National Indian Health Board

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The Red Feather of Hope and Healing

Testimony of the National Indian Health Board
Before the U.S. Senate Committee on Indian Affairs

Oversight Hearing on Proposals to Create Jobs
and Stimulate Indian Country Economies
Thursday, January 15, 2009

628 Dirksen Senate Office Building
Washington, DC

Introduction

Chairman Dorgan, and Vice-Chairman Murkowski and distinguished members of the Senate Indian Affairs Committee, I am Reno Franklin, a tribal council member of Kashia Band of Pomo Indians, Chairman of the California Rural Indian Health Board, and newly-elected Chairman of the National Indian Health Board (NIHB). [1] On behalf of the NIHB, it is an honor and pleasure

[1] *Established in 1972, NIHB serves Federally Recognized AI/AN tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the federal government's trust responsibility to AI/ANs. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the IHS, 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 Area. NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of the Tribes.*

to offer the NIHB's testimony on proposals to create jobs and stimulate Indian Country economies.

During our discussion we will focus on three recommendations to create job and stimulate Indian economies as it relates to healthcare. These recommendations are:

1. Reauthorization of the Indian Health Care Improvement Act
2. Improved Access and Enrollment in Medicare, Medicaid and SCHIP
3. Healthcare Funding of $1.485 Billion for Infrastructure and Support Needs in Indian Country

Before I continue, please allow me to express the gratitude of the Tribes for the work the Committee did during 110th Congress to advance the reauthorization of the Indian Health Care Improvement Act (IHCIA), S. 1200. We are especially thankful for the leadership of Senators Dorgan and Murkowski, and other members of the Committee, for their tenacity in ensuring successful passage of S. 1200 by an overwhelming bi-partisan vote of 83-10.

The NIHB believes strongly that the economic stimulus plan provides an ideal opportunity for reauthorization of the IHCIA. As members of this Committee appreciate, Indian Tribes ceded over 400 million acres of land in exchange for health care for their people. President-Elect Obama, in recognizing the unique government-to-government relationship with Indian Tribes, has said "*Indian nations have never asked much of the United States – only for what was promised by the treaty obligations made to their forebears. So let me be absolutely clear – I believe treaty commitments are paramount law, and I will fulfill those commitments as president of the United States.* Reauthorization of the IHCIA is not asking for much – only the same opportunities to receive basic health care services that the rest of the Country receives.

While the Nation suffers from an economic crisis – Indian Country has always suffered from both an economic and a health care crisis. American Indians and Alaska Natives (AI/AN) suffer disproportionate disease burden because of inadequate education, subpar housing, poverty, unemployment and lack of employment opportunities, and discrimination in the delivery and access to health services. AI/ANs live in some of the poorest and most remote locations where health care is limited and in some cases, completely not accessible. The Indian Health System (IHS) system is funded at only approximately 40% of the level of need in comparison to services available to the general population. In some parts of Indian Country, health care is limited to "life or death" emergencies. As a result, AI/ANs suffer lower life expectancies, disproportionate health disparities, and die at higher rates from alcoholism (550% higher), diabetes (190% higher), and suicide (70% higher) than the general U.S. population. Approximately 13 percent of AI/AN deaths occur among those under the age of 25; a rate three times that of the total U.S. population. Our youth are more than twice as likely to commit suicide, and nearly 70 percent of all suicidal acts in Indian Country involve alcohol.

In a speech on January 8, 2009, President-Elect Obama outlined his vision of a proposed American Recovery and Reinstatement Plan to jumpstart job creation and long-term growth. The plan proposes to invest in priorities like energy, education, health care and the new infrastructure necessary to keep us strong and competitive in the 21st century. As the President-Elect said: *"Perhaps more than anyone else, the Native American community faces huge challenges that have been ignored by Washington for too long. It is time to empower Native Americans in the development of the national policy agenda."* Today is your opportunity to change this. Invest in health care and infrastructure to strengthen Tribal economies and bring the Indian healthcare system into the 21st century. Just say – "Yes We Can."

NIHB Proposal to Create Jobs and Stimulate Indian Country Economies:

1. Reauthorization of the Indian Health Care Improvement Act

The reauthorization of the IHCIA should absolutely be included in an economic stimulus package because it provides authorities for methods to ensure a healthy Indian reservation workforce, creates jobs, provides for infrastructure development in Indian reservation communities, and expands access to safety net programs such as Medicaid and State Children's Health Insurance Program (SCHIP).

Including the IHCIA bill as part of the economic stimulus package is consistent with the position of the Senate Finance Committee, prominent national organizations and academic scholars who agree that health care reform is an important component to improving this Country's economic crisis. Reauthorization on the IHCIA bill would stimulate and promote more prosperous and self-sufficient Tribal economies.

The economic stimulus plan is expected to include key health care provisions to stimulate local economies. Some of these provisions would enhance the State Medicaid programs by providing funding opportunities and expansion of Medicaid services for the unemployed. It is also expected that the economic recovery plan will include healthcare specific provisions to address health care spending, incentives for health care professionals to participate in Medicare, and construction and maintenance of community health centers.

Including the IHCIA, and at a minimum, Title II of the bill, will help stimulate Tribal communities by ensuring a healthy workforce, create jobs, and provide new and expanded authorities for health care facilities construction. In some parts of Indian Country, such as the Rosebud Sioux Tribe located in South Dakota, unemployment rates are at 84 percent; and at Standing Rock located in North and South Dakota, the unemployment rates are at 71 percent.

As many Tribal leaders have testified before your Committee before – why is it that the United States sends billions of dollars abroad to build homes, jails, government buildings, schools and hospitals, yet cannot do things for its own citizens, the First Americans.

A healthy workforce is the foundation for any healthy economy. Tribal communities are no different: without good health, Indian people cannot go to work, might have to stay home to care for a family member, or will not seek employment or educational opportunities to improve their family's economic status. The IHCIA bill provides for new authorities to improve the health care of Indian people:

- new and expanded health promotion and disease prevention activities;
- expanded authorities to prevent and treat chronic conditions;
- expanded authorities for cancer screenings;
- comprehensive behavioral health care programs to address the high rates of alcohol and substance abuse and mental illness.

The IHCIA bill would facilitate creation of health care jobs in underserved Tribal communities which suffer from chronically high unemployment through:

- programs for recruitment, retention of health care professionals, with preferences for Indian applicants (who are more likely to remain in the Indian community);
- education allowances to encourage Indians to enter health care training;
- authority for hiring tribal outreach workers for Medicare, Medicaid and SCHIP enrollment assistance.

The IHCIA bill authorizes innovative methods for construction of health care-related and community sanitation facilities through:

- new authority for provision of long-term care and assisted living which will spur construction of such facilities in underserved reservation communities;
- revised criteria for selection of sites for construction of new and expanded hospitals and clinics and for identifying Indian communities in need of water and sewer facility construction;
- authority for construction of youth treatment facilities;
- authority for IHS and Tribal joint venture projects for health care facility construction;
- authority for construction of ambulatory clinics for small tribes.

2. Improved Access and Enrollment in Medicare, Medicaid and SCHIP

Title II of the IHCIA amends the Social Security Act and improves access to and enrollment of Indian people into Medicare, Medicaid, and SCHIP. Due to the economic crisis in some Tribal communities, we expect an increase in enrollment in these safety net programs. Revenues generated from Medicare, Medicaid and SCHIP (IHS estimate of $780 million annually) support Tribal economies through employment of health care professionals and maintenance and renovation of health care facilities.

3. Healthcare Funding of $1.485 Billion for Infrastructure Needs in Indian Country

Healthcare Facilities Construction

The average age of IHS facilities is 33 years, compared to mainstream healthcare facilities in the United States are only 9 years old. Many IHS facilities are overcrowded and were not designed in a manner that permits them to be utilized in the most efficient manner in the context of modern healthcare delivery. The condition of these facilities varies greatly depending on age and other factors. Some are in need of maintenance. In addition to maintenance, there is a

need for modernization or expansion to address population growth, to accommodate modern equipment, or to meet the needs of rapidly changing health care delivery systems. Some areas, like the Portland Area (representing Washington, Oregon, and Idaho) and the California Area, have no inpatient hospital facilities at all. Because there is no hospital for AI/AN patients in these IHS Areas, these facilities depend on Contract Health Services (CHS) funds. Forcing patients to travel great distances to receive specialty care with limited funds. There needs to be a large influx of funding for healthcare facilities construction so that the facilities on the IHS facility construction priority list are completed, and other Areas in Indian Country, that have no projects on the priority list, can receive health care facility construction funding to address their needs.

The IHS estimates that approximately 27 percent of the $2.6 billion in priority health facilities projects can be under construction within two years, approximately 35 percent of the $336 million in maintenance and improvement projects can be under construction within two years, and approximately 45 percent, or approximately $1.1 billion of the economically feasible projects, can be under construction within two years.

Health Information Technology

Approximately $233 million for enhancements in health information technology (HIT) can be implemented within two years. An investment in health information technology within the IHS will directly benefit the economy through expenditure of funds in the private sector for goods and services. The current HIT needs within the IHS require additional infrastructure acquisition at the local, regional and national levels. Meeting these needs requires significant purchases of technology hardware and other IT peripherals through commercial IT vendors.

Contract Health Services

CHS services are provided by private or public sector facilities or providers based on referrals from the IHS or tribal CHS program. Due to the severe underfunding of the CHS program, the IHS and tribal programs must ration health care. Unless the individual's medical care is Priority Level 1 request for services that otherwise meet medical priorities are "deferred" until funding is available. Unfortunately, funding does not always become available and the services are never received. For example, in FY 2007, the IHS reported 161,750 cases of deferred services. In that same year, the IHS denied 35,155 requests for services that were not deemed to be within medical priorities. In addition, in 2007, IHS was not able to fund 895 Catastrophic Health Emergency Fund (CHEF)[2] cases. Using an average outpatient service rate of $1,107, the IHS estimates that the total amount needed to fund deferred services, denied services not within medical priorities, and CHEF cases, is $238,032,283. This estimate also does not capture deferred or denied services from the majority of tribally operated CHS programs (nearly one-half of all tribes).

Contract Support Costs

Contract Support Cost (CSC) funding provides resources to Tribes and Tribal organizations, that operate health programs under the Indian Self-Determination and Education Assistance Act, to cover infrastructure and administrative costs associated with the delivery of health care services. Specifically, approximately 70 – 80% of CSC funding is used to pay salaries of Tribal health professionals and administrative staff. Without adequate CSC funding, Tribal health programs are forced to reduce the levels of health care in order to absorb the infrastructure and salary costs. In most instances, cutting health care services is the only alternative to financing these costs. Chronic underfunding has resulted in a substantial shortfall of CSC funding in the amount of $285 million (FY 2009 -$132 million and FY 2010 - $153

[2] The CHEF is administered by IHS Headquarters and pays for high cost CHS claims.

million). An influx of $285 million in CSC funding shortfall will enable Tribes to create more jobs in Indian Country.

NIHB Support of Senate Plan

The NIHB supports the January 9, 2009 letter from the U.S. Senate outlining a comprehensive plan to stimulate the economy in Tribal communities by addressing infrastructure needs and the creation of jobs. At the NIHB Winter Board meeting held on January 8 – 9, 2009, the NIHB passed Resolution 2009-01, which we have attached as part of this testimony. Consistent with the Senate request, the NIHB recommends that:

- $400 million in health care facilities construction
- $250 million in facilities improvement and maintenance
- $250 million in sanitation construction
- $200 million in contract health services
- $150 million in health information technology is included in the economic stimulus plan.

In addition, the NIHB resolution recommends that $285 million in CSC shortfall funding be included to stimulate employment opportunities in Indian Country. For every $10 million in CSC shortfall funding, it is estimated that 100 jobs and $6 million in third party revenues are lost.

Conclusion

On behalf of the NIHB, I appreciate the opportunity to present testimony on recommendations on healthcare infrastructure and support needs of Indian Country. The NIHB recommends that the American Recovery and Reinstatement Plan include reauthorization of the IHCIA, and in the alternative Title II of the bill, and infrastructure funding to address healthcare

facilities and sanitation construction, maintenance and improvement of facilities, contract health services, health information technology, and contract support costs.

We appreciate your leadership in bringing these important economic proposals forward for discussion and we look forward to working with you and your Committee to improve the health of Indian people and the health of our Tribal economies.

I am available to answer any questions the Committee might have.