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THE INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2007

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

ON

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H.R. 1328, THE INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2007

THURSDAY, JUNE 7, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 11:12 a.m., in room 2322 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Schakowsky, Solis, Hooley, Matheson, Deal, Sullivan, Wilson, and Burgess.

Staff present: William Garner, Amy Hall, Bobby Clark, Nandan Kerkeremeth, Chad Grant, Melissa Sidman, and Ken Keremath.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I call the meeting of the subcommittee to order, and I want to apologize for being so late. Unfortunately, we have so much to do in a short week here, and I wanted to make sure that we did in fact have this hearing on the Indian Health Care Improvement Act, but we are kind of fitting it in between a bunch of other things.

The hearing today is on H.R. 1328, the Indian Health Care Improvement Act amendments of 2007 and I recognize myself initially for an opening statement.

This is a bill that I introduced earlier this year with Representatives Nick Rahall and Don Young to reauthorize the Indian Health Care Improvement Act. Let me start by saying that I think this hearing is long overdue. The Indian Health Care Improvement Act expired 7 years ago in 2000. While there have been several attempts to reauthorize the legislation in previous Congresses, sadly none has been successful. In fact, this is the first time since the law expired that a hearing has been held in the Energy and Commerce Committee on reauthorizing it, and as someone who is very familiar with Native American issues, and particularly the health care issues they face, let me be the first to say that the failure of Congress to reauthorize the Indian Health Care Improvement Act had a very real impact, negative impact on Indian communities. I have no doubt that lives have actually been lost due to inaction, and it is my hope that my colleagues on the subcommittee will walk away from today's hearing understanding that Indian Country can no longer afford to wait. The unmet health needs of Amer-

ican Indians and Alaskan Natives are alarmingly severe and grow worse every day that we fail to act.

The statistics speak for themselves. Native Americans suffer disproportionately from almost every condition or disease when compared to the general population from obesity to diabetes and heart disease to HIV/AIDS. All are epidemics that are ravaging American Indian communities, which have too few resources to respond. A large part of the problem is that American Indians have greater difficulty in accessing quality health care services. For far too many years there has been a growing divide between the health care services afforded Native American communities and other segments of the population. In example after example, Native Americans do not receive the level of service comparable to other Americans, and I think the most shocking example that often comes to my mind is that we currently spend nearly twice the amount on health care services for Federal prisoners than we do for Native Americans, and I think that is unconscionable, especially given our trust responsibility to provide Native Americans with health care services according to the numerous treaties and agreements we have signed with them.

Native Americans have great difficulty in accessing the most simplest of services which many of us take for granted such as primary medical care, dental and vision services. Lengthy wait times, distant locations and transportation challenges act as significant barriers to receiving care. According to the GAO, Native Americans could expect to wait between 2 and 6 months or have to travel between 60 and 90 miles to receive certain services, and needless to say, specialty services are even harder to come by in Indian country. I can't imagine that any of us would tolerate such conditions so why should we expect Native Americans to do so.

This critical piece of legislation will help improve access to health care for the nearly 2 million Native Americans in this country. Specifically, the bill would improve the supply of health professionals in the Indian health system by creating new opportunities for American Indians and Alaskan Natives to pursue health careers. It would facilitate the construction and maintenance of safe water and sewage facilities and of hospitals, clinics and other health facilities and provide funding for urban Indian health programs as well, and these are just a few of the provisions in the bill that will help improve the current Indian health care system.

I mentioned in the beginning of my statement that I think today's hearing is long overdue and is a much-needed step towards accomplishing our goal of reauthorizing this important legislation. Even though it has been 7 years since we have been trying to do this, I am still pretty optimistic, but I just want to stress that it is going to take a lot of hard work. We want the administration's position. In the past, as you know, we have waited until the second year or the end of the Congress to try to address this and then found out that there were objections by the administration or that there was difficulty with the other body. So we are trying to start out early. The bill already passed out of the Resources Committee and I think that we are going to take on the responsibility, and I will ask our ranking member that we really want to sit down with the administration, sit down on both sides of the aisle and come up

with a bill that can pass, and I don't mean just pass the House, come to conference with the Senate, and be signed by the President. But that is not going to be easy to do, but I am making that commitment that that is what we are going to do. We are not just passing this out of here to some other committee or to the floor. We are passing this out of here with a bill that we think can be signed by the President. That is our goal.

There is quote from Lone Man of the Teton Sioux Indians that I was reminded of recently. It is, "I have seen that in any great undertaking, it is not enough for a man to depend simply on himself," and so what I am saying is, we need everybody to help us out here. We need the tribes, we need the administration, we need the health advocates, but we are going to move forward, and I just want to thank our witnesses. I think it will be a good hearing but we have got a lot of work to do.

With that, I will yield to our ranking member, Mr. Deal.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. I share your concern and interest in this issue and I am thankful that we got a referral on this legislation so that our committee can have some input into it. I look forward to the witnesses' testimony as we examine the proposed legislation, and hopefully, their input will allow us to make this legislation workable.

One aspect of the legislation that is before us though was always of concern and importance to my friend and a friend of everyone on this committee, the late Congressman Charlie Norwood. Charlie always expressed reservations regarding certain procedures that were being performed by dental health aides and dental health therapists in Alaska, and I recognize the unique dental health needs presented by the rural nature of Alaska, and I understand that this has led to the use of the therapists there. However, Dr. Norwood always raised an important concern about the irreversible nature of some of the procedures performed by these therapists, and I believe that Dr. Grim, who is one of our witnesses, is a dentist and I would be interested in hearing his opinion on this particular subject.

I am also especially concerned with how the legislation before us addresses the Medicaid and SCHIP programs. Nominal cost-sharing or co-payments have a role to play in these programs and I am concerned about any legislation that removes this flexibility. I understand H.R. 1328 contains other provisions which deal with the Medicaid and SCHIP and I hope our witnesses could speak to some of the changes that are being proposed.

Again, I look forward to the testimony of the witnesses, I welcome them here, and I yield back my time, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Deal.

The gentlewoman from California, Ms. Solis. You don't want to go next?

Ms. SOLIS. No.

Mr. PALLONE. It is order of seniority before the gavel, and then after the gavel, it is based on who shows up, and if I could compliment the gentlewoman from California because I know that she

took the lead on this whole issue of health care disparities and worked with the Native American Caucus and Hispanic Caucus and she has really been a champion on that.

I yield to the gentlewoman.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Mr. Chairman, and I am delighted to be here and to hear our witnesses today. It is true that the Native American population, in my opinion, has been sorely underserved for many, many years. I represent Los Angeles County, and we have, I believe, services provided to about 155,000 Native Americans who come through our one and only facility there in L.A. County. If you think about L.A. County, you are talking about well over 11 to 12 million people and those individuals that do come through are self-identified. There are so many more that are not even aware of services so this is a very timely piece of legislation, and I want to thank our chairman and all the members and people like myself who really understand that there is a really urgent need to increase services. We should not be in a predicament where the President is saying there is no value to these programs, and we continue to see chronic illnesses come before us here when we hear about them and the cost to society overall. I just think that that is an assault on our communities and especially communities of color where we are the populations that are continuing to grow.

I just want to say I am very excited to hear the witnesses today and know that there is a lot of issues that are at hand, one of which I think is having an adverse effect on many of our patients right now that receive Medicaid to show verification, verification from our tribes that they are eligible for this assistance. In many cases we have people that were born there on the reservation and may not have the appropriate paperwork or processes available to help establish their legitimacy.

So those are really important issues that we need to address, and I applaud those witnesses and the chairman and members that are supportive of this legislation. Thank you.

Mr. PALLONE. Thank you.

The gentlewoman from New Mexico.

OPENING STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mrs. WILSON. Thank you, Mr. Chairman. This is a very important day in Indian Country. I look back at when the last time was that this committee held a hearing on Indian health care and it was actually 1991. At least that is the latest one that we can find, so this day is long overdue, from my perspective.

The Indian Health Care Improvement Act was first enacted in 1976, and as the chairman said, the authorization expired almost 7 years ago. This bill of which I am a cosponsor will help address the high rates of diabetes by helping tribes identify and reduce the incidence of diabetes. It directs the IHS to screen all Indians receiving services for diabetes. It tries to improve nutrition programs

and exercise programs, authorizes dialysis programs and creates diabetes control officers in each IHS area office. It modernizes the Indian health care system, and while I still don't think it is perfect and there may be some things we need to change as we move it forward, I am very proud to be a cosponsor of legislation that establishes scholarships and loan programs to encourage Indians to go into the health profession. It authorizes construction and renovation of medical facilities, and frankly, our medical facilities in Indian Country, there is a $3 billion backlog in construction of medical facilities in Indian Country, and at the current rate of expenditure, it is going to take 120 years to overcome that backlog.

It improves services for urban Indians, about 48,000 of whom live in the greater Albuquerque area, and it creates new programs for substance abuse, for youth suicide prevention, for mental health care, for comprehensive behavioral health care and treatment programs. The truth is that teen suicide rates among American Indians is three times higher than the national average. The life expectancy among American Indians is 6 years less than the general population and diabetes is increasing. This legislation will matter tremendously to the 173,000 Indians who live in New Mexico and the 48,000 who live in the greater Albuquerque area.

It is my pleasure today to have a member of the Pueblo of Zia here, and I wanted to particularly welcome him. He will be part of the second panel. Ken Lucero is the chair of the All Indian Pueblo Council Health Committee and he has become since his involvement in public life from the Pueblo of Zia one of the State's leaders in health care and health policy with respect to Indians, and I wanted to thank him for coming all the way from New Mexico today to testify and to represent the All Indian Pueblo Council and the 19 pueblos in New Mexico so that their voice is heard on this issue.

I also wanted to welcome Ken's dad, the former governor of Zia Pueblo. Gilbert Lucero is here. Sir, I wanted to thank you for coming. We are honored by your presence.

Chairman Pallone, thank you for your leadership in introducing this bill. I really would like to see this bill brought to a markup before our July 4 recess. I agree with you that we need to get this moving and out of the House so that we get legislation to the President's desk and get this job done. The Resources Committee passed it through their committee on April 25. I think it has one more stop to go after it sees us but we need to move this legislation forward, get the job done and get the signature by the President of the United States. It will be a great advancement for Indian health care. There is more needed to reduce the disparities in health status and address the health concerns of Indian people, and we need to work not only on this bill but to make sure that the appropriations are there to accomplish the goals set out in this piece of legislation.

I thank you, Mr. Chairman.

Mr. PALLONE. Thank you, but I have a word of caution: we are not going to be able to do this by July 4 recess. I wish I could but we just have so many things to do with PDUFA and SCHIP and everything else that I can't make that commitment. We wanted to

get the hearing in but I don't think we are going to be able to mark it up that quickly.

We have two votes, 12 minutes left on the first one and then the second one is a 5-minute. I would like to get a couple of these in but I don't know if we can get all three in, so we will start with Ms. Hooley.

OPENING STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Ms. HOOLEY. Thank you, Mr. Chairman.

I particularly want to express my appreciation for your strong leadership on Native American health issues. You have long been recognized as a champion on those issues. With your continued leadership on the Indian Health Care Improvement Act, I hope that we can finally pass this important piece of legislation. Our tribes have been waiting since 1999 while we have been considering reauthorization of this act. This bill takes an important step to help fulfill our promise and our obligation to provide health care for American Indians and Alaskan Natives.

To understand the sense of the need for this legislation, we need to look no further than to the disconcerting statistics about health care outcomes for Native Americans. A 2004 report on the health of American Indians reads that Native Americans are 770 percent more likely to die from alcoholism, 650 percent more likely to die from TB, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents, and 52 percent more likely to die from pneumonia or influenza than the rest of the population. Those statistics are not acceptable and demonstrate a clear need to take proactive measures to improve health care for our tribes. The Indian Health Care Improvement Act will do just that and help our tribes meet their health care needs.

First, I believe the inclusion of health IT provisions will help modernize our Indian health care system. The promotion of home and community-based services will also provide American Indians with access to the type of services long available outside the Indian health care system. Moreover, the elevation of the Director of the Indian Health Services to assistant secretary should give the Director the enhanced authority needed to improve these appalling health care statistics for Native Americans that I noted earlier. Those are just a few of the provisions I know the Northwest Portland Area Indian Health Board and our tribes in Oregon see as particularly important to improving health care for Native Americans.

Finally, I understand that there is a tribal leader meeting later this afternoon to work on the facilities construction concerns that arose in the Resources Committee markup of the bill. I want to commend Chairman Rahall and his staff for convening this meeting so that tribes can work together toward a positive outcome on this matter. I believe a fair and equitable compromise is obtainable to ensure that tribes throughout the country have access to construction funds they need to enhance their health care infrastructure. This is an important issue not only for our tribes in Oregon but for all tribes and we look forward to a favorable outcome from today's meeting.

I thank you, Mr. Chairman. I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Illinois.

OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Chairman Pallone, for holding this hearing today and I know that you have made it a priority to reauthorize the Indian Health Care Improvement Act. I appreciate the hard work on your part toward that goal.

As Kenneth Scott, who is the director of the Indian Health Service Center of Chicago, puts it, the Indian Health Care Act has meant the difference between life and death for many of the 4.1 million American Indians and Alaska Natives living in the United States and has meant the world to those who are able to benefit from of the 34 urban Indian health programs. As the director of this program, Mr. Scott knows the importance of supporting these Indian health projects which serve approximately 330 Indians living in urban areas. I have the American Indian Center in my district in uptown Chicago and this is a very, very important service organization. The Bush administration zero-funded the urban Indian health centers because they thought community health centers could accomplish what they are doing but we know that that is not true and so this bill, H.R. 1328, does authorize funding for urban Indian health centers, and the community health centers have stated they are unable to cover the needs of urban Indians.

I look forward to hearing from our witnesses today. I am eager to hear your particular insight into the prevailing health care needs of Native Americans and Alaskan Native populations. Though we have made improvements to the delivery of health care for this population, current funding meets just half of the existing need. In fact, when compared with the general U.S. population, the American Indian and Native Alaskan population faces downright dismal health outlooks, and you have heard those statistics today, and while the rest of the Nation's health care infrastructure continues to evolve and modernize, we should take care to bring the American Indian and Alaskan Native system up to date including the integration of electronic health records. This effort should also include reinforcing the workforce available to staff these facilities. I am glad to see the initiatives in this bill that focus on scholarship programs and loan repayment programs that will help increase the number of American Indian and Native Alaskan medical professionals able to work on reservations and in urban Indian health service programs. Making a commitment to improving both the infrastructure and workforce needs of the Indian health service is paramount to improving access. I look forward to working with all of you toward that goal.

Thank you. I yield back.

Mr. PALLONE. Thank you.

The gentleman from Utah.

Mr. MATHESON. Mr. Chairman, in the interest of time, I will just submit a written statement for the record.

Mr. PALLONE. Thank you. Any other statements for the record will be accepted at this time.

[The prepared statements follow:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Thank you, Chairman Pallone. I thank our distinguished witnesses for appearing before the subcommittee to discuss the reauthorization of the Indian Health Care Improvement Act. I also wish to acknowledge the leadership of my friend, Chairman Pallone, for expediting this bill's consideration before the committee. I look forward to working on this important legislation to ensure that Indian Health Services has the resources to respond to the complex needs of American Indian and Alaskan Native communities.

For nearly a decade, Congress has considered the reauthorization of the Indian Health Care Improvement Act. Proposals have been offered in each of the past four Congresses, yet a reauthorization bill has never passed. Congress simply has not given sufficient priority and attention to reauthorizing this Act, even though this legislation would ensure that American Indians and Alaskan Natives receive the critical health care needed in their communities.

As this legislation moves forward, we want to meet several goals: improving tribal participation in negotiated rule-making, providing and strengthening needed health services, and addressing ongoing concerns about reimbursement provisions for Medicaid and other Federal programs.

When their lands were originally ceded, the Federal Government promised that these Native Americans would receive decent healthcare services. Unless we address the serious deficiencies in the current Indian Health Service programs, especially as they relate to accessing mental health services and urban health centers, we have failed to make good on our promise to the American Indian and Alaskan Native people.

Again, thank you Mr. Chairman for holding this hearing. I look forward to the testimony of our witnesses.

PREPARED STATEMENT OF HON. JIM MATHESON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Thank you, Chairman Pallone and Ranking Member Deal.

I want to thank you for holding this hearing today on H.R. 1328, the Indian Health Care Improvement Act of 2007. As a Member of Congress representing part of the Navajo Nation, the largest geographic Native American tribal land holding in the United States, I have had the opportunity to visit health care facilities in Utah and in Arizona. Moreover, more than 29,000 individuals in Utah are members of one of at least 35 different Native American tribes, which is why I am so concerned about improving access to health care on tribal lands.

Congress made many promises to Native Americans when it passed the Indian Health Care Improvement Act in 1976. Although that bill provided critical funding and allowed for improved access to health care for Native Americans, anyone who has been to the Navajo Nation—or to other tribal lands across this country—knows that Native Americans are still waiting for Congress to fulfill unkept promises. The current funding level for the Indian Health Service system has fallen short of the critical need. I commend you, Mr. Chairman, for sponsoring this legislation and making it a priority for this committee.

I am very supportive of Indian health services and particularly supportive of the Indian Health Service's Urban Indian Health Program (UIHP). As you may know, the UIHP provides funding for 34 non-profit, Indian-controlled and operated urban health programs across the nation. These centers are uniquely qualified to provide culturally appropriate primary health care services and outreach to urban Indians.

I look forward to learning more from our distinguished panel and working with the Committee to pass this vital piece of legislation.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

A major concern I have regarding the Indian Health Care Improvement Act is its continuance of the Community Health Aide/Practitioner (CHAP) created by the Alaska Dental Health Aide Program. Understanding that in frontier and rural areas it can be difficult to staff clinics with full-time dentists, I don't believe the way to address that gap in care is by using dental health aide therapists that have a lower

standard of training to irreversible procedures. By allowing the CHAP dental health aid therapist program to continue, I believe that IHCIA misses an opportunity to make an improvement to the dental workforce in rural and frontier areas. I hope we can work together to come up with a more workable solution that places as high a priority on access as it does on quality health outcomes.

This is by far a perfect bill and I have additional concerns with H.R. 1328's Medicaid and SCHIP provisions, but I look forward to hearing from both panels today. I hope that this committee can work together and move the Indian Health Service forward and improve health care for hundreds of thousands of Americans.

Mr. PALLONE.We will stand in recess for these two votes. We will probably be back maybe 20 minutes or so and then we will start with Dr. Grim. Thank you.

[Recess.]

Mr. PALLONE. The subcommittee will reconvene and we will now turn to our witness. Dr. Grim, do you want to come up here? I will introduce you. This is Dr. Charles W. Grim, who is Assistant Surgeon General and Director of the Indian Health Service. I welcome you for being here with us. Do you want to tell us who else you have with you?

STATEMENT OF CHARLES W. GRIM, D.D.S., M.H.S.A., ASSISTANT SURGEON GENERAL; DIRECTOR, INDIAN HEALTH SERVICE

Dr. GRIM. First, let me say thank you for holding the hearing. It is an honor to be before this committee. As Congresswoman Wilson pointed out, it has been a while since we have had an opportunity to testify before this subcommittee and we were excited to be able to do that. My name is Dr. Charles Grim. I am the director of the Indian Health Service and I am accompanied today by Mr. Robert McSwain, my deputy director for the agency; Dr. Rick Olson, who is our director for the Office of Clinical and Preventive Services; and Mr. Ron Ferguson, who is our director for the Division of Sanitation Facilities Construction. As you know, this is a very large bill with a lot of issues and so I have tried to bring a number of our subject matter experts, depending on what level of detail you all want to get in on discussing the bill.

As I said before, we are very pleased to appear before this committee to discuss the reauthorization of the Indian Health Care Improvement Act and I, like many of your colleagues, am very appreciative that you called this hearing. This landmark legislation forms the very backbone of the system through which Federal health programs serve American Indians and Alaskan Natives and it encourages participation of eligible American Indians and Alaskan Natives in these and other programs.

Two major statutes are at the core of the Federal Government's responsibility for meeting the health needs: the Snyder Act of 1921, Public Law 67–85, and the Indian Health Care Improvement Act, Public Law 94–437. As you know, this act was originally authorized in 1976. It was enacted to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs. Like the Snyder Act, the Indian Health Care Improvement Act provides the authority for the programs of the Federal Government to deliver health services to Indian people but it also provides additional

guidance in several areas. It contains specific language that addresses the recruitment and retention of health professionals serving Indian communities, the provision of health services, the construction, replacement and repair of health care facilities, access to health services and the provision of health services for urban Indian people. Since enactment of the Indian Health Care Improvement Act in 1976, Congress has substantially expanded the statutory authority for programs and activities in order to keep pace with the changes in health care services and the administration of those services.

Federal funding for the Act has contributed billions of dollars to improve the health status of American Indians and Alaskan Natives and much progress has been made, particularly in the areas of infant and maternal mortality. The Department under this administration's leadership has reactivated a very important council called the Interdepartmental Council on Native American Affairs. It allows for consistent HHS policy when working with the more than 560 federally recognized tribe, and I serve as the council's vice chairman.

In January 2005, the Department completed work ushering through a revised HHS tribal consultation policy involving tribal leaders in the process. The policy further emphasizes the unique government-to-government relationship between Indian tribes and the Federal Government and assists in improving services to the Indian community through better communications. Consultation takes place at different levels including the active participation of tribes in the development of the Department's annual budget request. For fiscal year 2008, tribes identified population growth and increases in the cost to providing health care as their top budget priorities and IHS's 2008 budget request included an increase of $88 million for those items.

While many of the HHS agencies are important to and work closely with tribes, perhaps one of the most important or most significant agency is the Center for Medicare and Medicaid Services. CMS has formed a technical tribal advisory group to provide tribes a vehicle for communicating concerns and comments to CMS on Medicare, Medicaid and SCHIP policies that impact their members, and the IHS has been vigilant about improving outcomes for Indian children and families with diabetes by increasing education and physical activity programs aimed at preventing and addressing the needs of those susceptible to or struggling with the potentially disabling disease. In addition, there is a tribal leaders diabetes committee that continues to meet several times a year at the direction of myself to review information on the special diabetes program for Indian activities and to provide general recommendations to the IHS. While the Department hasn't been a passive observer of the health needs, we do recognize that health disparities do exist among the population and are among some of the highest in the Nation for certain diseases and that improvements in access to IHS and other Federal and private sector programs will result in improved health status for Indian people.

We are here today to discuss the reauthorization of this Act and its impact on programs and services provided for in current law. The Department is supportive of the reauthorization and supports

provisions that maintain or increase the Secretary's flexibility to work with tribes and to increase the availability of health care. We are anxious to work with this committee to make progress in moving a program supportive of existing authority while maintaining the Secretary's flexibility to effectively manage the IHS program. However, in the last bill reported by this committee last year, there continued to be provisions which would negatively impact our ability to provide needed access to services. Such provisions establish program mandates and burdensome requirements that could or would divert resources from important programs. To the extent that those provisions are included in the newly introduced legislation, we hope to work with you to continue to address the concerns.

On behalf of Secretary Leavitt, we commit to work with this committee and others toward the passage of the Indian Health Care Improvement Act proposal that all stakeholders can support. My staff and I will be happy to answer any questions you may have regarding our statement.

[The prepared statement of Dr. Grim follows:]

STATEMENT OF CHARLES W. GRIM, D.D.S., M.H.S.A.

Mr. Chairman and members of the committee:

Good Morning. I am Dr. Charles W. Grim, Director of the Indian Health Service. Today I am accompanied by Mr. Robert McSwain, Deputy Director of the IHS, Mr. Gary Hartz, Director, Environmental Health and Engineering, and Dr. Richard Olson, Director, Office of Clinical and Preventive Services. We are pleased to have the opportunity to testify on the reauthorization of the Indian Health Care Improvement Act.

This landmark legislation forms the backbone of the system through which Federal health programs serve American Indians/Alaska Natives and encourages participation of eligible American Indians/Alaska Natives in these and other programs.

The IHS provides health services to more than 1.8 million federally-recognized American Indians/Alaska Natives through a system of IHS, tribal, and urban (I/T/U) health programs governed by judicial decisions and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indian/Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our duty is to uphold the Federal Government's responsibility to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor the inherent sovereign rights of Tribes.

Two major statutes are at the core of the Federal Government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, P.L.67–85, and the Indian Health Care Improvement Act (IHCIA), P.L. 94–437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the Federal Government programs that deliver health services to Indian people, but it also provides additional guidance in several areas. The IHCIA contains specific language addressing the recruitment and retention of health professionals serving Indian communities; the provision of health services; the construction, replacement, and repair of health care facilities; access to health services; and, the provision of health services for urban Indian people.

DHHS Activities

Federal funding for the IHCIA has contributed billions of dollars to improve the health status of American Indians/Alaska Natives. And, much progress has been made particularly in the areas of infant and maternal mortality.

The Department under this administration's leadership reactivated the Intradepartmental Council on Native American Affairs (ICNAA) to provide for a

consistent HHS policy when working with the more than 560 federally recognized Tribes. This Council's vice chairperson is the IHS Director, giving us a highly visible role within the Department on Indian policy.

In January 2005 the Department completed work ushering through a revised HHS Tribal consultation policy and involving Tribal leaders in the process. This policy further emphasizes the unique government-to-government relationship between Indian Tribes and the Federal Government and assists in improving services to the Indian community through better communications. Consultation may take place at many different levels. To ensure the active participation of Tribes in the development of the Department's budget request, an HHS-wide budget consultation session is held annually. This meeting provides Tribes with an opportunity to meet directly with leadership from all Department agencies and identify their priorities for upcoming program requests. For fiscal year 2008, Tribes identified population growth and increases in the cost of providing health care as their top budget priorities and IHS's fiscal year 2008 budget request included an increase of $88 million for these items.

Through the Centers for Medicare & Medicaid Services (CMS), a Technical Tribal Advisory Group was established which provides Tribes with a vehicle for communicating concerns and comments to CMS on Medicare, Medicaid and SCHIP policies impacting their members. And, the IHS has been vigilant about improving outcomes for Indian children and families with diabetes by increasing education and physical activity programs aimed at preventing and addressing the needs of those susceptible to, or struggling with, this potentially disabling disease. In addition, a Tribal Leaders Diabetes Committee continues to meet several times a year at the direction of the IHS Director to review information on the progress of the Special Diabetes Program for Indians activities and to provide general recommendations to IHS.

It is clear the Department has not been a passive observer of the health needs of eligible American Indians/Alaska Natives. Yet, we recognize that health disparities among this population do exist and are among some of the highest in the Nation for certain diseases (e.g., alcoholism, cardiovascular disease, diabetes, and injuries), and that improvements in access to IHS and other Federal and private sector programs will result in improved health status for Indian people.

The IHCIA was enacted to provide primary and preventive services in recognition of the Federal Government's unique relationship with members of federally recognized Tribes. Members of federally recognized Tribes and their descendants are also eligible for other Federal health programs (such as Medicare, Medicaid and SCHIP) on the same basis as other Americans, and many also receive health care through employer-sponsored or other healthcare coverage.

It is within the context of current law and programs that we turn our attention to reauthorization of the Indian Health Care Improvement Act.

REAUTHORIZATION

We are here today to discuss reauthorization of the IHCIA, and its impact on programs and services provided for in current law. In December 2006, the Department submitted to the Senate Indian Affairs Committee comments on proposed legislation under consideration by the 109th Congress (S.1057). Those comments also reflected concerns in the House bill (H.R.5312) and are the basis for our testimony today. Any changes introduced by the bill under review in the 110th Congress (H.R.1328) are being considered as we fully review the legislation. Improving access to healthcare for all eligible American Indians and Alaska Natives is a priority for all those involved in the administration of the IHS program. We have worked with this committee in the past and we have made progress in moving toward a program supportive of existing authority while maintaining the Secretary's flexibility to effectively manage the IHS program. However, in the last bill, H.R. 5312, there continued to be provisions which could negatively impact our ability to provide needed access to services. Such provisions established program mandates and burdensome requirements that could, or would, divert resources from important services. To the extent that those provisions are included in the new legislation, we hope to work with you to continue to address these concerns.

The Department is supportive of reauthorization of the IHCIA and supports provisions that maintain or increase the Secretary's flexibility to work with Tribes, and to increase the availability of health care. Committee leadership previously responded to some concerns raised about certain provisions and some of the changes went a long way toward improving the Secretary's ability to effectively manage the program within current budgetary resources.

I would like to note for you today our particular interest in provisions previously reported out of this Committee.

OVERARCHING CONCERNS

We have a number of general objections to the language, including, expanded requirements for negotiated rulemaking and consultation; new requirements using "shall" instead of "may"; use of the term "funding" in place of "grant"; expansion of authorities for Urban Indian Organizations; new permissive authorities; provisions governing traditional health care practices; new reporting requirements; establishment of the Bipartisan Commission on Indian Health Care; and new provisions that contemplate the Secretary exercising authority through the Service, Tribes and Tribal Organizations which is not tied to agreements entered into under the Indian Self-Determination and Education Assistance Act (ISDEAA). In addition, we have some concerns about modifying current law with respect to Medicaid and the State Children's Health Insurance Program (SCHIP) and, in some cases, we believe maintaining the current structure of Medicaid and the State Children's Health Insurance Program (SCHIP) preserves access, delivery, efficiency, and quality of services to American Indians.

We also have some more specific comments on proposals we have previously reviewed for comment.

In the area of behavioral health, proposed title VII provisions provided for the needs of Indian women and youth and expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. The Department supports this effort, but opposes language in sections 121, 201, 205, 208, 213, 704, 706, 711(b) and 712 that requires the establishment or expansion of specific additional services. The Department should be given the flexibility to provide for services in a manner that supports the priorities of Tribes and IHS, and to address specific needs within IHS overall budgetary levels.

REPORTING REQUIREMENTS

H.R. 1328 contains various new requirements for reporting to Congress, including requirements for specific information to be included within the President's Budget and new annual reports to Congress. The IHS and HHS will work with Congress to provide the most complete and relevant information on IHS programs, activities, and performance and other Indian health matters. However, we recommend striking language that requires additional specificity about what should be included in the President's Budget request and imposes new requirements for annual reports.

FACILITIES

Sanitation facilities construction is conducted in 38 States with federally recognized Tribes who take ownership of the facilities to operate and maintain them once completed. IHS and Tribes operate 49 hospitals, 247 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics supporting the delivery of health care to Indian people.

HEALTH CARE FACILITIES NEEDS ASSESSMENT & REPORT

One provision in last year's bill, section 301(d) (1), required Government Accountability Office (GAO) to complete a report, after consultation with Tribes, on the needs for health care facilities construction, including renovation and expansion needs. However, efforts are currently underway to develop a complete description of need similar to what would have been required by the bill. The IHS plan is to base our future facilities construction priority system methodology application on a more complete listing of tribal and Federal facilities needs for delivery of health care services funded through the IHS. We will continue to explore with the Tribes less resource intensive means for acquiring and updating the information that would be required in these reports.

We recommend the deletion of the reference to the Government Accountability Office undertaking the report because it would be redundant of and a setback for IHS's current efforts to develop an improved facilities construction methodology.

RETROACTIVE FUNDING OF JOINT VENTURE CONSTRUCTION PROJECTS

In last year's bill, section 311(a)(1) would permit a tribe that has "begun but not completed" the process of acquisition or construction of a facility to participate in the Joint Venture Program, regardless of government involvement or lack thereof in the facility acquisition. A Joint Venture Program agreement implies that all parties have participated in the development of a plan and have arrived at some kind of consensus regarding the actions to be taken. By permitting a tribe that has "begun or substantially completed" the process of acquisition or construction, the

proposed provisions could force IHS to commit the government to support already completed actions that have not included the government in the review and approval process. We are concerned that this language could put the government in the position of accepting space that is inefficient or ineffective to operate. We, therefore, would oppose such a provision.

SANITATION FACILITIES DEFICIENCY DEFINITIONS

Another section 302(h) (4) would provide ambiguous definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country. As previously proposed "deficiency level III" could be interpreted to mean all methods of service delivery (including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home) are adequate to meet the level III requirements and only the operating condition, such as frequent service interruptions, makes that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe it is important to distinguish between the two.

In addition, the definition for deficiency level V and deficiency level IV, though phrased differently, have essentially the same meaning. Level IV should refer to an individual home or community lacking either water or wastewater facilities, whereas, level V should refer to an individual home or community lacking both water and wastewater facilities.

We recommend retaining current law to distinguish the various levels of deficiencies which determine the allocation of existing resources.

THRESHOLD CRITERIA FOR SMALL AMBULATORY PROGRAM

Yet another section 305(b) (1) would amend current law to set two minimum thresholds for the Small Ambulatory Program - one for number of patient visits and another for the number of eligible Indians. In order to be eligible for the Small Ambulatory Program under the previously proposed criteria, a facility must provide at least 150 patient visits annually in a service area with no fewer than 1500 eligible Indians. Aside from the fact that these are both minimum thresholds and so somewhat contradictory, the proposed provisions would make implementation difficult. First, the IHS cannot validate patient visits unless the applicant participates in the Resource Patient Management System (RPMS). Since some tribes do not participate in the RPMS, it is difficult to ensure a fair evaluation of all applicants. Second, the term ″eligible Indians″ refers to the census population figures, which cannot be verified, since they are based on the individual's statement regarding ethnicity.

NEW NEGOTIATED RULEMAKING AND CONSULTATION REQUIREMENTS

In addition, we are concerned about the requirements for negotiated rulemaking and increased requirements for consultation in the bill because of the high cost and staff time associated with this approach. We are committed to our on-going consultation with Tribes under current Executive Orders, as well as using the authority of Chapter V of title 5, United States Code (commonly known as the Administrative Procedures Act) to promulgate regulations where necessary to carry out IHCIA.

The comments expressed today in this testimony do not represent a comprehensive list of our current concerns. And, we will continue reviewing H.R.1328 for any provisions that might be addressed.

I reiterate our commitment to working with you to reauthorize the Indian Health Care Improvement Act, and the strengthening of Indian health care programs. And we will continue to work with the Committee, other Committees of Congress, and representatives of Indian country to develop a bill that all stakeholders in these important programs can support. Again, I appreciate the opportunity to appear before you today to discuss reauthorization of the Indian Health Care Improvement Act and I will answer any questions that you may have at this time. Thank you.

Mr. PALLONE. Thank you, Doctor. Before I recognize myself for questions, I just wanted to say that your statement becomes part of the hearing record and you may, if you want, submit additional brief and pertinent statements in writing either in response to our questions or other things that you might want to bring in.

Dr. GRIM. Thank you, Mr. Chairman.

Mr. PALLONE. And I will recognize myself for some questions and then we will go to the other members.

As you heard me say in my opening statement, I am very frustrated over the fact that we—I say "we" collectively—the tribes, myself, many of the members have been working on this legislation essentially for more than 7 years and we haven't been successful, and I am not trying to point the finger because I am sure everybody can take some of the blame but it does seem that every time at the end of the 2-year session when we are close to getting something done that we get the administration coming in with some new objection, and it might be from HHS or it might be from the Department of Justice. That is certainly what happened last year at the end of the last Congress. And of course, what I am trying to do is avoid that this year. That is why we got it out of Resources. That is why we are here early. And as I said before, I would like to report a bill out of even the subcommittee that the President could sign. So you have got to give me some help here, first of all. I would like to have a commitment from you that the administration will work with us in good faith to reauthorize the bill this year, meaning 2007, if you would make that commitment.

Dr. GRIM. As you couldn't make a commitment by July 4, I am not sure about 2007, but I can tell you that we are very, very close within the Department to getting the comments on the bill to you. They are going through some final stages of clearances right now and we have made comments on the prior Senate bill that I think gave a lot of guidance and a number of those things were changed in the bill that you introduced so we can be very, very close to giving you some comments that I think you can work on.

Mr. PALLONE. When do you expect to give us those comments?

Dr. GRIM. I will have to get back to you for that on the record but they won't come in in the 12th hour at the end of the second year.

Mr. PALLONE. How about a month?

Dr. GRIM. It depends how many back-and-forths there are but the Department is close to getting them——

Mr. PALLONE. Well, if you could get them to us within the next month, frankly I would be happy.

Dr. GRIM. We will try to do everything we can to do that.

Mr. PALLONE. OK. Now, just briefly, because I know we don't have a lot of time, but did you want to comment on why we have this problem? It does seem like at the end we always get more objections. Is there some process thing that we need to address here to change so that it doesn't happen again and so that we move things quicker? You might not have an answer but I just——

Dr. GRIM. I would just say that we have all learned through the process that this it is a complex bill. It has a lot of sections and it touches a lot of other departments besides HHS. In a hearing that I testified before the Senate recently, who also had the Department of Justice. The Department of Justice committed as well to getting their comments and we are trying to——

Mr. PALLONE. Well, I think you hit on the point. I think since so many other departments are involved, maybe one thing I could ask you to do is to take it upon yourself to get back to us and tell us who within the administration other than HHS might have to

comment on this because I don't want to see HHS comments, then Justice and then we find somebody else has to, so maybe that is one way you can help me get back to me with whoever you think we need to have see this so that we can get everybody's comments.

Dr. GRIM. We are trying to gather all those in for you too. We are trying to make it a comprehensive set of concerns that will come forward.

Mr. PALLONE. That would address all the administration's departments?

Dr. GRIM. As much as can know at this time, yes, sir.

Mr. PALLONE. All right. Now, you mentioned objections to various provisions in the bill. Do you want to tell us what you support? What provisions in it right now would you support?

Dr. GRIM. There are a huge amount of provisions that we support and I don't know that I could go through them all, and I am assuming the committee has seen some of our comments on the previous bill and a lot of those were on the requirements, a lot of new requirements for reports that hadn't been done in the past that would draw resources away for a large——

Mr. PALLONE. Well, tell us as much as you can what you can support at this time as best you can.

Dr. GRIM. There are a lot of responses that we have made in the past that express concerns that have been addressed in areas of new requirements like negotiated rulemaking and consultation. There were a lot of requirements for negotiated rulemaking and consultation and a number of those have removed. There were some new and expensive requirements that have also been addressed, and we appreciate those responses to allow the Secretary to maintain flexibility to the greatest extent possible. I noted the reporting requirements that we felt were labor and time intensive and we note that there is at least one instance where such a requirement was addressed in this bill. One provision that restricted the Secretary's authority in the development of regulations also appears to have been addressed under section 802 in regulations, and we realize that was a very important accommodation that you all made. It will ensure that our resources are focused and prioritized by those most closely involved in program administration. Also, there were several provisions in the bill that we had made comments on, those comments that went in in December to the Senate that have been revised in this version of the bill. And so there have been numerous things that have already been addressed and——

Mr. PALLONE. Well, maybe again if you would in writing get back to us to tell us what you support, OK? Because I think you tell us what you don't like but I would like to know more about what you think you support at this time.

All right. My time has run out. I recognize the gentlewoman from New Mexico.

Mrs. WILSON. Thank you, Mr. Chairman. I neglected to do so in my opening statement, but I would like to ask for unanimous consent to include in the record a letter of support for this legislation from the Pueblo of Zia, from the All Indian Pueblo Council, and from the New Mexico State Legislature.

Mr. PALLONE. Without objection, so ordered.

Mrs. WILSON. Thank you, Mr. Chairman.

Doctor, the Acoma-Canoncito-Laguna Hospital in New Mexico is running a $4.6 million deficit, many believe due to poor management by the Indian Health Service. Apparently, individuals, IHS officials that are overseeing the hospital apparently were allowed to borrow some $2 million from another service unit within the Albuquerque area without the knowledge of tribal leaders and they owe about $2 million more in other contracted services. Our delegation from New Mexico has written to you several times on this matter, most recently in January of this year, without a response from your Department. What are the procedures that IHS uses to periodically review the financial situation of each facility, and what do you intend to do about the ACL Hospital?

Dr. GRIM. The regional leadership in each area on a regular basis, and it varies by region, have what are called governing board meetings with each facility, with each service unit within the region. That is one of the requirements under the Joint Commission on the Accreditation of Health Care Organizations and part of the things that they review at that time are financial transactions as well as other sorts of activities in the hospital. It has been a multiple-year process that we have been working on with ACL to try to address the issue. I personally have met with the tribal leadership and other congressional leadership about the situation going on out there. The tribe asked us to do a review of that program and asked that we include more members from their tribes. We had three Federal representatives on that review team. That report, the draft copy of that report has been shared with tribal leadership. They have asked for some changes to be made to it. We are also considering—and also Congressman Pearce, one of his senior staff came out and toured the facility and then went back to our regional office and we provided them with significant amount of financial information that went back a number of years.

Mrs. WILSON. Have you provided that financial information to the tribe? Because as I understand it, the preliminary report did not include financial information. The tribe has asked for it and we still haven't gotten a response to our request for that information that we put in writing to you in January.

Dr. GRIM. I guess you would have to ask the tribe that. I am assuming that that information has been shared. We sent out a large amount of information. But what people wanted it to be was better organized over a multiple-year period, and that was some of the information that was shared with the Congressman's office recently and so we do now have the data in what we think——

Mrs. WILSON. Well, you have not shared that information with this Congresswoman's office and I would remind you that that hospital does not just serve constituents from one congressional district, and if I sign a letter, I generally expect a response, and we have not gotten a response from the IHS and I would ask you to address that issue. You obviously can't address it here today, but we are not getting sufficient information and neither is the tribe, and there is obviously a problem there and I would ask you to put some attention on it.

Dr. GRIM. I apologize that you haven't gotten a response yet, and we will get you one as soon as possible.

Mrs. WILSON. There is also a problem, as I understand it, regarding the ability of dentists and others to volunteer with the IHS, and I understand there are some barriers that are in place. I understand you have a volunteer dentist program that you put in place last year but the participation has been low because of the burdensome credentialing requirements and process. As I understand it, there is no centralized system at IHS for credentialing and that volunteer dentists have to be re-credentialed each year. They have to fill out more paperwork for each clinic in which the practice. What do you recommend here to straighten out this process?

Dr. GRIM. I am going to make some preliminary comments and then I am going to let Dr. Olson speak to it a little bit more. The credentialing requirements that are placed upon our providers are not requirements that the Indian Health Service has placed upon them. Those are requirements that we have to meet to maintain our accreditation through the Joint Commission on the Accreditation of Health Care Organizations. Our hospitals and clinics go through that process.

Mrs. WILSON. It is my understanding that the military has a centralized credentialing process. Do they not have to be accredited?

Dr. GRIM. I am not sure if the military maintains that accreditation or not. Rick, do you want to——

Dr. OLSON. I don't know that I can answer whether the military does. I can talk some about the central credentialing program if you wish.

Dr. GRIM. Go ahead.

Dr. OLSON. OK. As Dr. Grim said, all Indian Health Service facilities are either Joint Commission accredited, certified by CMS or accredited by the Accreditation Association for Ambulatory Health Care Centers, and to meet those standards, which are to meet quality-of-care standards, we credential and privilege all providers, primary providers who work in our facilities so all physicians, all dentists, psychologists, various other ancillary staff who work in our facilities are all credentialed and privileged by standard providers in all our facilities and that includes all hospitals in the United States and large health care organizations that have a credentialing system. This has to be done every 2 years so all of our providers are re-credentialed every 2 years. I am sure they do that in the military. They certainly do that in the VA. I just don't know the military's system that well. What the centralized credentialing system does for the military and it probably makes a lot more sense for the military because their providers are deployed frequently. Their providers move form base to base every few years or so. In the Indian Health Service, we want our providers to stay in a location generally. A few folks move but most will stay and that is for continuity of care. Our patients want to see their physician, not somebody new every time.

Mrs. WILSON. This isn't an issue of continuity in the community. This is how do we credential—we have volunteer dentists who want to volunteer, pediatricians who want to volunteer, psychologists who want to volunteer, but there is, as I understand it, no centralized credentialing system at IHS. Do you think that is a

problem or are you just going to continue on with the same system you have?

Dr. OLSON. Well, I don't think that the centralization meets the issue at all. We did talk with the American Dental Association, the American College of OB/GYN, American Academy of Pediatrics folks last summer when we were aware of the report requirement, and one of the big issues that they identified which we are in the process of fixing now is to have one credentialed application form across our whole system. Now, that is at IHS facilities. Tribes run their own programs and so if they want to use our form, that is fine, but if a volunteer goes to a tribal program like in Alaska, that is not an IHS issue at all, but we are simplifying. We are going to make it Web-based application form and that can be transported from location to location so they don't have to fill out a form. But they still have to be re-credentialed and it is the same way in the military. What the centralized credentialing system basically does is have a repository electronically where different locations can go in and get the credentials that have been verified but then they still have to review the credentials and then review the privileging application. Privileges have to do with what we allow in a facility, and it is based on two things. One is the expertise and training of the provider. The other is the capacity of the facility to support that provider, and just to give you a brief anecdote to understand——

Mr. PALLONE. You have to be brief because we are like almost twice the amount of time here, so——

Dr. OLSON. All right. I am a physician and internist. I did a lot of cancer chemotherapy. I had the training and expertise to do that at my hospital, a small rural hospital in Oklahoma where I was for 11 years, but the facility didn't have the capacity to support me and so what we did to develop that capacity, we had to send off nurses and pharmacists in order to support the chemotherapy program and then I got the privileges to do that and ran a program for 8 years like that. So capacity of the facility is unique from facility to facility. So at every location where a provider goes, whether they are a physician, a dentist, a volunteer, we have to credential and privilege at each location and then we have to re-credential every 2 years for all providers whether they are volunteers or not.

Mrs. WILSON. Thank you, Mr. Chairman.

Mr. PALLONE. Sure. Ms. Solis.

Ms. SOLIS. Thank you, Mr. Chairman.

I want to direct my questions to Dr. Grim, and I will just ask you, how many people are actually served by the Urban Indian Health Care Program?

Dr. GRIM. I will have to get back to you with that number.

Ms. SOLIS. You don't have an estimate?

Dr. GRIM. The last number that I have was 150,000 but that was for a hearing a year ago. I just want to double-check and make sure that that is still accurate for you, and we will submit it for the record.

Ms. SOLIS. And can you break that down by State?

Dr. GRIM. We can break it down, yes, by State.

Ms. SOLIS. Thank you. One of the questions I have is, what would happen if these services were not available any longer, espe-

cially again in urban settings? And look at the case in Los Angeles and if you could just elaborate.

Dr. GRIM. I can elaborate some on that.

Ms. SOLIS. Where would the patients go, for example? Who would provide them with care?

Dr. GRIM. Well, the Indian Health Service funds about 34 such programs and our average funding for those programs is about 50 percent. It ranges from about 15 percent of their base funding to in some programs 100 percent. Some of the programs are only outreach and referral programs so they provide no direct services whatsoever, and others are full-blown ambulatory care clinics and so part of what I am saying is that not all the programs would close down without our funding. They have a lot of other grants and other resources. Some of them would have to close down, those that rely on us 100 percent, and the administration's view when it made that recommendation in the past is that some of the statistics that were cited by Congressman Pallone about the per capita funding in Indian Health Service, we redirected the funding from the Urban Indian Health Program to all of the hospitals and clinics that are on or near reservations that have in many cases there is no other place to go except an Indian Health Service location, and we would have——

Ms. SOLIS. I don't have a lot of time so I am going to interrupt. I would like to get information specifically on what impacts that would have in Los Angeles County. We only have one center there in Los Angeles downtown and we have got a vast number of urban Native Americans that I don't even believe are fully aware that there is a program that exists, and I would like to know how that money is being spent there. And then secondly, something I raised earlier was with respect to the new requirement to show proof of citizenship or some documentation. I know we are going to hear from a witness later about restrictions that are currently placed on tribes and I believe, and you can correct me, that there are only five tribes that have recognized status of showing acceptable proof of citizenship, so is that true? Is that correct?

Dr. GRIM. I know it is a very small number of tribes. I don't know the exact number. We can get that for the record.

Ms. SOLIS. So a vast number of the Native American population would not be eligible for assistance because they are not designated as one of those——

Dr. GRIM. No, that is not true, and right now CMS is currently in the process of reviewing comments. I have gotten over 1,400 comments on that particular regulation about——

Ms. SOLIS. Is there a need to change that regulation?

Dr. GRIM. Well, they are in the process of writing it right now. In fact, I submitted a comment myself about some of the concerns that Indian tribes had and the fact that some of their especially older membership might not have——

Ms. SOLIS. Will you share that with the committee?

Dr. GRIM. Sure. And the regulations are in the process of being developed finally right now and the issues that you are raising may be dealt with. I am just not sure yet.

Ms. SOLIS. With respect to community health aides, I know that there is such a program that exists right now providing culturally

competent care in Alaska. Would it behoove us to maybe look at how that can be expanded to serve communities like Los Angeles and other, say, mega urban areas where you have a very diverse population that might be able to benefit from information outreach campaigns and just prevention?

Dr. GRIM. I believe if I am interpreting your question right, I believe some of the concerns have been addressed in some language that we worked with one of the other committees where the program that is going on in Alaska right now would operate for a period of years and be evaluated. It is under evaluation right now, and at the end of that evaluation period we would take another look at it and see about applicability to the lower 48.

Ms. SOLIS. One of the issues that I am concerned with is the fact that there are so many cultural barriers, language barriers in accessing health care overall, particularly for Native Americans as well as Latinos, and in Los Angeles we have those communities intermixing very often and sometimes it is hard to identify and separate who is Latin American and who is Native American, and one of the things that I would like to see is that these kinds of programs are actually extended in urban areas, whether it be Chicago, New York or Los Angeles County, Arizona, and places such as that.

One last thing, Mr. Chairman, I want to bring up is, I really believe that when we are talking about health care and prevention, that we really need to go a step farther because we hear so many instances on the reservation where many of our Native American families are affected by groundwater contamination, different types of contaminants that are there that are remnants in their home and in their environment and what kind of steps could we take possibly through programs like this and others that might be able to help provide more information on prevention and what to look for because I can see where there is really a lack of information available to the people on the reservation. Thank you.

Mr. PALLONE. Thank you.

Mr. Sullivan of Oklahoma.

Mr. SULLIVAN. Thank you, Mr. Chairman, and thank you, Mr. Grim, for your being here today at the panel. As an Oklahoma native and a member of the Cherokee Nation, I know you understand the health challenges facing Native Americans in our State and Nation and we appreciate the job you do to serve the health care needs of Indian Country. In Oklahoma, we have 37 federally recognized tribes with each different challenges with respect to assessing and delivering quality health care. As a vice chairman of the Congressional Native American Caucus, I am deeply concerned with the status of Indian health care in America and their access to care. We know that nationally American Indians and Alaskan Natives have three times the rate of diabetes and up to three times the rate of suicide. In addition, Native Americans also have among the highest rate of cardiovascular disease. IHS recently estimated that more than two-thirds of the health care that is needed for American Indians is being denied. In your review, what are the barriers to access to care that Native Americans are experiencing and how would reauthorization of H.R. 1328 improve access to tribes? And also along those lines, if you can comment on prevention. I think prevention in health care, when you look at health

care is very important. We seem to deal mainly with chronic illnesses and not as much on the front end with prevention like I think we should, and especially in the Native American populations it is no different really than many others. What is being done, like I said, with diabetes prevention, drug addiction, alcoholism and also mental illness?

Dr. GRIM. We are focusing very heavily on all those areas you mentioned actually. We have major initiatives going on in prevention, in behavioral health and chronic care management. We have all over the country programs that tribes have run both because of the special diabetes program for Indian monies as well as appropriated funds through Congress of prevention initiatives. One of the things we are trying to do now is to integrate those three programs. We are working with an institute out of Massachusetts called the Institute for Health Care Improvement on a chronic care collaborative to change and re-engineer our system in the way we deliver chronic care. You talked about barriers to access to care and prevention is one component. If we could stop some of the disease from occurring, it would allow more people to access the types of care that they do need. Everyone I think in the country has realized that. We have and certainly tribes have and so as we integrate these three initiatives, better management of chronic care patients, dealing with the behavioral health issues that there are in our population. Suicide was mentioned, high alcoholism rates. Methamphetamine is on the rise in our population, and really a lot of those things are education and prevention are some of the keys to dealing with them, and those are some of the key things that we are focusing on right now. So I would say that No. 1, the authorities that we have are allowing us to do those things, and I am very excited that Congress is interested in focusing on prevention in this bill.

Mr. SULLIVAN. Well, for Native Americans suffering from the disease of alcoholism, can they go to a residential treatment facility now?

Dr. GRIM. We have limited residential treatment facilities. We have 11 of them right now, and right now those are focused on youth or youth residential treatment centers. For adults, some tribes have started residential treatment programs for adults. Right now the Agency has no residential treatment programs for adults, and if we do send them for care, it is using our contract health service dollars to refer them out to a private facility. So that is a gap in access, if you will, for the adult population.

Mr. SULLIVAN. Do you think it would be important to get some treatment facilities for them?

Dr. GRIM. The adults could use them, as I said, but they are not going without care right now. Those that need the care if we are able to refer them out, we do it with contract health service dollars into the private sector where facilities exist. Perhaps one of the bigger complaints we get though from tribes is that we do have to send them away. They are sent away to some location and then they come back. There is nowhere close. In some places we send them to other States.

Mr. SULLIVAN. I bet you are not sending them to Betty Ford, are you?

Dr. GRIM. I wouldn't swear we are not but I could get that information.

Mr. SULLIVAN. Well, I think that is important that we get some access to that. And also, what about mental illness? What are you doing about that?

Dr. GRIM. One of the line items in our budget is mental health and so a large majority of our facilities provide mental health services. They are often times in the smaller facilities triage sort of care only, kind of emergent-type care. We have tested some models and some larger facilities of on-demand-type care that seem to be working successfully and I guess one of the things I would want to point out is that we are constantly looking at best practice things that are going on, evidence-based best practice things in the medical sector, and as we can bring them into our system, we are doing that. There is mental health care available out there. Is it available for everyone that needs it? No, sir.

Mr. SULLIVAN. All right. Thank you, sir.

Mr. PALLONE. Thank you.

The gentlewoman from Illinois.

Ms. SCHAKOWSKY. Thank you very much, Mr. Chairman. I was concerned that you seemed reluctant to say that within a month that you could respond to some of the questions. I don't know, it seems like a reasonable amount of time. Do you think it is likely that you will be able to?

Dr. GRIM. I think it is likely that we can have it within a month. I am just not going to promise it on the record today.

Ms. SCHAKOWSKY. Is it your intention to stay for the second panel?

Dr. GRIM. I didn't know I was going to be here this late so I have an appointment with my boss, but if the Congress requests that I stay, I will stay.

Ms. SCHAKOWSKY. Well, I always think it is a good idea that the people who are actually dealing with these programs hear all the testimony, so if you could, I think it would be a good idea.

Dr. GRIM. Ninety percent of the time, I do that, but I am just not sure today.

Ms. SCHAKOWSKY. In developing your concerns and your testimony, did you do this at all in consultation with any representatives of the tribes and the deliverers of the health care to the Native American population?

Dr. GRIM. In preparing my——

Ms. SCHAKOWSKY. Your testimony today. Are your concerns that you listed reflective of what we may hear from the providers of the services?

Dr. GRIM. These are administration's concerns. I think you are going to hear some different things from the second panel. They would like to see things perhaps left in the bill that the administration would like to see removed and again the primary concerns are to leave flexibility for the Secretary, to not put new requirements and reporting provisions in that would take funds away from the delivery of care.

Ms. SCHAKOWSKY. One of the top priorities of the chairman of the full committee, Mr. Dingell, and I would say of our health subcommittee as well is the SCHIP program, and I notice that in your

testimony you have some concerns about SCHIP. You don't elaborate on those concerns. What is your concern?

Dr. GRIM. Well, one of the concerns of the SCHIP reauthorization is that—and I guess let me first say that one of the concerns is that there are SCHIP-type issues in the Indian Health Care Improvement Act and the administration would prefer to deal with SCHIP in the SCHIP reauthorization, so that is probably the first and the biggest concern. The other concern is the expansion that some States have done with SCHIP to go beyond some of the initial intent of it to cover adults and we think refocusing the efforts to between 100 and 200 percent of the poverty level, focusing back on children would be an immense help to our population. Much of our population falls into that 100 to 200 percent of the Federal poverty level and so those are examples of some of the concerns that we are dealing with, reauthorization of another bill within our bill and then a refocusing of the efforts on what the initial intent was.

Ms. SCHAKOWSKY. When you say our population, then are you saying that you think you are reflecting what your population, that is, the Native American population would agree that it should not include adults and it should focus only on 100 to 200 percent of poverty level?

Dr. GRIM. I was not trying to characterize that my population would think that, no, that we serve only that. We have a significant amount of population that falls in the 100 to 200 percent range and to the extent that expansions beyond that dilute what is available in the way of either services or eligibility to that group, that it would hurt the coverage within our population group.

Ms. SCHAKOWSKY. Unless more money were allocated for it. And with respect to Medicaid, you say you have concerns and you are not only talking about dollars, you say the current structure of Medicaid. What is the problem with Medicaid?

Dr. GRIM. I would like to get that to you in writing for the record.

Ms. SCHAKOWSKY. As I said, the American Indian Center in Chicago is located within my district, and the health center is really struggling. It is one of those 34. I would really like to arrive at a place where we could work with you to bolster those rather than this notion that other health care facilities or federally qualified health centers could address that population. All of our FQHCs are struggling with being overloaded and it would seem to me that this one, which is culturally sensitive, which has the capacity to do the kind of outreach we need to the Native American community could be helped. I am wondering if there are ways that we could work together to make sure that this particular facility could continue to exist and even flourish.

Dr. GRIM. We are willing to work with you. We have an Office of Urban Indian Health. I don't have the specifics on the type of funding that the center in Chicago gets but we either have that or can get that and we can work with you, Congresswoman, on that.

Ms. SCHAKOWSKY. Well, if you would take a look at that particular center and get back to me and perhaps we could set up a meeting with its director, Ken Scott, and talk about what we can do.

Dr. GRIM. Our director for the Office of Urban Indian Health happens to be in the room today, so she heard that from you and we will make sure we do that.

Ms. SCHAKOWSKY. Great. Thank you.

I yield back, Mr. Chairman.

Mr. PALLONE. Thank you. Hopefully you won't leave but before you step down from the panel, I just want to emphasize again that it is obvious that there are a lot of disagreements with the administration on this bill and I really would like to get those all on the table and try to iron them out and see that we can come to a consensus because we want a bill that is going to pass, that is going to come to conference with the Senate and go to the President. There are going to be differences but we would like to work them out but we can't work them out unless we have them all on the table, so I appreciate the fact that you are going to try to get us all these objections as well as what you support within the next month, and also that you are going to try to be sort of a clearinghouse for other departments or agencies, because that is just as important.

So thank you again. We have a lot of work to do. Thank you.

Dr. GRIM. Thank you, Congressman.

Mr. PALLONE. And I will ask the second panel to come forward. Welcome to all of you. Thank you for being here. Let me introduce each of you from my left to right. First we have James Crouch, who is executive director of the California Rural Indian Health Board, and then we have Mr. Ralph Forquera, who is executive director of the Seattle Indian Health Board, and then Mr. Ken Lucero, who is from the Pueblo of Zia, and then we have Rachel Joseph, who is co-chair of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act and also representing the National Indian Health Board. Good to see you again as well.

As I said before, your statements will be part of the hearing record and each of you may in the discretion of the committee submit additional pertinent comments either in response to our questions or on your own, if you like, and I will start with Mr. Crouch.

STATEMENT OF JAMES CROUCH, EXECUTIVE DIRECTOR, CALIFORNIA RURAL INDIAN HEALTH BOARD, INCORPORATED

Mr. CROUCH. Thank you very much. My name is Jim Crouch, executive director, California Rural Indian Health Board. I am proud to serve in that position for the last 20 years. I am presenting on behalf of California Rural Indian Health Board, its 12 member tribal health programs providing services to over 44,000 American Indians. I would like to keep my comments essentially focused on the new title II Medicare, Medicaid and SCHIP provisions. CRIHB is totally supportive of the entire bill. We are very pleased to have it in this committee again.

The Indian Health Service is a discretionarily funded Federal program. It is not an entitlement program. There could be no greater flexibility than is already provided in the Indian Health Service under the appropriations processes. The role of the health bill is to give them guidance to better meet the needs of the Indian community, and when this bill first passed in 1976, really the most

exciting part of it was the joint funding that responded from including the right of IHS facilities to bill the Social Security-based programs. A lot has changed in that time. Today the CMS programs provide about a third of the operating budget of the Indian Health Service. When you all think about the underfunded nature of the Indian Health Service, you are including through the level of need funded methodology participation and dollars from the CMS provides so when we say IHS is underfunded, typically that includes the contribution of the Center for Medicare and Medicaid Services programs.

What does this bill do that is new? It newly enfranchises tribal providers and IHS facilities to bill for not only programs at CMS but also for furnishing items, and as I stated in my written testimony, such critical things as wheelchairs, diabetic test equipment and strips would be therefore included that are currently problematic at this point. It also addresses the issue of outreach. Having access to an entitlement program coverage like Medicaid or SCHIP, Medicare, simply isn't real until you actually are enrolled, and without increased efforts on enrollment and outreach, which this bill provides, we will continue to have underutilization of particularly the Medicaid program in Indian Country. I can't believe that the Indian Health Service in fact would oppose or CMS would oppose any kind of increase in that work.

The real heart of the Medicaid provisions and the SCHIP provisions in this bill which are perhaps somewhat controversial for some is the issue of providing access to health care without premiums and co-pays. I would suggest that this is important for making that access real. I would like to share with you some material that was not in my written testimony about low access to health care. In California a few years ago, we did some research that matched by education, geography and Medicaid category of eligibility over 22,000 Indian people and compared them to non-Hispanic white population exactly matched by the same geography and age categories. What we learned from that is Medicaid coverage doesn't mean access. The actual visit counts were very different between those two populations. The pattern of providers that were seen were different and we were looking at both IHS tribal and non-IHS-funded providers because it is a payment study. And most importantly, the Indian received only 85 cents for every dollar expended on their similarly situated non-Hispanic white population. Why is that? It is in part because the geography is much greater. We couldn't actually match point by point for geography. It is also because of barriers that relate to accessing Medicaid through a share of cost arrangement. I would also point out that we looked at a broader study, looking at access to hospital-based services. The Indian community when we looked at just the rate of gross hospitalizations for all payers, and I would add non-payment of debt, if you have a problem in Canoncito with the payment of CHS dollars being reduced, that is true generally in Indian Country. Looking at bad debt, Medicaid payment and IHS payment, which in California was very little, overall hospitalization rates differed greatly between the non-Hispanic whites and the Indian population. American Indian women were getting to the hospital at a

52 percent higher rate than the other community and the men a more shocking 72 percent.

Lastly, I would like to particularly point out the issue of access to primary care. That is where we will make real progress in health care. This bill allows by expanding coverage and participation in Medicare, Medicaid and SCHIP. It will allow us to hopefully address some of these bad statistics. American Indian women are treated at the hospital level with ambulatory care sensitive diagnoses 106 percent of the rate of non-Hispanic white women in the same age, same sex and same geography in the State of California. It is documented over a university-level 3-year study. The ambulatory sensitive diagnostic rate for men is a whopping 136 percent of the non-Hispanic white rate for the same age and sex category. This research documents a lack of access. The Indian Health Care Improvement Act, particularly the title II new provisions, will improve the utilization of Medicare, Medicaid and SCHIP in Indian County. It will facilitate Indian program participation as providers and it will facilitate Indian enrollment as individuals. I urge that you support this bill and work for its speedy passage.

[The prepared statement of Mr. Crouch follows:]

Summary of Testimony to the Energy and Commerce Committee on HR1328
James Allen Crouch M.P.H.

I am Executive Director of the California Rural Indian Health Board, Inc. (CRIHB) I served as Tribal Co Chair of the Title IV Workgroup for the Reauthorization of the IHCIA. I am a founding member of the Tribal-Technical Advisory Group to the Centers for Medicare and Medicaid Services (CMS T-TAG), a graduate of the UC Berkeley School of Public Health and a member of the Cherokee Nation. CRIHB is a founding member of the National Indian Health Board (NIHB) and under Indian Self Determination Act contracts provides health and health related services to 22 tribes in California. One of the most important changes in the first generation of the IHCIA was the authorization for IHS facilities to bill Medicare and Medicaid for services provided to Indians. This joint funding process created many changes and makes IHS funds the payer of last resort secondary to Medicaid or Medicare coverage. Since that time the health needs of the Indian community have shifted as have standard methods of providing care. The movement has been away from acute conditions to chronic and away from facilities to community base programs. These changes have required a thoughtful response from Tribes, the IHS and now Congress as you consider the reauthorization of the Indian Health Care Improvement Act. CRIHB fully endorses HR 1328 and urges its quick passage.

The new Title II addressing programs under the Social Security Act is the most important part of HR 1328. It responds to current needs such as the increasing role of technology and equipment in maintaining health and quality of life by clarifying that the ITU system may seek reimbursement for furnished items such as wheel chairs, home diabetic equipment and diabetic test strips etc. It is designed to address persistent problems of under enrollment in CMS funded programs by eligible American Indians and Alaska Natives through state-tribal collaborations. It addresses new barriers to access that result from many American Indians having been born at home with out birth certificates or in federal facilities that did not collaborate with their state vital record departments. The most significant changes are in section 204 which has the general effect of waving all premiums and co payments for IHS eligible Indians who receive Medicaid, Medicare or S-CHIP funded services at or through referral by an ITU provider. The extension of this exception to services provided under referral is particularly important in IHS service Areas such as California, Nashville, Bemidji and Portland where there are no IHS hospital facilities. In these Areas almost all inpatient and specialty care is provided by non IHS providers. It calls for an annual report on Indian participation and health outcomes from the CMS and the IHS. This report will have the beneficial effect of increasing the understanding of both Agencies about the role they respectively play in providing health care to American Indians and Alaska Natives. A responsibility they have shared since the initial passage of the Indian Health Care Improvement Act in 1976.

Title I Section 209 of HR1328 concerning Epidemiology Centers clarifies their status as "public health entities" under HIPPA and that such data sharing will occur with out diminishment of HIPPA accountability. CRIHB strongly supports this provision. CRIHB also supports the Abercrombie amendment addressing this section recently adopted by the House Resources Committee.

CRIHB actively and fully supports HR 1328 and urges its quick passage into law.

Testimony James Allen Crouch M.P.H
Executive Director
California Rural Indian Health Board Inc

HR 1328, the Indian Health Care Improvement Act Amendments of 2007

I would like to begin by thanking the Committee for this opportunity to present the perspectives of the California Rural Indian Health Board Inc. (CRIHB) on HR 1328 the Indian Health Care Improvement Act Amendments of 2007 and to document our support for this important piece of Indian legislation. CRIHB is a Tribal Organization operating under the authority of the Indian Self Determination Act providing health and health related services to twenty-two tribes and other Indian Health Service (IHS) eligible Indians residing near those reservations. CRIHB was originally organized in 1969 at a time when all IHS services had been removed from the state and our first major accomplishment was the return of those services through Congressional action in 1972. Our founding documents call for CRIHB to be active in health policy at all levels of government. True to that mission, the organization has been actively involved in the initial passage of the IHCIA and in each cycle of reauthorization since that time. Today operating as an association of Tribally Operated Health Programs funded through various federal, state and philanthropic sources, we provide over $31 million in health related programming for the benefit of Tribes, Tribal Health Programs and Urban Indian Organizations in California. Our member Tribally Operated Health Programs serve over 46,200 American Indians and Alaska Natives with IHS-funded comprehensive health care services. As has been the case for the past decade, at our Annual meeting last October with over 200 Tribal and Tribal Health Program leaders in attendance, the reauthorization of the Indian Health Care Improvement Act was identified as our principal legislative goal for the year. We hope that this year marks the year in which that goal is achieved.

You may well ask yourselves why is the reauthorization of this bill, which has languished in Congress for a decade, so important to Indian country in general and in particular to Tribes, Tribal Health Programs and the American Indians and Alaska Natives they serve in California. The answer to that question is found in reviewing the role and purpose of the IHCIA itself and in the vast diversity among tribes across the nation. In 1976 with the initial passage of the IHCIA Congress for the first time provided a clear goal for the Indian Health Service: "the elevation of the health status of the American Indian people." To achieve this central purpose, the Act authorized a broad list of programs and improvements addressing problems of manpower development, staffing, organizational improvements and specific health interventions or programs. One of the most important provisions included in the IHCIA was the authorization many years ago for the IHS to bill for services provided to Medicare and Medicaid covered Indians in IHS facilities. Today CMS funded programs provide at least a third of the IHS operating program in places like California. This new "joint funding" of the IHS services requires that the IHS funds become the payer of last resort for services to Indians this has expanded the level of resources available to fund such care. At the same time this increasing dependence on

CMS funded programs increases the need for CMS to respond to the needs of Tribal communities. Today, more that ever, how Medicaid, S-CHIP and Medicare are implement in Indian county impacts on which Indians receiver which health service and at what price.

The bill is broad and lengthy because the diversity of Indian country requires a diversity of programs to effectively address problems as they exist. The IHS service population is widely dispersed from the polar regions of Alaska to the steamy forests of Florida. Tribes vary greatly in size of membership. Some Tribes are located on large reservations which are remotely located far from normal medical services and others, like many of those in California, have smaller reservations where the accessibility of non-IHS providers is less problematic. Today many members of federally-recognized tribes do not live on their own reservations. At present twenty five percent of the IHS Active User population receiving services from California based Tribally Operated Health Programs are members of federally recognized tribes based outside of the state of California. There are also many American Indians living in urban areas across the country. Reflecting back to 1976 and the initial passage of the IHCIA, there are also now differences in how IHS health services are provided either directly by the agency in consultation with the Tribes they serve or under Tribal control through contracts and compacts as authorized by the Indian Self Determination and Education Assistance Act (ISDA) which was initially passed as PL 93-638 in 1977. Today over half of the IHS system is operated by Tribes and Tribal Organizations through ISDA contracts and compacts. In spite of all this diversity and change there are still many common characteristics among tribes and Indian people. There is the shared heritage of first contact, eventual conflict, marginalization, and perhaps revitalization. IHS data describe a population which has overcome tuberculosis and infant mortality which now struggles with mental health and behavioral health problems, and is confronting the ravages of diabetes, obesity and hypertension with its attendant amputations and heart problems-- a population that is now living longer but still lags behind the majority of the U.S. population in average age of death.

The health needs of the Indian community have changed over time requiring a thoughtful response from the Indian community, the IHS and Congress in the reauthorization of the Indian Health Care Improvement Act (IHCIA). Since the first passage of the IHCIA meaningful progress has been made in addressing the health needs of the American Indian population and thereby improving their health status. It is, however, equally true that patterns of disease, life style and mortality within the Indian community are shifting bringing to the fore new problems that respond best to new modalities of care. HR 1328, the Indian Health Care Improvement Act Amendments of 2007, addresses these changes well and is fully supported by the California Rural Indian Health Board, Inc.

Most of my comments below address the provisions of the new Title II sections of the HR 1328 which I believe will have significant positive impacts on access to care for IHS-eligible American Indians and Alaska Natives. I urge that these provisions be enacted as currently drafted and as swiftly as possible. My recommendations are informed by my personal background as Executive Director of the California Rural Indian Health Board, a position I have held for the past twenty years; as Tribal Co-Chair of the Title V

Workgroup of the National Committee for the Reauthorization of the IHCIA; as a founding member of the Tribal-Technical Advisory Group to the Centers for Medicare and Medicaid Services (CMS T-TAG); as a graduate of the UC Berkeley School of Public Health; and as a member of the Cherokee Nation.

The new Title II Amendments to the Social Security Act up-dates clarifies and expands Indian participation in Medicare, Medicaid and the State-Children Health Insurance Program. This portion of the bill refers back to Title IV of the current IHCIA where the original authority for the IHS to bill Medicare and Medicaid was placed. First I should clarify some common IHS and tribal terminology. The different delivery modalities of the IHS funded system is often described collectively as the ITU system or individually as "I" "T" or "U" providers. "I" refers to the Indian Heath Service operated programs; "T" refers to the Tribally operated programs; and "U" refers to the Urban Indian programs.. Also, I will in general refer to the IHS eligible population as Indians instead of the more fully descriptive American Indians and Alaska Natives.

Section 201 clarifies that the Indian Health Service, Tribes, Tribal Organizations and Urban Indian Organizations are eligible for payment for services which are generally reimbursed by Medicare, Medicaid and S-CHIP. Responding to the increasing role that technology and assistive equipment plays in maintaining health and quality of life this section expands and clarifies that the ITU system may also seek reimbursement for furnished items like wheel chairs, home diabetic test equipment and diabetic test strips etc. To receive payment for these services the ITU provider would have to meet generally applicable standards and conditions. To facilitate entry into these new service areas, Section 201 allows ITU providers to operate for a limited one year time period under a Secretarial-approved plan for meeting general standards and conditions of participation. This is similar to the authority given to the IHS in 1976 when the billing of Medicaid and Medicare for clinical services was first granted directly to IHS facilities. Today to the extent that some ITU providers might want to provide new non-clinical services such as long term care services or home health care services, this provision provides for a reasonable start up period and process.

Section 202 is designed to address the persistent problem of under-enrollment in CMS funded programs by eligible American Indians and Alaska Natives. There are a number of reasons why participation in these programs is low including the lack of clear guidance to states on what they can do to address this situation. The bill addresses this and identifies several methods as being acceptable including the out stationing of state staff and entering into agreements with Tribal and Urban providers to provide outreach education and enrollment services. These efforts are intended to augment access to the Medicaid Administrative Match program which is operating successfully in some parts of Indian country. Lastly Section 203 provides a financial incentive to States to include ITU providers in S-CHIP funded outreach to Indian families and Indian children by exempting those costs from the state caps on such costs. Some states like California have previously entered into contract and grant agreements with Tribal Providers to expand Indian participation in S-CHIP but that practice has decreased over time as funding constraints became more common. Overall the cost of increasing enrollment in CMS-funded

programs would be minor compared to the positive improvement in access for individual Indian people and the increase in revenues that would accrue to the generally under-funded IHS, Tribal and Urban providers.

Not all barriers to Medicaid participation are financial. American Indians have had a particularly difficult time addressing the recent Medicaid requirement to document citizenship as part of the enrollment process. This has created a new barrier to access because many American Indians and Alaska Natives were born at home with no birth certificate being issued or in federal facilities that did not collaborate with their state vital record departments. Current Medicaid practice states that Tribal documents from only five tribes are fully acceptable as proof of US Citizenship. The selection process to identify these Tribal Governments is lost in history except for the recent inclusion of the Isleta Del Sur under authority of the Department of Homeland Security. Section 203 addresses this issue by including documents issued by federally recognized Indian tribes in the list of acceptable proof of US citizenship. For those tribes having an international border which have tribal members that are not US citizens, the Secretary, after consultation with the tribes, is to determine what would constitutes acceptable documentation. It should be noted that two of the current list of five Tribes able to provide acceptable documentation of citizenship are located on international borders.

The most significant changes of Title II Changes to the Social Security Act in HR 1328 are found in section 204 which has the general effect of waving all premiums and co-payments for IHS eligible Indians who receive Medicaid, Medicare or S-CHIP funded services at or through referral by an ITU provider. The American Indian/Alaska Native population is characterized by low rates of educational attainment, high rates of unemployment, disproportionably low health status and high rates of ambulatory care sensitive hospitalizations. In short, in spite of the existence of the IHS delivery system there is evidence of inappropriately low levels of health care utilization resulting from continuing barriers to care. The existing cost barriers to Medicaid funded care are unnecessary and should be removed because they decrease utilization of medically appropriate services. IHS facilities are prohibited from charging individual Indians for services that could be provided through the IHS congressional appropriation and therefore generally absorb these costs. Additionally in the Indian context Tribal responsibility expressed through Indian Self Determination Act contracting closes the circle of responsibility at the Trial level not merely at the individual level Lastly there is scarcely any creditable documentation of Indian over utilization of health services while there are mountains of evidence documenting underutilization and late utilization. In California for example a recent study documented that IHS clients there are receiving too few primary care services and are therefore twice as likely as their non Indian neighbors to be hospitalized for certain primary care sensitive diagnosis. The Congressional Budget Office has calculated the cost of this provision at $5 million in year one, $10 million in year two and $15 million there after. This is a small price to pay for the resulting increase in health services and the subsequent resulting improvements in health access and health outcomes. These special Indian provisions are similar to long standing practice under the S-CHIP program .

The extension of this provision waiving all premiums and co-payments for referral services is particularly important in IHS service Areas such as California, Nashville, Bemidji and Portland where there are no IHS hospital facilities. In these Areas, almost all inpatient and specialty care is provided through referral to non-IHS providers. In the other IHS Areas where IHS operates a vertically integrated preventive, ambulatory and inpatient system, there are no charges levied on individual Indian clients. Section 204 also establishes a prohibition against any attempt to reduce payments for services to IHS eligible Indians provided by the ITU system either directly or through medical referral for the furnishing of both items and services to Medicaid covered individuals. This prohibition is necessary in order to protect IHS and non-IHS providers from possible reductions in payments under state Medicaid plans that would inevitably reduce the number of non-Indian providers willing to provide services to Indians under those conditions. The third critical provision in this section elevates into statute and extends to the S-CHIP program existing Medicaid regulations that provide for a limited exemption of Indian trust based property and income from consideration in determining eligibility for those programs.

Section 205 through Section 208 address the relationship of the ITU system to Medicaid and S-CHIP contracting Managed Care Organizations. In general these provisions replicate rules long established by the State of California which have been successfully in operation for over a decade. These provisions allow for ITU participation while maintaining existing requirements for licensure and applicable standards for participation in such programs.

Section 206 addresses Consultation between Tribes and the Center for Medicaid and Medicare Services elevating into statue the existing Tribal-Technical Advisory Group and authorizing the addition of representation for IHS-funded Urban Indian Organizations. The current T-TAG operates under Federal Advisory Committee Act which does not allow for representation by non-governmental groups not based in the Washington DC area. The T-TAG has been of active assistance to CMS since September 2003 and has assisted in the start up of Medicare Part D program, implementation of Budget Reduction Act provisions, Medicaid Administrative Match program issues and issues surrounding Indian data in CMS data systems. This section further mandates that states with ITU providers establish a regular process for seeking advice in matters that are likely to have a direct effect on those providers including state Medicaid plan amendments and demonstration programs. The state of Washington has a well established program for this type of tribal consultation which has greatly facilitated collaboration between the Tribal Health Programs there and the state.

Section 207 addresses problems that might arise from the vertically integrated nature of the IHS delivery system where portions of the program are operated directly by the IHS and other portions are operated by Tribes and Tribal Organizations under Indian Self Determination Act contracts and compacts or by Urban Organizations under grants and contracts. This section calls for the Secretary to promulgate regulations though which certain transfers shall not be considered remuneration for the purposes of creating a Safe Harbor. These provisions protect the coordination of "medically necessary services"

between and among ITU providers under certain conditions. These provisions are also designed to prevent unnecessary utilization and cost concerns that can arise from self dealing in the commercial health services market.

Section 208 is similar to state regulations in California which address specific problems that arise when individual Indians who have established a medical home with an ITU provider are subsequently enrolled in non-Indian Managed Care Organizations. This situation occurs when states seek to expand their utilization of Managed Care Organizations for the provision of Medicaid and S-CHIP services. The proposed law guarantees the right of the individual Indian client to continue to choose their ITU provider as their primary care provider. For those MCO's that have a significant percentage of Indian enrollees, new requirements are established assuring participation of the ITU providers in their system of care and assuring that non-participating ITU providers are reimbursed in an equitable manner. These provisions are designed to assure the availability of culturally competent care to individual Indian beneficiaries. If the Tribe or Tribal Organization operates as a Federally Qualified Health Center or under the IHS/HCFA memorandum of agreement, the ITU providers are assured continued assess to that rate if they so choose. In cases where there is a difference between the CMS established encounter rate and the MCO rate, that difference shall be made up through direct payment by the state plan to the ITU provider. These provisions are congruent with existing federal law concerning FQHC participation in Managed Care Organizations.

This section goes on to address the special case of state-licensed Indian Managed Care Organizations and their participation as Medicaid or S-CHIP providers. It should be noted that to date all initial attempts to organize Indian controlled and focused Managed Care Organizations have not succeeded. The bill requires that such an entity meet generally applicable standards and conditions. However it also seeks to foster the development of Indian controlled Managed Care entities by establishing special conditions that would greatly facilitate the development of Indian controlled MCO's for participation in state controlled Medicaid Managed Care systems. This first of these special conditions is the authority to limit enrollment and distribute marketing materials selectively to American Indians and Alaska Natives. This is in conformity with the IHS mission and serves as a means of increasing access to culturally competent care for individual Indian beneficiaries. Enrollment provisions are established that both protect the rights of individual Indians to select non ITU providers and allowing for default enrollment of eligible Indians into Indian managed care plans. In those states where patient lock-in provisions have been established, the individual Indian's right to choose an Indian MCO supersedes those provisions. A provision is also made establishing that and Indian MCO would be deemed a public entity for whom standards of solvency would be established by the Secretary, not by an individual state. Issues which have arisen in the past concerning state requirements for MCO's to carry malpractice insurance are addressed by recognizing that the IHS and Tribal providers as well as Urban Programs operating as FQHC's are covered by the Federal Torts Claims Act.

HR 1328 ends with provisions that call for the Secretary acting through the Administrator of CMS and the Director of the Indian Health Service to provide an annual report to Congress regarding the enrollment and health status of Indians receiving items or services funded by CMS under the provisions of this act. As Chairman of the CMS/T-TAG Data Subcommittee I can attest to the need for this report. Calling for such a report will have the beneficial effect of increasing the understanding of both Agencies about the role they respectively play in providing health care to American Indians and Alaska Natives, a responsibility they have shared since the initial passage of the Indian Health Care Improvement Act in 1976. The current CMS data architecture hinders the collection of comprehensive data on Indian participation, service utilization, cost and outcomes. Anomalies in definitions used by CMS and the sources of individual Indian identifiers will eventually need to be addressed before system wide conformity can be achieved. This is not an impossible task but one that will evolve over time. It should be noted that IHS/CMS and the Social Security Administration have for several years been participating in a data sharing agreement that has greatly improved the quality of Medicare related Indian data and SSN identified IHS data. Equal improvement in Medicaid related data will be more difficult but not impossible to achieve. The increased utilization of Electronic Health Records systems by ITU providers will also facilitate the development of this report over time.

Recently the National Tribal Steering Committee for the Reauthorization of the Indian Heath Care Improvement Act requested that the Senate Indian Committee add a new provision to Title II which would clarify that CMS should address services to American Indians and Alaska Natives in conformity with the landmark U.S. Supreme Court decision in the case of *Morton v. Mancari,* 417 U.S. 535 (1974). That decision held that Indians are entitled to special services not as a racial or ethnic group, but instead because of their political status as members of Indian tribes. The Steering Committee is suggesting the following language be inserted into the bill.

> "In recognition of the unique responsibility of the United States to provide health care to Indians, the Secretary shall ensure the maximum participation by Indians and Indian Health Programs in the health benefit programs funded under this Act."

This change would be helpful to CMS as it addresses issues of how to change its data systems to reflect Indian participation and makes other policy decisions on the implementation if their health's benefit programs.

While reflecting on the issues of data, date quality and access, I would like to take this opportunity to address section 209 of Title I of HR1328 concerning Epidemiology Centers. For a number of years Congress has required the establishment of Epidemiology Centers in each of the twelve IHS Areas. HR1328 appropriately continues that goal and clarifies that such centers shall be treated as "public health authorities" for the purposes of access to data under the Health Insurance Portability and Accountability Act (HIPAA). A plain English reading of EpiCenter roles and responsibilities and a plain English

reading of how the "public health authority" of the IHS is delegated by contracts and grants to Tribes and Tribal Organizations has not been sufficient to foster appropriate and timely sharing of data between the IHS and its funded EpiCenters. Title I section 209 clarifies that such data sharing can occur and with no diminishment in HIPPA accountability. CRIHB strongly supports this provision. CRIHB also supports the Abercrombie amendment to this section which was recently adopted by the House Resources Committee which is more clearly drafted than parts of the current language and provides greater continuity with existing law.

In closing, I would like to express the strongest possible support for HR 1328 and urge its speedy passage into law. Over a decade ago a series of open national meetings were held to discuss and analyze how the IHCIA could be updated to reflect current conditions among the Tribes and changes in how health care is provided today. The current bill reflects the historic consensus proposal that was generated through this process and a few more recent, yet fully vetted, incremental changes. Passage of HR 1328 will not only achieve the goals of the Indian community to update the authorities under which Indian health care is delivered, but it is also a small but significant step towards national heath reform. Thank you for this opportunity to share my views and those of the California Rural Indian Health Board.

Mr. PALLONE. Thank you, Mr. Crouch.

Mr. Forquera, I know I am mispronouncing it probably.

Mr. FORQUERA. It is Forquera. Just think of four carrots and——

Mr. PALLONE. I am glad that Ms. Solis left because she corrects me on my Spanish pronunciations.

Mr. FORQUERA. It is OK. No problem. In my bio, I don't know if you noticed, but I try to put it into phonetics so that people can remember it.

Mr. PALLONE. OK. Thanks.

STATEMENT OF RALPH FORQUERA, EXECUTIVE DIRECTOR, SEATTLE INDIAN HEALTH BOARD

Mr. FORQUERA. Mr. Chairman, thank you for allowing me to be here today, and thanks for inviting me and to have a representative from the urban Indian health side of the aisle here to speak on the issue. My name is Ralph Forquera. I am the executive director for the Seattle Indian Health Board. I am an enrolled member of the Juaneno Band of California Mission Indians. It is a State-recognized Indian tribe from the San Juan Capistrano area of southern California, and it is a great pleasure for me to be here.

The Seattle Indian Health Board is one of the 34 urban Indian health programs along with the Chicago program and the one in Albuquerque as well as 32 other cities around the country that have urban Indian programs in them. I have been working in the field of urban Indian health for the last 25 years, first in San Diego where I served as the executive director for their program for 8 years and for the last 17 years I have been at the Seattle program in Seattle, Washington. My agency is a fairly comprehensive organization. It was one of the first funded by the Indian Health Service even prior to the Indian Health Care Improvement Act. We received our first Indian health resources in 1972 as part of the old OEO equal opportunities program, so we have been engaged with the Indian health program for quite a long period of time. We provide direct health care services to about 7,000 individuals a year, about 4,000 of whom are American Indians or Alaskan Native. The majority of our non-native people that we see tend to be family members of American Indian or Alaskan Native families. A lot of the cities Indian people live in mixed environments; mixed households, they marry into mixed racial backgrounds, and we try to take care of families as opposed to individuals through our organization. As we talk about health promotion and health prevention, you really need to talk about families. Talking about individuals is helpful but you really need to address the entire comprehensive nature of the environment in which these people live in order to be able to affect them, and that is really the kind of work that we try to do. Through our outreach and education programs, we interact with probably another 4,000 or 5,000 individuals, so we think that we see somewhere around 10,000 Indian people a year, interacting with them in Seattle. Seattle has a population of about 35,000 Indian people so about a third of the population.

Through our Urban Indian Health Institute, which we created in 2000, which is a research arm that we created, we have been able to finally document for the first time the fact that there are significant health disparities among the urban Indian population. That

information has helped us, I believe, to interact with other agencies of the Federal Government including the CDC and the NIH and others to try to get them to recognize the fact that this is a population of people with severe health disparities that have not been engaged in a lot of the health disparities initiatives around the country. The majority of those resources have gone to larger ethnic populations, primarily Hispanic and black populations, which have great needs for those kinds of services and there is an assumption that the Indian Health Service is taking care of the needs of Indian people so therefore Indian people that are not directly under the auspices of the Indian Health Service are oftentimes left out of that debate and so one of the initiatives that we tried to do through the Institute was to document this information, get this information in the hands of policymakers in hopes that that would translate into resources for our population.

The Urban Indian Health Program has also received a lot of resources from sources other than the Indian Health Service itself. In fact, we believe that we leverage about two to one the amount of resource that we get from the Indian Health Service for outside resources, primarily from local, State and other Federal programs and some private dollars. My organization, for example, the Indian Health Service resource that we get represents about 31 percent of our financing. The rest of it comes through a variety of different programs. I think we are managing somewhere around 35 or 40 different grants and contracts in a given year, so as you can tell, that takes an awful lot of administrative time and overhead as well as somebody was talking earlier about IT. Having a fairly comprehensive technological base to the work that you do is critically important in our operations in order to be able to manage both the numbers as well as the finances of those kinds of organizations to be able to report appropriately.

The urban Indian population is a very diverse population. We serve enrolled members of federally recognized tribes, which is a significant portion of the people that we see who are living in cities. We also see members of State-recognized tribes. There are 41 States in the country that recognize Indian tribes. I believe there is one in New Jersey. There are descendants of early Indian people who were displaced as a result of adoption back in the early part of the 1920's and 1930's. It has been very interesting for me to find a lot of Indian people living in Seattle who know that they were Indian but didn't grow up in that kind of environment, and one of the things that we work with, believe it or not, is the Mormon Church, who has a very big genealogical center in Seattle, as well as the archives in Seattle, the local archives, to help people try to link themselves back to their native culture, and it is amazing to me in terms of just this idea of health promotion and health improvement how getting people linked back to their heritage has such a profound effect on their mental health, recognizing the fact that they are native and they truly are native and then having that linked somehow to some kind of documentation is an amazing thing to witness. There is also a growing number of Indian people who we serve who are Indians of mixed race or of mixed tribal background who are not eligible necessarily for services at their tribal reservation sites anymore, and those individuals are native

people who also deserve and need assistance, and that is something that the urban Indian programs can provide.

Indians in most metropolitan areas are geographically dispersed. They don't live in one particular community so doing the work that we do is very challenging because we are having to do a lot more of the outreach that you were talking about earlier, a lot more case finding. We do a lot of cultural events in the community as a way of kind of gathering people together so we can communicate with them about the needs that they might have, and at those events we often do health screenings and other kinds of activities in order to be able to gauge where the people are at and hopefully focus them on services.

As you know, the Indian Health Service primarily serves Indians that live on and near reservations, which we think is an appropriate role for them. Title V was intentionally created as a way of providing core resources and core assistance to local Indian communities so that they could organize themselves in order to be able to develop health services, and that is exactly what we have done. I think that the contribution that the Congress makes of $34 million to the urban Indian programs is a very wise investment. I think that we have been able to leverage those resources and provide a comprehensive set of services in many cities around the country that would not be possible without the help of the Indian Health Service being that foundation on which to build

As you know, the Bush administration has been trying to zero out the Urban Indian Health Program and I really wanted to take the opportunity to recognize the leadership of Congresswoman Wilson from New Mexico. She and our Congressman from Seattle, Jim McDermott, took a leadership role in authoring a letter to get that money reinstated and we are very fortunate that it was done for the 2007 year. And Mr. Dicks also from Washington State has been very generous in making sure that that funding continues for the 2008 year.

We also really believe that the Urban Indian Health Program, as has been stated on several occasions here today, really has amassed an understanding and a knowledge of the urban Indian community——

Mr. PALLONE. I was so interested in what you were saying that I didn't realize you are 3 minutes over so you have to wrap up.

Mr. FORQUERA. I will wrap up.

Mr. PALLONE. All right.

Mr. FORQUERA. Basically I just wanted to say that the urban Indian programs have really amassed an awful lot of information and knowledge about the urban Indian communities and know how to serve those communities better than anybody, and even if they weren't, even if the community health centers could step forward and provide the services, they really couldn't provide the cultural and the connectedness that I think is necessary to engage the people in the health care process and I think that that is the real key to our work.

Thanks for the opportunity to be here. I appreciate your inviting me.

[The prepared statement of Mr. Forquera follows:]

TESTIMONY

by

Ralph Forquera, Executive Director
Seattle Indian Health Board
Seattle, Washington

Mr. Chairman and members of the Subcommittee on Health to the House Committee on Energy and Commerce, thank you for inviting me to testify regarding H.R. 1328, a bill to reauthorize and extend the Indian Health Care Improvement Act. My name is Ralph Forquera. I am Executive Director for the Seattle Indian Health Board, one of 34 private, non-profit organizations that contract with the Indian Health Service under Title V of the Act we are discussing. I am an enrolled member of the Juaneño Band of California Mission Indians, a state-recognized Indian tribe from the San Juan Capistrano region of Southern California.

For the past 25 years, I have worked to address the health needs of urban Indians first in San Diego, and for the past 17 years, as the Director for the Seattle program. During that time I have seen a steady migration of Indian people into American cities and according to the 2000 U. S. Census, 67% of the 4.1 million Americans self-identifying as American Indian or Alaska Native are living in cities. My agency provides direct health care to 7,000 individuals, about 4,000 of whom are American Indian or Alaska Native. Through our outreach,

community services, health education, and organizational work, we estimate that we interact with close to 10,000 Indians yearly, about one-third of the local Indian population in the Seattle area. Many of our non-Indian clients are family members of Indian households.

Through our work at the Urban Indian Health Institute at my agency, we have documented severe health disparities among urban Indians in all 94 U.S. Counties served by an urban Indian health organization. Factors such as poverty, inadequate education, homelessness, and other social conditions contribute to these inequities. Additionally, many urban Indians lack health insurance that limits their ability to receive adequate levels of health care. Like most health care institutions, we are experiencing an epidemic of chronic health conditions. Because we offer only primary health care as one element of our services through our organizations, access to specialty care has become increasingly limited. This problem inhibits some patients from seeing the type of improvement in their health that could be achieved with a more comprehensive system available for their needs.

The urban Indian health program within the Indian Health Service, outlined as Title V of this Act, is the foundation for our work. The resources and support we receive through the Indian Health Service is the anchor for our local planning and development that allows for direct participation by the local community in the planning and implementation of programs and services as envisioned by the

current policy of Indian self-determination. Most all urban Indian health organizations receive non-Indian Health Service funds from local, state, private, and other federal sources to expand their service capacity and address specific needs. Currently, the IHS funding leverages approximately $2.00 from other sources for every IHS dollar invested.

Urban Indians are a diverse group of aboriginal people. Many are enrolled members of federally-recognized tribes who live in cities. Some belong to state-recognized Indian tribes. 41 states currently recognize nearly 150 Indian tribes with many not recognized by the federal government due to the termination and relocation policies of the 1950s and historical events that have prevented federal acknowledgement. Urban Indians are also descendents of adoptees, Indian children taken from their families in the early 20th century and placed in non-Indian homes in an attempt to "civilize" and assimilate them. In recent years, there are a growing number of Indian people who are of either mixed-race heritage or mixed-tribal affiliation that prohibits them from membership in a tribe. Since individual tribes can determine membership, criteria to join are not automatic and tribal rolls may be closed or restricted by individual tribal choice.

Urban Indian communities are also geographically dispersed throughout metropolitan areas. They are often small compared to other minorities in cities. For this reason, advocacy and local involvement is critical to assure that urban Indians are not overlooked in local planning.

Finally, the majority of urban Indians do not have the option of returning to their home reservations for health care as is often claimed by opponents of the urban Indian health programs. Many do not have a reservation to return to or live a long distance from their home reservation, and those who do return may not be eligible for services or the services they need may not be available at their tribal program. In these instances, access through urban Indian health organizations is critical to their welfare.

The Indian Health Service (IHS) focuses its work on Indians living on or near Indian reservations and members of federally-recognized tribes. Title V is intended to provide core funding to allow local urban Indian communities to organize and build health capacity in cities. This effort has been overwhelmingly successful over the past 30 years since this legislation was first enacted. Receiving barely 1% of the overall IHS funding each year, just under $34 million in FY07, urban Indian health organizations have successfully maintained community-based programs and services sensitive to cultural concerns and effective in reaching out to urban Indians generally overlooked by other institutions. For this reason we believe that the Indian Health Care Improvement Act must be reauthorized and that the urban Indian health program be retained because health disparities continue to exist.

As you are well aware, the Bush Administration has proposed eliminating funding for urban Indian health in both the FY07 and FY08 Presidential budgets. Fortunately, the Congress has not agreed to this proposal and has continued its modest financing of our work. I have attached suggestions for changes to the bill that I believe will strengthen the standing of the urban Indian health program and will assure our continued involvement in the Indian health initiative. Our services are an essential part of the Indian health agenda for we have the capacity to reach out to all Indians throughout the nation and assure that their needs are addressed.

The Indian population has expanded beyond the boundaries of the reservation and many Indians in cities face enormous challenges that threaten their health. Urban Indian health organizations have amassed knowledge and experience that assures that Indians living in cities are not forgotten and that their needs are recognized and assistance is provided. With the trend toward urbanization to likely continue for decades to come, the importance of our work cannot be over stated. Therefore we ask for your earliest passage of this important bill and your continued recognition of the standing of urban Indians by passing the Act with the Title V provisions intact.

Thank you for the opportunity to provide this testimony. I appreciate your allowing me to share my thoughts on this important legislation for Indian people.

Appendix A

Recommendations for Changes in HR 1328

In Section 2 of the bill, FINDINGS: I believe that inserting the attached language consistent with Congressional intent and practice will serve to strengthen the standing or urban Indian health as an intentional initiative to address health concerns of urban Indians.

Proposed language:

( ) *the government's responsibility to provide health care services to Indians does not end at the borders of an Indian reservation, but follows that individual. Urban Indians maintain their standing as Indians when living in cities and, thus, the urban Indian health program is designed to assure that Indians living in cities are assisted in achieving improvements in their health status.*

Congress has made similar statements in reports (including Senate Report 100-508, Indian Health Care Improvement Act of 1987, September 14, 1988, p. 25, and elsewhere) but has not done so in statute. By adding this paragraph to the FINDINGS Section, the Congress will reassert its consistent intention to address health throughout Indian Country today, and will define that Title V, Health Services for Urban Indians, is your way of implementing this policy.

In Section 3: Declaration of National Indian Health Policy, I am requesting that the bill return to the language included in P.L. 102-573 that includes the words "and urban Indians" in paragraph (1) of this statement so that after the words "highest possible health status for Indians" adding, *"and urban Indians*." We have found that when urban Indians are not specifically spelled out in legislation, regulation, or grant and contract proposal requests, that the assertion is that we are NOT included. Therefore, if the bill intends to include urban Indians as a part of the national policy, I believe it essential that this be clearly stated in the language of the Act.

Mr. PALLONE. Mr. Lucero.

STATEMENT OF KEN B. LUCERO, PUEBLO OF ZIA

Mr. LUCERO. Good morning and thank you, Chairman Pallone, Ranking Member Congressman Deal, and members of the Subcommittee on Health. My name is Ken Lucero and I am a councilman from the Pueblo of Zia. I am here on behalf of the men, women and children of Zia Pueblo and the All Indian Pueblo Council. I would like to thank Congresswoman Wilson for her invitation to address the subcommittee of the Energy and Commerce committee. Her recognition of the need for the Pueblo Nations in New Mexico to articulate their needs concerning health care is greatly appreciated. Thank you on behalf of the Pueblo of Zia and the All Indian Pueblo Council.

My message is simple. The Indian Health Care Improvement Act must be amended and reauthorized in order to bring the Indian health system into the 21st century. The Act expired in fiscal year 2000 and since then American Indian and Alaskan Native leaders have petitioned Congress to reauthorize the Act so that Indian health care may be modernized and disparities in Indian health can be positively addressed. Tribal leader after tribal leader has come before you to bare their souls and share the tragedies endured by their people and yet the requests have not been granted, so today I add my voice to those honorable tribal leaders that have come before me in calling for the reauthorization of the Indian Health Care Improvement Act.

In 2003, the U.S. Commission on Civil Rights issued "A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country." This report highlighted the Federal Government's failure to provide adequate funding and meet trust obligations. Among the Commission report's findings, Native Americans are 318 percent more likely to die from diabetes, 630 percent more likely to die from alcoholism and 658 percent more likely to die from tuberculosis. Members of the committee, these statistics are gathered from tribal communities. These are our grandparents, our grandchildren, mothers and daughters, fathers and sons. These statistics are real.

I understand that it is difficult for this committee and your fellow members of Congress to identify with the stories and the data buried in the mountains of testimony provided on behalf of this Act. So for just a minute, I would like for you to pretend that the House of Representatives is a pueblo in New Mexico and that the Senate represents the groups of other Americans. Picture your fellow lawmakers as members of your community. You are all somehow related and you view each other as a large extended community. How would this report affect your community? In the case of diabetes, if one Senator died from complications of the disease, you could expect 14 of your members to also die from diabetes. If one Senator died from alcoholism, 27 of you are expected to do the same within your membership. And finally, if one member of the Senate dies from tuberculosis, 28 of your colleagues will meet the same fate. I think this room would look much the same if that were to be the case as it does now.

If this committee can keep this example in mind while listening to my testimony and the testimony of the rest of the panel today,

I hope that Congress can gain a better appreciation for the urgency of our message. In New Mexico, the State's 205,000 Native Americans have the highest rates of death for diabetes, alcoholism, pneumonia and influenza. Our children suffer the highest rates of behavioral health risks such as substance abuse, smoking, illicit drug use and obesity and the five major regions for outpatient care at IHS facilities are diabetes, respiratory infections, hypertensive disease, well-child care and prenatal health care. With such a demand for the important health care services, it is disheartening to report that the IHS health care programs are being ended completely or being drastically reduced. Santa Fe Indian Health Service no longer provides birthing services. The Albuquerque Indian Health Services are severely limited due to the lack of adequate funding, as the Congresswoman Wilson knows very well.

Now, while full and adequate Federal funding is extremely important, it is also important that the United States provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage maximum participation of Indians in the planning and management of their health care services. H.R. 1328 will pave the way and redefine the existing health care delivery system for American Indians and Alaska Natives and to bring that health care system into the 21st century.

In conclusion, the Indian Health Service services 1.8 million federally recognized American Indians and Alaskan Natives. The 1.8 million represents less than 1 percent of the United States population. Now, with this comparatively small service population, the Indian Health Service should be the gold standard of health care in the United States. The potential is there. Through the combined efforts of tribes, Congress and the executive branch, we can provide serious, meaningful benefits to Indian Country and to this country as a whole.

Mr. Chairman, members of this committee, I strongly encourage you to take this opportunity to raise the standards of health care provided by the Indian Health Service and to begin the work to ensure that American Indians receive the best possible health care. I ask that the committee for unanimous support of H.R. 1328 and passage at the earliest possible date. Thank you.

[The prepared statement of Mr. Lucero follows:]

WRITTEN TESTIMONY OF KEN LUCERO

COUNCILMAN, PUEBLO OF ZIA,

CHAIRMAN, ALL INDIAN PUEBLO COUNCIL HEALTH COMMITTEE,

CHAIRMAN, INDIAN HEALTH SERVICE ALBUQUERQUE SERVICE UNIT

INDIAN HEALTH BOARD

BEFORE THE

UNITED STATES HOUSE

COMMITTEE ON ENERGY AND COMMERCE

ON

THE REAUTHORIZATION OF

THE INDIAN HEALTH CARE IMPROVEMENT ACT

JUNE 07, 2007

Chairman Pallone, Ranking Member Congressman Deal and Members of the Honorable Subcommittee on Health:

My name is Ken Lucero and I am a Councilman from the Pueblo of Zia. I am here on behalf of the men, women and children of Zia Pueblo and the 19 Pueblo Nations of New Mexico. I bring greetings from Zia and the All Indian Pueblo Council. I thank Congresswoman Wilson for her invitation to testify on the Indian Health Care Improvement Act Reauthorization bill, H.R. 1328, to House Energy & Commerce Committee, Subcommittee on Health. Her recognition of the need for the Pueblo Nations in New Mexico to articulate their needs concerning health care is greatly appreciated. Congresswoman Wilson is genuinely concerned about the challenges faced by the Albuquerque Area Service Units and specific issues related to diabetes, dental care and youth suicide. Thank you on behalf of the Pueblo of Zia and the All Indian Pueblo Council.

The Indian Healthcare Improvement Act ("Act") was originally passed by Congress in 1976 and signed by the Late President Gerald R. Ford. The Act expired in FY 2000 and since then American Indian Alaska Native leaders and Indian health advocates have petitioned Congress to reauthorize the Act so that Indian health care may be modernized and that disparities in Indian health can be positively addressed.

Unfortunately, the reauthorization of this important, life saving, Act has not happened. For nearly a decade, Tribal leadership from many tribal nations have come before Congress and have shared their tribe's health care tragedies that have befallen their

elderly and their children alike. Today, I add my voice to those honorable tribal leaders that have come before me in calling for the reauthorization of the Indian Health Care Improvement Act.

In 2003, the U.S. Commission on Civil Rights issued "A Quiet Crises: Federal Funding and Unmet Needs in Indian Country." This report highlighted the Federal government's failure to provide adequate funding and meet trust obligations reported that American Indian health care is funded at only half of what is needed to meet the statutory goal of eradicating the health disparities of Native Americans. Among the Commission report's other findings, Native Americans are:

318% more likely to die from diabetes

630% likely to die from alcoholism

650 % more likely to die from tuberculosis

Honorable members of the Committee, these statistics are gathered from tribal communities; tribal members, grandparents, grand children, mothers, daughters, husbands, nephews, nieces. These statistics are real.

I understand how it is difficult for this committee and your fellow Members of Congress to identify with the stories and data buried in the mounds of testimony provided on behalf of the Act.

So, let us say that the House of Representatives is a Pueblo in New Mexico and the Senate represents other groups of Americans. Picture your fellow law makers as

members of your community. You are all somehow related and you view each other as a large extended family.

How would this report affect your community?

In the case of diabetes, if 1 Senator died from complications of the disease, you could expect 14 of your members to also die from diabetes. If 1 Senator dies from alcoholism, 27 are expected to do the same within your membership. Finally, if 1 member of the Senate dies from tuberculosis, 28 of your colleagues will meet the same fate.

In New Mexico alone, the state's 205,000 Native Americans have the highest rates of death among the state's total population for diabetes, alcoholism, pneumonia and influenza. Our children suffer the highest rates of behavioral health risks such as substance abuse, smoking, illicit drug use, and obesity. The five major reasons for outpatient care at Indian Health Service ("IHS") facilities, according to the 2006 Albuquerque Area IHS Annual Report are: Diabetes, respiratory Infections, hypertensive disease, well child care, and prenatal health care.

With such demand for these important health care services, it is disheartening to report that IHS health care programs are being ended completely or are being drastically reduced. Santa Fe IHS no longer provides birthing services. Albuquerque IHS services are severely limited due to the lack of adequate funding, as the Honorable Congresswoman Wilson knows very well.

As stated in testimony offered by Senator Jeff Bingaman before the Senate Finance Committee on March 22, 2007, "The Indian Health Service has struggled for years to meet the needs of the Indian population, but continues to face enormous challenges. Aging facilities, staff shortages, and funding shortfalls are emblematic of the challenges facing the Indian Health Service." Senator Bingaman went on to show a graph that compares historic funding levels to those for Medicare and Medicaid. It showed that per capita spending has grown steadily over the past decade to nearly $8,000 through Medicare and $4,500 through Medicaid, while the IHS national average funding remained almost flat at $2,130.

In the Albuquerque Area, the funding disparities are even greater. It would take an additional $48,158,854 to achieve the IHS national average of $2,130. If Congress were to bring the Albuquerque Area up to the U.S. average per capita for health expenditures of $6,423, it would require an additional $380,947,921 in Federal funding.

While full and adequate Federal funding is extremely important, it is also important that the United States provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level **and** to encourage maximum participation of Indians in the planning and management of their health care services.

Our message is simple: The Indian Health Care Improvement Act must be reauthorized. Reauthorization of the Act would:

- Modernize Indian Health care;
- Recruit and retain highly qualified Indian doctors and nurses;
- Address behavioral and mental health care needs; and
- Allow for in-home health care for Indian elderly

Furthermore, the Indian Health Care Improvement Act[1]:

- Establishes objectives for addressing health disparities of Indians as compared with other Americans
- Enhances the ability of Indian Health Services and tribal health programs to attract and retain qualified Indian health care professionals
- Provides innovative mechanisms for reducing the backlog in health facility needs
- Establishes a continuum of care through integrated behavioral health programs—both prevention and treatment –to address alcohol/substance abuse problems and the social service and mental health needs of Indian people
- Facilitates greater decision-making regarding program operations and priorities at the local tribal level in order to improve services to tribal populations.

The Pueblo of Zia, The Albuquerque Service Unit Indian Health Board, and the All Indian Pueblo Council support H.R. 1328 as Amended. Additionally, we strongly support the following key provisions:

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[1] Items provided by the National Indian Health Board.

TITLE I-INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT-

Sec. 102. Health Professions Recruitment Program for Indians-This program has in the past and will continue to provide opportunities for tribes and individuals to enter careers in the health professions.

TITLE II-HEALTH SERVICES

Sec. 201. Indian Health Care Improvement Fund-This section authorizes the Indian Health Service to expend funds for the purposes of eliminating deficiencies and health resources of all Indian Tribes as well as to eliminate the backlog in the provision of health care services to Indians. For the Albuquerque Area, any funds appropriated should go to the Indian Healthcare Fund. These funds would then be allocated within the Area based on the following funding priorities:

- Hospital and Clinics
- IHS Employee Cost of Living Adjustment
- Contract Health Service
- Inflation-including pharmacy costs
- Dental
- Population Growth
- Mental Health

Sec. 203. Health promotion and disease prevention services-This section seeks to improve the health and well being of Indians and to reduce the expenses for health care in Indians. In the Albuquerque Area the number one reason for outpatient visits is Diabetes. A disease that is controllable and visits that are avoidable.

Sec. 204. Diabetes prevention, treatment, and control-This disease is the number one reason for visits in the Albuquerque Area. Fortunately, we are seeing progress due to the Special Diabetes Program (SPDI) for Indians provided by Congress. The Pueblos respectfully request that the Congress continue to support this initiative

Sec. 209. Epidemiology centers-This section mandates that all IHS Areas establish and operate an epidemiology center. There are many reasons that make it necessary for establishing an epidemiology center in each IHS Area. Without an epidemiology center tribes and urban American Indian populations in the area are unable to: (1) access timely and accurate tribe-specific data that would help them develop and expand health service infrastructure; (2) develop both tribal and regional health plans; (3) make informed decisions about meeting their own health needs; or (4) foster the workforce development, academic interest, mentoring, and training that will allow them to actively participate in regional and national-level health discussions and initiatives.

The Albuquerque Area is fortunate to have recently established the Albuquerque Area Southwest Tribal Epidemiology Center. However, there is already a need to request additional funding to support this Center.

Sec. 213. Authority for Provision of Other Services Specifically, hospice care, assisted living, long term care and home- and community based services. It is so important for the Pueblos to ensure that its Elders remain within the community to pass along the stories and traditions of our people.

TITLE III-FACILITIES-This title authorizes the process for determination of construction of health facilities including inpatient, outpatient and specialized health care

facilities such as long-term care and alcohol and drug abuse treatment centers. Wellness centers, staff quarters and sanitation facilities are included in this title as well.

The New Mexico Pueblos support Title III Facilities as drafted in H.R. 1328. And the Pueblo of Zia specifically supports Sec 310-IHS/ Tribal Joint Venture as it prepares to construct a new ambulatory care facility with funds secured from the New Mexico State Legislature and New Mexico Governor Bill Richardson. The Pueblo of Zia has sent a letter of intent to utilize this innovate process.

TITLE VI-ORGANIZATIONAL IMPROVEMENTS-Sec. 601 (a) (2) Assistant Secretary of Indian Health. The establishment of an Assistant Secretary of Indian Health will elevate the status of the Indian Health Services Director to be consistent with similar positions in the Bureau of Indian Affairs and the Department of Housing and Urban Development.

The New Mexico Pueblos support the language in Section 601 of H.R. 1328 elevating the Director of IHS to Assistant Secretary of Indian Health.

TITLE VII-BEHAVIORAL HEALTH PROGRAMS-The purposes of Title VII are numerous and much needed with an emphasis on developing a comprehensive behavioral health prevention and treatment program. Title VII provides information, direction and guidance to Federal, State and Tribal programs in areas of mental illness, dysfunction and self-destructive behavior. Title VII will establish a continuum of care

through integrated behavioral health programs—both prevention and treatment–to address alcohol/substance abuse problems and the social service and mental health needs of Pueblo people. Most importantly it provides a framework for the development of tribally appropriate and culturally sensitive programs that are of the greatest benefit to our people.

In Conclusion, based on a January 2005 Indian Health Service, "Facts on Indian Health Disparities", the passage of this act affects only 1.8 million Federally-recognized American Indians/Alaska Natives and the IHS budget is only 2.8 billion. The 1.8 million represents less than 1% of the United States population and the existing IHS budget of 2.8 billion is an even smaller piece of a $697 billion Department of Health & Human Services budget. With its comparatively small service population, The Indian Health Service should be the shining example of health care in the U.S. It offers so much potential. With a solid policy, additional funding and a lot of hard work, the Indian health care can be the gold standard of health delivery. Through the combined efforts of Tribes, Congress and the Executive, we can provide serious meaningful benefits to Indian country and to this country as a whole.

Mr. Chairman, Ranking Member and Members of this Honorable Committee, I strongly encourage you to take this opportunity to raise the standards of care provided by the Indian Health Service and to begin the work to ensure that American Indians receive the best possible health care. I ask the committee for unanimous support of H.R. 1328 and passage at the earliest possible date.

NEW MEXICO PUEBLO HEALTH CARE AND RELATED STATISTICS

Population and Demographics

- 19 Pueblo Reservations in NM for a total land base of 3485 sq. miles (2000 U.S. Census Bureau)

- Pueblo Tribes include: Acoma Pueblo; Cochiti Pueblo; Isleta Pueblo; Jemez Pueblo; Laguna Pueblo; Nambe Pueblo; Picuris Pueblo; Pojoaque Pueblo; Sandia Pueblo; San Felipe Pueblo; San Ildefonso Pueblo; San Juan Pueblo; Santa Clara Pueblo; Santo Domingo Pueblo; Taos Pueblo; Tesuque Pueblo; Zia Pueblo; Zuni Pueblo.

- Total NM Pueblo population is 63,404: 3.5% of NM population (2000 U.S. Census Bureau)
    - Females – 32,530
    - Males – 30,874

Pueblo Health Facts

- Pueblo Birth account for 3.1% of all NM resident births (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)

- 73.6 % of Pueblo births are to single mothers (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)

- 21.2 % of Pueblo Births are to teenage mothers (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)

- Resident deaths with Pueblo affiliation ages 1-65 account for 28.7 % of NM American Indian deaths and 1.9 % of all NM resident deaths (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)

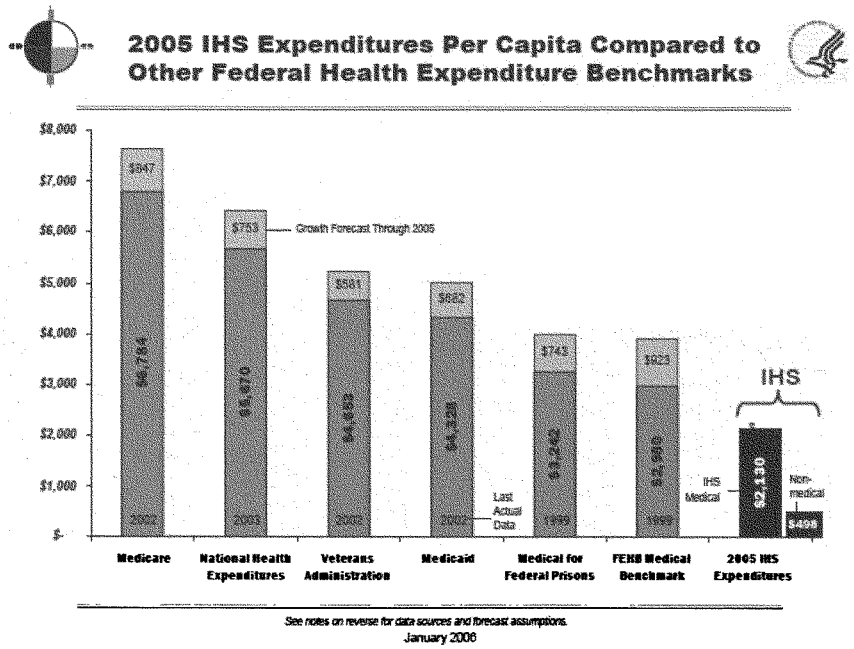
- Five leading causes of death for NM Pueblo residents 1991-1999 (2002 NM Tribe Specific Vital Statistics Report; NM Dept. of Health)
    - Heart disease at 13 % deaths to Pueblo individuals
    - Accidents (unintentional injuries) 12.6 %
    - Malignant neoplasms-Cancer 12.2 %
    - Diabetes Mellitus 10.5 %
    - Chronic Liver Disease and Cirrhosis 8.3 %

- Native Americans in New Mexico experience the worst rates of health disparities and have the highest rates of death due to diabetes, pneumonia and alcohol.
- Native American youth have the highest behavioral health risk factors in New Mexico for adolescent smoking, drinking, illicit drug use, and obesity.
- The Indian Health Service is cutting back on basic outpatient health and maternal care at the Albuquerque and Santa Fe Service Units.

- Contracted tribal health care programs are under funded and provide limited services.

ALBUQUERQUE AREA FUNDING FACTS

- The National IHS Average is half of the funding provided to federal prisoners
- Per User, overall funding for the Area is 1/3 less than the National IHS Average
- Loss of over $1 million per year in uncovered pay increases
- All Albuquerque Area facilities fund only Priority One CHS cases.



ALBUQUERQUE AREA INDIAN HEALTH SERVICES

COMPARISON TO NATIONAL IHS AND U.S. AVERAGE

FY2006

FUNDING ALLOCATION DEFICIT TO NATIONAL IHS AND U.S. AVERAGE

	NATIONAL IHS AVERAGE	U.S. AVERAGE		
FY2006 AAIHS User Population	77,519	77,519	(b)	
IHS National and U.S. Per Capita Average	$2,130	$6,423		
Funding Required Based on IHS Per Capita Avg	$165,115,470	$497,904,537		
Actual Recurring & 3rd Party Collections	$116,956,616	$116,956,616	(a)	
Estimated Deficit to IHS Average	$48,158,854			**$48,158,854**
Estimated Deficit to U.S. Average		$380,947,921		**$380,947,921**
Funding Per User (a) \ (b)	$1,509	$1,509		

PAY Funding Shortfall

	FY2005	FY2006	
Mandatory Pay Increase	$1,592,472	$1,835,168	
Actual Funding Distribution	$316,597	$666,850	
Pay Funding Shortfall	$1,275,875	$1,168,318	$2,444,193
Percent Funded	19.88%	36.34%	

Mr. PALLONE. Thank you.

Ms. Joseph, thank you for being here.

STATEMENT OF RACHEL A. JOSEPH, CO-CHAIR, NATIONAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT; NATIONAL INDIAN HEALTH BOARD

Ms. JOSEPH. Good afternoon, Mr. Chairman, members of the subcommittee. I am Rachel Joseph, co-chair of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act. I am also testifying on behalf of the National Indian Health Board, a national Indian organization that advocates health issues on behalf of all Indian tribes. Thank you for this opportunity to testify in support of H.R. 1328.

In 1999, the director of the Indian Health Service established the National Steering Committee comprised of tribal representatives from across the country and the national health organizations. Since then the steering committee and the National Indian Health Board have led reauthorization efforts, have accommodated administration and congressional concerns through endless compromises and reached consensus on key policy issues. We are guided by the principle of no regression from current law and protection of tribal interests. As you are aware, we will continue with that effort this afternoon when we meet with congressional staff to address facilities issues in section 301. As Congresswoman Heather Wilson articulated, we have not had the opportunity to update our reauthorization for over 14 years. Modernization is essential for our health care systems.

Indian tribes ceded over 400 million acres of land based on government promises including promises of health care. The U.S. Commission on Civil Rights in its 2003 report "A Quiet Crisis" found that the Federal Government has not lived up to its promise to provide adequate health care. The U.S. Commission on Civil Rights in its 2004 report "Broken Promises" evaluating the Native American health care system, found tremendous disparities as already articulated by Congresswoman Hooley. The travesty in our health conditions is knowing that the majority of illnesses and deaths from disease are preventable. Additional funding and contemporary programmatic approaches are necessary.

One of the key provisions in H.R. 1328 is the elevation of the Indian Health Service director. We believe an assistant secretary is essential to advocate for health care issues and certainly budget increases. In 2007 at consultation, tribal officials implored HHS officials to be an advocate, and there was no response, and so we feel that there was no commitment and the plea falls on deaf ears. We feel that an assistant secretary would be a point to oversee. For example, the issue related to regulations implementing section 506 from the Medicare Modernization Act of 2003 languished in the Department for years and just this week those regulations were published. We believe the regs bounce back and forth between IHS, CMS and HSS because of lack of ownership by someone for the regulation. We strongly support the behavioral health programs.

Mr. Chairman, I appreciate your question to the administration about when we might see their views. I quickly reviewed their tes-

timony this morning and their objection to section 712 in the behavioral health just astounds me, and we would appreciate any assistance you can give us to get a grip on what their objection is. Tribal leadership felt strongly because of the substance abuse epidemic in our communities that we needed to address fetal alcohol disorders and just one excerpt from that is to develop, print and disseminate education and prevention materials on fetal alcohol disorders. We have a hard time understanding what the objection to this authorization is, so your assistance will be greatly appreciated.

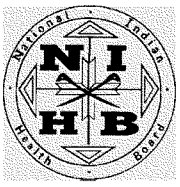
The issue related to "shalls" and "mays" it seems to me that the testimony is somewhat outdated. We made a commitment to scale back "shalls" and "mays" and the only new "shalls," and I believe there is two is something that congressional staff supported and felt needed to be included in the bill and we agree with that.

The issue of funding in place of grants, that was addressed a couple of generations ago in updating and addressing concerns. So we will do anything we can to work with you, other Members of Congress and the administration. We met with Laura Ott on April 17. Laura is the Deputy Assistant Secretary for Health Legislation and respectfully requested that we see their views before the markup in the Senate Indian Affairs Committee which has already been done on May 10 and reported unanimously or reported out. We think that because of the tremendous disparity in health care indicators we need to get this reauthorization soon.

Last year one of our respected and esteemed colleagues, Dr. Taylor Mackenzie, former president of the Navajo Nation, who served on the steering committee with us from the very beginning, in his drive and effort to keep us encouraged, leaned over and he said, "Rachel, do you think this will pass in our lifetime?" and we chuckled. It is not funny anymore. We lost Dr. Mackenzie a couple months ago. So to us, the challenges of providing health care are always present and always constant. Our proposal to provide assisted living long-term health care to our elders is essential. Tribal leaders feel strongly about having to send our grandparents and our aunties and uncles so far away from the reservation to receive necessary health care and certainly limited visitation opportunities for families. We think this kind of modernization and update is essential and certainly what is provided in other communities in our country.

Thank you for your efforts on our behalf, and we stand willing and able to do anything we can to move this legislation this year. Thank you again for this opportunity.

[The prepared statement of Ms. Joseph follows:]



NATIONAL INDIAN HEALTH BOARD

101 Constitution Ave. N.W., Suite 8-B02 • Washington, DC 20001
Phone: (202) 742-4262 • Fax: (202) 742-4285
Website: www.nihb.org

TESTIMONY OF RACHEL A. JOSEPH

Co-Chairperson of the

National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act

Before a Hearing of the Health Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
June 7, 2007 – 11:00 AM
Room 2322 Rayburn House Office Building

Good morning, Chairman Pallone, Ranking Member Deal, and members of the Subcommittee. My name is Rachel A. Joseph. I am a member of the Lone Pine Pauite-Shoshone Tribe of California and serve as the Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). I am a former Chairperson of the Lone Pine Pauite-Shoshone Tribe and am a current board member of the Toiyabe Indian Health Project, a consortium of nine Tribes, which serves Mono and Inyo Counties in central California. I have served for several years on the Indian Health Service (IHS) National Budget Formulation team representing California and have been elected to represent the IHS East Central California Tribes to the California Area Office Advisory Committee. In these capacities, and others, I have

been fortunate to work with Tribal Leaders from across the Country in addressing health care issues. Thank you for holding this hearing and providing us the opportunity to testify in support of H.R. 1328, to amend and reauthorize the IHCIA.

This testimony is also offered on behalf of the National Indian Health Board (NIHB). The NIHB serves all 561 Federally-Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to AI/ANs and upholding the federal government's trust responsibility to AI/AN Tribal governments. Over the last several years, the NIHB has provided tremendous administrative, technical, and policy development support to the NSC.

In June 1999, the Director of IHS established the NSC, comprised of representatives from Tribal governments and national Indian organizations, for consultation and to provide assistance regarding the reauthorization of the IHCIA, which was set to expire in 2000. The NSC drafted proposed legislation, which reflected the tribal consensus recommendations developed at area, regional meetings and a national meeting held here in Washington, DC. In October 1999, the NSC forwarded a tribal proposed IHCIA reauthorization bill to the IHS Director, to each authorizing committee in the House and Senate, and the President. An IHCIA reauthorization bill has been introduced in the 106th, 107th, 108th, and 109th Congresses; while none of the bills passed, the NSC has continued as an effective tribal committee by providing advice and "feedback" to the Administration and Congressional committees regarding the IHCIA reauthorization bills. We look forward to working with members of the Energy & Commerce Committee to guarantee passage of H.R. 1328 in this 110th Congress.

Reauthorization of the IHCIA is necessary to fulfill the Federal government's obligation to provide health care to AI/ANs

Recently, Home Box Office (HBO) released the film "Bury My Heart at Wounded Knee" an adaptation of Dee Brown's book of the same name. While the movie highlights the struggle of the Sioux Nation following the Battle of the Little Big Horn in 1876, Dee Brown's book describes the systematic removal of several Indian Tribes from their original homelands to reservations. In fact, one chapter of the book describes the removal of the Modoc Tribe from their original homelands in California to reservations in Oregon and Oklahoma. Throughout the nineteenth century, Indian Tribes ceded over 400 million acres of land to the Federal government based on promises made by the government, including promises of health care. The U.S. Commission on Civil Rights, in its 2003 report "A Quiet Crisis" found that the federal government has not lived up to its promise to provide adequate health care. The "funding for programs associated with those promises has fallen short, and Native peoples continue to suffer the consequences of a discriminatory history . . . . Native Americans continue to rank at or near the bottom of nearly every social, health, and economic indicator."

In 1976, Congress enacted the IHCIA to address the deplorable health conditions existing in Indian Country. Over the last thirty years, progress has been made in reducing the occurrence of infectious diseases and decreasing the overall mortality rates. But, today AI/ANs still experience significant health disparities and have lower life expectancy than the general population. The enhancements in H.R. 1328 will facilitate improvements in the Indian health care delivery system. Health services will be delivered in a more efficient and pro active manner that in the long term will reduce

medical costs, will improve the quality of life of AI/ANs, and more importantly, will save the lives of thousands of AI/ANs.

Enactment of H.R. 1328 will facilitate the modernization of the systems of health care relied upon by 1.8 million AI/ANs. The bill authorizes methods of health care delivery for AI/ANs in the same manner already considered standard practice by "mainstream" America. 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.

Indian Country has been working for over eight years to achieve reauthorization of the IHCIA ---- enactment of H.R. 1328 in this 110th Congress is critical to fulfilling the Federal government's obligation to provide health care to Indian people.

Health Care Disparities

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

We have demonstrated that 13 percent of AI/AN deaths occur in those younger than 25 years of age, a rate three times higher than the average US population. The U.S. Commission on Civil Rights, in its report "Broken Promises: Evaluating the Native

American Health Care System, (September 2004) that "Native Americans continue to experience significant rates of diabetes, mental health disorders, cardiovascular disease, influenza and injuries . . . Native Americans are 770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents, and 52 percent more likely to die from pneumonia or influenza than the rest of the United States." Rates of cardiovascular disease among AI/ANs are twice the rate than for the general public, and continue to increase, while rates for the general public are actually decreasing. Furthermore, according to the IHS, AI/ANs have a life expectancy six years less than the rest of the US population.

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/ANs 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 were 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.

I appreciate the opportunity to highlight some of the key provisions of H.R. 1328 that, if enacted, would further the health status of Indian people and reduce health disparities:

- ***Elevation of the Indian Health Service Director***
- ***Behavioral Health Programs***
- ***Access to Health Services***
- ***Long-Term Care and Home and Community Based Services***

Elevation of the Indian Health Service Director

The NSC and NIHB support the language in Section 601 of H.R. 1328 elevating the Director of IHS to Assistant Secretary of Indian Health. Tribal leaders have long advocated for elevation of the IHS Director to that of an Assistant Secretary of Indian Health. 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). The position is comparable to the administration of the Bureau of Indian Affairs programs with an Assistant Secretary in the Department of Interior and an Assistant Secretary for Public and Indian Housing in the Department of Housing and Urban Development.

While HHS has made great strides over the past several years to address Tribal issues, the elevation of the IHS Director to that of an Assistant Secretary would facilitate the development of AI/AN health policy throughout the Department. For instance, there are some Department meetings that are restricted to the Assistant Secretary level. Sometimes the IHS Director is not in attendance at meetings where preliminary decisions

are made that could impact Indian health. By the time the IHS Director is brought into the discussion, there is little opportunity to reverse or influence policy decisions made at previous meetings. An Assistant Secretary of Indian Health is necessary to ensure that when decisions are made that will impact Indian health, there is sufficient and timely opportunity to provide an Indian health perspective before a decision is made.

Many of the Indian health issues are crossing cutting issues that involve other agencies in the Department. At the Assistant Secretary of Indian Health level, Indian health issues, involving other agencies, could be better coordinated between the agencies. An Assistant Secretary of Indian Health would be in position to work with other HHS agencies to identify additional funding and grant opportunities for Tribes.

Most recently, events have occurred that further demonstrate the importance of the elevation of the IHS Director to an Assistant Secretary of Indian Health:

- At the HHS budget consultation meeting held in March 2007, the Tribes requested a substantial increase, of $600 – 800 million, in IHS funding. On an annual basis, HHS holds budget consultation with Tribes and each fiscal year, the tribal requests for increased funding are not successful. While Tribal leaders implored the IHS Director and other HHS officials to advocate on their behalf for increased funding, no commitments were made. By establishing an Assistant Secretary of Indian Health, there would be an office within the Department with responsibility to advocate for an increase in IHS appropriations.
- On June 4, 2007, HHS published final regulations implementing section 506 of the Medicare Modernization Act of 2003. Section 506 requires the Secretary of HHS to promulgate regulations establishing a payment methodology that

Medicare participating hospitals would accept as payment in full for services provided to IHS beneficiaries referred under the IHS contract health service program or referred by an urban Indian program. Section 506 required the Secretary to publish regulations by December 2004. For the last three years, the draft regulations have gone back and forth in clearance between IHS, Centers for Medicare & Medicaid and HHS, largely due to a lack of ownership of the regulation within HHS. If there were an Assistant Secretary of Indian Health, these regulations could have been promulgated in a more efficient manner.

- In addition, two regulations, impacting Indian health programs, were cleared through HHS without review and clearance by IHS, the primary agency within HHS for Indian health programs. One of the regulations defining "units of government" for Medicaid purposes was published on May 29, 2007. Tribes submitted comments to the regulations because the regulations, as proposed, would negatively impact the operation of tribal health programs. Yet, these regulations were not sent to IHS, as part of the HHS clearance process, before publication in the Federal Register.

Behavioral Health Programs

The NSC and NIHB strongly support the Title VII provisions of H.R. 1328, which authorize comprehensive behavioral health programs that reflect tribal values and emphasize collaboration among alcohol and substance abuse programs, social service programs and mental health programs. Title VII addresses all age groups and authorizes

specific programs for Indian youth including suicide prevention, substance abuse and family inclusion.

The Title VII provisions establishes a "systems of care" approach that 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. The provisions in Title VII are necessary to address the increased demand for behavioral health services in Indian Country:

- Indian Country is experiencing a methamphetamine epidemic: there are increased law enforcement efforts, meaning more arrests; but insufficient treatment programs to address the number of individuals needing recovery assistance. IHS is funded at less than 60% of the level needed to provide basic adequate health care services; meth treatment costs substantially more than most other addiction treatments and last substantially longer, often over a year.
- Indian Country is experiencing a youth suicide epidemic: suicide is the second leading cause of death for Indians between the ages of 15 and 24; and the third leading cause of death for children 5 to 14 years of age.

At the HHS tribal consultation meeting in March, 2007, a tribal leader from the White Mountain Apache Tribe stated, "Though we are located hundreds of miles away from the nearest metropolitan city our reservation has been swarmed with the deadly ills of society such as alcohol, illegal drugs and most recently, methamphetamine," and "in almost all cases, our suicide incidents involved the use of alcohol." For the White Mountain Apache youth, suicide rates among 15 to 24 year olds **are 10-12 times** higher than the U.S. average.

Access to Health Services

The NSC and NIHB support the provisions in title IV as well as the provisions in Title II of H.R. 1328 amending titles XVIII (Medicare), XIX (Medicaid), and XXI (State Children's Health Insurance Program (SCHIP) of the Social Security Act. These provisions will provide the IHS, tribal and urban Indian programs with more flexibility to provide Medicare, Medicaid and SCHIP covered services and to receive appropriate reimbursement for those services.

One of the more important provisions in Title II of H.R. 1328, is section 204 that ensures maximum participation and enrollment of AI/ANs in the Medicaid programs and SCHIP. The provisions exempt AI/ANs, who receive services from the Indian health programs, from Medicaid premium and cost sharing requirements, such as co-payments. In addition, the provisions exempt Indian property from being counted in making eligibility determinations and from Medicaid estate recovery rules.

Because AI/ANs ceded over 400 million acres of land to the federal government in exchange for promises of health care, the Indian health system is often called a "pre-paid" health plan. Indian people have already paid for their health care – and the most vulnerable of the Indian population, those eligible for Medicaid and SCHIP, should not spend their own money or subject their property to seizure, in order to receive Medicaid services. Often cost sharing requirements, for example co-payments, are imposed by private sector health plans to save money and to allow covered individuals to assume "personal responsibility" for their health care. However, within the Indian health system, the individual AI/AN does not expend personal resources for health care, the Indian health program would pay on behalf of the Indian beneficiary. The IHS has estimated

that it costs approximately $20.00 to process a purchase order for a $5.00 co-payment. The more efficient policy approach is to exempt AI/ANs, who utilize the Indian health programs, from cost sharing requirements, as provided for in section 204.

In addition, by removing barriers to enrollment through exemption of AI/ANs from Medicaid and SCHIP cost sharing requirements, the Indian health programs that provide health services to Medicaid and SCHIP eligible AI/ANs will see increased revenues. In the President's FY 2008 Budget Request, the IHS estimates that it will collect over $600 million in Medicaid and Medicare reimbursements at its IHS operated service units – representing almost 25% of the IHS budget. The Medicaid revenues are necessary to meet Medicaid accreditation and compliance requirements, including staffing and other program needs, at Indian health direct care sites, and result in cost savings to the IHS and tribal contract health services programs.

Long-Term Care and Home and Community Based Services

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

The NSC and NIHB support Section 213 of H.R. 1328 authorizing IHS and Tribally-operated health systems to provide hospice care, assisted living, long-term care, and home and community based services. Section 213 enables Indian elders to receive long term care and related services in their homes, through home and community based service programs, or in tribal facilities close to their friends and family. Section 213 provides Indian communities with necessary authorities to provide long term care and related services to its Indian elders that are currently available to the general U.S. population.

The NSC and NIHB support the definition of "home and community-based services" as contained Section 213(c)(1) of H.R. 1328. The definition references the definition of "home and community-based services" in title XIX of the Social Security Act. The NSC further supports standards that are consistent with Medicaid standards.

H.R. 1328 contains many important and innovative provisions that are desperately needed in Indian Country to raise the health status and reduce health disparities of Indian people. We appreciate the support of this Committee in our efforts to secure passage of the IHCIA this Congress. Thank you for providing me this opportunity to present testimony and I am available to answer any questions you may have.

Mr. PALLONE. Thank you so much. I am going to start with questions from myself and I have one question for each of you and I have 5 minutes, so I am going to try to be brief here.

I wanted to ask Mr. Crouch, first of all, I know and I think everyone knows that pursuant to the trust responsibility, theoretically you shouldn't be paying anything. There shouldn't be any co-pays, any premiums, any contribution—I guess one could argue—from the tribes at all because the obligation of the Federal Government from the way I understand it; is that the trust responsibility is 100 percent to pay for health care. But we know that is not the reality but that should be the reality. So I just wanted to ask you, Mr. Crouch, about the co-pays. In the bill there are no Medicaid co-pays or anything of that nature. What are the consequences of having co-pays or expenditures for Medicaid specifically? What are the consequences out there right now because that is the case?

Mr. CROUCH. The consequences of the co-pays, it is a barrier to care. You already have barriers to care that are based on geography, people traveling further. You have barriers to care being on the poverty and the cost of providing that transportation. When you have premiums and co-pays, you are adding another barrier to prevent access to care. What I tried to show in my numbers was that we have already documented under-access to care, low access to care for a population whose health status is well documented as being very poor. It is sort of like having—if Indian health was a fire, you would want to put the hose right where the fire is. The low health status is on flame, creating barriers so the fire truck can't get there. The patient can't get to the service. The clinic can't provide the service. It doesn't make sense.

Mr. PALLONE. All right. I appreciate that. I am just trying to move on.

Mr. CROUCH. Sure.

Mr. PALLONE. Mr. Forquera, you talked about contributions from outside the Federal Government. I have been to some of the reservations where because they may have a little money, they actually have to build the complete facilities from scratch, which again I think is not right. Just comment a little bit on what the tribes themselves have had to contribute on their own. You mentioned State and maybe others but a lot of cases the tribes themselves are contributing significant amounts of resources to health care. How extensive is that?

Mr. FORQUERA. For the urban programs or just——

Mr. PALLONE. No, just in general.

Mr. FORQUERA. In general, I don't know off the top of my head, but I would venture to say that more and more of the tribes are having to pick up more and more of the cost of health care because the appropriations dollar just isn't maintained, and those tribes that have the luxury of having a few resources available to them I think are making those contributions. I know some of the tribes in California have certainly invested in facilities and other kinds of things. The question becomes one of the use of those resources for the health care which should be taken care of, and the fact that there are other needs on those reservations that should be taken care of and where do you prioritize your dollar. Health care fortunately for most of us is seen as one of those fundamental resources

that are necessary and so I think that people tend to want to prioritize that, and I know a lot of the tribal communities are doing so.

Mr. PALLONE. And they really shouldn't have to.

I wanted to ask Mr. Lucero, we really haven't had much testimony about the negative impact of not reauthorizing. Do you just want to comment briefly on the fact that we keep waiting to reauthorize this bill? What are the negative impacts of the fact that we haven't done the reauthorization for 7 years? And you only have a minute, but——

Mr. LUCERO. OK. Well, I think the biggest impact is that we are not able to move into the 21st century. A lot of the programs have been held in shackles—that is the only thing I can think of right now—and they are not able to expand or to implement innovative ideas. One of the questions you asked about facilities is, tribes are being forced to go to the State and fortunately in New Mexico we have a good working relationship with the State and so we have been appropriated funds by the State to assist in building facilities. We are interested in participating with IHS, which is section 310, IHS tribal joint venture, and that is one of the programs that is within the Indian Health Care Improvement Act that the reauthorization will also assist with innovative ideas and moving into telehealth and new modern means of providing health care.

Mr. PALLONE. All right. Thank you.

And then Ms. Joseph, I know we could talk all afternoon. I wanted to ask you about the lack of providers available to Native Americans and the need for innovative solutions such as the community health aid program. In the Resources Committee, I was amazed when the gentleman said that there were only 400 or 500 Native American doctors in the country. I couldn't believe that. Do you just want to comment on what we should be doing to address the fact that there aren't enough Native American providers, whether it be doctors, nurses and what to do about that?

Ms. JOSEPH. Thank you, Mr. Chairman, for that question, because I wanted to make a comment on Ranking Member Deal's question about the community health aid program. I will just take you back a little bit. For whatever circumstances, there were times in our lives—use me, for example. I had an uncle who had an extracted tooth—my mom was sweet and kind and just couldn't deal with that—with a pair of pliers and an auntie tied another tooth to a string, do the old open the door thing and pull that. In Alaska in some communities, a dentist only comes once a year. Hopefully it is once a year. And through the community health program, and extensive at least 2-year training, we provide opportunities for emergency care to be provided under the supervision of a dentist. That particular language authorizing that or at least clarifying that was addressed. The concerns raised by I think Congressman Norwood and the American Dental Association was addressed before the bill was marked up and reported out of the Resources Committee last year and that compromise was facilitated by Congressman Don Young. So through the opportunity to provide creative ways of providing health care through telemedicine and other ways is one way and we certainly look toward some of those innovative approaches in the reauthorization.

Mr. PALLONE. OK. Thank you. Mrs. Wilson.

Mrs. WILSON. Thank you, Mr. Chairman.

Mr. Lucero, thank you again for being here. You mentioned in your testimony that the Santa Fe hospital is no longer providing OB/GYN services, and of course, you also mentioned cutbacks in the Albuquerque and Santa Fe areas. I wonder if you could expand on that and particularly what does that mean for a family in Nambay? Where do they get their OB/GYN care, if they can't get it at the Santa Fe Indian Hospital?

Mr. LUCERO. As far as where they are getting their OB/GYN, I think a lot of what is happening is, they are being referred to the St. Vincent's Hospital there in Santa Fe and are relying on contract health services, and again, we all know and have testified about the lack of funding in contract health services and that everybody is on a priority one, and so a lot of those dollars have to go or are taken away from other services to provide that when in fact they should be provided through the hospital clinics in the Santa Fe service unit.

Mrs. WILSON. Would you like to expand at all on the funding issues in Albuquerque and Santa Fe and what you are seeing?

Mr. LUCERO. Yes, please. There was testimony offered by Senator Jeff Bingaman before the Senate Finance Committee on March 22 and he indicated about how over the years that the Medicaid and Medicare funding has continued to increase and per capita spending had grown nearly $8,000 through Medicare and $4,500 through Medicaid while the IHS national average for funding remained almost flat at $2,100. Now, in the Albuquerque area, those funding disparities are even greater. It would take an additional $48 million to achieve even the IHS national average of $2,130, and if Congress were to bring the Albuquerque up to the U.S. average per capita for health expenditures, which is $6,423, it would require an additional $380 million in order to even get us up to that level. So those are kind of the numbers that we have available.

Mrs. WILSON. Ms. Joseph, a question for you on health education. Are there things that we can do either in the—as I understand it, there is a medical education program and there may be some caps on slots for, I think it is referred to as GME, in the Medicare or Medicaid programs. Are there changes to that program that we can make to increase the number of doctors who might be allowed to practice out in Indian Country or is the IHS able to tap into that pool of doctors under the GME program? Are you aware of that at all?

Ms. JOSEPH. I am not sure if they can tap into it or not but definitely if we can, we should. We can look into that because it seems to me we are always recruiting. There is a tremendous shortage of doctors and nurses in particular.

Mrs. WILSON. Because I have heard that there is some kind of a barrier there that makes it more difficult for residents to practice out in Indian Country, and if there is and there is a way to fix that, then I think we should and I would certainly appreciate your input on that. And finally, Mr. Crouch, I did have a question for you on telemedicine. I understand that there are some projects in California on telehealth and telemedicine and I wonder if you would describe those a little bit and I wonder if you have any opin-

ion on whether the telehealth provisions in this bill might help facilitate an improved telemedicine network in the IHS.

Mr. CROUCH. Those provisions would be helpful. If you think about California Indian Country, basically it is four times larger than Navajo but it has about one-eighth the population spread over that geography so it is very thinly distributed from the north of the State all the way to the south, so it covers the entire State. The Telemedicine Program that started initially with some philanthropic funds is often the case in California. The Indian Health Service is working with a number of tribal health programs where they are doing some I believe entry-level work, first starting out with diagnosing retinopathy in the eye with cameras, now moving into issues around dermatology and psychiatry. All of those are services that are easily sort of set up. Telemedicine is much more expansive in use in other areas such as Alaska and the Phoenix area is actually working on a project that would cover a lot of Arizona and Nevada. It does have promise. The fact that those services are billable through Medicaid is very critical to those services being continued because the Indian Health Service is indeed underfunded.

Mrs. WILSON. Thank you, Mr. Chairman.

Mr. PALLONE. I know a vote has been called so we are going to have to end, but I did want to ask a couple things and then if the gentlewoman from New Mexico would like to add something, she could, and then we are going to have to end because we have some votes.

Mr. Crouch, these Medicaid citizenship documentation requirements that were in the Deficit Reduction Act last year that says that States are prohibited from receiving Federal Medicaid reimbursement for individuals who have not provided documentation. Ms. Schakowsky got into it a little bit. Current Medicaid practice states that tribal documents from only five tribes are acceptable proof of citizenship but now we have this provision in the bill that changes that. Would you comment on whether you think that is going to address this problem sufficiently, what we put in the bill?

Mr. CROUCH. The bill language is superior to what is the case as we speak. When the new requirement to document citizenship came down, it seems almost oxymoronic that proof of tribal membership would suffice for this really low level need of documentation. I am a member of the CMS KTAG. We have had extensive review of this issue and the reality is that there are five tribes that have been granted over through history the opportunity to document citizenship. The rules that they follow don't exist. In other words, the rules at CMS that expects them to standards, I guess, whatever, CMS can't define, cannot find. Our language in the bill would make it clear that proof of tribal membership would be proof of citizenship, and for those tribes that do exist on borders but do have members who are not citizens, the Secretary would work with them to develop additional criteria so that those portions of their tribes would be identifiable to Medicaid and therefore not receive services.

Mr. PALLONE. So like use the Tohono Odham, in other words, that language isn't going to help the guys that are in Mexico——

Mr. CROUCH. It depends on how the Secretary rules. So I guess if you think about this rule coming down at a later date, one would only guess how it might change. Currently, the citizens of Tohono Odham, who are not citizens of the United States because of their residence on the reservation but south of the border would be excluded because they would not be able to document citizenship.

Mr. PALLONE. They have the option of becoming citizens though, right? They have that right?

Mr. CROUCH. Sure.

Mr. PALLONE. But they still because they're not citizens would not be eligible?

Mr. CROUCH. The Tohono Odham existed exactly where it is before the Gadston purchase. If you look at a map of Arizona from about 1880——

Mr. PALLONE. I know the history a little bit but what I am saying is, the problem is, even though they have a right to citizenship, and they are federally enrolled with the Interior Department, because they are not citizens, they are still not eligible because of the Act. Is that the way you read it?

Mr. CROUCH. The way I read it right now, they would not be eligible, and if the bill passed, it is possible that they would be eligible not as—they wouldn't be made citizens but they would be eligibilized for Medicaid.

Mr. PALLONE. They would be?

Mr. CROUCH. Yes.

Mr. PALLONE. All right. So the way you read this bill, we would be able to correct all these situations that have come up as far as we know?

Mr. CROUCH. As I read the bill as a member of KTAG, we firmly support this language.

Mr. PALLONE. All right. Thank you very much. I know we are always in a rush around here and it was important that we have the hearing today because we do want to move to markup and so I know it has been expedited somewhat but it is better that we at least did it, and I think we got some answers and hopefully we will get some more, and we do intend to move to markup as quickly as we can. Thank you very much and I appreciate all of your being here. If you have additional responses to our questions or things you want to put in the record, please do so. We will certainly take that letter. And I appreciate you all being here, and we will adjourn the hearing. Thank you.

[Whereupon, at 1:40 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

ALL INDIAN PUEBLO COUNCIL Office of the Chairman

Joe Garcia, Chairman Amadeo Shije, Vice-Chairman John Gonzales, Secretary-Treasurer

ALL INDIAN PUEBLO COUNCIL
RESOLUTION NO. 2007-01

Calling for Drastic Improvements to Healthcare for American Indians and Alaskan Natives

WHEREAS, the All Indian Pueblo Council ("AIPC") is comprised of the nineteen Pueblos of New Mexico including the Pueblos of Acoma, Cochiti, Isleta, Jemez, Laguna, Nambe, Ohkay Owingeh, Picuris, Pojoaque, San Felipe, San Ildefonso, Sandia, Santa Ana, Santa Clara, Santo Domingo, Tesuque, Taos, Zia and Zuni, each having sovereign authority to govern their own affairs; and

WHEREAS, all people should enjoy the highest possible standard of physical and mental health as a fundamental human right; and

WHEREAS, it is unacceptable that, at this time, the people of the 19 pueblos are afflicted with diabetes, alcoholism, mental health conditions, cancer, hypertension, arthritis, heart disease, asthma and other conditions at rates higher than the general population of the United States; and

WHEREAS, we envision a future where our people's health and quality of life are vastly improved through the provision of high-quality, integrated health services at our community-level, including health promotion and disease prevention, that address the most serious diseases and conditions affecting our health; and

WHEREAS, the United States government has a trust responsibility to provide health care to American Indians and Alaska Natives ("AI/AN"); and

WHEREAS, despite this, the Indian Health Service ("IHS") has been chronically underfunded at least 40% below the actual projected need; and

WHEREAS, the IHS is an antiquated system whose authorizing legislation the Congress and recent Presidential Administrations have allowed to expire over six years ago; and

WHEREAS, the appalling failure of the federal government to uphold its trust responsibility for AI/AN health has resulted in the diminishment of the quality of life as well as unnecessary and premature death of countless AI/AN people; and

WHEREAS, the AIPC believes that immediate significant and systematic changes are needed in law and appropriations to remedy this disgraceful federal abrogation of its trust responsibilities; and

WHEREAS, the AIPC feels that, if these actions are not taken by the conclusion of the 110th Congress, appropriate actions, including litigation, must be considered.

NOW THEREFORE BE IT RESOLVED, that AIPC strongly urges the Members of the United States Senate and the United States House of Representatives to pass the Indian Health Care Improvement Act

2401 12th Street NW • Albuquerque, New Mexico 87104
Telephone: 505-881-1992 • Fax: 505-883-7682

prior to the conclusion of the 110th Congress and therefore strongly urges President George W. Bush to sign this legislation into law.

BE IT FURTHER RESOLVED, that the AIPC strongly urges the United States Senate and the United States House of Representative to hold field hearings in New Mexico and other parts of Indian Country to determine the nature and extent of the federal governments failure to provide adequate and appropriate healthcare to Native Americans and assess the full extent of the costs and impacts to Native American people as a result of this failure.

BE IT FURTHER RESOLVED, that the AIPC strongly urges the United States Senate and the United States House of Representatives to enact, and President George W. Bush to sign, legislation that increases the Indian Health Service budget a minimum of 10% across-the-board above the amount appropriated for FY 2008.

BE IT FURTHER RESOLVED, that the AIPC strongly urges the United States Senate and the United States House of Representatives to enact, and President George W. Bush to sign, legislation that exempts the Indian Health Service budget from budget rescissions, similar to the exemption currently provided by law to the Veteran's Administration's health budget.

BE IT FURTHER RESOLVED, that the AIPC strongly urges the United States Senate and the United States House of Representatives to enact, and President George W. Bush to sign, legislation that locates the Indian Health Service budget in the entitlement part of the Health and Human Services Budget rather than in the discretionary part.

BE IT FURTHER RESOLVED, that, should all of these actions not be completed before the conclusion of the 110th Congress, the AIPC shall consider filing litigation against the United States of America for its failure to provide adequate healthcare to our Pueblo members.

BE IT FINALLY RESOLVED, that the AIPC Chairman and appropriate staff and consultants are hereby authorized and directed to take all actions necessary and appropriate to secure the actions requested in this resolution, including but not limited to working collaboratively with the National Congress of American Indians.

CERTIFICATION

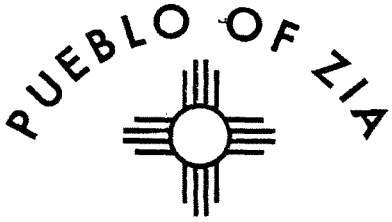
I, the undersigned, as Chairman of the All Indian Pueblo Council, do hereby certify that the foregoing Resolution No. 2007-01 was passed on February 22, 2007 at a duly called meeting at which a quorum was present with 15 voting for, 0 voting against, and 0 abstaining.

Joe A. Garcia, Chairman

ATTEST:

John Gonzales, Secretary-Treasurer

PHONE (505) 867-3304
FAX (505) 867-3308



IN REPLY REFER TO:

135 CAPITOL SQUARE DR.
ZIA PUEBLO, NEW MEXICO 87053-6013

Honorable Frank Pallone, Jr. Chairman Subcommittee on Health and Members of the Committee:

I am writing to thank you for your Sponsorship of H.R. 1328, the Indian Health Care Improvement Act ("IHCIA, The Act"). I would also like to thank the following members of your Subcommittee, Henry A. Waxman, CA, Lois Capps, CA, Tom Allen, ME, Eliot L. Engel, NY, Hilda L. Solis, CA, and Heather Wilson, NM, for their Co-sponsorship of the Act. The Act has the support of 42 of your colleagues. I would also kindly ask that the remaining 24 members of your Subcommittee pass the Act out of the Energy and Commerce Committee and to vote in favor of The Act when it comes to the House Floor.

As you know, Native Americans suffer from deplorable health disparities when compared to the rest of this great nation. In New Mexico, the health of 205,000 Native Americans ranks the highest for deaths from diabetes, alcohol, and pneumonia; deaths that are entirely preventable and treatable. New Mexico's Indian children suffer from the highest rates of suicide, illicit drug use, obesity, smoking, and drinking. Nationally, the statistics for Native American Health are not much better.

In 1976, Congress passed the first Indian Health Care Improvement Act to address a much worse health epidemic plaguing Indian Country. While improvements have been made, we have a long way to go to eradicating the poor health disparities in Indian communities.

Reauthorization of the IHCIA will take us further than we've gone in the past to modernizing and improving Indian health care delivery and services. The Act promotes recruitment and retention of highly qualified Indian health professionals and reduces the backlog in health facility funding and needs. And finally, the IHCIA sets forth comprehensive integrated behavioral health programs and services to treat substance abuse and the mental health needs of Indian people, among other important provisions.

Plainly stated, The Indian Health Care Improvement Act (IHCIA) must be amended and reauthorized in order to bring the Indian Health System into the 21st Century!

Sincerely,

Rudy Shije

Rudy Shije, Governor

Cc: Members of House Energy & Commerce Subcommittee on Health

A JOINT MEMORIAL

ENDORSING THE REAUTHORIZATION OF THE FEDERAL INDIAN HEALTH CARE IMPROVEMENT ACT.

WHEREAS, the federal Indian Health Care Improvement Act was enacted by congress in 1976 but expired in 2000 and has not yet been reauthorized; and

WHEREAS, Native Americans in New Mexico and across the nation experience the highest rates of cancer, obesity, diabetes and heart disease, yet are adversely affected by limited access to health care due to chronic underfunding of the Indian health service; and

WHEREAS, the federal government, through treaties entered into with tribal entities, has the primary responsibility for providing health care to the Native American population in New Mexico and the United States; and

WHEREAS, disparities in the health care provided to Native Americans have been documented many times, including in the July 2003 report of the United States commission on civil rights, entitled "A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country" and the September 2004 report of the United States commission on civil rights, entitled "Broken Promises: Evaluating the Native American Health Care System"; and

WHEREAS, New Mexico and other states cannot bear sole

fiscal responsibility for providing adequate health care to their Native American populations; and

WHEREAS, the reauthorization of the Indian Health Care Improvement Act would provide fiscal and other assistance necessary to improve the health care provided to Native Americans; and

WHEREAS, reauthorization of the Indian Health Care Improvement Act through fiscal year 2015 could have been accomplished by congress through the passage of S. 1057, the Indian Health Care Improvement Act Amendments of 2005 that was introduced on May 17, 2005; and

WHEREAS, a substitute for S. 1057 was reported favorably out of the senate committee on Indian affairs on March 16, 2006 but no further senate action was taken on that bill; and

WHEREAS, reauthorization of the Indian Health Care Improvement Act through fiscal year 2015 could have been accomplished by congress through the passage of H.R. 5312, the Indian Health Care Improvement Act Amendments of 2006 that was introduced on May 9, 2005; and

WHEREAS, a substitute for H.R. 5312 was reported favorably out of the house committee on resources on June 21, 2006 but no further house action was taken on that bill;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that it urge congress and the president of the United States to prioritize the reauthorization of the

Indian Health Care Improvement Act early in the first session of the one hundred tenth congress; and

BE IT FURTHER RESOLVED that it support the addition of the city of Albuquerque to the list of demonstration projects in order to support vital health care services serving urban Native Americans; and

BE IT FURTHER RESOLVED that it support language in a reauthorization of the Indian Health Care Improvement Act to encourage state-Indian health service partnerships to provide eligibility to workers in rural areas; and

BE IT FURTHER RESOLVED that it support providing access to residential treatment centers for Native American youth and adolescents close to their homes on reservations in light of the alarming rates of substance abuse and suicide within this population in New Mexico; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the president of the United States; the secretary of the United States department of the interior; the secretary of the United States health and human services department; the director of the United States Indian health service; the director of the United States office of management and budget; the majority leader of the United States senate; the speaker of the United States house of representatives; members of the United States senate committee on Indian affairs; members of the United States house of

representatives committee on resources; the president of the Navajo Nation; the speaker of the Navajo Nation council; the president of the Mescalero Apache Tribe; the president of the Jicarilla Apache Nation; the governors of the nineteen Indian pueblos in New Mexico; the members of the New Mexico congressional delegation; the governor; the secretary of health; and the secretary of Indian affairs.