

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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DIRECTOR

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BEFORE THE

HOUSE COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

OF THE

UNITED STATES CONGRESS

OVERSIGHT HEARING

ON

H.R. 2708

INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS

OF 2009

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STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good afternoon. I am Dr. Yvette Roubideaux and I am the new Director of the Indian Health Service (IHS). I am accompanied by Randy Grinnell, Deputy Director, IHS. I am pleased to have the opportunity to testify on H.R. 2708, the Indian Health Care Improvement Act Amendments of 2009. I am looking forward to working with you to ensure passage of this important authorizing legislation for the Indian Health Service.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and acts of Congress. This Indian health system provides services to nearly 1.5 million American Indians and Alaska Natives through hospitals, health centers, and clinics located in 35 States, often representing the only source of health care for many American Indian and Alaska Native individuals, especially for those who live in the most remote and poverty-stricken areas of the United States. The purchase of health care from private providers through the Contract Health Services program is also an integral component of the health system for services unavailable in IHS and Tribal facilities or, in some cases, in lieu of IHS or Tribal health care programs. In addition, unlike many other health delivery systems, IHS is involved in the construction of health facilities -- including the quarters necessary for recruitment and retention of health care providers -- and of water and sewer systems for Indian communities. IHS accomplishes such a wide array of clinical, preventive, and public health activities, operations, and program elements within a single system for American

Indians and Alaska Natives.

However, meeting the mission of the Indian Health Service has become increasingly challenging over time. Population growth, increased demand for services, rising medical costs, and the growing burden of chronic diseases such as diabetes, obesity, and cardiovascular disease have placed a significant strain on the system. Additionally, some facilities have trouble recruiting and retaining health care professionals.

In the opening statement of my confirmation hearing before the Senate Committee on Indian Affairs, I stated that, despite these challenges, I see evidence of hope and change. I have worked on a variety of projects and national initiatives over the past 16 years that have shown me the great potential that exists to improve access to, and quality of, health care. I know that thousands of committed and dedicated career staff in the Indian health care system work hard every day to provide health care to their patients in the face of the aforementioned challenges. And I have seen support from Tribes and Congress for change and improvement in the Indian Health Service. I believe we are at a unique moment in time, where we have the opportunity to take great strides toward fulfilling the mission of the Indian Health Service and improving the health of the American Indian and Alaska Native population.

President Obama's commitment to improve health care for American Indian and Alaska Native people is reflected by a significant funding increase for the Indian Health Service (IHS) in his FY 2010 budget request, which is the largest annual increase in the past 20 years. It responds to priorities established by Tribes during the Tribal budget consultation process and supports an investment that will result in healthier American Indian and Alaska Native communities. While the President, the Secretary, and I all understand money alone is not the whole answer, the significant increase in resources for IHS recommended in the President's Budget is essential for the Agency to increase services and effectively fulfill its mission. Now is the time to begin the important work

of bringing change to the Indian Health Service, to improve health care quality, to modernize and upgrade IHS facilities, to expand health promotion and disease prevention, and to ensure that American Indians and Alaska Natives are able to get the health care they deserve. Passage of the Indian Health Care Improvement Act will be an important step towards these goals.

Reauthorization of the Indian Health Care Improvement Act

Improving access to health care for all eligible American Indians and Alaska Natives is a priority for all those involved in the administration of the Indian Health Service. H.R. 2708 advances our common goal of reauthorizing the Indian Health Care Improvement Act (IHCIA). The IHCIA provisions provide the statutory basis for the implementation of “the Federal responsibility for the care and education of the Indian people by improving the services and facilities of the Federal Indian health programs and encouraging maximum participation of Indians in such programs.” The bill would renew the authorities which provide specific policy guidance on the delivery of health services to American Indians and Alaska Natives. It contains critical language addressing the recruitment and retention of health professionals serving Indian communities; the provision of health services, the construction, replacement, and repair of health care facilities; access to health services; and the provision of health services for urban Indian people.

The Department strongly supports reauthorization of the IHCIA and supports the effort to ensure that the IHS is able to meet the health care needs of American Indians and Alaska Natives and takes into account increased tribal administration of Indian health programs. It is within this context that today we offer our views on H.R. 2708.

First, we note that the authority for the Catastrophic Health Emergency Fund (CHEF) included in Title II of the existing authority has been excluded from this bill. We recommend the inclusion of the provision because the CHEF program is a key

component of the contract health program administered by IHS and tribal health programs. CHEF provides funding for high cost cases which cannot be absorbed by the local service units' contract health care programs.

We have a number of concerns with expanded requirements for negotiated rulemaking, since this can be a very long and time consuming process, along with other provisions in the bill. We also have other specific comments on certain proposed changes in the Indian health manpower and development, and in the facilities title of the bill, which are included below. We will provide additional comments once we've had an opportunity to conduct a complete review of this important reauthorizing legislation.

Indian Health Professions Scholarship Waivers and Suspension

IHS offers health profession scholarships to American Indian and Alaska Native students who agree to sign a legal contract agreeing to a service obligation upon completion of their health professional training. Unfortunately, a small number of these students default on this service obligation. Section 104(d)(4)(B) of Title I requires the Secretary to consult with entities that are not party to the contract entered into by the Secretary with the scholarship recipient before determining whether to discharge or suspend a defaulted service obligation. The determination whether to discharge or suspend a defaulted service obligation should remain entrusted, as under current law, to a review board charged with making impartial case-by-case decisions based on a detailed review of the requests. Moreover, the entities consulted may at times have interests that conflict with the federal government's interest to see that contract agreements are upheld. Accordingly, the need to insulate this process from outside influence of conflicts of interest mitigates against requiring or even permitting consultation on such decisions. We recommend the new consultation requirement in this section be dropped. Defaulting on this obligation is a serious breach of a legal contract, and the resolution must be decided in an impartial manner.

Indian Health Service Loan Repayment Approvals

The IHS also offers a loan repayment program to health professionals who agree to work in areas of high vacancy or need, and a list of priority sites is developed each year.

Section 110(d)(2) of Title I in H.R. 2708 changes current law to require the Secretary to approve loan repayment awards “notwithstanding” the priority ranking of positions for which there is a need or a vacancy required under Section 110(d)(1). This modification means the award approvals would be based on other priorities, undermining the development of the annual priority list. To keep the intent of the loan repayment program consistent with the goal of improving recruitment and retention of health professionals in areas of high vacancies or need, we recommend that the term “notwithstanding” be replaced by the terms “Consistent with”.

Sanitation Facilities Deficiency Definitions

Another section in H.R. 2708 – 302(h)(3) – would provide ambiguous definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country. The proposed definition of "deficiency level III" could be interpreted to mean that all methods of service delivery (including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home) are adequate to meet the level III requirements and only the operating condition, such as frequent service interruptions, makes that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe it is important to distinguish between the two levels of service.

In addition, the definition for deficiency level V and deficiency level IV, though phrased differently, have essentially the same meaning. Level IV should refer to an individual home or community lacking either water or wastewater facilities, whereas level V should refer to an individual home or community lacking both water and wastewater facilities.

We recommend retaining current law to distinguish the various levels of

deficiencies, which determine the allocation of existing resources.

In addition to comments I've made today on certain specific provisions of H.R. 2708, there will be additional comments once we've had an opportunity to conduct a complete review of this important reauthorizing legislation.

Mr. Chairman, this concludes my testimony. I appreciate the opportunity to appear before you to discuss the reauthorization of the "Indian Health Care Improvement Act of 2009," and we are committed to working with the Committee to ensure the reauthorization of this key legislative authority.

I will be happy to answer any questions that you may have regarding the Department's views on H.R. 2708. Thank you.