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HEALTH CARE WITHOUT AN IHS HOSPITAL: OVERTAXING THE CONTRACT HEALTH SERVICES PROGRAM

FIELD HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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SATURDAY, OCTOBER 2, 2010

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Reno, NV.

The Committee met, pursuant to notice, at 1:30 p.m. in the Hyatt Place Reno-Tahoe Airport Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

Senator DORGAN. We're going to begin the hearing today. I'm Senator Byron Dorgan. And this is a hearing of the U.S. Senate Indian Affairs Committee. I want to thank all of you for being here. This is a formal hearing of the Committee. We have held many, many hearings this year on the subject of Indian health care. And we will be holding at least one more hearing by the end of the year, but this is beginning to rap up a series of hearings that we've held on health care.

I wanted to say at the outset that we've made, I think, very significant progress this year on a range of issues dealing with Indian health care. For the first time in 18 years the United States Congress has taken action and the President has signed a piece of legislation that reauthorizes permanently in federal law the Indian Health Care Improvement Act. I'm enormously proud that we were able to do that. We got it passed through the Senate in the last Congress, and it died in the U.S. House. But this year we got it through the Senate and the House and it is now law. In addition to that, we passed the Tribal Law and Order Act, and, as you may know, the President had a signing ceremony in the East Room of the White House. We're enormously proud of that legislation, as well.

There are other things that we have done in the Indian Affairs Committee this year that are very, very important, but I wanted to mention those two especially, because I think both will have a very significant impact going forward with assistance to Native Americans in this country and to tribal governments, as well.

Senator Reid had asked if I would hold a hearing in Nevada on the subject of Indian health care. And I said I would. I wasn't able to get here until now, but I'm really pleased to be here now, and

on behalf of Senator Reid, say welcome to all of you. Since he's not able to be here on this day. This was the day I was able to come and he is somewhere else in the state. But I know that he asked me to hold a hearing here on Indian health for a couple of reasons.

I know that there is substantial use of contract health funds here in this area of Nevada. I know that the State of Nevada does not have a hospital within the Indian health care system and that often it's 700 or 800 miles to drive to the hospital in Phoenix. I know that in the Indian Health Care Improvement Act, there is a provision that requires the development of a plan to create an IHS area office here in Nevada, which I assume would be the precursor to all of the things that would accompany the designation as a region. This is the only state, I think, of its size that does not have a hospital within the Indian health care system. The State of Nevada previously, as I understand it, had two hospitals. Both, I believe, have lost certification and are no longer hospitals.

But it's pretty clear that if you are a Native American, one of the First Americans who welcomed everyone who showed up later—if you are a Native American living here in this state, you rely more heavily on Contract Health Services. It's also the case that Contract Health Services is inadequately funded by virtue of not having sufficient money in the budget; it never has. And it's also the case that the formula by which the basic amount of contract health money is distributed around to the various tribal governments is a formula that no one in the country understands, including those who distribute the funds. And that says something. If you ever want to try to get the bottom of it to say: Let us understand the base formula that goes back some many years? Be prepared to sit and listen until your eyes glaze over and still never understand the description from someone who's offering the description, because those who are offering it don't understand it either.

Having said all of that, this year we have embarked on something, in addition to passing legislation to improve Indian health care. We have also begun a very specific investigation of one region of the Indian Health Service. I know that many of you, perhaps, have read about this and understand it, but the specific investigation is of the Aberdeen region. We have undertaken the investigation for very important reasons. There are very significant allegations, and have been for a long, long while, of things that we should not allow to happen. I have always said as we begin this process—and I said it again the other day when we had a hearing—I think there are a lot of very wonderful people working for the Indian Health Service. I think every day there are men and women, doctors, nurses, health care professionals who go to work and are proud to serve, do everything they can possibly do to provide the kind of service that all of us are proud of.

I also know that at the Indian Health Service there's a bureaucracy that in some cases is not thinking very clearly, they do things they shouldn't do. They transfer people instead of fire people when people, in some cases, misappropriate money or in other cases, take narcotics, pilfer narcotics, or when they harass people. I can't describe to the whole series of things, but I'm just saying to you I know plenty of instances where problem employees in the Indian Health Service have not been to just one or two, but they have

been transferred to one and two and three and four different places in the Indian Health Service when they have failed at each place. That, in my judgment is shameful.

One example is a woman who has had four separate EEOC complaints against her, adjudicated against her, and in each case she was transferred to another facility, only to fail there. We cannot allow that to continue. Even as I'm proud of a lot of good work by a lot of people, I'm determined that the bureaucracy in the Indian Health Service has to begin making the right decisions on behalf of Native Americans in order to provide the best kind of health care for American Indians.

Now, even if we had the best people available in every circumstance and I didn't have horror stories to tell you or horror stories that required me to investigate one area of the Indian Health Service—and, by the way, there will undoubtedly be investigations of others—even if that were not the case, there are other problems that I think lead all of us to understand this system doesn't work very well.

I have told the story on the Floor of the Senate and used a chart that shows a very large photograph of a woman named Ardel Hale Baker. She happens to come from a tribe in my state, but that's just happenstance. I've also used photographs of others from other states. Ardel Hale Baker was having very serious chest pains. She went to a clinic on her reservation. She was told she was having a heart attack, diagnosed as having a heart attack, and she was sent to the nearest hospital, which is about 80 to 90 miles away off of the reservation. When they took her out of the ambulance—which she didn't want to go in because she was worried she would be stuck with paying a bill that she couldn't pay and ruin her credit—but, nonetheless, she was taken by ambulance, and when they took her out of the ambulance and transferred her from the gurney that she was on to the hospital gurney, they found a piece of paper taped to her thigh. It was an eight-by-ten piece of paper with masking tape attached to the thigh of this woman, it was a letter, from the Indian Health Service to the hospital, which said something like, Understand this: If you admit this woman to your hospital, you're doing that at your own risk because we are out of contract health care money.

Now, just think of the consequences of that. You're having a heart attack, being transferred to the hospital, and someone tapes a piece of paper to your leg to tell the hospital provider: "If you admit this person, understand we're out of contract health care money. Do it at your risk."

On that reservation, and on many others that have testified before our Committee, the mantra very clearly was: Don't get sick after June, because by June we're out of contract health care money. You get sick after June, tough luck.

The reason I tell you that story is I know that the majority of the reliance on health care in this region, because you don't have a hospital, is on contract health care. And the funding in contract health care is woefully inadequate. There should be front page headlines in newspapers about the rationing of health care to American Indians. It is rationing. About 60 percent of the need is met; 40 percent is not met. That means rationing. That ought to

be a scandal. That ought to be front page headlines in newspapers, but it's not. And this Committee has tried in every way that it knows how to hold a mirror to say to the Congress, to the Indian Health Service to say to Department of Health and Human Services: We can't allow this to continue; this must be fixed.

So as I indicated to you, Senator Reid asked me if I would hold a hearing in Nevada. I had hoped to get here a couple months ago, but was not able to do that. But this hearing is focusing especially on the difficult circumstance of contract health care funding.

Before I begin with witnesses, and I very much appreciate the witnesses for being here—I do want to introduce a couple of people who are joining me today. One is the Chief of Staff of the Indian Affairs Committee, Allison Binney. Allison is from a tribe in California.

There is also Erin Bailey, right behind me, who did a lot of work as a principal staffer on the Indian Affairs Committee on the health care bill that is now signed into law. Allison and Erin had everything to do with that. Wendy Helgemo is Senator Reid's staff person that works on the Indian Affairs Committee issues. And Wendy is with us back here.

As a matter of courtesy, I'm going to introduce all of the folks who are going to be witnesses today, but I want to especially introduce the tribal chairs. Before I do that, let me introduce Dorothy Dupree, who is the acting Director of the Phoenix Area Indian Health Service office. Dorothy is right back in the back of the room. We appreciate very much your being here today.

Ms. DUPREE. Thank you very much.

Senator DORGAN. We have a number of tribal chairs. I want to pay recognition to the tribal chairs, some of whom I'll introduce as witnesses. Let me indicate who is here. Chairman Waldo Walker from the Washoe Tribe. Right back over there. Mr. Chairman, thank you.

Chairman Mervin Wright, Pyramid Lake Tribe, right here. Mr. Chairman, thank you.

Daryl Crawford from the Inter-Tribal Council of Nevada.

Mr. CRAWFORD. Right here.

Senator DORGAN. Daryl is right over here.

And the Honorable Alvin Moyle, Chairman of the Fallon Paiute Shoshone Tribe. Right here. I'll introduce Alvin in a moment.

The Honorable Billy Bell, Chairman of the Fort McDermitt Paiute-Shoshone Tribe. Where are you? Right here.

The Honorable Loren Sammaripa, Chairman of the Walker River Paiute Tribe, right over here.

And Larry Curly is with the Indian Health Board of Nevada. He's right back here. Larry, it's good to see you again.

Let me thank all of you who worked on these issues, and especially thank the Chairmen of Tribes who are here. They represent the government leadership of the various tribes. As I understand it, there are 27 tribes in Nevada. It's a big old state. Somebody was telling me if you go from the north part to the south part, you're driving about 700 or 800 miles. It's a big place. And these tribes, based on the map that I looked at earlier, are spread out. I know that it is a challenge, even under optimum circumstances, to try to

make certain you've got the provisions for the delivery of health care in an area that size.

But let me say that those who have agreed to be witnesses today and talk to us about what they are facing and the challenges that confront them, I very much appreciate you being here.

Alvin Moyle is Chairman of the Fallon Paiute Shoshone Tribe of Fallon, Nevada. Mr. Moyle, thank you very much for being here. And what we will do is, we will take all of the formal statements that you have brought as part of the permanent record of the Committee, and we will ask each of you to summarize your testimony as best you can. We will have a two-week period following this hearing, and we will invite anyone who wishes to submit any testimony to the Committee to be a part of the permanent record, as well. We offer that invitation to any interested observer or tribe based on what they've heard at this hearing.

So, Mr. Moyle, welcome. Thank you very much for being here. And you may proceed.

STATEMENT OF HON. ALVIN MOYLE, CHAIRMAN, FALLON PAIUTE SHOSHONE TRIBE; PRESIDENT, INDIAN HEALTH BOARD OF NEVADA

Mr. MOYLE. Good morning. Thank you very much, Senator Dorgan, for taking the time out of your schedule to come out here to the State of Nevada. And I'd like you to also pass this on to Senator Reid: That we appreciate him asking you to do this. We are grateful to him and we are grateful to you. And we are grateful to a number of people that are advocates that helped pass the Indian Health Care Improvement Act. What I would like to do, Senator, on your permission—that we allow a blessing before we begin.

Senator DORGAN. I'd be honored. And who would——

Mr. MOYLE. Billy Bell.

Senator DORGAN. Chairman Bell, we would be honored if you would offer a blessing today.

Mr. BELL. Thank you for giving me this opportunity to offer this short prayer. On behalf of everyone here as well, Senator, thank you. If I may use my own language.

[Prayer/Blessing.]

Senator DORGAN. Chairman Bell, thank you very much for that blessing. I was thinking, as you completed the blessing, that among the things I'm very proud about this Committee is the passage some while ago of the Esther Martinez Language Preservation Act. It was a long time coming, and the passage of that was, I think, a very significant event.

Mr. Moyle, Chairman Moyle, you may proceed.

Mr. MOYLE. Thank you, Senator. Is this also recorded, other than the fact that we can turn in our testimony?

Senator DORGAN. What we have is a court reporter. That's the method of recording. We also have amplification as a result of the microphones.

Mr. MOYLE. Okay. Senator, I do ask that because of the fact that I have testimony prepared, but I would also like to speak on and with the subject as I am getting to that area.

Senator DORGAN. That's fine. Your formal testimony will be part of the record, but anything else that you say or add is also a part

of the record today as a result of the recorder that we have with us.

Mr. MOYLE. Thank you for that. I think that you have done well with taking a look at the Indian Health Care Improvement Act in that it's a needed item in the lives of the Indian people. And the order of summarization of that—there's no use of me restating something that you've already said, and it was part my oral statement. I want to thank you for being a big part of that. I'll go that far because I know that you were one of the major players in what went through Congress, as you stated it already; I'll still go ahead and state it because it is going to come from the leadership from the State of Nevada.

I happen to be, also, the President of the Indian Health Board in Nevada, and at the present time, President of the Inter-Tribal Counsel of Nevada. I also serve on two committees that have been set up by the Indian Health Service Director. One has to do with the consultation policy, which we pretty much, I think, completed at this point. There are two items that we're working on—the Contract Health Service and the formula. We had began talks at two meetings already on the Contract Health Service, and we have yet to begin on the formula. And this is one which, as you spoke on earlier, is a major issue. I appreciate the fact that you mention that there's going to be some investigations at some of these Indian reservations, because that is what we're trying to bring to you or Senator Reid, our Senators, is the story that's at our reservations. If Congress fails to observe what is actually happening and continues to disregard what is actually happening, our people will suffer, and continue to suffer. And it should not happen. Not in this century that we're living in, and it shouldn't have happened in the past. Not for what the Indian people gave. I wouldn't say "gave." What was taken. I'm talking about the land. They have contributed a lot to the United States of America. And to be treated like a third-world country is unreal. And I could say it in many different ways, but, myself, as a tribal leader, I have a responsibility, for one, a huge responsibility. And I am proud to be in a position that I'm at to be able to relate to you what some of those responsibilities are. And this morning what we're talking about today is health. And I don't want to go on and on about it, but I just want you to be aware.

In this case, I'm from Fallon, but there are tribal leaders here from some of the other reservations, which I'm grateful of, and I appreciate your asking for as many of them to show up here. But as being president of the Indian Health Board in Nevada, it is also, not only a responsibility for me to look at as far as my people in Fallon, but there's also the State of Nevada. But I do have other colleagues with me now that are going through the same, I guess you would call it an issue that is critical to our people, critical to the point of—there will be expressions made, and I appreciate the people that are here that I see sitting at the table that will explain what we're going through. And that is the other question I have that: If we provide you with testimony here and it will be going forward to another point in time, you did talk about another hearing, is that what we have looked at time after time—and I'll go back to being a member of NCAI, is that we asked for a follow up, and

you know, we were a big part of helping them move the Health Care Improvement Act with the efforts of all of the tribal leaders and NCAI, but the issue is still there, such as the one that, even more or less expounded on talking about the Aberdeen area. The State of Nevada is similar to that. Very similar. In the meetings that we've had the with the director, the tribal leaders that have been able to be appointed to that Committee, we talked about: Okay, we're doing this, we're working on this issue, but how far will it go? How far will this go? And we keep asking that.

Discussing it just a little bit further: At our last session that we had in Denver, we talked about that again. And we talked about it to the point of bringing it before the next assembly in NCAI, the one coming up. I know that you have been a person that has been at almost all the NCAI conferences. If you're not there in live person, you're there on screen. And there's a lot of people that realize that your heart is with us. I'd like to mention one of the items before I get into this testimony. You brought it out. The system that has been developed—and I'll say it's been developed by—in this case, the Indian Health Care system, let's call it—it has a beginning point of how to get to developing a program. It gets to a certain point of being developed and then it starts becoming where it gets into this political arena. And what I mean by that is that regardless of each year that the tribal leaders are asked to develop a budget for your reservation, and then we go further and develop the one for the State of Nevada, and then we turn that in and it goes to the Phoenix area office. And then from Phoenix, they take it further, and the budget continue on coming from around the country, and before it gets too far up the ladder, before it gets to the Congress that would make a decision on appropriation, O.M.B. takes their visit with it. And this is where I have, being a tribal leader for a number of years, have taken a look at that and listened to a lot of people that take a look at where is the—let's call it the real concern that those people sitting on the Office of Management and Budget, as far as making decisions about let's just cut this because we don't feel it's necessary. We feel that there is a gap in this, let's call it, the process that has been developed by Congress in this case of a need that has been asked for and requested for by tribes working day and night to develop a budget. And it goes to one point and it goes to another point and O.M.B. gets it on their desk and it gets cut.

And then in the meantime, behind the scenes at home, we have a lady dying, we have a young child that needs an operation that is being denied that because we don't have enough money or, like you said, that lady had a message taped to her leg that said that if she gets admitted, it's your bill, not ours. Now, that is totally wrong, and you brought that out; I appreciate that.

Anyway, my people are going through this of being denied services, and I do believe that there's a few more other people here that's going to say the same thing. And I don't want to take a lot of time and keep elaborating on that, but I do want to make that expression; I want you to know that. The testimony that I have is a few pages long and I've already said who I am and how many tribes are in the state of Nevada. I think that's very important.

There are a number of people that we have that we have a responsibility to help and I'm glad that you acknowledge that.

The Fallon Paiute Shoshone people live 65 miles from Reno, I'm pretty sure you're aware, in an area that has been known as the Oasis of Nevada, also it's what is called the Great Basin Area.

So getting back to the 27 tribes. And really three tribes in the state: the Washoe people, the Paiute people, and Shoshone people. But because over the years that bands were formed and they're from north to south, east to west in the state of Nevada, actually beyond the state, into Idaho, into California, California on into Arizona, the Paiute people, Shoshone people, and the Washoe people. We're not only in the state, but we do have a number of miles to go if we are to receive medical care, because of no hospital. And that is a detriment to our people. I think what I've done as far as expounding on some of the issues, I think I've provided you with that. I think you have a chance or opportunity to read my testimony and I appreciate Allison being here because, to me, she has been a real advocate for Indian people in working with those issues that you assign her to.

One of the areas that I think that is very important for—other than the fact that I have some of this in my testimony that I'm going to refer to, I guess I can start off: I do believe that you talked about another hearing happening—and I'm not just exactly sure, it might be happening in another area which will give that other group of tribes an opportunity to be able to testify—the one thing that I do believe is very important that happens in the state of Nevada, talking about that area office, we're talking about one way to take a look at this issue of adequate health—or the access to health care. Access to health care, to me, is very important. How does the State of Nevada justify to the people, at the area level, at the regional levels, and then at the headquarters level, and then further on into Congress? And I have to bypass O.M.B., because it's immaterial to them.

Getting back to my point is that access to health care: How is that really determined other than the fact that O.M.B.—we don't really—you know, that's no concern of ours. Congress says this is the amount of money we're going to have and this is what it will be. There has to be a, call it, a collection of data that can prove for a fact that this is what's happening in the state of Nevada; such as the one in I think that you're going to take a good look at in the Aberdeen area. There has to be a collection of data. And that's why when I look at, okay, what is the real benefit of an area office? To me, if you're looking at a problem, okay, let's get some people there and we'll take a serious look at this, and that's what I would like to see. That we take a serious look at this, not just a look at some spreadsheet that someone types up and it will tell the area of this and then we'll go further and tell headquarters of that. When you take a look at it, in some cases what we would have, we would have a number of denials that are not going to be on that spreadsheet. It flat isn't going to be on that spreadsheet. They'll be back at our clinic. And that is wrong.

In the meantime we have—other than the fact that we have that problem, we have a problem of people that would be treated, let's call it, with preventative medicine or preventative treatment that

could prolong the life of that person—be it in a youngster or in the oldest person we have—it could prevent that person from getting worse, and yet we're prohibited right now because of the funding from having that preventative care. I think it's just to me, I wouldn't want to offend you at all. You're probably way past that point. But to me, it's almost a replication of genocide. By denying a person treatment for cancer—and I'm talking about not a person, I'm talking about people, a number of people. And that's happening right today in the state of Nevada. To me, I'll put a label on it, this is a replication of genocide. It shouldn't happen. It should not happen.

Senator DORGAN. Well, Chairman Moyle, we certainly understand and can feel and hear your passion in the testimony. And we will hear from the others, as well, and then I'm going to ask a series of questions about some of the items that you've mentioned as well.

But I really very much appreciate your testimony and the fact that I know it is heartfelt. We appreciate your being here.

Mr. MOYLE. Thank you.

[The prepared statement of Mr. Moyle follows:]

PREPARED STATEMENT OF HON. ALVIN MOYLE, CHAIRMAN, FALLON PAIUTE SHOSHONE TRIBE; PRESIDENT, INDIAN HEALTH BOARD OF NEVADA

Senator Dorgan, Members of the U.S. Senate Indian Affairs Committee, and Staff. It is a pleasure and honor for me to welcome you to Nevada and the opportunity to address the Committee regarding the healthcare crisis that we, in Nevada, have endured for the past 24 years. There will be others who will present their views and comments on this crisis.

My name is Alvin Moyle. I am the Chairman of the Fallon Paiute Shoshone Tribe and currently the President of the Indian Health Board of Nevada and the Inter-Tribal Council of Nevada. There are twenty-seven Tribes in the State of Nevada with a total Indian population of over 36,000; approximately half of this number reside on the reservations and colonies previously mentioned. Twenty-five of the tribes are located in the northern half of the State—a State that measures over 777 miles from the Duck Valley Shoshone Paiute Reservation on the Nevada/Idaho border to Laughlin, Nevada at the southernmost tip of Nevada. It is mostly rural with at one County having 4/10's of a person per square mile! It is within this geographical environment that Nevada tribes exist—a place where they have lived for centuries. Approximately 65 miles east of Reno lies Lahonton Valley and referred to as the "Oasis of Nevada:" an area known for its agriculture and ranching environment. It is also an area where my ancestors lived, hunted, and gathered. This land was given to the United States government in exchange for a guarantee that the Federal Government will provide certain services to our tribe and one of them was the provision of health care. Unfortunately, it is a guarantee that has not been honored for the past few decades. It is within this historical background that 13 tribal health clinics were either contracted or compacted by tribes. There are no Indian Health Service Hospitals anywhere in the State and if specialized medical care is required by patients, they are either sent to Phoenix Indian Medical Center (PIMC) or to local providers using the Contract Health Service (CHS). Either of these options are daunting options: (1.) Traveling to PIMC requires enduring ground transportation of over 600 miles from the Fallon Paiute Shoshone Tribe to Phoenix or air travel that requires an hour and half of flight time—too long when one is sick and in pain; or (2.) being CHS-referred to local providers, who for lack of timely payment by the Indian Health Service will report the patient to collection agencies or worse, being requested to "pay up front" for their healthcare.

As the elected leader of my tribe, it is my responsibility to ensure the health, safety, and well-being of my tribal constituents. I have begun to conclude that access to quality healthcare in Indian country has become a struggle between the "haves and have nots." Nowhere on the Indian Health Service list of healthcare facilities to be built in the foreseeable future is there any mention of a Nevada tribe on the list—yet it appears that larger tribes with greater resources continue to inhabit the top rungs of that priority list. Maybe they continue to be on the list due to their

population growth and maybe they are growing in population because they are getting better healthcare and living longer! In some areas of the country, there are 3–4 Indian Health Service hospitals within a 50 mile radius of an IHS Medical Center. Yet, we in Nevada have no access to an IHS hospital Within a 600 mile radius and thus, our reliance on Contract Health Service funding for the provision of specialized medical care grows exponentially. When my medical director of our tribal health clinic makes a CHS referral, it is due to his knowledge of medicine. Yet his practice of medicine is dictated by the availability of CHS dollars. When President Obama signed an Executive Order requiring all federal departments to develop and implement their respective Tribal consultation policies, nowhere in that document was there an exemption for any federal department. Yet, the Office of Management and Budget (OMB) cuts Contract Health Service funds WITHOUT consulting with tribes—funds necessary for my medical doctor to practice medicine and provide the best medical care which was promised when we gave away the Lahonton Valley. The Federal Trust Responsibility is a federal responsibility of which the OMB is a part. Furthermore, it should be noted that the guarantee of healthcare to my people and the tribes of Nevada was not contingent on the availability of funds or whether it fit into the "Priority One" category of the CHS Program.

Senator Dorgan, the combination of these issues have impacted our communities, our families, and the future of Nevada tribes. The lack of CHS funds, the inequitable funding formulas, the non-existence of an IHS Hospital in Nevada, and the arbitrary treatment of tribes by OMB contrary to the promises made and the federal trust responsibility that are inherent to every federal agency. In the past decade, there have been many unnecessary deaths due to patients delaying their medical needs "until there are more funds at the beginning of the fiscal year." I have gone to far too many funerals in the past year and I am tired. Even with these dire circumstances, there have been rays of hope which is contained in the passage of the Indian Health Care Improvement Act. To you Senator Dorgan and members of the Indian Affairs Committee, we are grateful and thank you for your continued support. Specifically, contained in the new law is the establishment of the Nevada Area Office. We believe this to be a major accomplishment in beginning to address the healthcare disparities in Nevada. In order to make this a viable office, it will require funding. It is estimated that this amount is $8.7 million. Senator Dorgan, keep the promise that was made and ensure that it is funded adequately and ensure that CHS funds are available so I will not have to write condolences to families who have lost their loved ones unnecessarily.

Senator, thank you for the opportunity to provide our testimony and we continue to look to you for your leadership—whether you are in the Senate or whether you are at your favorite fishing pond.

Senator DORGAN. Next we will hear from Chairman Billy Bell, who is Chairman of the Fort McDermitt Paiute and Shoshone Tribes in Fort McDermitt, Nevada. Mr. Chairman Bell, thank you for being here. You may proceed.

STATEMENT OF HON. BILLY A. BELL, CHAIRMAN, FORT MCDERMITT PAIUTE AND SHOSHONE TRIBES

Mr. BELL. Thank you, Senator, and good morning and also welcome to Nevada. It's a great pleasure to be here this morning and represent Fort McDermitt Tribe. I, too, like the rest of the leadership here, and I'm sure the rest of the leadership throughout the country that you've heard so far, would like to discuss some of the impacts that the Contract Health Services inadequately provided for a lot of our tribal members. And it's created a lot of impacts for a lot of us.

And as far back as I can remember, it's been over a decade or so, where I recall as a tribal employee over at Fort McDermitt Tribe and its leaders are working pretty close with their neighboring tribes, some of who are represented here today, in fact. And I'm trying to make this awareness to the IHS leadership out of their service unit, as well as the area office, as well. I think at some point we realize that all of our people's health care is really

beginning to dwindle. In fact, you've heard Chairman Moyle's testimony of how some of it is really impacted a lot of us. And some people are not here today to testify if they were given that opportunity. And, I guess, there at Fort McDermitt, if you will, Senator, we're No. 9 on the map, which is way up on the top left-hand corner, Fort McDermitt side of the Nevada/Oregon border. I guess, what we looked at there at Fort McDermitt is the geographical location, the retention there, that we try to maintain, I suppose, at out clinic. We are a direct service tribe from the IHS. That's what separates us from the rest of Nevada. The tribe's under the Schurz Service Unit, which we're serviced under. And a lot of it has to do the inadequacy of our contract health funding and lack of oversight, the administrative part from the Schurz Service unit.

So more recently what we became more concerned with is the denial for referrals to outpatient treatment and diagnosis. And, of course, that has to do with the Contract Health Service budget, and also the IHS, which is a tier–1 system, that approval rating system that they have created. And, historically, Fort McDermitt is a former military reservation. It was established in 1865. It was abandoned in the late 1800s, and it became an Indian agency. We call ourselves the "Pah-na'kwit"; that means people that come from water. It has to do with the Great Basin itself. It was Lake Lahontan at the time. And, like many other tribes, we're located approximately 75 miles from any type of goods and services, which is in Winnemucca, Nevada, and that's our nearest hospital. And it doesn't provide all of the specialized services that we require. And for those specialized services, we highly depend on the Contract Health Service budget.

The majority of people, in order to receive that type of care, come here to Reno. Round-trip, that's an eight-hour drive. The majority of those people are diabetics, elderly, and very sick people that are transported in 15-passenger type vans. Right now we have an IHS health facility, the very first one. It was built somewhere in the early 1970s. And, then, more recently we had it replaced. Currently, we have about ten full-time IHS employees. We also have emergency medical service, which at some times is not staffed. And it also has to do with the budgetary issues. It also has to do with administrative oversight. And, I guess, the government's gone to contracting a lot, and not be able to maintain or hire any IHS employees. IHS has been contracting a lot of its services to people. And I believe that through contracting, in order to fulfill some of those quotas, we don't have the quality or qualified personnel to fill some of those vacancies.

And we also do have a diabetes program on my reservation, through a wellness center. And the tribe there has given or has an agreement with IHS to utilize our tribal health—or our tribal gym and our youth center. We've turned it into a wellness center for the people. And ever since Fort McDermitt realized these problems began, the tribal leaders, their efforts was to ensure that we at least somehow receive quality health care. And we banded with the other tribes. And, in fact, that's how the Indian Health Board became an entity itself because of the concerns from our people and the tribal leadership.

But, I guess, more specifically, Senator, we affirm that our basic health demands is the trust responsibility to the IHS for overseeing our health care delivery system and for ensuring that the delivery of that care of services and programs provided by IHS. And we continue to insist that our health services were mirrored by a lack of administrative oversight. An example is the Phoenix area office at one point owed health providers over $6.7 million in unpaid health costs, just like the Aberdeen office. As of a few days ago, when I spoke to the administrator of the Humboldt General Hospital which serves our reservation, IHS currently owes them $609,000 for the past two years. These are an unpaid debt that's owed to them still. And really there, Senator, has created an almost a defensive mode and somewhat similar to the story you talked about this lady that was brought into the ER. It's almost the same situation. It's created an animosity amongst the health care providers in our area, especially with our ambulance service when they bring in patients; they're ridiculed by some of the staff there because of this issue.

As you are aware, it's not just in Aberdeen, but here, we believe the service unit caused the catalyst amongst our Northern Nevada health care providers. Some of them has discontinued their relationship with us. Not only in the tribal clinics, but also through the IHS. Because of the IHS issue, our tribal members are denied those services. As you mentioned earlier, it does affect personal credit.

One thing that I would like to point out directly is that in Fort McDermitt, we assert that the Federal trust responsibility through President Barrack Obama Tribal Nation's address for government-to-government stability and transparency, and his overall all strategy on health care. We believe that it can be delivered to us through a Nevada IHS Indian hospital.

In closing, Senator, and to fulfill America's health care needs—which is a big concern and talk around many tables, I'm sure, around the country, and also to meet our tribal nations unmet health care needs, I urge the Senate Committee to take all of our testimonies here today and earnestly go to our request and utilize the contents. It shows how we care about our people. At the same time we strive to reside among ourselves within our own communities and with the other tribes and neighbors in our homelands here.

And I also want to thank you, Senator Dorgan, for this time here today, and also the diligence in serving the American people and the interests and allowing me to speak on behalf of all of my Na-Nuwuhs, relatives, Paiute and Shoshone and the Washoe peoples of Nevada. Thank you.

[The prepared statement of Mr. Bell follows:]

PREPARED STATEMENT OF HON. BILLY A. BELL, CHAIRMAN, FORT MCDERMITT PAIUTE AND SHOSHONE TRIBES

Good morning. Senator Dorgan, it is my great pleasure to appear before the Senate Committee on Indian Affairs this morning to discuss the IHS Contract Health Service and the impacts it created along the way for my Na-Nuwuh (relatives) of the Fort McDermitt Indian Reservation of Nevada and Oregon.

For over a decade the Fort McDermitt Paiute and Shoshone Tribe and its leaders has worked extensively with neighboring tribes to ensure that the Health needs of

our Tribes were met and made aware to the Schurz Service Unit, the Phoenix Area Office and their respective directors, especially when health care services on our reservations became ever so despairing as our people's health began to rapidly decline.

Fort McDermitt's efforts were based on our geographical location, retention of key medical and support staff, the inadequacy of contract health funding, lack of oversight from the Schurz Service Unit, and more recently, the Indian Health Service's denial of referrals to special providers for out-patient diagnosis and treatment due to the lack of funding in the Contract Health Service budget and the IHS tier–1 approval rating system.

The Fort McDermitt Indian Reservation straddles Nevada and Oregon, is a former military reserve built in 1865 and abandoned to become an Indian agency. We are known as the Pah-na'kwit (People from water). Today, we are located 74 miles from goods and services and our nearest hospital in Winnemucca, Nevada. For our specialized health care needs we highly depend upon the contract health services and receive this type of care our nearest facility is here in Reno, a tiresome eight hours round-trip drive.

Approximately 9 years ago our long-time resident provider retired due to his own ailing health, the medical records person is nearing retirement, and our substance abuse provider has retired. Currently, we have a temporary medical provider, a community health representative, a billing clerk, a facilities manager, facility maintenance, and two motor-vehicle operators, an Emergency Medical Service (two ambulances and several paid volunteers) and on a monthly basis we have a contract optometrist, dentist, podiatrist and psychologist. Our pharmaceutical and prescription requests are filled from the pharmacy at the Schurz Service Unit. We also have a diabetes program, which contracts two positions and operates our wellness facility. Our first health clinic was built in the early 1970s and was recently replaced in 2009.

Fort McDermitt is a direct service tribe, our administrative and support services to maintain and operate our clinic is managed and overseen by the Schurz Service Unit Director in Schurz, Nevada.

Over the past decade, our efforts to ensure we at least received quality health benefits, has fallen on deaf ears, from the unit director to the area director. Our remoteness, lack of providers, retention and recruitment, and distance from acute and long-term health facilities has attributed to the health needs of my *People*.

Moreover, we affirm that our basic health demands is the trust-responsibility of the IHS for overseeing our health care delivery system and for ensuring the delivery of that care consists of services and programs provided directly by the Indian Health Service. We continue to insist our health services were mired by the lack of administrative oversight. The Phoenix Area Office owed health providers $6.7 million in unpaid health costs and currently IHS owes Humboldt General Hospital $609,184.00 for the last two years. HGH serves the Fort McDermitt IHS area.

This oversight has caused a catalyst among some of Northern Nevada's health care providers to discontinue their relationship and refusal to provide specialized services to our tribal members and the unpaid bills turned over to collections affecting personal credit.

We assert that the Federal trust-responsibility through President Barrack Obama's Tribal Nation's address for government-to-government stability and transparency, and his overall strategy on health care can be delivered to us through a Nevada IHS Indian hospital.

In closing, to fulfill America's health care needs and to meet the Tribal Nation's unmet health care needs, I urge the Senate Committee to take our testimonies and earnestly look to our requests and utilize their contents to show how we care about our People while we strive to reside among ourselves and our neighbors in our homelands. Thank you Senator Dorgan, for your time here today and the diligence serving the American people's interests and allowing me to speak on behalf of all my Na-Nuwuh; the Paiute, the Shoshone and the Washoe Peoples of Nevada.

Senator DORGAN. Chairman Bell, thank you very much. My understanding is that $6.7 million that is owed to providers here in this region has grown to nearly $10 million, which I assume puts more and more pressure on some of these providers. To say, You know, we don't want to continue to offer these services is a serious problem. We'll talk about that in a bit.

Ms. Cindy Curley runs a tribal health clinic. So we're talking about the things in the abstract; now we're going to hear from a witness who is the Director of the Pyramid Lake Tribal Health

Clinic. My assumption is your experience is you go to work every morning trying to see what this clinic is doing and managing the affairs of the clinic, and you understand what day-to-day all of this is about. So we're very pleased that you're willing to be here with us today to testify.

Ms. Curley, you may proceed.

STATEMENT OF CINDY CURLEY, HEALTH DIRECTOR, PYRAMID LAKE PAIUTE TRIBE

Mr. CURLY. Thank you. I'd like to start off by saying thank you for the opportunity and honor to come up here and share my thoughts and views. I also want to thank the Chairman of the Pyramid Lake Paiute Tribe and the other counsel members for being here today. The Pyramid Lake Paiute Tribe is located in Nixon, Nevada, and we're 45 minutes northeast of Reno. You should go out there sometime; it's absolutely beautiful.

More to the point: Due to the depletion of the contract health funds, last year we ran into a huge problem. We had over 100 health care providers that refused or limited the services that they would provide to our patients, unless either the patient or the clinic paid up front. The situation got so bad that when we finally could get an approved referral, we had no provider to send our patients out to. We had cases that we would even try to send them to PIMC, Phoenix Indian Medical Center, to try to get care, and we couldn't even get them into Phoenix Indian Medical Center. They were turned away, saying that there was no time available to see our patients. This puts our patients in a really bad situation. We have had dialysis patients, patients we need to refer out for various kinds of heart disease, pacemaker implementations, no providers to send them to. Nevada is one of the highest health care states in the Nation.

And to further exacerbate this problem is the fact that we pay full billed charges for any health care to these contracted providers. So what little money we do get for contract health care, we pay the highest rate possible. We have asked for years that we have somebody that could negotiate with these specialty providers for a reduced rate agreement. And to date, this has not happened. So the CHS funds deplete rapidly. And in a lot of cases, we're out of CHS funds by April or May, and we have nowhere to send our patients. This not only puts our patients in a really bad situation, but it puts our providers that we have at our health care facilities in a very precarious situation. It forces our providers to work more and more outside of their scope of work. So there's a lot of liability issues.

We have cases, and we still deal with cases today, where we cannot get approved referrals to send our patients out that need care that we just cannot give in our facilities. If you were able to come out and take a look at a lot of our clinics, you would see that we don't have the same equipment that other clinics, like in Arizona and other places, have. We don't have all the equipment that they do. We have limited labs. We don't have the resources to provided good prenatal care. Yet we have denials, CHS denials for prenatal and delivery services. So those aren't getting paid for. We have patients who need their pacemakers put in, and that's not paid for. Seizure patients that we have to refer out that they don't get paid

for. Patients who we can send out and they can find out that they have cancer, but they won't be approved—the chemotherapy treatment that they need to save their lives. We have a patient who has a pacemaker and the battery was going dead. We couldn't get an approved referral for a new battery for that pacemaker. So if his heart stops, there's nothing to get it going again. These are just a few cases.

My contract health clerk put together a spreadsheet. And after I get approval, I would like to send it to you guys. There is a rather detailed spreadsheet that lists all of the referrals we've done in the last year. We did four hundred—and I updated the list—we had 486 referrals from November to current. Out of those 486 referrals, only 94 of them were approved. Ninety-four. That's it. Most times when we try to send our patients to Phoenix Indian Medical Center because we can't afford to pay the specialty providers out of our own clinic funds, we can't get them into Phoenix Indian Medical Center. The Schurz Service Unit Hospital wasn't shut down because it lost its certification; it was because it was condemned. And there was a promise of replacement—or repair by replacement, and today that hasn't happened.

We have a huge need. Almost every day I talk with the patients. For one reason or another a patient will come in to my office. We have patients that have severe 1 injuries that have never had the opportunity to be able to go in and have the surgical procedures to correct those injuries. So instead they're put on high-powered pain medications that were never intended to be taken for long periods of time. The prolonged use of these pain medications create other problems with these patients. It does liver damage, kidney damage. They become addicted. And then they're labled as addicts. Well, the patients didn't do this to themselves. They can't get referred out for the—and they can't afford the surgeries themselves. So by no choice of their own they're put on pain medications; they get addicted. And more and more the formularies in our pharmacies are being reduced. And we don't have pain management specialists. And we don't have access to them.

I called last week. For example, we had a few cases that we need to—some patients that we need to send for pain management. And this costs $391 for the first initial visit; between $45 and $91 for each follow-up visit thereafter. We can't afford that at our clinic. And it's not something that's paid for by contract health dollars. So we have a big problem on our hands. And we have had accidental overdoses. We have been faced with a huge gauntlet of problems. The patient, when we have to send them out—and we tell them up front that there's no guarantee that their health care bills are going to be taken care of. A lot of them, even if we get them a referral and it's been approved, they're still afraid to go to the doctor because they know they can't afford to pay that bill. They get hounded by the bill collectors, even though we send letters out telling the bill collectors you cannot send that to our patients if they have an approved referral. Therefore, they just won't go and seek the medical care they need. And this leads to a lot of other health conditions for them, a lot of health problems that they have that are totally preventable and avoidable.

And it's frustrating for the patient. It affects them mentally, it affects them physically, and emotionally. When they can't have their health care needs taken care of and they cannot go out and get a full-time job, it affects their quality of life. It not only impacts the patient, but it impacts the patient's family and relatives, as well. We have a very high unemployment rate out there. And we have a lot of patients that are in a lot of pain. Some of their medications that they take are not part of our formulary, and they are no longer approving for our patients to go to outside pharmacies to receive what they need. We have a very high diabetic population out there. They suffer from a lot of other health conditions and comorbidities that are actually preventable.

We have, as part of our CHS denials, one of our contract health patients, one of their denials was that they were a dialysis patient. We have a dialysis patient that did not get an approved referral. We have patients, not only at the Pyramid Lake Tribal Health Clinic, but at other tribes that will make the comment: They're just waiting to die. We had 18 mortalities this last year. And I can't sit here and say that their lack of health care is the only reason for them passing away, but it does contribute to a shortened life span for these guys. I mean, it is really sad. And the family members that they leave behind—and it's extremely frustrating.

All of us health directors—and there's a couple of us here today—work on the frontlines. And we spend a lot of time trying to find alternative resources for our patients. The problem is staggering. And it's not getting any better. And when we have less than one percent of the American Indian population here in Nevada that can access Phoenix Indian Medical Center, but we can't get a hospital here, this is a serious problem. And the providers are upset, the specialty providers we send our patients to, they're angry because they went for a long time without having their bills paid. They don't want to have to deal with this. In a lot of cases our patients come back and say they've been treated badly, so they don't want to go back again. So, the clinics—we do spend our own funds to try to help for medications. We had a dialysis patient—she was a kidney transplant patient—she got approved for a kidney transplant, but we cannot get an approved referral for the medications that she needs to keep her body from rejecting the kidney. The medications are not part of our formulary. So here's this huge cost for a kidney transplant, but if it was left up to the IHS contract health—this patient doesn't have the funds to pay for help, so she would die without any intervention. So we help pay for her medications to keep her going.

I'm trying to keep it toned down. This is a very frustrating issue. We've spent years talked about these situations. There was another hospital that was put in Nevada, but the tribes weren't consulted as to where that hospital should go and where it would be most effective.

Bottom line is we have patients that are suffering because they cannot get the health care they need. We're not equipped in our facilities to deal with a lot of the needs of these patients.

Senator DORGAN. Ms. Curley, I have a hunch that you could talk about this all day.

Ms. CURLEY. Yes, I could.

Senator DORGAN. And what you're telling me is pretty unbelievable in many ways. I expect we'll hear from Catherine Harris, as well. I think a lot of policy-makers would be very surprised to hear much of the testimony about the day-to-day difficulty of people who have very significant health issues. The provider knows it; that is, the Indian Health Service. That comes to the diagnosis at the clinic and then the question is, yes, that's a very serious health problem, but a patient can't get from "A" to "B" to "C," because the system doesn't allow that. And so it is—I'm going to ask some questions about the testimony that you've given me. But it appears to me when you talk about 59 percent that were turned down and I believe you indicated 6 percent of those died. That's 14 people that died, despite having shown up, tried to get help, and didn't get the help they needed. I mean, whoever those 14 people might be, no one will ever know because they just dropped through the systems.

Ms. CURLEY. Yes.

[The prepared statement of Ms. Curley follows:]

PREPARED STATEMENT OF CINDY CURLEY, HEALTH DIRECTOR, PYRAMID LAKE PAIUTE TRIBE

Mr. Chairman, members of the Committee and staff, thank you for the opportunity and the honor of sharing with you our views and thoughts about the healthcare crisis that we in Nevada face with a shortage of contract health service dollars.

My name is Cindy Curley; I am the Health Director for the Pyramid Lake Paiute Tribe located in Nixon Nevada which is 45 minutes northeast of Reno Nevada. I do not pretend to speak on behalf of the 26 other tribes in the State of Nevada. I will however; share with you our experiences with the CHS program, lack of access to healthcare and the impact of these two issues on our population at Pyramid Lake Paiute Tribe.

And what are these issues?

1. Due to the depletion of CHS funds, 106 local healthcare providers are either restricting or declining to accept any additional CHS patients who are referred to local health care provider UNLESS they are "paid up front."

2. Further exacerbating this problem is that local healthcare providers are still billing Tribal Health Clinics at "full charge billing." Although regulations were disseminated to clarify that the Tribal clinics are exempt from this practice, healthcare providers have interpreted the revised regulation as pertaining to only "inpatient care" and not "outpatient care."

3. As a result, patients who have been referred are being hounded by Collection agencies to collect the cost of the healthcare provided—bills that rightfully IHS should be paying. Patients are impacted by this situation—mentally, physically, and emotionally. Moreover, their credit ratings are being negatively affected.

4. More significant are the numbers of CHS-referred patients either declining or deferring their healthcare until additional CHS funds are available. As a result, their health status worsens and will eventually cost even more. The number one health issue affecting Nevada Tribal members is Diabetes—chronic disease with costly co-morbidities such as heart disease, chronic kidney disease, amputation.

5. CHS approves renal transplant yet patient unable to obtain required medications to support the transplanted kidney. Medications include: Cell Cept, and rapid acting insulin regimens per the Stanford protocol at high risk for rejection of donor kidney due to formulary restrictions.

6. Pain management issues are huge in this environment. Individuals with chronic pain are denied orthopedic and neurological consults with escalating narcotic requirements now at risk for sudden death due to extraordinary requirements without pain management availability. Sometimes the cost of the narcotics may be more than the procedure needed to correct the problem or the appropriate pain management which is not available.

7. In the past year, we have had 413 referrals of which 59 percent have been denied due to "not within priority" What constitutes priority? The response is: if you can make an appoint to have it done, it does not constitute priority level one. And Mr. Chairman, members of the Committee, of the 59 percent that have been denied; 6 percent have died. Yet we are told this problem is the same across the board. This explanation holds no comfort to the families affected by these untimely/preventable deaths.

Proposed solutions

The CHS Funding Formula Needs to be Revised to Reflect:

Distance Traveled

Members of the Pyramid Lake Paiute Tribe have to travel between 45 and 90 minutes to see a specialty provider or get to the hospital. Other tribes have to travel 2 hours or more each way to receive any sort of healthcare. This is extremely difficult and tiresome for Dialysis patients who have to make this trek 2 to 3 days per week.

Access to Healthcare

There is no Indian hospital in the state of Nevada since the Schurz hospital was shut down in the 1980s and further exacerbating the problem; less than 1 percent of the Nevada Tribal populations have had access to Phoenix Indian Medical Center.

Cost of Healthcare

Since no contracting has been done with specialty providers or hospitals, we are forced to pay full bill charges which rapidly deplete the CHS dollars.

Need for Preventive Healthcare

This would in the long run reduce CHS spending and improved the health status of Native Americans in Nevada.

Funding for the creation of the Nevada Area Office; this would give Pyramid Lake and other tribes in Nevada a louder voice and provide the Nevada tribes and clinics much needed assistance.

Senator DORGAN. Well, thank you for your testimony, Ms. Curley. And we're going to hear from a couple others and I have a series of questions I'd like to ask. Ms. Catherine Harris is Chief Financial Officer at the Reno Heart Physicians in Reno, Nevada. Ms. Harris, thank you for being here and giving us your perspective.

STATEMENT OF CATHERINE S. HARRIS, CFO, RENO HEART PHYSICIANS

Ms. HARRIS. Thank you for having me.

Good afternoon to all the tribal leaders and community members and Senator Dorgan. I do want to let you know that in my over 30 years of health care experience, it is a privilege to be here to be able to potentially have an impact on what is, not a minute by any chance, portion of the health care crisis that this country is facing right now.

I am here on behalf of the providers of care who, in their way shape or form are advocates for their patients and strive every day to make sure that we can accommodate the patients and their needs and provide the continuum of care that is so lacking.

My focus is more navigational within the system, and the reimbursement and being able to cover costs. I represent a 21 cardiology practice that provides services here in Reno, Sparks, Carson City, as well several rural areas, including Minden, Elko, Winnemucca, Fallon. Our providers generally have a passion for providing care to their patients, but they also have a a business to run. It is very frustrating when they insert a pacemaker and can't get the approval to have a pacemaker checked and follow ups. Al-

though, I would have to say that we've had a few meetings in the past and that situation specifically has gotten much, much better.

Being community-based health care professionals, we provide a very valuable service to this community. As far as the Indian Health Board goes and the beneficiaries, residents of the reservations, we are one community, as far as we are concerned, and our responsibilities to providing care for the members of this community, including those who are not always able to afford it.

Again, our focus is cardiology. It's been very sad for us, as a provider of care, to see how many local area providers, health care providers, have turned away and discontinued providing services to tribe beneficiaries. Most of those decisions have been made because they're not able to cover their costs of providing care. Again, very serious issue as our population continues to age and as we have longer life spans, the strain on health care resources and resource dollars continues to be an issue nationwide.

I do believe, though, it is our position that there are some deficiencies within the Indian Health Care system that are contributing significantly to these costs of providing care. And that what we would like to see is some review and refinement of the internal processes of processing claims, getting claims paid, getting visits approved. I think a lot of the panel here have already touched the topic of the continuity of care in a case-by-case basis. I don't believe that this is an issue that bubbles up to the budgetary and fiduciary owners of this process, in that they don't understand that where, as we may see ten patients for a pacemaker insert, there is a series of follow-up visits that have to occur after that in order to keep this patient well and to keep them healthy. No single one of our providers in our practice want to treat a patient and lose them because they don't have coverage.

About six months ago, as I was alluding to, the authorizations department of our practice made significant milestones and progress in getting these pacemaker checks approved so we're not getting as many denials as we were. However, we continue to experience frustrations in dealing with various individuals, particularly with the communications within the IHS clerical staff. We have certain individuals that we leave messages for and never hear back from them, so we can't get the authorizations or P.O.s we need to continue treating patients. We have individuals that we contact that are great at the claims processing piece and getting us paid and terrible at the initial authorization and approval of the visit. So it appears that there is just a lot of the inconsistencies in the practices and how the system is administering the authorization and approval of visits as well as the reimbursement. We have noticed, and I know that it is not the technical practice, but we have also noticed that every year, they run out of funds, the system runs out of funds. And every year, a portion of those current year funds are used for old claims. May not be the intention of the fiduciary responsibility party; however, it is what happens.

We currently have over $18,000 in unpaid claims from 2007 and 2009; that does not include any of the 2010 claims. And I do want to say that things have gotten better, but they still have a long way to go.

Again, the inconsistency between case workers is just very, very frustrating. Also, the inconsistency between IHS and their fiscal intermediary, particularly in New Mexico. Whereas I respect the comment that was made earlier about collecting data—what appears to be a major problem for us is that there's no consistency in the data. For example, we have a patient that has Hometown Health coverage as well as Indian Health Services coverage. We'll get a response from New Mexico that they received the explanation of benefits for this patient that has Hometown Health coverage, but they're waiting on information from Blue Cross. When we go ahead and investigate that particular case, the patient has no Blue Cross coverage; that coverage was termed three years ago. So then we have to go through the process of calling the Board, having them communicate with the fiscal intermediary in New Mexico, having to turn around and reprocess.

There is such a disparity in the system as far as the content of the data and consistency as far as it being updated on a regular basis. I don't need to tell anybody in this room how much that costs us on the back end. We've all heard comments about the detriment to the patient and not being able to have the access to the care. It's really heartbreaking on the back end when we have to spend many hours to get one case resolved, that really, if there were a refinement of the process and some consistency between the systems, it wouldn't be the case.

I want to assure everyone here that we have no intention of denying access to care. We care about our patients. We want to see them treated. We want to see them treated well. We want to be able to continue to provide excellence in quality in cardiology care to all of our patients, including our tribal patients. We are very much open to any improvements, conversations, communications that we can enter into jointly in making sure that we can go forward.

I feel very strongly that the concept of having negotiated rates with providers who have agreed to provide care, much like any other health system—the Cignas, the Blue Crosses—is an excellent idea, and would provide some budgetary stability. However, I think that there's a lack of understanding at the budgetary level that needs to be part of the budget process.

[The prepared statement of Ms. Harris follows:]

PREPARED STATEMENT OF CATHERINE S. HARRIS, CFO, RENO HEART PHYSICIANS

Thank you for the opportunity to speak to you today. I am here on behalf of Reno Heart Physicians, a 21 physician Cardiology practice that provides services in Reno, Sparks, Carson City and rural areas from Minden to Elko.

Community based healthcare professionals like Reno Heart Physicians provide a very valuable service to those in our community who are in need of cardiology services. Not only are our physicians board certified in their specialty, but being community based allows them to respond in a more timely, efficient manner to the needs of patients within our community. This ensures continuity of care and is also convenient for patients.

Indian Health Services beneficiaries are among community members who benefit from our quality cardiology care. They are also the beneficiaries of discounted rates that are reflective of our practices commitment to provide excellence as well as affordability to our community.

Sadly, more and more local providers are not, however, able to continue providing care to Indian Health Service patient because they are unable to cover their costs of providing care. As our population continues to age and live longer, the strain to

provide coverage and service to our community becomes like an elastic band that is stretched so tight that it is about to break.

The responsibility to continue to provide quality medical care to those who need it at an affordable rate is the responsibility of every citizen in our community. As providers, we are constantly evaluating our expenses and quality outcomes and making adjustments wherever necessary. We continuously strive to refine our processes in order to more expeditiously serve our population.

It is our position that there are a number of deficiencies within the Indian Health System that significantly contribute to the increase cost of care that our community providers are experiencing that have not received the same level of review and refinement. It is imperative that this take place in order for the safety net to remain in tact as the population ages and we are called upon to continue to provide care. The systems fiduciary responsibilities to their beneficiaries and providers as well as its internal claims processing practices need to be refined and improved upon.

Since the last meeting with IHS about six months ago the Authorization Department at Reno Heart Physicians requests for pacemaker checks are being approved without any denials with few exceptions. However, we are experiencing communication issues with IHS clerical staff. We can leave multiple messages and we don't get any correspondence back. We would like to see the communication between our business office and IHS be more consistent and timely, to make sure the care of the patient is not disrupted. Reno Heart Physicians believes that there should be a specified timeframe within which all patient related requests are responded to and that this should be no more than 24 hours.

Distribution of funds has been irresponsible at best. Not only are the rates nominal, but the delay in getting paid is unacceptable. Reno heart Physicians continues to carry over $18,000 in unpaid claims for IHS patients that date as far back as September 12, 2007 through 2009. This does not include any unpaid claims in 2010.

Of specific interest to us is the lack of consistency between case workers. It is apparent that once the claim is received by the contract health unit, no one can predict what will happen to it next, much less when it will be processed and paid. One specific individual case worker is responsible for the "old" accounts. Another specific case worker (who processes claims efficiently) is notorious for not returning messages, particularly from our authorizations department. Reno Heart Physicians believe that there should be a consistent, measurable, monitored process that these case workers are not only held to, but evaluated based upon. Giving them a stake in the outcomes, would make them more of a partner with providers of care and therefore improve the communication and response times.

There are also inconsistencies between the FI and IHS. Of particular interest to Reno Heart Physicians is the FI in New Mexico, Blue Cross. As providers, we are supposed to be able to get updates from IHS with regards to eligibility and other coverage, however we are not able to get that information and when we do it is not current. For example, we will get information on a patient who has Hometown Health Plan coverage as well as IHS; we will get a response from New Mexico that they have received the patients' explanation of benefits from Hometown Health Plan and are waiting for an explanation of benefits from Blue Cross; we will initiate researching the specific patient with Blue Cross we find that their coverage terminated 3 years ago. IHS and the FI in New Mexico are either not communicating and/or are working on disparate data systems.

Having to go through this lengthy process of calling the FI, then calling Blue Cross then contacting IHS to tell them that they are reflecting the same information as the FI cost us hundreds of dollars every case. Indian Health Services then has to call the FI in New Mexico and request that they update their system so that our claim can be processed. These two entities need to communicate consistently and have the same information in their systems for every single IHS beneficiary.

The distribution of funds has been unpredictable at best. It appears that every year when funding is received, a significant portion of those funds are used to "clean up" old accounts receivable. This creates a situation where the system is constantly in arrears—robbing Peter to pay Paul if you would. Perhaps if the data was accurate and consistent, then not only would the provider's cash flow be more stable and predictable, but IHS would have a better grasp on what their funding needed to be from one year to the next.

Reno Heart Physicians is dedicated to providing quality affordable care in our community. We are prepared to do whatever we can to improve the communication and or processes of IHS in order to make this possible. To do otherwise would be irresponsible. However, we are not in this alone. We need your help and commitment to making this process more efficient and productive so that our patients can continue to receive excellent cardiology care where they live.

Thanks again for your time today. Reno Heart Physicians is looking forward to partnering with you in improving the provision of cardiology care to our community at large, and more specifically to IHS beneficiaries.
Thanks again!

Senator DORGAN. Ms. Harris, thank you very much.

With respect to the point you made about not being able to get returned telephone calls and so on, I hope you will take advantage today of the fact Dorothy Dupree is here. I know that she's here because she wants to understand what's going on in the region. And so that would be very helpful to her, I think. I know she's shaking her head back there saying "Yes." You've indicated that there's been some improvement, but make sure you don't leave without accessing that opportunity. And I appreciate Ms. Dupree being here.

Ms. HARRIS. Thank you.

Senator DORGAN. Finally, the Honorable Loren Sammaripa, Chairman of the Walker River Paiute Tribe in Schurz, Nevada. Chairman Sammaripa, thank you for being here.

STATEMENT OF HON. LOREN SAMMARIPA, CHAIRMAN, WALKER RIVER PAIUTE TRIBE; ACCOMPANIED BY KENNETH RICHARDSON, HEALTH DIRECTOR

Mr. SAMMARIPA. Thank you, Senator. As you noticed on the map, we're No. 22. And I want to thank Mr. Moyle, Mr. Bell, Cindy Curley, and Catherine Harris for presenting their side of the issue that we all have our concerns with.

I know what we've talked about in various meetings with our health committees, and each and every time, you know, we address health issues, lack of service, denials. All this has surfaced, and we're still at this point. And as we continue through with our meetings and our attendance, no matter where it's at, we're going to still talk about it. And I appreciate you being here this afternoon to hear our concerns, and also your Committee.

And, again, I just want to say, my name is Loren Sammaripa, Chairman of the Walker River Paiute Tribe. I was born and raised in a hospital that we all talk about: Schurz Hospital. This was in the early 1940s, at which time the hospital was a full-staff hospital. We served the whole State of Nevada at one point. And the services that were provided there were services that we talk about today, and being that they denied, and here in the big cities.

But, again, the opportunity that I have here today and to speak regarding our Contract Health Service and our health care crisis that we are encountering on our reservations is a main concern. Our tribal members, they were currently placed on Level 1. These levels that we talk about, they've been established throughout our meetings that we meet with our health representatives. And Priority 1 is defined as: Emergent or acutely urgent care services that are necessary to prevent the immediate death or serious impairment of the health of the individual, because of the threat to the life or health of the individual necessitate the use of the most accessible health care available and capable of furnishing such services.

So, again, we talk about all these diagnosis and treatments that we are being denied on the outside service. Schurz being centrally

located in Nevada, we have to sometimes rely on air flights for our most severe cases of patients that needed direct attention. Our care flights are costing around $15,500 per flight. And we have no other alternative but to provide and pay for these services because IHS has not made any type of cost comparison with any other direct services. So we are located primarily 102 miles south of Reno. And which Fallon is about 30 miles north of Schurz; they provide the necessary care for some of our minor and emergency care, also. But our lab and X-rays and our pharmacy costs are well above, and quite severely drains our funding.

We have providers, also, that we have to make contracts with. A lot of times our providers are denying seeing our patients, because of the payment again. As our panel here has talked about, the needs that have been not addressed by CHS, we are imposed with all these issues. So, again, the referrals that we had for FY 2010 for Walker River was 740. And the number of denials for 2010 for Walker River was 586. We have a list of referrals that would be available to you in our pamphlet, and it will give you each and everyone of them that have been mentioned here.

I have some scenarios that I want to read a few to you on that tells of the devastating that we have encountered. We had a 63-year-old grandmother in November 2009; she was having chest pains. Our doctor requested a referral to have a scan done to rule out cardiac or a malignancy. She suffered through numerous clinic visits, pain, and weight loss. In December she was sent to the ER with left chest pains at Banner Hospital; that's in Fallon. And then later tranferred to Renown here in Reno with lung mass. This ER visit was approved. Subsequently, she was referred for CT scan and bronchoscopy of her lungs for her mass with possible malignancy, and the sad course continues. And by February 2010 she was severely debilitated, wheelchair bound, and wasting away. She had one more visit to the ER with prolonged hospitalization toward the end of her life. She passed on in March of 2010.

So as you can see, the concerns that we have and our elders that are chosen not to be seen by providers and for creating more bills, we are faced with this situation each and every day. But the struggle, we continue. And with the services, limited service that we have with our facility now, we have no other alternatives but to refer out our patients. And to be seen and the referrals denied, we have to deal with.

Numerous cases that we have are listed in the testimonies that I have here today. All our representatives here that we have sitting before you testified of the health concerns, just as I have done. We talk about area offices, our Schurz Service Unit has been condemned, but we are still providing services on a limited basis.

And we would also like to seek funds to build a facility that would benefit our people, not only for Schurz, but for surrounding communities. This would be something that I would like to see funded in my lifetime. I'm one of the few elders that are left on the reservation, and still have the ability to represent our tribe. We have a handful left that are dependent on dialysis, health care services, but they, too, have chosen not to go out and see a provider. A lot of the testimonies that we have presented, the distance that is involved to go to the PMS in Phoenix, the health services

there, that's the alternative. But when you get to the area in Phoenix, a few of our patients have also been denied. And they are left down there, stranded. Some of them are told that maybe you can return back or stay here for a week or so to come back in to be seen. But within that time frame, and the expense that occurs for them to be on a waiting list to be seen at the Phoenix unit is, you know, a burden on the families.

So, again, I can't stress the importance that we have presented to you today with our health issues. And until that is addressed, it would be a benefit to all of our tribes here in Nevada to hear that we would be refunded to address our health concerns.

And the funding in 2010 on the backlog of unpaid bills for five to six years total in the amount of 4.6 to 4.8 million. But to the money that was there, a lot our bills weren't paid. The money amount didn't reach it.

So, again, I thank you for being here today to hear the concerns of our Nevada people and our health services. We can go on with many scenarios of patients that have been denied, patients that chose not to be seen. So, again, the bill paying is something that we need to address so our people can survive. And I want to thank you for the concerns today for listening to us, and I'm sure that our Natives that are in attendance at this meeting today have more to add. So with that in mind and our testimony that we have presented as true facts. So, again, for Walker River I want to thank you for listening to our concerns and we'll continue on.

[The prepared statement of Mr. Sammaripa follows:]

PREPARED STATEMENT OF HON. LORREN SAMMARIPA, CHAIRMAN, WALKER RIVER PAIUTE TRIBE

Good afternoon Senator Dorgan and distinguished members of the Indian Affairs Committee. My name is Lorren Sammaripa, Chairman for the Walker River Paiute Tribe of Nevada. I would like to thank you for this opportunity to speak to the Committee regarding Contract Health Services (CHS) and the Health Care Crisis we are encountering on the Walker River Paiute Reservation and in the Schurz Service Unit.

Our Tribal Members are currently placed on Priority Level 1 services which is defined as Emergent or acutely urgent care services (diagnostic or therapeutic) that are necessary to prevent the immediate death or serious impairment of the health of the individual. Because of the threat to the life or health of the individual necessitate the use of the most accessible health care available and capable of furnishing such services. *Diagnosis and treatment of injuries of medical conditions that if left untreated, would result in uncertain but potentially grave outcomes.*

Due to years of funding shortfalls in the Schurz Service Unit, the Phoenix Area Office has begun the implementation of life or death only diagnosis for the patients of the Schurz Service Unit and payment by Indian Health Service Contract Health Service funding. As a result, services for treatment and follow-up care are no longer allowed. We were told by the Medical Director at Phoenix, "if you can make an appointment, then it does not meet the definition of Priority Level 1 services and any referrals will be denied.

The Schurz Service Unit is solely dependent on Contract Health Services for hospital stays, specialty visits, lab and X-rays and all Pharmacy costs paid for with CHS funds. For the past five (5) years, Walker River has had to call Care Flight out of Reno for severe cases at a cost of $15,500 per flight as IHS has failed to contract with a provider to lower these costs. This is the case for many of the providers.

Here are some of the case examples of the Health Care being provided or should I say not being provided to our Tribal Members and community. Services for all these cases had been DENIED for not being Priority Level 1 eligible.

- A 63-year-old grandmother in November 2009 was having chest pain. Our doctor requested a referral to have a scan done to rule out Cardiac or Malignancy. She suffered through numerous clinic visits, pain and weight loss. In December

she was sent to the ER with left chest pain at Banner Hospital and then transferred to Renown Medical with a lung mass. This ER visit was approved. Subsequently, she was referred for CT Scan and bronchoscopy of her lungs for her masses with possible malignancy. The sad course continued and by February she was severely debilitated, wheelchair bound and wasting away. She had one more visit to the ER with prolonged hospitalization toward the end of her life. She died on March 19, 2010.

- A 39-year-old mother of five came to the clinic with shortness of breath. She begged the provider to just give her antibiotics or a breathing treatment. She did not want to go to the ER and incur more bills she could not pay. She explained that IHS had not paid for her gall bladder removal or her heart catheterization. The provider informed her that she may have a pulmonary emboli. She still refused to go the ER. She died the next day from a pulmonary emboli.
- A 34-year-old mother of two with central abdominal pain near a hernia repair site was denied to go back to the surgeon. She went on her own and had a CT scan ordered by the surgeon for diagnosis to rule out a second hernia. Payment was denied. The CT scan showed a right ovarian cyst and the provider recommended a Gynecologist. This was denied. The patient's mother is currently being treated with chemo for ovarian cancer with metastasis.
- Two male patients have been diagnosed with brain and liver cancer. All services have been denied by IHS.
- A 63-year-old male with Diabetes since 1995. This disease has affected multiple body systems. He has had a partial foot amputation, his kidneys are beginning to shut down, endocrine referral was denied. Patient has had a heart attack with angioplasty with a 23 percent ejection fraction (normal is 60 to 80 percent). In early 2009 his pulmonary consult s were approved but later denied. He has hypoxia, fibrosing alveolitis, and chronic respiratory failure. Pulmonologist is requesting follow-up tests. This complex patient has over 30 significant active problems being managed by a family care physician. The Podiatrist, Nephrologist, Endocrinologist, Cardiologist and Pulmonologist have all been denied. Patient was sent to collections by the Endocrinologist for non-payment and he will not see the patient.
- A 11-year-old female patient with full blown Rheumatoid Arthritis was referred to Rheumatoid Arthritis specialist so he could prescribe Embril shots that the Drug Company would pay for at no cost to IHS. This was also denied.
- A 15-year-old female diagnosed with a type of Rheumatoid Arthritis called Raynauds. Parents paid for the diagnosis as all her referrals were denied. She must wear gloves to prevent severe pain, she also has syncopal episodes and altered mental status and palpitations with shortness of breath. Specialty referrals for a Neurologist, Cardiologist and Rheumatoid Arthritis were all denied.
- A 50-year-old male with a family history of Heart Disease came into the clinic with significant chest pain and had an EKG that showed a heart attack at age indeterminate. Cardiology referral was denied even though the standard of care dictates Cardiologist involvement.
- A 70-year-old female who has severe Obstructive Sleep Apnea documented by a sleep study previously approved by IHS in October 2009. Subsequently was denied treatment of this condition by IHS. Untreated Obstructive Sleep Apnea can cause or worsen many medical conditions including Hypertension, Coronary Artery Disease and Diabetes. She is at significant risk for a major medical event at any time. She has also been denied for a re-evaluation by her Cardiologist for chest pain and her nighttime oxygen supplementation in May 2010.
- A 24-year-old female had a gall bladder removal that had the risk of complication causing pancreatitis. She was admitted to the ER with pancreatitis at a small rural hospital then transferred to Carson Tahoe Regional Medical Center.

We have been told that we should utilize Phoenix Indian Medical Center as it was created as a tertiary care facility for the Phoenix Area Tribes of Nevada, Utah and Arizona.

- A 25-year-old male that tore his Achilles heel in February, 2010 was denied service to an Orthopedic Specialist in Reno and was told he had to go to PIMC for service. It took until the middle of May (3 months) before he got to see a specialist at PIMC.

There are currently no approvals for Orthopedic Care in the SSU, no physical therapy for patients after surgeries, no durable medical equipment for anyone including elders and no prenatal care. I am sure with what you have heard so far

that you now have a better understanding of the Health Care Crisis that my people have had to endure. These are only a few out of the total 511 cases denied by IHS.

It is appalling that bonuses are still being paid to all levels of personnel at the Phoenix Area Office while our people are dying on a daily basis for lack of funding for Healthcare.

IHS received the largest increase in CHS funding in 2010 which didn't even begin to address the healthcare needs of our Nevada Tribes and our Indian people especially when there was a backlog of unpaid bills for the previous 5–6 years at the Phoenix Area Office in the amount of $4.6 to $4.8 million.

There's also a huge difference in Priority Level 1 care between Tribal Health Clinics in Nevada compared to Hospitals in Arizona.

Senator DORGAN. Chairman Sammaripa, thank you for testifying.

Chairman Bell, you're a friend of Chairman Wright. I know that he had to leave very quickly. I have a note as to the reason for that. Is it appropriate or not for me to describe why? Would you wish to? He had to leave for a family emergency, I guess.

Mr. BELL. I think I'd leave that up to him.

Senator DORGAN. All right. Let me just say that my thoughts are with him. As we appreciate him being here, but understand the reason that he had to leave.

Let me thank all of you for being here today. I also wanted to mention that Susan Lisagor is with us. Susan is with Senator Harry Reid here in the State. I indicated when I started this, I'm here because Senator Reid, some while ago, had asked if I could hold a hearing on the subject of contract health because there's no state that has more reliance on contract health than the State of Nevada. And we know the problems with contract health. And when you are subject to having that kind of reliance on it, there are destined to be circumstances that are really dysfunctional and in some cases fatal.

Mr. Sammaripa, I read your testimony. And let me read one other example. You provided some really interesting and tragic examples. Let me read one, because it is at the heart of the reason that I'm here and the reason that Harry Reid and I are desparately trying to find a way to fix this.

This from Chairman Sammaripa's tribe, and I'm quoting now: A 39-year-old mother of five came to the clinic with shortness of breath. She begged the provider to just give her antibiotics or a breathing treatment. She did not want to go to the emergency room and incur more bills that she could not pay. She explained that the IHS had not paid for her gallbladder removal surgery or her heart catheterization. The provider informed her that she may have a pulmonary embolism. She still refused to go the ER. She died the next day from a pulmonary embolism.

Now, why did this 39-year-old mother of five die? Because she had had opportunities to get some amount of health care previously for which Indian Health Service and contract health did not provide reimbursement. My guess is she was living with a circumstance of her credit being destroyed, bills she couldn't pay, so she comes to the clinic with a very serious problem, and what's on her mind? "I can't pay for this; I can't possibly get health care that's going to cost me money." Now five children are without a mother. That is such a powerful description of the dysfunction that exists. Dysfunction that in this case proves fatal. And, you know, if all of us in this room knew this young mother, you know, our

heart would break. It breaks just talking about the story. So we've got to fix this. We can't ignore it. We have to find ways to fix it.

All of you have provided really interesting and troubling testimony in many ways. I want to ask a series of questions, if I might.

Let me ask: Miss Curley, tell me about the prevalence of diabetes. Would diabetes be one of the significance problems—and I would ask others, as well—the rate of diabetes multiple times the national average? Is diabetes a serious driver of health care problems on the reservations in Nevada?

Ms. CURLEY. For the Native American population, it is. The diabetes rate is higher than the non-Native. It is a big driver of a lot of health problems. A lot of diabetics have a lot of comorbidities that go along with them. They're hypertensive, they're obese, they have issues that lead to unpreventable amputations. There's a whole gauntlet of problems. Part of the problem is, you know, the kind of medications that we have in the formularies, you know as part of our formularies. Health conditions that are beyond what we can do for the patient, but we can't get the patient referred out to deal with.

Senator DORGAN. How about dialysis? Do you have people from your tribe on dialysis?

Ms. CURLEY. Yes.

Senator DORGAN. Where do they get the dialysis?

Ms. CURLEY. Carson City or Reno.

Senator DORGAN. And how far is that?

Ms. CURLEY. So to go to Reno for the dialysis patients, it's between 45 minutes and an hour to go to Carson City.

Senator DORGAN. One way?

Ms. CURLEY. One way. And Carson City is——

Senator DORGAN. How many times a week?

Ms. CURLEY. Two to three times a week, depending on the——

Senator DORGAN. So two to three times a week, a two-hour round-trip, plus the time they're on dialysis.

Ms. CURLEY. Yes, it's very taxing for them.

Senator DORGAN. How many people in your area are on dialysis?

Ms. CURLEY. I think we only have two left on dialysis. The others have passed away.

Senator DORGAN. Mr. Chairman, how about in your area: Is diabetes a significant problem? Do you have people on dialysis, and, if so, where do they get the dialysis?

Mr. MOYLE. Yes, thank you, Senator. The exact number right at this present time, I do know that we have six. We had eight, but as Ms. Curley said, some of them get to the point of they're gone.

Senator DORGAN. And where do they get the dialysis?

Mr. MOYLE. They just recently built a dialysis treatment facility in the town of Fallon. Prior to that, up until about a year and a half ago, they were getting their treatments at Reno. And I thank you for asking that, but the funding that comes from the Federal Government for diabetes, I will tell you that is very helpful. But once again, it gets back to the follow-up to that, other than the fact that we can educate our people and try to begin a program that would probably help relieve that from happening—that could be done. But then, again, let's say they get to the point of the dialysis issue and the fact that once again, I'll go back to that, decrease in

funding—we were thankful the hundred million got approved and the Schurz Service Unit was able to get some of that, but still, basically, what that did was almost like help out with inflation. It's helpful, but in a sense, when you get down to that many patients that—and I'll refer to our statement—is inadequate funding. Okay. So I hope I answered your question. Are you going talk with Mr. Bell?

Senator DORGAN. Yes, I'll ask Mr. Bell to answer the question.

Mr. MOYLE. Because his people——

Senator DORGAN. Yes. Go ahead.

Mr. MOYLE. Did I answer your question?

Senator DORGAN. Yes. Chairman Bell: Diabetes, dialysis?

Mr. BELL. Yes. Mr. Senator, I'm not sure of the percentages but we have a number of Diabetes Type 2. Most recently, within a year, we've learned that some of them are in our youth now. And like the rest of the tribes, our specialized services are here in Reno. And I've had to—I don't know if I want to call them a privelege or pleasure—about 11 years ago I used to ride on this transportation van. I used to transport dialysis patients. I guess the only reason why I liked riding with them is amongst themselves they had a pretty good charisma and they liked to joke a lot. But when we'd come back after their treatment, they'd be so worn out and tired. By the time we'd get going down the road, they'd be nagging on each other, so on and so forth. So, yes, we had a high number. A lot of those people are now deceased.

Senator DORGAN. I should mention that in the Economic Recovery Act that was passed, there was not Indian funding originally proposed. I was able to get $2.5 billion in the Economic Recovery Act, with Senator Reid's help, specifically for Indian Country. We were able to add $2.5 billion. Of that $2.5 billion, $300 million of it went to Indian country for health service facilities, especially, and the information technology system for the services. Now, that's not a lot of money, but it's more than is generally made available. And I have not yet seen how the IHS has moved that around the country. But there has been several hundred million dollars available building facilities in the last year and a half.

Ms. Harris, as I indicated to you previously, you know, we want to have the Indian Health Service have people working who return telephone calls and you know, the system doesn't work if you can't get answers, can't get responses, can't get approvals, and so on. So I hope we'll get that addressed. I just think it's very important that we try to find ways to make sure that when someone testifies they say, "You know what? This service is great because there are people there we know and we work with, and they respond quickly."

The thing that was troubling today is the issue of approval for a pacemaker, but not for a battery. Or approval for a kidney transplant but not for the drugs that will prevent rejection of the kidney transplant. I don't understand the decision-making process, where the decision-making process would break down. Because it's just common sense: Why would you approve a kidney transplant if you don't intend to approve the lesser cost of the drugs that would prevent rejection? Why would you possibly approve a pacemaker if you don't intend to provide batteries for the pacemaker? So where does this breakdown?

Ms. CURLEY. Well, what we're told is, and when our providers do a referral and refer a patient out and it gets denied, and we specifically ask, what do we have to do to get our patients approved for a referral? And the come back is: If you have to make an appointment to have it done, it's going to be denied. And that's the rational.

Senator DORGAN. Explain that to us again.

Ms. CURLEY. If our patient needs to go, say, into a specialty provider to have a new battery put in their pacemaker, you make an appointment to go and have that battery put in——

Senator DORGAN. Yes.

Ms. CURLEY.—therefore, it will be denied.

Senator DORGAN. So that means it's not Priority 1, Life or Limb?

Ms. CURLEY. Right.

Senator DORGAN. If you have to make an appointment, it means that there's not an urgent emergency at the moment if you have time to make an appointment, the thought process is to say I'm going to need this, therefore they say "It's not covered"?

Ms. CURLEY. Right.

Senator DORGAN. Okay.

Ms. CURLEY. But even as far as ER visits—my contract health clerk just came back after a CHS meeting the other day—and she came back to the clinic and told me that some of the information she found out through the course of that meeting is that they're looking at no longer approving a lot of ER visits. So even if you have to have an appointment to have it done, it doesn't get approved, but what if you have to race to the ER, those aren't going to get approved either?

Senator DORGAN. Right. Ms. Harris wanted to say something, then I'll call on Chairman Sammaripa.

Ms. HARRIS. I think the basic problem is a lack of understanding. A diagnosis and treatment does not cure a disease, it does not cure a spell of illness. There's a lack of case management and a case management approach to the provision of care, as well as the reimbursement. Again, it doesn't make sense to you or me that we would get a diabetic, diagnosed as a diabetic—diabetes is horribly debilitating disease if not treated; it is fatal—why would you go ahead and say, yes, this patient's a diabetic and not provide somewhere budgetarily as wells as physically for this patient and their life span? And I think that is an essential component that is missing.

Ms. Dupree and Mr. Curley were very reluctant when we sat down and said, "Listen, when we put a pacemaker in, here's the situation, here's the follow up." We have had very little trouble with those cases since then. But I think what we're getting to is a lack of understanding and a lack of a case management approach to the funding.

Senator DORGAN. Well, let me understand that point, though. Ms. Curley, you're the one who talked about a pacemaker without a battery, right?

Ms. CURLEY. Yes.

Senator DORGAN. Ms. Harris, you don't work in Ms. Curley's clinic. So you say that you've got an understanding and you feel pretty good about that.

Do you, Ms. Curley? Do you have that understanding? Or is it something that happened in the past that you think won't happen again?

Ms. CURLEY. No. This is a more recent one, and it's on our list of denied referrals that we have. And so this is a case that was brought to my attention about three months ago. I don't think this patient goes here. But, no, this is a more recent case that we had.

Senator DORGAN. Where would that approval or denial happen?

Ms. CURLEY. We do the referral at our facility.

Senator DORGAN. Right.

Ms. CURLEY. Then we send it—it used to be the Service Unit. But the referrals are getting approved or denied in Phoenix.

Senator DORGAN. All right. Ms. Harris, the understanding you have is working better with Phoenix; is that correct?

Ms. HARRIS. Well, locally, too.

Senator DORGAN. Okay.

Ms. HARRIS. And it is working well. I guarantee that's not one of our patients. And if it is, you call my office.

Senator DORGAN. Chairman Sammaripa?

Mr. SAMMARIPA. Yes, thank you. If I may, Mr. Richardson here that actually works with the referrals and runs our health care at Schurz, if I may turn this over to him to—he has some more to add to it, so with your permission.

Senator DORGAN. That would be fine.

Mr. SAMMARIPA. Thank you

Senator DORGAN. Mr. Richardson, welcome. Would you give us your full name.

Mr. RICHARDSON. Kenneth Richardson. I've worked for the Walker River Tribe for 23 years as health director. And I worked, before that, with the hospital when it was running.

And the thing that we're seeing right now, Senator, is that the heart patient that goes into Renown and is ready to die, they'll put a heart monitor in them so they will keep them alive. But right after that, then we're getting denied for everything. And it became very hard this year for our providers; we've lost providers because they couldn't live with this either, at our clinics. We have kids that have broken wrists, they were swollen up, the doctors couldn't do anything until a couple days when the swelling goes down. Well, that's been denied now. Because if you can make an appointment, it's not within priority.

Senator DORGAN. Let me understand. I don't understand the notion "If you can make an appointment." If a kid has a broken wrist that's "limb," right?

Mr. RICHARDSON. Right.

Senator DORGAN. I mean, you've got to set a broken wrist so it heals properly. And if you can't set it properly when it's swollen badly, you have to wait until the swelling goes down. And so the kid comes back three days later and two days later and gets it set, are you saying because an appointment is made for that return visit, it is denied?

Mr. RICHARDSON. It's denied.

Senator DORGAN. Now, who denies that? I mean, what's the basis—this almost seems to me like it would be impossible for someone to make that judgment. I mean, I know what you're tell-

ing me is what you believe and what you see. I'm just telling you what I hear is that has no basis in common sense. So someplace this is broken. It's a broken understanding somewhere between you and whoever is going to make this judgment that the kid with the broken wrist shouldn't get coverage because they showed up two days later.

Mr. RICHARDSON. Well, It goes way back. But like everybody said: Just last November, they started paying five years of bills for us, because we had all our providers quitting us, we had to bring a lawyer in, Senator Reid had to help us, you know, to get IHS to pay for five years of bills that were still out there on the table just to get services. And at that point, with the new fiscal year, FY10, it became a dollar amount, a figure that we were being told they had to control. And, basically, for the Schurz Service Unit, we get $6.4 million dollars for Contract Health Services to take care of 9,000 people. Out of that, $2 million is spent on pharmacy and labs and X-rays, anything like that. So it brings you down to about $4.4 million for services. And this is what we've had trouble explaining to Congress——

Senator DORGAN. Well, I understand it's short. I understand that. What I don't understand is the criteria by which someone says: We're going to allocate this based on a criteria that seems artificially ignorant; that is—not artificially—really ignorant, by saying that life or limb shall be described as whether you make an appointment or not. I can understand the rationale of suggesting that is true in many cases, perhaps, but never could I understand that that would be true in all cases. You've described one that is probably a perfectly good description of it: a broken wrist, unable to set it for two days, and, therefore, gets denied. Somehow, that suggests to me somebody's not thinking in this process.

Mr. RICHARDSON. And that's exactly how we feel. And that's why in our Chairman's testimony, that's the first thing we talk about, because it does say: Also for diagnostic and therapeutic purposes, a patient can be seen as long as you know, so we don't harm the patient.

And that's how we've felt like third world, we felt like, we're not part of the Phoenix area. And when you see, you know, our people sitting here dying because they can't get treatment, and we're expected to accept that.

Senator DORGAN. But let me ask you: If I might go to the 39-year-old mother of five—are you familiar with this case?

Mr. RICHARDSON. Yes, it came from our clinic.

Senator DORGAN. It came from your clinic?

Mr. RICHARDSON. Yes.

Senator DORGAN. A 39-year-old mother of five came to the clinic with a shortness of breath, begged the provider to just give her antibiotics or breathing treatment, did not want to go to the ER—where would she have gone, if she should not have gone to an emergency room?

Mr. RICHARDSON. We were trying to take her to Fallon. She was, actually, a Pyramid Lake patient that just happened to be visiting relatives that day.

Senator DORGAN. I see. Okay.

Mr. RICHARDSON. And so I also run with the ambulance service. I also had to deal with that on the ambulance side. You know, and also from the EMS side, it makes it very—you know, because do we care-flight that patient, because——

Senator DORGAN. Right, I understand the ambulance issue, as well, because I've been involved in some of that.

So this woman said that she doesn't want to go to the ER because IHS previously had not paid for gallbladder removal and her heart catheterization. So was that a case where she came in after you were out of funds and had procedures that didn't get paid, and I suppose ruined her credit—is that what we're talking about here?

Mr. RICHARDSON. That, and she'd also been denied, I believe, at Pyramid Lake——

Ms. CURLEY. Yes.

Mr. RICHARDSON.—for services to go be checked out.

Senator DORGAN. And why was that—tell me about that denial at Pyramid Lake.

Ms. CURLEY. It was denied due to "Not within priority."

Senator DORGAN. Not within priority one—you mean——

Ms. CURLEY. We did a referral, we had to refer her out to a specialty provider, and the referral comes back—because we can't make the appointment until we find out if it's going to get approved. And it came back, "Denied, not within priority."

Senator DORGAN. And that means, like, on Priority 1: 63 gunshot wounds, severe burns, coma, apendectomy, obstetrical emergencies, and if it's not within that, they're told "Sorry?"

Ms. CURLEY. Yes.

Senator DORGAN. I mean, that's what I——

Ms. CURLEY. But you don't get deliveries paid for anymore either. And we have prenatal deliveries that don't get paid for either.

Senator DORGAN. Well, that's what I talked about at the start of this, about health care rationing.

Ms. CURLEY. Yes.

Senator DORGAN. Everybody's always worried about rationing: It's going on in this country, every single day to American Indians.

Ms. CURLEY. Yes.

Senator DORGAN. It's unbelievable. It ought to be headline news. And then, perhaps, the country would say, We've got to stop this.

Ms. HARRIS. Yes.

Ms. CURLEY. Yes.

Senator DORGAN. Senator Reid and I and others have been grappling with this Contract Health Care issue for so long, and we have to get it fixed somehow. We just have to get it fixed.

Mr. RICHARDSON. One other thing.

Senator DORGAN. Yes.

Mr. RICHARDSON. Our prenatal care is all being denied. Yet we're expecting our mothers to go into ER, have emergency surgery that's costing more. I mean, this is what is hard for us as tribes to try to visualize is it's costing us more in the long run not doing the preventative care.

Ms. CURLEY. Yes. And I would like to add to that. We had a case study. We had an epidemiologist come and do a case study with some of our patients to track their health conditions over a prolonged period of time. And so when she was looking at them, it

took from the time that patient got that injury or whatever the health condition was, and then looking for all the referrals in their history and watch their health conditions decline over time to the point where it gets really severe, now your going to pay a much larger amount of money on the back end, and a lot of times it's still too late; the damage has already been done. Whereas, if you were spending a little more money in dealing with the immediate problem when it starts, the early intervention and prevention component, you would save a lot more money in the long run. But to wait until their health conditions deteriorate to the point where it's going to cost an astronomical amount doesn't make any sense to any any of us. You're spending a lot more money.

Senator DORGAN. What's it feel like to have to run a system like that—because you're at the ground level where all the patients show up?

Ms. CURLEY. It's extremely frustrating when we're trying to figure out how we're going to get the patients out of the facility with what they need, or dealing with a system that assumes that our facilities can do things that other facilities can't. Some of this rationale comes from an assumption that our clinics can do a lot more than what they really can. Our providers are extremely—we came "this close" to losing our provider, our doctor. You know, they're very frustrated. And they're terminology is "It should be illegal to make people suffer like this." They get angry because they know what the patient needs. It's a liability for everybody. The patient knows that their condition is just going to get worse. The doctor is working outside of his or her scope to try to help, and we're just equipped to deal with the cases that—we're a clinic; we're not—and it's extremely frustrating.

Our doctors and our nurse practitioners and our nurses, our benefits coordinator, contract health clerks, they do extraordinary things. Our staff took up a collection at the clinic to buy medications for our kidney donor patient, because she couldn't afford to buy it on her own. I mean, these are—Walker River—or, you know, Walker Lake: They do a lot of—but there's a lot of extraordinary things that we do within our clinic to try to help our patients. Our providers spend a lot of time working with the drug companies to try to get free medications for our patients. And we do a lot of things. We have money that we pull out of our own clinic funds, our third party revenue funds, that we spend to help our patients. But it's not enough. It's not enough.

Senator DORGAN. And, you know, the Chairmen of Tribes, I visited a lot of reservations, of course, as Chairman of the Indian Affairs Committee, and I know how the political system and the government system works in tribal government. And my guess is that all of the issues that confront the clinic, that they just can't deal with, end up, very often, with the tribal chairman, saying, "What are you going to do about this? And then what can the tribe—how do I get help? I'm assuming that, unless you represent tribes—I don't think you do—that have independent wealth and extra revenues, I'm assuming that when Contract Health Service runs out, you're all in the same dilemma, in the same situation.

Ms. CURLEY. Exactly.

Senator DORGAN. When does your Contract Health Care funding run out, on average, Mr. Chairman?

Mr. MOYLE. I've been the Chairman for going on 23 years now—it has been for years—you could look at May, we're out. And we began to get the, let's call it the, ripples of that going to be happening in April. By May, we are out. And going back to what they were all saying——

Senator DORGAN. So that's seven months out of the year, and then the next five months there's no money.

Mr. MOYLE. As you stated earlier that you've visited a lot of the Chairmen and realize a lot of what you might call frustrations—it really amounts to that, because I'm responsible for entire tribe. A lot of them are relations, a lot of them. They're dying. Not only my own relations, but other members of our same tribe, other members—we're related because of our closeness to Pyramid Lake, Walker Lake, and also Reno and Sparks that there's relations amongst all five of those tribes, even Fort McDermitt area. But all of our people are going through the same thing. Because of that lack of funding that handcuffs our people from being able to walk in the door and have a provider see him and then have a person—well, in this case, because of the insufficient dollar Phoenix follows, I'll just make a reference to this—the Bible, about Level 1 Priorities and which ones will be approved. You have some good examples of how drastic it's got to be before that person can be either seen or turned out the door. We're not going to authorize it. And that's daily.

Senator DORGAN. Chairman Bell?

Mr. BELL. Mr. Senator, Fort McDermitt is a direct service tribe. We did compact our 648R Fund, so the Schurz Service Unit is responsible for oversight on all of our administrative oversight. But as a tribal counsel, we've asked numerous occasions for the unit director to come to our reservation. All of these exact same concerns were brought to his attention. Basically, he's the health director for our clinic. And I could tell you that about maybe four or five years ago, basically what it boiled down to is this formula that we keep speaking of. And from my reservation, out of the youths, for me, and for everybody else, it's only for our contract health dollars for me to come to a contract health provider, it's only $500 for me. So I rarely use that source.

Senator DORGAN. Chairman Sammaripa, I assume you and Mr. Richardson confront these things every single day. When do you run out of Contract Health funds on your reservation?

Mr. SAMMARIPA. Well, Mr. Richardson can probably address that, and he has the facts and figures, so.

Senator DORGAN. All right.

Mr. RICHARDSON. Thank you. It's real hard to say, Senator Dorgan, because, like we're on a continuing resolution now, and, you know, health care is not static; it's continuing. Bills are coming in now that are probably piling up as we speak. So, basically, we are out of money for this quarter already, because those emergencies or whatever, they're coming in, and by the time we get the money, there still has to be pharmacy taken out of it, all the X-rays, laboratories, we're really out of money all the time. And one of the big things, like, for us, I can track historical spending of almost $1.8

million just for Walker River on a yearly basis. Now we're down to about 400,000 because we're basically being put on our user population. And the user population, in some cases, always benefits the bigger tribes. And we have to fight the Phoenix Indian Medical Center that has an urban population of 55,000, but you know we really fought this year with the big increases in CHS, you know, unheard of. And we get $1.1 million. And the bigger get bigger, richer, basically. And there's nothing in there about needs or any of those type of things, but we're always out of money. That's the way we feel. And this year was the worst. And it's one of the things that we put in our report—is that it's really hard for us to understand how I just can give out bonuses, which are monetary rewards, to their staff when our people can't even get care. You know, it really affects all the tribes.

Senator DORGAN. Ms. Harris, you may proceed. You wish to say something?

Ms. HARRIS. I'm sorry. Getting back to the disconnect, as far as the Priority 1 and the approval process, I can't speak for IHS, but as I alluded to before, I've been around the health care block for a while: What you have is you have a situation, you call for an approval, the person on the other end of the phone is not a clinician, what they hear is there's a child who has broken their wrist, and they say, "Okay. Go ahead." The child appears, there's too much swelling, the wrist can't be set, so they have to come back in two days. When you call for that, what the person on the end of the line, a nonclinician, is hearing "follow-up visit." A follow-up visit doesn't meet the criteria; broken wrist did. And that's part of the lack of understanding between the people who are granting the permission, if you would, for these visits and access to care.

Senator DORGAN. All right. I believe we've been at this about two hours. We've been at this so long that the roof starting leaking.

[Laughter.]

Senator DORGAN. I want to make a couple of comments to you. Number one, I indicated at the start that we passed the Indian Health Care Improvement Act. I'm really proud of that. It will not by itself, just like that, fix everything in health care; we understand that. But in the previous congress, the 110th Congress, I asked Senator Reid for time to get to the Floor to deal with this Indian Health Care Improvement Act. I told him we could be on and off the Floor of the Senate in just a couple days. Well, it turned out that wasn't the case. It took longer. It was controversial. Nonetheless, we got through it, and we passed it, and then it got hung up in the House of Representatives, and it didn't become law. This year, again, with the Indian Health Care Improvement Act, I went to Senator Reid and said, "We need to move this, get this done. I think we can get it through the House this time." So we got it added to the larger health care bill, and it is now law.

And we included a couple of things that are important. One of them written by Senator Reid, and I supported that, and that is there is now a requirement for the Secretary of Health and Human Services to develop a plan by which Nevada would become its own IHS area. This is a big state. I believe it's the only similar geography that doesn't have a hospital. I think it would be the first step towards finally getting a hospital. But, in any event, having to

drive 700 or 800 miles, 600 miles to access the hospital in Phoenix is just not an adequate way for our country to meet its promise, treaties and other responsibilities, trust responsibilities.

So, number one, there's a requirement, Secretary of HHS develop and report to Congress a plan for a regional IHS office here. Number two, the Act also requires the Secretary of—number one, we asked for a Government Accountability Office to conduct an investigation into the Contract Health Service program and also the formula for the program, and then after the study and tribal consultation, which is included in the language, required tribal consultation, which I think is critical. After the study and the tribal consultation is complete, if the Secretary determines that the formula will need to be changed, then she will recommend that to the Congress and recommend the type of change.

I think because no one can explain what the formula is or how it was developed, this formula must be changed. There are three things, it seems to me, that are critical here. One, you are the most reliant, of all the states, on Contract Health Service programs. Therefore, what happens to Contract Health Care Services is much more important—it's important to everybody, every tribe in the country, but even more important to you. So this process by which we finally at long, long last are going to say, "You've got to investigate this, work through it, and come up with a better approach," I think is going to be very important.

But most important, at the end of the day, is once we've discovered what kind of payments and how they are apportioned and so on. Once there is a plan for implementation of an Area Office here, then the question is how are we going to make certain that the Congress appropriates funds that are sufficient to avoid what is rationing for about 60 percent of American Indians health care needs? Again, I can't say it often enough: This ought to be a national scandal.

And, I mean, the story you have told today of a 39-year-old mother, I've heard that story over and over again in so many different ways. And the way that I was able to get the Indian Health Care Bill through the Senate was to put a face on the these issues. Some of you may have seen me on the Floor of the Senate. I guess I did it probably ten times, talking about Ardel Hale Baker. I brought a big picture of Ardel Hale Baker to the Floor of the Senate to say here's the woman on whose leg they masked-taped an eight-by-ten piece of paper as they hauled her in the hospital having a heart attack, saying, "If you let her in the hospital, you may not get paid." Here's the woman. Take a look at her.

And then I brought the photograph of Ta'Shon Rain Littlelight, whose grandmother gave me the photgraph at the Crow Reservation when I was there one day. I told the story of this six-year-old little girl over and over and over again. And I'll tell you the story just briefly because I think it bears repeating. Ta'Shon's picture that her grandmother gave me showed a little beautiful six-year-old girl with bright eyes in a fancy dress, because she loved to dance, and she was beautiful. Ta'Shon became ill. She was taken to the Indian Health Service clinic and taken again and taken again and taken again, and was always sent home with the diagnosis of depression, and medicine for depression. This for a six-

year-old girl. Well, finally, her condition became an emergency, and she was air-lifted to Denver, and they discovered she had terminal cancer. So Ta'Shon was not long to live.

Make-a-Wish Foundation asked her what Ta'shon wanted to do. She wanted to go to Disneyworld in Florida to see Mickey Mouse and Donald Duck. So Make-a-Wish Foundation made it possible for her and her mother to go to Disneyworld. In the hotel, the night before they were to go into the park, she said to her mother, "Mommy, I'm sorry that I'm sick." And then she died. Never got to Disneyworld World. She died in a hotel in her mother's arms. This is a six-year-old girl, believe it or not, who shouldn't have died.

But I asked her grandparents and her mother if I could use her photograph on the Floor of the Senate, not to exploit it, but, perhaps, to tell people: This is about real people; this is kids dying; it's elders dying; it's about real people. And I think enough members of the Congress finally said, "Boy, it's hard for me to turn my head to that; it's hard for me to resist doing what needs to be done. So we've made some progress.

It's not all the progress we need, but, you know, when I come here to the state that's most reliant on Contract Health Services and hear your stories, it reminds me how urgent it is that we continue to get the funding, continue to move with the two provisions that are in the Indian Health Care Bill dealing with these issues. Do what this country promised: Provide for Indian health care for the first people who were here who met everybody else, provide for the health care needs we promised them. And if you don't believe me, go look at the Treaties, see how they're written, we signed them. So we've got to do this and we've got to continue this fight.

Your willingness to come to a hearing and provide testimony and provide a base of information, especially about Nevada is very, very helpful. I know that Senator Reid wished he could have been here today, but he's asked me for some months if I could come and do this hearing in Nevada because this contract health care issue is so important. It turns out the day I was able to come, he's not able to be here in Reno. But I'm here because he cares about the issue and is with me to pass the Indian Health Care Improvement Act and the other things that we have done.

So let me say one more time that we will keep open the record of this hearing for two weeks from today. If you want to submit testimony from someone else in your tribe or others who have witnessed this hearing, you're welcome to submit formal testimony and it will become a part of our permanent record.

And let me, with that, close this hearing and ask if we might call on Chairman Bell, once again, to provide a blessing as we close this hearing.

Mr. MOYLE. May I ask one more question?

Senator DORGAN. Yes, you may, Chairman Moyle.

Mr. MOYLE. I want thank you because I know you have high standards and your staff.

The one thing that I feel is important to ask is that, as we read it and as we hear about it, the GOP is working daily on issues that they feel are wrong that should be passed by the present administration. Now, listening to the issue of the repeal of the health care reform that had been approved at this point: Will the Indian

Health Care Improvement Act, because it is a part of that, be affected by that decision if there is going to be one?

Senator DORGAN. If there were a repeal of the health care bill that was passed by the Congress, the Indian Health Care Improvement Act would similarly be repealed, because that's where we attached it. But let me just say this: That is not going to happen; it will not happen. Let me tell you why: Even if those who believe this should be repealed—and I don't; that would be a profound mistake to repeal that law—even if they had enough votes to repeal it, they would not have enough votes to override a presidential veto. There would need to be 67 senators that would say, yes, we want to repeal this law, and we would overturn a president veto. Clearly President Obama would veto a bill that would repeal the Health Care Bill, and clearly the Senate would be willing to sustain a veto.

Mr. MOYLE. Thank you very much. Thank you very much.

Senator DORGAN. All right. Chairman Bell, again, you opened this hearing with a blessing. Let me ask you, similarly, to close it with a blessing.

Mr. BELL. Thank you. First off, Senator, I want to thank you again. Thank you for listening to all of our testimonies here, each and every one of us. And I believe you are personable in the area that you're working with throughout this country in the testimonies that's already been provided to you on behalf of Contract Health. So I appreciate that. Appreciate the honor to meet your acquaintance. I've met you once before in Bizmarck, North Dakota, Tex Hall with the NCAI president, he held one of the conferences there when I was attending the college. So I appreciate that. I've had an opportunity to go back to your state. I enjoyed and look forward to going back; I've been invited as a guest speaker at the college. Thank you for being here.

[Prayer/Blessing.]

Senator DORGAN. This hearing is adjourned.

[Whereupon, at 3:37 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. LUCILLE CAMPA, TRIBAL CHAIRPERSON, LAS VEGAS PAIUTE TRIBE

As Chairperson of the Las Vegas Paiute Tribe (the Tribe) I would like to outline some key concerns regarding coverage for medical and dental care through Contract Health Services, utilization patterns, billing issues, and how these key issues have impacted the Tribe and our service population. We are aware that our fellow Tribes may face different issues where reimbursements and CHS budgets are concerned, and where certain common concerns exist—there are variations depending on the Tribe in question. Our hope is that we will be able to identify areas for improvement to avoid budget shortfalls and billing errors that have compromised access to much-needed healthcare.

Our service populations has experienced significant delays in obtaining medically services necessary specialty care for our covered members due to barriers to access at the nearest Indian Health Service facility, Phoenix Indian Medical Center. When possible, we rely on our local referral network; however, there are gaps in this system due to our inability to negotiate contracts with providers who are unwilling to accept Medicare's fee schedule. Due to funding limitations on CHS dollars, we have had to deny treatments and supplies that were deemed to be beneficial and necessary by our contracted providers. In addition, we are unable to meet the dental care needs of our orthodonture candidates, as well as our elders in need of dentures and bridge work. Some of our infirm elders, as well as some younger members, with major medical problems need enhanced medical and social service support that unfortunately we are unable to provide.

Las Vegas Paiute Tribe strongly supports the development of a Nevada Area Office of the Indian Health Service that would allow us to better channel Federal resources to Nevada Natives. In southern Nevada alone, there are an estimated 25,000 Indians who have no IHS services readily available. Further, the exclusions by PIMC have caused hardships to our patients, which is ironic given that the Tribe is part of the Phoenix Area. Extending the Medicare-Like-Rates rule to apply to outpatient services would dramatically alleviate the strain on CHS dollars and severely impact the services to our primary services population.

Please feel free to contact me or our Acting Clinic Director, Andrea Harper, if you have any questions or need further assistance.

PREPARED STATEMENT OF HON. ARLAN D. MELENDEZ, TRIBAL CHAIRMAN, RENO-SPARKS INDIAN COLONY (RSIC)

Background

The Reno-Sparks Indian Colony (RSIC) is uniquely situated in Washoe County, right at the borderline of the Cities of Reno and Sparks, Nevada. RSIC has also established the Hungry Valley community 19 miles away. The urban population is included in the tribe's catchment area.

Between our own patient count, the urban Indians and the patients crossing-over from nearby tribes, one would begin to understand the strain placed on the Contract Health Services (CHS) and Hospitals and Clinics (H&C) funds realizing that we exist in a Contract Health Services Delivery Area (CHSDA) state and adhere to the Indian Health Service (IHS') *open door policy*.

RSIC views the distribution of CHS funds as inequitable among the Service Units within the Phoenix Area. Our Tribe is located within a multi-tribal service unit. The Schurz Service Unit (SSU) is one of the few Service Units in the Phoenix Area that does not contain a hospital directly operated by the IHS, nor are the tribal clinics fully staffed, equipped or constructed per IHS standards. The seven (7) clinics within SSU rely solely on CHS funds to pay for hospital and certain outpatient specialty services. RSIC regards the difference in service availability as inequitable. This is especially true when Service Units are placed on Level 1 priority for CHS services,

where the Service Units without direct hospital or in-house ancillary services appear to suffer unfairly.

CHS Funding Inequity

It has come to our attention that the CHS-dependent Area Offices in Portland and California fared better in the last CHS funding distribution due to their CHS-dependency. Unfortunately, the Nevada Tribes fell under the Phoenix Area which is dominated by the Phoenix Indian Medical Center (PIMC) and Arizona hospitals operated by the IHS. Our CHS-dependent needs were "masked" in the formula.

Several options to address the CHS shortfall in Nevada, and more specifically, for the Reno-Sparks Indian Colony include the following:

- RSIC does recognize that a major problem in the Schurz Service Unit is the lack of *medical contracts with specialty and Hospital* providers which contributes to the high CHS costs. A concerted effort by the IHS needs to be made as soon as possible, to *contract with providers using Medicare or better rates;*
- The lack of direct inpatient care in Nevada creates an unfair service delivery for IHS beneficiaries in the Schurz Service Unit. The CHS distribution formula for new monies should contain the following factors, by Operating Unit:
  - CHS-dependency weight (75%)
  - Active CHS User Population (15%)
  - Cost Adjustment for Cross-over of patients (5%)
  - Cost Adjustment for Inflation and Population Growth (5%)
  - These rate adjustments to the formula are proposed; the final rate should be agreed upon after Tribal consultation with the affected tribes;
- Another option that IHS needs to consider is the reallocation of CHS base budgets to address the inequities among the IHS Areas nationwide.
- The limited CHS funds could be more efficiently used by using a portion of the CHS funding to establish a "Center of Excellence" within the Reno-Sparks Tribal Health Center to provide services that are currently paid for by CHS funds, namely:
  - Regional lab or radiology services;
  - Same day surgeries;
  - Or other specialty services.

By moving towards a *Center of Excellence* concept, the IHS will save the CHS program thousands of dollars. The Reno-Sparks Indian Colony is willing to plan for these services on a regional basis. Our tribe has already constructed a 65,000 square foot health center using private, public and tribal funds and we stand ready to expand services for the benefit of our beneficiaries. Funding for a *Center of Excellence* will go a long ways addressing health needs in Nevada as well as the CHS shortfalls.

- The limited CHS funds in the Schurz Service Unit are used to pay for pharmaceutical supplies for the tribes under this service unit. Should decisions be made to eliminate the financing of these costs, RSIC wants assurance that the IHS will allocate other additional funds to cover the costs, and not transfer the burden to the tribes.

Health Crisis in Nevada

Indian health care is on the verge of crisis in Nevada. The health care funding has been woefully inadequate. Denials of CHS care have increased *400*-fold in the last 9 months, ranging from life-saving treatment of dialysis to emergency room visits involving congestive heart failure, motor vehicle accidents, birthing, and other emergencies.

- To be more consistent with services provided elsewhere in the IHS, the IHS needs to drop the priority levels used by the Schurz Service Unit in favor of a "Medically Necessary" approach to medical care. The medical provider determines that care is needed and the care is arranged;
- The IHS has not addressed the "crossover" issue impacting the Reno-Sparks Tribal Health Center. As the regional hub of specialty and hospital services in northern Nevada, patients from surrounding Tribes have migrated to our facility out of convenience. The current funding formulas do not give credit to the crossover workload that is occurring. The term crossover is used to identify those patients whose community of residence lies with Tribal clinics throughout

northern Nevada and California. Our tribe is not given credit for the active users from the surrounding areas, since the IHS is defining active users as a patient's community of residence. This policy has added a financial burden to Reno-Sparks and there needs to be a process to compensate for the time and expenses incurred as a result, including but not limited to the providers, medical supplies, support personnel, ancillary services, transportation and any referrals to outside providers that must be prepared for the continuation of the care.

In Closing

In summary, we are fully aware that more funding is needed for Contract Health Service nationwide, but that does not mean that substantial increases will reach the most needy and CHS-dependent Tribes. The CHS funding formula needs to be changed to address the needs of the Tribes who are primarily dependent on CHS due to the lack of access to an Indian Hospital within close proximity to where they live. If there is a strong correlation between having Indian Health Service Hospitals and the need for CHS funding, then more funding should go to the primarily dependent Tribes without access to Indian Hospitals.

PREPARED STATEMENT OF ROSE MARY JOE-KINALE, HUMAN SERVICES DIRECTOR, YERINGTON PAIUTE TRIBE

This is my personal viewpoint, and the expressions are from my experience with IHS matters. I have worked in all the tribes under WNA–BIA and see virtually the same issues.

The Schurz Service Unit has been primarily the focal of misunderstanding, failed agendas, and always behind on paying the bills of the service population of the Native Americans of Nevada. To begin with there are several items that are in dire needed of changing in order to facilitate better services. These include:

- *Budget to the Unit:* The questions of who administers the funding, what clinics are involved, is there policy and procedures that govern the budget, do tribes have a say in their funding and though not directly involved in the clinics, as a tribal social worker I have always had to work with the local tribal clinic that I am assigned or work at. These are matters that I don't know about. I do know that we are always at Level 1 and referrals are not honored. As a matter of fact, one of the providers told me "I feel guilty, and don't know if my personal ethics will allow me to stay." I asked him what he meant and he said "your people come to me for their illness, I assess, evaluate, and diagnosis then make a referral which IHS-Schurz Service Unit many times denies." He said that he feels guilt because he than has to prescribe a stronger pain medication and there is addiction to pain relief medication and it is a vicious cycle to many native clients.
- *Policy and Procedures:* There is no policy laid out for the referral system. I was ill in June, and woke up at my Mother's home in Schurz, Nevada and had symptoms of a heart attack. I was taken by ambulance to Yerington, Nevada and the Care Flight—REMSA flew me to St. Mary's Hospital in Reno, NV. I didn't have an attack; however was referred back to my own physician. Than I had major issues about paying the bill although I had private insurance with my employer (Yerington Paiute Tribe) and Medicare—Part A.
- *Referrals:* After my discharge from St. Mary's several weeks later, I went to see my doctor to set up surgery for the diagnosed health issue. I was very aggressive as I was told at the Pyramid Lake Paiute Tribal Clinic that I need to go to Phoenix but would need to pay my own transportation and IHS would reimburse me. I asked why as I had two insurance plans, and also was concerned as if the procedure didn't go the way it was supposed to, than where I would go for follow-up. I told the referring staff person to schedule me anyway, and I would deal with IHS later. I did have complications.
- *Computers and Software for Billing:* The computers at the unit are very, very old, and with new computers and software the filling could be taken care of in a short time and we wouldn't always be behind in payments to our providers. In all of the tribal areas that I have worked at this is a major issue. There could be a centralized system with all Western Nevada tribal clinics working the billing system the same.
- *Training:* This brings up the responsibility of Phoenix Area Office to train and have a training packet so when new tribal clinic personnel began work they have some notice and ways to work. I believe that most tribal clinics are small

with the exception of the Reno-Sparks Indian Health clinic and maybe the Washoe clinic.

- *Meeting:* At a meeting that I went to there was a representative from IHS and St. Mary's Hospital in Reno and the representative offered to have a meeting with clinic directors, IHS personnel and others to set up what clinics should look like and this included a billing process. He stated that hospitals and all that is needed to provide comprehensive services was his business. He offered his CEO to be at the meeting and nothing came of this. This was information that he felt that he needed as now we no longer use the Renown Medical Center and have to go to St. Mary's.
- *Substance Program:* As a social worker, I see a dire need for this issue as any provider who gets this recommendation will tell you that this issue must be dealt before we see any results in a change of the person and than the family. Substance use and drugs are a major issue and there is a definite need for the program. Our clinic doesn't have funds to send anyone to in-patient treatment. Why are we left out?

I would like to see these major matters dealt with. For so long our Schurz Service Unit has been running like it is now and we are like 30 years behind in comprehensive services to our people. Something must be done with planning, adequate budgets, and programs.

Thank you for the opportunity to offer testimony.

PREPARED STATEMENT OF HON. MERVIN WRIGHT, JR., CHAIRMAN, PYRAMID LAKE PAIUTE TRIBE

INTRODUCTION:

On behalf of the Pyramid Lake Paiute Tribe, I would like to take this opportunity to thank Senator Byron Dorgan, Chairman of the Senate Committee on Indian Affairs for scheduling the recent field hearing in Reno, Nevada and for allowing the extended timeline to submit this testimony regarding the Contract Health Services Program. My testimony will focus primarily in two areas; 1) operational problems , and 2) funding problems that are both directly associated with Contract Health Services (CHS), with emphasis on a serious CHS inequity within the Indian Health Service (IHS) Phoenix Area.

The Pyramid Lake Indian Reservation is located 50 miles northeast from Reno, Nevada and is served by the IHS Schurz Service Unit (SSU) within the Phoenix Area. Pyramid Lake is one of seven (7) clinics within the SSU and is totally dependent on CHS funds that pay for hospital and specialty outpatient services due to the SSU not having a hospital available to its service tribes. A prime reason for the inequity that exists is the lack of funding for Nevada, and the manner that the Phoenix Area IHS manages its Medical Priority Level I funding for Nevada Tribes. The severe funding constraints force the IHS to apply strict eligibility and medical priority rules.

PROBLEM:

The CHS formula as applied to the Phoenix Area creates an inequity that muzzles any complaint or concern when raised as patients suffer and die from the continued denial of serious health care needs and services, including those that qualify only as Medical Priority Level I. Due to insufficient funding, IHS is on Priority I status – life or limb conditions to receive access to CHS care. Nevada Tribes are "masked" into the Phoenix Area CHS formula by the authority of the IHS. The population distinction between Arizona and Nevada along with the lack of hospitals in Nevada creates the inequity as the Phoenix Indian Medical Center and other Arizona hospitals dominate the funding in the Phoenix Area. The Medical Priority Level I CHS management and authorization is clearly demonstrated and administered differently due to the hospital availability in Arizona and the status of clinics in Nevada.

Operational problems include the IHS denial of legitimate claims for coverage under Medical Priority Level I. Under the definition, many patients qualify when they enter medical facilities as

emergent care needs, but still the payment is denied. Native Americans do not have professional medical providers and in emergency situations they are unable to have professional medical diagnosis provided unless they enter hospital emergency rooms. The Medical Priority Level I requirement leaves Tribal clinics with uncertain medical services.

IHS is not contracting in the Reno area for specialty and inpatient services that result in payment of full-billed charges. Instead bills are not paid and the patient is left with payment responsibilities. All medical referrals are not made locally, but rather medical referrals are reviewed and decided by a committee 600 miles away in Phoenix. It is so bad, that the Phoenix Area Office mandates that patients should travel from northern Nevada to Phoenix to receive their medical attention. Arizona Tribes have hospitals that can be used for routine laboratory work, x-rays, and inpatient stays, while Nevada tribes rely solely on CHS to provide these same services.

The funding issue is simple; IHS is out of money, or as it is exemplified by denying all levels of medical priorities except Medical Priority Level I. Medical providers are not accepting referrals because of the non-payment of their bills. Patients are named and their bills are sent to collection agencies, where their credit is ruined. Even in situations where a referral is made, patients do not visit specialists out of fear that IHS will not pay the bill.

OPTIONS:

There may be options to dealing with the CHS problems plaguing Nevada Tribes. These options however may or may not be feasible as agency authority may restrict or prohibit such actions that present solutions to the CHS problems. Taking over portions of the management of CHS such as laboratory work and radiology would require a feasibility analysis that would include listing pros and cons for such operations. Establishing a Nevada Area Office would remove the Phoenix Area completely from the cycle of CHS approvals. An analysis should be conducted on the Phoenix Area CHS administration of funding that could bring about answers to the many questions by tribal clinical staff that is deemed helpless in treating serious medical problems.

Other options that are out of the control of Nevada Tribes could include moving medical clerks to Reno instead of stationing them in Schurz; obtaining more contracts with medical specialists in the Reno area; funding Nevada/SSU CHS with surplus funding from other Phoenix Area service units; and expanding the definition of life and limb to include the entire episode of emergency room visits because

since patients cannot self-diagnose medical emergencies and when IHS is approving symptoms of life and limb as emergencies, it is reasonable and logical.

CONCLUSION:

President Barrack Obama acknowledges the need for a"comprehensive strategy" that includes doing more to address disparities in health care delivery for Native Americans. The overall IHS budget is insufficient, and the CHS moreover for Nevada in the Phoenix Area causes great concern for the life and well-being of our Native communities. It is our responsibility as Tribal leaders to assure quality services to our residents, our communities, and our reservations. This opportunity will provide for increasing much needed basic services leading to improving life for tribal communities.

I thank the Senate Committee on Indian Affairs for their attention to this matter and urge that your serious consideration brings forth positive results that increase quality health care for Native People in the state of Nevada. Thank you.

PREPARED STATEMENT OF HON. WALDO W. WALKER, CHAIRMAN, WASHOE TRIBE OF NEVADA AND CALIFORNIA

I greatly appreciate the opportunity to provide these written comments regarding Contract Health Services (CHS) and its impact on Indian Health Services (IHS) and Native American Tribes; and I thank you for your continued efforts to improve the health care services delivered to American Indians and Alaska Natives.

The Washoe people (Wa she shu) are the original inhabitants of Da ow age (Lake Tahoe) and all the lands surrounding area of the Sierra Nevada Mountains and the Washoe Tribe currently holds lands in both Nevada & California. The Washoe Tribal Health Center (WTHC) is the Tribe's primary health care service provider and is located about 45 miles south of Reno, Nevada, near Gardnerville. WTHC's service area covers Alpine and Northern Mono Counties in California, Douglas and Carson Counties in Nevada, as well as parts of Story and Lyon Counties in Nevada.

Most of the Nevada's population is concentrated in the Las Vegas and Reno metropolitan areas, with the remainder residing in small rural communities located vast distances apart. Nevada's American Indian population is overwhelming residing in these rural areas making the availability and accessibility of health care services problematic - especially regarding access to secondary and tertiary health care services. In addition to the considerable distances many must travel for health care services, the cost of medical care in the two

metropolitan areas of Nevada (where there is easier access to specialists and hospitals) is in the 95th percentile of the health care costs in the U.S.

In Nevada, IHS is divided into two Service Units - the Western (Shurz) Service Unit and the Eastern (Elko) Service Unit. Nevada has had no IHS hospital since the Schurz hospital was closed in the 1980's. Without a hospital facility, Nevada Indians are solely dependant upon CHS for secondary (Specialty Outpatient Care Services) and tertiary (Hospital/ Inpatient Services). The closest IHS hospital - the Phoenix Indian Medical Center (I.H.S. Regional Tertiary Hospital) - is located in southern Arizona and was supposed to be the impatient facility that Nevada Indians were to be sent for impatient and specialty care. However, distance and lack of family support, and the growing urban Indian population in Phoenix has lead to a lack of access to that facility for Nevada Indians.

Without an IHS hospital or specialty care facility in Nevada (other than primary care provided by tribal clinics) Nevada Tribes have had to rely solely on CHS funding to provide primary and tertiary services. Since the 1990's, the Schurz Service Unit has run out of funds for the CHS program have by April of each fiscal year. Due to the shortage of dollars being appropriated by Congress for the CHS program, IHS' national formula for distribution of CHS funds, and the problems emanating from the dependency on CHS funding in a high cost area, the Schurz Service Unit has had CHS providers deny services to American Indians due to lack of payment by IHS.

Twelve (12%) of Washoe Tribal members are diabetic, and this number is growing. The Washoe suffer disproportionately from significant hypertension and hypercholestremia (which leads to heart disease); significant depression with substance abuse; high rates of suicide; hypothyroidism; upper gastric disorders, upper respiratory disorders, rising cases of osteoarthritis, and rising cases of cancer.

Given this and other factors, the Washoe Tribe sought and gained its own clinic. Currently, the WTHC has 10,300 patients registered; half of which visit the Clinic on an active annual basis. WTHC is one of only a few area clinics providing health care services to both American Indians and Non-Indians residing in our service area, although about 90% of the patient population is American Indian. Services provided on site are: primary outpatient medical (family practice) services, optometry, dental, behavioral health, community health and disease prevention, case management, pharmacy, minimal waived lab test, minimal x-ray, patient transportation, and CHS.

Since 2003, the WTHC has been operating its own CHS program. The Tribe determined that it could operate the program more efficiently and effectively. As such, the WTHC has established a CHS priority system and has contracted with local medical specialists and hospitals. The WTHC pays all vendors within 30 days of date of service being provided, which has been something the Schurz Service Unit historically has been unable to do on a consistent basis.

At the field hearing in Reno, a significant number of the Tribes providing testimony were those that have not taken on their own CHS program, and instead have left their "shares" to be operated by IHS through the Schurz Service Unit. As such, the Washoe Tribe wanted to

present the perspective of a Tribe with a self-governance compact for the operation of a CHS program. Like the Schurz Service Unit, the Washoe CHS program suffers from lack of adequate funds to appropriately meet the medical needs of our patients. WTHC has to deny our people priority level two medical care because we have to make sure we maintain enough funding in our annual budget to assure we pay for all level one priorities. This in turn places a greater burden on the system as level two priorities, if not treated in timely basis when needed, soon become priority level one cases.

Last year (October 1, 2009 through September 30, 2010) the WTHC budgeted $1.7 million for CHS. We processed 2,732 referrals for hospital and specialty services we cannot provide on site during this period. We approved and paid 1,826 of these referrals or 66.8%, and deferred (denied) 906 of referrals or 33.2%. Congress has consistently only appropriated to the Indian Health Services about 60% of the level need established through scientific studies. If Congress would fund the unmet need, and the national IHS formula were changed to place more emphasis (weight) on access to care and high cost areas of care, this would address not only the funding needs of Direct Service Tribes (those leaving the shares with IHS to operate CHS programs) but also the Self-Governance Tribes (those Tribes that have compacted or contracted their CHS program).

The Tribe greatly appreciates you and the Indian Affairs Committee for taking the time to conduct the field hearing and listening to the Tribe's concerns. We also strongly urge continuing efforts to educate and persuade Congress to appropriate more funding for CHS programs for the Indians Health Service and to place a priority on revising the CHS national formula distribution to ensure that there is more funding being allocated to the Nevada Tribes to meet their CHS needs.

Thank you for the opportunity to present this testimony and for your attention to this matter.

YERINGTON PAIUTE TRIBE
171 Campbell Lane
Yerington, Nevada 89447

October 19, 2010

Dear Honorable Senator Dorgan:

I am writing this letter in response to the Field Hearing held in Reno Nevada on October 2, 2010 addressing several Health delivery concerns to Yerington Paiute Tribal Members. Before I elaborate on these concerns, I would like to provide you with a brief history of the Yerington Paiute Tribe. The Yerington Paiute Tribe is approximately 1,100 Enrolled Tribal Members strong with 450 of them residing on the Reservation/Colony. We are located in rural Yerington, Nevada, 85 miles east of Reno, Nevada, and have 85 homes on the Reservation. The Tribal Colony is located within the City of Yerington and there are 275 Tribal Members residing in this location with 44 homes. We also have Tribal programs and Tribal operated businesses on the Reservation and Colony.

After years of receiving "Priority Level One Health Care" through the Schurz Service Unit and the Phoenix Area Office, the Yerington Paiute Tribe negotiated a 638 Title V Compact in 2001. The level of care provided by IHS was inadequate to meet the needs of our community members. Priority level one only allows for care related directly to saving "life and limb". All other needs were unmet, i.e., prevention, health maintenance, early detection and intervention services. By compacting, our health care service has been successful in managing and providing a higher level of health care to the community.

As a result of compacting with IHS, the Yerington Paiute Tribe is able to offer routine preventive medical, dental and optometry care through a free standing clinic, staffed part time by a osteopathic physician, physician's assistant, nurse practitioner, dentist and optometrist. Through effective resource management and by utilizing funds generated by third party billing, the Tribe is able to provide basic health care needs. Unfortunately, not all Nevada Tribes have been as successful in meeting the needs of their people. In addition, there are significant disparities in health conditions between the Native and non-native populations. Native communities face a higher incidence of obesity, diabetes, diabetes related conditions, substance abuse, suicide, and behavioral health problems, among others.

The 26 tribes within the state of Nevada have a demonstrated need for high quality specialty care which is comprehensive, accessible and affordable. The top priority for funding from our standpoint should be the construction and staffing of an IHS acute

care hospital in the Reno-Sparks area. This area is accessible by ground transportation within seven hours for most of the Native population in northern Nevada, and is served by a commercial airport. The University of Nevada Medical School trains high quality practitioners who choose to stay in northern Nevada, thus the region is well populated by medical specialists who could be contracted to provide services at such a proposed facility. In conjunction with a free standing acute care hospital, the Nevada Tribes are in desperate need of increased access to residential substance abuse treatment facilities and mobile services to provide:

- *Routine diagnostics, such as mammograms and other cancer screenings.*
- *Dialysis treatments.*
- *Prenatal care.*
- *Dental services*

The Yerington Paiute Tribe is located 65 miles from Carson City and 85 miles from Reno, Nevada, requiring round trip mileage of 130 to 170 miles for many of the services listed above.

Under the current health care system we have limited and inadequate options. We can utilize the Phoenix Indian Medical Center (PIMC) for surgeries and other "specialty care". These services include anesthesiology, pediatrics, internal medicine, surgery, plastic surgery, obstetrics- gynecology, family practice, emergency medicine, ophthalmology, optometry, ENT, podiatry, pathology, radiology, psychiatry, physical therapy, and dental services. There are also subspecialties of gastroenterology, infectious disease, pulmonary, and future plans for cardiology. Tribal members are expected to travel from remote areas of rural Nevada to Phoenix in order to receive diagnostic services, hospitalization, surgery, etc. from the Phoenix Area Medical Center. The cost to travel to Phoenix is prohibitive for tribal members, and an inefficient use of health care dollars. Round trip air fare is at least $400 per person with advance ticket purchase. Air ambulance service for a medical emergency would be tens of thousand of dollars. Care Flight service from our reservation to Reno (85 miles to the north) is $17,000. Add the cost of a family member to escort the patient, the cost for lodging and meals away from home, the time involved to travel, and it becomes obvious that this is an ineffective health management system. In addition, the services available at PIMC are primarily routine services, i.e. obstetrics, internal medicine, pediatrics, podiatry, that should be readily accessible to the population at large.

The second option is to use Contract Health Care Funds to provide these services to tribal members. We are only one of the 26 Tribes in Nevada that are faced with disappearing health care dollars to provide tertiary, urgent and emergent acute care to our Tribal members. With the cost of health care in Nevada being among the highest in the nation, these dollars are inadequate to meet the needs of the population.

- *The Catastrophic Health Emergency Funds (CHEF) is funded based on a threshold amount set by IHS to cover Emergency Health Care Issues. The Tribe has to exceed the threshold amount set at $25,000.00, and then has to apply through the Contract Health Service Department to be reimbursed at an amount determined by IHS, and only a portion of the total Emergency Care expenditure for a patient is recovered. The Nevada Tribes have been without an Acute Care Hospital since the closing of the Schurz Service Unit Hospital, located on the Walker River Paiute Tribe.*
- *Yerington Paiute Tribe dialysis patients travel approximately 130 miles round trip to the dialysis center currently utilized in Carson City, Nevada. Extensive travel time on top of a lengthy dialysis procedure three times per week significantly reduces the quality of life for our kidney dialysis patients and their families. Many Tribal members face this eventuality, as 15%, or a total of 80 members, of the Yerington Paiute Tribe have been diagnosed with diabetes. Complications associated with diabetes are depression, hypertension, diabetic neuropathy, dental problems, and loss of vision, retinopathy, and renal failure. Many more Tribal members suffer from obesity, or have been identified as pre-diabetic, including youth. A small number of adolescents have already been diagnosed with type-two diabetes.*

In closing, Health Care for Nevada Tribes is limited due to the insufficient funding provided by the IHS. The Yerington Paiute Tribe is requesting your consideration of the issues stated in this letter addressing Health Care funding, CHS funding levels, and increase CHEF funding. We are requesting your support in establishing a Centralized Acute Care Hospital located in Nevada for Nevada Tribes to access, and substantially enhance the quality of health care provided to our Indigenous People of these lands.

The Yerington Paiute Tribes wishes are for a timely response to the issues stated above, and if you have any questions please call my office .

Sincerely,

Elwood L. Emm, Tribal Chairman
YERINGTON PAIUTE TRIBE

CC: Honorable Yerington Paiute Tribal Council
Honorable Senator Harry Reid
Honorable John Ensign
Dorothy Dupree, IHS/PAO, Acting Director
Jack Buckhold, Tribal Manager
Susan Rogers, Health Director
Indian Health Board of Nevada
Inter-Tribal Council of Nevada
Michael Wilden, DHHS Director State of Nevada

October 10, '10
Senator Bryan Dorgan
Chairman of the US Senator Committee on Indian Affairs
Washington, DC

RE: Lack of IHS funding and services for Native Americans – Service Unit - Walker River

Dear Honorable Dorgan:

It is with great sadness that we write this letter. We have lived on the Walker River Paiute Reservation for over 30 years and during those 30 years we have seen our medical services dwindle from a hospital with carrying doctors to a clinic with a doctor more concerned about writing nasty notes to his patient for not showing for visits. This same doctor has heard his nurse talk down to patients and condones her chastising the Native American people when we are sick and in need of medical help. Luckily, over the last 25 years we have been blessed with fairly good health. As we get older we find that we have new aches and pains, but cannot see the point in going to this IHS facility as they can't or won't help us with our medical needs.

We are fortunate to have a "physician's aid" who is trying her best to get medical referrals for her patients to no avail. As a matter-of-procedure we get denial letters for medical requests as there is NO money for medical needs for Native Americans in Schurz. Those of us fortunate enough to have medical insurance have gone to other medical facilities to get medical attention.

IHS will pay for those that abuse themselves and place themselves at risk by foolishly playing with snakes while drinking, or drive drunk while riding their motorcycle at break-neck speed and those that drink or drug themselves into poor health. IHS can find money to spend on their care and care-flight these folks to get top medical care outside of the reservation or spend money to get them new organs.

The IHS doctor at our clinic and his nurse are less than cordial. It appears that the only thing they want is for you to come to "their" clinic so in turn they can bill your insurance (providing you have) for 3rd party money. This 3rd party money is being used for other things besides funding medical needs (rodeo, etc.). We truly need a governing board to oversee the tribal health director. Medical information (confidentiality) could be a bit tighter. The medicine dispensed here is old and outdated, medicine that no other facility will use. In other word "...it is still good" give it to the Native Americans.

In the past we used to have top-notch military doctors that cared about the Native Americans in their charge - what happened to that? Our medical needs were met, no questions asked. If we had insurance it was considered a supplement to IHS. Now things are exactly the opposite. If you don't have any medical insurance and in serious medical needs, too bad, better get your affairs in order. However, if you have medical insurance this clinic will take your insurance for all it can get by way of 3rd party billing. The IHS office visit fees are more than our "outside" doctor's fee for the same thing. If Schurz IHS makes a referral they act like the money is being taken out of their pockets. They insist you be referred to one of "their" doctors first so they can bill your insurance company for sitting in their "office" for a few minutes. Why not write a referral - pop it in the mail to you to see the referral doctor? We don't feel that is right, considering it is our insurance is paying the lion share of the bill - duplication and a waste of our time and his. We have elders that have to go to dialysis out of town when we could very well have one right here in our community. If we had one, folks on dialysis in Hawthorne, Yerington, and Mina could come here instead of traveling on.

We understand that you were in Reno for a field hearing and the hospital director and our tribal chairman did not give you any ammunition to take back to Washington to fight for us, how very irresponsible of these folks. It would appear that those folks that stand up for the Native American people have had their voices lost to the wind. So with each passing year we lose more and more programs that once were promised to the Native Americans.

In closing, We would ask that you be our voice and do what you can restore funding to the Indian Health Services and return IHS administration to a viable state - our tribal government is broken on the Walker River Reservation – no checks and balances – just irresponsible spending for non medical things while we get taken to collections because IHS does not pay their bills (year old) in a timely manner.

Sincerely,
Tribal Members:
Bea McMinn, Walker River Paiute Tribe
Alex Conway, Walker River Paiute Tribe
James McMinn, Walker River Paiute Tribe

October 28 2010

Senator Dorgan
322 Hart Senate Office Bldg
Washington DC 20510

Hello Senator:

I hope this day finds you well as fall is upon us. Thank you for your concern for the Native population and the level of health care we are enduring. We are sending you comments from tribal members of the Walker River Paiute Tribe of Schurz Nevada, a rural Indian reservation with very little health care resources. We will also be sending in comments to the newly appointed Senior Advisor; Geoff Roth, who will be advising Ms. Robideaux of Indian Health Service by mid December.

Below are some testimonial comments from WRPT Tribal members who are and have had severe complications from critical health issues and even more complications from the denials of IHS contract care referrals. This does not reflect the many recent deaths due to the lack of health care funding. Most listed below are denied Per 42 Code of Federal Reg 36.23 e 1986.

!) Andrew/Beatrice Allen ages 80/79 Major health issues: Andrew is blind and diabetic with kidney sepsis and has rec'd 10 denials. Bea, wife, assists him in everyday living and herself has had knee surgery and asthma and been turned into collections. Denials for mammogram and knee follow-up. More health/stress related issues arising.

2) Alberta Quintero age 65 denied for neurological MRI for aneurysm and mammogram. Experienced extreme dizziness while she was full time caregiver to spouse who had stage 4 lung-Cancer patient. Stress related complications of worry of aneurysm.

3) Phil Collins 66 yrs Diabetic sent for kidney appt and rec'd bill for the $140 and was denied so unable to continue diabetic kidney follow-up. Unable to seek other care for diabetes.

4) Josephine David 65 yrs Recent Liver transplant patient. Currently has bi-monthly BBQ fundraisers to assist in the cost of her health care. She should be home and healing for the remainder of her life, yet, she is struggling to pay for her care and it further detriments her health.

5) Julie Charlie 48 suffers from left shoulder, Rt knee, also a reconstruction of ankle and has had several denials for the follow up therapy on knee, and denials on the painful cysts in ovaries. She is ineligible for state Medicaid resources.

6) Florence Brown 75 yrs has been diagnosed with multiple health issue attributed to

aging and has had several denial letters for any follow ups. Her daughter is living with her to assist with the daily needs. Her denials are causing more stress related issues such as higher blood pressure, and she is using living expenses to pay for medical care

7) Irma Foster 75 yrs suffers from the many health issues of the aging population. She has rec'd many denials from the IHS for referrals for mammograms and she feels frustrated of the quality of health care today. She has served as a nurse for the Native community for many years.

8) Levina Smith 65 yrs suffers from debilitating health complications, and has been a responsible citizen with paying all bills on time to keep her credit report clean and was just recently turned into collections for the denials of payment to health care providers and now is experiencing many more stress related health issues because of those denials.

9) Pancho Quintero 76 yrs has rec'd so many denials that he has applied to utilize the Veterans Medical system. He has frustration for the medical health care as it is currently on the Walker River Paiute Reservation.

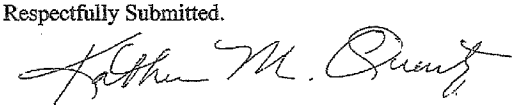
10) George Moose 58 yrs has metal pins in his legs/knees from a previous accident and is denied any follow-up for pain mgmt or physical therapy.

11) Inez Jim 75 yrs Cardiac Patient, has rec'd many denials for basic cardiac care and is frustrated and has given up on all health care as she knows any emergency room visit will end up in denial, and does not seek any other health care.

There are many more testimonials that could fill up the pages, Senator, however; I am certain you understand the severe need for funding for the communities such as Walker River Paiute Reservation, who are most reliant of the CHS process.

We thank you for your time and consideration for reading our letter of our concern for our community and the current health care status of the Walker River Paiute Reservation.

Respectfully Submitted.



Katherine Marie Quartz
Walker River Paiute Tribal Member # 2121

PO Box 125
Schurz NV 89427

Sir Senator Dorgan,

I want to sincerely thank you for your interest in Native American Health Care.

I want to express my thoughts about Health Care in my neck of the sagebrush of Northern Nevada in Owyhee, Nevada. I reside 100 miles north or south of any hospital facility that has the capability of taking care of health care needs.

I have serious doubts about the Owyhee Community Health Facility health care for the Owyhee area. I have had several incidents that are to many to count.

In May of 2007 my brother had a heart attack symptoms at his home in the morning, at 7:45 he became lethargic and his girlfriend (Malyna) said that he just yelled her name. She called the O.C.H.F. and told the nurse of his symptoms that he was unresponsive. The nurse on call said let me get your name and number to call you back. She called my workplace a little after 8:00 and was so hysterical that she couldn't hardly talk (his girlfriend). They asked what was the matter and she said she couldn't wake up my brother David. My secretary at DVHA told the Maintenance Staff who had asked what was happening. Jason (head Maintenance at DVHA) said that it was heart attach symptoms so he and 2 other Maintenance went to their home after 8:08 a.m. They started to preformed CPR on my brother. Malyna called back to the facility and asked where the H**L was the ambulance? They said they had to call someone to respond. After doing an investigation they had to at least 2 EMT's on duty and they did not respond to the call. They had waited for another EMT who had a full time job to respond. He had to go home and change his clothes to his EMT attire. This took 45 minutes for the OCHF to respond to this call. I had made it to my brothers residence at 8:40 exactly when the Ambulance arrived. They moved like turtles, one of the EMT's had been reported taking prescription medication. He appeared to be not in his state of mind (the EMT). I reported it when I went to the facility. The supervisors tested him days later.

I am very hurt that this had to turn out this way. My brother passed on that day due to the negligence of the facility. I am very hurt watching my brother die and the EMT's negligence to do their duties on that day.

In March of 2009 my father in law went to the facility because he couldn't breathe and was coughing up green fl em. The Doctor on duty sent him home with a bottle of pedialite and told him to drink that so he won't become dehydrated. The following morning he was unresponsive and we called the EMT's. They took him by Ambulance to Boise Hospital 150 miles north of Owyhee, Nevada. There he was diagnosed with pneumonia. He had heart failure and kidney failure due to the misdiagnosis. His death was very devistating to the family.

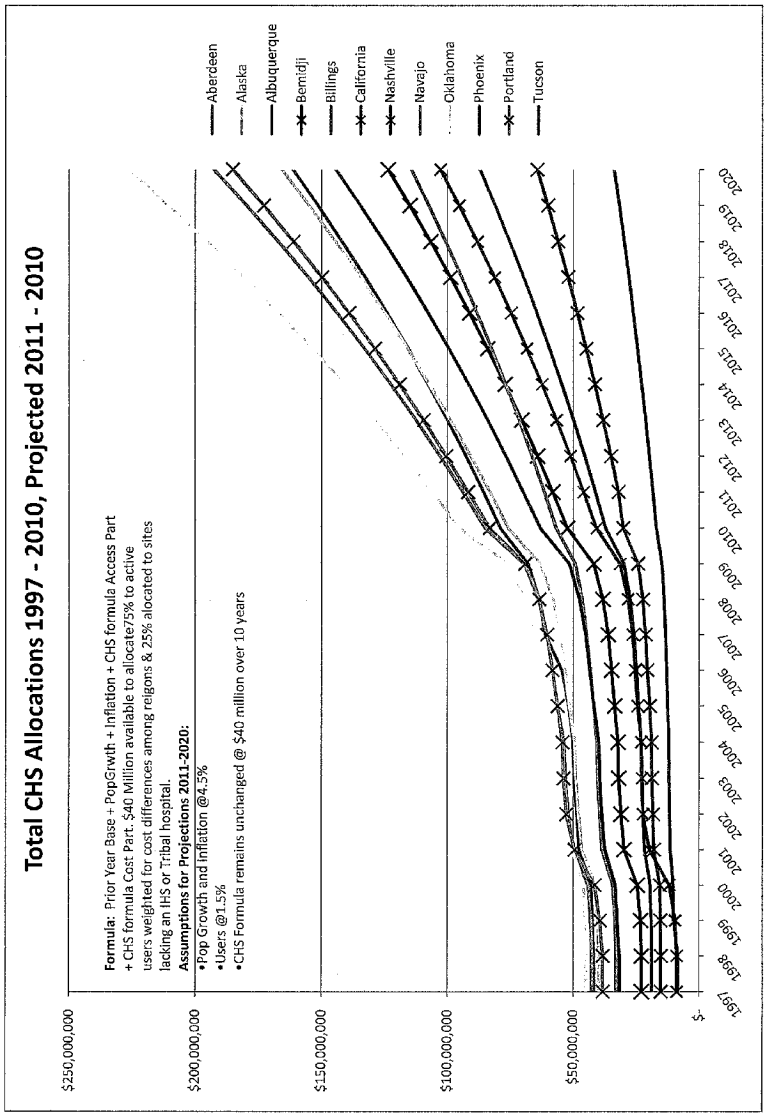
The OCHF has failed to meet the accreditation of JAHCO and are trying to regain the standards. In Indian Country everyone is so critical and all we expect is good health care. It is the Trust Responsibility of the United States Government to take care of the Health care needs of Native Americans. OCHF is not the health care it should be due to the tribes mismanagement of funding that has hurt us. Indirect costs are at an all time high of 40 percent that is taken out of the Health Care to serve the Tribes needs. I and many other Tribal Members believe that this amount should be taken down to help with health care. The facility needs qualified individuals to help get the credentials it needs to become a full pledged HOSPITAL. Since we do live 100 miles north or south of any facility that has the capabilities of taking care of the needs of the Tribal Membership and Community.

These are a few examples of what I have seen. I hear that all the finance have paid their medical bills first and we have to be second best in payments that has hurt our credit.

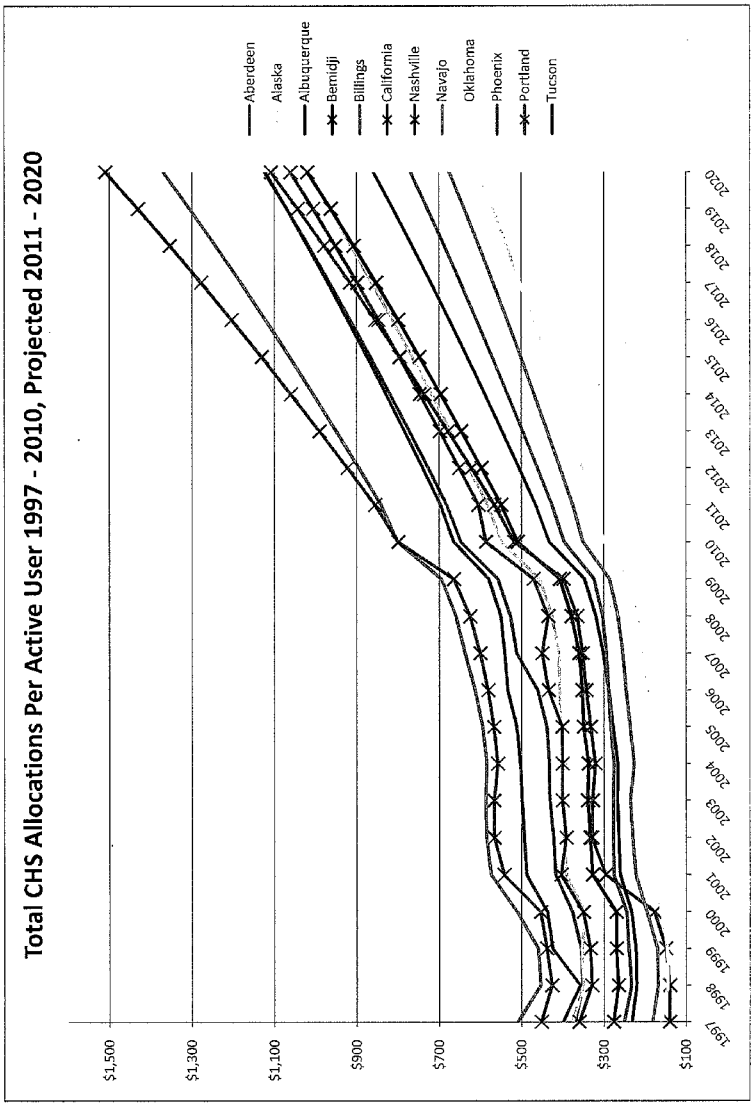
WE PLEAD, TAKE A GOOD HARD LOOK AT THIS FACILITY. HELP THE BUSINESS COUNCIL TO UNDERSTAND IF WE DONT HAVE OUR HEALTHCARE TAKEN CARE OF WE WILL ALL DIE OFF WITHOUT THE PROPER HEALTH CARE.

I appreciate your taking the time to understand the needs that I have spoken of for my people the shoshone paiute people of duck valley. .

Tina M. Nino



Data: Indian Health Service
Analysis: California Rural Indian Health Board, Inc.



Note: Active User Counts unavailable for 1999 and 2000. Active Users for 1999 came from 1998, and 2000 came from 2001, for the purposes of this graph.
Data: Indian Health Service
Analysis: California Rural Indian Health Board, Inc.

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