DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF
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FOR
PLANNING AND EVALUATION
DEPARTMENT OF HEALTH & HUMAN SERVICES

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS
APRIL 9, 2003

STATEMENT OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES HEARING ON S.285, "Native American Alcohol and Substance Abuse Program Consolidation Act"; S. 555, "Native American Health and Wellness Foundation Act"; and S. 558, IHS Director Elevation Bill

April 9, 2003

Good morning Mr. Chairman, I am William Raub, the Acting Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (DHHS). Accompanying me today are: Michel Lincoln, Deputy Director, Indian Health Services (IHS), and Richard Kopanda, Executive Director, Substance Abuse and Mental Health Services Administration (SAMHSA). I am here today on behalf of Secretary Thompson to present the views of the Department of Health and Human Services (DHHS) on S.285, a bill to authorize the integration and consolidation of alcohol and substance abuse programs and services provided by Indian Tribal governments; S. 558, a bill to elevate the position of the Director of Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health; and, S. 555, a bill to establish the Native American Health and Wellness Foundation; .

S. 285: "NATIVE AMERICAN ALCOHOL AND SUBSTANCE ABUSE PROGRAM CONSOLIDATION ACT"

The first official authorization for the IHS and Indian Tribes to provide alcoholism treatment services was established in 1976 by the Indian Health Care Improvement Act, P. L. 94-437. The Anti-Drug Abuse Act of 1986, P.L. 99-570, and the Omnibus Drug Bill Amendments, P.L. 100-690, expanded this authority to include alcoholism and other

substance abuse treatment and prevention services for American Indian/Alaska Native (AI/AN) youth, women, children, dual diagnosed youth, and family members. All of these authorities were later combined under title VII of the Indian Health Care Improvement Act Amendments of 1992, which is the existing authority for the IHS/Tribal/Urban (I/T/U) programs.

Currently, the IHS receives approximately $137 million in annual appropriations for tribal alcohol program activities. More than 90% of these alcohol-related funds are provided directly to the Tribes under Indian Self-Determination agreements for programs that they design and implement. Indian tribes now administer close to 50 percent of the total IHS funding for health services, including mental health services, under Indian Self-Determination agreements. This process of transferring the Federal functions related to health programs has taught both Tribes and the IHS many lessons in planning and implementing comprehensive health and social programs. Indeed, the evidence suggests that Tribes can address these issues in ways that the Federal partners cannot.

Our Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to States, sub-State jurisdictions, public and private non-profit entities for the purposes of providing mental health and substance abuse prevention and treatment services. The agency's budget is approximately $3.2 billion. The largest programs are the Substance Abuse Prevention and Treatment Block Grant appropriated at $1.753 billion for FY 2003, and the Community Mental Health Services Block Grant, appropriated at $437 million. These funds are distributed to States for their use in

providing substance abuse and mental health services. It is expected that the States will address the mental health and substance abuse needs of American Indians/Alaska Natives living within their borders.

In addition we have $857 million to support discretionary or competitive grants to non-profit private and public entities including Indian Tribes and tribal organizations for the provision of mental health or substance abuse services. In FY 2002, over $50 million of these funds went directly to provide services to American Indians/Alaskan Natives.

S. 285 would permit an Indian tribe to carry out a demonstration project, according to a plan approved by the Secretary, to consolidate grants for "Indian behavioral health care programs" (defined to include substance abuse and mental health programs) into a single, comprehensive program for purposes of providing improved services, facilitating implementation of an automated clinical information system, encouraging technology-based quality assurance activities, and facilitating evaluation of these programs.

The Department supports the principle that Indian Tribes best know how to meet the needs of their members for programs such as those addressed by S. 285. We have no objection to allowing Tribes to consolidate programs addressing substance abuse and mental health problems where appropriate, consistent with the purposes of the underlying programs and in order to achieve administrative efficiencies. However, while we welcome the Committee's work on this important legislation, we have concerns about critical provisions in S. 285 which we will outline below.

Programs Affected: Uses of Consolidated Funds

First, we note that the bill does not delineate clearly the programs that would be subject to consolidation under the proposed authority and the permissible uses of consolidated funds. We believe, based on our review of the bill as a whole, that the intent is to allow consolidation of those grant programs – and only those programs – whose sole or primary purpose is to address either mental health problems or substance abuse problems, or both.

Section 5 provides that a program may be consolidated if under the program the Indian tribe is "eligible for the receipt of funds," under a formula, or through competitive or other grants. We believe the quoted language does not conform to the language used in Federal grant statutes and regulations, and efforts to interpret and implement it would cause serious difficulties and disagreements. States, Tribes or other entities (as specified in a given grant statute or notice) are generally eligible to apply for funding. For competitive grant programs, eligible applicants are awarded funding only if they successfully compete for funding. Thus, the condition under section 5 should instead be that the tribe is eligible to apply for funding under a program and, in fact, is funded, depending on the amount of available funds after peer and advisory council review. We would have no choice but to interpret the term "eligible" in section 5 to mean the tribe has been awarded program funding, but we are concerned that the lack of precision in the bill's language would lead to substantial misunderstandings and quite possibly to litigation.

Lastly on the need for clarification, the bill is not sufficiently specific as to the extent to which consolidated funds may be used for an automated clinical information system that serves not only the behavioral health program but the entire Indian health care delivery system. We are concerned that these uncertainties could cause unnecessary misunderstandings, disagreements, and litigation.

Waiver Authority

Sections 6 and 7 provide waiver authority that could apply to a broad range of programs, as yet unidentified, of various Departments. The practical effect of these provisions may limit flexibility for the HHS Secretary (or other affected agency head) to consider the merits of a waiver request from the standpoint of the Federal grant programs proposed for consolidation.

In addition to authorizing the waiver of any regulation, policy or procedure promulgated by the Federal agency concerned, these provisions would authorize waiver of any statutory requirement, if found necessary to enable a tribe to implement its consolidation plan. The effect of the language suggests the waiver should be denied only if the agency head found the waiver inconsistent with the purposes of S. 285, or with a statutory requirement applicable to the program to be integrated that was specifically applicable to Indian programs.

Significantly, S. 285 does not require that the waiver be consistent with the statutory objectives of the underlying grant program proposed for consolidation, and thus

eliminates a fundamentally important standard for assessing the appropriateness of the waiver. As a practical matter this provision would leave the Secretary (or another affected agency head) no choice but to grant virtually all waiver requests. The failure to require consistency with statutory grant program objectives is highly unusual, and appears to create a troublesome precedent that is not essential to achieve the bill's objectives.

Timetable For Federal Action

Section 7 requires the Secretary, upon receipt of a plan from an Indian tribe, to consult with the tribe and with the head of each Federal agency "providing funds to be used to implement the plan" (which we understand to mean having a program to be consolidated into the tribal plan), and Section 8 requires the Secretary to inform the tribe within 90 days of the approval or disapproval of the plan, including the responsible agency's decision on any waiver request. This 90-day timetable, we believe, will be insufficient in most cases, given that a consolidation plan could involve up to seven separate Executive Branch agencies and multiple components of individual agencies. Substantially more time would need to be afforded, particularly in the early stages of implementation of this legislation, to permit thoughtful and appropriate decision making.

Lead Agency Designation

We strongly object to the language in section 10 designating the Indian Health Service (IHS) as "the lead agency under this Act", responsible for reporting, oversight, technical assistance, and convening meetings between the tribes and the Federal agencies under a

memorandum of understanding between the Secretary of HHS and the other affected Federal agencies. In general, HHS policy supports assigning statutory responsibilities to the Secretary absent particular circumstances making designation of an HHS component appropriate. In the circumstances involved in S. 285, statutory designation of IHS is not appropriate, both because the Secretary needs to retain authority to direct HHS's coordination of programs and activities with the numerous other Cabinet-level agencies involved, and because HHS components other than IHS, notably including the Substance Abuse and Mental Health Services Administration (SAMHSA), are also closely concerned with the programs that S. 285 would make subject to consolidation.

Uses Of Grant Funds

The bill as drafted does not control the amounts of grant funds that could be used for administrative overhead and information technology (IT). First, we foresee problems with respect to the total amount of a tribe's consolidation grant funds permitted to be used for program administration. Some of the grant programs that would be subject to consolidation include statutory or regulatory limits on the percentage of funds that may be so used, but S. 285 neither provides for carrying over these limits into the consolidated grant nor provides an alternative limit. We believe a clear statutory limitation to a modest percentage, or clear authority to insist on such a limitation, is important to ensure that the majority of grant funds are directed to delivering services to the intended program beneficiaries. For similar reasons, we are also very concerned that the provisions of the bill permitting use of grant funds for IT resources and training neither restrict the amount or share of grant funds that may be used for this purpose nor require

that the IT so purchased be closely related to a tribe's behavioral health program. The applicable bill language is so broad that potentially a substantial share of a tribe's consolidation grant could be spent for these extremely expensive resources. We consider it extremely important that these provisions of the bill be appropriately tightened, and that the entire bill be scrutinized carefully to identify any similar problems with other provisions, in order to ensure that the program under the bill be firmly focused on addressing the behavioral health problems that are its intended object.

Federal Oversight

We cannot support the consolidation program proposed by S. 285 unless the bill makes meaningful provision for adequate and effective Federal oversight. The current bill, as a practical matter, does not do so. The bill shifts responsibility for oversight of all consolidated programs to IHS (or, assuming the bill is amended to meet our objection discussed above, the HHS Secretary), as well as assigning to HHS responsibility for much of the coordination and negotiation with tribes and with other Federal agencies, for reports to Congress, and other related activities. But there is no provision for transferring to HHS any administrative resources from the other affected federal agencies for what would be a substantial increase of administrative responsibilities, and HHS (let alone IHS) has no available administrative staff or funds for these new tasks. Notably, section 12, which provides for interagency funds transfers, is explicitly restricted to funds available to Tribes. At a minimum, the bill should be revised to provide for transfer to HHS of an appropriate share of other participating "agencies" administrative resources.

In summary, we cannot support S. 285 as currently drafted, for the reasons discussed in this statement, but the Department is prepared to work with the Committee to address our concerns.

S. 558: ELEVATION OF THE DIRECTOR OF IHS

S. 558 proposes to establish within the Department of Health and Human Services an Office of the Assistant Secretary for Indian Health. The IHS is the principal point of contact on behalf of the Department on health matters related to Tribes. It exists because of the solemn promises the Federal government has made to Indian people. On matters of health care, the head of the Indian Health Service acts principally as the administrator of the vast Indian Health Service system, as well as an advocate on behalf of the Indian Health needs of the nation's more than 550 federally-recognized Indian Tribes.

Currently, the Director of the IHS enjoys direct access to the Secretary in the Department on all health services issues impacting Tribes and Tribal organizations. In addition, the Director serves as Vice-Chair of the Secretary's Intradepartmental Council for Native American Affairs. The Council serves as an advisory body to the Secretary and has the responsibility to assure that Native American policy is implemented across all Divisions in the Department including human services programs. The Council also provides the Secretary with policy guidance and budget formulation recommendations that span all Divisions of HHS. A profound impact of this Council on the IHS is the revised premise within HHS that all agencies bear responsibility for the government's obligation to the Native people of this country.

It is our view that the Director as the Vice Chair of the Intradepartmental Council for Native American Affairs currently enjoys an elevated status in the Department. He facilitates advocacy, promotes consultation, reports directly to the Secretary, collaborates directly with the Assistant Secretary of Health, advises the heads of all the Department's divisions and coordinates activities of the Department concerning matters related to Native American health and human services issues. This authority is provided in the Native American Programs Act of 1974. Consistent with the statute, Secretary Thompson has taken steps to assure that this Council receives the highest levels of attention within the Department.

Moreover, the Secretary and Deputy Secretary have traveled widely to Indian Country with their senior staff. These trips have raised the awareness of tribal issues and have contributed greatly to our capacity to speak with one voice, as One Department, on behalf of tribes. Secretary Thompson and Deputy Secretary Allen are daily committed to working with Tribal leaders on Indian health concerns.

In summary, the Director currently is assured the same access to the highest levels as other agencies in the Department and it is not necessary to elevate the IHS Director to the level of Assistant Secretary over other agencies serving American Indians/Alaska Natives (AI/AN).

S. 555: "NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION ACT"

S. 555, the "Native American Health and Wellness Foundation Act of 2003", amends the Indian Self Determination and Education Assistance Act to authorize the Secretary of HHS to establish a foundation through which the IHS mission to improve the health status of American Indians and Alaska Natives could be supported by private sector partnerships with the Federal government. The legislation is currently under review by the Executive Branch.

I want to thank you for the opportunity to testify today on these important bills, and we would like to continue to work closely with the Committee.

Please allow me to address any questions you may have at this time.