



**Testimony of United South and Eastern Tribes Sovereignty Protection Fund
And Self-Governance Communication and Education Tribal Consortium
Submitted to the United States House Committee on Natural Resources
Subcommittee on Indian, Insular, and Alaska Native Affairs for the Record of the July 12, 2016
Legislative Hearing on the “HEALTTH Act”**

July 26, 2016

On Behalf of The United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) and the Self-Governance Communication and Education Tribal Consortium, we write to provide the House Committee on Natural Resources Subcommittee on Indian, Insular, and Alaska Native Affairs with the following testimony for the record of its July 12, 2016, legislative hearing on H.R. 5406, the *Helping to Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act*. Our organizations stand with Tribal Nations across the country in sharing our deep concern regarding the deplorable conditions in the Great Plains Area. We appreciate Rep. Noem and the Subcommittee’s efforts to address the systemic issues which have persisted in the Great Plains region and throughout the Indian Health System for decades, and offer section-by-section recommendations intended to strengthen the provisions of the bill. It is in this spirit that we ask Rep. Noem and the Subcommittee to strongly consider the national (rather than regional) implications of H.R. 5406, and to work with Tribal Nations to ensure its impact is positive in all IHS Areas. In particular, we encourage Rep. Noem and the Subcommittee to reexamine provisions related to the Purchased/Referred Care (PRC) program. Moreover, we maintain that until Congress fully funds the Indian Health Service (IHS), the Indian Health System will never be able to fully overcome its challenges and fulfill its trust obligations. While our organizations support reforms that will improve the quality of service delivered by the IHS, we underscore the obligation of Congress to meet its trust responsibility by providing full funding to IHS and support additional innovative legislative solutions to improve the Indian Health System.

Uphold the Trust Responsibility to Tribal Nations

Through the permanent reauthorization of the Indian Health Care Improvement Act, “Congress declare[d] that it is the policy of this nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” As long as IHS remains dramatically underfunded, the root causes of the failures in the Great Plains and the Indian Health System will not be addressed, and Congress will not live up to its stated policy and responsibilities. In FY 2015, the IHS medical expenditure per patient was only \$3,136 while the Veteran’s Administration, the only other federal provider of direct care services, spent \$8,760 per patient. Disparities in health financing lead to disparities in health outcomes. Congress must authorize full funding for the IHS in order to make meaningful progress on the chronic challenges faced by the Indian Health System.

Additionally, we recommend the inclusion of language directing the IHS to request a budget that is reflective of its full demonstrated financial need obligation, as this is the only way to determine the amount

of resources required to deliver comprehensive and quality care. We remain hopeful that Congress will take necessary actions to fulfill its federal trust responsibility and obligation to provide quality health care to Tribal Nations, by providing adequate funding to the IHS.

Authorize Advanced Appropriations and Exempt the IHS Budget from Sequestration

Stability in program funding is a critical element in the effective management and delivery of health services. On top of chronic underfunding, IHS and Tribal Nations face the problem of discretionary funding that is almost always delayed. In fact, since Fiscal Year (FY) 1998, there has only been one year (FY 2006) in which appropriated funds for the IHS were released prior to the beginning of the new fiscal year. The FY 2016 omnibus bill was not enacted until 79 days into the Fiscal Year, on December 18, 2015. Budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts all depend on annual appropriated funds. Many Tribal Nations reside in areas with high Health Professional Shortage Areas and delays in funding only amplify challenges in providing adequate salaries and hiring of qualified professionals. As Congress seeks to improve IHS' ability to attract and retain quality employees, as well as promote an environment conducive to effective health care administration and management, we urge the inclusion of language that would extend advance appropriations to the IHS.

Additionally, IHS and Tribal Nations continue to face the specter of sequestration. Through the Budget Control Act of 2011 and subsequent failure of the Joint Select Committee on Deficit Reduction, the IHS budget was subjected to federal spending caps and across-the-board reductions, despite Congress' federal trust responsibility to finance health care services to Tribal Nations. As a result of the discretionary budget cuts, in FY 2013, IHS lost approximately \$220 million from its already underfunded budget. These cuts required the IHS and Tribal Nations to reduce the availability of health services to Tribal citizens who already face severe health disparities and are legally entitled to care through IHS. Reductions in funding and the overall instability of the IHS budget sustain conditions which lead to the crises observed in the Great Plains area and throughout the Indian Health System. Restoring these budget cuts and preventing future budgets from harmful reductions will be critical to advancing and improving the care delivered through IHS. We continue to assert that the IHS budget, and all funding for federal Indian programs, must be exempt from Sequestration.

Tribal Consultation

We appreciate Rep. Noem's initiative to take action in response to failures in the provision of health care in the Great Plains Area. H.R. 5460 seeks to address many of these issues and will have nationwide implications for the Indian Health System. In order to account for the diversity of management structures, including self-governance compacting and self-determination contracting, across the 12 IHS Areas as well as in patient access and experiences among these Areas, on-going Tribal consultation must be inclusive of all Tribal Nations impacted. First, we request that Rep. Noem and this Subcommittee consider holding an open listening session and soliciting additional comments from Tribal Nations across the country. Second, we request that additional language be inserted into H.R. 5406 requiring Tribal consultation on all provisions of the law, as it is implemented, to ensure Tribal Nations have a voice in accordance with the IHS Tribal Consultation Policy. On-going, meaningful Tribal consultation is essential to mitigating current challenges, preventing future crises, and increasing the health status of American Indians and Alaska Natives (AI/AN).

Section-by-Section Comments

In addition to urging the inclusion of the above proposals, we offer the following recommendations to strengthen the existing provisions of H.R. 5406. If implemented together, we believe these policies will

provide the necessary framework for IHS and Tribal Nations to improve patient health outcomes the quality of care delivered through the Indian Health System

Title I - Expanding Authorities and Improving Access to Care

Section. 101. Service hospital long-term contract pilot program

As Congress considers reform for the Indian Health System, we support initiatives which empower Tribal Nations to make their own decisions regarding their health care. Through the Indian Self-Determination and Education Assistance Act (ISDEAA) Tribal Nations have made considerable gains in health program administration, patient experience, and community health outcomes. We fully support Tribal Nations that choose to assume health and other programming under this authority. We do, however, want to ensure that Tribal Nations have the adequate infrastructure to assume these functions and that the programs being transferred are not in disrepair. We believe the interim option which would provide Tribal Nations with the authority to pilot Self Governance by contracting with the private sector could be a good first step on the path to full self-governance. However, we believe this partnership should be one that fosters mentorship and capacity building in order to ensure these arrangements do not have the adverse effect of diminishing Tribal governance.

To that end, we recommend the inclusion of language to clarify that Tribal Nations have the authority to exercise their right to assume programs under the ISDEAA at any time, notwithstanding the duration of any contracts with private entities. This language will ensure Tribal Nations do not unintentionally forfeit their right to assume programs under the ISDEAA while remaining under contract with a private entity. Further, we request additional language which would clarify provider-based status when a Tribal hospital is contracted with a private group. This provider-based status is critical to the collection of 3rd party revenue and any disruption could further harm the hospital. Finally, we request on-going consultation on this specific provision to ensure that this pilot truly provides greater tools and opportunities to enter into self-governance.

Section. 102. Expanded hiring authority for the Indian Health Service

Over the course of dialogue regarding this provision and similar language in S. 2953, many have expressed concerns about its constitutionality. Some have suggested that the Department of Justice may be unable to represent the Indian Health Service in cases where the Agency is sued pursuant to action taken under this language. If this is the case, we believe this provision has the potential to destabilize the Indian Health System, rather than strengthen it. Our organizations urge Rep. Noem and the Subcommittee to provide Indian Country with more information regarding the potential impact of Section 102. We further ask that this section, including whether to strike the language from the bill, be subject to Tribal consultation prior to further legislative action.

Section. 103. Removal or demotion of employees

We support expanding the Secretary's authority to remove or demote IHS employees based on performance or misconduct. However, in addition to the Secretary, Tribal Leadership must also be notified when employees within their Service Area become subject to a personnel action. In under Sec. 603 (c) "Notice to Secretary", we recommend inserting "Tribal Governments located in the affected service area". Further we recommend inserting similar language included in which S.2953 establishes "Employment Record Transparency" which ensures that prior to employee personnel actions are adequately notated and considered in future hiring processes. Increasing transparency and access to information for Tribal Nations will be essential to rebuilding the confidence and trust in the IHS.

Section. 104. Improving timeliness of care

This provision would establish standards to measure the timeliness of care and develop processes for submitting data to the Secretary on these measures. It is imperative that these measures and standards are developed in consultation with Tribal Nations. Further, for approximately 170 IHS and Tribally-operated sites that have chosen to participate in the Improving Patient Care (IPC) initiative, many have already taken steps to improve timeliness of care. We suggest aligning the standards with existing IPC activities and ensuring that standards or reporting are not overly burdensome for Tribal health programs. In addition, we request that any data regarding timeliness of care be provided to Tribal Nations, as well as the Secretary.

Title II – Indian Health Service Recruitment and Workforce

Section. 201. Exclusion from gross income for payments made under Indian health service loan repayment program.

We fully support the provisions which would exempt payments from the Indian Health Service Loan Repayment Program (LRP) from an awardee's taxable income. This will help reduce barriers to recruitment and achieve parity with other federal health workforce programs, such as loan repayment under National Health Service Corps. Additionally, language should be inserted to ensure that IHS Scholarship Awards receive similar treatment under the Internal Revenue Service Code. Exemptions like this already exist for the Armed Forces and this will assist IHS with creating a pipeline of providers into the Indian Health System.

LRP, and the IHS Scholarship Program, however, are severely underfunded, which has weakened efforts to improve recruitment and retention in the IHS. In FY 2015, LRP was unable to provide loan repayment funding to 613 health professionals who applied, of which only 200 accepted employment at an IHS or Tribally-operated health facility. IHS estimates that it would need an additional \$30.39 million to fund all the health professional applicants from that year. Until Congress moves to adequately fund these accounts, the IHS and Tribal Nations will continue to have challenges attracting qualified providers and there will be gaps in the continuity and quality of care.

Finally, we request that additional funding be made available to assist in the recruitment of AI/AN health professionals from within local Tribal communities. We believe that the best way to care for our citizens is to ensure that health professionals are deeply connected to the communities they serve. In order to promote pathways to AI/AN entrance into health professions, we request additional funding, beyond the President's FY 2017 budget request, be made available for the Health Professions Scholarship Program, American Indians into Nursing Program, Indians into Medicine (INMED) program and American Indians into Psychology Program.

Section 202. Clarifying that certain degrees qualify individuals for eligibility in the Indian Health Service Loan Repayment Program

We support the provision of the bill which would recognize degrees in business administration, health administration, hospital administration or public health as eligible for awards under IHS LRP. However, we also recommend inserting similar language to recognize these degrees as eligible under the IHS Scholarship Program. We believe including these degree types into the IHS Scholarship Program will increase the number of AI/AN seeking business and health administration degrees and increase the pool of qualified health professionals.

Section 204. Relocation reimbursement

In order to fight ongoing challenges with recruiting qualified providers into the Indian Health System, we support the provision allowing for reimbursement of reasonable costs associated with relocation. In addition to the criteria listed in the provision, we suggest broadening the language to include positions that are “difficult to fill in the absence of an incentive.” This language will allow IHS more flexibility when determining when to offer relocation awards.

In addition to relocation benefits, we recommend the inclusion of language which would authorize IHS to provide other incentives such as housing vouchers, performance based bonuses, and increased pay scales. Especially in the Great Plains and the other medically underserved areas where many of our Tribal Nations exist, access to housing for providers is a major barrier to recruitment. Providing IHS with the authority to offer a variety of benefits will help improve recruitment efforts. We suggest inserting similar language to the provision that exists in the S. 2953 bill under “Sec. 607 Incentives for Recruitment and Retention”

Although we support the proposed incentives, the IHS is not equipped to implement these initiatives without additional appropriations. With IHS funding not meeting demonstrated financial need, we are concerned any initiatives to provide housing vouchers, relocation costs, or increase pay scales must be funded using patient care dollars. While the attraction of qualified staff is critically important, it must not be done by diverting precious resources from health care services. For this reason, we request that H.R. 5604 include the authorization of additional funding to support these incentives without impacting patient care.

Sec. 205 Authority to waive Indian preference laws

Although we understand the need to seek ways to recruit qualified candidates, we have concerns regarding the waiver of Indian Preference laws. We firmly believe the providers best suited to care for our communities are ones that come from the communities themselves, and we cannot support efforts that would undermine Indian Preference. As we note above, our vision for a stronger Indian Health System includes a robust pipeline of AI/AN into health professions. In the meantime, we believe that the aims of this provision can be achieved by modifying hiring practices within the current legal framework. We understand the law may be applied in a way that does not provide for timely reviews or hiring of qualified non-Indian candidates where no qualified AI/AN candidate is available. Rather than waiving the laws completely, we think there is room for improvement in hiring practices to ensure that positions are being filled in a timely manner with qualified candidates. We recommend directing the Secretary to update and streamline Indian preference hiring practices to ensure that qualified non-Indian applicants will be considered in cases where no qualified Indian applicants are available, at the sole discretion of the Tribal Nations served.

Title III Purchased/Referred Care Program Reforms

Section. 301. Limitation on charges for certain Purchased/Referred Care Program services

Although we appreciate the language which would codify existing IHS regulation extending Medicare-Like Rates payment methodology to non-hospital based services, in absence of an enforcement mechanism, we believe this could create major access to care issues. Through the 2003 authorization of the Medicare Prescription Drug, Improvement, and Modernization Act, hospital-based Medicare providers and suppliers were required to accept Medicare-Like Rates from IHS and Tribally-operated Facilities as a condition of their participation in the Medicare program. This law has allowed PRC programs to extend their limited

resources, while preserving access to care for AI/AN patients by ensuring providers accept the lower rate of payment. Because IHS does not have jurisdiction over Medicare Conditions of Participation, they could not include a similar enforcement mechanism. In cases where physicians or other providers do not wish to accept lower payments from PRC programs, they may refuse to see AI/AN patients and gaps in access will continue to persist. We recommend that language be inserted to this section which would require the acceptance of the MLR for all services authorized by IHS PRC programs as a condition of participation in the Medicare program.

Section. 302 Allocation of Purchased/Referred Care Program funds

While we agree that “life and limb” PRC priority levels 1 and 2 provide woefully inadequate levels of care to IHS patients, we assert that rather than redistributing funding, Congress should simply fully fund the PRC account. Consistent underfunding results in the denial and deferral of medically necessary care. In Fiscal Year (FY) 2015, IHS reported 132,200 denied or deferred services, which amounted to \$639,177,512 in unmet health care obligations. As a result, medically-necessary services are denied by PRC departments and health conditions worsen, quite possibly contributing to many of the issues in the Great Plains. The PRC Medical Priority Level system itself, which forces Tribal Health Programs to ration care based on health condition as a result of underfunding, substantiates the need for Congress to fully fund the account.

We are concerned with the HEALTTH Act’s current language, which would impose funding freezes for IHS programs which authorize care at priority level 3 and redistribute funding increases to programs treating only more emergent cases. This will not improve access to care for AI/AN patients, but rather, will spread financial inadequacies across the Indian Health System. Although PRC funding is inadequate, some PRC departments are able to extend their resources through effective financial planning. This provision could penalize PRC programs which have created these types of efficiencies through negotiating competitive rates with providers and have been successful in funding higher levels of care. Further, the care delivered at priorities 3 and below is more likely to be preventive care. A critical element in the fight against the types of emergent and chronic health problems treated at priorities 1 and 2 is preventive care. Treating health problems early avoids more difficult and expensive treatment down the road.

Additionally, we note that the current formula employed by IHS was established in consultation with Tribal Nations. The formula was crafted in recognition of Area differences in cost of services, number of patients, access to hospitals, inflation and a number of other factors. In fact, the PRC funding formula is regularly reviewed in consultation with the PRC workgroup and Tribal Nations, so additional work to evaluate the formula is unnecessary at this time. Further, H.R. 5604 lists a number of factors the Secretary must consider in the redevelopment of the formula, which, to our knowledge, were not formulated in consultation with all Tribal Nations.

Section. 303 Purchased/Referred Care Program backlog

While we understand that backlogged payments are a major concern in the Great Plains Area, this is not true across the Indian Health System. Many Tribal Nations have instituted or agreed to prompt payments. We recommend that the language in this section be amended to exempt Tribally-operated facilities and limit the review to IHS Areas and direct service sites.

Additionally, we contend that the PRC backlog is not simply the result of delayed payment due to inefficiencies within the IHS. Many PRC providers are unfamiliar with the IHS system and the laws that govern the provision of health care to AI/AN. First, there are the payer of last resort provisions which require private insurance, and other coverage through Medicare and Medicaid, to pay claims prior to IHS PRC programs. In cases where a patient does not have an alternate resource, the determination process

may take weeks. Similarly, in cases where a patient fails to attain prior authorization for a service, the PRC department will not pay on the claim and financial liability will go to the patient. Lastly, some PRC services may meet medical priority but be denied due to lack of funding. In emergent cases, patients will need to receive this care regardless of ability to pay. These scenarios can happen frequently which result in delays or denials of payment of PRC providers. With this in mind, we recommend the inclusion of language call for a Government Accountability Office report on the causes of the PRC backlog, as well as recommendations regarding PRC provider education.

Conclusion

Our organizations appreciate Congressional efforts to seek solutions to the long-standing challenges within the Indian Health System. However, we note the initiatives proposed in H.R. 5604 do not address the root cause of these issues: the chronic underfunding of the IHS. Only when Congress acts to uphold the federal trust responsibility by providing full funding and parity for the Agency will the Indian Health System be equipped to provide an adequate level of care to AI/AN people. We thank the Subcommittee for the opportunity to provide comments on this bill and look forward to an ongoing dialogue to address the complex challenges of health care delivery in Indian Country.