S. HRG. 111–181

REFORMING THE INDIAN HEALTH CARE SYSTEM

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

JUNE 11, 2009

Printed for the use of the Committee on Indian Affairs

U.S. GOVERNMENT PRINTING OFFICE

53–636 PDF WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
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REFORMING THE INDIAN HEALTH CARE SYSTEM

THURSDAY, JUNE 11, 2009

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:20 p.m. in room 628, Dirksen Senate Office Building, Hon. Jon Tester presiding.

OPENING STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. I call the Committee to order.

I appreciate the panelists giving testimony today. Unfortunately, Chairman Dorgan is unable to be with us here for this hearing, and I can tell you I know that he would love to be here because this is a big issue in Indian Country, and he knows it. It is something he talks about all the time.

Today's Committee is to discuss ideas for how to reform the Indian health care system. Everybody in this room knows that the Indian health system is broken. Estimates are that the Indian Health Service is funded at about 52 percent of need.

However, the issues in the Indian health system extend far beyond lack of funding. Myself, as well as Chairman Dorgan and other Members of this Committee, have expressed serious concerns about the IHS. It has been over 10 years since Indian Country first asked Congress to reauthorize the Indian Health Care Improvement Act.

Last Congress, this Committee brought the Indian health care bill to the floor and it was debated for the first time in 16 years. The Senate passed the bill overwhelmingly. Regrettably, the House did not.

Health care continues to be a top priority for this Committee. We must do something to address the appalling health statistics among Native Americans. In my home State of Montana, Native American women have a median life expectancy of 64 years as compared to 81 for the general population. That is a difference of 17 years.

Native Americans have the highest rate of Type II diabetes of any population in the world. Native Americans have tuberculosis at a rate of 650 percent higher than the general population. Infant mortality rates for Native Americans are 12 per 1,000 compared to 7 per 1,000 for the general population. Suicide rates are nearly double than the general population. Among Native Americans, my State of Montana has one of the highest rates of suicide for Indian

Country. American Indians die of alcoholism at the rates of 670 percent higher than the general population.

You get the idea. It is clear that the Federal Government is not fulfilling its trust responsibility to provide health care for Native Americans in this Country.

On May 6, the Senate confirmed Indian Health Service Director Yvette Roubideaux. Having an IHS Director committed to addressing the deficiencies at the agency is an important step toward improving Indian health. Dr. Roubideaux has also expressed a commitment to reforming the Indian health care system, and I look forward to working with her and achieving that goal.

President Obama has tasked Congress with passing national health care reform this year. With health care gaining such attention, there is a unique opportunity to improve the Indian health care system.

The Committee is working on a draft bipartisan legislation that does more than reauthorize the Indian Health Care Improvement Act. We want to look for ideas in the Indian health care system that are needed and significant reform, which is why we are here today. We hope to hear ideas from our witnesses today on how Indian Country can move forward with reform. We want to address and find solutions to such areas as serious health disparities, health provider shortages, rationing of health care services.

Myself, like Chairman Dorgan and the Committee, look forward to working with the new Administration, the Indian Health Service tribes, and all of you to bring meaningful change to truly reform the Indian health care system.

I want to thank our witnesses for being here, and I would remind the witnesses to limit their remarks to five minutes. Your entire testimonies will be in the official hearing record.

The expert witnesses that we have here today are Jefferson Keel, Vice President of the National Congress of American Indians. Good to have you here, Jefferson.

Buford Rolin, Vice President and Nashville Area Representative of the National Indian Health Board. Good to have you here.

Geoffrey Roth, Executive Director of the National Council of Urban Indian Health. Geoffrey.

Valerie Davidson, Senior Director of Legal and Government Affairs for the Alaska Native Tribal Consortium.

And Dr. Paul Carlton, Jr., Director of Homeland Security of Texas A&M Health Science Center.

A powerful group of witnesses, and we look forward to tour testimony. I believe that we will just go from Jefferson and go down the line. Is that okay? All right. Yes.

So how about it, Jefferson? Thank you.

STATEMENT OF JEFFERSON KEEL, FIRST VICE PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS

Mr. KEEL. Good afternoon. Thank you, Mr. Chairman, Members of the Committee who could not be here, we look forward and want to thank you for being here.

My name is Jefferson Keel. I am Lieutenant Governor of the Chickasaw Nation and First Vice President of the National Congress of American Indians.

I want to thank you for the opportunity for testifying today. I am honored to be here.

First and foremost, the provision of health care to American Indian and Alaska Native tribes is founded on a sovereign government to government relationship between the United States and tribes. As such, the provision of health care to American Indian and Alaska Native people is based on a unique political relationship and is not based on race.

This provision of health care is formalized as a Federal trust responsibility to American Indian and Alaska Native people that has been guaranteed as a Federal trust responsibility, and been guaranteed through numerous treaties and Federal law.

Health care for American Indian and Alaska Native people was permanently authorized in the Snyder Act of 1921. The Indian Health Care Improvement Act, as you mentioned, Senator, needs to be reauthorized immediately. Perhaps no where in the Country is debate on health care more important or will have more of an impact than in tribal communities.

Tribal leaders and tribal health advocates have been working diligently to ensure that Indian Country and current Indian health delivery systems are being included in a meaningful way in the national plan for health care reform. We are poised to consider achievable reform opportunities for the delivery of health care throughout the Indian health care delivery system.

We have provided for the record a copy of health care reform Indian Country recommendations put forth by the National Indian Health Board, the National Council on Urban Indian Health, and the National Congress of American Indians.

I might also add that the Chickasaw Nation has provided testimony for the record, and those are included in the testimony.

These recommendations have been shared with all committees of jurisdiction in the House and Senate working on health care reform.

The National Congress of American Indians respectfully offers the following recommendations. I want to quickly address eligibility before we get into the recommendations.

To be clear, there is no problem with eligibility. The issue that should be addressed, however, is resource allocation. If the Committee wishes to examine the issue of resource allocation more closely, tribes and the National Congress are happy to assist, and you will also hear later about self-governance tribes and how they are innovative in this approach.

It has been proven that self-governing tribes are the most efficient and deliver the highest quality of health care to our people. Self-governing tribes have developed sophisticated collection systems to enable them to enter partnerships with other agencies to utilize every dollar effectively. Current law authorizes tribes to set priorities for health care delivery, therefore avoiding bureaucratic delays and life-threatening situations. We urge that those current laws be preserved.

Tribal consultation. Given the expeditious nature of moving health care reform forward, we would like to thank the Committee for engaging and including Indian Country. We need to continue the consultation process. Realizing the short time frame involved,

we would suggest partnering with the Department of Health and Human Services, who will be conducting a consultation session in Denver later in July.

Contract health services. Reducing the spiraling cost of health care is a priority for Indian Country, as you well know. Astronomical medical inflation rates, the expense of providing services in extremely rural communities, along with an increasing Indian population and limited competitive pricing have all tremendously hindered tribes' and IHS's ability to provide health care to Indian people.

One of the most impacted areas of the Indian health system is the Contract Health Service Program. This program provides funding for primary and specialty health services that are not available at IHS or tribal health facilities to be purchased from the private sector health care providers. This includes hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy and transportation services. It is estimated that CHS is currently funded at about 50 percent of the need.

While the Committee has previously heard from Indian Country on this issue, we must continue to stress that anything less than full funding and recurring funding of CHS compromises the health and lives of those in our communities. By supporting us in these efforts, you will be ensuring that tribes have the ability to deliver the highest quality services to the tribal members.

One way to immediately and dramatically address the shortfall in CHS funding is by ensuring that all American Indians and Alaska Natives are auto-enrolled in Medicaid. Creating an Indian-specific subsection or category of Medicaid would facilitate access to the comprehensive health care benefits of this program, while easing the already overburdened CHS system. This joint proposal submitted by the national Indian organizations provides recommendations of fast-tracking Indian patients into the Medicaid system. We suggest that proper consideration be made to establishing a new category of eligibility under Medicaid for Indian patients.

Tribal health facilities are oftentimes located in remote rural geographic locations, making them in some instances the only viable option of health care delivery. With the anticipated increase in demand for health services, tribes recognize that they are likely to be asked to open their doors to serve non-Indians. This is a challenging decision that requires consideration of capacity and resources, and whether adding users will improve the services that can be offered or would diminish an already limited capacity.

Senator TESTER. Jefferson?

Mr. KEEL. Yes?

Senator TESTER. Your entire statement will be in the record. I would ask you to try to wrap it up. It is a critically important issue that literally we all could talk on for a long time, but if you could hit your high points so we can do it, then we will move on.

Mr. KEEL. Okay. I certainly will.

Senator TESTER. Okay.

Mr. KEEL. Indian health care workforce. Indian Country is not alone in its concern on how to address this ever-increasing workforce shortage. Mid-level practitioners is one answer.

Exclusion of health benefits as income. This is an important part, and I want to touch this and I will wrap up.

Tribal governments have been trying to meet the challenge of addressing the health care needs in our communities. Some tribal governments have met this challenge by providing supplemental services above and beyond the limited IHS services, while others are providing more comprehensive care through self-insured funds or third party plans. This type of universal health coverage for tribal citizens is similar to Medicare.

However, some IHS field offices are asserting that this type of coverage when provided by a tribal government should be treated as a taxable benefit. In order to continue to encourage tribal governments to provide such benefits to their members on a nondiscretionary basis, NCAI seeks a statutory exclusion to clarify that the health care benefits and coverage provided by tribal governments to their members are not subject to income taxation and excluded from gross income in the same manner as Medicare.

Senator, I thank you for the opportunity to speak here. One final note. As a tribal leader, I would simply ask that the gains that we have made since 1975 in the Indian Self-Determination and Education Assistance Act not be compromised, and the Indian Health Service has been characterized as broken. We believe it is starved because we can't determine how much is broken until we fully fund it.

Thank you.

[The prepared statement of Mr. Keel follows:]

PREPARED STATEMENT OF JEFFERSON KEEL, FIRST VICE PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS

Chairman Dorgan, Vice Chairman Barrosso, and the members of the Committee, thank you for having me here today. My name is Jefferson Keel and I am the Lt. Governor of the Chickasaw Nation and the First Vice President of the National Congress of American Indians (NCAI), the oldest and largest national organization representing tribal governments. I am delighted to be here.

BACKGROUND

The Federal government provides health care to American Indians and Alaska Natives based on its trust responsibility found in the U.S. Constitution and affirmed by treaties, federal court decisions, and federal law. Today, health care is provided to 1.9 million to American Indians and Alaska Natives primarily residing on or near Indian reservations located in 35 states.

The health statistics for Indian Country are not new. In fact, sadly, the numbers seem to get worse with each new report. The life expectancy of American Indian and Alaska Natives is nearly six years less than any other race or ethnic group in America[1]. We are three times more likely to die from diabetes[2] and suffer from a rate of tuberculosis that is six times higher than the non-Native population[3]. Our youngest are often the most vulnerable. The American Indian and Alaska Native infant mortality rate is 40 percent higher than that of non-Natives[4], and our youth, ages 15-34, commit suicide at a rate three times the national average[5].

The U. S. Indian Health Service (IHS) has been the primary provider of health care to American Indian and Alaska Native people since 1955. Much has been accomplished since then in terms of improvements in public health care delivery, but many more improvements are still needed. The American Indian and Alaska Native population still suffer vast disparities in health status and the funding appropriated is abysmal relative to the per capita health care amount provided to other federally funded population groups such as federal employees, Medicaid beneficiaries, and even federal prisoners.

Moreover, the IHS has been characterized over the past decade as a "broken" system. The truth is that the IHS system is not so much broken as it is "starved". The IHS has

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[1] National Vital Statistics Reports, U.S. States Life Tables, 2003. Available from http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_14.pdf. (accessed April 2008).
[2] National Center for Health Statistics, Health, United States, 2007, With Chartbook on Trends in the Health of Americans.
[3] Trends in Indian Health 1998-1999. Indian Health Service. http://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp
[4] CDC 2008. Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports 57(2).
[5] Trends in Indian Health 1998-1999. Indian Health Service. http://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp

been grossly underfunded for decades and as such, cannot be expected to function optimally. Such inadequate funding has created the perception that the system is broken.

Despite these desperate statistics, the reauthorization of the Indian Health Care Improvement Act, the baseline authority for providing direct health care to American Indian and Alaska Natives, has not been reauthorized for ten years. The bill establishes objectives for addressing some of the basic and overwhelming health disparities confronting Indians as compared with other Americans and provides progressive approaches to health care delivery that will help move Indian health care into the 21st century. Passage of this much needed legislation is not only necessary to fulfill the Federal government's responsibility of health care to Indian people; it must happen so that Indian people are placed on parity with the majority population and able to engage meaningfully in national health care reform.

REFORMING THE INDIAN HEALTH DELIVERY SYSTEM

Perhaps nowhere in the country is the debate on health care reform more important, or will it have more of an impact, than in tribal communities. Tribal leaders and tribal health advocates have been working diligently to ensure that Indian Country and the current Indian health delivery system are being included in a meaningful way in the national plan for health care reform. As such, we are poised to consider achievable reform opportunities for the delivery of health care through the Indian health delivery system.

Attached is a copy of "Health Care Reform: Indian Country Recommendations" put forth by the National Indian Health Board, the National Council on Urban Indian Health, and NCAI. These recommendations have been shared with all committees of jurisdiction, in the House and Senate, working on health care reform. In an effort to not be repetitive in testimony, subjects and issues were divided among our organizations.

NCAI offers the following recommendations:

Tribal Consultation

Given the expeditious nature of moving health reform forward, we would like to thank the Committee for engaging and including Indian Country. It is only by speaking with knowledgeable tribal leaders, before policy approaches are evaluated and implemented, that meaningful consultation occurs. As such, there may be a need to continue the consultation process. Realizing the short time frame involved, we suggest partnering with the Department of Health and Human Services who will be conducting a consultation session on "Health Care Reform and the Indian Health Care System" in July, 2009.

Contract Health Services

Reducing the spiraling costs of health care is a priority for Indian Country. Astronomical medical inflation rates, the expense of providing services in extremely rural communities, along with an increasing Indian population and limited competitive pricing have all tremendously hindered tribe's and IHS's abilities to provide health care to Indian people.

One of the most impacted areas of the IHS system is the Contract Health Service (CHS) program. The CHS program provides funding for primary and specialty health care services that are not available at IHS or tribal health facilities to be purchased from private sector health care

providers. This includes hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services.

It is estimated that CHS is currently funded at 50% of need. While the Committee has previously heard from Indian Country on this issue, we must continue to stress that anything less than full and recurring funding of CHS compromises the health and lives of those in our communities. By supporting us in these efforts, you will be ensuring that tribes have the ability to deliver the highest quality services to their tribal members.

One way to immediately and dramatically address the shortfall in CHS funding is by ensuring that all American Indians and Alaska Natives are auto-enrolled in Medicaid. Creating an Indian specific subsection or category of Medicaid would facilitate access to the comprehensive health care benefits of this program while easing the already overburdened CHS system. The joint proposal submitted by the national Indian organizations (see attached) provides the recommendation of fast-tracking Indian patients into the Medicaid system. NCAI supports this approach; however, if the Committee is serious about examining ways to improve the CHS system, we suggest that proper consideration be made to establishing a new category of eligibility under Medicaid for Indian patients.

Other suggestions to augment limited CHS funding include extending Medicare like rates (MLR) to outpatient settings and the reduction in administrative overhead within the IHS. The extension of MLR would be a cost neutral fix that would allow tribes to extend their limited CHS funding even further. We would request however that when a mechanism for applying MLR to outpatient services is devised, that it is created in a manner that does not cut off or limit the current supply of medical providers. Likewise, reducing the administrative costs of IHS would extend the already limited funding of the Indian health delivery system. Reductions should include limits on the departmental-imposed administrative paperwork, systems, programs, etc., as well as limit the dollar amount of resources that may be utilized for administrative costs versus cost to directly fund healthcare.

Expanding Services to Non-Indians

Tribal health facilities are often times located in remote, rural geographic locations – making them, in some instances, the only viable option of health care delivery. As a result, some tribes have made the decision to implement expansions of capacity in their local health care delivery system through economies of scale and supplemental funding mechanisms. Others have sought to improve their local systems through the provision of excess capacity and/or select services in short supply in their communities by extending services to others in the general public (*i.e.,* non-beneficiaries of existing IHS health programs).

With the anticipated increase in demand for health services, tribes that have not opted for such expansion recognize that they are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. This is a challenging decision that requires consideration of capacity and resources and whether adding users will improve the breadth of services that can be offered or would diminish an already limited capacity. As such, Indian tribes must retain the authority to decide whether or not to serve non-Indian at their health facilities.

Tribes making this decision may also be well-poised to become a preferred provider organization within the state exchange or network in which they reside. To allow for such growth and expansion of services, an update to existing legislation is needed to remedy a significant barrier to

such initiatives – malpractice insurance. While tribal health programs are generally covered by Federal Tort Claims Act (FTCA) for their Indian patients, there is controversy over whether this protection extends to non-beneficiaries. By allowing FTCA to cover non-beneficiaries seen by tribal health programs, the IHS could provide additional capacity that will be needed after health care reform is enacted. For those tribes who choose not to serve non-beneficiaries, FTCA coverage must be extended to any non-beneficiary whose service is publically funded through grants, insurance, or other public subsidy. We would also recommend that the current law, which prohibits the inclusion of non-Indians as a portion of the IHS user population, is preserved. .

Health Care Workforce

Indian Country is not alone in its concern on how to address the ever increasing health care workforce shortage. Our health facilities however face daunting challenges in recruiting and retaining health care professionals due to our often remote and isolated geographic locations. As the competition for these personnel intensifies with the influx of new patients, under the new U.S. health care system, the IHS system must also adapt to meet Indian Country's health delivery needs.

Mid-level practitioners are an underutilized resource in health care delivery. These front-line health workers, while not doctors, have been trained to diagnose and treat common health problems, to manage emergencies, to refer appropriately, and to transfer the seriously ill or injured for further care. Increasing the number of these licensed and qualified health care workers, including nurse practitioners and physicians' assistants will allow Indian health facilities to better meet the health care needs of their communities while providing a financially feasible delivery option to health care.

Dental health aid therapist (DHAT) is an example of an innovative and successful mid-level program being implemented in Indian Country that could become a model for the IHS system and throughout rural America. Indian Country faces profound oral health disparities compared to the majority population. For example, Native children face an alarming rate of tooth-decay, suffering at rates four times higher than the general population[6]. Compounding this problem, Native communities face a lack of access to dentists and consistent dental treatment and prevention, low dentist to patient ratios, identified backlogs of treatment, and grossly inadequate expenditure levels. By employing a mid-level oral health provider model, such as DHAT, tribal members will be able to receive a variety of dental care practices, such as routine exams, simple extractions, restorative procedures, as well as health promotion and disease prevention to the communities in which they reside.

A final benefit to both mid-level practitioners and the DHAT program is the ability to "grow-your-own". As mentioned above, one of the major workforce shortage issues facing the IHS is retention. Tribal health facilities can coordinate with local Tribal Colleges and Universities to recruit community members to fill these much needed positions. In addition, these community members will be better prepared to deliver the culturally appropriate and competent care needed.

Exclusion of Health Benefits as Income

Tribal governments have been trying to meet the challenge of addressing the health care needs in their communities. Some tribal governments have met this challenge by providing supplemental services above and beyond the limited IHS services while others are providing more

[6] American Indian and Alaska Native Oral Health Access Summit. American Dental Association, 2002. Retrieved June 9. 2009 from http://www.ada.org/prof/resources/topics/topics_access_alaska_summit.pdf.

comprehensive care through self insured funds or third-party plans. This type of universal health coverage for tribal citizens is similar to Medicare. However, some IRS field offices – in examining specific tribal governments for their compliance dating back to 2002 or 2003 – are asserting that this type of coverage, when provided by a tribal government, should be treated as a taxable benefit.

In order to continue to encourage tribal governments to provide such benefits to their members on a non-discretionary basis, NCAI seeks a statutory exclusion to clarify that the health care benefits and coverage provided by tribal governments to their members are not subject to income taxation. Our proposal clarifies that the health services, benefits, or coverage received by Indians is excluded from gross income, in the same manner as Medicare - another government benefit health plan that is not viewed as taxable[7].

CONCLUSION

Thank you for your ongoing commitment to Indian Country. On behalf of the Chickasaw Nation and NCAI, I thank you for the opportunity to share our health reform recommendations for the Indian health delivery system. We urge you to make a strong commitment to Indian Country by ensuring that American Indians and Alaska Native receive high quality health care through a strong Indian health care system.

The attachment to this prepared statement is printed on pg. 69 of the Appendix

[7] See, e.g., Rev. Rul. 57-102, 1957-1 C.B. 26 (payments to the blind); Private Letter Ruling 200845025 (November 7, 2008) (ruling that payments made by an Indian tribe to elderly tribal members who were displaced by a flood were general welfare payments); Bailey v. Commissioner, 88 T.C. 1293 (1987) (considering whether grants to restore a building façade were excludable from income as general welfare payments).

Senator TESTER. Thank you very much.

You are exactly right, and have great hopes for Yvette when she gets fully going that we can get some good recommendations out of Indian Health Service.

We have a vote that has just started, but I think Senator Dorgan is on his way. Correct? And so, Buford, if you want to start. If in

fact he doesn't get here, I don't want to miss this vote, so I may have to call you down.

Better yet, we are going to adjourn for a minute, because evidently Senator Dorgan may not. And I will run down and catch the vote and I will be right back, or potentially Senator Dorgan may be here.

So we sit in adjournment until one of us returns.

[Laughter.]

[Recess.]

Senator TESTER. I call the Indian Affairs Committee hearing back to order.

Welcome, Senator Johanns.

And Buford Rolin, if you want to continue with your statement, we would much appreciate it.

Mr. ROLIN. I will begin.

Senator TESTER. All right.

STATEMENT OF BUFORD ROLIN, CHAIRMAN, POARCH BAND OF CREEK INDIANS; VICE CHAIRMAN, NATIONAL INDIAN HEALTH BOARD

Mr. ROLIN. Thank you, Mr. Chairman and Members of the Committee, I am Buford Rolin, Chairman of the Poarch Band of Creek Indians and Vice Chairman of the National Indian Health Board, and I co-chair the Tribal Leaders Diabetes Committee, in addition to serving on the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act.

The National Indian Health Board worked together with the National Congress of American Indians and the National Council of Urban Indians to examine reform proposals from the perspective of the Indian health care system. These organizations have taken the first step to make recommendations on national health care reform and NIHB has submitted a joint paper for the record.

The Indian health care system is not health insurance, but it is Indian Country's health care home. Our system was designed by the Federal Government to carry out its trust responsibility for providing and making health care accessible to all Indian people.

The Indian health care system is a community-based delivery system that provides culturally appropriate health care services to our people. Thus, we must be assured that reform measures do not inadvertently cause harm to our system. We ask you and your colleagues to evaluate all components of health care reform proposals to guarantee that the proposals do not harm the Indian health care system.

Assure that the legislation supports and protects the Indian health care system through Indian health-specific provisions where needed. Ensure that the Indian people in the Indian health programs have full opportunities to participate in and benefit from national health care programs, and respect the status of Indian tribes as sovereign nations.

On behalf of the NSC and NIHB I would like to express our appreciation to the Chairman and this Committee for their leadership in the Senate's passage of S. 1200. We shared your disappointment that the House did not complete their job. Reauthorization of the

Indian Health Care Improvement Act remains a top priority for Indian Country.

Today, I request Congress to fulfill the Nation's responsibility to Indian people by reauthorizing the Indian Health Care Improvement Act this year. I also urge Congress to make this law permanent, as Congress has done with other major Indian laws such as the Snyder Act and the Indian Health and Self-Determination Act.

The joint paper includes a list of the Indian Health Care Improvement Act provisions which would bring long-sought authority and advancement to the Indian health care system. We ask this Committee to advocate for their inclusion in national health care reform legislation.

This joint paper also sets forth recommendations for protecting the Indian health care system in the area of national health care reform.

Today, I would like to discuss three of these recommendations. First, the joint paper notes that in one sense, the IHS system does not constitute credible coverage because it is not health insurance, and not all locations are able to provide a comprehensive health benefits package. However, American Indians and Alaska Natives need the protections offered by the concept of credible coverage in order to shield individual Indians from any penalty imposed for failing to obtain health insurance and for many late enrollment penalties.

It would be a gross violation of the trust responsibility for the Federal Government, which is responsible for providing health care to Indian people, to then penalize these beneficiaries for failing to obtain insurance coverage.

Second, American Indians and Alaska Natives should be expressly exempt from all such cost sharings. This policy is consistent with the recent amendments to the Title 19 Medicaid of the Social Security Act, which prohibits the assessment of any cost-sharing against any American Indian, Alaska Native enrolled in Medicaid who is served by the IHS or by a health program operated by a tribe, tribal organization or urban Indian organization.

Third, health care reform legislation must assure that programs operated by IHS, tribes and urban Indian organizations are admitted to provide a network established by insurance plans. This is essential to ensure that these providers are not excluded from network and denied payment for services to insured patients.

Lastly, I would like to make some observations about the Indian health system. We can all agree that the Indian health care system is grossly underfunded, with a funding level of only 50 percent. I am very hopeful that this unacceptable situation will end in a reform environment.

Some have suggested that the Indian health care system is broken, but I would disagree. Even though it is burdened with having to do more with less, our system has made many strides towards fulfilling its mission of improving the health status of our Indian people.

I am particularly proud of the many innovations and improvements made by many of our tribes and tribal organizations. For example, the Special Diabetes Program, for instance, has led to a dra-

matic decline in blood sugar levels. Just imagine the success we could achieve if our system were fully funded.

Finally, this is not to say, however, that our system is perfect or that the only thing needed to make it perfect is more funding. There are inequities and inefficiencies in the system that require attention. I am aware that the Committee would like to make some changes in IHS operations, such as facilities construction and contract health service. Indian Country looks forward to hearing these ideas and to working in partnership with the Committee to advance those ideas that truly promise for our Indian health care system.

Thank you very much.

[The prepared statement of Mr. Rolin follows:]

PREPARED STATEMENT OF BUFORD ROLIN, CHAIRMAN, POARCH BAND OF CREEK INDIANS; VICE CHAIRMAN, NATIONAL INDIAN HEALTH BOARD

Chairman Dorgan, Vice-Chairman Barrasso and distinguished Members of the Committee:

I am Buford Rolin, Chairman of the Poarch Band of Creek Indians, Vice-Chairman of the National Indian Health Board (NIHB) and Co-Chairman of the Tribal Leaders Diabetes Committee (TLDC). I also serve as the Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). In these capacities and others, I have been fortunate to work with Tribal Leaders from across the country to address issues that affect the Indian health delivery system and the health status of Indian people.

Thank you for holding this hearing and providing this opportunity to testify on reform of the Indian health care system. I am honored to provide this testimony on behalf of the National Indian Health Board (NIHB).

With Congress and the Obama Administration proposing to make sweeping reforms to the nation's health care system, Indian Country has examined reform components to evaluate their impact on the Indian health system. Our system was designed by the Federal government to carry out its trust responsibility for Indian health and to make health care accessible to Indian people, including those who reside in remote, sparsely-populated reservation and Alaska Native communities where little, if any, other health infrastructure exists. Our system is very different from the mainstream health care system; thus, we must assure that "reform" measures do not inadvertently cause harm to it. Thus, we ask you and your colleagues to –

- Evaluate all components of health care reform proposals to assure they "do not harm" the Indian health system,
- Assure that the legislation actually **supports** and **protects** the Indian health system through Indian-specific provisions where needed,
- Ensure that Indian people and Indian health programs have full opportunities to participate in and benefit from reform programs and
- Acknowledge and respect the status of Indian tribes as sovereign governments.

The National Indian Health Board (NIHB), together with the National Congress of American Indian (NCAI), and the National Council of Urban Indian Health (NCUIH), has examined reform proposals from the perspective of the Indian health system, and determined that Indian-specific policies must be included in order to assure that the Indian system is not harmed. These organizations have taken the first step and presented Congressional leaders with a joint paper titled "Health Care Reform – Indian Country Recommendations" ("Joint Paper.") See Exhibit 1. NIHB fully endorses this paper.[1]

I. Principles for Reforming the Indian Health Care Delivery System

Honoring the Trust Responsibility

Reform of the Indian health care system must rest on the unique trust relationship. As Tribes ceded millions of acres of land to the government, the United States, in its role as "guardian," agreed to provide a variety of services to Indian people. This federal trust responsibility forms the basis of providing health care to American Indians and Alaska Natives (AI/ANs). The unique relationship between the U.S. and federally recognized Indian Tribes is rooted in the United States Constitution and has been reaffirmed by judicial decisions, executive orders and congressional law. With every action of the drafting pen, Congress must remember the duty that the federal government owes to Indian people.

Recognizing the Importance of the Indian Health System

The Indian Health Services is responsible for providing health care to some 1.9 million American Indians and Alaska Natives in the United States. This system consists of services provided by the Indian Health Services); programs operated by Indian tribes and tribal organizations through Indian Self-Determination and Education Assistance (ISDEAA) agreements; and by urban Indian organizations who receive funding from IHS. [Collectively, these three components are referred to as the "Indian health system."]

The Indian health system is not health insurance but is Indian Country's health care home. This community-based delivery system supplies culturally appropriate health care services essential to promoting a healthy lifestyle. Existing health disparities, high rates of poverty, and the remote, rural nature of Indian communities demand a unique health care delivery system. The Indian health system was designed in large part to reach these beneficiaries in these communities.

II. Reauthorization of the Indian Health Care Improvement Act is Necessary to Facilitate Reform of the Indian Health Care System

On behalf of the NSC and NIHB, I would like to express our appreciation for your outstanding leadership in achieving Senate approval of IHCIA reauthorization legislation last

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[1] Indian Health Boards from throughout Indian Country have hosted or will soon host discussions on health care reform. A table listing the dates of these discussions are included here as Exhibit 2. We are pleased to share with the Committee reports from these gatherings.

year. We shared your disappointment that the House did not complete the job. Enacting an IHCIA reauthorization bill remains a top priority for Indian country. The IHCIA is the foundation for the delivery of health care services to AI/ANs. Today, I respectfully request Congress and the Administration to fulfill the nation's responsibility to Indian people by finally enacting an IHCIA bill this year. I also urge Congress to make this law permanent – without a sunset date – as Congress has done with other major Indian laws such as the Snyder Act, the ISDEAA and the BIA education laws.

The NSC's long-standing policy has been to seek passage of IHCIA reauthorization provisions on other legislation where possible – such as the recently enacted CHIPRA and ARRA laws, which included significant Indian health provisions. In furtherance of that strategy, the Joint Paper includes a list of IHCIA provisions, which would bring long-sought authorities and advancements to the Indian health system. We ask this Committee to advocate for their inclusion in health care reform legislation. I would like highlight a sample of these provisions that will likely be critical for Indian Country in national health care reform.

Third Party Collection: This revised provision would strength IHS and tribal program authority to collect reimbursements from third party insurers including insurance company, health maintenance organization, employee benefit plan, and third-party tortfeasor. (Sec. 403 of S. 1200)

Payor of Last Resort: This provision would codify in law the existing IHS regulation which makes IHS payor of last resort, meaning that all other available sources (e.g., Medicare, Medicaid, private insurance, other) pay for care before IHS appropriated funds are used. To assure such policies are properly implemented, legislation should require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (Sec. 407 of S. 1200)

Comprehensive Behavioral Health Programs. A major goal of the IHCIA reauthorization process has been to establish coordinated, comprehensive programs to address the myriad of behavioral health problems in Indian Country, such as substance abuse, suicide (especially among youth), and domestic violence. The resulting new Title VII in the IHCIA reauthorization bills, if properly funded, would make major strides toward addressing these chronic problems. I am hopeful this entire Title VII can be enacted on a health care reform measure.

III. Application of Indian Policies to National Health Care Reform

The Joint Paper sets forth recommendations for protecting the Indian health system and assuring that health care reform efforts will have a beneficial effect on it. These recommendations are based on honoring the trust relationship and carrying out the government-to-government relationship between the U.S. and tribes. I would like to refer you to this paper but bring additional attention to the following recommendations for which we seek your advocacy.

Application of an Individual Mandate to Beneficiaries served by the Indian Health System and the Concept of "Creditable Coverage"

A key component of health care reform is that every American has a responsibility to acquire health insurance coverage – through his/her employer; through enrollment in Medicare or Medicaid; by purchasing coverage; or by qualifying for subsidized premiums. The Joint Paper correctly notes that in one sense, the IHS system does not constitute "creditable coverage" because it is not insurance, and not all locations are able to provide a comprehensive benefits package. Nonetheless, AI/ANs need the **protections** offered by the concept of "creditable coverage" in order to shield individual Indians from any penalty imposed for failing to obtain health insurance, and from any late enrollment penalties. It would be a gross violation of the trust responsibility for the Federal government, which is responsible for providing health care to Indian people, to then penalize these beneficiaries for failing to obtain insurance coverage.

Exemption from Any Cost Sharing in a Government Subsidy

The Federal government's trust responsibility to provide health care to Indian people dictates that no cost sharing (premium, co-pay, etc.) would be imposed on an AI/AN who qualifies government subsidized insurance. An AI/AN should be expressly exempt from all such cost-sharing. This policy is consistent with the recent amendments to Title XIX (Medicaid) of the Social Security Act, which prohibit the assessment of any cost-sharing against any AI/AN enrolled in Medicaid who is served by the IHS or by a health program operated by a tribe, tribal organization or urban Indian organization.

Assure Indian health programs are Admitted to Exchange/Gateway Provider Networks

Health care reform legislation must assure that programs operated by IHS, tribes and urban Indian organizations are admitted to provider networks established by insurance plans, which market their products through the proposed insurance Exchange or Gateway. This is essential to ensure that these providers are not arbitrarily excluded from networks and thereby denied payments for services to insured patients. It is also vital that the legislation direct the Secretary to establish terms for such participation that recognize their unique treatment under Federal law, such as the law which applies the Federal Tort Claims Act to Indian health programs.

Tribal Involvement in Development of Reform Policies and Decisions

Health care reform boards and commissions

Tribal representatives must be included on key commissions, boards or other groups created by health care reform legislation, and the Secretary of HHS must be required to consult with tribes and tribal organizations on health reform policies and regulations. Tribal governments and tribal organizations are the experts in the implementation of services that tribes and tribal members receive, administer, and purchase. Only by engaging knowledgeable Tribal leaders, advocates and administrators in policy development can health reform promises to improve the Indian health system and the health status of AI/ANs be achieved.

Opening the doors of tribal facilities to serve non-Indian patients

With the increased demand for health care services, Tribes may be asked to open their doors to serve non- Indians and receive payment for such care. Indian tribes must retain the authority to decide whether to serve non-Indians at their health facilities, as they must consider capacity and resources and whether adding patients would enhance the breadth of services that can be

offered or would diminish an already limited capacity. To support tribes who are interested in expanding their patient base by serving non-Indians, legislation must –

- Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers, which receive funding from HRSA under Sec. 330 of the Public Health Services Act.)
- Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians. Sec. 813 sets out the criteria that must be applied to determine whether an Indian health facility serve non-Indians. One of those requires a determination whether reasonable alternative health services are available to the non-Indian population. Congress should consider dropping this criterion. In a reformed environment with the enormous new demand for health care services, this criterion would be obsolete and merely impede a tribe's determination to open its doors to non-Indian patients.

Exemption from Penalties under the Employer Mandate

Indian tribes should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. Tribes, who are both sovereign government and employers, must be permitted to determine for themselves the extent to which they can or will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so.

Out of State Medicaid Applicability

Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools.

Furthermore, this proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such a patient who travels out of state in order to receive culturally competent care at an Indian health facility, including care related to behavioral health needs and substance abuse treatment.

Medicare Amendment

The Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services. At present, the system for making Medicare reimbursements to IHS and tribally operated facilities provides payment at only 80%, as Medicare presumes 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. Because of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes Medicare by paying the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would infuse over $40 million more into the Indian health system annually, funds that would be used to reduce health status disparities.

Authority and Funding for Outreach and Education to Assist with Enrollment in Any Public Funded Health Program such As Medicaid or Any Government Subsidy Offered Through the Health Exchange or Connector

Indian Country needs additional mechanisms to assist with enrolling individual Indians into expanded entitlement programs and access health insurance thru the proposal of health exchange or connector. AI/AN participation in entitlement programs and services has been hindered by a number of factors, including consumer cost sharing, lack of transportation to offices where eligibility determination is made, difficulty filling out applications and documentation requirements, difficulty navigating the bureaucracy, confusion about choices regarding managed care plans, and language barriers. These barriers face many rural and remote communities were telephone and computer enrollment methods are often not readily available. Additional resources such as fast track or express lane enrollment may assist with enrollment in programs. In addition, tribal governments should be authorized as portals for accepting such applications.

Addressing the Indian Health System's Personnel Shortage

A critical component of any health care delivery system is the workforce. Indian health programs already have difficulty recruiting and retaining needed health care professionals, and competition for health care workforce personnel will intensify as millions of individuals enter the ranks of the insured. As of June 9, 2009, Indian Health Service listed on its website 1,188 job vacancies across the Indian health care system. Educational and training programs must be implemented to recruit and retain health professionals to fill these vacancies across the Indian Health system.

Some of the ideas to help Indian programs attract and retain health care personnel include:

- The legislation should enhance funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs.
- Mechanisms for assignment of National Health Service Corps personnel should be revised to facilitate participation by Indian health programs and enable these programs to access NHSC personnel based on their Indian service population.
- Expand funding to train and support alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aide therapists.
- Include the Indian health delivery system as a key focus area in the coordinated national strategy to address health care workforce shortages.

Prevention Services and Traditional Health Care Practices

NIHB applauds Congress for focusing greater attention on prevention services through such means as requiring insurance coverage for such services and perhaps barring co-pays to encourage individuals to seek them. Indian health programs have long emphasized prevention programs, often in conjunction with traditional health care practices. We would ask you to assure that where an Indian health program integrates its traditional methodologies into its prevention/wellness programs, it does not thereby lose its ability to collect reimbursements for prevention services.

IV. SOME OBSERVATIONS ABOUT THE INDIAN HEALTH SYSTEM

I believe we can all agree that the Indian health system is grossly underfunded. That is the only conclusion one can reach knowing that we are provided with only 54% of the resources needed to supply all the health care that should be supplied our people. I am very hopeful that this unacceptable situation will be end in a reform environment.

Some have suggested that the Indian health system is "broken", but I would disagree. Even though it is burdened with having to do more with less, our system has nonetheless made commendable strides toward fulfilling its mission of improving the health status of Indian people. I am particularly proud of the many innovations and improvements that have come about through hands-on involvement of tribes and tribal organizations in the exercise of Indian Self-Determination rights. For example, the Special Diabetes Program for Indians has led to a dramatic decline in blood sugar levels.[2] Just imagine the successes we could achieve if our system were fully funded.

This is not to say, however, that our system is perfect or that the only thing needed to make it perfect is more funding. There are inequities and inefficiencies in the system, which require attention. I am aware that this Committee expects to suggest some changes in IHS operations and in fundamental programs such as facilities construction and contract health services. Indian Country looks forward to hearing these ideas and to *working in partnership* with this Committee to advance those ideas that truly hold promise for a system charged with providing health care to underserved populations in remote areas. I would urge the Committee to avoid "solutions" which merely redistribute already scarce resources. Creating new winners and losers is not "reform". Instead, we should look for ways to enhance and expand the health infrastructure we have worked so hard to establish in Indian communities.

V. CONCLUSION

Indian Country will address the tough questions raised during the course of the health care reform discussion and will continue to work diligently with the Administration and Congress to ensure that the Indian health system is included in health care reform legislation. We request that the Administration and Congress honor its trust responsibility and insist that the Federal Government meaningfully consult with Tribes and tribal organizations at all stages of development of health care reform legislation and include Indian-specific provisions in the legislation where needed to protect and enhance the Indian health system.

Thank you so much for your time today, and we look forward to all of us working together on improving and starting a new legacy for the Indian health care system.

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[2] The mean blood sugar level (A1C) decreased by more than 1% from 9.00% unit in 1996 (before the Special Diabetes Program for Indians) to 7.85% unit in 2007 (after the Special Diabetes Program for Indians). This decrease is a major achievement over ten years.

Senator TESTER. Thank you, Mr. Rolin. I appreciate your comments.

Geoffrey Roth?

STATEMENT OF GEOFFREY ROTH, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Mr. ROTH. Thank you, Mr. Chairman.

My name is Geoffrey Roth. I am the Executive Director of the National Council of Urban Indian Health and the President of the

National Native American AIDS Prevention Center in Denver, Colorado.

I am a descendant of the Hunkpapa Band of Lakota Sioux Nation, part of the Standing Rock Sioux Tribe.

On behalf of NCUIH, our 36 member organizations, and the 150,000 Indians that we serve annually, I would like to thank the Senate Committee on Indian Affairs for allowing us to testify on Indian Country's recommendations for health care reform.

I would also like to thank the tribal leaders for allowing us to be here today and testify.

NCUIH strongly supports the joint recommendations drafted together with the National Indian Health Board and the National Congress of American Indians. All of our organizations believe that these recommendations are the minimum of what must be included in health care reform.

NCUIH also strongly encourages the Committee to pursue a standalone bill to reauthorize the Indian Health Care Improvement Act.

While NCUIH fully endorses all the recommendations in the joint document, I would like to highlight a few of the recommendations.

Health care reform must take into account the trust responsibilities to Native American people. As the Members of this Committee understand, the trust responsibility to provide health care follows Indian people regardless of where they reside. Congress has clearly and unequivocally stated this since 1921 in the Snyder Act.

While we do not object to an individual mandate for health care coverage, we firmly believe that any penalty enforced on Indian people for failing to acquire health insurance would violate the Federal trust responsibility.

There are three other areas of recommendations I would like to highlight: health information technology, a needs assessment for urban Indian health programs, and fast-tracking provisions for Medicaid and SCHIP enrollment.

Health information technology is the future of health delivery. Any provider that does not develop HIT infrastructure and systems now will be behind in the advance of medicine, to the detriment of their patients. Given that Indian health providers are already at such a disadvantage and our communities suffer high health disparities and disease burden, all possible support should be given to Indian health providers that are trying to develop HIT infrastructure and technology.

The Indian Health Service should be encouraged to work with Indian providers to develop interoperable HIT systems that link together the ITU system.

A comprehensive needs assessment must be conducted for off-reservation Native Americans. Such a needs assessment must be undertaken in order to determine health status, health outcomes, health access and utilization, and the availability of health services. The study must be conducted not only in areas where current urban Indian health program exist, but also in all major urban cities.

The last comprehensive needs assessment undertaken by the Indian Health Service was done in 1981. We have seen indications

of increased migration and need in the cities that do not currently have urban Indian health programs.

We need to allow urban Indian organizations to expand needed health services by alleviating financial and bureaucratic strain. A fully developed and actualized urban Indian health program could be the center for health services, social services, enrollment in all public programs, and the cultural center for the urban Indian community.

Many urban Indian health providers would be able to expand their current range of health services if they were able to better access third party billing opportunities either through inclusion in the all-inclusive rate, better IHS support of third party billing software, directly billing Medicaid and Medicare, or if they were able to alleviate some of their overhead costs with medical liability insurance coverage.

The Indian Country recommendations also include fast-tracking provisions for Medicaid and SCHIP enrollment. The ability of all urban Indian health providers to undertake fast-track enrollment and be provided funding for staff to do this would help urban Indian health program providers identify Indians eligible for enrollment in Medicaid, get them enrolled, and then start providing services at the very moment the patient presents at the clinic.

Urban Indian health program providers excel at preventive health care and fast-track enrollment would help these programs reach patients at earlier stages of illness and even maybe prevent illness.

On behalf of NCUIH and the urban Indian organizations that we represent, I want to take this opportunity to thank the Committee for allowing us to testify today. We thank the Committee also for the dedication on Indian health care reform and Indian health. We have a rare moment with this Administration and this Congress to seriously reform the health delivery system for this Nation and for Indian Country.

NCUIH strongly urges the Committee to seize this moment and undertake comprehensive health care reform with Indian health in mind. Pass the Indian Health Care Improvement Act and initiate a comprehensive review of the Indian health care delivery system.

Thank you.

[The prepared statement of Mr. Roth follows:]

Prepared Statement of Geoffrey Roth, Executive Director, National Council of Urban Indian Health

Introduction: Honorable Chairman and Committee Members, my name is Geoffrey Roth. I am the Executive Director of the National Council of Urban Indian Health (NCUIH) and the President of the National Native American AIDS Prevention Center. I am also a descendent of the Hunkpapa band of The Lakota Sioux Nation, part of the Standing Rock Tribe. On behalf of NCUIH, our 36 member clinics, and the 150,000 American Indian/Alaska Native patients that we serve annually, I would like to thank the Senate Committee on Indian Affairs for this opportunity to testify on Indian Country's recommendations for health care reform. NCUIH strongly supports the joint recommendations drafted together with the National Indian Health Board and the National Congress of American Indians. All of our organizations believe that these recommendations are the very minimum of what must be included in health care reform. The National Council of Urban Indian Health also strongly encourages this Committee to pursue a standalone bill to reauthorize the Indian Health Care Improvement Act. Given the tight schedule for health care reform, I am honored for this opportunity to present what we feel are the key foundations that must be included in health care reform if it is to be meaningful for American Indians and Alaska Natives, whether they reside on or off Tribal land.

The 2000 Census reported that 66% of individuals identifying as American Indians and Alaska Natives reside off reservation[1] and IHS estimates that roughly 930,000 of those living in those locations are eligible for services at Urban Indian Health Clinics. Our clinics are often the main, if not sole, source of health care for those off-reservation communities. The Urban Indian Health Program is a small, but critical and innovative component of the Indian health delivery system. Congress has repeatedly stated that the Trust Responsibility to provide health care extends to Native Americans regardless of where they reside; the Urban Indian Health Program works to fulfill that solemn obligation.

Congress has repeatedly acknowledged that the government's Trust Responsibility extends to American Indians and Alaska Natives (AI/AN) living away from their tribal homes. From the original Snyder act of 1921[2] to the Indian Health Care Improvement Act of 1976 and its Amendments, Congress has consistently found that: "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation*. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instance forced Indian

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[1] US Census Bureau. *We the people: American Indians and Alaska Natives in the US. Special Report*, 2006
[2] Snyder Act, Public Law 67-85, November 2, 1921.

people who did not [want] to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there."[3]

The UIHP provides an important link between reservations and off-reservation communities as Native people move between the two. As one Federal court has noted, the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups."[4] Reservation and off-reservation health services are deeply interconnected as we serve the same people and desire the best possible health outcomes for all Native peoples. The I/T/U is an integrated system serving all American Indians and Alaska Natives as those patients move between their reservation homes and urban centers depending upon the demands of their lives. If one part of the system is damaged or performing poorly the entire system suffers, and more importantly the vulnerable patients who are dependent upon this system suffer.

Health care reform must take into account the complexities—and innovations—of the Indian health delivery system. The recommendations drafted by the National Council of Urban Indian Health, the National Indian Health Board, and the National Congress of American Indians are an opening dialogue for how the Indian health delivery system could and should be impacted by health care reform. Our recommendations should be seen as setting the absolute floor for what health care reform must contain in order to not harm Indian people. NCUIH's testimony today goes over not only the recommendations from the perspective of off-reservation Indian people, but also recommendations for how to further develop services for off-reservation communities. This testimony should be read as beginning a dialogue for how we can work together to fully develop the I/T/U as a complete system of care for Indian people regardless of where they reside.

Developing the Urban Indian Health Program: The Urban Indian Health Program has always been considered a minor, secondary part of the Indian health delivery system with off-reservation communities being an after-thought in the provisioning of health care for American Indians and Alaska Natives[5]. While the government-to-government relationship between the Tribes and the federal government is deeply important to the continued wellbeing and development for all American Indians and Alaska Natives, the federal government owes a trust obligation to off-reservation communities that will remain unfulfilled as long as the UIHP continues to be underdeveloped and underfunded[6]. Health care reform offers a unique opportunity to truly develop the Urban Indian Health Program into an entity capable of serving the needs of all American Indians and Alaska Natives living away from their tribal homes[7]. The discussion of health care reform must be centered on patient health and reforming the health delivery system to provide the best possible health care outcomes. Urban Indian health clinics

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[3] Senate Report 100-508, Indian Health Care Amendments of 1987, Sept 14, 1988, p25. Emphasis added

[4] *United States v. Raszkiewicz*, 169 F.3d 459, 465 (7th Cir. 1999).

[5] As demonstrated by the declining percentage of the IHS appropriated for the Urban Indian Health Program. FY2008 was the first time that the UIHP line item was less than 1% of the IHS operational budget. *See also*, Trombino, Caryn, *Changing the Borders of the Federal Trust Obligation: the Urban Indian Health Care Crisis*, 8 N.Y.L. L.Rev1, 130(2005)

[6] Ibid.

[7] Although the UIHP clinics and programs leverage their IHS funds, receiving $2 dollars for every dollar of investment, the UIHP has never been funded—or granted the necessary authorities and protections—to truly develop all of the services desperately needed by off-reservation communities. *See*, FY2010 Interior Appropriations Native American Witness Day Testimony, National Council of Urban Indian Health, 3/15/2009

and programs have proven that they are efficient, effective health care providers that reduce health disparities for their patients in ways that no other provider can match[8]. UIHP clinics and programs see patients from every Tribe and every walk of life; providing culturally appropriate health care that otherwise would not be available to American Indian and Alaska Natives living off reservation[9].

With meaningful support, the Urban Indian Health Programs could expand their services beyond primary clinical care and reach more than the 150,000 American Indians and Alaska Natives that it currently serves. Developing and expanding the Urban Indian Health Program must be a component of any modernization of the Indian health delivery system in order to be responsive to the needs of our population. As our economy becomes more mobile, more urban-focused, we must be able to provide health care to those in our community who move off-reservations due to the demands of their lives. The National Council of Urban Indian Health has three key recommendations for developing the Urban Indian Health Program:

Health Data Collection—the lack of sufficient health data collection systems for American Indians and Alaska Native health delivery systems is not a new problem. The Tribal Technical Advisory Committee for CMS has long maintained that CMS fails to collect adequate data on American Indians and Alaska Natives enrolled in Medicaid, Medicare, and SCHIP[10]. The Urban Indian Health Institute (UIHI), an epidemiology center dedicated to Urban Indian health, further reports that health research data rarely includes data specific to American Indians and Alaska Natives, much less for those AI/AN who live in off-reservation communities[11]. Private foundations and research centers have also reported difficulty in capturing health data for American Indians and Alaska Native communities[12]. Government research agencies, such as the Agency for Healthcare Research and Quality (AHRQ) also report difficulty in securing American Indian and Alaska Native data sets, resulting in AI/ANs being absent from, or only briefly mentioned in key reports[13].

Health data collection is critical to assessing the needs of off-reservation Indian communities. The fact that health data on American Indians and Alaska Natives is slim to none continues to be a barrier to both Tribes and Urban Indian health providers in competing for grants and contracts. It also continues to contribute to American Indians and Alaska Natives being underrepresented in key research that forms the basis of evidence-informed best practices; meaning that those best practices are not, in fact, the best for American Indian and Alaska Native patients. Lack of data from Indian health providers makes assessing disease burden and need difficult; compounding the difficulties in securing needed funding. The Urban Indian Health Program is especially damaged by the lack of data as it is difficult to expand the

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[8] Testimony of David Rambeau, *Advancing Indian Health Care* before the Senate Committee on Indian Affairs, 2/5/2009
[9] *See*, Letter to the House Committee on Interior Appropriations from the National Association of Community Health Centers, 1/20/2007.
[10] Tribal Technical Advisory Group to CMS, *American Indian and Alaska Native Medicaid Program and Policy Data Summary Report*, February 2009; National Council of Urban Indian Health, *Urban Indian Health Programs Survey* 2008
[11] Urban Indian Health Commission 2007, Robert Wood Johnson Foundation Report: *Invisible Tribes: Urban Indians and their Health in a Changing World*, Urban Indian Health Institute 2007.
[12] *See* Kaiser Family Foundation, *Key Health and Health Care Indicators by Race/Ethnicity and State* 4/01/2009
[13] *National Healthcare Disparities Report*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, 2008

program to off-reservation Indian communities not currently served by an Urban Indian health provider without clear data demonstrating the level of need for these communities.

- National Needs Assessment: a comprehensive needs assessment must be conducted for the off-reservation American Indian and Alaska Native community. Such a needs assessment must be undertaken at regular intervals in order to determine health status, health outcomes, health access, utilization, and the availability of health services. This study must be conducted not only in areas where UIHP clinics and programs are already located, but in all major urban centers. The last comprehensive needs assessment undertaken by the Indian Health Service was conducted in 1981. NCUIH believes that the size of those communities, and their corresponding needs, have most likely grown, making the need for a new needs assessment all the more critical. A new needs assessment is desperately needed.
- Funding Authority for Urban Indian Health Data Collection: Current funding levels are insufficient for Urban Indian Health Programs to develop necessary data collection systems to disaggregate, analyze or disseminate comprehensive health data. While all UIHP programs provide GPRA reporting, UIHP clinics and programs rarely have the resources necessary to conduct independent analysis or dissemination of the data collected. Targeted grant and contract opportunities must be made available to Tribal and Urban Indian health providers to develop modern data collection systems. Unfortunately Urban Indian Organizations were not included in the American Recovery and Reinvestment Act appropriations that could have helped Urban Indian health providers develop these systems and infrastructure.
- Over-sampling of AI/AN in Health Research: As medicine turns towards evidence-informed and outcome driven best practices, any research to develop such measures must over-sample American Indians and Alaska Natives in order for the research to be meaningful to our communities. American Indians and Alaska Natives live in such remote areas, are such a small part of the general population and are often very difficult to find in clinical research trials, thus any research undertaken by the federal government to determine health disparity, form best practices, or would otherwise impact American Indians and Alaska Natives must over-sample our communities. NCUIH strongly encourages the Committee to support this recommendation from NCUIH, NIHB, and NCAI.

Health Information Technology (HIT) —The Obama Administration has strongly supported the development of HIT infrastructure to encourage the formation of an interoperable HIT system across the United States. Such a system would help providers' better control health care costs, track health data, and provide individually tailored health care to patients. NCUIH strongly encourages Congress to include authorization for HIT appropriations for Urban Indian Health Programs. To date direct appropriations authority for HIT funding does not exist for Urban Indian Health Programs. Indirect authority through the Snyder Act exists, thus IHS could—if the Agency so chose—fund UIHP HIT endeavors, but direct Congressional intent to support Urban Indian Organizations' HIT initiatives is lacking. This became readily apparent when the Indian Health Service was developing plans for spending the 85 million dollars appropriated for Health Information Technology infrastructure and development. UIHP clinics and programs were not included in the infrastructure support calculations. Express authorization for HIT

appropriations would encourage the Indian Health Service to fund grants and contracts to Urban Indian Organizations to develop HIT infrastructure and systems.

Health Information Technology is the future of health delivery. Any provider that does not develop HIT infrastructure and systems now will be behind the advance of medicine to the detriment of their patients. Given that Indian health providers are already at such a disadvantage and our communities suffer high health disparity and disease burden, all possible support should be given to Indian health providers that are trying to develop HIT infrastructure and technology. The Indian Health Service should be encouraged to work with Indian health providers to develop interoperable HIT systems that link the I/T/U together rather than the current silo-ing of resources and technology that continues to hinder both Tribal health providers and Urban Indian Organizations.

Expanding Health Services—The National Council of Urban Indian Health was heartened to see the prominence of cultural competent health care delivery in the Senate HELP Committee draft bill and encourages the Senate Committee on Indian Affairs to bolster the HELP Committee's efforts by further developing the Urban Indian Health Program. As the only culturally appropriate health provider for off-reservation Indian communities, the UIHP should be fully utilized to provide services—both health care and social services—to American Indians and Alaska Natives. Often times the UIHP clinics and programs are the focus for not only health care, but for the social fabric of the off-reservation Indian community itself. A fully developed and actualized UIHP could be a center for health services, social services, enrollment in all public programs, and the cultural center for the urban community. Many Urban Indian health providers would be able to expand their current range of health services if they were able to better access 3rd party billing opportunities either through inclusion in the all-inclusive rate, better IHS support of 3rd party billing software, directly bill Medicaid and Medicare, or were able to alleviate some of their costs such as medical liability insurance. NCUIH's core suggestions are contained below:

- Support UIO 3rd Party Billing: Currently the Indian Health Service needs assistance in helping Urban Indian Organizations develop the capacity to undertake 3rd party billing. In fact, the electronic records system advocated by the Indian Health Service, RPMS, does not have 3rd party billing capacity without labor intensive programming patches. Urban Indian Organizations should be allowed to select electronic records systems that best maximize their ability to undertake 3rd party billing initiatives.
- IHCIA Section 201: This provision is discussed in greater detail below. This provision of IHCIA would allow Urban Indian Organizations to directly bill Medicaid and Medicare. NCUIH strongly encourages the Senate Committee on Indian Affairs to advocate for the inclusion of this provision in health care reform.
- Federal Tort Claims Act Coverage: This provision is discussed in greater detail below. However, FTCA coverage would alleviate a significant financial burden on Urban Indian Organizations providing clinical primary care services. Medical liability for UIOs is often one of the largest barriers to expanding health care services.

Recommendations from the Urban Indian Health Perspective: The National Council of Urban Indian Health was delighted to help draft recommendations for health care reform and thanks the Senate

Committee on Indian Affairs, Senate Finance Committee, and Senate Health Education Labor and Pensions Committee staff for their support in this process. As stated above, these recommendations are the bare minimum for what must be included in health care reform in order for American Indians and Alaska Natives to simply not be damaged in health care reform efforts.

We strongly support the Tribal recommendations and believe that health care reform must take into account the unique government-to-government relationship between Tribes and the Federal government. Health care reform must not, in any way, damage the health and health care delivery for American Indians and Alaska Natives. It must also be careful not to infringe upon treaty rights and Tribal sovereignty. We believe that health reform must be meaningful for all American Indians and Alaska Natives. Furthermore, as the trust responsibility extends to Indian people regardless of where they reside, we strongly advocate that insofar as these recommendations would not damage the government-to-government relationship between Tribes and the Federal government, they must be read to include Urban Indian Health Programs. These recommendations were written from the perspective of protecting and strengthening the entire I/T/U system; which means integrating—to the extent that such integration does not threaten Tribal sovereignty—the entire I/T/U so that Indian people can be assured of health services regardless of where they may travel. There are several recommendations about which NCUIH feels especially strongly:

Cost Sharing and Penalties—In order to preserve the trust responsibility owed to Native people for the cessation of their lands, no penalty on any Indian individual who fails to obtain such insurance can be levied. NCUIH feels very strongly that it is not only bad law for any penalty to be assessed against an Indian individual who fails to obtain health insurance; it is morally reprehensible to force American Indian and Alaska Native individuals to pay for health care in any way whether it be cost-sharing or a penalty. We believe that current federal law protections afforded to Indian people and passed in the American Recovery and Reinvestment Act[14] must apply to their participation in any health insurance plan. We believe that the trust responsibility demands that Indians be exempted from all cost-sharing (including premiums, co-pays, and deductibles), which is consistent with recent amendments to the Social Security Act.

The issue of cost-sharing in public health programs is especially important for off-reservation Indian people who are often underemployed, low income, and with complex health needs[15]. Indian people living away from their tribal homes are likely to be eligible for enrollment in Medicaid or Medicare, and these programs may be their only source of health care if they do not live near one of the 36 Urban Indian health programs and clinics. Even when they do live near UIHP or Tribal health provider, enrollment in these services is necessary for the financial stability of the Indian health provider which provides care to these individuals.

Culturally Competent Care and Traditional Health Practices—As the only culturally-competent health provider for off-reservation Indian communities, Urban Indian health providers strongly believe

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[14] *See, e.g*, 25 USC §§1407, 1408; 43 USC §1626; see also, Pub. L. 111-5, Sec. 5006(d) (Feb. 17, 2009)

[15] *The Health Status of Urban American Indians and Alaska Natives*, Urban Indian Health Institute, 2004; *See also, Unnatural Causes: Is Inequality Making Us Sick?* PBS Documentary, 2008.

that culturally competent health practices should be protected and encouraged in health care reform. NCUIH was heartened to see that the HELP committee draft health care reform bill prominently supported culturally appropriate health care and research. Urban Indian health providers have developed their own promising practices, despite continuing problems with data collection, and health care reform must encourage these efforts. NCUIH encourages this Committee to adopt the recommendations contained in the research and health care workforce development recommendations. We further suggest that the Committee consider working with the HELP Committee to develop residency programs at I/T/U provider facilities through the Department of Health and Human Service to help train culturally competent health care professionals.

The recommendations regarding traditional health practices is also especially important to Urban Indian health providers who are often operating within communities with little knowledge of traditional health practices. We firmly believe that the thoughtful integration of traditional health practices should not 'taint' the entire health service in terms of reimbursement. We call upon Congress to lead the way in demonstrating sound policy by assuring that prevention and wellness programs are covered services in all public programs and that to the extent that Indian health programs integrate traditional health practices into its prevention/wellness programs and treatment, it should be permitted to do so with no adverse impact on its ability to receive federal support. Traditional health practices are not only core components of culturally competent care; it also helps center American Indian and Alaska Native patients when they receive care.

Creditable Coverage— The issues of creditable coverage is a complicated one that the recommendation document initially drafted by NCUIH, NIHB, and NCAI does not fully articulate. In order to protect Indian patients and ensure that they are not harmed by health care reform the term 'creditable coverage' must be understood in two lights. First, eligibility for health services through an I/T/U provider cannot be seen as 'insurance' because I/T/U health providers are not insurers. Moreover, eligibility for I/T/U services cannot be seen as baring an AI/AN individual for qualifying for insurance subsidies under an Exchange mechanism. Just as eligibility for I/T/U services cannot be seen as baring an individual from Medicaid, neither can such eligibility bar an individual from any public plan or subsidy.

However, there are some situations where eligibility for Indian Health Service health care should be interpreted as constituting 'creditable coverage: first, to shield any AI/AN individual from a penalty for not acquiring health insurance; second, eligibility for I/T/U services should shield an AI/AN patient from late enrollment penalties should he or she move away from their I/T/U provider and is forced to find a non-Indian health provider. In this situation prior eligibility for I/T/U services should not be used to punish such an individual.

Medicaid & SCHIP Expansion—As many American Indians and Alaska Natives are eligible for Medicaid and SCHIP enrollment, but are often unaware of their eligibility or otherwise unable to navigate the enrollment process on their own, NCUIH strongly supports the recommendations regarding outreach and enrollment in these key programs. We have long known that the enrollment of American Indians and Alaska Natives in these key programs is far lower than our community's apparent eligibility would otherwise suggest. Increase outreach and enrollment measures must be included within any

expansion of Medicaid and Medicare. NCUIH encourages the Committee to pay particular attention to the recommendations regarding aggressive outreach and enrollment mechanisms, such as:

- **Fast-track enrollment**—The ability of all Urban Indian health providers to undertake fast track enrollment, and be provided funding for staff to do so, would help Urban Indian health providers identify Indians eligible for enrollment in Medicaid, get them enrolled, and then start providing services from the very moment a patient presents at a clinic. Urban Indian health providers excel at preventative health care and fast track enrollment through the Community Health Representative program would help UIOs reach patients at earlier stages of illness, or even prevent illness.
- **Tribes as Medicaid Application Portals**—NCUIH strongly believes that Tribal governments must be authorized as portals for accepting Medicaid applications. Many American Indians and Alaska Natives living off-reservation do not enroll in Medicaid because they distrust the state and local governments. The greater involvement of I/T/U providers and Tribal governments in simplifying and easing the Medicaid enrollment process should increase enrollment of American Indians and Alaska Natives because they have greater trust in their I/T/U providers and Tribal governments.

Health Care Work Force—Urban Indian health providers face many of the same problems as Tribal health providers in attracting and retaining health care professionals, particularly culturally competent health care professionals. Most Urban Indian health providers operate in Health Provider Shortage Areas (HPSA) and serve Medically Underserved Populations (MUP), thus they already have difficulty finding health professionals. Programs and scholarships to direct health professionals from all levels—from doctors and nurses to physicians' assistants and health aides—must be targeted toward Urban Indian health providers as well as Tribal health providers as neither is able to compete with the lucrative salaries offered by physician owned clinics. If Urban Indians health providers are not explicitly included in a coordinated national strategy to address health care workforce shortages, many programs will be unable to find necessary personnel to expand services to meet the rising need of off-reservation Indian communities. NCUIH's key recommendations are:

- **Develop & Support a Residency Program for Cultural Competent at I/T/U Provider Facilities**—Some Urban Indian health programs—most notably the Seattle Indian Health Board—have developed a residency program that trains physicians in cultural competence. This program should be used as a demonstration project to develop a broader residency program.
- **Enhance Scholarship and Loan Programs**—Current Indian health scholarships are not sufficient to meet the need for health providers in I/T/U facilities. These programs must be expanded beyond current targeted health providers to reach alternative provider types with proven records of providing quality care. They should also be expanded in terms of funding, accessibility, and focus.

IHCIA Provisions and the UIHP: As NCUIH has previously testified, there are several provisions that we strongly advocate should be included in any standalone bill put forward by the Senate Committee on

Indian Affairs. Passing the Indian Health Care Improvement Act Reauthorization and making serious progress on improving the health of all American Indians and Alaska Natives is the first priority for NCUIH. We believe that our clinics would be in a stronger position to deliver care in these difficult times[16] if IHCIA had been passed in an earlier Congress. However, this Congress, with the health care reform debate blazing, is perhaps the single best opportunity we may have to pass the IHCIA reauthorization. NCUIH urges the Senate Committee on Indian Affairs to consider re-including the Urban Indian health programs in the provisions listed below:

110th Congress Section 201: Expansion of Payments Under Medicare, Medicaid, and SCHIP for All Covered Services Furnished By Indian Health Programs—The Senate Finance Committee has continued to support the inclusion of Urban Indian Organizations in this provision despite previous attacks upon Urban Indian Organizations by the previous Administration. Section 201 of the Indian Health Care Improvement Act (IHCIA) amends sections 1911 and 1880 of the Social Security Act. The proposed amendments would allow Indian Health Programs and Urban Indian Health Programs to directly bill Medicaid and Medicare for providing services or items to Indian patients. Due to an unfortunate misunderstanding of the UIHPs third party bill capacity, the previous Administration advocated for the removal of Urban Indians from this provision. The general argument for removing UIOs from this provision is that UIOs already have authority to bill Medicaid and Medicare through the FQHC and RHC provisions. The argument for excluding Urban Indian Organizations overestimates the number of Urban Indian Organizations that are eligible for FQHC, RHC or FQHC look-a-like status. Currently 8 UIOs are full FQHCs, 15 are FQHC look-a-likes, 2 are RHCs, and 11 neither FQHCs or FQHC look-a-likes. The argument that the number of Urban Indian Organizations impacted by removing them from section 201 would be trivial is false.

Inclusion in section 201, and thus in the amendments to sections 1911 and 1880 of the Social Security Act, would mean that a full third of the Urban Indian Health Programs that currently are unable to bill Medicaid and Medicare would be able to do so. It would also protect those programs that are currently FQHC and FQHC look-a-likes from losing Medicaid and Medicare reimbursements should the FQHC or FQHC look-a-like requirements change in ways that they are unable to meet. The current reporting and third party billing requirements outside the FQHC statute for billing Medicaid and Medicare are beyond what any small outpatient clinic is able to meet without a massive initial investment. The Urban Indian Health Programs are unable to make such an investment given years of zeroed out of the Presidential Budget, the incredible demand upon the programs due to the recession, and the steady drying up of private grants and donations.

The trust responsibility demands that the federal government provide health care to American Indians and Alaska Natives regardless of where they reside. Despite this solemn responsibility born of treaty obligations and the history of secession of lands, the Indian health care system has never in its entire existence been fully funded. The Urban Indian Health Program is funded at 1% of the Indian Health Services budget when it should be funded at closer to 5% of the Indian Health Service budget in

[16] Many UIHP clinics and programs report staggering numbers of new patients as the recession deepens. Many American Indians and Alaska Natives have been forced from their tribal homes to urban areas to look for work. *See* fn 7.

order to serve the roughly 900,000 eligible patients. The ability to bill Medicaid and Medicare makes up some of the deficit in funding. The primary reason for allowing American Indians and Alaska Natives to enroll in Medicaid, Medicare, and SCHIP—and thus allowing Tribal and Urban Indian Health Programs to bill Medicaid, Medicare, and SCHIP—was to try to make up some of that funding. It was a tacit developed from the recognition that the Indian health care system was chronically underfunded and desperately needed some transfusion of funds. By excluding Urban Indians from section 201 Congress is making the statement that trust responsibility may not, in fact, extend to Urban Indians in bold contradiction to years of legislative intent.

110th Congress Section 520 Additional Authorities —After extensive negotiations with the Senate Committee on Indian Affairs, certain new authorities for Urban Indian Organizations found outside Title V were consolidated into section 520. Unfortunately, last minute negotiations caused this section to be dropped from S.1200 as it moved to the floor. NCUIH strongly encourages the Senate Committee on Indian Affairs to include this provision in any standalone bill reauthorizing the Indian Health Care Improvement Act. Section 520 provides that the Secretary is authorized to establish programs for Urban Indian Organizations that are identical to programs established pursuant to sections 126 (behavioral health training), 210 (school health education), 212 (prevention of communicable diseases), 701 (behavioral health prevention and treatment services) and 707(g) (youth multidrug abuse). These provisions deal with authorities and programs that go to the core mission of the Urban Indian Health Program and directly address afflictions that are especially severe in the urban environment. Urban centers in particular have large patient populations with the very type of problems these programs address given the nature of living in an urban center where there is ready access to alcohol and a wider variety of illicit drugs. Moreover, Native Americans suffer additional stress in urban environments as they are separated from their Tribal homes and surrounded by, in many respects, a foreign culture.

Many problems on the reservations are imported from urban locations because there is substantial migration between the reservation and Urban Indian communities. Tribal members with drug, alcohol and infectious diseases—like HIV/AIDS (which would be addressed under Section 212)—bring those illnesses back with them to the reservation. But that chain can – and has been – broken when they are treated at the urban center and always in a far more cost efficient manner then if the same patient receives significantly delayed care at an on-reservation IHS facility because they were forced to wait until they reached medical crisis and then return home. Urban Indian Health Programs form a critical link in preserving the health and viability of the Native American population by confronting many illnesses and substance abuse at their point of origin. The sad and fundamental truth is that eventually these patients must be seen and either they can be seen early, before the most destructive behaviors or illnesses set in, or they will be seen much later at the Tribal or IHS facility after the drug or alcohol abuse has destroyed their families or HIV/AIDS has gone untreated for months if not years and been spread to more individuals.

106, 107, 108 Congresses' Section 517: Use of Federal Government Facilities and Sources of Supply — This provision was lost at the end of the 108th Congress. The proposed new section 517 would extend to Urban Indian Organizations with a contract or grant under this title the same access to federal facilities and property (including excess property) and sources of supply that is currently available to

programs operated by Tribes or Tribal organizations under sections 105(f) and 105(k) of the ISDA. Currently the Secretary is authorized to extend the use of federal facilities to Urban Indian Organizations. Without this provision that current law authorization would be lost. Current law, however, does not extend access to sources of supply to Urban Indian Organizations.

Proposed New Section: Federal Tort Claims Act Coverage for Urban Indian Organizations – Currently Urban Indian Health Programs do not have access to FTCA protection despite carrying out a contract to provide health care services under Title V on behalf of the Federal government. NCUIH argues that Urban Indian Organizations providing clinical services pursuant to a grant or contract under Title V should be eligible for FTCA protections just as Community Health Clinics are protected under FTCA for clinical health services provided under a 330 grant.

Proposed New Section: Health Information Technology for Urban Indian Organizations –Under the current language of IHCIA Urban Indian Organizations have no authorizing language for HIT appropriations. NCUIH advocates for the creation of such a section either as an addition to Section 509 or current Section 520, or as an entirely new section under Title V. This section would allow Urban Indian Organizations to obtain separate appropriations for HIT necessary for bringing UIOs into the 21th century.

Conclusion: On behalf of the National Council of Urban Indian Health and the Urban Indian health organizations that we represent, I thank you for the opportunity to provide testimony on Indian Country's recommendations for health care reform. NCUIH thanks the Committee for its support and dedication to Indian health. We have a rare moment with this Administration and this Congress to seriously reform the health delivery system for the Nation and for Indian Country. NCUIH strongly urges the Committee to seize this moment and undertake comprehensive health care reform with Indian health in mind; pass the Indian Health Care Improvement Act; and initiate a comprehensive review of the Indian health care delivery system.

We are deeply grateful for your leadership and your commitment to improving Indian health, as we are grateful to all of the leaders who have come to give testimony today. We all have the same ultimate goal: ensure the best possible health care for our people.

I am available to answer any questions the Committee might have.

National Council of Urban Indian Health
924 Pennsylvania Ave, SE Washington DC 20003

Excellence, Equity, Effectiveness

National Council of Urban Indian Health
Health Care Reform General Policy Statement

The iniquity in the state of health care in the United States can no longer be ignored. American Indians and Alaska Natives understand that our health care system is broken. Experiencing health problems at rates far greater than other ethnic or racial groups[1], American Indians and Alaska Natives are among the most vulnerable of citizens. The Indian health care system consisting of Indian Health Service, Tribal, and Urban Indian Health Providers (I/T/U)[2] are directly affected by the failures of the general health care system. As a discretionary part of the federal budget, the Indian health system is chronically underfunded, understaffed, and American Indian and Alaska Native patients are generally uninsured, thus unable to access our financially-driven health care industry.

All Americans deserve solutions, and the National Council of Urban Indian Health stands ready to assure that the Urban Indian voice is heard during this critical debate. Native Americans face the highest health disparities for chronic disease, mental health disorders, and substance abuse[3]. Without a health care system that provides affordable, accessible health care coverage and equity of health care access, health care disparities for not just Urban Indians but all minorities will continue to climb. For Urban Indians, addressing the health care crisis means finally fulfilling the Trust responsibility to Urban Indians, ensuring access to culturally competent health care, removing the barriers to health insurance, and developing a solid basis of research and data in order to develop culturally appropriate best practices.

The National Council of Urban Indian Health believes that serious health care reform must come in three main parts: reform of the health insurance market, reform of the health care delivery system, and reform of health care research field. The current health care system in America is not affordable, effective, culturally competent or accessible for Urban Indians. NCUIH believes that, as part of the Trust responsibility to provide health care to American Indians regardless of where they reside--which is a solemn promise between the United States federal government and the Indian people who have given up so much, that reforms must include a guarantee of quality, culturally competent, affordable health care for everyone.

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[1] *Indian Healthcare Improvement Act Fact Sheet*, National Indian Health Board, 2008. *See also, Unnatural Causes: Is Inequality Making Us Sick?* PBS Documentary, 2008.

[2] The health care system dedicated to serving American Indians and Alaska Natives is constituted by direct service through the Indian Health Service, tribes who have decided to compact or contract their health care through section 638 of the Indian Self Determination Act, and Urban Indian Health Program clinics and programs created through the Indian Health Care Improvement Act of 1976. Urban Indian Health Programs clinics and programs are 501(c) organizations dedicated to serving American Indians and Alaska Natives living in urban centers. The National Council of Urban Indian Health is the national representative of these 36 programs and clinics.

[3] 2006 National Survey on Drug Use and Health: National Findings; see further, *The Health Status of Urban American Indians and Alaska Natives*, Urban Indian Health Institute, 2004

The National Council of Urban Indian Health will be fighting for health care reform legislation that will:

- Assure full funding and support for Urban Indian Health Program clinics and programs.
- Assure no cost sharing for American Indians and Alaska Natives who have already paid through the cessation of the lands of the United States.
- Maintain access to culturally competent health care providers for all Urban Indian community, which means expanding the UIHP to reach all urban centers with sizeable Urban Indian communities.
- Equity in health care access, treatment, research and resource for Urban Indians and all communities of color, resulting in the elimination of racial disparities in health outcomes and real improvement in health and life expectancy for all.
- Invest in developing a larger, more diverse, and culturally competent health care workforce. Concrete strategies must be developed and supported to address chronic shortages in the entire spectrum of health care professionals in not only Urban Indian communities but all communities of color. Pipeline incentives as well as reimbursement reform aimed at attracting, training, supporting and retaining a diverse, culturally competent work force.
- Implement payment reform that encourages the integration, rather than segregation, of health services so that patient-centered healthcare home models of care, and other models that integrate all aspects of care, are the norm.
- Supports targeted research and best practice benchmarking appropriate to American Indians and Alaska Natives. Best practices in prevention and treatment must be grounded in evidence-based study on the actual populations involved. Research and development must be cognizant of, and linked to disparity factors, and research must include sufficient representation of Urban Indians, women, people of color, and other marginalized populations. Best practice research and development must be community-informed and community-based.
- Reinforces the health care infrastructures. Mechanisms must be implemented to support safety net institutions and quality improvement initiatives in all health care settings. These include: expanding and strengthening culturally competent health care providers such as Urban Indian Health Programs and Community Health Centers; prioritizing investment in the primary infrastructure, including facilities, equipment and health IT; and promoting the adoption of patient-centered healthcare home models of care.
- Due to the chronic under funding of the Indian Health Service American Indians and Alaska Natives **must** be automatically eligible for all federal or state health plans or services.

- Also due to the chronic underfunding of the Indian Health Service, tribal and Urban Indian health clinics and programs **must** be able to bill any federal health plan such as Medicaid, Medicare, SCHIP or a public plan.
- Many Urban Indians are uninsured and underinsured as they are unable to secure adequate insurance through the private or public market; therefore, NCUIH strongly supports a choice of private insurance plan, including keeping the insurance an individual has if they like it, or a public insurance plan without a private insurer middleman that guarantees affordable coverage.
- Urban Indians suffer from high rates of diabetes and other chronic disease. Private insurance plans and many State Medicaid plans do not cover services needed by Urban Indians who often have complex health needs; therefore, NCUIH argues that there must be a standard for health benefits that covers both preventative and curative interventions.

Senator TESTER. I want to thank you for your comments. Our work is laid out ahead of us. Thank you.

Valerie Davidson?

STATEMENT OF VALERIE DAVIDSON, SENIOR DIRECTOR, LEGAL AND INTER–GOVERNMENTAL AFFAIRS, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Ms. DAVIDSON. I thank you for the opportunity to testify today. [Greeting in native tongue.]

My name is Valerie Davidson, and in the interest of time, I will skip through some of my qualifications. And I want to thank the Committee for the opportunity to testify today on behalf of self-governance tribes.

I think as we are thinking about health reform as it applies to Indians, I think we should be mindful that Indian families want what every family wants. We want our families to be healthy. We want them to be happy, and we want them to live in safe communities.

But because of our history, because of our circumstances and some of our unique political status, in order to be able to accomplish that, we have to do things a little bit differently in our communities. And what works for one tribe may not necessarily work for another.

Some tribes have chosen to have their health care services provided directly by the Indian Health Service. Other tribes choose to contract or compact services through self-governance compacts or contracts.

The other that is equally important is that opportunities for individual tribal members who live in urban centers need to continue to have access to urban Indian programs for their health care.

And those three things really work together to make sure that the Indian health system really is a public health system that works as well as the funding allows. And any diminishment of those choices really further limits the already limited resources that are available to the collective Indian health system.

Some of my written testimony outlines the fact that self-governance tribes, we provide more services and more facilities than the

Indian Health Service does. Because of self-governance, we are able to actually leverage our IHS funds and seek additional grant funds to be able to extend our reach and extend our programs in ways that a direct Federal agency is unable to, for example, because they are barred from applying for other agency grants.

One of the reasons that many tribes choose self-governance isn't because it is an indictment of the Indian health system. We actually choose to be able to provide that because we have greater control. We have greater flexibility, and we can provide services as close to home as possible. One of the things that is important to know is that kind of flexibility is not necessarily as possible before self-governance.

Through self-governance, we have been able to do very innovative things in our communities. Examples include the Community Health Aid Program, the Behavioral Health Aid Program, and the Dental Health Aid Program, which allow us to be able to extend our provider types in very, very small communities.

The Cherokee Nation also has an incredible PACE Program that provides services for elderly patients in their communities, and those services are really amazing.

In the interest of time, I am not going to spend any more time. I am just going to go highlighting some of the accomplishments. I am just going to go straight to the recommendations.

First, we have incredible opportunities to be able to eliminate barriers where they exist, for example, with veterans' services. It really makes more sense where veterans' services are not available in small rural Indian communities for the Veterans Administration to be able to partner with tribes and Indian health facilities to be able to extend that reach. And there is no reason why the Veterans Administration can't provide reimbursement to the already underfunded Indian health system to make sure that health services can continue.

We recommend specifically the creation of a VA clinical encounter rate to reimburse IHS facilities for that care, and precedent is already there.

Anytime we talk about health reform, we need to be really mindful of the opportunities for the existing funding, as well as the opportunities to expand third-party reimbursement. We already know that the Indian health system is severely underfunded. That point has been made by many folks who have spoken here today.

Specifically, if health reform legislation is really inclusive of Indian health providers and creates opportunities for expanded coverage for individual American Indians without breaking the trust responsibility, it will help to provide additional resources to be able to cover that gap in funding.

Health reform also has to include individual American Indians and Alaska Natives without imposing penalties on those who choose to use the Indian health system. It also has to assure so on the one hand we need to be mindful of the opportunities that are available to individuals, but we also have to be mindful of the implications that health reform has on providers, that providers have to be able to have the full opportunity to be participants in the same way that other private providers are.

And finally, we have to extend to Indian health care programs all of the resources that are available to any other safety net providers. And in health reform, if there are any other special considerations that are made to, for example, Federally qualified health centers, the 330 clinics, I would ask that the Committee take a moment and pause and ask yourselves: Is there an opportunity? Does it make sense to include Indian health facilities?

And I would guess that 99 times out of 100, that is probably true.

We endorse the recommendations that were provided by the National Indian Health Board, NCAI, NCUIH, as well as the Northwest Portland Area Indian Health Board, tribes.

I do want to clarify one inconsistency with regard to the whole issue of creditable coverage. I don't want to get caught up in the details, but one thing we all actually agree on is that Indian health people shouldn't be barred from qualifying for subsidies due to their eligibility for health care from the Indian Health Service health care delivery system, whether it is the I, whether it is the T or whether it is the U.

Similarly, though, I think there is universal support among the panel for objection to imposing any penalties on an Indian individual who fails to obtain mandatory health insurance.

We strongly support expanding Medicaid coverage or any other kind of coverage options as indicated earlier. Funding alone is not enough. There is a tremendous opportunity to look beyond the Indian Health Service and look at Title VI as an opportunity to expand health care delivery. This Committee actually made great progress. Unfortunately, we weren't able to actually realize that in the prior Administration.

There is incredible opportunity here, and we believe that it is the greatest opportunity to be able to extend health care.

Some folks thought it was kind of odd that we recommended Title VI, but the reason is pretty simple, that you can't undo the economic status of people with their health status, and therefore it really makes sense to the extent that we can, to utilize TANF programs, where often it is the first time people hear about Medicaid and health programs that might be available.

Finally, we urge passage of the Indian Health Care Improvement Act. We have been waiting too long. It is time. I served as one of the founding members of the National Steering Committee on the Indian Health Care Improvement Act I think 10 years ago. Many of us are hoping that this year will really be the year. My kids ask me every year, is this the year that it is passed? And every year, I keep having to say, not quite, but maybe next year.

Finally, I just wanted to emphasize that full funding really is critical. It is a critical piece of being able to accomplish what we need to. We really need full funding for contract support costs. In the event that you are considering insurance participation, tribes are employers. We are providers of health care as well. Contract support cost is what pays for buying health insurance for employees, so we urge that as well.

Thank you so much for the opportunity, and I appreciate it and will be available to answer any questions.

[The prepared statement of Ms. Davidson follows:]

Prepared Statement of Valerie Davidson, Senior Director, Legal and Inter-Governmental Affairs, Alaska Native Tribal Health Consortium

Good afternoon. Quyana (thank you) for the opportunity to be here today. My name is Valerie Davidson, and I am the Senior Director of Legal and Intergovernmental Affairs at the Alaska Native Tribal Health Consortium (ANTHC). I also serve as the Chair of the Centers for Medicare & Medicaid Service Tribal Technical Advisory Group (CMS TTAG) and as a member of the National Steering Committee on the Indian Health Care Improvement Act Reauthorization. I previously served on the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee and on the Title V Self-Governance Negotiated Rulemaking Committee.

I was privileged to work for seven years for the Yukon-Kuskokwim Health Corporation, the tribal health program that serves 58 federally-recognized Tribes in a region roughly the size of Oregon, of which Bethel is the hub. I am now honored to work for over 3 years for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 231 federally-recognized Tribes in Alaska, co-manages (with Southcentral Foundation) the Alaska Native Medical Center (ANMC), the tertiary care hospital for all American Indians and Alaska Natives (AI/ANs) in Alaska, and carries out almost all of the Area Office functions of the IHS, except for inherently federal functions.

My testimony today addresses the issue addressed to me in the invitation from the Committee: ***how health care reform may affect Tribes and tribal organizations exercising the rights of Self-Determination and Self-Governance under Titles I and V of the Indian Self-Determination and Education Assistance Act (ISDEAA) by providing health care services to AI/ANs that would otherwise be provided by the IHS.*** On behalf of all of the Tribes in Alaska and throughout the United States, I want to express our appreciation for your foresight in asking this question.

On a more personal note, my testimony addresses what American Indian and Alaska Native families want from health reform. Indian families want what every American family wants. We want our children and family members to be healthy, happy and safe. However, because our history, political status, and circumstances are different, we may need to do things differently from others to be able to achieve those goals. Likewise, what works for one Tribe may not work for another.

Indian Health System is Unique

The Indian health system is a unique delivery system within the United States. It is strong because it is a system; it arises out of the unique relationship between Indian tribes and the United States, is grounded in the enduring commitment of Tribes and their leaders to assure that the responsibilities of the United States to Tribes are satisfied, and relies on a partnership among Tribes and the IHS to provide culturally competent and appropriate care to AI/ANs. It is vulnerable because of the persistent under-funding that restrict its ability to meet the needs of a

population that experiences extraordinary disparities in health status and because of the same pressures that affect all other health providers.

Health care reform provides opportunities for improvement and risks of damage. If in the process of considering this important but complex legislation, the Congress can take time out to assure that the unique needs of the 1.9 million American Indians and Alaska Natives who rely on the IHS and Tribes and tribal organizations that serve them, then we expect that health reform will advance the interests of this country's first citizens.

Guiding Principles Indentified by Tribal Leadership in Health Care Reform

Because the first health reform bill, the 615 page legislation offered by the Health, Education, Labor and Pensions (HELP) Committee became available for review literally on the day this testimony was being prepared, there has been no opportunity to closely review or analyze it. I understand this Committee is in the same position. Please understand that the remarks included in this testimony should not be considered my final views. Rather they are offered as preliminary comments and recommendations on potential proposals for national health care reform legislation that have been discussed.

Finally, as a preliminary matter, not all Tribes will be affected in exactly the same way by any piece of legislation, including health care reform. However, tribal leaders have been coming together since the beginning of the Clinton Administration to discuss health reform and its potential impacts. Certain principles have emerged clearly. These principles guide my testimony today and include:

Trust Responsibility: Health care reform initiatives must be consistent with the federal government's trust responsibility to Indian tribes acknowledged in treaties, statutes, court decisions and Executive Orders.

Government-to-Government Relationship: Indian tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. Based on the government-to-government relationship with the federal government, tribes need to be at the table in any discussions on health care reform initiatives that affect the delivery of health services to AI/AN people.

Special Legal Obligations: It is the policy of the United States, in fulfillment of its legal obligation to tribes, to meet the national goal of achieving the highest possible health status for AI/ANs to provide the resources necessary for the existing health services to affect that policy.

Tribal Control and Management: The legal authority of tribal governments to determine their own health care delivery systems, whether through the Indian Health Service (IHS) or tribally-operated programs, must be honored.

Distinctive Needs of AI/AN People: A community-based and culturally appropriate approach to health care is essential to preserve Indian cultures and eliminate health disparities. The extremely poor health status of Indian people demands specific legislative provisions and increased funding to break the cycle of illness and addiction that began with the destruction of a balanced tribal lifestyle.

Access to Care: Indian health care services are not simply an extension of the mainstream health system in America. Through the IHS, the federal government has developed a unique system based on a public health model that is designed to serve Indian people in remote reservation communities. The Indian health delivery system must be supported and strengthened to enhance access to health care for AI/ANs.[1]

These principles have been restated so frequently over the last fifteen years that they may seem like mere platitudes or merely a defense of the status quo. Nothing could be further from the truth. Instead, they are the bedrock on which the work of tribal health programs (and that of the IHS) rests.

American Indian/Alaska Native (AI/AN) Health Disparities

No one understands the challenges facing AI/ANs better than the Tribes that serve them. American Indian and Alaska Natives have among the highest rates of disease and poorest health status of any other group in the United States. In the first half of the twentieth century, AI/ANs had a much shorter life expectancy than the general population and routinely suffered from markedly higher rates of diseases. Over the past 50 years, the AI/AN population diseases have transitioned, along with the U.S. general population, from infectious diseases pandemics to those of aging and lifestyle disease, such as diabetes and cardiovascular disease, cancer, and alcohol and drug abuse. Data for the AI/AN population is often incomplete. However, some of the comparisons with the non-Native population are dramatic:

- AI/ANs die at higher rates than other Americans from: alcoholism (517%), tuberculosis (533%), motor vehicle crashes (203%), diabetes (210%), unintentional injuries (150%), homicide (87%) and suicide (60%);
- AI/ANs born today have a life expectancy that is almost 4 years less than the U.S. all races population (72.9 years to 76.5 years, respectively; 1996-98 rates), and AI/AN infants die at a rate of 8.8 per every 1,000 live births, as compared to 6.9 per 1,000 for the U.S. all races population (1999-2001 rates);
- AI/AN adults have a 15.3% higher diabetes rate compared to the 7.3 percent rate among all U.S. adults;
- Heart disease is now the leading cause of death among AI/ANs;
- Suicide and homicide among AI/ANs nationally were almost twice that of the U.S. population of all races;
- The death rate for all unintentional injuries was more than three times that of U.S. all races;
- Alaska Natives and the Northern Plains Indians have a higher mortality rate from all cancers than the U.S. all race rate; and
- AI/ANs nationally have higher death rates from stomach, renal, and liver cancers.

These are not only statistics. They are the daily reality in my family and in the family of every American Indian and Alaska Native. They are the daily challenge of every Indian health provider – tribal and IHS. They shape the way I, and every other leader in the delivery of Indian health, thinks about health delivery. I know they weigh on each of you on this Committee.

These dreadful numbers are a constant reminder about why so many Tribes have chosen to assume responsibility under the ISDEAA for delivery of their own health programs. The decision to do so is not an indictment

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1/ National Indian Health Board, "The Indian Health Perspective in Health Care Reform," http://nihb.org/docs/the_indian_perspective_in_health_care_reform.pdf.

of the IHS, but rather a positive statement about the power of Self-Determination and Self-Governance. Tribal governments, directly and through the tribal organizations they authorize, have demonstrated their success in focusing health care services on the most pressing needs in each of their tribal communities and in emphasizing the need to invest in prevention and early intervention.

Self-Determination and Self-Governance

Since implementation of the first Self-Governance compact and funding agreement on September 30, 1993, the interest and growth in Self-Governance has been dramatic. According to the IHS, there are 73 Title V compacts, funded through 94 Funding Agreements, totaling over $1 billion representing 323 Tribes, representing 57% of the federally recognized tribes. There are also 238 Tribes and tribal organizations that contract under Title I of the ISDEAA, with a total funding of $425 million. In total, over 40 percent of the IHS budget authority appropriation is administered by tribes, primarily under agreements entered into under the ISDEAA.

Collectively, tribes and tribal organizations operate 14 hospitals, 227 health centers, 166 Alaska village clinics, 102 health stations, and 13 school health centers. IHS by contrast operates only 31 hospitals, 61 health centers, 30 health stations, and 2 school health centers. Tribes and tribal organizations also operate youth residential treatment facilities and residential and outpatient mental health and substance use disorder programs.

All of these hospitals are accredited by The Joint Commission or certified by the Centers for Medicare & Medicaid Services (CMS). Most large clinics and many smaller ones are accredited by The Joint Commission or the Accreditation Association for Ambulatory Health Care (AAAHC). In additions most of the residential treatment programs are accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. This was not the case when tribes and tribal organizations assumed responsibility for many of these facilities (first under Title I, then for many, under Title V).

One reason Self-Governance and Self-Determination are successful is because the funds, control and accountability for programs are pushed as close to the delivery of the services as possible. At the local level, tribal leaders and tribal citizens best know the needs of their people and communities. Given the opportunity to make decisions regarding priority of funding and the subsequent design and delivery of program services, tribal governments will do what is best for their members and community.

A one size fits all approach does not work in Indian country. This was recognized by ISDEAA which addressed this problem by allowing Tribes the flexibility to choose the best way to administer their programs. Tribes have used the flexibility that Self-Governance provides to create innovative programs that better serve their beneficiaries. This was not possible before Self-Governance.

Success of Tribal Self-Determination and Self-Governance

There have been remarkable accomplishments throughout Indian Country as tribes and tribal organizations have assumed responsibility for delivering health services in their own communities. In Alaska, we are especially proud of the multi-faceted, interdependent Native health care system with sophisticated patterns of referral developed over 40 years. This system which is controlled by the 231 Tribes in Alaska provides health care to more than 130,000 Alaska Natives, half of whom live in remote communities stretched over 586,412 square miles of largely

road-less land. The system includes seven hospitals, including the Alaska Native Medical Center, the only Level II Trauma Center in Alaska. It also includes village-based services where the addition of a mid-level practitioner is a huge accomplishment. The system is well known for both its close connection to the IHS and also for its innovations, which include development of the community health aide program, certification of dental health aide therapists, and telemedicine.

Other tribes have similar stories – such as the Cherokee Nation, which was able to establish the first tribal Program of All Inclusive Care for the Elderly (PACE) program (in fact, the first rural PACE program) after it assumed responsibility for the majority of the health programs previously operated by IHS. It is a capitated benefit authorized by the Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The Nation's PACE program offers the full range of long term care to the people who live in its service area. Similar success stories are prevalent across Indian Country.

These accomplishments are representative of the achievements of tribal health programs under the ISDEAA. Achieving these improvements has only occurred through careful exercise of the rights available under the ISDEAA – mostly funded through increased third-party revenue, NOT increased appropriations.

Indian Health Service/Tribal and Veterans Administration Facilities

While we are excited by the promise of health care reform, we naturally get nervous as we hear about some changes that are contemplated. We know from experience that as resources get tighter, individual American Indians/Alaska Natives and the IHS facilities that provide their care will feel the impact more than any other. Why? The highest rates of unemployment occur in Indian Country. We have some of the lowest income levels. We have the poorest health status of any other population in the country. Tribal communities are often rural communities where access to care is a problem. There is a higher cost of providing care and with the high cost of living, so limited incomes get stretched even further. What this means is that when our people do finally get the care they need, they have traveled farther with money they simply don't have, are sicker than the average person, are seen in clinics / hospitals that have fewer resources than most other clinic / hospitals in the country that also, have a higher cost of providing care, and when people return to their rural community, they often need of follow-up care that is not available in the community.

We appreciate this Committee's efforts to address the very important issue on behalf of AI/AN veterans and their families and other veterans who live in Indian Country. Every veteran, regardless of race or geographic location who needs medical care (including primary and behavioral health care) should have access to culturally appropriate care. In much of Indian Country, the main barriers to local access to care are the lack of Veterans Administration (VA) infrastructure in rural communities, the lack of funding to support the already existing rural health system, and the lack of systems providing meaningful medical information between health systems.

Rather than build additional VA health infrastructure in rural Alaska and other parts of Indian country, for example, it makes more sense to use our limited federal resources wisely to complement the existing system of culturally relevant services that are available through the Indian health system.

The most effective and efficient way to extend the VA's capacity to provide health care to veterans who live in Indian country, is by enhancing the existing tribal health system's capacity to provide care for those veterans. Specifically, we recommend the creation of a VA clinical encounter rate to reimburse IHS

(including tribally operated) facilities that provide care to veterans and their families. The clinical encounter rate should be flexible enough to extend to behavioral health and telemedicine encounter rates. Since tribal providers are often the only health care services available in local communities, we should ensure that non-Native veterans can also access care there. The precedent for such extensions of care for contracted community-based services has already been established by the VA in other locations through the VA's Community Based Outpatient Clinic Program.

Funding Disparities

The point about third-party revenue is critical to the discussion about how health reform may affect tribal health programs. No amount of determination or commitment can overcome completely the barriers the Indian health system experiences as a result of persistent under-funding.

The IHS Federal Disparity Index (FDI) measures the proportion of funding provided to the Indian health system, relative to its actual need, by comparing healthcare costs for IHS beneficiaries in relation to beneficiaries of the Federal Employee Health Benefits (FEHB) plan. This method uses actuarial methods that control for age, sex, and health status. In 2006, per capita healthcare spending totaled $2,130 for AI/ANs, compared to $3,903 in other federal sector financing programs serving the non-elderly population. It is estimated by the FDI, that the IHS system is funded at less than 60% of its total need. To fully fund the clinical and wrap-around service needs of the Indian healthcare system, the IHS budget would need to be $18 billion. The FDI workgroup determined that at least $10 billion is needed for health services, and an additional $8.7 billion as a non-recurring facilities request.

If health reform legislation is fully inclusive of Indian health providers and creates opportunities for expanded coverage of AI/ANs (without breaking the promises in the trust responsibility), it will help to overcome the extraordinary gap between what is needed and what is available. Health reform must include AI/ANs without imposing penalties on those who use the Indian health system; it must assure Indian health programs are given the opportunity to be full participants so they can continue to provide culturally appropriate and competent care; it must assure that opportunities for increasing the number of providers – particularly AI/AN providers – are extended specifically to the Tribes and tribal organizations; and, it must extend to tribal health programs all of the resources made available to other safety net providers.

It is also crucial to ensure that there is adequate funding to support the entire system and continuum of care. The IHS/tribal system is just that – a system. Relying on a fee-for-service reimbursement model, for example, would undermine the IHS/tribal system by ignoring preventive, community, environmental and other types of care essential to a true public health system. It also tends to neglect crucial infrastructure that is still lacking in much of Indian country, where clean water and basic sanitation lag 20 years behind the rest of the country.

Specific Health Reform Recommendations

Tribal leadership has been working as quickly as possible to review concept papers regarding health reform and to articulate specific suggestions about how Indian health should be addressed. I participated in, and endorse, the recommendations made by the National Indian Health Board, National Congress of American Indians, and the National Council of Urban Indian Health in their recent paper, "Health Care Reform: *Indian Country*

Recommendations".[2] I also endorse the recommendations made by the Affiliated Tribes of Northwest Indians and the Northwest Portland Area Indian Health Board in their June 4, 2009, letter to the Chair of the Senate Finance Committee, and the Oklahoma City Area Inter-Tribal Health Board Health Care Reform Paper. All documents are attached to my testimony. Please consider each of the recommendations in those papers in their entirety and inclusive herein as part of my formal written testimony.

As you examine the recommendations, you will note the common themes derived from the principles set out earlier that stress the unique relationship between the United States and Tribes, the importance of retaining the culturally appropriate and competent system of care provided by tribal health programs and IHS, and from the tremendous need to overcome the funding limitations that plague Indian health. It is our hope that expansion of Medicaid and other coverage made available under health reform, combined with increased direct appropriations[3], will assist us in closing the gap between what is needed to provide a robust array of health services and the current funding levels.

As the recommendations I enclose demonstrate, however, funding alone is insufficient. Current protections for the Indian health system need to be continued and expanded to new structures that may exist under health care reform. Outreach and enrollment must be supported so that all AI/ANs know about what may be available to them. Tribal health systems must be afforded the opportunity to fully participate in workforce development and support options may available to other safety net providers. Health information technology must be expanded and facilities improved by creating as wide a range of options for Tribes and tribal organizations, as possible. And, authorization and encouragement must be provided for expanding access to behavioral health services that can address mental health and substance use disorders; domestic violence, sexual assault and child abuse and neglect services; and long term care options (home-based and residential).

Title VI of the ISDEAA

True health care reform cannot occur in an environment in which medical care is divorced from the rest of the needs to the individual. One of the reasons tribal health programs are successful is that they build from the understanding that the body and the spirit cannot be separated. A hungry person will not be able to take care of his

or her health needs, nor can a person who has experienced violence or suffers from a mental health or substance

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2/ It has been extremely challenging to use words that have meaning in one context accurately in another. There is universal agreement among tribal leaders that "Indian people should not be barred from qualifying for subsidies due to their eligibility for care from the Indian health delivery system." "*Indian Country Recommendations*," p. 3 Subsidies, section 1. Similarly, there is universal support for the objection "to imposition of a penalty on an Indian individual who fails to obtain [mandatory] insurance". *Id.*, p. 2, Personal Responsibility Coverage Requirement (Individual Mandate. In the paper, these statements translated into the phrase: "IHS is not creditable coverage." *Id.*, p. 3, Subsidies, section 1. References to "creditable coverage" frequently are references to a term of art that takes on specific meaning that may be contrary to the two underlying statements. Therefore, I avoid trying to say whether access to Indian health programs should constitute "creditable coverage" or not, and focus instead on advising about the outcomes we seek (no penalties imposed on individuals or tribes and maximum access to subsidies and other support), not the words by which to achieve those outcomes.

3/ Direct appropriations must include funding for contract support costs so that the administrative needs of tribal health programs can be addressed without reducing services.

use disorder. Tribal health programs work as diligently as they can, within the constraints of lack of funding and the law, to integrate the services that address the whole person. Much more is possible however.

Congress enacted Title VI as part of the Tribal Self-Governance Amendments of 2000.[4] Title VI required the Secretary of Health and Human Services to conduct a study to determine the feasibility of a demonstration project under which Tribes could include in Self-Governance agreements non-IHS programs, services, functions, and activities within DHHS. The Secretary was to consult with Tribes and other stakeholders, and consider a number of factors: effects on program beneficiaries, statutory or regulatory impediments, likely costs or savings, quality assurance and accountability measures, and others. In short, should Congress authorize Tribes to compact non-IHS programs, just as Title IV allows Tribes to compact certain non-Bureau of Indian Affairs programs within the Department of the Interior?[5]

Over the next few years, tribal representatives worked with DHHS to ensure that core Self-Governance principles—such as redesign and reallocation authority—informed the feasibility study. In its final report to Congress in 2003,[6] DHHS concluded that it was feasible and desirable to extend tribal Self-Governance within the Department. The report listed eleven programs from three non-IHS agencies that could be included initially.[7]

Beneficiaries of these programs would likely benefit from their inclusion in the demonstration project, the report concluded. Stakeholders such as state and local governments did not oppose the demonstration project. The Department's recommendation was to move forward with legislation implementing the demonstration project.

Shortly after the feasibility study was released, the Senate Committee on Indian Affairs (SCIA) crafted legislation, the Tribal Self-Governance Demonstration Project for the Department of Health and Human Services

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4/ Pub. L. No. 106-260, § 5 (Aug. 18, 2000).

5/ *See* 25 U.S.C. § 458cc(b)(2).

6/ DHHS, Office of the Ass't Sec. for Planning and Evaluation, *Tribal Self-Governance Demonstration Feasibility Study* (March 12, 2003).

7/ The programs (and DHHS agencies) identified by the IHS for inclusion in the demonstration project were the following:

Administration on Aging
- Grants for Native Americans

Administration for Children and Families
- Tribal Temporary Assistance for Needy Families (TANF)
- Low Income Home Energy Assistance
- Community Services Block Grant
- Child Care and Development Fund
- Native Employment Works
- Head Start
- Child Welfare Services
- Promoting Safe and Stable Families
- Family Violence Prevention: Grants for Battered Women's Shelters

Substance Abuse and Mental Health Services Administration (SAMHSA)
- Targeted Capacity Expansion

which basically tracked the recommendations of the DHHS feasibility study. The demonstration project would run for five years. The eleven programs identified by DHHS would be eligible, along with Substance Abuse and Mental Health Services Administration (SAMHSA) block grants regarding mental health and substance abuse and the Health Resources and Services Administration (HRSA) community health center grant program. The Secretary could add up to six additional programs annually. DHHS would prepare annual reports for Congress on the costs and benefits of the demonstration project using evaluation and reporting data provided by participating Tribes, with additional funding to be made available to Tribes for that purpose.

The Committee held a hearing and several tribal leaders and representatives testified in strong support of the bill. Despite an invitation from the Committee, however, no representative from DHHS appeared at the hearing. This absence was perplexing since the bill largely reflected the agency's own recommendations from just one year before. While some provisions departed from the DHHS recommendations, those provisions were not unlike similar ones in Title V.

On June 16, 2004, this Committee favorably reported out the bill to the full Senate and recommended passage. In its committee report on November 16, 2004, the Committee chronicled the success of the self-determination policy, and described the extension of these successes to other programs beyond BIA and IHS as "the next evolution in tribal self-governance."[8] With its goals of minimizing federal bureaucracy and maximizing tribal authority in decision-making, [S. 1696] "continues the steady march of meaningful tribal control of programs affecting their communities."[9]

Despite the favorable Senate report and strong support from Tribes, the bill died at the end of the session. The prior administration's lack of support carried forward through a second term, with DHHS flatly refusing to participate in any discussion of the bill. Under a new SCIA the Committee shifted its legislative focus to reauthorization of the Indian Health Care Improvement Act, and tribal leadership did the same.

The time is now right to revive this or a similar Title VI bill. Direct tribal operation of non-IHS DHHS programs would be a major achievement, yet it should also be relatively non-controversial. The Department's own study demonstrates the feasibility of the Title VI demonstration project. And as this Committee recognized six years ago, Title VI represents simply the next logical step in the "evolution in tribal self-governance."[10] Self-Governance Tribes strongly support legislation to create a demonstration project under Title VI.

It may seem odd that I include this discussion of Title VI in my testimony about health care reform. But, in fact, it is integral to reform. Economic and employment security are closely linked with health status. Under TANF, Tribes have an opportunity to provide both. TANF also provides important access points for individuals to obtain benefits – not just cash, but also Medicaid. Head Start and child care programs include opportunities for early identification of health issues and outreach – both to get people enrolled in benefits like Medicaid, but also in direct contact with health providers. Safe, violence free environments are essential to improving health status. If we are to achieve savings in the cost of administration and improvements in the delivery of services, then the artificial barriers among these funding sources and programs must be broken down.

8/ S. REP. NO. 108-412 at 2 (2004).
9/ *Id.* at 4.
10/ S. REP. NO. 108-412 at 2 (2004).

Support for Passage of the Indian Health Care Improvement Act

Finally, we strongly urge that health care reform not replace the Indian Health Care Improvement Act. We urge you to support this legislation that has been the lifeline for the delivery of health care for a nation of people that would otherwise be comprised or neglected.

Conclusion

Thank you again for focusing on Self-Governance and Self-Determination and how health care reform will affect them. The members of Congress hold the key to finding the answers. If the Indian health system is a full participant in health care reform with no diminishment in the trust responsibility, then health reform will both support Self-Determination and increase the opportunities for Tribes to meet the needs of their members. If the Indian health system is ignored or undercut, then Self-Governance will be undercut. More importantly, the opportunity to improve the health status of AI/ANs will be put on hold again. That must not be allowed to happen.
I count on each member of this Committee to endorse the recommendations for specific Indian provisions that should be part of health care reform and for the expansion of Self-Governance authority.

Thank you for the opportunity to testify. I am happy to respond to questions and to help you get more information if I cannot respond today.

Senator TESTER. Thank you very much.
Paul Carlton?

STATEMENT OF PAUL K. CARLTON, JR., M.D., DIRECTOR, OFFICE OF HOMELAND SECURITY, HEALTH SCIENCE CENTER, TEXAS A&M UNIVERSITY

Dr. CARLTON. Mr. Chairman, Members of the Committee, it is nice to be here from Texas A&M.

Senator TESTER. Good to have you here.

Dr. CARLTON. Texas A&M focuses on solutions. As you know, we regard complaints without solutions as whining, and we live in a no-whine zone.

I am a Professor of Surgery at Texas A&M and a retired Air Force Surgeon General. We have the only college of medicine dedicated to rural health in the Country, and we have been addressing the rural health issues aggressively for the last several years.

As universities are wont to do, we had a semester-long project in the fall of 2007 with our College of Architecture and the Health Science Center saying: How can we bring this new revolution in construction into the health care industry?

We invited many of the players to come. We got actually several of our Iraqi senior officers to come. And out of that spun the testimony that I will give you today.

Specifically, what we learned is the building industry in our Country has truly undergone a revolution in efficiency, with new methods and new thinking in the last decade. This is prefabrication of larger portions of buildings, done in climate-controlled facilities. Literally led by the modular building industry, they have progressively improved their quality, their efficiency and their timeliness. There are currently over 100 manufacturers scattered throughout the Country.

As you look at the value equation of cost, quality and time, timeliness is what always wins on the modular side. We have a perfect example of that in Balad in Iraq. We contracted for two major headquarters to be built, same square footage, same signing time.

One was completed in 18 weeks component. The other is four years, site-built, still under construction. Same cost. And so in the value equation, time counts.

Now, literally in the component building industry, what you do is you don't build 25 hospitals. You build one hospital 25 times, each unique on the outside, but common on its inside. So you don't pay the engineering, the architectural firm, et cetera, 25 different times.

Now, in that revolution that has been going on, the in-patient facilities started in Bensalem, Bucks County, Pennsylvania in 2007, a combination of factory-built and site-built. This is a consistently superior quality, literally 24 hospital beds were laid in two days. The timeliness of this is remarkable. It is understandable. It is done in a factory by a staff that does things repetitively, increasing their individual productivity, as well as avoiding weather delays. It is exactly what Henry Ford taught us.

On the outpatient side, we had a facility languishing at Creech Air Force Base north of Las Vegas, where money had been allocated and no contractor could come within four times of the price. Out of this group that we pulled together in fall 2007 at Texas A&M, we said we can do this. We brought it in on time, on price. After languishing for four years, it was completed in four and a half months, a remarkable meets all standards steel and concrete building, a beautiful building.

As we look at our critical access hospitals, I am learning an awful lot as those come due to be replaced, and it is much the same story as our IHS facilities. We have a perfect example in Tehachapi, California which has recently been estimated at $67 million. It was turned down in a component proposal at $25 million. And it is all about change, as the standards, they are the same way either way.

An innovative physician from Nashville has come back and said, I can do better than that. Instead of $25 million, I can do $14.5 million and put in an electronic medical record.

So the question is: Can we afford to resist change at that difference in price? We are doing exactly the same thing for Iraq today, recommending to them that we use the workforce in America to rapidly solve many of the pressing issues they face in medicine, in housing and in other areas.

Now, how does this apply to the Indian Health Service? Well, using factory-built options literally replacing critical access hospitals at half the price, for that $2.4 billion construction backlog that I have now see, I believe we could more timely and cost-effectively bring that backlog down considerably using these two techniques.

On the outpatient facility, if Creech really is a model for the Nation, we could put in new clinics in the Indian Health Service at a fraction of the current cost, delivery time measured in months, not in years.

Now, the piece that pulls all of these together I call the mobile health care. Obviously, there is no difference in quality. These are State-certified, joint commission-certified, meet all standards. But what it would do is allow you to turn any clinic into a full-up hospital. As a practicing physician, that took care of a referral popu-

lation throughout my 37 years in the military. Every time I stuck my hand out and said, I'm Dr. Carlton and I am here to help you, if the patient was local, it was fine. If they were from far away and had traveled, the other side of that was, you rascal. You are telling me you are more important than I am because you have made me travel instead of you.

We then started an outreach program that we call Medical Center Without Walls. We did it for 25 years. The same thing could be done in the Indian Health Service through a concept that we call the Thursday Hospital. This literally pays for itself by training the Public Health Service, if this equipment using mobile facilities was available and it was designated as going to the FEMA. Then whatever medical national emergency there was, you would have already trained the Public Health people there on its use, by using it every day in Indian Country.

Now, linking all of those together, then, with an electronic medical record or telemedicine, literally I think we could build an integrated delivery system that was first class in the world. There would be no isolated nurse practitioners, no isolated physicians. They would all be part of a bigger piece so that you could have morning rounds. You could have weekly rounds. You could have grand rounds, literally university-based, but tying all of them together. I believe that would solve a tremendous recruitment problem as well, and again tell people they are important members of the team.

So I encourage you to go look at these facilities. They are very first-class facilities. Bucks County is just outside Philadelphia. Our clinic at Creech, you may see when you have other business in Las Vegas. The mobile units are out of St. Johnsbury, Vermont. All of these are available to see.

What we lack right now is the vision to say, I am sorry, quite whining. Let's solve the problem at the current dollars. We are not asking for money.

Thank you for this opportunity to share some thoughts.

[The prepared statement of Dr. Carlton follows:]

PREPARED STATEMENT OF PAUL K. CARLTON, JR., M.D., DIRECTOR, OFFICE OF HOMELAND SECURITY, HEALTH SCIENCE CENTER, TEXAS A&M UNIVERSITY

I am Dr. Paul K. Carlton, Jr., currently a professor of surgery at The Texas A&M Health Science Center, TAMHSC, and the retired Air Force Surgeon General. As part of the Texas A&M land grant mission, the TAMHSC seeks to provide solutions to the many challenges we face in healthcare delivery, particularly in rural, frontier, and emerging regions. This includes training providers willing to serve these areas, promoting the use of innovative technologies to increase access to healthcare, and application of the breadth of science across the Texas A&M University System to improve the public health. This focus on solutions led to a joint conference hosted by the Texas A&M Health Science Center and the Texas A&M College of Architecture in the fall of 2007. This conference presented a pioneer effort on how to use the component building method in medical applications. Out of this conference came many new and innovated ideas for the reconstruction of Iraq, applications for Air Force facilities and applications for the Indian Health Services. These medical construction innovations comprise the rest of this testimony.

The building industry in our country has been undergoing a revolution in efficiency using new methods and new thinking with pre-fabrication of larger portions of buildings, done in climate controlled factories. The Modular Building Industry has been leading this charge by progressively improving their quality, their efficiency, and their timeliness. They currently have over 100 manufacturing facilities scattered across our country.

They recently started moving into the healthcare field with both in-patient and out-patient facilities. The largest user of out-patient, pre-fabricated facilities has been in the dialysis field. By moving these facilities closer to their population served, they are able to give better service, closer to home. The in-patient pre-fabrication world opened with a full up hospital in Bensalem, Bucks County, PA., in 2007. This was a combination of factory built and site built. The factory portion of this building is what allows the efficiencies and quality improvement that have been noted. A consistently superior quality has been delivered by these factories because of the excellent working conditions that are not influenced by weather or availability of professional workers. These are done in a factory by a staff that does tasks repetitively, increasing their individual productivity as well as avoiding the weather delays. The facilities were even certified as meeting all standards before leaving the factory by the State of Pennsylvania. The transportation issues are worked through by designing exactly what the transportation system will allow in terms of moving these larger portions of buildings.

A provider of these types of facilities, U3 Innovations of San Antonio, along with Modern Renovators and Aspen Street Architects built the Air Force their first truly component, pre-fabricated section clinic in the last six months at Creech AFB, Nevada. All of these businesses participated in the fall semester project with the College of Architecture and Health Science Center at Texas A&M in 2007. This clinic was to fulfill a need that had languished for over two years, with no bids coming close to the allocated amount of money. Using pre-fabricated sections, this clinic was built in four and a half months and on budget for $1.5M. Our group from the fall project held a grand opening for all of our colleagues to see what high quality this building represented. It has an all-steel frame, concrete floors, and an exterior that blends with its surroundings nicely. It was built in six components in Loretto, TN., and transported by truck to the site. The beauty of this approach is that it was built to cost and we will add a nicer parking lot and nicer roof as money becomes available. Pending those, we have a fully functional facility to meet the needs of this isolated Air Force Base so vital to the current wartime mission.

Our critical access hospitals (and many urban hospitals) have now reached their life expectancy, having been built about 50 years ago under the enlightened funding initiatives of the Hill-Burton act. These under 25 bed facilities, vital to the nation's healthcare system in rural American, need to be replaced and we cannot afford to do so. A critical access hospital construction project in Tehachapi, California, was recently estimated at $67M, to be completed in three to four years. The similar sized pre-fabricated hospital, using all components, had been contractor proposed at $25M. It was cancelled because pre-fabricated construction was considered unacceptable. Standards are standards and both would have met all standards. Unfortunately, the change was more than Tehachapi was ready to accept. Change is hard for all of us but fiscal reality has to be considered at some point.

One innovative physician executive from Nashville, Dr. Jerry Tannenbaum, has designed such a critical access hospital and is ready to write contracts on such facilities for $14.5M. That design includes 12 beds, two large operating rooms, a post anesthesia recovery unit, a complete imaging suite, a full laboratory, a 12 bed patient wing, Emergency Department, and administrative section. This would be 33,000 sq. ft., all pre-fabricated, and up in nine months from contract signing with a fixed guaranteed price. Comparing that to the $67M that Tehachapi estimated for their hospital and you have to say "what is the difference?" Can we afford to resist change at that difference in price?

I am currently involved in the rebuilding process of medical activities in Iraq. We are proposing all pre-fabricated section type construction for them, using the work force in America, to rapidly solve many of the pressing issues they face in medicine and in housing. We have also proposed using mobile surgical vans, that meet all standards of care, to turn any clinic into a full up hospital whenever and wherever it is needed. The Iraqis currently have one of these units in country and love its flexibility and ease of use.

How does all of this then apply to the Indian Health Service? I believe that what we have learned could easily be applied by providing better service to the Indian Nation at a more affordable cost:

1. In-patient facilities: If we used the critical access model proposed by Dr. Tannenbaum, the physician from Nashville, at $14.5M each, you could provide twice the number of hospitals for the same cost. A similar component model by the Rural Health Consortium in California, comprised of 13 critical access hospitals, has similar numbers. If you used either of these models, tailored it to the exact size needed in any location, using pre-fabricated sections, you could

cut down on the $2.4B construction backlog that currently exists for the Indian Health Service. Better service at a lower cost is hard combination to beat.

2. Out-patient facilities: If we use the Creech AFB model for clinics for the Indian Health Service, we could be building modern state of the art out-patient facilities for fractions of the cost of what we are paying now. The issue of timeliness is also a critical portion here—these are done in a factory, with fixed pricing, and they meet delivery dates because weather is not a factor.

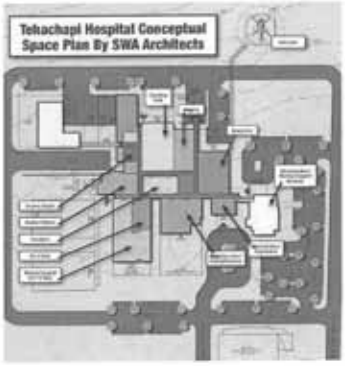
3. Mobile Medical Care—You could also use the mobile surgical vans, as the Iraqis do. These vans are used in our country for operating room renovations routinely and meet all standards of care including Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Medicare certification and state licensure. They would allow us to turn any clinic into a full up hospital for the number of days per month that it would be effectively used at our more remote Indian Health Service locations. This would allow each reservation to have surgical or other specialty services offered to them as the need dictated. The real payback for using such a concept is that by providing better service for the Indian Nation, we would be fulfilling a training requirement for the Public Health Service. We call this the "Thursday Hospital" concept, moving the surgical vans from place to place as demand exists. These vans, which are totally self-contained, could then be the foundation of a national response system for any medical large scale disaster. Since they meet all standards of care, they can be used daily for non-emergency healthcare. The Indian Health Service, comprised of Public Health Service people, would have been using them daily, so no equipment training would be required to respond to national emergencies. You would use them like you use a portable CT scanner or MRI machine, simply have a docking station built onto the clinic or hospital so the patient never has to move outside. To have the potential of superb mobile facilities, no training tail involved for the professional staff, and used every day is exciting to contemplate! There would then be little fixed cost for preparedness for equipment for our nation in times of a medical emergency. From a national preparedness perspective, this is a very cost effective alternative to consider.

The Indian Health Service has a great mission, to take care of the health needs of our Native Americans. You have a great group of people to do this with, the Indian Health Service medical professionals. Perhaps these new methods for providing high quality facilities could enhance the delivery of healthcare to this deserving group of people—at an affordable cost. I encourage you to look closely at all I have discussed. Go see the facilities I have described in Bucks County, PA; at Creech AFB, NV; and in St. Johnsbury, VT. Look closely at how to allocate the tax payer dollars involved. I believe that you will find this revolution in the building industry applicable to the Indian Health Service and other federal building projects.

Thank you for this opportunity to share these thoughts.

Attachment

New hospital price tag: $67 million



Tehachapi News 30Nov08

Description: The nearly 66,000 square-foot project could be done by January 2013.

A new Tehachapi hospital came several steps closer to reality with the presentation March 18 of a proposed $67 million, 65,909-square-foot master space plan.

Hospital Project Executive Manager Norm Clendenin told the Tehachapi Valley Healthcare District Board of Directors that the $67 million preliminary project budget amounts to about $720 a square foot and includes contingencies.

"I'm suggesting that's about as tight as we can get," Clendenin said.

He said the target date for license approval and to welcome the hospital's first patients is January 2013.

Stephen Wen, AIA, senior principal in SWA Architects of Pasadena and Phoenix, presented the space plan, which is an outline of the overall traffic flow and placement of the elements of the hospital.

"There is no fat in this program," Wen said. "It is pure muscle, pure functional."

The healthcare district directors, who junked a previous state-approved but unsatisfactory hospital design at a loss of $1 million, were pleased with SWA's conceptual plan.

"It looks great," district director Dr. Susan Hall said. "I love how it's expandable. The flow really looks good. It seems to make sense." The board is accepting bids from architects to refine and develop the final design.

Sought staff input

Wen said that to develop the made-to-order master plan, his team spent the last four months working closely with Tehachapi Hospital's senior staff. Detailed interviews with all the staff, he said, "allowed us to trim this and fine tune that."

The hospital components will be comprised of more expensive medical sections that must be approved by the Office of Statewide Health Planning and Development (OSHPD, pronounced "OSH pod") and less expensive non-medical sections that include administration, storage and reception ("Non–OSHPD").

The OSHPD components amount to 54,296 square feet.

The non–OSHPD components amount to 5,413 square feet in Phase I and an additional 6,200 square feet in Phase II. The hospital complex, to be built on a 22.36-acre hospital property at Capital Hills north of Highway 58 near the Post Office, will fit snugly into a gently sloping hillside that will require minimal grading, Wen said.

"We would like it to be readily visible but not on the steep slope," he said, "So we placed it on the lower end."

Wen studied the morning and afternoon sun angles as well as view sightlines before selecting the optimum location to build on the property.

The public entrance will be on Magellan Road, with a side entry for emergency vehicles, a service road that loops around the structure and a heliport on the north side.

Core elements of the emergency room, lab, radiology, operating suite, medical surgical units, imaging, surgery supply and intensive care unit were placed "in close functional relationship" with each other, he said.

The plan includes "growth directions" for core elements that are expected to expand, notably the operating room and the emergency room.

Wen's plan provides for 141 parking spaces, more than double the required number.

Healthcare District CEO Alan Burgess said the new hospital will be as green as possible, "No grass—that saves water for other purposes—and we will use indigenous plants like Joshua Trees and yucca."

Squeezed 'em down

Clendenin said Wen and his team had quite a job on their hands when they got the Tehachapi assignment last October.

"I made it very difficult for SWA to get this done," Clendenin said. "They had to get it down from 88,000 square feet to 54,000 [OSHPD] square feet. I squeezed 'em down as far as they could go."

The new 25-bed hospital is designed to replace the 1954-vintage existing hospital on F Street, which will be remodeled as a rehabilitation center and outpatient clinic featuring global consultation via telemedicine, according to Burgess. The original plan to retain the old hospital as a skilled nursing facility is unworkable because of state seismic requirements related to overnight bed stays.

The old structure must abandon its role as an acute care, overnight hospital by the last day of December, 2012, Burgess said. The state granted the Healthcare District a five-year extension past Jan. 1, 2008, to meet new seismic requirements, which will be met by the new hospital complex at Capital Hills.

Clendenin said that he has received 40 responses to requests for architectural bids on the new hospital and it is a good time to build.

At the beginning of the board meeting, held at the Golden Hills Community Services District boardroom, Clendenin introduced Division Chief Gordon Oakley and Regional Compliance Officer Brian Coppock from OSHPD. They promised their support to Tehachapi.

Oakley said the state is happy to approve incremental or phased construction "instead of waiting for the big package." He called the phased process "bite-sized, like eating one scoop of ice cream at a time."

Now for the money

Bringing the space concept and the total cost into focus is the first step in formulating an aggressive fundraising plan, according to Healthcare District Chief Financial Officer Joe Demont.

Demont said the financial picture for the Healthcare District is positive.

Cash collections are up and adjustments are down, he said, and the district operating budget is on its way to being "significantly in the black."

In 2004, voters authorized $15 million in bonds to seed development of a new hospital. The district raised $12.7 million under Series A and B, he said, and the C series was never raised.

That $12.7 million has increased in value to $14 million, which is sitting safely in the bank.

Further fundraising could take the form of a new bond issue, donations, government grants and other sources.

Burgess said he will approach local religious congregations and other organizations to help fund the "quiet room," which in former times was called a chapel. The room will be available for meditation and will offer a place for families to meet with spiritual advisors and counselors.

At least $50 million has to be raised or borrowed to build the hospital.

"We have been holding back until we got the numbers accurate and the conceptual site plan," Burgess said. "There's error in to going out too early. We have to do a sales job. The whole community has to get behind it."

Tehachapi cannot afford to lose its hospital and its emergency room, Burgess said, and building a new one is the only option.

Burgess said that $5 million will put the name of the angel donor on one of the core elements.

Senator TESTER. I thank you all for your testimony. I appreciate it very, very much.

As long as you are warmed up, Dr. Carlton, we will start with you, and I will just go in reverse order.

What is the disadvantage of the component construction?

Dr. CARLTON. I am sorry?

Senator TESTER. What is the disadvantage? You talked about a lot of advantages. Are there disadvantages?

Dr. CARLTON. Oh, yes, sir. Tremendous disadvantages, it is different.

Senator TESTER. That is it?

Dr. CARLTON. That is it. It is the same concrete. It is the same steel. You do it in a climate-controlled environment. The quality is consistently better. It is just different.

Senator TESTER. You have dealt with Federal agencies, mainly the military. Is there problems with this kind of construction with guidelines that you know of through other government agencies?

Dr. CARLTON. Well, sir, I have learned a lot about construction, a nice physician has had to learn an awful lot about construction. The reality is there are national guidelines. There are State guidelines. There are international guidelines. Every one of these meets those guidelines, and literally the facility in Bucks County was certified by the State of Pennsylvania before it left the factory.

Senator TESTER. Okay. I just got a note that said Jefferson, you have to leave. So I will jump over to you. And then I will turn it over to Senator Udall in case he has any questions for you, and then we will kind of hop around here a little bit.

The National Congress of American Indians, the National Indian Health Board, the National Council on Urban Indian Health all produced a position paper with proposals for health reform in Indian Country. Was this vetted with individual tribes that you know of?

Mr. KEEL. Yes, sir. The individual tribes around the Country, or the National Indian Health Board represents tribes around the Country. And all of those tribal leaders from all of the different areas and different regions have had an opportunity to provide input to that, to review it, to take a look at it, provide comments. And then they brought it back and put together a comprehensive set of recommendations.

There are some specific areas around the Country that have some innovative ideas. Portland area has some specific ideas. The Oklahoma City area Indian health boards, all of those have some very innovative folks who look at these plans and provide various ideas and input to this comprehensive set. Thank you.

Senator TESTER. Okay. And in your testimony, you spoke about mid-level practitioners, actually, and how they are underutilized in health care delivery in Indian Country. Do you have any barriers that come to mind as to why this is the case?

Mr. KEEL. Well, primarily there are some issues. One, I would specifically talk about would be the dental health practitioner, the dental health aides that are utilized in Alaska. Those are not well utilized around the Country primarily because of funding. However, there is an opportunity for the self-governing tribes to partner with the local universities. For instance, in the Chickasaw Nation,

we have an opportunity to contract with the University of Oklahoma Health Science Center to contract and provide internships with PAs and nurse practitioners. The problem is funding for those. I could talk a lot about it.

Senator TESTER. I come from frontier America where nurse practitioners and physician assistants are the standard. That is who is providing the front line care. And if they are not being utilized in Indian Country, I would love to know why. If it money, that is one thing. If it is something else, then we want to go the direction to fix it, is what I am saying.

Mr. KEEL. I think, Senator, that the self-governing tribes, you are absolutely right. The nurse practitioners and PAs are pretty much the norm for the self-governing tribes. I think the problem exists in the direct service tribes and it is a lack of funding.

Senator TESTER. Okay. All right.

Senator Johanns, did you have any questions? The reason I do is Jefferson Keel has to leave quicker than the rest. So if you have any questions for him in particular? Okay.

Senator Udall?

STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO

Senator UDALL. So you are suggesting we get our questions out of the way?

Senator TESTER. I don't want to see him leave unscathed.

Senator UDALL. Good, good. Oh, okay, okay.

[Laughter.]

Senator UDALL. Let's see here.

Mr. Vice President Keel, you mentioned Medicaid auto-enrollment and the establishment of an American Indian/Alaska Native category of eligibility as an easement on the Contract Health Service program. As you know, there are very strict criteria for Medicaid eligibility. Do tribal data collection systems currently have the capability for supporting auto-enrollment practices?

Mr. KEEL. Yes, sir, they do. The self-governing tribes are perfectly capable of collecting all the data that is required. They have sophisticated business systems, business models to allow for data collection, auto-enrollment, providing partnerships with all of those agencies to enhance the overall level and quality of care for those patients.

So, yes, sir, they do have the capability.

Senator UDALL. And you state there should be a limit on the amount of funds that the Indian Health Service can use for administrative costs. That way, more money can be used for direct health care services. Would you also support a limit being placed on the amount of funds a tribe can use for administrative costs when it is the tribe that is operating the facility?

Mr. KEEL. I really can't answer that directly because there is such a wide variance across the board with different tribes. Some tribes, for instance, have sophisticated third party collection systems that are required in order to meet the shortfall in funding that is provided by the Indian Health Service. Those collection systems enable us to hire practitioners, provide other services that are

not normally provided by the Indian Health Service in terms of funding.

So providing a limit on those administrative costs is normally offset by those third party collections that the tribes enjoy right now.

Senator UDALL. And you also state that Indian tribes must retain the authority to make decisions regarding whether to provide services to non-IHS eligible beneficiaries. One reason that the tribes may choose to provide services to non-IHS beneficiaries is so they may become a preferred provider organization in a State network.

If a tribe decides to serve non-IHS beneficiaries at its health facility, what protections would need to be in place to ensure that the IHS-eligible patients continue to receive the care they need?

Mr. KEEL. Thank you, Senator. That is a very good question. The only protection that would be needed, the only legislative fix would be that the Federal tort claims would be extended to cover the liability of the tribe providing those non-beneficiaries. The tribal leaders will guarantee that their citizens are provided the highest quality of care that is available.

Senator UDALL. Thank you.

Thank you, Chairman Tester.

Senator TESTER. Absolutely.

Senator UDALL. Doesn't that sound great?

Senator TESTER. I don't know. We will have to talk to Chairman Dorgan about that.

[Laughter.]

Senator TESTER. Mr. Rolin, you stated that the Indian Health Care Improvement Act should be made permanent. This is a change. And you mentioned some of the ones that were permanent, the Indian Self-Determination Act, Snyder and some others. Can you give me some insight into why the change and is this a new position of the tribes, too?

Mr. ROLIN. Well, as I said in the testimony, for years now we have been trying to get the Indian Health Care Improvement Act reauthorized, some 10 years.

Senator TESTER. Yes.

Mr. ROLIN. As you have heard. We just feel like it is time now to make this reauthorization a permanent part of health care for our Indian people. I gave you some examples that we have already. We just believe with tribes that are now going into self-governance or contracting or compacting, we have found that working with the local health providers in our communities and adjoining cities that we can provide and make better use of that dollar that is available to us, and as Mr. Keel said, provide some additional services here, and that is what we are all looking for, is better use of that dollar.

Senator TESTER. Okay.

Mr. Roth, you demonstrate a need for funding authorities for urban Indian data collection. The Committee has demonstrated strong support for strong information technology. What kind of information technology systems do urban programs currently operate, if any?

Mr. ROTH. Good question. Well, it is kind of a patchwork system right now. The programs have been highly encouraged by IHS as of the last couple of years to move to the RPMS system which is

difficult for our programs because it doesn't have a real strong third party billing application to it. It takes a lot of maneuvering and then programming support in order to get the system working.

But other than that, our organizations tend to buy off-the-shelf software packages, and many times end up having to hire individuals to do data input in two different systems in order to keep reporting with the RPMS system and the other system that actually works for their program.

So there needs to be some reform and a uniform system across the board.

Senator TESTER. Okay. Are there specific areas where data collection is particularly difficult?

Mr. ROTH. Are you talking about geographic areas?

Senator TESTER. I mean, it wasn't geographic. I was thinking more of just areas where you try to get information from the folks and you can't get it, or from the medical professionals, too, as far as it goes.

Mr. ROTH. Yes. I would say that data is a really difficult issue, especially for us as a system, an urban Indian health system, and I believe the entire ITU system. The Indian Health Services seems to be a bit fragmented in the way that it is administered right now through the areas. And I don't know how good the accountability is back to headquarters and the ability to bring data together. So that is one area that we have had difficulty in getting data from.

Senator TESTER. Okay.

Ms. Davidson, you stated that the Alaska Native Medical Center is a level two trauma center in Alaska. It is tribally operated. Does it serve any non-IHS beneficiaries?

Ms. DAVIDSON. We primarily serve IHS beneficiaries, but we do have authorization to serve some non-IHS beneficiaries who are Public Health Service employees.

Senator TESTER. Are there protections against malpractice claims?

Ms. DAVIDSON. Yes, there are. Those services are covered under Federal Tort Claims Act. One of the things that it is really important for the Committee to understand is that over the last Administration, sometimes there are protections in the law that have been construed very, very narrowly by the previous Administration, and that sometimes those terms were constrained a little bit too narrowly. For example, with FTCA coverage, so long as a service and activity is adequately described in your resolution, your tribe's resolution, with applicability to non-IHS beneficiaries, FTCA coverage applies.

The challenge we have is sometimes we have to go to incredible steps to get the Department of Justice to overcome that determination.

I do want to revisit one of the questions you asked earlier about data.

Senator TESTER. Yes?

Ms. DAVIDSON. Quite honestly, our capabilities to be able to access that data really vary depending on where you go. And the simple reason for that is because there are not sufficient funds for health information technology enhancements.

For example, some folks are able to use RPMS, but right now with RPMS the only way to be able to get it to work effectively is it has to be so customized to each service unit that any upgrades that happen, tribes and tribal organizations really have to spend a lot of money to be able to make it work, to be able to fix those patches.

The other piece is that, for example, the recent funds that came through ARRA for health information technology, zero of those funds went through self-governance tribes or urban Indian programs. And so to the extent that tribes should have the opportunity to get their health information technology funds met, we should be clear that that opportunity should be available through ONC.

The other piece is that normally what pays for health information technology systems is contract support costs. So the simple answer is we have that capability to the extent that we are able to use contract support cost dollars to fund that.

Senator TESTER. Okay.

Mr. Carlton, I especially appreciate your perspective that talked about meeting people on their home turf instead of making them come to you. Can tribes purchase the mobile units at this point in time? Are they available?

Dr. CARLTON. Yes, sir, they are available. The mobile units are literally used in the VA system right now for operating room renovation. University of Virginia just finished a four year contact. So the key is not the equipment. The key is the staffing. And the Indian Health Service's chief problem is they end up needing a .1 or a .2 full-time equivalent staff. This solves that problem by serving multiple areas.

Senator TESTER. Got you.

I am going to turn it over to Senator Barrasso, the Ranking Member, to take the hearing from here.

STATEMENT OF HON. JOHN BARRASSO,
U.S. SENATOR FROM WYOMING

Senator BARRASSO. [Presiding.] Thank you very much, Mr. Chairman.

And I want to thank all of you for being here today. This is a very important hearing, as the health care debate continues nationwide. It is timely, Mr. Chairman, that we hear from Indian Country today.

Recently, I had a meeting in Riverton, Wyoming on this very issue. I also met on the Wind River Reservation with the Joint Business Council of the Eastern Shoshone and the Northern Arapaho Tribes. The Wind River community was generous to meet with me and my staff to share their concerns and their priorities for health care reform, prevention, accountability, increasing access to care. They really were among the most important issues that we raised.

And Mr. Chairman, I also want to, while you are still here, thank Senator Dorgan, as well as the capable staff from the majority, Allison and John, who attended the meeting in Wyoming. They fully participated in the meeting and their input was significant and very much welcome.

There is significant support, of course, for reauthorizing the Indian Health Care Improvement Act. There is also recognition that we must do more than simply reauthorize a troubled, inefficient system. That is why I was so pleased that Senator Dorgan and I have been able to work together and that Senator Dorgan has agreed that we begin a path to reform. I expect a significant amount of work is going to be done this summer. The Committee operates in a very bipartisan manner. We roll up our sleeves. We work together. Our work is going to require outreach to our tribal friends to help with refining health policy.

We need to act in a quick way, as well as a cooperative way so that Indian Country does not get left behind in the nationwide health care reform effort.

And I would like to say that Senator Murkowski has not been able to be here today. She has asked me to express her regret for not being able to join us. She is wrapping up amendments in both the Energy Committee, as well as the Appropriations Committee. But Ms. Davidson, she specifically wanted me to welcome you with the Alaska Native Tribal Health Consortium, to welcome you to the Committee. And I know that she is going to be very interested in reading all of your testimony and the answers to your questions. So thank you so much for traveling such a great distance.

And with that, I would like to turn it over to Senator Johanns, who has some questions. Thank you.

STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Well, let me thank each of you for being here today. It is a very important topic.

Let me, if I could, start with Mr. Roth, a couple of questions on IHS-funded urban Indian clinics. I think you mentioned in your testimony, or mentioned that 36 member urban Indian clinics serve about 150,000 American Indian/Alaska Natives. Congress has gone on record, as you know, in support of the trust responsibility to Indian people no matter where they reside. Of the 36 member clinics, do you know how many utilize IHS eligibility regulations to determine who receives services?

Mr. ROTH. They all do. It is part of their contract with their areas and IHS. So all of the programs adhere to their contracts. Now, some of our programs are dual-funded, so they are also funded by other sources of funding, so they provide services to other non-Indian individuals as well, but all the programs adhere to those.

Senator JOHANNS. Okay. What other eligibility standards, then, would they use in addition or in place of IHS? Are there any that you are aware of?

Mr. ROTH. Well, I believe it is seven of the programs are dual-funded urban Indian programs and community health center programs. So they are funded, 330-funded programs. They would use the 330 funding formula for eligibility of non-native individuals to provide services to them.

Senator JOHANNS. Okay. Something you said in your testimony, I must admit, kind of lit up the light bulb, if you will. I think you were talking about health care reform and the potential that a Fed-

eral mandate might have on already existing Federal obligations in Indian Country. Can you talk me through that a little more extensively, your concerns there?

Mr. ROTH. Was that in relations to the trust responsibility?

Senator JOHANNS. Yes.

Mr. ROTH. At the beginning? Yes. The trust responsibility, we believe and I believe, that it extends to all Native Americans in this Country no matter where they live. And there is a Federal obligation at that point to provide health care services to all Indian people.

The Federal Government isn't doing that right now. There are cities where Indian people live where they cannot access services that are provided by Indian Health Services or services that are free of charge.

So that is what I was intending to get across there, and I hope that that did.

Senator JOHANNS. Okay. Great. That clarifies it.

Chairman Rolin, if I could ask you a question, and actually this was not in your testimony. This was in Jefferson Keel's testimony, but I am hoping you will have some thoughts on this.

He had a section in his testimony relative to service to non-Indians out of Indian health care facilities. And he basically, at the risk of paraphrasing his position, he said, look, we need to continue to reserve the power to decide whether we will provide those services or not. Again, the light bulb kind of came on. In our State, we have reservations that are in parts of the State that aren't very populated. And I can think on one reservation that I visited, they had a dialysis facility there, very much utilized, providing a very necessary service there in Indian Country.

And then it occurred to me as I was reading that testimony, gosh, I wonder where the next dialysis equipment is at. It could be 150 miles away.

Talk me through this whole issue about making that available to non-Indians and what concerns you might have about that, if you would.

Mr. ROLIN. Well, the issue before us, sir, is in most cases, our Indian tribes, there is just not enough resources to provide the services that we had hoped to provide to our own people. However, in different areas, the situations are quite different. And as far as Indian tribes are scattered throughout the Nation, in my area, I live in South Alabama, I have access to the city of Mobile, Alabama; the city of Pensacola, Florida. We are in a general area right on the Alabama line there. Working within the community that I live, we utilize, you mentioned dialysis, we utilize the system that is within our county because that one particular area that you mentioned there in Dallas is so expensive. And we have been able to provide services for our people by referring them to that facility, which is utilized by all of the people that live within the area.

As far as tribes, again, that is a new aspect of whether tribes want to move in to providing services to the community. It is certainly an opportunity for them to have some additional resources and income. But most of the time, the problems that we have on our reservations is that we just, the facilities that we have we can barely provide care, something like maybe 50 percent at the most,

to our people. And when you start providing these services beyond that, it really takes a way from the needs of your community.

Senator JOHANNS. So it is more of a resource issue and a what you have got.

Mr. ROLIN. It is indeed, sir, resources.

Senator JOHANNS. Okay. That helps me understand that because, again, if we could somehow solve these problems, that may be a resource for that area and provides, I am sure, necessary revenue for the facility.

Let me, if I might, turn to Valerie Davidson. I had a couple of questions for you, and I hope I am asking the right person.

I come from a State, the State of Nebraska, where we have everything from very urban areas, Omaha, Lincoln, Kearney, Grand Island, I could name other communities, to very, very rural areas. One of the things that we have been working to put in place quite successfully is telemedicine. And we have found real advantages not only in delivering mental health services like counseling, but diagnostic services and that sort of thing.

How much telemedicine is available in Indian Country, or maybe even more specifically, in your State? Has that been something we have been able to move down the field a little bit?

Ms. DAVIDSON. I think the availability of telemedicine in Indian Country is really varied. It is like many of the things we have talked about. In Alaska, we are fortunate that we do have telemedicine in many of our communities.

One of the things that telemedicine has been able to allow us to do is to be able to extend the reach of the provider. In many of our villages, in Alaska we have a four-tier health care delivery system, where about half of the patient encounters occur in a small village community, average population of about 350 people. And they get their care from a community health aide. That is where I got most of the health care during my entire childhood.

And one of the great things about having a person who is from that community, who speaks the language, who knows who you are, and quite frankly knows all of the things you are or your should or should not be doing as a child, it is amazing how much those folks know about you, and can set you in the right direction.

Having that relationship with that person at the community level is what we have found, along with interactions with small children, really helps to be able to shape health care decisions, and also be able to focus on wellness and prevention.

Now, what telemedicine brings to the equation, though, is if it is service that is beyond that person's training or capability, then for them to be able to be hooked up to a telemedicine machine to be able to have that conversation with a doctor or a psychiatrist or a dentist or another person in another community, that also extends their ability to provide care.

In other parts of the Country, however, telemedicine really isn't utilized at all, and there is a tremendous opportunity to make those services available.

The other piece besides just having the equipment available, and we have Alaska Federal Health Care Access Network has a great telemedicine cart that is available that we have developed over time. But in addition to the hardware, the other piece that is a

really critical piece is having the available band width to be able to provide that service.

And the USAC, the Universal Services Administrative Companies, subsidies to be able to provide decent band width to rural communities, including tribal communities, is critical because tribe simply can't afford a $13,000 a month T1 line, whereas USAC comes in, pays the difference, and it will cost about $1,000 a month.

Senator JOHANNS. Has the stimulus package helped any in that area? I know there was some money identified in the stimulus package to try to get broadband into more rural areas. Is that impacting this at all?

Ms. DAVIDSON. I believe it has the opportunity to provide impact, but I am not sure that the rules are actually out for how tribes can actually access that. And I appreciate the question today so much because things are moving so quickly that sometimes tribes aren't necessarily aware of some of the issues and opportunities that are available. So to the extent that this Committee can do its part to make sure that as services or opportunities are available for any other health care provider, for individual, if you can help to make sure that tribes are included in that mix, that will help tremendously.

I did mention earlier that we were concerned that the Health Information Technology Funds that were made available to the Indian Health Service, we were hoping that some of those resources would be available to self-governance tribes, as well as to urban Indian programs, to be able to meet that unmet need. And unfortunately, that did not happen.

So any opportunity, we should be careful that sometimes when we are making funds available to the Indian Health Service, it is important to keep in mind not only direct service programs, but all three, not only direct service, but also self-governance, tribally operated programs, as well as the Urban Indian Centers, because it takes all three working together to be able to meet the need of individual American Indians and Alaska Natives.

Senator JOHANNS. Those are really excellent points. Sometimes I think that part of our challenge is just getting everybody on the same page, and making sure that the funding that we are providing really gets to helping people, if you know what I am saying. Not to indict anybody, that is not what I am suggesting. It is just, gosh, this seems terribly complicated to me sometimes.

Ms. DAVIDSON. On that point, if I may? There has been a lot of talk about how the Indian health system is broken, et cetera. And there was a point that was made earlier, I think by Jefferson, that we are not broken. We are starved. And I don't know any other health care delivery system who could continue to operate year after year after year with the level of funding at about 54 percent.

And if you are looking at making investments in health care reform, and making investments in the right place, I would challenge this Committee to look for any other health care delivery system in this Country that has shown that it can do more with less. Quite frankly, we have been innovative because we have been forced to. We live in these communities. We don't have that option.

And this Committee could do so much in health care reform by remembering the impact that it has on individual American Indians and Alaska Natives. So if there is a health benefit that is available, make sure that Indians are expressly eligible. If there is an opportunity for health providers to be able to get additional reimbursement or additional considerations, make sure that the Indian health system, whether it is an IHS facility, direct operated; whether it is tribally operated; or whether it is an Urban Indian Center, also has that express authority.

And then finally, because tribes are, like many areas, we are employers. If there are any opportunities that are available for employer health plans, for us to be able to get some tax benefits just like any other employer, please also remember to expressly include tribes.

Unfortunately, our experience has shown that unless that express authority is there, we encounter resistance after resistance after resistance. And often what we hear is, well, if Congress intended that to happen, Congress would have provided express authority. And so therefore, we are asking the Committee that if there is any opportunity to provide that express authority, please do so, because otherwise we may just be left out of the mix.

Senator JOHANNS. Okay.

Dr. Carlton, I will wrap up my questions with you.

I was reading your testimony and I have to admit I was just amazed by what you were laying out there in terms of the capacity to put something up quickly, that gets the job done. Let me zero in, if I might, a little more on cost. Give me just a rough idea of how what you are suggesting with this kind of facility, compares with ground-up sort of construction, that sort of thing. What are the cost differentials here? Is there a rule of thumb?

Dr. CARLTON. Well, when we talk cost differentials, you break it down into housing, commercial buildings, and then the highest end is medical, and the most expensive. So standard housing construction generally $100 to $150 per square foot; commercial buildings, $150 to $250; and unfortunately medical has gone skyrocketing. The Air Force planned to reconstruct their medical facilities in San Antonio at $400 a square foot. By the time the bill was passed, it was $600 a square foot, and in many areas of our Country, it is $1,000 a square foot today.

So what we are talking about is we are talking about critical access hospital for $14 million is you have minimized the space so that the staff is more effective. And so what used to take 50,000 feet and the staff having to walk twice as far, now can be done in 33,000 feet, and the staff is more effective.

So it is an efficiency model, but when you come down and say, well, how big a hospital do you need? The critical access is defined as it can't be bigger than 25 beds, but the reality is that most of them are running five and six-bed censuses, because their world has changed. We have changed to an outpatient environment for surgery.

So when we have an example, and I included the Tehachapi example specifically for you, that was bid in a component fashion for $25 million and construction ready to start. An outside consultant

came in and said, oh, we don't do component in the medical world. You need to go to site-built, stick-built, $67 million.

Now, at some point, fiscal reality has to come to our Nation. And I am not sure it has in the medical world. Now, that $14.5 million isn't $14.5 million. It is $14.5 million with a full lab, with a full x-ray, fully equipped nurses station, beds and an electronic medical record.

So it is not exactly an apple to an apple. And so we have to be careful as we talk about even Tehachapi. Tehachapi at $25 million was 50,000 square feet, $500 a square foot. And at $67 million, it is 60,000 square feet because they wanted more administrative area.

Well, if you keep it under the same roof under California directives, you have to then built to the highest standard. Where if you separate by seven feet, you can build an administrative area at a lower standard, which is what the component builders had done.

So it is a complicated issue, but for rural States like yours, to be able to replace a rural hospital that then has an electronic medical record, and the other piece of this, we are talking facilities and I am talking equipment and facilities with you, but you have to have people, equipment, facilities, training and organization all at the same time.

What we are trying to do in Texas is tie this on the people side into the university. The biggest problem we have in rural Texas is getting people to go. So the nurse, the physician won't go because they are all by themselves.

Well, if we tie them to a central location so that if they train in our training program, they never leave the boss. They can always call back. They can present the cases. It is part of the deal.

And the Congress has made that available. That is a pass-through under this critical access, but we are not doing it because that is not the way we do things. So the potential is remarkable.

Senator JOHANNS. I agree with you based on what I know. Like I said, as I was reading through your testimony, I just was amazed by what you were laying out there. The challenge, I think, for us today with this hearing is how to interface the knowledge you have and the experience, with what we are trying to do out there. Because you are absolutely right, with budget issues and everything else going on, we have to bring reality to this.

So I would encourage you to continue somehow to interface with Committee Members, but then also with your Senate delegation back home because oftentimes they will come to a meeting where we are all together, and say, hey, I have a good idea, and that is another way of keeping you in the loop, because I do think there are some things here that we can use.

I will wrap up there, and I just and I just want to say to all the panelists again thank you so very much for being here today.

Senator BARRASSO. Thank you, Senator Johanns.

Just following up on what you were asking Mr. Carlton, I am also very interested in what you are doing with these mobile clinics and then the way you can do this, because in limited health resources and big distances, I think it would be really the answer for the future.

I was going to ask, have you engaged other Federal agencies on the use of this kind of activity with mobile units and the component construction? What have you found? Has there been any difficulty moving forward in a big government bureaucracy?

Dr. CARLTON. Senator, as a physician, we understand change is difficult for all of us. In a governmental setting, change is difficult for all of us.

I am the architect of the Iraq War plan, laid it out in 1983 on the medical side. It took 20 years to implement because it wasn't the way we do business.

Far forward, surgery critical care, the air, and integrated delivery system, right now, our centers in San Antonio, we have two level one trauma centers are two standard deviations above the mean for survival on identically injured patients. And you say, why? It is because we have a standardized protocol. We do things the same way.

We may deviate from that and explain it just like a pilot in command, but our charter now I believe as military members or former military members is to share that with our community and bring the standard deviation up on the civilian side. If we are running two standard deviations above, it means that we are in a 97 percentile. We are doing something right.

And we need to come talk to the Senate, and we need to say, well, here is what we have done in Iraq. We are doing better for the severely injured in Iraq across a system of 8,000 miles than we are in rural Nebraska. Well, there is something wrong with that.

And so, with the Mayo Clinic and Texas A&M, we have now started a program to say, okay, let's integrate the lessons learned. Maybe we even need different types of surgeons. Maybe a general surgeon, maybe a general orthopedic surgeon shouldn't do everything, but we should all teach them salvage surgery, how to get a survivor in the first 12 hours, knowing that your partner will be behind you six hours later, connected by a transportation system. For the Indian Health Service, the same thing.

So the challenge before us now is how do we standardize construction in a cost-effective manner, delivery of health care in a cost-effective manner, and the lessons learned in wartime how can we quickly bring them to the United States of America. And I think rural America, you two gentlemen, are the perfect examples of how we might be able to show that, and then integrate that.

I mean, I am very excited about it. But it is a 20-year program, and so we could be a two-year program into the civilian world. We just have to figure out how to properly reward it.

Senator BARRASSO. So then specifically with regard to the Indian Health Service, obviously there is huge value there. Are there bureaucratic barriers? Or how do we get this accomplished in a timely manner?

Dr. CARLTON. Our Government has bureaucratic barriers. I presented this in 2003. The Surgeon General was a very good friend, Rich Carmona. And he said, you have to bring this to our architects, this component construction. It was a solid turn-down, no, we are not going to do that. No, thank you.

And that is okay. We had to prove it. Now, we have proven on the inpatient side, on the outpatient side, and oh, by the way, we

can then connect them all with a mobile system and a telemedicine system, and an electronic medical system, and do a much better job than we are doing today.

That is not to say we haven't done a good job in the past. We can just do better.

Senator BARRASSO. Okay.

For the other panelists, usually you come to these hearings, you testify, and then you say, I just wish I had said this one other thing. And I would just go down, Ms. Davidson and Mr. Roth and Mr. Rolin, if there are any last things that you would like to share with the panel, the Committee, as part of the formal record, I would love to hear what you have to say now.

Ms. DAVIDSON. I just want to go back to a statement that we made earlier that may have gotten lost in the comments, which is that I think time and time again, we have shown that we are a good investment, that we do every year more with less. But you also need to know that we are at a point right now where our resources, we have no more margin. I mean, we don't have it.

And a lot of times when we talk to people about contract support cost, people immediately think contracts, lawyers, litigation, and they completely turn off. But to us, contract support cost is really providing necessary infrastructure. It is about jobs and it is about people.

If we know that we have to use resources to be able to pay rent, to buy insurance, to do all of the things that are required, but those resources aren't available, then what happens is that instead of being able to provide as many direct services as we could, what happens is that we necessarily, because we have to do all those other things, all the infrastructure that it takes to be able to operate, those come from the service that we would be able to provide.

So contract support cost is more than just about infrastructure because when we don't fund infrastructure, we have to take that money from direct services and from services that we otherwise would be able to provide, things like dental services, things like long-term care services, things like behavioral health services, residential treatment services. Those are things that we just don't have the resources to provide. And contract support costs lack of funding means that there are even fewer resources that are available.

So thank you.

Senator BARRASSO. Thank you.

Mr. Roth?

Mr. ROTH. Yes, I realized about 10 minutes after Senator Tester asked me my question that I answered it incorrectly.

Senator BARRASSO. Go right ahead.

Mr. ROTH. So I would like to highlight a little bit more about data and the need for really doing a comprehensive review in this Country on where urban Indian people live and how or if they are accessing services. We know that there is a lot of migration between reservation and urban communities, and we know there is a great deal of need in communities that don't have urban Indian health programs now.

I was recently in Riverton as well, and was able to tour the 330 clinic that the tribe has started up in Wyoming. And that is a great example of a tribe that has come in and has decided that they are

going to deal with the urban Indian population there by providing services because the access or the funding didn't exist within Title 5 of the Indian Health Care Improvement Act to do that and to expand services to that. So I applaud the tribe there and I applaud Riverton for being able to do that.

What we really need is a needs assessment to get an accurate picture of what the population looks like and examine systemic issues related to delivery of health care to urban Indians, facilities, buildings, issues and workforce development issues.

Thank you.

Senator BARRASSO. Thank you for the clarification. Thank you.

Mr. Rolin?

Mr. ROLIN. Thank you.

Well, as you have heard from all of us here in our comments, there is a need in Indian Country. I want to first make that known for the record. We have all done well at some point, and we have this and utilize the services and have the services that we do. We really utilize those resources to the very end. And it is important for us as Indian people to provide health care to our tribal members. In certain areas we have talked about, certainly providing that service has not been the hardship as it has other areas. And that is our concern, is to be able to bring health care up to the level.

Earlier years when Dr. Everett Rhoades was Chair, I mean Director of the Indian Health Service, he used an example of getting us to a level. At that time, he said if we could get to 70 percent. Well, we haven't been able to get there, Senator, and that is a goal that we are all working on.

And if we could get to that level and go beyond that level, certainly by meeting the needs of our people, certainly that would benefit us all, and we would be a much happier community.

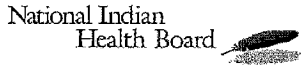
Senator BARRASSO. Well, I want to thank all of you for coming to testify. We will keep the record open for two weeks if there is some additional information you would like to supply us. We may supply you with some additional written questions.

But I want to thank everyone who has come here to participate and to listen.

And with that, this hearing is adjourned.

[Whereupon, at 3:57 p.m., the Committee was adjourned.]

A P P E N D I X



HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

EXECUTIVE SUMMARY

Tribal leaders concur with Chairman Baucus's proposal to augment funding for the Indian health system, and concur with his observation that "IHS desperately needs additional funding. It is impossible to keep America's promise to provide care to Native Americans and Alaska Natives with the current level of IHS funding."[8]

Indian Country strongly supports health care reform and seeks to ensure that the Indian health care delivery system is strengthened and improved so that Indian people and Indian health programs benefit from reformed systems.

Some key features of our recommendations include:

- Increasing the number of Indian people enrolled in Medicaid, CHIP and other publicly-funded insurance programs, including using fast track methodologies for Medicaid enrollment.

- Exempt Indian tribes from any employer mandate penalties and individual Indians from individual mandate penalties.

- Innovative ideas for addressing health care workforce shortages in the Indian health system such as pipeline incentive and utilizing alternative provider types.

- Expanding options for delivery of long term care services in Indian Country.

- Support targeted research and best practice benchmarking appropriate to American Indians and Alaska Natives.

- Achieve advancements for the Indian health system by incorporating provisions from legislative proposals to update and modernize the Indian Health Care Improvement Act.

Inquiries for this document may be directed to:

Jennifer Cooper, Legislative Director
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May 31, 2009

[8] Baucus, Senator Max, *Call to Action: Health Reform 2009* (Nov. 12, 2008), at 28.

INTRODUCTION

Foundation of Federal Obligation to Provide Health Care to Native Americans. When Indian tribes ceded certain lands – lands which now constitute the United States –agreements were made with the United States government. Among them was the establishment of a "trust" responsibility for the safety and well-being of Indian peoples in perpetuity. In addition, a number of the treaties specifically outlined the provision of education, nutrition, and health care. Since the creation of the Indian reservation system, and the subsequent federal policy of trying to move Indians to specific urban communities, the United States government has implemented that trust and treaty health care obligation through different forms of what is now the Indian Health Service.

Current Indian Heath Care Delivery Structure. The current system consists of services provided by: the Indian Health Service (IHS) (an agency of the Department of Health and Human Services); programs operated by Indian tribes and tribal organizations (through contractual agreements with IHS); and urban organizations that receive IHS grants and contracts (collectively the "Indian health system" or "I/T/U"). The I/T/U system serves approximately 1.9 million Native people and medical and dental care is delivered through more than 600 health care facilities.

Most beneficiaries served by the Indian health system live on very remote, sparsely-populated reservations and Alaska Native Villages. The Indian health system was designed in large part to reach these beneficiaries, who often have no other options. Even in more populated urban areas, where the Federal government moved Indian people during the 1950s and 60s, the Indian health system provides the most meaningful access as it is the only culturally competent provider and the only provider with a direct Federal-tribal relationship. The incentives in the Indian health system are not financial; its mission is the improvement of the health status of Indian people.

Inadequacies of Current System. Historical inadequate funding is the most substantial impediment to the current Indian health system's effectiveness. A 2008 CBO report on IHS stated that due to "staff shortages, limited facilities, and a capped budget, the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population."[9] IHS expenditures per capita are roughly one-third the amount spent per capita for the general public and one-half the amount spent on federal prisoners.

RECOMMENDATIONS

Set out below are recommended systemic changes that, in concert with increased appropriations, will dramatically improve health care delivery for American Indians and Alaska Natives (AI/ANs).

Personal Responsibility Coverage Requirement (Individual Mandate)

Indian tribes do not object to the requirement that all Americans acquire a minimum level of health insurance, but would object to imposition of a penalty on an Indian individual who fails to obtain such insurance. The United States has a trust responsibility to provide health care to Indian people without cost, so assessment of any penalty for failing to acquire health insurance would violate this Federal responsibility.

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[9] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals,* at 127 (Dec. 2008).

Subsidies

1. IHS is not creditable coverage. Indian people should not be barred from qualifying for subsidies due to their eligibility for care from the Indian health delivery system. The Indian health system should not count as creditable coverage for two reasons: (i) it is not a health insurance program; and (ii) the Indian health system is unable to provide a consistent, comprehensive package of health benefits to its beneficiaries.

2. Insurance subsidies. To the extent tribal governments provide health insurance for their employees or members who would be eligible for premium subsidies, the subsidies should be made available to the tribal government to offset the cost of acquiring coverage that should be available to Indian people without cost.
   - This same support should also be extended to tribal organizations carrying out programs under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act, as well as urban Indian organizations.

3. Apply Federal law protections. The protections afforded to Indians regarding their participation in Medicaid should apply to their participation in any health insurance plan:
   - Indians should be exempted from all cost-sharing (including premiums, co-pays and deductibles), consistent with the recent amendment to the Social Security Act which exempts Indians from cost-sharing under Medicaid.
     - If the law nonetheless requires that Indians pay premiums, Indian health delivery system (I/T/Us) must have the authority to pay the premiums on behalf of their beneficiaries and administrative barriers to doing so must be removed.
   - Individual Indian income from Federally-protected sources must be excluded from the calculation of an individual AI/AN's income for purposes of determining eligibility for a subsidy. See, e.g., 25 USC §§1407, 1408; 43 USC §1626.
   - AI/ANs must not be subject to any restriction on selection of a provider. They must be permitted to obtain care from their IHS, tribal, or urban Indian organization program without any financial or other penalty. See recent amendment to Sec. 1932(h)(1) of the Social Security Act to permit an Indian enrolled in Medicaid to select an Indian health care provider as a primary care provider. Pub. L. 111-5, Sec. 5006(d) (Feb. 17, 2009).
   - A special enrollment period should apply to Indian beneficiaries in order to maximize opportunities for enrollment.

4. Allow integration of traditional health practices. Assure that prevention and wellness programs are covered services in all public programs (Medicare, Medicaid and CHIP). To the extent an Indian health program integrates traditional health care practices into its prevention/wellness programs, it should be permitted to do so with no adverse impact on its ability to receive federal support for prevention and wellness programs.

5. Outreach in Indian communities. Expressly designate Indian health delivery system as a location for outreach and enrollment activities for public programs.

Employer Mandate

Indian tribes, as employers, should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. As sovereign governments, tribes must be permitted to determine for themselves the extent to which they can/will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so.

Medicaid and CHIP Expansion

1. Medicaid income eligibility. Medicaid eligibility should be expanded to 150% of the Federal poverty level, and should be expanded to make childless adults eligible.

2. Cost-sharing exemption. All expansions of Medicaid and CHIP (including any waiver or demonstration programs) must expressly exempt AI/ANs served by the I/T/U system from any form of cost-sharing pursuant to the recent amendment to Title XIX made by Sec. 5006(a) of Pub.L. 111-5 (Feb. 17, 2009).

3. Out of state Medicaid applicability. Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools.
   - This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such a patient who travels out of state in order to receive culturally competent care at an Indian health facility, including care related to behavioral health needs and substance abuse treatment.

4. Outreach and enrollment. Aggressive mechanisms are needed to increase enrollment of eligible Indians in Medicaid and CHIP. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of Medicaid and CHIP eligibility, but Indians are under-enrolled in these programs.
   - States should be authorized to rely on a finding of eligibility for Medicaid and CHIP made by an I/T/U to the same extent as they would rely on such a finding by an Express Lane agency (as defined in Sec. 203 of CHIPRA).
   - Indian health providers should be permitted to apply fast-track enrollment methods and to participate as Express Lane or other Medicaid enrollment simplification network entities.
   - States must be required to demonstrate they have employed effective outreach and enrollment activities on/near Indian reservations and in off-reservation Indian communities, with penalties attaching for failure to do so.
   - Tribal governments should be authorized as portals for accepting Medicaid applications.

Health Insurance Exchange

1. All insurance plans admitted to a health insurance exchange (including any public option) should be subject to the protections for Indian beneficiaries and Indian health system providers recently applied to Medicaid managed care programs by Sec. 5006 of Pub.L. 111-5 (Feb. 19, 2009). These include:
   - Assurance that an Indian enrolled in a plan in the exchange is permitted to obtain care from his/her Indian health program without any financial or other penalty.
   - A requirement that provider networks includes sufficient Indian health care providers to assure access for Indians.
   - A requirement that I/T/U providers be paid (whether or not enrolled in the network) at a rate negotiated with the I/T/U, or if no rate is negotiated, at the rate paid to a non-Indian network provider.
   - A requirement for prompt payment to an I/T/U provider.

2. The legislation should include a requirement that the Secretary establish terms for I/T/U participation in provider networks that take into account their unique treatment under Federal laws that apply to the Indian health delivery system such as the Federal Tort Claims Act.
   - This recommendation builds on lessons learned during implementation of the Medicare Part D drug program where it was necessary for CMS to require specific terms for pharmacy contracts in order to assure participation opportunities for I/T/U pharmacies.

3. Outreach and enrollment. Aggressive mechanisms are needed to assure that Indians eligible for insurance subsidies can quickly obtain subsidy determinations. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of people who will be eligible for a subsidy. Experience demonstrates that Indians are under-enrolled in Medicaid and CHIP; thus it is expected that aggressive outreach and enrollment efforts will be needed to encourage Indian people to avail themselves of premium subsidies for which they are eligible.
   - Insurance plans for which subsidies are available should be authorized to rely on a finding of subsidy eligibility made by an I/T/U to the same extent as means-tested programs rely on eligibility findings by Express Lane agencies (as defined in Sec. 203 of CHIPRA).
   - Indian health providers should be permitted to apply expedited mechanisms (similar to fast track processes in Medicaid) to subsidy determination
   - Authorize Tribal governments to serve as portals for accepting insurance subsidy applications.

Other Safeguards Needed for Indian Health System

1. Health care workforce. Indian health programs already have difficulty recruiting and retaining needed health care professionals, and competition for health care workforce personnel will intensify as millions of individuals enter the ranks of the insured. The Indian Health Service budget must be enhanced to assure that Indian programs can attract and retain health care personnel.
   - The legislation should enhance funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs.
   - Mechanisms for assignment of National Health Service Corps personnel should be revised to facilitate participation by Indian health programs and enable these programs to access NHSC personnel on the basis of their Indian service population.
   - Expand funding to train and support alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aide therapists.
   - Include the Indian health delivery system as a key focus area in the coordinated national strategy to address health care workforce shortages.

2. Medicare amendments.
   - The Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services. At present, the system for making Medicare reimbursements to IHS and tribally-operated facilities provides payment at only 80%, as Medicare presumes a 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. Because of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes Medicare by paying the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would infuse over $40 million more into the Indian health system annually, funds that would be used to reduce health status disparities.
   - Remove from Section 1880 of the Social Security Act the sunset date (December 31, 2009) applicable to IHS and tribal program authority to receive payment for certain Medicare covered items and services.

3. Research. Reform legislation must support targeted research and best practice benchmarking appropriate to AI/ANs. Best practices in prevention and treatment must be grounded in evidence-informed study on the actual population involved.
   - Any Federally-funded population survey or collection of data to establish best practices, or benchmarking must ensure that AI/ANs are over-sampled to be able to generate statistically reliable estimates.
   - Conduct a comprehensive national health needs assessment for off-reservation Indian communities to measure undocumented need.
   - Funding should be provided to I/T/Us to create and maintain comprehensive data collection systems.

4. Health information technology. HIT improvements must reach all Indian health providers. The remote location of many I/T/U facilities and complex relationships with IHS lead to wide disparities in health technology capabilities. Explicit policies are needed to assure that all Indian health providers receive an equitable distribution of resources for improving health information technology and that Indian health providers are not penalized for lack of information technology.
   - Supply funding to develop and implement a system for monitoring and measuring the needs of the Indian health system to assure that budgetary resources are sufficient to support the level of need throughout the system.
   - The Secretary of HHS should be required to conduct a feasibility study to determine how the Indian health system can efficiently integrate smart card technology through which a patient's medical history can be stored on a portable microchip pocket card.

5. Payor of Last Resort. Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort.

6. Facilities. The quality and capacity of facilities throughout the Indian health system differ widely as the IHS construction budget has never kept up with the level of need. Thus, tribes need the authority to explore innovative ideas for addressing facility needs and the flexibility to utilize existing facilities fully and efficiently. Proposals follow:
   - Establish a loan program through which Indian tribes can borrow funds to construct health care facilities.
   - Enact incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.
   - Facilitate tribal authority to decide whether to serve non-Indians at their health facilities. The demand for health services will greatly increase in a reformed health care environment and tribes are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. This is a challenging decision that requires consideration of capacity and resources and whether adding users will improve the breadth of services that can be offered or would diminish an already limited capacity. To support tribes who are willing to expand accessibility to health care by serving non-Indians, the legislation must –
     - Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers which receive funding from HRSA under Sec. 330 of the Public Health Service Act.)
     - Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.

Long-Term Care Services and Support in Indian Country

1. Federal support. Grant funding and federal support should be made available to assist tribes and tribal organizations to develop the full range of long-term care services needed to meet their community needs, with an emphasis on culturally appropriate home and community based services, including care management services that will delay or prevent the need for nursing home care. Specifically, Indian tribes must be expressly included as entities eligible for long-term care grant programs, including: the Community Choice Act Demonstration Project, Real Choice Systems Change Grant Initiative, Aging and Disability Resource Centers (ADRC), Informal Caregivers and Green House Model.

2. State support. State Medicaid programs should be required to enter into agreements with IHS and tribal health programs under which reimbursement would be made for the range of long term care services tribal programs are able to offer, and assure covered services include care management and home health care.

Other Matters

1. Tribal involvement. Include Tribal representation on key commissions, boards and other groups created by health reform legislation, and direct the Secretary of HHS to consult with Tribes on health reform policies and regulations. Only by engaging knowledgeable Tribal leaders before policy approaches are evaluated, refined and implemented can health reform promise to improve the Indian health system and the health status of AI/ANs.

- Tribal organizations (as defined in the ISDEAA) which operate health programs should be included in the consultation, as they are created by tribal governments expressly to perform health care delivery.
- Consultation should occur throughout Indian Country, as Indian cultures, tribal resources and health system structures differ greatly.
- The views of Federally-funded programs serving Indian people in urban communities should also be sought.

2. Exclusion of health benefits as income. Indian tribes, as sovereign governments, and the tribal organizations that serve them by providing health services, should have the express authority to pay the costs of providing health insurance coverage to their members and beneficiaries and the value of such coverage should not be considered to be taxable income to the AI/AN. (See Appendix A.)

Indian Health Care Improvement Act Amendments

Legislation to amend and reauthorize the Indian Health Care Improvement Act contains many provisions that would improve the Indian health delivery system and enable it to better perform its mission. Since the IHCIA legislation has not yet achieved enactment, Congress should consider including in Health Care Reform legislation some provision from IHCIA bills, and should make the IHCIA a permanent law of the United States. Recommendations follow.

Provisions from 110th Congress IHCIA reauthorization legislation *(S. 1200 section numbers)*

1. **Sec. 123 – HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.** This demonstration program is intended to address the chronic shortages of health care professionals in the Indian health system.
2. **Sec. 205 – SHARED SERVICES FOR LONG-TERM CARE.** This would authorize IHS and ISDEAA tribes/tribal organizations to operate long-term care programs, and to share staff and facilities.
3. **Sec. 213 – AUTHORITY FOR PROVISION OF OTHER SERVICE.** This provision would expressly authorize IHS and tribes to offer hospice, assisted living, long-term care and home- and community-based care.
4. **Sec. 207 – MAMMOGRAPHY AND OTHER CANCER SCREENING.** This provision updates current law standards for cancer screenings.
5. **Sec. 209 – EPIDEMIOLOGY CENTERS.** This revision to current law would give epi centers access to IHS health data which they need to do their jobs. NOTE: revise text to combine Sec. (e) of S. 1200 and H.R. 1328 (110th Congress bills).
6. **Sec. 222 – LICENSING.** This provision would enable tribal health programs to employ health care professionals licensed in other states just as the IHS is currently able to do. This authority is needed to aid in recruitment and retention of needed professionals.
7. **Sec. 403 – THIRD PARTY COLLECTIONS.** This revised provision would strengthen IHS and tribal program authority to collect reimbursements from 3rd party insurers, and would make the Federal Medical Care Recovery Act applicable to tribal programs.
8. **Sec. 405 – PURCHASING HEALTH CARE COVERAGE.** This would authorize tribes and tribal organizations to use appropriated funds and Medicare/Medicaid revenue to purchase health benefits coverage for beneficiaries.
9. **Sec. 407 – PAYOR OF LAST RESORT.** This provision would codify in law the existing IHS regulation which makes IHS payor of last resort, meaning that all other available sources (e.g., Medicare, Medicaid, private insurance, other) pay for care before IHS appropriated funds are used.
    - To assure such policies are properly implemented, require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (NOTE: Federal law formally recognizes the TTAG and directs the Secretary to maintain this panel within CMS. See Pub.L. 111-5, §5006(e) (Feb. 17, 2009)).
10. **Sec. 509 – FACILITIES PROGRAM FOR URBAN INDIAN ORGANIZATIONS.** Authorize funding for acquisition and construction of facilities for urban Indian organizations, and authorize feasibility study for creation of a loan fund for construction of urban Indian organization facilities.
11. **Sec. 514 – CONFERRING WITH URBAN INDIAN ORGANIZATIONS.** – Authorize the IHS to confer with urban Indian organizations.
12. **Sec. 517 – COMMUNITY HEALTH REPRESENTATIVES.** Authorize grants/contracts to urban Indian organizations to operate Community Health Representatives programs authorized by Sec. 109 of current IHCIA.
13. **Sec. 601 – ELEVATION OF IHS DIRECTOR TO ASSISTANT SECRETARY FOR INDIAN HEALTH.** This provision would revise current law to elevate the position of IHS Director to an Assistant Secretary of HHS.

14. **Sec. 814 – CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS.** This provision would facilitate quality assurance program reviews for IHS, tribal and urban Indian organization programs. [NOTE: The National Tribal Steering Committee recommends minor revisions to the S. 1200 text.]
15. **New Title VII on BEHAVIORAL HEALTH.** This new title broadens the existing law's title VII which focuses only on substance abuse programs. [NOTE: The National Tribal Steering Committee recommends revisions to recognize systems of care treatment for youth and families.]
16. **Bill title II, Sec. 201 – EXPANSION OF MEDICARE, MEDICAID AND CHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS AND URBAN INDIAN PROGRAMS.** This provision would amend the Social Security Act to facilitate access to payments from Medicare, Medicaid and CHIP by IHS, tribal and urban Indian organization programs.
17. **Bill title II, Sec. 209 – ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.** This provision would require HHS to collect on an on-going basis much needed data on Indian enrollment in Medicare, Medicaid and CHIP. Congress and tribal health advocates need such data to design policies to assure proper access to these programs. HHS does not now have a mechanism in place to collect this information.

Other recommendations not contained in 110th Congress IHCIA reauthorization bills:

1. **TAX EXEMPTION FOR IHS SCHOLARSHIPS AND LOANS.** [Sec. 124 from S. 211, 107th Cong.]. Make health profession scholarships and loans from IHS non-taxable to recipients.
2. **ACCESS TO FEDERAL FACILITIES AND FEDERAL SOURCES OF SUPPLY FOR URBAN INDIAN ORGANIZATIONS.** [Sec. 517 from S. 212, 107th Cong.) Authorize the Secretary to permit urban Indian Organizations to access FSS, and to acquire excess and surplus Federal property.
3. **ADDITIONAL PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.** Authorize urban Indian organizations to operate the following types of programs authorized by IHCIA current law: mental health training (per Sec. 209); school health education (per Sec. 215); prevention of tuberculosis (per Sec. 218); and behavioral programs in proposed new IHCIA Title VII (see above): Sec. 701 (behavioral health prevention and treatment services); and Sec. 707(g) (multi-drug abuse program).

APPENDIX A

PROPOSAL TO CLARIFY THE EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBES FROM INCOME

Current Law

Internal Revenue Code ("Code") Section 61 provides that, except as otherwise provided, gross income includes all income from whatever source derived. The U.S. Supreme Court has ruled that Code Section 61 generally includes in-kind benefits and payments to third parties satisfying the obligations of the taxpayer.[10] Treasury Regulation Section 1.61-1(a) states that "gross income" means all income from whatever source derived unless excluded by law.

The Internal Revenue Service ("IRS") and federal courts have consistently held that payments made under legislatively provided social benefit programs for the promotion of general welfare are not includable in the recipient's gross income.[11] Revenue Ruling 76-131, 1976-1 C.B. 16 explicitly lists health as a need that promotes the general welfare. Consistent with this position, in Revenue Ruling 70-341, 1971-2 C.B. 31, the IRS ruled that government provided health care benefits for the elderly, commonly known as Medicare benefits, were nontaxable to recipients. However, in recent non-binding guidance, the IRS has required individuals participating in state-sponsored health-related assistance programs to satisfy a financial means test.[12]

Reasons for Change

A statutory exclusion is needed to clarify that health benefits and health care coverage provided by Indian tribes to their members are not subject to income taxation. The Federal government has a longstanding policy of providing tax-free medical care to Indians. To effect this policy, federal statutes have been enacted stating that a major "goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level"[13] and providing specific authorization for the Indian Health Service, a federal agency that administers funds provided by Congress for the promotion of Indian health care services.[14] However, the federal funds appropriated for Indian Health Service programs have been consistently inadequate to meet even basic health care needs,[15] and Indian tribal governments have been encouraged to use gaming revenues to provide for the health care needs of their members, including through universal coverage programs.[16]

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[10] See Old Colony Trust Co. v. Commissioner, 279 U.S. 429 (1929).

[11] See, e.g., Rev. Rul. 57-102, 1957-1 C.B. 26 (payments to the blind); Private Letter Ruling 200845025 (November 7, 2008) (ruling that payments made by an Indian tribe to elderly tribal members who were displaced by a flood were general welfare payments); Bailey v. Commissioner, 88 T.C. 1293 (1987) (considering whether grants to restore a building façade were excludable from income as general welfare payments).

[12] See e.g., Chief Counsel Advice 200648027 (July 25, 2006).

[13] 25 U.S.C. §1601(b).

[14] 25 U.S.C. §13.

[15] See Overview of Federal Tax Provisions Relating to Native American Tribes and Their Members (JCX-61-08) (stating that "the average funding of an IHS site was found to be 40 percent less than an equivalent average health insurance plan").

[16] See NIGC Bulletin No. 05-1 (Subject: Use of Net Gaming Revenue) (January 18, 2005) (available at http://www.nigc.gov under the "Reading Room" tab and "Bulletins" sub-tab).

Consistent with the Federal government's policy of providing health care services to Indians, the proposal would clarify that health care benefits provided to Indians are not subject to income taxation. It would also encourage Indian tribes to provide such benefits to their members on a non-discriminatory basis.

Description of Proposal

The proposal clarifies that the value of "health services," "health benefits" or "health coverage" received by Indians, whether provided or purchased by the Indian Health Service, either directly or indirectly through grants to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service; or by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or health insurance (or through an arrangement having the effect of accident or health insurance) is excluded from gross income. It also provides for the exclusion from gross income any other benefit or service provided by an Indian tribe that supplements the programs and services provided by the federal government to Indian tribes, or other general welfare benefits or services provided by Indian tribes to their members.

The terms "accident or health insurance" and "personal injuries and sickness" have the same meaning as such terms do in Code Section 104 and, as such, are intended to include preventative health care services.

The term "Indian tribe" is defined in the proposal as any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
The term "tribal organization" follows the definition in the Indian Self-Determination and Education Assistance Act and means the recognized governing body of any Indian tribe (or consortium of Indian tribes) or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization (see 25 U.S.C. 450(*l*)).

The term "Indians" or "Indian" is based on the definition of the term "Indians" or "Indian" under the Indian Health Care Improvement Act (25 U.S.C. 1603(c)). The proposal states that "Indians" or "Indian" means any person who (A) is a member of an Indian tribe, as defined in subsection (b)(2) of this section, (B) (i) irrespective of whether the individual lives on or near a reservation, is a member of tribe, band, or other organized group terminated since 1940 and those recognized now or in the future by the State in which they reside, (ii) is a descendant, in the first or second degree, of any such member, (C) is an Eskimo, Aleut or other Alaska Native, or (D) is considered by the Secretary of the Interior to be an Indian for any purpose.

No inference is intended as to the tax treatment of governmental benefits (including, but not limited to health care benefits not covered under this proposal) provided by Indian tribes to Indians before, on, or after the date of enactment of this section.

Health Benefit Exclusion Language (Internal Revenue Code Section 61)

(a) Gross income does not include

(1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service;

(2) health services, health benefits or other amounts for health care services, including preventive care and treatment of personal injuries or sickness and other health conditions, provided by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or health insurance (or through an arrangement having the effect of accident or health insurance);

(3) the value of health coverage provided or premiums paid by an Indian tribe or tribal organization to or on behalf of an Indian under an accident or health plan (or through an arrangement having the effect of accident or health insurance); or

(4) any other benefit or service provided by an Indian tribe that supplements the programs and services provided by the federal government to Indian tribes or Indians, or other general welfare benefits or services provided by Indian tribes.

(b) Definitions.

(1) The terms "accident or health insurance" and "personal injuries and sickness" shall have the same use and meaning as 26 U.S.C. 104.

(2) The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(3) The term "Indians" or "Indian" means any person who

(A) is a member of an Indian tribe, as defined in subsection (b)(2) of this section,

(B) (i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, (ii) is a descendant, in the first or second degree, of any such member,

(C) is an Eskimo or Aleut or other Alaska Native,

(D) is otherwise eligible for services provided or funded by the Indian Health Service under applicable law, or

(E) is considered by the Secretary of the Interior to be an Indian for any purpose.

(4) The term "tribal organization" means the recognized governing body of any Indian tribe (or consortium of Indian tribes) or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization (see 25 U.S.C. 450b(*l*)).

(c) No inference is intended as to the tax treatment of governmental benefits (including, but not limited to health care benefits not covered under this section) provided by Indian tribes to Indians before, on, or after the date of enactment of this section.

Affiliated Tribes of Northwest Indians
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Northwest Portland Area Indian Health Board
527 S. W. Hall Street, Suite 300
Portland, OR 97201

The Honorable Max Baucus
United States Senate
Finance Committee
Senate Dirkson Building 219
Washington, D.C. 20510

Dear Mr. Chairman:

The Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization, organized under the Indian Self-Determination and Education Assistance Act (P.L. 93-638), to represent the health care interests of forty-three federally recognized Indian Tribes in the states of Idaho, Oregon, and Washington. Affiliated Tribes of Northwest Indians (ATNI) was established in 1953, and represents 53 federally-recognized Tribes in Idaho, Oregon, Washington, southeast Alaska, northern California, and western Montana.

We are transmitting to the Finance Committee our recommendations on how to include and improve the Indian health system in the current health reform proposals that are being discussed by the Administration and Congress. Our recommendations have been organized into a matrix to follow the Finance Committee's three policy option papers issued on April 29th, May 14th, and May 20th, 2009. The matrix is organized by each paper's section/policy proposal and followed by our recommendations for how to address the issues for the Indian health system. Our intent is to make it as easy as possible for the Finance Committee and drafters of the legislation to correlate our recommendation back to the Committee's proposals.

Our recommendations were developed at our "*Northwest Roundtable on Health Care Reform Policy Options for the Indian Health System*," held on June 2-3, 2009 in Portland, Oregon. During our health reform roundtable, Tribal leaders and health directors stressed three overarching policy areas for the Congress and the Administration to be mindful of as they craft legislation to move toward national health reform:

1. ***There is a Special Legal Obligations Involving American Indians***: it is the policy of the nation, in fulfillment of its legal obligation to Indian Tribes, to meet the national goal of providing the highest possible health status to American Indians and Alaska Natives (AI/AN) and to provide existing health services with all resources necessary to affect that policy. Indian Tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. It is unacceptable either legally or pragmatically to distribute funds or program authority to state governments and private insurance companies or HMOs for distribution to Tribes and Indian people. Because of this, Tribes must be consulted with in the development of any health reform legislation and included on any commissions, boards and other groups created by health reform legislation.

1. ***Containing Costs and Improving Quality***: Tribal governments, like the Administration and Congress, support containing costs and improving health quality outcomes. The Indian health system has proven to be a leader at doing more with less, and improving quality outcomes for AI/ANs served by its system. In order to continue to build on this, all Indian health providers must be able to participate in prevention initiatives. Health information technology improvements must reach all Indian health providers and include systems used by Tribal government and not just those selected by federal agencies and providers participating in the Exchange. The Indian health system should be exempt from provider disincentives used to contain health costs.

2. ***Expanding Coverage:*** Indian health programs need special considerations as essential providers in Indian communities. Health coverage mandates for individuals or employers need to take into consideration the special relationship between Tribes and the federal government. Permit Tribes the option to purchase employee health insurance through the federal employee's health benefits program. Protect the right of AI/ANs to use Indian health providers. Extend Federal Tort Claim Act (FTCA) to permit Tribal health programs to provide health care access to non-Indian patients. Ensure research and benefit designs take into account the unique needs and culture of AI/AN people.

In addition to our recommendations included here, we are attaching a list of Indian Health Care Improvement Act provisions that the National Indian Health Board, National Congress of American Indians, and National Council of Urban Indian Health provided the Committee on May 31, 2009. We are conveying our support for these recommendations to be included in the health reform legislation.

Please note, that our Tribes, like the rest of Indian Country have only recently started the dialogue on national health reform. While our recommendations represent a consensus of Northwest Tribes, that each Tribe may submit their own recommendations on specific issues as this process moves forward.

Thank you in advance for your consideration!

Sincerely,

Brian Cladoosby

Brian Cladoosby,
ATNI Chairman
Chairman, Swinomish Tribe

Andrew C. Joseph Jr.

Andrew Joseph, Jr.
NPAIHB Chairman
Colville Tribal Council Member

NPAIHB and ATNI Recommendations on Health Care Reform Policy Options for the Indian Health System[1]

Submitted to the Finance Committee
June 4, 2009

The Portland Area Indian Health Board (NPAIHB) believes that the May 31, 2009 joint letter (National Indian Health Board, National Congress of American Indians and National Council of Urban Indian Health) contained a serious error that needs to be corrected. On page 3, under "Subsidies", the letter says, "IHS is not creditable coverage". If this policy is adopted, many American Indians and Alaska Natives (AI/AN) will NEVER be able to achieve the important promise of "portability".

- Although IHS is not insurance it is health coverage.
- Provisions under Medicare Part D (42 CFR 423.56(b)(9)), which granted Indian health provider coverage as creditable coverage have worked well. New health insurance programs, especially those coordinated through "The Exchange" must explicitly recognize the Indian health system as creditable coverage. To underscore this important point, many AI/AN elders did not enroll in Medicare Part B when first eligible because they received care through Indian health services. For those who subsequently moved away from tribal communities and needed to rely on non-Indian providers, they found they could only enroll in Part B with a very significant and unaffordable financial penalty. Most Indian health programs are not prepared to provide extensive counseling to patients who receive health care under treaty rights about why they need to purchase health insurance.
- NPAIHB is also concerned about the unintended incentives created by not deeming Indian health creditable coverage. If AI/AN found themselves "locked into" the Indian health system, because if it is not recognized as creditable coverage, would it force AI/AN to remain in the Indian health system because they could not afford to leave? This would further burden already inadequately funded providers.
- While Indian health providers are proud of the public health, community based delivery model they have built over the years, they still must coordinate public and private insurance coverage for patients and thus are very familiar with the complexities of the broken health care system that Congress hopes to fix. As such, NPAIHB strongly encourages Congress to explicitly include the Indian health system as creditable coverage so individual AI/ANs are able to purchase insurance, without penalty when they are unable to access Indian health services. Only knowledgeable Indian health providers, who work everyday coordinating coverage for AI/AN can adequately advise policy makers on how the details of health reform can help or hurt tribal communities.
- AI/AN using Indian health system must be deemed to have creditable coverage and any penalty assessed for failure to enroll in a health insurance plan must be waived. Creditable coverage must not disqualify AI/AN for any health insurance or subsidy for which they would otherwise qualify.
- Portability for AI/AN requires that the Indian health system coverage be deemed creditable coverage.

Tribal Specific Recommendations:

1. **Include Tribal representation on key commissions, boards and other groups created by health reform legislation. Direct the Secretary of HHS to consult with Tribes on a government to government basis on health reform policies and regulations.** Only by engaging knowledgeable Tribal leaders before policy approaches are evaluated, refined and implemented, can health reform promise to improve the Indian health system and the health status of AI/ANs.

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[1] The Northwest Portland Area Indian Health Board and Affiliated Tribes of Northwest Indians convened a regional meeting, "Northwest Roundtable on Health Care Reform Policy Options for the Indian Health System," on June 2-3, 2009 in Portland, Oregon. This paper transmits the recommendations of Tribal leaders and health directors, urban Indian program directors, and other Indian health advocates that participated in the meeting.

2. **Consult with Tribes on a government to government basis across the county to be sure health reform policies and regulations are developed in a way that will create positive changes in the diverse Indian communities.** Across the United States Indian cultures, tribal resources and tribal health system structures differ greatly. Health reform must work in all of these situations. Only by directly consulting with Tribes as policies and regulations are being developed can HHS develop policies and regulations that will work in all Indian communities.

3. **Confer with representatives of urban Indian organizations to determine the impact of reform proposals on the Indian people served by those programs.**

4. **Indian tribes perform several roles in a health care context: They are governments, employers, health care providers (through Indian Self-Determination agreements), patient advocates, and beneficiaries of the U.S. trust responsibility for health. All of these roles must be respected, together with the recognition that Indian people are unique and distinct political group, not merely a minority classification.**

5. **Indian tribes must retain the authority to decide whether or not to serve non-Indians at their health facilities.** Tribes recognize that the demand for health services will greatly increase in a reformed health care environment and that they are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. The I/T/Us must be able to either open their doors or continue to serve only IHS beneficiaries. This is a challenging decision that requires consideration of capacity and resources and whether adding users will improve the breadth of services that can be offered or would diminish an already limited capacity. To support tribes who wish to serve non-Indians, the legislation must –
    a. Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers currently.)
    b. Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.

6. **Health care reform should require Tribal collaboration across all HHS agencies (e.g. HRSA, SAMSA, Administration on Aging, CMS) and other federal health programs, such as but not limited to, the Veterans Administration to coordinate health care resources in order to ensure health related funding is more effectively available to tribes.**

7. **The Indian Health Service budget must be protected from offsets and must be enhanced to assure that Indian programs can attract and retain health care personnel needed to fulfill the Federal government's trust obligation to "permit the health status of Indians to be raised to the highest possible level".**
    a. Chairman Baucus has noted that "[i]n fiscal year 2008, total funding for IHS was $4.3 billion, about 48 percent of estimated need."

8. **Health reform should provide opportunities and incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.**

9. **While health care reform holds great promise for ensuring coverage for all Americans, in Indian Country it will create a short term financial burden on the already seriously under funded Indian health system.** Tribes need to be involved in policy analysis and rule making, but there are no new resources. At the tribal level staff will need training and the resources to build the local systems that are needed to effectively educate, enroll and coordinate patient participation in a reformed system. When new funding is available for implementing health reform in Indian Country, provisions must be made to ensure that it is available to all Tribes equally.

10. **If the Indian Health Service (IHS) is provided additional resources to fund health services consistent with what would be provided in a publicly-funded health plan or other programs addressed under health reform, the IHS shall distribute funds equitably to tribal and urban health programs under the terms and conditions of Indian Self-Determination and Education Assistance Act (ISDEAA) and the Indian Health Care Improvement Act (IHICA) on the same allocation basis IHS makes funds available to directly operated service units.**

Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans Finance Committee Paper - May 14, 2009		
Section	**Policy Issue**	**Recommendations**
I: Insurance Market Reforms	***Page 2***	
	Non-Group and Micro-Group Market Reforms	
	Small Group Market Reforms	
	Health Insurance Exchange	1. In order to AI/AN access to a public insurance plan, the legislation shall expressly authorize and fund outreach and enrollment activities to take place at I/T/U sites. 2. In recognition of the Federal government's trust responsibility to provide health care to Indian people, a special (open) enrollment period should apply for AI/ANs eligible for Indian health programs and electing to participate in insurance coverage 3. Any new publicly-sponsored health insurance plan established to provide coverage for low/moderate income individuals must assure that AI/ANs who meet the income requirements are eligible to enroll, and that eligibility for services from the Indian health system is not a barrier to participation. a. AI/ANs eligible for care through the Indian health system have been encouraged to also enroll in Medicaid if they meet the eligibility criteria. The same opportunity must be made available for any federally supported or subsidized health insurance coverage. 4. AI/AN using Indian health system must be deemed to have creditable coverage and any penalty assessed for failure to enroll in a health insurance plan must be waived. Creditable coverage must not disqualify AI/AN for any health insurance or subsidy for which they would otherwise qualify. 5. Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort. a. To assure such policies are properly implemented, require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (NOTE: Federal law formally recognizes the TTAG and directs the Secretary to maintain this panel within CMS. See Pub.L. 111-5, §5006(e) (Feb. 17, 2009)).
	Transition	
	Role of State Insurance Commissioners	
II: Making Coverage Affordable	***Page 8***	
	Benefit Options	1. In recognition of the Federal government's trust responsibility to provide health care to Indian people, for any cost-sharing (premium, co-pay, etc.) that would apply to a publicly-subsidized plan, an AI/AN served by the Indian health system

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		should be expressly exempt from all such cost-sharing. a. Such a policy is consistent with the recent amendments to Title XIX (Medicaid) of the Social Security Act which prohibit the assessment of any cost-sharing against an AI/AN enrolled in Medicaid who is served by the IHS, or by a health program operated by a tribe, tribal organization or urban Indian organization. 2. For Indian communities, consider options for that will build on the holistic and public health model of health. In particular, enact provisions that permit and encourage integration of behavioral health services (mental health and substance use disorder) with other health services, especially primary care.
	Low-Income Tax Credits	
	Small Business Tax Credits	
III: Public Health Insurance Option	***Page 13***	
Approach 1: Medicare-Like Plan Approach 2: Third Party Administrator Approach 3: State-Run Public Option		1. NPAIHB supports Approach 1 for several key reasons: a. Indian tribes' relationship is directly with the federal government. Approach 1 preserves that relationship. b. Most ITU providers are currently able to bill and receive reimbursement for Medicare services. If a new private contractor administers the public health insurance, Indian health providers will be required to expend significant new resources in contracting, and establishing new relationships at the regional or state level. Approach 1 will save significant administrative resources as well as minimize disruptions in reimbursement collections. 2. If Approach 2 or 3 is adopted: a. AI/ANs must not be subject to any restriction on selection of a provider. AI/ANs must be permitted to elect to obtain care from their IHS, tribal, or urban Indian organization program without any financial or other penalty. See recent amendment to Sec. 1932(h)(1) of the Social Security Act to permit an Indian enrolled in Medicaid to select an Indian health care provider as a primary care provider. 3. If the legislation requires either the Secretary or outside entities to establish provider networks to serve individuals covered by a public insurance plan, it should contain assurances of participation by Indian health system (I/T/U) providers including: a. Assurance that the network provides access to all Indian health care providers t; b. A requirement that I/T/U providers be paid (whether or not enrolled in the network) at a rate negotiated with the I/T/U, or if no rate is negotiated, at the rate paid to a non-Indian network provider; and c. A requirement for prompt payment to an I/T/U provider. 4. Such express language is needed to assure that these providers are not arbitrarily excluded from participation as has occurred with some Medicaid managed care entities. When an I/T/U provider serves an individual enrolled in a public plan, the

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		provider must be able to claim reimbursements and be assured of receiving payments. a. Congress recently enacted protections for Indian health providers *vis-a-vis* Medicaid managed care entities which can be used as a model for similar protections for public plan network creation. 5. The legislation should also include a requirement that the Secretary establish special terms for participation by I/T/Us that takes into account the unique circumstances of those providers in order to facilitate their participation. a. This recommendation builds on lessons learned during implementation of the Medicare Part D drug program where it was necessary for CMS to require special additions to pharmacy contracts in order to assure participation opportunities for I/T/U pharmacies. For example, FTCA coverage meets the requirements of malpractice insurances when entering into agreements with provider networks, but some insurance plans will not accept this and require additional malpractice insurance. 6. Explicitly permit Indian plans to qualify as options available through the Exchange and allow them to limit enrollment to the beneficiaries determined by tribes
IV: Role of Public Programs	***Page 14***	
• Eligibility Standards and Methodologies • Medicaid Program Payments • Options for Medicaid Coverage Approach 1: Increased Coverage through the Current Medicaid Structure Approach 2: Increased Coverage through the Exchange Approach 3: Increased Coverage through Both the Current Medicaid Structure and the Health Insurance Exchange	Medicaid Coverage	1. Aggressive mechanisms are needed to increase enrollment of eligible Indians in Medicaid and CHIP. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of Medicaid and CHIP eligibility, but Indians are under-enrolled in these programs. a. States should be authorized to rely on a finding of eligibility for Medicaid and CHIP made by an I/T/U to the same extent as they would rely on such a finding by an Express Lane agency (as defined in Sec. 203 of CHIPRA). b. Indian health providers should be permitted to apply fast-track enrollment methods and to participate as Express Lane or other Medicaid enrollment simplification network entities. c. States must be required to demonstrate they have employed effective outreach and enrollment activities on/near Indian reservations and in off-reservation Indian communities, with penalties attaching for failure to do so. d. Tribal governments should be authorized as portals for accepting Medicaid applications.
	Children's Health Insurance Program (CHIP)	
	Quality of Care in Medicaid and CHIP	1. Membership in the MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC) should include at least one representative of the CMS Tribal Technical Advisory Group pursuant to requirements that CMS consult with the TTAG at .
• Enrollment and Retention Simplification • Family Planning Services and Supplies • Treatment of Selected Optional Benefits	Other Improvements to Medicaid	1. NPAIHB supports establishing a distinct national/federal tribal Medicaid option for administration, eligibility, payment, and delivery of Medicaid eligible services. This would assure a Medicaid "uniform benefit package" for AI/AN across the country to address the significant health disparities that exist in Indian Country. This concept has been discussed many times

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• Interstate Coordination Requirements for Child Medicaid Beneficiaries • Mandatory Coverage for Prescription Drugs • Change the Status of Some Excludable Drugs • Changes to Medicaid Payment for Prescription Drugs • Transparency in Medicaid and CHIP Section 1115 Waivers • Changes to the FMAP Formula • Automatic Countercyclical Stabilizer		over the years and could comprise a key component of health reform for Indian people. A national approach could help ensure that LTC reaches tribal communities and that an integrated approach to a benefit package could specifically address the unique cultural needs of AI/AN residing in tribal communities. 2. Indian health providers must be permitted, but not required to enroll eligible AI/AN beneficiaries on site and to participate as Express Lane or other Medicaid enrollment simplification network entities. 3. Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools. a. This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such an patient who travels out of state in order to receive culturally competent care at an Indian health facility, including care related to behavioral health needs, including substance abuse treatment. 4. All expansions of Medicaid and CHIP (including any waiver or demonstration programs) must expressly exempt AI/ANs from any form of cost-sharing pursuant to the recent amendment to Title XIX made by Sec. 5006(a) of Pub.L. 111-5 (Feb. 17, 2009).
	Medicaid Disproportionate Share (DSH) Hospital Payments	
• Waiver Authority for Dual Eligible Demonstrations • Cost-Effectiveness Test • Office of Coordination for Dually Eligible Beneficiaries	Dual Eligibles	
• Reduce or Phase-Out the Medicare Disability Waiting Period • Temporary Medicare Buy-In	Medicare Coverage	1. Pursuant to the Federal trust responsibility for Indian health, the Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services. At present, the system for making Medicare reimbursements to IHS and tribally-operated facilities provides payment at only 80%, as Medicare presumes a 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. But in recognition of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would annually infuse over $40 million more into the Indian health system, funds that would be used to reduce health status disparities. 2. Medicare changes should correct an omission in MMA that will permit CHS or other Tribal payments to count toward Part D

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Section	**Policy Issue**	**Recommendations**
		TROOP. 3. In order to continue to permit billing for Medicare part B services: 4. ▯Remove from Section 1880 of the Social Security Act the sunset date (December 31, 2009) applicable to 5. IHS and tribal program authority to receive payment for certain Medicare covered items and services. 6. All AI/AN who do not have Part B should be granted equitable relief in order to enroll in Medicare Part B and be exempt from financial penalties. Over the years some AI/AN elders did not enroll in Part B because they trusted that services would always be available for them through the Indian health system. Others were told in some meetings by federal officials that they didn't need to pay for Part B.
V: Shared Responsibility	***Page 39***	
	Personal Responsibility Coverage Requirement	1. Indian tribes, as sovereign governments, should have the express authority to pay the costs of providing health insurance coverage to their members and the value of such coverage should not be considered to be taxable income to the tribal member. 2. Because of the Federal trust responsibility to provide health care to Indian people, AI/ANs must be exempted from any penalty for failing to obtain or purchase health insurance if an individual mandate is included in the legislation. (creditable coverage) 3. Despite this, the fact that an AI/AN is eligible for health care from the Indian health system should not be a barrier to an AI/AN's eligibility for any publicly-funded health program such as Medicaid, or any publicly-subsidized health insurance option. 4. To the extent premiums and cost-sharing apply to AI/ANs, I/T/Us should be expressly permitted to make such payments on behalf of their Indian beneficiaries, and administrative barriers to doing so must be removed. 5. In recognition of the Federal trust responsibility to Indian people, individual Indian income from Federally-protected sources must be excluded from the calculation of an individual AI/AN's income for purposes of determining eligibility for participation in a publicly-subsidized plan.
	Employer Requirement	1. To the extent reform legislation includes an employer mandate, Indian tribes should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. As sovereign governments, tribes as employers must be permitted to determine for themselves the extent to which they can/will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so. a. The exemption of Indian tribes from any penalty or tax must also apply with regard to any tribal employees who opts out of a tribally-sponsored group health plan and buy insurance on their own outside of the workplace.

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		2. Indian Tribes should be given the option to purchase health insurance for their governmental employees through the Federal Employees Health Benefit Plan. As employers, some Indian tribes have been unable to find affordable health insurance. Indian tribes should have the option to purchase coverage for their governmental employees through the FEHBP, an option that would benefit both tribes – by making an affordable option available – and the FEHBP – by increasing the volume of insured. a. This option should be extended to tribes and tribal organizations for their employees who perform agreements issued under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act. b. Some tribes have extreme difficulty finding affordable employee coverage in the commercial market – some, but not all, are small employers. FEHBP would assure affordable coverage for these tribes.
VI: Prevention and Wellness	***Page 43***	1. Assure that prevention services are eligible for payment by all publicly-supported health programs (Medicare, Medicaid, CHIP and any new public health insurance option), and that I/T/U providers are eligible to collect such payments. a. To the extent an Indian health program integrates traditional health care and promising practices into its prevention programs, it should be permitted to do so with no adverse impact on its ability to collect reimbursements for covered prevention services. Preventive services that are considered to be effective in Indian Country should be included as covered preventive benefits
• Personalized Prevention Plan and Routine Wellness Visit • Incentives to Utilize Preventive Services and Engage in Healthy Behaviors Coverage of Evidence-Basad Preventive Services	Promotion of Prevention and Wellness in Medicare	1. In light of the significant health disparities for AI/AN, include tribal representation on groups that determine services so unique cultural considerations can be addressed.
• Access to Preventive Services for Eligible Adults • Incentives to Utilize Preventive Services and Encourage Healthy Behaviors	Promotion of Prevention and Wellness in Medicaid	1. In light of the significant health disparities for AI/AN, include tribal representation on groups that determine services so unique cultural considerations ca be addressed.
• "RightChoices" Grants • Prevention and Wellness Innovation Grants	Options to Prevent Chronic Disease and Encourage Healthy Lifestyles	1. Include tribes as entities eligible for Right Choices Grants.
	Employer Wellness Credits	
SECTION VII: Long Term Care Services and Supports	***Page 49***	
	Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid	1. State Medicaid agencies have varying relationships with Indian tribes. For a variety of reasons, AI/AN have difficulty accessing LTC services. To assist with this access problem, authorize tribes to secure LTC waivers either directly with CMS or require

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Section	Policy Issue	Recommendations
	HCBS State Plan Option	States to submit LTC waivers on behalf of a tribe or tribal organization.
	Eligibility for HCBS Services	
	Increase Access to Medicaid HCBS	1. Include provisions which require States, all agencies of the Department of Health and Human Services, and the Department of Veterans Affairs to demonstrate how they will assure that AI/ANs have meaningful access to Federally-supported long-term care programs and services. 2. A demonstration project should be funded through CMS, Administration on Aging and IHS to assist tribes and tribal organizations to develop the full range of long-term care services needed to meet their community needs, with an emphasis on culturally appropriate home and community based services, including care management services that will delay or prevent the need for nursing home care. This project should specifically address identifying and removing impediments to building LTC services in tribal communities as well as establishing effective methods to link/integrate LTC with ITU medical, dental and behavioral health services. 3. Include research on using cost based reimbursement for tribal LTC services 4. State Medicaid programs should be required to enter into agreements with IHS and tribal health programs under which reimbursement would be made for the full range of long term care services tribal programs are able to offer, and assure covered services include care management and home health care.
	Increase Federal Match for Medicaid HCBS	
	Medicaid Spousal Impoverishment Rules	
	Medicaid Resources / Asset Test	
	Long Term Care Grants Program	1. Indian tribes must be expressly included as entities eligible for long-term care grant programs, including, but not limited to: the Community Choice Act Demonstration Project; Real Choice Systems Change Grant Initiative; Aging and Disability Resource Centers (ADRC); Informal Caregivers; prevention and Health Promotion; and Green House Model.
	Functional Assessment Tool for Post-Acute LTC	
	Money Follows the Person Rebalancing Demonstration	1. Authorize tribes to directly access federal funding under this program.
SECTION VIII: Options to Address Health Disparities	*Page 56*	1. Establish an Indian Health Reform Task Force to conduct comprehensive research and a decision making process to redesign the Indian health system within the context of health reform goals. The Indian health system has evolved over time and by and large has been successful at recognizing and responding to the challenges of serving diverse and very poor populations with health status that is unacceptable by any

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Section	Policy Issue	Recommendations
		measure. Significant inroads have been hampered primarily by a serious lack of funding. Indian health has adopted a community based, public health model to provide services. Health reform activities are using a competitive, insurance based model, which will not work in many Tribal communities. To research the options and develop the most promising changes for the Indian health system will take time and money. It is important to preserve the strengths while ushering in new system changes that are specifically designed to improve the health of AI/AN in a culturally relevant way. The Task Force will: a. Review and analyze gaps in the levels of health care services provided across the Indian health system that are a result of the varying levels of IHS funding, facilities infrastructure, staffing packages, and third-party collections: b. Gather evidence on utilization, third party collection data; c. Identify conditions that have lead to the poor health of AI/AN across the country; d. Identify models of Indian health care delivery that are successful; e. Identify and recommend actions for revising statutes and regulations that impede or restrict access to funding or services needed to systematically improve the health of AI/AN across the country. f. Submit a report back to the Secretary within 12 months of convening. g. The Secretary, acting through the IHS Director shall appoint members of the Commission and must include a majority membership of tribal representatives. h. The Task Force shall submit its recommendations to the HHS Secretary one year after enactmant of the health reform bill.
	Required Collection of Data	1. Health reform legislation must include funding to develop, and support implementation by all I/T/Us, a system for monitoring ,measuring and evaluating the needs of the Indian health system to assure that budgetary resources support the level of need throughout the system and improve the quality and effectiveness of care.
	Data Collection Methods	
	Standardized Categories for Data	
	Public Reporting, Transparency, and Education	1. Beginning one year after enactment of the health reform bill, the Secretary shall submit a report to Congress regarding enrollment and health status of AI/ANs receiving items or services under Medicaid, Medicare, CHIPRA, or other health benefit programs funded under the health reform bill in order to evaluate health care outcomes. Each report shall include the following: a. Total number of AI/ANs enrolled in, or receiving items or services, under such programs. b. The number of Indians described above that also received benefits under programs funded by the

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Section	**Policy Issue**	**Recommendations**
		Indian Health Service. c. General information regarding the health status of the Indians described above disaggregated with respect to specific diseases or conditions and presented in a manner that is consistent with protections for privacy of individually identifiable health information under section 264(c) of the Health Insurance Portability and Accountability Act, of 1996. d. Provide a specific appropriation to fund this report.
	Language Access	
	Elimination of Five-year Waiting Period for Non-Pregnant Adults	
	Reduction in Infant Mortality and Improved Maternal Well-Being	NPAIHB wants to thank Senate Finance for specifically including tribes as entities eligible to apply.

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Section	**Policy Issue**	**Recommendations**
Section I: Payment Reform - Options to Improve the Quality and Integrity of Medicare Payment Systems	***Page 2***	
• Physician Quality Reporting Initiative (PQRI) Improvements and Requirement • Quality Reporting	Linking Payment to Quality Outcomes	1. Extend the option for bonus payments to physicians and clinics that receive FQHC "look alike" status.
• Primary Care and General Surgery Bonus • Payment for Transitional Care Activities	Primary Care	
Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration	***Page 11***	
	Chronic Care Management	
• Sustainable Growth Rate (SGR) • Medicare Shared Savings Program (i.e. Accountable Care Organizations) • Extension and Expansion of the Medicare Health Care Quality Demonstration Program	Moving From Fee-for-Service to Payment for Accountable Care	

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Section	Policy Issue	Recommendations
Section III: Health Care Infrastructure Investments -- Tools to Support Delivery System Reform	***Page 19***	1. Establish a loan guarantee fund and loan repayment program at the Treasury of the United States to be known as the Health Care Facilities Loan Fund to provide to Indian Tribes and tribal organizations direct loans, or guarantees for loans, for construction of health care facilities (including but not limited to inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities—such as behavioral health and elder care facilities).
• Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals • Improving Quality Measurement	Health IT	1. Health information technology improvements must reach all Indian health providers. The remote location of many I/T/U facilities and complex relationships with IHS lead to wide disparities in health technology capabilities. Explicit policies are needed to assure that all Indian health providers receive a fair share of resources for improving health information technology and that Indian health providers are not penalized for lack of information technology. 2. Health reform legislation must include funding to develop, and support implementation by all providers within the I/T/U of, e system for monitoring ,measuring and evaluating the needs of the Indian health system to assure that budgetary resources support the level of need throughout the system and improve the quality and effectiveness of care.
	Comparative Effectiveness Research	1. Ensure that Tribes and Tribal organizations as defined by the ISDEAA are included in the national framework to set national priorities and eligible to conduct such research.
• Physician Payment Sunshine • Physician-Owned Hospitals Nursing Home Transparency	Transparency	
• Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians • Promoting Greater Flexibility for Residency Training Programs • TANF Health Professions Competitive Grants • Proposal on Development of a National Workforce Strategy	Workforce	1. The proposed coordinated national strategy to address health care workforce shortages must be included as a key focus area in the Indian health delivery system: a. Expand training and funding for mid-level providers and allied providers who have proven records of providing quality care, such as, but not limited to, community health representatives, community health aides, behaviorel health aides, and dental health aide therapists. b. Resources for training, recruiting and retaining health providers should be made available to the I/T/U directly. c. Indian health programs must be provided with the resources needed to enable them to compete for health care professionals, to recruit parsonnel to fill existing vacancies, and to retain existing staff. d. Funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs must be enhanced. 2. Unlimited access to the National Health Service Corp should be made available to the I/T/U. a. Mechanisms for assignment of National Health Service Corps personnel should be revised to enable tribally operated programs to access these personnel on the same basis as the Indian Health Service.

Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs Finance Committee Paper - April 29, 2009		
Section	**Policy Issue**	**Recommendations**
		3. Unlimited access to Nursing education loan repayment program be made available to the ITU.
Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management	***Page 37***	
Section V: Public Program Integrity - Options to Combat Fraud, Waste and Abuse	***Page 42***	
	Provider Screening	
	Data Base Creation and Data Matching	
	Provider Compliance and Penalties	
	Program Integrity Funding and Reporting Requirements	

Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options Finance Committee Paper - May 20, 2009		
Section	**Policy Issue**	**Recommendations**
SECTION I: Health System Savings	***Page 4***	
o Improving Payment Accuracy through Adjusting Annual Market BasketUpdates o Updating Payment Rates for Home Health Services o Updating Payment Rates for Inpatient Services o Adjusting Reimbursement for High-Growth, Over-Valued Physician Services o More Appropriate Payment for Durable Medical Equipment o Increase the Medicaid Brand-Name and Generic Drug Rebate Amounts o Extend to and Collect Rebates on Behalf of Managed Care Organizations o Application of Rebates to New Formulations of Existing Drugs	Ensuring Appropriate Payment	1. Authorize the extension of the Medicare Modernization Act of 2003 (MMA) (Section 506) "Medicare like rates" to all Medicare paticipating providers. This would save I/T CHS significant money without costing the federal government anything. Expand from current hospital policy to all Medicare providers.
	Capturing Productivity Gains	
	Reducing Geographic Variation in Spending	

Financing Comprehensive Health Care Reform:
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Section	Policy Issue	Recommendations
o Making Beneficiary Contributions More Predictable o Means Testing Part D Premiums	Modifying Beneficiary Contributions	
SECTION II: Options to Modify the Exclusion for Employer-Provided Health Coverage	***Page 16***	1. AI/AN are entitled to receive health care as a federal trust responsibility. As such, AI/AN (as defined in the Legal citations) must be exempt from any personal income tax on health benefits, services, premiums or cost sharing paid or provided on their behalf. 2. (See attached explanation and proposed language)
SECTION III: Other Health Care Related Revenue Raisers	***Page 18***	
	Modify or Repeal the Itemized Deduction for Medical Expenses	
	Repeal of Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and Blue Shield or Other Qualifying Organizations	
	Modify Health Savings Accounts	
	Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses Under Flexible Spending Arrangements and Health Reimbursement Arrangements	
	Limit the Qualified Medical Expense Definition	
	Modify FICA Tax Exemption	
	Extend Medicare Payroll Tax to all State and Local Government Employees	
	Modify the Requirements for Tax-Exempt Hospitals	
SECTION IV: Lifestyle Related Revenue Raisers	***Page 33***	
	Impose a Uniform Alcohol Excise Tax	
	Enact a Sugar-Sweetened Beverage Excise Tax	
SECTION V: Administration's Revenue Raising Proposals	***Page 35***	

Oklahoma City Area Inter-Tribal Health Board

Health Care for American Indians and Alaskan Natives & U.S Health Care Reform

Background

The provision of health care to American Indian and Alaskan Native (AI/AN) people has been guaranteed through treaties and federal law. Health care for AI/AN people was permanently authorized in the Snyder Act of 1921 (25 U.S.C. § 13).

Indian Health Care Improvement Act (P.L. 94-437), as amended, is a cornerstone to the health care delivery system for AI/AN people. The IHCIA has provided numerous benefits to the AI/AN delivery system by creating provisions to increase manpower and infrastructure capacity, participate in federal entitlement programs, enhance behavioral health services and provide care for AI/AN people located in the major urban centers throughout the U.S. However, this law has expired, and reauthorization efforts have languished in Congress. Some current proposals in Congress even suggest to dismantle the IHCIA by severing various provisions and incorporating them into a comprehensive national health care reform bill. The 44 tribes that comprise the Oklahoma City Area Inter-Tribal Health Board (OCAITHB) oppose any such effort, and insist that the IHCIA be reauthorized expeditiously by the 111th Congress.

On June 5, 2009, the OCAITHB hosted a meeting to discuss national health care reform and supports the majority of the proposals of offered by the joint effort of the National Congress of American Indians/National Indian Health Board, including selected provisions of previous Indian Health Care Improvement Act reauthorization legislation. However, provisions that affect and expand the authority of Urban Indian health programs must be carefully examined in order to have a full understanding of the implications on the unique legal and political status of Tribes.

U.S. Indian Health Service

The U.S Indian Health Service (IHS) has been the primary provider of health care to AI/AN people since 1955. Much has been accomplished since then in terms of improvements in public health and health care delivery, but much more improvements are still needed. The AI/AN population still suffers vast disparities in overall health status, and the funding appropriated to the IHS is abysmal relative to the per capita health care amount provided to other federally-funded population groups (e.g., federal employees, Medicaid beneficiaries and even federal prisoners).

Moreover, the IHS has been characterized over the past decade as a "broken" system. The truth is that the IHS system is not so much broken, as it is "starved." The IHS has been grossly underfunded for the past several decades, and as such, cannot be expected to perform optimally. Such inadequate funding has created the perception that the system is broken.

The IHS has recently announced an initiative calling for a "Renewal of the IHS," wherein core benefits packages are determined and eligibility for services is revised. While the concept of a core benefits package is ideal, without the necessary funding, it is not realistic. The disparity is size of the tribes throughout the U.S., ranging from a few dozen citizens in some to over 300,000 citizens in the largest tribes, makes such benefits packages unattainable at current appropriations levels. Correspondingly, eligibility for service benefits must not be changed.

Eligibility for Services

General:

Current eligibility regulations clearly define who may receive services within the scope of IHS-funded health care programs. Any change in eligibility without dramatically increased funding, and a corresponding change in funding allocation methodologies, as well as changes in the type and volume of services offered at each local delivery program would result in catastrophe. Patients would naturally choose to seek care wherever the most comprehensive level of care is provided, thereby taxing the capacity and resources of a select few local delivery systems, while rendering the deserted systems unnecessary.

Additionally, an examination of eligibility criteria for the purpose of limiting the number of beneficiaries to individuals that the federal government deems to be an acceptable American Indian/Alaska Native blood quantum is unacceptable. Rather than examining methods to reduce the number of IHS eligible beneficiaries, Congress has a real opportunity to better utilize the Indian health system, which has demonstrated the ability to provide efficient and effective health care, even with inadequate resources.

Services to Non-Beneficiaries:

Some, but not all, Tribes have been able to implement expansions of capacity in their local health care delivery system through economies of scale and supplemental funding mechanisms. Others still, have sought to improve their local systems through the provision of excess capacity and/or select services in short supply in their communities by extending services to others in the general public (i.e., non-beneficiaries of existing IHS health programs). A significant barrier to such initiatives is malpractice insurance. While tribal health programs are generally covered by Federal Tort Claims Act (FTCA) for their AI/AN patients, there is controversy over whether this protection extends to non-beneficiaries. By allowing FTCA to cover non-beneficiaries seen by tribal health programs, the IHS could provide additional capacity that will be needed after health reform is enacted.

Tribal programs must have the decision making authority on whether to serve non-beneficiaries or not. For those tribes who choose to serve non-beneficiaries, FTCA coverage must be extended to any non-beneficiary whose service is publically funded through grants, insurance or other public subsidy.

AI/AN Participation in U.S. Entitlement Programs

1. If an AI/AN is in an I/T/U service area then they should be eligible for voluntary enrollment if they are otherwise eligible in any of the new plans and they shall be eligible for any subsidies to which they would otherwise be eligible.
2. AI/AN beneficiaries eligible for new programs or expansion of programs shall have no time limitation on enrollment to allow freedom of choice for beneficiaries and tribes.
3. Tribes and AI/AN beneficiaries shall be exempt from taxation on health benefits and premiums.
4. Provisions shall be added to any reform legislation for tribes to be able to pay premiums for insurance and Medicare on behalf of tribal members.
5. All managed care protections in the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) must extend to health care reform legislation.
6. Tribes shall be exempted from employer mandates and financial penalties included in the mandate.
7. Should a mandatory participation for individuals be included in health care reform legislation, allowing the (AI/AN) population to "opt-out" of mandatory participation solely based on an individual's status as a Tribal citizen must be carefully examined. While the Indian health system should meet all of the health needs of AI/ANs, the reality is that it does not. The lack of adequate funding, sparsely located facilities, and limited services have created a situation where AI/ANs do not have access to health care. For this reason, the U.S. Census Bureau's Current Population Survey (CPS) has determined that individuals who report Indian Health Services (IHS) and no other coverage are classified as uninsured. Therefore an exemption from mandatory participation without addressing the funding and accessibility deficiencies within the Indian health system will have a negative affect on the health of AI/ANs.
8. Clarification of IHS eligibility as "creditable coverage". An IHS eligible AI/AN should not be barred from qualifying for a subsidized premium through an "exchange," "connector," or "gateway" which offers public subsidies for individuals without actual insurance coverage, and should not be assessed a penalty if he/she does not acquire such insurance coverage. Additionally, and IHS eligibility should be considered creditable coverage in order to protect an AI/AN from penalties in the form of added cost (such as a late enrollment penalty) if the AI/AN does not immediately acquire insurance coverage.

Funding

The IHS is currently funded at approximately 54% of the identified need. Until the IHS is fully-funded (i.e., 100% of need), the extent to which this system is truly broken, and therefore, in need of reform, cannot be determined.

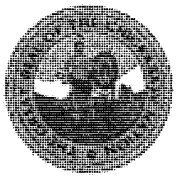
Conclusion

While advocating for adequate resources to carry out the federal government's trust responsibility, Tribes have often been placed in a precarious position of highlighting the deficiencies within the Indian health system while promoting the positive aspects. OCAITHB Tribes have reached the conclusion that the framework for a strong system exists to meet the health needs of AI/ANs, many positive things are happening, and with

adequate funding the Indian health system could be a model for a health care delivery system that emphasizes primary care services.

Out of necessity, the Indian health system has demonstrated the ability to provide a high level of care with miniscule resources. A shining example of realizing cost efficiencies with federal resources is the Special Diabetes Program for Indians (SDPI). Through the SDPI, numerous activities have been initiated including the hiring of health professionals, education programs, nutrition counseling, exercise programs, medical supplies, health screenings, school grants, specialty care, and a host of other services designed to address the diabetes epidemic in Indian Country. While it has required a financial investment, the SDPI has realized substantial cost savings through decreases in pharmaceutical use, amputations, kidney failure , etc.

The Chickasaw Nation



Health Care Reform in Indian Country

- American Indian and Alaskan Native (AI/AN) tribes are unique.
- The relationship between the U.S. federal government and AI/AN tribes is unique.
- The health care delivery system for AI/AN tribes is unique.
- AI/AN tribes do not want to be assimilated into the mainstream of U.S. society.
- Nor do AI/AN tribes want their health care system assimilated into the mainstream.
- The AI/AN health care delivery system (i.e., U.S. Indian Health Service [IHS]) has been wrongfully characterized as "broken."
- The IHS health care delivery system has been drastically and chronically underfunded.
- The extent to which the IHS is truly "broken" cannot be determined without full funding first.
- Incorporating only those pieces of the IHS deemed not to be broken in national health care reform will fragment the AI/AN health care delivery system and harm the health status of AI/AN people.
- Comprehensive reforms that honor and augment the uniqueness of AI/AN tribes and their health care delivery system will be more successful than a piecemeal assimilation approach.

Background

First and foremost, the provision of health care to American Indian and Alaskan Native (AI/AN) tribes is founded on a sovereign government-to-government relationship between the United States and tribes. As such, the provision of health care to AI/AN people is based on a unique political relationship, and is not based on race.

This provision of health care is formalized as a federal trust responsibility to AI/AN people that has been guaranteed through numerous treaties and federal law. Health care for AI/AN people was permanently authorized in the Snyder Act of 1921 (25 U.S.C. § 13).

The Indian Health Care Improvement Act (IHCIA), (P.L. 94-437, as amended), is another cornerstone to the health care delivery system for AI/AN people. The IHCIA has provided numerous benefits to the AI/AN delivery system by creating provisions to increase manpower and infrastructure capacity, participate in federal entitlement programs, and enhance behavioral health services, to name a few. However, this law has expired, and reauthorization efforts have languished in Congress.

Despite over a decade of effort to reauthorize the IHCIA to affect the modernization of health care for AI/AN people, some current proposals in Congress go so far as to suggest the dismantling of the IHCIA now that national health care reform has become popular. Severing select provisions of the IHCIA and assimilating them into a comprehensive national health care reform bill will create more harm than benefit to the AI/AN health care system. The Chickasaw Nation opposes any such efforts, and insists that the IHCIA be reauthorized expeditiously by the 111th Congress.

U.S. Indian Health Service

The U.S. Indian Health Service (IHS) has been the primary provider of health care to AI/AN people since 1955. Much has been accomplished since then in terms of improvements in public health and health care delivery, but much more improvement is still needed. The AI/AN population still suffers vast disparities in overall health status, and the funding appropriated to the IHS is abysmal relative to the per capita health care amount provided to other federally-funded population groups (e.g., federal employees, Medicaid beneficiaries and even federal prisoners).

Moreover, the IHS has been characterized over the past decade as a "broken" system. The truth is that the IHS system is not so much broken, as it is "starved." The IHS has been grossly underfunded for the past several decades, and as such, cannot be expected to perform optimally. Such inadequate funding has created the perception that the system is broken.

The IHS is currently funded at approximately 54% of the identified need. Until the IHS is fully-funded (i.e., 100% of need), the extent to which this system is truly broken, and therefore, in need of reform, cannot be determined. The Chickasaw Nation urges the 111th Congress to fully fund the IHS first, prior to any efforts to fragment the IHS system through assimilation initiatives in national health care reform.

Furthermore, the IHS has recently announced an initiative calling for a "Renewal of the IHS," wherein core benefits packages are developed and eligibility for services is revised. While the concept of a core benefits package is ideal, without the necessary funding, it is not realistic. The disparity in the size of the tribes throughout the U.S., ranging from a few dozen citizens in some to over 300,000 citizens in the largest tribes, makes such uniform benefits packages unattainable at current appropriations levels.

Correspondingly, eligibility for service benefits must not be changed. Current eligibility regulations clearly define who may receive services within the scope of IHS-funded health care programs (see 42 C.F.R. §§ 36.12, 36.14 and 36.23). Any change in eligibility without dramatically increased funding and a corresponding change in funding allocation methodologies, coupled with changes in the type and volume of services offered at each local delivery program, would result in catastrophe. Patients would naturally choose to seek care wherever the most comprehensive level of care is provided, thereby overburdening the capacity and resources of a select few local delivery systems, while rendering the deserted systems unnecessary.

Services to Non-Beneficiaries:

Some, but not all, AI/AN tribes have been able to implement expansions of capacity in their local health care delivery system through economies of scale and supplemental funding mechanisms. Others still, have sought to improve their local systems through the provision of excess capacity and/or select services in short supply in their communities by extending services to others in the general public (i.e., non-beneficiaries of existing IHS health programs). A significant barrier to such initiatives is malpractice insurance.

While tribal health programs are generally covered by Federal Tort Claims Act (FTCA) for their AI/AN patients, there is controversy over whether this protection extends to non-beneficiaries. By allowing FTCA to cover non-beneficiaries seen by tribal health programs, the IHS could provide additional capacity that will be needed after health reform is enacted.

Tribal programs must have the decision making authority on whether to serve non-beneficiaries or not. For those tribes who choose to serve non-beneficiaries, FTCA coverage must be extended to any non-beneficiary whose service is publically funded through grants, insurance or other public subsidy.

The Value of Health Services as Taxable Income

Recent concerns have been raised regarding the U.S. Internal Revenue Service seeking to tax the value of health care services provided to individual tribal citizens that are tribally-funded. As stated, the IHS is grossly underfunded. Therefore, supplemental funding to the IHS health care delivery system is drastically needed, and regardless of whether such supplemental funding comes from tribally-generated revenue sources or other sources, such funding cannot justifiably be presumed as the personal income of individual tribal citizens. All attempts to tax the value of health care services provided to tribal citizens should be abandoned.

AI/AN Participation in U.S. Entitlement Programs

Under the authorities of Title IV of the IHCIA, tribes have been allowed to participate in the U.S. Medicare, Medicaid and State Children's Health Insurance Program entitlements through the enrollment of AI/AN people and billing for reimbursement of covered services. Such authorities must be maintained through the permanent reauthorization of the IHCIA, or through national health care reform legislation, but in a way that solidifies the AI/AN health care delivery system.

To date in the health care reform initiative, national Indian organizations have distributed position papers that focus on making targeted changes to AI/AN participation in entitlement programs. Such papers contain recommendations that address enrollment and opt-out provisions, negotiation of reimbursement rates, tribal inclusion in networks, cost-sharing and the like. While these recommendations are important to the current structure of the health care delivery system, they do not address the fundamental uniqueness of AI/AN tribes and the AI/AN health care delivery system.

Such approaches can be characterized as assimilation approaches into the mainstream health care system. A path for AI/AN participation in entitlement programs must be found that honors tribal sovereignty and the government-to-government relationship. Carving-out AI/AN resources of entitlement programs and reallocating them directly to the IHS would do just that.

Per capita expenditures for entitlements at the national level can be easily calculated, as can the user population figures and workload data of the IHS. Therefore, it would follow that an aggregate amount of entitlement funding provided to AI/AN beneficiaries could be easily calculated and reallocated directly to the IHS. Not only would such an approach be an enormous cost savings in the administration of entitlements for AI/ANs at the federal and state levels, it would drastically reduce the administrative costs for tribal health care programs associated with third-party collections.

Many tribes already perform various functions related to the application, documentation and verification processes to determine individual eligibility and enrollment in entitlement programs. However, tribes do not currently have the final authority to certify eligibility. Furthermore, most tribes have a long history of conducting compliance and audit functions, as well as case management and reporting. In any health care reform proposals, tribes must be granted final certification authority for individual enrollment and participation in entitlement programs.

Tribes are fully capable of determining eligibility, facilitating enrollment, managing case work, billing for reimbursement and reconciling aggregate financial information. In consideration of these capabilities, providing a direct entitlement carve-out to the Indian health system would not only simplify the flow of resources, it would do vastly more to cover the uninsured AI/AN population than fragmenting the current system through individual or employer insurance mandates. Furthermore, any proposed expansions in current entitlement programs would simply be an extension of carve-out authority and resources.

Such an approach would be an innovative method of providing a unique and comprehensive set of entitlement services to tribes nationwide, under a single set of guidelines, rather than negotiating, seeking individual approval for, and managing changes for specific issues in 36 separate state plans for AI/AN beneficiaries.

Treatment of Non-Profit and Other Incorporated Organizations:

Additional concerns have been raised about health care provided to AI/AN people that reside in urban centers. The Chickasaw Nation believes that such urban AI/AN people deserve health care just as much as the AI/AN people that reside in Indian country. However, urban Indian organizations (UIOs) or other tribal organizations (TOs) that serve as the delivery system of health care to AI/AN people are not tribes. Therefore, such UIOs and TOs should not be granted similar status as tribes, either through law, regulation or federal policy.

Granting UIOs and TOs similar status as tribes through the government-to-government relationship diminishes and devalues tribal sovereignty. Any authorities granted or funding allocated to UIOs and TOs must be specific and separate from those afforded to tribes, and further emphasize that such authorities and funding are not based on a government-to-government relationship, but rather as a trust responsibility to the individual AI/AN people that such organizations serve.

Summary of Recommendations:

- **Reauthorize the Indian Health Care Improvement Act as the health care reform legislation for the Indian health system.**
- **Fully fund the IHS based on 100% of the identified level of need for health care.**
- **Abandon any proposal to change existing IHS eligibility regulations.**
- **Authorize Federal Tort Claims Act coverage of all health care services provided through the Indian health system, regardless of funding source or category of beneficiary.**
- **Abandon any proposal to tax individuals for the value of health care services provided within the Indian health system.**
- **Authorize tribes to certify eligibility, enrollment and participation in U.S. entitlement programs.**
- **Authorize a nationwide entitlement carve-out for AI/AN beneficiaries, and reallocate such resources directly to the Indian health system.**
- **Abandon any proposal that would grant urban Indian organizations or tribal organizations authority or status on the same basis as tribes.**

PREPARED STATEMENT OF CARMELITA SKEETER, CEO, INDIAN HEALTH CARE RESOURCE CENTER OF TULSA, INC.

Good day, Senators, Ladies and Gentlemen. I am Carmelita Skeeter, CEO of Indian Health Care Resource Center of Tulsa (IHCRC). Our Urban Indian Clinic is one of the two national Urban Demonstration Projects – our counterpart is the Oklahoma City Indian Clinic.

The Board of Trustees of our nonprofit Urban Indian health organization strongly supports the reauthorization of the Indian Health Care Improvement Act (IHCIA) with the language in H.R. 2708 Section 513 that assures our organization will retain its current ability to manage its own affairs and provide locally directed health care services. As an Indian Health Service Urban Demonstration project, our organization has steadily grown and offers a comprehensive program of outpatient care. Our Urban clinic provides medical, dental, optometry, pharmacy, mental health and substance abuse treatment. What we seek in the renewal of the Indian Health Care Improvement Act is an assurance that our organization can continue to provide health care within the legal structure of the very successful Urban Demonstration delivery system. Our urban clinic has received the Outstanding Program award from the National Council of Urban Indian Health.

The Oklahoma Urban Demonstration clinics have proven ourselves to be effective projects and want to continue to operate in the future in the same way that we have functioned since we became Demonstration programs in 1987. Let me provide a little background and history about the two Oklahoma Urban Demonstration programs. The Indian Health Service provides partial funding to 32 nonprofit Urban Indian clinics and to the two Oklahoma Urban Demonstration clinics. The Indian Health Care Improvement Act enacted in 1976, included the basic Title V authorization for Urban Indian health programs. Nationally, the enactment of Title V was vitally important to the evolution of Urban Indian health care, for it provided an effective means for IHS to partner with community-based organizations to more effectively serve the basic health care needs of the Urban Indians who comprise over 60% of the nation's American Indian and Alaska Native population.

Due to the instability and inadequacy of Title V funding for Urban Indian Clinics throughout the 1980s, and the overwhelming unaddressed health care needs of Oklahoma's large Indian population, the Tulsa and Oklahoma City Urban Indian health programs advocated for special status as Indian Health Service Demonstration projects. This effort was successful in 1987 when the Interior Appropriation Act moved the funding for the Tulsa and Oklahoma City Urban Indian centers from Title V Urban program to the IHS Direct Care Program (Line Item 01 for Hospitals

and Clinics of the IHS annual budget). This action established the Tulsa and Oklahoma City Urban clinics as the only two Urban Demonstration Projects for IHS in the nation.

Since the creation of the Oklahoma Demonstration Projects, the Indian Health Service and Congress have provided a series of incremental interpretations and statements to more clearly define the nature of the Urban Demonstration program and its operations. The two urban health programs do not neatly fit within the IHS/Tribal/Urban framework. Although they came into existence through the Title V Urban Health program, they have moved beyond this origin. When Congress established the Oklahoma Demonstration projects it created a "hybrid," unlike any other in the IHS clinical delivery system. We are independent nonprofit corporations and are not a federal IHS facility. **Our Demonstration status within the I/T/U system has had a positive effect on the level of IHS service unit funding received and the expanded scope of services we are able to provide to Indians in Tulsa and Oklahoma City** and has led to better integration of the Urban programs with the operation of other IHS facilities and programs.

From a tribal perspective, urban clinics, including the Oklahoma Demonstrations are not affiliated with any single tribe – rather, the Urban Demonstration projects maintain an open door to serve members of all tribes. Like all of the Title V Urban clinics, **the designation of the Tulsa and Oklahoma City clinics as Demonstration programs kept in force the Title V language which guarantees the nonprofit corporate independence of all Urban Indian Clinics from the potential of being compacted or contracted** under the provisions of the Indian Self-Determination and Education Assistance Act (ISDEA).

Urban Indian funding was developed by the federal government to provide a means to fill in gaps between Tribal and federal programs. In 1992 Congress enacted P.L. 102-573 stating the following:

> *The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to assure the highest possible health status for Indians <u>and Urban Indians</u> and to provide all resources necessary to affect that policy. (underline added for emphasis)*

Returning to the current situation we face today regarding the reauthorization of the Indian Health Care Improvement Act, extended roundtable discussions were held by the Indian Health Service, Tribal and Urban (I/T/U) system partners to consider appropriate language and changes to IHCIA. These discussions were far-ranging, yet throughout the process there was **strong and clear agreement among the I/T/U roundtable participants that the two Oklahoma Urban Demonstration projects –**

1) Should be made <u>permanent programs</u> in the IHS direct program;

2) Should continue to be treated as <u>Service Units</u> in the allocation of resources and coordination of care while still being treated as a Title V Urban program;

3) <u>Should not be subject to the Section 638</u> Tribal compacting and contracting provisions of the Indian Self Determination and Education Act.

These three provisions were agreed upon nationally by the I/T/U partners and have been incorporated in the Section 513 IHCIA language of H.R. 2708 (2009). The Section 513 language of the current IHCIA bill remains unchanged from last session's bill, though the numbering changed from Section 512 (previous bill) to Section 513 (current bill).

Today I am here to reiterate the need to keep all three of these components of Section 513 in place. The Oklahoma Demonstration Projects operate in a unique manner within the Oklahoma I/T/U delivery system. Because the entire state of Oklahoma is designated as a "Contract Health Service Delivery Area" (CHDSA), Oklahoma Indians (including members of non-Oklahoma tribes living in Oklahoma) have the right to receive services from any IHS, Tribal or Urban clinic. The two centrally located clinics operated by Oklahoma's two Urban programs are the most efficient means to serve the diverse intertribal population living in the state's two major Urban areas. The Tulsa metro area has one of the nation's largest concentrations of Native Americans – in the 2000 Census over 86,000 Oklahomans living in the five-county Tulsa MSA responded as American Indians or Alaskan Natives.

The Demonstration status and the corresponding enhanced baseline service unit funding that two Oklahoma Urban Indian clinics receive (as compared being funded at the much lower Title V Urban clinic funding level) has enabled the Tulsa and Oklahoma City Urban Demonstration projects to:

- Construct new clinical facilities, expand clinical services and improve quality of care; the Tulsa Urban clinic has been accredited by the Accreditation Association of Ambulatory Health Centers (AAAHC).
- Maintain continuity of care for a steady stream of patients and clients who move to Urban cities from the rural towns – enabling these patients to transfer their care from rural tribal and IHS health facilities;
- Coordinate care for Urban Indians who access health care at the Urban clinics and at the IHS direct care and Tribally-controlled health programs; we serve as patient advocates to help patients access IHS contract health care and other health services not available at our Urban ambulatory clinics.
- Assist Native Americans qualify for Medicaid and Medicare so they can access additional health care through non-IHS health providers and insurance networks;
- Bill for third-party Medicaid reimbursement as an IHS outpatient clinic at the OMB "all-inclusive" rate generating additional program income to expand services.
- Grow our overall operating budgets. In Tulsa, the Demonstration baseline service unit funding has enabled us to expand our operating budget by nearly times our base IHS funding through grants, contracts and third party insurance billings. As documented in IHCRC's FY 2008 audited annual report, we expended $4,208,758 in IHS base funding of our total annual expense budget of $11,786,008.

The Urban clinics are partners with the federal government and a wide range of community partners. By definition, the contractual partnership which the Urban clinics have with the federal government to deliver health care services requires the Urban clinics to coordinate care with Tribal health programs, as well as IHS controlled health services. Although the Urban clinics operate as partners with the federal and Tribal governments, they operate independently of their direct control. IHCRC and the Oklahoma City Urban clinic are private nonprofit, non-stock membership corporations. IHCRC is a community-based corporation with a local Board of Trustees who are elected by the membership of Indian patients who utilize the clinic's services. Elected Tribal representatives are eligible and have served on the IHCRC Board of Trustees. **The health care our clinic provides to tribal members is provided at no cost to the tribe.**

Establishing Demonstration status, with a corresponding increase in service unit funding, has enabled the two Oklahoma Urban organizations to grow. The two Oklahoma Urban clinics have constructed new facilities through lease/purchase agreements. Although the base IHS funding is helping to finance these new facilities, the principal source of funding that enabled services to be expanded has been through billing for Medicaid reimbursement of services using the OMB rate.

The base IHS service unit funding the Tulsa Urban project (IHCRC) receives represents <u>only 36% of the annual operating budget of the organization</u> – however it is the core funding that is gives stability of the entire clinical operation. IHCRC has a long track record of success in using the base IHS funding to leverage additional contracts and grants. Private philanthropic and corporate donations were used to help furnish the new IHCRC clinic. In order to receive state substance abuse funding for Indians, IHCRC has served both Indians and non-Indians for over a dozen years as a state-certified substance abuse contractor. Keeping a patchwork of 10-15 grants in place on an ongoing basis requires organizational stability and maintenance of good relations with the funding sources.

All of us within the I/T/U system need to work together to improve the Indian care health care delivery – and ultimately – to improve the health of our Indian people. The Tulsa and Oklahoma City Urban Clinics believe the health care of Indian people is best served by an Indian health delivery system that ensures the continued presence of the federal Indian Health Service programs and initiatives, Tribal health services and Urban programs operated by locally-controlled Urban Indian nonprofit organizations. Indian Health Care Resource Center functions both as a major provider of I/T/U services and as a key local provider of essential safety net health care services within the general Tulsa community.

Conclusion

I urge the Senate and Congress to reauthorize the Indian Health Care Improvement Act with the language of Section 513 in the "as introduced" version of H.R. 2708, which would make permanent the current "Demonstration" status of IHCRC and its Oklahoma City Indian Clinic counterpart, protecting the two Oklahoma Urban clinics from tribal control and guaranteeing they continue to receive their fair share of IHS service unit funding for the population they serve. It is also very important that the Oklahoma Demonstration Projects continue to be able to provide care to patients with Medicaid and Medicare insurance coverage and receive appropriate OMB and FQHC reimbursement.

IHCRC facility expansion ready for groundbreaking in 2009

For over 30 years, Indian Health Care Resource Center of Tulsa (IHCRC) has been committed to improving the health of Indian people living in the Tulsa area. We serve a large intertribal population, comprised of members of over 150 federally recognized tribes. According to the 2000 Census, the metro Tulsa area is home to more than 86,000 Indian people. We serve the medical, vision, dental, mental health and substance abuse treatment needs of our patients.

After moving in 1999 from leased space in downtown Tulsa to our current facility at 550 S. Peoria, we have seen the demand for our health services steadily grow. To meet this critical health care need, the IHCRC Board of Trustees has worked the past five years to complete a comprehensive planning process to expand our facility. Our facility expansion plans will double the size of our medical care areas, substantially expand our mental health and substance abuse treatment capacity and create a permanent home for our health and wellness department. When completed, the 52,392 square foot facility will have grown by more than 24,000 square feet and 14,000 square feet of existing space will have been remodeled.

Importantly for the patients we serve, the facility expansion will bring all our staff together again under one roof. For the past three years, we have had to lease 10,000 square feet of space to office much of our wellness department, the WIC nutrition program and portions of our mental health and substance abuse staff. Integrating all services into one facility is a major goal of the facility expansion project thereby enabling our patients to conveniently access all our services with "one-stop-shopping."

The IHCRC Board of Trustees signed a letter of commitment to borrow up to $7.1 million to finance the facility construction and remodeling project. As we have done in the past, IHCRC Trustees plans to use long term, tax-exempt debt financing to undertake the project. Groundbreaking is planned for July 2009 and we anticipate moving into our completed facility by close of 2010.

During the past two years we have continued efforts to implement an electronic health records system (EHR) in accord with mandates from the Indian Health Service. We have also developed companion plans to convert all x-ray systems from film-based systems to digital imaging and record storage. We have recently completed the due diligence to quantify the pricing and desired specifications for our proposed x-ray and mammography digital imaging system improvement plan.

Continued development of health promotion, mental health and substance abuse services.

Looking beyond the construction activity, IHCRC has a number of exciting new initiatives that will be getting underway in the community in the year ahead. Our medical department has become a Reach Out and Read partner to promote early childhood reading and well-baby and well-child pediatric visits. Our Health Education and Wellness Department will use a new five-year federal Centers for Disease Control grant to conduct a "Building Community – Strengthening Traditional Ties" program. This program will promote community gardening and increase access to affordable nutritious foods that are prepared in accord with traditional, pre-westernized, American Indian dietary practices. We are also using a U.S. Department of Agriculture community food project grant to improve healthful food security through community education, policy change and local community projects.

Our "Circles of Care" children's behavioral health staff is helping implement two Systems of Care projects – one with the Muscogee (Creek) Nation and the other with the Oklahoma Department of Mental Health and Substance Abuse Services. With the support of six-

year federal grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), IHCRC's Behavioral Health Department will serve as a subcontractor on both of these projects.

The completion of the Circles of Care children's mental health community planning process provided valuable guidance and community input to develop of a culturally sensitive system of care for Native children with behavioral health needs. The systems of care approach to services recognizes that the needs of children with serious mental health issues can best be met within their home, school, and community, and that families and youth should be the driving force in the transformation of their own care. The systems of care grants will provide a full array of mental health and support services organized on an individualized basis into a coordinated network in order to meet the unique clinical and functional needs of each child and family.

A "system of care" is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. With appropriate care, these young people are far more likely to experience success in school and far less likely to become tangled in either the juvenile justice system or the institutional care system.

Many Paths to Recovery. Indian Health Care is a new partner with the Cherokee Nation in the ongoing battle against substance abuse. The Cherokee Nation has received a major federal "Access to Recovery" (ATR) grant to support its "Many Paths" substance abuse treatment program. The goal of the program is to improve *access* to substance abuse and recovery services for American Indian adolescents, men and women. With parental consent, Native adolescents from age 13-17 are eligible for ATR services; upon reaching the age of majority at age 18, they can self-refer.

Access to Recovery is a grant program funded by the SAMHSA that provides vouchers to clients to purchase of substance abuse clinical treatment and recovery support services. Goals of the program are to expand capacity, support client choice, and increase the array of faith-based and community-based providers for clinical treatment and recovery support services. The Access to Recovery concept recognizes that people need to be able to make choices and take an active role in their path to recovery. Recovery can take many pathways – physical, mental, emotional or spiritual. The Cherokee Nation Many Paths program offers participants choices ranging from conventional medical providers to faith-based and native healers.

Clients are empowered to choose who they want to provide their substance abuse treatment and recovery services through a unique voucher system. The Cherokee Nation is committed to ensuring all clients are given a genuine, free and independent choice from a referral list of eligible substance abuse agencies in the community. In addition to treatment services, all clients will have access to a broad range aftercare support services to support their recovery from substance abuse.

Since 1976, IHCRC has been committed to improving access to quality, affordable health care for Tulsa area Indian people of all tribal heritages. Medical, wellness, dental, optometry, pharmacy, mental health and substance abuse services are provided at our federally qualified health center by a staff of over 115 employees. Our "safety-net" clinic guarantees access to comprehensive primary care for patients with limited financial means.

PREPARED STATEMENT OF CHAD SMITH, PRINCIPAL CHIEF, CHEROKEE NATION

On behalf of the Cherokee Nation, please accept this correspondence as testimony regarding reform in the Indian Health Care System. The Cherokee Nation believes it is vital that the Indian health care system join in the broader discussion of national health care reform and have the ability to fully participate in any implemented advancements in health care policy. Through our engagement in state-level health care reform, the Cherokee Nation has identified three key areas where the Indian health system can play an active role in national reform: Addressing the Uninsured, Increasing Access, and Improving Information Technology Capacity.

Addressing the Uninsured

Although increasing health coverage alone does not necessarily equal reform, the lack of health coverage does serve as one of the largest barriers to seeking health care. Because the Indian health system is able to access 3rd party payment sources, the Indian Health Service (IHS) and Tribal Nations have a vested interest in increasing the number of American Indians/Alaska Natives (AI/AN) with health insurance.

Community outreach and education efforts must be undertaken to ensure existing programs are serving all that are eligible to participate. Outreach and education is especially important for the AI/AN population as many do not participate in Medicare, Medicaid, State Children's Health Insurance Program, or private insurance because of the misperception that participation is not necessary due to IHS eligibility. It is important to note that according to the U.S. Census Bureau's Current Population Survey, individuals who report IHS eligibility and no other coverage are classified as uninsured. Due to inadequate funding and limited access, IHS eligibility does not equal health coverage. Therefore, national health reform legislation should include language that will allow IHS/Tribally-operated Programs/Urban Indian Health Organizations (I/T/U) expenditures to apply toward Medicare Part D True Out-of-Pocket-Expenses. Another legislative effort that would greatly improve the ability of the Indian health system to access private insurance resources is automatically classifying services provided within the Indian health system as "in-network" for purposes of payment.

The Cherokee Nation is aware of recent proposals to explore "privatizing" Indian Health Services by providing AI/ANs with a voucher or credit to seek health care in the private sector. Based on the per capita funding level for IHS users in Oklahoma ($976 annually) and nationally ($1,914 in 2003), funding is woefully inadequate to purchase comparable health services in the private sector. In recent reviews of similar efforts at the state and federal level, the Cherokee Nation has found that the State of Oklahoma in a 2006 privatization pilot project determined that it spent an average of $3,453 per capita annually on Medicaid beneficiaries. In FY 2003, the Federal Government spent $5,200 per capita annually for patients within the Veterans' Health Administration (VHA) system. These findings lead the Cherokee Nation to conclude that the level of funding provided by the Federal Government for IHS beneficiaries is not adequate to seek coverage through the private sector.

Additionally, the Cherokee Nation urges the Committee to take into consideration that in FY 2001 IHS provided health services to only 1.3 million American Indians and Alaska Natives. Using 2000 Census figures, even if every one of the 4.1 million eligible AI/AN accessed the IHS system, the federal fiscal impact would still be negligible compared to the 37.7 million Medicare enrollees, 29.2 million Medicaid enrollees, and the 8.4 million accessing services through the VHA and Department of Defense.

Given the significant disparity in per capita spending for Indian health system users relative to other populations, the fact that the AI/AN population represents only a small segment of the overall population, and the Indian health system's consistently demonstrated ability to provide quality care with minuscule resources, the Committee should champion an effort to fully implement the framework of the Indian health system in order to increase the services for current patients and improve access for those unable to utilize the system.

Increasing Access to Healthcare Services (workforce and rural needs)

In order to address the impending healthcare workforce crisis, efforts must be made to both increase the workforce and make the current workforce more accessible to the rural population. The Cherokee Nation supports appropriate expansions of the quantity and quality of health care professionals and workers, and supports practices that allow this workforce to operate at "the top of their licenses."

While it may not be practical to construct full-time, dedicated clinics in remote areas, efforts can be undertaken to utilize existing infrastructure such as schools, places of business and retail establishments, to host health provider sites. The flexibility to allow the IHS and Tribally-operated health systems to carry out such efforts is critical.

In FY 2008, the Indian Health Service Scholarship program accepted only 101 (or 5.3 percent) of the over 1,900 new applications were able to be funded. It is apparent that the IHS Scholarship Program is an attractive program designed to both meet the needs of the Indian health system and enable qualified individuals to pursue health careers. Adequate funding will allow this existing program to accomplish its designed purpose.

National health reform should also include specific language to ensure Tribal facilities operated by a Tribe or Tribal organization authorized by Title I or III of the Indian Self-Determination and Education Assistance Act, aka ISDEA (P.L. 93–638, as amended) are eligible to participate in the National Health Service Corp (NHSC).

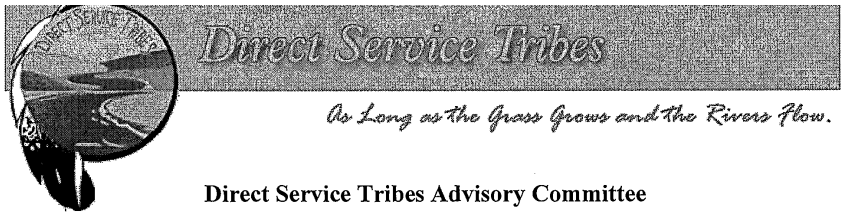
Further, facilities in Indian Country continue to be desperately needed. The IHS Joint Venture (JV) program demonstrates the shared commitment of Tribal Nations and the Federal Government in providing additional health facilities within the Indian health system and the staff necessary to support the facilities. The JV program is a proven success in leveraging resources to construct and build critically needed health facilities, making federal funds go farther. The JV program would greatly benefit from funding on an annual basis, including contract-support-costs funds and adequate operational funds.

Finally, it is a well settled principle that the government-to-government relationship between the United States and federally recognized Tribal Nations provides the foundation for the federal trust responsibility to carry out various programs and services for Tribal citizens. Eligibility for such programs and services should be based on the political status of the individual. By virtue of citizenship in the Cherokee Nation, an individual should have equal access to all programs and services carried out by the Federal Government as part of the federal trust responsibility. For uniformity and objectivity, the Cherokee Nation recommends eligibility criteria be based on citizenship in a federally recognized Tribal Nation.

Improving Information Technology Capacity

Tribal Nations still need further assistance in developing Universal Enterprise Network Systems to build inter-network connectivity and operability. An investment in the technological capacity of Indian Country will enable the expedited implementation of electronic health records, telemedicine, health information exchange and related initiatives in an efficient, secure and user-friendly manner.

The Cherokee Nation fully embraces the principle that, in order for health care reform to be effective, preventive health must be considered on the same level as health coverage, access, and information technology. To create and implement effective preventive health programs however, better data collection and dissemination procedures are needed. To address the health disparities facing AI/AN, improved data collection is particularly needed on topics such as the quantification of chronic disease prevalence, chronic disease risk factor reduction, hypertension, and stroke prevalence and prevention. One of the most beneficial improvements in this area would be the establishment of a single, integrated website with data available to calculate simple statistics, such as incidence and prevalence rates, as well as access to relevant published data.



Direct Service Tribes Advisory Committee

Resolution No.: DSTAC-2009-007

Resolution Supporting The Indian Health Care Improvement Act and Health Care Reform As Separate Issues

WHEREAS, Direct Service Tribes (DST) elect, either in whole or in part, to receive primary health care directly from the Indian Health Service (IHS) and this decision is an expression of Self-Determination and an acknowledgment that the United States and the federal government have a legal and moral obligation to provide health care to Indian Tribes as defined in treaties, statutes, and executive orders. This DST status reinforces the Government-to-Government relationship between Indian Tribes and the United States, and it guarantees that the health care needs of the DST shall be met; and

WHEREAS, the Direct Service Tribes Advisory Committee (DSTAC) was established on April 27, 2005 by the IHS Director to provide expertise on policies, guidelines, and programmatic issues that impact the delivery of health care for Indian Tribes with an emphasis on policies that impact the DST; and

WHEREAS, the DSTAC adopted BYLAWS on January 11, 2006 to govern their operations; to provide their mission statement; and to outline protocols for DSTAC; and

WHEREAS, The IHCIA expired in 2000, and was extended through FY 2001 and for a decade, Tribal leaders, members and advocates have worked tirelessly with Congress to provided advice and feedback to several Administrations, House and Senate leaders, committees and members about IHCIA reauthorization bills introduced in the 106th, 107th, 108th, 109th and 110th Congresses; and

WHEREAS, the IHCIA is the baseline authority for providing direct care to American Indian and Alaska Natives (AI/AN). These baseline authorities are critical to continue to provide health care to our people – today, tomorrow, next month and next year; and

WHEREAS, We desperately need to affirm current and obtain new authorities offered by IHCIA legislation, particularly those that will authorize modern methods of health care delivery; and

WHEREAS, the Administration and Congress are also working hard to reform health care to all American including Native American and Alaska Natives; and

WHEREAS, Indian Tribes are stakeholders in Health Care Reform and Indian Tribes play multiple roles in the health care system. They are providers, networks, payers, employers, beneficiary advocates, and government entities; and

WHEREAS, Indian health care services are not simply an extension of the mainstream health system in America, but a treaty right paid for by the exchange of millions of acres of land and reaffirmed by Executive Orders, Acts of Congress and Supreme Court decisions; and

WHEREAS, Through the Indian Health Service (IHS), an agency within the Department of Health and Human Services, the federal government has developed a unique system based on a public health model that is designed to serve Indian people in remote reservation communities; and

WHEREAS, The Indian health delivery system must be supported and strengthened to enhance access to health care for all AI/ANs; and

WHEREAS, In any National Coverage Plan developed by the Administration and Congress, the following must be considered:

- There must be specific language protecting Tribal Nations, Entities and Individuals from any form of premiums or copayments.
- The obligation and responsibility to Tribal Nations for the provision of healthcare must not be reduced or in any way adversely affected by individual AI/AN participation in such a program.
- The Indian Health Service must be able to participate fully in the reimbursement for services provided to AI/AN enrolled in any public plan.
- Any public plan must contain specific language requiring the entity to participate in Tribal Consultation.

NOW THEREFORE BE IT RESOLVED, that the Direct Service Tribes advise the Indian Health Service that the Reauthorization of the Indian Health Care Improvement Act is not Health Care Reform.

BE IT FURTHER RESOLVED THAT Health care reform legislation must take into account the multiple roles of Indian Tribes in all stages of reform development and implementation.

BE IT FURTHER RESOLVED THAT the Direct Service Tribes advises the Indian Health Service to do everything under its authority to ensure that the Administration, Congress and other interested parties understand the differences as outlined.

BE IT FINALLY RESOLVED, Reauthorization of the IHCIA is critical to ensure that authorities are in place to bring Indian health care into the 21st century and to reduce health disparities in Indian Country.

CERTIFICATION

The foregoing resolution was hereby adopted by the Direct Service Tribes Advisory Committee by a vote of **_5_ In Favor, _0_ Opposed, with _1_ Abstaining** on the **3rd day of June, 2009** at a duly at a duly convened meeting of the Direct Service Tribes Advisory Committee with a quorum present.

George E. Howell, Chairman

Recorded: Ken Lucero, Secretary Treasurer

PREPARED STATEMENT OF JOSEPH ENGELKEN, CEO, TUBA CITY REGIONAL HEALTH CARE CORPORATION

Introduction

Thank you, Chairman Dorgan, Vice Chairman Barrasso, Senator Testor and all the Members of this Committee for allowing us to submit our testimony. As providers of healthcare in Indian country, we thank this Committee for this important hearing. We welcome your leadership in reforming the Indian Health Service (IHS) for the benefit of American Indians and Alaska Natives everywhere.

Background

The Tuba City Regional Health Care Corporation (TCRHCC), is a former IHS operated hospital under the Navajo Area Indian Health Services system, located at Tuba City, Arizona. In 2002, in coordination with the IHS, the Navajo Nation authorized a contract according to the Indian Self Determination provisions of Public Law 93-638, designating TCRHCC a '638 Tribal Organization.' TCRHCC employs nearly 800 people and is a Regional Medical Center for northern Arizona serving over 28,000 primary care patients and specialty care services for over 75,000 (regional) referrals. Geographically, TCRHCC's medical service area in northern Arizona includes a majority of the western portion of the Navajo Nation, the Hopi Village of Moenkopi, the cities of Flagstaff and Page located in the northern regions of Coconino County and Navajo County.

Indian Health Service Medicaid Reimbursement Rate is Killing Us

The Office of Management and Budget (OMB) has one Medicaid reimbursement rate for all Indian Health Service (IHS) facilities, whether those facilities are outpatient clinics or regional medical hospital centers. The current rate of IHS Medicaid reimbursement in the lower 48 states is $268 per client, per visit, regardless of the type or quantity of procedure a facility provides. This "one size fits all" Medicaid reimbursement rate is suitable for Out-patient Clinics but grossly underfunds Regional Medical Centers providing more comprehensive specialty services.

A reimbursement rate of $268, which is based upon a sore throat model of need, can not begin to cover the cost of such high intensity, critical care trauma, which costs on

average $28,000 to $30,000 per patient. The IHS Medicaid reimbursement cap forces regional critical care medical centers on Indian reservations to refer specialty care cases to tertiary care facilities outside of the IHS system. Ironically, these outside providers receive market rate reimbursement, which means that the federal government is paying more in referral costs than it would spend on a new, more realistic Medicaid reimbursement rate(s) for IHS critical regional care medical centers. This model only serves as a disincentive for medical centers like TCRHCC from developing specialty and critical care services "at home".

A study is needed immediately to look into the cost efficiencies of creating a higher, second level of OMB reimbursement for IHS regional medical centers. The study should assess whether higher reimbursement rates would promote the development of specialized medical care, such as oncology, orthopedics, general surgery and trauma, on Indian reservations. An additional component of the study should focus on how the creation of a separate, higher reimbursement rate for approximately 20 IHS regional referral hospitals would impact the more than 1,000 IHS outpatient clinics.

The findings of a study on the IHS Medicaid reimbursement should be reflected in reforms this Committee seeks through reauthorization of the Indian Health Care Act.

Lack of Tribal Trauma Systems is Killing our Patients

TCRHCC is the first certified regional trauma center on tribal lands in the United States. Unfortunately, trauma systems do not exist within Indian Country. The lack of such systems on reservations is literally killing us because the golden hour does not exist on reservations.

Trauma is a time sensitive condition and every reservation in the country lacks the trauma systems needed to mitigate the risk of death within the first hour of injury – the golden hour.

As a result, motor vehicle accidents are the number one cause of death among younger Native Americans, with the trauma rate on the Navajo Nation being 215% higher than the national average. People have a far greater chance of surviving accidents off an Indian reservation because there are trauma care systems nearly everywhere else in America.

A Trauma Care System is part of an integrated regional emergency medical system centered around designated regional trauma centers. Its components include:

- Trained Personnel: Rescue personnel trained in Advanced Trauma Life Support and Advanced Cardiac Life Support;

- Access: Regional response organizations to ensure access and to optimize the golden hour;

- Agreement: Memorandums of Agreement among hospitals, transport and specialty care.
- Transportation: Ambulances – ground and air - for EMS transport, inter-hospital transfers with right level professional staff; and
- Specialty/Critical care centers.

We implore this committee to hold a separate hearing on this important issue and elevate it to a high priority within your own Indian health care reauthorization bill.

Conclusion

Once again, we urge this Committee to also consider a future field hearing in Tuba City, Arizona on the Navajo Nation.

Thank you.

PREPARED STATEMENT OF ROBYN SUNDAY-ALLEN, CEO, CENTRAL OKLAHOMA AMERICAN INDIAN HEALTH COUNCIL, INC.

Good day, Mr. Chairman and distinguished members of this committee. I am Robyn Sunday-Allen, CEO of the Oklahoma City Indian Clinic. Thank you for the opportunity to provide written testimony regarding the issue of Health Care Reform. I respectfully request that my written testimony be made a part of the hearing record. My testimony today will address the importance of reauthorizing the Indian Health Care Improvement Act (IHCIA).

The Central Oklahoma American Indian Health Council, Inc., also known as the Oklahoma City Indian Clinic (OKCIC), is an independent non-profit corporation governed by an all Indian Board of Directors. The OKCIC has since its inception in 1974 used the same eligibility requirements as the Indian Health Service; providing services to only members of federally recognized tribes. Our Clinic is one of only two congressionally established urban demonstration programs, the other being our "sister clinic," the Indian Health Care Resource Center of Tulsa, Inc.

On behalf of the Board of Directors of the Central Oklahoma American Indian Health Council, Inc., I strongly urge retention of the existing language in H.R. 2708 Section 513 which maintains the current status of the two Oklahoma Urban Demonstration Projects, and allows our Clinic to continue to operate as a direct care service unit component of an integrated model of health care within the Indian Health Service delivery system.

Oklahoma Demonstration Projects

Both the Oklahoma City and Tulsa projects originally contracted with the Indian Health Service (IHS) under Title V of the IHCIA as Buy Indian contractors. In the years following the enactment of the IHICIA, Urban Health Programs remained seriously underfunded and were vulnerable to efforts to reduce funding or even eliminate programs. In 1987, the Oklahoma Congressional delegation proposed that the two urban programs in Oklahoma become demonstration projects, examining the potential value of allocating funds to them from the IHS Hospitals and Clinics account rather than from Title V (Urban) funds and further making the allocations to them as if they were IHS Service Units. The authorizing language creating the Oklahoma City and Tulsa Urban Indian Demonstration Projects was contained in the Fiscal Year 1987 Interior Appropriations Act, and subsequently placed on a more firm basis in the 1992 reauthorization of the Indian Health Care Improvement Act. We are requesting that the Congress further support these special programs through language contained in the proposed reauthorizations for 2009.

In Fiscal Year 1994 the Congress provided funds for facility replacement. The IHS provided the House and Senate Appropriations Subcommittees with an analysis of local service units needs **including the two demonstration sites** based upon an IHS formula called "Level of Need Funded". Congress, based upon the report, provided explicit instructions to the IHS as follows:

"...Within the increased provided, funds may be used for a new lease for expanded space..." (Senate Report 103-114)

As a result of this congressional direction, both Demonstration Projects promptly moved to develop new and expanded replacement facilities, permitting them to relocate from existing rundown store front facilities not designed for patient care. As a result, in 1995 the Oklahoma City Indian Clinic began serving patients from its new 27,000 square foot Corrine Y. Halfmoon Medical Facility, delivering a wide range of services, including medical, dental, behavioral health and substance abuse, optometry, laboratory, radiology, and pharmacy. This was possible only because the Oklahoma City Indian Clinic existed as a demonstration project.

It is important to note that because the Oklahoma City and Tulsa populations were included in the Area-wide eligible population, and their populations included in the IHS allocation of resources to the Oklahoma City Area, no funds were diverted from the other IHS programs to support the new Demonstration Projects.

The demonstration projects are unlike other IHS tribal, or other urban programs. Both are appropriately unique as demonstrations and are perhaps best considered to be "hybrids," possessing some of the characteristics possessed by other IHS/Tribal/Urban delivery systems. The "hybrid" status is relevant to the fact that the entire state of Oklahoma is a "Contract Health Service Delivery Area" (CHSDA). As a statewide CHSDA, Indian beneficiaries may reside anywhere in the state and still maintain their IHS eligibility for direct and contract health services. The entire Oklahoma Indian population, including that of Oklahoma City and Tulsa, is counted in IHS calculations for resource allocations to the Oklahoma Area. **Oklahoma City and Tulsa Urban populations account for a significant proportion of the resources that are allocated to the Oklahoma City Area. Between the two programs, more than 30,000 patients are provided health care. The Oklahoma City Indian Clinic provides services under an open-door policy to 15,412 patients who represent 234 federally recognized tribes in the United States, employs a diverse staff of over 100 individuals, and adheres to IHS's Indian preference hiring policy. All of the OKCIC's Board of Directors are enrolled members of a federally recognized tribe and reside in the urban area they serve.**

OKCIC is accountable to the population it serves, comprising members of federally recognized tribes throughout the United States. As such, the demonstration projects actively support tribal sovereignty. Urban health care programs such as the Oklahoma City and Tulsa Clinics have absolutely no reason to be anything other than staunch supporters of tribal sovereignty. It is worth emphasizing that the OKCIC is governed by, primarily staffed by, and serves only American Indian/Alaska Natives all of whom are members of tribes.

The two demonstration projects fill an important void in access to health services. Logistically, our patients reside too far away from alternative IHS or tribal providers.

OKCIC and the Tulsa Clinic are active partners with the IHS and tribal health facilities. The Urban facilities offer services to tribal members that do not live on tribal lands or in the tribal jurisdictions for services.

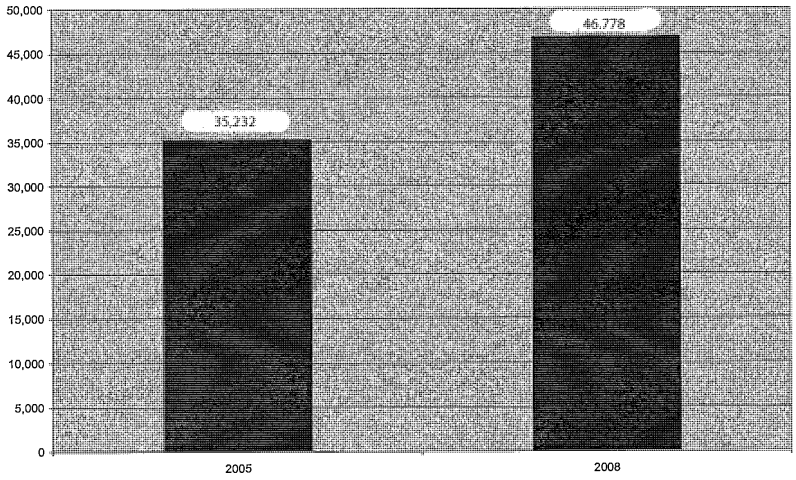
The Demonstrated Projects Have a Record of Outstanding Success

The Demonstration Projects have been able to document significant contributions to the health care delivery system in Oklahoma by:

- Constructing new state-of-the-art health care facilities that provide a full-range of services at absolutely no cost to the patient or tribe. The OKCIC is accredited by the Accreditation Association of Ambulatory Health Care (AAAHC).

- The OKCIC continues to show an increase in the total number of outpatient visits. The number of outpatient visits provided to the Oklahoma City urban population has increased by 33% from 2005 to 2008 being limited only by lack of additional funds, space, and staff (Figure 1).

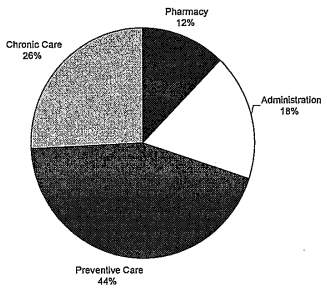
Figure 1 - A comparison of Outpatient Visits to Oklahoma City Indian Clinic 2005 and 2008



There is not an IHS, tribal, state or community health Clinic that could absorb this volume of patient services.

- Our focus is on prevention. Forty-four cents on every dollar is spent on prevention while maintaining an administrative cost of less than 20 cents on the dollar (Figure 2).

Figure 2- Expenditures by OKCIC FY 2008



- Both demonstration projects utilize the IHS resource patient management system (RPMS) for patient tracking, data collection, and reporting.

- The OKCIC participates in the data collection for the Government Performance Results Act (GPRA). In GPRA year 2008, the OKCIC met or exceeded 86% of all GPRA standards. OKCIC is on track to meet or exceed 100% of the national GPRA standards for GPRA year 2009.

- Both demonstration projects are the only Urban diabetes programs in the nation that hold the status of IHS Integrated Diabetes Education Recognition Programs.

- The OKCIC is one of only two Urban programs nationally that have been chosen by the Director of the IHS to participate in Innovations in Planned Care (chronic care initiative) in partnership with the Institute for Healthcare Improvement.

Health Care Reform

The OKCIC in conjunction with the National Indian Health Board, National Congress of American Indians, and the National Council of Urban Indian Health supports health care reform and seeks to ensure that the Indian health care delivery system is strengthened and improved so that Indian health programs benefit from reformed systems. This can be done by reauthorizing the IHCIA (Dorgan Staff Concept Paper, 2009).

The IHS has been characterized over the past decade as a "broken" system. The truth is that the IHS system is not a broken system but one that is "starved" (Jefferson Keel oral testimony, 2009). When increases in special appropriations or overall budgets occur, programs at the OKCIC show favorable outcomes in regard to patient services.

In 1997 the OKCIC began receiving special funding through Congress for the Special Diabetes Programs for Indians (SDPI). The SDPI budget has grown from $105,711 in 1997 to $396,679 in 2008. With the increase in budget, the OKCIC diabetes program has been able to show and demonstrate significant improvements in the health status patients with diabetes. For example, with this program the average hemoglobin A1C (average blood sugar over 3 months) of our patients with diabetes has improved from an average of 8.4 to 7.4. Further the proportion of diabetes patients with adequate blood pressure control has increased from 22% to 61%, an extraordinary improvement that undoubtedly is among the best in the nation for any population. Finally, the proportion of patients with diabetes with LDL cholesterol of less than 100mg/dl increased from 27% to 58%, again extraordinary improvement.

The data is being presented to demonstrate the need to increase funding for a system that is not broken but one that has learned to operate as optimally as can be expected with limited resources. The OKCIC diabetes education program is an example of what an organization can do with an increase in appropriations.

Conclusion

The mission of the Oklahoma City Indian Clinic, a specially congressionally created urban demonstration project, is to promote and elevate the health status of American Indian people in the Oklahoma City metropolitan area to its highest possible level. The staff of qualified and culturally sensitive health professionals provide comprehensive services to the Oklahoma City Indian Community.

Spanning 35 years of service to urban Indians, the Oklahoma City Indian Clinic strives to be Central Oklahoma's clinic of choice for the Native American community. We work constantly to improve and expand our programs in creative and innovative ways. The heart and soul of the Clinic truly is the patients we serve.

I urge the Congress to reauthorize the Indian Health Care Improvement Act with the language of Section 513 in the "as introduced" version of H.R. 2708. This language would make the two Oklahoma Demonstration Projects (1) permanent programs (2) continue to be treated as operating units in the allocation of resources (3) not be subject to tribal compacting and contracting provisions of the Indian Self Determination Act. The language is necessary to provide the stability necessary to permit the projects to continue to function as congressionally mandated demonstrations.

PREPARED STATEMENT OF MICHAEL COOK, EXECUTIVE DIRECTOR, UNITED SOUTH AND EASTERN TRIBES, INC.

Mr. Chairman and Members of the Committee:

My name is Michael Cook. I'm an enrolled member of the St. Regis Mohawk Tribe, located in upstate New York. I've been a long time advocate for Indian people, having served as Tribal Health Director for my Tribe, the Oneida Indian Nation as the Government Programs Director, and now in my current position as Executive Director of the United South and Eastern Tribes, Inc. (USET).

First, I'd like to thank you for taking time out of your busy schedule to hold this very important hearing and allowing Tribes an opportunity to provide testimony on the Indian health reform efforts.

USET Background

USET is a non-profit inter-Tribal organization that represents twenty-five (25) federally recognized Indian Tribes. The USET membership consists of Direct Service, Contract and Compact Tribes. The Tribes are located in twelve different States from Maine continuing south to Florida then across to eastern Texas. The USET member Tribes have always maintained that the government-to-government relationship exists between the Federal Government and federally recognized Indian Tribes. Therefore, the following comments are made in accordance with this principle.

Indian Country and Health Reform

With the legislative effort to improve access to health care for many millions of uninsured or underinsured Americans will, without question, impact the Indian health system through which health care is now delivered to some 1.9 million American Indians/Alaska Natives (AI/ANs). As you know, the Indian health system is unique in that it was created and designed by the Federal government to carry out the Federal trust responsibility for Indian health. In addition, Federal policy dictates that the Federal Government interact with Indian Tribes on a government-to-government basis. Tribes must be viewed as partners with the Federal government in the national effort to reduce costs, guarantee provider choice, and ensure access to affordable quality healthcare for all.

The Indian health system has evolved over time and by large has been successful at recognizing and responding to the challenges of serving a diverse and very poor population community with health status that is unacceptable by any measure. Significant inroads have been made but improvement is still needed. The lack of adequate funding hampers the quality of care that is provided to American Indian/Alaska Natives. If the Indian health system was provided adequate funding for all services they could focus more on health care quality improvement activities which would ultimately improve the overall level of health care services to Tribal communities.

On June 4, 2009, USET convened a Tribal Roundtable to discuss how Indian Country can be engaged in the health care reform efforts and to develop an official position to send forward to Congress. The position document developed from this meeting was sent to your staff on June 5, 2009. I'll touch on some of the issues that were discussed during the below.

1. Reauthorization of the Indian Health Care Improvement Act (IHCIA). Like the rest of Indian Country, USET supports and encourages passage of the IHCIA. The IHCIA is the foundation for the Indian Health Care system and reauthorization would be a vast improvement toward reforming the health care delivered to AI/ANs.

2. Consult with Tribes across the country to be sure health reform policies and regulations are developed in a way that will create positive changes in the diverse Indian communities.

3. Include Tribal representation on key commissions, boards and other groups created by health reform legislation, and direct the Secretary of Department of Health and Human Services (HHS) to consult with Tribes on health reform policies and regulations.

4. Permit the health status of Indians to be raised to the highest possible level. The Indian Health Service budget must be protected from offsets and must be enhanced to assure that Indian programs can attract and retain health care personnel needed to fulfill the Federal government's trust obligation.

5. Extend the new Indian-specific provisions of American Recovery and Reinvestment Act and Children's Health Insurance Program Reauthorization Act to all health programs in which the federal government participates financially.

6. Apply Federal law protections. The protections afforded to Indians regarding their participation in Medicaid should apply to their participation in a health reform insurance plan. This is merely augmenting an existing program to include a broader spectrum of programs. Indians should be exempt from all cost-sharing (including premiums, co-pays, and deductibles), consistent with the recent amendment made to Title XIX by Sec. 5006(a) of P.L. 111-5 for Medicaid.

7. Out of State Medicaid applicability. USET fully supports the proposal of the Senate Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs associated with a patient who travels out of state in order to receive culturally competent care at an Indian health facility, including behavioral health needs and substance abuse treatment. USET Tribes continued to battle the issue of cross-border payments. Within the USET area, there are two culturally competent substance abuse treatment facilities, Partridge House (an adult program in upstate New York) and Unity (a youth program in Cherokee, North Carolina). Tribes are forced to limit the number of patients they send to these out-of-state programs due to cost, as state Medicaid will not cover the costs of out-of-state care, even if there

are no comparable facilities within the home-state. So extending the Senate Finance Committee proposal to include adult Indian coverage would a great success for the USET Tribes.

8. Medicare amendments. The Medicare laws should be amended to provide 100% payment to the Indian health programs for covered Medicare. At present, the current rate for Medicare reimbursement is at 80% for regular qualifying services. This would infuse over $40 million more into the Indian health system annually.

9. Payor of Last Resort. Indian health systems must always remain the payor of last resort. IHS is funded at the fifty percent level of need. Mandating that IHS is the payor of last resort will conserve the already stretched budget.

10. Authority to decide whether to serve non-Indians at a Tribally-operated health facility. Tribes are aware that the demand for health services will greatly increase in a reformed health care environment and Tribes are likely to be asked to open their doors to service non-Indian patients. This is a challenging decision that should be left to the Tribal Governments. To those Tribes who are willing to expand accessibility to health care by serving non-Indians, the legislation must extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. This is consistent with the FTCA coverage extended to community health centers which receive funding from HRSA under Sec. 330 of the Public Health Service Act.

11. Health Care Facilities. The quality and capacity of facilities throughout Indian Country differs widely as the IHS construction budget has never kept up with the level of need. Thus, Tribes need the authority to explore innovative ideas for addressing facility needs. Include language from the 110th Congress IHCIA Reauthorization bill (S.1200): Sec 301(f) DEVELOPMENT OF INNOVATIVE APPROACHES. The Secretary shall consult and cooperate with Indian Tribes and Tribal Organizations, and confer with Urban Indian Organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, that may include: (1) the establishment of an area distribution fund in which a portion of health facility construction funding could be devoted to all Service Areas; (2) approaches provided for in other provisions of this title; and (3) other approaches, as the Secretary determines to be appropriate.

12. Workforce. Indian health programs already have a difficult time recruiting and retaining needed health care professionals. Competition for health care workforce personnel will intensify as millions of individuals become insured. The IHS budget must be enhanced to assure that Indian programs can attract and retain health care personnel. The legislation should expand the categories eligible for scholarship and loan services, increase funding to train and support alternative provider types with have proven records of providing quality care (i.e. community health representatives, behavioral health and dental health aids, etc.), and establish a mentorship program to increase interest in entering the health professions field.

13. Inclusion of IHCIA provisions within the reform legislation. Since the IHCIA has not yet achieved enactment, Congress should consider including the provisions identified in the NCAI/NIHB/NCUIH position document, submitted on May 31, 2009, in any reform legislation.

Indian Tribes are Sovereign Governments

The USET member Tribes believe Indian Tribes are sovereign governments and should be treated as such by the United States. There are several recommendations being discussed that could either affirm or infringe upon the sovereign rights of Indian Tribes (i.e. decisions to serve non-Indians, determining eligibility, etc). USET recommends that the U.S. Congress consider the impacts to Tribal governments and consult with Indian Tribes before imposing any mandates.

Conclusion

The USET member Tribes appreciate the efforts of the Administration and Congress to include Tribal Governments in the discussion regarding this important issue. I thank you on behalf myself and our member Tribes for the opportunity to provide this testimony and look forward to working in a consultative and collaborative effort with the Administration and Congress to develop legislation and policies that:

1. Promote the fulfillment of the United States' trust responsibility towards Tribes.
2. Recognize, reaffirm and support the sovereign rights of Tribal Governments.
3. Protect or improve upon existing legislation, rules/regulations and policies that Tribal Governments currently benefit from.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO BUFORD ROLIN

Behavioral Health

Question 1. In the absence of expressed authority, what types of behavioral health services are being provided by tribes?

Answer. Behavioral health programs in Indian Country address key health priorities such as suicide prevention, violence/injury prevention, and alcohol/drug use prevention. Services may include mental health and alcohol and drug assessments, counseling, consultation, and training services. In the delivery of behavioral health services, many Tribes emphasize a culturally sensitive method that respectfully integrates tribal spirituality and cultural awareness into the full range of behavioral health assessment and treatment.

Examples of these programs include:

- From Legacy to Choice—A suicide prevention program run by the Colville Confederated Tribes.
- Youth Prevention Programs—The Penobscot Nation Health Department supports various youth programs that provide skills in the areas of substance abuse prevention, chronic disease prevention and suicide prevention.
- The Home Grown Project—A healthy eating program developed by the Little Traverse Bay Bands of Odawa Indians to encourage nutritious eating by utilizing a more traditional approach/relationship with growing, gathering and cooking food.
- Healthy Lifestyle Programs—The Houlton Band of Maliseet Indians implemented seven behavior health programs to address tobacco prevention, increased physical activity, diabetes self-management and nutrition.

Additionally, the Indian Health Service Health Promotion and Disease Prevention Program has compiled a database of the best and promising practices and local efforts in Indian Country regarding behavioral health. Topic areas include cardiovascular disease, oral health, injury/violence, mental health, overweight/obesity, sexual behavior, substance abuse, physical activity, and tobacco use. To access the comprehensive database of best and promising practices and local efforts, please visit: *http://www.ihs.gov/hpdp/* or *http://www.ihs.gov/NonMedicalPrograms/HPDP/BPTR/index.cfm?module=BestPractices&option=BPPPLE*.

However, not all tribes are able to provide such integrated services or have limited availability of such services due to chronic under-funding. The proposed Title VII in the Indian Health Care Improvement Act would provide the authority for all tribes to have authority to access comprehensive behavioral health programs to address the behavioral needs of their tribal members. In addition, additional funding would enable IHS and Tribal governments to provide culturally appropriate behavioral health services in a more timely and efficient manner.

Question 2. How are behavioral health services being funded?

Answer. Tribal behavioral health services may be funded through a number of sources such as:

- Office of Minority Health (example: Cooperative Agreement with the Association of American Indian Physicians)
- Office of Juvenile Justice and Delinquency Prevention Tribal Youth Program
- Indian Health Service
- Substance Abuse & Mental Health Services Administration
- Center for Disease Control and Prevention

- Department of Health & Human Services (via various grant opportunities through the agencies and divisions of the DHHS)
- State and local agencies/health departments
- Tribes (through the Public Law 93–638 contract with the Bureau of Indian Affairs and a Self Governance Compact with the Indian Health Service)
- Health organizations (e.g. American Heart Association, American Diabetes Association)
- Private entities/donors

Question 3. Do you know of any successful tele-mental health programs being operated in Indian Country?

Answer. The Indian Health Service has compiled a database of current Telemedicine programs existing in Indian Country broken down by the twelve Tribal areas. The IHS reports that there are about forty telemedicine programs and partnerships within the IHS that are delivering care to smaller, more isolated communities. These programs (including mental health programs) are listed on the IHS Telemedicine website at *http://www.oehe.ihs.gov/telemed/*.

Creditable Coverage

You stated in your testimony that IHS does not qualify as creditable coverage in all instances, but that sometimes it does or should for "protections". This concept is new to the Committee.

Question 1. In what instances would IHS be considered "creditable coverage"?

Question 2. In what instances would IHS not be considered "creditable coverage"?

Question 3. Has Indian Country considered other terminology to alleviate the confusion?

Answer. The implications of the term "creditable coverage" can only be understood in the context of the program or policy in which the term is used. In the Medicare Part D context, for example, a Medicare beneficiary who already has prescription drug coverage which meets the minimum requirements of Part D would not suffer any adverse consequences if he/she retained the existing coverage instead of enrolling in a Part D prescription drug program immediately upon becoming eligible to do so. By contrast, a Medicare beneficiary without "creditable coverage" who delayed enrolling in a Part D plan as soon as he/she became eligible would be subject to a late enrollment penalty when he/she did decide to enroll. The amount of the penalty is calculated according to the number of months delay in enrollment.

The prescription drug programs operated by IHS, tribes and urban Indian organization (I/T/U) pharmacies were declared to be "creditable coverage" for purposes of Medicare Part D. Thus, an Indian Medicare beneficiary served by an I/T/U pharmacy would not be subject to a late enrollment penalty if he/she later decided to enroll in a Part D plan—which might occur if the Indian moved to a location where an I/T/U pharmacy was not available to him/her.

The term "creditable coverage" is not used in any of the draft health care reform bills released so far. The Senate HELP draft uses the term "qualifying coverage", and the House draft employs "acceptable coverage". In essence, both terms are intended to describe existing health insurance coverage, which includes certain minimum benefits set out in the drafts. If the coverage does not meet these minimums, the individual is considered uninsured. Such an uninsured individual is required to comply with the individual mandate—meaning he/she must acquire "qualifying" or "acceptable" health insurance coverage. Failure to do so would result in assessment of a penalty in the form of a tax.

In most cases, the health services offered by I/T/Us do not meet the minimum benefits packages because IHS programs are so badly funded they cannot afford to supply the minimum required services.[1] In that case, IHS would not be "qualifying coverage" or "acceptable coverage", and the Indian beneficiary would be subject to the individual mandate, and to the tax penalty if the individual does not purchase or otherwise obtain such coverage. Assessing a penalty on an Indian who was promised adequate health care by the United States but does not receive the appropriate level of care, would, in our view, constitute a gross violation of the trust responsibility for Indian health. That is why Indian Country has asked that individual Indi-

[1] The Congressional Budget Office, in its paper titled *Key Issues in Analyzing Major Health Insurance Proposals* (Dec. 2008), observed (at page 127): "Because of staff shortages, limited facilities, and a capped budget, the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population; as a result, estimates of the uninsured population in the United States do not treat the IHS as a source of insurance."

ans be exempted from the penalty for failing to comply with the individual mandate called for in the health care reform proposals.

Furthermore, it must be noted that IHS offers direct care services to Indian beneficiaries; *IHS is not an insurance program.* In that sense, then, eligibility for IHS services is very different from having insurance coverage.

Health care reform proposals are expected to offer subsidized insurance to low/moderate income individuals and families who do not have qualifying/acceptable coverage. Indian Country wants to assure that eligible Indian individuals can qualify for these subsidies to the same extent as all other Americans, and that Indians enrolled in such insurance plans can use their benefits at I/T/U providers.

At the same time, Indian Country wants to assure that Indian people who currently receive care from an I/T/U can, at some future date, elect to enroll in a subsidized (or even an un-subsidized) health insurance plan *without* suffering any penalty for a delay in enrollment—such as a late enrollment penalty or a waiting period for eligibility—consequences that might otherwise attach to a delay in enrollment.

You ask whether Indian Country has considered using terminology other than "creditable coverage" to avoid confusion. Selecting other terms is not within Indian Country's authority. We must work with the terms used in each legislative proposal and make sure that we know what they mean in any given bill. When Indian Country developed its first policy paper for the health care reform debate, no draft bills had yet been released. Thus, we used the terminology of "creditable coverage" as that term was already in use in Medicare Part D and other health insurance contexts.

Cost Sharing

Question 1. Has the National Indian Health Board discussed tribally imposed cost sharing provisions?

Answer. The issue of whether a tribally-operated health program charges a co-pay to an Indian beneficiary is and should remain a decision made by the tribe in the exercise of its self-determination rights.

Question 2. Do you have a sense of what Indian Country's view of this issue is?

Answer. Like other issues affecting Indian Country, there are tribes who support and tribes who are against cost sharing levied by tribes for tribally delivered health care. Although there is not a uniform perspective across Indian Country, this decision, like other areas affecting a tribe's administration of its government and services, should be left for Tribes to decide.

Working in Partnership

You stated, with emphasis, the interest of working in partnership with the Committee on reforming the IHS facilities construction and Contract Health Services programs. This Committee agrees that the best solutions will be developed in partnership with the tribes, tribal organizations, urban organizations and IHS.

Question 1. Is there the perception that the Committee has not worked in partnership with key stakeholders like the National Indian Health Board?

Answer. Our emphasis on "working in partnership" with this Committee was by no means intended to convey the notion that such a cooperative relationship does not already exist. We believe that it does—and are very grateful for it.

The emphasis was merely intended to recognize that any legislation which would make changes in the operation of critical programs such as facilities construction and CHS must be supported by both the lawmakers who order them and the tribes who will be impacted by them. We sincerely doubt that this Committee would ever want to force on the Indian health system alterations whose consequences have not been fully considered and found to be desirable. We seek the opportunity to examine in detail any proposed changes; in fact, we have a responsibility—both to the Committee and to our beneficiaries—to do just that. If we believe a new idea will *strengthen* the system's ability to provide better/greater care to Indian people, we will support it; but if we believe a change would *harm* the system, we know you want us to tell you that, too.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO BUFORD ROLIN

Personnel Shortages

Your written testimony urges some new approaches to address the personnel shortages in the Indian health system.

Among other things, you suggest revising mechanisms for assignment of National Health Service Corps personnel.

Question 1. How would you revise those National Health Service Corps mechanisms to be more user-friendly for the Indian health system?

Answer. The placement of National Health Service Corps personal would help address the significant shortage in personal within the Indian health care system. However, the competition with other Health Professional Shortage Areas (HPSAs) for National Health Service Corps personnel decreases the probability for placement. HPSAs are designated by Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Although an Indian health service site is likely to located in a designated HPSA, Tribes and IHS must compete with other designated HPSA areas for the limited Corps personal available. The other qualified sites typically have a larger population and the ratio for need is likely higher.

Another limitation of placement of National Health Service Corps personnel in IHS or Tribal facilities is the requirement that qualified sites must accept all patients who can receive care covered by Medicare, Medicaid, and The Children's Health Insurance Program. Currently, I/T/U may not have the physical capacity or resources to provide services to non-Indians who may qualify to receive care under these entitlement programs. An example of a solution to this issue is in the House bill H.R. 2708. Sec.124 (b) provides that for the service of National Health Service Corps member assigned to an I/T/U may be limited to the persons eligible for services from the I/T/U.

Question 2. How could telehealth programs assist in addressing personnel shortages in the Indian Health System?

Answer. Through telehealth programs, patients located in geographic isolated areas of Indian Country, may received initial diagnosis and services from medical staff located miles away. Application of such programs could reduce the need for health care personnel, reduce travel for health care professionals and patients and improve diagnosis. Various I/T/U sites could all rely on the same specialists for care. The health care professional would also gain an experience in delivering care to the AI/AN population. Also, telehealth programs would reduce the need for such health professionals and patients to travel long distances during unsafe weather periods. Only patients who require necessary care in person would be required to travel. Likewise, only health professionals who had to provide care in person would be required to travel to isolated and remote tribal communities. Lastly, telehealth programs provide the opportunity for the initial diagnosis or review of such diagnosis to be conducted by experience specialists located in other parts of the country.

As noted in a response to Senator Dorgan, there are forty telemedicine programs and partnerships within the IHS that are delivering care to smaller, more isolated communities. These programs are listed on the IHS Telemedicine website at *http://www.oehe.ihs.gov/telemed/*.

Your written testimony also recommends expanding funding to train and support alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aid therapists. Several of these alternative providers are already authorized under the Indian Health Care Improvement Act for the Indian health system.

Question 3. How would those alternative providers which are not authorized across the Indian health system such as the dental health aide therapists be regulated?

Question 4. What standards of practice or care would apply to the services performed by these alternative providers?

Answer. Dental health aide therapists are regulated under the Indian Health Care Improvement Act now, as they are part of the Community Health Aide Program (CHAP) for Alaska authorized by Sec. 119 of the current law (25 USC § 1616l). That provision requires CHAP aides and practitioners to undergo rigorous training programs with established curricula, and to quality for certification from the Community Health Aide Certification Board. Their work is subject to ongoing review and evaluation "to assure the provision of quality health care, health promotion, and disease prevention services." 25 USC § 1616l(b)(6).

Current law authorizes the CHAP program to operate in Alaska, only. Tribal leaders have supported expansion of CHAP authority to tribes in the Lower 48 states, and S. 1200, the 110th Congress bill from this Committee, contained such a provision. If enacted, new money and development of appropriate curricula and certification standards would be needed to implement the Lower 48 authorization. Because of issues previously raised by the American Dental Association, the 110th

Congress legislation did not permit expansion of the dental health aide therapist component of the CHAP program to Lower 48 tribes. Instead, the legislation ordered an evaluation of Alaska's DHAT component. Presumably, if that evaluation demonstrates the value and soundness of DHAT services, as we expect it will, the Committee would recommend new legislation to permit Lower 48 tribes to also offer a DHAT component in the CHAP program.

With regard to standards of practice, the CHAP aides and practitioners in Alaska must comply with the standards set by the Certification Board for each discipline. This same procedure would be followed for regulation of CHAP programs for Lower 48 tribes if program authority is extended to them.

Facilities

The committee received testimony that pre-fabricated health care facilities have been constructed in this country and in Iraq which have cut construction costs and time delays.

Question. How would these types of in-patient and out-patient facilities fit within the Indian health care system?

Answer. Such facilities may be tailored to address the unique health needs of each tribal community. For example, a tribal community with a high rate of diabetes but without local access to a dialysis treatment facility may consider having a pre-fabricated facility serve as its own dialysis center. Indeed, there are many possibilities to incorporate such facilities into the Indian health care system. Still, due to the prevalent presence and historic experience with prefabricated and mobile homes in tribal communities, Indian people may be initially hesitant to using pre-fabricated buildings as their tribal health care facilities. Indian Country must be reassured that such facilities are safe and cost efficient. In addition, there must be a guarantee that such structures satisfy all building safety codes. Serious discussions must occur in each tribal community to determine that if this tribe would like this type of structure and the structure can addressed the health needs of the community.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO BUFORD ROLIN

Question 1. How does the tribal experience with stimulus funds provide any insights for Indian Health Care Improvement reauthorization, or is it too soon to tell?

Answer. It is probably too soon to fully evaluate the extent of stimulus funding provided for construction and maintenance of Indian health facilities, although the promise of funding for the two projects identified for new construction has brought the hope for better and expanded health care to the tribal communities in which they are being built—Barrow, AK and Eagle Butte, SD. Both communities have waited a long time to qualify for facility construction. While we are grateful that these projects can now move forward, there are many projects on the IHS facilities construction priority which still await funding, and many more tribal communities in need of facilities who have not yet had the chance to be added to the priority list.

It was a big disappointment to Indian Country to learn that none of the $85 million appropriated for health information technology will be made available to tribes who operate health programs. Rather, the IHS Director decided that all funds will be retained and expended at the headquarters level. This decision denies tribally operated programs the resources needed to upgrade their health IT systems and to realize the efficiencies upgrades would provide. The IHS Director's decision also means that tribes will not be able to take advantage of the incentives/rewards federal law offers to health programs, which meet IT goals.

Question 2. What is available for the tribes to help Indian people develop health behavior—such as smoke free and having a healthy weight, in order to prevent diabetes and heart disease?

Answer. Focusing on wellness is good public health practice and reflects Tribes' traditional cultural values. Tribes cite a variety of effective strategies, including: community-based health education, patient case management, screening and early detection campaigns, training for healthcare professionals, and incorporating traditional healing approaches to improve wellness. As noted in a previous response to Senator Dorgan, the IHS's Indian Health Service Health Promotion and Disease Prevention Program has compiled a database of the best/promising practices and local efforts in Indian Country regarding behavioral health. Topic areas include cardiovascular disease, oral health, injury/violence, mental health, overweight/obesity, sexual behavior, substance abuse, physical activity, and tobacco use. To access the comprehensive database of best & promising practices and local efforts, please visit:

http://www.ihs.gov/hpdp/ or *http://www.ihs.gov/NonMedicalPrograms/HPDP/BPTR/index.cfm?module=BestPractices&option=BPPPLE*

Question 3. With health care reform about to be debated in Congress, what changes would tribes recommend to enhance the health outcomes of Native Americans?

Question 3a. What are the major stumbling blocks to improving these outcomes? What assets/strengths helped tribes achieve the successes that have been reached so far?

Answer. Since our system suffers from chronic underfunding (we are funded at only 54% of need), the most meaningful and beneficial "change" we can recommend is to greatly improve the level of resources supplied to the Indian health system. The budget process for Indian health must build in automatic increases for medical inflation and population growth merely to avoid losing ground, and it should routinely request actual program funding increases to enhance the quality and quantity of care these programs should be providing. In addition, the unmet backlog of facilities needs remains staggering—in the billions of dollars.

Health care reform could pump additional revenue into the Indian health system by assuring that Indian providers have full opportunity to participate in provider networks serving individuals enrolled in insurance products listed on the proposed insurance Exchange/Gateway. We heartily support reform proposals which would encourage prevention/screening services by exempting such services from patient copays. Also, incentives to enlarge the health workforce must apply to the Indian health system which constantly experiences difficulty in recruiting and retaining health care professionals in all specialties.

In terms of identifying assets/strengths which have helped tribes achieve successes that have been reached so far, tribal contracting/compacting of health care programs gets my vote. The Indian Self-Determination and Education Assistance Act has empowered tribes in all areas of Indian Country to become knowledgeable about health care delivery; to design programs which respond to local community needs; to hire and train community members to operate programs and deliver culturally appropriate care; and to be accountable to their beneficiaries for program outcomes. Because of chronic resource shortages, we are constantly challenged to do more with less and to develop more efficient methods of operation. Knowing how much tribally-operated programs have achieved with inadequate funding makes me dream of how we could improve the health status of Indian people if we were funded at our *real* level of need.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO GEOFFREY ROTH

National Needs Assessment

Question 1. What federal agency would the urban programs propose to conduct a needs assessment study?

Answer. In 1981 the Indian Health Service conducted a comprehensive needs assessment not bound to the current locations of the urban Indian health programs. This was not only the last study conducted on the needs of the urban Indian community, but the most comprehensive needs assessment conducted for the urban Indian community by any federal agency. This study is the basis upon which NCUIH has developed its own recommendations for a new needs assessment.

Given the good work that the Indian Health Service did with that assessment, NCUIH would suggest that IHS be the ideal federal agency to oversee the study. We feel strongly that the study should be undertaken with the maximum amount of urban Indian participation as possible to ensure that such a study is truly reflective and understanding of the unique position of urban Indians.

If the Indian Health Service, for reasons not currently considered, is unable or not the ideal federal agency for conducting—or overseeing the contract/grant process for this study—then NCUIH would suggest either the National Institutes of Health or the Agency for Healthcare Research and Quality. Both of these institutions are well equipped to conduct such a study in theory. However, in practice neither NIH nor AHRQ have undertaken an extensive study involving Native Americans involving social determinants of health. The 2008 AHRQ study on health disparities indicates that AHRQ would find doing such a study for urban Indians to be difficult as they cited difficulties obtaining data on American Indians and Alaska Natives as the primary reason for the very short section on AI/AN health disparities in their report.

NCUIH believes that Indian health organizations and epidemiology centers are best equipped to do such a study through collaboration with either the Indian Health Service or NIH. Any contractor chosen to conduct the needs assessment must be thoroughly grounded in and accountable to the urban Indian community.

Question 2. Has your organization considered what methodology and criteria would be required of such a study?

Answer. While NCUIH has not developed a detailed proposal for the needs assessment, recommended methodology is included in Appendix A. NCUIH does rely heavily upon the 1981 needs assessment conducted by the Indian Health Service as a guide for which criteria and methodology should be used, with the caveat that new criteria explained below must be included. That study was a complete analysis of the health status of urban Indians including the social determinants of health. Comprehensive demographic data was pulled from various sources to understand the various communities across the country. Comprehensive demographic data is necessary to determine not only where UIHP providers are needed, but also what kinds of services are needful. The social determinants of health extend beyond traditional health indicators such as health care access to economic and social status.[1] Such details are necessary to better understand the urban Indian community and its needs.

Service access was thoroughly examined in the 1981 report; however, service access, utilization, and availability should be more clearly delineated. These three concepts are imperative for helping identify the health status of American Indians and Alaska Natives and are not interchangeable. For example, a patient may have a particular service available in their community; however they may not be able to access the service. Likewise, a patient may be able to access a service but may not utilize the service for a variety of reasons that include environmental barriers and cultural barriers. Perhaps most importantly, the 1981 report had no focus on health outcomes for American Indians and Alaska Natives. Available, accessible, and utilized health care is ineffectual if people do not receive positive outcomes. Today, we must demand that the available health care people access and use is appropriate, needed, and results in improvements in health. Therefore, examining availability, access, utilization, and outcomes of health care is a necessity in determining the current state of health for urban Indian people. These are the criteria that NCUIH would suggest.

For a full discussion of proposed methodology please see Appendix A.

All-Inclusive Rate, Federal Tort Claims Act Coverage and Federal Supply Schedule

Question 1. Has your organization conducted a review of requirement and/or guidelines for all-inclusive rates, Federal Tort Claims Act coverage and the federal supply schedule to make certain they can be met by the urban Indian programs?

Answer. Unfortunately NCUIH has not had sufficient resources to undertake a comprehensive review of the requirements or guidelines for the all inclusive rate, the Federal Tort Claims Act, or the federal supply schedule. NCUIH could conduct such a review if it would be helpful to the Committee, but has not currently been able to direct resources to doing so. However, NCUIH has developed an initial legal analysis of the FTCA coverage insofar as it could be extended to urban Indian health providers with minimal amendments to current law.

In developing our ask for FTCA coverage for urban Indian health programs, we envisioned the protections largely applying to urban Indian health programs in a manner analogous to the Federally Qualified Health Clinic (FQHC) FTCA protections, which would mean that only those programs providing comprehensive primary care would be eligible for FTCA protections. NCUIH does have a great deal of experience with the FQHC requirements for FTCA coverage as 8 urban Indian health providers are FQHCs. Another 13 are FQHC look-a-likes and 2 are Rural Health Clinics (RHC). Under current law neither FQHC look-a-likes nor RHCs receive FTCA coverage, meaning the majority of urban Indian health programs providing comprehensive primary care services are currently ineligible for FTCA coverage despite meeting all other requirements for FQHC status except receiving a section 330 grant. Some urban Indian health providers have made a principled decision not to pursue 330 status as it would require serving non-Indians. Some urban Indian health providers have decided not to pursue 330 status as they do not have the support staff necessary to maintain the necessary accounting firewall between their Title V grant funds and funds received through a potential 330 grant. These

[1] *See generally, Unnatural Causes: Is Inequality Making Us Sick?* PBS Documentary, 2008; *see further,* "Health Inequality, Not Health Disparities" lecture by Dennis Raphael at the Center for Health Disparities 12/14/2006.

programs have FQHC look-a-like status which confers upon them higher Medicaid/Medicare reimbursement, but does not include FTCA coverage.

Full FQHC programs receive FTCA coverage under the theory that as 330 grant or contract recipients they are contracting with the federal government to provide a service and thus deserve protection from liability for those services. NCUIH believes that those programs who meet the requirements for FQHC look-a-like status and receive a grant/contract under Title V of the Indian Health Care Improvement Act should be treated in an analogous manner as they, like a Community Health Clinic (CHC), are providing clinical health services as part of a grant/contract with the federal government. The 13 FQHC look-a-likes and 2 RHCs already met all necessary requirements for FQHC status except for a 330 grant.

With regard to the all inclusive rate, it is NCUIH's understanding that the all inclusive rate is not the result of any statute, regulation, or other law—but rather the result of an agreement or understanding between the Centers for Medicare and Medicaid and Tribes and Tribal organizations, and thus the requirements are a matter of agency policy and thus do not require legislative activity. As NCUIH currently understands the all inclusive rate, the main requirement is being deemed an eligible Indian health provider by CMS. Currently the agency employees the definition of Indian health program found in the current law text of the Indian Health Care Improvement Act which does not include urban Indian organizations. While changes to existing law—such as 100% FMAP or FTCA coverage—would make negotiations with CMS for the inclusion of urban Indian health providers in the all inclusive rate easier, there exists no law for Congress to directly amend for the inclusion of urban Indians in the all inclusive rate as the all inclusive rate exists nowhere in statute. However, urban Indians could potentially be included within this agreement between CMS and Tribes/Tribal organizations if urban Indian organizations were included in the definition of Indian health program. NCUIH does strongly encourage the Committee to consider writing a letter suggesting that CMS consider including urban Indians in the all inclusive rate.

Question 2. Will the requirements/guidelines require amendments or modifications? Please describe.

Answer. To NCUIH's current understand of FTCA law, and how NCUIH envisions it being applied to urban Indian health providers, requirements/guidelines for that law would not need any major amendments, although not all urban Indian health programs would be able to access FTCA coverage.

NCUIH cannot definitively state at this time whether or not inclusion in the federal supply schedule would require amendments or modifications any applicable federal law as we have been unable to complete a comprehensive legal review of all impacted law. It is, however, NCUIH's initial impression that no amendments or modifications to existing law should be necessary beyond the proposed amendment that urban Indian health programs be given similar status as Tribal health organizations, though of course deferment should be granted to Tribes and Tribal organizations.

Adequate Data

Question 1. Lack of adequate data is often cited as problematic when addressing and improving Indian health care. Does this problem exist strictly within the Center's for Medicare and Medicaid Services or does it extend beyond that particular agency?

Answer. Unfortunately the lack of data on American Indians and Alaska Natives is not unique to the Center for Medicare and Medicare Services. CMS has particular constraints upon their data collection as their methods for collection of current enrollment are woefully inadequate and antiquated;[2] however, federal agencies such as the Agency for Healthcare Research and Quality also have reported difficulties in obtaining necessary data to conduct a complete health disparities analysis for American Indians and Alaska Natives. The 2008 AHRQ health disparities report only spends a scant 3 pages out of over 289 on American Indians and Alaska Natives because of the difficulty obtaining needed data.[3]

The difficulty with obtaining health data for American Indians and Alaska Natives stems from several interconnected causes that are difficult for any one agency to overcome. American Indians and Alaska Natives are a small portion of the population, generally live in isolated communities, have cultural and linguistic difficulties communicating with researchers, and are often an afterthought to many public

[2] California Rural Health Board (CRIHB), *American Indian and Alaska Native Medicaid Program and Policy Data,* 2009.

[3] Agency for Healthcare Research and Quality (AHRQ). *National Healthcare Disparities Report* 2008

and private studies. Other institutions that have reported difficulty obtaining data on American Indians and Alaska Natives include the Kaiser Family Foundation,[4] Centers for Disease Control,[5] and Harvard School of Public Health.[6] In fact Indian and urban Indian epidemiology centers have also reported difficulties obtaining necessary information.[7]

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO GEOFFREY ROTH

Health Information Technology

Question 1. Please describe the current capabilities urban Indian clinics have for health information technology?

Answer. It is important to recognize that the urban Indian health program within the Indian Health Service consists of a wide array of programs and services, not all of which constitute clinical care. The vast majority of those offering clinical care have some technology as the demands for patient documentation and billing demand technological support. Only 2 have an electronic health record. One operates on the Indian Health Services, RPMS system. The other uses a private source.

The capabilities for carrying out operations with Health Information Technologies (HITs) in Urban Indian Health Programs (UIHPs) as a group are—in general—varied. However, it is critical to note that UIHPs present a variety of developmental stages; therefore readiness to implement operations through HITs will depend very much on the stage of development that each UIHP operates within. The introduction and use of Information and Communication Technologies (ICTs) for health matters is precisely one of the quickest and most efficient manners for clinics and public health programs to leapfrog developmental stages and expand services in an optimal fashion. The latter explains the recent Obama Administration's extensive focus on the use of technologies for all American health facilities . The main issues in the introduction of these technologies have been;

1. They require an initial moderately expensive investment in hardware and personnel training.
2. The right technology must be used in order for these systems to render the maximum benefits. If the technology used is not the correct one, the implementing agency may find itself thwarting its own path for ongoing development.

A comprehensive assessment on the HIT capabilities for UIHPs must be conducted in order to find the best approach to introduce or improve the HIT capacity of our programs. There is, however,[8] one issue that is ongoing and common to many Urban Indian Health Programs: the compatibility of the current Indian Health Service strongly preferred Resource and Patient Management System (RPMS)[9] with current technologies. There is also a lack of flexibility with RPMS when it needs to be improved in a comprehensive fashion. RPMS was a pioneer HIT when it was first launched (30 years ago), but its current version does not seem to work in a seamless fashion with other systems.[10]

For instance, the information entered and electronically stored into RPMS cannot be migrated or used by other software systems for Third Party Billing, which, in many cases, forces the UIHPs to duplicate efforts in both entering information and in training personnel for the use of various systems. As mentioned, a comprehensive and in depth assessment for solving this common issue must be conducted in order to find the best solution for all UIHPs.

Aside from the afore-mentioned specific issue, the National Council of Urban Indian Health believes that in order to make HITs effective for UIHPs the following

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[4] Kaiser Family Foundation, *American Indian and Alaska Natives: Health Coverage Access to Care,* 2004.

[5] Recent documentation on H1N1 have be unable to quantify impact on Indian communities.

[6] Sallie Sharp, *Symposium Addresses Disparities in Native American health care,* Harvard Science online. November 10, 2007 @ *http://www.harvardscience.harvard.edu/medicine-health/articles/symposium-addresses-disparities-native-american-health-care;*

[7] *See* fn 2.

[8] *http://www.ehealthinitiative.org/stimulus/education.mspx*

[9] *http://www.ihs.gov/CIO/EHR/*

[10] To be "locked-in" in a technology that is hard to update, upgrade or obsolete is a common problem faced by early technological adapters as explained by various technology theorists. For a quick and easy explanation about this issue see: Miozzo, Marcela and Grimshaw, Damian. Knowledge Intensive Business Services: Organizational Forms and National Institutions Edward Elgar Publishing (2006). p. 142

factors must be addressed: (a) Basic Infrastructure—PC's, Server, other hardware; (b) Appropriate Software, (c) Correct Training; (d) Updates for the previous three.

Information in these four factors is very scarce and indeed necessary. Having that in mind, NCUIH recently carried out a survey to preliminary assess UIHPs in a variety of fields, including the basics of e-readiness (the ability of an organization to use electronic systems for their operations). The survey was responded to by 20 out of 37 UIHP members (around 61% of all members). The following results shown below must be taken into context as most of the programs responding the survey were those on the *middle and higher* ends of the average UIHP development stage. It must be taken into account that some of the non-respondents are far from being considered technologically ready, infrastructure and personnel-wise.

NCUIH UIHP 2008 Survey results for—basic e-Readiness Components

Of UIHP's reporting, 72.2% of UIHP's reporting have T1 Internet Service (broadband), 16.7% Dial up connection. Approximately 95% of all staff has e-mail access.

UIHPs use the following methods for Internal Operations:

- 41.88% using Email/PDF
- 2.64% Fax
- 11.50%Written
- 33.00% Face-to-face
- 2.67% intercom
- 2.86% memos
- 16.40% phone/cell

UIHPs use the following methods for External operations:

- 48.75% Email/PDF
- 6.07% Fax
- 25.31% Telephone/Cell
- 10.93% Written letters
- 14.47% face to face
- .46% text

All UIHPs reporting have their own server, with a specific email for work used by staff, and most with an organizational website (94.1%). UIHP websites offer General UIHP Information (100%), Programmatic Information (100%), Contact Information (87.5%), News/Events (81.3%), Job Opportunities (31.3%), Community Resources (43.8%), Online Services (25%), Community Stats (25%), and Forums (12.5%).

According to this same survey the top three UIHP priorities for an information technology grant are (1) Online RPMS Infrastructure, (2) Online RPMS Training and Upgrading computer equipment (tied), and (3) Training on Special Software.

Again, comprehensive assessment on both Information and Communication Technologies and on HIT capabilities for UIHPs must be conducted in order to find the best approach to introduce or improve the capacity and capabilities for our programs. NCUIH would be glad to participate in the conducting and coordination of such assessment if necessary.

Please see Appendix B for further information on HIT and urban Indian health programs.

Question 2. Please explain why urban Indian programs are not able to currently access this source of supply.

Answer. Current law does not permit urban Indian health programs as urban Indian health programs to access the federal source of supply. Some urban Indian organizations may be able to access certain aspects of federal sources of supply through their status as Community Health Centers. However, that access is extremely limited, temporary, and any resources received under the 330 grant must be kept separate from resources received through the Indian Health Service in terms of accounting. However, only 8 of the 36 urban Indian health providers are also CHCs. 13 are FQHC look-a-likes and 2 are Rural Health Clinics, but neither FQHC look-a-likes nor the 2 RHCs have access to the federal supply schedule under current statute. The type of access given to Tribes and Tribal organizations through the Indian Health Care Improvement Act's current law provisions are not currently available to urban Indian health programs, even those that are full FQHCs.

In terms of federal Indian law currently only Tribes and Tribal organizations have the legal authority to access to the federal supply schedule. Urban Indian health programs are not included in those provisions and FQHC look-a-likes—13 urban Indian health providers are FQHC look-a-likes—are not permitted to access federal sources of supply for property. Urban Indian health providers may, in certain situa-

tions, have access and use of federal facilities, but not of other property such as medical equipment.

Question 3. Please describe how urban Indian programs will ensure accountability if such access is authorized, particularly regarding the pharmaceutical programs.

Answer. As Indian Health Service contractors, and since the Indian Health Service would be the primary point of contact for accessing the federal supply schedule, urban Indian health programs would be bound by the new requirements and accountability procedures recently enacted by the Indian Health Service to combat waste and misuse of federal supply.

Moreover, those urban Indian health programs with pharmacy capacity would be already bound by federal law and regulation regarding the safe and accountable access of those pharmaceuticals. The 23 urban Indian health programs with pharmacy capacity (8 full FQHCs, 13 FQHC look-a-likes, and 2 Rural Health Clinics) already have implemented policies and procedures compliant with federal law to ensure the safety and accountability of pharmaceuticals and pharmaceutical scripts handled by the urban Indian health provider. It is difficult to describe a single set of policies or procedures for accountability as the difference between FQHC, FQHC look-a-like, and RHC status among the urban Indian health programs means that each program, depending upon status, may have different sets of standards and requirements to follow.

Access to federal sources of supply will not elevate those programs currently unable to meet the requirements of federal law for class D pharmacies, or the regulations surrounding FQHC/RHC pharmacies, to the position of maintaining pharmacies. Those programs will still be required to meet such requirements as set in place by agency regulation or federal law.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO GEOFFREY ROTH

Question 1. What are the two most important changes you would recommend to improve the health care system delivery for Native Americans?

Answer. Full funding of the Indian Health Service, including full funding of the Urban Indian Health Program—it's well documented that the Indian health delivery system is underfunded and that lack of funding has a deep, damaging impact upon the ability of Indian health providers to provide comprehensive health services. The Indian Health Service is funded at roughly 50% of actual need[11] and the Urban Indian Health Service is funded at 22% of estimated need. While Indian health providers are among the most innovative and dedicated, there are limitations on a providers ability to make up for lack of funds through sheer determination and creativity. Funding for Indian health providers must be the very first priority in order to deliver serious change to the health status of Indian people. Changes to the law and additional programs are necessary and helpful, but without the underlying sustainable funds to support them those programs can only go so far.

With full funding Indian health providers—including urban Indian health providers—would no longer be force to essentially ration health care services. Complete funding would allow Indian health providers to develop comprehensive, community based intervention strategies, and workforce development programs focused on cultural competence. Indian health providers are required to spend an inordinate amount of time simply struggling to stay financially stable and maintain the base level of services required by their communities. If Indian health providers were financially stable these resources—both financial and human—could be freed to focus upon developing new best practices.

Complete funding for the Indian health system—and for the urban Indian health programs within IHS—would allow Indian health providers to build upon their innovations that have been born from necessity. Programs such as the special diabetes program for Indians could be expanded beyond diabetes into the co-morbid, chronic diseases suffered by many American Indians and Alaska Natives such as hypertension, heart disease, and depression.

Fully integrate the I/T/U system so that each element of the Indian health delivery system is fully supported and fully integrated with the other providers. We know our patients move between provider types within the Indian health delivery system. They may see a direct service provider (I) one year and then be living in Los Angeles being seen by an urban Indian health provider the next. However, there is very little continuity of care or continuity of service level. Indeed many pro-

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[11] *See* National Indian Health Board. *Testimony to the Subcommittee on Interior Appropriations.* 2008.

viders across the Indian health service exist at wildly different capacities. While certain communities may require different services, the entire community still requires the highest level of services and to be assured that as they move from one provider to another that they will receive the services that they require.

Full integration would mean assured portability of health care regardless of where and Indian patient went. Under the proposed changes to the health care system under the American Affordable Health Choices Act Indian patients need to be able to access Indian health providers without fear of penalty. Furthermore, Indian health providers need to be included in any and all preferred provider organizations/networks for public health programs.

Protections need to be secured for Indian health providers that preserves the choice of Indian people to use Indian health providers, protections such as section 50006 and 50007 of the American Recovery and Reinvestment Act. Moreover, urban Indian health providers must be included in any such protections—such as section 201 of Title II of HR 2708 the Indian Health Care Improvement Act—because when urban Indian health providers are not included in these provisions they are unable to maintain financial stability which in term threatens the health of Indian patients.

Question 2. What would you say are the current priorities areas for urban Indian health services?

Answer. Financial stability is the first and foremost priority for urban Indian health providers. Unless a program is fully financially secure that provider will always be fighting for survival rather than building upon existing services.

Fully developing the urban Indian health providers—this priority is less easy to concretely describe or even really give definitive dates for conclusion. Ultimately the development of the urban Indian health providers will only be completed when all urban Indian health providers are able to fully serve all of the needs of the urban Indian communities in which it exists—and that all urban Indian communities have culturally appropriated health providers.

Question 3. How would you characterize the options urban Indians have for health services if they don't have access to the Indian Health Service?

Answer. NCUIH would have to characterize the health services available to urban Indians outside the Indian Health Service in one word: poor. Urban Indians are often poor, underemployed, and lack health care benefits. Accessing non-Indian health providers is difficult for most urban Indians as non-Indian health providers are not culturally accessible, often not financially accessible, and in the case of some areas are not locationally accessible. [12]

Financial and cultural accessibility are the largest barriers to health care outside the Indian health provider network. Despite the high rate of poverty and underemployment in Indian communities, the enrollment rates for American Indians and Alaska Natives in public health programs such as Medicaid, Medicare, and CHIP remain very low. [13] Enrollment rates in private insurance for the urban Indian community are even lower than enrollment in Medicaid, Medicare or CHIP. [14] Without the financial means to pay for health care, many urban Indians are forced to delay care until they can return to their tribal homes or are forced to seek emergency care when they reach medical emergency.

Cultural inaccessibility is the companion problem to financial inaccessibility as urban Indians, even if they are able to afford non-Indian health provider care, are often unable to effectively communicate with a non-Indian health care provider leading to higher rates of misdiagnosis and poor care. [15] Moreover, most urban Indians will simply refuse to seek care at non-Indian health providers as they feel shut out and shut down by those providers.

Question 4. What solutions are there for improving this situation?

Answer. Expand the urban Indian health program to serve all cities with significant urban Indian communities and assure the portability of health care. Currently the urban Indian health program has 32 programs across the country and accounts

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[12] One of the things noted by the DC health department in a lecture given to the Tri-Caucus health brain trust was that in most major cities health care providers—particularly primary health care providers—have migrated to the suburbs leaving inner city dwellers without reliable access to health care.

[13] *See* fn 2 and fn 4. Neither the Kaiser Family Foundation nor the California Indian Health Board are able to determine the exact reason for the low rates of eligibility given the lack of necessary data on enrollment from CMS; however, both note a low rate of enrollment given the statistical calculation of probability of eligibility for the population.

[14] *See* Urban Indian Health Commission. *Invisible Tribes: Urban Indians and Their Health in a Changing World.* 2007

[15] ibid.

for only 25 of the major US cities. Urban centers such as Atlanta, New Orleans, and Nashville where the Census bureau has reported large Indian communities remain without urban Indian health programs because the urban Indian health program has been struggling to simply survive and has not been able to make the necessary steps to expand the program. The best first step to fully developing the urban Indian health program would be a comprehensive needs assessment to determine not only where urban Indians are currently without necessary Indian health providers, but to also determine what needs exist in areas with current Indian health providers. Plans to build upon the urban Indian health program in a comprehensive, sensible manner can begin after this necessary first step is taken.

American Indians and Alaska Natives need the ability to not only move between Indian health providers, but also to move between the Indian health system and the general health system. American Indians and Alaska Natives need the ability to participate in any public health program as well as be assured that private insurance plans will accept their decision to see Indian health providers. NCUIH strongly encourages the Senate Committee on Indian Affairs to endorse and enact Indian health care provider protections that assure that American Indian and Alaska Native patients can seek care at Indian health providers without penalty.

APPENDIX A: METHODOLOGY

NCUIH suggests that a National Needs Assessment on Urban Indian Health should begin with the development of an Urban Indian Health Advisory Board to guide the project. The Advisory Board would include 13 members representing the following: tribal leader, urban Indian leader, urban EPI Center representative, a representative from a national, membership based urban Indian health organization, a representative from a national tribal health organization, federal representatives (HHS, IHS, CMS, Census), urban Indian Community member, urban Indian elder, community cultural/spiritual leader, and a university partner.

Data collection will include archival data collection and both qualitative and quantitative data collection.

1.) The Archival Data Review would involve a stepwise process. [16]

The first step will be a review of Census data to determine the population of American Indians and Alaska Natives in cities across the United States. This review will be reported in both real numbers, as well as, percentage of population. Census data will also report demographics by city, such as income, educational levels, and other household information.

In collaboration with the advisory board, the entity conducting the study will develop criteria for selecting 70 communities based on Census data for further assessment of archival data. Once selected, archival data will be reviewed for each of the selected cities from:

CMS
HHS
Justice
Education

This data should provide insight into the current state of health, primarily service access and use, for urban Indians living in the respective cities.

In collaboration with the advisory board, the entity conducting the study will develop criteria for selecting 50 communities for original data collection. These 50 communities will be selected from the 70 that were selected for more in-depth data collection.

2.) Original Data Collection will involve both qualitative and quantitative data from a variety of stakeholders, including:

Urban Indian Leaders (ED's Board Members)
Urban Indian Staff (Direct Care Providers, Ancillary and Support Staff)
Consumers (Elders, Adults, Youth)
Urban Indian Community Leaders (Spiritual, Cultural)

3.) Methodology will include random selection of both consumers of services, as well as, those who choose not to use area services (or have limited and/or emergency use).

4.) Specific assessment tools will be developed in consultation with the advisory board and include the major constructs identified in the assessment. The constructs

[16] "Stepwise" refers to the process of building knowledge and systems from each step of a proposed methodology so that information builds upon previous developments.

will include service availability, access, use and patient outcomes. The broader service system will be examined given that many of the cities identified for assessment will be those without current Urban Indian Health Programs.

5.) The entity conducting the study will work with the selected communities to identify and train local evaluators to complete the assessment at the local level. These evaluators will either comprise or work with an independent review board. Training will be provided by teleconferences, webinars, and teleconferencing. The entity conducting the study will use a community-based participatory research model with university partnerships at both national and local levels. Community evaluators will be compensated for their work.

Data Protection

A national Institutional Review Board will provide oversight of the project through a university partner. All data will be de-identified at the local level and reported to the entity conducting the study for data analyses and reporting.

Data Analyses

All data will be reported in aggregate. Site specific reports will be generated for each of the 50 communities selected for original data collection. National aggregated reports will be generated for:

The US Census Archival Data Review

The 70 sites selected for further archival data review from various federal agency data.

The 50 sties selected for original data collection

Data Dissemination

Site specific reports will be shared with local communities (i.e., Indian organizations, local FQHCs, community advocacy organizations), area tribal communities, other stakeholders (such as Indian Health Services Area office), US representative(s) and state legislators.

National reports will be shared with legislators, Indian Health Services, and Indian organizations.

APPENDIX B: INFORMATION ON HIT FOR UIHPS

What exactly is Health Information Technology?

In plain English, it is the use of electronic means to carry out an operation related to a health care or to a medical management task.[17] HITs therefore, range from purely administrative operations, to task-specific tools for management systems; to highly specialized, patient-customized solutions.

How does it affect me and my Clinic?

The most common notion about the use of information technologies for health is the use of Electronic Health Record (EHR) systems. These systems bring about a great deal of benefits to any implementing clinic by making information: quickly available, customizable, shareable and searchable in a quick fashion (in addition to greatly lowering the costs and making management more efficient). However, there are many other e-health-based systems and applications that once implemented can help our health programs expand services, improve existing ones and/or leapfrog stages of development and catch up with national trends. According to international expert, Dr. Per-Gunnar Svennsson, e-Health Care Management can be divided according to their type of user: (a) Consumers informatics, Clinical Informatics and Biomedics.[18]

A recent report of the Health Information Management Systems Society (HIMSS) stresses the potential for HITs to help clinics provide better, more customized and efficient care for their patients: "Today much of the driving clinical need centers around efforts at enhancing patient safety, patient satisfaction throughout and the demand for quick and accurate access to clinical information in order to provide not only quality patient care, but also access real time information for crucial leadership

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[17] The official language states HIT as an IT system that "allows for comprehensive management of medical information and its secure exchange between health care consumers and providers." To learn more about these systems visit: *http://www.hhs.gov/healthit/*

[18] Svennsson, Pre-Gunnar. eHealth Applications in Health Care management. E-health International journal.2002. *http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=135526*

decision making."[19] In general terms, there are three crosscutting themes where HITs can improve health care facilities and practitioners' performance: (a) Administrative tasks, (b) Clinical Support; and (c) infrastructure efficiency. Some examples of specific areas where HITs can positively impact performance are:

- Clinical Decision Making— generating case-specific advice
- Chronic Care
- Managing clinical competency
- Maintaining cost control
- Monitoring medication orders
- Avoiding duplicate or unnecessary tests
- Support of patient safety
- Clinical research
- Education of future caregivers[20]

As technologies evolve, it is expected that HITs will be embedded in many more specific tasks and supportive areas of health care. The more practitioners get used to working with e-health systems, the more customized solutions will arise.[21]

Why are Urban Indian programs better suited for HITs; and why is this a great opportunity for us?

Traditionally, the government has fostered the use of information technologies as great alternatives for getting rural and isolated areas connected to regional and national systems. Under this general notion, urban communities were greatly overlooked, regardless of the fact that cities offered the advantage of services agglomeration—that is, the series of services that can be found in urban settings— such as technology providers, cheaper broadband access, skilled personnel, transportation options, etc.

The American Recovery and Reinvestment Act takes a two-pronged approach to advanced education relating to the use of health information technology, providing support both for health informatics programs and for clinical education programs that integrate HITs.[22]

How HITs are tools for Sustainable development in my organization

HITs can foster sustainable development in three main ways:

a.) Freeing up resources: although the initial investment can be expensive funding and training wise, Information technologies have proven to lower fixed costs significantly through significantly faster operations and increased efficiency.[23] These resources can be used for improving or expanding services.

b.) Knowledge Transfer and Foundation: once the technology has been engrained in the health facility, it creates a technological foundation that can be used by managers to find customized solutions according to the challenges they are facing—which can expand capabilities without much investment.

c.) Standardized systems: the technology to be provided through this government initiative would be standard for all facilities, which reduces costs as well as it eases both management and IT personnel recruitment, etc.

What if we do not join these efforts?

The technological and medical gap will increase considerably. As health care providers, UIHPs would not only be missing the opportunity to take advantage of the funds and efforts this administration is putting into creating the basis for a sustainable health care system for all (including minorities and the Indian Health Service); but we would also be thwarting our own way to get further government funding in the future—as federal and local initiatives and grants will most likely require the utilization of these systems. Lastly, our population would suffer from not getting the improved and expanded health care services that could potentially be provided with HIT systems.

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[19] To Learn more about the use and impact of HITs go to: *http://www.himss.org/content/files/ClinicalPerspectives*__whitepaper__052907.pdf

[20] Idem.

[21] For a list of HITs applications please visit *http://www.medpac.gov/publications/congressional*__reports/June04__ch7.pdf

[22] For more information on the stimulus package: *http://www.ehealthinitiative.org/stimulus/education.mspx*

[23] *http://esciencenews.com/articles/2009/01/27/health.information.technologies.associated.with.better.outcomes.lower.costs*

Where can I find more information on HITs?

There is plenty of literature available depending on the specific topic you would like to research on. You may also contact your regional I.H.S Office for information on the initiatives to be implemented. Alternatively you may visit the following informational websites:

Indian Health Services: *http://www.ihs.gov/cio/ihimc/*

e-Health Initiative: *http://www.ehealthinitiative.org/*

U.S. Dept. of Health and Human Services: *http://www.hhs.gov/healthit/*

National Alliance for Health Information Technology: *http://www.nahit.org/*

Human Resources Services Administration: *http://www.hrsa.gov/healthit/*

Center for Information Technology Leadership: *http://www.citl.org/*

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO PAUL K. CARLTON, JR., M.D.

Mobile Health Units

Question 1. How much do the mobile medical units cost? What are the financial benefits to using mobile units?

Answer. The units that are certified by Medicare, licensed in nine states, and recognized as meeting all standards by the Joint Commission are the only ones that I would recommend, to do otherwise would be very controversial. They are made in St Johnsbury, Vt., by a company called Mobile Medical International. Their basic surgical unit cost about $2.5M, dialysis unit cost about $2.1M for four chairs fully equipped, dental unit about $2.5M, ICU unit a little more at $2.7M, so the round number to use is $2.5M each.

The financial benefits to using the mobile units are that you can make any clinic fully hospital capable simply by pulling one up to the door and hooking it up. This would meet the ambulatory surgical needs of most reservations very nicely. I will attach a proposal that I gave to the Public Health Service about five years ago, outlining exactly how these could be used to greatest effectiveness. This was for the Aberdeen Area Indian Health Service in the Dakotas. Instead of building an Ambulatory Surgical Unit that cost over $10M each and is not used on a regular basis, you could pull up one of these mobile surgical units, use it for one day or longer, then move on to the next reservation and provide the surgical services to that area. This would solve the biggest challenge to the Indian Nation on medical care, the requirement for care that is only 0.1 or 0.2 Full Time Equivalents medical practitioner. The demand is not on the reservation to keep full time people assigned, so today they must travel for their medical care. Unfortunately, this tells the Indian customer that his time is not as important as the medical practitioners—a bad customer relations position. This would allow you to deliver the care on site to the reservation in any specialty that is ambulatory in nature and then move to the next reservation.

The most complex and harder to measure financial benefit is the use of these mobile units in disaster situations. If we have complex medical equipment sitting and not being used, it will last as long as it would if it were being used every day. Medical technology progresses so fast that any medical piece of equipment has a half life of about 3–4 years max. By using your response equipment everyday for elective surgical or conscious sedation care, you are telling the Indian customer that they are important and using the medical equipment that you might need in a true national medical disaster. You can then, in such a national disaster, delay that on reservation convenience care and move this same surgical unit down to the site of the disaster, set it up in hours, and use it in austere environments while meeting all standards of care. The best part is that the Public Health Service would be the group that uses this equipment every day, and they are also designated to be the disaster response group. So you could avoid the expense of training the Public Health service on different equipment, just let them use the equipment that they have been using every day.

That is a double return on investment–no training cost and you are using disaster equipment everyday while waiting for that disaster to occur, instead of letting it sit and outdate.

Unless you put both of these two functions together, regular care on site on the reservation and disaster response, you have not optimized your investment! Together, they give you the double return!

Question 2. Are you aware of any mobile units used in Indian Country now?

Answer. Yes, the Tuba City Reservation has a mobile breast care unit that has been in use for several years and been very well received. It provides comprehensive screening tests for woman's health issues. That mobile breast care unit was also manufactured by the group in St Johnsbury, Vt, Mobile Medical International.

Question 3. Is it possible for the units to rotate between Reservations? Do you have recommended schedules? Do you see this being a problem during winter months in cold, snowy climates like North Dakota?

Answer. The units should rotate between reservations to optimize their usage. It is not a necessity, but to maximize their utility, I would certainly plan to rotate them.

I will attach a schedule that I proposed in 2005 for how such units could be used on different Indian Reservations in the Dakotas. You could rotate daily if distances are short, or on a weekly basis if distances are long. If the weather is really bad, as sometimes occurs in our northern areas, then the mother hospital could just keep the units and use them themselves. I have included an architect's drawing of what such a mother facility would look like. These would allow the units to be actually indoors for each location, yet the facility could utilize the space for waiting rooms or whatever when the mobile units are on the road.

Question 4. As you know there is very high rate of diabetes in Indian Country, could mobile health units be used for dialysis services and other specialty care? Do you see a benefit to using these units in Indian Country?

Answer. The dialysis question is a more difficult one because the typical dialysis patient requires every other day treatment (Monday, Wednesday, Friday or Tuesday, Thursday, Saturday). This limits your mobility distances greatly if you use only one mobile unit to take care of two different locations. For distances of less than one hundred miles, it would be easy to run a morning clinic in one location, fold up, drive the next location, set up for an afternoon and next morning dialysis run, then come back to the original facility and pick up the afternoon dialysis run. This would give you the capability to run two locations easily. You could do four if the numbers were small at each location, and the distances were short

My recommendation for this dialysis concern, because of the frequency of treatment, would be to go component instead of mobile for these. Several hundred of these component dialysis clinics have been built around the country at prices less expensive than mobile and removes the challenges of moving the dialysis units. These are then steel framed structures that the Army Corps of Engineers calls 100 year construction. The mobile units are great, but will not last 100 years. Such component construction could be on site and fully functional in 3–4 months easily. Two such component dialysis facilities would cost the same as one mobile system.

Other specialty care is certainly something that could be planned for using these types of sophisticated mobile medical units. The Mobile Medical group just built a mobile endoscopy unit for a VA hospital in West Virginia. Every medical group has different requirements for support. Any reasonable outpatient surgery or conscious sedation could be accomplished in the mobile unit. Any outpatient oriented medical specialty could be set up for full function in such vehicles. The Breast Care unit in Tuba City is a perfect example.

For Example – based on population needs

Aberdeen Area Indian Health Service
Mandan Hidatsa Anikara Tribes

- Allocate medical vans based on projected population needs
- Adjust as demands dictates

1 Week at Cheyenne River Service Unit

8,816 estimated population by 2015

Monday	Tuesday	Wednesday	Thursday	Friday
General Surgery	Gynecology	Ophthalmology	ENT	Gastro

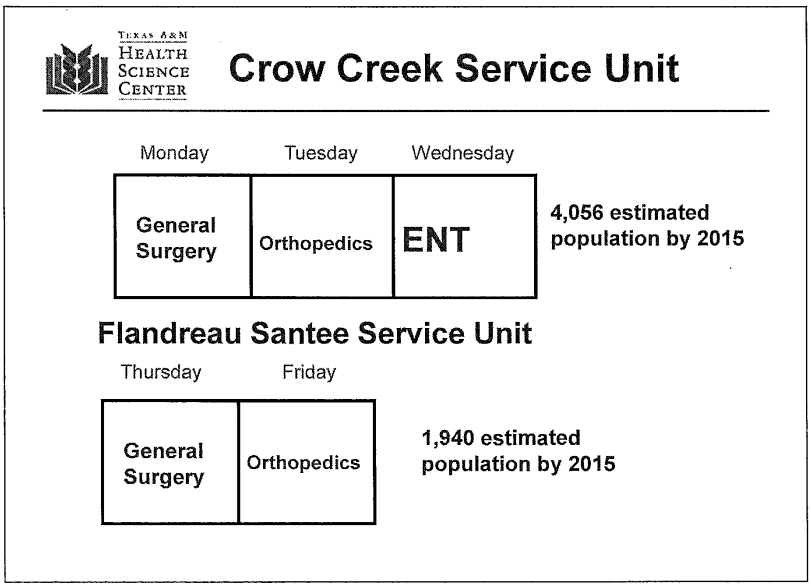
Saturday – Travel and set up

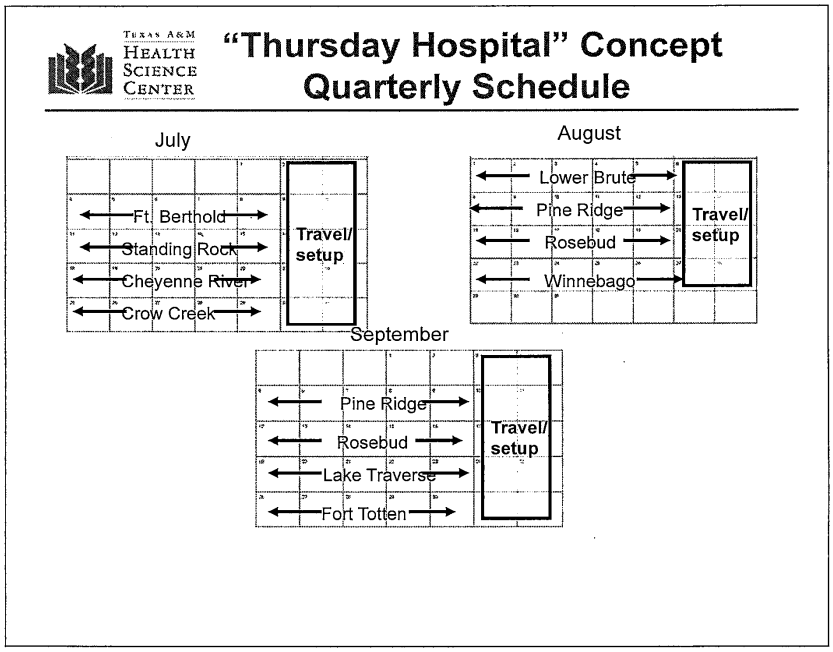
Vary by demand

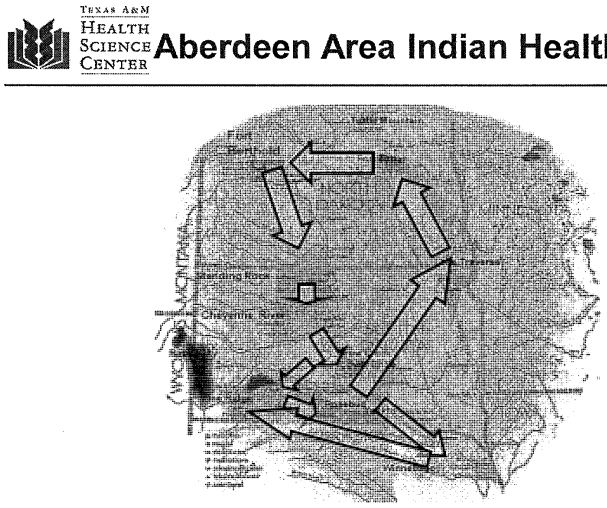
Pine Ridge – 3 Weeks/quarter (as demand dictates)

25,729 estimated population by 2015

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	General Surgery	Gynecology	Ophthalmology	ENT	Gastro
Week 2	General Surgery	Gynecology	Orthopedics	Plastics	Hand
Week 3	General Surgery	Gynecology	Ophthalmology	ENT	Gastro


Texas A&M Health Science Center
Crow Creek Service Unit
Monday
Tuesday
Wednesday
General Surgery
Orthopedics
ENT
4,056 estimated population by 2015
Flandreau Santee Service Unit
Thursday
Friday
General Surgery
Orthopedics
1,940 estimated population by 2015


Texas A&M Health Science Center
"Thursday Hospital" Concept
Quarterly Schedule
July
Ft. Berthold
Standing Rock
Cheyenne River
Crow Creek
Travel/ setup
August
Lower Brule
Pine Ridge
Rosebud
Winnebago
Travel/ setup
September
Pine Ridge
Rosebud
Lake Traverse
Fort Totten
Travel/ setup



Intended Consequences

- Lower cost
- Better quality of medical care
- Better access to medical care
- Dual use opportunities for state emergencies

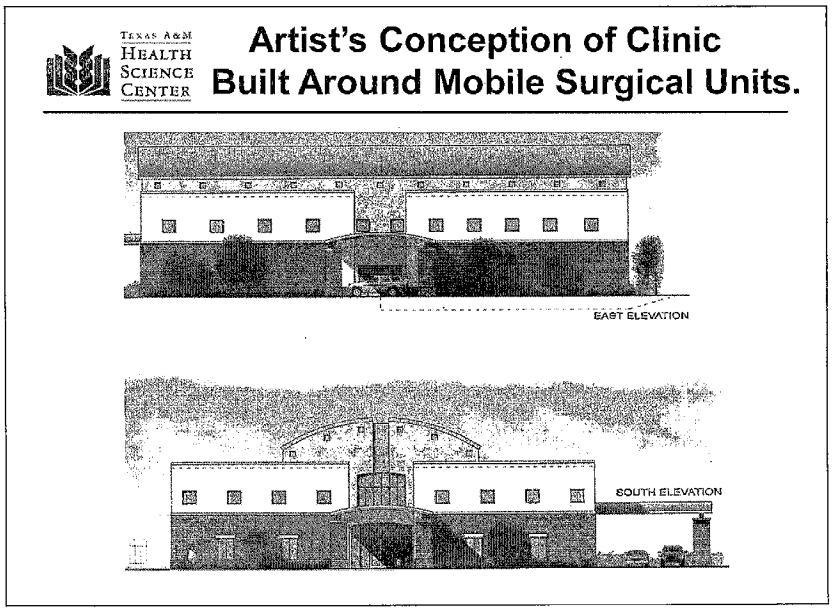
Unintended Consequences

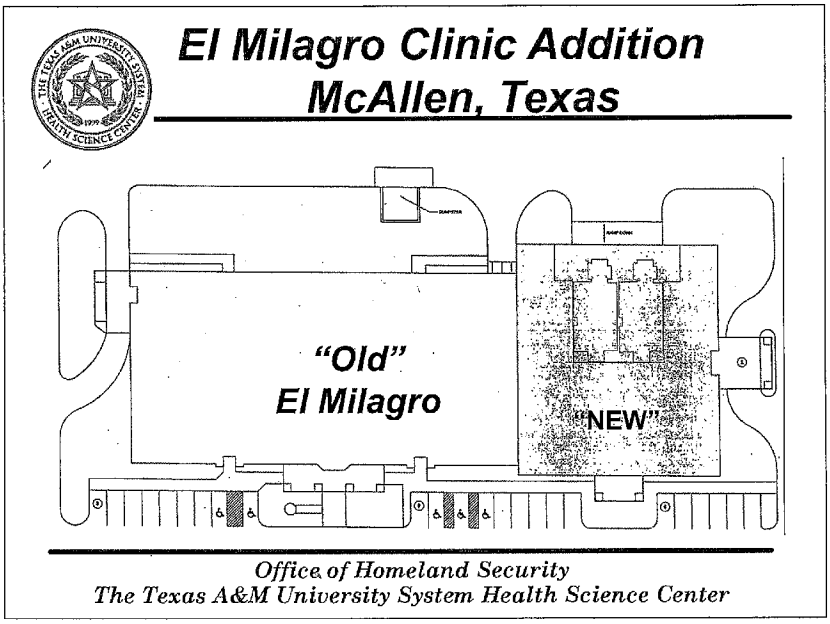
- Financially untenable – too expensive
- Potential for weather disruption
- Does not cover emergency care

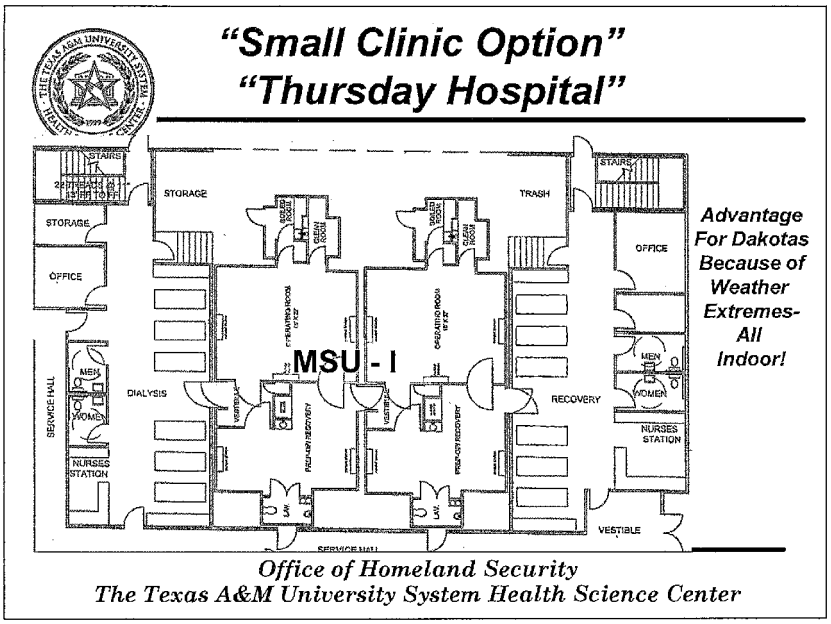
Medical Care

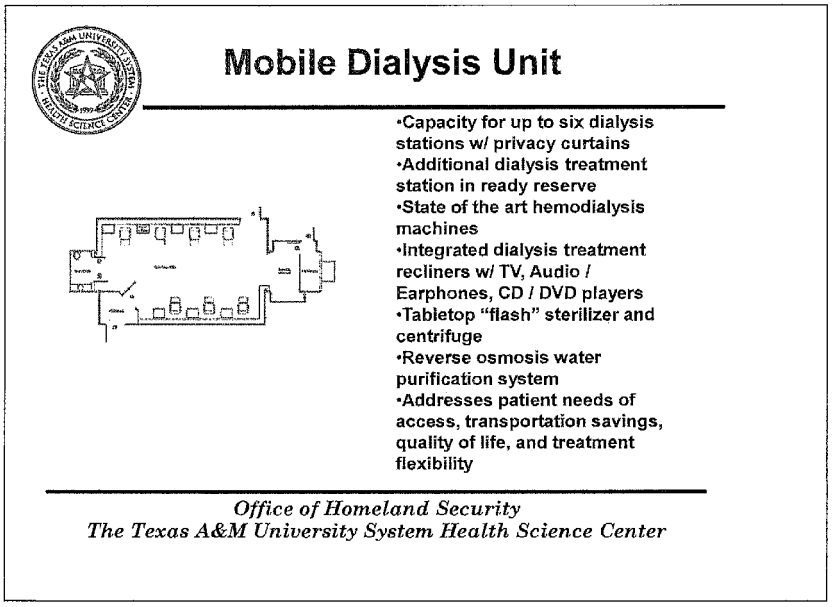
- Routine scheduled medical care in normal hours
- Emergency – not scheduled – all hours

This discussion focuses on routine care NOT emergency care


Texas A&M
Health
Science
Center
Artist's Conception of Clinic
Built Around Mobile Surgical Units.
EAST ELEVATION
SOUTH ELEVATION


El Milagro Clinic Addition
McAllen, Texas
"Old"
El Milagro
"NEW"
Office of Homeland Security
The Texas A&M University System Health Science Center





Component Model Construction

Question 1. Could you explain briefly how component construction was selected for the federally funded facility at Creech Air Force Base?

Answer. The project was funded in FY 2005 at $1.5M. No one gave a bid that came close until the pressure really got high from the SECDEF to make our training base at Creech AFB fully mission capable (the people assigned to Creech AFB were driving over 60 miles one way for routine medical and dental appointments,

which hurt mission capability a lot). That opened the Corps to entertain other potential construction methods. A group called U3I out of San Antonio teamed with an 8A company to do this in a component fashion and built it to cost. That meant that it was built and fully functional 4.5 months after contract signing but other things can be added as needed in the future. A planned better parking lot, nicer looking roof, expanded Dental Clinic, etc., are all planned for the future. But the fully functional component Clinic and Dental facility were delivered on time and on cost in 4.5 months.

Question 2. Have you engaged other federal agencies on the use of component construction or mobile units? Has there been difficulty moving forward with this type of construction at federal agencies?

Answer.

A. Other federal agencies have used the mobile units:

1. The White River Junction VA Medical Center in White River Junction, Vt., used two Mobile Surgery Units for an operating room renovation in Jan-Feb 2008. This saved them money and preserved the function of the medical center for surgical workload.

2. The Miami VA is building the docking stations to bring in six surgical units for a two year operating room renovation to begin fall 2009.

3. The Muskokee VA has started initial procurement to use two Mobile Surgery Units for an operating room renovation in late 2009 or early 2010.

4. The Naval Hospital Pensacola is in process of leasing two surgical vans for an operating room renovation in FY 2010.

5. The New Orleans VA is beginning the process for a major renovation project for the operating rooms in 2010 and begun negotiations for use of the surgical units.

6. FEMA used the surgical units to respond to the Hurricane Ike problems in Galveston in Sept 2008. The vans were on site and fully functional three days after being requested to provide surgical support for the damaged University Medical Center.

7. The countries of Oman, Saudi Arabia, and Iraq have bought these surgical units and use them on a regular basis. Oman modified their Police Hospital in Muskat to house these surgical units, use them on a regular basis, and make them available for disaster response.

B. Other federal agencies have begun to use the component construction method cautiously, mostly in non-medical activities:

1. Non-Medical Facilities

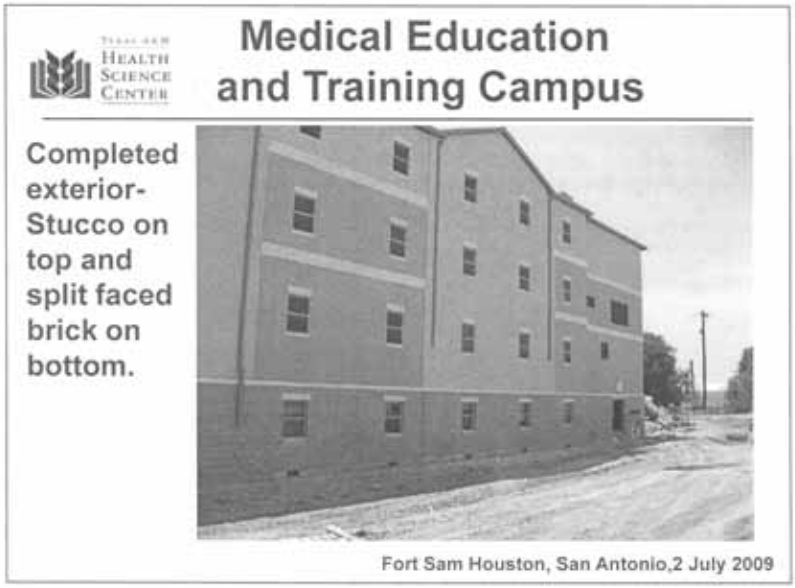
a. Fort Bliss has built entire complexes using these component methods. A local Texas group from DeSoto, Warrior Group, has gotten several of these large contracts that include headquarters buildings, training buildings, and dormitories.

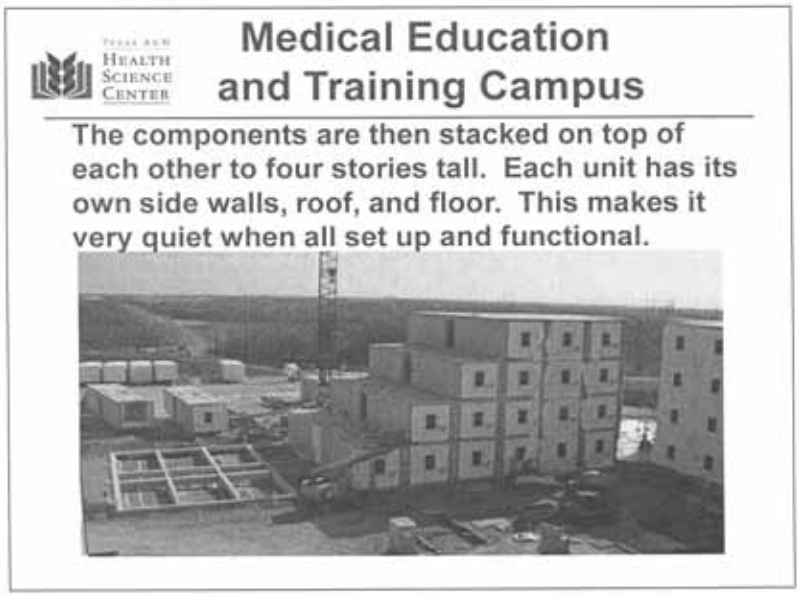
b. Fort Carson, in Colorado, has used this component method of construction and they are very happy with its results. Again, the Warrior Group has gotten several of these contracts, building a 3 story Headquarters building and multiple 2 story barracks.

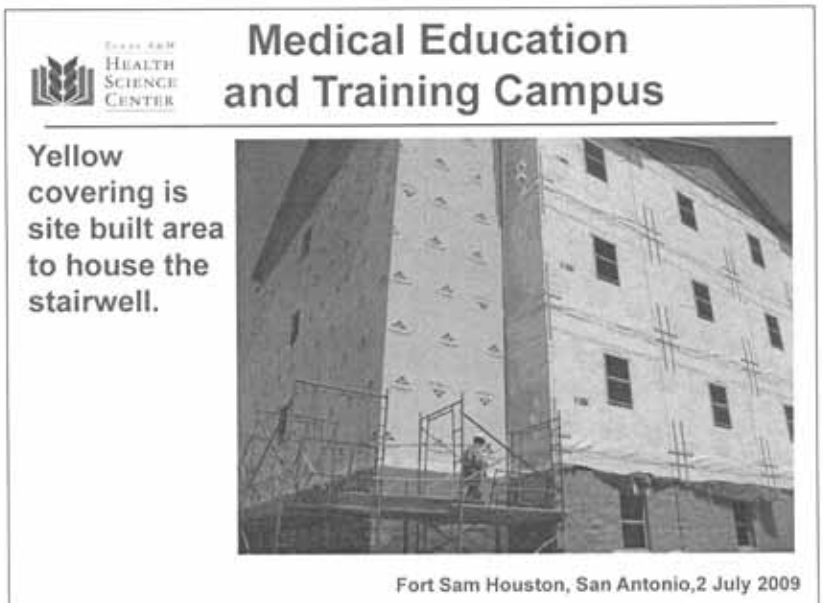
c. Fort Hood has also used this method of construction and been very happy with the results.

d. The Immigration and Customs Enforcement Agency has purchased a number of these component facilities for their outposts in the unpopulated areas of New Mexico and Arizona. A Texas firm from Burleson, Modular Designs have done these outposts.

e. I just toured the Medical Education and Training Complex, METC, in San Antonio that was begun under BRAC 2005 to consolidate all enlisted medical education and training on one campus on Fort Sam Houston, Tx. It is a hybrid facility, about ⅓ site built, and ⅔ factory built. It is a huge project at 1.9M sq. ft. and $500M in total cost, and is on time and on cost right now. It was a very short timeline from contract award to completion, which was greatly facilitated by the use of component construction. I have just built a brief on this method, which I would be happy to share with the group. The Air Force Civil Engineers and the Army Corps of Engineers are monitoring all of these projects very closely and are very impressed with their quality and timeliness. Again, the Warrior Group has been awarded the component portion of this project.


Texas A&M
Health
Science
Center
Medical Education
and Training Campus
Completed exterior- Stucco on top and split faced brick on bottom.
Fort Sam Houston, San Antonio,2 July 2009





2. Medical Facilities

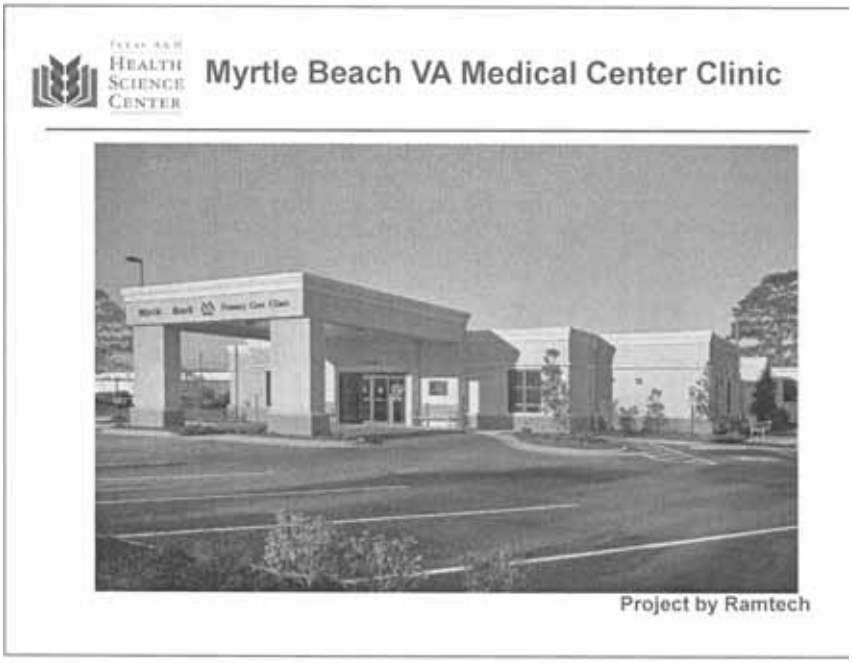
a. Clinic at Creech AFB, delivered February 2009.

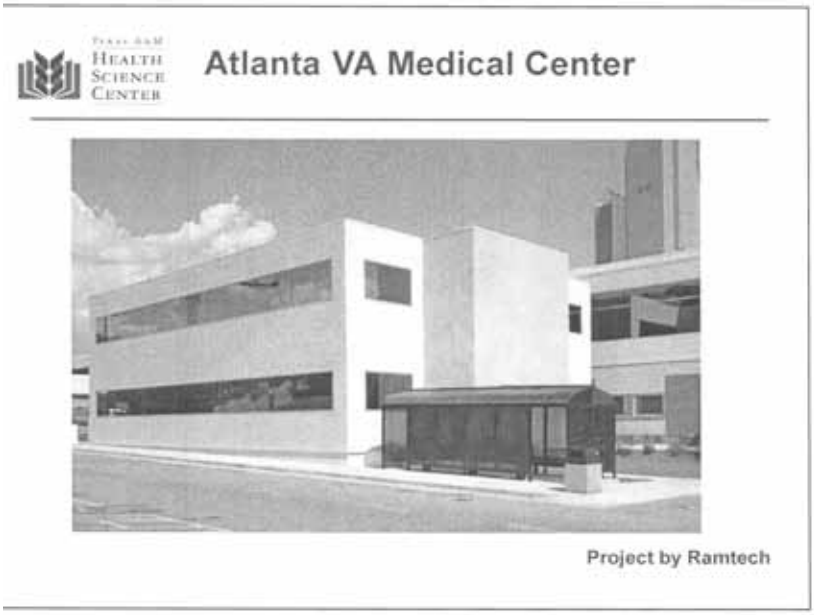
b. MRI unit, refurbished at 60% of new cost, to Tuba City Reservation 2009.

c. MRI unit, refurbished at 60% of new cost, to Brook Army Medical Center, August 2008. The above represents one of the greatest savings–you can pull a component out totally, refurbish it to new standards in the factory, and save the customer about 40% off new cost by this recycling. A group out of Loretto,

TN, Modern Renovators, has done the MRI units and showed us the utility of recycling these components.

d. The VA Medical System has built several clinics using component methods and they have been very impressed with their quality, cost effectiveness, and timeliness. The VA considers this permanent construction and has done both offices and clinics.





Question 3. What are the disadvantages to component construction?

Answer. Overcoming the stereo-type of poor quality! This is not the mobile home industry, it is factory building in the same manner and using the same methods used on site, only doing it in the comfort and convenience of a factory. The economies of scale, comfort of a factory environment, and repetitive tasks all lead to a higher quality of product at a lower cost and in a more timely manner.

I see no other disadvantage to this method. I have made multiple visits to factories around the country, gone to medical component building construction sites, non-medical component construction sites, and seen how this works in detail. I was a skeptic about this method until I did my very thorough investigations and am now its biggest supporter!

Question 4. How long do these types of facilities last?

Answer. The Army Corps of Engineers calls the wood based frame a 40 year structure. That is what the ICE group has bought for their outposts. They call the steel frame construction a 100 year structure. That is what the Air Force bought for our Clinic at Creech AFB, Nv. These can be specified to any wind strength, any snow load, or any seismic activity load—just as any site built building can be.

Component Construction in Indian Country

In our Committee's research of component construction, one of the concerns we have developed is the fixed structure of units. Health facilities in Native American communities tend to be very culturally appropriate–with Native art, ample light and circle-shaped rooms.

Question 1. How flexible are the component units for these types of features?

Answer. As flexible as you would like them to be. This is a method of construction, not any different than conventional in its innovations or culturally appropriate features. The METC construction site in San Antonio is a perfect example of the flexibility of this method. It was designed as a hybrid, part site built and part factory built. It has innovative traditional features and maximizes the efficiency of factory building. Any exterior or interior design can be created using these methods.

Question 2. Are you aware of any Indian Tribes or groups approaching people like yourself about using component construction?

Answer. No Indian Tribe or group has approached me personally regarding component construction.

However, the Past President of the Modular Building Industry, Mike Mount, was invited with other representatives of the industry out to Albuquerque, NM June 17–18, 2009, to discuss this method with the Bureau of Indian Affairs. Since our hear-

ing as on June 11, 2009, that makes me believe that the BIA is listening and doing their homework now to move into a new and very exciting future!

U3 Innovations, the group that did our medical facility at Creech AFB, met with the Indian Health Services' Facility Planning Consultant in Denver this week, July 6–8, 2009. They discussed the applicability and advantages of modular construction for IHS clinics and small hospitals.

So, the process seems to have started for the application of component construction into Indian new construction of all types.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO PAUL K. CARLTON, JR., M.D.

The prefabricated facilities discussed in your testimony have been used for both in-patient and out-patient facilities in this country and in Iraq.

Question. Can you elaborate on the potential life-span and maintenance costs of these facilities, particularly in harsh climates such as in Wyoming or the Dakotas?

Answer. The Army Corps of Engineers refers to these facilities in year expected life span. For the wooden framed component construction buildings, they call them 40 year life structures. For the steel framed component construction buildings, they call them 100 year life structures.

When the state of California directed that 10% of their classrooms be built with high end modular construction 20 years ago they never expected these buildings to last so long. When they went in to do renovation/modernization to the schools they found that the modular buildings were in better shape and required less upgrades than the traditional site built structures.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO PAUL K. CARLTON, JR., M.D.

Question. Ideally we will construct facilities that meet the needs of Indian people at a cost that meets the needs of the government. You discussed modularity being the most efficient way to lower construction costs of Indian health facilities. How do you see IHS implementing this proposal?

Answer. In a perfect world, I would recommend that several pilot programs be started to prove the concept in many different areas of the Indian Health Service and see if we have missed anything in our thinking.

However, your needs are great and the facilities are old, so I would ask your IHS/BIA architectural and engineering staff to go to several of the facilities that I have described, see the quality, see the innovation, see the timeliness, and recognize that there is nothing experimental about any of this. That could be done in a matter of weeks and may have even already started with the meetings in Albuquerque and Denver. Then I would plan a significant percentage of your building program for the next several years to be component in its method of construction.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO VALERIE DAVIDSON

Veterans Affairs

Question 1. What recommendations do you have regarding the Memorandum of Agreement (MOA) between the Indian Health Service (IHS) and Veteran's Administration (VA) to address the issue raised in your testimony?

Answer. American Indian and Alaska Native (AI/AN) veterans frequently come from very rural and remote locations within the United States. There are few, if any, Veterans' Administration facilities in these locations. As a result AI/AN veterans must travel long distances to use their veteran's health benefits. Because this is impossible for many, instead they use the IHS or tribal health program that is nearer to them. Under current VA practice, no reimbursement is provided to the Indian health program. As I stated in my oral testimony, a VA clinical encounter rate needs to be established so that Indian health facilities can bill the VA for care provided to VA-eligible individuals. The VA should be directed to work with IHS to develop the VA clinical encounter rate. We believe there is no legal obstacle to implementing the VA–IHS MOA. The primary holdup in implementing the MOA seems to be resistance from an entrenched bureaucracy within the VA that is resistant to change.

Question 2. Describe any legislative fixes that may be required to serve this unique population?

Answer. Related to the answer to question one, there would appear to flexibility under current law to currently serve this population, however unfortunately there has been little action to take advantage of that authority. Sections 406, which amends section 816 of current law, and 407 of the recently introduced Indian Health Care Improvement Act Amendments of 2009 (IHCIA), H.R. 2708, would address this issue by granting explicit authority for reimbursement from VA to IHS, and vice-versa, for services rendered to dual eligible American Indian and Alaska Native (AI/AN) veterans. This would allow these individuals to be served by Indian health providers when VA providers are not available and for the Indian health providers to be reimbursed for providing services for which VA is obligated to provide. This would lessen the unfair burden on the significantly underfunded Indian health system, provide better care to these individuals and allow more care to be provided to other AI/AN beneficiaries with additional resources provided by VA reimbursement.

Title VI of the Indian Self-Determination and Education Assistance Act

Question 1. You reference a 2003 HHS report supporting Title VI which proposed 11 programs that could be accessed to begin expansion of Self-Governance. Is this report still applicable 6 years later?

Answer. The report is even more applicable today. Self-Governance began in 2000, so the data for the 2003 report was collected in the early years of Self-Governance. Even then, the data and report showed that tribes were overwhelmingly good stewards of federal funds and programs and recommended expansion of Self-Governance. Now six years later these findings have been proven valid. Self-Governance is one of the few federal programs for Indian country that has been an unequivocal success. Tribes have countless stories of how Self-Governance has allowed them to succeed in meeting the unique needs of their communities and provide better and more care to their members. Expanding Self-Governance to the 11 other HHS agencies and beyond would greatly enhance the success of Self-Governance. It would eliminate administrative burdens and costs by lessening the number of different reporting requirements on tribes and decrease the confusion and complexity of tribes having to follow many different rules, policies and regulations when utilizing funds from these many separate agencies.

As I briefly mentioned in my oral testimony, the health of AI/ANs is affected by many factors, economics and education being among the most significant. Expanding Self-Governance to Temporary Assistance for Needy Families and Head Start programs would allow tribes to address employment and education issues that affect the health of AI/ANs.

Question 2. The ISDEAA is already law, in your opinion what can Congress do to make sure Title VI is implemented?

Answer. The genius and challenge of self-determination and self-governance are that they require the "bureaucratically unthinkable"; they require federal agencies to transfer funding and authority upon demand to the Tribes they serve. The tendency toward bureaucratic entrenchment is as predictable as it is unfortunate. The legislative history of the Indian Self-Determination and Education Assistance Act is riddled with legislative "fixes" of various administrative interpretations that were unworkable and clearly at odds with congressional intent and, often, contrary to the plain language of the statute. A number of the proposed provisions in the IHCIA and the implementation of Title VI follow suit.

In order for Title VI to be successfully implemented at this point, Congress would need to pass legislation granted authority to go forward with a demonstration project. We believe that there is ample data to support that Congress should indeed authorize the Title VI demonstration project. The 2003 HHS report was supportive of the ability of tribes to run HHS programs. The Senate Committee on Indian Affairs has already drafted the legislation and held hearings on this issue and favorably reported out the draft bill to the full Senate in 2004. That bill, or a similar one, should be revived and reintroduced in Congress.

Question 3. Has Title IV of the ISDEAA been successfully implemented within the Department of Interior (DOI)? Please provide some examples of why or why not?

Answer. Although we do not have a contract with DOI for any programs under Title IV, I can speak to the issues that other tribes have voiced regarding Title IV. At past Congressional hearings tribes have voiced concerns that Title IV is outdated and that Title V has been vastly superior in allowing tribes greater flexibility in operating HHS programs. Many tribes have voiced their desire that DOI programs be given analogous authority to Title V.

Level II Trauma Center in Alaska

Question 1. Does this medical center serve non-IHS beneficiaries?

Answer. The Alaska Native Medical Center (ANMC) provides services to a small proportion of non-IHS beneficiaries under specific circumstances. Many of these cases involve individuals who need immediate emergency medical services because they have been seriously injured. ANMC, as the only level II trauma center in Alaska, is sometimes the only facility in Alaska with the capacity to provide the care they need. As a Medicare provider, ANMC must comply with the Emergency Medical Treatment and Labor Act by providing emergency medical screening and stabilization services within its capability and capacity to all individuals who come to the emergency room.

ANMC also provides services to non-IHS beneficiaries in other limited circumstances under the auspices of the Alaska Federal Health Care Partnership agreement and the authority of several statutes and regulations, such as the Public Health Services Act and the Indian Health Care Improvement Act. For example, ANMC provides pre-natal care and labor and delivery services for non-Indian women who are pregnant with the child of an AI/AN. Similarly, ANMC may treat an infectious disease of a member of a Native household or community to help safeguard the health of beneficiaries.

Question 2. What protections does the facility have against malpractice claims?

Answer. Several provisions of federal law combine to protect ANMC from the financial liability for most malpractice claims (primarily 25 USC § 450f(d), 25 USC § 1680c, 25 USC § 1638c). Because these laws provide a remedy to individuals through the Federal Tort Claims Act, these provisions are sometimes referred to as "FTCA protection" or "FTCA coverage."

These laws protect ANMC from malpractice claims brought against ANMC when the activity the led to the claim is related to fulfilling ANTHC's and Southcentral Foundation's (SCF) compact and funding agreements with HHS/IHS, are described in the resolutions ANTHC and SCF have adopted pursuant to section 813 of the Indian Health Care Improvement Act (25 USC § 1680c), or when the claim is otherwise covered by law. As a practical matter, these claims are "deemed" to be claims against the federal government. The Department of Justice defends the claims. Settlements and judgments are paid by the Treasury. Claims are subject to the limitations and protections of the Federal Tort Claims Act. Employees of ANTHC and SCF are similarly protected when they act within the scope of their employment. (The Federally Funded Health Care Assistance Act provides somewhat similar protection to "330 Community Health Clinics," which tribes and tribal organizations sometimes combine with ISDEAA clinics, resulting in potentially overlapping protection and considerable confusion due to the differences in protection. Section 314 of P.L. 101–512 provides similar protection for other types of claims.)

Although we think that virtually all ANMC services should be within the ambit of the so-called FTCA protection, both ANTHC and SCF purchase supplemental malpractice insurance due to concerns about some ambiguities in existing law and, more importantly, due to our lack of confidence in how the HHS Office of General Counsel and the DOJ will interpret the laws in specific cases.

These laws also create an inadvertent gap in protection for peer review activities that almost all other providers have, including providers for the Veteran's Administration and the Department of Defense. Section 814 of the proposed IHCIA amendments would fill this inadvertent gap. However, neither these laws nor section 814 in H.R. 2708, shield physicians and other providers from being reported to licensing authorities or from the National Practitioner Data Bank.

Fee for Service Model

You state that using a fee-for-service model would undermine the IHS/tribal system because it ignores preventive, community, and environmental health, etc.

Question 1. What kinds of billing mechanisms would you recommend that support the IHS/tribal system?

Answer. IHS (and the tribal programs) rely on both appropriated funds and revenue from third-party payors, which include Medicaid, Medicare, private insurance and other payors. The latter are generated only for direct health care services. As I noted in my written testimony before the Committee, even with both sources of funding, Indian health programs receive less than 60 percent of the funding necessary to provide services equivalent to those provided under the Federal Employee Health Benefit Program.

For direct medical services, the current reimbursement model used by Medicaid and Medicare that provides for an encounter rate is a very efficient reimbursement method. Most Indian health programs still lack the health information technology infrastructure and financial capability that is necessary to assure that Indian health programs have the same financial and billing infrastructure of private facilities. Thus, encounter rates are preferred.

Other critical components of Indian health programs, such as preventive, community, and environmental health, are funded only with direct appropriations, supplemented somewhat by grants when they are available. These program components are essential to improvement in health status, but are not addressed in any billing mechanism. My testimony regarding the limitations of fee-for-service was intended to highlight the fact that the Indian health system is far more expansive in its scope than of a typical health provider and that fee-for-service reimbursement does not address the wrap-around elements of our programs, which are critical to our mission and to achieving the goals in the Indian Health Care Improvement Act and the goals trying to be achieved under health care reform. No fee-for-service payment of which we are aware addresses these critical services. Nor, is fee-for-service a viable model for funding such services since they are generally community-based services in which frequently the population as a whole is benefiting.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO VALERIE DAVIDSON

Federal Tort Claims Act Coverage

Under limited circumstances, non-Indian patients may receive health care at tribal health facilities. The Committee has received testimony suggesting that the current Federal Tort Claims Act coverage for tribal programs should be expanded to include tribal services to these non-Indian patients.

Question 1. Please elaborate on what tribes currently have to do to provide services to non-Indians that would be covered by the Federal Tort Claims Act?

Answer. In general, tribes and tribal organizations could provide services to non-Indians that would be *theoretically* covered by the ISDEAA/FTCA protection in one of three ways: (1) negotiate with the IHS for the inclusion of those services for that population in their funding agreements; (2) provide the services in accordance with other legal authority; or (3) adopt a tribal resolution in accordance with section 813 of the Indian Health Care Improvement Act (25 USC 1680c(b)(1)(B)).

Section 813 includes several significant requirements for the governing body's resolution. The governing body must consider the extent to which other services are available to the non-IHS beneficiaries and whether extending services to them would result in the denial or diminution of services to IHS beneficiaries. Although it appears to be contrary to the statute, the IHS and one administrative tribunal have taken the position that the resolution is not effective for the purposes of ISDEAA/FTCA protection unless IHS concurs with these findings and agrees to incorporate the resolution into the individual funding agreements of each tribe/tribal organization.

The IHS typically rejects tribal resolutions regarding services to non-beneficiaries unless it concludes there are no other providers of the particular service anywhere in the area. Some of the circumstances in which tribes concluded services to non-beneficiaries should be offered and IHS rejected the resolution, include:

- locations in which elders who rely on Medicare or children with Medicaid coverage cannot find a non-Indian provider who will accept new Medicare or Medicaid patients;
- communities in which there are only part-time practitioners who have limited their practices leaving many (particularly those with only Medicare or Medicaid coverage) without access to a primary care or dental provider;
- communities in which some services are available only through the emergency room (for instance, IHS rejected a resolution authorizing services to non-beneficiaries in a community-based health program for homeless individuals that would have served both AI/AN and non-Indian homeless people even though the program was not viable unless both were served and the only access to health care for the non-AI/ANs was in the hospital emergency room and the AI/ANs were much less likely to seek care if it were not offered in this kind of alternative setting.)

Also, the IHS/HHS and DOJ have taken the position that ISDEAA/FTCA protection cannot be determined in advance, but must be decided on a case-by-case basis. Their case-by-case determinations (together with discussions in other contexts) demonstrate a marked tendency to apply the protection as narrowly as possible (and often more narrowly than could be justified by any plain language interpretation of the law). In a recent (non-malpractice case), we were very disturbed to see what appeared to be a form letter automatically denying protection, despite language in our funding agreement clearly describing the activity that led to the lawsuit and despite

signed agreements with the IHS approving those very projects. Although the correct determination was eventually made, the practice is similar to that of insurance companies that automatically deny everything in hopes of discouraging people from benefiting from assistance to which they are entitled.

At the same time, the DOJ tries to take advantage of any insurance policy that a tribe/tribal organization may have purchased, even if the policy was intended just to fill the gaps and provide a backup plan.

As a *practical* matter, there is some ambiguity and vagueness in existing law providing ISDEAA/FTCA protection, partially because it results from a series of piecemeal enactments. Unfortunately, the DOJ, HHS and IHS have expanded considerably the uncertainty associated with ISDEAA/FTCA protection through their unreasonably stingy interpretations and various practices that undermine the value of that protection.

Question 2. Do tribes obtain medical malpractice coverage and, if so, what is the cost of that coverage?

Answer. There are a wide range of practices with respect to purchasing malpractice insurance due to the practical uncertainties described above together with the great variety of circumstances among self-determination contractors and self-governance compactors. Some tribes and tribal organizations rely entirely on the protections provided through ISDEAA and the FTCA, while others purchase a full spectrum of insurance. Some, like ANTHC, try to purchase policies specifically designed to fill the "gaps" in ISDEAA/FTCA protection rather than paying the full price for policies that provide duplicative coverage.

The price of "gap" policies can vary considerably, depending on what the limits and deductibles are, how well the insurance brokers and carriers understand the ISDEAA/FTCA protection, the negotiating skill of the tribe/tribal organization, and whether the insurance is intended to cover other things that are clearly not within the ambit of the ISDEAA/FTCA protection. For ANTHC, which co-manages the Alaska Native Medical Center with the SouthCentral Foundation (SCF), a supplemental "gap" policy for malpractice related to inpatient hospital care, outpatient specialty services, emergency care, specialty field visits to small Alaskan communities, etc. is about 25–30% of the cost of a full policy. (Gap insurance for primary care, behavior health and other programs administered by SCF is purchased separately.) While this price is much improved over prior years, it is still too much from our vantage point. As noted below, this is a cost that is allocated to the Secretary by law. Also, ANTHC is paying 25–30% of the cost of a full malpractice policy (even though there is little, if any, activity that we think should not be covered by the ISDEAA/FTCA protection) rather than 100% of a policy for those few things that might genuinely be unprotected. Without more decisive answers about what exactly is or is not covered, however, actuarial determinations are elusive.

We understand that some insurers provide little, if any credit for the ISDEAA/FTCA protection to other tribes/tribal organizations, which pay considerably more for malpractice insurance.

This is both the cause and effect of a practice of the DOJ that has injected another element of uncertainty that artificially elevates the price of supplemental coverage as well. It often demands to be treated as an implied insured so that the supplemental gap policy essentially becomes the primary policy for a wide range of risks that the tribe and insurer specifically intended to exclude. Since it is difficult to predict when this might happen, the price is adjusted upward to compensate the insurer for this risk.

While we agree with the DOJ and courts that the insurance companies should not be permitted to enjoy windfall profits under these circumstances, the better policy would be to disgorge the profits in favor of the tribes and tribal organizations that have been taken advantage or to simply enforce existing law which requires the Secretary of Health and Human Services to purchase liability insurance for tribes and tribal organizations, taking into account the extent of ISDEAA/FTCA protection—that is to fill the gaps. (25 USC 450f(c).) To the best of our knowledge, the Secretary has neither purchased such insurance nor issued any determination no such insurance is needed since there are no real gaps in the protection. The latter would be especially helpful, assuming courts would be required to adhere to the determination. In any case, the cost of procuring insurance for each individual tribal program is likely to be significantly more expensive than pooling the cost at a national level.

Title VI Expansion

Your written testimony recommends expanding the self-governance program to other programs within the Department of Health and Human Services such as Head Start.

Question 1. Please explain how expanding self-governance principles to these other programs will ensure accountability, particularly that the funds will be used in accordance with governing statutes and purposes.

Answer. The 2003 HHS report found that self-governance programs are good stewards of federal funds and exhibited high degrees of accountability for federal fund and complied with the use of the funds for which they were intended. Title VI would merely be an expansion of Title V authorities to other HHS programs outside of IHS. The auditing standards and reporting requirements would still be the same as Title V for any programs compacted for under Title VI and should have the same high degree of accountability and effectiveness that tribes have shown under Title V IHS programs. Title VI is not about eliminating accountability for federal funds provided to tribes, it is about eliminating bureaucratic red-tape and administrative burdens that tribes are encumbered with by having to deal with a multitude of reporting requirements from the different HHS agencies. It is also about respecting the tribe's priorities within its own tribal community. Title VI would eliminate this problem by only requiring tribes to meet one reporting and accountability requirement for all the programs—one that has shown to be effective in providing accountability through Title V.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO VALERIE DAVIDSON

Question 1. All of us have habits that promote our health and habits that compromise our health. I imagine that you have encountered obstacles in your efforts to motivate tribal members to take charge of their health and to motivate tribal leaders to provide adequate health services. What can we learn from your experience that would help us improve Indian health?

Answer. Indian health programs are unique among providers in their focus on prevention and community health. Unfortunately, funding for health promotion and disease prevention is inadequate, particularly as the health challenges have changed from those that can be addressed with immunizations to those that require behavioral changes. Passage of H.R. 2708, the Indian Health Care Improvement Act Amendments of 2009, is important as it broadens the definitions of health promotion and disease prevention to bring them up-to-date. The integration of behavioral health in Title VII is also important. Many tribal health programs have begun this process, and some have even begun to fully integrate behavioral health assessment and treatment into their primary health programs. This is important to earlier identification of mental health and substance use disorders that trigger or confound other health problems.

As I alluded to in my oral testimony, improving Indian health is a complex issue and to successfully address the issue a multitude of approaches must be taken. This is why the authorization of the demonstration project of Title VI of the Indian Health Care Improvement Act is so important. The 2003 HHS report, *Tribal Self-Governance Demonstration Feasibility Study,* concluded that it was feasible and desirable to extend tribal self-governance to the Department of Health and Human Services (HHS) programs outside of the Indian Health Service. The report recommended 11 HHS programs that could be included to begin with. The eleven included programs such as Temporary Assistance for Needy Families and Head Start that would allow tribes to better address economic and education issues in their communities that have been shown to have a significant impact on the health of AI/AN communities.

Question 2. I am aware that one element of improving Indian health services is to increase the number of skilled Indian health care providers. What specific suggestions could you offer this Committee to inspire more American Indians and Alaska Natives (AI/ANs) to succeed in school and become doctors, dentists, nurses, and other health care providers on reservations or in the urban areas where other Indians live?

Answer. First, more mid-level health providers, such as a community and behavioral health aides, are needed to provide services in Indian country. Obtaining education and training to be certified as a community or behavioral health aide lowers the burden for many Native American members of these communities who may want to provide health services to their community but do not want to be away from their communities for years and years to obtain the training necessary to become a physician or psychologist.

Second, for those AI/ANs that do wish to pursue higher education and training outside of their communities, there needs to be proper and adequate support. This can be accomplished by expanding the Indian health professions program by allow-

ing more scholarships for AI/AN students pursuing health professions. Additionally, the waiver of taxation on scholarship and loan repayments can be waived as it is for the Veteran's Administration. Providing health services to AI/AN people is not a lucrative career, health professionals work for the Indian health system because they believe in what they are doing and want to make a positive contribution to the health of AI/AN and their communities. Whatever opportunity there is to allow AI/AN students and providers to accomplish this should be pursued.

Question 3. Providing care for Indian children with disabilities is a major need. I know that the IHS has a contract with three universities (Utah State, Northern Arizona University and New Mexico State University) to serve Indian children with special needs in the Southwest region of the country. These universities are looking for funding to expand tele-behavioral health to serve rural, geographically isolated communities in New Mexico and Arizona. Can you comment on successful strategies that provide health promotion and health services to rural areas such as in my sate of New Mexico?

Answer. As I stated at the hearing, Alaska has a long history and advanced model for providing health services to rural areas. The model that has worked for us in Alaska for providing care in rural communities is a combination of having mid-level health providers in the rural communities who are able to consult with higher-level health providers through a telehealth network.

By necessity the Community Health Aide (CHA) program was born in the 1950s to address the TB outbreak in remote Alaska villages, where CHAs were needed to provide vaccinations. Through ingenuity this program has been improved and expanded. First by establishing a uniform and accepted certification standard for CHAs, and later by expanding the program to include Dental Health Aides and Behavioral Health Aides.

The small rural villages in Alaska do not have the population base to support higher level providers, such as physicians or psychiatrists, to be in the communities full-time. However, they can support health professionals that are mid-level providers. These mid-level providers still have training and expertise and are more willing to work in rural communities at salaries that smaller communities can support. Additionally, while people from these small communities may neither have the desire or opportunity to obtain a medical or dental degree and study for 10 years outside of their communities, they can obtain training and certifications as CHA, DHAT and BHAs without having to leave home for too long and with much less financial burden. This allows them to return to their communities to provide services and allows for a steady and trusted presence in those communities.

Telehealth is an important support for the modern CHA program because it allows higher-level providers located in more populated areas to actually see how various symptoms present rather than relying exclusively on verbal descriptions from CHAs in difficult cases. This helps to extend their expertise out into the rural areas in cases that would otherwise require patients to travel to a regional hub or Anchorage for care. ANTHC has developed special AFHCAN telehealth carts and software that provide CHAs with the tools they need to capture photos, images and other data that often allows the higher-level providers to evaluate and direct the treatment of patients at great distances without the high cost or time involved in travel.

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