Testimony of Linda Holt

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Before:

Senate Finance Committee
Dirkson Office Building, Room 215

"Keeping America's Promise: Health Care and Welfare Services for Native Americans"

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10:00 a.m.

Good morning Chairman Baucus, Ranking Member Grassley, and members of the Committee. My name is Linda Holt; I am an elected Tribal Council Member of the Suquamish Tribe and serve as the Chairperson of the Northwest Portland Area Indian Health Board (NPAIHB). I also serve in a variety of capacities on national Tribal committees for agencies within the Department of Health and Human Services and serve as the Portland Area representative on the National Steering Committee (NSC) for the Reauthorization of the Indian Health Care Improvement Act. In my role serving our 43 Northwest Tribes, I am quite familiar with the health care needs of Indian Country. It is indeed honor and a pleasure to offer my remarks concerning Indian Health issues affecting American Indian and Alaska Native (AI/AN) people.

Established in 1972, NPAIHB is a P.L. 93-638 tribal organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health related matters. The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts policy and budget analysis, and operates a number of health promotion and disease prevention programs. NPAIHB is dedicated to improving the health status and quality of life of Indian people and is recognized as a national leader on Indian health issues.

I want to commend the Finance Committee for its work on the Indian Health Care Improvement Act (IHCIA) in the last Congress. Even though the bill did not pass in the 109th Congress, you all demonstrated your support to work on Indian health issues by passing the Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006 (S. 3524). The work you all completed on S. 3524 would have greatly enhanced the ability of the Indian health system to address the significant health disparities that AI/AN people face. The Finance Committee's work was a glimmer of hope for Indian Country to get this bill passed after seven years of hard work. Northwest Tribes hope that you will continue to be supportive of the IHCIA and we look forward to working with the Committee.

I. Indian Health Disparities

The IHCIA declares that this Nation's policy is to elevate the health status of the AI/AN people to a level at parity with the general U.S. population. Over the last thirty years the IHS and Tribes have made great strides to improve the health status of Indian people through the development of preventative, primary-care, and community-based public health services. Examples are seen in the reductions of certain health problems between 1972-74 and 2000-2002: gastrointestinal disease mortality reduced 91 percent, tuberculosis mortality reduced 80 percent, cervical cancer reduced 76 percent, and maternal mortality reduced 64 percent; with the average death rate from all causes dropping 29 percent.[1]

Unfortunately, while Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that other types of diseases are on the rise for Indian people. For example, national data for Indian people compared to the U.S. all races rates indicate they are 638 percent more likely to die from alcoholism, 400 percent greater to die from tuberculosis, 291 percent greater to die from diabetes complications, 91 percent greater to die from suicide,

[1] FY 2000-2001 Regional Differences Report, Indian Health Service, available: www.ihs.gov.

and 67 percent more likely to die from pneumonia and influenza.[2] In the Northwest, stagnation in the data indicates a growing gap between the AI/AN death rate and that for the general population might be widening in recent years. In 1994, average life expectancy at birth for AI/ANs born in Washington State was 74.8 years, and is 2.8 years less than the life expectancy for the general population. For 2000-2002, AI/AN life expectancy were at 74 years and the disparity gap had risen to 4 years compared to the general population. The infant mortality rate for AI/AN in the Northwest declined from 20.0 per 1,000 live births per year in 1985-1988 to 7.7 per 1,000 in 1993-1996, and then showed an increasing trend, rising to 10.5 per 1,000 in 2001.[3]

What is more alarming than these data is the fact that there is abundant evidence that the data might actually ***underestimate*** the true burden of disease and death among AI/AN because, nationally and in the Northwest, people who classify themselves as AI/AN are often misclassified as non-Indian on death certificates. A caution in using AI/AN data is that, due to small numbers, death rates are more likely to vary from year to year compared to rates for the general population. Unfortunately, it is safe to say that the improvements for the period of 1955 to 1995 have slowed; and that the disparity between AI/AN and the general population has grown. Factors such as obesity and increasing rates of diabetes contribute to the failure to reduce disparities.

II. Indian Health Financing: Medicare and Medicare

The major trend in the financing of Indian health over the past ten years has been the stagnation of the IHS budget. With exception of a notable increase of 9.23 percent in FY 2001, the IHS budget has not received adequate increases to maintain the costs of current services (inflation, population growth, and pay act increases). In FY 2007, it was estimated that it would take at least $436 million to maintain current services[4]. Unfortunately, the FY 2007 Continuing Resolution will only provide $138.5 million increase over the FY 2006 enacted level. This leaves over $297 million in inflation, population growth, and pay act increases to be absorbed by IHS programs.

The IHS Federal Disparity Index (FDI) is often used to cite the level of funding for the Indian health system relative to its total need. The FDI compares actual health care costs for an IHS beneficiary to those costs of a beneficiary served in mainstream America. The FDI uses actuarial methods that control for age, sex, and health status to price health benefits for Indian people using the Federal Employee Health Benefits (FEHB) plan, which is then used to make per capita health expenditure comparisons. It is estimated by the FDI, that the IHS system is funded at less than 60 percent of its total need.[5]

In light of this chronic under-funding, Medicare and Medicaid collections are now a growing and critical component to providing basic health care services by the Indian health

[2] Ibid.
[3] American Indian Health Care Delivery Plan 2005, American Indian Health Commission of Washington State, available at: www.aihc-wa.org.
[4] FY 2007 IHS Budget Analysis & Recommendations, Northwest Portland Area Indian Health Board, March 18, 2006; available: www.npaihb.org.
[5] Level of Need Workgroup Report, Indian Health Service, available: www.ihs.gov.

system. While Medicare and Medicaid have become critically important to the health of AI/AN people, the expenditures constitute a very small share of overall costs in these programs. For example, it is estimated that Medicaid accounts for almost 20 percent of the IHS budget but less than 0.5 percent of the overall Medicaid expenditures go to Indian health. As the IHS has experienced a growing reliance on Medicaid reimbursements, another benefit has resulted from Medicaid coverage.

The IHS Contract Health Services (CHS) program purchases specialized health services for AI/AN beneficiaries that are not provided in IHS and Tribal health facilities. In order to budget the CHS resources so that as many services as possible can be provided, the agency applies stringent eligibility rules and uses a medical priority system. CHS services must be pre-authorized or no payment will be made. The agency also has adopted a payer of last resort rule which requires patients to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. Medicare and Medicaid are the most important alternate resources to pay for care outside of the CHS budget. Furthermore, Medicaid helps protect CHS budgets from unpredictable catastrophic medical occurrences, especially for tribes with small populations and very limited CHS allocations—thereby avoiding rationing of health care.

III. IHCIA and Health Facilities Construction

It is critically important to have adequate facilities and medical staff in order to be able to provide Medicare and Medicaid related services. The third-party reimbursements from these programs allow Tribal health programs to compliment their IHS budget, which in turn allow health programs to deliver a wider range of health services. If CHS budgets are in a "priority one" status and medical services are outside the scope of medical priorities than patients often go without health care.[6] Those IHS Areas without hospitals (CHS Dependent Areas) are at a disadvantage since most inpatient hospitals often have medical staff that can provide services that might otherwise be purchased through the CHS program. In effect, those Areas with inpatient hospitals are able to "internalize" the costs associated with purchasing specialty care that are normally borne by CHS programs; and provide more services since they continue to have the unobligated CHS amounts that would have been used to purchase such care. This creates a funding and access to health services disparity within the Indian health system.

The Medicare and Medicaid programs provide tens of billions of dollars for facilities construction annually, but there is no discussion of facilities construction before the Congress and no separate appropriation for facilities construction in connection with the Medicare or Medicaid program. Yet most American seniors receive care in the most modern clinics and hospitals in the world. Indeed it is remarkable, but true, that poor Americans who are eligible for

[6] Priority One Defined - Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. Priority One represents those diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

Medicaid in Washington, Oregon, and Idaho now receive their care in the same facilities as other non-poor Americans, that's right, in the very same clinics and hospitals that are the envy of the world. But what about Indian people? Our clinics in the Northwest are notable exceptions; most on average are more than 40-50 years old. A clinic on the Colville Indian reservation is over 70 years old; and in other Northwest Tribal communities, clinics are housed in mobile homes. The clinics are not just old; they are also inadequate. They are often too small, the equipment is often outdated, and the staff is forced to make do as best they can. That is, the staff that is willing to stay under these less than desirable conditions. Many tribes continually battle recruitment and retention of medical doctors and nurses because of the less than desirable working conditions. Who can blame someone for not wanting to work up to his or her potential in a modern state of the art facility?

Section 301(c) of the IHCIA:

I want to take an opportunity to alert the Finance Committee about an issue that is becoming a growing concern with the reauthorization of the IHCIA. This concern has to do with the IHS' facility construction funding process and a new priority system for ranking construction projects. Section 301 establishes the authority for the IHS to develop a Health Facilities Construction Priority System (HFCPS). It affects the ability of CHS dependent Areas like the Portland, Bemidji, California, and Nashville to collect third party resources under the Medicare and Medicaid programs. If you do not have an adequate health facility with appropriate medical personnel how can you provide the full range of health services that other Areas within the IHS system can. This raises serious questions about access to services and funding inequities.

The Senate Committee on Indian Affair's current bill draft includes a "grandfathering" provision in Section 301 that will protect all facility construction projects that are on the current priority list. The language contained in Section 301 was carried over from current law and developed through Tribal consultation, which responded to Tribal needs and concerns in 1999, however given recent changes in the construction priority system, the language is now out of date. It is estimated that at the current rate of appropriations for facilities construction, it would take 20-30 years to clear the current projects, thus prohibiting a new facilities construction priority system from ever being implemented and prohibiting the IHS from responding to a Congressional directive.

The reason the language at Section 301 is out of date is that over the last three years the IHS and Tribes have worked to develop a new and more equitable construction priority system. The FY 2000 Interior Appropriations Act directed the IHS to "work closely with the Tribes and the Administration to make needed revisions to the facilities construction priority system." Specifically, Congress directed the Agency to address projects "...funded primarily by tribes; anomalies such as extremely remote locations; recognition of projects that involve minimal increases in operational costs; and options for alternative funding and modular construction." The recommendations for the new system are complete and have been forwarded to the IHS Director to make a decision on the final implementation of a new HFCPS. If the Section 301 bill language was to pass today, it would seriously hamper the ability of the IHS Director to implement the new system and continue the long-standing inequities in allocating facilities construction funds.

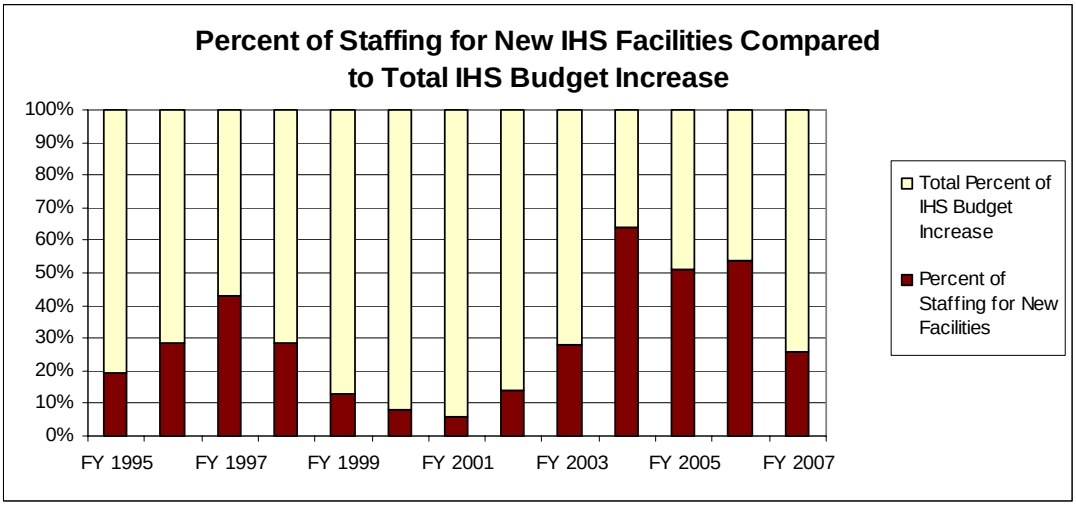
Just as the current bill language has gone through Tribal consultation, so too have the recommendations for revising the HFCPS. In fact, the HFCPS recommendations have gone through much more rigorous Tribal consultation than language in the current bill draft. A review of this Tribal Consultation process follows. In June 2004, the IHS sent out for comment a draft of a revised HFCPS. The IHS received over 1,200 comments during the comment period. Because of the complexity of the issues, the IHS Facilities Advisory Appropriation Board (FAAB) established a workgroup to review the comments and address specific issues identified by Tribes. Like the NSC, the FAAB includes Tribal representatives from each of the twelve IHS Areas and two federal representatives.

The workgroup met over six months in three meetings held in Portland, Oklahoma City, and Tucson and also conducted numerous teleconference meetings. The workgroup reported their recommendations to the full FAAB on May 11-12, 2005. Based on this report, the FAAB developed specific recommendations to make improvements in the facilities priority system and transmitted their recommendations to IHS on July 21, 2005. In October 2005, the workgroup met again in Rockville, MD to finalize their recommendations based on feedback from the IHS. The revised recommendations were transmitted to IHS on February 28, 2006. On June 26, 2006, the IHS Director sent a letter to Tribal leaders requesting additional facility data to assess the impact on projects under the new system. The full FAAB met in October 2006 in Minneapolis to review a "dry run" of facility construction project scores under the new system. There were concerns related to the project rankings, so the FAAB adjusted their recommendations that were transmitted to IHS on March 3, 2007.

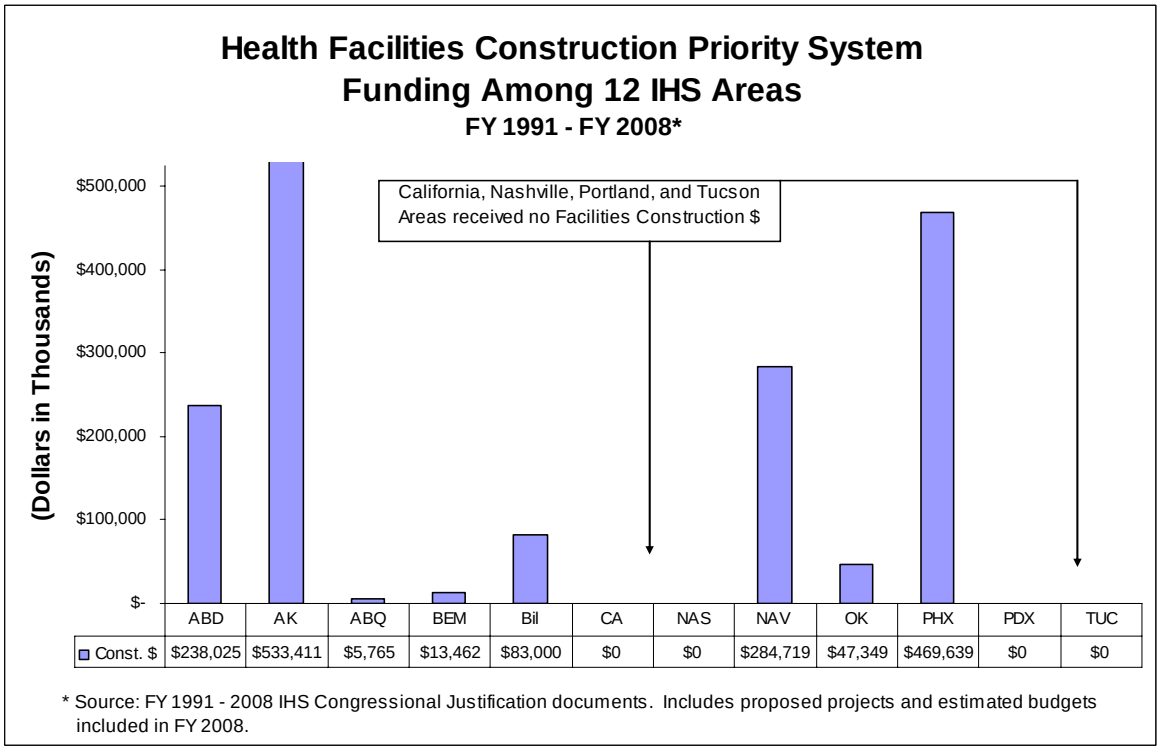
This process culminates over three years of work to revise the facilities construction priority system. If this bill language passes as proposed it will prohibit the new system from being implemented today.

Tribal Concerns:

There are many Tribal concerns associated with facilities construction. Many of these concerns have been addressed in the revision of the new priority system. Generally, Tribes are opposed to the old system because it has been locked since 1991 and allocates a disproportionate share of resources to a select few Tribal communities that results in gaps in the level of health services provided to AI/AN people. The staffing requirements for newly constructed health facilities have always been a concern for Tribes that are dependent on CHS funding to provide health care. The inequities associated with health facilities construction provide a significant amount of resources to one to three Tribes that are fortunate to score well under the priority system and receive a new facility—along with a new staffing package. The significance of staffing new facilities is that it removes funds necessary to maintain current services (pay costs, inflation, and population growth) from the IHS budget increase, which then become recurring appropriations. As the graph below illustrates, staffing packages for facilities construction cuts considerably into budget increases for the IHS.

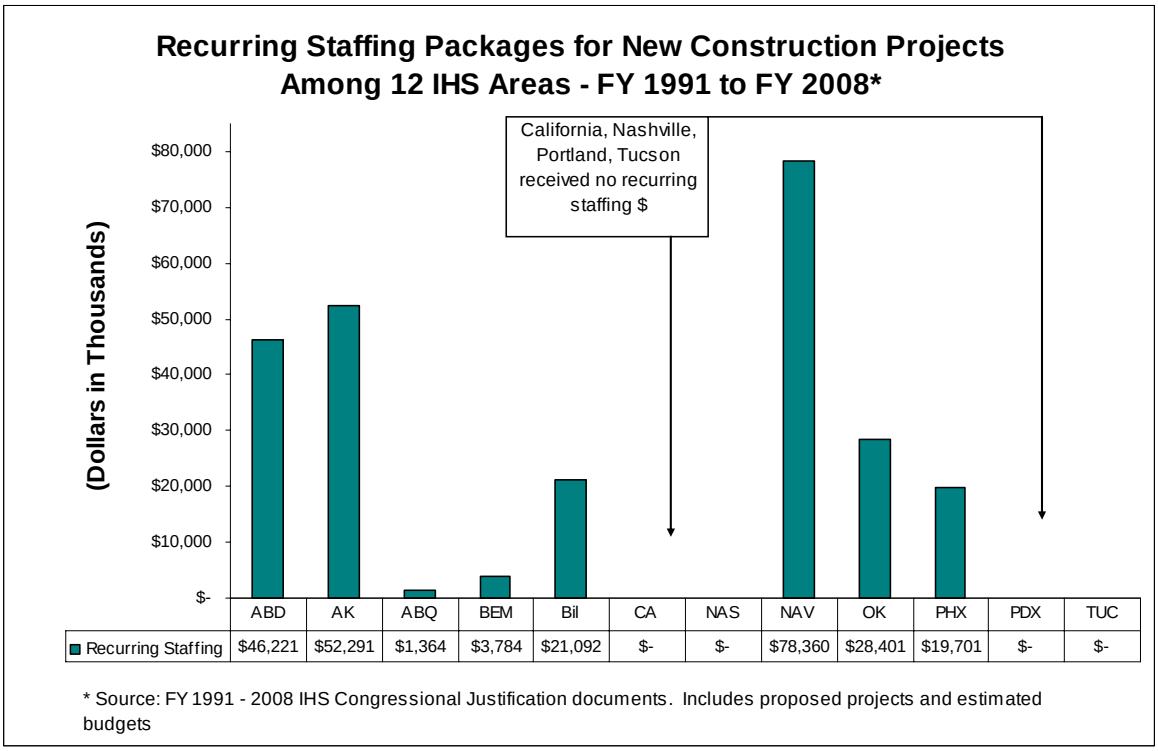


The graph above demonstrates that phasing in staff at new facilities is a growing problem within the Indian health system. The decline in FY 2007 is a result of the pause in facilities construction in part due to the fiscal effects of the federal deficit. Otherwise, the percentage for staffing new facilities would be considerably more. In FY 2004, the new staffing was over 60% of the IHS budget increase. In FY 2005 and FY 2006, new staffing costs consumed over 50% of the increase. It simply is not fair that one or two Tribes benefit by receiving 40-60 percent of the IHS budget increase, while 550-plus Tribes must divide the remaining budget to fund their mandatory cost increases.



* Source: FY 1991 - 2008 IHS Congressional Justification documents. Includes proposed projects and estimated budgets included in FY 2008.

The graphs above and below demonstrate the inequities associated with allocating health facilities construction funding and recurring staffing packages among the twelve IHS Areas. While facilities construction funding is significant (approximately $1.7 billion since 1991), the real resources are tied to recurring staffing packages estimated at approximately $251 million (unadjusted for inflation) since 1991. These staffing packages become recurring dollars that are included in subsequent year's budgets and receive pay act, inflation, and population growth increases. The graphs above and below depict that CHS dependent Areas (California, Nashville, Bemidji, Portland) have not received an equitable amount of facilities construction funding and recurring staffing resources since the existing system has been locked since 1991.

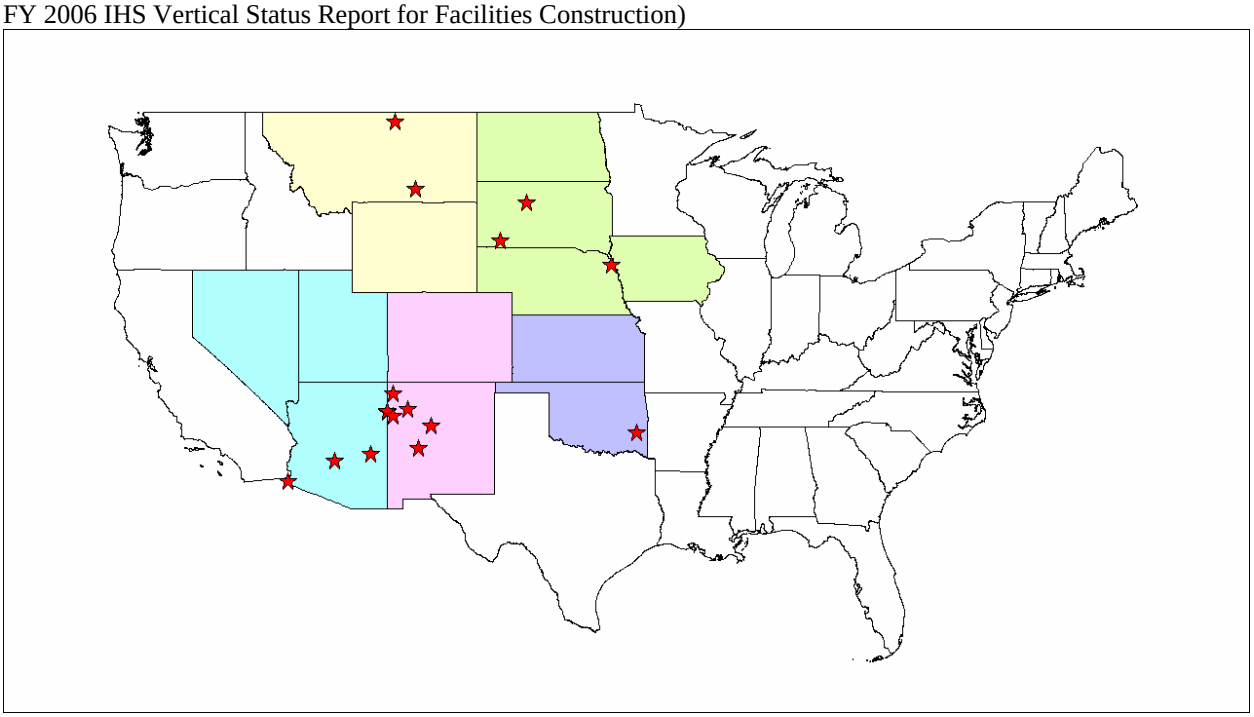


* Source: FY 1991 - 2008 IHS Congressional Justification documents. Includes proposed projects and estimated budgets

Inpatient Facilities Construction:

The following map demonstrates the inequities in allocating facilities construction funding for inpatient hospitals. The map indicates that there has not been one inpatient hospital built in the Bemidji, California, Nashville, and Portland Areas under this system. It is important to note that there have been facilities built in these Areas under the joint-venture and small ambulatory program authorities. However, these authorities do not provide for a staffing package similar to those projects built under the HFCPS. This is critical as it provides those projects built under the HFCPS with a generous staffing package that recurs year after year. This in effect provides a disproportionate share of resources to projects built under this system. How can Congress implement a provision in the IHCIA that unjustly provides funding for facilities construction? The work that the FAAB has undertaken over the last three years will address the inequities of this system and levels the playing field for Tribes to compete for facilities construction funding.

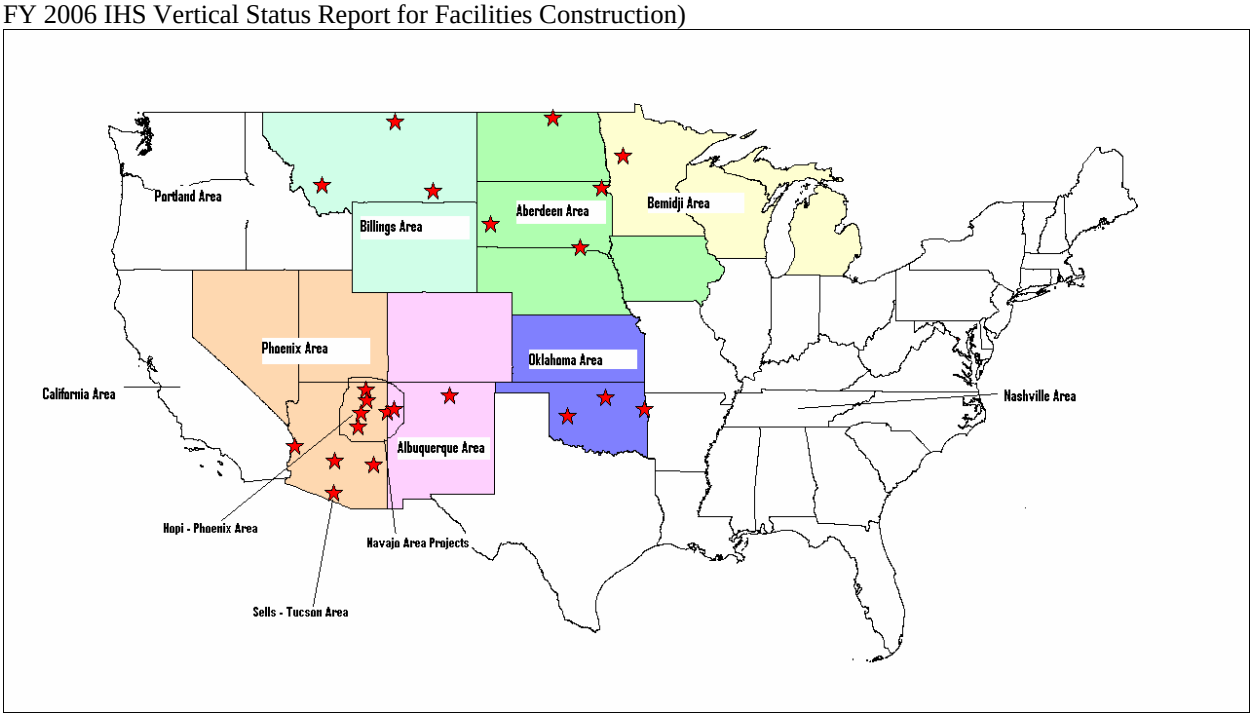
Completed and proposed Inpatient Hospitals from the 1991 Health Facilities Construction Priority System. (Source: FY 2006 IHS Vertical Status Report for Facilities Construction)



Outpatient Facilities Construction:

Again, the following map demonstrates the inequities in allocating facilities construction funding for outpatient clinics built under the current health facilities construction system. The map indicates that there has not been one outpatient clinic built in the California, Nashville, and Portland Areas under this system.

Completed and proposed Outpatient Clinics from the 1991 Health Facilities Construction Priority System. (Source: FY 2006 IHS Vertical Status Report for Facilities Construction)



What is important to note about the above maps is the concentration of facilities construction projects located in the Albuquerque, Navajo, Aberdeen, and Phoenix Areas. The continued funding of projects from the old priority list will perpetuate a Indian health care system that disadvantages those Areas like Bemidji, California, Portland, and Nashville that do not benefit from the facilities construction program. It is time to stop the inequities of this system by revising the language at Section 301(c). In keeping with the principles of this bill, it is highly recommended that the Senate work to address the issues in Section 301(c) so that it is consistent with H.R. 1328's Declaration of National Indian Health Policy. That policy states that it will, "...assure the highest possible health status for Indians and to provide all resources necessary to effect that policy and raise the health status of Indians." Addressing the inequities of health facilities construction is consistent with this principle.

Recommendation to address Section 301 concerns:

Being respectful of the work of the NSC and keeping with the consensus that has been developed with the IHCIA bill, Portland Area Tribes are supportive of retaining most of the bill language at Section 301(c). As a compromise, we urge the Finance Committee to work to adopt

the FAAB recommendations for revising the facilities construction priority system and revise the language in subsequent provisions of Section 301(c). The first recommendation is the establishment of an Area Distribution Funding methodology. This recommendation would add a provision at Section 301(c)(1)(A) that will allow those Areas that do not benefit from the construction priority system to receive funding to address the facilities construction projects in their Areas. We further recommend language changes at Section 301(c)(2)(B) and at 301(c)(1)(D). NPAIHB has provided Finance Committee staff with a copy of our proposed language for your consideration and we are happy to discuss our recommendations in detail.

IV. Conclusion

I know that Finance Committee members understand that the Indian health system is unlike any other. It serves the poorest, sickest, and most remote populations in the United States. Despite the effective use of a public health delivery model and the advances the Indian health system has made toward addressing health disparities, the funding constraints often result in rationing health services. It has been because of the access to Medicare and Medicaid programs that have often kept many Tribal health programs from going bankrupt.

The legislation that we are discussing here today will authorize important programs for the Indian Health Service and greatly improve the lives of many American Indian and Alaska Native people. We hope you will continue to support Indian health issues and endorse similar provisions that the Committee passed in S. 3524.

In closing, I want to thank the Committee for all the work you have done and your support on Indian health issues!