S. HRG. 111–12

ADVANCING INDIAN HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

FEBRUARY 5, 2009

Printed for the use of the Committee on Indian Affairs

U.S. GOVERNMENT PRINTING OFFICE

47–690 PDF WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON INDIAN AFFAIRS

BYRON L. DORGAN, North Dakota, *Chairman*
JOHN BARRASSO, Wyoming, *Vice Chairman*

DANIEL K. INOUYE, Hawaii
KENT CONRAD, North Dakota
DANIEL K. AKAKA, Hawaii
TIM JOHNSON, South Dakota
MARIA CANTWELL, Washington
JON TESTER, Montana
TOM UDALL, New Mexico

JOHN MCCAIN, Arizona
LISA MURKOWSKI, Alaska
TOM COBURN, M.D., Oklahoma
MIKE CRAPO, Idaho
MIKE JOHANNS, Nebraska

_____, _____

ALLISON C. BINNEY, *Majority Staff Director and Chief Counsel*
DAVID A. MULLON JR., *Minority Staff Director and Chief Counsel*

CONTENTS

WITNESSES

APPENDIX

ADVANCING INDIAN HEALTH CARE

THURSDAY, FEBRUARY 5, 2009

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

The Committee met, pursuant to notice, at 11:10 a.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. We will next turn to the hearing, an oversight hearing, on the subject of Indian health care.

This issue is not a stranger to this Committee, the subject of Indian health care. I mentioned when I opened this hearing that we are doing the Economic Recovery Bill on the floor of the United States Senate. We had, I think, 13 votes last evening starting at 6:30. We are going through long traunches of votes on this particular piece of legislation, and they have now set 11:45 for another traunch of votes. That would mean that we don't have to be on the floor right at 11:45, but it means we have to be there probably very close to 12 o'clock. They give us about a 15 minute period to get to the Floor.

So I am going to try to move this hearing along, because I don't want to have a hearing that requires you to wait an hour and a half to two hours to come back. If you will give us your cooperation, I would appreciate that.

Let me say this, and I believe I speak for my colleagues on the Committee, this is, one of the most important issues that we face. We struggled mightily in the last session of the Congress, as you know. We passed an Indian Health Care Improvement Act out of this Committee, and passed it through the United States Senate. But it did not become law, as it did not get through the House. I am dedicated, I know my Vice Chairman is as well, to turn once again to Indian health care.

We have a crisis in Indian health care. We need to address it and fix it. And we are going to begin immediately to write new legislation. That is why I have invited those of you who are going to be at the table to give us your perspective. And we will keep the record open and ask for submissions of testimony as well.

I do want to mention my colleague from South Dakota who is also from the northern Great Plains. We have a sort of a terrific geographical representation right at the moment with the three of

us. But all three of us are dedicated to addressing these issues. We will do so aggressively.

[The prepared statement of Senator Dorgan follows:]

PREPARED STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

Today, we will hold an oversight hearing on Advancing Indian Health Care. The purpose of the hearing is to obtain input from representatives of Indian Country about how to proceed with reforming the Indian health care system.

I don't need to tell anyone in this room that the current system is broken. We all know it is. We have a federal health care system for Indians that is only funded at about half of its need. Clinician vacancy rates are high; and misdiagnosis is rampant. Only those with "life or limb" emergencies seem to get care. More than 1.9 million American Indians and Alaskan Natives must ration their health care services.

The impacts of this system on the Native population are clearly shown in the health disparity statistics. **[Chart 1]** As you can see in Chart 1, the health disparities between the general U.S. population and American Indians are vast:

- Native Americans die of tuberculosis at a rate 510 percent higher than the general population.
- Infant mortality rates for Native Americans are 12 per 1,000 persons compared to 7 per 1,000 persons for the general population.
- Suicide rates are nearly double the general population among Native Americans.
- American Indians die from alcoholism at rates 510 percent higher than the general population.
- The rate of diabetes amongst Native Americans is 189 percent higher than the general population.

These numbers are appalling and represent Third World conditions right here in the United States.

So what do we do about it? Well, ten years ago, Indian Country asked Congress to reauthorize and modernize the Indian Health Care Improvement Act. This is the primary law that governs the current Indian health care system. Indian Country even presented Congress with a draft bill to consider in 1999.

Since then, certain Members of Congress have been trying to get an Indian Health Care bill passed. Every Chairman of this Committee, since 1999, introduced an Indian Health Care bill. When I became Chairman of this Committee last Congress, I made passage of an Indian Health Care bill my number one priority.

In February of 2008, the Senate debated an Indian health care bill on the floor for the first time in 16 years. The result was passage of the bill by a vote of 83–10. Regrettably, the House of Representatives was unable to do the same.

Like many of you in this room, I started the year very optimistic about finally improving the Indian health care system. I was hopeful that we would be getting a Secretary of Health and Human Services that would make reforming Indian health care a priority. The withdrawal of Tom Daschle as the nominee for Secretary was very disappointing. I believe that he would have been a great advocate for reforming Indian health care.

Regardless of who becomes the new Secretary of Health and Human Services, improving Indian health care will remain a top priority for this Committee. I am encouraged by the fact that our new Vice Chairman is a doctor (an orthopedic surgeon). Senator Barrasso comes from a state with lots of Indians and a large reservation—the Wind River Indian Reservation. I also believe he serves as a rodeo physician for the Professional Rodeo Cowboy's Association.

So, I remain optimistic that this Committee will continue to work in a bi-partisan fashion to address the health care needs of our First Americans.

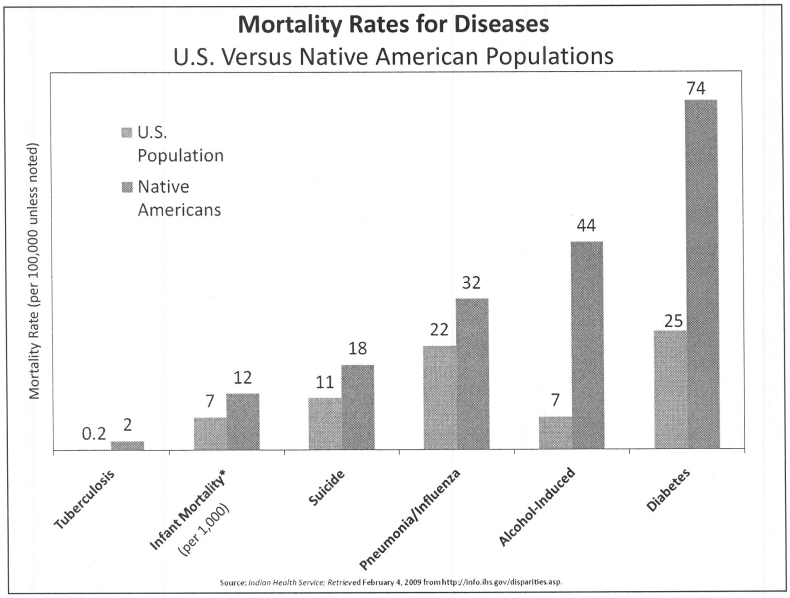
I want to end my comments with a reminder of why we work so hard on this issue. **[Chart 2—Ta'shon Rain Littlelight]** This is a picture of Ta'shon Rain Littlelight. She was five-years-old when she died. When the little girl lost her appetite, began sleeping more, and her attitude changed, her family took her to the tribal clinic. Unfortunately, the clinic did not have the testing capabilities or Contract Health dollars to send her to another facility for testing. Repeatedly, this beautiful little girl was misdiagnosed with depression. It was not until it was far too late that doctors found that cancer had taken over her little body. She lived the last three months of her life in unmedicated pain. She died in September, 2006.

Ta'shon was not given the chance to have a normal life because of a terrible disease and an inadequate Indian health care system. She never had a chance to fulfill her potential. Our First Americans deserve better than this. We must all work to achieve adequate health care for families like Ta'shon's.

We stand at the beginning of this Congress with an opportunity to reevaluate our strategy and plan for improving Indian health care.

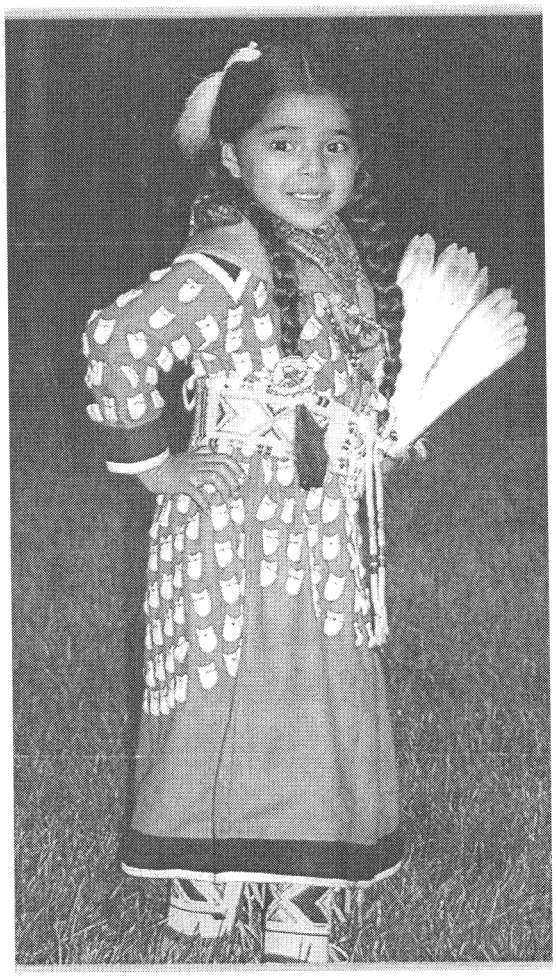
Today, I am asking Indian Country to provide us input on how to move forward. Tribal leaders and tribal advocates are on the ground every day. We are not asking that Indian Country come up with all of the solutions, but this Committee would like to hear your recommendations on how best to move forward.

CHART 1



C

CHART 2



With that, I turn it over to our new Vice Chairman. Senator Barrasso?

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

Senator BARRASSO. Thank you very much, Mr. Chairman. I look forward to the new role. I want to thank Senator Murkowski for her years of commitment and her contributions to this Committee.

I would also like to make a statement, because I am pleased, Mr. Chairman, that we are beginning this new Congress with a hearing on Indian health care. As a physician, I have worked for two decades to help people stay healthy and to reduce their medical costs. I know it requires a considerable amount of coordination and collaboration and innovation and good data, which is a big part of this. As I have mentioned in previous hearings, those principles are critical to support and modernize the Indian health system. I am looking forward to this hearing today, Mr. Chairman.

I would like to submit the rest of my statement, just to give more time for our folks today to testify and then we can get to the questioning, if that is all right with you.

[The prepared statement of Senator Barrasso follows:]

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

Good Morning, and I'm pleased, Mr. Chairman, that we are beginning this new Congress with a hearing on Indian health care.

As a physician, I have worked for two decades to help people stay healthy and reduce their medical costs.

I know it requires a considerable amount of coordination, collaboration, innovation, and good data.

As I have mentioned in previous hearings, those principles are critical to support and modernize the Indian health system.

After the many health hearings this Committee has held in previous Congresses, it appears that reform and modernization are truly needed but slow in coming.

The rates of disease and, even more tragically, mortality have not shown an appreciable decline, and that should disturb us all.

On the Wind River Indian reservation in Wyoming, which is the home of the Eastern Shoshone and Northern Arapaho tribes, the average age of death was 49 years old.

That is younger than most other Indian communities, which in turn is younger than the rest of the U.S. populations.

The staff at the Wind River Service Unit do their best in the face of considerable challenges, but that service unit is the lowest funded in the Billings Area.

Meanwhile, both the service population and the medical inflation rate have grown substantially.

Moreover, the Service Unit is housed in a building that is well over 100 years old and is not scheduled to be included on the IHS health care facility priority list anytime in the near or distant future.

These examples are just a few facing the tribes in Wyoming, and I suspect that they are similar to what other tribes face around the country.

But what these examples tell us is that we must be diligent and more efficient with the scarce resources available for Indian health. There never seems to be enough resources to address all the Indian health care needs, so it's all the more critical that the scarce resources that we do have available are not wasted.

However, last fall, we held a hearing on the property management issues at the HIS. The hearing brought to light instances of millions of dollars in lost or stolen property.

This is completely unacceptable.

Mr. Chairman, I look forward to working with you to determine whether we are spending appropriately and efficiently to achieve the best return from taxpayer dollars.

I welcome your continued efforts at reform, Mr. Chairman. I look forward to working with you on this significant and important initiative.

But in doing so, we must also look to the front-line providers in Indian health for their help and their ideas.

I want to thank all of our witnesses for their participation today and look forward to their testimony.

The CHAIRMAN. Thank you so much.

Senator Johnson, do you have an opening statement, or do you want to put it in the record?

Senator JOHNSON. I will just put my statement in the record, Mr. Chairman.

The CHAIRMAN. All right. We will include the full statement in the record.

[The prepared statement of Senator Johnson follows:]

PREPARED STATEMENT OF HON. TIM JOHNSON, U.S. SENATOR FROM SOUTH DAKOTA

Thank you Chairman Dorgan for holding this hearing. For the nine treaty tribes in my state, for whom the government pledged to provide adequate health care, the current failures of the Indian health system are of vital concern. I am glad that this is a priority for the Committee.

There are dire health care conditions facing American Indians and Alaska Natives of this country. I have witnessed these conditions first hand on the Indian reservations in South Dakota, where, sadly, six reservation counties share the unfortunate distinction of having the lowest life expectancy in the country. Poor quality and lack of access to healthcare also negatively impact the quality of life for many American Indians. My office receives hundreds of calls from constituents needing help with even the most basic needs that ought to be met by the Indian Health Service. Some of the most common complaints involve the Contract Health system and I look forward to working with the Committee to solve this problem.

As you know, I returned from my own health challenges with a better appreciation of what individuals and families go through when they face the hardship of catastrophic health issues. Providing better healthcare will serve not just American Indians but protect the overall public health network for my state and the rest of the Country. This is not just a tribal issue, and it is not charity. This is a moral issue, an ethical issue, and a legal treaty obligation of this country.

Thank you Mr. Chairman for your leadership and persistence on this vital issue that affects the lives of so many American Indians in South Dakota and across Indian Country.

The CHAIRMAN. Sally Smith, Alaska Area Representative of the National Indian Health Board. Sally has done a lot of work on these issues for a long time. Ron His Horse Is Thunder, the Chairman of the Aberdeen Area Tribal Chairmen's Health Board, an Indian leader on so many different issues, and especially health care. Rachel Joseph, too, so much work for so long, and all of us look forward to being able to achieve success. Thank you for your work.

David Rambeau, the President of the National Council of Urban Indian Health. David, thank you for your considerable work on these issues. Andy Joseph, the Chair of the Northwest Portland Area Indian Health Board. And Mickey Peercy, the Executive Director of health services at Choctaw Nation. Both of you have, I know, spent a lot of time on these issues.

So thanks to the six of you. We apologize in advance for the brevity that we must confront today, but we deeply appreciate you being here. We expect the three of us to be connected to you in significant ways throughout this Congress. Working together, we are going to get something done.

Ms. Smith, why don't you proceed?

STATEMENT OF H. SALLY SMITH, ALASKA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Ms. SMITH. Thank you for inviting the National Indian Health Board to participate in this discussion to advance Indian health issues in the new Congress and the Obama Administration. Thank you, Chairman Dorgan, Vice Chairman Barrasso, and other members of this Committee.

You have asked us for suggestions on how to manage expected legislative activity that will impact Indian health, namely, efforts to reauthorize the Indian Health Care Improvement Act, the comprehensive health care reform that is a high priority for the Obama Administration, and a possible deep examination of the Indian health care delivery system.

We believe each of these efforts will likely proceed on different tracks and on different time tables. All will in some way impact how health care is delivered to American Indians and Alaska Natives. But the separate objectives of each should not be blurred by attempting to accomplish our goals through only one over-arching effort.

My first recommendation is that this Committee vigorously continue to proceed and complete our decade-long effort to reauthorize and to revitalize the Indian Health Care Improvement Act. Last year, through your yeoman efforts, Chairman Dorgan, and our Alaska Senator Murkowski, a reauthorization was finally debated and approved by the Senate. We were all disappointed that the House did not complete the job in 2008, but we are not discouraged. In fact, we have great hope that our long struggle will bear fruit in the 111th Congress and that a bill will be approved by both houses and signed into law by President Obama.

Our ten years of work on this legislation has been productive. While no legislation is ever perfect, the bill this Committee brought to the Floor last year was heartily supported by Indian Country and should serve as a starting point as we sprint toward the finish line this year.

As you requested, Mr. Chairman, we are taking a fresh look at tribal requests that we have dropped or scaled back over the last ten years. We recognize that even if the health care reform effort and the comprehensive examination of the Indian health system go forward apace, these activities will take many years or months to complete. In the meantime, we must continue to provide health care to our people today, tomorrow and for next year. We desperately need the new authorities offered by the Indian Health Care Improvement legislation, particularly those that will authorize modern methods of health care delivery. The NIHB urgently requests that Congress finish work on this bill within the next 90 days.

On behalf of Indian Country, the National Indian Health Board will be actively involved in the health care reform effort. We face several challenges in health care reform. First, our health care delivery system is unique. Second, reform developers must honor the trust responsibility for Indian health and take into account the multiple roles played by tribes in health care delivery as providers, as payors, as employers and as governments. Reform proposals should support and strengthen our system. Indian-specific provi-

sions will likely be needed in order to make a good idea work for us.

Any public or private coverage for the uninsured must provide an opportunity for American Indians and Alaska Natives to enroll and to obtain their care through Indian health care system providers. The chronic under-funding of the Indian health system must be addressed in the reform context.

With regard to the health care reform, our request to you is twofold. First, continue your leadership role on behalf of the Indian health interests, and second, assure the Indian Country advocates are integrally involved on all levels of the debate. It has been more than 50 years since the Indian Health Service was created. Much has changed in health care delivery over these decades. Although some improvements in the health status of Indian people have been marked, our people continue to suffer disproportionately high health deficiencies and health status disparities stubbornly persist.

Thus, we can understand why you believe it is time to critically examine the fundamentals of the Indian health system. The National Indian Health Board agrees with you. But it will be a big job. We offer some thoughts on how to proceed with such an undertaking.

First, find out what Indian people themselves think. Supply resources to tribes, undertake examinations in a comprehensive manner. This is vital to assure that tribes know you are serious.

Seek Indian Country input through regional meetings, hearings, and even survey mechanisms. Obtain critical analyses and innovative ideas from experts, especially those skilled in providing care to under-served populations in remote, rural areas. Identify what health care is needed, which needs are being met, which are not, and the most effective ways to deliver those services.

It is critical to avoid solutions which merely redistribute existing resources. Our system already suffers from serious under-funding, and imbalances in the distribution of the scarce resources we do have. Merely creating new winners and losers is not reform.

To be meaningful, any real reform must be fueled by new funding for unmet needs, to correct imbalances and to fully fund the contract support costs of tribal contractors.

Recognize and encourage improvements in Indian health and in the health care delivery system brought about by Indian self-determination contracting. Focus on areas we need attention. Therefore, long-term care delivered in Indian communities, prevention efforts, facilities construction and recruitment and retention of qualified providers. There are promising practices in Indian Country. Preserve and encourage them.

We appreciate your leadership and your commitment to the betterment of the Indian health system. We all share a common goal: enhancement of the quality of life and health of our Nation's first citizens.

Thank you so very much. I am available to answer any questions you may have.

[The prepared statement of Ms. Smith follows:]

PREPARED STATEMENT OF H. SALLY SMITH, ALASKA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Introduction

Chairman Dorgan, and Vice-Chairman Barrasso and distinguished members of the Senate Indian Affairs Committee, I am H. Sally Smith and I appear today as the Alaska Representative to the National Indian Health Board (NIHB), and the immediate past Chairman of the Board.[1] I also serve as Chairman of the Bristol Bay Area Health Corporation in Alaska. Thank you for inviting the NIHB to participate in the discussion about how to advance on Indian health issues in the new Congress and with the new Obama Administration.

The NIHB sees a number of tremendous opportunities for the advancement of Indian health in the 111th Congress. In fact, some are already well on their way to enactment—for example, the Indian-specific provisions included in the State Children's Health Insurance Program (SCHIP) reauthorization bill and in the American Recovery and Reinvestment Act. We are grateful that these provisions could be enacted into law very soon. But these accomplishments represent only the beginning of what we hope will be achieved in this Congress. The other major undertakings include:

1. Renew efforts to reauthorize the Indian Health Care Improvement Act;
2. Undertake comprehensive Health Care Reform spearheaded by the Obama Administration; and
3. Institute a deep examination of the Indian health care delivery system.

The NIHB and the Indian health community are ready and eager to roll up its sleeves to work hard to achieve success on all of these efforts.

Today I offer suggestions, on behalf of NIHB, on how each of these efforts should be pursued in order to obtain maximum benefit for the Indian health system; to faithfully discharge the United States' trust responsibility to provide American Indians and Alaska Natives (AI/ANs) with access to high quality health care; and to end the deplorable disparities in the health status of Indian people.

We must recognize that each of these efforts will necessarily be pursued on different tracks and on different timetables. All will in some way impact how health care is delivered to AI/ANs, but the separate objectives of each should not be blurred by attempting to accomplish our goals through only one overarching effort. The NIHB extends its commitment, on behalf of all Tribes, to the achievement of this goal.

1. Reauthorization of the Indian Health Care Improvement Act

The first recommendation is that this Committee vigorously proceed to complete our decade-long effort to reauthorize—and revitalize—the Indian Health Care Improvement Act (IHCIA). Last year, through the yeoman efforts of you, Chairman Dorgan, and Senator Murkowski, a reauthorization bill was finally debated and approved by the Senate. We were all disappointed that the House did not complete the job in 2008, but we are not discouraged. In fact, we have great hope that the long struggle to amend and extend the IHCIA will bear fruit in the 111th Congress and that Indian Country will finally see a bill approved by both Houses and signed into law by President Obama.

Our ten years of work on this legislation has been productive. While no legislation is ever perfect, the bill this Committee brought to the floor last year was heartily supported by Indian Country and should serve as the starting point as we sprint to the finish line this year. Mindful that many tribal requests were dropped or scaled back over the last ten years, you, Mr. Chairman, asked us to take a fresh look at these topics. The National Tribal Steering Committee commenced that review this week and will soon recommend whether some provisions should be reinstated or revised. The NIHB stands ready to advocate for these recommendations throughout the halls of Congress.

We ask all to recognize that even if the Health Care Reform effort and the comprehensive examination of the Indian health system go forward apace, those activi-

[1] Established in 1972, the NIHB serves Federally Recognized AI/AN tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the Federal Government's trust responsibility to AI/ANs. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the IHS, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their Area. The NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of the Tribes.

ties will take many months or years to complete. In the meantime, we must continue to provide health care to our people—today, tomorrow, next month and next year. That is why we desperately need the new authorities offered by IHCIA legislation, particularly those that will bring to the Indian health system modern methods of health care delivery such as hospice, long-term care, assisted living and home- and community-based care, and an integrated system for comprehensively addressing the behavioral health needs of Indian youth, families, and communities.

Quickly enacting an IHCIA bill is vital to the forward progress of the Indian health system. The NIHB urgently requests that Congress finish work on an IHCIA bill within the next 90 days.

2. Health Care Reform

The NIHB, on behalf of Indian Country, will be actively involved in the Health Care Reform effort. An AI/AN Health Care Reform Workgroup has been established by the NIHB to evaluate reform proposals and determine how the aspects of each would impact the Indian health care system. We hope the members of this Committee will stand with us in this effort. We will need your help to reach key policymakers in the Administration and on Congressional committees of jurisdiction. Indian Country faces several challenges in Health Care Reform:

- The Indian health delivery system is unique and operates very differently from the mainstream health care system. Thus, we must constantly educate policymakers to assure that reform ideas do not inadvertently harm our system which provides culturally competent care to 1.9 million AI/ANs.
- We must also assure that reform developers honor the trust responsibility for Indian health, and take into account the multiple roles played by tribes in health care delivery—as providers, payors, employers and as governments.
- We must assure that reform proposals support and strengthen our system. Achieving this will likely require writing Indian-specific provisions in order to make a good idea work in the Indian health context.
- Any legislation that expands public or private coverage to reach the uninsured must include a meaningful opportunity for all AI/ANs to enroll and to obtain their care through the Indian health system providers.
- The chronic underfunding of the Indian health system must be addressed in the reform context. But in order to do this in a meaningful way, new permanent mechanisms must be designed that protect the Indian health system from the ups and downs of budget development.

The recent development of economic stimulus legislation encourages us that Indian Country's interests are being taken seriously. Members of this Committee and other Congressional leaders involved in development of that legislation actively undertook to assure that our needs were not overlooked. In fact, in response to advocacy from Indian Country, the legislation targets significant funding for job creation and infrastructure development to bolster poor Indian economies.

We are gratified by this attention and want to build on it during the Health Care Reform debate. We must vigorously work toward achieving high visibility for Indian health concerns as well. In order to assure that reform proposals avoid damage to our system and actually strengthen it, we need a seat at the table where reform ideas are developed. Indian Country cannot afford to be consulted only after the decisions have been made.

Thus, with regard to Health Care Reform our request to you is two-fold: Continue your leadership role on behalf of Indian health interests and assure that Indian Country advocates are integrally involved in all levels of the debate.

3. Critical and Thorough Examination of the Indian Health System

It has been more than fifty years since the Indian Health Service was created, and more than thirty years since the original IHCIA directed how health care should be delivered to AI/AN beneficiaries. Much has changed in health care delivery over those decades. Although some improvements in the health status of Indian people have been marked, our people continue to suffer disproportionately high health deficiencies and health status disparities stubbornly persist.

Thus, we can understand why you, Chairman Dorgan, and other Senators believe it is time to critically examine the fundamentals of the IHS system, to identify what's working and what's not, and to design structural reforms. The NIHB agrees with you.

Undertaking such a deep examination is an enormous task, but is well worth the effort. It will take a willingness to address hard questions, require contributions of

experts from within and outside the system, demand innovative ideas, and necessitate a commitment to see the job through to completion.

The NIHB offers some thoughts on how to proceed with such an undertaking:

- Find out what Indian people themselves think—health care consumers, health care providers, and tribal leaders. Supply resources to tribes to undertake these examination and analysis in a comprehensive manner. This is vital to assure that tribes know you are serious.
- Seek Indian Country input through regional meetings, hearings, even survey mechanisms and other methods.
- Obtain critical analyses of our system and innovative ideas from experts, both inside and outside of Indian Country, in the field of health care delivery, especially those skilled in providing efficient and effective care to underserved populations in rural, remote areas.
- Identify what health care is needed, which needs are being met, which are not, and the most effective ways to deliver services.
- Avoid "solutions" which merely redistribute existing resources. Our system already suffers from serious underfunding and imbalances in the distribution of the scarce resources we do have. Merely creating new winners and losers is not "reform".
- To be meaningful, any real reform must be fueled by new funding for unmet needs, to correct imbalances and to fully fund the contract support costs of tribal contractors.
- Recognize the improvements in Indian health and in the health care delivery system brought about by Indian self-determination contracting. Any changes made to the Indian health system should encourage and facilitate exercise of self-determination rights whenever any tribe seeks to use these rights.
- Focus in particular on areas we know need attention: long-term care services delivered in Indian communities, prevention, facilities, and recruitment/retention of qualified providers.
- Remember that there are promising practices in Indian Country. With the long list of what is needed to improve the Indian health system, it can be difficult to remember that there are tribes, clinics and hospitals providing noteworthy care and improving the lives of AI/AN across the country. These need to be showcased and honored in any new system.

Conclusion

The NIHB On behalf of the National Indian Health Board, I thank you for the opportunity to present testimony on how to advance Indian health care. The NIHB recommends: renew efforts to reauthorize the Indian Health Care Improvement Act; undertake comprehensive Health Care Reform; and institute a deep examination of the Indian health care delivery system.

We appreciate your leadership and your commitment to the betterment of the Indian health system. We all share a common goal: enhancement of the quality of life and health for our Nation's first citizens.

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

The CHAIRMAN. Ms. Smith, thank you very much.

We have a tradition of allowing five minutes for witnesses, and you were five minutes right on the dot. Congratulations.

[Laughter, applause.]

The CHAIRMAN. Chairman His Horse Is Thunder.

STATEMENT OF HON. RON HIS HORSE IS THUNDER, CHAIRMAN, STANDING ROCK SIOUX TRIBE, GREAT PLAINS TRIBAL CHAIRMAN'S ASSOCIATION (GPTCA), ABERDEEN AREA TRIBAL CHAIRMAN'S HEALTH BOARD (AATCHB)

Mr. HIS HORSE IS THUNDER. Thank you, Mr. Chairman, members of the Committee.

I have been known to take more than five minutes, but I will try to make this brief. I want to thank you for inviting us, and for all

your support and effort in trying to take care of Indian health care in this Country.

The question that was posed to me was this: how do we proceed forward? I know that S. 1200 went forward relatively quickly last year in the Senate and of course, got stopped in the House side. We didn't see any movement. Therefore, we are here today trying to figure out how best to proceed.

Great Plains Aberdeen Area Tribal Chairman's Health Board, of which I am the chairman, would ask that that we not, we not, reintroduce the current bill as it now stands. We think that there are a number of amendments that need to take place before it goes forward.

And we would ask that you secure through hearings or other mean tribal elected leaders' support. We believe that this is a great framework, S. 1200 was a great framework. It had some provisions in it which we find objectionable, and I will try to run through those as fast as possible.

One of the areas that we object to is that we don't believe it upholds necessary tribal sovereignty, that truly, there should be a government-to-government, there has been established a government-to-government relationship, and we think that needs to be upheld. We think there are a number of areas that go against the tribal sovereignty, if you will, or tribes' sovereign status. One of those things is the idea of enrollment and eligibility issues, that tribes themselves should be the ones who determine who are members. That is one.

Another area which we have concern with is the proposed sliding fee scale for services, in other words, charging your own members for services. We believe that those are services that were promised to us for giving up many acres of our own land. So we are opposed to any sliding fee.

We understand that because of the lack of appropriations or adequately appropriations that some of the tribes are taking a look at innovative ways in how to improve or deliver more services to their people. However, that is a funding issue. If Congress would fully fund Indian health care in this Country, those types of initiatives which go against what we believe are treaty obligations wouldn't be necessary. So we are opposed to anything that talks about a sliding fee scale.

One of the other areas that we have a problem with is regional distribution, that it pits one region against the other. So we would like to have that looked at.

There are other areas, and they are in my written testimony, so I won't go through every one of them. Suffice it to say that the Great Plains is opposed to having the bill introduced as it was, and we need to take a look at some technical amendments to it. We would ask that tribal leaders be the ones who will respond to the technical amendments.

We understand that there are many health organizations out there, and they have done a great job at having input into what should be the content of this bill. However, as tribal leaders, we need to look at not only just health care issues, but how health care issues affect all the tribes, especially with the ideal, again, and I reiterate the point of tribal enrollment, that we as elected

tribal leaders, and I must emphasize that point, elected tribal leaders must have input into these issues. Not every health care professional, not every health care organization out there has to take a look at all the gamut or ranges of issues that tribal leaders must look at. They look at specifically health care issues, and they have done a good job at that.

However, we as tribal leaders, elected tribal leaders, have some issues with some of the content. Therefore, we would ask that future amendments to the bill, and the bill again is a good framework, but future amendments be primarily led by tribal leaders. Again, we must take a look, we as tribal leaders have to protect our tribal sovereignty. There are other issues that we must take a look at as tribal leaders that health care professionals don't necessarily have to look at. They do a good job providing health care for us.

With that said, there are two other areas that I think do need some thought. Besides funding health care, actual services, we also need to take a look at training for health care professionals. I think the tribal colleges are a good start at that. They have the ability to train our people, and those people they train stay in our communities. Other programs, such as the Quinton Burdick program that is primarily at UND is a good way of getting health professionals into the field, and we think those programs need to be emphasized.

Likewise, because of the lack of funding, many tribes do not now contract for services. In our Aberdeen area, we only contract for 25 percent of the services. We probably would contract for more of the services, but because of the lack of contract support dollars, we are not allowed to go beyond the 25 percent we are now at. Likewise, it reduces the amount of services that we can provide for our people, because we have to dip into the funding to take care of the indirect costs that are associated with running 638 programs. We would like to ask for full funding for contract support services.

I see my time is up. Thank you very much, Mr. Chairman.

[The prepared statement of Mr. His Horse Is Thunder follows:]

PREPARED STATEMENT OF HON. RON HIS HORSE IS THUNDER, CHAIRMAN, STANDING ROCK SIOUX TRIBE, GREAT PLAINS TRIBAL CHAIRMAN'S ASSOCIATION (GPTCA), ABERDEEN AREA TRIBAL CHAIRMAN'S HEALTH BOARD (AATCHB)

Introduction

Mr. Chairman and other Members of the Committee, we thank you for your hard work to ensure that the appropriate authority and funding for healthcare services is available to meet the needs of the 17 Tribal Nations of the Great Plains. I am Ron His Horse Is Thunder, Chairman of the Standing Rock Sioux Tribe of South Dakota, and Chairman of the GPTCA and AATCHB—an Association of seventeen Sovereign Indian Tribes in the four-state region of SD, ND, NE and IA. The Great Plains Tribal Chairman's Association is founded on the principles of unity and cooperation to promote the common interests of the Sovereign Tribes and Nations and their Members of the Great Plains.

Great Plains Region

The GPTCA stands on the Fort Laramie Treaty of 1868 (15 Stats. 635) Articles V and IX that guaranteed that the United States will provide services at the local level to our people and reimburse the Tribes for any services lost. It was clearly understood by the Indian signers of that Treaty that necessary assistance would be provided to the signatory Tribes by a local agent (or Superintendent or Director of Indian Health in the modern era) and that sufficient resources would be made available to the agent to allow him to discharge the duties assigned to him. Indian Healthcare is a Treaty fulfillment which our Tribal people take very seriously.

The Great Plains Region, aka Aberdeen Area Indian Health Care has *18 IHS and Tribally managed service units.* We are the largest Land based area served of all the Regions with land holdings of Reservation Trust Land of over 11 Million acres. There are 17 Federally Recognized Tribes with an estimated enrolled membership of 150,000. To serve the healthcare needs of the Great Plains there are *7* IHS Hospitals, *9* Health Centers operated by IHS and *5* Tribally operated Health Centers. There are *7* Health Stations under IHS and *7* Tribal Health Stations. There is one Residential Treatment Center and *2* Urban Health Clinics. *The Tribes of the Great Plains are greatly underserved by the IHS and other federal agencies with the IHS Budget decreasing in FY 2008 over the FY 2007 amount. This is in spite of increased populations and need.* The GPTCA/AATCHB is committed to a strengthening comprehensive public healthcare and direct healthcare systems for our enrolled members.

Health Data and Overview

As documented in many Reports, the Tribes in the Great Plains region suffer from among the worst health disparities in the Nation, including several-fold greater rates of death from numerous causes, including diabetes, alcoholism, suicide and infant mortality. For example, the National Infant Mortality Rate is about 6.9 per 1,000 live births, and it is over 14 per 1,000 live births in the Aberdeen Area of the Indian Health Service—more than double the National rate. The life expectancy for our Area is 66.8 years—more than 10 years less than the National life expectancy, and the lowest in the Indian Health Service (IHS) population. Leading causes of death in our Area include heart disease, cancer, unintentional injuries, diabetes and liver disease. While these numbers are heart-breaking to us, as Tribal leaders, these causes of death are preventable in most cases. They, therefore, represent an opportunity to intervene and to improve the health of our people.

Additional challenges we face, and which add to our health disparities, include high rates of poverty, lower levels of educational attainment, and high rates of unemployment. All of these social factors are embedded within a healthcare system that is severely underfunded. As you have heard before, per capita expenditures for healthcare under the Indian Health Service is significantly lower than other federally funded systems.

In FY 2005, IHS was funded at $2,130 per person per year. This is compared to per capita expenditures for Medicare beneficiaries at over $7,600, Veterans Administration at over $5,200, Medicaid at over $5,000 and the Bureau of Prisons at nearly $4,000. Obviously, our system is severely underfunded. It is important to note that as Tribal members, we are the only population in the United States that is born with a legal right to healthcare. This right is based on treaties in which the Tribal Nations exchanged land and natural resources for several social services, including housing, education and healthcare. Tribes view the Indian Health Service as being the largest pre-paid health plan in history.

Positives

In spite of significant underfunding, we do have some positive news in terms of successful programs. The Aberdeen Area Tribal Chairmen's Health Board operates a Healthy Start program that is funded by the Health Resources and Services Administration (HRSA). Healthy Start is a Targeted Case Management program whose goal is to reduce infant mortality. In recent years, the Infant Mortality Rate for participants in the Healthy Start program has been about *6.5* per 1,000 live births—this is lower than the National Infant Mortality Rate of *6.9,* and it is in the population of highest risk pregnancies.

In a critical example of how we have tried to utilize various federal agency resources to a combined effort, we received a grant of $1.25 million per year from HRSA to operate sixteen Healthy Start sites in our Area. Sadly, the $1.25 million for sixteen sites is not enough funding for all of these sites. This circumstance is driven by the vast and rural nature of many of our reservations, and the time-intensive nature of case management services. In the past, we received additional funds from IHS, to join with the HRSA funds, to operate the Healthy Start program at full capacity.

Regrettably, IHS is no longer able to contribute additional resources to this effective and essential program. In a frustrating cascade effect, we have been told by HRSA that we need to secure an additional $450,000 from other sources by March 1st, or we will need to start closing down Healthy Start sites in our region. Mr. Chairman, Committee Members, which communities should lose Healthy Start sites due to this funding cutback? Healthy Start is successful in our region in reducing Infant Mortality. But it will become less successful without adequate resources. These cutback decisions will lead directly to more infant deaths.

In another vital step forward, the Health Board operates an Epidemiology Center that is focused on studying disease patterns in our Area. We will be addressing the impact of behavioral health issues on chronic diseases like diabetes and on health generally. We consider our Epi Center a successful program directly due to its numerous partnerships and programs. It would be much more successful if we had adequate resources to improve information technology and electronic health records.

Issues of the Day

National Health Care Reform should be set up as an umbrella not straight jacket. Many of the current proposals for full insurance coverage, tax breaks and regional purchasing cooperatives are not an easy fit in Indian country or rural American. We would like to see that Tribal Nations have strong input, beyond those from Indian "health experts or organizations". As you are aware, Tribes have multiple roles, as other sovereigns, to regulate and provide services, and as employers. These different roles require careful thought on how a National plan will impact the Great Plains and other Tribes with strained resources and broad expanse of territory and population to protect.

Self-Determination should be viewed as multi-faceted. The current IHS view of Indian Self Determination is that Tribes must assume 100 percent control of their health programs, under a "638 compact" to be able to enact innovative changes. Self Determination, however, also means that Tribal Nations can choose not to "compact", and can make major decisions affecting course of their program by using other means than a "compact". There are cooperative agreements and other "mechanisms" available to permit Tribes, who are choose to rely on Federal "direct service", to have significant input into their health programs' policy decisions. (i.e. particular staffing needs for physical therapist or other specialty care, emphasis on home health care beyond CHR's).

Core Policy Principles

Government-to-Government is intended to recognize Tribal Nations' sovereign status. This should not be diminished, whether by the expansion of governmental treatment to more than federally recognized Tribes, including non-profits, or by those federal departments who "listen" but do not act on Tribal suggestions and concerns.

Enrollment and Eligibility Issues are at the heart of Tribal Nation sovereignty. Federal efforts to enter into this arena, especially with a one-size-fits-all approach or side-stepping Tribal internal proceedings, is a dangerous step. For example, the Cherokee Freedman dispute should not be a matter attached to any Indian health bill. If one Tribe wishes to restrict health services to only their enrolled citizens, then Tribal Citizens who are not served in such a restricted Tribal community need to be accommodated, through appropriate resource allocation adjustments in another venue (Tribal, CHS).

Self-Determination Scope. We are aware that some Tribes wish to impose sliding fees upon their members (Susanville Rancheria decision) for certain health services. We are opposed to using federal legislation as way to institute the "billing of Indians" for their health care. Under current federal Indian legal principles, and in accord with our treaty rights, our Tribal Nations and their citizens are to receive certain benefits for lands transferred to the United States. This principle ensures, and the current Indian health care improvement act has enunciated, that there is no individual Indian financial liability for health services when the IHS or Tribes bill such individual Indian's third party resources.

Department of Health and Human Services (DHHS) Wide Application of Self-Determination. Tribal access to other Departmental programs has improved. Meaningful consultation can be improved. Improved Tribal access is very useful in our efforts to complement the IHS health care delivery system. We need to continue this department-wide agency resource access, and with more direct Tribal funding and less Tribal Subordination to State block grants. Programs and resources provided by other agencies in DHHS, such as HRSA, SAMHSA, CDC and others are essential components of the Indian Health system, and we need continued facilitated access to these resources. We have been, overall, pleased with our Tribal input into the Center for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) and recommend this approach with strong Tribal Nation emphasis, as well as establishing a strong DHHS level Tribal Affairs office.

Key Program, Resource Issues

Sufficient Resources. What would it take to give the Indian Health Service (IHS) sufficient resources to address our health needs? The current appropriation for IHS clinical services is about $3.4 billion. Our estimated funding percentage based on level of need is approximately 50–60 percent. In order to bring IHS up to a more appropriate level of funding, an additional $2 billion for clinical service would be

needed and making our annual appropriation closer to $5.4 billion. This would be a major increase, but a small one relative to the $700 billion budget for the Department of Health and Human Services (DHHS).

We applaud the Committee Chairman and others for pushing for greater funding in the Economic Stimulus bill, in last Congress's Global AIDs health bill, in budget reconciliation amendments attempts, and appropriation increases. We hope that this hearing, our testimony and others, will assist you in your efforts to continue this good fight.

Other areas that could function more effectively with full funding and clearer guidance include:

- *Contract Health Services* (CHS) timely approval (and appeals) for all priorities, prompt private provider payment, and assistance to IHS Clients who have found out too late their healthcare wasn't taken care of by IHS with their bills were turned over to Creditors;
- *Transportation Coverage* for Patients and Families when a patient needs private provider care, and Emergency Medical Transportation improvements (maintenance, gas, equipment);
- *Access to contemporary Prescription Drugs Formulary* to ensure effective drug treatment to complement direct or private health care;
- *Administrative Improvements* in Management Accountability in hiring and placement decisions, in particular; and
- *Establishing a Direct Service Tribes' (DST) Office* within the Indian Health Service, beyond a cosmetic name change.

Facility Funding. The Committee Chairman, and other Members, are aware of the great need for inpatient and outpatient facility funding. However, the Great Plains does not support fragmenting the current facility funding into regional pots, and by the equal area distribution of facility amounts. This is simply the reallocation of a small amount into equally smaller amounts. Such move would leave our large land based and direct service Tribes with insufficient funds to even do necessary repairs to aging facilities.

Most of our facilities are old, outdated structures unsuited for current medical technology and are in need of replacement. The estimated average age of IHS facilities is about 37 years as compared to about 9 years in the private sector. We are hoping that numerous facilities will be funded through the economic stimulus package being developed as we speak. There are two major facilities on the IHS "Ready List" for facilities construction in the Aberdeen Area—the facility in Rapid City and the facility in Eagle Butte. Unfortunately, the budget for IHS facilities construction has been significantly decreased over the last eight years, adding to our disparities, and I urge you to invest in new facilities in addition to our clinical services budget.

Specialty Clinics. We have a significant need for expansion into preventive and specialty chronic care facilities. We also have great need for Long Term Care services for the elder and disabled population. Long Term Care is not currently provided by IHS, and access to these services is simply not available on most of our reservations. With appropriate funding, we could serve our most vulnerable community members with adequate Long Term Care. Wellness and diabetes clinics are examples of preventive or intervention style facilities. We need to identify processes to expand our workforce and identify other resources to focus on prevention. We also need to surmount State barriers to establishing reservation-based facilities which rely on Medicare or Medicaid.

Catastrophic Funding Needs. As in other populations, our Indian population is seeing the unfortunate increase in cancer and other serious illnesses or diseases. The IHS's Catastrophic fund is a good start but is inadequately funded and has a major coverage gap between when a patient and service unit can tap into this National fund, and after it has depleted all of its local funding. This arrangement makes our local IHS service units reluctant to authorize funding for the initial treatment of serious diseases. The result is that these illnesses take root and become fatal when they might have been halted with early treatment. The Catastrophic Fund needs to be reviewed for ways of improving this system, to overcome reluctance to spend all local funds on one severe case.

Veterans Needs. HIS cooperation with Veterans Administration is not occurring to the depth hoped for. S. 1200 proposed some fixes to this problem, and should be followed through on, including the IHS authority to make the VA individual co-payment in order to collect reimbursement for services rendered to an eligible Indian veteran, when such authorized service is performed in an IHS or Tribal facility.

Violence Against Women. The Congress enacted the Violence Against Women's Act, and also incorporated Tribal provisions. These provisions are a large and impor-

tant step but, in our implementation efforts, we have learned that we still face hurdles to helping our Indian women victims. The IHS funding priorities have excluded the provision for rape kits, to enable their health professionals to properly document and assist in these crimes. Nor are the IHS health care professionals, who have treated our women in these traumatic events, often available immediately after such assaults to document them to any degree.

This delayed or absent documentation, and delayed treatment, results in health professionals who are unwilling to testify in court on their "findings" when these are so minimal and unable to meet court evidentiary standards. This becomes a more dangerous situation when the perpetrator is a non-Indian assaulting an Indian, as non-tribal courts are even less willing to consider stand-alone victim testimony, absent such evidence. Our women are, thus, victimized several times by:

(1) their initial assault and perpetrator,

(2) the lack of timely and effective treatment,

(3) the dismissal of their complaint, should they find the strength to do so in absence of supporting documentation, and

(4) the likelihood of reprisal or continued sexual assault.

Your help in this particular issue is strongly sought, for both adequate agency treatment guidance, sexual assault funding, and tribal court strengthening.

Summary

We have demonstrated that we can operate successful programs in spite of underfunding. We have shown that we can utilize complementary resources to the greatest benefit, and to further our direct health care delivery system goals.

In closing, we have the opportunity in the new Congress and the new Administration to address many of the root causes of health disparities in American Indian communities. We seek to attack, not band-aid, the terrible disparities that make our population's health status comparable to a third world country. The above are our initial thoughts and can be refined as other health care reform initiatives are identified, and as Tribal Nations continue their own work in this regard. Thank you, again, for this opportunity and your attention to these vital matters.

The CHAIRMAN. Chairman His Horse Is Thunder, thank you very much.

Rachel Joseph, thank you very much for being here.

STATEMENT OF RACHEL A. JOSEPH, CO–CHAIR, NATIONAL STEERING COMMITTEE TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

Ms. RACHEL JOSEPH. Good morning, Chairman Dorgan, Vice Chairman Barrasso and Senator Johnson. I am Rachel Joseph, Co-Chair of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act. I appreciate the opportunity to testify before this Committee to present views to enhance the delivery of health care.

The following recommendations are made to advance and improve the health care delivery. Foremost, passage of the Indian Health Care Improvement Act reauthorization is a vital component of any health care reform, so that the underlying authorities for the operation of Indian health systems reflects 21st century health care practices. Since the enactment of the Indian Health Care Improvement Act in 1976, the health care delivery system in America has evolved and modernized, while our system authorities for health care have not kept up.

Secondly, the Indian health care delivery system needs to be fully funded, especially full funding for contract support costs and contract health services. Renewal or revitalization or enhancement, whatever the word may be, should not turn into code for being told to do more with less.

And finally, the Committee should explore extending health care coverage to IHS beneficiaries through the Federal Employees Health Benefit Program or other universal health care coverage established under any health care reform legislation that might be enacted.

I would like to report to you that yesterday, the Steering Committee met for nine hours to grind through six pages of revisions that we think we needed to address that either were revised or dropped out since the bill was initially introduced and that we think that will revitalize and enhance the delivery of health care. I am also pleased to report that Indian Country still reflects consensus on the two issues that the Chairman just raised. We also agree that we should not have language in there addressing the copay issue. And we do not have consensus on the area distribution funds, so that is not a provision that we discussed.

We are excited that we think we have an opportunity to revisit a number of those issues, and we will be getting to you next week a summary of our nine hour deliberations and the update of our consensus positions. We appreciate the Chairman that stood with us, our colleague Chairman Joseph was there for the whole time as we worked these through and worked to develop consensus on a number of issues that have been a challenge through the years.

The travesty in the deplorable health conditions of American Indians and Alaska Native populations is knowing that a majority of illnesses and deaths from disease could be prevented if additional funding and contemporary program approaches to health care were available to provide a basic level of care enjoyed by most Americans. Despite treaties and two centuries of promises, American Indians endure health care conditions and a level of health care finding that would be unacceptable to most U.S. citizens.

On behalf of the NSC, I would express appreciation to your leadership in bringing S. 1200 to the Floor last year, and securing its passage in the 110th Congress. Although we were not successful in the House in securing passage of the companion bill, we believe you raised the awareness again of our health care needs. We believe the progress resulted in certain important provisions in Title 2 of that bill being included in CHIP and in the Reauthorization Act pending, and the American Recovery and Revitalization Act, the economic stimulus. The amendments to Social Security will result in increased access to the enrollment of our populations in CHIP and Medicaid. We appreciate the Senate and House leadership including Indian-specific provisions in these important bills and we respectfully request your continuing support to ensure these provisions stay in the economic stimulus legislation.

At this Committee's oversight hearing on proposals to create job stimulus and jobs, and address Indian Country economies, a question was raised regarding infrastructure needs to address long-term health care for the elderly. While infrastructure needs for long-term care such as nursing home is needed in Indian Country, it is important to clarify that long-term care authorities in Indian Country do not reflect long-term care practices available to the general population. We need to be able to provide hospice care, assisted living, long-term care, home and community-based services. Indian elders need to receive care in their homes, through home

and community-based health services programs or in tribal facilities close to family and friends.

As part of our revitalization and update, I will be submitting a revised testimony, because after lengthy discussions yesterday we no longer support the creation of a study commission. When we initially had the legislation introduced, we were talking about entitlements, how we would be entitled. We feel that the timeliness is important, that we be prepared to engage in the broader health reform discussions now. We think the $4 million that was scored by CBO could better be spent to help us do necessary studies now. And we think that we need to be at the table in the broader discussion of reform. And that is happening.

On behalf of the National Steering Committee, I respectfully request that as part of this Committee endeavor to advance Indian health care, that legislation to reauthorize Indian health care be introduced as early as possible in this Congress. We do not want to lose the momentum and all the progress that we have made in the 110th Congress and during these long ten years.

We are pleased to support again the reauthorization and we have reviewed the record of those tribes that have come in and testified to and provided information to the Obama transition team that there is still strong support for reauthorization. We stand ready to assist in any way that we can to advance and address the health care needs of Indian Country.

Thank you for this opportunity, and I will be happy to respond to any questions that you might have.

[The prepared statement of Ms. Rachel Joseph follows:]

PREPARED STATEMENT OF RACHEL A. JOSEPH, CO-CHAIR, NATIONAL STEERING COMMITTEE TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

Introduction

Chairman Dorgan, and Vice-Chairman Barrasso, and distinguished members of the Senate Indian Affairs Committee, I am Rachel Joseph, a member of the Lone Pine Pauite-Shoshone Tribe of California and Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Health Care Improvement Act (IHCIA). I appreciate the opportunity to testify before this Committee and present views on the advancement of Indian health care.

I have served as a Chairperson and Vice Chairperson of the Lone Pine Pauite-Shoshone Tribe and served ten years on the Board of the Toiyabe Indian Health Project, a consortium of nine Tribes, in Mono and Inyo Counties in central California. I represent the California Area on the Indian Health Service (IHS) National Budget Formulation team and was elected by the East Central California Tribes to the IHS California Area Tribal Advisory Committee.

The following recommendations are made to advance and improve the Indian health care delivery system.

First and foremost, passage of the IHCIA reauthorization is a vital component of any health care reform so that the underlying authorities for the operation of the Indian health system reflect 21st century health care practices.

Secondly, the Indian health care delivery system needs to be fully funded, and specifically, full funding is needed for contract support costs (CSC) and contract health services (CHS).

And finally, the Committee should explore extending health care coverage to IHS beneficiaries through the Federal Employees Health Benefit Program or through universal health care coverage established under any health care reform legislation that might be enacted.

Reform of Indian Health Care Necessary to Address Health Care Disparities in Indian Country

No other segment of the American population is more negatively affected by health disparities than the American Indians and Alaska Natives (AI/ANs) popu-

lation; and, our people suffer disproportionately higher rates of chronic disease and other illnesses. Thirteen percent of AI/AN deaths occur in those younger than 25 years of age, a rate three times higher than the average U.S. 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." These disparities are largely attributable to a serious lack of funding sufficient to advance the level and quality of health services for AI/AN.

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. However, AI/ANs still have lower life expectancy than the general population.

Reauthorization of the IHCIA Is a Vital Component of Indian Health Care Reform

On behalf of the NSC and Indian Country, I want to express our upmost appreciation for your leadership, in bringing S. 1200 to the Senate Floor and securing its successful passage in the 110th Congress. Although we were not successful in obtaining passage of the House companion bill, the work you did raised the awareness of Indian health care needs. And, we believe the progress made by this Committee and the Finance Committee in the 110th resulted in certain important provisions in Title II of the IHCIA being included in the Children's Health Insurance Program Reauthorization Act of 2009 and the pending American Recovery and Reinvestment Act of 2009. The amendments to the Social Security Act (SSA)[1] will result in increased access to and enrollment of American Indians and Alaska Natives (AI/AN) in the CHIP and Medicaid programs. We appreciate Senate and House leadership including Indian health specific provisions in these major pieces of legislation. We respectfully request your continuing support to ensure these provisions stay in the economic stimulus legislation.

Our work is never done—the NSC strongly believes reauthorization of the IHCIA is a vital component in advancing and improving the Indian health care system. The IHS, Tribal, and urban Indian programs need modern and updated authorities in order to provide the same opportunities for health care to Indian people that are standard practice for the rest of our Country. Legislation to reauthorize the IHCIA should be introduced early in this 111th Congress and should not be postponed pending further examination on how to advance Indian health care.

In 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. When the NSC began its work, the NSC had many options: it could have recommended reauthorization of current law, plus additional amendments to address specific health care issues, or it could have presented a concept paper and let Congressional legislative counsel draft the legislation. However, since 1992, when the IHCIA was last reauthorized, the Indian health delivery system changed considerably with the enactment of the Indian Self-Determination Education and Assistance Act Amendments of 1994, providing the Tribes with more flexibility and empowerment to operate their health programs. It was important for the NSC to incorporate the emergence of Tribally-operated programs throughout the bill. Thus, the NSC drafted proposed legislation, which reflected the tribal consensus recommendations developed at area, regional and a national meeting.

For the last ten years, the Senate and House have introduced IHCIA legislation based on the original bill drafted by the NSC. Throughout the years, the NSC has continued as an effective tribal committee by providing advice and "feedback" to the Administration and Congressional committees regarding the IHCIA reauthorization

[1]The SSA amendments include: grants for outreach and enrollment of Indian children in CHIP, recognition of Tribal enrollment cards as Tier 1 documentation for Medicaid citizenship purposes, Medicaid cost-sharing exemptions for Indians, exemption of Indian trust property and resources from eligibility and estate recovery act purposes, and provisions to ensure Indian health participation in Medicaid managed care programs.

bills. Although there were "compromises" to the bill we still remain committed to our position that there should be no regression from current law.

The IHCIA reauthorization is a necessary first step to any reform of Indian health care because any reform must ensure 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. Although not an exhaustive list, the following are some of the provisions that were contained in S. 1200 that, if enacted, would bring about advancements and improvement in Indian Country.

Expanded Authorities for Mammography and Other Cancer Screening

We need to expand authorities for the IHS and Tribal programs to provide mammographies and other cancer screenings, consistent with recommendations of the United States Preventive Services Task Force.

AI/ANs have the poorest cancer survival rates compared to other U.S. populations due to genetic risk factors, late detection and lack of timely access to diagnostic and treatment methods. The cancer mortality rates for AI/ANs are highest in Alaska and the Northern Plains. The American Cancer Society statistics indicate that detection of cancer results in higher survival rates. Providing for preventive cancer screenings, would improve, and save, the lives of AI/ANs.

New Authorities for Long Term Care

At the Committee's Oversight Hearing on Proposals to Create Jobs and Stimulate Indian Country Economies, a question was asked regarding infrastructure needs to address long term care for the elderly. While infrastructure needs for long term care, such as nursing homes, is needed in Indian Country, it is important to clarify that long term care authorities in Indian Country do not reflect long term care practices available to the general population.

Section 213 of S. 1200 would have provided 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. Indian elders need to receive long term care and related services in their homes, through home and community based service programs, or in tribal facilities close to friends and family. We need necessary authorities to provide long term care and related services to our elders that are currently available to the general U.S. population.

Expansion of Indian Health Care Delivery Demonstration Projects

We need new authorities to establish convenient care demonstration projects to provide primary health care, such as urgent services, non-emergent care services, and preventive services outside the regular hours of operation of a health care facility. This provision would enhance the health care delivery options; reducing the need for contract health services (CHS) and emergency visits.

National Bipartisan Commission

We have consistently recommended a National Bipartisan Commission on Indian Health Care. During the reauthorization process, our recommendations have been modified several times and now reflect general authority for a Commission to study the provision of health services to Indians and to 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.

A Commission would provide a mechanism for this Committee to advance Indian health care by requiring a Commission to study the health care needs in Indian Country and to identify and make recommendations to improve the Indian health care delivery system.

Behavioral Health Services

The NSC and Indian Country strongly support 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. We need to address all age groups and authorize specific programs for Indian youth, including suicide prevention, substance abuse and family inclusion.

Enhancements in an IHCIA reauthorization bill needs to facilitate improvements in the Indian health care delivery system. Health services need to 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 lives of AI/ANs.

On behalf of the NSC, I respectfully request that as part of this Committee's endeavor to advance Indian Health Care, that legislation to reauthorize the IHCIA be introduced early in the 111th Congress. Indian Country does not want to lose the momentum and all of the progress we made in the 110th Congress. After almost ten years, Tribal consensus in support of the IHCIA reauthorization remains strong. At Tribal Leader meetings with President Obama's Transition Team, there was a resounding appeal for the need to reauthorize the IHCIA. The NSC is committed to working with this Committee in making recommendations and providing input to advance the IHCIA reauthorization in the 111th Congress.

Full Funding of the Indian Health Services Is Necessary to Advance the Health of Indian People

I represent the IHS California Area on the I/T/U Budget Formulation Workgroup. As part of the budget formulation process, the IHS established a Level of Need Funded workgroup to measure 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 2002, per capita healthcare spending totaled $2,130 for AI/ANs, compared to $3,903 in other public sector financing programs serving the non-elderly population.

It is estimated that the IHS system is funded at less than 60 percent of its total need. To fully fund the clinical and wrap-around service needs of the Indian healthcare system, the IHS budget would need an additional $15 billion dollars. This estimate uses standard economic and actuarial forecasting methods that take into consideration actual inflation rates to measure growth and inflation. OMB routinely uses non-medical inflation estimates to calculate budget increases for the IHS budget which vastly underestimates true healthcare inflation rates. Applying the Federal Disparities Index (FDI) to estimate the true health care needs of Indian people corroborates the long-held view that less than 50 percent of true need is funded by the IHS budget.

In FY08, the IHS appropriations were $3.3 billion—which falls short of the level of funding that would permit the Indian health programs to achieve health and health system parity with the majority of other Americans.

Contract Support Costs Need to be Fully Funded

Contract Support Cost (CSC) funding provides resources to Tribes and Tribal organizations, that operate health programs under the Indian Self-Determination and Education Assistance Act, to cover infrastructure and administrative costs associated with the delivery of health care services. Approximately 70–80 percent of CSC funding is used to pay salaries of Tribal health professionals and administrative staff. Without adequate CSC funding, Tribal health programs are forced to reduce the levels of health care in order to absorb the infrastructure and salary costs. In most instances, cutting health care services is the only alternative to financing these costs. Chronic under funding has resulted in a substantial shortfall of CSC funding in the amount of $285 million (FY 2009—$132 million and FY 2010—$153 million).

Contract Health Services Need to be Fully Funded

Contract Health Services (CHS) services are provided at private or public sector facilities or providers based on referrals from the IHS or tribal CHS program. Due to the severe underfunding of the CHS program, the IHS and tribal programs must ration health care. Unless the individual's medical care is Priority Level 1 request for services that otherwise meet medical priorities are "deferred" until funding is available. Unfortunately, funding does not always become available and the services are never received. For example, in FY 2007, the IHS reported 161,750 cases of deferred services. In that same year, the IHS denied 35,155 requests for services that were not deemed to be within medical priorities. Using an average outpatient service rate of $1,107, the IHS estimates that the total amount needed to fund deferred services, denied services not within medical priorities, and Catastrophic Health Emergency Fund (CHEF) cases, is $238,032,283. This estimate also does not capture

deferred or denied services from the majority of tribally operated CHS programs (nearly one-half of all tribes).

Explore Alternatives for Extending Health Coverage to IHS Beneficiaries

The chronic under funding of the Indian health programs, annual appropriations for FY 2008 and FY 2009 are at $3.3 billion and projected level of need funding is estimated at $9 to $15 billion. This suggests that alternative funding streams and additional health care coverage is needed to address health care for AI/ANs. The Federal Government has not lived up to its trust responsibility to provide health care to Indians—this is evidenced by Indian people suffering from higher health care disparities than the rest of the U.S. population.

The current Indian health care delivery system that provides culturally competent health care to AI/ANs, who reside in the most remote, isolated and poorest parts of this Country must be retained and modernized. What is needed is expanded coverage of AI/ANs through existing health care coverage, such as the Federal Employees Health Benefits Program (FEHBP). An earlier draft of the IHCIA contained a provision that would explicitly authorize the Tribes and Tribal organizations to purchase health care coverage under the FEHBP. The Committee should consider reexamine this provision and require the Federal Government to extend coverage to all AI/ANs under the FEHBP. The IHS, Tribal and urban Indian health care programs would be designated participating providers of the FEHBP. This would allow the Indian health programs to bill and receive reimbursements from the FEHBP to supplement annual appropriations. For services not available at an IHS or tribal facility, coverage under FEHBP could serve as an alternate resource for payment of services under the CHS program.

Reauthorization of IHCIA would put in place new services and authorities in the Indian health system. With better services and facilities, Indian Country can then participate in discussions about national health reform which will focus on the financing of available services from various health systems.

We look forward to working with this Committee to explore how to advance and improve the Indian health care system. Health care reform legislation must include Indian-specific provisions to assure that reform options can work in a self-determination and self-governance health delivery system. Health care reform must address the chronic underfunding of the Indian health system and must include full funding and/or mechanisms to achieve full funding. Renewal should not turn into code for continuing to be told to do more with less. The Indian health system (I/T/U) have already proven themselves experts in that. It is time to give the Indian health system a chance to prove how well it could work if fully funded.

In closing, it is exciting to be apart of the federal/tribal partnership and all of us working together can make it better. Thank you for this opportunity and I will be happy to respond to any question.

Attachment A

How the Indian Health Care Improvement Act addresses Health Issues in Indian Country

The Indian Health Care Improvement Act (IHCIA), first enacted n 1976, is the underlying statutory authority for the Federal Government to provide health care to American Indians and Alaska Natives (AI/ANs). The government's responsibility to provide health care is based on the U.S. Constitution and is carried out by the Indian Health Service (IHS), an agency within the Department of Health and Human Services. The IHCIA has not been reauthorized since 1992 – 16 years ago. New and expanded authorities contained in the IHCIA reauthorization bills (H.R. 1328/S. 1200) will address health care disparities and improve the quality of life, and save the lives, of 1.9 million AI/ANs living in some of the most isolated areas of the U.S.

Health Issue	Current Problem	IHCIA Solution
Health Care Provider Shortage	**High Vacancy Rates** of Health Professionals at IHS and tribal sites are primarily the result of the remote geographic locations of the sites. • *Dental Professionals = 31%* • *Nurses = 18%* • *Physicians = 17%* • *Pharmacists = 11%*	**Strengthens** programs that help to recruit and retain health professionals for the IHS and tribal sites: • *Scholarship and Loan Repayment Programs similar to the National Health Service Corps recruitment programs* • *Specific programs to recruit Indian students into medical, nursing, psychology, and behavioral health professions* • *Community health provider programs and training for community health providers at tribal colleges*
Facilities & Sanitation	**IHS and tribal health care facilities/equipment and sanitation facilities are old or non-existent:** • *Average age of IHS facilities = 35 yrs (vs. 9 yrs in U.S.)* • *Medical and Laboratory Equipment = 12 yrs (vs. 6 yrs in U.S.)* • *Lack safe & adequate water supply = 11% of Indian Homes* • *Lack basic sanitation facilities = up to 35% of Indian Country*	**Authorizes** innovative ways to overcome deficient and non-existent health care facilities and sanitation systems. **Updates** existing authorities for the construction of health facilities and sanitation facilities **Provides** authorities for innovative approaches for facility construction and funding through grants, joint venture agreements, and loan programs
Elder/Long Term Care	**Lack of authority and facility space to provide care to the elderly and the disabled** • *Nursing homes and assisted living centers are not available on most reservations* • *Elderly and disabled have to travel hundreds of miles to obtain care* • *AI/AN Elders will need potential home care = 14-40%* • *AI/AN Elders (over 65 yrs) have difficulty dressing, bathing, or getting around the home. = 14 %*	**Authorizes** the creation of elder care programs that focus on behavioral health and in home/community care. **Authorizes** programs for hospice, assisted living, long-term care and home &community based services.

Cancer	**Lack of authority to provide cancer screenings, except mammograms**
	• *Poorest cancer survival rates among all ethnic groups due to:*
	  ○ *Genetic risk factors*
	  ○ *Late detection of cancer*
	  ○ *Lack of timely access to diagnostic and/or treatment methods*
	• *Cancer mortality rates for AI/ANs are highest in Alaska and Northern Plains*
	• *Cervical cancer is #2 cause of death for AI women and leading cause of death for AN women*
		Expands preventive services to cover cancer screenings based on national standards and recommendations of the United States Preventive Services Task Force. Some of the new cancer screenings would include:
		• *Prostate Cancer*
		• *Cervical Cancer*
		• *Skin Cancer*
		• *Colon Cancer*
		
		American Cancer Society statistics document early detection of cancer results in higher survival rates and saves lives.

Diabetes	**AI/ANs die at higher rates than other Americans from diabetes.** • *AI/ANs diagnosed with diabetes = 2.6x higher* • *AI/AN deaths from diabetes = 190% higher*	**Reauthorizes** effective diabetes projects, such as screening and prevention activities, and creates the ability to manage diabetes through culturally appropriate IHS and tribal programs
Medicare & Medicaid (M/M)	**Lack of access** to Medicare & Medicaid services due to rural and remote locations of tribal communities **Under-enrollment** of AI/ANs in Medicaid programs, especially on reservations which have high poverty rates. • *Percent of people below poverty = 27.2% AI/ANs on and off reservations*	**Updates** existing authorities for IHS and tribal facilities to provide services and collect Medicare & Medicaid reimbursements, grant opportunities for Medicare & Medicaid enrollment and outreach activities, and to collect reimbursements from other third party payors. **Removes** barriers that prevent AI/ANs from being eligible for, and enrolling in, Medicare & Medicaid
Behavioral Health	**Lack of authority to create new programs** to address rising need for services and treatment for mental health, alcoholism, and substance abuse. • *Death from Suicide = 70% higher* • *Highest rate of U.S. suicide = AI/ANs (age group of 15-24 yrs)* • *2nd leading cause of death for AI/AN youth* • *Death from alcoholism = 510% higher* • *Percent of AI/ANs population who use Methamphetamine = 1.7%*	**Consolidates** existing authorities to provide for a comprehensive approach to behavioral health assessment, treatment, and prevention. **Expands** grant opportunities for behavioral health programs to include **youth suicide** and other new prevalent behavior health problems not previously listed.
Infant Mortality & Maternal Health Rates	**Lack of modern authorities to address maternal and infant health issues:** • *Low incidences of Prenatal Care = 69 % in 2000 (vs. 85% white non-Hispanic women)* • *Death of AI/ANs infants = 150% greater* • *Incidence of Sudden Infant Death Syndrome (SIDS) = 3-4x greater than white infants* • *The prevalence of Fetal Alcohol Spectrum disorder in Alaska = 5.6 per 1,000 live births for AI/ANs (vs. 1.5 per 1,000 in the State overall).*	**Authorizes** health promotion and disease prevention programs: • *To provide prenatal, pregnancy and infant care* • *To avoid fetal alcohol spectrum disorders through educational health programs* • *To prevent SIDS and to reduce infant mortality*
Unintentional Injuries	**Lack of modern authorities to address high incidence of unintentional injuries:** • *Injuries are the leading cause of death for AI/AN ages 1 to 44 & the 3rd leading cause of death overall* • *Leading cause of death for AI/ANs 19 yrs. and younger = Motor vehicle crashes* • *Injures result in 41 % of Years of Potential Life Lost for AI/ANs*	**Authorizes the IHS and tribal** Epidemiology Centers to access data, data sets, monitoring systems, delivery systems, and other protected health information for the purpose of preventing and controlling disease, injury or disability. **Authorizes** programs to provide first aid and CPR training. **Promotes** the elimination, reduction, and prevention of contaminants that create unhealthy household conditions.

Attachment B

NATIONAL INDIAN HEALTH BOARD—ANNUAL CONSUMER CONFERENCE—SEPTEMBER 22–25, 2008

"Renewing the Indian Health Care System" by Robert G. McSwain, Director, Indian Health Service (September 23, 2008)*

Greetings and welcome to National Indian Health Board's 25th Annual Consumer Conference. My remarks today will focus on ideas for improving and renewing the Indian health system. It is not that our system is "broken" but that our system needs to able to adapt readily in response to serious present and future challenges.

Powerful forces have at been at work over the past few decades that have shaped and changed the face of health care in this country. I am sure all of you here today are aware of many if not all of these forces: escalating medical costs; rapid technology advances; the emergence of chronic health condition as the pervading health issue of our times; and increased service populations, to name a few.

*The text is the basis of Mr. McSwain's oral remarks at the National Indian Health Board Consumer Conference on Sept. 23, 2008. It should be used with the understanding that some material may have been added or omitted during presentation.

We are getting set to transition in a new administration. It is a time of change for the nation and I think it is a time to consider change in the Indian health system. We need to start positioning ourselves now to adapt and improve our system to meet the needs of the future. We want to focus on changing what is not working as well as it should, while preserving what does works well.

I want to emphasize that nothing has been decided yet. I will present some ideas we might want to explore, together with our tribal partners, in order to be ready for the future of Indian health. We didn't decide just this month to examine our system. We've been watching and listening for a long time. We heard about both successes and failures. Some voices we've heard:

- From *nurses* about the national nursing shortage—especially in critical care.
- From *doctors* about risk of deferred care, recruitment in crisis, shortages in family practice.
- From *pharmacists* about accelerating drugs costs, insufficient time to counsel patients.
- From *patients* about denials and losses to creditors because CHS could not pay bills.
- From *communities* worried about facility closure or desires for a new facility
- From tribal *leaders,* some who say our system is floundering and ask us to try something different.
- From *CEOs* who wonder if some sites will remain sustainable in 5 years.
- From *employees* who are stressed by mounting work and are concerned about jobs.
- From *patients* who say they can't get appointments and who ask: "Why can't IHS pay for care my doctor says I need?"
- From *elders* about waiting rooms filled with descendants less connected to the community.
- From community *members* questioning "Why isn't more done for kids to preserve their health?" or "Why are scarce CHS dollars spent for chronic alcohol abusers?"
- From business *partners* who want to work with us, but can't if we can't pay for their service.

We've been considering what we saw and heard. We have formed some initial ideas we want to discuss with you. Some of our ideas are pretty clear. Other ideas are sketchy. You may be able to help clarify or offer better ideas. We hope to give a fair picture of the condition of our system so that you may provide well informed ideas of your own. I think we need to start by examining what works well and what doesn't in our present system. And a good place to start is by observing the encouraging signs.

Total healthcare services provided by the Indian health care system have gradually expanded over decades. Our system serves more American Indians and Alaska Natives today than ever before. And like medical trends nationwide, our services have evolved to include less hospital care and more comprehensive ambulatory care.

Congress has continued to support IHS programs, although major budget increases in recent decades have been rare. It is worth noting that our model has a high reputation both within the U.S. and internationally.

Our programs are geographically spread out and our facilities are often on or near reservations. Because our model is the only source for services in many isolated places, this accessibility factor is an important feature.

A broad spectrum of programs and services are provided that include medical services to individuals and also public health and environmental programs that benefit communities.

Our healthcare model is focused on American Indians and Alaska Natives—their unique needs, cultures, and circumstances. We place a high importance on respecting traditional beliefs and integrating traditional healing practices with recent medical science. This has resulted in a medical environment that is more comfortable and welcoming to all Indian people.

Our healthcare system has contributed to spectacular health gains in health status in many ways, especially in establishing access to primary care services located in the Indian communities, lowering the high rates of infectious disease, and improving safe water and community sanitation facilities.

Our programs are operated with a large degree of local autonomy while sharing administrative and support functions through Area and national offices. Even more autonomy is achieved through self-determination, which has been very successful in

the Indian health system, with about half of the IHS budget currently being administered by Tribes.

Advances in technology, transportation, and communications are reducing some of the delivery problems linked with isolation. Innovations in tele-health, remote sensing, and online linkages among healthcare sites are improving both cost efficiency and quality of care.

People are a core asset of our model. To put it simply, we have great people working for us! Their commitment to Indian people and our mission has been extraordinary even under stressful and trying conditions. One important aspect of our workforce is that it is predominantly Indian—71 percent of our entire workforce is Indian, and the percentage of American Indians and Alaska Natives in our medical professions continues to rise.

Turning our attention from encouraging to troubling signs: Many sites through out our system are experiencing difficulties making financial ends meet. Financial troubles are, of course, prevalent throughout healthcare in the U.S. But the immediate consequences to Indian people are more pressing because many Indian people have few fall-back options. Couple this with an ever-increasing service population and drastic inflation in medical costs, and you have a severely strained system. The results of this can be as drastic as temporary shut-downs of facilities and cut-backs in services.

Payments are strictly limited by law to available CHS funds, which results in thousands of patient referrals without any source of payment. CHS funds regularly run out before year end. This produces hardships for patients and undermines relationships with hospitals and other providers.

At many sites in our system, essential services are unavailable. If available, limited staff, equipment, and facility space often result in deferring services. These deficiencies contribute to backlogs that result in more severe health problems over the long run. And the inequity of services across the system is an issue that needs to be addressed.

Another troubling sign: clinic space and equipment use in our facilities are often strained beyond capacity, especially in ambulatory care. The space for exam and treatment rooms, staffing, equipment, etc., are especially limited in ambulatory settings. Our overall space configuration was created in an era when hospital admissions were the norm, which is a mismatch for the high-volume ambulatory care practices of today.

Recruitment and retention of a highly skilled medical workforce has always been challenging due to geographically dispersed and remote sites. We simply cannot fulfill our mission without them, so we need to find ways to remove barriers and increase incentives for hiring and retention of qualified professionals.

Strained relations with partners outside our model are rising. Some are a legacy of racial and community tensions. But other strains are directly related to referrals without means of payment.

Although we strive to serve any Indian person who seeks services without regard to tribal affiliation, the shear volume of demand and the incapacity to meet it have forced some Tribes to reconsider whom they can serve.

Other troubling signs are more directly health-related. Rates of obesity and problems linked to lifestyle are epidemic in America. Too often such problems are more pronounced among Indian people. These trends point to grim prospects for declining health and even greater demands on our already over-extended healthcare system.

Perhaps the most troubling sign is that the overall health status of Indian people remains below that for most Americans, and in some places that gap appears posed to widen further. Recent studies have detected rising rates of diabetes, heart disease, and cancer among Indian people, which are almost certainly related to changing lifestyles and environments. For decades, significant advances in raising health status have been documented in our statistics. Now it is clear our model is no longer producing the big gains it once did, largely because of the shift in health problems from infectious disease and sanitation control patterns to lifestyle-related chronic conditions.

We have just examined some of the strengths and weaknesses of our present health care system. We now turn to some ideas for renewing this system, which I hope we can consider together as we prepare ourselves and our health care model for a historic transition period. Please realize that we are not considering a dismantling of the present system, but a variety of ideas for renewing and strengthening it.

It is important to keep in mind that both tribal and federal sites experience the conditions and forces that we have discussed, often in tandem. Equally important, Self-Determination law recognizes that tribally-operated sites may respond to these conditions differently than the IHS may respond. We encourage all Tribes to fully

consider all the ideas for renewal. Self-Determination allows tribal sites to choose to participate or not participate. Participation by tribal partners in renewing and adapting our system is welcomed but not required.

This partnership effort will also include the active participation of patients with the entire health system as we renew our common vision for a patient-centered, compassionate, comprehensive, and culturally appropriate model of health care. Before we talk about some ideas for renewal, we need to restate some essential principles and goals that may guide us in thinking about these ideas. These include:

- Securing a healthcare system for Indian people that fulfills our mission, goal, and foundation;
- Strengthening our core model of a community-oriented primary care;
- Transforming but not diminishing services;
- Equalizing access to healthcare services;
- Seeking consultation on policies that affect Indian people; and
- Honoring tribal choice.

The future of our health system requires continuing evolution and adaptation to historic and emerging health challenges. Before discussing new ideas, it is important to acknowledge renewal efforts that are already underway and making impressive progress.

Many individual sites in our system have launched efforts to more successfully adapt clinical and administrative operations to local conditions. I endorse these important, often innovative, efforts. For instance, pilot projects underway in the "Chronic Care Initiative" are producing some exciting results. I will not offer more details on these locally driven efforts this morning, but much more information is available upon request.

Rather, I will focus the balance of my talk on ideas for renewal of our system as a whole, for as we have seen, many of the forces that stress individual sites go well beyond local boundaries. Even sites with the most favorable local conditions can not effectively address all of these issues. That is why it is timely for all of us to have a national dialogue about the whole Indian health care system.

The patient is at the center of our ideas for renewal. The key idea is a package of services that surrounds every patient. This concept, which is based on the Indian health system already in place now, includes:

- Core services—Community oriented primary care is the central core of the service package. Core services should be accessible in or near Indian communities to maximize their effectiveness. We think primary prevention services should have highest priority because we see them as providing the greatest contributions to improved health status for the entire Indian population now and in the future. The core package combines primary care services that are focused on individuals with essential public health programs that are focused on the community.
- Intermediate and advanced medical services for individuals would be delivered through regional/in-network referral facilities that can provide high quality care efficiently. Most advanced services would be purchased.

A closely connected idea is an integrated delivery system in which each type of service is provided in manner that is most efficient and effective.

Core primary care services should be broadly available and accessible in or near Indian communities. This includes routine ambulatory, screening, diagnostic, and treatment services; basic preventive care; covered prescription medications; some dental services; and some mental health and substance abuse services. Much of the success of our model can be linked to these types of services. These services usually would be delivered in a Monday–Friday clinic in or near the community.

Intermediate services include 24/7 inpatient professional services, advanced ambulatory screening, diagnostic and treatment services, vision, hearing, PT, orthopedic, and both noncomplex ambulatory and inpatient surgery. Intermediate services would be provided through an interlocking network of centers that accept and support the core community sites.

Advanced services such as highly specialized diagnostic, surgical, and treatment services include transplants and sophisticated surgery. These would usually be purchased from centers of excellence to the extent that funding allows, or in some cases maybe obtained from in-network medical centers.

We have a firm idea of the overall integrated framework, which builds on and extends successful features of our present system, but there are many details that require study:

- Timing—Even though this integrated concept builds on our present model, we realize this involves transformation of frontline sites as well as behind the scenes support systems. This is not a quick fix. We think it will take a long time to fully achieve.
- Thresholds for facilities—As we try to enhance community access to core services, we also need to consider costs when establishing community size thresholds for core sites and we need to consider realistic and practical groupings for referral networks.
- HFPS—we need to see if the Health Facilities Priority System is aligned with this framework.
- Resource Formula—We may need to align budget and resource allocation formulas.
- Reimbursement—We think that spreading costs of secondary services through a referral system offers significant gains in efficiency and quality. But we will need a way to fairly reimburse the in-network referral centers for costs.
- Conversion Costs—We know there will be one-time costs for converting. We must estimate conversion costs and options.
- Infrastructure—These costs may include investments in infrastructure such as Electronic Health Record, beneficiary ID, communications and transport capacity, etc.

For the integrated model to function coherently and fairly, CHS funded services and policies should be aligned to fit. One challenge involves authorization policies known as CHS medical priorities. CHS funds could be used to fill some gaps in core services to promote wider and more consistent availability of primary care services. Currently, the CHS policy prioritizes urgent medical treatment over primary and prevention services.

Eligibility rules differ for CHS and direct care. We think eligibility should be consistent for both. We need to decide if the uniform eligibility should follow the CHS model, the Direct Services model, or some other. CHS funds have long been treated as fixed, immovable, and tied to sites. There is no inherent reason to bind CHS funds to particular sites, particularly as we move towards a more integrated, mutually supporting network. We should consider aligning CHS management, authorization policies, and funds within the integrated framework. This could involve aligning some CHS funds within core community sites to plug gaps in primary and preventive services and align other CHS funds at a regional (or Area) level for intermediate and advanced services. Some issues that need to be addressed include:

- Integrating Services—The implications and impacts of an integrated service package on the CHS medical priorities must be considered as well as affects on present CHS users.
- Balancing Priorities—While everyone can support the idea of expanding availability and access to core primary services, if CHS spending on core services reduces funds for urgent care, some people may find such a tradeoff disturbing. We will need to thoroughly consult on this complex ethical issue.
- Eligibility—We need more exact numbers for unifying direct services eligibility rules and CHS eligibility rules. Roughly, 250,000 persons are direct service users in our present system who are not CHS eligible. Most of these reside in cities and counties adjacent to reservations but are not members of the local Tribes.
- Budget—We also need to forecast budget implications for the eligibility unification options. Expanding CHS eligibility could create addition funding needs.
- Management Options—Realigning management of CHS to reflect an integrated layered delivery system has logical appeal, but we have not yet explored operational implications. It should be noted that a previous attempt to apply CHS uniformly for an entire state (Arizona) could not be fully implemented because of insufficient funding.

The future of our health system requires continuing evolution and adaptation to historic and emerging health challenges. Our vision is to work in partnership with tribal governments; Indian people; and federal, state, and local governments to respond in every way possible to preserve and improve our health system for future generations of Indian people.

The CHAIRMAN. Ms. Joseph, thank you very much.
Next we will hear from David Rambeau.

STATEMENT OF DAVID RAMBEAU, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Mr. RAMBEAU. Good morning, Mr. Chairman and members of the Committee.

My name, as stated, is Dave Rambeau. I am a member of the Paiute Tribe of California. I am also the Executive Director for United American Indian Involvement, the urban program in Los Angeles.

As many of you are aware, Los Angeles has the largest population of off-reservation Indians living in any one particular county. We have, for those who indicated in the last Census as single race, American Indian, we have 90,000 Indians that live in our service area. Those who indicated multiple race, we have 150,000 Indians that live within the L.A. County area.

On behalf of the National Council on Urban Indian Health, our 36 member clinics throughout the United States, urban clinics, and the 150,000 American Indian and Alaska Native patients that we serve annually, I would like to thank the Senate Committee on Indian Affairs for the opportunity to testify on advancing Indian health care.

As we enter into not only a new Congress but also a new Administration, it is critically important that reforming and improving the health care system for American Indians remains a high priority. I would like to thank Chairman Dorgan and Senator Murkowski and indeed, the entire Committee for all the hard work that they have done on behalf of the Indian people and the Indian health care system.

It is my hope that in the new Congress, that we can move forward on the critical issues facing the Indian health care system, and that immediate attention be given to passing the Indian Health Care Improvement Act as soon as possible, as stated, within the next 90 days if at all possible. I am particularly honored and grateful to be able to present testimony for the nearly one million Indian people living in urban centers. Congress has repeatedly stated that the trust responsibility to provide health care extends to American Indians regardless of where they reside. This is an historical mandate by Congress over the many years that the Federal Government has been managing the affairs of Indian people, starting from right after the Revolutionary War.

Congress has repeatedly stated that the trust responsibility is to provide health care to American Indians regardless of where they reside. Indian Health Service estimates that roughly 930,000 of American Indians and Native Alaskans are living in the urban locations and are eligible for services at the Urban Indian Health Programs and clinics.

The people who live in the urban settings historically is a situation that started, like I said, right after the Civil War, when they started deciding what to do with the Indian problem. Those of us who live in urban settings are there because of many reasons which includes jobs, lack of jobs on our reservations, education and the need to progress and the need for survival in many cases. We are people of the reservations. I am a person that is enrolled in my reservation and I do visit the reservation quite frequently and I am involved with the business of my reservation. As people living in

urban centers, we realize that we need to be part of the system that provides health care and other services to the Indian people. We support the National Indian Health Board's efforts to provide better care for all Indians throughout the United States.

My time is running out. I am letting it run out. Thank you.

[Laughter.]

The CHAIRMAN. Mr. Rambeau, we don't run anybody out.

[Laughter.]

The CHAIRMAN. We appreciate very much your testimony.

Mr. RAMBEAU. It is like the last football game, the last 20 seconds you have to let run out.

[Laughter.]

The CHAIRMAN. It is called the two-minute drill, by the way.

[The prepared statement of Mr. Rambeau follows:]

PREPARED STATEMENT OF DAVID RAMBEAU, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Introduction

Honorable Chairman and Committee Members, my name is David Rambeau. I am the president of the National Council of Urban Indian Health and the Executive Director of the United American Indian Involvement in Los Angeles California. On behalf of the 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 "Advancing Indian Health Care." As we enter into not only a new Congress but also a new Administration it is critically important that reforming and improving the health care delivery system for Native Americans remains a high priority. I would like to thank Senator Dorgan, Senator Murkowski, and indeed the entire Senate Committee on Indian Affairs for all of their hard work on behalf of Indian health. It is my hope that in this new Congress that we can move forward on the critical issues facing the I/T/U system.

I am particularly honored and grateful to be able to present testimony for the nearly one million urban Indians. Congress has repeatedly stated that the trust responsibility to provide health care extends to Native Americans regardless of where they reside. The 2000 Census reported that over 60 percent of American Indians and Alaska Natives reside in urban centers 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 communities. It is a small, but critical component in Native healthcare.

The UIHP provides an important link between reservations and urban centers 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." [1] Reservation and urban 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 system is precisely that, and integrated system serving the same group of patients 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.

It is critical that the Indian Health Care Improvement Act is passed this Congress in order to modernize and restore the I/T/U system; moreover, the entire I/T/U system must be fully funded from contract health to the Urban Indian Health Program. While NCUIH feels that Indian health organizations must be included in the larger debate around health care reform—and indeed Indian health providers have many sound suggestions for overall system reform—passing the Indian Health Care Improvement Act must be the priority for the 111th Congress. It has been over a decade since this important piece of legislation has been last reauthorized. While the Indian health delivery system certainly needs critical examination, that examination cannot come at the expense of passing the Indian Health Care Improvement Act.

Today I would like to offer suggestions and examples on the behalf of the Urban Indian Health Program, on how we can not only move forward with the Indian

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

Health Care Improvement Act, but advance Indian health care in the context of comprehensive health care reform. We believe that the Indian Health Care Improvement Act is not the final say of health care reform for Indian people, but the first step in a larger discussion.

State of the Urban Indian Health Organization

I would like to give the Committee a brief overview of the incredible work that the clinics and programs of the UIHP have been doing. Despite the great obstacles facing them, urban Indian health organizations have had many great successes with both individual patients and in raising the entire wellness of the community. Many clinics are leaders in innovative health care delivery and community based medicine. UIHP clinics and programs are also seeing impressive health outcomes through the integration of traditional medicine practices with western medicine.

NCUIH firmly believes that health care reform must involve reform of the health care delivery system in the United States, not just reform of the insurance market. NCUIH feels that the Urban Indian Organizations and, indeed all Indian health programs, can be examples of how to reform health delivery in order to address health disparities. Urban Indian health organizations are particularly sensitive to changes in the general health care system as, due to their structure, they are far more integrated in state and local level health care systems. NCUIH, therefore, has been much more closely involved in state level health care reform initiatives and believes Indian health organizations have many areas where they could be leaders in changing how the general population conceives health care delivery.

Innovative Health Care Delivery: Urban Indian Organizations excel at developing innovative, culturally competent, efficient health care methods. Providing comprehensive care to Native Americans requires re-conceptualizing many western medical health delivery models in order to ensure that effective care is actually being provided. Cultural barriers for Native American patients, along with fiscal barriers, are the biggest continuing drivers of health disparities for American Indians and Alaska Natives living in urban centers. NCUIH strongly advocates for the aggressive reform of the current general health care delivery because the current delivery system fails to address soaring health disparities, chronic disease, and fails to provide preventative health services. The following examples are areas where the urban Indian health organizations are leading in innovation, and their lead should be followed in reforming the general health care delivery system.

NCUIH is working with the Urban Indian Organizations to develop a database to collect the best practices and disseminate them to not only other Urban Indian Organizations, but to any interested Indian health organizations. Often times Urban Indian health organizations are quiet leaders in innovative health delivery, but have not been able to adequately disseminate their successes due to their small size. Many Indian health organizations have developed best practices that are only now being identified and employed by the general health delivery system. If better communication between providers within the I/T/U system were available, and better communication between the Native health system and the general health system were also available, many of these models of care would have been disseminated much earlier.

Medical Home Model of Care: Long before the general health policy community coalesced behind the medical home mode of care[2] the Urban Indian health organizations have been employing that theory of care. The American Academy of Family Physicians has called the patient-centered medical home model one of the single most powerful methods of eliminating racial and ethnic disparities in health care quality and access while improving care and management of chronic conditions for all patients.[3] NARA of the Northwest in Portland Oregon has been following the medical home model for nearly two decades in both its inpatient residential treatment center and its medical clinic. More recently the Seattle Indian Health Board has worked with the University of Washington to develop a medical home model specific to the urban Indian health community.

---

[2] Somnath Saha, Mary Catherine Beach, Lisa Cooper, *Patient Centeredness, Cultural Competence, and Healthcare Quality, Journal of the National Medical Association* 2/2/2009 (calling for health care organizations and providers to adopt principles of both patient centeredness and cultural competence jointly.)

[3] AAFP, "Medical Home Model Helps Eliminate Health Care Disparities." 7/11/2007. *http://www.aafp.org/online/en/home/publications/news/news-now/health-of-the-public/20070711commonwealthstudy.html Last accessed 1/30/2009; see also,* The Commonwealth Fund, "Closing the Divide," *http://www.commonwealthfund.org/publications/publications*__show.htm?doc__id=506814 last accessed 1/30/2008.

Community Based Health Care: Urban Indian health organizations also have developed many community based approaches to health delivery. Working closely with community health workers and focusing on the wellness of the entire community, the San Jose and San Francisco programs have developed a number of outreach programs aimed at encouraging early preventative care that have resulted in increased diagnosis of pre-diabetic conditions and early heart disease. By focusing on the entire community and using the community member to community member model of health education, the San Jose and San Francisco programs have drastically reduced the levels of health disparity in diabetes diagnosis and treatment for their areas. Many urban Indian health programs have launched effective community based education and early detection programs that have dropped the rates of chronic disease in their community. Many programs are also developing Native American specific health communication tools so that Native American patients are better equipped to understand and communicate within our incredibly complex health care system. Moreover, by giving patients methods for translating their conception of their health and wellness into a language that non-Native providers can understand, the Urban Indian health programs are able to empower their patients to have better control over their health outcomes.

Traditional Medicine: Almost all urban Indian health programs involve traditional medicine practitioners in their health care delivery. By incorporating traditional medicine practitioners, UIOs are able to not only link patients to their community, but also help foster a sense of community and safety within the clinic itself. Integrating traditional medicine into the entire service delivery has resulted in many urban Indian health programs making a dramatic medical model shift away from the typical western model based around treating those in medical crisis, to a more wellness and preventative based approach. As stated earlier, the medical crisis model of care is particularly damaging to Native American patients and results in poor health outcomes and health disparities. Moreover, the inclusion of traditional medicine practitioners ensures the necessary cultural accessibility for Native American patients.

Impact of the Recession: Despite these great accomplishments the UIHP clinics and programs are feeling the impact of several years of short funding and the burgeoning recession. The UIHP is a fraction of the entire Indian health system operating at a little over 1 percent of the entire IHS budget. The clinics and programs of the UIHP have become adept at finding outside resources, leveraging every dollar of original IHS investment with two dollars from other sources. However, prolonged short funding of the UIHP has stretched UIHP resources to the breaking point. Programs are even more strained as the recession progresses which increases patient loads and reduces the availability of outside grants and resources.

Increased Patient Load: Many clinics are seeing increased patient visits due to the recession. As people lose their jobs and their regular health care provider, many are turning to the urban Indian health programs for health care. The Hunter Clinic in Wichita Kansas saw an increase of 1,200 new patients in one month alone. Most clinics are reporting an increase of 25 to 100 new patient visits per month since the economic collapse in September. These figures are not static, but steadily increasing as the recession grinds on. Most Urban Indian health clinics were already working at full capacity and are struggling to provide services to the influx of new patients. Those programs in areas dependent upon single-source economies are particularly hard hit as people remain unemployed and uninsured for far longer. Clinics and programs are also seeing increased patient loads for social services such as food banks, unemployment support, and occupational education and training.

State Budget Crisis: As state budgets are forced to cut back due to the recession and the 2007 CMS regulation limiting federal reimbursement for outpatient clinics, many clinics are not receiving full or any reimbursement from state Medicaid plans for certain services. The urban Indian health organizations are particularly sensitive to changes in state and federal policy as they do not receive the OMB all inclusive rate for CMS reimbursement, nor do they have 100 percent of FMAP. Therefore, when state governments are forced to cut back on their Medicaid plans, Native American patients in urban centers suffer. If the Indian Health Care Improvement act had been passed prior to the start of the recession many of the urban Indian health programs would have been in a much stronger position and better equipped to deal with these issues.

Need for Expanded Services: Many clinics are also seeing increased patient demand for expanded services as other providers are increasingly refusing to serve

Medicaid and Medicare patients due to low reimbursement rates. Patients are finding it increasingly difficult to access dental, optometric, and skilled nursing services. Either providers for these services are leaving the area (Montana and Nebraska) or non-Native providers are increasingly unwilling to take referrals from Urban Indian health programs (Kansas, Massachusetts, Washington) and patients are left without a provider for these critical services.

Conclusion: The Urban Indian health organizations are making impressive progress in combating health disparities and barriers to care for their Native American patients. However, many of these programs would have been in a better place to deal with the surge of new patients and patient demands caused by the recession if the Indian Health Care Improvement Act had been passed. In particular, the provisions increasing enrollment under Medicaid, Medicare, and SCHIP would have helped numerous patients access critically needed services. While a complete review of the I/T/U system within the context of health care reform is definitely necessary, such a review cannot delay the passage of the Indian Health Care Improvement Act. The Urban Indian Health Program is only a small part of the I/T/U system, but even this small part would have been significantly more stable during this economically uncertain time had the bill passed.

Urban Indians and the Indian Health Care Improvement Act

Passing the Indian Health Care Improvement Act and making serious progress on improving the health of all Native Americans is a priority for the Urban Indian Health Program. Our clinics and programs see patients from every tribe and every walk of life. Many of our patients would not seek care elsewhere due to problems of fiscal and cultural accessibility. As described above, the clinics and programs of the Urban Indian Health Program deliver innovative, culturally competent care despite funding shortfalls, the economic downturn, and active hostility from the previous Administration. However, NCUIH feels that UIHP would be in a much stronger position to deal with these issues had Congress successfully passed the Indian Health Care Improvement Act in the 110th Congress. Indeed, the entire I/T/U system desperately needs the modernization and increased capacity promised by the Indian Health Care Improvement Act.

The National Council of Urban Indian Health would like to outline those provisions which are particularly helpful for Urban Indian Organizations as well as describe provisions which have been lost in negotiations to the Bush Administration. NCUIH feels that the provisions lost in prior negotiations with the previous Administration could potentially be restored without delaying the passage of the entire bill. Indeed, NCUIH encourages the Senate Committee on Indian Affairs to complete all necessary work on the bill and introduce it within the next 180 days. NCUIH strongly feels that this administration and the focus on health care reform present a rare opportunity to pass the Indian Health Care Improvement Act this session.

Positive Provisions: The history of the Urban Indian Organizations within the Indian Health Care Improvement Act has often been fraught with peril. The inclusion of Title V—which authorizes the Urban Indian Health Program—has frequently been attacked and nearly successfully stripped from the bill entirely. Therefore, the simple inclusion of Title V without losing any of the authorities which currently exist under current law is considered a victory by most of the Urban Indian Organizations. While it is sad that the expectations of Urban Indian Organizations have been so reduced by years of negotiating away authorities and programs, it does speak to the tenacity of the programs, the support of Tribes, and the support of Congress that Title V yet endures. While the Indian Health Care Improvement Act of 2008 does not provide for many new authorities for the Urban Indian Health Program it did: (1) reaffirm the trust responsibility to urban Indians—a relationship that has been under attack for the past three years; (2) provided better outreach and enrollment in Medicaid, Medicare, and SCHIP for Native Americans, and; (3) provided increased competitive grant opportunities for the clinics and programs of the UIHPs. The provisions regarding Medicaid, Medicare, and SCHIP all would have helped the urban Indian health programs better deal with the sudden State budget deficits and resulting cut backs in State Medicaid reimbursements. Moreover, the Indian Health Care Improvement Act of 2008 would have helped stabilize tribal health programs, which would have in turn helped the Urban Indian Health Programs. When one of the pillars of the I/T/U system is damaged, the entire system shakes.

Conferring with Urban Indian Organizations: Although NCUIH and its member organizations do not have a government-to-government relationship with the Federal Government, and it would be appropriate to use the term 'consult' which has a special meaning in this context, the Urban Indian Organizations

do represent Native Americans to whom a Trust responsibility is owed. Within the confines of that obligation, the Federal Government must make the effort to confer with those the urban Indian stakeholders.

Congress has consistently acknowledged the government's trust responsibility extends to American Indians and Alaska Natives (AI/AN) living in urban settings. From the original Snyder act of 1921[4] 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 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*."[5] This trust responsibility includes, from the perspective of NCUIH, the obligation to confer with the Urban Indian community through their duly authorized representatives regarding how that trust responsibility is met. Given the soaring health disparities facing the Urban Indian population[6] it is particularly necessary for meaningful discussion to take place in order for both the Federal Government and the Urban Indian health providers to ensure that the best possible care is provided to the vulnerable American Indian and Alaska Native community.

Inclusion of UIOs in Title II—Improvement of Indian Health Care Provided under the Social Security Act: The provisions contained in this Title would significantly help those programs currently billing Medicaid and Medicare and would help those programs who do not currently bill Medicaid and Medicare develop the capacity to do so. Third party reimbursements significantly stabilize the Urban Indian health programs that are capable of doing so. Expanded ability to seek reimbursement for medical services could mean the difference between providing certain key services such as dental and primary care and not being able to provide those services. When Urban Indian health programs are unable to provide services often times Native American patients simply will not seek care elsewhere, even if they are enrolled in Medicaid, Medicare or SCHIP. Provisions that are particularly important to the Urban Indian health programs are section 201 which amends section 1911 and section 1880 of the Social Security Act to include the Indian Health Service, Indian Tribes, Tribal organizations, and Urban Indian health programs as eligible entities. Currently Urban Indian health programs are treated as Federal Qualified Health Centers (FQHC) which are vulnerable to fluctuating reimbursement rates, particularly under the Medicaid program. NCUIH strongly encourages the Senate Committee on Indian Affairs to maintain Urban Indian Organizations in these provisions as it means the difference between fiscal stability and instability for many programs.

Section 509: Facilities: This provision provides for the Secretary to make grants to contractors for the "lease, purchase, renovation, construction or expansion of facilities, including leased facilities in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements." This provision is very important to Urban Indian health programs as they are not currently eligible for facilities construction funding, though they currently have authority for facilities renovation. Many programs have construction projects that are necessary to maintain or expand services to their patient base. Unfortunately these programs do not currently have appropriations authority for construction projects and the private market for the large scale loans necessary for such projects has disappeared with the onset of the recession. NCUIH strongly encourages the Senate Committee on Indian Affairs to maintain this provision.

Provisions to be Reformed or Re-included: There are, of course, provisions that the National Council of Urban Indian Health would like to see reformed, or added; however, it is imperative that this act be passed in the 111th Congress. NCUIH urges the Senate Committee on Indian Affairs to consider re-including the Urban Indian

[4] Snyder Act, Public Law 67–85, November 2, 1921.

[5] Senate Report 100–508, Indian Health Care Amendments of 1987, Sept 14, 1988, p.25. Emphasis added.

[6] *The Health Status of Urban American Indians and Alaska Natives,* Urban Indian Health Institute. 2004; *see also, Invisible Tribes: Urban Indians and Their Health in a Changing Worlds.* Urban Indian Health Commission funded by the Robert Wood Johnson Foundation. 2007.

health programs in the provisions listed below. These provisions deal with authorities and programs that are 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 community and surrounded by, in many respects, a foreign culture.

Many problems on the reservations are imported from urban locations because there is substantial movement back and forth 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.

Section 701 Behavioral Health Prevention and Treatment Services—This provision provides grant, cooperative agreement, and contract opportunities for the development of comprehensive behavioral health prevention and treatment programs. This section also directs the Secretary to act through the Service, Tribes, Tribal Organizations, and previously Urban Indian Organizations, to develop plans to participate in developing area wide plans for Indian Behavioral Health Services.

Section 707(g) Indian Youth Program: Multidrug Abuse Program—this subsection directs the Secretary to provide programs and services to prevent and treat the abuse of multiple forms of substances through Tribes, Tribal Organizations, and previously Urban Indian Organizations.

Section 212 Prevention, Control, and Elimination of Communicable and Infectious Diseases—this provision provides grant opportunities to develop a variety of projects and programs to for the prevention, control and elimination of tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, STDs and H. Pylori.

Conclusion: It is the first and foremost recommendation from the National Council of Urban Indian Health is that the Senate Committee on Indian Affairs move with all deliberate haste to complete our decade-long fight to reauthorize the Indian Health Care Improvement Act. The 110th Congress came achingly close to passing this critical act through the truly herculean efforts of yourself, Senator Dorgan and Senator Murkowski and the other members of this Committee. As stated before, this bill is not perfect but is the bill drafted through negotiation and compromise. The Chairman has requested that we take a fresh look at those areas where Tribal and urban Indian requests and provisions were dropped. NCUIH has included those areas that we hope the Committee continues to protect and those provisions that we hope the Committee will consider re-including. As members of the National Steering Committee, we will be working with other Indian advocates to review the entire bill. We will then work with our Tribal partner, NIHB, to vigorously advocate for these provisions.

Moving Indian Health Care Forward

As stated above, a quickly enacted IHCIA bill is the first vital step in moving all of Indian health forward. Once that step has been taken a full review of the entire Indian health care delivery system can begin. This would be an arduous, intensive process as it has been over fifty years since the Indian Health Service was created. It has been over thirty years since the original IHCIA was enacted creating not only the Urban Indian Health Program but many other Indian health programs. Health care delivery has significantly evolved in that time—and stands to significantly evolve yet again under the health care reform effort spearheaded by the Obama Administration. We hope that the critical review of the Indian health system will happen within the context of this reform effort so that the two efforts may inform each other. As stated earlier, it is critical that Indian issues are considered during the

larger health care reform process, as many suggestions and best practices from Indian and Urban Indian health organizations could be put to good use in the larger context.

The National Council of Urban Indian Health believes that in order to move Indian health forward in the context of this reform effort we must be willing to take a cold, hard look at many of our programs and our conceptualization of health care delivery. We agree with the National Indian Health Board that it will require contribution of experts from both within and without the system, demand innovative ideas, and demand a willingness to challenge the current status quo. It will also take strength of will from both Congress and Indian leaders to see serious reform through to the end.

NCUIH offers the following recommendations for such a serious reform:

- Consult with all Indian people—tribal and urban. NCUIH strongly urges this Committee to seek out the opinions and thoughts of individual health care consumers, service providers, and tribal and urban leaders. Unless all Indian people are involved in this reform effort it will not reach all of the people that desperately need the I/T/U system to be running as the world-class system it could be.
- NCUIH strongly agrees with NIHB that any "solution" that simply redistributes scarce existing resources is not a real solution. It only divides Native Americans against themselves and further damages the entire system of care for Native Americans.
- Conduct a needs assessment that includes the urban Indian health programs. It has been over twenty years since any needs assessment has taken the needs of urban Indians into account despite the fact that nearly 60 percent of the Native American population currently lives in urban centers.
- NCUIH also supports the NIHB suggestion that the Committee seek out Indian input through regional meetings, hearing and other potential mechanisms. NCUIH further urges the Committee to not forget Urban Indians in this effort.
- Serious reform must be accompanied by full funding of the I/T/U system to address unmet needs.
- Seek out and encourage the dissemination of Native American best practices. Our programs and clinics have been quiet leaders in innovative health care delivery for decades, but due to their small size have been unable to disseminate these best practices. Moreover, in order for the health disparities facing Native Americans to be seriously addressed best practices that actually work for Native people must be employed.

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 and suggestions on how to advance Indian health care. NCUIH thanks the Committee for its support and dedication to Indian health. We have a rare moment with this Administration and this Congress to pass IHCIA and to pass it now without further delays or negotiations. 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.

The CHAIRMAN. Mr. Joseph.

STATEMENT OF ANDREW JOSEPH, JR., CHAIRPERSON, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Mr. ANDREW JOSEPH. Good morning, Chairman Dorgan, Vice Chairman Barrasso. [Greeting in native tongue.]

My name in my dad's language is Badger. I am Andy Joseph, Jr., from the Colville Confederated Tribal Council and the Portland

Area Indian Health Board Chairman. I also serve as the Vice Chair for the Direct Service Tribes.

Before I begin, I want to commend you, Senator Dorgan and Committee, for your hard work in getting S. 1200 passed in the Senate last year. I have submitted written testimony to the Committee and respectfully request to enter it into the record of hearing. Let me summarize my testimony for the record.

I am aware that the members of the Committee understand that the United States has a Federal trust responsibility to provide health care services to American Indians and Alaska Natives. I would be neglecting my duty as an elected tribal leader not to remind us of this responsibility. We as tribal leaders and members of Congress should not take this duty lightly. Our forefathers, yours and mine, entered into agreements that guaranteed certain rights and privileges, in exchange for millions of acres of land and precious resources.

One of these is the reason why we are here today, health care. It is important to underscore the significant health disparities that Indian people face. While the IHS and tribes have made great strides to address the health status of Indian people, we still face the highest health disparities of any group in the United States. My written testimony documents these concerns, and reauthorizing the Indian Health Care Improvement Act will help to address these concerns.

Tribal leaders have been working on the reauthorization for 13 years. I have included a chart with my testimony that lays out the history of the Indian Health Care Improvement Act. The chart shows that immediately following the passage of the Act in 1976, Congress passed a number of amendments to improve the Act on several occasions. As a tribal leader, I am very frustrated that we have not been able to get this bill passed in the last five sessions of Congress.

We have spent an extraordinary amount of time and resources to get the bill passed. Given the chronic under-funding of IHS, these resources could be put in patient care and truly make a difference. As a tribal leader, I have a responsibility to my tribe to be responsible for the resources I use. I sometimes have difficulty justifying the resources we have spent over the last 12 years. Yet I know this bill will make a difference.

Every day I see the difference that the Indian Health Care Improvement Act would make on the Colville Indian Reservation. My tribe has more than 9,300 members, one of the largest in the Portland area. Many of our members live on or near the reservation. The long distances that our members must travel to receive health care is a tremendous burden and expense. The Indian Health Care Improvement Act would allow us to provide hospice care, assisted living, home and community-based services. These services could be provided in the immediate community of our members, so they wouldn't have to travel.

The Indian Health Care Improvement Act will improve access to health services and the ability of tribes to be reimbursed for providing care. This will help to reduce chronic under-funding of the Indian health system. Medicare and Medicaid reimbursements allow our health programs to provide additional health services

that might not be provided by IHS funding alone. There are improvements that allow tribes to recruit and retain qualified Indian health professionals to work on the reservations.

The Colville Indian tribes have had a serious bout dealing with youth suicides on our reservation. Last year alone, the Colville Indian Reservation suicide rate was 20 times higher than the national average. The Indian Health Care Improvement Act passed in the 110th Congress has an expanded emphasis on behavioral health programs that provide for a comprehensive approach to behavioral health, providing important prevention and treatment programs for American Indians and Alaska Native people and coordinating services related to alcohol, substance abuse, child welfare, suicide prevention and social services. This is a marked improvement that addresses youth suicide issues in Indian Country.

Over the last four years, the National Steering Committee has compromised on a number of provisions that have been altered or dropped from the bill. Many of these issues were not supported by the previous Administration. In light of the new Administration and Congress, I urge the Committee to consider adding important provisions back into the bill. I also urge the Committee to take opportunities to improve the Indian health system during health reform, but also caution that we must protect the Indian health system during this time. I caution making sweeping changes in IHS, since the system is only funded at approximately 60 percent of its need. Any evaluations and improvements for the Indian health system should consider this fact.

Thank you for this opportunity to testify, and I welcome any questions the Committee might have.

[The prepared statement of Mr. Andrew Joseph follows:]

PREPARED STATEMENT OF ANDREW JOSEPH, JR., CHAIRPERSON, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Good morning Chairman Dorgan, Ranking Member Barrasso, and distinguished members of the Committee. My name is Andy Joseph I serve as a Tribal Council member for the Confederated Tribes of the Colville Reservation. I thank you for the opportunity to provide my testimony to the Senate Committee on Indian Affairs.

In my role as a Tribal leader, I also serve as the Chairperson of the Northwest Portland Area Indian Health Board (NPAIHB). Established in 1972, NPAIHB is a P.L. 93–638 tribal organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health related matters. NPAIHB is dedicated to improving the health status and quality of life of Indian people and is recognized as a national leader on Indian health issues.

I want to commend Senator Dorgan and the Indian Affairs Committee for their work to get S. 1200, the Indian Health Care Improvement Act (IHCIA) Amendments of 2008, passed by the Senate last year. As you know there was a tremendous amount of work that went into getting this bill passed and we acknowledge your leadership and the commitment of the Committee and its staff to get this done. Thank you for holding this hearing and your continued work to support legislation to reauthorize the IHCIA.

Federal Trust Responsibility for Health Care

The United States government has a legal and moral responsibility to provide health care services to American Indian and Alaska Native (AI/AN) people. This responsibility is based upon numerous treaties signed between the United States and Indian Tribes which ceded millions of acres of land and resources in exchange for certain reserved rights and basic provisions guaranteed by the United States—including health care. The unique relationship between Tribes and the Unites States is underscored in the U.S. Constitution (Article I, Section 8), numerous Federal laws and court decisions, and Administrative policies which all affirm the unique relationship between Indian Tribes and the Federal Government and its obligation to

provide health services to American Indians and Alaska Natives. This obligation is further compelling when the limited access to health care and significant health disparities impacting AI/AN people are considered.

Indian Health 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. Over the last thirty years the IHS and Tribes have made great strides to improve the health status of Indian people through the development of preventative, primary-care, and community-based public health services. Examples are seen in the reductions of certain health problems between 1972–1974 and 2000–2002: gastrointestinal disease mortality reduced 91 percent, tuberculosis mortality reduced 80 percent, cervical cancer reduced 76 percent, and maternal mortality reduced 64 percent; with the average death rate from all causes dropping 29 percent.[1]

Unfortunately, while Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that other types of diseases are on the rise for Indian people. For example, national data for Indian people compared to the U.S. all races rates indicate they are 638 percent more likely to die from alcoholism, 400 percent greater to die from tuberculosis, 291 percent greater to die from diabetes complications, 91 percent greater to die from suicide, and 67 percent more likely to die from pneumonia and influenza.[2] In the Northwest, stagnation in the data indicates a growing gap between the AI/AN death rate and that for the general population might be widening in recent years. In 1994, average life expectancy at birth for AI/ANs born in Washington State was 74.8 years, and is 2.8 years less than the life expectancy for the general population. For 2000–2002, AI/AN life expectancy was at 74 years and the disparity gap had risen to 4 years compared to the general population. The infant mortality rate for AI/AN in the Northwest declined from 20.0 per 1,000 live births per year in 1985–1988 to 7.7 per 1,000 in 1993–1996, and then showed an increasing trend, rising to 10.5 per 1,000 in 2001.[3]

What is more alarming than these data is the fact that there is abundant evidence that the data might actually *underestimate* the true burden of disease and death among AI/AN because—nationally and in the Northwest—people who classify themselves as AI/AN are often misclassified as non-Indian on death certificates. A caution in using AI/AN data is that, due to small numbers, death rates are more likely to vary from year to year compared to rates for the general population. Unfortunately, it is safe to say that the improvements for the period of 1955 to 1995 have slowed; and that the disparity between AI/AN and the general population has grown. Factors such as obesity and increasing rates of diabetes contribute to the failure to reduce disparities.

Reauthorization of the IHCIA

Today, I want to speak about why it's important to get the Indian Health Care Improvement Act (IHCIA) reauthorized in this session of Congress. As the Committee is aware—and with its support—Tribes have been working since 1998 on the reauthorization of the IHCIA. I want to bring your attention to a chart that we have included as an appendix to my testimony. The chart shows that immediately following passage of the IHCIA in 1976, Congress has taken action on a number of measures to address and improve health care delivery for AI/ANs by amending the Act on several occasions. Unfortunately, Tribes have not seen the level of Congressional experienced in the 1980s and 1990s and our people are suffering because we have not improved our health system. In 1998, Congress extended the IHCIA by authorizing appropriations through FY 2001; however the Congress has not passed a bill since this time.

It was in 1998, that the IHCIA's National Steering Committee (NSC) began to work on legislative objectives for reauthorization. It has taken a tremendous amount of Tribal resources to work on the reauthorization effort and has been an extremely frustrating process. As a Tribal leader, I recognize that these important resources could be put toward patient care, but I also understand the importance of getting the IHCIA reauthorized. So from this standpoint it's been very frustrating to get the IHCIA reauthorized, knowing that past Congresses have passed legislation on a number of occasions to improve the health conditions for AI/AN people. Tribal leaders have been working on reauthorization of the IHCIA for eleven years, and it is critical that we get this bill passed as soon as possible in this Congress. The im-

---

[1] FY 2000–2001 Regional Differences Report, Indian Health Service, available: *www.ihs.gov.*
[2] Ibid.
[3] American Indian Health Care Delivery Plan 2005, American Indian Health Commission of Washington State, available at: *www.aihc-wa.org.*

provements contained in S. 1200 would allow the Indian health system to modernize the way in which it provides health care so that AI/AN people enjoy some of the same health benefits as most Americans.

Every day I see the difference that the IHCIA would make on the Colville Indian Reservation. Our reservation encompasses nearly 2,300 square miles (1.4 million acres) and is in northcentral Washington State. The Colville Tribe has more than 9,300 enrolled members, making it one of the largest Indian Tribes in the Pacific Northwest. About half of our members live on or near the Colville Reservation. The long distances that our Tribal members must travel to receive health care is a tremendous burden and expense. Some the provisions in the IHCIA would allow us to develop our health programs to provide hospice care, assisted living, and home and community based services. These provisions would allow the Colville Tribe to make health services available to those that might not be able to get to health facilities.

As the Committee is aware, a significant issue for Tribes is the lack of funding to provide health care services. The IHCIA provides authority for programs to improve access for health services and addresses mechanisms to allow the Indian Health Service (IHS), Tribes, and urban Indian organizations authority to be reimbursed for services they provide. This will assist to reduce the chronic underfunding for the Indian health system. The Title IV provisions are very important to the delivery of health care services for the Colville Tribal health programs. The Medicare, Medicaid, and SCHIP reimbursements allow our health program to provide additional health services that might not be provided by IHS funding alone.

Another improvement that the IHCIA would allow is for the IHS and Tribes to be able to recruit and retain qualified Indian health professionals. Like many parts of Indian Country, it is often difficult to recruit and retain qualified health professionals to work on Indian reservations. The amendments made to the Indian health scholarship programs will permit greater flexibility for IHS and Tribes to recruit, train, and retain health professionals. This would allow the IHS and Tribes to address the high health professional vacancy rates experienced in the Indian health system.

Lastly, the Colville Indian Tribes have had a serious bout of dealing with youth suicide on our reservation. It is estimated that the national Indian suicide rate is four times greater than the national average; however, last year the Colville Indian Reservation suicide rate was twenty times higher than the national average. The Senate passed IHCIA (S. 1200) has an expanded emphasis on behavioral health for IHS and Tribal health programs. The improvements contained in S. 1200 provide for a comprehensive approach to behavioral health, providing important prevention and treatment programs for AI/AN people. The bill also emphasizes the coordination of services related to alcohol and substance abuse, child welfare, suicide prevention and social services. The addition of the youth suicide provisions will greatly assist Tribes to address suicide issues in their communities.

New Opportunities for the IHCIA

Since 1999, the IHCIA National Steering Committee (NSC) has worked to develop bill language that is representative of the health needs of Indian Country and has the consensus of over 560 federally-recognized Tribes. Over the last four years, the NSC has worked to negotiate with Congressional Committees and the Administration to arrive at the final bill language that was passed in S. 1200. As the NSC negotiated to get a bill passed by the Senate, they compromised on a number of provisions that were changed or dropped from the bill. Many of these issues were not consistent with the previous Administration's policies concerning Indian health.

In light of the new Administration and Congress, we would urge the Committee to work with the NSC to revisit some of the IHCIA provisions that were significantly altered or dropped from the bill that passed in the 110th Congress. There were important provisions that would have exempted AI/AN people from cost sharing in the Medicare program and waiving late enrollment premiums in the Medicare Part B program, that would be important to increase access and services for Tribal elders. Another key provision would have established a Qualified Indian Health Program (QIHP) as a new provider type through which Indian health programs and urban Indian health programs could more fully exercise authority to receive payments under Medicare, Medicaid and SCHIP. Tribal leaders also agreed to delete a provision that would have extended the 100 percent FMAP to services provided to Medicaid eligible Indians referred by IHS or tribal programs to outside providers, such as referrals made through the Contract Health Services (CHS) program. This would be a very important provision to addressing the backlog of CHS denied and deferred services. There were other Social Security Act provisions that would have been beneficial for Indian programs but were dropped from the reauthorization bills

because the Department of Health and Human Services objected to negotiated rulemaking requirements.

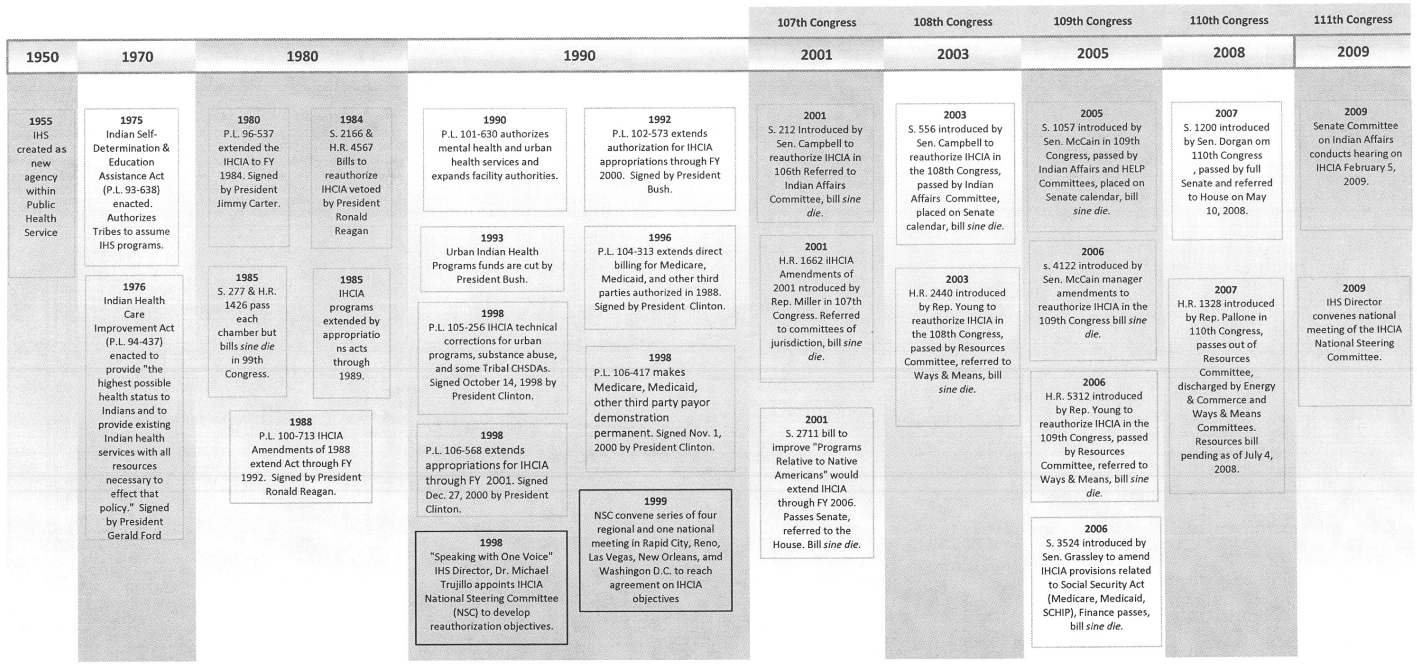
The Administration has stated that health reform will be a priority on its agenda. The President's plan to provide affordable and accessible health care for all Americans, will build on the existing health care system. Any time the Administration and Congress have undertaken a change to the nation's health care system it has had an impact on IHS and Tribal health programs. During this era of health reform there could be some opportunities to improve the Indian health system. There could also be threats to destroy the current system that provides culturally competent health care for AI/AN people. So it will be important for Congress to work with the NSC to understand these reform proposals and build in the protections for the Indian health system, but also allow it to be improved when and where appropriate.

It is important to note that there could be critics of the Indian health system during this time of reform. I want to stress the fact that the Indian health system is only funded at approximately 50–60 percent of its level of need. The improvements included in the IHICA, if adequately funded, would allow the IHS and tribally managed health programs to make marked improvements in overall health status of AI/AN people. It is not fair to evaluate the Indian health system under the current circumstance due to the fact that it is only funded at approximately 50–60 percent of its level of need. The Indian health system has done remarkably well with the limited funding that it receives. Health improvements made since the Agency was established and recent improvements tracked by GPRA indicators demonstrate this. Imagine the improvements that could be made if the system was funded at 100 percent of its level of need. The Indian health system should be given the same opportunity to provide comparable health care along the lines as that provided by the Veterans Administration. This can be accomplished by passing the IHCIA and providing adequate funding.

Conclusion

On behalf of the Northwest Portland Area Indian Health Board, I want to thank the Committee for allowing me to testify on Advancing Indian Health Care. I encourage the Committee to continue to work with the IHCIA National Steering Committee to identify key provisions that have been eliminated from the bill in order to improve health services provided by IHS and tribally operated health programs. And I urge Congress to make sure to protect and improve the Indian health system whenever appropriate as the Administration and Congress undertake health reform.

Chronology of the Indian Health Care Improvement Act
1955 - Present



The CHAIRMAN. Mr. Joseph, thank you.

Finally, we will hear from Mickey Peercy, the Executive Director of Health Services of the Choctaw Nation in Oklahoma.

STATEMENT OF MICKEY PEERCY, EXECUTIVE DIRECTOR, HEALTH SERVICES, CHOCTAW NATION OF OKLAHOMA

Mr. PEERCY. Good morning. I want to thank the Senators for allowing the Choctaw Nation to be here. I also want to beg your indulgence, I am from Oklahoma, so I talk more slowly than most. I may need seven minutes.

[Laughter.]

Mr. PEERCY. Greetings to the Chair and all the members of the Committee, and thank you for inviting the Choctaw Nation to provide testimony on Indian health care. We extend to you the support of the people of the Choctaw Nation to work with you in addressing priority issues of all Native American people. We have provided written testimony that will expand on my oral testimony.

The Choctaw Nation is located in rural southeast Oklahoma. We are ten and a half counties roughly the size of Vermont. We have managed our own health care system since 1985 totally. Our system includes one hospital, eight outpatient clinics, two substance abuse programs, diabetes wellness and a preventive health program. We have 831 employees, a $102 million annual budget, half of that being Federal, the other third party and tribal dollars. We know how to deliver health care.

We also know that the majority of tribal leaders and tribal nations are capable of managing their own systems. In 2003, the Commission on Civil Rights prepared an extensive report on Federal funding and unmet needs in Indian Country. And again, in 2004, as a follow-up the Commission reported more extensively on health care disparities in the report, Broken Promises: Evaluating the Native American Health Care System. We applaud those reports. These reports cannot continue to be ignored.

The Indian Health Service, and this is the first issue, the Indian Health Service authority should be reviewed to determine the effectiveness of the service in response to the needs of Indian beneficiaries, and whether it is in the best interests of the Indian people to change how the Indian Health Service provides primary health care. Most of us have been in the business, I know I have, over 28 years. And many of you have been in the same position.

It is the sense of the Choctaw Nation that given the current status of health care in this Country, health care for tribes should be targeted more at the tribal community levels for the best return on the investment, using best practices as a key denominator in the equation for health care service delivery, management and accountability. We do not need another redesign of Indian Health Service. Senators, much like the fox and the henhouse, the fox will never remodel the henhouse and give the hens control over their own destiny. It is not in their best interest. There is no incentive for that. The fox will always eat the hen.

IHS does not redesign, they only replace jargon and fortify their staffing and control. There must be tribal government and governance over tribal health care delivery. The gentlemen sitting here

are elected leaders. These folks are elected leaders. That relationship needs to be driven by these tribal leaders.

For the past decade, Indian Country has rallied behind and supported the reauthorization of the Indian Health Care Improvement Act. The most critical Indian health care legislation has been rewritten, renegotiated and dissected so much since 1999 that we are left to question if it is sufficient to make a dent in the needs of the intended beneficiaries today. The Indian Health Care Improvement Act bill can serve as the foundation on which to build a more comprehensive and responsive plan to address the financial and service needs of tribal communities.

Choctaw Nation asks that this Committee give every consideration to reassess the contents of the bill to do what is necessary to restructure and meet the needs and provide quality care of benefits for people. To answer a question that the Chairman mentioned, contract support costs is a big issue. We need to do something about contract support costs. What we would recommend is that we fund the shortfall, we take care of the shortfall, and then we adopt an administrative cost plan. For large tribes it could be 30, 35 percent. For small tribes, 18 to 20 percent. This is something that tribes could plan on. It gets the indirect cost proposals out of the equation. It also gets litigation out of the equation. So we would like to certainly talk about as we go farther.

Medicare-like rates, and the Medicare Modernization Act, I know three Medicare-like rates was adopted in 2007. This, I know Senator, your thing of contract health is a big issue. And what happens with Medicare-like rates now, folks go to the hospitals, the hospitals can only require Medicare-like rates from the health systems. We are asking that Section 506 be amended to include ambulatory services as well as the inpatient services. That is in my testimony.

One quick thing, facilities construction. Choctaw Nation is asking that this Committee convene a body to take a look at facilities construction within the Indian health system. There have been two priority systems that have been put in place. And we don't know where we are with facilities construction. We would ask that this Committee bring IHS forward, take a look at it or convene a body to really address what is going on with facilities construction.

With that, we thank you for the opportunity to give you comments, and would answer questions.

[The prepared statement of Mr. Peercy follows:]

PREPARED STATEMENT OF MICKEY PEERCY, EXECUTIVE DIRECTOR, HEALTH SERVICES, CHOCTAW NATION OF OKLAHOMA

Good Morning Chairman Dorgan, Vice-Chairman Barrasso and distinguished Members of this Committee. On behalf of Chief Gregory Pyle, of the Great Choctaw Nation of Oklahoma, I offer congratulations on this inaugural hearing to you Mr. Barrasso as the new Vice-Chairman, and new Members of the Committee Senators Udall, Crapo and Johanns. I extend to you the support of the people of the Choctaw Nation to work with you in addressing the priority issues of Native American peoples. Thank you for inviting Choctaw to provide testimony on advancing Indian health care.

The Choctaw Nation of Oklahoma is an American Indian Tribe organized pursuant to the provisions of the Indian Reorganization Act of June 26, 1936–49. Stat.1967. and is federally recognized by the United States government through the Secretary of the Interior. The Choctaw Nation of Oklahoma consists of ten and one-

half counties in the southeastern part of Oklahoma and is bounded on the east by the State of Arkansas, on the south by the Red River, on the north by the South Canadian, Canadian and Arkansas Rivers. The western boundary generally follows a line slightly west of Durant, then due north to the South Canadian River.

We have been operating under a compact of Self-Governance since 1995 in the Indian Health Service/Department of Health and Human Services and in the Bureau of Indian Affairs/Department of the Interior since 1996. The Choctaw Nation of Oklahoma believes that responsibility for achieving self-sufficiency rests with the governing body of the Tribe. It is the Tribal Council's responsibility to assist the community in its ability to implement an economic development strategy and to plan, organize, and direct Tribal resources in a comprehensive manner which results in self-sufficiency. The Tribal Council recognizes the need to strengthen the Nation's economy, with primary efforts being focused on the creation of additional job opportunities through promotion and development. By planning and implementing its own programs and building a strong economic base, the Choctaw Nation applies its own fiscal, natural, and human resources to develop self-sufficiency. These efforts can only succeed through strong governance, sound economic development and positive social development.

In 2003, the Commission on Civil Rights prepared an extensive report on the *Federal Funding and Unmet Needs in Indian Country.* Again, in 2004, as a follow-up, the Commission reported more extensively on health care disparities in the report, *Broken Promises: Evaluating the Native American Health Care System.* We all applauded the attention that both of these reports received and the level of education they provided to the novices on the topics of need and disparity that plague Indian communities in all venues, on all levels, in all areas each and every day. More importantly, these reports shared what is real and what continues to deprive Indian people of the basic pleasantries of life and benefits that most Americans enjoy that is so inaccessible at the reservation level.

The health care needs that were identified in the sequel Commission report have consistently increased the level of need in our Tribal communities because of a plethora of shortfalls and rescissions. In fiscal year 2008, total funding for the Indian Health Service (IHS) was $4.3 billion, some 48 percent short of the need identified by the Tribal/IHS Budget Formulation Committee. The Choctaw Nation has been aggressive in addressing the need of our people, as well as those who live in proximity to our reservation. We have become impatient with the current system of health care service delivery that is the responsibility of the IHS. It is the directive of the Tribal Council at the Choctaw Nation to move forward in advancing and addressing the needs of our communities through outreach, alliance building and partnerships to accomplish our health care goals.

The Indian Health Service authority should be reviewed to determine the effectiveness of the Service in response to the needs of Indian beneficiaries and whether it is in the best interest of Indian people to change how IHS provides primary health care. It is the sense of the Choctaw Nation that given the current status of health care in this country, health care for Tribes should be targeted more at the Tribal/community levels for the best return on the investment using best practices as a key denominator in the equation for health care service delivery, management and accountability.

The Choctaw Nation Health Services is the leader in health care in southern Oklahoma and continues to expand to meet the ever-changing needs of our people. The Choctaw Nation and Senior Health Officials from other Tribes and the Urban Program recently convened a meeting with the Oklahoma Hospital Association. We feel the need to reach across the aisle to share best practices, learn about the health needs of our neighbors and forge partnerships to improve and expand the health care services that are being provided in Oklahoma. We are not seeking to just serve the Indian community but rather to identify the needs of others while offering Tribes access; knowledge and choices about what other services and types of facilities are available to them in our state.

The Choctaw Nation currently provides the following health services to the Choctaw people and surrounding communities:

- Choctaw Nation Health Facilities
- Community Health Representative
- Eyeglasses, Dentures and Hearing Aid Program
- Office of Environmental Health
- Recovery Center
- Women's and Children Residential Treatment Program
- Diabetes Wellness Center
- Drug and Alcohol Testing

- Mail Order Pharmacy
- Behavioral Health
- Youth Advisory Board

For the past decade, Indian Country has rallied behind and supported the reauthorization of the Indian Health Care Improvement Act (IHCIA). Tribes remain vigilant in their quest to make the bill a product that will bring health care for Indian people into the 21st Century. Unfortunately the previous Administration and Congress fell short of getting the job done. The most critical Indian health legislation has been rewritten, renegotiated and dissected so much since 1999 that we are left to question if it is sufficient to make a dent in the needs of the intended beneficiaries today. How have we allowed something that is so important to the lives of 1.5 million Indian people to become so bare-boned at a time when the current economic crisis has nothing better to offer? Now is as good a time as any to look at overhauling the overall health package; to redesign a health system that meets the needs of Indian people locally in our communities. The IHCIA bill can serve as the foundation on which to build a more comprehensive and responsive plan to address the financial and service needs of the Tribal communities. The Choctaw Nation asks that the SCIA gives every consideration to reassess the contents of this bill and to do what is necessary to restructure it to meet the needs of and provide the quality of benefits that Indian people are entitled to receive.

While it is not easy to design and overhaul a health care system, the greatest need we are confronted with is funding. We are denied full funding to operate contracts and compacts with the Indian Health Service and yet we are expected to perform as any and all other vendors in the delivery of goods and services. Contract support costs (CSC) has not fully been paid under P.L. 93–638. Therefore, we ask that Congress work with Tribes and the IHS to design a mechanism that will allow for an administrative cost rate rather than CSC. For smaller tribes, the administrative cost rate could be as great as 30 percent, and for larger Tribes possibly 18–20 percent. While these percentages are random, such a concept supports the need to consider an alternative to what does not currently work. This could stabilize the outlay and allow Tribes to recover cost associated with performing the services under the contracts and compacts. In addition, an administrative cost rate would eliminate litigation fees.

Medicare-Like Rates

The Centers for Medicare and Medicaid (CMS) issued Section 506 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. This section generally provided authorization for contract health services and urban Indian programs to pay "no more than Medicare-like rates" for referred services (inpatient) furnished by Medicare-participating hospitals upon the effective date of enacting regulations. On June 4th the Department of Health and Human Services published regulations in the *Federal Register* effective July 5th to implement Section 506. The regulations describe the payment methodologies and other requirements covered providers must adhere to when processing claims for services authorized for purchase by a Contract Health Service or urban Indian program. Regulations require hospitals that participate in the Medicare program to accept Medicare-like rates as payment in full when providing services to Indian patients. The rules place a cap on the amount hospitals may charge for patients referred by the IHS, tribal and urban Indian organization Contract Health Service (CHS) programs. The new law will provide IHS and Tribally-operated CHS programs with similar benefits to those enjoyed by other Federal purchasers of health care.

The Choctaw Nation is requesting that Section 506 be amended to include ambulatory services.

Facilities Construction

The Health Facilities Construction Priority System (HFCPS) is a two-tiered priority process that has been the culprit of conflict among the Tribes and the IHS for years. The IHS Backlog of Essential Maintenance and Report (BEMAR) survey for October 2007 estimates that there is a backlog of $371 million in needed repairs to Indian health facilities. The replacement value of facilities eligible for Maintenance and Improvement (M&I) is $2.42 billion. The current priority list was developed in 1991 (nearly two decades ago) and embargoes Tribes from access to construction dollars unless they are one of the facilities on the list. The current rate of health facilities appropriations will keep the health facilities construction priority system locked for at least another decade.

There is yet another priority list from previous years that demonstrates the complacency of the IHS in acknowledging the enormous level of need that exists for replacement and construction of health facilities. Many Tribes support a moratorium

on facilities construction until IHS, in consultation with Tribes, develops an equitable funding methodology. The Choctaw Nation is requesting that you make an inquiry about the status of the funding methodology. Tribes would support a study on this issue that will update the inventory, the level of need and provide recommendations on how to address the backlog. However, as I've stated previously, the facilities improvement and construction backlog is primarily attributed to the lack of funding.

The Joint Ventures and Small Ambulatory construction programs are an efficient way to maximize resources of the Federal Government and the Choctaw Nation supports both. Tribes have been able to build more health care space than IHS at a 3–1 ratio with the Joint Venture Program and the Small Ambulatory Program. The Joint Venture program was an amendment to the IHCIA under Section 818 and authorizes Congress to appropriate recurring funds for increased staffing, operations and equipment for new or replacement facilities constructed with non-IHS funding acquired by Tribes. Self-Governance Tribes have been the primary applicants for Joint Venture and Small Ambulatory programs but due to the lack of funds, applications continue to gather dust as the need for alternative facilities increases on a daily basis.

The Choctaw Nation entered into a Joint Venture Construction Project and constructed the Idabel Clinic in 2005. The Idabel Health Care Center provides a wide range of services in the 53,262-square-foot building. The Choctaw Nation built the $11 million clinic with tribal funds, and is named in honor of Charley Jones, a former Councilperson. Services include dental, a diabetes component, general medicine, optometry and a full lab and pharmacy.

In addition to Idabel, Choctaw has health facilities at the following locations:

- Talihina Hospital
- McAlester Clinic
- Hugo Clinic
- Broken Bow Clinic
- Poteau Clinic
- Atoka Clinic (Opened in 2008)
- Stigler Clinic
- Hospitality House in Talihina
- Choctaw Nation Diabetes Clinic
- Children and Family Services—McAlester
- Children and Family Services—Atoka
- Recovery Center
- Chi Hullo Li

On behalf of the Choctaw Nation we appreciate the opportunity to offer our views on some of the needs and changes to the health care service delivery system for Indian people.

Thank you for allowing me to testify this morning.

The CHAIRMAN. Thank you very much for your testimony.

I want to ask a couple of questions. First, a number of you have mentioned contract health. And that is a very important set of issues that we have to try to resolve. I mean, if we are saying to people that money is only available for life and limb, we are consigning a whole lot of folks to a lifetime of pain and suffering.

We have all heard the stories about it. But in many cases, our Indian populations live far from established cities. They live on reservations, many miles from other hospitals. So the Indian Health Service is where they must go to get health treatment and health care. And when they go to some other facility, because that facility has the means, the equipment, and the ability to treat them, depending on the time of the year, they may or may not get contract health care coverage. If the services are not covered it may ruin their credit rating, and they may continue to suffer from pain and illness and so on. So we just have to try to address this issue of contract health care.

But one of the things I wanted to ask about was something Ron His Horse Is Thunder discussed, and some others did as well, this

issue of blood quantum. I fully understand the sovereignty issue. I think perhaps more than most, I understand that. On the other hand, when we write a health bill, the question of eligibility is obviously important. And if one tribe defines eligibility and another tribe says, no, no, eligibility is way over here, those tribes then have an opportunity to decide by themselves how many people will be eligible. Some perhaps, Oklahoma is probably a pretty good example, say that if you have any kind of Indian blood at all, you are eligible for everything.

So I think those of us who look at this question, how do you deal with blood quantum? If one Tribe says, if you have one-500th, that triggers enrollment. And Ron His Horse Is Thunder is short of Indian health care money because somebody else has decided we are going to take a lot of that money by the way we define blood quantum. Is that unfair? How do we deal with this without some standard? Mr. Chairman?

Mr. HIS HORSE IS THUNDER. Thank you for the question, Mr. Chairman. It is a very complex issue. The only thing that we ask in the Great Plains is simply that, is allow tribes to determine for themselves who are tribal members. I guess the point I was trying to make in terms os the current, the language of the current bill, was that it allowed for self-identification, I believe, and/or for States to identify who were and who weren't tribal members, besides tribes.

That is the portion of it that we object to, is States determine who are and aren't tribal members. It should be tribes who determine who are tribal members.

The CHAIRMAN. But that doesn't answer the question yet.

Mr. HIS HORSE IS THUNDER. That leads to the issue that you were trying to get a handle on, and all tribes are trying to get a handle on, and that is, simply, as you pointed out, some tribes don't require blood quantum at all. It is just a lineal descendance is all that require.

That is an issue that all tribes have to grapple with. But I wouldn't, as a tribal leader, want to impose my tribal eligibility criteria on another tribe. I couldn't do that. Nor could I ask any other tribe to accept our eligibility standards as well, too. It is something that all tribes are going to have to come to grips with, simply because of the fact of the matter that those who require a quarter blood quantum are going to breed themselves out of existence. So tribes are changing their blood quantum requirements. My tribe has just done so this past year, to include all Sioux blood, where in the past we only counted just Standing Rock blood.

So a number of our members weren't eligible, even though they were full-blooded Sioux. So we are finally coming to grips with that as an individual tribe. But that is our tribe's right to choose who are members and who are not. And again, I would not want to impose my standards on somebody else.

The CHAIRMAN. We wouldn't pass an Indian health care bill that describes Indian health care by tribe. We will do it generally. Then the question of who is eligible is an important question. You talk about the tribes needing to grapple with this; I understand that, they understand it. But they have understood it for a long time and

not been able to grapple with it, because I assume no one wants to cede that decision-making capability to anyone else.

And yet, if somehow the tribes can't deal with this, we will never have an adequate definition. A definition that doesn't, in some way, suck money away from one part of Indian Country, because someone created a definition that was in their interest on blood quantum.

I'm very sensitive to this issue of sovereignty, but I also believe, Mr. Chairman, that somehow the tribes have to come together to find a way to resolve this. Because I don't think you just put an Indian health care authorization bill out there and say, okay, now whatever it is you decide, that is okay, because it doesn't have an impact on others. It has an impact on others.

Let me just make one other point, if I might. I think the advice a couple of you have given us today of not reintroducing the same bill, is good advice. We have worked hard on trying to create a framework, an architecture for a bill. But time has changed. It has really been a couple of years.

So I think it would make sense to me if I and Senator Barrasso and others members of this Committee, working with all of you, can try to evaluate what should be the new approach in this legislation. Obviously, we will continue with much of the same structure, but use different approaches as well. So your suggestions and thoughts about that, I think, will be beneficial to us as we begin in a serious way trying to put all this together.

We wanted to have the first hearing to be on health care to signal our understanding that this is the priority. There are a lot of priorities, but this is the priority. We need to get this done. This is life or death for some people. So we need to get it done and get it right.

All of you have given us some good things to think about. Mr. Peercy, were you seeking recognition a moment ago?

Mr. PEERCY. I was just going to address real quickly your question, as the Chairman did, the blood quantum issue. You alluded to the Oklahoma tribes. And it is really just the Five Civilized Tribes in Oklahoma, it is based on history and it is based on constitution. So that is in the constitution, it is a sovereign issue.

But with us, we receive about $3 million from the Federal Government in contract health care dollars. Those are used. But the tribe also, and we are a gaming tribe, so there are lots of uniquenesses and differences. Our council and chief put an additional $7 million into our contract health program. So we have about $10 million, but we still do not get out of category one. So it is a major issue.

But the blood quantum issue may at some point come down to the road where tribes such as us, we have to look at a tiered sort of approach based on blood quantum. That we have not done, that we try to stay away from. But as you say, the dollars get thin and health care costs rise and populations rise. Thank you, sir.

The CHAIRMAN. Senator Barrasso.

Senator BARRASSO. Thank you very much, Mr. Chairman. I also want to congratulate you on calling attention to the issues of Indian health care and having the first committee meeting of the year really to set the tone of where we need to go. We have heard

some incredible testimony today. First, we congratulated Sally for being five minutes on the dot. It wasn't just perfect timing, but it was very informative. You talked about under-funding, imbalance of resources, and that is what we heard all the way across.

We heard, write a new bill, use the old bill as a framework. You talked about training physicians, recruiting physicians, protecting tribal sovereignty, the tribal colleges as a way to make sure that people who are trained in the communities then stay there. In Wyoming, we are just trying to get accreditation for our tribal college. It is helping with economic development, with all the computer training. But to get from that step to actually training of health care providers is going to take time. We are not there yet.

As you said, don't tell us just to do more with less. And then you told us of the incredible commitment of a group of people who spent nine hours working on six pages. I wish that the Senate would spend that kind of time just focusing on six pages. We kind of do the opposite, less time on a lot more pages. But that shows a level of commitment that is really an example for all of us to try to learn from.

We talked about what is happening with urban care, where it is different. We have established a community health center in Wyoming where we have a third of the Board by the Eastern Shoshone, a third by the Northern Arapahoe and a third by the other members of the community at large. So there are different challenges of going from urban centers to rural centers, very difficult problems.

And then as we go across, we heard about health discrepancies, I think was the word you used. You talked a lot about the youth suicide and you said we were only funded at 60 percent of the needs. So again, talking about the failure to get the required resources and insufficient resources.

And then, it was so obvious listening to your voice, you could hear in your voice the frustration with the entire bureaucracy of the Indian Health Service. It sounded to me, Mr. Chairman, like we are talking about good people trapped in a dysfunctional system. No matter what you do right, it still doesn't solve the problem.

So I know we have to vote, and we have some other obligations, but I just have a couple of quick questions, Mr. Chairman. When we take a look, and maybe for Chairman Joseph, what recommendations do you have for evaluating the Indian Health Service system and the context you noted for including any particular areas beside just the contract health service program? Because we talked about Medicare and Medicaid. Do you have specific ideas? And you may want to give more information in writing to our staff.

But are there specific ideas that you have? Because in your written testimony you included several areas to consider for reform that pertain to Medicare and Medicaid. But you cautioned that it wasn't fair to evaluate the entire Indian health system under the current under-funded circumstances. So are there additional things we should be doing?

Mr. ANDREW JOSEPH. Well, the under-funding of the system is really critical. If we were funded at 100 percent of the need, then evaluating the system would be more fair to the system. The IHS, the GPRA that we had to go through, IHS scored probably the

highest in the Nation out of all the health departments with the limited amount of money. If we had the full amount of money, it would definitely be the best program. But there are a lot of things that do need to be changed, need to make it more equal all across the Country so that all tribes could benefit and all our children would benefit in a good way.

The funding is a real big issue. Our board had a meeting last year in January, and we got a report from our area director. Just the frustration that you talked about, I was so frustrated I made a motion to declare the IHS funding in an emergency crisis situation. And that resolution passed without anybody denying it from any tribe. From there it went to the Affiliated Tribes of Northwest Indians. And it was passed there unanimously. From there it went to NCAI, this declaring a state of emergency for Indian Health Service funding. And as a direct service tribe's vice chair, we passed that same resolution.

If we had the full funding, it would really, I think it would help. I've seen Chairman Dorgan in his testimony in the Senate and I was there when he was at the Crow Tribe. And the grandmother of this young lady that they lost, our tribes have all kinds of similar situations. And I really respect you, Chairman Dorgan, for bringing that onto the Floor. I think that we really need to turn this Indian Health Service corner as soon as possible. I know that the Steering Committee could put in all the requests and the language that, it is pretty much already done, it just needs to be reentered into the Act.

Senator BARRASSO. And Chairman His Horse Is Thunder, if I could ask you, going through this, the differences. Congress intended through the Indian Self-Determination and Education Assistance Act for tribes to gain more control over the programs, particularly through the annual budget consultation process. But yet there are certain tribes, in Wyoming, the Eastern Shoshone, the Northern Arapahoe, those tribes that do not take over administration of the services like the direct service tribes.

How much control and input do they have? Is this a system that is working in determining the level of resources because we heard about unequal resource distribution. Any thoughts on that?

Mr. HIS HORSE IS THUNDER. There is a rule in IHS right now, and we object to it. They say if you want to contract for services that is, you must compact, you must compact for 100 percent of the services. And we object to that. We believe that you should be able to 638 a portion of the services, up to what you think you can handle. As tribes grow and progress in terms of their administrative skills and their policy-making, as well as being able to handle their own health care services, provide those services, they should be able to 638 them up to the level that they are comfortable with. If they want to 638 25 percent, 50 percent, 75 percent, that should be their choice. Right now, IHS says you compact 100 percent or you don't compact at all.

Senator BARRASSO. So one step at a time rather than the whole thing at once?

Mr. HIS HORSE IS THUNDER. That is correct.

Senator BARRASSO. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. In fact, they have just delayed the vote briefly, so we are in pretty good shape with respect to time.

I believe Chairman Joseph, you raised the issue of youth suicide. We have had a couple of hearings on that subject here. I know Chairman His Horse Is Thunder has had some suicide clusters among youth on his reservation. And it breaks your heart to go visit with some of the young people and some of the family members of those who have felt that things were so hopeless that they should take their own life. We need to work, continue to work on that.

We have done some telemental health work here on this Committee to try to extend services. I recall a hearing where a young woman just broke down in tears. She was a young woman on the Spirit Lake Nation Reservation. She was working on a wide range of investigations of sexual abuse against children and so on. She said there was a stack in her office, like that, that had not even been investigated. Then she began talking about children, some who had been abused, some who had emotional difficulties, threatened suicide. She said, I don't even have a car to get some child to mental health help. And we don't have enough mental health help in the first place. But even if there was enough help, there is not even a way to get that young person to the place where they can get some help. Then finally she just broke down sobbing and couldn't testify anymore. This is the person who was working for the tribe in this area. About three weeks later, she quit her job.

There is such under-funding of the resources needed to address these range of issues. And elders are dying, children are dying. We just have to do a better job. And we are determined to try to do that.

The agenda for our Committee, as Senator Barrasso and I spoke a couple of days ago, is obviously to pay a lot of attention to health care and focus to try to write a bill and work with all of you to get that through the Congress. We are also going to deal with law enforcement, which I think is very, very important. We have some tribal recognition bills that we will have some hearings on and try to respond to. In addition to health care, there are housing and education issues that we will pay some attention to. And I mentioned the issue of teen suicide.

There is a lot to do. I am passionate about it, excited about it. I know the same is true with Senator Barrasso. I am enormously pleased that he will now fulfill the role that Senator Murkowski filled in the last Congress. This Committee is one that has a lot to do. I don't think there is a population in this Country that is as affected with unemployment, poverty, lack of health care, good housing and education challenges than this population. It happens to be the First Americans who are often finding themselves getting second class education, second class housing, second class health care. We are determined to try to do something about that.

So thanks for traveling to Washington, D.C. to testify. It is the first step of what will be a journey that we will take together. I hope at the end of that journey, we all will have felt we have done something that advances Indian health care in this Country.

This hearing is adjourned.

[Whereupon, at 12:05 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF MEAD TREADWELL, CHAIR, U.S. ARCTIC RESEARCH COMMISSION

My name is Mead Treadwell. Since 2002 I have been a member, and since 2006 I have chaired, the U.S. Arctic Research Commission (USARC).[1] As a senior fellow at the Institute of the North, based in Anchorage, Alaska,[2] and in the private sector, I have worked for much of my career on Arctic issues. My testimony represents the view of the USARC, an advisory body to the Executive Branch and Congress, which includes as a Commissioner Warren Zapol, MD, the Reginald Jenney Professor of Anesthesia and Critical Care at Harvard Medical School, and a Member of the Institute of Medicine. The Commission formulates its positions in public meetings. The recommendations made by the Commission do not necessarily represent the views of the Administration. Nevertheless, I am proud to report that every relevant office we work with in the White House and every relevant agency we work with in the Executive Branch, takes conditions in the Arctic, and recent changes to those conditions, very seriously.

As the Committee works to reauthorize the Indian Health Care Improvement Act and add provisions that directly support health care research, both in basic science and clinical care delivery, the USARC wants to further stress the health research needs of Arctic residents.

In the Goals Report for the U.S. Arctic Research Program that the USARC will shortly present to Congress, USARC will recommend, as it did two years ago, that federal agencies develop an Arctic Health Research Plan. The U.S. Government, as a committed provider of health care to American Indians and Alaska Natives, can only improve its results in fulfilling this responsibility with research that addresses real health differences and meets real health needs of Arctic residents. The Interagency Arctic Research Policy Committee within the Executive Branch has adopted our recommendation, in principle, and several agencies in the government responsible for health care delivery, as well as health research, have made some progress in responding to that direction. We are unable though, as yet, to point to a plan with specific funding goals. The Arctic Research and Policy Act of 1984, as amended, instructs the Commission to inform the Congress when budgets and funding do not meet specific goals adopted in the U.S. Arctic Research Plan. At present, we see disparate funding for health research in the budgets of agencies, but, lacking an overall plan, we cannot point to a coordinated effort. That fact gives the Commission great concern.

We want the Committee to be aware of startling facts that have motivated us, as a Commission, to turn up our efforts to see the U.S. expand health research in the Arctic region.

Alaska's rural communities are experiencing a suicide epidemic. Alaska Natives hold first place in national suicide incidence, with the predominance occurring in 15–25 year olds. Indeed, the most recent Indian Health Service statistics show that Alaska Natives commit almost four times as many suicides as the general U.S. population.[3] An Alaska suicide follow-back study shows the complexity and depth of the

---

[1] Under the Arctic Research and Policy Act of 1984, the seven Commissioners of the USARC are appointed by the President and report to the President and the Congress on goals and priorities of the U.S. Arctic Research Program. That program is coordinated by the Interagency Arctic Research Policy committee, (IARPC), chaired by National Science Foundation Director Dr. Arden Bement, who is also an *ex-officio* member of the Commission. See *www.arctic.gov* for Commission publications, including the Commission's 2007 Goals Report.

[2] The Institute of the North, *www.institutenorth.org,* was founded by former Alaska Governor and U.S. Interior Secretary, Walter J. Hickel. The Institute's work on Arctic issues supports the work of the eight-nation Arctic Council and the circumpolar, regional governments of the Northern Forum.

[3] Regional Differences in Indian Health, 2002–2003 Edition, Part 4, Chart 4.19, p. 58.

problem.[4] Alaska Natives form a disproportionately high number of Alaska's elevated suicide rate. During the 36-month study period, Alaska Natives had a significantly higher average rate of suicide than the non-Native population (51.4/100,000 compared to 16.9/100,000).[5] The leading mechanism of death was firearms, accounting for 63 percent of the suicides.[6] Even more troubling, a recent 2007 Youth Risk Survey reports that of 253 Alaska Natives in high school, 22.5 percent "had seriously considered attempting suicide during the past 12 months," whereas 13.9 percent of 753 white students answered this question positively.[7] Clearly this reflects the unacceptably high incidence of successful suicides, and is believed to be based on many underlying problems including depression, darkness and seasonal affective disorder, culture change, genetic susceptibilities, alcoholism and gun prevalence.

USARC is taking a number of steps to move its recommendations for an Alaskan health research plan forward.

USARC is working with the National Institutes of Health (NIH) Fogarty International Center for Advanced Study in the Health Sciences, to sponsor a conference in June 2009 that will develop a research plan focusing on Arctic behavioral health. The conference will explore Arctic health issues on an international scope, looking particularly to learn if any Arctic country, such as Greenland or Canada, manages mental health problems with more success than the U.S. It will focus on what has worked elsewhere to expand what will be tried here.

Concurrent with its upcoming goals report, USARC is urging this Congress to fund a study by the Institute of Medicine of the National Academy of Science and the Polar Research Board to explore Alaska Native genetic and environmental issues and develop a health research agenda in both basic science and the clinical delivery of care that goes beyond existing clinical and social work. Although many of the mental and behavioral health and health-related social issues of Alaska Natives are similar to those faced by other Native American populations in other states, the problems in Alaska occur with greater incidence and are made worse by the difficult physical environment (including extreme cold and photoperiodic changes), rapid climate change affecting subsistence resources and the stability of coastal dwellings, and the limited availability of and access to health services, compounded by rapid social changes in the past several decades.

The mental health problem cries out for research. Over the past two decades, the Indian Health Service and Alaska government have tried a variety of clinical and social work methods to improve Alaska Native mental health. They simply are not working. Alaska Native mental health problems remain far more severe than the general population, and Natives in the Arctic experience a startling higher incidence, not only of suicide, but also of depression, alcoholism and mental illness. Suicide is only the tip of the iceberg. The study we recommend will get the process started to identify which approaches have worked best and what other research paths should be explored to address the epidemic of Alaska Native mental health problems. It will review research and prioritize what needs to be done, focusing on both basic science and exploring effective interventions. It will examine new techniques, such as telemedicine and telepsychiatry that will help us reach Alaska's remote villages more effectively.[8]

USARC is urging this Committee, and Congress, as it reauthorizes the Indian Health Care Improvement Act, to make specific provision and authorization for long-term, extramural research programs to support Alaska Natives as a population at high risk. In the 21st Century as we move to reform health care in our nation to be more effective, patient-centered, timely, efficient and equitable, we must learn the techniques, methods and practices that can improve Alaska Native mental health most effectively. Through health care research, the best practices can be identified and expanded. We believe health care for Alaska Natives can be made

---

[4] Alaska Suicide Follow-back Study Final Report, Study Period September 1, 2003 to August 31, 2006, submitted by the Alaska Injury Prevention Center, Critical Illness and Trauma Foundation, Inc. and American Association of Suicidology to the Alaska Statewide Suicide Prevention council, Alaska Department of Health and Social Services, Alaska Mental Health Trust Authority.

[5] *Id.* p. 5.

[6] *Id.*

[7] Alaska (Recoded Race) High School Survey, 2007 Youth Risk Behavior Survey Results, p. 17

[8] Along these lines, the Institute of Medicine has observed that scientific knowledge about best care is not applied systematically or expeditiously to clinical practice. It has recommended that the Department of Health and Human Services establish a comprehensive program aimed at making scientific evidence more useful and accessible to clinicians and patients. Also, it recommends using information technology, including the Internet, to transform the health care delivery system. "Crossing the Quality Chasm: A New Health Care System for the 21st Century," Institute of Medicine, National Academy Press, March, 2001, pp. 5–6.

much more efficient by focusing some money and resources on research to determine what techniques and interventions are most effective.

Finally, USARC urges this Committee and Congress to press the Department of Health and Human Services, NIH and the Centers for Disease Control to report back soon on their actions taken in responding to the current Alaska Native health crisis.

Thank you for the opportunity to present this testimony.

PREPARED STATEMENT OF JOSEPH ENGELKEN, EXECUTIVE DIRECTOR, TUBA CITY REGIONAL HEALTH CARE CORPORATION

I want to thank Chairman Dorgan, Vice-Chairman Barrasso, and all the Members of this Committee for allowing us to submit our testimony. As providers of healthcare in Indian Country, we thank Congress for passing the American Recovery and Reinvestment Act and for committing significant resources to begin to address the serious backlog of facilities construction, deferred maintenance and improvement projects for Indian people. This is a crucial step towards advancing Indian Health Care, however Congress can do much more than merely provide funding, Congress can provide the leadership necessary to streamline the administration of the Indian Health Service (IHS) so that the delivery of health care is done efficiently, effectively, and economically.

The Tuba City Regional Health Care Corporation (TCRHCC), is a former IHS hospital within the Navajo Area Indian Health Services system, located in 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 Tribal Organization. TCRHCC employs nearly 800 people and is a Regional Medical Center for northern Arizona serving nearly 28,000 primary care patients and administering over 75,000 regional referrals. Our medical service area serves most of the western part of the Navajo Nation, and the Hopi Nation, which encompasses the northern regions of Coconino County and Navajo County, including the cities of Flagstaff, Page, and Kayenta.

In order to advance Indian healthcare from the perspective of a 638 facility, Congress must follow through and support the philosophy of the P.L. 93–368 legislation of 1975. That is, to encourage tribal entities to take responsibility for their own future. To create economic development opportunities in service delivery, to leverage funds across sources, and to expand our healthcare missions. To do this, Congress must ensure that IHS become a pass through agency with true accountability placed with the on the ground providers and not with Rockville.

The current IHS structure of bureaucracy effectively cancels out innovative ideas and makes entrepreneurialism impossible. For 638 contracted entities, this is diametrically opposite of the intention of being community based, creative stewards who can leverage other sources of funds to expand our health care services and mission. For example, IHS's antiquated information system is designed specifically for the purpose of extracting the minimal information that Rockville needs to feed Congress the same old data reports it always has. As providers, we have no way to data mine the IHS system for disease identification or to share our information with other providers. The duplicative testing, medical errors, and other problems with the Tuba City hospital's existing system are currently causing loss of revenues estimated at $10 million per year.

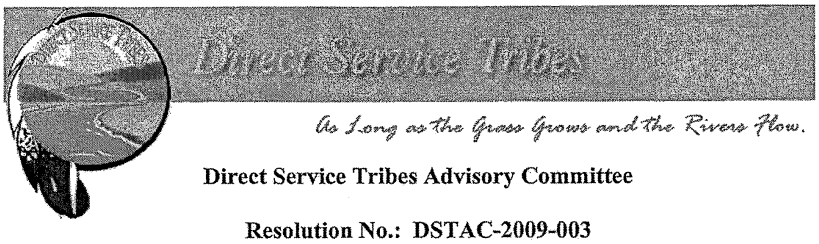
Another example is the regulations of IHS's national construction list, which require justification documents and duplicative engineering reports. We have a proposed satellite facility, the Bodaway/Gap health clinic, which ranks as a priority 3 on the national IHS construction list, it has been in process for 25 years and has approximately another 5 years to wait before any construction occurs. If 638 facilities were allowed to operate as any other private sector health entity, we could build the health clinic at much less than estimated by IHS and complete the project within 3 years.

The average age of a medical building in the private market is 9 years. TCRHCC operates out of two outdated IHS facilities. The old hospital was built in 1954 and has outlived it's useful life. The current medical center was built in early 1970s and was designed inadequately even for its time. Both buildings are used today to house hospital operations despite the deteriorated infrastructure and space constraints because we have no other choice. According to a recent estimate, expanding the hospital workspace will likely increase a "return on investment" in clinical productivity up to $1 million per year. It is obscene the way IHS' capital projects are handled. Without a requirement that morbidity and mortality be factored into the 30 year

wait for a community care facility then IHS projects will continue to exist only on lists.

If Congress wants to advance Indian health care then it must get away from top down approach that is our historical legacy. The best way to advance Indian health care is to make it a part of the Administration's overall healthcare reform policy. As long as Indian healthcare continues to be marginalized it will continue to be seen as an Indian problem only. This committee must work in collaboration with the Administration, the House Energy and Commerce Committee and the Senate Committee on Health, Education, Labor and Pensions to ensure that Indian health care is considered as one part of our national healthcare policy.

A first step towards beginning a meaningful dialogue on these matters is for the Committee to seriously consider conducting a field hearing in Indian Country. The purpose would be to gather the perspectives of those on the ground delivering the services. We have the experience dealing with IHS to know what works and what can be improved. Such a hearing can also give your members an opportunity to see first hand how the current IHS system is impeding the delivery of healthcare service. Once again, we urge the Committee to also consider a joint field hearing with the House Committee on Natural Resources, and any other congressional committees of jurisdiction, to be held in the near future in Tuba City Arizona on the Navajo Nation. Thank you.



Direct Service Tribes Advisory Committee

Resolution No.: DSTAC-2009-003

Declaring a State of Emergency for Indian Health.

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 National Congress of American Indians convened in Phoenix, Arizona in October 2008 and adopted a resolution declaring a State of Emergency for Indian Health and the DSTAC is in full support of that resolution.

WHEREAS, over 1.7 million American Indians and Alaska Natives (AI/AN)living in the United States rely on the Indian Health Service (IHS) access to health care services; and

WHEREAS, AI/AN people have long experienced lower health status when compared with other Americans that include lower life expectancy and a disproportionate disease burden because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences; and

WHEREAS, given the higher health status enjoyed by most Americans, the lingering health disparities of AI/AN people is troubling with the most important factor associated with these health disparities is the inadequate funding for the Indian health care delivery system; and

WHEREAS, it is estimated that funding for Indian health needs in the United States is only provided at 50-60% of its level of need with per capita expenditures for AI/AN people significantly less than other populations served by federal health programs, such as:

- Per capita expenditures for an AI/AN beneficiary served in the IHS is $1,914 per year;
- Per capita expenditure for a Medicare beneficiary is $5,915 per year;
- Per capita expenditure for a Medicaid beneficiary is $3,879 per year;

• Per capita expenditure for a VA beneficiary is $5,214 per year;

• Per capita expenditure for an inmate in the Bureau of Prisons is $3,803 per year; and

WHEREAS, these health and funding disparities have resulted in a health care crisis for Tribal governments and AI/AN people in the United States.

NOW THEREFORE BE IT RESOLVED THAT the Direct Service Tribes Advisory Committee hereby urges the Congress to declare a State of Emergency for Indian health programs; and

BE IT FURTHER RESOLVED, that the DSTAC hereby urges Congress to provide emergency funding to deal with the Indian health care crisis; and

BE IT FINALLY RESOLVED, that this resolution shall be the position of the DSTAC until it is withdrawn or modified by subsequent resolution.

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 **4th day of December, 2008** 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

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO RACHEL A. JOSEPH

Indian Health Care Improvement Act

Question 1. How do you see you and your Co-Chair, Buford Rolin's role in participating in the efforts to move Indian health forward to pursue reform efforts?

Question 1a. How do you think we can best build upon the work we did to pass the Senate bill last year?

Question 1b. Please provide the Committee with a list of provisions from S. 1200 which are essential and which provisions are not necessary. Also, please provide the Committee with any other information you think would be helpful in moving forward.

Answer. The NSC was established in 1999 by the Director of IHS to provide assistance regarding the reauthorization of the IHCIA, set to expire in 2000. The IHS asked tribes in each Area to designate a representative and alternate to work together with IHS to make recommendations for the reauthorization. The recommendations that resulted and have largely addressed in the legislation considered by Congress were intended to modernize the delivery of care by the IHS and to formally authorize the improvements that tribes were making.

Ten years later the role of the NSC remains limited to the reauthorization of IHCIA. Co-Chair Buford Rolin and I are deeply committed to the passage of this critical piece of legislation. The reauthorization of the IHCIA is an important first step in reform efforts, however the NSC purpose is limited to that step and it is not tasked to participate in reform discussions. The National Indian Health Board (NIHB) is participating in health care reform discussions at the Congressional and Administration level, informed in part by the tribal leaders' discussions that have guided the NSC. The NSC is confident in the NIHB's ability to advocate for Indian Country as the reform efforts continue.

Many of the provisions added to the reauthorization bill as it was amended on the Senate floor during the 110th Congress weakened the bill and its ability to pass through the House. The NSC recommends moving forward with the bill as drafted

by the Senate Committee on Indian Affairs or the House Natural Resources Committee, with updates. The NSC over the course of a two day meeting and numerous conference calls has revisited provisions that have been dropped or scaled back during the ten year reauthorization efforts. Some of the current NSC recommendations also reflect changes in view that result from the passage of time. We have provided the SCIA staff with these recommendations.

Extensive tribal consultation was held to develop the initial tribal draft of the IHCIA legislation and it has been the subject of countless meetings and updates in the intervening 10 years. This draft developed by the tribes contains the essential provisions for Indian Country. While numerous provisions regarding Medicare, Medicaid and the Children's Health Insurance Program from the IHCIA legislation were enacted into law through CHIPRA and ARRA, essential and necessary provisions remain to be enacted either through the IHCIA or in the course of health care reform.

Entitlement Programs

Question 2. Do you see increasing enrollment in entitlement programs like CHIP, Medicaid and Medicare as a satisfactory way to increase the access and quality of care in Indian Country?

Answer. Increased enrollment in entitlement programs like CHIP, Medicaid and Medicare is a pragmatic and critical vehicle for increasing access and quality of care in Indian Country given the insufficiency of direct appropriations. It is vital that no one come to believe that these programs can substitute for the Indian health system, which includes the health programs operated by the Indian Health Service, tribes, and urban Indian organizations. Culturally competent and appropriate health care must remain an integral part of the system and these entitlement programs do no address this when they work in isolation from the Indian health system. Thus, we continue to urge that the entitlement programs be designed to recognize and accommodate the unique characteristics of the Indian health system and American Indian and Alaska Native people. Indian specific provisions of the Children's Health Insurance Program Reauthorization Act of 2009 and the American Recovery and Reinvestment Act of 2009 provide good examples of how legislation of general application can be tailored to better support the Indian health system.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO RACHEL A. JOSEPH

Health Care Reform

Question 1. Can you provide the Committee with examples of general principles that should be adhered to when addressing Indian health care reform?

When addressing Indian health care reform the NSC strongly recommends no regression from current law as a starting point. As stated in my response to Senator Dorgan's question on health care reform, the NIHB has the capacity to participate in the health care reform debate. The NIHB has outlined guiding principles for the new Administration and Congress to follow in the development of any health care reform. I have provided those guiding principles below and the NIHB stands ready to work shoulder to shoulder with Congress on ensuring that Indian Country is at the table and included in the health care reform debate.

- *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 to 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.

As discussed above in response to the question from Senator Dorgan regarding the role of entitlement programs, the vehicles for health care reform, whether existing programs or new ones, need to be adapted to support the Indian health system. To fulfill these principles, Congress must expressly provide for meaningful participation by tribal governments functioning in each of their capacities: as governments, as employers of tribal members and non-Indians, as providers of health care services, and as advocates for their members as users of health care systems with unique cultural perspectives and needs. This participation must respect the structures that already exist and provide access and resources for them to grow and improve.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO H. SALLY SMITH

Indian Health Care Improvement Act

Question 1. Do you think that S. 1200 should be the framework for future IHCIA legislative efforts?

Question 1a. Please provide the Committee with a list of provisions from S. 1200 which are essential and which provisions are not necessary. Also, please provide the Committee with any other information you think would be helpful in moving forward.

Answer. S. 1200, as reported by the Committee and as revised by the Manager's amendment accepted during floor debate, was a very good product. But a number of objectionable provisions were added during Senate debate—such as Sen. Vitter's amendment applying a far stricter anti-abortion policy on the Indian health system and to Indian women than applies to other federally-funded health programs and women whose health care is provided by those programs.

H.R. 1328 was not burdened by the objectionable Senate floor amendments. Thus, with regard to those issues, the House bill would be the more preferred vehicle. Nonetheless, there are some instances where the Senate's language is preferable to the companion provision in H.R. 1328.

The National Tribal Steering Committee for IHCIA reauthorization recently transmitted to House and Senate staff recommendations for refinements in the IHCIA legislation being developed for 111th Congress introduction. The Committee stands ready to offer additional recommendations as you or your staff require.

Input from Indian Country

Question 2. You noted in your testimony that holding listening sessions would be a good way for the Committee to hear from Indian Country. How do you see these meetings structured?

Answer. I recognize that you, your Committee colleagues and tribal leaders all have many demands for their time. Thus, it would seem most efficient to continue what you have been doing—that is, holding listening sessions with local tribal officials when your Senate business requires you to travel to other parts of the country, and scheduling meetings with tribal leaders when they are in Washington, such as you did during the NCAI Winter Session in Washington, D.C. The Committee could also schedule field hearings in various parts of Indian Country as you see fit. Establishing an agenda for discussion—as the Committee did for the NCAI meeting—is very helpful as it enables tribal leaders come prepared to discuss topics of interest to you.

Question 2a. Can you describe a timeline of how NIHB plans to be helpful with moving forward with the health bill?

Answer. Enactment of an IHCIA reauthorization bill remains NIHB's top priority. Therefore, our Board members and staff are committed to providing any assistance requested by Congressional staff, and to being pro-active in advocating for passage.

In February, NIHB helped arrange the meeting of the National Steering Committee which produced the recommendations referenced above, and has had follow-up meetings with House and Senate staff who are working on a bill. We also intend to advocate with leadership in both parties, with individual members, and with the Obama Administration officials to keep the IHCIA bill high on the agenda for action.

Indian Health Service Efforts

Question 3. Do you see NIHB playing a role in the process taking place at IHS? How so?

Answer. We have heard about IHS's internal self-examination but have so far not been asked to participate in it nor has the Board been asked to comment on any findings or recommendations. IHS officials made a presentation on this at the October 2008, NIHB Consumer Conference, and we are aware that Area Directors were instructed to make a power-point presentation to tribes in their Areas. NIHB has not been asked, however, to comment on any recommendations or proposals flowing from this examination.

American Recovery and Reinvestment Act

Question 4. What type of impact do you think the provisions in ARRA will have on Indian Country?

Answer. While we always have a greater need than we have funding, Indian Country is sincerely grateful to have received such a generous share of the ARRA funding. We appreciate the tremendous effort exerted by you and others in Congress and the Administration to bring this about.

We were extremely disappointed that the Conferees dropped the additional funding for Contract Health Services which the Senate had proposed.. We are eager to hear the details of the President's FY10 budget request for IHS, and hope that a good portion of the encouraging increase in IHS funding will be targeted to CHS.

The funding for health care facilities construction is welcome, but as you know, it is expected to fund only two construction projects currently on the priority list. While the Indian people to be served by those two projects will benefit from new facilities, many projects that have been on the priority list for many years must continue to wait for funding. Plus, a myriad of facilities needs exist throughout Indian Country but do not yet appear on the priority list. A meaningful dent in the facilities construction backlog will not be achieved unless/until the Federal Government makes a commitment to supply a healthy amount for new construction in the area of at least $300 million annually.

It is too early to tell the extent to which the ARRA funding for facilities maintenance and improvement and sanitation facilities will be effective in curing the long-standing shortfalls for these programs. We must first find out how these funds will be apportioned by IHS.

Question 4a. How does NIHB plan to take an active role in ensuring these funds are utilized by Indian Country?

Answer. It is not within NIHB's authority to apportion funding or direct how or on what projects it is spent by the agency or by tribes who receive it. The ARRA gives IHS broad discretion in deciding how to expend these new resources. We are hopeful that the agency will be evenhanded in exercising this discretion, and will assure that projects and programs operated by both IHS and tribes benefit from the funds. If the Board receives complaints that the agency is not being evenhanded, we will do our best to advocate for correction.

Indian Health Care Reform

Question 5. As a part of moving forward with Indian health and reform you recommended in your testimony a deep examination of the Indian health system. The goal would be to fully understand the issues and come up with innovative solutions. How do you see the examination structured? Please describe.

Answer. Ideally, a deep examination of the Indian health delivery system would be a multi-year effort and be staffed by a cadre of experts from inside and outside of Indian Country, particularly persons experienced in delivering health care to underserved populations. A special appropriation to fund the effort would likely be needed to do it properly. Whether Federal resources for such an undertaking would be available in the current economic environment is Questionable. You would have greater insight on this than I do.

The next-best option is for the Administration and Congress to assure that the Indian health system is an integral component of President Obama's health care reform initiative. Like the mainstream health care system, ours suffers from insufficient and uneven distribution of resources, lack of access to care, problems with recruitment and retention of providers to serve in remote areas, and large numbers

of underserved people. But statistics demonstrate that our challenges are even greater, as the IHS system is funded at only 50 percent of need (at best), and Indian people suffer health disparities far out of proportion to the overall American population.

Thus, Indian Country must have a seat at the table as health care reform ideas are developed. To the extent Federally-funded health care coverage is expanded, these opportunities must be extended to the IHS/tribal service population with the costs covered by the Federal Government as part of its trust responsibility for Indian health. We agree that our Nation must put a greater emphasis on health education, disease prevention and healthier lifestyles. The IHS system has long followed these aspects of the public health model to the extent its resources allow, but there are insufficient resources to achieve these goals and to provide needed acute care, too.

I know from personal experience that tribally-operated programs use their scarce funding as efficiently as possible and direct resources to the specific needs of their local populations to the extent they can. But we need help in many areas to achieve greater efficiencies. For example, the ARRA provides much-needed funding for health information technology—some of which will be directed to the IHS system—but it will not close the gap.

I do not mean to suggest that all ills can be cured by more funding alone. We also need authority to utilize modern methods of health care delivery such as home- and community-based care which, for many patients, is far more effective and less costly than facility-based care. Your bill from the 110th Congress, S. 1200, would authorize such care for the IHS system, as well as authority to provide assisted living, long-term care and hospice care—all of which are prevalent in mainstream America but not in Indian Country. Your bill would also re-vamp behavioral health programs that are so badly needed to enable Indian people to lead healthier lives, both physically and mentally. With authority to use modern care delivery options, we can achieve great economies and improved health status.

Please assure that Indian health advocates have a meaningful voice in health care reform.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO MICKEY PEERCY

1) **Input from Indian Country:** *How do you think it is best for the Committee to reach out to and communicate with administrators and other people in roles such as yours?*

Allow time for listening conferences with health administrators' positions and others who have the responsibility to provide primary health care for the American Indian/Alaska Native population. Committee members always have an invitation to come to Indian Country and see firsthand the difficulties of providing health care in an underfunded system.

2) **Status of Indian Health Care Services:** *How does your health facility provide efficient and cost-effective emergency response care in dealing with the rural nature of your population?*

The Talihina hospital has responsibility for emergency room care for the entire community. There is no other emergency room within a 1 ½ hour radius of the facility, so eligibles as well as non-eligibles are treated through our emergency room. We do the best we can.

The Choctaw Nation is Rural, much like North Dakota. Have you formed partnerships between other rural health networks near the Reservation as a way to increase access and quality of care? If not, do you see this as an opportunity to improve health care?

We network with all health care agencies within our service area. We use outside emergency assistance when necessary and have a relationship with an aviation company to provide helicopter emergency services. We also work closely with the Oklahoma State Dept of Health, local community action programs and local community mental health programs.

Does a network exist, among Oklahoma Tribes, where programs exchange information?

Yes. The Oklahoma City Area has a strong inter-tribal health board which represents tribes in Oklahoma, Kansa and Texas. We also have a strong Self-Governance coalition which meets on a quarterly basis to discuss and take action on health-related activities.

WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO
HON. RON HIS HORSE IS THUNDER*

1. **Status of Indian health care services.** Problems within the Indian health system are not uniform. Health disparities as well as health care access and quality vary throughout Indian Country.
   - What do you see as the most serious health care issues facing the Aberdeen Area?
   - Are any issues unique to this Area?
   - What provisions in the Indian health bill specifically address the uniqueness of the Aberdeen Area?

2. **Entitlement Programs.** There are current efforts to expand entitlement programs of Medicare, Medicaid and the Children's Health Insurance Program (CHIP) to Indians. An increase in outreach and enrollment for Indians, like the provision included in CHIP, provide additional increases in health services and funding to Indian Country.
   - Do you see increasing enrollment in entitlement programs like CHIP, Medicaid and Medicare as a satisfactory way to increase the access and quality of care?
   - How do entitlement programs affect the health care provided to Indians in the Aberdeen Area?

3. **Indian Health Program Partnership.** Some of the most successful Indian health programs were developed and are run by multiple organizations in a partnership. When resources are scarce like they often are in Indian Country and the population is rural, partnerships between federal agencies and organizations have been beneficial in program operation.
   - In your testimony you listed local programs being operated in the Aberdeen Area by the Great Plains Tribal Chairman's Association and the Aberdeen Area Tribal Chairman's Health Board which have been very successful. Do you think programs developed through local partnerships are more successful than national program implementation?
   - Also, you explained that the Aberdeen Area often looks outside of the Indian Health Service, to other government agencies for grants. Do you see partnerships with other agencies as a potential avenue for reform? How?
   - Do you see partnerships between other rural health networks near the Reservations as a way to increase the access and quality of care?

*Response was not available at the time this hearing went to press.

WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO DAVID RAMBEAU *

1. **Status of Indian Health Care Services.** Problems within the Indian health system are not uniform. Health disparities as well as health care access and quality vary across Indian Country. In order to move forward with the IHCIA and then further explore Indian health reform, the Committee will need to gain input from across Indian Country.
   - Do you feel the issues within the urban population are uniform?
   - What is the best way for us to gain comprehensive input from the Urban Indians?
   - In your testimony, you mentioned the movement of Indians between the Reservation and urban areas as a public health issue. Do you think that a lack of basic public health service programs intensifies this problem?

2. **Indian Health Program Partnership.** Some of the most successful Indian health programs were developed and are run by multiple organizations in a partnership. When resources are scarce like they often are in Indian Country and the population is rural, partnerships between federal agencies and organizations have been beneficial in program operation. Urban programs may supplement Indian Health Service funds with other resources in order to succeed.
   - Can you explain which agencies, grants or other funding sources have been most helpful to the development of urban programs?
   - Do urban Indian programs often combine or partner with other urban minority health programs? Do you see these partnerships as increasing access and quality of care, while still containing costs?
   - Do you see a way to showcase specific urban programs so they could serve as a model?
   - Does a structure exist for urban groups to exchange ideas and replicate programs that are working in other areas?

WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO DAVID RAMBEAU *

1. **Addressing the Needs of Urban and Reservation-Based Indians.** In my home state of Washington we have over one-hundred thousand urban Indians. Making sure that this population has adequate access to quality health care is important to me. The topic of urban Indian health services has been controversial in the past.
   - **Do you have any general suggestions for how we can draft a reauthorization bill that addresses the needs of both urban Indians and reservation-based Indian populations?**

* Response was not available at the time this hearing went to press.

WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO ANDREW JOSEPH, JR. *

1. **Status of Indian Health Care Services.** Problems within the Indian health system are not uniform. Health disparities as well as health care access and quality vary across Indian Country.
   - What do you see as the most serious health care issues facing the Portland Area?
   - Are any issues unique to this Area?
   - What provisions in the Indian health bill specifically address the uniqueness of the Portland Area?

2. **Indian Health Care Improvement Act.** The Indian Health Care Improvement Act, the primary law under which the current Indian health care system operates, was first enacted in 1976. This law is the principal statute through which Congress gives direction to federal programs which provide health care to and elevate the health of American Indians and Alaska Natives. IHCIA has not been reauthorized since 1992.
   - Please explain how you see S.1200 allowing modernization for Indian health, as you mentioned in your testimony.
   - Which areas of the Indian health system need modernizing the most?

3. **Urban Indian Health.** There is a relatively high population of Indians in urban settings within the Portland Area. Thus, there is migration to and from urban areas. Mr. Rambeau of the National Council of Urban Indian Health mentioned this in his testimony.
   - Has the Northwest Portland Area Indian Health Board worked extensively with the present urban population?
   - Has your organization often partnered with the National Council of Urban Indian Health or other organizations to develop? If so, how were these partnerships formed and programs structured?

4. **Entitlement Programs.** There are current efforts to expand entitlement programs of Medicare, Medicaid and the Children's Health Insurance Program (CHIP) to Indians. An increase in outreach and enrollment for Indians, like the provision included in CHIP, provide additional increases in health services and funding to Indian Country.
   - Do you see increasing enrollment in entitlement programs like CHIP, Medicaid and Medicare as a satisfactory way to increase the access and quality of care?
   - How do entitlement programs affect the health care provided to Indians in the Portland Area?

* Response was not available at the time this hearing went to press.

WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO ANDREW JOSEPH, JR. *

1. **Heath Care Reform.** As we begin to work on fulfilling this country's trust responsibility to provide health care to all Native Americans, can you provide the Committee with examples of general principles that should be adhered to when addressing Indian health care reform?

2. **Contract Health Service Program.** The Contract Health Service (CHS) Program is very important in the Indian health system and for Pacific Northwest Tribes. Can you explain how some of the improvements in the Indian Health Care Improvement Act could result in cost savings in the CHS program?

3. **Heath Care System.** Can you provide any examples of programs or services that are currently being carried out in the Indian health system that have been beneficial and would be a program to model as part of reforming this country's health care system?

○