



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 1921¹ 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 reservation³ 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 idea¹¹ 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.

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 population¹³ 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 than if the same patient receives significantly delayed care at an on-reservation IHS facility because they were forced to wait until they reached medical crisis and then return home. Urban Indian health programs form a critical link in preserving the health and viability of the Native American population by confronting many illnesses and substance abuse at their point of origin. The sad and fundamental truth is that eventually these patients must be seen and either they can be seen early, before the most destructive behaviors or illnesses set in, or they will be seen much later at the Tribal or IHS facility.

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 (IHCA) amends sections 1911 and 1880 of the Social Security Act. The proposed amendments would allow Indian Health Programs and Urban Indian Health Programs to directly bill Medicaid and Medicare for providing services or items to Indian patients. Due to 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.