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Testimony of United South and Eastern Tribes Sovereignty Protection Fund Submitted to the House Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs for the Record of the June 21, 2017 Legislative Hearing on the “Restoring Accountability to Indian Health Service Act of 2017”

July 5, 2017

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) we write to provide the House Subcommittee on Indian, Insular and Alaska Native Affairs with the following testimony for the record of its June 21, 2017 legislative hearing on H.R. 2662, the Restoring Accountability to Indian Health Service Act of 2017.

USET SPF is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine¹. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

While we appreciate efforts to address the healthcare disparities identified within the Great Plains Area of the Indian Health Service (IHS), we feel a broad, one-size-fits-all approach to addressing these problems is unwarranted. Not all IHS Areas are experiencing these same types of failures, and there are lessons to be learned from the best practices they employ. In addition, despite Tribal concerns with similar legislation last Congress, this bill was introduced without broad Tribal consultation. Any attempts to reform IHS, through Congressional action or otherwise, must be accomplished through extensive Tribal consultation. USET SPF was pleased to see that a provision appearing in the IHS reform legislation introduced last Congress (Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act, or HEALTHH Act), which would have made sweeping changes to the Purchased/Referred Care program, was not included in H.R. 2662. We note that this is the result of conversations with Tribal Nations from across the country and hope Congress continues to reexamine the across-the-board impacts the provisions of H.R. 2662 may have on the Indian Health System nationally. We urge the Committee to ensure that this Tribal consultation occurs

¹ USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

prior to enacting legislation that reforms the IHS as Tribal Nations can provide valuable insight to the impacts of proposed reforms. Finally, we maintain that until Congress fully funds the IHS, the Indian Health System will never be able to fully overcome its challenges and fulfill its trust obligations.

Uphold the Trust Responsibility to Tribal Nations

The United States has a trust responsibility to Tribal Nations that has been reaffirmed time and time again. The most recent reaffirmation came through the permanent reauthorization of the Indian Health Care Improvement Act when, “Congress declare[d] that it is the policy of this nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” This trust responsibility obligates the federal government to provide quality healthcare to Tribal Nations. Providing quality healthcare can only be accomplished when these programs are fully funded. We further recommend the inclusion of language directing the IHS to request a budget that is reflective of its full demonstrated financial obligation, as this is the only way to determine the amount of resources required to deliver comprehensive and quality care.

As long as IHS remains dramatically underfunded, the root causes of the failures in the Great Plains Area will not be addressed. Although IHS appropriations have increased by \$1.7 billion since Fiscal Year (FY) 2008, this funding is barely able to meet non-medical inflation rates and is completely unable to meet the rates of medical inflation. It is misleading to suggest that slight increases in funding to a deeply underfunded system would meet the increase in costs to deliver quality healthcare to Tribal Nations. In FY 2015, the IHS medical expenditure per patient was \$3,136 while the Veteran's Administration, the only other federal provider of direct health care services, spent \$8,760 per patient – a 36% difference. Disparities in financing for health care such as these lead to disparities in health outcomes.

Though it has been suggested that IHS consider inquiring with similar programs that deliver healthcare to rural and/or underserved communities, USET SPF feels that it is inappropriate for a federal agency to seek the assistance of non-federal programs, when it is the obligation of all branches of the federal government to meet the trust responsibility to deliver quality healthcare to Tribal Nations. . The Indian Health System is unique and already working to stretch vital funding in an underfunded environment. Rather than seek input from non-federal entities, Congress must authorize full funding for the IHS in order to make meaningful progress on the chronic challenges faced by IHS. We remain hopeful that Congress will take necessary actions to fulfill its federal trust responsibility and obligation to provide quality health care to Tribal Nations, by providing adequate funding to the IHS.

Authorize Advanced Appropriations

On top of chronic underfunding, IHS and Tribal Nations face the problem of discretionary funding that is almost always delayed. Stability in program funding is a critical element in the effective management and delivery of health services. Since FY 1998, there has only been one year (FY 2006) in which appropriated funds for the IHS were released prior to the beginning of the new fiscal year. The FY 2016 omnibus bill was not enacted until 79 days into the Fiscal Year, on December 18, 2015. Delays in funding only amplify challenges in providing adequate salaries and hiring of qualified professionals, particularly in areas with high Health Professional Shortage Areas where many Tribal Nations are located. Budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts all depend on annual appropriated funds. As Congress seeks to improve IHS' ability to attract and retain quality employees, as well as promote an environment conducive to effective health care administration and management, we urge the inclusion of language that would extend advance appropriations to the IHS.

Clarification for Tribal Health Programs

When it comes to Tribal Nations operating facilities pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, the current language is ambiguous. We recognize that many provisions contain a “rule of construction” clause that appears to be intended to ensure that the new obligations placed on the IHS in these areas would not interfere with Tribal health programs’ ability to enter into or maintain contracts or compacts under the ISDEAA. We believe that such a rule of construction is helpful, but are concerned that the precise language used does not achieve its goal. Instead, these provisions should be revised to simply state they do not apply to Tribally-operated health programs. Tribal Nations should have a clear sense of which provisions apply to our Tribally-operated programs and which do not.

Section-by-Section Comments

Below, USET SPF offers section-by-section comments and concerns. Again, H.R. 2662 should not move forward without additional, thorough Tribal Consultation on a national basis.

Section 101 – Incentives for Recruitment and Retention

In order to address the ongoing challenges with the recruitment and retention of IHS staff, the legislation would allow HHS to provide housing vouchers or reimburse the costs for those relocating to an area experiencing a high level of need for employment. Though this provision provides the Secretary discretion to determine whether a location is experiencing a high level of need, USET SPF suggests including language for positions that are “difficult to fill in the absence of an incentive.” This addition would allow IHS more flexibility when determining when to offer relocation compensation.

USET SPF agrees that there is a need for recruitment and retention programs. However, the establishment of these programs should not come at the cost of health care services. USET SPF recommends that additional appropriations be authorized for the proposed recruitment and retention programs.

Additionally, it is unclear why the bill includes a sunset date on the housing voucher program. It is unlikely that IHS staff housing needs will be fully addressed in only a 3-year period. USET SPF suggests that the sunset date be stricken.

Section 102 – Medical Credentialing System

USET SPF has deep concerns about the centralization of any Area Office functions, including credentialing. Nashville Area Tribal Nations have consistently advocated for Area Office presence and for services to be administered at the Area level. Collectively, we have worked hard to establish the strong and high functioning Area Office we have today. Taking away functions from Area offices causes significant backlogs in services, and disrupts an established and trusted relationship between the Area Office and Tribal Nations. We believe credentialing should be kept at the Area level, utilizing established best practices.

Section 103 – Liability Protections for Health Professional Volunteers at IHS

While USET SPF understands that providing an incentive for healthcare professionals to volunteer at IHS facilities by protecting them from liability would aid in delivering quality healthcare to Indian Country, we believe this provision needs further technical evaluation to ensure patients and healthcare providers are adequately protected. In addition, USET SPF recommends adding language to ensure similar protections are available at Tribally-operated facilities.

Section 104 – Clarification Regarding Eligibility for IHS Loan Repayment Program

USET SPF encourages efforts that would expand the Indian Health Service Loan Repayment Program to include degrees in business administration, health administration, hospital administration, or public health professions as eligible for awards. We recommend including language that would expand these degrees as eligible under the IHS Scholarship Program as well. Allowing for comprehensive eligibility under these programs would increase the number of American Indian/Alaska Native (AI/AN) individuals seeking business and health administration degrees, as well as increase the pool of qualified health professionals within Indian Country.

Section 105 – Improvements in Hiring Practices

When it comes to improvements in hiring, three provisions are included in H.R. 2662. On the first of these, Direct Hire Authority, language should be included that would require the Secretary to consult with the Tribal Nations served by the Area office where the position will be filled prior to any secretarial action.

On the second provision, we appreciate the inclusion of Tribal Notification of individuals who have been appointed, hired, promoted, transferred or reassigned within IHS. However, language should also be included that would provide notification to Area Tribal Nations on removals based on performance or misconduct. This would supplement the effort of this legislation in increasing transparency and allow Tribal Nations to have greater knowledge and confidence in healthcare professionals providing services to their citizens.

On Waivers of Indian Preference, USET SPF firmly believes that the providers best suited to care for our communities are ones that come from the communities themselves. Therefore, we cannot support the inclusion of this provision, which would set a dangerous precedent throughout other federal agencies that serve Tribal communities. The aims of this provision can be achieved by modifying hiring practices within the current legal framework. There is room for improvements in hiring practices to ensure that positions are being filled in a timely manner with qualified candidates. We recommend directing the Secretary to update and streamline Indian preference hiring practices to ensure that qualified non-Indian applicants will be considered in cases where no qualified Indian applicants are available, at the sole discretion of the Tribal Nations served.

Section 106 – Removal or Demotion of IHS Employees Based on Performance or Misconduct

While USET SPF understands the purposes of including language that would expand the Secretary's authority to remove or demote IHS employees based on performance or misconduct, we believe Tribal governments must also be notified when IHS employees within their Service Area become subject to a personnel action such as removal, transfer or demotion. In under Sec. 606 (d) "Notice to Congress", we recommend including "Tribal Governments located in the affected service area" to the list of entities the Secretary would be required to provide notification to 30 days after the Secretary takes a personnel action on an IHS employee.

Section 107 – Standards to Improve Timeliness of Care

It is imperative that any timeliness of care standards are developed in consultation with Tribal Nations. We note that IHS is currently implementing a timeliness standard in accordance with its Improving Patient Care (IPC) Initiatives. We urge consultation with the 170 IHS and Tribally-operated sites that have chosen to participate in the IPC Initiative, as well as aligning with these standards with IPC to ensure that the

standards and reporting are not overly burdensome for Tribal health programs. In addition, we request that any data collected under the provision be provided to Tribal Nations as well as the Secretary.

Section 108 – Tribal Culture and History

We support the inclusion of Section 108 that would require annual and mandatory cultural competency trainings for IHS employees, including contractors. However, because each Tribal Nation is unique, language should be included that would require IHS to compile these trainings through consultation with the Tribal Nations they serve, on a regional basis.

Section 110 – Rule Establishing Tribal Consultation Policy

While IHS is currently operating under an existing Tribal Consultation Policy, it may be appropriate for Tribal Nations to reexamine and reevaluate its efficacy, in particular, reevaluating how IHS responds/resolves consultative events or issues. Often times, IHS initiates Tribal Consultation but does not report on the findings of the consultation to Tribal Nations. Tribal consultation is a cornerstone of the relationship between federally recognized Tribal Nations and the federal government and needs to be maintained. We do, however, have concerns about the functionality of a negotiated rulemaking and its potential to divert attention and resources away from patient care. USET SPF encourages the use of a Tribal/Federal workgroup to examine, evaluate and update the existing policy and approve through the Public Comment procedures versus official negotiated rulemaking.

Section 202 – Fiscal Accountability

USET SPF has concerns with this section and its effect on base funding. This section requires further technical evaluation and explanation, including from IHS, in order to assess its true impact.

Section 302-304 – Reports by the Secretary of HHS, Comptroller General, Inspector General

USET SPF recommends including language that would require greater collaboration and consultation with Tribal Nations. We feel the reports laid out in this section should be conducted in collaboration with Tribal Nations and provided to those Tribal Nations for consultation prior to their release to Congress or the public.

Section 305 – Transparency in CMS Surveys

As above, USET SPF recommends adding language that would require collaboration and consultation with Tribal Nations during the formulation of these compliance surveys. We also believe the results of these surveys should be provided to Tribal Nations prior to their public release.

Conclusion

USET SPF acknowledges the efforts of the Committee and others within Congress in seeking to address the long-standing challenges within IHS. However, we believe that H.R. 2662 continues to fail to recognize the deep disparities in funding faced by IHS and how these disparities contribute to failures at the Area level. We maintain that until Congress fully funds the IHS, the Indian Health System will never be able to fully overcome its challenges and fulfill its trust obligations. Finally, a number of provisions within H.R. 2662 seem to be responding to Area-specific concerns. While we stand with our brothers and sisters who are experiencing these failures, we ask that the Committee strongly consider the national (rather than regional) implications of H.R. 2662, and work with Tribal Nations to ensure its impact is positive in all IHS Areas. We thank the Committee for the opportunity to provide comments on this bill and look forward to further consultation on H.R. 2662, as well as an ongoing dialogue to address the complex challenges of health care delivery in Indian Country.