H.R. 2708, THE INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2009

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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H.R. 2708, THE INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2009

TUESDAY, OCTOBER 20, 2009

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

The Subcommittee met, pursuant to call, at 2:10 p.m., in Room 2318 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. [Chairman of the Subcommittee] presiding.

Members present: Representatives Pallone, Schakowsky, Baldwin, Christensen and Shimkus.

Staff present: Andy Schneider, Chief Health Counsel; Bobby Clark, Policy Advisor; Alli Corr, Special Assistant; Mitchell Smiley, Special Assistant; Matt Eisenberg, Staff Assistant; Brandon Clark, Minority Professional Staff; Aarti Shah, Minority Counsel; and Chad Grant, Minority Legislative Analyst.

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

Mr. PALLONE. The hearing of the Health Subcommittee is called to order and today we are having a hearing on H.R. 2708, the Indian Health Care Improvement Act Amendments of 2009. And I will yield to myself for an opening statement initially and then we will get to the other members.

For over the past 10 months our country has been engaged in an important debate about how to reform our nation's healthcare system. But what few people realize is that for over the past 10 years a similar debate has been going on in Indian country as well as in Congress about how to reform the healthcare system that serves American Indians and Alaska Natives. Since 1999, legislation has been pending before the Congress to reauthorize the Indian Health Care Improvement Act which is the cornerstone legal authority for the provision of healthcare to American Indians and Alaska Natives. I know for those testifying before us today and for many of those in the audience, it is well known that the Federal Government has a legal, and I would say moral responsibility to provide free and quality healthcare to this country's Native peoples.

This responsibility often referred to as the trust responsibility is born from a legal doctrine consisting of various treaties, contract and court decisions. Putting all the legal aspects aside, I think the trust responsibility can be summed up by saying that something is owed to American Indians for the lands that they were both volun-

tarily given—that they voluntarily gave to the United States or were forcefully taken as well as the atrocities that were committed against their peoples. And what is owed to them is a pledge from this government to ensure that their wellbeing is taken care of after centuries of mistreatment. But the Federal Government has consistently failed to live up to this responsibility in almost every aspect. They have mismanaged the lands that they hold in trust for Native peoples and American Indian students struggle to receive a proper education that is on par with their peers who are non-Indian, and most important, the quality of healthcare services available to American Indians certainly falls well-below the rest of the general population which in turn has resulted in worse outcomes for Native communities.

Now, I can't tell you how many times I have recited the statistics I am going to now give you and I am sure everyone in this room has heard them too many times as well but I do want everyone to understand what is at stake. For Native Americans ages 15 to 44 years, mortality rates are more than twice those of the general population, and American Indians and Alaska Natives have substantially higher rates of disease than the rest of the U.S. population. Based on recent statistics, American Indians and Alaska Natives have seven times the rate of tuberculosis, more than six times the rate of alcoholism, nearly three times the rate of diabetes and a 62 percent higher rate of suicide. The Indian Health Service also estimates that more than two-thirds of healthcare that is needed for American Indians and Alaska Natives is simply denied.

Over the course of the health reform debate, some opponents have used these statistics and pointed to the Indian Health Service as an example of the failures that would occur under a government-run healthcare system. I even had this in some of my town meetings but these portrayals of the IHS are unfortunate, gratuitous and misleading. The IHS has not failed. Rather the Federal Government has historically failed to properly fund the IHS. A 2004 report on Native American health issued by the U.S. Commission on Civil Rights found that inadequate Federal funding was the major obstacle to eliminating disparities in Native American healthcare. The report stated that annual increases in funding for the Indian Health Service did not include adjustments for inflation or population growth and were significantly less than those allocated to other arms of the Department of Health and Human Services. And this is an important point, in being less is spent on providing healthcare to American Indians per capita than any other subpopulation. In fact, we spend more money to provide healthcare to Federal inmates than we do for American Indians and I think that is probably the most shocking statistic of all.

We have made some headway in recent months. Provisions relating to Indian health were included in legislation enacted earlier this year including CHIP or SCHIP as I call it and the ARRA, the Recovery Act or the Stimulus Bill. In both bills we were able to include provisions that would improve outreach in enrollment of American Indians eligible for Medicaid and CHIP. In addition, the Recovery Act included a substantial increase in funding for the Indian Health Service and in May of this year the IHS released 500 million of those funds to be used for health facilities construction

or maintenance and improvements, health information technology, sanitation facilities, construction and health equipment that will help improve healthcare in Indian country.

In addition to these funds, President Obama proposed a 13 percent increase for the IHS in his fiscal year 2010 budget proposal, and I am happy to say that both the House and the Senate are on track to approve the level of funding requested by the President or even exceed it. Simply by adequately funding the Indian Health Service we can substantially increase the health and well-being of Native communities. But we can't simply say we are going to increase funding for the IHS and call it a day because it is not just a matter of funding. It is a matter of making sure these programs work well and can meet the needs that are present in those communities. The bill we are looking at today would make important changes to the delivery of healthcare services in Indian communities to make sure needs are being met. That is why we must make sure this bill is passed this Congress. It has languished around here for far too long.

I want to say I think many of you know that this effort to try to include as much of the Indian Health Care Improvement Act in various legislation as well as in the healthcare reform bill that is moving is an ongoing effort, and we are still trying to do that as much as possible. But I do think that we needed a hearing today because whatever isn't included obviously we would like to move as separate legislation if that becomes necessary and so having the hearing today is which is a legislative hearing as our effort to continue down that path as quickly as possible.

I want to thank our witnesses for testifying. We have some new faces including Dr. Yvette Roubideaux, who is the new Director of the IHS. We also have some returning witnesses including Rachel Joseph, who is the co-chair of the National Tribal Steering Committee to reauthorize the Indian Health Care Improvement Act, and thank you, Rachel, for all you have done on this bill. So I want to welcome our witnesses.

And I will now—well, I was going to recognize—I will have to recognize Mr. Shimkus for an opening statement if he likes.

Mr. SHIMKUS. Thank you, Mr. Chairman, and I want to welcome our guests here, also. I want to first apologize. This is a day when I conduct a monthly tour for Army veterans and their families at the Capitol which I am already 15 minutes late for so but I wanted to make sure that the hearing got off on time with members from the Minority Party here too to welcome you and I look forward to your testimony.

The only point that we will add to this debate and it has been a debate in the last reauthorization, and it was addressed in the Senate legislation and we have this debate now with the overall healthcare reform, is the issue of taxpayer funds that would go to abortion and abortion services. There are many of us who will not—will want us to maintain the position of the Hyde language amendment which has been very important in the past legislation. It is under challenge today and so it is important for you all to know that they will be many of us in the pro-life community and it is really a bipartisan group of members, Republicans and Demo-

crats, who will make—want to really ensure that taxpayer dollars not go for those specific type services.

So with that, I appreciate the time, Mr. Chairman. I apologize for departing but I have dual commitments.

Mr. PALLONE. Thank you. Donna, the gentlewoman from the Virgin Islands, Ms. Christensen, who has actually both the two both of my colleagues who are here today have had major roles in pushing this legislation. So I appreciate both of your being here and all that you have done.

The gentlewoman from the Virgin Islands.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you. Thank you, Mr. Chairman, and thank you for holding this hearing.

You know, preparing for this hearing today just rekindled my indignation over the way indigenous people of this country have been treated. I don't think it even rises to the level of benign neglect. It really can't when one looks at the tragic impact it has had on individuals, families, tribes and Native populations over the centuries. But H.R. 2708, the Indian Health Care Improvement Act Amendments of 2009 is a good and welcome start however it just scratches the surface.

Disease, illness or in the converse, health and wellbeing don't exist in a vacuum. They are the consequences of genetics to some degree, and behavior as well, but the most influential factor is the environment, for the environment affects behavior for sure and can even have some impact on the genetics. Given the deterioration of the environment in which Native people are now confined to, there are extremely poor health, no life expectancy and adverse health behavior resulting in high rates of injuries, suicide, alcoholism and other substance abuse would be expected outcomes of any population group.

Having had no change in Indian Health Service provisions since 1976 despite the dire health indicators and given the many advances of health knowledge and technology is truly a shame. The fact that we have not been able to pass a reauthorization since 2001 is also unacceptable. So I am glad that we are having this hearing today following on the one in the Committee on Natural Resources where the chairman and I are both also members and I am also pleased that in addition to the provisions in CHIP and ARRA that H.R. 3200 includes some eye care provisions and I am proud to say that the tri-caucus has included eye care provisions in our health equity bill and that we have fully included concerns of our American Indian, Alaskan and Hawaiian Native brothers and sisters in our efforts and our initiatives. But these can only be considered first steps in the effort that we owe to these first members of the American family.

So I look forward to working with you, Chairman Pallone and Ranking Member Deal, to make sure that the Indian Health Care Improvement Act Amendments of 2009 are finally passed in 2009. So thank you for holding this hearing. Thank you to the witnesses who are here with us today, not only for being here but for all of

the work that you have done over the years to improve upon the bill that we have before us today.

Thank you. I yield back the balance of my time.

Mr. PALLONE. Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman. Thank you for convening us and convening this hearing on The Indian Health Improvements Act. I know that this is a major priority for you, Mr. Chairman, and for this subcommittee and I am eager to lend my support and help achieve the goal of reauthorization during this Congress.

One of my primary concerns like the gentlelady from the U.S. Virgin Islands, one of my primary concerns is the stark disparities experienced by minority populations in the United States in the healthcare system and with healthcare outcome and access. The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans, and a recent report from the Agency for Health Research and Quality outlined a number of areas in which American Indians and Alaska Natives lag behind others and the specific areas where these disparities are growing worse. The report uses a number of measures to assess access to care including prenatal care, rate of preventative screening and other basic services that are key to preventing illness and disease.

One of the most alarming and difficult issues to address is the rampant spread of diabetes in Indian country. Lack of public health initiatives leave families without the information they need to get healthy and to stay healthy, and diabetes ends up being a persistent chronic disease that costs the Indian Health Service an extraordinary amount of money but much more importantly too many Native Americans their lives.

That is why I am especially proud of a facility I want to boast about it in the district that I represent run by the Ho-Chunk Nation. The House of Wellness is a state-of-the-art facility designed to offer a full range of health services with the focus on prevention and wellness. It is a fitness and aquatic facility featuring a range of programs designed to promote exercise, a professionally trained staff, indoor walking track and studio lifestyle classes. The House of Wellness also offers childcare services for parents who need a little bit of time to take care of their own health and it also offers a health clinic and pharmacy services to help meet the needs of the community, both Native and non-Native. Through promotion of exercise and helping people of all ages focus on prevention, facilities like this one can change the health trajectory of many Native American families.

The Indian Health Service also provides vital water and sanitation assistance to members of the Ho-Chunk Nation. As you know, ensuring that housing is safe and provides access to safe and clean water is one of the most important steps we can take towards improving the health of communities. It is unacceptable to me that

we have languished so long without reauthorizing this incredibly important legislation. I want to thank our witnesses here today who will help us understand how much more pressing the need becomes with each passing day.

Again, Mr. Chairman, thank you for convening this hearing and I also must apologize. I am going to be skipping between two simultaneous hearings this afternoon but I hope to be here as long as I can to hear your testimony.

Mr. PALLONE. Thank you.

And we will now move to our witnesses and on our first panel we have the Director of the Indian Health Service, Yvette Roubideaux, thank you for being here today. I guess I normally say that we have 5 minutes but since you are the only witness, I am not going to worry about it too much but thank you and if you would like to begin.

STATEMENT OF YVETTE ROUBIDEAUX, M.D., M.P.H., DIRECTOR, INDIAN HEALTH SERVICE

Dr. ROUBIDEAUX. Thank you, Mr. Chairman and members of the committee.

Good afternoon. My name is Dr. Yvette Roubideaux and I am the new Director at the Indian Health Service. I am accompanied by Mr. Randy Grinnell, the Deputy Director of the Indian Health Service. I am really pleased to have this opportunity to testify on H.R. 2708, the Indian Health Care Improvement Act Amendments of 2009. I am looking forward to working with you to ensure passage of this important authorizing legislation for the Indian Health Service.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services because it is a healthcare system that was established to meet the Federal Trust Responsibility to provide healthcare for American Indians and Alaska Natives. The mission of the Indian Health Service is a partnership with the American Indian and Alaska Native people to raise the physical, mental, social and spiritual health to the highest level. The Indian Health Service provides high quality, comprehensive primary care and public health services through a system of IHS, tribal and urban operated facilities to nearly 1.5 million American Indian and Alaska Natives through hospitals, health centers, clinics located in 35 States. However, meeting the mission of the Indian Health Service has become increasingly challenging over time. Population growth, increased demand for services, rising medical costs and the growing burden of chronic disease have place significant strain on the system.

In the opening statement of my confirmation hearing before the Senate Committee on Indian Affairs, I stated that despite these challenges I see evidence of hope and change. I have worked on a variety of projects and national initiatives over the past 16 years that have shown me the great potential that exists to improve access and quality of healthcare. I know that thousands of dedicated and committed career staff in the Indian Health System work hard everyday to provide healthcare to their patients in the face of all these challenges and I have seen support from tribes and Congress for change and improvement in the Indian Health Service. I believe

we are at a unique moment in time where we have the opportunity to take great strides towards fulfilling the mission of the Indian Health Service and improving the health of American Indian and Alaska Natives.

President Obama's commitment to improve healthcare for American Indian and Alaska Native people is reflected by a significant funding increase for the Indian Health Services you mentioned and the fiscal year 2010 budget. While the President, the Secretary and I all understand that money alone is not the whole answer, the significant increase in resources for IHS recommended in the President's budget is essential for the agency to increase services and effectively fulfill its mission.

Now is the time to begin the important work of bringing change to the Indian Health Service to improve healthcare quality, to modernize and upgrade IHS facilities, to expand health promotion and disease prevention, and to ensure that American Indians and Alaska Natives are able to get the healthcare that they deserve. Passage of the Indian Health Care Improvement Act will be an important step towards these goals. The Department strongly supports reauthorization of the Indian Health Care Improvement Act and supports the effort to ensure that IHS is able to meet the healthcare needs of American Indians and Alaska Natives and takes into account increased tribal administration of health programs. It is within this context today that we offer our views on H.R. 2708. We will provide a few comments today and we will provide additional comments once we have had an opportunity to conduct complete review of this important reauthorizing legislation.

First, we note that the authority for the Catastrophic Health Emergency Fund or CHEF fund included in title 2 of the existing authority has actually been excluded from this bill. We recommend its inclusion because the CHEF program is a key component of the contract health program administered by the IHS and tribal health programs. CHEF provides funding for high-cost cases which cannot be absorbed by local service units contract healthcare programs.

Our next comments are in title 1. IHS offers health profession scholarships to American Indian and Alaska Native students who agree to sign a legal contract agreeing to a service obligation upon completion of their health professional training. Unfortunately, a small number of students default on their service obligation. We believe the determination of whether to discharge or suspend a defaulted obligation should remain entrusted as is under current law to a review board charged with making impartial case by case decisions based on a detailed review of the requests. We recommend that the new consultation requirement in this section of title 1 be dropped. Defaulting on this obligation is a serious breach of a legal contract and a resolution must be decided in an impartial manner.

The IHS also offers a loan repayment program to health professionals who agree to work in areas of high vacancy or need and a list of priority sites is developed each year. In title 1, H.R. 2708 changes current law to require the Secretary to approve loan repayment of where it is not withstanding the priority ranking of positions for which there is a need or a vacancy required under the section. This modification means that award and approvals would be based on other priorities undermining the development of our

annual priority list. So to keep the intent of the loan repayment program consistent with the goal of improving recruitment and retention of health professionals in areas of high vacancy or need, we recommend the term notwithstanding be replaced by terms consistent with the priority list.

My next comments are on title 3, the sanitations facility deficiency definitions. H.R. 2708 would provide ambiguous definitions of sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country. Our written testimony provides examples of the problems with these definitions. We recommend retaining current law to distinguish the various levels of deficiencies which determine allocating existing resources.

In addition to the comments I have made today on certain provisions of H.R. 2708 there will be additional comments once we have had an opportunity to conduct a complete review of this important reauthorizing legislation. Mr. Chairman, that concludes my testimony. I appreciate the opportunity to appear before you to discuss the reauthorization of the Indian Health Care Improvement Act of 2009. We are committed to working with you to ensure the reauthorization of this key legislative authority. I will be happy to answer any questions that you have. Thank you.

[The prepared statement of Dr. Roubideaux follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

YVETTE ROUBIDEAUX, M.D., M.P.H

DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

HOUSE COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

OF THE

UNITED STATES CONGRESS

OVERSIGHT HEARING

ON

H.R. 2708

INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS

OF 2009

October 20, 2009

STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good afternoon. I am Dr. Yvette Roubideaux and I am the new Director of the Indian Health Service (IHS). I am accompanied by Randy Grinnell, Deputy Director, IHS. I am pleased to have the opportunity to testify on H.R. 2708, the Indian Health Care Improvement Act Amendments of 2009. I am looking forward to working with you to ensure passage of this important authorizing legislation for the Indian Health Service.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and acts of Congress. This Indian health system provides services to nearly 1.5 million American Indians and Alaska Natives through hospitals, health centers, and clinics located in 35 States, often representing the only source of health care for many American Indian and Alaska Native individuals, especially for those who live in the most remote and poverty-stricken areas of the United States. The purchase of health care from private providers through the Contract Health Services program is also an integral component of the health system for services unavailable in IHS and Tribal facilities or, in some cases, in lieu of IHS or Tribal health care programs. In addition, unlike many other health delivery systems, IHS is involved in the construction of health facilities -- including the quarters necessary for recruitment and retention of health care providers -- and of water and sewer systems for Indian communities. IHS accomplishes such a wide array of clinical, preventive, and public health activities, operations, and program elements within a single system for American

Indians and Alaska Natives.

However, meeting the mission of the Indian Health Service has become increasingly challenging over time. Population growth, increased demand for services, rising medical costs, and the growing burden of chronic diseases such as diabetes, obesity, and cardiovascular disease have placed a significant strain on the system. Additionally, some facilities have trouble recruiting and retaining health care professionals.

In the opening statement of my confirmation hearing before the Senate Committee on Indian Affairs, I stated that, despite these challenges, I see evidence of hope and change. I have worked on a variety of projects and national initiatives over the past 16 years that have shown me the great potential that exists to improve access to, and quality of, health care. I know that thousands of committed and dedicated career staff in the Indian health care system work hard every day to provide health care to their patients in the face of the aforementioned challenges. And I have seen support from Tribes and Congress for change and improvement in the Indian Health Service. I believe we are at a unique moment in time, where we have the opportunity to take great strides toward fulfilling the mission of the Indian Health Service and improving the health of the American Indian and Alaska Native population.

President Obama's commitment to improve health care for American Indian and Alaska Native people is reflected by a significant funding increase for the Indian Health Service (IHS) in his FY 2010 budget request, which is the largest annual increase in the past 20 years. It responds to priorities established by Tribes during the Tribal budget consultation process and supports an investment that will result in healthier American Indian and Alaska Native communities. While the President, the Secretary, and I all understand money alone is not the whole answer, the significant increase in resources for IHS recommended in the President's Budget is essential for the Agency to increase services and effectively fulfill its mission. Now is the time to begin the important work

of bringing change to the Indian Health Service, to improve health care quality, to modernize and upgrade IHS facilities, to expand health promotion and disease prevention, and to ensure that American Indians and Alaska Natives are able to get the health care they deserve. Passage of the Indian Health Care Improvement Act will be an important step towards these goals.

Reauthorization of the Indian Health Care Improvement Act

Improving access to health care for all eligible American Indians and Alaska Natives is a priority for all those involved in the administration of the Indian Health Service. H.R. 2708 advances our common goal of reauthorizing the Indian Health Care Improvement Act (IHCIA). The IHCIA provisions provide the statutory basis for the implementation of "the Federal responsibility for the care and education of the Indian people by improving the services and facilities of the Federal Indian health programs and encouraging maximum participation of Indians in such programs." The bill would renew the authorities which provide specific policy guidance on the delivery of health services to American Indians and Alaska Natives. It contains critical 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.

The Department strongly supports reauthorization of the IHCIA and supports the effort to ensure that the IHS is able to meet the health care needs of American Indians and Alaska Natives and takes into account increased tribal administration of Indian health programs. It is within this context that today we offer our views on H.R. 2708.

First, we note that the authority for the Catastrophic Health Emergency Fund (CHEF) included in Title II of the existing authority has been excluded from this bill. We recommend the inclusion of the provision because the CHEF program is a key

component of the contract health program administered by IHS and tribal health programs. CHEF provides funding for high cost cases which cannot be absorbed by the local service units' contract health care programs.

We have a number of concerns with expanded requirements for negotiated rulemaking, since this can be a very long and time consuming process, along with other provisions in the bill. We also have other specific comments on certain proposed changes in the Indian health manpower and development, and in the facilities title of the bill, which are included below. We will provide additional comments once we've had an opportunity to conduct a complete review of this important reauthorizing legislation.

Indian Health Professions Scholarship Waivers and Suspension

IHS offers health profession scholarships to American Indian and Alaska Native students who agree to sign a legal contract agreeing to a service obligation upon completion of their health professional training. Unfortunately, a small number of these students default on this service obligation. Section 104(d)(4)(B) of Title I requires the Secretary to consult with entities that are not party to the contract entered into by the Secretary with the scholarship recipient before determining whether to discharge or suspend a defaulted service obligation. The determination whether to discharge or suspend a defaulted service obligation should remain entrusted, as under current law, to a review board charged with making impartial case-by-case decisions based on a detailed review of the requests. Moreover, the entities consulted may at times have interests that conflict with the federal government's interest to see that contract agreements are upheld. Accordingly, the need to insulate this process from outside influence of conflicts of interest mitigates against requiring or even permitting consultation on such decisions. We recommend the new consultation requirement in this section be dropped. Defaulting on this obligation is a serious breach of a legal contract, and the resolution must be decided in an impartial manner.

Indian Health Service Loan Repayment Approvals

The IHS also offers a loan repayment program to health professionals who agree to work in areas of high vacancy or need, and a list of priority sites is developed each year. Section 110(d)(2) of Title I in H.R. 2708 changes current law to require the Secretary to approve loan repayment awards "notwithstanding" the priority ranking of positions for which there is a need or a vacancy required under Section 110(d)(1). This modification means the award approvals would be based on other priorities, undermining the development of the annual priority list. To keep the intent of the loan repayment program consistent with the goal of improving recruitment and retention of health professionals in areas of high vacancies or need, we recommend that the term "notwithstanding" be replaced by the terms "Consistent with".

Sanitation Facilities Deficiency Definitions

Another section in H.R. 2708 – 302(h)(3) – would provide ambiguous definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country. The proposed definition of "deficiency level III" could be interpreted to mean that 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 levels of service.

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.

In addition to comments I've made today on certain specific provisions of H.R. 2708, there will be additional comments once we've had an opportunity to conduct a complete review of this important reauthorizing legislation.

Mr. Chairman, this concludes my testimony. I appreciate the opportunity to appear before you to discuss the reauthorization of the "Indian Health Care Improvement Act of 2009," and we are committed to working with the Committee to ensure the reauthorization of this key legislative authority.

I will be happy to answer any questions that you may have regarding the Department's views on H.R. 2708. Thank you.

Mr. PALLONE. Thank you and now we will take questions from the panel. I will start with myself.

First of all let me thank you for actually getting specific because unfortunately and I know it sounds partisan but in the previous administration we—I don't remember any of the open testimony at all being, you know, specific about the bill. And I also appreciate the fact that you are going to get back to us quickly because as I said I would like to see as much of this included in the healthcare reform as possible and so, you know, as we move with that whatever comments we can get from the administration will be very important, you know, over the next few weeks or the next few months.

I want to try to get in three questions here quickly if I can. You know, obviously this legislation has languished for many years in Congress so could you tell us why it is so important to reauthorized the Act and what are the consequences to the IHS and those who rely upon it that we have other than if we continued not to reauthorize?

Dr. ROUBIDEAUX. Well, reauthorization of the Indian Health Care Improvement Act is extremely important. It is important to our patients and our tribes because they view it as their version of healthcare reform and what the Act does is modernizes and updates the Indian Health Service so that we can provide better care for the patients that we serve. The consequences of not acting are that again are our patients and tribes are waiting for this important legislation to be reauthorized so we strongly support its passage.

Mr. PALLONE. OK and then the second question, you know, I wanted to thank you and for the President obviously for making, you know, the additional funding available that is in the budget. Clearly, that is very important but IHS doesn't rely solely on its annual appropriations to finance services to tribes. It collects reimbursements from Medicare/Medicaid and private payer so how important is it to make sure that tribal members are enrolled in other public programs like Medicare and Medicaid or private insurance when they are eligible for such coverage? And what types of barriers do tribal members face in enrolling in these other programs? How can we overcome those barriers that exist?

Dr. ROUBIDEAUX. Right, well, as I had stated the resources that we have available in the Indian Health System make it difficult for us to meet our mission and so we rely on the ability of serving patients who have other resources in terms of insurance or Medicare and Medicaid coverage. Third party reimbursements from these sources are extremely important. For some of our facilities, over half of their operating budget comes from third party reimbursements so they serve an extremely important source of care for us. I think some of the barriers that we have to having some of our patients enroll in these forms of coverage is that the paperwork can be confusing. There may be a misunderstanding of why they need to provide the information that they do for the applications. And with regard to private insurance, I think that for many of our patients they just can't afford to pay the premiums or can't afford to pay the co-pays. That is why a national health reform provides an

opportunity to perhaps American Indians and Alaska Natives have access to better coverage as well.

Mr. PALLONE. Thank you. And then my third question was about the, you know, some of the changes. I know you were able to offer us some of the administration's positions on organizational structural changes and you said you are going to get back to us with more which again, I would appreciate as soon as possible. But did you want to talk a little more about any of these organizational structural changes, say particularly the elevation of the IHS Director to the position of assistant secretary because that is the important part of this legislation for a long time?

Dr. ROUBIDEAUX. Right, we understand that the proposal to elevate the Director of the Indian Health Service to an assistant secretary level is extremely important to our tribes and it has been a recommendation by them because they would like their healthcare needs to be addressed at the highest levels in the Department. I am working with the Secretary and her staff on exploring this issue and once we receive—once we develop a position on it we will let you know but we definitely understand that the health needs of American Indians and Alaska Natives need to be addressed at the highest levels in the Department of Health and Human Services and we are committed to that.

Mr. PALLONE. And that is obviously one that if you could get back to us as quickly as possible. Thank you.

The gentlewoman from the Virgin Islands, Ms. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and welcome, Dr. Roubideaux. I missed you at the first hearing.

My first question refers to some of the recommendations that Dr. Rock has made that the urban Indians be restored in section 1 and 6 of section 3 be included in the women's health section and in the section that deals with payments under Medicare and Medicaid and SCHIP. Would your office be supporting those recommendations again? Are you aware of them?

Dr. ROUBIDEAUX. Well, while I can't comment on the specific provisions of the bill I can tell you that we are supportive of the needs of urban American Indians and Alaska Natives. We know that many of our American Indians and Alaska Native people choose to leave the reservation and go to urban areas but unfortunately that leaves them in many cases uncovered by the Indian Health Service. So fortunately in some communities we do have the 34 Urban Indian Health programs that are funded by the Indian Health Service and those programs are supported by title 5 of this particular Act, and certainly other provisions apply to them as well. So we recognize these clinics as extremely important sources of healthcare for Native people who go to urban areas. Especially because it is the only source of culturally appropriate care that they can receive in urban areas and these places often help them have a sense of community and a sense of home while they are away from the reservations. And so with regard to the specific provisions what we will include that in our review but we are very supportive of generally doing what we can to support the urban Indian population.

Mrs. CHRISTENSEN. Thank you. The bill has provisions to help and recruit and retain health professionals and I believe that the

best providers are those from our community—from the community themselves. In the African-American community the biggest barrier to achieving that kind of diversity in the health workforce is the K through 12. I know this is not specifically related to the bill but is there some commensurate thing from the initiative happening with K through 12 to ensure that this provision to train and recruit them and retrain perhaps Native American providers would not be an empty promise?

Dr. ROUBIDEAUX. Well, there are a number of programs that are already funded by various agencies to deal with the health professional shortages in our communities. One program that we find is the Indians Into Medicine program that looks at recruiting young American Indians and Alaska Native individuals into the health professions. We have a site in North Dakota and we also have a site in Arizona and those address the K through 12 population to try to get them interested in science careers. One of the most innovative projects that we have been involved with is the diabetes and science and education project in tribal schools that was developed in partnership with the National Institute of Diabetes, Digestive and Kidney Diseases. And a curriculum was developed by tribal colleges to be given to students in the K through 12 grades to expose them to science but using diabetes as the example not only to expose them to the science of the disease but also how to be healthy and in that process helps them learn about health professional careers and we are very excited that curriculum is just now available and will be disseminated throughout Indian country. So I think there is some opportunities to improve the exposure of students to science and to health careers in our communities but we clearly need more efforts.

Mrs. CHRISTENSEN. Thanks. The bill makes reference to under sanitation facilities the inordinately high incidence of disease, injury and illness directly attributed to the absence or inadequacy of sanitation facilities. And it also says that the long term cost is far greater than the short term cost of providing those sanitation facilities. Is the bill language strong enough to provide the services that would be needed in terms of the sanitation to create those savings not only in money but in terms of illness and lives?

Dr. ROUBIDEAUX. Well, one of the important functions of the Indian Health Service is to provide sanitation facilities. The Indian Health Care Improvement Act has provided the foundation for that. With this bill we have discussed some problems that in the definitions of how they are defining those.

Mrs. CHRISTENSEN. Right.

Dr. ROUBIDEAUX. And I think that reauthorization of this bill is important in terms of what services we could provide for our communities.

Mrs. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you and thanks so much for your testimony. I appreciate it.

Dr. ROUBIDEAUX. Thank you.

Mr. PALLONE. Good luck with everything.

Dr. ROUBIDEAUX. Thank you very much.

Mr. PALLONE. I would ask the second panel to come forward.

Our second panel has four witnesses and I will introduce them starting on my left is the Honorable Jefferson Keel who is Lieutenant Governor of the Chickasaw Nation and President-Elect of the National Congress of American Indians. And then is Rachel Joseph who is Co-Chair of the National Tribal Steering Committee for the Reauthorization of the Indian Health Care Improvement Act. And then we have another Joseph, Andrew Joseph, Jr. who is Chairman of the Human Services Committee, Direct Services Tribe Advisory Committee. And finally, Dr. Patrick Rock who is Executive Director of Indian Health Board of Minneapolis and President-Elect of the National Council of Urban Indian Health. Thank you for being here and thank you for all that you have done over the years on this legislation.

As I said, you know, we have 5 minutes but there is not a lot going on today so we are not going to stick to that too much and we will start with Mr. Keel.

STATEMENTS OF HONORABLE JEFFERSON KEEL, LIEUTENANT GOVERNOR OF THE CHICKASAW NATION AND PRESIDENT-ELECT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS; RACHEL JOSEPH, CO-CHAIR, NATIONAL TRIBAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT; ANDREW JOSEPH, JR., CHAIRMAN, HUMAN SERVICES COMMITTEE, DIRECT SERVICES TRIBE ADVISORY COMMITTEE; AND PATRICK ROCK, M.D., EXECUTIVE DIRECTOR, INDIAN HEALTH BOARD OF MINNEAPOLIS, PRESIDENT-ELECT, NATIONAL COUNCIL URBAN INDIAN HEALTH

STATEMENT OF JEFFERSON KEEL

Mr. KEEL. Thank you, Mr. Chairman.

Good afternoon and first I want to begin by just saying as the President of the National Congress of American Indians I am honored to be asked to present testimony to our friends at the Health Subcommittee of the Energy and Commerce Committee. On behalf of the National Congress of American Indians I greatly appreciate the opportunity to again provide comments and support for a House bill on the Indian Health Care Improvement Act.

I want to begin by thanking you Congressman Pallone for your continued efforts to improve the healthcare services delivered to American Indians and Alaska Natives. The Indian country extends its thanks for your hard work over the last several years on the Indian Health Care Improvement Act. We appreciate all that you and the committee have done. Now it is time to get this bill out of committee and passed by the full House of Representatives.

My colleagues today will be providing you testimony on duty, rights and obligations for Indian health. They will also provide you with the shocking statistics on health disparities in our communities and why the reauthorization is so desperately is needed, all of which the committee is very familiar with. What I would like to do today is simple. I would like to ask the committee to set a schedule and procedure for when the bill will be passed and enacted.

Over the last 10 years, NCAI has worked side-by-side with the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act and the National Indian Health Board for the same procedures. We work with numerous committee staff on drafting language, watch leadership in the House change and have seen two Presidents come and go in office. With each passing year there seems to be a new must-pass priority and the Indian Health Care is relegated to the sidelines. The nation is now focused on reforming the health insurance industry. As with the rest of the country, this issue is of critical importance to tribes and we support the efforts of the Obama Administration and Congress. Speaker Pelosi and Mr. Pallone have recognized the importance of protecting and preserving the Indian healthcare delivery system during this reform effort and the National Congress of American Indians thanks you for your commitment to Indian country.

The Indian Health Service as you well know is in need of updates and modernization. The current House Bill H.R. 2708 is a starting point for reforming the IHS. As with the national health reform bills its goal is to provide cost-saving features for healthcare delivery by shifting the healthcare delivery paradigm in the IHS to preventative health. Indian country has been waiting for and asking for these updates for over 10 years. We do not believe the national health insurance reform should be used as an excuse for abandoning the effort to reauthorize the Indian Health Care Improvement Act. We now come before the committee to ask for an assurance that as the nation moves forward with health reform the Indian country will be included and our bill the Indian Health Care Improvement Act will be passed. What I ask again to the committee is, what is your strategy for passing the Indian country's health modernization bill? The National Congress of American Indians knows what this committee can do when it sets its mind to it. We all saw how quickly you came together to write and pass the Affordable Health Choices Act. We witnessed the hard work of the staff in drafting the Indian protections needed within that bill and the dedication of the committee in passing those key provisions. We now ask that that same enthusiasm and commitment be provided for the Indian Health Care Improvement Act.

The National Congress of American Indians stands ready as I do and I am sure the other members of this panel do to do whatever it takes to get this bill passed. Again, thank you for this opportunity and I look forward to working with you for passage of this important bill. Thank you.

[The prepared statement of Mr. Keel follows:]

NATIONAL CONGRESS OF AMERICAN INDIANS

TESTIMONY ON THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

House Subcommittee on Health; Energy & Commerce Committee
October 20, 2009

Jefferson Keel
President, National Congress of American Indians
Lt. Governor, Chickasaw Nation

Good morning, Chairman, and distinguished committee members. It is an honor to be invited to provide my first testimony as the newly elected President of the National Congress of American Indians (NCAI) to our friends at the Health Subcommittee of the Energy and Commerce Committee. On behalf of NCAI, I greatly appreciate the opportunity to again provide comments and support for a House bill on the Indian Health Care Improvement Act (IHCIA).

I would like to begin by thanking Congressman Pallone for his continued efforts to improve the health care services delivered to American Indians and Alaska Natives. Indian Country extends its thanks for your hard work over the last several years on the IHCIA. However, while we appreciate all that you and the Committee have done, it is past time to get this bill out of Committee and passed by the full House of Representatives.

My colleagues today will be providing you testimony on treaty rights and obligations for Indian health. They will also provide you with the shocking statistics on health disparities in our communities and why the reauthorization is so desperately needed. All of which the Committee should be very familiar with at this point.

What I would like to do today is simple. **I would like to ask the Committee to set a schedule and procedure when the bill will be passed and enacted.**

TEN YEARS OF WORK

Over the last ten years, NCAI has worked side-by-side with the National Steering Committee for the reauthorization of IHCIA and the National Indian Health Board to pass the IHCIA. We have worked with numerous committee staff on drafting language, watched Leadership in the House change, and have seen two Presidents come and go in office. With each passing year there seems to be a new "must pass" priority and Indian health is relegated to the sidelines.

The Nation is now focused on reforming the health insurance industry. As with the rest of the County, this issue is of critical importance to tribes and we support the efforts of the Obama Administration and Congress. Speaker Pelosi and Mr. Pallone have recognized the importance in protecting and preserving the Indian Health System during this reform effort and NCAI would like to extend our appreciation for your commitment to Indian Country.

The Indian Health Service (IHS), as you well know, is also in need of updates and modernization. The current House bill, HR 2708, is a starting point for reforming the IHS. As with the National health reform bills, its goal is to provide cost saving features for health care delivery by shifting the health delivery paradigm in IHS to preventative health. The following is a sample of some of the reform features in HR 2708:

- Improved standards for mammography and other cancer screening.
- Authorization for modern methods of health care delivery, including authority for IHS and tribes to operate hospice, long-term care and assisted living programs.
- Upgraded authorities for epidemiology centers so that they are expressly authorized to access the data they need to assist tribes and urban Indian organizations.
- Establishment of convenient care demonstration projects to provide primary health care such as urgent services, non-emergent care services, and preventive services outside the regular hours of operation of a health care facility.
- The integration of mental health, social services, domestic and child abuse, youth suicide, and substance abuse into the Indian health delivery system.

Indian Country has been waiting for and asking for these updates for over ten years.

We do not believe that National health insurance reform should be used as an excuse for abandoning the effort to reauthorize the IHCIA. We now come before the Committee to get an assurance that as the Nation moves forward with health reform, Indian Country will be included – and our bill, the IHCIA, will be passed.

What I would like to ask the Committee is: **What is your strategy for passing Indian Country's health modernization bill?**

CONCLUSION

NCAI knows what this Committee can do when it sets its mind to something. We all saw how quickly you came together to write and pass the Affordable Health Choices Act. We witnessed the hard work of the staff in drafting the Indian protections needed within that bill, and the dedication of the Committee in passing those key provisions. We now ask that that same enthusiasm and commitment be provided for the Indian Health Care Improvement Act.

NCAI stands ready, as do I, and I am sure the other members of the panel, to do what it takes to get this bill passed.

Thank you for providing me with the opportunity to testify before you today. I am available to answer any questions you may have.

NCAI is the oldest and largest American Indian organization in the United States and has the responsibility of representing over 275 tribal governments and hundreds of thousands of Indian people. NCAI is dedicated to our collective efforts to advance tribal sovereignty, protect treaty rights and the trust responsibility, and promote the health and welfare of American Indian and Alaska Native people.

Mr. PALLONE. Thank you, Mr. Keel.
Ms. Joseph.

STATEMENT OF RACHEL JOSEPH

Ms. RACHEL JOSEPH. Good afternoon, Mr. Chairman, and distinguished members of the committee.

I am Rachel Joseph, Shoshone Paiute of the Lone Pine Paiute-Shoshone Tribe of California and Co-Chair of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act, the NSC. I appreciate the opportunity to testify today and to state our strong support for H.R. 2708. On behalf of the NSC and National Indian Health Board, we appreciate your ongoing support for improving healthcare for Indians. I also acknowledge the contribution of tribal leaders who have served on the NSC over the past 10 years.

The foundation of our participation in this reauthorization is based on two principles. One, that the legislation allow no regression from current law and that the healthcare system be modernized and strengthened.

In the Chairman's opening statement he recited the health status and the statistics of our population. No other segment of the American population experiences greater health disparities than the American Indian and Alaska Native populations. The heartbreaking aspect of these statistics is the knowledge that a majority of illnesses and deaths are preventable if additional funding and modern programmatic approaches to healthcare were available. Despite two centuries of treaties and promises, American Indians and Alaska Natives endure health conditions and a level of healthcare that would be unacceptable to most Americans.

Today I respectfully request Congress to fulfill our nation's responsibilities to Indian people by reauthorizing the Indian Health Care Improvement Act this year. The Indian Health Care Improvement Act also needs to be a permanent law, thus we urge the committee to amend H.R. 2708 to remove the sunset dates and permanently authorize appropriations for the Act's programs. Our request for a permanent authorization is not unique. Congress has permanently authorized other Federal Indian Laws such as The Snyder Act, The Indian Self-Determination and Education Assistance Act and other laws which I listed in my written testimony.

There are many provisions in the bill which embody the improvements needed for the Indian healthcare system. I would like to highlight just three of them. Section 208 recognizes a need for tribal epidemiology centers to be expressly authorized to access the data they need to monitor the incidents of diseases in Indian communities and to help tribes in urban Indian organization design programs to attack those diseases. Complete fulfillment of this mission requires epicenters to operate like public health authorities and to access Indian country data compiled by HHS agencies.

Secondly, we strongly support the bill's revisions to current law authorizing a comprehensive system of behavioral health programs. Title 7 authorizes the integration of programs for mental health, social services, domestic and child abuse, youth suicide and substance abuse. Attacking these chronic problems is vital to improve

the quality of life in Indian country and strengthening Indian families.

Lastly, section 807 addresses a serious issue in Indian country when tribes are compelled to try to fill the funding gap by expanding direct services, augmenting contract healthcare, paying premiums for Medicare part B and D, and developing self-insurance plans for their members. Unfortunately, the tax consequence of such efforts are unclear. Section 807 will clarify that these benefits are tax-exempt as they should be. They were prepaid through the cessation of over 400 million acres of tribal lands and other resources. American Indians and Alaska Native people are entitled to healthcare and should not be taxed when their tribes step in to assist them in obtaining care.

While the NSC is extremely supportive of this bill there are a few provisions that require revision and additional provisions we would like to see inserted into the bill. Our proposals are outlined in the section by section revisions document which was included with my written testimony submitted for the record.

I would like to conclude by sharing my personal observations and experiences with this reauthorization which have been the most positive and uplifting experience in my life and at the same time the most frustrating experience. During the consultation with the tribes that began in 1998 and continued through 1999, tribal leaders across the country made some strong commitments that we would spend long hard hours—no cell phones was one of my ground rules which was pretty exciting as the tribes developed consensus on the proposal that we submitted to Congress. We believe that consensus was necessary so that, you know, we would not be in a divide and conquer position but as you balance the diverse and the varied needs of our tribes it was a tremendous project and undertaking and we did it and we have been able to maintain consensus through all these years.

The disappointment part of course is that our job is not done. Mr. Chairman, we appreciate your sponsorship of this bill and we particularly appreciate our relationship that we have been able to have. Excuse the—no pun intended, frank and forthright discussions about the need for reauthorization and we are fortunate that we have that kind of communication. I also would be remiss if I did not acknowledge the support and ongoing efforts of Chairmen Rayhall, Waxman and Rangel and former Chairman Don Young and Dingell and of course Chairman George Miller who has never wavered in his support since he first introduced Indian Health Care Improvement Act when he was chairman of the Natural Resources Committee. Together with our many sponsors who have consistently stayed with us throughout the years, there is no reason in our view that this legislation should not be enacted this year.

I would be happy to respond to any questions that you have and look forward to working with you to get this job done. Thank you.

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

National Indian Health Board

TESTIMONY OF RACHEL JOSEPH
ON BEHALF OF
THE NATIONAL TRIBAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT
AND
THE NATIONAL INDIAN HEALTH BOARD
BEFORE THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE, HEALTH SUBCOMMITTEE
REGARDING
H.R. 2708 -- INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2009

OCTOBER 20, 2009

Chairman Pallone, Ranking Member Dell, and distinguished Members of the Committee:

I am Rachel Joseph, a member of the Lone Pine Paiute-Shoshone Tribe of California and Co-Chair of the National Tribal Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). I appreciate the opportunity to testify before this Committee to present views on the advancement of Indian health care and to state our strong support for the swift passage of H.R. 2708.

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

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

> First and foremost, reauthorization of the IHCIA is vital to enable the Indian health system to utilize more efficient, effective and updated methods of health care delivery in the 21st Century. To bring stability to our system, it is critical that the IHCIA be made a permanent law of the United States, just as the Federal Government's trust responsibility to provide health care to Indian Tribes is a permanent obligation of the Federal government.

Second, the Indian health care delivery system must be fully funded in order to meet the Federal government's trust obligation. In particular, I urge Congress to properly fund the contract health services (CHS) program through which we purchase care which the Indian health system is unable to supply directly, and contract support costs (CSC) of Tribes who elect to exercise Indian self-determination rights provided by Federal law to take over direct operation of health programs at the local level.

HEALTH DISPARITIES IN INDIAN COUNTRY

No other segment of the American population experiences greater health disparities than the American Indian and Alaska Native (AI/AN) population. Our people have long suffered disproportionately higher rates of chronic diseases due to lack of timely diagnosis and treatment.

Thirteen percent of deaths in Indian Country occur among our people below the age of 25, a rate that is three times higher than the average in the U.S. population as a whole. The U.S. Commission on Civil Rights reported in 2003 that American Indian youths are twice as likely to commit suicide; Native Americans are 630 percent more likely to die from alcoholism; 650 percent more likely to die from tuberculosis; 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental death compared with other groups.[1] These disparities are largely attributable to a serious lack of funding sufficient to advance the health care infrastructure, and the level and quality of health services for AI/AN.

The most heartbreaking aspect of these deplorable statistics is the knowledge that the majority of illnesses and deaths from disease could be prevented if additional funding and modern programmatic approaches to health care were available to provide even the most basic level of care enjoyed by most Americans. Despite two centuries of treaties and promises, American Indians endure adverse health conditions and a substandard level of health care that would be unacceptable to most of their fellow citizens. While over the last thirty years, progress has been made in reducing the occurrence of infectious diseases and decreasing the overall mortality rates in Indian Country, AI/ANs still have lower life expectancy and a lesser quality of life than the general population.

THE IHCIA MUST BE MADE A PERMANENT LAW OF THE UNITED STATES, COMMENSURATE WITH THE PERMANANCE OF THE FEDERAL TRUST RESPONSIBILITY FOR INDIAN HEALTH

It is time to make the IHCIA a permanent Federal law. We ask that the Committee revise H.R. 2708 to remove the "sunset" dates and permanently authorize the appropriation of funds to carry out the programs and services the Act requires, to assure Indian people that the IHCIA will continue to direct how their health care will be delivered, and to demonstrate that Congress is committed to honoring its trust responsibility for health.

The theory that "sunset" dates are needed to spur Congress to periodically review and update major laws has not worked in the IHCIA context. Such review and updating of the IHCIA

[1] U.S. Comm'm on Civil Rights, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*, at 34-35 (2003).

should have occurred in 2000, but for ten years, despite intense work and advocacy from throughout Indian Country, Congress and the Executive Branch have not carried out their responsibility to reauthorize this law.

Our request for a permanent authorization is not a unique one. Congress has, in fact, used the permanent authorization approach for significant Federal Indian laws that implement Congress's plenary power over relations with Indian tribes – such as the Snyder Act, the Indian Self-Determination and Education Assistance Act, the BIA elementary and secondary education law, the Tribally Controlled Schools Act, the Indian Financing Act, the Indian Gaming Regulatory Act, the Johnson-O'Malley Act, the Indian Child Welfare Act, the Indian Law Enforcement Reform Act, the National Indian Forest Resources Management Act, and the Native American Graves Protection and Repatriation Act. It is now time to add the Indian health law to that list. Under separate cover, you, and other Members of Congress and the President will receive a letter signed by numerous Tribal leaders making this request.

Making the IHCIA permanent would not, of course, prevent Congress from amending and revising the IHCIA whenever it sees fit. Both the Medicare and Medicaid laws – the cornerstones of Federal support for delivery of health care to elderly and low-income Americans – are permanent laws of the United States and are routinely subject to amendment when Congress recognizes a need to so act. The law which directs Federal supervision of health care delivery to AI/ANs should have similar permanent status.

H.R. 2708 REFLECTS INDIAN TRIBES' PRIORITIES

On behalf of the NSC and Indian Country, I want to express our appreciation to you for including in IHCIA reauthorization legislation many recommendations made by tribal leaders and health advocates. We are particularly gratified that in preparing H.R. 2708, the bill's sponsors accepted so many of our recent recommendations to assure the bill is as up-to-date as possible. For this, we specifically acknowledge the contributions of Chairman Pallone.

H.R. 2708 is noticeably shorter than its predecessor from the 110th Congress, as a number of provisions from the prior bill were enacted into law earlier this year through the Children's Health Insurance Program Reauthorization Act and the American Recovery and Reinvestment Act. These Indian-specific amendments to the Social Security Act (SSA)[2] will result in increased access to and enrollment of AI/AN in the CHIP and Medicaid programs.

Your – and our – work is not done, however. We must now assure that reauthorization of the IHCIA is accomplished this year and validates the ten years worth of effort from tribal leaders and Members of Congress who have never waivered from the ultimate goals of bringing modern methods of health care delivery to Indian people and empowering Indian tribes to direct their

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

own health care delivery systems, as promised by the Indian Self-Determination and Education Assistance Act..

This is the tenth year anniversary of the NSC releasing its initial draft legislation; it set out the advancements we knew were necessary for enhancing the health status of Indian people. While the legislation has changed and matured over the past decade, the basic framework remains that prepared by tribal leaders at the request of key Congressional leaders. Indian Country has willingly and substantively participated in this process while steadfastly insisting that two principles be observed: that the legislation allow no regression from current law authorities, and that the Indian health system be modernized and strengthened. Please let us all now finally finish the job we all set out to accomplish.

I wish to mention just a few of the H.R. 2708 provisions that epitomize the advancements we seek.

Improved Standards for Mammography and Other Cancer Screening. Section 206 of the bill would adopt national standards for mammography and other cancer screening. Early detection and treatment are particularly important in Indian Country, as Indian people have the poorest cancer survival rate of any racial group in the United States, and this disease has become the leading cause of death among Alaska Native women, and the second leading cause of death among all AI/AN women. [3]

Authorization for Modern Methods of Health Care Delivery. Bill section 212 will provide express authority for IHS and tribes to operate hospice, long-term care and assisted living programs and to supply health services in homes and community-based settings. All such delivery methods are commonplace in mainstream America, but are rare in Indian Country. Not only are such approaches very effective, they are demonstrably more efficient and cost-effective ways of getting care to individual beneficiaries. We heartily support this provision.

Upgraded Authorities for Epidemiology Centers. Section 208 recognizes the need for tribal epidemiology centers to be expressly authorized to access the data they need to monitor the incidence of diseases in Indian communities in order to help tribes and urban Indian organizations design programs and services targeted to attack those diseases. Proper fulfillment of this mission necessarily requires epi centers to operate like Public Health Authorities and to access Indian Country data compiled by HHS agencies.

Expansion of Indian Health Care Delivery Demonstration Projects. Section 306 contains new authorities to establish convenient care demonstration projects to provide primary health care such as urgent services, non-emergent care services, and preventive services outside the regular hours of operation of a health care facility. This provision would enhance the health care delivery options and has the potential to reduce the demand for contract health services (CHS) and emergency visits.

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[3] U.S. Comm'n on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, at 17 (Sept. 2004).

Comprehensive Behavioral Health Programs. One of the biggest accomplishments of the NSC was re-focusing the IHCIA Title VII – which currently addresses only substance abuse programs – to reflect a comprehensive system of behavioral health programs. This new title calls for the integration of programs for mental health, social services, domestic and child abuse, youth suicide and substance abuse into the Indian health delivery system. Attacking these chronic, debilitating problems is vital to improving the quality of life in Indian Country and strengthening Indian families.

Elevation of IHS Director to Assistant Secretary for Indian Health. We are grateful that the Committee continues its steadfast support for elevating the Indian Health Service into the policy-making hierarchy of the Department of Health and Human Services. Bill Sec. 601 would accomplish this by elevating the chief officer of the Indian Health Service to the rank of Assistant Secretary. Enactment would fulfill a longstanding goal of the Indian health community.

Tax Treatment for Certain Services and Benefits. Bill section 807 addresses a serious issue that has only recently arisen in Indian Country. As decades have passed in which the funding for Indian health care has remained at barely over sixty percent of what is available to federal employees under their insurance plan, Tribes have felt compelled to step in to try to fill the gap. They have expanded direct services, augmented contract health services funding in order to purchase more care, paid premiums for Medicare Part B and D or other insurance, and developed self-insurance plans that cover their members. Unfortunately, the tax consequences of such programs is unclear. Several Internal Revenue Service auditors have cited the fact that there is no statutory exclusion from gross income for such benefits and several tribes have been selected for audit. This new section 807 will clarify that these benefits are tax exempt – as they should be. They were paid for through the exchange of tribal lands and resources. American Indian and Alaska Native people are entitled to health care at no cost to them and should not be taxed when their tribes step in to assist in obtaining that care for them.

We must point out, however, that subsection (c) must be revised to add "before, on, or" prior to the word "after" in order to assure that this new provision will not result in IRS taking the position that benefits offered prior to its enactment must have been taxable.

REVISIONS WE SEEK TO H.R. 2708

While the NSC is extremely supportive of H.R. 2708, there are, nonetheless, a few provisions which require revision and additional provisions we would like to see inserted into the bill. Our proposals in this regard are outlined in the section-by-section revisions document which I attach to this testimony. I wish to highlight one important needed revision here.

Catastrophic Health Emergency Fund (CHEF). Continuing authorization for this long-standing, vital program is missing from H.R. 2708. The CHEF provision is contained in current law as Section 202 and has appeared in all IHCIA reauthorization bills since the initial one was introduced in 1999. We believe the omission was a mistake; most likely the bill's sponsors intended instead to delete Sec. 202 of bill title II – the Social Security Act amendments – as Sec.

202 in that title was enacted into law earlier this year in the CHIPRA amendments. We ask the Committee to restore the CHEF provision as it appeared in H.R. 1328 (110th Congress bill.)

CONCLUSION

Words cannot express my gratitude to the sponsors of H.R. 2708 for producing a nearly perfect bill. I am particularly gratified that this legislation reflects a true Federal/tribal partnership whose shared goal is the improvement of the health status of Indian people by strengthening the system created by the Federal government to deliver health care to them.

I am happy to answer any questions you may have.

**NATIONAL TRIBAL STEERING COMMITTEE (NSC)
FOR IHCIA REAUTHORIZATION
AND
NATIONAL INDIAN HEALTH BOARD**

**SECTION-BY-SECTION DESCRIPTION OF
REQUESTED REVISIONS TO H.R. 2708**

Permanent Authorization Needed for IHCIA. Please delete Secs. 128, 226, 317,417, 521(a), 603, and 717 which authorize appropriations only through 2015. Revise Sec. 818(a) to read as follows:

> **SEC. 818. AUTHORIZATION OF APPROPRIATIONS; AVAILABILITY.**
>
> "(a) AUTHORIZATION OF APPROPRIATIONS. – There are authorized to be appropriated such sums as may be necessary to carry out this ~~title~~ Act."

Sec. 2 – Findings. Insert as a new paragraph the finding from H.R. 2440 (108th Congress) which reads as follows:

> "(6) Through the cession of over 400 million acres of land to the United States in exchange for promises, often reflected in treaties, of health care Indian Tribes have secured a de facto contract that entitles Indians to health care in perpetuity, based on the moral, legal, and historic obligation of the United States."

Sec. 4 – Definitions: add "Traditional Health Care Practices". Insert definition of this term from S. 1057 (109th Congress):

> "(__) The term 'traditional health care practices' means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to Western healing sciences) which embody the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which call upon these influences or forces in the promotion, restoration, preservation, and maintenance of health, well-being, and life's harmony."

IHCIA Title I – add section to make IHS scholarships and loan reimbursements non-taxable to recipients. Insert Sec. 124 from S. 212 (107th Congress):

> "SEC. ___. – **SCHOLARSHIPS.** Scholarships and loan reimbursements provided to individuals pursuant to this title shall be treated as 'qualified scholarships' for purposes of section 117 of the Internal Revenue Code of 1986."

Sec. 110 – Indian Health Service Loan Repayment Program. Two subsection cross-references are inaccurate. On bill p. 46, line 10, change "subsection (k)" to read "subsection *(l)*"; and on p. 47, line 7, change "subsection (j)" to read "subsection (k)".

IHCIA Title II – Catastrophic Health Emergency Fund. This provision, a significant and essential provision in current law, was inadvertently omitted from H.R. 2708. (We believe the sponsors intended to delete Sec. 202 of bill title II – an amendment to the Social Security Act regarding Medicaid outreach – as that provision was enacted into law in the ARRA (Pub. L. 111-05; Feb. 15, 2009). Instead, Sec. 202 of IHCIA Title II – the CHEF authorization – was deleted instead. Please re-insert the text of this provision as it appeared as Sec. 202 in H.R. 1328 (110th Congress bill).

Sec. 302(e) – Financial Assistance for Sanitation Facility Operating Costs. This bill provision [HR 2708 p. 149] limits the extent of Federal assistance that can be provided to help tribes operate and maintain sanitation facilities. Such a limitation would create particular hardship to small Indian communities. Thus, we request that the language for Sec. 302(e) as included in H.R. 1328 (as reported by the Natural Resources Committee in the 110th Congress) be used instead:

> "(e) FINANCIAL ASSISTANCE. – The Secretary is authorized to provide financial assistance to Indian Tribes, Tribal Organizations, and Indian communities for operation, management, and maintenance of their sanitation facilities."

Sec. 303(b) and (c) – Davis-Bacon Act applicability. We note that Sec. 303 contains two subsections which address Davis-Bacon applicability: (b) labeled "Pay Rates" and (c) labeled "Labor Standards". These subsections appear to be duplicative. We recommend using the text of subsection (b) which reflects current law language and is the text used by the Senate in its 110th Congress bill, S. 1200. [HR 2708 p. 156-7]

Sec. 309 – Facilities Loan Program. This bill provision calls for a study of whether to create a loan program to help tribes construct health care facilities. The NSC supports instead the restoration of the provision from 107th Congress bills which would, in fact, create such a loan program. Please insert the text that appeared as Sec. 310 in S. 212 (107th Congress).

Sec. 402(a) – Grants for Outreach. This provision contains an introductory prepositional phrase which is unnecessary and contains an inaccurate cross-reference. We recommend deletion of the following words from Sec. 402(a): "From funds appropriated to carry out this title in accordance with section 414,". [HR 2708, p. 190]

Sec. 521(b) – Authorizations for Urban Indian Organizations. This subsection identifies five programs authorized in other sections of the bill for which the IHS is authorized to establish similar programs for urban Indian organizations. Two of the referenced sections numbers are incorrect: the school health education program is Sec. 209, not Sec. 210; and the prevention of communicable diseases is Sec. 211, not Sec. 212. Plus, we

note that urban Indian organizations are included in the text of Sec. 211. [HR 2708, p. 242]

Sec. 807(c) – Treatment of Certain Services and Benefits. This provision would provide that "gross income" does not include health benefits purchased for or provided to individual Indians. This is heartily supported by Indian Country. But subsection (c) – "No Inference" – requires revision to assure that the policy of the section is actually advanced, not regressed. Please revise as follows:

> "(c) NO INFERENCE. – Nothing in this section is intended as an inference to the tax treatment of governmental benefits (including health care benefits not covered under this section) provided by Indian tribes to Indians before, on, or after the date of enactment of this section."

Unless this revision is made, the entire subsection (c) should be deleted. In its current form, negative inferences could be drawn with regard to tax reviews conducted by IRS anytime prior to enactment. Such an outcome is vigorously opposed by Indian Country.

H.R. 2708, title II, Sec. 201 – Social Security Act amendments. Sec. 201 of H.R. 2708 revises two provisions of the Social Security Act regarding the Indian health system: Sec. 1911 (Medicaid) and Sec. 1880 (Medicare). The NSC continues to support revisions to both provisions to facilitate collection of Medicare and Medicaid payments by IHS and Indian tribal programs, including updating the subsections of both 1911 and 1880 which provide a "grace period" for these programs to come into compliance with Medicare + Medicaid standards.

> MEDICAID. Please revise Sec. 201(a) of the bill to read as it did in H.R. 1328 (110th Congress). There, Sec. 1911(b) of the SSA was amended to provide a 12-month grace period for IHS/tribal programs to come into compliance with Medicaid standards. Specifically, the provision we seek appeared in H.R. 1328 as Sec. 201(a)(2) which would amend Sec. 1911(b) of the Social Security Act.

> MEDICARE. Sec. 201(b) of H.R. 2708 does two conflicting things: It repeals Sec. 1880(b) [p. 351, lines 6-7]; and amends Sec. 1880(b) [p. 351, lines 11-25; p. 352, lines 1-3]. The NSC supports the amendment to Sec. 1880(b). The repeal of that subsection should be deleted.

H.R. 2708, title II, Sec. 202 – Increased Outreach to Indians under Medicaid and SCHIP. This provision has already been enacted into law and should, therefore, be deleted from H.R. 2708. It was added to the Social Security Act by Sec. 202 of the CHIPRA amendments, Pub.L. 111-3 (Feb. 4. 2009).

Mr. PALLONE. Thank you.
Mr. Andrew Joseph.

STATEMENT OF ANDREW JOSEPH, JR.

Mr. ANDREW JOSEPH. Chairman Pallone and distinguished members of the committee.

My name is Badger in my language. I am Andrew Joseph, Jr. I Chair the Health and Human Services Committee of the Colville Federated Tribes. I Chair the Portland Area Indian Health Board and the Vice-Chair for IHS–DST, Direct Service Tribes.

Thank you for inviting the Direct Service Tribes to testify today. The Direct Service Tribes are tribes that have decided to receive their healthcare services directly from the IHS. The Direct Service Tribes consider the decision as an exercise of self-determination and the fulfillment of the Federal Trust Responsibility. Out of 564 federally recognized tribes, IHS provides direct healthcare services for over 100 tribes and accounts for over 50 percent of the total IHS population served. Since 1999 tribes have been seeking reauthorization of the Indian Health Care Improvement Act. However for reasons it is difficult to understand, passage of the Indian Health Care Improvement Act Reauthorization Bill has been obstructed each year by concerns of unrelated non-Indian issues. I hope the committee will work with us to ensure that this bill is not sidetracked this year and the bill is passed as soon as possible.

For the Indian people, Federal responsibility to provide health services represents a prepaid right. Tribes hold and affirm that the treaties with the Federal Government ensure that healthcare will be delivered effectively in our communities to exchange for the millions of acres of valuable land that are ancestors ceded. Today the Indian Health Care Improvement Act continues to be a vital important policy with—that honors these treaties and serves as a foundation for delivery of healthcare to Indian people.

I would like to speak on a few provisions of H.R. 2708 that would have significant impact for Direct Service Tribes. First, section 212 provides express authority for IHS and tribes to operate hospice, long term care, assisted living programs to supply health services in homes and community-based settings. All such delivery methods are common in the rest of the country but are rare in Indian country.

Second, the elevation of the IHS director as an assistant secretary level that is in the Department of Health and Human Services would be a strong step in creating a direct link to address the needs of tribes especially Direct Service Tribes. With an assistant secretary position, the collaborative efforts of tribes and IHS would be enhanced through true government to government dialog.

Additional recommendations—in my remaining time, I also would like to touch on two recommendations for H.R. 2708, permanent authorization of the Indian Health Care Improvement Act. The process of having the Indian Health Care Improvement Act authorized has been long. Tribes have invested into the process for over 10 years. As a tribal leader I need to justify the resources of my—that my tribe puts into trips to Washington, D.C. I know that these vital resources could be put towards critical patient care, however I and my tribe also understand the importance of ensuring

that the Indian Health Care Improvement Act is reauthorized. To honor our treaties and to ensure the continual authority for our healthcare system, the bill should be amended to ensure that the authorization for appropriations is permanent.

Establishing an office of Direct Service Tribes, H.R. 2708 should also be amended to include the establishment of an office of Direct Service Tribes located within the proposed office of assistant secretary. The responsibilities of this office would honor the relationship with tribes by providing technical support to Direct Service Tribes in serving as a point of contact for tribal consultation.

I wish to thank the committee for the opportunity to provide these comments and I will be pleased to answer any questions the committee may have. Thank you.

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

TESTIMONY OF ANDREW JOSEPH, JR.

CHAIRMAN, HUMAN SERVICES COMMITTEE,
DIRECT SERVICES TRIBE ADVISORY COMMITTEE

PORTLAND AREA BOARD MEMBER, NATIONAL INDIAN HEALTH BOARD
CHAIRMAN, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

OCTOBER 20, 2009

Chairman Pallone, Ranking Member Deal and distinguished members of the committee, I am Andrew Joseph Jr. testifying on the behalf of the Direct Services Tribe Advisory Committee (DSTAC). I serve as a Tribal Council Member of the Confederated Tribes of the Colville Reservation. Also, I serve as the Chairman of the Northwest Portland Area Indian Health Board and the Portland Area Representative to both the National Indian Health Board and National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act (IHCIA).

Thank you for inviting the DSTAC to testify today on H.R. 2708 - the *Indian Health Care Improvement Act Amendments of 2009*. The DSTAC represents those Tribes that have elected to receive their health care services directly from the IHS (Direct Service Tribes or DST). The Direct Service Tribes consider the decision to receive primary health care directly from IHS as an exercise of self-determination and the fulfillment of the federal trust responsibility owed to the Tribes. Out of the 564 federally recognized Tribes, IHS provides direct health care services to over 100 Tribes. The Direct Service Tribes account for over 50% of the total IHS population served and of the IHS resources. Many consider the Portland Area to be comprised entirely of self-governance Tribes and while 90% of our Tribes manage their programs under contracting or compacting agreements with IHS, there are five Tribes that continue to have IHS manage their health programs, which account for approximately 45% of the Portland Area budget. From a fiscal standpoint, this makes the Portland Area evenly split between direct service and tribally operated health programs. We appreciate the Committee's recognition to provide the DST the same consideration in providing testimony today as those Tribes who choose to exercise their self-determination rights by operating their own health services facilities.

Also, I would like to thank Congressman Pallone for introducing H.R. 2708 earlier this year. While H.R. 1328 was not passed last year, I hope we can build on the momentum from the last Congress and see H.R. 2708 passed this year. Since 1999, Tribes have been seeking reauthorization of the IHCIA. As you know, the reauthorization, or modernization, of the IHCIA is necessary so that improvements are made in the Indian health system to raise the health status of Indian people to the highest level possible. However, for reasons it is difficult to understand, passage of an IHCIA reauthorization bill has been obstructed each year by concerns of unrelated non-Indian legislation and issues, by an uncooperative Administration, or by non-Indian interests groups. I hope that the Committee will work with us to ensure that this bill is not sidetracked this year and this bill is passed as soon as possible.

Treaty and Federal Trust Responsibility for Health Care

The United States government has a duty to ensure that comprehensive health care is provided to all AI/AN, at a level, which should be comparable to the care provided to any other American. For AI/AN people, the federal responsibility to provide health services represents a "pre-paid" right, paid for by the cession of over millions acres of land to the United States as documented by our treaties. DST hold and affirm that the treaties with the federal government ensure that health care will be delivered effectively in our communities in exchange for the millions of acres of valuable land that our ancestors ceded and that our treaties would be honored, *"as long as the grass grows and the rivers flow."* In many of the treaties negotiated between the Tribes and the United States government, specific provisions were included for basic health care, such as the services of a physician and the construction and maintenance of hospitals and schools. The treaties are the sacred words of our ancestors, carrying the hopes, beliefs and assurances that the trust

obligation of the federal government will be fulfilled resulting in healthy individuals, communities and Tribes.

In 1976, Congress enacted the Indian Health Care Improvement Act (IHCIA), which forever changed the face of Indian health policy. With the IHCIA, Congress intended to honor the federal government's duty to provide health care; to address long-standing deficiencies in Indian health care; to increase the number of health professionals serving Indian communities; to authorize services to urban Indian populations; to rectify health facility problems; and to provide access for Indian patients to other federal health resources such as Medicaid and Medicare.

Today, the IHCIA continues to be a vitally important policy that serves as the foundation for the delivery of health care to AI/AN. Yet, the AI/AN population still suffers vast disparities in overall health status, and the funding appropriated to the IHS is abysmal relative to the per capita health care amounts provided to other federally-funded population groups (e.g., federal employees, Medicaid beneficiaries and even federal prisoners). IHCIA needs to be reauthorized to assure this baseline authority for providing direct health care to AI/AN is in place.

The Indian health delivery system also needs to incorporate many of today's health care practices. The American health care delivery system has been revolutionized while the Indian health care system has not. For example, mainstream American health care has moved away from hospital based treatment of disease to primary preventive care. The focus on prevention has been recognized as both a priority and a treatment. Also, the delivery of care has moved from the hospital settings to home and community based service providers, which is less expensive and more appropriate. The coordination of mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Reflecting these improvements in the IHCIA is a critical aspect of the reauthorization legislation.

Key Provisions in H.R. 2708

Health care remains the top priority in Indian Country, and reauthorization of the IHCIA holds the most promise of improving the health status and outcomes in Indian Country. The IHCIA is a comprehensive piece of legislation like the Indian health programs that it authorizes. It addresses every aspect of what it takes to provide a true system of care for AI/AN people. I would like to speak to few provisions of H.R. 2708 that would have significant impact for the Direct Service Tribes.

Development of Health Care Professionals

Title I addresses the critical need to increase the number of AI/AN entering the health professions, as well as ensure a sufficient supply of health providers throughout Indian Country. It is critical to the existence of our people that we have the most qualified and dedicated health personnel available. Unfortunately, many factors serve as barriers to the development, recruitment, and retention of qualified health personnel to serve in Indian Country. Such factors include the lack of opportunity for American Indians and Alaska Natives to receive quality medical education, disproportionate pay for health professionals, and the geographical remoteness of most health facilities. Continuity of care is dependent on the ability of a facility or Tribe to retain health

professionals. Title I seeks to fix many of the problems that hinder our ability to bring the best and brightest physicians, dentists, nurses, and other health professionals to Indian Country.

Long-Term Care – An Innovation for Indian Country

Sections 204 and 212 of Title II provides for the authorization for the Indian Health Service and Tribally-operated health systems to provide long-term health care, assisted living, home health services, hospice, and other related programs. If the Indian health system is to be modernize, then the Indian health programs must be authorized to make these services available for their patients. While the life expectancy of AI/AN 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. If you were to ask American Indians and Alaska Native what services or programs are absent and/or inaccessible in Indian Country, the response you will receive is long-term health care, quality nursing homes, home-health programs, hospice and other similar programs.

Elevation of the Indian Health Service Director

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

The Direct Service Tribe's close relationship with the IHS relies on the active support and partnership of the IHS, led by the IHS Director. The identification of service priorities for DST is the responsibility of the IHS Director working with the area office personnel serving our people at the local community level. Elevation of the IHS Director of an Assistant Secretary within the HHS would be a strong step in creating a direct link to the needs of the DST and the IHS budget priorities. The DSTAC and the IHS collaborative efforts would be enhanced through government to government dialogue with an Assistant Secretary position that would ensure tribal input, thus assisting the federal government in meeting its treaty obligations.

Behavioral Health Programs

Indian Country strongly supports Title VII authorizing the development of comprehensive behavioral health prevention and treatment programs which reflect tribal values and emphasize collaboration among social service programs, mental health programs, and alcohol and substance abuse programs. Title VII addresses all age groups and authorizes specific programs for Indian youth including suicide prevention, substance abuse and family inclusion. Improving the health status of AI/AN cannot be achieved without fully integrating behavioral strategies and services in every aspect of our systems of care.

Additional Recommendations

In the recently introduced Senate bill S. 1790 to reauthorization of the IHCIA, two key recommendations were included and should be included in H.R. 2708.

Permanent Authorization of the IHCIA

As noted, this process to have the IHCIA reauthorized has been long with considered investment of the tribes. As a tribal leader, I have to be able to justify the resources that our Tribe puts into trips to Washington, D.C. to seek to have legislation passed over the past 10 years. Recognizing the chronic underfunding of our health programs, I know that these vital resources could be put toward critical patient care. However, I and my tribe also understand the importance of ensuring that the IHCIA reauthorized. To honor our treaties and to ensure the authority for our programs and for appropriations for our delivery care system, the bill should be amended to ensure the authorization for appropriations is permanent.

Establishing an Office of Direct Service Tribes

H.R. 2708 should also be amended to include the establishment of an office of Direct Service Tribes located within the office of the Director, or preferably, office of Assistant Secretary. The responsibilities of this office would include, among other things, providing technical support to the DST and serving as a point of contact for tribal consultation between DST and IHS.

Tax Exemption for IHS Scholarships and Loans

A full workforce of health professionals is a critical part of delivery of health care. Scholarship programs were designed to recruit and support AI/AN students into health profession and to link scholarship recipients to work directly in IHS and Tribal programs. To provide additional support to such recruitment and retention efforts, the NSC recommends adding a provision to make such scholarships and loans non-taxable to the recipient. This provision, incorporated in a previous IHCIA reauthorization bill, would provide the same tax-exempt status to IHS scholarships as those awards provided to members of the National Health Service Corps.

Conclusion

There are many important provisions in this bill that could be highlighted. As the Congress and Administration move toward developing health care reform policy for the United States, passage of the IHCIA represents a modernization of the Indian Health care delivery system, and is essential for IHS and Tribal health programs to become viable partners in health care reform options.

I wish to thank the Committee for the opportunity to provide these comments and will be pleased to answer any questions the Committee may have.

Mr. PALLONE. Thank you.
Dr. Rock.

STATEMENT OF PATRICK ROCK, M.D.

Dr. ROCK. Thank you. Good afternoon.

My name is Dr. Patrick Rock, Leech Lake Band enrollee and also the President-Elect for the National Council of Urban Indian Health, and also the CEO of my organization called the Minneapolis Indian Health Board.

On behalf of the National Council of Urban Indian Health and the 9,000 patient visits that my clinic serves annually, I would like to thank Representative Pallone for introducing this important bill. I would also like to thank the subcommittee for holding this hearing.

The Urban Indian Health Program serves over 150,000 American Indians and Alaska Natives annually through 36 urban Indian programs across the county. It is a comprehensive health delivery system that integrates public health, preventative health measures, behavioral health and primary care services. The urban Indian programs providing health services are at various levels of services dependent upon the needs of the community and the funding. Our programs are both innovative and cost effective. As a whole, the urban Indian health program leverages $2 for every dollar of Indian health service investment.

We are also a unique system of care designed to fulfill the trust responsibility to Indian people living in urban areas. Congress has repeatedly stated that the government's trust responsibility extends to American Indians and Alaska Natives living away from their tribal homes. From the original Snyder Act of 1921 to the Indian Health Care Improvement Act Congress has affirmed and reaffirmed its commitment to ensure that trust responsibility to Indian people is met regardless of where they reside.

Despite this commitment, the trust responsibility to Indian people has not been fully met. The Indian healthcare delivery system is innovative and well-situated to address the health disparities suffered by Indian people in a comprehensive, culturally appropriate manner. However, the Indian health delivery system needs full funding and modernization promised by this bill in order to meet its mission.

H.R. 2708 provides a number of new tools and updates for the Indian health providers. These programs and modernizations will help the Indian health delivery system tackle the serious health disparities facing our people.

I would like to take the opportunity to highlight three provisions that I believe will greatly benefit urban Indian health providers such as myself. First, in section 515, conferring with urban Indians, in order to—in order of the trust responsibility to urban Indians are fully met, urban Indians need the opportunity promised by this section to discuss the health needs of urban Indians with the Federal Government.

Second, section 521, authorization for urban Indian organizations, H.R. 2708 creates tools and programs to address behavioral health disparities suffered by Indian people, especially with regard to Indian youth suicide. This provision assures that urban Indian

programs will have such programs available through them through title 5 of IHCIA.

Third, section 522, health information technology, health information technology is the future of health delivery. Any provider that does not develop HIT infrastructures and systems now will be behind the advances of medicine to the detriment of their patients. This provision assures that title 5 programs will have the support and the opportunities they need.

There are also three revisions that the National Council of Urban Indian Health seeks. First, NCUIH strongly supports the National Steering Committee's recommendation that IHCIA be made permanent Federal law. There are several major laws which Congress has permanently authorized. We believe that the time has come to give IHCIA the same permanency.

Second, NCUIH also asks the committee to restore urban Indians to section 3, the Declaration of National Indian Health Policy. Removing urban Indians from this provision is a regression from current law. By not including urban Indians, Congress opens the door to inferences that it no longer believes that the trust responsibility extends to urban Indians. We believe that dropping urban Indians from this provision was done in error and ask the committee to restore urban Indians.

Third, NCUIH asks the committee to restore urban Indians to section 201 of title 2. These provisions pertain to third-party billing, a critical necessity for any health provider. Including urban Indians in this section would greatly help urban Indian organizations strengthen their third-party billing capacity which could be a difference between fiscal stability and instability for many programs.

As President-Elect of the National Council of Urban Indian Health and the CEO of Minneapolis Indian Health Board, I would like to give Representative Pallone, the committee and the sponsor of the H.R. 2708 my deepest and most sincere thanks for producing this bill. H.R. 2708 provides the necessary modernization for Indian health delivery system and all Indian health providers from the Indian health service to urban Indian health providers will benefit greatly from this passage. While there are few provisions—important provisions for urban Indians that NCUIH feels should be reconsidered we believe that this bill truly reflects the priorities of tribes and of urban Indian health programs.

Thank you.

[The prepared statement of Dr. Rock follows:]

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Excellence, Equity, Effectiveness

Written Testimony of
Dr. Patrick Rock, MD, President-Elect of the
National Council of Urban Indian Health before
House Committee on Energy and Commerce
On the Indian Health Care Improvement Act Amendments of 2009
October 20th, 2009

Introduction: On behalf of the National Council of Urban Indian Health (NCUIH), our 36 member clinics, and the 150,000 American Indian/Alaska Native patients that we serve annually, I would like to thank the House Committee on Energy and Commerce for this opportunity to testify on the Indian Health Care Improvement Act Amendments of 2009. NCUIH strongly supports the quick reauthorization of this critical piece of legislation as it is desperately needed to modernize and support the Indian health delivery system. As the debate around national health care reform sweeps through Congress, it is important that the needs of Indian people are remembered and addressed. I would like to thank Representative Pallone for introducing the Indian Health Care Improvement Act in this new Congress. It is my hope that in this new Congress that we can move forward on the critical issues facing the Indian healthcare delivery system.

H.R. 2708 incorporates many of the recommendations made by the National Steering Committee and by including those recommendations have made the bill much stronger. The Indian health delivery system is well positioned to comprehensively address the high rates of health disparities facing American Indians and Alaska Natives. No other health delivery system blends public health and community based interventions with culturally competent health care better than the Indian health delivery system. With the enactment of H.R. 2708 the Indian health delivery system will receive a much needed modernization. NCUIH is delighted that Representative Pallone has seized the opportunity presented with health care reform to move the Indian Health Care Improvement Act forward. While NCUIH believes that there are some provisions that should be reconsidered or modified, we feel this is a stronger bill and its passage will make all Indian health providers stronger and more able to comprehensively address the health disparities suffered by American Indians and Alaska Natives. This testimony walks through some of the provisions about which we are particularly excited and grateful that the Committee has included them in the bill, as well as calling attention to some problematic provisions that we hope we can work with the Committee to remedy.

Federal Trust Responsibility to Urban Indians: Congress has repeatedly acknowledged that the government's trust responsibility extends to American Indians and Alaska Natives (AI/AN) living away

from their tribal homes. From the original Snyder act of 1921[1] to the Indian Health Care Improvement Act of 1976 and its amendments, Congress has consistently found that: "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation*. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instance forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there."[2] The 2000 Census reported that 66% of individuals identifying as American Indians and Alaska Natives reside off reservation[3] and IHS estimates that roughly 930,000 of those living in those locations are eligible for services at Urban Indian Health Clinics. Urban Indian health clinics are often the main, if not sole, source of culturally competent health care for those off-reservation communities. The Urban Indian Health Program is a small, but critical and innovative component of the Indian health delivery system.

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

Current Health Disparities Levels: Americans Indians and Alaska Natives continue to face the highest levels of health disparities for all races combined. The infant mortality rate is 150% greater for Native Americans than that of Caucasian infants.[5] For a quick comparison, the rate of Sudden Infant Death Syndrome for Native American infants is the same as for infants in Haiti. American Indians and Alaska Natives are 2.6 times more likely to be diagnosed with diabetes than the general population.[6] Native Americans suffer higher mortality rates due to "accidents (38% higher than the general population rate), chronic liver disease and cirrhosis (126% higher), and diabetes (54% higher)."[7] Native peoples ages 15 to 34 constitute 64% of all suicides nationwide.[8] As a recent example, in the past 12 months there have been 213 suicide attempts on the Rosebud Sioux reservation. Alcohol-related deaths

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

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

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

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

[5] Fn 3.

[6] *Indian Healthcare Improvement Act Fact Sheet*, National Indian Health Board, 2008. *See also, Unnatural Causes: Is Inequality Making Us Sick?* PBS Documentary, 2008.

[7] *The Health Status of Urban American Indians and Alaska Natives*, Urban Indian Health Institute, 2004.

[8] 2006 National Survey on Drug Use and Health: National Findings

in general were 178% higher than the rate for all races combined.[9] Native Americans also have the fastest transition between diagnosis and death for HIV/AIDs and most forms of cancer.[10]

These health disparities are the direct result of continuing social and economic inequality that lead to disparities in health care accessibility. The idea that health disparities are the direct result of health inequality is not a new idea[11] and in the Native American community its existence is well documented.[12] However, the Indian health delivery system is well situated to address these health disparities in a comprehensive, culturally appropriate manner. It simply requires full funding and the modernization promised by H.R. 2708. This bill provides a number of new tools and updates for Indian health providers. These programs and modernizations will help the Indian health delivery system tackle the serious health disparities facing our people and NCUIH thanks the Committee for moving forward with this important bill.

Make IHCIA Permanent Law: NCUIH strongly supports the National Steering Committee's recommendation that the Indian Health Care Improvement Act be made a permanent federal law. We believe that it is a matter of fulfilling the trust responsibility for Indian health and demonstrating undeniable Congressional intent and will to ensure the health of Indian people. NCUIH joins with the NSC in asking Congress to revise H.R.2708 to remove the 'sunset' dates and permanently authorize the appropriation of funds to carry out the programs and services the Act requires.

NCUIH believes that the concept of using 'sunset' dates to spur Congressional review and revision of major laws has not worked in the context of the Indian Health Care Improvement Act. While the Indian Health Care Improvement Act is a major law for Indian people and the people who serve them it is often not considered a major law next to issues such as national health care reform. Indian people have poured countless resources into work on and advocating for the reauthorization of the Indian Health Care Improvement Act. These resources could have been spent on other priorities for the benefit of Indian people.

Removing the 'sunset' dates from IHCIA would not be new in the context of federal Indian law. There are several major laws which Congress has permanently authorized—the Snyder Act, the Indian Self Determination and Education Assistance Act, the BIA elementary and secondary education law, the Tribally Controlled Schools Act, the Indian Financing Act, the Indian Gaming Regulatory Act, the Johnson-O'Malley Act, the Indian Child Welfare Act, the Indian Law Enforcement Reform Act, the National Indian Forest Resources Management Act, and the Native American Graves Protection and Repatriation Act. Each of these are major laws for Indian people and they have all been made permanent. We believe that the time has come to give IHCIA the same permanency.

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[9] ibid
[10] fn 1.
[11] *See Reducing Health Disparities*, presentation by Dennis Raphael, PhD Dec 14th, 2006 http://video.google.com/videoplay?docid=-4129139685624192201&hl=en last accessed 6/23/2008
[12] fn 3.

Revising H.R. 2708 to make IHCIA permanent would not prevent nor otherwise confound Congressional oversight of the Indian Health Service or the amending and revising of the IHCIA as Congress deems appropriate. Indeed, both Medicaid and Medicare are permanent laws and hardly a legislative session passes where Congress has not engaged in some form of amending or revising either of those laws. We believe that the trust responsibility owed Indian people demands that the federal law directing the delivery of health care to Indian people be provided similar permanent status.

Commendable Provisions of H.R. 2708: Passing the Indian Health Care Improvement Act so we can modernize the Indian health delivery system for our patients is the very first priority for the National Council of Urban Indian Health. Our clinics and programs see patients from every tribe and every walk of life. Many of our patients would not seek care elsewhere due to problems of fiscal and cultural accessibility. As described above, the clinics and programs of the Urban Indian Health Program deliver innovative, culturally competent care despite funding shortfalls, the economic downturn, and active hostility from the previous Administration. We would like to outline those provisions which are particularly helpful for Urban Indian Organizations.

The history of the Urban Indian Organizations within the Indian Health Care Improvement Act has often been fraught with peril. The inclusion of Title V—which authorizes the Urban Indian Health Program—has frequently been attacked and almost successfully stripped from the bill entirely. It speaks to the tenacity of the Urban Indian Health Programs, the support of Tribes, and the fierce advocacy of Representative Rahall and Representative Pallone that Title V yet endures. While the Indian Health Care Improvement Act of 2008 did not provide for many new authorities for the Urban Indian Health Program it: 1) reaffirmed the trust responsibility to urban Indians—a relationship that was attacked by the previous Administration; 2) provided additional facilities support for urban Indian health providers; 3) increased protections for American Indians and Alaska Natives under Medicaid, Medicare, and SCHIP, and; 3) provided increased competitive grant opportunities for the clinics and programs of the UIHPs.

NCUIH is delighted to find that H.R. 2708 not only incorporated these previous provisions and principles but expands upon them, creating from the Urban Indian perspective an even stronger bill than was presented in the 110th Congress. NCUIH offered a number of recommendations for new or restored provisions to H.R. 2708 through the National Steering Committee, and to our great pleasure, the Committee has incorporated several of those provisions. NCUIH believes that these provisions will greatly strengthen the Urban Indian Health Program and allow urban Indian health providers greater flexibility and stability in serving their patients. We would like to highlight a few of the new provisions we feel are particularly beneficial to urban Indian health providers:

1. Section 504 Use of Federal Government Facilities and Sources of Supply: This provision is a minor expansion from current law but an important one for urban Indian health providers. This section extends to urban Indian health providers the same access to federal facilities and property (including excess property) and sources of supply that is currently available to programs operated by Tribes or tribal organizations under section 105(f) and 105(k) of the Indian Self Determination Act. The Indian Health Services is currently authorized to extend the use of federal facilities to urban Indian health providers but not the sources of supply. The

ability of urban Indian health providers to access the same sources of supply as other Indian health providers would greatly help programs struggling to obtain necessary equipment and upgrades.

2. Section 515 Conferring with Urban Indian Organizations: H.R. 2708 retains section 515 from the previous version of the Indian Health Care Improvement Act but changes the language from 'consultation' to 'conferring'. This is a critical distinction that NCUIH supports as it protects the unique government-to-government relationship between the Tribes and the federal government. NCUIH feels that this provision is particularly important to the well-being and stability of the Urban Indian Health Program. Although NCUIH and its member organizations do not have a government-to-government relationship with the federal government, and it would be inappropriate to use the term 'consult' which has a special meaning in this context, the Urban Indian Organizations do represent American Indians and Alaska Natives to whom a Trust responsibility is owed. Within the confines of that obligation, the federal government must make the effort to confer with those the urban Indian stakeholders.

   The United States federal government owes a solemn trust responsibility to American Indians and Alaska Natives. When Indian tribes ceded certain lands—lands that now constitute the United States—agreements were made by the tribes with the United States government that established a "trust" responsibility for the safety and well-being of Indian peoples in perpetuity. In addition, a number of treaties specifically provided for the education, nutrition, and health care of Indian people. Congress, as stated earlier, has repeatedly stated that this solemn obligation does not end at the reservation borders, but follows Indian people regardless of where they reside. This trust responsibility includes, from the perspective of NCUIH, the obligation to confer with the Urban Indian community through their duly authorized representatives regarding how that trust responsibility is met. Given the soaring health disparities facing the Urban Indian population[13] it is particularly necessary for meaningful discussion to take place in order for both the federal government and the urban Indian health providers to ensure that the best possible care is provided to the vulnerable American Indian and Alaska Native community.

3. Section 521(b) Authorizations for Urban Indian Organizations: This provision authorizes the Secretary establish programs for Urban Indian Organizations that are similar to programs established pursuant to sections 126 (behavioral health training), 209 (school health education), 211 (prevention of communicable diseases), 701 (behavioral health prevention and treatment services) and 707(g) (youth multidrug abuse). This section also provides that to the extent that programs established under these sections are required under the Act, they shall also be required under this section. These provisions deal with authorities and programs that go to the core mission of the Urban Indian Health Program and directly address afflictions that are

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

especially severe in the urban environment. Urban centers in particular have large patient populations with the very type of problems these programs address given the nature of living in an urban center where there is ready access to alcohol and a wider variety of illicit drugs. Moreover, Native Americans suffer additional stress in urban environments as they are separated from their community and surrounded by, in many respects, a foreign culture.

Many problems on the reservations are imported from urban locations because there is substantial movement back and forth between the reservation and Urban Indian communities. Tribal members with drug, alcohol and infectious diseases—like HIV/AIDs (which would be addressed under Section 211)—bring those illnesses back with them to the reservation. But that chain can – and has been – broken when they are treated at the urban center and always in a far more cost efficient manner then if the same patient receives significantly delayed care at an on-reservation IHS facility because they were forced to wait until they reached medical crisis and then return home. Urban Indian health programs form a critical link in preserving the health and viability of the Native American population by confronting many illnesses and substance abuse at their point of origin. The sad and fundamental truth is that eventually these patients must be seen and either they can be seen early, before the most destructive behaviors or illnesses set in, or they will be seen much later at the Tribal or IHS facility.

Please note that section 521 of H.R. 2708 misidentifies two of the section numbers: the school health education program is section 209, not section 210; and the prevention of communicable disease is section 211, not section 212. We also noticed that urban Indian organizations are still included in the direct text of section 211.

4. Section 522 Health Information Technology: NCUIH is especially heartened by the inclusion of this provision as we believe that strong HIT systems are critically necessary for every provider as we enter into an age of unprecedented technological development. The Obama Administration has strongly supported the development of HIT infrastructure to encourage the formation of an interoperable HIT system across the United States. Such a system would help providers' better control health care costs, track health data, and provide individually tailored health care to patients. By including a provision directly authorizing appropriations for health information technology for urban Indian health programs the Committee has provided incredible support to urban Indian providers.

   Health Information Technology is the future of health delivery. Any provider that does not develop HIT infrastructure and systems now will be behind the advance of medicine to the detriment of their patients. Given that Indian health providers are already at such a disadvantage and our communities suffer high health disparity and disease burden, all possible support should be given to Indian health providers that are trying to develop HIT infrastructure and technology.

Revisions to H.R. 2708 Sought by NCUIH: There are, however, also provisions from which NCUIH believes urban Indians and urban Indian organizations have been erroneously removed. Chief among

these are: Title I, section 3 Declaration of National Indian Health Policy which would imply a potential change in Congressional intent towards urban Indians. There are also two other provisions from which urban Indians have been removed that NCUIH believes should be reconsidered by the Committee. We believe that urban Indians and urban Indian health providers have been removed from these provision due to oversight or due to concessions made to the previous Administration that no longer have the support of the current White House. The following two provisions are ones about which NCUIH feels especially strong as they would have significant impact on either federal policy towards urban Indians or would provide authorities that could potentially financially stabilize several urban Indian health providers:

1. Section 3 Declaration of National Indian Health Policy: NCUIH strongly advocates that urban Indians be restored in subsections 1 and 6 as the absence of urban Indians from this subsection would signal an alarming and, we believe, false intent of Congress to limit or otherwise diminish the trust responsibility to American Indians and Alaska Natives who live away from their tribal homes. Moreover, removing Urban Indians from this section is a regression from current law. This section lays out the fundamental tenants of the federal policy towards Indian health and by not including urban Indians implies that Congress does not believe any such policy extends to those individuals living in urban centers. Not including urban Indians in this section could potentially weaken the legal authority for extending the trust responsibility to urban Indians as it could signal a change in Congressional intent.

   Urban Indian organizations have also been removed from subsection 6 of this section which states the Congressional intent to fund and support Indian health providers. Removing urban Indian organizations from this provision would weaken their legal support for continued appropriations. Given that this implication is refuted by the newly strengthened Title V, NCUIH believes that the removal of urban Indians from this section was done in error and strongly urges the Committee to review this section.

2. Section 213 Indian Women's Health: This provision directs the Secretary to specifically monitor the health status of Indian women and work to improve the quality of health care for all Indian women. Given that disease knows no boundaries, urban Indian women suffer the same health disparities and the same high disease burden as women living on the reservations. We respectfully ask the Committee consider re-including urban Indian women in this provision.

3. Title II Section 201 Expansion of Payments Under Medicare, Medicaid, and SCHIP for all Covered Services Furnished by Indian Health Programs: Section 201 of the Indian Health Care Improvement Act (IHCIA) amends sections 1911 and 1880 of the Social Security Act. The proposed amendments would allow Indian Health Programs and Urban Indian Health Programs to directly bill Medicaid and Medicare for providing services or items to Indian patients. Due to what NCUIH believes is an unfortunate misunderstanding of urban Indian health providers' third party bill capacities, Urban Indian Organizations have been removed from this provision. The general argument for removing UIOs from this provision is that UIOs already have authority to bill Medicaid and Medicare through the FQHC and RHC provisions. NCUIH also believes that

there has been some degree of confusion regarding the interplay between the HRSA FQHC program and I/T/U programs.

The FQHC program is complicated when it comes to Indian health care providers. FQHC's traditionally come in two forms 'full' FQHCs—or clinics who have received a 330 grant from HRSA—and clinics who are FQHC 'lookalikes'—or clinics that meet all of the requirements for the 330 grant but have not been awarded such a grant. In Indian Country there is a third FQHC provider type which is an health program operated by a Tribe, Tribal Organization, or Urban Indian Organization which reaches the FQHC requirements. These programs are automatically qualified for the FQHC program.

One argument against including Urban Indian Organizations in this provision is that it would create a new provider type not contemplated in the law. However, this provision would already create two new provider types in the form of health clinics operated by Tribes or Tribal Organizations. Excluding urban Indian health providers for this reason makes no sense. Furthermore, under the authorizing legislation of the Federally Qualified Health Clinic Program Tribes, Tribal Organizations, and Urban Indian Organizations who meet the service requirements (though not the access requirements) of the FQHC program are automatically designated as FQHCs. For this reason it does not make sense to differentiate Tribal, Tribal Organizations and Urban Indian Organizations on the basis of potential FQHC status.

Moreover, the argument for excluding Urban Indian Organizations overestimates the number of Urban Indian Organizations eligible for FQHC, RHC or FQHC look-a-like status. Currently 8 UIHPS are 'full' FQHCs meaning they have received a 330 grant, 15 are either FQHC lookalikes or tribal FQHCS, and two are RHCs. One third of the Urban Indian Organizations are not able to bill Medicaid and Medicare through the FQHC statutes. Thus the argument that the number of Urban Indian Organizations impacted by removing them from section 201 would be trivial is clearly not true.

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

Indian Organizations in provisions as it means the difference between fiscal stability and instability for many programs.

Conclusion: As the President Elect of the National Council of Urban Indian Health and the Executive Director of the Minneapolis Indian Health Board, I would like to give Representative Pallone, the Committee and the sponsors of H.R. 2708 my deepest and most sincere thanks for producing this bill. H.R. 2708 provides the necessary modernization for the Indian health delivery system and all Indian health providers from the Indian Health Service to urban Indian health providers will benefit greatly from its passage. While there are a few provisions—important provisions for urban Indians—that NCUIH feels should be reconsidered, we believe that this bill truly reflects the priorities of the Tribes and of the urban Indian health programs. Thank you.

Mr. PALLONE. Thank you, Dr. Rock.

And we will take questions from myself initially and then my colleague from the Virgin Islands.

Let me address some of the things you mentioned. First, Mr. Keel talked about schedule and procedure for moving the bill and I would just, you know, like to reiterate what I said before which is that, you know, I would like to see as much of this included in the larger healthcare reform as possible, and so it may very well be that until we know where we are going with that in the next few weeks that, you know, we would have to wait until that is sort of resolved.

And then I wanted to mention with regard to Ms. Joseph, I am very much supportive of what you suggested about not taxing health benefits provided by tribes. I mean my view of going back to what I said in the opening statement is that, you know, since we have a responsibility on the part of the Federal Government to provide healthcare completely for Native Americans, if and we are not doing it, if the tribes set in to make up for that difference it is even more outrageous to consider taxing them for it when we are supposed to be providing the benefit completely. So I have sent letters to IRS and of course, you know, co-sponsored the legislation that would change—that would make it clear that they are not taxable. Now, that is the Ways and Means issue as you know. It doesn't actually come before this committee but it is something that we are mindful of as well, you know, as we move forward with the healthcare reform.

I wanted to ask you because several of you mentioned about the, you know, making the Act permanent and I was going to ask Ms. Joseph initially, I mean there is some precedent for that especially with respect to Indian law but tell me in a little more detail why you think there is a need for permanent authorization. I mean why is that needed as a—I mean normally we don't do it so would be your justification?

Ms. RACHEL JOSEPH. Well, thank you, Mr. Chairman, for the question.

I think after this long 10-year experience of course, you know, the expenditure of resources that Chairman Joseph spoke to, we certainly, you know, don't want to have to go through that exercise. But more importantly, we think if we have a permanent authorization and Congress we know can revisit that and revise and amend it as necessary, we think that in the future we would have an opportunity to focus on one or two or three issues that need to be addressed, and have some extensive conversations and dialog spent on those issues, and we think that we should do more of that.

Mr. PALLONE. OK, I wanted to ask Mr. Joseph a different question and that is about long term care services. You raised that in your testimony and this is something that I am very interested in, you know. There is probably not going to be much in the healthcare reform, the larger healthcare reform on that because of the expense but I am curious to know more about, you know, those long term care supports and services provided in Indian country. I mean how are the American Indian elders provided long term care now and how would the revised authority under this bill change the delivery of care?

Mr. ANDREW JOSEPH. Honorable Mr. Pallone, right now our tribe we have—the Colville tribe has a rest home. We have a area agency on aging and we have some of the people that take care of our elders at home. Some of our elders, you know, because of sanitation reasons need to be cared for 24 hours a day, you know, everyday of the year. And, you know, we all would like to take our last breath in our own home but for some of us, you know, we are not able to do that. Some people are really physically impaired and some elders are trying to take care of elders. So what we would like to be able to do is figure out, you know, put an amendment in the bill that would be able to help us, you know, take care of our elders. The Makah tribe has elders in rest homes that are over an hour, an hour and a half away from their reservation. In order to be able to go and visit them it is a long commute. And by having this in the bill, we can provide that care for ourselves and it would provide jobs and it would be allowed for if we can bill through IHS an Indian counter-rate through Medicaid or Medicare. To me, our convalescence and our elder rest home is culturally run. We have our cultural ceremonies there and our elders feel more at home there.

Mr. PALLONE. Well, that is what I was going to ask you. I would imagine your biggest concern is that if, you know, elders have to be taken to a nursing home or some institution off the reservation is that very common now amongst tribes? I imagine you try to prevent that but is that—is it very common that they have to actually go to a, you know, or what I call a mainstream nursing home off the reservation?

Mr. ANDREW JOSEPH. Because of the lack of sufficient funding for IHS, a lot of our elders become into more of a critical need by the time they, you know, find that their illnesses take them to a rest home facility and because it is not in the bill right now tribes aren't able to really, you know, help fund, you know, for those services to build their own and take care of their own.

Mr. PALLONE. All right, thank you.

Let me just ask Dr. Rock, you of course talked about the urban Indian health program primarily and you mentioned that the urban Indian health program and how the last Administration tried to eliminate it from the bill. Of course, I never quite understood that. Can you talk about how that urban Indian program why it is so important that it stays in place and needs to be expanded the way this bill proposes? And, you know, we hear various things that there are more and more, you know, Native Americans that are moving off reservations, living in cities but then we also hear that a lot of them are coming back. Well, maybe that is less so now with the recession or maybe more so, I don't know. I mean I guess it depends upon whether there is economic opportunities on the reservation but do you want to comment on that in terms of, you know, particularly now with the recession or where we are going in the next few years?

Dr. ROCK. Certainly, well that makes two of us that we didn't understand why we were zeroed out to begin with but we play a really important part as far as this healthcare system that Indian Health Service provides. We see a number of patients that are either in transition that are moving in and through the Twin Cities,

specifically my program the Twin Cities, Minneapolis and Saint Paul. People are looking for work. I see a number of patients of mine, I still practice medicine, that have lost their jobs that have no insurance and they have absolutely nowhere to go. They have no access to care. Even though we—our clinic is right smack in the middle of several hospitals, we have the university system there. We have a couple of private hospital systems there that offer clinical services too, but our patients feel like they don't have the access there because they don't have the funding to pay for healthcare, and we often see folks that come in that have really advanced disease. They are diabetes, take for example, is to the point to where now they are starting to see kidney problems or eye problems and we try our best to get people to the care they need but we are often at that level of where we are just putting a Band-Aid on something that could be addressed more appropriately if the funding sources were there.

Mr. PALLONE. Has the recession resulted in more people moving back to the reservation, moving off or both? Is there—I mean I know I am asking you anecdotally but?

Dr. ROCK. Yes, that is exactly right. It is just through my anecdotal experience of seeing patients one-on-one everyday. We do see a number of folks that are just moving to the Twin Cities looking for opportunities for work. Again, some statistics that we see these days that are 60 percent of Native populations live in urban settings and I will be interested to see what the new census data will show as we head into the census as to what that is now currently but anecdotally, I have a number of patients who have lost their jobs. I have had one gentleman who worked in the foundry, lost his job, his insurance. He was a Native man. He was enrolled in the White Earth Band of Ojibwe in Northern Minnesota, and his wife recently—was recently diagnosed with cancer so she was—the family was struggling, and let alone him losing his job and presenting to me with new onset congestive heart failure which requires, of course, treatment and therapies that he couldn't afford. So that is one person that I see but everyday, everyday we are open we see this.

Mr. PALLONE. OK, thank you very much. Thank all of you.

Before I move to our other panels, let me just ask unanimous consent that a statement from Congressman Dale Kildee and also from the California Rural Indian Health Board, if those would be entered into the record, and without objection, so ordered.

The gentlewoman from the Virgin Islands.

Mrs. CHRISTENSEN. Thank you again, Mr. Chairman.

President Keel, just from the frustration that hint in your testimony I would imagine that you support the permanent reauthorization of IHCIA?

Mr. KEEL. Absolutely, yes, I do.

Mrs. CHRISTENSEN. Thank you. I just wanted to get your—that on the record.

And, Dr. Rock, you talked about HIT and the importance of improving healthcare but do you see this technology as being really important to linking the urban Indian to the tribes and to services? Do you think that it can be assistance because I understand that we don't even know how many American Indians are living in

urban centers and the difficulties that they have when they need services?

Dr. ROCK. I think it does have a potential. I know the current thought behind health information technology is the key word of interoperability of how the system is actually going to work together, and we have an invested interest also from an urban standpoint of being part of that system. We think that we could provide really a real high quality of care to our patients with the utilization of a system as well even cutting our costs as far as healthcare if we have an interoperable system and a system that is workable with their providers.

Mrs. CHRISTENSEN. Well, I was on Homeland Security before I came to Energy and Commerce and interoperability is something that we are still working on over there and that has been what, 7 years.

Let me see, I guess let me see who I would ask, Ms. Joseph, maybe or anyone can really answer this. I am a strong believer and supporter of primary prevention and the high prevalence of deaths from injury, from auto accidents, from suicide has always been something that I have been concerned about. And I notice similar patterns in not only in the American Indian but the Alaska Natives and I wonder if—I don't think that just treating something to the use of alcoholism is enough because there are all kinds of conditions as I said in my opening statement but is there anywhere that you can see that we could do something within this reauthorization that would address maybe some of the social determinants as well. We talked about the modernization of approaches of medicine and to me one of the more the newer, some of the newer thinking is about the social determinants to health. But does anybody have any—to what would you attribute the high prevalence of death and injury and suicide on the reservation and how could we better address that?

Ms. RACHEL JOSEPH. Well, we always—I hesitate to say, of course we need more money and but we need more money for one thing. We are opposing a comprehensive approach to behavioral health which addresses a number of those issues you raise and we think, you know, with a comprehensive approach we are able to use our money more efficiently which would be some. I do believe that some of the safety funding related to ambulances and so forth and so on, that comes through another agency and HHS and through the States, and some States, you know, have a better working relationship with their tribes and some don't. So some of that, you know, accident prevention, you know, auto accidents.

Mrs. CHRISTENSEN. Services when you have had an accident.

Ms. RACHEL JOSEPH. Yes, that money needs to flow directly to the tribes and not through the States.

Mrs. CHRISTENSEN. Is there enough in the bill that supports the traditional healers or is there a need for us to incorporate the traditional healers more in this legislation?

Ms. RACHEL JOSEPH. Yes, there—thank you, Councilman, there is language in the bill that addresses traditional healers and it is, you know, a tribe by tribe situation and patient by patient and, you know, as the patients and the doctors view that traditional healing as necessary, there is authorization to provide for that.

Mrs. CHRISTENSEN. So you are satisfied with it with the way it is treated in 2708?

Ms. RACHEL JOSEPH. We are satisfied with it. We do have a little definition recommendation that we would like to, you know, we would like to include in a revision.

Mrs. CHRISTENSEN. OK, I don't have any further questions, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you.

First, let me apologize for coming in at the last minute but I didn't want to miss the opportunity to let you all know that I am a big supporter of the Indian Health Care Improvement Act amendments and I am a partner with you in trying to get better healthcare.

I am from Chicago where in my district there is the American Indian Center and in my Chicago office, which isn't far from there, I have a star quilt that was given to me by the Chicago Indian Health Service, and I work very closely with them and, you know, want to make sure that the resources that are needed are always available. The organization does operate a health clinic, conducts education and outreach in diabetes, provides home visits to people with diabetes to ensure they are managing the disease correctly. In Illinois, there is about 73,000 American Indian and Alaska Natives and the really there is a big concentration in my district. So I just really wanted to congratulate you on your advocacy on the good work that you have been doing and to make sure that I didn't miss the opportunity to tell you that I am grateful for your advocacy, for the care that you provide and for the chance to work with you to make it even better.

Thank you. I yield back.

Mr. PALLONE. Thank you and thank you all. I know this was short hearing today but I don't—I want you to know that doesn't in any way take away from, you know, our efforts to try to move this bill or as I said before, include it in the larger healthcare reform. And I know all of you have been playing a major role in all of this and will continue to as we move forward over the next few weeks.

Did you have a question? Sure.

Mr. ANDREW JOSEPH. Chairman Pallone, Dr. Roubideaux talked about the CHEF and not being included in this and to me it is really important that it be included into the bill. One of the reasons why is we are in the CHS dependent area and are—my tribe's reservation is in a remote location as some of the Alaska Native villages and some of the other Direct Service Tribes are in remote locations, and by not having that in the bill, I would be afraid that we would be losing a whole lot more lives. The distance that our people have to travel to get to a hospital facility, if we don't have hospitals in our area, you know, we have a real need for these funds. My own grandbaby had to be heart flighted out a little over a year ago into to Spokane and that cost over $10,000. That is where the CHEF funds money comes into play. It is almost like sending our troops to war and not paying for the helicopters to

bring them in, you know, once they get wounded. So it is really important.

Mr. PALLONE. Now, I am glad you brought it up and my assistant tells me that that was basically a drafting error and we are conscious of it and we are going to try to correct it, you know, as we move along because I know how important it is so thank you for bringing it to our attention again.

All right, thanks very much and we do intend to move forward. Thank you.

[Whereupon, at 3:25 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

OPENING STATEMENT
HONORABLE JOE BARTON, RANKING MEMBER,
ENERGY AND COMMERCE COMMITTEE
HEARING OF THE SUBCOMMITTEE ON HEALTH ON
H.R. 2708 INDIAN HEALTH CARE IMPROVEMENT ACT
OCTOBER 20, 2009

Thank you, Mr. Chairman, for convening this hearing into H.R. 2708.

This is a very complex piece of legislation. While I believe several portions of the bill are worthwhile, I do have concerns about some of its provisions.

This bill seeks to expand the urban native American Indian program and contains new programs for this population. It also establishes a Division of Urban Indian Health in the Indian Health Service. Like other Americans, Indians access to numerous health care options via Federal, State, local, and private providers. That's why I look forward to hearing a persuasive explanation as to why another, separate health program needs to be created in addition to

those that already consume the billions of dollars that the Federal government already in these same areas.
I believe we should tread lightly when addressing the idea of building separate centers for separate racial groups in the same urban areas. If there are health reasons based on real science that argue in favor of such racially separate facilities, I certainly want to hear more about them.

I also have concerns about the language that purports to restrict federal funding of abortions. The bill needs stronger language prohibiting the use of federal funds for abortion. In the 110th Congress, the Senate passed S. 1200 which included a provision that stated no federal funds could be used for abortion.

Also problematic are the numerous grant provisions. It seems to me that we're on the road to creating even more waste and duplication than already exist. I want to understand what federal funds are already being spent on these activities. Where and what are the needs for this

community? All of these questions need to be answered before we start spending billions of additional dollars.

The bill talks about special trust responsibilities and legal obligations. I would like to understand the specific basis of these obligations. Is it the position of the authors that current law fails in addressing these obligations? Ordinarily, we would be strongly opposed to programs that deliver different treatment or unique status according to the race. So we need to understand why we should apply racial distinctions in programs like Medicaid or SCHIP.

These are just a few of my concerns regarding the underlying bill. The Indian Health Service is only a small part of the Department of Health and Human Services, but several of the issues I have raised reach far beyond the scope of delivery of Indian health care.

Lastly, Mr. Chairman, I would also like to reiterate my request that this Committee hold a legislative hearing on health reform where witnesses and in particular witnesses

from the Administration can answer substantive questions about efforts to radically redo our health system. Before the House votes on health care overall legislation the Members of this Committee, as the Committee of primary jurisdiction, should have the ability to understand the effects it will have on their constituents' health care choices, the cost that will be born by individual taxpayers, and the debt we will be passing on to future generations.

I yield back the balance of my time.

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
4400 Auburn Blvd. ▪ 2nd Floor ▪ Sacramento ▪ CA 95841 ▪ (916) 929-9761 ▪ Fax (916) 929-7246

CRIHB fully supports HR 2708 **October 19, 2009**

Reauthorization of the Indian Health Care Improvement Act (IHCIA) Amendments of 2009 (H.R. 2708) includes the provisions agreed to through consensus with Tribes and Tribal Health Programs throughout the U.S. and is vital to enable the Indian health system to utilize more efficient, effective and updated methods of health care delivery in the 21 Century. To bring stability to our Indian health care delivery system, it is critical that this version of the IHCIA be made a permanent law of the United States, just as the Federal Government's trust responsibility to provide health care to Indian Tribes is a permanent obligation of the Federal government.

We urge the subcommittee to fully support the contract health services (CHS) program as outlined in H.R. 2708 and through which the Tribal Health Programs in the California Indian Health Service (IHS) Area purchase care which the Indian health system is unable to supply directly. We also urge the subcommittee to fully support the contract support costs (CSC) program for Tribes who elect to exercise Indian self-determination rights to take over direct operation of health programs at the local level. Given that the IHS Facilities Construction program has yet to build a single health facility in California, the subcommittee should fully support the Joint Venture and Small Ambulatory Grant program and the facility construction loan repayment program. This is especially true if this Congress authorizes the Tribal version of the Indian Health Care Improvement Act, which would allow for the use of SAP funds to retire loan amounts used to create IHS supportable space.

I cannot express enough the importance of Tribal Health Programs in the California IHS Area having access to adequate CHS funds. The California IHS Area is one of only two IHS Areas that have no IHS Hospitals to provide inpatient and specialty services. Of the four so-called "Contract Health Service (CHS) Dependent Areas", California has the second lowest Level of Need Funded, the second lowest CHS allocation per active user, and the absolutely lowest Catastrophic Health Emergency Fund (CHEF) utilization rate of the entire IHS system. These are not new facts — rather an ongoing crisis reflected in a decade of IHS funding history. It is time to rectify this long standing funding inequity and fully support the CHS Dependent Areas.

There are two technical amendments relevant to California that we would urge for your consideration when you go into a mark up session on HR 2708. The first of these is the removal of the word Sacramento from Page 128 lines 8&9 which is from Section 218 concerning California as a Contract Health Service Delivery Area. The re-recognition of the Wilton Rancheria located in Sacramento County makes the current exclusion of this county out dated. The second is a request to change the work "in" to "of" on page 309 line 6 which is from Section 805 Eligibility of California Indians. This change would clarify that eligibility for descendents of California Indians was provided on the same basis as eligibility for descendents of tribes from other states and in no way is limited to services provided in California.

Statement of Dale E. Kildee, M.C.
Committee on Energy and Commerce
Legislative Hearing
H.R. 2708 Indian Hearing Care Improvement Act Amendments of 2009
October 20, 2009

Good morning Mr. Chairman, I would like to thank you for the opportunity to speak in support of H.R. 2708. I also want to thank you for scheduling this hearing.

I would like to express my strong support for H.R. 2708, the Indian Health Care Improvement Act Amendments of 2009. I am very proud to be an original co-sponsor of this important piece of legislation.

The original Indian Health Care Improvement Act was approved in 1976 and is the cornerstone of Federal law that made immense improvements in the delivery of health care provided to millions of Native Americans and Alaska Natives.

Despite these major improvements made to address the disparity of health care provided to Native Americans and Alaska Natives, these two groups still suffer from disproportionally higher rates of diabetes, heart disease, tuberculosis, alcoholism as compared to non-Indian communities.

Previous amendments have proven to advance the health care delivery provided to Native Americans and Alaska Natives, these amendments also responded to the desire of many Tribes to have more control and responsibility over programs and target the higher incidences of certain diseases that afflict Native American populations.

The proposed changes found in this bill will build upon the framework of the original Indian Health Care Improvement Act. This bill demonstrates years of negotiation and is based on the recommendations made by the Native American health community including Tribal leaders, Tribal health directors and health care experts.

It will drastically improve access to quality health care for **1.9 million** Native Americans and Alaska Natives. It will provide a more comprehensive approach to the health delivery of medical care to all Native Americans and Alaska Natives.

I look forward to and strongly support the passage of H.R. 2708. I also welcome the testimony from today's witnesses. Thank you.

National Indian Health Board
Details of Grants Received
2009

Grant Source	Grant Date	Grant Amount
Indian Health Service	2/6/2009	120,000.00
Indian Health Service	5/14/2009	100,000.00
Indian Health Service	5/23/2009	276,000.00
Indian Health Service	8/19/2009	172,876.00
Indian Health Service	9/26/2009	100,000.00
Indian Health Service	9/26/2009	100,000.00
Indian Health Service	9/26/2009	150,000.00
Indian Health Service	9/26/2009	120,000.00
Indian Health Service		
		1,138,876.00
Centers for Disease Control	8/29/2009	309,000.00
Total		**1,447,876.00**