Testimony of Andy Joseph, Jr.

Chairperson, Northwest Portland Area Indian Health Board;
Tribal Council Member, Confederated Tribes of the Colville Reservation

Before:

House Natural Resources Committee Hearing on
Indian Health Care Improvement Act Amendments of 2009 (H.R. 2708)

June 25, 2009
10:00 a.m.

Good morning Chairman Rahall, Ranking Member Hastings, and distinguished members of the Committee. My name is Andrew Joseph, Jr., I serve as the Chairman of the Northwest Portland Area Indian Health Board (NPAIHB) and am a Tribal council member of the Confederated Tribes of the Colville Reservation. . I also serve as the Portland Area representative on the National Steering Committee (NSC) for the Reauthorization of the Indian Health Care Improvement Act (IHCIA).

Established in 1972, NPAIHB is a P.L. 93-638 Tribes organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health related matters. The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts policy and budget analysis, and operates health promotion and disease prevention programs. NPAIHB is dedicated to improving the health status and quality of life of Indian people and is recognized as a national leader on Indian health issues.

I want to commend the work of the Committee to move this bill forward, both this year and in years past. While we did not get a bill passed out of the House last year, the fact that H.R. 1328 was reported out of the Resources Committee was an important step to getting this bill passed in this 111th Congress. I hope that we can build on the momentum from the 110th Congress and get H.R. 2708 passed in this Congress. The bill will improve the health care delivery to American Indian and Alaska Native (AI/AN) people, a population that has the most acute health care needs in this Country. The IHCIA is overdue for reauthorization, and the bill – while long – is generally not controversial. For reasons it is difficult to understand, passage of the bill has been impeded each year by concerns about unrelated Indian legislation, by an uncooperative Administration, or by non-Indian interests groups. I hope that the Committee will work with us this year to ensure that the bill – which has already been considered at length by all interested parties – is passed as soon as possible.

I. Federal Trust Responsibility for Health Care

The United States government has a legal and moral responsibility to provide health care services to AI/AN people. This responsibility is based upon numerous treaties signed between the United States and Indian Tribes which bi-laterally ceded millions of acres of land and resources in exchange for certain reserved rights and basic provisions guaranteed by the United States—including health care. The unique relationship between Tribes and the Unites States is underscored in the U.S. Constitution (Article I, Section 8), numerous Federal laws and court decisions, and Administrative policies which all affirm the unique relationship between Indian Tribes and the federal government and its obligation to provide health services to American Indians and Alaska Natives. This obligation is further compelling when the limited access to health care and significant health disparities impacting AI/AN people are considered.

II. Indian Health Disparities

The IHCIA declares that this Nation's policy is to elevate the health status of the AI/AN people to a level at parity with the general U.S. population. Over the last thirty years the IHS and Tribes have made great strides to improve the health status of Indian people through the development of preventive, primary-care, and community-based public health services. Examples are seen in the reductions of certain health problems between 1972-74 and 2000-2002: gastrointestinal disease mortality reduced 91

percent, tuberculosis mortality reduced 80 percent, cervical cancer reduced 76 percent, and maternal mortality reduced 64 percent; with the average death rate from all causes dropping 29 percent.[1]

Unfortunately, while Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that other types of diseases are on the rise for Indian people. For example, national data for Indian people compared to the U.S. all races rates indicate they are 638 percent more likely to die from alcoholism, 400 percent greater to die from tuberculosis, 291 percent greater to die from diabetes complications, 91 percent greater to die from suicide, and 67 percent more likely to die from pneumonia and influenza.[2] In the Northwest, stagnation in the data indicates a growing gap between the AI/AN death rate and that for the general population might be widening in recent years. In 1994, average life expectancy at birth for AI/ANs born in Washington State was 74.8 years, and is 2.8 years less than the life expectancy for the general population. For 2000-2002, AI/AN life expectancy was at 74 years and the disparity gap had risen to 4 years compared to the general population. The infant mortality rate for AI/AN in the Northwest declined from 20.0 per 1,000 live births per year in 1985-1988 to 7.7 per 1,000 in 1993-1996, and then showed an increasing trend, rising to 10.5 per 1,000 in 2001.[3]

What is more alarming than these data is the fact that there is abundant evidence that the data might actually *underestimate* the true burden of disease and death among AI/AN because—nationally and in the Northwest—people who classify themselves as AI/AN are often misclassified as non-Indian on death certificates. A caution in using AI/AN data is that, due to small numbers, death rates are more likely to vary from year to year compared to rates for the general population. Unfortunately, it is safe to say that the improvements for the period of 1955 to 1995 have slowed; and that the disparity between AI/AN and the general population has grown. Factors such as obesity and increasing rates of diabetes contribute to the failure to reduce disparities.

III. Reauthorization of the IHCIA

In June 1999, then Indian Health Service Director, Dr. Michael Trujillo, convened a National Steering Committee (NSC) composed of representatives from Tribes governments and national Indian organizations to provide assistance and advice regarding the reauthorization of the IHCIA. Over the course of five months, the NSC drafted legislation, which was based upon the consensus recommendations developed at four regional consultation meetings held earlier in that year. The consensus recommendations formed the foundation upon which the NSC began to draft proposed legislation to reauthorize the IHCIA. In October 1999, the NSC forwarded their final proposed bill to the IHS Director and to each authorizing committee in the House and Senate and to the President. The House and Senate introduced legislation based on the Tribes bill, but neither passed. Subsequent NSC meetings were hosted by the NPAIHB and held in Portland, OR in May 2002 and March 2003 to refine the proposed legislation that has served as the basis for bills introduced in the 108th, 109th, 110th and now the 111th Congress.

---

[1] FY 2000-2001 Regional Differences Report, Indian Health Service, available: www.ihs.gov.
[2] Ibid.
[3] American Indian Health Care Delivery Plan 2005, American Indian Health Commission of Washington State, available at: www.aihc-wa.org.

As the Committee can see, it has taken a tremendous amount of Tribal resources to work on the reauthorization effort. 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 get legislation passed. There have also been significant Tribal contributions by Area Health Board staff, fees for technical expertise, and retainers for attorneys. Recognizing the chronic underfunding of our health programs, I know that these vital resources could be put toward patient care, but I also understand the importance of getting the IHCIA reauthorized. So from this standpoint it's been very frustrating to get the IHCIA reauthorized, knowing that past Congresses have passed legislation on a number of occasions to improve the health conditions for AI/AN people, however we have not been able to get this bill passed in the last four Congresses. Tribal leaders have been working on reauthorization of the IHCIA for eleven years, and it is critical that we get this bill passed as soon as possible in this Congress. The improvements contained in H.R. 2708 would allow the Indian health system to modernize the way in which it provides health care so that AI/AN people enjoy some of the same health benefits as most Americans.

Every day I see the difference that the IHCIA would make on the Colville Indian Reservation. Our reservation encompasses nearly 2,300 square miles (1.4 million acres) and is in north-central Washington State. The Colville Tribe has more than 9,300 enrolled members, making it one of the largest Indian Tribes in the Pacific Northwest. About half of our members live on or near the Colville Reservation. The long distances that our Tribal members must travel to receive health care is a tremendous burden and expense. Some the provisions in the IHCIA would allow us to develop our health programs to provide hospice care, assisted living, and home and community based services. These provisions would allow the Colville Tribe to make health services available to those that might not be able to get to health facilities.

The Colville Indian Tribes have had a serious bout of dealing with youth suicide on our reservation. It is estimated that the national Indian suicide rate is four times greater than the national average; however, last year the Colville Indian Reservation suicide rate was twenty times higher than the national average. Last year's Senate passed IHCIA (S. 1200) had an expanded emphasis on behavioral health for IHS and Tribal health programs. The improvements provide for a comprehensive approach to behavioral health, providing important prevention and treatment programs for AI/AN people. The bill also emphasizes the coordination of services related to alcohol and substance abuse, child welfare, suicide prevention and social services. The addition of the youth suicide provisions would greatly assist Tribes to address suicide issues in their communities.

IV. Key Provisions in H.R. 2708

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. The provisions in Title I address the health professional shortage in Indian communities. Congress specifically included these provisions in 1976 because the existing programs to improve manpower capabilities were woefully inadequate or completely unsuitable for Indian health providers and communities. The scholarship programs are designed to recruit and support AI/AN students into health professions; and link scholarship recipients to work directly in IHS and Tribal programs. These programs

specifically target the needs of the Indian health system. Scholarship priorities are developed through a consultation process and are based on the IHS and Tribal health professional projected needs, vacancies and available positions. These programs have become a hallmark for recruitment and increasing the number of available Indian health professionals in the United States.

Section 121 authorizes the Community Health Aide Program (CHAP)has been so successful that it was expanded at the request of Alaska Natives Villages to address new crises in access to other health services – specifically dental services. The CHAP Certification Board adopted standards for training, supervision, and certification of specialized health aides who provide a range of preventive and direct dental care services. At the highest level of certification, the Dental Health Aide Therapist (DHAT) can perform a number of dental procedures including fillings under the general supervision of a dentist. The supervising dentists and DHATs use the time proven CHAP model of distance supervision and consultation and the advances of telemedicine to help reduce the plague of dental caries in Alaska Native villages, while assuring high quality care. While organized private practice dentistry has supported most of the DHA certification, the American Dental Association and the Alaska Dental Society have opposed the certain parts of the practice of the DHATS, who follow in the footsteps of mid-level dental practitioners in 42 other countries—the State of Minnesota. By contrast, virtually every major public health organization, including those made up of dentists, have endorsed the DHAT component of the CHAP Program.

Most recently, the State of Minnesota became the first state to pass legislation to create a training option for a mid-level dental health provider to be licensed, with the goal of providing more basic services to underserved rural populations in the state. The passage of this legislation is historic and paves the way to have a new midlevel provider, like DHATs, to enter into the healthcare system to provide care to populations who currently have limited or no access to dental services. We urge the Resources Committee to join with the State of Minnesota, and allow the expansion of the DHAT program to include Tribes located in the lower 48 states and not restrict this program to that State of Alaska.

Title II provisions expand health care program options and address the delivery of health care services—such as diabetes programs and epidemiology centers—and the distribution of funds to IHS and Tribal programs through the Indian Health Care Improvement Fund (IHCIF) and the Catastrophic Health Emergency Fund (CHEF). Marked improvements in H.R. 2708 include authorizing services needed at the end of one's life and from services to be provided on an out-patient basis to inpatient services. Section 204 and 213 authorizes services such as home health care, long-term care and hospice care, which are a standard part of the health care system that most American enjoy today. If the Indian health system is to modernize, then Indian health programs must be authorized to make these services available for their Indian patients. Indian Tribes want to ensure that the services authorized in Title II are consistent with those services reimbursable by Medicaid and, in particular, those services already authorized in compacts or contracts entered into by the Tribes or Tribes organizations and the IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA).

Section 208 establishes Tribal epidemiology centers and clarifies their status as a "public health authority" under the Health Insurance Portability and Accountability Act (HIPAA). The clarification of this status is essential for data sharing to occur without diminishment of HIPAA accountability. NPAIHB strongly supports this provision in order for Tribal epidemiology centers to carry out their mission.

Title IV provisions as well as the amendments to the Social Security Act found at the end of the bill are perhaps the most important provisions of the IHCIA. These provisions authorize IHS facilities access to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) revenue sources and eliminate barriers to participation in these programs. Medicare and Medicaid collections are vital sources of revenue for Indian health programs; they now represent approximately one-fourth of all funding that flows into the Indian health system. This section also requires that any Medicare, Medicaid, or CHIP payments received by the I/T/U for services provided to eligible Indians shall not be considered in determining appropriations for the provision health care and services. This provision is very important given the consistent and chronic underfunding of the Indian health system. The IHS budget (when adjusted for inflation) has remained flat, meaning that general inflation is outpacing the budget for health care services. For example, between 1998 and 2009, the IHS service population has increased at least 16 percent, and medical costs have grown 10-12 percent annually, yet the IHS has not received the annual budget increases that other federal health programs like Medicaid and Medicare receive. Adequate money for health care, especially preventive health care and modern facilities, is consistently absent from the federal budget. The Title IV provisions ensure access to health services and protect the vital third party reimbursements of IHS and Tribal programs.

Title VI provisions are organizational improvements that establish the IHS within the Public Health Service of the Department, and elevate the position of the IHS Director to that of the Assistant Secretary for Indian Health. Northwest Tribal leaders have long advocated for elevation of the IHS Director to that of an Assistant Secretary of Indian Health. Elevation is consistent with the government-to-government relationship and the trust responsibility to AI/AN Tribal governments throughout all agencies of the Department of Health and Human Services. The position is comparable to the administration of the Bureau of Indian Affairs programs with an Assistant Secretary in the Department of Interior and an Assistant Secretary for Public and Indian Housing in the Department of Housing and Urban Development. While HHS has made great strides over the past several years to address Tribal issues, the elevation of the IHS Director to that of an Assistant Secretary would facilitate the development of AI/AN health policy throughout the Department.

Title VII provisions authorize the development of a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs. The behavioral health provisions recognize the importance of integrating services and assuring a continuum of care from prevention through residential and inpatient treatment. Improving the health status of AI/AN people cannot be achieved without fully integrating behavioral health strategies and services in every aspect of our systems of care.

V. Recommendations to Improve Title III: Facilities

Title III authorizes the IHS to establish facilities construction, sanitation, and maintenance and improvement programs. During the 110th Congress, much discussion between the IHCIA National Steering Committee and Congress centered around section 301, which directs the Secretary to maintain a health care facility priority system for construction. In 1999, in the conference report accompanying the FY 2000 Interior Appropriations Act (H. Rpt. 106-406), Congress directed the IHS to work closely with Indian Tribes , to review and revise the Priority System. In recognizing the "extreme need for new and replacement hospitals and clinics," Congress noted that "there should be a base funding amount, which serves as a minimum annual amount in the budget request." Congress further noted that several issues needed to be considered in revising the Priority System and that "a more flexible and responsive program can be developed that will more readily accommodate the wide variances in Tribes needs and capabilities."

In response to this directive, the IHS Director charged the Facilities Appropriations Advisory Board (FAAB) to review the Priority System and make recommendations for revision. The FAAB submitted its recommendations to the IHS Director on February 2, 2007, however no action has been taken to date by the IHS to implement its recommendations. The FAAB is comprised of 12 members representing Indian Tribes from each of the twelve IHS Areas, and two members representing the IHS.

Meanwhile, in 1999, the IHCIA National Steering Committee developed language regarding the Priority System contained in section 301 of the various iterations of bills introduced for the reauthorization of the Act. The language in section 301 remained primarily the same until 2006, when the IHCIA National Steering Committee refined certain provisions and included an additional protected category in section 301(c)(1)(D), referred to as the "grandfather" provision, in S. 4122, introduced at the end of the 109th Congress. The "grandfather" provision of section 301(c)(1)(D) protects the priority status of health care facilities (in certain categories) on the Priority List from being affected by changes to the Priority System being contemplated by the IHS, pursuant to the 1999 Interior Appropriations Conference Report instruction.

One of the FAAB recommendations to revise the Priority System included the establishment of an Area Distribution Fund as an innovative and alternative approach to address the unmet facility construction needs for those Tribes that are not currently a project listed on the Priority System. Under an Area Distribution Fund, a portion of construction funding could be devoted to IHS Area priorities. This localized approach would allow other smaller projects to be completed, instead of waiting until the entire current Priority List is completed. It is estimated that the backlog of Priority System projects totals at least $3 billion and could take as long as 20-30 years to complete.

NPAIHB encourages the Committee to take into consideration the fiscal circumstances under which the 1999 congressional directive occurred, relative to those experienced today, and how innovative approaches to financing construction may be implemented in such a manner which is fair and equitable to those Indian Tribes to be served by the projects on the current Priority List and those Indian Tribes which have not had the opportunity to have their projects placed on the list. Specifically,

we urge the Committee to include in a manager's amendment the language that was passed by the Senate in S. 1200 (at Section 301(f)(1)) that authorizes the establishment of an Area Distribution Fund.

This change would modify Section 301(f), which authorizes the Secretary, in consultation with Tribes , to develop innovative approaches for construction of health care facilities. The change does nothing more than clarify that in considering any number of constructive, innovative approaches to address the unmet need for the construction of health facilities, the Secretary *may* consider an Area Distribution Fund as a possible alternative; it neither *creates* nor does it *require* the Secretary to do so. When the language at Section 301(f)(1) was offered as an amendment by Senators Smith, Cantwell, Murray, Wyden, and Crapo, it was supported by 501 of the 560 federally-recognized Tribes in the United States that come from seven of the twelve IHS Areas. The amendment was also supported by seven IHS Area Health Boards or organizations that include the Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada Tribes), and Portland Areas. This recommendation is consistent with the recommendation developed by the FAAB and would be a marked improvement to address the facility construction needs of Tribes nationally.

Conclusion

In closing I would like to express the Northwest Portland Area Indian Health Board's strong support for H.R. 2708, and urge its immediate passage into law. The reauthorization of the IHCIA has been identified as our top legislative priority by our 43 member Tribes in Idaho, Oregon, and Washington.

There are so many important provisions in this bill that could be highlighted. As the Congress and Administration move toward developing health 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 reform options.

I am happy to respond to questions and to get your more information if I cannot respond today.

I want to thank Chairman Rahall and Ranking Member Hastings for inviting me to testify.