

TESTIMONY OF RACHEL A. JOSEPH
CO-CHAIR OF THE
NATIONAL STEERING COMMITTEE ON THE
Reauthorization of the Indian
Health Care Improvement Act, P.L. 94-437

Before the United States Senate
Committee on Indian Affairs
March 8, 2000

Good Morning, Mr. Chairman and members of the Committee. My name is Rachel A. Joseph, Co-Chair of the National Steering Committee (NSC) on the Reauthorization of the Indian Health Care Improvement Act (IHCIA). I am here today on behalf of the National Steering Committee to testify in support of the Reathuroization of the Indian Health Care Improvement Act (IHCIA) and joined by Henry Cagey, my Co-Chair during the development of the Tribally-drafted proposed legislation. The IHCIA, first enacted in 1976, is scheduled to expire at the end of fiscal year 2000 (September 30, 2000). The draft bill, which we presented to this Committee, is the most comprehensive to date. And, we believe that it addresses this Nation's policy. Further, it contains the recommendations for modifications and changes that are necessary to improve and enhance the ability of tribal health programs, and urban health programs, and the IHS to provide comprehensive personal and public health services that are available and accessible to all American Indian and Alaska Native people.

I. BACKGROUND

The IHS, an agency in the Department of Health and Human Services, was founded in 1955. Prior to 1955, health services for Indian tribes in the United States were provided by the Bureau of Indian Affairs in the Department of the Interior, which was established in 1849. Some treaties with Indian tribes provided specifically for health services and before 1849, the War Department and philanthropic organizations provided some health care to tribes. The Congress intermittently appropriated funds for Indian health after 1832. By 1880, four hospitals for Indians were operated by the Bureau. In 1908, for the first time, the BIA heath program was placed under the direction of a health care professional. Until 1921, BIA heath services were funded by Congress without any authorizing legislation.

Although Congress expressly authorized the Bureau to expand federal appropriations for the conservation of health in 1921 (the so-called Snyder Act), very little progress was made in addressing Indian health needs from 1921 until 1955. By that time, the poor BIA record had led to a demand for a transfer of Indian health programs to the Public Health Services in the Department of Health, Education and Welfare .

On August 17, 1954, Congress enacted the so-called Transfer Act, which transferred "all functions, responsibilities, authorities, and duties of the Department of the Interior"...relating to the maintenance and operation of hospital and health facilities for

Indians and the conservation of the health of Indians”, to the United States Public Health Service. Since the implementation of the Transfer Act in 1955, the Indian Health Service, as part of the U.S. Public Health Service, has achieved very significant improvement in the health status of Indians and Alaska Natives. Also, since 1955 the Indian Health Service has grown in budget and staffing, which enabled it to be more responsive to the health needs of Indians. According to IHS figures, between 1955 and the late 1970s, the three-year average infant mortality rate for Indians was reduced by 74 percent, maternal mortality was reduced by 90 percent, and Indian deaths per thousands from tuberculosis dropped by approximately ninety-one percent.

Nevertheless, in 1976 the Congress found that “the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.” Rates of death from tuberculosis, influenza, cirrhosis, and infant death remained well above the national average. The failure of the Indian Health Service to involve Indians in planning and delivering health services was also severely criticized.

Consequently, the Congress enacted the Indian Health Care Improvement Act, “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, and for other purposes”. The Act has been the cornerstone for Indian health services developed since its enactment in 1976. The Act has been reauthorized four times, most recently in 1992.

The current authority for the IHCA expires at the end of fiscal year 2000. The reauthorization of the IHCA represents an opportunity to address changes in the current health care environment and the impact of these changes on the evolving needs of the I/T/U/ health care delivery systems:

“A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and delivery of health services.” (P.L. 94-437

As amended in 1988, the Indian Health Care Improvement Act provides detailed directions to the IHS with respect to Indian health manpower, equity in funding Indian health services, alcoholism programs, programs for urban Indians and many other health-related matters. Achievements under the Indian Health Care Improvement Act have been limited by inadequate funding. Nevertheless, the 1976 legislation provided the first detailed statutory guidance to the Indian Health Service as to the particular services and programs which Indians and Alaska Natives are entitled to receive.

The Federal health services to Indian has resulted in a reduction in the prevalence and incidence of illnesses and unnecessary and premature deaths.

Despite such services, the unmet health needs of the American Indian people today remain alarmingly severe, and even continue to decline, and the health status of Indians is far below the health status of the general population of the United States. The disparity to be addressed is formidable. In death rates, for example, Indian people suffer a death rate for diabetes mellitus that is 249 percent higher, a pneumonia and influenza death rate 71 percent greater, a tuberculosis death rate that is 533 percent greater, and a death rate from alcoholism that is 627 percent higher than the rate for all races in the United States.

II. CONSULTATION PROCESS

For almost ten months, tribes have been engaged in a tribally-driven consultation process with the Indian Health Service (IHS) and urban Indian health providers regarding the reauthorization of the Indian Health Care Improvement Act. This process began with the first Area consultation meeting in San Diego, December 1998, with over 100 participants who gathered to develop California Area recommendations for the reauthorization. Subsequent to the San Diego meeting, each Area of the IHS convened meetings of Tribal leaders and urban providers to discuss the reauthorization of this important legislation. These discussion were held over the course of one or more meetings with the expectation that these Area concerns and recommendations would be forwarded to the next step in the consultation process. It was agreed, that the goal of the process was to build a consensus on the issues before us and that the draft, which was to be submitted to Congress, would reflect a consensus of the Indian Health Service/Tribes/Urban Programs (I/T/U), to ensure that when we spoke of the reauthorization we would be ***“Speaking with One Voice”***.

Regional Consultation:

From January to April, 1999 four regional meetings were held across the United States. These regional meetings were intended to provide a forum for I/T/U's to provide input, to share the recommendations from each Area, and to build consensus among the participants for a unified position from each region and through-out Indian Country.

National Steering Committee:

Upon completion of the four regional meetings, this IHS Director convened a National Steering Committee to develop a report on national policy issues and IHCIA recommendations. The National Steering Committee is composed of one elected tribal representative and one alternate from each of the twelve Areas, a representative from the Tribal Self-Governance Advisory Committee, the National Indian Health Board, and the National Council on Urban Indian Health. The membership is as follows:

ABERDEEN

- *Tex Hall, Chairman
Three Affiliated Tribes Business Council
- *Jim Cournoyer (Alternate)
Yankton Sioux Tribe

ALASKA

- *H. Sally Smith, Chairperson
Bristol Bay Area Health Corp.
- *Larry Ivanoff (Alternate)
Norton Sound Health Corp. Inc.

ALBERQUERQUE

- *Rick Vigil, Vice Chairman
All Indian Pueblo Council
- *Robert Nakai (Alternate)
Albuquerque Indian Health Board

BEMIDJI

- *Eli Hunt, Chairman
Leech Lake Band of Ojibwe
- *Sandra Ninham (Alternate)
Oneida Tribal Council

BILLINGS

- *Alvin Windy Boy, Council Member
Chippewa Cree Business Committee
- *Pearl Hopkins, Council (Alternate)
Ft. Peck Tribal Executive Board

CALIFORNIA

- *Rachel A. Joseph, Vice Chairperson
Lone Pine Paiute-Shoshone Reservation
- *Jack Musick, Chairman (Alternate)
La Jolla Reservation

NASHVILLE

- *Joyce C. Dugan, Principal Chief (Former)
Eastern Band of Cherokee Indians
- *Eddie Tullis, Tribal Chairman (Alternate)
Poarch Band of Creek Indians

NAVAJO

- *Dr. Taylor McKenzie, Vice-President
Navajo Nation
- *Jerry Freddie, Council Delegate (Alternate)
Navajo Nation Council

NATIONAL INDIAN HEALTH BOARD

- *Buford Rolin, Chairman

OKLAHOMA

- *Merle Boyd, Second Chief
Sac & Fox Nation of Oklahoma
- *Mammie Rupnicki, Chairperson (Alternate)
Prairie Band of Potawatomi Nation

PHOENIX

- *Arlan Melendez, Chairman
Reno-Sparks Indian Colony
- *Merna Lewis, Vice President (Alternate)
Salt River Pima Maricopa Indian Community

PORTLAND

- *Julia Davis, Secretary
Nez Perce Tribal Executive Committee
- *Pearl Capoeman-Baller, President (Alternate)
Quinalt Indian Nation

TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE PRIMARY

- *Henry Cagey, Council
Lummi Nation
- *Dennis Smith, Vice Chairman (Alternate)
Duck Valley Shoshone Paiute Tribe

TUCSON

- *Edward Manual, Chairman
Tohono O'odham Nation
- *Benito Valencia, Chairman (Alternate)
Pasqua Yaqui

URBAN INDIAN HEALTH PROGRAM

- *Kay Culbertson, Executive Director
Denver Indian Health & Family Services
- *Seh Welch, J.D. (Alternate)
American Indian Health & Services

A 135-page matrix, comparing the recommendations from each of the four regions for every section of the IHClA, was reviewed by the National Steering Committee to develop a final consensus document. The work was divided into five teams as follows:

- (1) Health Services Workgroup for Titles I, II, V, and VII, Chaired by Dr. Taylor McKenzie;
- (2) Health Facilities Workgroup for Title III, Chaired by Julia Davis and Robert Nakai;
- (3) Health Financing Workgroup for Title IV, Chaired by Buford Rolin;
- (4) Miscellaneous Workgroup for Titles VI and VIII, Chaired by Tony Largo; and,
- (5) Preamble Workgroup, Chaired by Henry Cagey.

Each group had primary responsibility for the final presentation of recommending setting forth a framework for reauthorization legislation.

It was agreed by the NSC that, specific "draft bill language" would be developed and proposed by the National Steering Committee to minimize any misinterpretation of our position. The NSC maintained an aggressive schedule of meeting as follows:

Rockville, MD	June 3, 4, 1999
Gaithersburg, MD	June 17, 18, 1999
Rockville, MD	July 7, 8, 9, 1999
Reno, NV	July 13, 14, 1999
Washington, DC	July 27, 28, 29, 1999 (National Meeting)
Salt Lake City, UT	August 30, September 1, 2, 1999
Rockville, MD	September 28, 29, 1999
Palm Springs, CA	October 5, 1999

The National Steering Committee discussed many of the important issues in the full group and others were delegated to individual workgroups. Some of the major issues requiring much discussion by the full group included:

1. **Entitlement:** Whether to seek legislative changes to create an Indian health entitlement was discussed. The issues were referred to a special committee who performed research and provided an overview of the pros and cons of making the delivery of Indian health care an entitlement. It was a consensus that a commission be established to further study and develop recommendations. A key issue is the definition of what an entitlement would be for Indian health.
2. **Urban Programs:** There was much discussion on how urban health programs should be included in the IHClA. It was agreed by the full NSC that urban health issues should be addressed fully in Title V, and in certain areas in other titles as appropriate (research, consultation and certain financial authorization) where it would be unnecessarily cumbersome to duplicate language in Title V.

3. **Permanent or Term Legislation:** There was considerable discussion about whether to seek permanent legislation or term reauthorization. It was agreed that Congress and Indian Country should revisit the question of Indian health periodically. A term of 12 years is proposed for this reauthorization, to the end of Fiscal Year 2012.
4. **Political Follow-Up:** The NSC discussed and agreed to form a special initiative to work on the passage of reauthorization legislation. The National Steering Committee will continue to function as the link between grass roots concerns and the reauthorization process. A special committee comprised of the two Co-Chairs of the NSC, the alternate Co-Chairs of the NSC, Chairs of the NSC work groups and representatives of the National Indian organizations was established to coordinate efforts to ensure timely passage of the reauthorization legislation.
5. **Tribal-Specific Proposals:** The Steering Committee agreed that tribal specific proposals in the Steering Committee bill would not be included unless the following criteria was met:
 - o The provision had national significance with potential for benefit and replication nationwide, but current federal law does not authorize or prohibits implementation or funding;
 - o The provision will not adversely affect or diminish funding which is available to other Indian programs or the I/T/U system that it has a right to; and,
 - o The provision was reviewed and endorsed at the Area, Regional and National IHCA consultation levels.

The NSC also recognized that Congress and tribes could work through the legislative process and that the final law could contain tribal-specific proposals.

National Forum:

At the conclusion of all four regional meetings and after the NSC had met four times and developed draft consensus bill language, a national meeting, co-sponsored by this Committee was held here in Washington D.C. This meeting was to provide time for Tribal leaders, urban health representatives, national organizations, federal agencies, and friends of Indian health, to provide feedback on the legislative proposal. Before this meeting, on July 16, 1999, the draft bill language was mailed to over 1200 tribal leaders, tribal health directors, IHS officials, and urban health programs and other health organizations.

The Steering Committee addressed all of the approximately 1000 comments received and incorporated the many comments and changes into the proposed bill to reauthorize the Indian Health Care Improvement Act. A copy of the draft bill was delivered on October 8, 1999 to this Committee, the House Committee on Resources and other appropriate committees with jurisdiction. A copy of our proposed bill was mailed to every tribe and Indian organization.

III. KEY PROVISIONS

The NSC draft bill, based on all the input and recommendations which we received, addresses the following major issues:

Preamble

The Preamble Section of the Act, as revised in the NSC proposed bill, includes sections on Findings, Declaration of National Policy, and Definitions. Enhanced emphasis was placed on the trust responsibility of the Federal government to provide health services and the entitlement of Indian tribes to these services. The proposed bill has changed the "Declaration of Health Objectives" to the original "Declaration of National Policy". The NSC proposed bill eliminates the enumeration of 61 distinct objectives and would provide that the Federal government will raise the health status of Indians to the levels set forth in "Healthy People 2010". The new Preamble underscores consultation with Indian people and the importance of the Federal-Tribal relationship. Numerous additions to the Definitions Section were made to conform to changes in later titles. When definitions applied only to one section of the Act, the definition is provided in that section and not in the Definitions Section.

Local Control (Self-Determination)

Several programs which have been administered by IHS headquarters were decentralized, with funds distributed to IHS Area Offices for local priority-setting and decision-making by tribes, and includes decisions about whether further distributions should be made available to individual tribes or service units. This feature has been incorporated in most Title I programs for recruitment and training of health professionals.

Entitlement

The NSC heard from many tribal leaders on the subject of authorizing Indian health as an "entitlement" program. Currently, funding for Indian health is considered a "discretionary" program in the federal budget.

NSC Members and tribal leaders considered the critical issues — e.g. what does entitlement mean: (1) how to effectively set out the basis for an entitlement from a political perspective; (2) how to address the anticipated increased cost of an entitlement program; (3) how an entitlement provision would effect the overall bill; and, (4) how an entitlement program would

be designed.

While the NSC agrees that the Federal government has a trust responsibility to provide Indian health services and facilities, it recognizes that there are many unanswered questions regarding what constitutes an entitlement; what criteria should be applied to define the entitlement class; whether the entitlement flows to tribes or individual Indian people; and, what benefits should be included in an entitlement package.

At the recommendation of its Entitlement Subcommittee, the NSC included in Title VIII of the draft bill, a provision that would create a Tribal/Congressional Commission to evaluate entitlement issues and make recommendations to Congress on how Indian health care can be provided on an entitlement basis. The NSC considers this provision to be a starting point and welcomes further comments.

Qualified Indian Health Program (QIHP)

The proposal would create QIHP as a new “provider type” for Medicaid and Medicare reimbursement eligibility. All I/T/Us would qualify [new Sec. 1880A of the Social Security Act].

- There are several payment options from which a QIHP could select, including a full cost recovery method that would include indirect costs (but precluding any over recovery of indirect costs).
- A QIHP could elect to include the following services in its recovery rate: preventive primary care; CHIP services; various immunizations; patient transportation; and, services performed by an employee licensed/certified to perform such services that would be reimbursable if performed by a physician.

Direct Billing/Collections Demonstration

The proposed bill would make permanent and extend to all Tribal health programs the demonstration project for direct billing under Medicaid and Medicare.

Facilities

Title III regarding health facilities underwent several changes in order to provide a broad view of the total unmet facilities needs of Indian tribes and tribal organizations and to develop innovative funding opportunities to meet these needs. The Title was expanded to overcome previous limitations and to give Indian tribes and tribal organizations a greater capacity to meet their various facilities needs, including the use of private sources of credit to address the health facility construction backlog. Facilities-related provisions from other Titles we’re re-located here.

Behavioral Health Programs

Title VII in the current law is limited to substance abuse programs. In the draft bill, substance abuse, mental health and social service programs are combined in a new Title VII under the heading of "Behavioral Health Programs". The objective is to integrate these services. Provisions have been added to clarify that programs are subject to contracting and compacting by tribes and tribal organizations. The term "funding" has been used to replace "grant" in order to clarify that Tribes and tribal organizations can utilize contracts, compacts, grants, or any other funding mechanisms, and are not limited to grants.

Development of local and area-wide behavioral health plans are encouraged, and the requirement for a National Indian Mental Health Plan is dropped. The section on Youth Treatment Centers has been amended to allow at least one center per Area. New authority is proposed for the establishment of at least one in-patient psychiatric treatment facility per IHS area.

IV. SUMMARY OF TITLES

Title I - Indian Health, Human Resources, and Development

Title I was substantially rewritten to shift priority-setting and decision-making to the local Area levels. Throughout the Title, the listing of distinct disciplines of health professionals was eliminated and replaced with more generic terminology, which includes all health professionals, with only a few exceptions. Special programs were eliminated if these professional disciplines were eligible to receive support under generic programs of this Title. The setting of preparatory and scholarship priorities have been decentralized to the Area Offices based upon Tribal consultation. The administration of scholarship funds is proposed to remain an IHS headquarters function. Language was included to require Title I recipients to fulfill their scholarship job placement requirements in the Areas from which they received their scholarship assistance. Language was also proposed to protect Title I recipients who are already in the "pipeline" for assistance. Eligibility requirements for scholarship and preparatory scholarships were amended so that only persons who are Indian are eligible. Demonstration projects were eliminated in lieu of establishing regular funding for Tribal programs across the board. A new section was proposed, clarifying that all scholarships, loans, and repayment of loans are "non-taxable". Amendments were proposed in this Title to clarify that tribal "matching" requirements for scholarship programs can be from any source, including other federal funds. The training and certification sections for mental health and substance abuse workers were relocated from Title II and Title VII to this Title.

Title II - Health Service

Title II represents a collection of diverse sections addressing issues related to the delivery of health services to Indian populations. This Title continues to address issues of “equity” in the allocation of health resources and attempts to address health care deficiencies. A new section provides a listing of types of services authorized, which were not previously listed. One major change proposed in Title II is the removal of Section 209 “Mental Health Services” from this Title, transferring it to Title VII “Behavioral Health”. Throughout most provisions, the term “Indian Tribes and tribal organizations” has been inserted as equal partners with the IHS. A significant change in Section 202, “Catastrophic Health Emergency Fund” (CHEF) is proposed. This change will authorize the IHS to allocate total CHEF funds among the twelve Areas for administration at the Area level. The IHS Area Offices must consult with Tribes in establishing and operating the Area CHEF program. An earlier proposal, considered by the NSC, to set a lower national threshold for Tribes or Areas “dependent” upon Contract Health Services was deleted in favor of this Area-specific approach. An Area-specific allocation methodology must be negotiated with Tribes through a rule-making process. Language was included that prohibits the allocation or assignment of shares of CHEF funds under the provisions of the ISDEAA.

Section 204, “Diabetes Prevention and Treatment”, was expanded to establish a national program, not a “model” based program, to provide authority for the continuation of funded diabetes projects. Individually name community “models” were deleted in the bill, in favor of a national emphasis, with the intent that these programs will continue as a part of a national strategy. Several sections regarding reimbursement and managed care will be shifted to Title IV.

Section 207 was expanded to focus attention on “all cancers” including, but not limited to, mammography screening for breast cancer. Language was added to require that “Epidemiology Centers” be established in each of the twelve IHS Areas. They can be contractible under the ISDEAA, but not divisible. The Comprehensive School Health Education and the Indian Youth Programs were changed to provide funding to Tribal or urban programs throughout the United States.

The Office on Indian Women’s Health Care was also changed to a Women’s Health Program providing funds for Tribes and tribal organizations, as opposed to an office in the IHS headquarters. In addition, several sections from Title VIII were moved to Title II, including the provision on Nuclear Resource Development and Health Hazards. This Section was changed to Section 215, Environmental and Nuclear Health Hazards, and made applicable nationally to address environmental health hazards that may require ongoing monitoring or study. Section 220 provides for the fair and equitable funding of services operated by the Tribes under funding agreements just like those operated directly by IHS. Section 221 requires that the licensing requirements of staff employed by Tribally operated programs be consistent with

IHS employees. There was an effort to consolidate all the Contract Health Service (CHS) provisions within this Title (sections 216, 217, 218, 219, 222, 223, and 224), which

strengthens the prohibition against CHS providers from holding individual Indian patients liable for CHS approved bills.

Title III - Health Facilities

Numerous changes are proposed for Title III to address facility concerns, Section 301 states that Tribal consultation shall be required for any and all facility issues not just facility closures. Recommendations on the accreditation of health care facilities were made “not to be limited only to the Joint Commission for the Accreditation of Health Care Organizations”, but instead, open to any nationally recognized accreditation body. Annual reporting on facility requirements should not be limited to the “10 top priority projects”, but reflect the true unmet need in Indian Country. A clause was included to provide protection for all projects on the existing priority list.

Language was proposed in Section 302, which will strengthen the relationship between IHS and the U.S. Department of Housing and Urban Development (DHUD), regarding safe water and sanitary disposal, and authorize the use of IHS funds to leverage additional resources. To be consistent with P.L. 86-121, the term “facilities” was used in place of “systems”.

Section 305 clarifies that Tribes, to assist in the expansion, as well as the renovation or modernization of IHS or Tribal health facilities, may use any source of funds. Language was also provided to allow for peer review for small, ambulatory care facilities applications. The Indian Health Care Delivery Demonstration Project was expanded to include facilities such as hospice care, traditional healing, childcare, and other activities. Originally, the NSC attempted to make this section more national in scope and deleted references to the nine individually named Tribal communities. However, the NSC added the list back, pending a final update or status report from the IHS regarding the necessity for listing each project. If it is not necessary, the NSC supports deleting these tribal-specific references in this Title.

The bill seeks to encourage the use of private credit sources for construction of health facilities by requiring that leases of such facilities from Tribes to the IHS be treated as “operating leases” for Federal budget purposes.

Land transfers under Section 308 are authorized for all Federal agencies. A major new provision, Section 310, provides for loans, loan guarantees, a revolving loan fund and a grant program for loan repayment on new health facilities. It also provides that Congress appropriates funds for a Health Care Facilities Loan Fund made available to Tribes and tribal organizations for the construction of health care facilities.

A new section was established for the IHS/Tribal Joint Venture Program, which was originally in Title VIII. The Joint Venture Program now appears as Section 312 and provided for creative, innovative financing by Tribes for the construction of health facilities, in exchange for the IHS commitment for equipment and staffing. A new Section 314 authorizes the use of “Maintenance and Improvement” funds to be used to replace a facility when it is not economically practical to repair the facility. Section 315, another new section, provides

clarification for Tribes operating health care facilities under the ISDEAA. It states that Tribes can set their own rental rates for all occupants of Tribally operated staff living quarters and collect rents directly from Federal employee occupants. Another important new provision to Title III, provides for "Other Funding" to be used for the construction of health care facilities and opens the door for alternative financing options for Tribes and tribal organizations.

This new Section includes a provision to ensure that the use of alternative funding does not jeopardize a Tribe's placement on the priority list referred to in Section 301.

Title IV - Access to Health Service

The provisions in this Title attempt to eliminate barriers which prevent IHS, Tribes, tribal organizations and urban Indian health programs from fully accessing reimbursement from other federal programs, including Medicaid, Medicare, and the Children's Health Insurance Program (CHIP), for which their patients are eligible. By eliminating barriers, it is intended that IHS, Tribes and urban programs take maximum advantage of these other federal funding streams. The severe and longstanding lack of adequate appropriations for the IHS requires that alternative funding streams be accessed to the maximum extent possible consistent with the unique Federal trust responsibility to provide health services to Indians.

The provisions in Title IV of the IHCA, and the related conforming amendments to the Social Security Act, seek to accomplish three major goals:

- To maximize recovery from all third-party sources, including Medicaid, Medicare, and CHIP, and any new Federal funded health care programs;
- To ensure that Indians have access to culturally competent care provided by the Tribes, tribal organizations or urban Indian organizations, and therefore are not automatically assigned without approval to non-Indian managed care plans; and,
- To ensure that when an Indian health program provides services, the full cost of providing services will be reimbursable.

In order to achieve these goals, specific amendments to the Social Security Act must be enacted. Medicaid and Medicare are amended to provide authorization for the IHS and tribal health programs for cost recovery for all services for which these programs pay. This will eliminate out-of-date limitations to payment for services in certain facilities. The requirement that Medicaid and Medicare payments to tribal health programs be processed through the IHS "special fund" has also been eliminated and IHS is required to send 100% of its Medicaid and Medicare receipts to the Service Unit that generated the collection. See Sections 401, 402, and 405. To ensure accountability, Section 403 requires all Indian health programs to submit provider enrollment identification to allow the IHS and the Health Care Funding Administration to track payments and reimbursements for services for the purpose of

reporting and monitoring.

Several amendments, including Sections 404 and 420, are intended to improve relations between States and Indian health programs and to provide increased flexibility in these historically difficult relationships. Section 408 proposes to authorize Tribes to purchase insurance using IHS funds. Specific new language is provided in Section 410, clarifying that IHS is the “payor of last resort”. Section 411 provides corollary authority which authorizes the Indian health system to bill for other federal reimbursements unless explicitly prohibited. A new Section 412 established the “Tuba City Demonstration Project” one of only two new demonstration projects recommended by the NSC in Title IV. This demonstration project authorizes the IHS operated Service Unit in Tuba City to function as a “managed care organization” as part of the Arizona plan. Section 413 authorizes Tribes and tribal organizations to purchase Federal health and life insurance for their employees. In Section 414, specific consultation and negotiated rulemaking procedures are included to address issues with HCF.

Other amendments seek to address related problems faced by the IHS and tribal health programs in their relationship to Medicaid and Medicare and to other health providers accepting payment under contract health. Section 415 requires “most favored” status to be provided to IHS, Tribal or urban Indian organizations when purchasing service. It provides for Indian health system providers to receive the same rates given to other preferred Federal customers, such as Medicare.

A new provider type has been created for the IHS and tribal health programs; the Qualified Indian Health Program (QIHP). It recognizes the unique cultural and programmatic characteristics of Indian health programs and provides for full cost recovery subject to efficiency measures. This section was carefully crafted to ensure that Indian health programs, to which the United States owes a specific duty, receive the benefits made available to other health providers who meet the needs of specific populations. The draft bill also provides that the 100% Federal Medical Assistance Percentage will be provided to states for CHIP services reimbursed to Indian health programs, as is currently the case with Medicaid, and extends that definition to include referral services paid by the Indian health program. This minimizes artificial and unfair distinctions between Indian health programs that provide direct services compared to those that must rely on contract health. A new section also authorizes the Secretary of the Department of Health and Human Services (DHHS), to contract directly with Indian Tribes through block grants for the administration of CHIP programs to Indian children within the Tribe’s service area. Section 428 will eliminate or “waive” all cost sharing for IHS eligible beneficiaries served by Indian health programs under Medicaid, Medicare, and CHIP. This section also includes language to ensure that Indian people are not subject to estate recovery proceedings or that the impact of estate recovery is minimized by eliminating trust income, subsistence or traditional income. Similarly, a new section will protect parents who are required to apply for Medicaid as a condition of receiving services for their Indian children from an IHS or tribal health program or under the contract health program, for their children from being obligated to repay Medicaid under a medical child support order. Other new provisions address managed care plans. It ensures that

Indian people may not be assigned involuntarily to these plans and that such plans must pay for the services provided by Indian health programs.

Section 430 established the second demonstration included in the Act, the Navajo nation Medicaid Agency” to serve Indian beneficiaries residing within the boundaries of the Navajo Nation, authorizing a direct relationship between the Tribes and the HCF. The NSC elected to promote the Navajo Nation Medicaid Agency as a demonstration effort.

The NSC recognizes that these provisions are ambitious. However, they are critical to ensuring that Indian health programs have fair access to critical Federal funding sources and the opportunity to modernize their programs to address the needs of and fulfill the responsibility of the United States to Indian People.

Title V - Health Services for Urban Indians

This Title covers the majority of provisions for urban Indians. With only a few exceptions, funding authority for urban Indian health was specifically limited to only Title IV and Title V. All other references to urban Indian health found in other titles address issues of consultation, rulemaking, planning or reporting. Title V provided authority for the IHS to fund health service programs serving urban Indian populations. It serves approximately 149,000 urban Indians in 34 different cities throughout the United States. The programs funded under Title V represent a wide range of services, from outreach and referral programs to comprehensive primary care centers. The amendments recommended by the NSC provided minor changes to the existing law and adds new provisions to Title V. The major changes proposed in the bill for Title V include the following:

- To streamline the current law relating to the standard and procedures for contracting and making grants to urban Indian organizations;
- To require the agencies in the DHHS to consult with urban Indians prior to taking actions that would affect them and to establish a negotiated-rulemaking process;
- To expand the Secretary’s authority to fund, through grants, loans, or loans guarantees, the construction or renovation of facilities for urban Indian programs;
- To enable urban Indian programs to obtain malpractice coverage under the Federal Tort Claims Act, similar to Tribes and community health centers; and,
- To authorize a demonstration program for residential treatment centers for urban Indian youth with alcohol or substance abuse problems.

Language is proposed to allow urban programs the authority to receive advance, lump-sum payments for IHS contracts or grants under this Title, and to use carry-forward funding from

one year to the next. Reporting requirements have been changed from quarterly to semi-annually, and language is proposed to clarify audit requirements. In addition, language is proposed which will allow for funds to be used for facility construction, renovation, expansion, leasing or other purposes. To be consistent, with the redesign of IHS, the department title "IHS Urban Branch" was changed to the "Office of Urban Health". Language was added requiring IHS and the DHHS to consult with urban programs on issues affecting urban Indian populations. A new provision proposes to establish at least two (2) urban Indian youth treatment centers as demonstration programs. The bill proposes similar provisions, as is available to Tribes, for access to federal facilities and suppliers, diabetes prevention and treatment. Section 512 proposes no changes to the Oklahoma City program, but recommends the Tulsa program be made permanent and not subject to the provisions of the ISDEAA. The NSC was notified that consensus had not been achieved among tribes regarding the Oklahoma City program, therefore the NSC did not recommend any changes to existing law regarding this program.

Title VI - Organizational Improvements

Only a few changes are proposed in this title. Future amendments will be considered to incorporate the elevation of the Director of the Indian Health Service to an Assistant Secretary for Indian Health, if legislation currently pending in Congress do not move forward. Unnecessary provisions were deleted in this title if activities had already been completed. New language was proposed authorizing the IHS to enter into contracts, agreements or joint ventures with other federal agencies to enhance information technology.

Title VII - Behavioral Health

Title VII is recommended for major revisions, specifically to integrate Alcohol and Substance Abuse provisions with Mental Health and Social Service authorities. Section 209 from Title II has been moved to the new Title VII. Where appropriate, the terms "Tribes, Tribal organizations and Indian organizations" are referenced in addition to IHS. Provisions that require a "National Plan" were deleted, in lieu of new language establishing a process for locally based behavioral health planning. A broad range of behavioral health services is described under "continuum of care". Several related sections were moved from Title VIII, including sections on Fetal Alcohol Syndrome and Child Sexual Abuse. Demonstration programs were eliminated and replaced with language authorizing programs for Indian Tribes and tribal organizations. The section on Youth Treatment Centers has been amended to allow

for at least one center per Area (including Phoenix and Tucson Areas) and retained authority for two treatment "networks" in California. A new section was proposed in this Title authorizing the establishment of at least one in-patient psychiatric treatment facility for each IHS Area.

These new centers would be funded on a similar basis as the Regional Youth Treatment

Centers. All Tribal-specific programs have been deleted in Title VII, except for facilities operated by the Tanana Chiefs Conference and the Southeast Alaska Regional Health Corporation, with the understanding that continued funding is authorized under general provisions of this Title.

Title VIII - Miscellaneous

Ten sections were moved out of Title VIII to more appropriate sections in the IHCA. All Contract Health Services provisions were moved to Title II. A majority of the “free-standing and severability” provisions were incorporated into Title VIII. A listing of all reporting requirements, contained in the Bill, have been restated in Section 801 of this title. New language was proposed, in regard to negotiated rulemaking procedures in Section 802, requiring the Secretary to initiate these procedures 90 days from the date of enactment. This section also establishes a maximum amount of time for negotiated rules to be printed in the federal register, not later than 270 days after the date of enactment. The authority to promulgate regulations under this Act expires after 18 months from the date of enactment; thus, expecting the rulemaking process. Section 803 requires the Secretary, in consultation with Tribes and urban Indian organizations, to develop a “plan of implementation” for all provisions of this Act. Section 804 continues the prohibition on abortion funding, as it exists in current law. Eligibility of California Indians was covered under Section 805 except that provisions which have already been accomplished, are deleted. Health Services for Ineligible Persons is included in the proposed bill as it appears in current law, with only minor technical changes.

Section 812 amends the Eligibility Moratorium and provides that the Secretary shall continue to provide services in accordance with eligibility criteria in effect on September 15, 1987 until such time as new criteria governing eligibility for services is developed in accordance with negotiated rulemaking provisions in Section 802.

Finally, a major amendment is proposed in Section 816, with the Establishment of a National Bi-Partisan Commission on Indian Health Care Entitlement. The NSC, based upon strong recommendations from the Regional and National consultation meetings, examined the establishment of an entitlement provision for Indian Health Services through the IHCA reauthorization process. The Committee found that a number of issues related to the establishment of an entitlement provision, and that the need for extensive and representative Tribal consultation required further study.

A Commission was therefore proposed. The Commission will review all relevant data, make recommendations to Congress, establish a “Study Committee”, and submit a final report to Congress.

The membership of the Commission will be 25 members, including:

- 10 Members of Congress
- 12 persons appointed by Congress from Tribal nominees (who are members of Tribes)
- 3 persons appointed by the Director of the IHS (who are knowledge about health care services for Indians, including one specifically addressing urban Indian issues).

Meetings require that a quorum of not less than 15 members be present, to conduct business. The Commission will have the power to hire staff, hold hearings, request studies from the General Accounting Office, the Congressional Budget Office and the Chief Actuary of HCFA, detail federal employees, and expend appropriated funds. Two reports are proposed. The first report, "Finding and Recommendations", must be made to the Commission by the Study Committee no later than 12 months from the date all members are appointed. The second, "A report to Congress: On Legislative and Policy Changes," must be made by the Commission to Congress no later than 18 months from the date all members are appointed.

V CONCLUSION:

The decision of the NSC to develop bill language, as opposed to general recommendations, required the actual writing of detailed bill language to be entrusted to a "Drafting Team" composed of the NSC co-chairs, tribal attorneys, and program staff. After each drafting session, the full NSC, at its next regular meeting, reviewed the new draft language.

The National Steering Committee completed a monumental task, on time, and with the broad support of Indian Tribes and communities across the United States. There was overwhelming support for the vast majority of changes described in the NSC Proposed Bill and for the highly participatory consultation process. We addressed complex and controversial issues and developed consensus solutions that met the needs of those most concerned. There were areas where there was considerable debate, which exemplified the complexity and controversy of some issues. A conflict resolution was approved and used when necessary.

This process of consultation was one of the most rewarding experiences I have been engaged in and I strongly believe that those involved "stepped up to the plate" in an aggressive, "take control approach" to fulfill what we believed was a major responsibility to Indian Country.

Thank you for the opportunity to present testimony on behalf of the National Steering

Committee.