NATIONAL INDIAN HEALTH BOARD

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Statement of Buford Rolin

Member at Large

National Indian Health Board

On the

Indian Health Care Improvement Act Reauthorization

July 23, 2003 – 10:00 a.m.

Senate Russell Building, Room 485

Chairman Campbell, Vice-Chairman Inouye, and distinguished members of the Senate Indian Affairs Committee, I am Buford Rolin, Member at Large of the National Indian Health Board. I am an elected official of the Poarch Creek Band of Indians, serving as Vice-Chairman. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on the Reauthorization of the Indian Health Care Improvement Act.

The NIHB serves nearly all Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. We strive to advance the level of health care and the adequacy of funding for health services that are operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their regional area.

I would first like to commend the witnesses that testified before me this morning, Mim Dixon and Myra Munson, for their tireless work and expertise on American Indian and Alaska Native issues related to Medicare, Medicaid and the Children's Health Insurance Program. I am also much honored to testify this morning alongside Chief Executive Melanie Benjamin of the Mille Lacs Band of Ojibwe.

Given the two previous hearings the Committee has held on the Indian Health Care Improvement Act during the 108th Congress, I'm going to be brief this morning. I realize the members are quite aware of the need and purpose of the reauthorization; therefore I would like to focus on the efforts of Tribal leaders to craft legislation that addresses previous concerns raised by the Administration and responds to the current political realities facing Congress.

National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act (IHCIA)

The National Steering Committee (NSC) was formed by the Indian Health Service in 1999 to develop and submit recommendations for changes to the Indian Health Care Improvement Act. The NSC is comprised of elected tribal representatives throughout Indian Country, and also includes urban health program representation. The NSC is currently co-chaired by Julia Davis-Wheeler, NIHB Chair, and Rachel Joseph of the Lone Pine Paiute Shoshone Tribe.

Over the last several years, the NSC has worked closely with Indian Country, the Administration, Congress, and the Indian Health Service to develop amendments to the Indian Health Care Improvement Act. Indian Country has proceeded through this process in a spirit of cooperation and negotiation and the language has gone through several changes.

Centers for Medicare and Medicaid Services Tribal Technical Advisory Group (TTAG)

At the request of Tribal leaders, the Centers for Medicare and Medicaid Services (CMS) established the Tribal Technical Advisory Group (TTAG) to advise CMS on Medicare, Medicaid, and Children's Health Insurance (CHIP) policy issues related to American Indians and Alaska Natives. The TTAG was formed in 2001 and consists of Tribal leaders, Area Indian Health Boards, and designated national Tribal organizations, including the National Indian Health Board. The activities of the TTAG are coordinated primarily through the Intergovernmental and Tribal Affairs Office within CMS.

The TTAG has forwarded several recommendations to Congress and CMS regarding recommended changes to the reimbursement methodologies in place for the Indian Health Service, Tribal health programs, and Urban Indian programs. The TTAG is adamant in its position that any reform or changes in the Medicare, Medicaid, or CHIP programs must allow for Tribal allocation or other direct funding mechanisms that authorize Indian health programs access to Centers for Medicare & Medicaid Services (CMS) program funding.

The TTAG has worked closely with the National Steering Committee to develop the changes to Title IV of the Indian Health Care Improvement Act that are reflected in H.R. 2440, which are the most recent NSC recommendations.

The Need to Access Third Party Revenues

As the Committee is well aware, funding for the Indian Health Service lags far behind other segments of the population and has failed to keep pace with population increases

and inflation. Current Indian Health Service funding is so inadequate that less than 60 percent of the health care needs of American Indians and Alaska Natives are being met. In order to address the need for additional health care resources, Title IV of the Indian Health Care Improvement Act addresses access to Medicare, Medicaid and other third party reimbursements. It is one of the most important provisions of the Indian Health Care Improvement Act as it makes IHS hospitals eligible for Medicare reimbursements, and also makes IHS facilities eligible for Medicaid reimbursements. Title IV makes it possible for Medicare and Medicaid eligible American Indians and Alaska Natives to utilize these benefits.

Since the passage of the Health Care Improvement Act in 1976, Medicare and Medicaid payments have become vital sources of revenue for basic Tribal hospital and clinic operations. In FY 2002 alone, IHS and tribally operated hospitals and clinics collected $460 million for services provided to Indian people enrolled in these programs. This amount enhances the resources available for the IHS hospitals and health clinics budget by nearly 30%.

In order to further improve the ability of Indian Country health providers to access third-party resources, the NSC developed several changes to Title IV that were included in S. 212 introduced during the 107th Congress. When asked to respond to the language contained in S. 212, several concerns were raised by Health and Human Services Secretary Tommy G. Thompson regarding the proposed changes to Title IV. The concerns were primarily related to costs. I would like to note that S. 556 introduced during this Congress is identical to S. 212 and therefore many of the concerns raised in regards to S. 212 remain.

In response to those concerns, the National Steering Committee revised their recommendations for the reauthorization and those changes are reflected in H.R. 2440, which was introduced on June 11, 2003. I think it was quite helpful to hold the joint Senate Committee on Indian Affairs and House Resources Committee hearing on the IHCIA last week as it illustrates the efforts of both houses to pass a bill this session. Although the bill was introduced in the House, it was developed with input and involvement from both Senate and House members and staff.

H.R. 2440 reflects several changes made to the original tribal proposal prepared in 1999 by the National Steering Committee (NSC). The legislation includes revisions to the 1999 proposal in response to the Secretary Thompson's concerns. Some of the major changes of the revised Tribal recommendations made in H.R. 2440 that respond to the Administration's concerns about S. 212.

Qualified Indian Health Program (QIHP). This provision has been removed. The NSC designed QIHP as a new provider type through which Indian health programs and urban Indian health programs could more fully exercise their statutory authority to receive payments under Medicare, Medicaid and SCHIP. Secretary Thompson expressed concern that QIHP was complex and would be administratively burdensome. Tribal leaders acknowledged that the CBO score of this provision – in excess of $3

billion over ten years – could be a barrier to Congressional acceptance of QIHP and therefore removed it.

In place of the QIHP proposal, Tribal leaders seek a comprehensive study by the Department of Health and Human Services (DHHS) of reimbursement methodologies of Medicare and Medicaid for the Indian Health Service (IHS), Tribal health programs, and health programs of urban Indian organizations. The new provision found in H.R. 2440 directs the Secretary to perform such a study and report the findings to Congress. The Secretary is to examine whether payment amounts under current methodologies are sufficient to assure access to care and whether these methodologies should be revised consistent with those applicable to the "most favored" providers under the Social Security Act. The current "all-inclusive" rate system through which IHS and tribal hospitals and some clinics now receive Medicare and Medicaid reimbursements would remain in place until the Secretary's recommendations are reported to Congress and Congress decides whether to make any changes.

Extension of 100% Federal Medical Assistance Percentage (FMAP). Tribal leaders also agreed to delete a provision that would have extended the 100% FMAP to services provided to Medicaid eligible Indians referred by IHS or tribal programs to outside providers, such as referrals made through the contract health services program. Under current interpretation of the Centers for Medicare and Medicaid Services (CMS), the 100% FMAP is made available to States only for reimbursements for services provided directly in an IHS or tribal facility, even though the only reason the patient required care outside the IHS or tribal facility was that the facility could not directly provide the service and had to rely on an outside provider.

While State governments are very supportive of the 100% FMAP expansion, DHHS objected that its cost was too high – more than $2 billion over ten years – and that its financial benefits would flow only to the States, not to Indian health programs and their Indian beneficiaries. While the NSC disagrees with the Department's interpretation of the statute and their conclusions about the effect of the proposed amendment, we agreed to delete the provision from the IHCIA.

Waiver of Medicare Late Enrollment Penalty. The 1999 tribal proposal (and S. 212 and S. 556) sought to waive the premium penalty for any Medicare-eligible Indian who did not timely enroll in Medicare Part B because of a number of barriers. The DHHS strongly objected to this provision as it would treat Indians differently than other Medicare-eligible persons who do not timely enroll. The DHHS asserts that the penalty is needed to encourage eligible persons to enroll and begin paying Part B premiums when they first become eligible, rather than waiting until they become ill and need to use their Medicare coverage. Tribal leaders also agreed, reluctantly, to delete this provision.

Regulations. Secretary Thompson objected to the tribal leaders' call for all regulations – including Social Security Act regulations affecting Indian health providers – to be prepared through Negotiated Rulemaking with tribal representatives. He asserted that

the large number and complexity of Social Security Act regulations makes negotiated rulemaking unfeasible. In response to this concern, tribal leaders eliminated Social Security Act changes from the bill's negotiated rulemaking provision.

We believe the changes to the original tribal proposal submitted in 1999 significantly reduce the bill's federal budget impact. S. 212 (identical to S. 556) was scored in 2001 as having a federal budget impact of $6.9 billion over ten years. Deletion of the QIHP and the 100% FMAP provisions together reduce the bill's score by about 70 percent. We ask that the Committee submit a request to the Congressional Budget Office to either score S. 556 without the above mentioned provisions, or provide a fiscal budget impact on H.R. 2440.

Conclusion

On behalf of the National Indian Health Board, I would like to thank the Committee for its consideration of my testimony and for your diligence in making the health of American Indian and Alaska Native people a high priority of the 108th Congress. I have been involved with the National Steering Committee since its inception in 1999 and have seen the hard work and compromises that the Tribal leaders have made. Tribal leaders have come to the table to work out the more contentious provisions and we urge the Committee to act swiftly on this important piece of legislation. Further, we request that any concerns regarding this legislation are raised in a timely manner so that passage of this bill during this session is not jeopardized.