National Indian Health Board

**U.S. HOUSE OF REPRESENTATIVES**
**SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS**
**LEGISLATIVE HEARING ON THE "HEALTTH Act"**

**Testimony on Behalf of the National Indian Health Board**
**Stacy A. Bohlen, Executive Director**
**July 12, 2016**

Good afternoon, my name is Stacy Bohlen, and I am the Executive Director of the National Indian Health Board (NIHB). Chairman Young, Vice Chairwoman Coleman Radewagen, and Members of the Subcommittee, thank you for holding this important hearing on the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act.

The National Health Board (NIHB) is a 501(c) 3 not for profit, charitable organization providing health care advocacy services, facilitating Tribal budget consultation and providing timely information and other services to Tribal governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Service (IHS), NIHB is their advocate. Because the NIHB serves all federally recognized Tribes, it is important that the work of the NIHB reflect the unity and diversity of Tribal values and opinions in an accurate, fair, and culturally-sensitive manner. It is our mission to be the **one voice** affirming and empowering American Indian and Alaska Native (AI/AN) peoples to protect and improve health and reduce the health disparities our people face. I appreciate the opportunity to provide this testimony before the Subcommittee on Indian, Insular and Alaska Native Affairs today. I am here today to offer the national perspective of all 567 federally recognized Indian Tribes.

This hearing today, and the proposed legislation we are here to discuss, have arisen because of longstanding, systemic issues within the IHS that have led to crisis situations – especially, in the Great Plains Service Area. In the last year, several hospitals in this region have lost, (or received threats of revocation) their ability to bill Centers for Medicare and Medicaid Services (CMS) due to the failure of federally run sites to comply with basic safety and regulatory procedures. However, many of the issues now coming to light are not new to American Indian and Alaska Natives that rely on the Indian Health Service as their primary source of health care and health information. At least five years ago, then-Senator Dorgan released a report exposing the chronic mismanagement occurring at both the IHS regional (Area Office) level and the Headquarters level of the Agency. A 2011 report by a separate U.S. Department of Health and Human Services (HHS) task force specifically noted that: "…the lack of an agency-wide, systematic approach makes it virtually impossible to hold managers and staff accountable for performance and to correct problems before they reach crisis proportions."

Now that we are in such crises situations, there must be two separate courses of action taken. First and foremost, immediate corrective action must be taken to rectify the closing and cutting of IHS services so there are no more unnecessary deaths of our people, not just in the Great Plains Area, but at the national level as well. Once the crisis is stabilized, we must then address the fundamental and systemic issues that have been occurring within the Agency for decades. These reforms may start in the Great Plains Area; but they must be implemented nationally in order for all American Indians and Alaska Natives to have access to safe, reliable and quality health care.

The HEALTTH Act (H.R. 5406), proposed by Representative Krisi Noem, is attempting to address long-standing Tribal concerns about the IHS, and outlining how to move forward with better staffing practices, improving the timeliness of services, increasing cultural competency and reforming the Purchased/Referred Care program. The spirit and intent of this legislation is clearly aimed at responding to the call of Tribal leaders, patients and the families of those who have had adverse experiences within the IHS system. The National Indian Health Board stands ready to work with the Committee as the bill is shaped and formed through a Tribally-engaged and informed process.

Many of the provisions within this bill will provide the IHS with the authorizations they need to improve the quality of health care services delivered at IHS facilities. However, especially because this legislation proposes to amend the Indian Health Care Improvement Act (IHCIA), it is the position of the National Indian Health Board that the bill must be vetted further with a process similar to that utilized during the IHCIA reauthorization. During the years that Indian Country and Congress worked to achieve the reauthorization of IHCIA, the NIHB facilitated a Tribal leader led committee. Furthermore, it is the hope of the NIHB that this legislation, and the similar Senate bill (S. 2953), the IHS Accountability Act of 2016, are the keys that this Congress needs to move into an era where the Indian Health Service can be fully funded at the level of need year after year. While the provisions in these bills that will improve transparency, accountability, and administrative functions are absolutely necessary, increased funding to carry out health care services in parity with the general U.S. population is just as, if not more so, necessary to erase the severe health disparities experienced in Tribal communities.

**Federal Trust Responsibility**

The federal trust responsibility for health is a sacred promise, grounded in law and honor, which our ancestors made with the United States. In exchange for land and peaceful co-existence, American Indians and Alaska Natives were promised access to certain remunerations, including health care. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives. The Snyder Act of 1921 (25 USC § 13) further affirmed this trust responsibility, as numerous other documents, pieces of legislation, and court cases have. As part of upholding its responsibility, the federal government created the Indian Health Service and tasked the agency with providing health services to AI/ANs. Since its creation in 1955, IHS has worked to provide health care to Native people. As recently as 2010, when Congress renewed the Indian Health Care Improvement Act, it was legislatively affirmed that, *"it is the policy of this Nation, to ensure the highest possible health status for Indians … and to* ***provide all resources*** *necessary to effect that policy."*

**Disparities**

While some statistics have improved for American Indians and Alaska Natives over the years, they are still alarming and not improving fast enough. Across almost all diseases, American Indians and Alaska Native are at greater risk than other Americans. For example, American Indians and Alaska Natives are 520 percent more likely to suffer from alcohol-related deaths; 207 percent greater to die in motor vehicle crashes; and 177 percent more likely to die from complications due to diabetes. Most recently, a report has come out reporting that American Indian and Alaska Natives are disproportionately affected by the hepatitis C virus (HCV). Furthermore, Natives have the highest HCV-related mortality rate of any US racial or ethnic group – resulting in 324 deaths in 2013. And, most devastatingly to our Tribal communities, suicide rates are nearly 50 percent higher in American Indian and Alaska Natives compared to non-Hispanic whites.

Although the statistics highlight the severity of the problem, behind each statistic is the story of an individual, a family and a community lacking access to adequate behavioral health and health care services or traditional healing practices, and traditional family models that have been interrupted by historically traumatic events. Devastating risks from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. American Indians and Alaska Natives have a life expectancy 4.8 years less than other Americans. But in some areas, it is even lower. For instance, in South Dakota, for white residents the median age is 81, compared to only 58 for American Indians.

**Structural Reform**

There are unique challenges to delivering health care in any rural area, including provider shortages, isolation, long travel distances, scarcity of specialty care, and under-resourced infrastructure. However, there are successful rural health systems operating all around the country that are able to deliver especially innovative and locally responsive care. A pressing need and opportunity exists within the Indian Health Service, and its many rural, geographically isolated hospitals and clinics, to reform the structure in its administrative oversight of Service Units and Area offices.

The HEALTTH Act would provide one unique approach to rethinking the way current IHS federally run and Tribally run facilities are structured. The Act would provide authority to the agency to conduct a pilot program for a "third way" of health care delivery – in addition to Direct Service and Self-Governance. The NIHB supports piloting this proposed program, as it would create joint hospital boards consisting of IHS, Tribal representatives, hospital administration experts and private contractors. The proposed program is written in a way that honors Tribal sovereignty by placing decision making authority in Tribal leadership and providing resources to prepare Tribes to take on self-governance of their clinics and/or hospitals if that is what they choose.

We believe that rather than reinventing a health system out of whole cloth, or reform around the edges of a system desperately in need of dramatic and deep reforms, IHS should aspire to achieve parity with mainstream, successful medical and health systems. The long-term contract pilot program would be a good start to improving administrative oversight and, hopefully, lead to strengthened partnerships between the Tribes; the IHS Area and Service Unit employees; and the private healthcare providers within the region. However, other elements absolutely necessary to such an aspiration are dramatic increases in the current funding levels and the adoption of standard and generally accepted business practices. NIHB believes that creating partnerships with mainstream and private entities will help IHS improve operations and systems and perhaps provide a learning laboratory for system-wide reform.

**Quality Assurance**

Many reports attribute the deplorable quality of care at IHS-operated facilities to poor agency management at all levels. We know that hiring decisions are often lengthy, and poor performing employees at both the Service Unit, clinic and hospital administration and Headquarters are not terminated, but rather moved to other positions within IHS – often to a position of equal or higher responsibility level. The cyclical chronic lack of funding and mismanagement of funds also means that managers are often doing more than one job, and managerial oversight of medical conditions is compromised. In addition to the staffing and accountability provisions included in the newly proposed legislation we are discussing here today, attention must be directed at improving the quality of care provided at federally run IHS facilities. This can be done by strengthening agency-wide standards for hiring qualified individuals who are capable of fulfilling the role as expected and improving the timeliness of care.

On April 28, 2016, the Government Accountability Office (GAO) released a report on patient wait times at the Indian Health Service (IHS). As part of this report, GAO found that "IHS has not conducted any systematic, agency-wide oversight of the timeliness of primary care provided in its federally operated facilities." The report further found that the electronic health record system used by IHS does not "provide complete information on patient wait times," making it harder for staff to track the wait times. The GAO recommended that IHS "(1) communicate specific agency-wide standards for patient wait times, and (2) monitor patient wait times in its federally operated facilities, and ensure corrective actions are taken when standards are not met." The NIHB supports these recommendations and applauds the HEALTTH Act for including provisions that would do just that.

Quality would also be increased through implementing and nurturing a culture and practice of continuous quality improvement, management and supervisory training and setting performance benchmarks that are reviewed twice-yearly. If employees are not performing, generally accepted management practices and principals must be in place, respected and consistently upheld. The HEALTTH Act does include provisions that would expand the hiring authority of IHS to that of other federal medical care services like the U.S. Department of Veterans Affairs, as well as provide expanded authorities to fire or demote underperforming employees. However, before IHS is given greater authority to remove problem employees, the NIHB would like remind Congress that there are procedures already in place to remove problem employees; the real question is whether IHS is using those authorities. We recommend that this committee request a report from IHS documenting the number of times it has exercised its authority to do just that.

**Recruiting & Retention of Personnel**

Title II – the Indian Health Service Recruitment and Workforce of the HEALTTH Act would greatly strengthen the Agency's ability to recruit qualified health professionals by excluding the IHS student loan repayment program from gross income payments, essentially making the scholarship payments tax free. The Agency has asked for years to have similar authorizations as the National Health Service Corps, in order to recruit qualified health professionals to work in Indian Country. Additionally, we are pleased to see the list of degrees that qualify for the loan repayment program would be expanded to

include health administrators. One of the inherent flaws in the Indian Health system is the lack of qualified hospital administrators and lack of basic business acumen in the management, leadership and operation of health systems. This provision within the bill will help to recruit, retain and fund students to enter Masters of Business Administration, Hospital Administration and related professions necessary to achieving and sustaining meaningful reforms in the IHS system.

While we understand that it can be challenging to recruit medical professionals and health administrators to remote areas, it is critical that IHS, and other related agencies within HHS, employ all tools at their disposal to do so. Although there are strong provisions within this bill to improve recruitment practices, there is little that would help with chronic retention issues that we see in all IHS Service Areas – especially in our more remote Tribal communities. We have long heard from healthcare professionals on isolated reservations that a lack of housing and quality education are barriers to long-term tenure at Indian health facilities. To rectify this, there will need to be further collaboration among the Tribes, government agencies such as HHS and the U.S. Department of Housing and Urban Development (HUD), and Congress to make investments in housing so that people working in IHS facilities have adequate living quarters available. It is also critical to provide support for schools so that the families of medical providers will have access to adequate educational opportunities.

Many policymakers do not realize that the system the United States employs to train medical residents, as well as dentists and some nurses, is through an entitlement program, Graduate Medical Education, within Medicare. The GME program exceeds $15 billion annually. Congress capped the number of residency training positions in the United States as part of the Omnibus Budget Reconciliation Act of 1997. Since 1997, several legislative amendments and changes have occurred to make slight increases and variances on the resident limit; however, the medical specialties remain highly motivated to increase the number of residency training positions within their various colleges and academies. One potential opportunity to increase the number of physicians serving in Indian Country is to set aside a certain number of *new* residency training positions for those willing to serve in Indian Country. The number of years of service in Indian Country following completion of residency training would be equal to the number of years the resident took to complete the residency. In states like Connecticut, where residency training positions are approximately $155.000 per resident per year, that is an astonishing incentive to complete service to Indian Country. Likewise, since most of the GME funding is in Indirect Medical Education expenses – paid directly to the training institution, perhaps a similar incentive could attach to the training institute if the resident does not fulfill the commitment. Further, there are very limited numbers of residency training programs in IHS facilities – and exceptions to the caps on new residency positions include rural or medically underserved communities or if a residency training program has never before existed in the training center. The Secretary of HHS has the authority to approve such growth: indeed, is this not the very definition of Indian Country?

Tribes and the NIHB also advocate that a long-term solution to addressing American Indian and Alaska Native health disparities lies in investing in our youth. We can improve the future of the Indian health care workforce by developing a culturally and linguistically competent workforce of Native health professionals and administrators. We know that AI/AN providers are more likely to remain in their own communities long-term and to provide culturally appropriate care. Therefore, Congress and the IHS should prioritize resources and relationship building with academic institutions and national health

professional organizations to engage Native youth in cultivating interest and capability in pursuing medical and health professions.

**Purchased/Referred Care Reform**

In addition to the direct healthcare services provided by the Indian Health Service, eligible American Indians and Alaska Natives can also access healthcare services by non-IHS providers through the Purchased/Referred Care Program (PRC). PRC funds are used to supplement and complement other health care resources available to eligible Indian people. The funding for PRC is distributed among the 12 IHS Service Areas through a formula that was created through consultation with the Director's Workgroup on Purchased/Referred Care and Tribal consultation. Regional and national priorities were taken into account when the formula was created and the section of the HEALTTH Act that requires the IHS to develop and implement a new allocation formula within three (3) years, needs to be further consulted on with Tribes all across the nation. The National IHS Tribal Budget Formulation Workgroup, reported to the Secretary of the HHS on June 20, 2016, that "a major concern for Tribal leadership is that PRC policies have not been updated in years. The current policies were written during a time when the IHS had to restrict access to services by creating limits to eligibility and scope of services provided. Tribes have asked the IHS to update these policies and bring them up to today's standard of quality care in order to have a better picture of what the true funding need is for PRC services. The truth is that these needs have been understated for at least 40 years." The HEALTTH Act provides a good opportunity for the Agency to continue working with Tribes and the Director's Workgroup to assess and improve the program and allocation formula.

As with the rest of the IHS budget, PRC funds have not kept pace with the health needs of Tribal members, the cost of health care and the growth of Tribal populations. As a result, PRC funds, which are managed by the IHS, are typically reserved for emergency and specialty services based on a priority schedule developed by the IHS. However, Self-Governance Tribes are able to develop their own priority schedules, so the provision within the HEALTTH Act that would freeze the funding level of facilities who have achieved Priority Level III-V for a three-year transition period, could disparately impact Self-Governance Tribes and would be a disincentive for high performing facilities. An alternative solution may be to allow IHS facilities or Service Units the same flexibility as Tribally-operated facilities for developing their own, locally-responsive priority schedules.

Furthermore, the provision of the HEALTTH Act that codifies the recent IHS Purchased/Referred Care Final Rule that was published on March 21, 2016, needs to take into account some of the Tribal concerns with the final rules. While the rules were created with Tribal consultation and input, some concerns remain such as private providers refusing to see AI/AN patients that utilize PRC funds, that implementing PRC rates will increase the volume of services being sought and decrease the quality and length of visits, and that the software systems needed to calculate payment rates are too costly for the already underfunded federal and Tribal run health facilities.

**Conclusion**

In conclusion, the NIHB overall supports the recent efforts made by both the Indian Health Service and Congress to address long-standing issues that our people have faced for far too long. Since issues have come to light in the Great Plains Service Area in the past year, the IHS has sought new leadership and pursued innovative policies and programs. Most recently, the IHS issued a new policy on opioid

prescribing that is the first of its kind for a government agency that provides direct medical care. Additionally, law makers have been engaged with Tribes across the country and, very much so, with the Tribes of the Great Plains region.

Finally, because this legislation seeks to amend the Indian Health Care Improvement Act, the National Indian Health Board would like to take this opportunity to remind the Committee that the Indian Health Care Improvement Reauthorization and Extension Act (S. 1790, enacted in H.R. 3590) permanently reauthorized and made several amendments to the Indian Health Care Improvement Act (IHCIA). Numerous provisions of S. 1790 have not yet been fully implemented. Below is a summary of the progress in implementing these provisions. The strides we have already made to achieve quality improvement will remain unfulfilled and continued or future efforts will not be successful without full funding and implementation of these important authorizations for improved Indian health.

National Indian Health Board

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| **I. INDIAN HEALTH MANPOWER** | **67% of provisions not yet fully implemented** | |
| Sec. 119. Community Health Aide Program | Authorizes the Secretary to establish a national Community Health Aide Program (CHAP). | Sufficient funds not yet appropriated. |
| Sec. 123. Health Professional Chronic Shortage Demonstration Project | Authorizes demonstration programs for Indian health programs to address chronic health professional shortages. | Sufficient funds not yet appropriated. |
| **II. HEALTH SERVICES** | **47% of provisions not yet fully implemented** | |
| Sec. 106. Continuing Education Allowances | Authorizes new education allowances and stipends for professional development. | Sufficient funds not yet appropriated. |
| Sec. 201. Indian Health Care Improvement Fund | Authorizes expenditure of funds to address health status and resource deficiencies, in consultation with tribes. | After consultation, IHS decided to make no change in use of funds at this time. |
| Sec. 204. Diabetes Prevention, Treatment, and Control | Authorizes dialysis programs. | Sufficient funds not yet appropriated. |
| Sec. 205. Other Authority for Provision of Services | Authorizes new programs including hospice care, long-term care, and home- and community-based care. | Sufficient funds not yet appropriated for long term care programs. |
| Sec. 209. Behavioral Health Training and Community Education Programs | Requires IHS and DOI to identify staff positions whose qualifications should include behavioral health training and to provide such training or funds to complete such training. | Identification of positions has occurred, but IHS and DOI have lacked funds to provide required training. |
| Sec. 217. American Indians into Psychology Program. | Increases institutions to be awarded grants. | Sufficient funding not yet appropriated for additional grants. |
| Sec. 218. Prevention, Control, and Elimination of Communicable and Infectious Diseases | Authorizes new grants and demonstration projects. | Sufficient funds not yet appropriated. |
| Sec. 223. Offices of Indian Men's Health and Indian Women's Health | Authorizes establishment of office on Indian men's health, maintains authorization of office on Indian women's health. | New offices have not yet been created due to lack of funds. |

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| **III. HEALTH FACILITIES** | **43% of provisions not yet fully implemented** | |
| Sec. 307. Indian Health Care Delivery Demonstration Projects | Authorizes demonstration projects to test new models/means of health care delivery. | Sufficient funds not yet appropriated. |
| Sec. 312. Indian Country Modular Component Facilities Demonstration Program | Directs the Secretary to establish a demonstration program with no less than 3 grants for modular facilities. | IHS has not yet established the program due to lack of funds. |
| Sec. 313. Mobile Health Stations Demonstration Program | Directs the Secretary to establish a demonstration program with at least 3 mobile health station projects. | IHS has not yet established the program due to lack of funds. |
| **IV. ACCESS TO HEALTH SERVICES** | **11% of provisions not yet fully implemented** | |
| Sec. 404. Grants and Contracts to Facilitate Outreach, Enrollment, and Coverage Under Social Security Act and Other Programs | Directs IHS to make grants or enter contracts with tribes and tribal organizations to assist in enrolling Indians in Social Security Act and other health benefit programs | IHS has not yet established the grants due to lack of funds. |
| **V. URBAN INDIANS** | **67% of provisions not yet fully implemented** | |
| Sec. 509. Facilities Renovation | Authorizes funds for construction or expansion. | Sufficient funds not yet appropriated. |
| Sec. 515. Expand Program Authority for Urban Indian Organizations | Authorizes programs for urban Indian organizations regarding communicable disease and behavioral health. | Sufficient funds not yet appropriated. |
| Sec. 516. Community Health Representatives | Authorizes Community Health Representative program to train and employ Indians to provide services. | Sufficient funds not yet appropriated. |
| Sec. 517-18. Use of Federal Government Facilities and Sources of Supply; Health Information Technology | Authorizes access to federal property to meet needs of urban Indian organizations.<br><br>Authorizes grants to develop, adopt, and implement health information technology. | Protocols developed, but property transfer costs require additional funding.<br><br>Sufficient funds not yet appropriated. |
| **VI. ORGANIZATIONAL IMPROVEMENTS** | **0% of provisions not yet fully implemented** | |
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| **VII. BEHAVIORAL HEALTH** | **57% of provisions not yet fully implemented** | |
| Sec. 702. Behavioral Health prevention and Treatment Services | Authorizes programs to create a comprehensive continuum of care. | Sufficient funds not yet appropriated. |

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| Sec. 704. Comprehensive Behavioral Health Prevention and Treatment Program | Authorizes expanded behavioral health prevention and treatment programs, including detoxification, community-based rehabilitation, and other programs. | Sufficient funds not yet appropriated. |
| Sec. 705. Mental Health Technician Program | Directs IHS to establish a mental health technician program. | IHS has yet not established the program due to lack of funds. |
| Sec. 707. Indian Women Treatment Programs | Authorizes grants to develop and implement programs specifically addressing the cultural, historical, social, and childcare needs of Indian women. | Sufficient funds not yet appropriated. |
| Sec. 708. Indian Youth Program | Authorizes expansion of detoxification programs. | Sufficient funds not yet appropriated. |
| Sec. 709. Inpatient and Community Health Facilities Design, Construction, and Staffing | Authorizes construction and staffing for one inpatient mental health care facility per IHS Area. | Sufficient funds not yet appropriated. |
| Sec. 710. Training and Community Education | Directs Secretary, in cooperation with Interior, to develop and implement or assist tribes and tribal organizations in developing and implementing community education program for tribal leadership. | Comprehensive community education program has not been implemented due to lack of funds, although IHS and agencies do provide some trainings. |
| Sec. 711. Behavioral Health Program | Authorizes new competitive grant program for innovative community-based behavioral health programs. | Sufficient funds not yet appropriated. |
| Sec. 712. Fetal Alcohol Spectrum Disorders | Authorizes new comprehensive training for fetal alcohol spectrum disorders. | Sufficient funds not yet appropriated. |
| Sec. 713. Child Sexual Abuse and Prevention Treatment Programs | Authorized new regional demonstration projects and treatment programs. | Sufficient funds not yet appropriated. |
| Sec. 715. Behavioral Health Research | Authorizes grants to research Indian behavioral health issues, including causes of youth suicides | Sufficient funds not yet appropriated. |
| Sec. 723. Indian Youth Tele-Mental Health Demonstration Project | Authorizes new demonstration projects to develop tele-mental health approaches to youth suicide and other problems. | Sufficient funds not yet appropriated. |
| **VIII. MISCELLANEOUS** | **9% of provisions not yet fully implemented** | |
| Sec. 808A. North Dakota and South Dakota as Contract Health Service Delivery Areas | Provides that North Dakota and South Dakota shall be designated as a contract health service delivery area. | IHS has not yet implemented citing lack of funds. |

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