Self-Governance Communication & Education Tribal Consortium

303 South Fifth Street
McAlester, OK 74501
P: 918.302.0252
F: 918.423.7639

Written Testimony of
The Honorable Chief Marilynn Malerba, Mohegan Tribe, Board Member of Self-Governance Communication & Education Tribal Consortium, & Chairwoman of the IHS Tribal Self-Governance Advisory Committee (TSGAC)

Submitted to the
U.S. Senate Committee on Indian Affairs
Listening Session on Putting Patients First: Addressing Indian Country's Critical Concerns Regarding Indian Health Service

February 8, 2016, Washington, DC

Introduction
On behalf of the Self-Governance Communication & Education Tribal Consortium (SGCETC)[1], I am pleased to formally submit this written testimony to support the ongoing efforts of the Indian Health Service (IHS). This testimony will highlight policy, legislative, budget, and administrative changes that would work to improve health care delivery for those that depend on medical and public health services from IHS, to raise their health status to the highest level possible and to ensure the success of the Indian Health Care System. I commend the Committee for hosting this opportunity to gather input from Tribal Leaders and Administrative officials to address critical concerns regarding the IHS.

Self-Governance is a Tribally-driven, Congressional legislative option that recognizes the inherent right of Tribes, as sovereign nations, to negotiate annual appropriated funding and assume management and control of programs, services, functions and activities that were previously managed by the Federal government. It allows Tribes to determine their governmental priorities, redesign and create new programs and services and reallocate financial resources to more effectively and efficiently fit the needs of their Tribal citizens and communities. The growth and success of Self-Governance, within the IHS is best documented by the 351 Tribes currently participating in Self-Governance compared to the 14 Tribes who initially signed agreements in 1992. Together Self-Governance and Title I Contracting Tribes represent 62% of Tribal governments who operate $1.8 billion in healthcare programs each year.

Over the last two decades, Self-Governance Tribes have markedly improved the nation-to-nation relationship between the United States and Tribes. However, this success has required active engagement, cooperation and the collaboration of administrative officials across the Federal government, Congress, and Tribal Leadership. Improving patient care throughout the entire Indian Health Care System requires a similar approach. First, Congress must uphold its commitment to Tribal Nations by fully funding IHS. Without adequate funding the system cannot be expected to provide quality care to patients or to attract qualified, long-term providers and administrators. Second, the entire

[1] The Self-Governance Communication and Education Tribal Consortium consist of Tribal Leadership whose mission is to ensure that the implementation of the Tribal Self-Governance legislation and authorities in the Bureau of Indian Affairs (BIA) and Indian Health Service (IHS) are in compliance with the Tribal Self-Governance Program policies, regulations and guidelines.

Federal system must work collaboratively to improve the conditions at Indian Health Service, Tribal and Urban (ITU) facilities within the Indian Health Care System. Lastly, Tribal Leaders must have a leading voice in decisions made regarding the health delivered in their communities.

SGCETC proposes Congress focus its work in three areas: (1) stabilize and increase funding to IHS; (2) encourage administrative flexibility and collaboration; and, (3) adopt effective communication and partnership with Tribal Nations.

I. Stabilize and Increase Funding to the Indian Health Service

Despite trust and treaty obligations to provide for the health care of the American Indian/Alaska Native (AI/AN) populations, Congress continues to severely underfund IHS without regard to meeting basic health care service needs for AI/AN and fulfilling requirements such as providing adequate health care facilities. Underfunding healthcare directly contributes to the poor health status and life expectancy of AI/AN. Within this overall context, SGCETC has identified the following top budget and related issues that would improve patient care by increasing appropriations and leveraging current opportunities:

Protect the IHS budget from sequestration. Despite the unprecedented increase of 29% in the past 4 years, funding levels for AI/AN healthcare remain dangerously low.[2] Tribal governments experienced severe budgetary cuts after the 2012 sequester – which resulted in a decrease to the IHS budget of $220 million.[3] These cuts had a devastating impact on direct services provided to AI/AN patients, with an estimated elimination of 804,000 outpatient visits and 3,000 inpatient visits. As Congressional members debate the FY 2017 appropriations, Self-Governance Tribes first, urge Congress to restore Tribal funding cuts and, second, to uphold the Tribal trust responsibility and amend the Budget Control Act of 2011 to exempt Tribal funding from future sequesters, budgetary reductions and/or rescissions.

Support Advance Appropriations for IHS in the FY 2017 Budget Request. Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year. Late funding creates significant challenges to Tribes and IHS provider budgeting, planning, recruitment, retention, provision of services, facility maintenance and construction efforts. Providing sufficient, timely, and predictable funding is needed to ensure the Federal government meets its obligation to provide health care for AI/AN people. Enacting advanced appropriations will ensure more stable funding and sustainable planning for the entire Indian Health Care system by appropriating funding two years in advance.

End discretionary decisions within the IHS budget. Unlike other health programs such as Medicare and Medicaid, IHS is funded as a nondefense, discretionary line item, creating an inconsistent funding environment year-to-year and ignoring external factors that contribute to the recognized growing gap between IHS and other public health programs.[4] Transferring the IHS budget to the mandatory side of the budget would adequately represent the trust and treaty responsibility due to AI/AN, while creating a consistent budget based on important factors such as population growth, inflation and evolving technology.[5]

---

[2] National Congress of American Indians Policy Research Center. (2013). Geographic & demographic profile of Indian country.
[3] Native Care Act, H.R. 4843, 113th Congress (2013–2014) (2014).
[4] Moss, Margaret. P Ed. and Malerba, Marilynn. American Indian Health and Nursing. Springer Publishing NY, NY pp323-336.
[5] White, J. (1998). Entitlement budgeting vs. bureau budgeting. Public Administration Review, 58 (6), 510–521.

Fully fund Indian Health Care Improvement Act (IHCIA) provisions related to patient care. Health reform represents a significant opportunity for Tribal and IHS programs to sustain, improve, and build innovative health systems in Tribal communities. However, to date, there are more than twenty-five (25) unfunded authorities in the Indian Health Care Improvement Act (IHCIA), each representing an unleveraged opportunity to increase and improve services for American Indians and Alaska Natives across the Nation. Therefore, successful implementation of the law is of great importance to Tribes and hinges on the full funding of the permanent reauthorization of the IHCIA and the overarching Affordable Care Act (ACA). The SGCETC respectfully requests funding increases to begin implementing the twenty-five unfunded authorities in IHCIA and countless others in the ACA.

Fully support the IHS Information Technology System.
The Resource and Patient Management System (RPMS) is the decentralized health information system used to manage both clinical and administrative information in IHS healthcare facilities. However, due to budget constraints and demands to meet growing industry and government standards, IHS has not been able to commit resources to update RPMS in every Area. Failure to maintain this system properly has resulted in lost revenue to IHS and Tribal facilities across the country. A short term influx in funding to bring RPMS up to industry standards in every area could result in more streamlined care as well as increase third-party revenue to the Indian Health Care System.

Invest in Self-Governance Planning and Negotiation Grants.
More than two decades of Self-Governance in IHS has shown that Tribal governments can and often do deliver better quality care in a more efficient and culturally competent manner, improving the health and welfare of communities significantly. Congress should increase its support for Tribes wishing to plan, prepare, and negotiate for Self-Governance programs. The easiest way to build the internal capacity for Tribes to make the transition into Self-Governance is to commit more Federal funds for planning and negotiation cooperative agreements. This year, due to inadequate funding, only five planning and two negotiation cooperative agreements were provided to a growing list of Tribes seeking alternative and innovative solutions to provide better care.

II. Encourage Administrative Flexibility and Collaboration.

Ultimately, improving patient care requires more than the provision of adequate funding. We must also embrace and advance innovative and collaborative approaches to providing programs and services in order to achieve sustainable healthcare. The Administration can take action to improve its business practices, open additional streams of revenue, and leverage funding opportunities that already exist within the Federal government to provide quality care, expand services, and hire qualified providers and administrators. However, each of these solutions requires Federal agencies across the entire government to allow greater flexibility and collaboration. SGCETC offers the following solution to administratively improve patient care:

Expand the IHS-Veterans Administration Memorandum of Understanding to Include Purchase and Referred Care.
When the IHS and the Department of Veterans Administration (VA) negotiated the first national agreement, required under the IHCIA, they only included reimbursement for direct care provided by IHS facilities. Failure to include Purchased and Referred Care (PRC) is a disservice to Veterans and does not adequately address the specialty care that is needed while imposing a financial burden on Tribal healthcare systems which provide eligible veterans care at its own expense. After

two years of implementation and changes to the VA health care delivery, Self-Governance Tribes believe the time is right to revisit the reimbursement agreement and include PRC.

Enact Medicare-Like Rates for IHS outpatient services for ITU facilities.
IHS, Tribes and Tribal organizations currently cap the rates they will pay for hospital services to what the Medicare program would pay for the same service (the "Medicare-Like Rate" or "MLR"). Currently, this MLR cap applies only to hospital services, which represent a fraction of the services provided through PRC. In December of 2014, IHS proposed a rule to amend the current rule to apply Medicare methodology to all physicians, other health care professional services and non-hospital based services that are authorized for purchase by the IHS and Tribal PRC programs or urban Indian health programs. Tribes generally support the proposed rule with limited changes and provided recommendations to allow for the greatest flexibility. To date however, a final rule has not been published.

Previously, Congress also proposed legislative fixes to amend Section 1866 of the Social Security Act (SSA) to expand application of the MLR Cap. It would direct the Secretary to issue new regulations to establish a payment rate cap applicable to medical and other health services in addition to the current SSA cap on services provided by hospitals. It would make the MLR cap apply to all Medicare-participating providers and suppliers. Self-Governance Tribes support this legislative fix to leverage the limited resources provided to IHS, Tribal and Urban health programs.

Bolster the recruitment and retention of qualified providers and administrators.
Recruitment and retention of qualified health providers and administrators is at the crux of improving patient care. IHS, along with Federal partners such as the Departments of Housing and Urban Development (HUD) and Agriculture (USDA), the Health Resources and Services Administration (HRSA) and others, must adopt a reengineered business model that directly focuses on identifying the external factors and effective strategies that contribute to physician and administrator recruitment.

Additionally, Congress could take steps to approve legislation that would amend the Internal Revenue Code to exclude from gross income, amounts received under the IHS Loan Repayment Program and the Indian Health Professions Scholarships Program, which are currently a drain on the appropriations extended to IHS.

Support legislation to expand Self-Governance under a Demonstration Project within HHS, by amending the Indian Self-Determination and Education Assistance Act (ISDEAA). Title VI of the ISDEAA required the Secretary of Health and Human Services (HHS) to conduct a study to determine the feasibility of a Tribal Self-Governance demonstration project for appropriate HHS programs, services, functions, and activities (and portions thereof) in agencies other than IHS. HHS submitted the required report to Congress in March of 2003. The report concluded that the demonstration project was feasible. Although Congress has considered legislation to authorize a Self-Governance demonstration project, legislation to advance this initiative has not been enacted into law to date.

HHS has more than 300 grants specifically available to Tribal governments. Yet, Tribes are unable to fully maximize these opportunities because they are often short-term or one-time sources of funding. Additionally, these opportunities often focus on prevention or treatment of the same health issues, such as suicide, substance abuse prevention, heart health, or diabetes, but cannot be leveraged together to provide holistic health care to AI/ANs. Distributing funding through grants does not fulfill the trusty responsibility and does not lead to improved, long-term health status

indicators. Expanding a model with a proven track record, such as Self-Governance, would continue to improve the nation-to-nation relationship and allow Tribes to leverage funding from across HHS to support preventative and direct care, to enhance substance abuse and behavioral health services, and to manage their health systems similarly to other public and private entities.

Tribal efforts to continue working on the expansion of Self-Governance was recently realized in the transportation reauthorization legislation. P.L. 114-94, the Fixing America's Surface Transportation Act (FAST Act) made several important changes to the Tribal Transportation Program, most notably created a Department of Transportation (DOT) Tribal Self-Governance Program which extends many of the Self-Governance provisions of Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA) to DOT. The FAST Act also provides modest funding increases for the Tribal Transportation Program (TTP) and the Tribal Transit program as well as a number of technical changes to these programs. ***So why, after more than a decade of asking has HHS been so unwilling to advance the same opportunities for Self-Governance in HHS?***

III. Adopt Effective Communication and Partnership with Tribal Nations.

During its sixty-year history as an agency committed to improving the health of American Indians and Alaska Natives, IHS has had many successes and downfalls. Like any other public or private organization, IHS will require consistent and transparent methods to evaluate and identify issues, to implement changes, and to respond to external, unknown factors. Instead of relying on Congressional action each time, the following recommendations should be adopted:

Utilize formal and informal communication methods to encourage community partnership with Tribal Leaders. Delivering proper health care in Tribal communities requires true partnership between Tribal Leaders and agency officials. Since the Clinton Administration, Presidents have reaffirmed the responsibility of Federal agencies to consult with Tribal governments before taking actions that affect their communities. Though Tribal consultation is an excellent way to establish a set of principles, direction, or directly respond to a proposal, this formal communication does not allow for regular exchange regarding issues that arise outside of the formal policy process. Tribal Leaders maintain a close pulse on their community and the effects of proper health delivery. IHS should adopt methods to efficiently and effectively exchange information with Tribal Leaders in a manner that allows them to identify issues earlier and respond more rapidly.

Institutionalize stakeholders throughout the Indian Health Care System. Another opportunity to tie Tribal communities to the performance of the Indian Health Care System is to regularly engage leadership in the administration and direction of local health facilities. IHS has adopted a process in other areas that allows Tribal Leaders and other experts to participate regularly in the governance of hospitals and clinics that impact the health of their citizens. Replication of this process would provide IHS with another avenue to hear from stakeholders and allow Tribes an opportunity to be part of the solution before issues negatively impact patient care.

Direct IHS to develop an annual report which shows how well the Federal government has upheld its Treaty Obligations and Trust Responsibilities to Tribes. Reporting on achievements is critical to winning and maintaining support. If the "performance-based budgeting" uses statements of missions, goals and objectives to explain why the money is spent, then similar objectives, goals and measures should be tied to the United States government honoring the treaties and fulfilling the trust responsibility. While our budgets remain at the discretion of Congress to sequester, decrease and eliminate services, we have no tools to leverage the broken promises to Indian people. There should be equal standards of performance and results to hold the United

States accountable for not upholding the agreements between our nations and not honoring its word.

Summary

In closing, SGCETC again thanks the Committee for the opportunity to submit testimony. We look forward to working with you to initiate positive changes that will improve the health and welfare of every Tribal citizen throughout Indian Country.