**TESTIMONY OF RACHEL A. JOSEPH**
**Co-Chair of the**
**NATIONAL STEERING COMMITTEE ON THE**
**REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT**

**Before the United States**
**Senate Committee on Indian Affairs**
**and**
**House Committee on Resources**
**July 16, 2003**

Good morning, Chairman Campbell, Chairman Pombo and members of the Committees. My name is Rachel A. Joseph Chairperson of the Lone Pine Paiute-Shoshone Tribe and Co-Chair of the National Steering Committee (NSC) on the Reauthorization of the Indian Health Care Improvement Act (IHCIA). I also serve as Chairperson of the Toiyabe Indian Health Project, Inc. which is a consortium of nine Tribes serving Inyo and Mono counties on the eastern side of the beautiful Sierra Nevada mountains in Central California. I am here today on behalf of the National Steering Committee to testify in support of the reauthorization of the Indian Health Care Improvement Act. The draft bill which we presented to these committee was the most comprehensive since the IHCIA was first enacted in 1976; and, we believe that draft was consistent with our Nation's policies and priorities. Further, it contained recommendations for changes that are necessary to improve the ability of Tribal health programs, urban health programs, and the Indian Health Services (I.H.S.) to provide comprehensive personal and public health services that are accessible to American Indian and Alaska Native people.

## I. BACKGROUND

The I.H.S., 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; and, by 1880 four hospitals for Indians were operated by the Bureau. In 1908, for the first time, the BIA health program was placed under the direction of a health care professional. Until 1921, BIA health 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(Snyder Act); but very little progress was made in addressing Indian health needs from 1921 until 1955. By that time, the poor BIA record for the administration of health care services 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 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 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 I.H.S. figures, between 1955 and the late 1970's, 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.

In 1976, 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, 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 IHCIA has been the cornerstone for Indian health services since its enactment in 1976. The Act has been reauthorized four times, most recently in 1992.

The reauthorization of the IHCIA represents an opportunity to address changes in the health care environment and the impact of these changes on the needs of the I.H.S./Tribal/Urban (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 1998, the Indian Health Care Improvement Act provides detailed directions to the I.H.S. concerning 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 particular services and programs which Indians and Alaska Natives are entitled to receive.

Federal health services to Indians and Alaska Natives has resulted in a reduction in the prevalence and incidence of some 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. 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. Oral health conditions of our population is poor with our patients experiencing approximately 3 times that amount of tooth decay and periodontal disease that the US general population.

The mortality rate for Indian people due to diabetes is 420% of the rate for the rest of the nation. The occurrence of Type 2 diabetes is rising faster among our children and young adults than in any other population; and, its occurrence is 2.6 times the national average. The number of American Indians and Alaska Natives suffering due to end stage renal disease is 2.8 times the rate for white people; and, the rate of diabetic end stage renal disease is 6 times the rate for the rest of the nation. Amputations due to diabetes occur at rates 3 to 4 times the rates for the rest of the nation. Cardiovascular disease is now the leading cause of mortality among Indian people, with a rate that is almost 2 times that of the U.S. general population. The death rate for Indian people, due to accidents, is 280% of the rate for the U.S. general population; and, for alcoholism the rate is at 770%. Our pneumonia and influenza death rate is 52% greater and the tuberculosis death rate is 650% greater. The recent fully analyzed and racially adjusted mortality data (FY 1999) available from the National Center for Health Services documents an overall 4.5% increase rate for American Indian and Alaska Native people from 698.4 per 100,000 population for the period 1994-1196 to 730.1 per 100,000 for the period 1997-1999.

## II. CONSULTATION PROCESS

In 1999, for almost ten months, tribes engaged in a tribally-driven consultation process with the Indian Health Service (I.H.S.) 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 I.H.S. convened meetings of Tribal leaders and urban providers to discuss the reauthorization of this important legislation. Discussions were held over the course of several meetings with the expectation that 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 legislation 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 through April, 1999, four regional meetings were held across the United States. These regional meetings were intended to provide a forum for I/T/Us 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 throughout Indian Country.

**National Steering Committee:**

Upon completion of the four regional meetings, the I.H.S. 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 National Indian Health Board, National Council on Urban Indian Health and the Tribal Self-Governance Advisory Committee.

A 135-page matrix, comparing the recommendations from each of the four regions for every section of the IHCIA, 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 Wheeler 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 final presentation of recommendations setting forth a framework for reauthorization legislation to the full NSC.

It was a consensus of 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 meetings as follows:

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| Rockville, MD | June 3, 4, 1999 |
| Gaithersburg, MD | June 17, 18, 1999 |

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| 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 care entitlement was discussed. The issues were referred to a special committee who did research and provided an overview of the pros and cons of making the delivery of hdian 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 care.

2. **Urban Programs:** There was much discussion on how urban health programs should be included in the IHCIA. 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 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 Indian health care periodically. We propose a term of 12 years for this reauthorization.

4. **Follow-up:** The NSC discussed and agreed to form a special initiative to work on the passage of reauthorization legislation. The National Steering Committee continues to function as the link between grass roots concerns and the reauthorization process. A special committee comprised of the two NSC Co-Chairs, Chairs of the NSC work groups and representatives of the National Indian organizations was established to coordinate efforts related to the 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:

- The provision had national significance with potential for benefit and replication nationwide; and, current federal law does not authorize or prohibits implementation or funding;

- 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,

- The provision was reviewed and endorsed at the Area, Regional and National IHCIA consultation levels.

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

**National Forum:**

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

The Steering Committee addressed all of the approximately 1000 comments received; and, incorporated many comments and recommendations 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 both the Senate Indian Affairs Committee and 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

S.556 and H.R. 2240 reflects the NSC recommendations which were based on all the input and recommendations we received and addresses the following major issues:

### Preamble

The Preamble Section of the Act, as revised by the NSC, includes sections on Findings, Declaration of National Policy, and Definitions. Emphasis is placed on the trust responsibility of the Federal government to provide health services and the entitlement

of Indian tribes to these services. The "Declaration of Health Objectives" has changed to "Declaration of National Policy". The NSC proposed and S.556 and HR 2240 eliminates the enumeration of 61 distinct objectives and provides that the Federal government will raise the health status of Indians to the levels set forth in "Healthy People 2010" or successor standards. 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)**

Some programs which have been administered by I.H.S. headquarters were decentralized, with funds distributed to I.H.S. 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 Title I programs for recruitment and training of health professionals.

**Entitlement**

The NSC heard from many tribal leaders supporting authorizing Indian health care 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 issue such as what would entitlement mean for Indian health care: (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 may 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 created a 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; SCHIP 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.

In May of 2002, in a meeting at Portland, Oregon the NSC agreed that the provision authorizing this new provider type could be deleted in response to Secretary Thompson's concern that QIHP was complex and would be administratively burdensome. Also, we acknowledged that the CBO score of this provision – in excess of $3 billion over ten years – could be a deterrent to timely reauthorization of the IHCIA.

## Direct Billing/Collections Demonstration

The NSC proposed making permanent and extending 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 approach to address the 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 were re-located here.

## Behavioral Health Programs

Title VII in the current law is limited to substance abuse programs. In S.556 and H.R. 2440, 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 mental health care facility, or the equivalent, per I.H.S. area.

## IV. SUMMARY OF TITLES

### Title I – Indian Health, Human Resources, and Development

Title I was rewritten to shift some 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 professionals disciplines were eligible to receive support under generic programs of this Title. The NSC determined that the decision for the Health Professions Scholarships should be decentralized to the Area Offices based upon Tribal consultation. The administration of scholarship funds is proposed to remain an I.H.S. headquarters function. The NSC also prefers that Title I recipients fulfill their scholarship job placement requirements in the Areas from which they received their scholarship assistance unless special circumstances require otherwise. Language was also provided to protect Title I recipients who are already in the "pipeline" for assistance. Demonstration projects are eliminated in lieu of establishing regular funding for Tribal programs across the board. A new section clarifies that all scholarships, loans, and repayment of loans are "non-taxable". Amendments in this Title 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 in the IHCIA Title II is the removal of Section 209 "Mental Health Services" from this Title and 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 I.H.S. A significant change in S.556 in Section 202, "Catastrophic Health Emergency Fund" (CHEF) is proposed. This change will authorize the I.H.S. to allocate total CHEF funds among the twelve Areas for administration at the Area level. The I.H.S. 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 is included that prohibits the allocation or assignment of shares of CHEF funds under the provisions of the ISDEAA. In H.R. 2440 the CHEF provision continues to provide for the administration of chef funds as currently done.

Section 204, "Diabetes Prevention and Treatment", is expanded to establish a national program, not a "model" based program, to provide authority for the continuation of funded diabetes projects. Individually named community "models" are deleted in the bills, 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 were shifted to Title IV.

Section 207 is expanded to focus attention on "all cancers" and not limited to, mammography screening for breast cancer.

Language is added in Section 209 to require that "Epidemiology Centers" be established in each of the twelve I.H.S. Areas. They can be contractible under the ISDEAA but not divisible.

The Comprehensive School Health Education and the Indian Youth Programs are changed to authorize funding to Tribal or urban programs throughout the United States.

The Office on Indian Women's Health Care is changed to a Women's Health Program providing funds for Tribes and tribal organizations, as opposed to an office in the I.H.S. headquarters. In addition, several sections from Title VIII are moved to Title II, including the provision on Nuclear Resource Development and Health Hazards. This Section is 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 I.H.S. Section 221 requires that the licensing requirements of staff employed by Tribally operated programs be consistent with I.H.S. employee requirements. All the Contract Health Service (CHS) provisions are consolidated within this Title (sections 216, 217,

218, 219, 222, 223, and 224), and strengthens the prohibition against CHS providers from holding individual Indian patients liable for CHS approved bills.

### Title III – Health Facilities

Numerous changes are made in Title III to address facility concerns, Section 301 states that Tribal consultation shall be required for all facility issues not just facility closures. Recommendations on the accreditation of health care facilities are 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 in S.556; and in H.R. 2440 the requirement is to meet standards recognized by the Secretary for the purposes of medicare, Medicaid and SCHIP programs under title XVIII, XIX, XXI of the Social Security Act. 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 is included to provide protection for all projects on the existing priority list.

Language concerning Safe Water and Sanitary Waste Disposal Facilities in Section 302 of S.556, reiterates a cooperative relationship between I.H.S. and the U.S. Department of Housing and Urban Development (DHUD), regarding safe water and sanitary disposal; and, authorizes the use of I.H.S. funds to leverage additional resources. To be consistent with P.L. 86-121, the term "facilities" was used in place of "systems". After the consensus position was reached on this issue reflected in S.556 Section 302 there has been an effort by some housing advocates to amend the language that prohibits the use of I.H.S. funds for newly constructed HUD homes. Why do it since the I.H.S. Section 302 funding is already critically under funded for this "Safe Water and Sanitary Waste Disposal Facilities" program? Since 1982 Congress has repeatedly expressed its intent that none of the funds appropriated to the I.H.S. may be used for sanitation facilities for new HUD constructed homes. This system worked fairly well until 1996 when NAHASDA was enacted and funding is now distributed by a formula which does not currently account for deficiencies or cost of off-site sanitation facilities. The I.H.S. has as one of its Government Performance Results Acts (GPRA) indicators for FY 2005 to increase the proportion of American Indians and Alaska Native population recovering optimally fluoridate water by 0.5% over FY 2004 levels. The FY 2002 indicator committed to a 5% increase of American Indian and Alaska Native benefiting from fluoridated drinking water. While the FY 2002 indicator was not fully achieved, 15 small systems, not previously optimally fluoridated, became fluoridated adding 20,580 individuals to those receiving the benefits of fluoridated water. Since fluoridation is one of the most cost effective public health measures for reducing the prevalence of dental decay in all age groups we must do what we can to ensure that these limited funds remain available for these purpose. I.H.S. GPRA indicator number 35 for FY 2005 is to provide sanitation facilities to 22,300 new or like-new homes and existing Indian homes.

For FY 2004 the goal is to service 15,150 homes and in FY 2002 15,255 homes were served (2,528 new/like new and 12,727 existing).

Section 305 clarifies that Tribes, to assist in the expansion, as well as the renovation or modernization of I.H.S. or Tribal health facilities, may use any source of funds. Language in H.R. 2440 allows for peer review for small, ambulatory care facilities applications. The Indian Health Care Delivery Demonstration Project in section 306 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 I.H.S. regarding the necessity for listing each project. If it is not necessary, the NSC supports deleting these tribal-specific references in this Title.

The bills facilitate the use of private credit sources for construction of health facilities by requiring that leases of such facilities from Tribes to the I.H.S. be treated as "operating leases" for the purpose of scoring under the Budget Enforcement Act.

A major new provision of S.556, Section 310 and Section 309 of H.R. 2440 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 is established for the I.H.S./Tribal Joint Venture Program, which was originally in Title VIII. The Joint Venture Program now appears as Section 312 of S.556 and Section 311 in H.R. 2440 and provides for creative, innovative financing by Tribes for the construction of health facilities, in exchange for the I.H.S. commitment for equipment and staffing. A new Section 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. 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 I.H.S., 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 (SCHIP), for which their patients are eligible. By eliminating barriers, it is intended that I.H.S, Tribes and urban programs take maximum advantage of these other federal funding "streams". The severe and longstanding lack of adequate appropriations for the I.H.S. requires that alternative funding "streams" be assesible 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 IHCIA, and the related conforming amendments to the Social Security Act, accomplish three major goals:

- To maximize recovery from all third-party sources, including Medicaid, Medicare, and SCHIP, 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 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 need to be amended to provide authorization for the I.H.S. 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 I.H.S. "special fund" has also been eliminated and I.H.S. 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, S.556 Section 403 requires all Indian health programs to submit provider enrollment identification to allow the I.H.S. and the Health Care Funding Administration to track payments and reimbursements for services for the purpose of reporting and monitoring.

Several amendments 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 I.H.S. funds. S.556 adds specific new language in Section 410 and HR 2440 Section

407, clarifying that I.H.S. is the "payer of last resort". S.556 Section 411 provides corollary authority which authorizes the Indian health system to bill for other federal reimbursements unless explicitly prohibited.

A new Section 412 in S.556 establishes the "Tuba City Demonstration Project" one of only two new demonstration projects recommended by the NSC. Recent changes in the Navajo Nation's administration of some of its programs caused the NSC to agree to delete this provision. S.556 Section 413 authorizes Tribes and tribal organizations to purchase Federal health and life insurance for their employees. In S.556 Section 414, specific consultation and negotiated rulemaking procedures are included to address issues with HCFA (CMS). The NSC, in response to the Administration's concerns agrees to remove this provision; and, H.R. 2440 authorizes states to consult with Tribes in Section 409.

Other amendments address related problems faced by the I.H.S. and tribal health programs in their relationship to Medicaid and Medicare and to other health providers accepting payment under contract health.

In S.556 a new provider type has been created for the I.H.S. 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 NSC proposed 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. 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 of S.556 and Section 412 of H.R. 2440 will eliminate or "waive" all cost sharing for I.H.S. eligible beneficiaries served by Indian health programs under Medicaid, Medicare, and SCHIP. 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 I.H.S. 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.

In S.556 Section 424 and in H.R. 2440 Section 414 established the second demonstration program, 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 CMS. 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 our programs to address the needs of our patients 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 limited to Title IV and Title V. All other references to urban Indian health found in other titles address issues of consultation, planning or reporting. Title V provides authority for the I.H.S. 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 provides minor changes to the existing law and adds new provisions to Title V. The major changes 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;

- 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 authorizing urban programs the authority to receive advance lump-sum payments for I.H.S. contracts or grants is included in this Title. Reporting requirements have been changed from quarterly to semi-annually, and language is proposed to clarify audit requirements. In addition, the bills authorize funds to be used for facility construction, renovation, expansion, leasing or other purposes. To be consistent, with the redesign of I.H.S., the department title "I.H.S. Urban Branch" was changed to the "Office of Urban Health". Language was added requiring I.H.S. 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. In S.556 Section 512 both the Tulsa and Oklahoma City demonstration projects are made permanent. However, in H.R. 2440, the Tulsa and Oklahoma City urban programs are subjected to ISDEAA but would be "non divisible" to ensure that the program funds would be kept intact.

**Title VI – Organizational Improvements**

Only a few changes are made in this title. In S.556 Section 601 authorizes the elevation of the Director of the Indian Health Service to any Assistant Secretary for Indian Health. This elevation is consistent with "on-going" Tribal support for this elevation. Unnecessary provisions were deleted in this title if activities had already been completed. New language is in both bills authorizing the I.H.S. to enter into contacts, agreements or joint ventures with other federal or state agencies to enhance information technology.

**Title VII – Behavioral Health**

Title VII reflect 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 I.H.S. 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 in this Title authorizes the establishment of at least one in-patient mental health care facility for each I.H.S. 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 IHCIA. 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 bills, have been restated in Section 801 of this title. In S.556 new language negotiated rulemaking procedures is in Section 802. This section also establishes a maximum amount of time for negotiated rules to be printed in the federal register, not later that 270 days after the date of enactment. The authority to promulgate regulations in S.556 expires after 18 months from the date of enactment; thus, expecting the rulemaking process to be completed. In H.R. 2440 Section 802 requires rulemaking applicable to only titles I, II, III, IV, VII, and Section 817; and no regulations are to be issued for titles VI, and VIII. Section 803 of the bills, requires the Secretary, in consultation with Tribes and urban Indian organizations, to develop a "plan of implementation" for all provisions of the Act. Section 804 continues the prohibition on abortion funding, as it exists in current law. Eligibility of California Indians is addressed in Section 806. Health Services for Ineligible persons is included in Section 807 of the bills as it appears in current law, with only minor technical changes.

Section 811 of the bills 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.

Finally, a major amendment is reflected in Section 814 of S.556 and in Section 815 of H.R. 2440 with the establishment of a National Bi-Partisan Commission on Indian Health Care Entitlement. The NSC, responding to strong recommendations from the regional and national consultation meetings, examined the establishment of an entitlement provision for Indian health services through the IHCIA reauthorization. The Committee found that a number of issues, related to the establishment of an entitlement provision requires extensive study, research and Tribal consultation. Therefore a Commission is 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, as follows:

- 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 I.H.S. (who are knowledge about health care services for Indians, including at least one specifically nominated by urban Indian programs).

Commission 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 CMS, 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 by 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 draft language and made any necessary clarifications before its final decisions.

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 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 process was approved as one of the NSC's ground rules and used when necessary.

This process of consultation was one of the most rewarding experiences I have been engaged in. I observed that those elected officials who were involved "stepped up to the plate" in an assertive "take control approach" to fulfill what we believe was a major responsibility to Indian Country. Thank you for this opportunity to present testimony on behalf of the National Steering Committee stating our strong support for the reauthorization of the Indian Health Care Improvement Act which is a priority for Indian Country.