Testimony by Rachel A. Joseph
Co-Chairperson of the
National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act

Before a Joint Hearing of the Senate Committees on Indian Affairs and Health, Education, Labor, and Pensions

July 14, 2005 – 2:30 PM
Room 430, Senate Dirksen Building

Good afternoon Chairman McCain, Vice Chairman Dorgan, Chairman Enzi, Ranking Member Kennedy and members of both Committees. My name is Rachel A. Joseph. I am Co-Chair of the National Steering Committee for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA) and Chairperson for the Toiyabe Indian Health Program, a consortium of nine Tribes which serves Mono and Inyo Counties in central California. I have served for several years on the Indian Health Service (IHS) National Budget Formulation team representing California and have been elected to represent the East Central California Tribes to the California Area Office Advisory Committee. In these capacities, and others, I have been fortunate to work with Tribal Leaders from across the Country in addressing health care issues. Thank you for having this joint hearing and providing me the opportunity to testify in support of S. 1057, a bill to reauthorize the Indian Health Care Improvement Act.

This testimony is also offered on behalf of the National Indian Health Board (NIHB) and the National Congress of American Indians (NCAI). NIHB serves Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives, as well as upholding the federal government's trust responsibility to American Indian and Alaska Native Tribal governments. The NCAI was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments dedicated to preserving, protecting, and promoting the inherent sovereign rights of Indian nations.

The National Steering Committee is pleased that the Senate Reauthorization bill, S. 1057, was introduced early this year and that hearings are being held.

Today, I respectfully request Congress and the Administration to work together to enact the reauthorization of the Indian Health Care Improvement Act and to support the efforts of Indian Affairs Committee Chairman John McCain and Committee Vice Chairman Dorgan in this endeavor. Also, we thank Chairman Enzi and Ranking Member Kennedy for your interest in this legislation. We are committed to working with you to achieve the passage of S. 1057 during **THIS** Congress.

History of Reauthorization Efforts

This reauthorization effort has been long, difficult and disappointing for us. We believe we also need to be "at the table" with Congress and the Administration as we continue the dialogue on

reauthorization and it is consistent with a meaningful government-to-government relationship. During the last session of Congress Indian Country did not have this level of participation; however, we remain ready to work with the Administration and look forward to it.

In June 1999, the Director of the Indian Health Service (IHS) convened a National Steering Committee (NSC) composed of representatives from Tribal governments and national Indian organizations to provide assistance and advice regarding the reauthorization of the IHCIA. I was elected co-chair of the NSC during the organizing meeting in 1999. Over the course of five months, the National Steering Committee drafted proposed legislation, which was based upon the consensus recommendations developed at Area meetings, four (4) regional consultation meetings held earlier in that year and a national meeting here in Washington, DC. The consensus recommendations formed the foundation upon which the National Steering Committee began to draft proposed legislation to reauthorize the IHCIA. In October 1999, the National Steering Committee forwarded our final proposed bill to the IHS Director, to each authorizing committee in the House and Senate and the President. The House and Senate have introduced legislation based on the tribal bill, but none have passed.

The bill, S. 1057 is a culmination of a bi-partisan, community-based endeavor arising from exemplary tribal coordination and consultation. At the request of the Department of Health and Human Services, Native American leaders drafted changes to this lengthy law, worked out endless compromises and reached consensus on key policy issues. We discussed and agreed to what would contribute to good health and well-being of AI/AN families.

The IHCIA has had a unique legislative history. After passage in 1976, it was amended in 1980, continuing authority for appropriations for the provision of health care services to American Indians and Alaska Natives (AI/AN) through September 30, 1984. Despite majority support in the Congress, under both Democrat and Republican leadership, reauthorization has failed too many times. A reauthorization bill was vetoed in 1984, and twice failed because the Congress could not resolve differences in bills that had passed the House and the Senate. Since passage it has been reauthorized five times. However, the Snyder Act still forms the basis for Indian health care programs' appropriations.

Important pieces of legislation dealing with human needs are reconsidered and amended periodically so programs stay relevant and effective in carrying out the intended purposes of the original law. For example, the elementary and Secondary Education Act of 1965 is reviewed and amended by Congress approximately every five years. Congress enacted the Indian Health Care Improvement Act in 1976 and it has not been reauthorized since 1992.

Congress passed the Indian Health Care Improvement Act (IHCIA) in 1976 with a specific mission: to bring the health status of Native individuals and communities up to the level of other populations. Although Native people still experience significant health disparities and have lower life expectancy than the general population, progress has been made and the enhancements in S. 1057 will facilitate further improvements.

Among the key priorities of IHCIA are:

1. Equivalence: To end disparities, control diseases and environmental hazards, and to provide equivalent basic and specialized medical resources.
2. Quality: To assure quality services and facilities. To facilitate and support provider training and to help Native people become health professionals.

3. Local Control: To allow tribes and urban centers to fill gaps in services and to have more control over health programs to meet local needs.
4. Coordination: To permit the collection of monies from insurance companies, Medicare, Medicaid, Children's Health Insurance Program and other sources.

Highlight on Key Provisions of S.1057

Behavioral Health Programs

Indian Country strongly supports Title VII of S. 1057 authorizing comprehensive behavioral health programs which reflect tribal values and emphasizes collaboration among alcohol and substance abuse programs, social service programs and mental health programs. Title VII addresses all age groups and authorizes specific programs for Indian youth including suicide prevention, substance abuse and family inclusion.

We also need to ensure that the "systems of care" approach to mental health services is available in Indian Country.

The "systems of care" approach means more than just coordinated or comprehensive mental health services. It involves making families and communities partners in the development of behavioral/mental health services, a methodology formally recognized and encouraged by the Substance Abuse and Mental Health Services Administration (SAMHSA). In fact, an existing SAMHSA program, operated in coordination with other federal agencies, provides six-year grants to a number of Indian tribes for the express purpose of developing systems of care for mental health services in Indian communities.

Increased IHS/tribal utilization of Systems of Care methodologies for delivery of mental heath services will help tribes leverage assistance from SAMHSA, the National Institutes of Mental Health and other agencies for services to Indian children. Local evaluations of Systems of Care programs have shown less acute psychiatric hospitalizations and out-of-home placements for adolescents, better school performance and fewer crimes by children in the program. As the recent tragic events on the Red Lake Reservation have demonstrated, we must improve and enhance the effectiveness of mental health services for Indian children.

Elevation of the Indian Health Service Director

Tribal leaders have long advocated for "elevation" of the IHS Director to that of an Assistant Secretary. We believe "elevation" is consistent with the government-to-government relationship and the trust responsibility to AI/AN Tribal governments throughout all agencies of the Department of Health and Human Services (HHS). While HHS has made great strides over the past several years to address Tribal issues, the elevation of the IHS Director to that of an Assistant Secretary would facilitate the development of AI/AN health policy throughout the Department and provide greater collaboration with other agencies and programs of the Department concerning matters of Indian health.

The disparities in Indian health indicators compared to the general population requires us to assert that we need to approach our responsibilities differently. Status quo is not acceptable. We believe that "elevation" would be comparable to the administration of the Bureau of Indian Affairs programs by an Assistant Secretary in the Department of Interior and the Assistant Secretary for Public and Indian Housing in the Department of Housing and Urban Development.

Bipartisan Commission

The NSC strongly supported the authorization of an Entitlement Commission to study and make recommendations for the optimal manner in which to provide health care to AI/AN. Indian tribes ceded 400 million acres of land to the United States in exchange for promises of health care and other services, a fact that is reflected in treaties. We believe these documents and actions secured a de-facto contract, which entitles Native peoples to health care in perpetuity and are based on moral, legal and historic obligations of the United States. An Entitlement Commission would provide recommendations to Congress concerning the delivery of health care and other services to Indians, and advise Congress about which should be discretionary or entitlement programs. The NSC recommendation is addressed in S. 1057, Title VIII, Sec. 814, which authorizes a National Bipartisan Commission on Indian Health Care.

Alaska Dental Health Aide Program (DHA) – A Local Solution to a Crisis

Alaska has a severe shortage of dentists. Imagine your child has an unbearably painful toothache and the dentist comes to your community just once a year. In fact, the only ways in or out of your village is by boat or airplane; and, the airfare is several hundred dollars.

Tribal and IHS dentists make the care of children's teeth their first priority; thus, an adult may not get an appointment during the dentist's annual visit. This is reality for approximately 85,000 Alaska Natives in rural Alaska. Alaska Natives are fighting an epidemic of dental decay and have implemented the Alaska Dental Health Aide (DHA) program as an effective means of fighting these conditions. DHAs are needed to address shocking rates of oral disease in Alaska; for example, Alaska Natives suffer rates of dental caries 2.5 times the national rate; one-third of rural Alaska school children miss school because of dental pain; one quarter of the children report covering their laughter or smiles because of the way their teeth look. A few more startling statistics are detailed in the chart below.

American Indian and Alaska Native Children		
Age	**Have had caries**	**Untreated caries**
2-4	79%	68%
6-14	87%	66%
15-19	91%	68%

The DHA Program is a local solution to a critical problem and consists of a specialty practice area focused on prevention, relief of pain and infection, and basic restorative services. Dental Health Aides and Therapists provide sorely needed access and continuity of dental care in rural Alaska. The DHA program is authorized under section 121 of the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1616l.

The American Dental Association has been advocating for the removal of this authorization, arguing that DHAs do not have the training necessary to perform within their scope of practice. It is important to note that DHAs must meet rigorous requirements, which includes training that

requires hands-on practice under a dentist's supervision; continuous education; federal certification; and, ongoing performance evaluations.

DHA therapists receive two years, or 2,400 hours, of classroom training and clinical experience. They spend about 760 hours in a clinic treating children. While in college, they perform more clinical procedures than the average graduate of American dental schools experience.

While DHAs are new to the United States, New Zealand has a 75-year history of success in using dental health paraprofessionals. The World Health Organization shows that dental health aide/therapists now work in 42 countries, including Great Britain and Canada. After Canada started its program, the ratio of teeth pulled to teeth fixed dropped from over 50 percent to less than 10 percent. A study of the Canadian effort compared the work of dental therapists and dentists and found that the quality of restorations by therapists equal that of the dentists.

Significantly, organizations with a profound interest in public health, but no profit motive, support the DHA program. Some of these include the Indian Health Service, under Director Dr. Charles Grim, who is a dentist; the Alaska Department of Health and Social Services, whose Commissioner, Joel Gilbertson, said [DHA] "holds great promise for addressing the profound dental problems of rural Alaskans, and we applaud Congress for giving the program a chance to demonstrate its potential for success" and the American Association of Public Health Dentistry.

America has seen this kind of resistance to mid-level health practitioners and physician extenders for many years. For example, chiropractors fought for more than a decade to provide patient care, unfettered, within their scope of practice, despite vociferous objections by the American Medical Association. That conflict was decided in favor of the chiropractic profession in the Supreme Court decision on *Wilk, et. Al .v. AMA*. Nurse Anesthetists, Osteopathic Physicians, occupational therapists, physical therapists and other health professions have fought, and continue to fight, battles similar to the one the DHAs now face. Today, mid-level medical personnel have proven to be an effective, cost efficient and important part of the health care team. We support the DHAs as part of a health care team.

Long-Term Care – An Innovation for Indian Country

Title II, Section 213 provides for the authorization for the Indian Health Service and Tribally-operated health systems to provide long-term health care, assisted living, home health services, hospice, and other related programs. While the life expectancy of American Indians and Alaska Natives is substantially lower than the rest of the general population, the ability to provide health care and related services for the elderly population remains one of the most pressing issues for Indian country. The need to improve and expand services for all stages of the life cycle are desperately needed, however services utilized during the waning years of life are severely lacking in AI/AN communities. If you were to ask American Indians and Alaska Native what services or programs are absent and/or inaccessible in Indian Country, the response you will receive is long-term health care, quality nursing homes, home-health programs, hospice and other similar programs.

Health & Wellness Foundation

Title VIII of S. 1057 authorizes the establishment of the Native American Health & Wellness Foundation, which is a new authorization for the Indian Health Care Improvement Act.

The Foundation will be a charitable and non-profit federally chartered corporation. The duties of the Foundation shall be to encourage, accept and administer private gifts of real and personal

property, and any income from or interest in such gifts for the benefit of, or in support of, the Indian Health Service. We see the Foundation as an exciting opportunity to supplement the funding for the HIS; and, we emphasize any funding provided to the IHS by the Foundation should not supplant Federal appropriations to the IHS.

Centers for Medicare & Medicaid Services (CMS)

In response to the growing importance to Indian country of programs administered by the Center for Medicare and Medicaid Services (CMS) which includes the S-CHIP program, the National Steering Committee (NSC) for the reauthorization of the IHCIA and Tribes recommended the establishment of a formal consultation body for CMS to assist in the development of CMS Indian policy and regulation. In response to these requests CMS established a Tribal Technical Assistance Group (TTAG).

The TTAG has been active in reviewing the impacts of the recently passed Medicare Modernization Act (MMA). The first round of MMA implementation focused on the Transitional Assistance program which was touted as a "new benefit" for seniors, especially low income seniors. Unfortunately, the roll out was too slow and the program too confusing to have much affect in Indian country. Out of a nationwide projected benefit of $12,000,000, only a little over $1,000,000 was actually collected by IHS and Tribal programs. The implementation of the permanent program (Medicare Advantage and Part D Pharmacy Benefits) is occurring under statute with less Indian specific language than the Transitional Assistance section. Of particular concern going forward is the affect of the MMA on dual eligibles who currently receive their pharmacy coverage through the Medicaid program. Low income elders make up a large portion of the Indian elder population. Like other elders they are confronting confusion of enrolling in a plan and face new co-payments for services. They will also experience the gap in coverage when their costs exceed the $1500 initial coverage limit. These clients will expect their IHS and Tribal Clinics to pay for their pharmaceuticals after they fully utilize their Part D coverage. Sadly, IHS expenditures will not be counted toward the threshold to qualify for catastrophic coverage under Part D. IHS will have to absorb all pharmacy costs for Indian elders up to the **$3600 annual True Out of Pocket costs (TrOOP).**

Of equal concern is the issue of charging Indian clients premiums and co-pays. We recommended that premiums and co-payments should be waived as was done in the State Children's Health Insurance program. Some provisions of the MMA will be helpful to Indian country such as the "capping" of Contract Health Service payments at Medicare rates and reimbursement for hospital emergency treatments provided to undocumented immigrants. These issues and the establishment of the CMS/TTAG is reflective of recognition by both CMS and Tribes of the increasing importance of CMS programs to improving the health of the Indian communities.

Reauthorization Is Important

Health Disparities in Indian Country

Indian Country must have access to modern systems of health care. Since the enactment of the IHCIA in 1976, the health care delivery system in America has evolved and modernized while the AI/AN system of health care has not kept up. Reauthorization of the IHCIA will facilitate the modernization of the systems of health care relied upon by 1.8 million AI/ANs. S. 1057 authorizes concepts and methods of health care delivery for AI/AN in the same manner already considered standard practice by "mainstream" America. There is a critical need for health promotion and disease prevention activities in Indian Country and provisions of S. 1057 address

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

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

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

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

Public health indicators, such as morbidity and mortality data, continue to reflect wide disparities in a number of major health and health-related conditions, such as Diabetes Mellitus, Tuberculosis, alcoholism, homicide, suicide and accidents. These disparities are largely attributable to a serious lack of funding sufficient to advance the level and quality of adequate health services for AI/AN. Recent studies reveal that almost 20 percent fewer AI/AN women receive pre-natal care than all other races and they engage in significantly higher rates of negative personal health behavior, such as smoking and the consumption of alcohol and illegal substances during pregnancy.

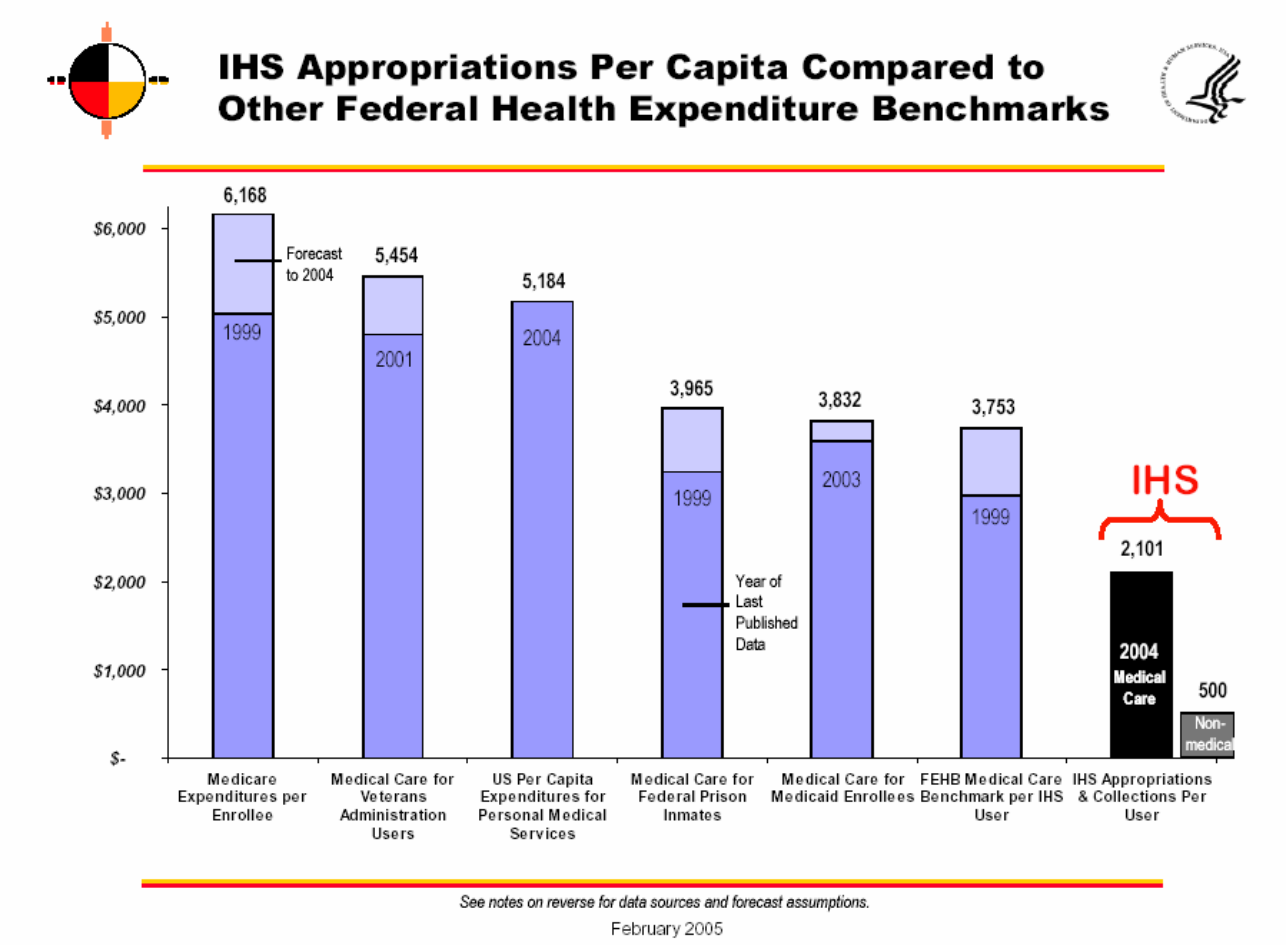
A travesty in the deplorable health conditions of AI/AN is knowing that the vast majority of illnesses and deaths from disease could be prevented if additional funding and contemporary programmatic approaches to health care was available to provide a basic level of care enjoyed by most Americans. It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

Funding Realities

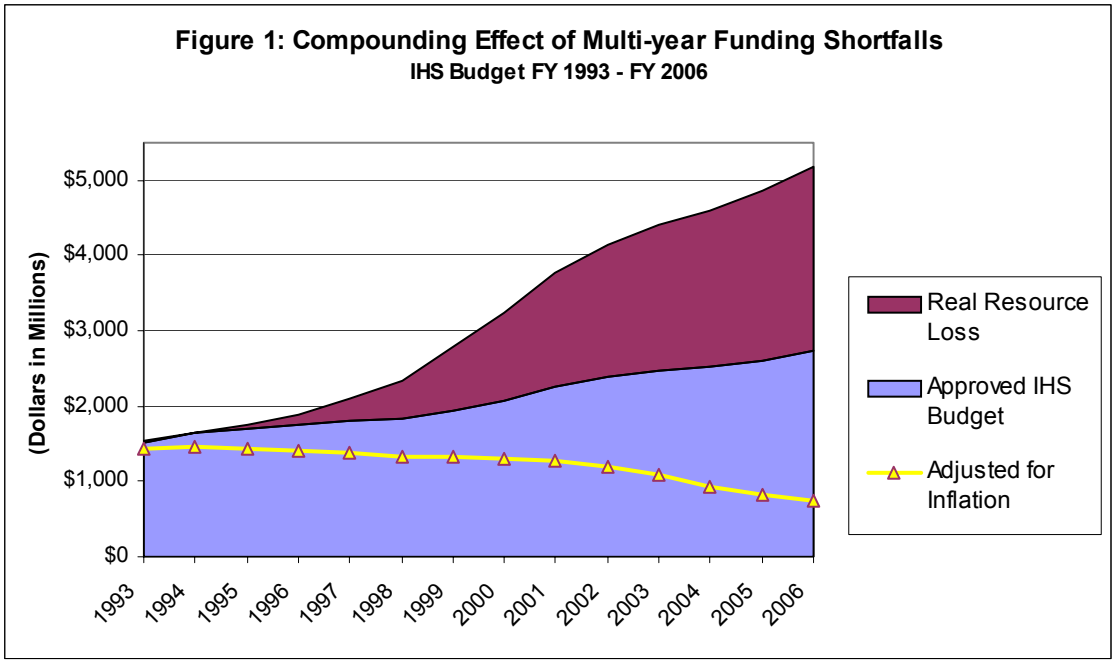
Indian Country continuously advocates for equitable health care programs and funding. Health care spending for AI/AN lags far behind spending for all other segments of society. For example, per capita expenditures for AI/AN beneficiaries receiving services in the IHS are approximately one-half of the per capita expenditures for Medicaid beneficiaries. In fact, the federal government spends nearly twice as much money for a federal prisoner's health care than it does for AI/AN.

When an AI/AN elder requires medical care, they may not receive it, or if they do, it could be at substandard levels.

Funding for the Indian Health Service (IHS) has not kept pace with population increases and inflation. While programs such as Medicare and Medicaid accrue mandatory annual increases to address inflation, the IHS does not receive comparable increases. According to the United States Commission on Civil Rights report entitled "A Quiet Crisis," between 1998 and 2003, industry experts estimate that medical costs grew approximately 10 to 12 percent annually, while IHS funding increases are less than 5 percent annually. Consequently, a large and expanding gap exists between needed and available services, or unmet needs, in Native American communities. The following chart, prepared by the IHS, further demonstrates this standard practice of funding disparities in federally supported health care programs.



The following graph illustrates the diminished purchasing power of the IHS budget over the past fourteen years. The graph demonstrates the compounding effect of multi-year funding shortfalls that have considerably eroded the IHS base budget. In 1993, the IHS health services accounts received $1.52 billion; and, had the accounts received adequate increases for inflation and population growth, that amount would be $5.2 billion today. The Northwest Portland Area Indian Health Board estimates that the IHS budget has lost over $2.46 billion over the last fourteen years.



Trust Obligations of the Federal Government

The federal responsibility to provide health services to AI/AN reflects the unique government-to-government relationship that exists between the Tribes and the United States. The importance of this relationship is reflected in the provisions of Article I, § 8, clause 3 of the United States Constitution, which gives the federal government specific authorities in its dealings with Indian Tribes.

Article VI, § (2) of the United States Constitution refers to all treaties entered into under the Authority of the United States as the "Supreme Law of the Land." Treaties between the federal government and our ancestors – negotiated by the United States government in return for the cession of over 400 million acres of Indian lands – created a fiduciary responsibility for the federal government to provide American Indians with health care services and adequate funding for those services. Additional Treaties, Statutes, U.S. Supreme Court decisions and Executive Orders have consistently reaffirmed this Trust responsibility.

The Snyder Act of 1921 has been the foundation for the many federal programs for Tribes instituted since its enactment, including programs targeting Indian health. It authorizes broad authority for Congress to appropriate funds to preserve and improve the health of AI/AN.

Since 1964, three public laws have dramatically changed the delivery of health care to the Tribes. First, the Transfer Act of 1954 removed responsibilities for health care of AI/AN from

the federal Department of the Interior to the, then, Department of Health, Education and Welfare (HEW).

Second, the Indian Self Determination and Education Assistance Act of 1975 changed forever the nature of relationships between Tribal organizations and the federal government and revolutionized the manner in which health services are delivered in Indian country. The Act provided guidance and direction to IHS to enable it to work with Tribes to develop Tribal based health systems in which Tribal organizations are authorized to operate their own health programs.

Approximately half of all appropriations to the IHS fund programs that are operated directly by Tribes administering health care systems offering local, accessible and coordinated services responding to the needs of individual Tribal members. In a 1998 NIHB study "Tribal Perspectives on Indian Self Determination and Self Governance in Health Care Management," 94 percent of the Tribal leaders and health system directors surveyed reported plans to enter into Self Determination or Self Governance agreements with the IHS. Tribally operated systems reported significantly greater gains in the availability of clinical services, community-based programs, auxiliary programs and disease prevention services. In most cases, Tribes contracting or compacting with IHS reported improved and increasingly collaborative relationships with the agency, with both IHS Area Offices and Tribal organizations working together to facilitate the transfer of program management.

Finally, with its comprehensive, far-reaching provisions, the Indian Health Care Improvement Act of 1976 created opportunities for enhancement of services to Tribes through innovative interventions that are responsive to the health needs of the Tribes and their members. Tribes and the IHS have intervened to achieve positive changes under the Act which includes: virtually every component of service delivery; health professions training, recruitment and retention; targeted disease prevention and treatment; funding of health systems; and mechanisms for integrating Tribal systems with federal programs, such as Medicaid and Medicare.

PART

We have worked hard over the last six years on the reauthorization of the IHCIA and hope that the 109th Congress will pass this important legislation which authorizes effective programs.

One of the ways to determine the effectiveness of federal programs is the Program Assessment Rating Tool (PART), developed by the Office of Management and Budget (OMB), which is used to evaluate programs and link performance to appropriations. The PART assessments review overall program effectiveness, spanning from how well a program is designed to how well it is implemented and what results are achieved. As such, the PART examines factors that the program or agency may not directly control but may be able to influence. For example, if a PART assessment identifies a statutory provision that impedes effectiveness, the agency may propose legislative changes to fix it. The PART is central to the Administration’s Budget and Performance

Integration (BPI) Initiative because it drives a sustained focus on results. To earn a high PART rating, a program must use performance to manage, justify its resource requests based on the performance it expects to achieve, and continually improve efficiency; all goals of the BPI Initiative.

Year	Program	Avg. Score	Rating
FY 2004	Federally Administered programs	78.0%	Moderately Effective
FY 2004	Sanitation Facilities Programs	84.8%	Moderately Effective
FY 2005	Urban Indian Health	70.5%	Adequate
FY 2005	Resource & Patient Management System	86.8%	Effective
FY 2006	Health Care Facilities Construction	95.8%	Effective

The Indian Health Service (IHS) and tribes have been active participants in the PART reviews conducted by OMB and embrace the process as a means to provide critical outcome analysis for documenting improvements in the delivery of health care to AI/AN people. Since FY 2004, IHS has had five of its programs reviewed under PART. All of the IHS programs that have been rated under PART have at least an "adequate" rating with an average score of 83.2%. Moreover, the IHS has continually scored better than other agencies within the Department of Health and Human Services under PART. The IHS Health Facilities Construction program has received one of the highest scores in the federal government receiving 100% in three of the four PART categories for a combined score of 95.8%.

Agency	Avg. Score
Indian Health Service	83.2%
Centers for Medicare & Medicaid Services	78%
Health Resource Services Administration	64%
Federal Drug Administration	58%
Depart of Defense*	55%
Centers for Disease Control	53%
Administration for Children & Families	49%
Veterans Administration*	47%
HHS Total (not including IHS)	57.8%
* Health Care Components only Source: OMB, available at: www.whitehouse.gov/omb/budget/fy2006/pma/hhs.pdf	

The IHS is currently working with Office of Management and Budget on a PART submission for its direct tribally operated health programs. The outcome of that PART review will not be

known until later in the year. However, based on the performance of past IHS submissions, it is anticipated that the direct tribally operated programs will be reviewed favorably by OMB.

While PART reviews are used to justify and substantiate funding requests in the appropriations process, the IHS has used the information to identify opportunities to improve its programs and operations. For example, the urban program is being reviewed by a task force of stakeholders specifically charged by the IHS Director to make recommendations for addressing the specific deficiencies identified by the PART assessment. The other IHS programs assessed under PART are also using the insights gained by the evaluation to make improvements internally.

The available evidence does not support that there are any design flaws associated with programs operating under the IHCIA. The success and effectiveness of IHCIA programs are further supported in the "results" of the PART assessments. From our perspective the IHS programs represent a success story for effectiveness. The IHS PART scores combined with system changes resulting from knowledge gained in the PART process speak to the effectiveness of using government resources to carry out health care services to Indian people. The effectiveness of the IHCIA and its programs are clearly demonstrated in the PART process and substantiates our strong position that reauthorization of the IHCIA should not include any regression from current law.

Again, thank you for providing me this opportunity to present testimony.