Statement of R. Turner Goins before the
White House Conference on Aging Solutions Forum,
May 25, 2005, Morgantown, WV

R. Turner Goins, Ph.D.
Associate Professor, Department of Community Medicine
Associate Director for Research, Center on Aging
West Virginia University School of Medicine
One Medical Drive, HSC Annex, P.O. Box 9127
Morgantown, WV 26506-9127
Telephone: (304) 293-3129
Fax: (304) 293-2700
rgoins@hsc.wvu.edu

Chairperson Hardy, Distinguished Members of the White House Conference on Aging Policy Committee, and guests: Good afternoon. My name is Turner Goins, and I am an Associate Professor at West Virginia University's Department of Community Medicine and the Associate Director for Research at the Center on Aging. I am honored to have this opportunity to speak with you today to summarize the issues regarding long-term care access for rural and reservation-based American Indians and Alaska Natives and make recommendations for improving their access to long-term care. I would also like to note that this population has the largest proportion residing in rural areas compared to other racial/ethnic groups.

Federally recognized tribes have a unique political status which has influenced health service provision. This includes the sovereign status of federally recognized tribal governments, the treaty-making process under which the U.S. assumed certain responsibilities to tribal governments, and the resulting federal-Indian relationship. Indian Health Service (IHS) is a federal agency in the U.S. Department of Health and Human Services which provides free health care to tribally enrolled American Indians

and Alaska Natives, more than 1.6 million individuals, principally through the operation of 61 health centers and 36 hospitals. Federally recognized tribes can either choose to receive their health care through IHS or can receive funds from IHS to operate their own health care delivery through a contracting/compacting system. If a tribe chooses to manage its own health care, it can contract with IHS to take over the management of specific programs and after a few years with a good record, the tribe is eligible for a compact. A compact is more like a treaty or block grant than a contract and affords greater management authority and flexibility to move funds between programs and to develop new programs. Neither IHS nor tribes provide the full range of medical specialty care within their clinics and hospitals, so they contract with the private sector for some services. The Indian Health Care Improvement Act provided that IHS could be reimbursed through Medicare and Medicaid programs for care rendered to eligible American Indians and Alaska Natives. However, American Indian and Alaska Native enrollment in Medicare and Medicaid has been relatively low compared to other ethnic groups. The critical issues facing American Indians and Alaska Natives today are that IHS is not specifically authorized in legislation to provide comprehensive long-term care services and funds have never been appropriated to IHS for long-term care. American Indian and Alaska Native elders most often rely on tribally-funded services, Medicaid/State funded services, and Administration on Aging funded services for long-term care. The other option for many American Indians and Alaska Natives is to go without needed long-term care.

A 1995 study funded by the Administration on Aging examined issues affecting home- and community-based long-term care service access among American Indians

and Alaska Natives. Results indicated that home health care was one of the most frequently needed services among this population. Further, 88% of the services sometimes, rarely, or never met the need and 36% of services were rarely to never available. Today, there are only 12 tribally-operated nursing homes in the U.S., which rely predominantly on funding from Medicaid and tribal subsidies. Many tribes would like to have nursing homes but are blocked by state certificate-of-need requirements, Medicaid licensing requirements, and lack of commercial financing. The lack of alternative resources, whether private insurance or public programs, limits access to specialty medical and long-term care not included as part of IHS benefits. These factors make older Native Americans particularly vulnerable to experience disruption in the continuity of care. Tribes have expressed a growing interest in providing home- and community-based long-term care options to keep elders in their homes for as long as possible.

Members of the Committee, these are the issues. The next challenge is to implement clear and viable solutions.

First, decisions regarding long-term care planning and program development belong at the community level. For tribes, this means decision-making at the tribal level rather than the state or county level. It is critical that tribes have the freedom to identify the specific problems facing their communities and work toward their own solutions.

A recent agreement set between the state of Minnesota and a tribe provides a nice illustration of this recommendation in action. Until recently many persons of the White Earth Band of Chippewa had limited access to Medicaid and state Alternative Care waiver services. These services are county specific and the majority of tribal

members with disabilities were reluctant to allow county staff into their homes to conduct the screenings for service eligibility. In response, the White Earth Band, with the cooperation of the state of Minnesota, started a five-year demonstration project to have a public health nurse and licensed social worker employed by the tribal home health agency conduct eligibility screenings and provide ongoing case management. Today, approximately 55 tribal members receive state waiver services as compared to one or two prior to this demonstration. This demonstration serves as an excellent model that needs to be replicated in other states with other tribes.

Secondly, give tribes more direct control of the current stream of monies, such as Medicaid and Older Americans Act Title III dollars. Title VI is a model that works well because funding is given directly to tribes. Some American Indians and Alaska Natives are eligible for Title III funding and this funding is distributed via State Units on Aging, rather than at the tribal level.

Third, we need to ensure that health policy recognizes long-term care as an integral part of health care delivery and provide funding at a level which meets the federal government's treaty and trust obligations to federally recognized tribes.

Finally, I would like to encourage your support for the reintroduced bill to amend the Indian Health Care Improvement Act, which includes specific provisions for long-term care.