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Before a Hearing of the Senate Committees on Indian Affairs

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Room 485, Senate Russell Building

Good morning Chairman Dorgan, Vice Chairman Thomas, and members of the Committee. My name is Rachel A. Joseph. I am a member of the Lone Pine Pauite-Shoshone Tribe of California and serve as the Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). I am a former Chairperson of the Lone Pine Pauite-Shoshone Tribe and am a current board member of the Toiyabe Indian Health Project, a consortium of nine Tribes, which serves Mono and Inyo Counties in central California. I have served for several years on the Indian Health Service (IHS) National Budget Formulation team representing California and have been elected to represent the IHS East Central California Tribes to the California Area Office Advisory Committee. In these capacities, and others, I have been fortunate to work with Tribal Leaders from across the Country in addressing health care issues. Thank you for holding this hearing and providing us the opportunity to testify in support of legislation to amend and reauthorize the IHCIA.

This testimony is also offered on behalf of the National Indian Health Board (NIHB). The NIHB serves Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to AI/ANs,

and upholding the federal government's trust responsibility to AI/AN Tribal governments. Over the last several years, the NIHB has provided tremendous administrative, technical, and policy development support to the NSC.

In June 1999, the Director of IHS established the NSC, comprised of representatives from Tribal governments and national Indian organizations, for consultation and to provide assistance regarding the reauthorization of the IHCIA, set to expire in 2000. The NSC drafted proposed legislation, which reflected the tribal consensus recommendations developed at area, regional meetings and a national meeting held here in Washington, DC. In October 1999, the NSC forwarded a tribal proposed IHCIA reauthorization bill to the IHS Director, to each authorizing committee in the House and Senate, and the President. For the last eight years, the Senate and House have introduced IHCIA legislation based on the tribal bill. The NSC has continued as an effective tribal committee by providing advice and "feedback" to the Administration and Congressional committees regarding the IHCIA reauthorization bills introduced in the 107th, 108th, and 109th Congresses, none of which passed. The NSC and tribal leaders are committed to working with you to achieve passage of an IHCIA reauthorization bill during the 110th Congress. Today, I respectfully request Congress and the Administration to work together with Indian Country to enact the reauthorization of the IHCIA. The NSC appreciates the support of the Senate Indian Affairs Committee Chairman Dorgan and Committee Vice Chairman Thomas in this endeavor.

History of the IHCIA

Over thirty years ago, the IHCIA was first enacted. On October 1, 1976, the late President Gerald R. Ford, went against the veto recommendations of the then Department of Health and Human Services and the Office of Management and Budget, and signed the IHCIA into law. In his signing statement, the late President Ford wrote:

> "*I am signing S. 522, the Indian Health Care Improvement Act. This bill is not without faults, but after personal review I have decided that the well-documented needs for improvement in Indian health manpower, services, and facilities*

outweigh the defects in the bill. While spending for Indian Health Service activities has grown from $128 million in FY 1970 to $425 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our first Americans should not be last in opportunity."

The late President Ford signed the IHCIA into law with a specific mission: to bring the health status of first Americans to the level of other populations.

The current framework of the IHCIA is similar to the same bill that President Ford signed into law. With the emergence of tribally operated health programs under the Indian Self-Determination Education and Assistance Act and the establishment of 34 urban Indian health centers, the Indian health care delivery system has changed considerably since 1976. Although the IHCIA was reauthorized in 1988 and again in 1992, the IHCIA has not been updated in over 14 years. Modernization of this law is necessary so that improvements are made in the Indian health systems to raise the health status of Indian people to the highest level possible.

Reauthorization Is Important

Indian Country must have access to modern systems of health care. Since the enactment of the IHCIA in 1976, the health care delivery system in America has evolved and modernized while the AI/AN system of health care has not kept up. For example, mainstream American health care is moving out of hospitals and into people's homes; focus on prevention has been recognized as both a priority and a treatment; and, coordinating mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice.

Reauthorization of the IHCIA will facilitate the modernization of the systems of health care relied upon by 1.8 million AI/ANs. The IHCIA reauthorization bill authorizes methods of health care delivery for AI/AN in the same manner already considered standard practice by "mainstream" America. There is a critical need for health promotion

and disease prevention activities in Indian Country and provisions of the reauthorization legislation address this need. Disease prevention and health promotion activities elevate the health status at both the individual and community level. Indian Country needs flexibility to run its health care delivery systems in a manner comparable to health care systems expected by "mainstream" America.

Health Care Disparities

The IHCIA declares that this Nation's policy is to elevate the health status of the AI/AN people to a level at parity with the general U.S. population. No other segment of the American population is more negatively impacted by health disparities than the AI/AN population and our people suffer from disproportionately higher rates of chronic disease and other illnesses.

We have demonstrated that 13 percent of AI/AN deaths occur in those younger than 25 years of age, a rate three times higher than the average US population. The U.S. Commission on Civil Rights reported in 2003 that "American Indian youths are twice as likely to commit suicide…Native Americans are 630 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental death compared with other groups."

In addition, according to the IHS, AI/ANs have a life expectancy six years less than the rest of the US population. Rates of cardiovascular disease among AI/ANs are twice the amount for the general public, and continue to increase, while rates for the general public are actually decreasing.

Public health indicators, such as morbidity and mortality data, continue to reflect wide disparities in a number of major health and health-related conditions, such as Diabetes Mellitus, tuberculosis, alcoholism, homicide, suicide and accidents. These disparities are largely attributable to a serious lack of funding sufficient to advance the level and quality of adequate health services for AI/AN. Recent studies reveal that almost 20 percent

fewer AI/AN women receive pre-natal care than all other races and they engage in significantly higher rates of negative personal health behavior, such as smoking and the consumption of alcohol and illegal substances during pregnancy.

A travesty in the deplorable health conditions of AI/AN is knowing that the vast majority of illnesses and deaths from disease could be prevented if additional funding and contemporary programmatic approaches to health care was available to provide a basic level of care enjoyed by most Americans. It is unfortunate that despite two centuries of treaties and promises, American Indians endure health conditions and a level of health care funding that would be unacceptable to most other U.S. citizens.

Over the last thirty years, progress has been made in reducing the occurrence of infectious diseases and decreasing the overall mortality rates. Today, AI/ANs still experience significant health disparities and have lower life expectancy than the general population. The enhancements in the IHCIA reauthorization bill will facilitate improvements in the Indian health care delivery system. Health services will be delivered in a more efficient and pro active manner that in the long term will reduce medical costs, will improve the quality of life of AI/ANs, and more importantly, will save the lives of thousands of AI/ANs.

IHCIA Reauthorization Efforts

Since 1999, the NSC and the NIHB has led reauthorization efforts which have often been long, difficult; and, at times, disappointing. Throughout these years, the NSC has accommodated Administration and Congressional concerns by working out endless compromises and by reaching consensus on key policy issues. At the same time, the NSC held to its guiding principles of no regression from current law and protection of tribal interests.

After so many years of working to secure reauthorization, you can appreciate how disappointed Indian Country was when the IHCIA failed to pass the Senate in the 109th Congress. This time, the bill was derailed largely due to an unofficial Department of

Justice (DOJ) memorandum provided to key Senators during the last hours on the last day of the pre-Election Session of Congress. This memo, highly critical of many elements which are the foundation of the Indian health care system and issues that would erode sovereignty, contained several inaccurate and erroneous claims. Because the Tribes received a copy of the DOJ document late Friday afternoon (September 29, 2006), there was insufficient time for Tribes to respond before the Senate recessed. At the 11th hour for action on the reauthorization bill, Indian Country faced a nameless opponent whose assertions threatened current practices of AI/AN health care.

The NIHB responded to the DOJ document and forwarded its response to the Attorney General Alberto Gonzales and the President asking the Administration to withdraw the DOJ document. The DOJ raised two major objections that are of great concern to the NSC. The DOJ raised Constitutional questions regarding the definition of "Indian". The definition of "Indian" in the IHCIA reauthorization is the same definition in the current IHCIA, which has been in law for over thirty years, and has never been challenged on Constitutional grounds. In fact, this definition of Indian is found in other Federal laws. The NSC strongly recommends that the definition of Indian in section 4 (12), definition of urban Indian in section 4 (27), and eligibility of California Indians in section 806 of the IHCIA reauthorization be retained so there is **no regression from current law**.

The DOJ also objected to the extension of Federal Tort Claims Act (FTCA) coverage to home and community-based services provided outside of a health facility, and traditional health care practices. The DOJ was apparently concerned that these services would not be carried out following appropriate standards of care. Currently, the IHS and tribes provide home health care services following State Medicaid standards of care. Traditional health care practices are usually provided as complementary services to Western medical practices at the request of family members. In most cases, the traditional health care practitioners are not employees of the IHS or tribes so FTCA coverage would not apply in the event that a malpractice claim was ever filed.

The NSC appreciates the work of this Committee during the 109th Congress to secure passage of the IHCIA, S. 1057. It is the NSC's understanding that S. 4122, introduced on the last day of the Session, reflects last minute changes to the IHCIA that were made to address the Department of Justice and Republican Steering Committee concerns. Over the last few months, the NSC has had an opportunity to review the IHCIA bills, S. 1057, and S. 4122, and has worked with Congressional committee staff in recommending legislative changes to any draft reauthorization bill to be introduced. I appreciate the opportunity to highlight some of those key provisions:

Elevation of the Indian Health Service Director

Tribal leaders have long advocated for "elevation" of the IHS Director to that of an Assistant Secretary. We believe "elevation" is consistent with the government-to-government relationship and the trust responsibility to AI/AN Tribal governments throughout all agencies of the Department of Health and Human Services (HHS). We believe that "elevation" would be comparable to the administration of the Bureau of Indian Affairs programs by an Assistant Secretary in the Department of Interior and the Assistant Secretary for Public and Indian Housing in the Department of Housing and Urban Development.

While HHS has made great strides over the past several years to address Tribal issues, the elevation of the IHS Director to that of an Assistant Secretary would facilitate the development of AI/AN health policy throughout the Department. There are many cross-cutting issues from various Department agencies, such as the Centers for Disease Control and Centers for Medicare & Medicaid Services, which impact Indian health programs. Elevating the Director's position to that of Assistant Secretary would facilitate greater collaboration with other agencies and programs of the Department concerning matters of Indian health.

The NSC recommends that the language elevating the Director of IHS to Assistant Secretary of Health be included in any reauthorization bill introduced, including any conforming amendments to the definition and other sections, as appropriate.

Bipartisan Commission

Section 814 of the IHCIA reauthorization bill, S. 1057, authorizes a National Bipartisan Commission on Indian Health Care. During the reauthorization process, section 814 has been modified several times and now reflects general authority for the Commission to study the provision of health services to Indians and identify needs of Indian Country by holding hearings and making funds available for feasibility studies. The Commission would make recommendations regarding the delivery of health services to Indians, including such items as eligibility, benefits, range of services, costs, and the **optimal** manner on how to provide such services. The NSC supports section 814 of S. 1057.

The NSC was concerned to read that S. 4122 modified section 814 to require the commission to study utilization rates and included language that could be interpreted to call into question the foundation for the Federal government's responsibility to provide health care to AI/ANs. Indian tribes ceded 400 million acres of land to the United States in exchange for promises of health care and other services, a fact that is reflected in treaties. We believe these documents and actions secured a de-facto contract, which entitles Native peoples to health care in perpetuity and are based on moral, legal and historic obligations of the United States. The NSC would object to any language in the bill that would undermine the government's obligation to Indian people.

Long-Term Care and Home and Community Based Services

While the life expectancy of AI/ANs is substantially lower than the rest of the general population, the ability to provide health care and related services for the elderly population remains one of the most pressing issues for Indian country. The need to improve and expand services for all stages of the life cycle are desperately needed; however, services utilized during the waning years of life are severely lacking in AI/AN communities. Under current authorities, in some Indian communities, AI/ANs elders are placed in assisted living or nursing homes located off-reservation. Families have to travel hundreds of miles from their home to visit their elderly relatives.

Section 213 provides for the authorization of IHS and Tribally-operated health systems to provide hospice care, assisted living, long-term care, and home and community based services. Section 213 would enable Indian elders to receive long term care and related services in their homes, through home and community based service programs, or in tribal facilities close to their friends and family. Section 213 provides Indian communities with necessary authorities to provide long term care and related services to its Indian elders that are currently available to the general U.S. population. Section 213 is a prime example of why the IHCIA needs to be modernized.

The NSC was dismayed to read that S. 4122 modified the definition of “home and community based services” by deleting certain services such as “personal care services” and “training for family services.” The NSC recommends that the definition of “home and community based services” should include the same services that title XIX of the Social Security Act includes in its definition of “home and community based services.” The NSC further recommends that any standards should be consistent with Medicaid standards.

Behavioral Health Programs

S. 4122 did not modify Title VII of the IHCIA reauthorization. The NSC and Indian Country strongly support the Title VII provisions authorizing comprehensive behavioral health programs which reflect tribal values and emphasize collaboration among alcohol and substance abuse programs, social service programs and mental health programs. Title VII addresses all age groups and authorizes specific programs for Indian youth including suicide prevention, substance abuse and family inclusion.

We support making the “systems of care” approach to mental health services available in Indian Country. The "systems of care" approach means more than just coordinated or comprehensive mental health services. It involves making families and communities partners in the development of behavioral/mental health services, a methodology formally recognized and encouraged by the Substance Abuse and Mental Health Services Administration (SAMHSA). In fact, an existing SAMHSA program, operated in

coordination with other federal agencies, provides six-year grants to a number of Indian tribes for the express purpose of developing systems of care for mental health services in Indian communities.

Increased IHS and tribal utilization of "systems of care" methodologies for delivery of mental heath services will help tribes leverage assistance from SAMHSA, the National Institute of Mental Health and other agencies for services to Indian children. Local evaluations of "systems of care" programs have shown less acute psychiatric hospitalizations and out-of-home placements for adolescents, better school performance and fewer crimes by children in the program.

Innovative Health Care Delivery Systems

Senator Dorgan, in your Senate Floor statement of January 22, you discussed the need for improving emergency access to reservation-based health care through expanding clinic hours and other innovations. Specifically, you discussed the need to establish a new Indian health care delivery model to replace existing emergency rooms at Indian health hospitals with low-cost, "after hour", walk-in clinics – a model currently available in the private sector. We appreciate your leadership in proposing to develop new health care delivery systems in Indian Country that are accessible to the general public.

Some tribal programs have extended ambulatory health care center hours using current authorities. For instance, many tribal programs have established "after-hour" programs, such as on Saturday mornings, specifically geared to particular health promotion and disease prevention (HP/DP) activities. A tribal program in California operates a dental preventative program on Saturday mornings for families who are not able to access these services during the week due to school and work commitments. Thus, the tribal program has health professionals on staff to provide dental preventative services. At the same time, the health professionals are available to treat walk-in patients seeking other medical treatment or to provide necessary emergency medical treatment or referrals. Some tribal programs provide "after hour" services by establishing a toll-free number for patients to call physicians or nurses who are "on call" to handle routine care and/or emergencies.

While the NSC would support legislative language clarifying existing authorities, or expanding existing authorities through demonstration projects, sufficient additional funding is needed to ensure the viability of these new programs.

In reviewing S. 4122 for any changes made to S. 1057 (Managers' Amendment), the NSC reviewed all provisions in the bill including Section 301 – Consultation, Construction and Renovation of Facilities; Reports. The NSC reviewed Section 301 in particular because during the 109th Congress changes were made to Section 301(c) - Health Care Facility Priority System, as reflected in S. 1057 (Managers' Amendment). These provisions were not modified further by S. 4122, and at a February 15 -16th meeting of the NSC, the NSC reached consensus to support language in Section 301(c), including the priority of certain projects protected language in Section 301(c) (1) (D), as contained in S. 1057 and S. 4122.

As a result of tribal concerns about proposed closures of health care facilities, including emergency departments and urban Indian clinics, the NSC would ask the Committee to revisit Section 301 (b) Closures. During a meeting with Senator Dorgan and NIHB Executive Board members, Lester Secatero, NIHB Member at Large, expressed concerns that the IHS might be planning to close emergency departments in existing IHS operated hospitals in the Albuquerque Area. If these emergency departments are closed, tribal members will be required to travel over 60 miles to Albuquerque to receive emergency services. Closure of existing emergency departments of hospitals, without sufficient notice to Congress, will only exacerbate the concerns regarding the availability of "after hour" services available to Indian people.

Section 301 (b) as currently contained in the IHCIA reauthorization would prohibit the agency from closing a facility unless the agency has submitted a report to Congress at least 1 year prior to the date of the proposed closure. Under current law, the agency is prohibited from closing "a Service hospital or other outpatient health care facility of the Service, or any portion of such a hospital or facility" unless the agency has submitted a report to Congress at least 1 year prior to the proposed closure date such hospital or facility (or portion thereof). The NSC recommends that Section 301 (b) be modified to

require the IHS to submit a report to Congress even when contemplating closure of a portion of a hospital, such as an emergency room. Congress could require, before closure of any emergency department of a hospital, that the IHS include as part of its report to Congress an analysis of the feasibility of converting the emergency department to an "after hour" walk-in clinic.

Other Miscellaneous Provisions:

The NSC reviewed S. 4122 for modifications to other provisions of the IHCIA reauthorization and was concerned that some of these modifications were either a regression of current law or not consistent with tribal interests. The following is a summary of some of those provisions and NSC's recommendations:

Section 124 (b): This provision exempts National Health Service Corps (NHSC) scholars qualifying for the U.S. Public Health Service Commissioned Corps to be exempt from the NHSC and IHS full time equivalent (FTE) limitations when serving at a Tribal or urban Indian program. This provision was deleted in S. 4122 and the NSC recommends that Section 124(b) be reinserted into the IHCIA reauthorization bill. Placement of Commissioned Corps officers at tribal or urban sites is an important health professional recruitment tool and should not count towards FTE limitations.

Section 302 (c)(5): S. 4122 deleted this provision that allows tribes to use appropriated dollars to pay back loans acquired through other federal loan programs. There are other Federal loan programs where money is available for tribes to construct sanitation facilities, but tribes cannot access these funds because they do not have the resources to pay back these loans. The NSC recommends reinserting this provision into the bill. Also, S. 4122 revised section 302 by adding a new provision at 302 (c)(9) to clarify that goods and services from other sources can be used for all related costs associated with sanitation facility construction. The NSC has no objection to this new provision.

Section 314 (a): S. 4122 revised Section 314 (a) to require that rental rates for quarters be established according to OMB Circular A-45. The reference to OMB Circular A-45 defeats the purpose of the section which was intended to provide tribes with flexibility to

set rental rates based on **reasonable** rental rates available in their local communities. The NSC would recommend deleting the reference to OMB Circular A-45 in Section 314(a).

Section 403: S. 1057 and S. 4122 currently provide that the IHS and tribes have a right of recovery from third parties for "reasonable expenses incurred." During the 109th Congress, the tribes requested to change this language to "reasonable charges billed" because some tribes have encountered problems with insurance companies not reimbursing the tribes because of the "expenses incurred" language. The NSC recommends that the "reasonable expenses incurred and billed" language in section 403(a) be changed to "reasonable charges billed."

The NSC recommends that section 403 be further amended to clarify that tribes or tribal organizations operating programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), have authority to file actions under the Federal Medical Care Recovery Act (FMCRA) on the same basis as the federal government. FMCRA authorizes the Federal government to recover medical costs from a responsible party, or their insurer, resulting from a tort injury, such as an automobile accident. Tribal programs operating under the ISDEAA should be afforded similar authorities to recover medical costs resulting from tort injuries to their tribal members resulting.

Section 805: S. 4122 revised Section 805, by adding a new subsection (b) that would allow the Secretary to promote traditional health care practices, but would exclude FTCA coverage of traditional health care services. The NSC would recommend deleting subsection (b) because excluding particular services from FTCA coverage is a **regression from current law**.

While we can build on previous legislative activities, we look to this new Congress and the introduction of a new reauthorization bill. However, in order to facilitate passage of the IHCIA in the 110th Congress, tribal leaders need to be "at the table" with Congressional and the Administration staff to discuss the IHCIA, which is consistent with a meaningful government-to-government relationship. The NSC stands ready to

work with Congress, and the Administration to ensure passage of the IHCIA during this Congress.

Thank you for providing me this opportunity to present testimony and I am available to answer any questions you may have.