NATIONAL INDIAN HEALTH BOARD

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TESTIMONY OF H. SALLY SMITH

BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS ON THE PRESIDENT'S FISCAL YEAR 2008 BUDGET REQUEST FOR TRIBAL PROGRAMS THURSDAY, FEBRUARY 15, 2007, 9:30 AM SENATE RUSSELL BUILDING ROOM 485

Good Morning, Chairman Dorgan and Vice-Chairman Thomas, and members of the Indian Affairs Committee. I am Sally Smith, Chairman of the National Indian Health Board. I am Yupik from Alaska and I also represent the Bristol Bay Area Health Corporation in southwestern Alaska. On behalf of the National Indian Health Board (NIHB), it is an honor and pleasure to offer my testimony on the President's FY08 Budget for Indian Programs.

Established in 1972, NIHB serves Federally Recognized American Indian and Alaska Native Tribal governments by advocating for the improvement of health care delivery to American Indians and Alaska Natives (AI/ANs), as well as upholding the federal government's trust responsibility to American Indian and Alaska Native Tribal governments. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the Indian Health Service (IHS), programs operated directly by Tribes and Tribal organizations pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), and urban Indian organizations pursuant to Title V of the Indian Health Care Improvement Act (IHCIA). 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.

The Budget

The President's Budget recommends increases in nearly every line item of the Indian Health Service's budget, requesting that Congress appropriate $4.1 billion dollars for FY 2008 for health care delivery to America's Native Peoples. Based on the President's budget request, this amount represents a net increase of $212 million over the FY 2007 Continuing Resolution and an increase of $101 million over the FY 2007 President's budget. NIHB notes with appreciation that the FY08 budget request continues the Administration's trend of slight increases to the IHS each year – but, with calculation for population growth included, as well as inflation, America's Native populations cannot maintain even the status quo under this budget. Unfortunately the budget, as in FY 2007, completely eliminates funding to urban Indian programs. With all due respect, we simply do not understand the Administration's reasons for eliminating the urban Indian program line item especially when Congress restored funding to the urban Indian program in the Senate and House FY 2007 appropriation bills. The urban Indian program is a significant component of the Indian health care delivery system. The urban Indian health programs provide health care services to Indian people who move to urban centers to improve employment and education opportunities for their families. Many of these families do not have ready access to health care services from Federal, State or other health care providers. Elimination of funding to the urban Indian program is a recommendation that is completely unacceptable to us.

Except for the urban Indian program, we realize the IHS fared quite well compared to other agencies; however, it and the Tribal governments providing health care services cannot begin to provide adequate health care with a 7% funding increase, especially considering inflation and, according to information provided by the National Center for Health Statistics, birth-death records indicating that the American Indian and Alaska Native population is increasing at 1.7% per year. The 1.7% population increase translates to approximately 70,000 new patients entering into the Indian Health care system annually.

According to the "Needs-Based Budget" developed for FY06 documents the IHS health care funding needs at least $19.7 billion. The FY08 budget request amount of $4.1 billion (including third-party reimbursements of $700 million, $150 million in Special Diabetes Program for Indians (SDPI) and mandatory spending) falls well short of the level of funding that would

permit AI/AN programs to achieve health and health system parity with the majority of other Americans. This funding meets only 60 % of established need for the IHS.

However, it is critical to realize that even the status quo for AI/AN health should not be acceptable to Congress – it would not be acceptable to your families - and is not acceptable to us. We request a financial and policy commitment from Congress to help America's Native People move beyond the status quo and begin to achieve true progress in changing the reality of health care inferiority known to us.

Indian Country is acutely aware of the funding challenges faced by the federal government. The release of the President's budget last week confirmed the reality that federal spending for all non-defense discretionary programs will be extremely limited. AI/ANs have long been supportive of national security efforts and will continue to do so. However, we call upon Congress and the Administration to work with Indian Country to find innovative ways to address the funding disparities that continue to hamper Indian Country's efforts to improve the health status of AI/ANs. Funding for the IHS has not adequately kept pace with population increases and inflation. While mandatory programs such as Medicaid and Medicare have accrued annual increases of 5 to 10 % in order to keep pace with inflation, the IHS has not received these comparable increases on a consistent basis.

We in Indian Country deeply feel the challenges facing our nation. One of the most pressing challenges is the continual restoration of the lives of those ravaged by brutal forces of nature - the hundreds of thousands forced from their homes, moved to distant and strange locations and wondering whether relief will be swift and complete, or when it will happen, at all. There are entire cities to be rebuilt and lives to be reconstructed. AI/ANs, such as those relocated to urban Indian centers during the 1950's Federal government's relocation policy, know what it is like to be uprooted from their home communities. We support Congress's efforts to continue to assist Katrina disaster victims with rebuilding their lives, their families and their cities. In fact, many of the tribally operated health programs were impacted by Katrina as a direct result by damage to tribal health facilities and communities, or by the reduced availability of tribal health professionals, such as Public Health Service Commissioned Corps officers, who were ordered to leave tribal program assignments to assist others in need. The tribal programs were required to

adjust to the loss of personnel or incur additional expenses by hiring other health professionals to replace the Commissioned Corps officers.

The NIHB recognizes that there are many realities confronting the federal government that create enormous fiscal challenges. America continues to be at war both in distant lands and here in our own homeland. I remind you, that as citizens of this great nation, American Indians have the highest per-capita participation in the armed services of any ethnic group. AI/ANs continue to support disaster relief, national security, and fiscal responsibility and will continue to do so. The release of the President's budget last week made clear federal spending will be remarkably limited. We must, however, once again call upon Congress to work with Indian Country and the Administration to confront and make measurable progress in addressing the funding disparities that persist and promote our mission and the law of this land to improve the health status of AI/ANs.

No other segment of the population is more negatively impacted by health disparities than the AI/AN population. Tribal members suffer from disproportionately higher rates of chronic disease and other illnesses. AI/ANs lag behind every other group in America in most economic indicators – but we are in 1st place for health disparities – in some cases – such as in the speed with which we acquire HIV and AIDS in certain age groups and in infant mortality in the Northern Plains – we are first in the whole world. But in the richest, most powerful country in the world, a country whose very foundation – quite literally – sits on the American Indian homeland that was largely traded for guarantees of peace and health care, among other things– can and should do better to produce health equity for its first Americans. When the U.S. was contemplating methods through which it could provide universal healthcare to the people of Iraq – the IHS health care system was deemed a model system to emulate. However, before the U.S. holds out the IHS system as a model system for other countries in the world to adopt, the U.S. needs to uphold its obligation to provide adequate funding to support a health care system to the first Americans. We simply ask that our Nation look within its own borders first – and invest and commit to its relationship with the first Americans – its relationship with Native America.

There are many health care funding priorities in Indian Country; the health care needs are so great and vary greatly from each area of Indian Country. Each year the Department of Health

and Human Services (HHS) and IHS holds regional tribal budget consultation meetings with tribal leaders to seek advice and input from tribal communities on health care funding priorities. For instance, the FY 2009 funding priorities identified by the IHS areas will be compiled and prioritized at a national budget consultation meeting to be held March 28-29, 2007 at the HHS building.

Based on last year's regional tribal budget consultation meetings and input from the NIHB Area Health Boards, the following is a summary of some of the FY 2008 health care funding needs identified by the NIHB that need particular attention:

Diabetes

As testified to by the Chairman Buford Rolin of the Poarch Band of Creek Indians and the NIHB's Vice-Chair, at last week's oversight hearing on Diabetes in Indian Country and the Special Diabetes Program for Indians, AI/ANs are first in the Nation for incidence of Diabetes: It is an epidemic. In Indian Country we are 318 % more likely to die from diabetes compared to others and about 73 % of people with diabetes also have high blood pressure. The NIHB appreciates that the President's budget included $150 million for the SDPI for FY 2008. The SDPI provides critical funding for clinical exams, laboratory tests, screening, education and awareness but is set to expire October 1, 2008. The renewal of the SDPI funding is a top priority for NIHB and we ask that it be a top priority for Congress, as well.

There is little doubt that these statistics could be radically improved if adequate funding was available to provide consistent, basic health care and to enhance and continue public health programs that promote healthy lifestyles. The SDPI is a successful example that health promotion and disease prevention work.

Cancer

The President's budget includes $2 million for building effective disease prevention and health promotion practices at the local level. However, this amount of funding is not sufficient to address preventative services and cancer screenings in Indian Country. As Chairman Rolin noted in his testimony at the Oversight hearing on Diabetes, it has taken the U.S. 75 years to

identify a reduction in cancer rates in the general population as a result of increase preventative services such as education and awareness as to the causes of cancer and screening services for early detection of cancer. However, cancer rates in Indian Country have not declined: lung cancer is the leading cause of cancer death among American Indians and Alaskan Natives; cancer is the second leading cause of death for all AI/ANs 45 years of age and over; cancer is the leading cause of death for Alaska Native Women; cancer is the third leading cause of death for all American Indian and Alaska Natives of all ages, and AI/ANs have the poorest survival from most cancer sites in comparison with other racial and ethnic groups in the US (e.g. African American, White, Hispanic, Asian American and Pacific Islander).

The IHCIA, if reauthorized, would allow the IHS and tribal programs to provide new and expansive authorities for preventative services and screenings for cancer. But funding is needed to ensure AI/ANs have access to cancer screenings in a timely manner. In addressing the need for additional authority and funding for cancer screenings in the IHCIA, one tribal council member from the Shoshone-Arapahoe Tribe told how he had a pain in his stomach area and he was not tested for cancer for almost two years due to limited funding. When the tribal member was finally tested for cancer, he was found to have cancer of his kidneys and one of his kidneys had to be removed. If adequate funding for cancer screenings were available, this tribal member, as well as other AI/ANs would not have to suffer the loss of their organs, or more importantly, their lives to cancer.

Contract Health Services

The President's Budget includes a request for $570 million in Contract Health Service (CHS) dollars, a $53 million increase from the FY 2006 budget and a $49 million increase over the FY 2007 Continuing Resolution. As you know, CHS funds are used to purchase health care services from the private and public sector where there is not an IHS and tribal direct care facility available or services are not available at the IHS or tribal facility because the services are specialized or cannot otherwise be provided due to workload capacity and reduced staffing.

An increase of approximately $50 million to the CHS line item is not sufficient. The Northwest Portland Area Indian Health Board (NPAIHB) has estimated that an additional $300 million is

needed to meet unmet CHS needs. This estimate is based on FY 2005 data and could be higher if all the CHS data from Tribal programs were available. In most IHS Areas, CHS funds are authorized for services that meet medical priority one: life or limb emergencies. Due to limited funding, the CHS programs are unable to authorize payment for health care services that are identified as medically necessary but do not reach medical priority status. The CHS programs place these non-emergent medical services on a "deferred" list which are not approved for payment until funding becomes available. AI/ANs, whose medical treatment is placed on this deferred list, are then faced with the incomprehensible choice of forgoing necessary medical treatment until CHS funds are available or seeking medical treatment on their own without knowing how the services will be paid. The NPAIHB has reported that many IHS beneficiaries do not visit their health facilities to request CHS referrals because they know they will be denied services due to funding shortfalls. Many tribal programs no longer report deferred or denied services because of the expense associated with tracking and reporting. Thus, the $300 million estimate could be conservative and the amount of funding for unmet CHS health care needs could be even higher.

In Alaska, the CHS program is crucial to provide necessary health care services to Alaska Natives who live in very remote areas. Because there are few roads in Alaska, Alaska Natives who require emergency or specialized services must be air transported to Anchorage. The air transportation costs are very expensive and constitute a major drain on the CHS budgets of local tribal programs.

An important measure that will increase the availability of CHS funds is the publication of final regulations required by section 506 of the Medicare Modernization Act. Section 506 requires the Secretary of HHS to develop by regulations "Medicare like rates" that Medicare participating hospitals would be required to accept as payment of full for services provided to AI/ANs referred under the CHS program. In some parts of Indian Country, IHS and tribal programs pay full-billed charges to private and public sector hospitals for services provided to AI/ANs. Thus, publication of these regulations would ensure that Indian health programs pay reasonable rates similar to Medicare rates paid to Medicare participating hospitals. Tribal programs have estimated that the CHS program could save approximately $25 million a year – savings that

could be used to pay for more CHS services. Section 506 indicates that these regulations should have been published no later than December 2004. Although the HHS published a proposed rule in April, 2006, the "Medicare like rates" are not effective until a final regulation is published. Four years have passed since enactment of the MMA and as of this date, the final regulations have not been published.

Poor Health Funding = Poor Health Status

We request $100 million for the Well Indian Nations Initiative – crafted to undertake disease prevention and health promotion activities in Indian Country. The SDPI could serve as the model for distributing Well Indian Nations Initiative as grant awards to the IHS, tribes, and urban Indian programs.

AI/ANs have a lower life expectancy (6 years less than the rest of the population) and higher disease burden than others. Approximately 13 % 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 % of all suicidal pacts in Indian Country involve alcohol. We are 630 % more likely to die from alcoholism, 650 % more likely to die from tuberculosis and 204 % more likely suffer accidental death. Disproportionate poverty, poor education, cultural differences, and the absence of adequate health service delivery are why these disparities continue to exist. According to the 2006 National Healthcare Disparities Report, AI/ANs received poorer quality of care than Caucasians in 38% of the core measures analyzed.

Public health is the underpinning for wellness in Indian Country and public health includes clean, safe drinking water and sanitation services as well as disease prevention through education, immunization and screening programs for early detection and intervention; mental health; dental health; social services; nutrition counseling; public health nursing; substance abuse treatment and injury prevention.

Alternative Health Care Delivery Models

Mr. Chairman, you discussed with the NIHB members in the President's Room of the Capitol the need for innovative health care delivery systems to address the lack of "after hour" health care needs in Indian Country. We appreciate your leadership in proposing to develop new health care

delivery systems in Indian Country that are currently available to the general public. The NIHB supports your effort to address the problem in Indian Country of services not being available after 5 p.m. on Friday, but funding is necessary to enable IHS and tribes to provide medical services as needed during off-hours, such as in the evenings or weekends.

Tribal programs have tried to extend ambulatory health care center hours with existing funding, but the programs have not always been successful due to the lack of patients to justify the increase in staffing and operational costs. Tribes have had to be innovative using existing authorities and funding to develop "after hour" programs that serve unique purposes. For instance, many tribal programs have established "after-hour" programs, such as on Saturday mornings specifically geared to particular health promotion and disease prevention (HP/DP) activities. A tribal program in California operates a dental preventative program on Saturday mornings for families who are not able to access these services during the week due to school and work commitments. Thus, the tribal program has health professionals on staff to provide dental preventative services, and at the same time, the health professionals are available to treat walk-in patients seeking other medical treatment or to provide necessary emergency medical treatment or referrals.

Contract Support Costs (CSC)

We request an additional $90 million over the current request in order to assure that contract support costs obligations will be met.

The President's FY08 budget request includes a $7 million increase in contract support costs. We understand that these are difficult budgetary times and that this increase represents successful efforts on behalf of the Administration and Tribal Leadership to increase funds for contract support costs. In that spirit of appreciation, it also must be stated that the demonstrated need for contract support costs is in excess of $90 million over existing appropriated levels. The President's request of a $7 million increase is the first step toward meeting the government's obligations and we request that Congress continue to seek opportunities to advance this effort and provide the necessary resources to Tribal governments operating their own health care systems.

The $90 million gap is between current funding and the funding needed for the contracts with tribes into which IHS already has entered. The President's budget request for IHS contract support costs will not begin to address existing contractual obligations and does not address contract support cost needs for new and expanded programs. Since 2005, the IHS has demanded that Tribes waive their statutory rights to contract support costs as a condition to taking on any new IHS programs or facilities. Some Tribes have concluded that IHS services to their communities are so poor that they are willing to take over an IHS program even if doing so means waiving their rights to contract support costs (and thus forcing the Tribe to absorb those costs within the amount of the contract designated for health services). Other Tribes have concluded that they cannot enter into new contracts if they must suffer the penalty of waiving all contract support cost rights. One Tribe has filed a lawsuit challenging IHS' policy as illegal, but to date no decision has yet been issued in the case. Congress should expressly prohibit IHS' policy requiring tribes to "waive" their statutory right to contract support costs and address increased contract support cost funding for new and expanded programs.

Funding is necessary to adequately support Tribes who are interested in entering into new Self Determination contracts or Self Governance compacts or expand the services they have contracted or compacted. We ask you to fund contract support costs at a level that is adequate to meet the needs of the Tribes and to further the important Trust responsibility charged to the federal government. We recommend an additional $90 million to meet the shortfall for current contracting and compacting, and to allow for funding in anticipation of the 20-25 additional Tribal programs anticipated.

This funding is critical to support tribal efforts to develop the administrative infrastructure gravely necessary to successfully operate IHS programs. Tribal programs have clearly increased the quality and level of services in their health systems fairly significantly over IHS operated health service programs. Failure to adequately fund contract support costs is defeating the very programs that appear to be helping improve health conditions for AI/ANs.

Urban Clinics

Once again, the President's FY08 budget recommends cutting all funding to the urban health programs for AI/ANs. We strongly support the continuation of the urban Indian health programs and request continued funding at FY07 levels while enjoying the same 7% increase the general ledger of IHS is recommended to receive under the President's FY08 budget.

Urban Indian health programs, which receive only 1% of IHS funding, provide unique and non-duplicable assistance to Urban Indians who face extraordinary barriers to accessing mainstream health care. The President's justification for eliminating funds to the urban Indian program is that "Unlike Indian people living in isolated rural areas, urban Indians can receive health care through a wide variety of Federal, State, and local providers." Many AI/ANs, from remote areas of Indian Country, move to urban centers to access improved employment and educational opportunities for their families. It cannot be assumed that other health care resources are available to AI/ANs residing in urban centers. These alternative health care providers cannot come close to matching the effectiveness of the urban programs in addressing the needs of urban Indians. Through a culturally savvy and cultural-competency-based approach to Native health, these programs overcome cultural barriers to health care delivery. Many Native Americans are reluctant to go to health care providers that are unfamiliar with Native cultures. Through disease prevention and health promotion activities, urban Indian health programs save money and improve medical outcomes for the patients they serve. As stated in the Indian Health Care Improvement Act, Congress has recognized the value of these programs by stating that:

"It is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and urban Indians and to provide all resources necessary to effect that policy."25 U.S.C. Section 1602(a)(emphasis added)."

AI/ANs receive health care through IHS not because they are poor, although it is clear that most are economically disadvantaged; rather, it is because they are Indian. Providing health care is part of the Federal Government's trust responsibility toward America's Native People and is not an obligation that is determined by geography-alone.

In the 21st Century, it is imperative that the Federal Government act more prudently when making policies that will clearly create upheaval of large numbers of American Indians. No one knows what will happens if the urban clinics are closed. AI/ANs are the most vulnerable population in this Nation, and it is an unacceptable Federal policy to enter into a plan for which no clear outcome is known. It is possible that because alternative health care providers are not trained in AI/AN cultural competency and are not adequately funded to absorb this new population, urban Indians will either forego seeking care or return to their reservations or Native communities to acquire medical attention.

If urban Indians return to their reservations or communities to seek health care, there is no subsequent increase in funding to the Tribes to accommodate this potential increase in patients. Because there could not only be an impact on the Tribes, but the potential exists for a substantial impact on the Tribes – we request that HHS Tribal Consultation takes place before any policy decisions are made to close the Urban Indian Clinics.

If closing the Urban Indian health clinics is a goal of the Federal government, in addition to Tribal Consultation, we also request that the General Accountability Office be engaged to conduct a study to estimate possible outcomes and recommend fact-based options – and that no such plan be wholesale foisted upon the Nation's Native People – but, a demonstration project in a single Area be undertaken to ensure continuity of care.

Indian Health Care Improvement Act

Finally, Mr. Chairman, I would be remiss if I did not mention it has been nearly 14 years since the Indian Health Care Improvement Act (IHCIA) was updated. Indian Country is grateful to you for your leadership, the commitment of the Committees' time and staffing resources, and the personal time and energy you have invested into achieving the reauthorization of the IHCIA. Unfortunately, the IHCIA was derailed in the 11th hour of the 109th Congress. Mr. Chairman, we urge you to introduce a reauthorization bill as soon as possible in the 110th Congress so that we, working with you and other members of the Senate and House, can achieve passage this year.

As you know, the United States has a longstanding trust responsibility to provide health care services to AI/ANs. This responsibility is carried out by the Secretary of the Department of HHS through the IHS. Since its passage in 1976, the IHCIA has provided the programmatic and legal framework for carrying out the federal government's trust responsibility for Indian health. The IHCIA is the law under which authority under which health care is administered to AI/ANs. That is why it is so important to all AI/ANs that this law be modernized and reauthorized this year. The National Indian Health Board is committed to seeing IHCIA successfully reauthorized during the 110th Congress.

In Conclusion

On behalf of the NIHB, I thank the Committee for inviting me to be here today and for its consideration of our testimony. We are grateful for your commitment and for your concern for the improvement of the health and well-being of AI/AN people. We must abate the terrible disparities between the health of AI/ANs when compared to other Americans and that demands a greater increase in funding of the IHS. Specifically, we request a financial and policy commitment from Congress to help America's Native People's move beyond the status quo and begin to achieve true progress in changing the reality of health care inferiority known to us. At least a 10% increase over current funding levels would be a convincing articulation of that commitment.

I am happy to answer any questions you may have.