



**Testimony of Geoffrey Roth, Executive Director
National Council of Urban Indian Health before the
Senate Committee on Indian Affairs
Regarding Healthcare Reform
June 11th, 2009**

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

The 2000 Census reported that 66% of individuals identifying as American Indians and Alaska Natives reside off reservation¹ and IHS estimates that roughly 930,000 of those living in those locations are eligible for services at Urban Indian Health Clinics. Our clinics are often the main, if not sole, source of health care for those off-reservation communities. The Urban Indian Health Program is a small, but critical and innovative component of the Indian health delivery system. Congress has repeatedly stated that the Trust Responsibility to provide health care extends to Native Americans regardless of where they reside; the Urban Indian Health Program works to fulfill that solemn obligation.

Congress has repeatedly acknowledged that the government's Trust Responsibility extends to American Indians and Alaska Natives (AI/AN) living away from their tribal homes. From the original Snyder act of 1921² 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

¹ US Census Bureau. *We the people: American Indians and Alaska Natives in the US. Special Report*, 2006

² Snyder Act, Public Law 67-85, November 2, 1921.

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

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

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

Developing the Urban Indian Health Program: The Urban Indian Health Program has always been considered a minor, secondary part of the Indian health delivery system with off-reservation communities being an after-thought in the provisioning of health care for American Indians and Alaska Natives⁵. While the government-to-government relationship between the Tribes and the federal government is deeply important to the continued wellbeing and development for all American Indians and Alaska Natives, the federal government owes a trust obligation to off-reservation communities that will remain unfulfilled as long as the UIHP continues to be underdeveloped and underfunded⁶. Health care reform offers a unique opportunity to truly develop the Urban Indian Health Program into an entity capable of serving the needs of all American Indians and Alaska Natives living away from their tribal homes⁷. The discussion of health care reform must be centered on patient health and reforming the health delivery system to provide the best possible health care outcomes. Urban Indian health clinics

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

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

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

⁶ *Ibid.*

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

and programs have proven that they are efficient, effective health care providers that reduce health disparities for their patients in ways that no other provider can match⁸. UIHP clinics and programs see patients from every Tribe and every walk of life; providing culturally appropriate health care that otherwise would not be available to American Indian and Alaska Natives living off reservation⁹.

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

Health Data Collection—the lack of sufficient health data collection systems for American Indians and Alaska Native health delivery systems is not a new problem. The Tribal Technical Advisory Committee for CMS has long maintained that CMS fails to collect adequate data on American Indians and Alaska Natives enrolled in Medicaid, Medicare, and SCHIP¹⁰. The Urban Indian Health Institute (UIHI), an epidemiology center dedicated to Urban Indian health, further reports that health research data rarely includes data specific to American Indians and Alaska Natives, much less for those AI/AN who live in off-reservation communities¹¹. Private foundations and research centers have also reported difficulty in capturing health data for American Indians and Alaska Native communities¹². Government research agencies, such as the Agency for Healthcare Research and Quality (AHRQ) also report difficulty in securing American Indian and Alaska Native data sets, resulting in AI/ANs being absent from, or only briefly mentioned in key reports¹³.

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

⁸ Testimony of David Rambeau, *Advancing Indian Health Care* before the Senate Committee on Indian Affairs, 2/5/2009

⁹ See, Letter to the House Committee on Interior Appropriations from the National Association of Community Health Centers, 1/20/2007.

¹⁰ Tribal Technical Advisory Group to CMS, *American Indian and Alaska Native Medicaid Program and Policy Data Summary Report*, February 2009; National Council of Urban Indian Health, *Urban Indian Health Programs Survey* 2008

¹¹ Urban Indian Health Commission 2007, Robert Wood Johnson Foundation Report: *Invisible Tribes: Urban Indians and their Health in a Changing World*, Urban Indian Health Institute 2007.

¹² See Kaiser Family Foundation, *Key Health and Health Care Indicators by Race/Ethnicity and State* 4/01/2009

¹³ *National Healthcare Disparities Report*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, 2008

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

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

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

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

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

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

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

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

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

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

Cost Sharing and Penalties—In order to preserve the trust responsibility owed to Native people for the cessation of their lands, no penalty on any Indian individual who fails to obtain such insurance can be levied. NCUIH feels very strongly that it is not only bad law for any penalty to be assessed against an Indian individual who fails to obtain health insurance; it is morally reprehensible to force American Indian and Alaska Native individuals to pay for health care in any way whether it be cost-sharing or a penalty. We believe that current federal law protections afforded to Indian people and passed in the American Recovery and Reinvestment Act¹⁴ must apply to their participation in any health insurance plan. We believe that the trust responsibility demands that Indians be exempted from all cost-sharing (including premiums, co-pays, and deductibles), which is consistent with recent amendments to the Social Security Act.

The issue of cost-sharing in public health programs is especially important for off-reservation Indian people who are often underemployed, low income, and with complex health needs¹⁵. Indian people living away from their tribal homes are likely to be eligible for enrollment in Medicaid or Medicare, and these programs may be their only source of health care if they do not live near one of the 36 Urban Indian health programs and clinics. Even when they do live near UIHP or Tribal health provider, enrollment in these services is necessary for the financial stability of the Indian health provider which provides care to these individuals.

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

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

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

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

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

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

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

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

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

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

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

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

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

Indian Affairs. Passing the Indian Health Care Improvement Act Reauthorization and making serious progress on improving the health of all American Indians and Alaska Natives is the first priority for NCUIH. We believe that our clinics would be in a stronger position to deliver care in these difficult times¹⁶ if IHCA had been passed in an earlier Congress. However, this Congress, with the health care reform debate blazing, is perhaps the single best opportunity we may have to pass the IHCA reauthorization. NCUIH urges the Senate Committee on Indian Affairs to consider re-including the Urban Indian health programs in the provisions listed below:

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

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

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

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

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

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

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

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

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

Proposed New Section: Federal Tort Claims Act Coverage for Urban Indian Organizations –

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

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

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

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

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