthcare spending levels for non-Indians.

National Bipartisan Commission on Indian Health Care Entitlement The Navajo Nation is in support of the new provision under Title VIII to establish a 25-member National Bipartisan Commission on Indian Health Care Entitlement to study the provision of health care to Native Americans and Alaska Natives as an entitlement. The Navajo Nation recognizes the unique relationship between Native peoples and the United States government and the federal government's admitted responsibility to Native health care. The Navajo Nation supports this Title as a mechanism to improve delivery of services to Native Americans.

Expansion of Diabetes Prevention and Treatment Program

Diabetes continues to ravage Indian communities. Type 2 or Adult Onset Diabetes is of particular concern as it is affecting Indians in greater numbers at lower age groups. Estimates from I H S and the CDC suggest that an average of 45% of the total Native American community is affected by diabetes. Diabetes is listed as the fifth cause of death among Navajos. Navajos die from diabetes at a rate two thirds higher than the national average. A section under Title II has been revised to eliminate a specific list of model diabetes projects and move toward establishing more comprehensive diabetes prevention and treatment programs. The Navajo Nation is in full support of expanding the diabetes program with funding.

Inpatient Rehabilitative Therapy

While covering outpatient rehabilitative therapy, I H S does not pay for inpatient rehabilitation. This is often problematic since according to medical professionals interviewed at rehabilitative facilities that are frequented by Native patients, the inability of Indians to enter into inpatient rehabilitative therapeutic situations places them at higher risk for re-injury and slows the pace at which they ultimately recover. Outpatient rehabilitative therapy for patients who have experienced strokes, cranial injury or spinal cord injuries often includes long drives to and from facilities and inconsistent care often resulting in impeded recoveries and re-injuries. Ultimately, the expenses incurred in these situations are higher than the inpatient therapy. The Navajo Nation

strongly urges the inclusion of inpatient rehabilitative therapy and other therapies recommended by attending physicians or other health care providers under I H S benefits.

Cultural Issues

Staff at most health care facilities that treat large numbers of Indians rarely speak the Native language or have a clear understanding of the cultures they are serving. The presence of a tribal member familiar with the language and customs of his/her constituency is vital to the quality of Indian healthcare, especially in situations where large numbers of elderly frequent the facility. The Navajo Nation supports partnerships with I H S facilities or private health care organizations in maintaining staff who speak the dominant Native language and are trained to assist in the delivery of services such as therapies, patient care, nutritional consultation, tests along with cultural and religious consultation to other staff members, networking with Indian communities.

Conclusion

In closing, I thank you for your consideration and urge your continued support for the reauthorization of P.L. 94-437, the Indian Health Care Improvement Act. Of course if the Committee requires further information or assistance with respect to any of the suggestions put forth by the Navajo Nation, we stand ready to work with the Committee.