

W. Ron Allen, President
National Congress of American Indians
Testimony on

S. 299, to Elevate the Director of the Indian Health Service within the Department of Health and Human Service to Assistant Secretary for Indian Health,
And S. 406, the Alaska Native and American Indian Reimbursement Act of 1999
Before the Senate Committee on Indian Affairs
Washington, DC

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I. INTRODUCTION

Good morning Chairman Campbell, Vice Chairman Inouye and distinguished members of the Senate Committee on Indian Affairs. My name is W. Ron Allen. I am President of the National Congress of American Indians (NCAI) and Chairman of the Jamestown S'Klallam Tribe located in Washington State. On behalf of NCAI, the oldest, largest and most representative Indian organization in the nation, I would like to thank you for the opportunity to present testimony in support of S. 299 and S. 406. NCAI was organized in 1944 in response to termination and assimilation policies and legislation promulgated by the federal government which proved to be devastating to Indian Nations and Indian people throughout the country. NCAI remains dedicated to the exercise of tribal sovereignty and the continued viability of tribal governments. NCAI also remains committed to advocating aggressively on behalf of the interests of our 250 member tribes on a myriad of issues including enhancing the performance of inherent federal functions operated by the Director of the Indian Health Service (IHS) and improving the current system of IHS-managed collections.

II. ELEVATION OF THE IHS DIRECTOR
TO ASSISTANT SECRETARY FOR INDIAN HEALTH

Since the passage of the Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDA), the fundamental policy of the federal government with respect to Indian nations has been to encourage tribal self-determination and self-governance based on a government-to-government relationship between tribal governments and the federal government. This involves the interaction of tribal leaders and federal agency representatives at the highest levels. The Director of IHS holds a position of extreme importance for the health of Indian people and deserves a rank commensurate with the responsibilities of such a position.

The IHS, the largest direct health care provider within the Department of Health and Human Services (HHS), should answer directly to the HHS Secretary to insure that the issues that impact tribes are addressed. There are many legal and cultural issues that are unique to Indian health programs, and tribes look to the IHS Director to insure that these are taken into consideration when Department policy and regulation are developed. In order to do this effectively, the Director should report directly to the Secretary and serve at the top policy making level within the Department. Assistant Secretary for Indian Health is an appropriate rank for the head of the IHS since this agency is responsible for the health care services of over 1.4 million American Indians and Alaska Natives.

Mr. Chairman, the member tribes of NCAI have overwhelmingly supported every effort to elevate the position of the Director of the IHS to the rank of Assistant Secretary for Indian Health. Most recently, our member tribes unanimously provided support for the passage of S. 299 and H.R. 403, the House companion bill (see attached Resolution #VAN-99-048).

III. THE IMPACT OF SELF-DETERMINATION AND SELF-GOVERNANCE ON THE INDIAN HEALTH CARE DELIVERY SYSTEM

As this Committee is well aware, the needs in Indian Country are many; however, the improvement of the health status of Indian people must be of primary concern to the federal government as well as tribal leaders. According to a recent study¹, the following three epidemiological trends define the current health status of Native people:

- ▶ Tuberculosis and gastroenteritis, once major cause of death among Native populations, have been reduced to levels very close to the levels of all other races. However, Native people are at disproportionately high risk of such infections as meningitis, acute respiratory infections, viral hepatitis, sexually transmitted diseases and intestinal infections.
- ▶ The incidences of end-stage renal disease is three times higher among Native populations than white populations, with six times higher due specifically to diabetes. Diabetes is a particular problem to older Native Americans, and its incidence among the youth is increasing. For Native people 55 to 64 years of age, diabetes is the third greatest cause of death.
- ▶ Injuries, intentional and unintentional, represent the second most predominant cause of death among all Native people, but the leading cause of death for ages 5 to 24. The second major cause of death for those 5 to 24 is homicide; for ages 15 to 25, the second

¹ T. Kue Young, Changing Numbers, Changing Needs: American Indian Demography and Public Health, 1996.

major cause of death is suicide, followed by homicide. Indian youth are more likely than youth in the general population to die from accidents, homicide, and suicide. The alcoholism death rate for Native youth ages 5 to 24 is more than 17 times the comparable rate for all races.

In light of these statistics, any effort to improve the health care delivery system in Indian Country should be fully explored by Congress. Given the success of tribal self-determination and self-governance programs throughout the BIA and the IHS, expansion of these opportunities within other federal agencies is the next logical step in the process of improving tribal health care through tribal government assumption of federal health delivery systems.

The passage of Public Law 93-638, the Indian Self-Determination and Education Assistance Act in 1975, marked the beginning of a fundamental turning point in modern federal Indian policy. This new law allowed for tribes to operate federal programs on their reservations through a process known as self-determination "contracting." However, while the process of returning decision-making and funds to local tribal governments had begun in earnest by the mid-1980's, many tribes were frustrated with a federal bureaucracy that was still reluctant to change its role from that of a service provider and manager of tribal affairs to that of an administrator of government contracts.

In 1988, the concept of tribal self-governance was implemented with the passage of Title III to the Indian Self-Determination Act. Through the development of self-governance "compacts", tribal governments were provided greater authority to exercise their inherent self-governing powers. Through self-governance "compacting," tribes can administer and manage programs, services, activities and functions previously managed by the Bureau of Indian Affairs (BIA) and are provided the authority and flexibility to redesign programs and re-program funding to meet the needs of their respective tribal communities. In 1993, the self-governance initiative was extended to include the Indian Health Service (IHS).

Since the initiation of self-determination and self-governance policies, tribes have successfully demonstrated that the concept of redirecting resources based on local priorities and needs has resulted in more effective use of those resources. Tribal governments have repeatedly reported on the numerous benefits of tribal control and decision-making to better meet the health care needs of their people. These benefits include: 1) less regulation; 2) increased financial flexibility; 3) consolidation and redesign of health programs; and, 4) ability to access new programs and funds.

In a study of the National Indian Health Board entitled, "Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management", issues regarding the quality of health care under tribal control and assumption are examined. This study also considers the opportunities and barriers to self-determination "contracting" and self-governance "compacting."

This is the first large-scale review that specifically asks tribal leaders and health directors about their perceptions of the quality of care in the health systems that serve their tribes.

In its findings, the study concludes that:

- ▶ Tribally-managed programs have a better track record than IHS in the addition of new programs, services and facilities;
- ▶ When tribes assume control of health care, they care a high priority to prevention programs; and,
- ▶ As the federal system of Indian health care changes, integration of services is occurring through tribally-controlled organizations.

In summary, the study states that self-determination and self-governance is working, and that tribes that have chosen to manage their health care programs are very successful.

Despite the success of tribal self-determination and self-governance, barriers such as inadequate contract support cost funding are preventing some tribes from exercising their option to choose whether to enter into a contract or compact with the IHS for the assumption of their health care programs.

Unmet health care needs and inadequate funding are also major barriers to tribal contracting and compacting. Unmet health care needs in Indian Country have been as perpetual as the federal appropriations process itself. These growing needs have been documented and testified in countless hearings before congressional appropriators, with adequate funding levels rarely, if ever, provided. The IHS Service population alone is increasing at a rate of 2.1 percent per year, with tribal and urban Indian service area populations keeping pace.² The past four fiscal years (FY1996-99) are examples of the de minimis increases in federal Indian health care programs, which, when compared to rising unmet health care needs throughout Indian Country, are truly token in nature. The expanded authority of tribes to direct bill Medicaid and Medicare would assist tribes in stretching existing funding through increased collections.

IV. EXPANDED TRIBAL AUTHORITY TO DIRECT BILLING OF MEDICAID AND MEDICARE

² INDIAN HEALTH SERVICES, U. S. DEPT. OF HEALTH AND HUMAN SERVICES, TRENDS IN INDIAN HEALTH -- 1996. (This figure excludes the impact of new tribes, or new member participation rates stemming from welfare reform migration of Indian people back to tribal communities).

In examining recommendations for addressing the unmet health care needs in Indian Country, NCAI looks toward a holistic concept of healthy Indian communities, including the expansion of self-determination contracting and self-governance compacting of the Indian health care delivery system. The role and capacity of tribal governments today have changed dramatically over the last century and even more so over the last few decades. Whether providing fundamental services, or programmatic functions that reach out into the community, tribes have learned to overcome the historical impediments to self-sufficiency established and propagated by the federal government. The increased capacity of a tribal governments to administer programs and services independent of federal government intervention breaks historic federal paternalism over the day-to-day management of an Indian tribe's operations and activities. Tribal governments are perfectly capable of assuming federal resources, authorities and responsibilities over federal government programs and services that benefit Indian tribes, including the direct billing of major entitlement programs such as Medicaid and Medicare.

S. 406 authorizes tribes and tribal organizations to directly bill and be reimbursed by Medicare, State Medicaid programs and other third-party payors. This bill makes permanent and extends to all tribes and tribal organizations authority that has been granted to four tribes and tribal organizations under a demonstration project authorized by Section 405 of the Indian Health Care Improvement Act. This project is vitally important to achieving efficiencies in the delivery of and reimbursement for health care services provided by tribes and tribal organizations. Without passage of this bill, the payments due tribes and tribal organizations will continue to be paid first to the IHS, then, after many months, will be transferred back to the tribal health program.

The experience of the four tribal health programs that participated in the demonstration has proven unequivocally that tribal health programs are capable of managing their own billing and collections. Moreover, they have demonstrated that direct access to these important funds lead to improvement in facilities – all of which are now accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Once again, tribes and tribal organizations have proven that the conversion of federal programs and services from federal control to tribal control has led to a far greater level of efficiency in administering those programs and services at the tribal level. In fact, in most instances, tribal health programs now exceed the capacity of the IHS.

As Chairman of one of the original self-governance tribes, I have had the privilege of being able to observe our own effort at streamlining the federal system based on what we refer to as tribally driven initiatives. Since 1988, there are also many other tribes who have enjoyed a great deal of success in implementing such initiatives and feel that their progress shows the Congress and the Administration that tribes can take a federal bureaucratic system and reshape, modify and downsize it into an increasingly effective and efficient system. More important, those federal resources identified in the streamlining process can be transferred directly to the tribes to further increase program and service deliveries. Economic and governmental self-sufficiency has

increased throughout Indian Country, due in large part to the enactment of self-determination and self-governance initiatives³ over the past several years. Increased tribally-controlled government functions, however, created a natural tendency for tribes to begin critically analyzing the service delivery system. This increased tribal autonomy has encouraged sharper criticism of the function of the IHS, specifically that the administration of many federal Indian programs has been consistently both inefficient and ineffective. This charge has come from not only tribal governments, but by members of both the House of Representatives and the Senate.

Although NCAI supports S. 406, it should be noted that the objectives of this measure are not the ultimate goal. Tribes fully believe that the government-to-government relationship between themselves and the federal government is one that for too long has been limited to just the BIA and the IHS. The SCIA is urged to take the lead in expanding this relationship to all cabinet-level departments and their agencies, including the Health Care Financing Administration (HCFA) that oversees this country's major entitlement programs such as Medicaid, Medicare, Supplemental Security Income (SSI) and the Children's Health Insurance Program (CHIP). Until this relationship is expanded, the total capabilities of tribal governments over the management and delivery of federal programs and services in the health care arena will not be fully realized.

V. CONCLUSION

Mr. Chairman, we urge the Congress to fulfill its fiduciary duty to American Indians and Alaska Natives and to uphold the federal trust responsibility as well as preserve the government-to-government relationship, which includes the fulfillment of health care needs of all Indian tribes in the United States. We ask that Congress take into consideration the unique legal and cultural issues at all levels of decision making and service provision in order to fulfill tribal health care needs and improve the health status of all Indian people. This can partially be accomplished by elevating the Director of the Indian Health Services to Assistant Secretary for Indian Health.

Additionally, as the process of amending and further implementing the Indian Health Care Improvement Act (IHCIA) continues through this Congress, NCAI will continue to serve as a lead advocate on eliminating barriers to tribal self-determination in the area of Indian health care. Furthermore, NCAI looks forward to working with the Senate Indian Affairs Committee to develop legislation, such as S. 406, as a way to insure the protection and support of tribal sovereign rights aligned with the provision of Indian health care and its delivery systems to its members.

³See generally, The Indian Self Determination and Education Assistance Act, 25 U.S.C. §§ 450a - 450n.

Mr. Chairman, this concludes my statement. Thank you for allowing me to present for the record, on behalf of our member tribes, the National Congress of American Indians' initial comments on S. 299 and S. 406.

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ATTACHMENT NOT INCLUDED