S. HRG. 110–519

ACCESS TO CONTRACT HEALTH SERVICES IN INDIAN COUNTRY

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

JUNE 26, 2008

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ACCESS TO CONTRACT HEALTH SERVICES IN INDIAN COUNTRY

THURSDAY, JUNE 26, 2008

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m. in room 562, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

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

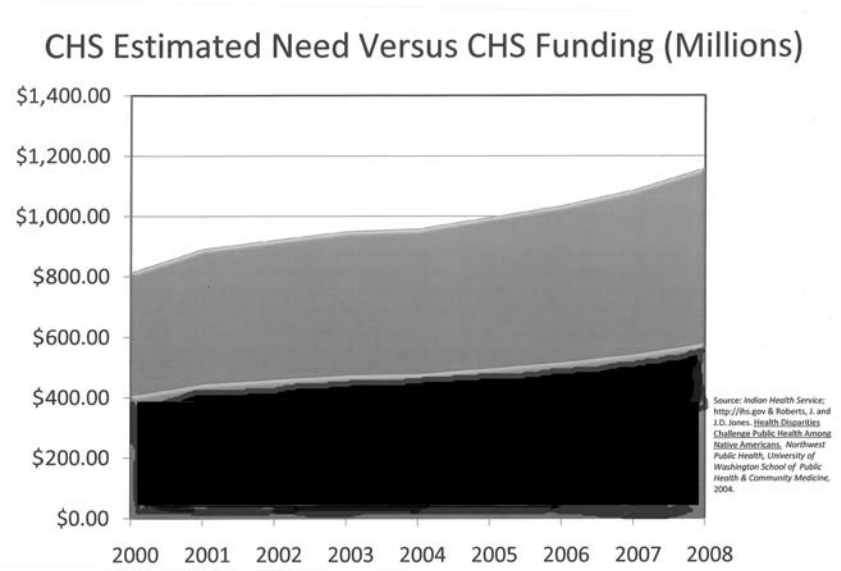
The CHAIRMAN. I am going to begin the hearing. Our Vice Chair, Senator Murkowski, will be here shortly and other members of the Committee will be joining us this morning. In the interest of time, I want to begin the hearing.

I am Senator Dorgan. This is the Senate Committee on Indian Affairs. We have a hearing today on a very important subject called Contract Health Services in Indian Country.

As you know, the Contract Health Service is a very significant and vital part of Indian health care. The program is crucial to providing the full range of health care services to individual Indians.

In March of this year, I sent out a letter soliciting tribal leaders for their thoughts on the current system. In response, the Committee received dozens of letters. This is the stack of letters I received, from reservations across the Country, describing their experience with contract health care—all of them indicating that the system is broken.

One of the main concerns raised is inadequate funding, which leads to denials and rationing of health services. I am putting up a chart that shows the Contract Health Service is only funded at about 50 percent of need. The black represents the amount of health care that is funded. The grey represents the amount of health care that is unmet and that is lacking with the current funding of Contract Health care.



The program is funded at about $580 million at this point. It is estimated that $1.3 billion would be necessary to meet the current need. This level of funding results in full-scale rationing, which should be a news headline across this Country. Rationing is scandalous and ought to produce headlines, but it doesn't because it goes on every day.

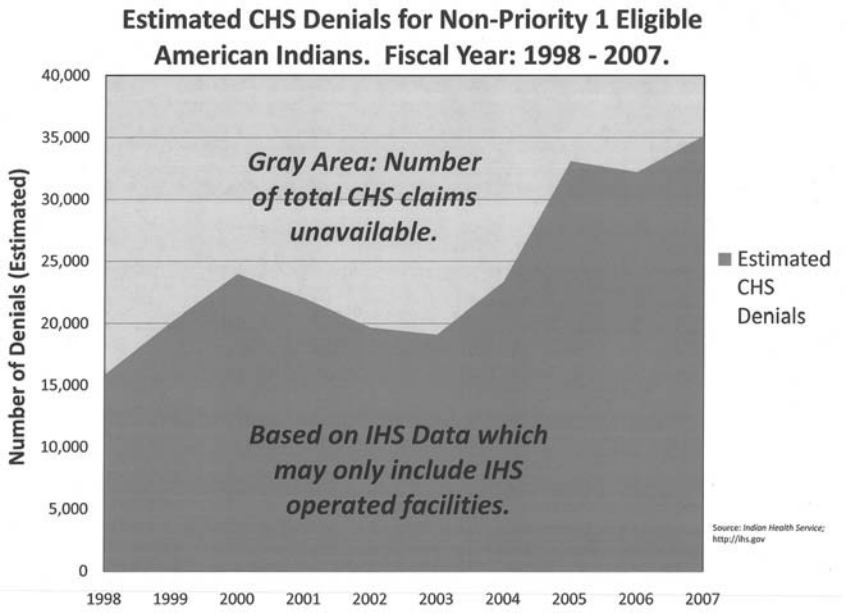
Chart two shows what Indian health considers to be priority-one matters. In these situations, services are necessary to prevent death or serious harm. I don't think you will be able to see all of that, but category one, or priority level one, is acutely urgent care. We will talk about category one in a moment.

Contract Health Service Medical Priorities

Priority level	Category	Type of Services	Example of Services
I	Emergent/Acutely Urgent Care	"Life or Limb"; Diagnostic/therapeutic services necessary to prevent immediate death or serious harm to health	Gunshot wound, severe burns, coma, appendicitis, obstetrical emergencies
II	Preventive Care Service	Services effective in avoiding the occurrence or services proved effective in mitigating consequences	Mammograms, routine prenatal care, cancer-related MRI or other early disease detection
III	Primary & Secondary Care	Treatment of prevalent illnesses/conditions with a significant impact on morbidity and mortality	Specialty consultation, knee replacement, specialized meds
IV	Chronic Tertiary & Extended Care	Care not essential for initial/emergent diagnosis or therapy	Rehabilitation care, restorative orthopedic surgery, organ transplant
V	Excluded	Services with no proven medical benefit	Cosmetic procedures

The current levels of funding often do not cover the need even for priority-one cases; this means that categories two through four, you don't even talk much about since we can't even meet priority-one cases. Priority two, as you will see, deals with mammograms, cancer screenings, knee replacements, some organ transplants. You would expect category two to be very significant, but in many cases clinics don't even get to category two because they can't afford to fund category one.

Chart three illustrates the number of life or limb denials for contract health care and how they continue to increase. These are what are called non-priority denials, and you will see the line which shows a very substantial increase in the number of denials.



I think the process for getting approval and the level of denials is out of control. These are necessary services, promised services as a result of a trust responsibility. Denying these services harm the lives of hundreds of thousands of Native Americans.

One young woman recently shared with us her experience. I want to share it with you and I do that because she allowed us explicitly to do it. Otherwise, I would certainly not. But this is Tracie Revis, who is a member of the Creek Nation in Oklahoma. In 2005, she was at law school in Kansas. She was diagnosed with pneumonia at the local Indian Health Service clinic. Her situation didn't improve, so she went back home for additional care. The IHS clinic told her that she had to go home to the clinic at the nearest reservation in Oklahoma, so she left school and went home.

In Oklahoma, the IHS clinic referred Tracie to a specialist to get a biopsy on a mass that was discovered in her sternum. During the biopsy, the surgeon found a six-inch cancerous tumor. At that time, the surgeon decided to cut out three-quarters of that tumor. She had not received prior approval, however, for the additional surgical service. Because of this, the Contract Health Service denied coverage for the surgery. That resulted in Tracie being personally responsible for paying $25,000 in additional costs.

She then went back to the Contract Health program to get approval for chemotherapy. It took three months to get approval. In that time, the tumor tripled in size. Additionally, the facility that Tracie was referred to for chemotherapy did not want to treat her because there was a history of non-payment by the Indian Health Service. After a long battle, the facility finally decided to treat her.

Over the next year, Tracie would go back to work where she was able to get private insurance. Although her cancer returned, she was able to get necessary treatment, get coverage for it, and I am pleased to say this young woman is now cancer-free and back in law school. But the entire experience has left her with a $200,000 debt, because Contract Health program would not meet the obligations to her.

I hope she is not embarrassed if I point out that Tracie Revis is in the room. Tracie, would you stand?

[Applause.]

The CHAIRMAN. Tracie, thank you for sharing your story. It is an important story because it describes so much of what we need to fix.

Finally is the story of Russell Lente. His doesn't quite have the same ending, but I want to tell you the story because it was described to us by people who want the story to be known. Russell was a young, talented artist from Isleta Pueblo in Mexico. He loved to paint. Russell's creative works are featured on billboards and murals and skateboards even now. He recently lost his battle with cancer at age 23.

When he found out he had cancer, he sought early treatment to help him fight the disease, but Contract Health Service denied Russell these services. Although he had cancer, the disease had not progressed to a stage where it was determined that it would be considered priority one, which we all know as "life or limb". I don't understand that. There is something wrong with a system that suggests that almost any cancer is not somehow priority one or "life or limb". But Russell's story ends at age 23, regrettably.

A talented young man is lost to all of us, and his story again describes why we need to fix this system. This illustrates the problems faced by tribal members and by Indian communities. It is my hope that this hearing will give voice to those affected by the system, those in the system, those providers—some of whom provide the care even though they are not reimbursed for it because they know Contract Health is not going to pay, but they will assume the cost and eat the cost.

We, as you know, have passed an Indian Health Care bill through the Indian Affairs Committee thanks to the excellent work of the Vice Chair, Senator Barrasso, Senator Johnson, Senator Tester and so many others. It has been passed through the entire Senate. We are now waiting for the House to pass an equivalent bill so we can go to conference.

This is but a first step. We must adequately fund, and we must make Contract Health Services work. The stories I have described today demonstrate it does not work. There are some success stories, but there are far too many failure stories in a circumstance where about half of the money that is needed is not available. So you have full-scale rationing of health care for Indians.

We have two panels today because we have many witnesses. I am going to call on others for brief statements, but I wanted to say that the witnesses have been asked, as is always the case and has always been the case, for a five-minute summary of their full written statements. The full written statements, of course, will be made a part of the permanent record.

So let me call on the Vice Chair, Senator Murkowski.

STATEMENT OF HON. LISA MURKOWSKI,
U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman. I appreciate your calling this hearing. So often when we are talking about Contract Health costs and services, we get into the statistics, we get into the percentages. Your introduction this morning of Tracie and the story of Russell reminds us that it is not just statistics. These are sons and daughters and mothers and uncles. They are real people, and I appreciate you reminding us of that in a very poignant way.

I want to welcome all of the witnesses her today, with a particular welcome to Sally Smith, a leader, Chair of the National Indian Health Board, and also a leader of the Bristol Bay Area Health Corporation. Your dedication in the health area, not only in the State but around the Country with Indian Health Care, is greatly appreciated. I appreciate your making the long haul back here and your comments here this morning.

As you pointed out, Mr. Chairman, Contract Health Services Program is probably one of the most important components of the overall Indian health care delivery system, and yet the challenges that it faces are quite significant—the vacancy rates for key health professionals, the lack of facilities, the ever-increasing cost of health care, and then the narrowing medical priorities, and they all contribute to either increasing CHS demand or reducing the available services that are out there.

Up in Alaska, we have the added challenge of transporting our Native patients to obtain the care. This is done mostly by airplane. We simply don't have the road systems up north, and so people are transported not by car, not by ambulance, but really by air ambulance, if you will, because we don't have any roads. You can't really see from the chart, but you can look to the numbers there. For somebody flying in from Ninilchik to Anchorage to receive care, it is an $1,100 airplane ticket. Coming out of Savoonga, it is a $1,000 airplane ticket. Coming from Old Harbor, which is over in Kodiak, it is over $1,300.

I think these figures are actually several months old. In fact, I know that they are several months old and they haven't been updated since we have seen the astronomical price increases in the State as they related to the cost of avgas and how we are moving our folks around. So we know that the numbers are much higher.

I understand that last year, the Bristol Bay Area Health Corporation received approximately $697,000 total for CHS, but they spent approximately $2 million in patient travel alone. So when you look at this imbalance—and that is not counting the cost of the service, that is just counting the cost of the air travel. And we all know it is not luxury air travel.

Mr. Chairman, you already mentioned the denials. In looking at the IHS data for the tribes that are reporting, in fiscal year 1998 there were 15,844 denials and 84,090 deferrals. In fiscal year 2006, there were 33,000 denials, 158,000 deferrals. In fiscal year 2007, there were 35,000 denials—and I am rounding these up—and 161,751 deferrals. These charts indicate that there has been a 46 percent increase in denials from efforts to effectively manage the available resources.

We should all be troubled by these declination and these deferral rates. But again, as I mentioned and as you have pointed out, this isn't just data that we are discussing. These are Native people. These are American Indians all around the Country that are suffering until they can finally access the services that they need.

We appreciate that funding is a major issue for Contract Health Services, but I know that that isn't the only one. I do appreciate the hearing today as a step in examining all of the impediments to the program. We recognize that the challenges are large, but we have very committed individuals working with us. I am hopeful that we will make some progress in addressing it.

Thanks, Mr. Chairman.

The CHAIRMAN. Senator Murkowski, thank you very much.

Senator Johnson?

STATEMENT OF HON. TIM JOHNSON,
U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Thank you, Chairman Dorgan, for holding this hearing.

For the nine treaty tribes in my State, the failures of the contract health system cause more pain and more tragedy than anything else they face. The stories are heart-wrenching. People have called my office because they have cancer and been told by the IHS that they can't receive treatment because it is not a priority-one threat to life and limb.

In South Dakota, we recently lost a great leader to cancer. Harvey White Woman was a man who lived an honorable life and worked for the Lakota Sioux people. After he was diagnosed with a rare form of cancer, he received four rejection letters from the IHS telling him that his treatment was not a priority. The strain this must have put on a man who was already fighting for his life is impossible to imagine.

Sadly, Harvey's story is not unique and others have gone through similar tragedies. While we have worked to increase funding for the Indian Health Service, there are problems far beyond funding. The Direct Service Tribes and tribal members in my State want their stories about Contract Health to be heard and have been sending them to my office. Mr. Chairman, I would like to submit these stories and have them made part of the Committee record.

Thank you and I look forward to hearing from the witnesses.

The CHAIRMAN. Senator Johnson, thank you very much.

Senator Barrasso?

STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

Senator BARRASSO. Thank you very much, Mr. Chairman.

Before beginning my opening statement, I would like to introduce to the Committee the Chairman of Wyoming's Northern Arapaho Tribe, Al Addison. Chairman Addison, would you please stand and be recognized? Thank you very much for being with us today.

[Applause.]

Senator BARRASSO. As I mentioned during our last hearing, Chairman Addison and the Northern Arapaho Tribe continue to mourn the loss of three teenage girls who passed away a few weeks ago. Chairman Addison, thank you for being here with us today amid such terrible circumstances. You and the Northern Arapaho tribal members are in our thoughts and in our prayers.

Mr. Chairman, as a physician, I have worked for over two decades to help the people of Wyoming stay healthy and lower their medical costs. This is a challenge in rural and frontier States. Our unique circumstances require us to work together, to share resources, and to develop networks. These same principles are critical to support and modernize the Indian health care delivery system. We all know the serious problems the Federal Government and the tribes face to deliver health care services in a cost-effective and efficient and in a culturally sensitive way.

Wyoming's Wind River Reservation is home to approximately 10,500 members of the Eastern Shoshone and Northern Arapaho Tribes. It is the third-largest reservation in the United States, covering more than 2.2 million acres. Tribal members in Wyoming have worse than average rates of infant mortality, of suicide, substance abuse, alcohol abuse, unintentional injury, lung cancer, heart disease and diabetes. When I last visited the Wind River Reservation, the tribal leaders told me how difficult it is for them to recruit and retain staff, to stretch each dollar to deliver essential services, to respond to cultural barriers, and to give families information to make better lifestyle choices.

I want to commend Rick Brannon. He and the Wind River Service Unit staff have incredible compassion, dedication and do incredibly hard work. Rick and his very capable staff are holding the two Wind River Reservation health clinics really together with duct tape. Medical inflation, increasing service demands, limited competitive pricing structures and rural access issues are all putting severe financial pressures on our clinics in Wyoming.

In response, their only option is to require strict adherence to a medical priority system. Basic care is still available—stitches for a cut or antibiotics for a sinus infection or a brace for a sprained ankle—but trauma patients injured in a car accident or a house fire, they will get immediate emergency treatment.

Those with medical needs that fall outside the priority system may not. An enrolled tribal member may need to see an outside specialist to assess a severe skin condition or undergo knee surgery. But if the injury falls outside the priority system, then the

Indian Health Service clinic will provide pain medication and place the patient on a waiting list.

Due to this situation, Mr. Chairman, many of these patients in my State then develop narcotic addictions while waiting for a specialty consultation. Using this medical priority system, my State's Indian Health Service clinics carried a $1 million Contract Health Services deficit last year. On top of that, they denied almost $11 million in medically necessary specialty care.

Recent Indian Health Service and Contract Health Service fiscal intermediary reports show that annual medical costs continue to increase, while the level of services offered continues to decrease. The cost per visit is increasing, while the purchase services are decreasing.

We need to reduce the health care disparities among American Indians and Alaska Natives. We need continued and sustained improvements in access to treatment and prevention services. I want to make sure that the people on the Wind River Reservation and all Native people across America have equal access to quality, affordable medical care. That is why I supported the Indian Health Care Reauthorization bill that was passed by the Senate earlier this year. It is long past time for the House to act on the Senate's legislation. We must act now and get the bill to the President for his signature.

It is equally as important that the care we provide is cost-effective and produces results. The Indian Health Service is not like other Federal health care programs. Congress has only limited access to the research data that is needed to modernize and improve Indian health care. I know this Committee will continue to focus our efforts to improve health care services. To do so, Mr. Chairman, we need good data and research to evaluate the current delivery system. We need to expose barriers that prevent collaboration and networking, that prevent innovation and sharing of resources.

Today, neither the government nor private advocacy groups can explain exactly how all the funds are used to coordinate medical services. If we do not know where the resources are being spent, the number of programs dedicated to provide services, how these programs coordinate the services, or the outcomes achieved, then how can we be certain we are maximizing our ability to help the people?

I offered an amendment to the Indian Health Care Improvement Act that will provide us this critical information. Once evaluated, we will know how best to target Federal funds to programs making the greatest impact. Then we can focus on additional areas where Native Americans and Alaska Natives need our support.

Thank you, Mr. Chairman, for holding this hearing.

The CHAIRMAN. Senator Barrasso, thank you very much.

I would note, given Senator Barrasso's statement, that this Committee has two doctors serving on the Committee and that is very helpful to us as we deal with Indian health care issues. So we welcome you again. I know Senator Barrasso has contributed a great deal since joining our Committee.

Let me ask again, if I might, of the witnesses that you adhere to the five-minute rule. We do have a light up here. When the light turns red, you probably know what that means. We have asked if

Mr. McSwain, the Director of the Indian Health Service would be willing, and he is willing, to testify following our first panel. I very much appreciate his willingness to do that. It means extra time out of his day, but I think it will be very helpful for him to hear the witnesses and then allow us and Mr. McSwain to respond to it.

This Committee, with my support and the support of the Vice Chair and others, unanimously supported Mr. McSwain and his nomination as Director of the Indian Health Service. We want him to succeed. We appreciate his willingness to testify today, but I have specifically asked if he would wait until the first panel so that he could listen to you.

Thanks to the panel for being here. Many of you have come long distances. You are going to provide some important information to us. We will begin with Sally Quinn, speaking of leadership. Sally Quinn is Chair of the National Indian Health Board. Excuse me, Sally Smith, not Quinn. I apologize. I know Sally Smith. Yes, a nickname.

[Laughter.]

The CHAIRMAN. Now, they will call you Quinn.

Ms. SMITH. Yes, they will. Thank you, Senator.

[Laughter.]

The CHAIRMAN. I know Sally Smith. I am sorry about that. She is Chair of the National Indian Health Board. She will provide the national perspective on Contract Health Services. Let me also say she played an integral role in helping us pass the Indian Health Care Improvement Act. Ms. Smith's work is very important.

You may proceed.

STATEMENT OF SALLY SMITH, CHAIR, NATIONAL INDIAN HEALTH BOARD

Ms. SMITH. Thank you so very much.

The National Indian Health Board is honored to be able to present today on behalf of the 562 federally recognized tribes. On a note, though, let me say that I am disappointed that we do not have the perspective of the Direct Service Tribes here today as I look at the list. The Direct Service Tribes and the Land-based Tribes are not testifying today. I believe it is very important that the Committee hear their views with regard to Contract Health Services so that you can hear the views from throughout Indian Country.

Dr. Greg Vanderwagen, former Chief Medical Officer of the Indian Health Service, spoke on rationing health care, and I quote, "We hold them off until they are sick enough to meet our criteria. That is not a good way to practice medicine. It is not the way providers like to practice. If I were an Indian tribal leader, I would be frustrated."

The Contract Health Service programs should support all costs so any Indian person can access the treatment that will support the best patient outcomes, instead of the most cost-effective or cost-avoidance method to stretch CHS dollars. The CHS program should pay for preventive care and medical interventions, instead of authorizing payment for only emergency cases.

The CHS program need to move into the 21st century by providing adequate funding to address the level of need in Indian

Country. Congress and the Administration should live up to the promises made in treaties, made in good faith, by the ancestors of people who are asking today for the ability to control the destiny of the quality of life for our people.

Senators Dorgan and Murkowski, excuse me, before I continue, please allow me to express the gratitude of the tribes for the work the Committee has done to advance the reauthorization of the Indian Health Care Improvement Act, S. 1200. We are especially thankful for the leadership of Senators Dorgan and Murkowski and other members of the Committee for their tenacity in ensuring successful passage of S. 1200 by an overwhelming bipartisan vote of 83 to 10.

Tribes are also especially grateful to you, Chairman Dorgan, for introducing the amendment to the Senate budget resolution to increase the IHS appropriation by $1 billion. And Vice Chair Murkowski, we are appreciative, and I am personally appreciative, for your support also of the $1 billion amendment, as well as other members of the Committee who voted for its passage.

I know that due to limited CHS funding, the IHS and tribal programs are, in most cases, only able to authorize CHS funding under a medical priorities system that gives most of the funding to the priority level one emergent or acutely urgent care services. These services are necessary to prevent the immediate death or serious impairment of the health of the individual that if left untreated would result in uncertain, but potentially grave outcomes.

Native beneficiaries who do not have access to alternate health care resources such as private insurance, Medicare or Medicaid health care services under the CHS program, are limited to emergency or urgent care services, most of which are not guaranteed.

If the CHS program paid for other medical priorities like preventive care services such as cancer screenings, specialty consultations, and diagnostic evaluations, early detection and treatment of diseases or illnesses could result in substantial savings to the CHS program, but more importantly lives would be saved and the quality of life would improve. Without cancer screenings and diagnostic evaluations, life-threatening illnesses go untreated and the patient dies or lives a short painful life.

That is not to say that the CHS program doesn't save lives, however. The IHS estimates, and we heard earlier, that there are $238 million in unmet CHS needs. In our opinion, this is a very low estimate. Further complicating this estimate is the fact that one of the unintended consequences of patients experiencing perpetual denials of needed health care services is that they finally stop seeking needed care. Therefore, it is difficult to determine an accurate aggregate CHS financial need because Native parents learn from experience that is it futile to request services they know will be denied or deferred.

This estimate also does not capture deferred or denied services from the majority of tribally operated CHS programs, which is nearly one-half of all tribes. More importantly, the estimated amount of unmet CHS needs does not capture all of the requests for CHS services that were denied that could be dubbed bureaucratic reasons, for instance noncompliance with the CHS regulatory requirements, emergency notification not within 72 hours, non-

emergency and no prior approval, and that the resident lives outside a CHSDA, and the story goes on. I could go on with a half-dozen stories, if time permits.

There is grave concern in Indian Country that there is a trend of increasing denial of CHS claims which is compounded by the continued under-funding of the CHS program. Because CHS programs are so consistently shamefully under-funded, we know that there are consequences. Very quickly, let me say it results in poor credit ratings, self-imposed impoverishment, helplessness and depression, and the list goes on. You have those in your handout there.

Again, I come armed with stories. If questioned, I would be happy to relate the stories from here in Alaska. There is one thing, though. I know the Committee has received many letters—Senator Dorgan, you have shown those to us—from tribes across the Country. There are so many stories to tell. My hope is that this is not the only hearing that will be held on CHS. I strongly encourage to hold field hearings in all areas of Indian Country.

The Direct Service Tribes' national conference will be held August 5–7 in Spokane. As the Chair of the National Indian Health Board, I invite you to hold a field hearing at our NIHB annual consumer conference to be held in Temecula, California September 22–25.

Thank you so very much for the opportunity to provide testimony. I would be happy to answer any questions.

[The prepared statement of Ms. Smith follows:]

PREPARED STATEMENT OF SALLY SMITH, CHAIR, NATIONAL INDIAN HEALTH BOARD

Introduction

Chairman Dorgan, and Vice-Chairman Murkowski and distinguished members of the Senate Indian Affairs Committee, I am H. Sally Smith, Y'upik Eskimo and Chairman of the National Indian Health Board (NIHB).[1] On behalf of the NIHB, it is an honor and pleasure to offer the NIHB's testimony on access to contract health services in Indian Country. During our discussion we will focus on how inadequate contract health services (CHS) funding has created a health care crisis in Indian Country and if not corrected, will continue to undermine the Federal Government's trust responsibility to provide health care to American Indians and Alaska Natives (AI/ANs). Today, we will describe how the lack of CHS funding has created and perpetuated a system of denials and deferrals that results in rationing of health care. As Dr. Craig Vanderwagen, M.D., a former chief medical officer for Indian Health Service (IHS), acknowledged in talking about the CHS program:

> "We hold them off until they're sick enough to meet our criteria. That's not a good way to practice medicine. It's not the way providers like to practice. And if I were an Indian tribal leader, I'd be frustrated."[2]

Before I continue, please allow me to express the gratitude of the Tribes for the work the Committee has done to advance the reauthorization of the Indian Health Care Improvement Act (IHCIA), S. 1200. We are especially thankful for the leadership of Senators Dorgan and Murkowski, and other members of the Committee, for

[1] Established in 1972, NIHB serves Federally Recognized AI/AN tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the Federal Government's trust responsibility to AI/ANs. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the IHS, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their Area. NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of the Tribes.

[2] Interview with Dr. Vanderwagen as documented in the Report published by the U.S. Commission on Civil Rights, Broken Promises: Evaluating the Native American Health Care System, September 2004.

their tenacity in ensuring successful passage of S. 1200 by an overwhelming bi-partisan vote of 83–10. Now that the Senate bill passed, Indian Country is working hard to ensure passage of the House companion bill, H.R. 1328. We look for continued support from you and ask you to reach out to House Leadership on both sides of the Aisle to help us make reauthorization of the IHCIA a reality in this Congressional Session.

Tribes are also especially grateful to you, Chairman Dorgan, for introducing your amendment to the Senate Budget Resolution to increase the Indian Health Service (IHS) appropriations by $1 billion. Vice-Chairman Murkowski, we are appreciative for your support of the $1 billion amendment; as well as, others members of the Committee who voted for its passage. At that time, I was serving as Chair of the Department of Health and Human Services (HHS) Tribal Budget Consultation meeting, and when I announced that the amendment passed, the audience erupted into a huge round of applause. As this committee well knows, the increase in IHS funding is vitally needed to address the funding shortfall for CHS, and other health care needs such as, increased funding for health care facility construction and contract support costs.

Snapshot of the Health Status of American Indians and Alaska Natives

AI/ANS have a lower life expectancy and higher disease burden than all other Americans. Approximately 13 percent of AI/AN deaths occur among those under the age of 25; a rate three times that of the total U.S. population. Our youth are more than twice as likely to commit suicide, and nearly 70 percent of all suicidal act in Indian Country involve alcohol. We are 670 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis and 204 percent more likely suffer accidental death. Disproportionate poverty, poor education, cultural differences, and the absence of adequate health service delivery are why these disparities continue to exist.

Background: Contract Health Services

The IHS is the Federal agency with the primary responsible for the delivery of health care to AI/ANs. The provision of health care to AI/ANs are provided through two types of services:

1.) direct care services that are provided in IHS or tribally operated hospitals and clinics; and

2.) contract health services (CHS) that are provided by private or public sector facilities or providers based on referrals from the IHS or tribal CHS program.

The IHS established the CHS program under the general authority of the Snyder Act, which authorizes appropriations for the "relief of distress and conservation of health of Indians." The IHS first published regulations in 1978.[3] These regulations were revised in 1990 to clarify the IHS Payor of Last Resort Rule and today, continue as the effective regulations for the operation of the IHS CHS program and are found at 42 CFR Part 136. Pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), tribes and tribal organizations may elect to contract or compact for the operation of the CHS program consistent with the CHS eligibility regulations. Approximately 52 percent of the CHS programs are operated by tribes and tribal organizations.

While the majority of services to AI/ANs are provided in IHS or tribally operated hospitals and clinics, the IHS and tribal programs authorize services by private or public sector facilities or providers pursuant to the CHS regulations when:

- a direct care facility is not available,
- the direct care facility is not capable of providing the required emergent or specialty care, or
- the direct care facility is not capable of providing the care due to medical care workload.

The IHS is a payor of last resort and CHS funds are authorized subject to the availability of alternate resources, such as Medicare, Medicaid, or private health insurance.

[3] In 1987, the IHS published final regulations revising the eligibility criteria for direct and contract health services to members of Federally-recognized Tribes residing in Health Service Delivery Areas. These regulations were intended to make the eligibility criteria for direct and contract health services the same. However, these regulations remain subject to a Congressional moratorium prohibiting implementation until such time as the IHS conducts a study and submits a report to Congress on the impact of the 1987 final rule.

The basic eligibility criteria for both direct care and contract health services requires that the person being served is of "Indian descent belonging to the Indian community served by the local facilities and program." For eligibility for direct care services, residency is not required in the particular Indian community where services are being sought as long as the person is a member or descendent of a Federally-recognized tribe. However, eligibility for CHS requires residency in a Contract Health Service Delivery Area (CHSDA), a geographic area defined by regulation or in statute, but in general, includes the reservation and the counties contiguous to that reservation.

CHS regulations require that request for services must be pre-approved by the local CHS review committee, consisting of clinical and administrative staff, and determined to be medically indicated and within medical priorities. If emergency services are provided by a non-IHS provider, notification must be made to the local IHS or tribal CHS service unit within 72 hours, or 30 days for emergency care provided to the elderly or disabled.

It is worthy of note that the often-quoted "Don't get sick after June 1st" statement stems from the time of year that CHS funding is depleted annually. The NIHB Board has embraced the creation of a foundation called "The June First Fund," which would offer Indian people a place to go for funding to access emergency and chronic health care financing that would otherwise be depleted by June 1st. This program is in its infancy and organizational structures are currently under consideration. While NIHB wholly supports sovereignty and recognizes the obligation of the federal government to provide adequate health care services to Indian people, it also recognizes that many Indian people die each year, have amputations that could be avoided and suffer needlessly—all because the federal obligation to provide health care services is not met.

Medical Priorities

Due to limited CHS funding, IHS and tribal programs are in most cases only able to authorize CHS funding under a medical priority system that gives most of the funding to the *Priority Level 1: Emergent or Acutely Urgent Care Services.* A review of the CHS medical priorities provides a picture of services authorized under the CHS program based on current funding levels versus what should or could be covered if the CHS program were fully funded. One of the major frustrations for tribal programs is the continual need to educate non-IHS providers that the CHS program is not an insurance plan and because of limited CHS funding not all medical claims for services can or will be paid. The priority system is outlined as follows:

Priority Level 1: Emergent or Acutely Urgent Care Services are defined as services that are necessary to prevent the immediate death or serious impairment of the health of the individual and that if left untreated, would result in uncertain but potentially grave outcomes. Examples of Priority Level 1 services are as follows:

- Emergency room care for emergent/urgent medical conditions, surgical conditions, or acute trauma
- Emergency inpatient care for emergent/urgent medical conditions, surgical conditions, or acute injury
- Renal dialysis, acute and chronic
- Emergency psychiatric care involving suicidal persons or those who are a serious threat to themselves or others
- Services and procedures necessary for the evaluation of potentially life threatening illnesses or conditions
- Obstetrical deliveries, acute perinatal care and neonatal care

Priority II: Preventive Care Services are defined as primary health care aimed at the prevention of disease or disability. For those IHS and tribal programs that are not able to provide screening and preventive services in direct care IHS or tribal facilities, authorization of preventive care services places additional burdens on the CHS program funding. Examples of the preventive care services include:

- routine prenatal care
- cancer screenings such as mammograms and screenings for other diseases
- non-urgent preventive ambulatory care
- public health intervention.

Priority III: Primary Secondary Care Services involve treatment for conditions that may be delayed without progressive loss of function or risk of life, limb or senses. Examples include:

- specialty consultations in surgery, obstetrics, gynecology, pediatrics, etc

- diagnostic evaluations and scheduled ambulatory visits for non-acute conditions.

Priority IV: Chronic Tertiary and Extended Care Services include such services as rehabilitation care, skilled nursing home care, highly specialized medical procedures restorative orthopedic and plastic surgery, elective open cardiac surgery, and organ transplantation.

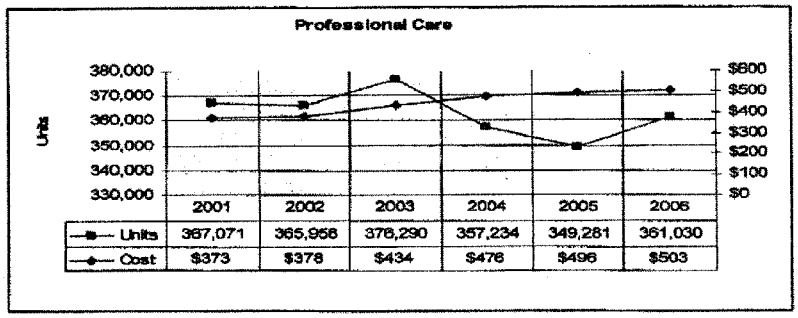
Priority V: Excluded Services such as cosmetic procedures and experimental services.

For AI/ANs beneficiaries, who do not have access to alternate health care resources such as private insurance, Medicare or Medicaid, health care services under the CHS program is limited to emergency or urgent care services, most of which is not guaranteed. For those of you on the Committee, would you tolerate health insurance coverage for you and your family limited to only emergency or urgent care? We think not: and it is not tolerable for those AI/AN beneficiaries dependent on the CHS for their health care needs not otherwise available in IHS or tribal facilities.

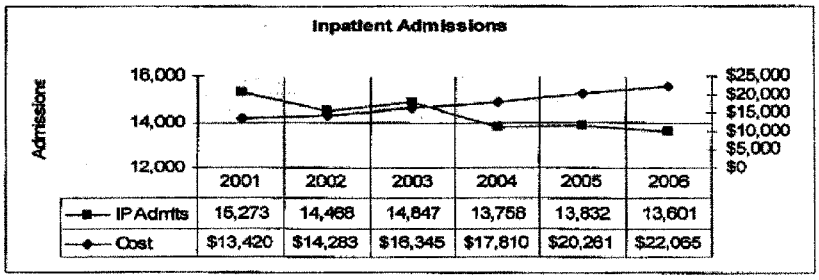
If the CHS program paid for other medical priorities like preventive care services, such as, cancer screenings, specialty consultations, and diagnostic evaluations, early detection and treatment of diseases or illnesses would result in substantial savings to the CHS program. But more importantly, lives would be saved and quality of life would improve. Without cancer screenings and diagnostic evaluations, life threatening illnesses go untreated and the patient dies or lives a short, painful life.

The Reality:

The IHS Budget Justification of Estimates for Appropriations Committees FY 2009, includes the following charts indicate that the annual medical costs continue to increase while the level of services provided annually is decreasing. This correlates with increases in the number of deferred and denied CHS services:



- From FY2001 to FY2006, CHS purchased professional services decreased 6,041 or 2% from 367,071 to 361,030 units.
- At the same time, costs per visit increased $130 or by 35% from $373 to $503.



- From FY 2001 to FY 2006 CHS Inpatient admissions declined by 11% from 15,277 to 13,601
- At the same time, inpatient billed costs per admission increased 64% from $13,420 to $22,065

The funding levels for the IHS CHS program have increased since 1990 but have not kept up with increases in health care costs:

CONTRACT HEALTH SERVICES
FUNDING LEVEL

YEAR	CHS	CHEF	/ *Threshold*	TOTAL	INCREASE	*% chg.*
1990	$ 225,647,000	$12,000,000	*$ 15,000*	$ 237,647,000	$ 20,193,000	9.29%
1991	$ 268,220,000	$12,000,000	*$ 15,000*	$ 280,220,000	$ 42,573,000	17.91%
1992	$ 296,589,000	$12,000,000	*$ 15,000*	$ 308,589,000	$ 28,369,000	10.12%
1993	$ 316,394,000	$12,000,000	*$ 15,000*	$ 328,394,000	$ 19,805,000	6.42%
1994	$ 337,848,000	$12,000,000	*$ 16,000*	$ 349,848,000	$ 21,454,000	6.53%
1995	$ 350,564,000	$12,000,000	*$ 16,900*	$ 362,564,000	$ 12,716,000	3.63%
1996	$ 350,564,000	$12,000,000	*$ 17,700*	$ 362,564,000	$ -	0.00%
1997	$ 356,325,000	$12,000,000	*$ 18,400*	$ 368,325,000	$ 5,761,000	1.59%
1998	$ 361,375,000	$12,000,000	*$ 19,000*	$ 373,375,000	$ 5,050,000	1.37%
1999	$ 373,801,000	$12,000,000	*$ 19,500*	$ 385,801,000	$ 12,426,000	3.33%
2000	$ 394,756,000	$12,000,000	*$ 20,100*	$ 406,756,000	$ 20,955,000	5.43%
2001	$ 430,773,000	$15,000,000	*$ 20,800*	$ 446,756,000	$ 40,000,000	9.83%
2002	$ 445,776,000	$15,000,000	*$ 21,700*	$ 460,776,000	$ 14,020,000	3.14%
2003	$ 457,139,154	$17,883,000	*$ 22,700*	$ 475,022,154	$ 14,246,154	3.09%
2004	$ 461,291,268	$17,778,206	*$ 23,800*	$ 479,069,474	$ 4,047,320	0.85%
2005	$ 480,318,065	$17,749,935	*$ 24,700*	$ 498,068,000	$ 18,998,526	3.97%
2006	$ 499,561,823	$17,735,177	*$ 25,000*	$ 517,297,000	$ 19,229,000	3.86%
2007	$ 525,099,000	$18,000,000	*$ 25,000*	$ 543,099,000	$ 25,802,000	4.99%
2008	$ 552,755,366	$26,578,800	*$ 25,000*	$ 579,334,166	$ 36,235,166	6.67%

Some Promises Met

The CHS program does save lives. In FY 2006, the IHS fiscal intermediary (FI),[4] Blue Cross/Blue Shield of New Mexico, processed 298,000 purchase orders and, after coordination of third party benefits, made payments of approximately $230 million. The payments were made for a variety of diagnosis such as: $45 million for injuries resulting from such incidents as motor vehicle accidents and gun shot wounds, $31 million for heart disease, $18 million for cancer treatment, $16 million for end stage renal dialysis, $6 million for mental disorders and substance abuse, and $4 million for pregnancy complications and premature births. These payments were made on behalf of AI/ANs who met the CHS eligibility criteria and medical priorities, in most instances, Priority Level 1: emergent or acute urgent care.

Underfunding and Its Unintended Consequences

Due to the severe underfunding of the CHS program, the IHS and tribal programs must ration health care. Unless the individual's medical care is Priority Level 1 request for services that otherwise meet medical priorities are "deferred" until funding is available. Unfortunately, funding does not always become available and the services are never received. For example, in FY 2007, the IHS reported 161,750 cases of deferred services. In that same year, the IHS denied 35,155 requests for services that were not deemed to be within medical priorities. In addition, in 2007, IHS was not able to fund 895 Catastrophic Health Emergency Fund (CHEF)[5] cases. Using an average outpatient service rate of $1,107, the IHS estimates that the total amount needed to fund deferred services, denied services not within medical priorities, and CHEF cases, is $238,032,283, as detailed below:

$20,058,448—CHEF
$179,057,250—Deferred
$38,916,585—Denied

This estimate of $238 million for annual unmet CHS needs is arguably a very low estimate. Further complicating this estimate is the fact that one of the unintended consequences of patients experiencing perpetual denials of needed health care services is that they will stop seeking care. Therefore, it is difficult to determine an ac-

[4] The IHS contracts with the FI to process CHS claims and make payments consistent with IHS CHS eligibility regulations and CHS payment policies. Nearly all of the tribes and tribal organizations that operate 52% of the IHS CHS programs do not use the FI for claims processing. Thus, the reports produced by the FI are based on claims from IHS operated CHS programs and only seven of the tribal CHS programs.

[5] The CHEF is administered by IHS Headquarters and pays for high cost CHS claims.

curate, aggregate CHS financial need because AI/AN patients learn from experience that it is futile to request services that they know will be denied or deferred. This estimate also does not capture deferred or denied services from the majority of tribally operated CHS programs (nearly one-half of all tribes). But more importantly, the estimated amount of unmet CHS needs does not capture all of the other requests for CHS services that were denied for what could be dubbed "bureaucratic reasons"; i.e., non-compliance with the CHS regulatory requirements, as indicated by the CHS FY 2007 Denial Report:

CONTRACT HEALTH SERVICES
FY 2007 DENIAL REPORT
AREA: IHS WIDE

22-Jan-2008

	A	B	C	D	E	F	G	H	
	Eligible But Care Not Within Med. Priority	Eligible But Alternate Resource Available	Patient Ineligible For CHS	Emergency-Notification Not Within 72 Hours	Non-Emergency No Prior Approval	Patient Resides Outside CHSDA	IHS Facility Available & Accessible	All Other Denials	TOTALS
AREA	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER	NUMBER
Aberdeen	9,116	17,463	2,409	774	3,357	2,565	3,969	1,398	41,051
Alaska	1,463	5,472	602	129	3,459	464	1,389	478	13,456
Albuquerque	2,078	4,448	223	220	66	1,180	186	256	8,657
Bemidji	572	1,909	872	964	1,930	617	626	1,811	9,301
Billings	6,707	4,740	1,227	236	3,577	1,529	3,118	187	21,321
California	318	1,308	352	303	274	25	13	7,532	10,125
Nashville	2,650	237	234	362	412	137	218	103	4,353
Navajo	2,654	16,247	229	1,311	523	602	2,026	2,779	26,371
Oklahoma	5,069	1,313	89	1,262	2,961	856	2,869	8,381	22,798
Phoenix	1,941	9,457	546	922	906	1,307	1,538	922	17,539
Portland	2,562	1,916	1,525	1,425	3,440	187	500	0	11,555
Tucson	25	1,535	93	125	14	173	1	11	1,977
TOTALS	35,155	66,045	8,401	8,033	20,919	9,642	16,453	23,858	188,504

Source: CHS Denial Report FY2007
Author: Contract Health Services, Office of Resource Access & Partnerships
Contact: Clayton Old Elk (301) 443-2694
CONTRACT HEALTH SERVICES

The FY 2007 CHS denial report indicates that over 16,000 CHS claims were denied because an IHS facility was available and accessible. While we don't know all the details of why these claims were denied, of the over 600 health care facilities operated by the IHS or tribes, only 46 hospitals have emergency room care. The health care provider vacancy rates at IHS facilities are 17% for physicians, 18% for nurses, and 31% for dentists. In addition, many of the IHS facilities are over 30 years old and do not have the necessary equipment and staff to provide many of the health services needed. When direct care services cannot be provided in an IHS or tribal facility, extra demand is placed on the CHS program funding and the facility loses revenue from third party payors. Many of the IHS and tribal facilities are located in very remote locations where transportation between a patient's home and the nearest IHS facility can be limited or non-existent.

Members of the Navajo Nation living in the community of Ganado, Arizona used to regularly receive denial of CHS claims until the IHS Navajo Area reached an agreement with the Sage Memorial Hospital, a non-IHS provider at the time, to provide services to 18,000 Navajo tribal members residing in the Ganado catchment area. Because the closest IHS hospital was approximately 40 miles away from Ganado, Navajo tribal members would seek treatment at Sage Memorial Hospital located in Ganado. The IHS Navajo Area would deny payment of these services because an IHS facility was available and accessible albeit 40 miles down the road. The IHS Navajo Area, using CHS funds, negotiated a contract with Sage Memorial Hospital to provide care to Navajo tribal members in the Ganado catchment. Tribal members no longer have to travel long distances for their health care and the local hospital receives payment for the care provided. This model might not work in all tribal communities but represents a 21st century approach to address the health care needs of the tribal members.

The FY 2007 CHS denial report indicates that approximately 21,000 claims were denied because the care provided was non-emergency and there was no prior approval. Again, we do not know the underlying facts for why these claims were denied. However, prior approval is required for non-emergency cases and that deter-

mination is made by a CHS review committee consisting of both clinical and administrative staff of the facility. But many of the claims could have been denied because the services were provided after-hours, (e.g., after 5 pm or over the weekend), when many IHS or tribal ambulatory centers are closed. For example, an Indian child could break his or her ankle playing softball on a Saturday. Under a prudent layperson's standard,[6] this would be considered an emergency. But the NIHB has heard from tribal communities that CHS claims are denied because a "broken ankle" is not considered an emergency. Where else in America would a parent hesitate to take their injured child to an emergency room for fear that the services would not be covered by their insurance? Many tribal clinics, such as the Oneida Tribe of Wisconsin, contract with local hospitals to provide services to its members during non-operational hours.

The FY 2007 CHS denial report shows that 66,000 CHS claims were denied because an alternate resource was available. Some Tribal Leaders object to the IHS Payor of Last Resort Rule because AI/ANs should not have to apply for other alternate resources, such as Medicaid, as a condition of receiving health services from the IHS—health care is a responsibility of the U.S. government. Unfortunately, the IHS is a discretionary program, with limited CHS dollars, and until it becomes an entitlement program, is dependent on the availability of other government programs, Medicare, Medicaid or the Veteran's Administration to supplement the CHS program.

Tribal CHS programs have expressed frustration with having to require its tribal members to apply for alternate resources. Due to income fluctuations, such as seasonal employment in the Alaska fishing industry, many tribal members are dis-enrolled from alternate resource programs, such as Medicaid, and then have to re-apply. This can be burdensome, especially for the elderly. Tribal members have expressed concerns that CHS claims are denied or payment is delayed due to coordination of third party benefits. Tribal members receive collection notices from providers for unpaid medical bills and this ruins their credit history.

There is grave concern in Indian Country that there is a trend of increasing denial of CHS claims which is compounded by the continued underfunding of the CHS program. The result: a failure of the Federal government to fulfill its trust responsibility to Indian people. A major influx of CHS funding is desperately needed to bring the CHS program into the 21st century; however, not all of the "problems" in accessing CHS is due to a lack of funding. The CHS eligibility regulations were promulgated thirty years ago; clearly, the delivery of health care in mainstream America has changed. The CHS regulations contain requirements such as prior approval, 72 hour emergency notification, and other regulatory requirements unique to the Indian health system. The regulations are complicated to understand both by the AI/AN patients and non-IHS providers. The CHS regulations were intended to limit the IHS's liability for CHS services, but, because the CHS program is so consistently, shamefully underfunded, CHS decisions are driven by the need to save costs to the detriment of AI/ANs ability to receive standard health care, which is preventing AI/ANs from living healthy lives. Other unintended consequences, include:

1. Poor credit ratings because of unpaid medical bills due to CHS denial
2. Self-imposed impoverishment in order to qualify for Medicaid
3. Unnecessary prolonging of pain leading to addictions, such as: painkillers
4. Helplessness and Depression
5. Untreated conditions can lead to chronic illness that leads to disability
6. Providers refuse to see AI/AN patients for fear of not being reimbursed for services
7. Community economic loss due to prolonged injury or illness that prevents one from working

Chairman Dorgan, I know your Committee has received many letters from Tribes identifying CHS issues in their particular community. For the record, I have included as part of my testimony, two letters submitted by our Board members representing the Bemidji and Billings Area that tell their personal stories and reflect many of the same concerns expressed in this testimony.

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[6] An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The Alaska Perspective

In addition to being the Chair of the National Indian Health Board, I am also the chair of the Board of Directors of the Bristol Bay Area Health Corporation (BBAHC), a co-signer of the Alaska Tribal Health Compact which provides health care to Alaska Natives in the 45,000 square mile Bristol Bay service area and operates the only inpatient hospital in the region near Dillingham, Alaska. From my service with BBAHC, I am well aware of the severe impact which the shortage of contract health service funding has on both the IHS and tribally-operated health programs in rural areas, especially rural Alaska.

In Alaska they tell a story about a federal official who telephoned to an Alaska Native health care program and asked why, when you send patients to the Alaska Native Medical Center (ANMC) in Anchorage, you always send them by air. Why don't you send them by car? The official did not understand that in many parts of Alaska there are no roads. We do not have roads between the Kanakanak Hospital near Dillingham and many of the villages where we operate out-patient clinics or regional clinics. There is no road between Dillingham and Anchorage where the IHS-funded Alaska Native Medical Center (ANMC), the tertiary care facility serving Alaska Natives throughout Alaska, is located. We are separated from Anchorage by a range of snow-capped mountains, and air travel is the only way we can send patients there or to any other hospital facility.

Although much of our tertiary care is provided by the IHS-funded ANMC, what is often overlooked is that our budget must cover the cost of patient transportation to Dillingham from the villages and to Anchorage from Dillingham. In fact, the entire contract health care budget which we presently receive is consumed by transportation costs. In FY 2007, BBAHC spent $425,000 in regular seat or charter fair for non-emergency cases plus an additional $1,200,000 in Air Medivac costs. This cost was up $250,000 from the previous year and, given the rising costs of air travel, it can be expected to continue to climb. There has been no adjustment in our contract health funding to enable us to meet these increases. BBAHC has been covering the differences between the CHS funding received verses costs expended. For instance, in FY 2007, the BBAHC received $564,000 in CHS funding plus the $111,000 for Medivac funding and expended the $425,000 in regular seat or charter fare for non-emergency travel and $1,200,000 in Air Medivac costs for a difference of $951,000.

There are, of course, many factors affecting our budget that makes the high cost of patient travel even more serious than it seems in isolation. For example, there is no adequate provision for maintaining our out-patient clinics. These are provided to our program through a system called "village built clinics." Our member villages are relied upon to obtain funding for the construction of out-patient clinics. The clinics are then leased by the villages to the IHS which makes them available to BBAHC to operate through the Alaska Tribal Health Compact. The villages remain responsible for maintenance and, in theory, they are provided with the funding for maintenance through the rental payments from IHS. This system applies to 169 village-based out-patient clinics in rural Alaska.

While this system enabled us to replace a number of drastically deteriorated clinic facilities and to provide clinics in some remote villages where there were none, it has not adjusted to the rising costs which affect maintenance and repair as well as air transportation. The total amount provided by IHS in rental payments to the BBAHC villages in FY 2008 was $3.7 million, the same level it has been at for l9 years. A recent analysis shows that this level of funding covers only 55 percent of the actual cost of maintaining these facilities. In addition, IHS provided these payments unusually late this year and at least one of our clinics was threatened with closure due to the absence of maintenance funding. We understand that this problem is not directly related to contract health care, but the increased costs cut across-the-board. To the extent that BBAHC must divert funding from providing health care to patient transportation or to keeping clinics operational, the quality of our direct patient care is impacted. We have made a priority request to the Appropriation Committees to increase the Village Built Clinic lease program funding by $3,000,000 in FY 2009 (with an additional increase of $2,000,000 by the end of five years).

On top of this, we should note that for many years the IHS has not funded, in accordance with federal law, the administrative costs of our program as required by section 106 (a)(2) of the Indian Self-Determination Act. This provision was intended to assure that tribes are able to have at least the same level of resources that the IHS does in providing health care by assuring that activities which tribe must perform (which IHS does not) or which are paid for by sources other than the IHS budget are fully funded in self-determination and self-governance agreements. Again, this is not an issue that might seem related to contract health care, but it

is. In a variety of different ways the federal government is not providing BBAHC, as well as many other tribal and Alaska Native health programs throughout the United States, with financial support reasonably related to the purposes sought to be achieved and, in some case, required by law.

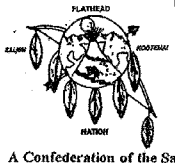
Recommendations:

Before I conclude my testimony, I do not want to leave the impression that the CHS program is beyond repair—it provides access to vital services that the IHS and tribally operated programs cannot provide in their facilities. But I would like to take this opportunity to provide the Committee with the Board's recommendations for improving the CHS program. I offer the assistance of the NIHB staff in implementing these recommendations and providing the Committee with any additional information or analysis.

- Hold field hearings in all areas of Indian Country.
- Require the GAO to conduct a study on CHS:
  - —Billing and reimbursement rates paid by CHS programs and comparison of reimbursement rates paid by other providers of health services
  - —Accessing health care after-hours
  - —Number of unpaid medical bills of AI/AN
  - —Study to measure the correlation between medication addiction and the rate of denied CHS services.
  - —Credit scores and impoverishment resulting from CHS denials
- Work through the Medicare Graduate Medical Education Program to achieve lower health professional vacancy rates and improve infrastructure at direct care sites
- Create charity partnerships
- In consultation with Tribes, update the CHS regulations
- Congressionally mandated CHS Advisory Committee, of which 51% would be Tribal leaders. Other suggested members should be the IHS Director, the Chair of MedPAC, provider groups, and academics proficient in health system structural reform.

I appreciate the opportunity to present testimony on behalf of the NIHB on CHS issues in Indian Country. We appreciate your leadership in bringing these issues forward for discussion. There is much work to be done and as always, Tribal leaders support your endeavors to improve the CHS program and the health of Indian Country.

Attachments



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A Confederation of the Salish, Upper Pend d'Oreilles and Kootenai Tribes

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Reuben A. Mathias
Charles L. Morigeau
Terry L. Pitts

May 29, 2008

Honorable Byron L. Dorgan
Chairman, Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington DC 20510
VIA FAX: 202-228-2589

Re: Contract Health Services Program of the Indian Health Service, U.S. Department of Health and Human Services

Dear Senator Dorgan:

On behalf of the Salish, Kootenai, and Pend d'Oreille people of The Confederated Salish and Kootenai Tribes (CSKT), it is my duty to provide comments regarding the Contract Health Services Program of the Indian Health Service. The CSKT extends its appreciation to you for providing this opportunity, and we commend you and the Committee for your commitment to improve health care services and health status for American Indians and Alaska Natives.

The CSKT's homeland is the Flathead Indian Reservation in northwestern Montana. Under the 1855 Hellgate Treaty, the Salish, Kootenai, and Pend d'Oreille people ceded over 20 million acres of indigenous territory in exchange for a permanent homeland of 1.3 million acres. At present, there are approximately 7,200 enrolled CSKT members of which two-thirds reside on the Reservation.

Since October 1993, the CSKT has operated its health care delivery system through funding agreements with the Indian Health Service under the Indian Self-Determination and Education Assistance Act, as amended. At present, the CSKT is serving an estimated user population of 11,085 (as of FY 2007) with total annual expenditures of approximately $16.5 million (IHS funding, grant funding, and third-party collections). ***This is an average of $1,500 annually per user, and is far below the amount per user spent by Medicaid, Medicare, Veterans Administration, mainstream health insurers, and for persons incarcerated in federal prisons.***

Since the establishment of the Reservation, health care has been provided to our Indian people largely by the private sector. By 1955 when the Indian Health Service was established, it

continued the trend of purchased care through Contract Health Services (CHS). There has never been an Indian Health Service hospital on the Flathead Reservation and perhaps never will be under the current funding and methodology for construction of health care facilities. Therefore, the majority of the Indian Health Service user population has received primary, specialty, and hospital care through CHS-purchased services from the private sector. There are two hospitals on the Reservation (St. Luke's Hospital in Ronan, Montana and St. Joseph's Hospital in Polson, Montana) and four hospitals near the Reservation (Kalispell Regional in Kalispell, Montana; St. Patrick's Hospital and Community Medical Center in Missoula, Montana; and Clark Fork Valley Hospital in Plains, Montana).

In October 1993 the CSKT began operating all programs, functions, services, and activities that had been carried out by the IHS Flathead Service Unit, including Contract Health Services. However, the demand for CHS-purchased services and the continual increase in CHS expenditures—which was not matched by increased funding—forced the CSKT to return the CHS program to IHS in October 2005. By that time the CSKT was spending twice as much for CHS—$17 million—as was allocated. For several years the CSKT attempted to resolve the issue with the Indian Health Service but ultimately, retroceding the CHS program was the only option. To date, CHS remains the only program ever returned to federal management by the CSKT after we had assumed it under self-determination or self-governance.

Some of the specific examples of how Contract Health Services is not adequately serving our user population are described below:

- **Sleep apnea untreated (50 cases)** – The Indian Health Service, CHS does not pay for sleep studies nor the C-pap therapy prescribed after the sleep study. This would save lives – patients would not need to wait until their situation became "life threatening".

- **Denial of MRI's and CT scans (450 cases)** – The IHS, CHS has denied payment of MRI's and CT scans leaving the patient without a diagnosis and leaving the patient in pain; and for some patients, the inability to go back to work because of the pain and the inability to use their limbs. Many times, the patient is prescribed pain medication and some become addicted to the pain medicine. This in itself has caused many problems and additional funding is needed to take care of this addiction problem. Surgery may be required, but without the appropriate testing this cannot be determined.

- **Denial of cholecystectomies (30 cases)** – The IHS, CHS continues to deny these because they are not "life threatening" conditions, but IHS, CHS will pay for the inpatient hospitalizations and emergency room visits related to this condition that the patient requires to mitigate the condition and the dollars expended amount to more than the amount that the surgery would have cost. In the meantime the patient's health and well-being is compromised because this truly can be a debilitating disease. Patients lose many hours of work because of being sick.

- **Denial of cardiac rehabilitation, physical therapy, and occupational therapy (25 cases)** – The IHS, CHS won't pay for therapy before surgery to prevent surgery, nor after surgery, leaving the patient in a situation whereby he could lose his life or limb. Surgeons are telling us they are very concerned with 'quality of care' issues and for the well-being of the patient without these therapies. In fact, surgeons don't want to care for these patients if the patient cannot get the full spectrum of care. The CSKT's Tribal Health Department was recently notified by an orthopedic provider off the Reservation that they would no longer accept any new patients whose primary insurance is IHS or Tribal Health, noting "It has become apparent through conversations with staff at Tribal Health as well as IHS that orthopedic care is not a priority for IHS" and "...given our physicians do not feel that they have been allowed to exercise their best clinical judgment in caring for these patients, we have no choice but to suspend working with IHS and Tribal Health as health care payers." (April 13, 2008 letter from Missoula Bone & Joint Surgery Center)

- **Denial of diagnostic testing if not "life threatening" (125 cases)** – Without testing, many cases of life threatening circumstances have gone undiagnosed until it is too late and the patient either passes on or lives a very short, painful time. Colonoscopies are recommended, nationwide, for individuals age 40 and over. The IHS, CHS has denied payment for these diagnostics.

- **Denial of minor surgical procedures (25 cases)** – The IHS, CHS won't pay for tonsillectomies, adenoidectomies, or ear tubes for children and adults. As a result, the children are sick often and they cannot function at school nor can they join in activities that other children are doing. With all the programs that exist to encourage our children to stay in school and to do their best, chronic tonsillitis can be very debilitating and does cause a lot of absenteeism. Also, there are many documented cases of children with speech delays due to abnormal tonsils and adenoids which further cause problems with development.

- **Denial of specialty care services (1,150 cases)** – With healthcare becoming specialized, the primary care physicians (PCP) increasingly refer patients to specialists for further testing, diagnoses and treatment. The IHS, CHS has denied payment for such referrals.

- **Denial of Skilled Nursing Home Care** – The IHS, CHS does not pay for and will not supplement Medicare with Skilled Nursing Home Care days, leaving our most fragile population, our elders, in an unsafe environment. In the past, families took care of their parents and grandparents, but in this new day families have had to rely on nursing homes to help with the care of their elders. These elders do not have alternate resources, i.e., Medicaid, available to them because of over-resource and/or income. With every hospital admission our elders can potentially become a skilled nursing home patient so this number constantly varies.

Between April 2007 and January 2008, the CSKT underwent a long-term strategic planning process in order to effectively plan for health care needs for the next decade. The results of the planning process recommended that we expand the primary care services we deliver in our Tribally-operated program because we have a better opportunity to serve our population's needs rather than the current CHS-dependent scenario. However, the strategic concept requires over $80 million to construct, equip, and staff two facilities. The concept is successful if third-party collections can increase to offset the cost of providing more health care services. But until that concept can be implemented, the CSKT must continue under the current inadequately funded health care delivery system. In that respect, we strongly advocate for substantial increases in the amount of CHS funding appropriated by Congress. The enacted FY 2008 amount of $579 million is only half of the need. For the last seven years, Contract Health Services has been the number one priority expressed by the tribes served by the Billings Area as part of the annual IHS Budget Formulation process. These tribes are located on the seven Reservations in Montana and the one Reservation in Wyoming. In this two-state region, only two Indian Health Service hospitals are in operation—at Crow Agency, Montana and at Browning, Montana. For that primary reason, there is a significant need for CHS-purchased services for the more than 70,000 eligible Indian users in the Billings Area.

The CSKT thanks you and the Committee for your consideration of our comments. We look forward to continued dialogue and discussion to resolve the urgent issue of health care needs for all of Indian country. Please contact us if you have any questions.

Sincerely,

THE CONFEDERATED SALISH AND KOOTENAI TRIBES

James H. Steele, Jr., Chairman
Tribal Council

Copied to:
Senator Max Baucus
Senator Jon Tester
National Indian Health Board
Montana-Wyoming Tribal Leaders Council
Self-Governance Communication and Education Project
IHS-HQ – Mr. Robert McSwain, Director, Indian Health Service
IHS-BAO – Mr. Pete Conway, Area Director, Billings Area
CSKT – Kevin Howlett, Tribal Health Department Head

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June 23, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Dorgan,

I would like to extend my thanks for your interest and intent regarding the hearings on the Contract Health Services program.

I represent a small newly reaffirmed Tribe located in the northwest lower peninsula of Michigan, the Little River Band of Ottawa Indians. Our tribe operates a small ambulatory clinic with one full time provider and two full-time registered nursing staffs providing primary family practice medicine to eligible American Indian/Alaskan Natives. In addition to family practice medicine, we operate Contract Health Services for those specialty services we do not currently provide at our clinic site, including inpatient hospital and other medically necessary services upon referral of the primary provider.

I agree; CHS is not working well in Indian Country. We have assessed the programmatic requirements for the utilization of CHS funds against the needs of our community and have found the two are on the far ends of the spectrum. This is primarily due to the designation of priority category I health issues that drive the types of care patients seek. The program is centered on disease treatment at its most extraordinary costs; imminent threats to life and limb. In light of this, funding preventative health initiatives, that diminish the occurrence of these catastrophes, are not within the parameters of current program administrative mandates. This is archaic in this century. Indian Country and our community specifically, need the flexibility to address preventative medicine that reaches beyond immunizations and dental sealants; we need to have the flexibility to purchase services that diagnose disease in its earliest stages, when treatment options may assist with preserving the quality of life of our people.

Dr. Charles Grim, past Director of Indian Health Services put forward three initiatives for Indian Health Services creating a network of delivery focus integrating medical case management targeted at significant problems in Indian Country. All of those initiatives are preventative in nature and the current structure of CHS funds obligated to pay for services under priority I definitions does not embrace these initiatives as part of the overall picture of health care coordination. In fact, according to the defined parameters set forward in regulation, the chronic care model that speaks to our most significant disease processes and necessary management activity falls outside the primary life and limb priority therefore, case management costs become the responsibility of the patient. This is due to the lack of adequate available funding and the allowable cost categories under CHS. If we are truly expected to case manage chronic health conditions, Tribes need the flexibility to pay for those services as part of an integrated primary care treatment plan. We simply do not have the available staff or the coordinating CHS resources to adequately address chronic disease management intervention which may be deemed "not medically necessary." Instead, we may pay for services when the patient reaches significant disease process and end up in emergent/critical care, when the burden of cost is extraordinary instead of part of effective chronic disease management. Why should we continue to pay for services that are the most expensive, when we should be able to engage our patients in a treatment planned process of case management?

Behavioral Health is yet another challenge; we have a lack of available professionals that will accept our patients in the private sector and case coordination is non-existent through our community health care networks. As we examine the program dynamic, and apply the available services operated by Tribal facilities, collaboration is difficult. In our area, crisis management is the nearest available emergency room and this is ineffective. Long term patient centered treatment plans do not generate out of the emergency rooms, and available collaborating agencies are short staffed. In light of a call for behavioral change which takes longer, intensive treatment objectives, we are limited to the number and types of visits we can assist. Little River Band's funding pool is less than $600,000 for all CHS encounters, including Substance Abuse/Mental Health treatment. We are often faced with making the choice between medically significant management of threats to life or limb and treatment of behavioral health issues. As a result, behavioral health and substance abuse counseling costs always take a backseat. Locally, we have one available psychiatrist to address the needs of a three county area. The management of psychiatric conditions falls to our physician, who is not counseling the patient in the course of their care. The primary physician must refer to other services. Referrals are often four to six weeks out for psychiatric services, and its back to the emergency room for crisis management. Little River Band recently implemented drug testing as part of our chronic pain medication pharmacy management plan. We began

urine spot testing our patients receiving pain medications as part of an agreed pain management compliance with the following result:

- From a period beginning January 1, 2008 through February 25, 2008, 155 patients were seen in clinic operations and testing for pain medication therapeutic levels. Of the 155 tested, 146 tested positive for illicit drugs, and did not test appropriately for the medications prescribed in their treatment plan.

At 95% of the tested population findings outside of an accepted parameter, we can assume that we have similar issues within our community not seeking treatment locally. For our behavioral health/substance abuse program, we are overwhelmed by our findings. This speaks to the need for increased dedicated funds in either substance abuse/alcohol treatment or CHS dollars that can be utilized to assist Tribes in securing appropriate treatment options.

Health promotion/disease prevention activities fall well outside priority I health criteria. Tribes are expected to submit competitive grant proposals to meet these needs. Smaller tribes like ours often cannot submit grant applications that meet the criteria requested in the RFP, and we do not have the implementing resources to assist with grant objectives. Staffing is a constant factor in health promotion/disease prevention activity; registered nurses are providing diabetic education, nutritional counseling and performing foot clinics as contracting those services is costly. Funds often must be detailed to other types of medical cost, leaving little room to address favorable medical outcomes from a preventative medicine standpoint. It is difficult to provide health promotion teaching when the bulk of the day for our providers and nursing professionals is spent doing patient care. There has to be a change in the mandates of CHS and priority I defining criteria; Indian Country needs to be able to pay for case management that meets health promotion/disease prevention centered planning for optimum patient outcomes. If we are truly embracing the informed, engaged patient model, the patient needs to be able to access services before disease becomes a chronic management model.

Senator, I would like to relate this to a few of my own experiences as a Health Director with program oversight responsibilities, and a significant occurrence in my family. First, let me relate the CHS issue from a Health Directors perspective.

Often, our clinic operation must schedule out patient visits; we treat acute issues giving special priority to children and elders. However, in some instances, we must triage our clinic visits to accommodate those with scheduled appointments, working in our most significant cases as we identify them on a walk-in basis. It is unacceptable

that we are forced to direct some of our cases to emergent care, simply due to the number of patients with pre-scheduled appointments, the types of visits scheduled and a lack of adequate diagnostic tools to assist the physician. It is not uncommon for our clinic physician to direct a person away from our facility if during triage, it is determined that the reported symptoms may be more extraordinary. The difficulty is upon receipt of the patient records from the emergency room, and the issue is not life or limb specific; bronchitis versus cardiac, sprained ankles versus broken bones or ear infection versus stroke. This is not to say that our professional staff does not know how to triage; this is the effort to respond to patient concerns in a manner that provides the most immediate diagnosis to the symptoms we are presented. As we do not have many of the diagnostic tools on site, we are forced to send out the patients. However, when the notes are sent to CHS for payment consideration, and the matter is not life or limb, the costs are usually denied. When our clinic operation is closed, after 5:00 p.m. and during weekends, the emergency room becomes our urgent care provider. We experience the same issue; the care delivered in the emergency room does not meet priority I criteria for payment. This forces the patient to incur out of pocket costs, or in some instances, sends them into collections as they do not have the means to pay for the treatment.

Our CHS program works diligently to seek reduced treatment fees either prior to approved treatment costs or after the care has been administered. We are not always successful in securing reduced rates and it is not uncommon for a provider to seek pre-payment for some referred services, as CHS is not an insurance benefit. Providers are reluctant to accept CHS payment arrangements in some cases, and this delays patient treatment. This year, we had this unfortunate occurrence as we sought treatment for a cancer patient with an aggressive form of breast cancer in a 45 year old patient of record. Our primary provider referred the patient to an oncologist who was out of the insurance carrier network; in our area oncologists rarely participate with an insurance group. The oncologist requested a $3,000.00 deposit from the patient before they were willing to begin necessary chemotherapy and radiation treatment to reduce the tumor prior to surgical intervention. The patient, who had Blue Cross/Blue Shield insurance, was requested to provide this payment as this was part of the fee for services, and the provider required the patient to balance bill the insurance assignment. We worked with the patient to secure an estimated treatment cost plan, coordinated with the alternative resource, and ultimately through CHS funds, sent the deposit that was requested by the provider so she could commence her therapy. After the treatments were completed, the patient was referred for surgical intervention that included reconstructive treatment. We requested a treatment plan, with estimated costs and the probable level of coordinating benefits to meet the costs. The provider, a non-BC/BS participating physician, reduced some of the fees, but the hospital did not. CHS was accessed by the patient to pay the uncovered costs. During the time we were waiting for coordinated explanation of benefit reports, the hospital began the collection process on the patient due to lagging payments. Accessing the CHEF fund was not an option to our CHS program as the funds were

depleted by the time this patient's treatment occurred. This is not an isolated occurrence in CHS program administration; any Health Director can relate a similar story to you from their community. The tragedy occurs when the patient, who should have access to medically necessary potentially lifesaving treatment must rely on a discretionary program fund. As Native American citizen of the United States, promised health care by treaty obligations made in good faith, the uncertainty of the continuance of program dollars should not influence the access to appropriate treatment. The effort to become well should not be compounded by the fear and worry that treatments will be stalled or discontinued, their life and livelihood desecrated, all for the lack of appropriate funding to purchase health care at a level enjoyed by mainstream America.

I would like to relate a personal story to demonstrate how important CHS is to my family; or rather, how CHS funds are prioritized by persons with significant disease issues who have the ability to pay. My daughter, who is nine years old, was diagnosed with Type I Juvenile diabetes on February 27, 2007. I will never forget that date as our entire family's existence was turned upside-down. No one more than my daughter. I provided a small snippet of her story during the national budget consultation that same year. My daughter is a jingle dress dancer, and her only concern was her ability to continue to dance for her people. Part of the untold story, is the decision that I made with my husband, regarding her treatment costs and accessing CHS funds at our Tribe; we decided to leave those funds for persons who had no means to assist with medical costs, rather than deplete the pool. This was not a noble gesture; this is how I was raised as an Indian person. When a person has the means to support themselves, it is inappropriate to take from others who do not. We made this determination not knowing what the costs would be, if there would be complications or other extraordinary issues as a result of her disease management. Fortunately, she is doing well on her intensive therapy, which is being assisted by an insulin pump. The shocking aspects are the costs which have been covered by insurance or paid for out of pocket. As I relate this, keep in mind, most Indian people would not have access to these items under a CHS program benefit as the costs would be prohibitive. Therefore, access to the most effective diabetes control treatment would most likely be unavailable to the typical CHS beneficiary. The insulin pump was over $5,000.00, and the necessary pump infusion support equipment is $900.00 per month. Her insulin costs are $60.00 per month for the insurance co-payment. Due to the nature of her disease, we have a blood keytone monitor, which costs $70.00, and the strips to perform the tests if her glucose levels are high to monitor her for ketoacidosis are $40.00 for 10 testing strips. The monitor for blood glucose costs approximately $60.00, and testing strips for her to maintain a testing regimen of 5 times per day are $150.00 per month. There are other related costs; pediatric endocrinology specialty practice fees, travel to and from appointments at the children's hospital 130 miles one-way ground travel, wages/missed time to attend appointments and the

fees associated with the treatment visits, which include diagnostics testing every time. If we were to seek payment for these costs, this would be a significant drain on the limited funds at our Tribe. Further, there are other children with this same disease in our Tribal community, who are reliant on CHS to pay their treatment costs, and they are not accessing insulin pump therapy. Consequently, their control is not as consistent as it could be, and the number of needle sticks on a daily basis for them is significant. Prior to our decision to seek insulin pump therapy, my daughter endured 10 needle sticks per day; the pump allows her to place an infusion set once every three days, eliminating 5 corrective dose injections daily, in addition to her testing regimen. I cannot relate the significance of that to you; her self-esteem, coping and overall psychological well being improved dramatically as a result of eliminating the fear of "getting the shots" all the time. Her hemoglobin A-1c test levels demonstrate she is in better control of her diabetes. This treatment option, infusion pump therapy, should be the standard in Indian country for Juvenile diabetes treatment. Unfortunately, it is not.

It is my belief that CHS should support all of these costs, so any Indian person can access the treatment that will support the best patient outcomes, but the current level of funding will not allow it. If there would be one compelling testimony resulting in change for the CHS program, Senator Dorgan, I would respectfully ask that treatment access for Native Americans be funded at a level such that any child's family would not have to face having a decision made for them by a CHS administrator to be able to seek the most effective methods of treatment, over the most cost effective to stretch program dollars. I would respectfully request that Health Directors be allowed the ability to seek preventative medicine interventions instead of authorizing payment for amputations. I would respectfully request that Congress and the President recognize that we must move CHS into the 21st century by providing adequate funding to address the level of need in Indian Country. I would respectfully ask for what was promised by treaties, made in good faith, by the ancestors of people who are asking today for the ability to control the destiny of the quality of life of their people.

Senator Dorgan, I thank you for your attention to this letter, your interest in Our People and expressing your sincere concern and commitment to improving Health Care for Native Americans and Alaskan Natives; our fellow American citizens.

Respectfully Submitted,

Jessica L. Burger, RN
Health Director
Little River Band of Ottawa Indians

The CHAIRMAN. Ms. Smith, thank you very much for your testimony. We appreciate that.

Next, we will hear from Marlene Krein. Marlene Krein is the President and CEO of Mercy Hospital in Devils Lake, North Dakota, a wonderful institution that I have visited many times. She will share insights from a private provider that is often forced to cover the costs of care provided to American Indians when the Contract Health Service program denies their claims.

Ms. Krein, thank you very much for being with us. You may proceed.

STATEMENT OF MARLENE KREIN, PRESIDENT/CEO, MERCY HOSPITAL

Ms. KREIN. Thank you, Senator Dorgan. I appreciate the opportunity to speak before this Committee and tell you some of our stories of how we serve the Native Americans.

We are a faith-based hospital and our values speak for human life and community service. We are located near Spirit Lake Nation, which has approximately 7,000 members. We have served the lake region community for 106 years. This also includes the Spirit Lake Nation. I do want you to know that I have not been there 106 years, but just 35.

[Laughter.]

Ms. KREIN. It is well known that the Indian Health Contract Service has not been funded adequately. Fort Totten has an IHS clinic with limited services. They are open Monday through Friday, 8 a.m. to 4:30 p.m. During after hours, holidays and other days when they are closed, the people of Spirit Lake Nation come to Mercy Hospital for much of their primary care. IHS only pays for priority one and the rest is left unpaid. Currently, we write off approximately $200,000 a quarter for IHS service in our emergency department.

As a small rural provider, we are disproportionately impacted by the lack of payment for provision of services that are clearly a Federal obligation. In January of 2008, we assumed responsibility of staffing the emergency department 24/7 when the physicians from the local clinic said they would no longer cover the ED during their office hours. This has increased our costs considerably and now it is up to about $1 million for staffing in the emergency room.

In August of 2000, I had the privilege of testifying before this Committee at a field hearing in North Dakota. What has changed is the number of Native Americans we serve in the emergency department and it has resulted in larger unpaid bills. I have been an employee of Mercy Hospital for 35 years, and the CEO since 1984. In the beginning of my tenure when the bills were not paid, I turned to Senator Burdick to ask for help. As the years went by and the unpaid dollars increased, I then turned to Senator Dorgan and Senator Conrad. I very much appreciate all that these Senators have done and do.

I do understand that IHS does not pay for anything except priority one in the ED, but that leaves me in a difficult position with the limited hours of the clinic being open. When there is a need, the people of Spirit Lake Nation have nowhere to go except to the Mercy Hospital Emergency Department. We serve them because we are called to from our heritage and government regulations.

A few years ago, I decided I needed to be part of the solution, not a part of the problem, and began meetings. I have met with people at the IHS Spirit Lake Health Center, Spirit Lake Tribal Council, the IHS Aberdeen Area Office, and over the years I have had numerous meetings in Washington, D.C. as well. At one time, the IHS clinic was looking into staying open longer hours. Their budget was several million dollars because they would need to hire an entire new staff of physicians, nurses, lab and X-ray technologists, et cetera.

The issues remain, and every time there is a suggestion, and there have been very many, there is a roadblock by IHS, the tribe or the government. I have nowhere else to go except to you for help. It is my responsibility to ensure that Mercy Hospital remains open to serve the people of the lake region, which certainly includes members of the Spirit Lake Nation. We have a close relationship with many of the tribal members as they were born at our hospital, and through the years they have put their trust in us. We appreciate this and consider it an honor.

We also know a solution must be found so that we can continue to serve. I believe we can all agree there is a problem with expected care and payment. It may be my pragmatism, but I believe we, you and I, the government and Mercy Hospital have a shared responsibility to see that the people of the Spirit Lake Nation have access to health care 24/7 and that Mercy Hospital is compensated.

After considerable thought and several avenues that I have tried through the years, I believe it is necessary for IHS to contract with Mercy Hospital for $500,000 per year for all after-hours care. The needs of Spirit Lake Nation and Mercy Hospital will be met, and Mercy Hospital would still be providing their share of charity care.

Thank you for hearing my story, and for any assistance you can provide.

[The prepared statement of Ms. Krein follows:]

PREPARED STATEMENT OF MARLENE KREIN, PRESIDENT/CEO, MERCY HOSPITAL

History of Mercy Hospital of Devils Lake, North Dakota

The Sisters of Mercy arrived in Devils Lake in 1895. Rev. Vincent Wehrle, O.S.B., had purchased the old public school and moved it across from the church. Farmers from around the county helped by digging and hauling stones to secure its foundation. The old school was renovated into a hospital with two wards and eleven private rooms. The hospital was named in honor of Wehrle—St. Vincent de Paul Hospital. Bishop Shanley dedicated the building on October 20, 1895, and the first patient was admitted on November 3, 1895.

As the town grew, it was soon evident the size of the hospital was inadequate. The Sisters purchased eighty acres of land on the highest point in northeastern Devils Lake, and built a new hospital. The cornerstone of Mercy Hospital was laid in June of 1902, and the first patient was admitted on June 6, 1902. The new hospital had three wards and twenty-five private rooms.

Through the years Mercy Hospital has re-invented itself to meet the changing needs of the times in health care. In 1974 Mercy Hospital was a 115 bed acute care hospital, in 1992 Mercy Hospital right-sized to 50 acute care beds, and on January 9, 2008, became a 25 bed Critical Access Hospital, with a very active Emergency Department, seeing more than 950 patients per month.

Just as the Sisters served the community, 106 years later we hold that commitment in trust. As a Catholic Health Initiatives hospital, we honor the mission the Sisters and CHI have entrusted to us.

Mercy Hospital Emergency Department and Spirit Lake Nation

Mercy Hospital of Devils Lake, North Dakota is a 25 bed CAH located in an agriculturally based market. We serve a primary service population of approximately 15,000 people. Approximately twenty-five percent of the primary service population is Native Americans. This segment of the population presents special, significant, underfunded service requirements.

Mercy Hospital has a high Medicaid payor mix related to a large local indigent population, and has faced long term non payment issues with Indian Health Services for the ED. Fort Totten has an I.H.S. clinic with limited hours of service with no after hours care available on week days, weekends, holidays and when providers are not present. Because the clinic hours are limited, the people of the Spirit Lake Nation often choose to use the Mercy Hospital ED, not only for trauma care, but their primary care. The burden to Mercy Hospital, however, is significant because I.H.S. pays only for Priority One care in the ED. We understand this and because

of this non payment, a significant portion of total reported charity is rendered annually to this group of patients. We write off approximately $200,000 a quarter for ED care for I.H.S.

On January 1, 2008, Mercy Hospital assumed responsibility of staffing the ED 24/7 when the physicians from the clinic in Devils Lake stated they would no longer cover the ED during their office hours. This increased our ED costs considerably to about $1 Million per year, increasing the burden of unpaid ED services provided.

I had the privilege of speaking before the Committee on Indian Affairs field hearing in North Dakota on August 4, 2000. At that time I.H.S. was not adequately funded, and service to the Native Americans in our ED was about 40% of our total volume.

In 2000 Mercy Hospital ED had 8,466 visits a year, and in 2007 the ED visits had increased to 11,123. To date in 2008 we see as many patients, with small increases.

Solutions

I have been an employee of Mercy Hospital for 35 years, and the CEO since 1984. In the beginning of my tenure, when the bills were not paid, I turned to Senator Burdick to ask for help. As the years went by the unpaid dollars increased, and I then turned to Senator Dorgan and Senator Conrad. I do understand that I.R.S. does not pay for anything except Priority One in the ED. But, that leaves me in a difficult position, with the limited hours of the I.H.S. clinic being open. When there is a need, the people of the Spirit Lake Nation have nowhere to go except to the Mercy Hospital ED. We serve them because we are called to from our heritage, and Government regulations.

(See attached report of Mercy Hospital Uncompensated Services to Native Americans 2001–2007)

A few years ago I decided I needed to be a part of the solution, not a part of the problem, and began meetings. I have met with people at the I.H.S. Spirit Lake Health Center, Spirit Lake Tribal Council, the I.H.S. Aberdeen Area Office, and over the years I have had numerous meetings in Washington, D.C., as well.

At one time the I.H.S. clinic was looking into staying open longer hours, their budget was several million because they would need to hire an entire new staff of physicians, nurses, lab and x-ray technologists, etc.

The issues remain, and every time there is a suggestion, there is a roadblock by I.H.S. or the Government.

I have no where else to go, except to you, for help. It is my responsibility to ensure that Mercy Hospital remains open to serve the people of the Lake Region, which certainly includes members of the Spirit Lake Nation. We have a close relationship with many of the tribal members as they were born at our hospital, and through the years they have put their trust in us. We appreciate this and consider it an honor. We also know a solution must be found so that we can continue to serve.

Conclusion

I believe we can all agree there is a problem with expected care and payment. It may be my pragmatism, but I believe we, you and I, the Government and Mercy Hospital, have a shared responsibility to see that the people of the Spirit Lake Nation have access to health care 24/7, and that Mercy Hospital is compensated.

After considerable thought, recalling all the avenues I have tried, I believe it is necessary for I.H.S. to contract with Mercy Hospital for $500,000 per year for after hours care. The needs of the Spirit Lake Nation and Mercy Hospital would be met, and Mercy Hospital would still be providing their share of charity care.

Thank you for hearing my story, and for any assistance you can provide.

Mercy Hospital										
Uncompensated Services to										
Native Americans										
Trend by Service Line										
REPORT AS OF JUNE 30, 2007										
		6/30/2001		6/30/2002		6/30/2003		6/30/2004		6/30/2005
SERVICE	CLAIM	UNPAID	CLAIM	UNPAID	CLAIM	UNPAID	CLAIM	UNPAID	CLAIM	UNPAID
CATEGORY	COUNT	BALANCE	COUNT	BALANCE	COUNT	BALANCE	COUNT	BALANCE	COUNT	BALANCE
INPATIENT										
ICU	1	4,552			0	0	3	18,711	0	0
MED/SURG	11	61,413	6	23,164	14	83,308	12	56,948	12	72,483
PEDIATRIC		0		0		0	0	0	0	0
NEWBORN	8	7,087	16	16,483	14	15,526	5	7,006	7	9,998
OBGYN	1	2,939	10	30,620	7	18,827	4	15,824	3	10,290
MONITORED BED					0	0	1	12,081	1	8,060
OUTPATIENT										
Miscellaneous	3	532	7	469	6	2,065	7	441	4	1,410
Surgery					0	0	4	18,425	1	5,097
Observation	5	11,755	2	5,340	8	17,736	6	13,860	6	22,093
Emergency Room	830	185,838	651	201,172	659	266,704	683	314,145	623	330,417
Lab General	0	0	2	78	3	198	0	0	1	112
Imaging Services	9	3,051	21	5,333	23	10,713	8	2,451	9	4,894
Endoscopy	1	775	0	0	3	2,422			1	794
Physical Therapy	4	1,440	2	355	1	279			1	578
Other									0	0
HHA/HOSPICE	2	192							0	0
Total Inpatient	21	75,991	31	70,166	35	117,661	25	110,570	23	100,821
Total Outpatient	654	204,403	685	212,747	703	300,117	708	347,312	646	365,395
Grand Total	675	280,474	716	282,913	738	417,777	733	457,882	669	466,216
AVERAGE										

Mercy Hospital						
Uncompensated Services to						
Native Americans						
Trend by Service Line						
REPORT AS OF JUNE 30, 2007					TOTAL	TOTAL
		6/30/2006		6/30/2007	PR FY	PR FY
SERVICE	CLAIM	UNPAID	CLAIM	UNPAID	CLAIM	UNPAID
CATEGORY	COUNT	BALANCE	COUNT	BALANCE	COUNT	BALANCE
INPATIENT						
ICU			4	11,744	8	35,007
MED/SURG	14	79,931	32	136,860	101	513,897
PEDIATRIC	1	3,705	0	0	1	3,705
NEWBORN	8	12,101	9	8,906	66	77,106
OBGYN	4	18,862	5	19,758	34	117,009
MONITORED BED	1	3,362	7	13,689	10	37,183
OUTPATIENT						
Miscellaneous	5	367	13	1,970	45	7,254
Surgery			8	8,500	13	30,022
Observation	4	13,318	6	20,690	37	104,782
Emergency Room	815	440,043	1,566	646,131	5627	2,383,449
Lab General	1	190	4	818	11	1,396
Imaging Services	32	20,528	120	30,218	222	78,088
Endoscopy	2	2,381	12	3,689	19	10,061
Physical Therapy			5	7,221	13	9,873
Other			2	204	2	204
HHA/HOSPICE					2	192
					0	
Total Inpatient	28	117,961	57	190,747	220	783,807
Total Outpatient	859	476,826	1736	718,441	5991	2,625,129
Grand Total	887	594,777	1793	909,188	6211	3,409,036
AVERAGE						

The CHAIRMAN. Ms. Krein, thank you very much. We appreciate your being here today.

Next, we will hear from Stacy Dixon, the Chair of the Susanville Indian Rancheria in Susanville, California. Chairman Dixon will share his tribe's experience with the shortage of Contract Health Service funding, which led their tribe to start charging tribal members a co-pay for some services.

Chairman Dixon, thank you very much for being here. You may proceed.

STATEMENT OF HON. STACY DIXON, CHAIR, SUSANVILLE INDIAN RANCHERIA

Mr. DIXON. Thank you, Mr. Dorgan. Good morning. Thank you for the opportunity to be here today.

My name is Stacy Dixon. I am the Tribal Chairman of the Susanville Indian Rancheria, a federally recognized Indian tribe located in Susanville, California.

I am pleased to testify about a topic of great importance to my tribe: the severe under-funding of Contract Health Service in Indian Country. Health care to eligible beneficiaries who reside in our geographic area is provided out of the Lassen Indian Health Center, a small health care facility built and owned by the tribe located on the Susanville Indian Rancheria. The tribe has been providing health service at the Lassen Indian Health Center under an Indian Self-Determination and Education Assistance Act agreement since 1986.

In 2007, the tribe and the Indian Health Service entered into a self-governance agreement under Title V of the Act. Like most of the other tribes, we have struggled to achieve and maintain a high level of health care service, despite chronic under-funding, especially of CHS funds. CHS, like the rest of IHS-funded programs, is extremely under-funded. Conservative estimates are that Congress would need to appropriate an additional $333 million per year to meet unmet CHS needs nationally. When added to the current IHS budget line item for CHS, the CHS budget should be no less than $900 million.

Lack of adequate CHS funding has led to health care rationing and barriers to access to care because there are simply no enough appropriated funds to meet all needs. Patients eligible for CHS who do not get approved for funding are left with a choice between having to pay for service themselves or not getting the service they need.

The impact of CHS under-funding has been particularly devastating in California. In the 1950s, during the termination period, the Federal Government withdrew all Federal health care service to Indians in California. Health care services to Indian beneficiaries resumed in 1969. As a result of this unique history, none of the facilities and programs that tribes use to carry out health care functions in California originated as facilities and programs previously operated by the IHS. There are also no IHS hospitals in California. Tribes have been forced to rely heavily on the CHS programs to pay for specialty and in-patient care.

In 1986, when my tribe took over the delivery of health care services, our goal was simple: to provide the best possible health care to our people. We wanted to provide a continuum of care to our patients that would include as many possible health services to one location as possible so that the care provided by physicians who are providers that could be integrated and coordinated.

The challenge that we have faced with our pharmacy program are an illustration of the impact that CHS under-funding and IHS under-funding in general has on tribal health programs and tribal sovereignty. For many years, the tribe tried to operate its pharmacy program using funds diverted from other health purposes. The tribe had to close the pharmacy between January of 2004 to June of 2005 because it concluded that it could not afford to do that. During this time, prescription drugs had to be purchased from local pharmacies.

To pay for these retail pharmacy services, the tribe used its already limited CHS funds. While the tribe was providing pharmacy service with the CHS funds, it had to make significant cuts in the CHS service that it had been providing. Some of the services that we could no longer provide include services such as CT scans, MRIs, podiatry exams, cardiac evaluations, and colonoscopys.

In 2005, the tribe decided that the problems associated with using already-scarce CHS funds to pay for pharmaceutical supplies off-site and the other negative consequences of not having a pharmacy on-site could only be corrected by reopening the on-site pharmacy. The tribe resumed pharmacy operations in July of 2005. It immediately was able to once again use CHS funds to pay for needed CHS services.

After much study and analysis, the tribe determined that the only to run a financially viable in-house pharmacy program without jeopardizing the CHS funding needed for the other critical services was to charge a small co-pay of $5, along with the acquisition cost of the medicine to those patients who could afford it. Indigent and elderly patients are exempt from these charges. The tribe implemented these policies in July of 2006.

Unfortunately, the tribe pharmacy policy became a focus of a lawsuit between the IHS and the tribe and remains a lightning rod today in the legal and policy debate about what legal authority tribes have to supplement health care funding they receive from IHS. This January, a Federal judge upheld the legality of our pharmacy policy and affirmed the tribe's right to determine for itself whether to charge beneficiaries for services at a tribally operated program.

The IHS did not appeal the judge's decision, yet IHS staff is convinced it was wrong. Recently, they have told tribes around the Country that they do not plan to follow the Susanville decision, that it does not constitute precedent that IHS has to follow. They have even gone so far as threaten to cut the funding of any tribe that charges beneficiaries. As quoted in an article last week in Indian Country Today, a high IHS official called tribal billing inappropriate and said the IHS is contemplating terminating the relationship with tribes that have been discovered to be doing so.

The IHS and tribes agree on one important thing. When the Federal Government fails to meet its trust responsibility by chronically under-funding CHS and other areas of IHS budget, it is inappropriate to force Indian beneficiaries to shoulder part of the burden by allowing IHS to charge the very people to whom it owes the trust duty. Recognizing this, Congress prohibited the IHS from charging beneficiaries through the ISDEAA. Congress also recognized the flip-side of this coin, however: Tribes are sovereign governments that have the right to decide how best to carry out the health care programs for their people and to supplement any inadequate Federal funding by any and all reasonable means. While the decision whether to charge tribal members and other beneficiaries is not appealing, it is a choice Congress has left to tribes in the exercise of their right of self-governance.

I can assure you that my tribe would prefer not to charge eligible beneficiaries for any portion of the costs of providing health care to them. However, I firmly believe in the right of all tribes to make

that decision themselves, rather than it being made for them by the IHS.

Ironically, we would not be having these disagreements with IHS if Congress fulfilled its trust responsibility to Indian people and address the larger crisis of chronic IHS program under-funding. If IHS and other IHS programs were adequately funded, tribe would not be forced to consider charging beneficiaries in the first place.

I urge the Committee to work on making sure that CHS and other Indian health programs are fully funded. Thank you for the opportunity to testify on these important issues vital to the well being of my tribe and of Indian Country.

Thank you.

[The prepared statement of Mr. Dixon follows:]

PREPARED STATEMENT OF HON. STACY DIXON, CHAIR, SUSANVILLE INDIAN RANCHERIA

Good morning. Thank you for the opportunity to be here today. My name is Stacy Dixon. I am the Chairman Susanville Indian Rancheria, a Federally-recognized Indian tribe whose reservation is located in Susanville, California, a small community located about 85 miles from Reno, Nevada. I am pleased to testify about a topic of great importance to my Tribe: the severe underfunding of Contract Health Services in Indian country.

Let me begin by providing a little background on my Tribe's health care delivery system. Health care to eligible beneficiaries who reside in our geographic area is provided out of the Lassen Indian Health Center (LIHC), a small rural health care facility located on the Susanville Indian Rancheria. The Tribe has been providing health services through the LIHC to tribal members and other eligible beneficiaries under an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement since 1986. In 2007 the Tribe and the Indian Health Service (IHS) entered into a self-governance agreement under Title V of the ISDEAA. Like most other tribes, we have struggled to achieve and maintain a high level of health care services despite chronic underfunding, especially of Contract Health Services (CHS) funds.

As you are aware, CHS funds are used to supplement and complement other health care resources available at IHS or tribally operated direct health care facilities. Under the CHS program, primary and specialty health care services that are not available at IHS or tribal health facilities are purchased from private and public health care providers. For example, CHS funds are used when a service is highly specialized and not provided at the IHS or tribal facility, or cannot otherwise be provided due to staffing or funding issues, such as hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services.

CHS, like the rest of IHS funded programs, is extremely under-funded.[1] Based on FY 2007 data, the Northwest Portland Area Indian Health Board (NPAIHB) conservatively estimates that Congress would need to appropriate an additional $333 million per year to meet unmet CHS needs nationally. When added to the current IHS budget line item ($588,161,000 million is requested for FY09) for CHS, the CHS budget should be no less than $900 million. The CHS program is also greatly affected by medical inflation, as the costs are not controlled by the IHS or by tribal health care providers, but are determined by the private sector health care environment.

The lack of adequate CHS funding has led to health care rationing and barriers to access to care because there are simply not enough appropriated funds to meet all needs. In expending limited CHS resources, the IHS and tribal health care providers use a strict medical priority system. Most IHS Areas lack enough CHS funds to even pay for medical priority one—emergent and acutely urgent care services. These services are ones necessary to prevent the immediate death or serious impairment of health—so called "life or limb emergencies." Any medically-necessary health care services that are needed but do not reach that priority status, such as priority

[1] U.S. Comm'n on Civil Rights, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country* at 49 (July 2003) (concluding that "the anorexic budget of the IHS can only lead one to deduce that less value is placed on Indian health than that of other populations").

two preventive care, priority three chronic primary and secondary care or priority four chronic tertiary care, are put on a deferred list and are not approved for payment unless funding becomes available. If no funding becomes available, payment is denied and the patient's condition goes untreated unless he/she has an alternate resource such as Medicare or Medicaid, or can afford to pay for the care him/herself.

According to the IHS in its FY 2007 CHS Deferred and Denied Services report, IHS programs denied care to 35,155 eligible cases because they were not within medical priority one, representing a 9% increase in denials over the previous year. Many tribally operated health programs no longer track deferred or denied CHS services because of the expense of doing so, meaning that figure is understated, particularly in California where there are no direct care programs operated by IHS, and would be higher if all CHS data from tribal programs were available.

Patients eligible for CHS but who do not get approved for funding are left with an unconscionable choice between having to pay for the service themselves (many cannot afford to even consider that option) or not getting the services they need. In the Susanville Indian Rancheria's experience, many tribal beneficiaries do not even visit health facilities when they expect CHS to be denied, which adversely impacts their overall health status.

The impact of CHS underfunding on access to health care has had a particularly devastating impact in California. To fully grasp the extent of CHS under-funding in our state, it is helpful to first understand the history of health services in California and tribes' efforts to bring about equity in funding. This history is unique within the U.S. Indian Health Service system.

In the 1950's, as part of the termination of tribes' special status across the United States, the Bureau of Indian Affairs (which was responsible for health care until that responsibility was transferred to the U.S. Public Health Service in 1954) withdrew all federal health services from Indians in California. Studies of the health status of California Indians in the late 1960s revealed that their health was the worst of any population group in the State. The routine health services available to Indians through the IHS in other states were not accessible or available to Indians in California. At the urging of the tribes in California through the work of the California Rural Indian Health Board and the State of California, at the direction of Congress the IHS began to restore federally provided health care services for Indians living in California in 1968—but through tribally owned and managed health programs rather than direct services from the Federal Government. Funding was insufficient and the programs grew slowly.

Indians in California were left out of the IHS's growth that occurred between 1955—when the U.S. Public Health Service began discharging its responsibility for Indian health care—and 1969—when the IHS again assumed responsibility for Indian health care services in California. To address that shortfall and force the issue of equitable care, Tribes filed a class action against the IHS. In *Rincon Band of Mission Indians v. Harris,*[2] the Ninth Circuit Court of Appeals ordered the IHS to provide California Indians with the same level and scope of services that it provides to Indians elsewhere in the United States. Despite winning this victory, California tribes continued to be short-changed: the IHS distributed only $13.7 million to California tribes out of the $37 million in additional funding Congress originally appropriated to address IHS funding inequities following the *Rincon* decision. The IHS never fundamentally altered its funding allocation method, and California tribal health programs have remained chronically under-funded.

According to the Advisory Council on California Indian Policy (ACCIP), in a report and recommendations made to Congress in September 1997, IHS service population figures for 1990 to 1995 show that California was the fifth largest Area out of the twelve IHS Areas, but ranked third lowest in per capita IHS funding levels.

Today, many tribes in California have taken on the responsibility for developing and operating health care facilities pursuant to the ISDEAA. None of the tribal facilities and programs in California originated as facilities and programs previously operated by the IHS, as is the situation in most of the other IHS Areas. California tribal health programs were never built or staffed under the IHS system, there are no IHS inpatient facilities in California and the IHS provides no direct care services in California. Without having had such infrastructure and services in place, IHS was unable to base the amount of funds for tribally-operated health care in California on the amount IHS itself had spent. This is the funding calculation methodology used in many other Areas and is required by the ISDEAA.

There are no IHS hospitals in California. Thus, tribal providers rely heavily on the CHS program to fund specialty and inpatient care. When CHS resources are exhausted, Indian beneficiaries in California have no recourse. IHS facilities can rely

[2] *Rincon Band of Mission Indians v. Harris,* 613 F.2d 569 (9th Cir. 1980).

on their specific Area Offices to assist them with a major crisis that requires additional CHS, where in a true emergency the Area Offices can shift funds or ask IHS Headquarters for assistance. The California Area Office, however, does not have reserves or other ability to shift funds between and among already inadequately funded tribal programs.

In its September 1997 report, ACCIP determined that the California CHS budget as of that time was the lowest in the entire IHS system at $114 per user, compared to $388 per user in the Portland Area, which also lacks IHS hospitals. California received $7,085,200 in CHS funds for FY 1995 compared to $16 million and $28 million provided to the Bemidji Area and the Billings Area, respectively, which have similar user populations to that of California. ACCIP determined that the CHS funding shortfall for California was $8 million in 1997. Now more than ten years later, that figure is no doubt considerably higher. Recently, research done by the California Rural Indian Health Board which matched data for the IHS Active User population in California with data from the California Hospital Discharge Data set identified $19,355,000 in unfunded hospital care for the year 2007. That number does not address other needs such as diagnostic services, specialty care and pharmacy services.

With respect to California beneficiaries, the IHS's FY 2005 CHS Deferred and Denied Services report shows that IHS programs deferred payment for services for 2,611 eligible cases and denied care to 519 eligible cases that were not within the medical priority. The report for 2006 indicates that the number of eligible cases denied care in 2006 in the California Area rose to 841. As mentioned above, these figures understate the problem given that there are no IHS direct care providers in California and tribal programs do not all track this type of data.

In 1995, the Susanville Indian Rancheria undertook a comparison analysis to look at three IHS Indian Health Centers—one each in Arizona, Utah and Oregon—to review similarities and differences between them and the tribally operated LIHC in California, with respect to CHS and other IHS funding. The comparison facilities were all IHS-operated and had similar staffing, workloads and service populations (one facility had a service population slightly lower than the LIHC's). By doing that comparison, we discovered that the IHS health facilities had considerably more resources. For example, the LIHC had a CHS budget in FY 1994 of $93,000, compared to the much higher budgets for the comparison facilities in the same period: $770,125, $629,224 and $1,371,156. Even taking into account differences in the service population, the funding levels should have been somewhat similar for similar workload and number of active users. Our comparison showed what we already knew, which is that the IHS resource allocation methodology has consistently demonstrated a bias toward larger facilities and toward IHS facilities rather than tribally operated facilities.

In 1986, when the Tribe took over the responsibility to deliver health care services, our goal was simple: provide the best possible health care to our people. One important aspect of that goal was to provide a continuum of care, including as many possible health services in one location so that care provided by physicians and other providers could be integrated and coordinated. We firmly believe that the continuum of care approach provides the highest quality health care for the patients served.

Key to our continuum of care approach is the provision of on-site pharmacy services. This allows our patents to obtain direct counseling on the use of prescription drugs being dispensed and to obtain necessary drugs at a low cost as part of an integrated health program. The challenges that we have faced with our pharmacy program provide a vivid illustration of the impact that CHS under-funding—and the IHS's under-funding in general—on tribal health programs and barriers to access to care problems.

Historically the IHS has never provided the Tribe with any funds specifically to operate its pharmacy program or, for that matter, to purchase pharmacy supplies. In fact, the Tribe receives today only about one-half the funds from the IHS that are needed to carry out the Tribe's health programs. To compensate for this chronic lack of funding the Tribe has made decisions to reallocate available funds, redesign programs, and seek additional resources (thought third party reimbursements, Medicare and Medi-Cal reimbursements, and even through tribal contributions from its own funds) to fund the health care needs of its beneficiary population.

For many years, the Tribe attempted to operate its pharmacy program using a substantial amount of funds diverted from other health purposes at a significant cost to the Tribe. The Tribe had to close the pharmacy between January 2004 and June 2005 because it concluded that it could not afford to operate the pharmacy any longer. During this time, prescription drugs had to be obtained from a local pharmacy, where the Tribe's patients experienced long waiting lines to receive their

medications, errors in prescribing the correct drug, and prescriptions being given to the wrong patients. The Tribe also experienced a drop in patient visits, which was directly related to the Tribe having no on-site pharmacy and the disruption of services through its continuum of care.

To pay for these retail pharmacy services while the LIHC on-site pharmacy was closed, the Tribe used its already limited CHS funds. Obtaining prescription medications outside of the Tribe's facility was not only more inconvenient for the Tribe's patients and interfered with the continuum of care, but the cost for billing and administration in working with retail pharmacies was significant. The Tribe did not (and still does not) have enough CHS resources to pay for pharmaceuticals through retail pharmacies.

Each dollar of CHS funds used for pharmacy services is a dollar that cannot be used for other critically needed CHS-funded services. When using CHS for pharmacy services, the cost of the pharmaceuticals is higher than it would be in a direct care environment, because outside retail pharmacies do not want to provide federal discount pharmaceutical pricing to the Tribe. Moreover, given the dramatic rise in the cost of pharmaceuticals over the past several years, and the continuing trend of substantial increases in price, we concluded that in a short time all of the CHS dollars available to the Tribe would have been spent on pharmaceuticals, meaning no CHS dollars would have been available for other critical CHS services.

While the Tribe was providing pharmacy services through CHS, it had to make significant cuts in other CHS services that it had been providing. For example, the Tribe could only cover CHS priority level one for medical and CHS priority levels one through four for dental. In 2005 the tribe decided that the problems associated with not having a pharmacy on-site could only be corrected by re-opening the on-site pharmacy. When the Tribe resumed pharmacy operations in July 2005, the Tribe was able to once again use CHS funds to meet the growing backlog of needed CHS services for medical and dental care.

In CY 2006, the Tribe supplemented approximately $908,458 of tribal third-party funds to operate its IHS programs. The Tribe operated its pharmacy that year at a net loss of $18,007.08. In many of the previous years, the losses were greater than $100,000. Because the IHS provides the Tribe with no funds specifically for its pharmacy program and the Tribe's other health programs are severely under-funded by the IHS, every dollar the Tribe receives through its ISDEAA agreements and through third-party resources such as Medicare and Medi-Cal, are very carefully managed. There are no excess revenues or available funds the Tribe can reallocate to provide pharmacy services without hurting other health programs.

After much study and analysis, the Tribe determined that the only way to run a viable in-house pharmacy program without jeopardizing the CHS needed for other critical services was to charge a small co-payment ($5.00) along with the acquisition cost of the medicine to those patients who could afford it. Indigent members and elders are exempt from this charge. The Tribe implemented this policy in July 2006.

The Tribe's Pharmacy Policy, made necessary by chronic CHS underfunding, became the focus of a lawsuit between the IHS and the Tribe and remains a lightning rod today in a legal and policy debate about the means available to tribes to supplement their health care funding. The decision in *Susanville Indian Rancheria v. Leavitt* upheld our Pharmacy Policy and affirmed a tribe's right to determine for itself whether to charge beneficiaries for services at a tribally-operated program. Disturbingly, this decision in favor of tribal self-governance has led the IHS in recent weeks to threaten to revoke the ISDEAA funding of other tribes that decide to charge beneficiaries.

Despite the fact that the IHS had never provided the Susanville Tribe with funds specifically for pharmacy services, for many years the Tribe had included a pharmacy services program in its ISDEAA agreement. In 2006, after the Tribe was admitted into the Title V self-governance program, it began negotiating with the IHS for a self-governance compact and funding agreement for Calendar Year 2007.

The Tribe's proposed agreement included pharmacy services, but said nothing about its co-pay policy. IHS negotiators, however, learned of the Pharmacy Policy, and informed the Tribe of the IHS's position that the Tribe could not charge eligible beneficiaries for pharmacy services. The IHS gave the Tribe two choices: (1) delete pharmacy services from the agreements entirely, or (2) include language in the contract stating the Tribe would not charge eligible beneficiaries for pharmacy services. The Tribe refused to accept either of these options and presented IHS with a final offer that included pharmacy services.

The IHS rejected the Tribe's proposal on two primary grounds. First, the IHS argued that the Secretary lacks authority to enter an agreement to do something that the Secretary cannot do—namely, charge beneficiaries for services. Second, the IHS

argued that the Tribe's co-pay policy would result in a "significant danger or risk to public health".

The Tribe appealed the IHS rejection decision to federal district court in the Eastern District of California. The court found that the IHS's public health argument failed because the agency cited only speculative risks that did not meet the agency's burden of proof under the ISDEAA. The court then addressed the IHS's argument that the Tribe could not charge because the IHS cannot charge. This issue turned on the interpretation of Section 515(c) of Title V of the ISDEAA, which provides as follows:

> The Indian Health Service under this subchapter shall neither bill nor charge those Indians who may have the economic means to pay for services, *nor require any Indian tribe to do so.* [3]

The Court decided that this provision prohibits the IHS from charging—for good reason, as it would directly violate the federal trust responsibility—but that it does not prohibit tribes from doing so.

The court also rejected the IHS argument that the agency cannot approve an ISDEAA agreement under which a tribe will conduct activities (such as billing) that the IHS itself has no legal authority to carry out. The court pointed out that, "[a]s Title V makes clear, the Tribe is not required to operate a [program] in the same manner as the IHS." Tribes are not federal agencies, which can only do what Congress authorizes them to do. Tribes retain inherent authority beyond that delegated by Congress.

Events subsequent to the *Susanville* decision are troubling and bring into question the IHS's understanding of tribal rights to self-governance. Despite the *Susanville* decision—and the plain language of the ISDEAA on which the decision was based—the IHS has sought to prohibit tribes (other than our Tribe) from charging eligible beneficiaries. The IHS did not appeal the *Susanville* decision, yet the agency insists the court was wrong and has not heeded its ruling. In a series of recent "consultation" sessions with tribes in various regions, the IHS has stated that the *Susanville* decision is limited to one tribe, and does not constitute binding precedent. The agency made clear that "the existing IHS policy, which prohibits Tribes from charging eligible beneficiaries, remains unchanged."

In fact, the IHS has threatened to cut the funding of any tribe that charges beneficiaries (again, except for Susanville). As quoted in an article last week in *Indian Country Today,* an IHS official called tribal billing "inappropriate" and said the IHS is "contemplating terminating relationships with tribes that have been discovered to be doing so." [4]

But the IHS and tribes agree on at least one thing: When the federal government fails to meet its trust responsibility, as it has by chronically underfunding CHS (and other areas of the IHS budget), it is inappropriate to force Indian beneficiaries to shoulder part of the burden by allowing the IHS to charge the very people to whom it owes the trust duty. Recognizing that this is so, Congress has flatly prohibited the IHS from billing or charging in the Title V provision at issue in the *Susanville* case and quoted above. Congress also recognized the flip side of this coin, however: Tribes are sovereign governments that have the right to decide how best to carry out health care programs for their people and to supplement inadequate federal funding by any and all reasonable means. While the decision whether to charge tribal members and other beneficiaries is not appealing, it is a choice Congress has left to Tribes in the exercise of their right of self-governance.

The Susanville Indian Rancheria—just like many other tribes—would prefer not to charge eligible beneficiaries for any portion of the cost of providing health care to them. Doing so forces hard choices for individuals and tribes alike, and should be unnecessary given the Federal Government's trust responsibility to provide the highest possible level of health care services to Native peoples, or provide sufficient resources for tribes to do so.

Many, perhaps most, tribes have no plans to charge beneficiaries for health care services under any circumstances. Nonetheless, the tribal leaders I have heard from strongly support the right of Tribes and tribal organizations to make that decision themselves rather than have it made for them by the IHS. We believe that the IHS should abandon its contrary position, which comports neither with the law nor the policy of self-governance, and instead work with Tribes to find ways to ensure that sufficient funds are provided to tribal programs so that they do not need to consider

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[3] Pub. L. 93–638, Title V, § 515(c), as added Pub. L. 106–260, § 4, Aug. 18, 2000, 114 Stat. 711, *codified at* 25 U.S.C. § 458aaa–14(c) (emphasis added).

[4] Rob Capriccioso, *IHS Considers Stopping Funds for Tribe Requesting Patient Copays,* INDIAN COUNTRY TODAY (June 20, 2008).

billing beneficiaries. Even more important, we urge Congress to address the larger crisis of chronic CHS underfunding so that tribes do not even have to consider charging beneficiaries in the first place.

Thank you for the opportunity to testify on these important issues vital to the well-being of Indian country.

The CHAIRMAN. Chairman Dixon, thank you very much for being here and sharing your experience.

Next, we will hear from the Lieutenant Governor of the Chickasaw Nation in Oklahoma, Jefferson Keel. Mr. Keel will discuss the challenges his tribe faces.

Thank you for being here.

STATEMENT OF HON. JEFFERSON KEEL, LIEUTENANT GOVERNOR, CHICKASAW NATION; FIRST VICE PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS

Mr. KEEL. Thank you, Mr. Chairman, members of the Committee. Senator Johnson, it is good to see you back.

On behalf of the Chickasaw Nation and the National Congress of American Indians, which I serve as the First Vice President, I am honored to be asked to provide testimony on this important issue, particularly around the complex issue of contract health services. You have our testimony for the record, and I will provide a brief summary.

As you know, the Chickasaw Nation is a self-governing tribe. However, on behalf of the National Congress of American Indians, and as Sally Smith has said, I must express our concern that our Direct Service Tribe, our member of the Direct Service Tribes, has not been asked to provide testimony. Considering the enormity of this issue, it would be helpful that the Committee would seek out additional testimony to address their concerns.

Today, I would like to talk about some of the emergency issues tribes must face due to the rationing of health care created by the under-funding of Contract Health Services. I will conclude with six recommendations to the Committee that I would ask that they consider.

In 1995, the Chickasaw Nation assumed control of the Indian Health Service Program at the Ada, Oklahoma service unit under a self-governance compact. At that time, the Indian Health Service owed millions of dollars for contract care due to their lack of payment and because they would not refuse authorization of services due to lack of funds. This built up to the point where there were several million dollars that were still owed, and it took some time to get those paid off.

Faced with growing medical inflation rates, the increased expense of providing services in a rural area, a rapidly increasing Indian population, and limited competitive pricing, our tribe's only option is to require strict adherence to a medical priority system. You have seen what that system is.

These covered services are generally used for emergency care or the treatment of life-threatening conditions only. Medical needs falling outside of the priority system are not funded. Our situation is difficult and challenging. Do we cover one catastrophic hospitalization, resulting after a car wreck in another city? Or do we

use those same funds to provide treatment for heart disease or cancer or other life-threatening illnesses?

For example, cataract removal is one of the most common operations performed in the United States. It is also one of the safest and most effective types of surgery. In about 90 percent of the cases, people who have cataract surgery have better vision afterwards. We are unable to provide cataract surgery as a covered service, leaving untold numbers of elders in our tribe, just our tribe alone, in an unnecessary dependent state.

Another example, just last week, a Tribal citizen, who is a heart patient, came to our facility with an emergency-type situation. Under ordinary circumstances, we have an arrangement with the Oklahoma Heart Hospital in Oklahoma City where we are able to refer that patient and they receive treatment and we provide payment under the Medicare rates. However, if that hospital is full or at capacity, as it was last week, then they would not accept that patient for the Medicare rates. Consequently, he was not able to receive adequate treatment. We had to make other arrangements. The bottom line is that because of a lack of adequate funding for Contract Health Services, our people often must accept second-class health care treatment.

In light of the crisis situation we are facing, we propose the following recommendations.

Number one, extend Medicare-like rates to the ambulatory setting. Extension of Medicare-like rates to the out-patient setting will be cost-neutral and allow tribes to extend Contract Health Services funding even further. We would request that when this program is implemented that it is created in a manner that it does not cut off or limit the current supply of medical providers.

Two, reduction of administrative overhead within the Indian Health Service. The reduction in administrative costs should include departmental-imposed administrative paperwork, systems and programs, as well as limit the dollar amount of resources that may be utilized for administrative costs versus cost to directly fund health care.

Number three, work with tribes to fund proactive procedures currently denied under Contract Health Services. For example, funding bariatric surgery would directly impact the patient's quality of life and life span. Obesity is an important risk factor for cardiovascular disease and diabetes, which are chronic diseases that affect a disproportionate number of American Indians today. New studies demonstrate a direct correlation between the bariatric surgery and a cure for the patient's type II diabetes. These patients are routinely off diabetic medication by the time they are discharged from the hospital. Additionally, many patients are able to discontinue medication for high blood pressure and cholesterol.

Number four, adequately fund Indian Health Service and the services provided by Contract Health Service. Tribes should not be forced to make decisions regarding the health and oftentimes lives of their members due to inadequate funding of Contract Health Service programs. The National Congress of American Indians passed a resolution at our May, 2008 mid-year conference in Reno, Nevada in support of an additional appropriation of $1 billion for

the Indian Health Service, to be used in part to address underfunding of services provided by Contract Health Service programs.

Number five, remove the new CMS documentation requirements. The historic practice of accepting tribal membership or Certificate of Degree of Indian Blood as proof of citizenship should be accepted for the indigenous people of our country.

Number six, benefits of Contract Health Services Delivery Area. At a minimum, the American Indians who reside in our geographic service unit area and are Contract Health Service-eligible should qualify for emergency and life-threatening treatments.

Thank you for your dedication to Indian Country, Senator, and for taking the first steps to examining this difficult issue. We are aware that there are hurdles we must face when confronting Contract Health Service programs, as well as other health care issues in this Country, for instance reauthorization of the Indian Health Care Improvement Act, as you have mentioned.

We thank you in advance, and we look forward to working with you, and I will be happy to answer any questions at a later date. Thank you.

[The prepared statement of Mr. Keel follows:]

PREPARED STATEMENT OF HON. JEFFERSON KEEL, LIEUTENANT GOVERNOR, CHICKASAW NATION; FIRST VICE PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS

On behalf of the Chickasaw Nation and the National Congress of American Indians (NCAI), I am honored to present testimony to the Senate Committee on Indian Affairs for the hearing on Contract Health Services.

NCAI is the oldest and largest American Indian organization in the United States. NCAI was founded in 1944 in response to termination and assimilation policies that the United States forced upon the tribal governments in contradiction of their treaty rights and status as sovereign governments. Today NCAI remains dedicated to protecting the rights of tribal governments to achieve self-determination and self-sufficiency.

Contract Health Services

Under the Contract Health Service (CHS) program, primary and specialty health care services that are not available at Indian Health Service (IHS) or tribal health facilities may be purchased from private sector health care providers. This includes hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services.

The Indian Health Service (IHS) is the Payor of Last Resort. This means that patients are required to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. The results of this policy have been devastating in Indian Country.

Considering the astronomical medical inflation rates experienced while providing services in a rural area along with an increasing Indian population and limited competitive pricing, the Tribe's only option is to require strict adherence to a medical priority system. These covered services are generally used for emergency care or the treatment of life threatening conditions. Medical needs falling outside the priority system are not funded.

The resulting rationing of health care creates numerous emergency issues for the Tribes. Principal among them:

The creation of a priority system, in which patients who are not facing life or limb threatening conditions are denied referral to a private provider for medical attention from the IHS;

Patient billing issues arising from eligible tribal members being denied payment for medical services provided by non-IHS providers. Tribal members are left coping with credit problems, a lack of ability to get future medical services, and often times an unwillingness to seek preventive medical services;

The "don't get sick after June" phenomenon in Indian Country—or in some cases earlier—due to the underfunding of CHS programs; and

An ongoing dilemma in the maintenance of adequate record keeping for referrals and denials and medical services.

Inadequate CHS Funding Forces Tough Choices

At the present, less than one-half the CHS need is being met and the President's FY 2009 CHS budget request of $588 million. This discrepancy in funding means that some of the most basic and needed services that have the potential to dramatically improve quality of life for patients are routinely denied under existing CHS funding.

In 1995 when the Chickasaw Nation took over the IHS program in the Ada Service Unit under a Self Governance compact, the IHS owed millions of dollars for contract care provided by local physicians and hospitals. This problem was caused when the IHS failed to pay its bills and would not refuse authorization of services due to lack of funds.

Today Chickasaw Nation providers see in excess of $7 million dollars in unmet healthcare needs annually, forcing us to make the strategic decision to deny all emergency services that are not initiated by our health system. Our situation is difficult and challenging: *Do we cover one catastrophic hospitalization resulting after a car wreck in another city, or do we use those same funds to provide treatment for heart disease or cancer?*

If a facility has a high number of vacancies in primary care areas, this will result in an increase in contract health resources. On the other hand, the more direct services that are provided by a facility translates into a decrease in contract health resources. The Chickasaw Nation has developed a method of using third party reimbursements to fund additional providers in our clinics. This allows us to see more patients and handle more medical needs. Unfortunately due to limited funds, we also do not have the benefit of providing the state-of-the-art procedure and treatment for our patients:

Upon diagnosis of breast cancer, the standard treatment for most American patients is a lumpectomy followed by chemotherapy and radiation. However, a total mastectomy without chemotherapy or radiation will have the same success rate and can be accomplished as a direct healthcare service. For this reason, this is the typical form of treatment within our clinics. Since CHS does not provide for reconstructive surgery, our mothers and daughters are forced to not only face this horrific disease, thus must go through with a curative surgery that will leave them disfigured for life.

An Indian male with a diagnosis of prostate cancer typically has two treatment "choices". A radical prostatectomy reports good success but the surgery can result in erectile dysfunction and incontinence. A modified prostatectomy, TURP, followed by radioactive seed implants is a less invasive but a more expensive treatment choice. Due to the restrictions our clinics face with CHS, the first choice is most typically the treatment option.

Cataract removal is one of the most common operations performed in the United States. It also is one of the safest and most effective types of surgery. In about 90 percent of cases, people who have cataract surgery have better vision afterward. We are unable to provide cataract surgery as a covered service, leaving untold numbers of elders in an unnecessary, dependent state.

American Indians face some of the highest level of diabetes in the world; however, due to funding level restrictions, organ transplantation surgery is not covered. This means that corneal transplant is out of reach for our patients with diabetic retinopathy—resulting in blindness. Patients with diabetic kidney disease are faced with a lifetime of hemodialysis with no hope of kidney transplant.

Recent changes in federal laws have placed other burdens on an already burdensome and exhaustive citizenship documentation process. These new rules require applicants to provide certain documents to verify that they comply with rules governing citizenship and identity. States were notified of the new requirement on June 9, 2006, and the interim rule was published in the Federal Register on July 12, 2006. Oklahoma began implementation planning in January and operationalized the plan on July 1, 2007.

- Citizenship: Medicaid eligibility has long been restricted to U.S. citizens and certain legal immigrants such as refugees.
- Identity: Identity is not an eligibility requirement, per se, but individuals and parents are required to apply on behalf of themselves and their children. In addition, applicants already must provide Social Security numbers and information regarding family income.

The new laws require applicants, include those renewing their eligibility to document citizenship and identity through one of the following criteria:

- A *primary* document that verifies both citizenship and identity, such as a passport or birth certificate or naturalization; or
- Separate *secondary* documents, one verifying citizenship, such as a birth certificate and another verifying identity such as a driver's license or school picture ID.

According to I.H.S. per capita funding formula, Oklahoma is one of the lowest funded of the 12 Indian Health Service areas. The new CMS documentation requirements have resulted in a 13 percent decline in the American Indian population enrolled in the Oklahoma State Medicaid program, of which 60 percent were American Indian children. Because of this decline, contract health expenditures have increased for all IHS/Tribal/Urban programs. It would be safe to assume that most contract health service programs in Oklahoma are seeing a 13 percent increase in all contract health services expenditures.

The Contract Health Services Delivery Area (CHSDA) is designed to allow for those American Indians who reside in a geographically service unit area to receive treatments. At a minimum, the American Indians who reside in our service unit area and who are CHS eligible will qualify for most emergency and life threatening treatment. However, there are hundreds of American Indians who reside outside the geographic service unit area which is normally sixty (60) miles, who routinely come to our clinics for treatment. Many of these patients live in Texas, and travel many miles to receive treatment. They do not qualify for CHS funding.

Recommendations

1. *Extend Medicare like rates (MLR) to the ambulatory setting.* The application of MLR to inpatient CHS services had a direct impact for Tribes. The Chickasaw Nation saw an immediate 40 percent savings for some inpatient claims. Extension of MLR to the outpatient setting will be cost neutral and allow Tribes to extend CHS funding even further. We would request however that when a mechanism for applying MLR to outpatient services is devised, that it is created in a manner that does not cut off or limit the current supply of medical providers.

2. *Reduction of administrative overhead within the Indian Health Service.* This reduction in administrative costs should include the departmental-imposed administrative paperwork, systems, programs, etc., as well as limit the dollar amount of resources that may be utilized for administrative costs versus cost to directly fund healthcare.

3. *Work with Tribes to fund certain proactive procedures currently denied under Contract Health Service funding.* For example, funding bariatric surgery would directly impact the patient's quality of life and life span. Obesity is an important risk factor for cardiovascular disease and diabetes which are chronic diseases that affect a disproportionate number of American Indians today. New studies demonstrate a direct correlation between the bariatric surgery and a cure for the patient's type II diabetes. These patients are routinely off diabetic medication by the time they are discharged from the hospital. Additionally many patients are able to discontinue medication for high blood pressure and cholesterol.

4. *Adequately fund Indian Health Service and the services provided by Contract Health Service.* Tribes should not be forced to make decisions regarding the health—and often times lives—of their members due to inadequate funding of CHS programs. NCAI passed a resolution at their May 2008 Mid Year conference in Reno, NV in support of an additional appropriations of $1 billion for the IHS to be used, in part, to address underfunding of services provided by the CHS program.

5. *Remove the new CMS documentation requirements.* And the historic practice of accepting tribal membership or Certificate of Degree of Indian Blood (CDIB) as proof of citizenship be accepted for the indigenous people of our country.

6. *Benefits of CHSDA.* As stated above, at a minimum, the American Indians who reside in our geographically service unit and are CHS eligible will qualify for most emergency and life threatening treatment.

Conclusion

The Chickasaw Nation and NCAI commend the committee's dedication to Indian Country and for taking the first steps into examining this difficult issue. We are aware that there are hurdles we must face when confronting CHS programs—such as reauthorizing the long overdue Indian Health Care Improvement Act. We must however continue to stress that anything less than full and recurring funding of contract health services compromises the health and lives of those in our communities.

By supporting us in these efforts, you will be ensuring that Tribes have the ability to deliver the highest quality services to their tribal members.

The CHAIRMAN. Lieutenant Governor Keel, thank you very much for being with us.

Next, we will hear from Linda Holt, the Chair of the Northwest Portland Indian Health Board, and a Suquamish Tribal Council Member in Washington State.

Ms. Holt, thank you very much for being here. You may proceed.

STATEMENT OF HON. LINDA HOLT, CHAIR, NORTHWEST PORTLAND INDIAN HEALTH BOARD

Ms. HOLT. Thank you. Good morning, Chairman Dorgan and Vice Chairman Murkowski, and Senator Johnson. It is my honor to be here today to testify before your Committee.

My name is Linda Holt. I am a Suquamish Tribal Council Member with the Suquamish Tribe in Washington State. I also serve as Chair of the Northwest Portland Area Indian Health Board. Our organization represents 43 tribes in the States of Washington, Oregon an Idaho. We serve a combination of Direct Service Tribes and self-governance tribes.

I would just like to echo the concern of Ms. Smith and Mr. Keel that the Direct Service Tribes have not been invited to give input.

The CHAIRMAN. Let me address that. We did try to get a Direct Service Tribe to this hearing. In fact, we were unsuccessful in doing that. We will have other hearings. In fact, Marlene Krein is testifying about her experience with the Direct Service Tribes, and Sally Smith represents an organization that also includes them. But we will have Direct Service Tribes at the next hearing. We tried at this hearing and it just didn't work out.

Ms. HOLT. Thank you.

The CHAIRMAN. So it is not a matter of will. We will certainly get that done.

Ms. HOLT. Okay. Just for the record also, there is a Direct Service Tribes meeting in Spokane, Washington on August 5, 6, and 7, which I would like to invite the Committee to hold a field hearing with the Direct Service Tribes.

The Portland area is commonly referred to as a CHS-dependent area. CHS-dependent areas do not have access to IHS or tribally operated hospitals and must purchase all in-patient and specialty care services through the CHS program. This dependence is clearly demonstrated in the Portland area budget. Nationally, the CHS program is 19 percent of the IHS health service budget. However in the Portland area, CHS makes up 31 percent of our overall health service budget. This dependence poses unique challenges for our tribes.

One of the most critical issues affecting tribes has been the persistent under-funding of the CHS program. This simply does not make sense, given the significant health disparities that Indian people face and it is time Congress fully funded the IHS budget. My written remarks document these disparities and I know you are aware of these concerns.

The Northwest Portland Area Indian Health Board takes a leadership role in conducting analysis and advocating for the IHS budget. Our estimates indicate that the CHS program has lost $778 mil-

lion in unfunded inflation and population growth since 1992. The table on page eight of my written remarks documents this chronic under-funding. This is attributed to the fact that the Administration and IHS have not requested adequate funding and the failure of Congress to provide appropriations sufficient to meet the needs of medical inflation and population growth.

This failure has resulted in a health care crisis in the CHS program. As a tribal leader, it is infuriating to know that other public health service programs like Medicaid and Medicare receive adequate increases to fund medical inflation, yet the CHS program provides similar services and purchases care from the private sector as Medicaid does, however does not get the same respect.

The graph on page nine of my testimony compares growth in the Medicaid and CHS programs and illustrates the funding disparity between the two. This has resulted in a CHS system that rations care with a backlog of over 300,000 denied or deferred services. Our board has analyzed the denied and deferred services report and estimates that it would take at least $333 million to address the backlog of services. We performed the same analysis two years ago which yielded similar results for fiscal year 2006.

Our analysis consistently indicates that an increase of at least $300 million is needed in the CHS program. Ideally, to restore the CHS program to the same level of services provided in fiscal year 1991, Congress would have to restore $778 million to the CHS program. Our estimates indicate that the CHS budget today should be $1.3 billion per year.

If there is one thing that Congress could do to address the health care crisis, it would be to direct the IHS to use real medical inflation and provide adequate funding to cover this mandatory cost. The OMB medical inflation rate used by IHS to develop its budget is completely inadequate. This rate has averaged four percent over the last 10 years, despite the fact that medical inflation in many of these years has exceeded 10 percent. The CHS program is most vulnerable to the effects of inflation more than any other IHS budget line item.

Within the Indian health system, there is a wide range of dependence on the CHS program. However, a fundamental distinction in the IHS system is the dichotomy between those areas that have hospitals and those that are CHS-dependent. This difference is the result of a decades-old facility construction process that prioritizes large user populations in remote areas over small populations in mixed population areas. The priority facility construction may have been logical at one time. However, over time it has created two types of systems: those that are hospital-based with expanded health services, and those that are CHS-dependent with limited ability to provide like services.

In many instances, areas with hospitals can provide many types of services, but must be purchased from the private sector in CHS-dependent areas. The consequences is that CHS-dependent areas do not receive a fair share of health service resources. This is demonstrated in many aspects of IHS programs, with the disparities in facilities construction funding and staffing packages. This is very true when the effect of staffing new facilities is factored on IHS budget increases. Portland tribes question why they receive less

than 1 percent increases, when Congress provided a 5 percent increase of the IHS budget. The answer is the phasing-in staff at new facilities takes between 50 percent to 60 percent of the budget increase.

Another concern with the formula is the manner in which inflation is calculated. The formula requires that inflation be funded prior to allocating any remaining funds under the new formula requirements. If an inadequate inflation rate is used, it can result in a surplus of CHS funds to be allocated under the new formula. The new formula uses the OMB medical inflation rate, which I explained earlier, and is much less than true medical inflation. It does not account for increased health service costs purchased from the private sector.

We have all heard the quote, "don't get sick after June." In the Portland area, almost all of our tribes begin the new fiscal year clearing the backlog of deferred services from the previous fiscal year. This immediately places our health programs in priority-one status. This means that patients will not receive care under the CHS program unless life or limb tests apply. This process has repeated itself annually.

For Portland-area tribes, as it is for other CHS-dependent areas, it is don't get sick at all or you will not receive care in the CHS program.

The CHAIRMAN. Ms. Holt, I want you to summarize the remainder of your testimony if you would.

Ms. HOLT. Thank you.

Finally, more needs to be done in the Indian Health Service toward identifying best practices for delivering care in the CHS program. For example, my Suquamish Tribe health program was established as an alternative delivery demonstration project. We do not have a clinic. We use our CHS money to purchase a health benefits program for our tribal members. We contract with Kitsap Physicians Health Plan in Kitsap County to administer the health benefits program for our tribal members.

We have approximately 475 Suquamish tribal members enrolled and 45 members of other federally recognized tribes enrolled in this health plan. Benefits of the demonstration project include services parallel to those purchased in the CHS program. There is no prior authorization required for receiving services, and there have been beneficial changes to out-patient utilization for tribal members. Prior, they had to go to emergency rooms to receive care, which drove up the cost. That has come down with this health benefits package. We would like to see this health alternative project looked at by IHS and find better ways to utilize the CHS program.

I would like to thank you for your time today.

[The prepared statement of Ms. Holt follows:]

PREPARED STATEMENT OF HON. LINDA HOLT, CHAIR, NORTHWEST PORTLAND INDIAN HEALTH BOARD

Chairman Dorgan, Vice-Chair Murkowski, and members of the Committee, I thank you for this opportunity to testify today on, "Access to Contract Health Services in Indian Country."

The Northwest Portland Area Indian Health Board (NPAIHB) was established in 1972, as a P.L. 93-638 tribal organization that represents forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington.[1] The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts policy and budget analysis, manages a Tribal epidemiology center, and operates a number of health promotion and disease prevention programs. Our Board is dedicated to improving the health status and quality of life of all American Indian and Alaska Native (AI/AN) people.

I. Federal Trust Relationship

The United States and the federal government have a duty and an obligation—acknowledged in treaties, Executive Orders, statutes, and court decisions—to provide for the health and welfare of Indian Tribes and their members. In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to AI/ANs through a system of the Indian Health Service programs, Tribal health programs, and urban clinics. These services are provided to members of 567 federally-recognized tribes in the United States, located in thirty-five different states.

II. Indian Health Disparities

The Indian Health Care Improvement Act (IHCIA) declares this Nation's policy to elevate the health status of the AI/AN people to a level at parity with the general U.S. population. Over the last thirty years the IHS and Tribes have made great strides to improve the health status of Indian people through the development of preventative, primary-care, and community-based public health services. Examples are seen in the reductions of certain health problems between 1972-74 and 2000-2002: gastrointestinal disease mortality reduced 91 percent, tuberculosis mortality reduced 80 percent, cervical cancer reduced 76 percent, and maternal mortality reduced 64 percent; with the average death rate from all causes dropping 29 percent.[2]

Unfortunately, while Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that other types of diseases are on the rise for Indian

[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.
[2] FY 2000-2001 Regional Differences Report, Indian Health Service, available: www.ihs.gov.

people. For example, national data for Indian people compared to the U.S. all races rates indicate they are 770 percent more likely to die from alcoholism, 650 percent greater to die from tuberculosis, 420 percent greater to die from diabetes complications, 91 percent greater to die from suicide, and 52 percent more likely to die from pneumonia and influenza.[3] Northwest data indicates a growing gap between the AI/AN death rate and that for the general population. In 1994, average life expectancy at birth for AI/ANs born in Washington State was 74.8 years, and is 2.8 years less than the life expectancy for the general population. For 2000-2002, AI/AN life expectancy were at 74 years and the disparity gap had risen to 4 years compared to the general population. The infant mortality rate for AI/AN in the Northwest declined from 20.0 per 1,000 live births per year in 1985-1988 to 7.7 per 1,000 in 1993-1996, and then showed an increasing trend, rising to 10.5 per 1,000 in 2001.[4]

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

Despite widely documented health disparities, the federal government spends less per capita on AI/AN health care than on any other group for which it has this responsibility. This includes Medicaid recipients, prisoners, veterans, and military personnel. Each year, IHS spends 60 percent less on its beneficiaries than is spent on the average American for health care. What frustrates Tribal leaders is that each year, public health programs such as Medicare and Medicaid accrue annual interest to keep pace with inflation, while IHS programs do not. The disparity in funding is amplified by the poorer health conditions of AI/AN people. The Indian health system has done remarkably well with limited resources in carrying out health programs however, if funded sufficiently it could do more to stem the health crisis in Indian Country.

III. The Indian Health Service

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[3] Jon Perez, Testimony before the U.S. Commission on Civil Rights, briefing, Albuquerque, NM, Oct. 17, 2003.
[4] American Indian Health Care Delivery Plan 2005, American Indian Health Commission of Washington State, available at: www.aihc-wa.org.

The Indian health system is comprised of a network of programs operated directly by the Indian Health Service (IHS) or by Tribal health programs and urban clinics. The IHS, directly and through Tribal governments, carry out programs under the Indian Self-Determination and Education Assistance Act (P. L. 93-638). These programs provide health services to more than 2.3 million AI/AN people in the United States.[5] These services are provided to members of 567 federally-recognized tribes located in 35 different states.

Currently, IHS provides access to healthcare services for AI/ANs through 31 Hospitals, 50 health centers, 31 health stations and 2 school health centers. Tribes also provide healthcare access through an additional 15 hospitals, 254 health centers, 166 Alaska Village Clinics, 112 health stations, 18 school health centers, and 34 urban Indian health clinics that provide outreach and referral services in addition to direct medical care. Nineteen of the hospitals have operating rooms while health centers and health stations vary in their scope of services and in hours of operation.

Health services not available through direct care must be purchased through the Contract Health Service (CHS) program. In most cases, the facility that provides a patient's direct care services also authorizes payment under the CHS program. The use of contract care services varies considerably. For example, in two areas (California and Portland) all hospital-based services are purchased through contract care. In the other ten Areas, some hospital-based services are provided at IHS-funded facilities, while others are purchased through contract care. Tribes have the option of operating their own direct care facilities and contract care programs. Tribes operate 27 percent of the 49 hospitals and 70 percent of the 364 health centers and health stations. The remaining facilities were federally operated. For fiscal year 2005, approximately 50 percent of the IHS budget was allocated to Tribes to deliver services.

IV. Portland Area Tribes

The Portland Area Office provides access to health care for forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington. Fifty-five different health facilities provide an array of health services to an estimated 167,000 AI/AN people. A range of health services are provided through thirty-nine outpatient health centers, thirteen health stations and preventive health programs, and three urban programs. The health centers provide a wide range of clinical services and are open forty hours each week. Health

[5] Indian Registrants, Active Indian Registrants, and User Population data are all referenced in this testimony are from the "IHS Final User Population Estimates – FY 2007," accessed December 27, 2007, available at www.ihs.gov.

stations provide a limited range of clinical services and usually operate less than forty hours per week. Preventive programs offer counselor and referral services. The three urban programs provide direct medical care in addition to outreach and referral services.

Of the health centers, twenty-nine are tribally operated and ten are federally operated. One of the health stations is federally operated, while the remaining thirteen are tribally operated. There were 954,375 direct care outpatient visits provided in the Portland Area in FY 2006. There are no hospitals in the Portland Area, therefore inpatient care and specialty care services that are not available in health facilities must be purchased through the CHS program. This important distinction makes Portland Area Tribes dependent on CHS funding for all specialty care services. Those Areas that do not have inpatient hospitals and must purchase all specialty care services under the CHS program are often referred to as "***CHS Dependent***" Areas.[6]

V. Contract Health Service Program

The IHS Contract Health Service (CHS) program originated under the Department of Interior, Bureau of Indian Affairs (BIA) when authority to enter into health services contracts for AI/ANs was provided under the Johnson O'Malley Act of 1934. The program was continued when responsibility for Indian health was transferred from the BIA to the Department of Health, Education, and Welfare in 1955 when IHS was established. The CHS program is used to supplement and complement other health care resources available to eligible AI/ANs. The CHS program is administered through twelve IHS Area Offices that include 163 IHS and Tribal service units. The CHS program purchases health care services for IHS beneficiaries from non-IHS providers. Purchasing health care services from non-IHS providers is essential to the overall IHS health care delivery system, as many IHS hospitals and clinics cannot provide these services. These services are critical for Tribes that do not have access to needed clinical services. The CHS funds are used in situations where:

1. No IHS direct care facility exists,
2. The direct care facility cannot provide the required emergency or specialty services,
3. The direct care facility has an overflow of medical care workload.

The CHS budget supports essential healthcare services from non-IHS or Tribal facilities and include, but is not limited to, inpatient and outpatient care, routine and emergency

[6] ***CHS Dependent*** Areas are those Areas of the IHS that rely on the CHS program for all of their inpatient care which include the California and Portland Areas, and; for nearly all their inpatient care in the Bemidji and Nashville Areas.

ambulatory care, medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy. Some additional services include treatment and services for diabetes, cancer, heart disease, injuries, mental health, domestic violence, maternal and child health, elder care, refractions, ultrasound examinations, dental hygiene, orthopedic services, and transportation. The agency applies stringent eligibility rules and uses a medical priority system in order to budget CHS resources so that as many services as possible can be provided.

The regulations at 42 CFR, Part 136 require that CHS services must be authorized or no payment will be made. Non-emergency services must be pre-authorized and emergency services are only authorized if notification is provided within 72 hours of the patient's admission for emergency treatment. The agency also has adopted the financial position that it is the Payer of Last Resort. This requires patients to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. The IHS also negotiates contracts with providers to ensure competitive pricing for the services provided; however, there may be only one or a limited number of providers or vendors available to the local community. The CHS authorizing official from each IHS or Tribal health program either approves or denies payment for an episode of care. If payment is approved, a purchase order is issued and provided to the private sector hospital.

CHS regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of care needed. Because of insufficient funding in the CHS program, many IHS and Tribal health programs begin the year at a Priority One level. If they do not begin the year at Priority One, they will move to this status by the second or third quarter of the fiscal year. These priorities are categorized into four Priority Levels described as follows:

Priority One - Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. Priority One represents those diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

Priority Two - Preventive Care Service: Primary health care that is aimed at the prevention of disease or disability. This includes services proven effective in

avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention).

Priority Three - Chronic Primary and Secondary Care Services: Inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It includes services that may not be available at many IHS facilities and/or may require specialty consultation.

Priority Four - Chronic Tertiary Care Services: Inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, elective, and often require tertiary care facilities.

VI. CHS Budget Concerns

The CHS budget is the most important budget item for Northwest Tribes since there are no hospitals in the Portland Area. CHS dependent Areas lack facilities infrastructure to deliver health services and have no choice but to purchase specialty care from the private sector. Nationally, the CHS program represents 19 percent of the total health services account. In the Northwest, the CHS program represents 30 percent of the Portland Area Office's budget. This makes the CHS budget the most critical line item for Portland Area Tribes.

Our estimates indicate that the CHS program has lost at least $778 million due to unfunded medical inflation and population growth since 1992.[7] This has resulted in rationing of health care services using the CHS medical priority system, in which most patients in the Portland Area cannot receive care unless they are in a Priority One status (see Priority levels discussed above). In FY 2007, this under-funding resulted in a backlog of over 300,000 health services that were not provided because there simply was not enough funding. These services were not provided because they did not fall within the medical priorities, administrative processes were not followed, or a patient had moved outside of the CHSDA.[8] What is most concerning is that the patients requiring these services do not go away. The

[7] "The FY 2009 IHS Budget: Analysis and Recommendations," p. 22, March 17, 2008, available at: www.npaihb.org.

[8] 42 CFR Part 136, Subparts A–C. Subpart C defines a Contract Health Service Delivery Area (CHSDA) as the geographic area within which contract health services will be made available by the IHS to members of an identified Indian community.

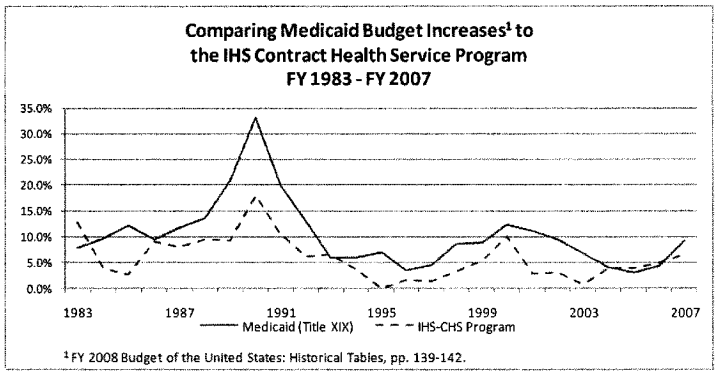
patients are put onto a "denied/deferred" services status and when health programs receive funding for the new fiscal year, most health programs begin clearing this backlog of service. This process puts almost all Portland Area Tribes into a Priority One status at the beginning of each fiscal year. Furthermore, postponing treatment of these services results in higher costs once a patient is finally able to receive care.

Contract Health Services (CHS)
Lost Purchasing Power 1993 - 2009
(Dollars in Thousands)

Year	Approved Budget	Required CHS Budget with Medical Inflaton	Un-funded Medical Inflation	Un-funded Population Growth	Total Unfunded
FY 1992	$ 308,589	(Base Year)			
FY 1993	$ 328,394	$ 331,425	$ 3,031	$ 6,480	$ 9,511
FY 1994	$ 349,848	$ 354,260	$ 4,412	$ 6,896	$ 11,308
FY 1995	$ 362,564	$ 373,635	$ 11,071	$ 7,347	$ 18,418
FY 1996	$ 362,564	$ 390,428	$ 27,864	$ 7,614	$ 35,478
FY 1997	$ 368,325	$ 406,744	$ 38,419	$ 7,614	$ 46,033
FY 1998	$ 373,375	$ 419,433	$ 46,058	$ 7,735	$ 53,793
FY 1999	$ 385,801	$ 438,218	$ 52,417	$ 7,841	$ 60,258
FY 2000	$ 406,000	$ 414,350	$ 8,350	$ 8,102	$ 16,452
FY 2001	$ 445,773	$ 444,570	$ (1,203)	$ 8,526	$ 7,323
FY 2002	$ 460,776	$ 490,350	$ 29,574	$ 9,240	$ 38,814
FY 2003	$ 475,022	$ 518,373	$ 43,351	$ 9,500	$ 52,851
FY 2004	$ 479,070	$ 536,558	$ 57,488	$ 9,581	$ 67,069
FY 2005	$ 498,068	$ 557,836	$ 59,768	$ 9,961	$ 69,729
FY 2006	$ 517,297	$ 581,959	$ 64,662	$ 10,346	$ 75,008
FY 2007	$ 543,099	$ 605,714	$ 62,615	$ 11,405	$ 74,020
FY 2008	$ 579,334	$ 648,854	$ 69,520	$ 12,166	$ 81,686
FY 2009	$ 588,161	$ 636,688	$ 48,527	$ 12,166	$ 60,693
		Seventeen Year Total:	**$ 625,924**	**$ 152,520**	**$ 778,444**

There are at least two ways to calculate the amount of additional funding needed in the CHS program. The first would be take the IHS denied/deferred services reports and apply an average outpatient cost to the number of services. Last year, 300,779 unfunded services would have been approved had adequate funding been available. Applying an average outpatient rate of $1,107 to these services estimates that an additional $333 million was needed for the CHS program in FY 2007. Adding this amount to the FY 2008 CHS budget indicates that minimally, the CHS program needs at least $912 million per year. The second method of calculating additional funding needed in the CHS program, is to estimate the unfunded inflation and population growth over a period and apply that amount to the current funding level. Since 1992, we estimate that the CHS program has not received adequate

funding for mandatory cost of inflation ($625.9 million) and population growth ($152.5) and that the CHS budget should be at least $1.3 billion.[9]



The reason the CHS budget has eroded so badly is due to the fact that the Administration and Congress—or the IHS—have not adequately provided inflation increases. The CHS program is more vulnerable to inflation pressures than any other program in the Indian health system. CHS budget increases have averaged 4.5 percent over the last ten years, despite the fact that medical inflation has exceeded 10 percent in many of these years. Similar public health programs like Medicaid obtain budget increases that are based on actual medical inflation estimates. The Medicaid program has averaged an annual budget increase of 7.5 percent over the same period. The CHS program should receive medical inflation adjustments equal to the Medicaid program since both provide similar services and purchase care from the private sector. Medicaid's enrollment in FY 2008 is expected to grow by 2.2 percent and is comparable to the growth rate of 2.1 percent for IHS, so population growth alone does not justify the higher inflation rate for Medicaid. Surely, the relatively small Indian Health Program is not able to secure better rates from providers than the Medicare and Medicaid programs. It is reasonable to expect that Medicaid program inflation rates will exceed 10 percent in FY 2009. It seems clear that CHS, while an efficient alternative to building hospitals and specialty clinics, is subject to higher rates of inflation than the rest of the IHS budget and should be provided with an appropriate increase annually.

[9] The FY 2008 CHS budget is $579.3 million, our estimates for unfunded inflation $625.9 million, and population growth $152.5 million equate to a CHS budget of $1.3 million in FY 2009.

Almost all Tribes in the Northwest contribute Tribal resources to compliment their health budgets and most often for the CHS program. Tribes in the Northwest see resources needed for economic development and other priorities increasingly absorbed by health care expenses in violation of treaty obligations of the federal government to provide for these health care services. If Tribes do not provide these resources the situation would be drastically worse and Congress must be aware of this.

VII. Denied/Deferred Services

The IHS maintains a deferred and denied services report that is updated each year. The report is inclusive of CHS data from IHS direct operated health programs and may include limited data from Tribally-operated health programs. Unfortunately, the denied/deferred services report **understates** the true need of CHS resources due to the data limitations and the fact that many tribes no longer report deferred or denied services because of the expense involved in tracking. More disturbing is that many IHS users do not even visit health facilities because they know they will be denied services due to funding shortfalls. The result of this is that using the denied/deferral report to estimate funding shortfalls in the CHS program is not always appropriate because it under represents the amount of funding required to address unmet need.

IHS FY 2007 CONTRACT HEALTH SERVICE PROGRAM
DEFERRED & DENIED SERVICES REPORT
ALL AREA OFFICES
January 22, 2008

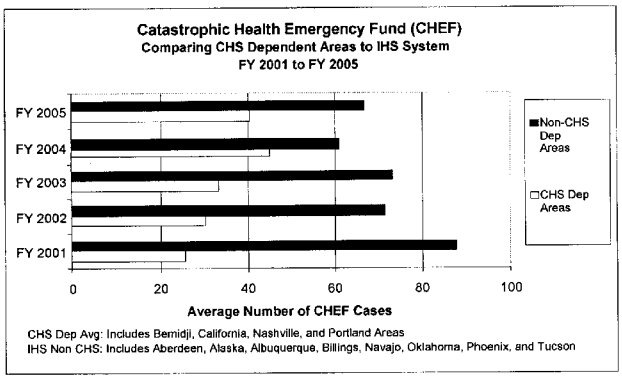
IHS AREA	A Deferred Services Within Med Priorities	Denied Service Categories: B Eligible But Care Not Within Med. Priority	C Eligible But Alternate Resource Available	D Patient Ineligible for CHS	E Emergency-Notification Not Within 72 Hours	F Non-Emergency No Prior Approval	G Patient Resides Outside CHSDA	H IHS Facility Available & Accessible	I All Other Denials	TOTAL
Aberdeen	*7,895*	9,116	17,463	2,409	774	3,357	2,565	3,969	1,398	41,051
Alaska	*2,785*	1,463	5,472	602	129	3,459	464	1,389	478	13,456
Albuquerque	*3,383*	2,078	4,448	223	220	66	1,180	186	256	8,657
Bemidji	*2,278*	572	1,909	872	964	1,930	617	626	1,811	9,301
Billings	*14,319*	8,707	4,740	1,227	236	3,577	1,529	3,118	187	21,321
California	*2,123*	318	1,308	352	303	274	25	13	7,532	10,125
Nashville	*1,927*	2,850	237	234	362	412	137	218	103	4,353
Navajo	*75,673*	2,654	16,247	229	1,311	523	602	2,026	2,779	26,371
Oklahoma	*45,159*	5,069	1,313	89	1,262	2,961	856	2,869	8,381	22,798
Phoenix	*2,720*	1,941	9,457	546	922	906	1,307	1,538	922	17,539
Portland	*3,389*	2,562	1,916	1,525	1,425	3,440	187	500	0	11,555
Tucson	*100*	25	1,535	93	125	14	173	1	11	1,977
TOTALS	***161,751***	***35,155***	***66,045***	***8,401***	***8,033***	***20,919***	***9,642***	***16,453***	***23,858***	***188,504***

The denied/deferred service issue is a special concern for CHS dependent Areas. When a patient is not authorized to receive care; or does not report to a health clinic because they will be denied care, their visit may not be counted in IHS User Population or workload reports. This is an important issue, because User Population and workload data are used in many formulas to allocate IHS funds, including the CHS program. Those Areas with inpatient hospitals can internalize costs associated with providing care that would normally be purchased by CHS dependent Areas. Hospital based systems can provide care in some of these instances and get to count the patient visit in their User Population and workload data. The effect of this, is that CHS dependent Areas may not receive a fair share of resources if they cannot deliver the same level of services as those Areas that have inpatient care. This special concern should require an updated formula to allocate CHS funding.

VIII. Catastrophic Health Emergency Fund

The CHS program also includes a Catastrophic Health Emergency Fund (CHEF) that covers high cost cases and catastrophic illness. The term "catastrophic illness" refers to conditions that are costly by virtue of the intensity and/or duration of their treatment. Cancer, burns, high-risk births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds, and some mental disorders are examples of conditions that frequently require multiple or prolonged hospital stays and extensive treatment after discharge. The CHEF is used to help offset high cost CHS cases that meet a threshold of over $25,000 per incident. The CHEF is available until it has been depleted, generally between March and June of each fiscal year. In FY 2007, the CHEF program provided funds for 738 high cost cases totaling $18 million. For FY 2008, the CHEF fund has been increased to $27 million.

One of the most fundamental distinctions in the IHS system is the dichotomy between those Areas that have hospitals and those that are CHS dependent. This division is a result of a decades old facility construction process that prioritizes dense populations in remote areas over small populations in mixed population areas. The priority for facility construction may have been logical at one time, however, over time has created two types Areas—those that are hospital based with expanded health services and those that are CHS dependent with limited ability to provide hospital like services. Unlike hospital based Areas that can provide specialty care services, CHS dependent Areas must purchase all specialty care utilizing CHS resources.



The core issue is that IHS hospital level care can substitute for CHS purchased services in some Areas but not in others. Yet the annual distribution of CHS funds does not consider this fundamental exchange. This problem and the resulting reductions in access to care will continue as long as access to CHS funds are considered in isolation from access to directly provided hospital care. The impact of this problem is compounded in the CHS dependent Areas by organization structure and IHS policy on access to the CHEF. This inequity is depicted in the graph above comparing those CHS dependent Areas to those that have hospital based services. Clearly, the average CHEF claims for those CHS dependent Areas has lagged significantly behind those Areas that have hospital services.

CHS dependent Areas are disadvantaged in three fundamental ways. First they lack access to inpatient and specialty services such as radiology, specialty diagnostics, laboratory, and pharmacy services. These types of services tend to be associated with hospital based facilities. Comparatively, CHS dependent Areas have very few facilities with specialty services and limited pharmacy. In CHS dependent Areas access to services is restricted not only by the general underfunding, but also by the fragmentation of resource into a large number of independently operated Tribal health programs. This can result in excess funds in one operating unit while other operating units are denying even life threatening care.

Lastly the relatively high threshold for access to CHEF disproportionably impacts CHS dependent Areas, where hospital services cannot be substituted for CHS coverage. This is because rational management of small CHS pools leads to policies that restrict high cost cases in favor of extending program activity to all four quarters of the year. One proof of this analysis is the persistent pattern of comparative CHEF utilization between two similarly sized IHS Areas one with hospital capacity and one without. A decade long comparative

analysis of California Area and Billings Area CHEF utilization indicates a persistent rate for Billings Area that is 500 percent higher than that for the California Area.

To address this issue, it is recommended that Congress consider establishing an intermediate risk pool for CHS dependent Areas of Bemidji, California, Nashville, and Portland using a portion of the CHS or existing CHEF budgets.

IX. CHS Dependency Concerns

There is a wide range of dependency on the CHS program as part of the overall Indian health system, however, some IHS Areas are more dependent on the CHS program for inpatient, and specialty care services than other Areas. These Areas include the California, Bemidji, Nashville, and Portland Areas. CHS dependent Areas with no access to IHS or Tribal hospitals for inpatient care justify increased consideration in CHS funding. CHS dependent Areas do not take for granted the fact that severe under-funding of the Hospital & Clinic budgets over previous years have undermined the ability to provide adequate health care services and that CHS funds are very important even in Areas with inpatient facilities. However, CHS funding is less problematic for those Areas that have hospital based systems since recurring staffing packages provide funding for medical staff to provide health care services through existing inpatient facilities. This is not the case for CHS dependent Areas identified above, who must purchase such care under the CHS program.

The quote, "don't get sick after June," is often used by some Indian health advocates and is a misnomer for CHS dependent Tribes. The quote speaks to an administrative issue in which the CHS program moves into a Priority One status. This means that unless life or limb tests apply, patients may not receive health care according to CHS regulations. The quote is associated with Areas that have inpatient care and that generally move into Priority One status sometime in June. Having to be placed into Priority One status sometime in June is an option that CHS dependent Areas never have. Most Tribes from CHS dependent Areas begin the year in a Priority One status. CHS dependent Area Tribes begin the new fiscal year by clearing the backlog of denied and deferred services from the previous fiscal year. This immediately puts them into a CHS funding crisis and they must begin the year in a Priority One status. This process has repeated itself annually for many Tribes from CHS dependent Areas. So for Tribes from CHS dependent Areas, the quote is "don't get sick at all" as most begin the year in Priority One status.

CHS Distribution Methodology

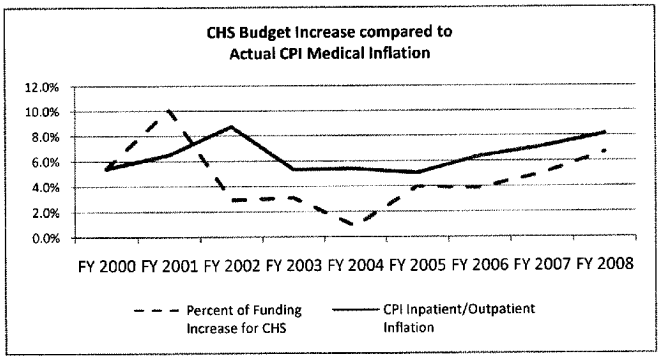
Perhaps the most critical concern for CHS dependent Areas is the distribution methodology used to allocate CHS resources. The basic framework of the CHS distribution methodology is that: (1) Congressional earmarks, new Tribes funding, and CHEF requirements must be met first; (2) any remaining amount is used to fund CHS inflation requirements, and; (3) if there is a balance after funding inflation, it is to be distributed using the new formula recommendations.

The former CHS distribution methodology was made up of three components with a percentage appropriated to each as follows: (1) Workload and Cost – 20 percent; (2) Years of Productive Life Loss – 40 percent, and; (3) CHS dependency – 40 percent. The former methodology carried a greater weight for CHS dependency than the new formula, which resulted in more funding for CHS dependent Areas. The new CHS dependence component was adopted because it was felt that the former component was not related to the population being served, did not recognize that all Areas have some degree of CHS dependence, did not consistently measure for CHS dependence, and was distorted when applied to the operating unit level data.

The new formula resulted in significantly less funding for CHS dependent Areas due to the fact that there is less weighted value given to the new variable to measure CHS dependence. If this formula continues to be utilized, Portland Area Tribes recommend that this same level of scrutiny be applied to the Hospitals & Clinics budget line items and for the method in which facilities construction funding and staffing packages are allocated.

Another concern with the formula is the manner in which inflation is determined. This component is just as important as CHS dependency. The new formula requires that inflation be funded prior to allocating any remaining funds under the new requirements. If an inadequate inflation factor is used, it can result in a surplus of CHS funds being allocated under the new formula, and is not fair for any Tribe receiving less than had a true inflation factor been used. The new formula uses the OMB medical inflation rate which has averaged around 4 percent over the past ten years. This year, the Consumer Price Index for hospital outpatient care is estimated to be 9.9 percent.[10] This is 5.5 percentage points higher than the average used by OMB! The graph above compares CHS budget increases to inpatient/outpatient inflation for hospital care. The OMB inflation factor is not the amount that is necessary to fund true medical inflation.

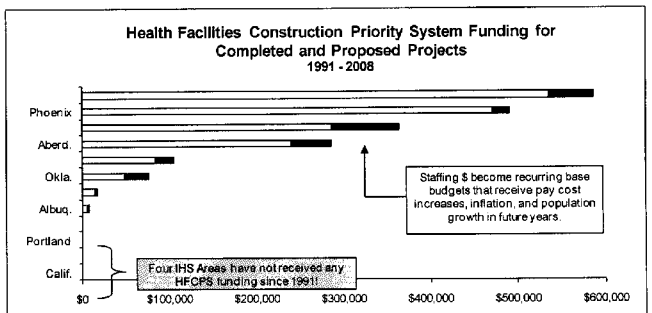
[10] Consumer Price Index Series CUSR00000S5703 available at: www.bls.gov



It is recommended that Congress direct the IHS to use actual medical inflation rates to purchase inpatient and outpatient hospital care when determining inflation amounts for CHS distributions to Tribes. The IHS and Tribal workgroup that developed the new formula also recommended that future refinements for this component in the formula should be considered. The workgroup recommended that additional items related to the formula should continue to be addressed. We urge Congress to direct the IHS to appoint a technical workgroup to develop recommendations to address these on-going concerns.

CHS and Facilities Construction

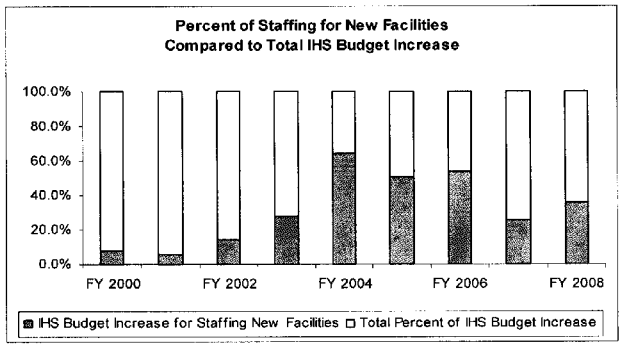
CHS dependent Areas have long been concerned with the methodology to prioritize facilities construction projects. This is very true in the case of constructing hospitals that are provided significant staffing packages to provide health services. A portion of phasing-in staff at new facilities includes additional funding for CHS services. This is inconsistent with the purpose of providing a staffing package. With a new facility and staffing package, the facility should be able to internalize costs associated with providing certain health services. To provide these same services, CHS dependent Areas must use contract care funds, as they do not have the benefit of new facilities and staffing. This is completely unfair to those Tribes from CHS dependent Areas that do not get an opportunity to compete for facilities construction resources on an equal basis as other Areas with inpatient hospitals.



	Calif.	Nash.	Portland	Tucson	Albuq.	Bemidji	Okla.	Billings	Aberd.	Navajo	Phoenix	Alaska
□Const. $	$0	$0	$0	$0	$5,765	$13,46	$47,34	$83,00	$238,0	$284,7	$469,6	$533,4
■Staffing $	$0	$0	$0	$0	$1,364	$3,784	$28,40	$21,09	$46,22	$78,36	$19,70	$52,29

(Dollars in Thousands)

The graph above and below demonstrates the inequities associated with facilities construction funding for CHS dependent Areas. In addition to the recurring staffing packages that are able to provide health services despite the level of funding for CHS services, the facilities and staff are also able to bill for services provided to patients eligible for Medicare, Medicaid, SCHIP, and private insurance. This in effect provides the facility—that is provided additional funding for staffing over and above CHS funds—to collect additional third party reimbursements that can further be used to provide additional services beyond the initial IHS funding. This dichotomy between CHS dependent Areas and those Areas that receive facilities with staffing funds is that there now begins to emerge a system within the Indian health care program that provides disproportionately more services when compared to CHS dependent Areas. This process is creating a health care system of "haves and have nots."



The graph above illustrates the impact that staffing new facilities has on IHS budget increases. Staffing packages for new facilities are like pay act costs in two respects: (1) They come 'off the top,' (i.e. they are distributed before other increases), and; (2) They are recurring appropriations. CHS dependent Tribes frequently ask, "Why did our health program receive a 1 percent increase in funding this year when Congress provided a 5 percent increase for the IHS budget? The answer is that once funding for phasing-in staff at new facilities is factored, the balance of the increase is distributed among 560 or more Tribes.

X. CHS and the Medicaid Program

The major trend in the financing of Indian health over the past ten years has been the effective stagnation of the IHS budget and a greater reliance on the Medicare, Medicaid, and SCHIP programs. The payor of last resort rule in the CHS program requires patients to exhaust all health care resources available from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. As IHS and Tribes have experienced a growing reliance on Medicaid reimbursement to sustain clinic services, a less obvious benefit has resulted from Medicaid coverage for services the Indian health system cannot provide. The CHS budget has limited capacity to pay for care outside of Indian health facilities. Medicaid coverage is the most important alternate resource to pay for this care. Medicaid helps protect CHS budgets from unpredictable catastrophic medical occurrences, especially for Tribes with small populations and very limited CHS allocations—thereby avoiding rationing of health care.

The IHS Federal Disparity Index (FDI) is often used to cite the level of funding for the Indian health system relative to its total need. The FDI compares actual health care costs for an IHS beneficiary to those costs of a beneficiary served in mainstream America. The FDI uses actuarial methods that control for age, sex, and health status to price health benefits for Indian people using the Federal Employee Health Benefits (FEHB) plan, which is then used to make per capita health expenditure comparisons. It is estimated by the FDI, that the IHS system is funded at less than 60 percent of its total need.[11]

In light of this chronic under-funding, Medicare and Medicaid collections are now a growing and critical component to providing basic health care services for Northwest Tribes and the Indian health system. While Medicare and Medicaid have become critically important to the health of AI/AN people, the expenditures constitute a very small share of overall costs in these programs. For example, it is estimated that Medicaid accounts for

[11] Level of Need Workgroup Report, Indian Health Service, available: www.ihs.gov.

almost 20 percent of the IHS budget but less than 0.5 percent of the overall Medicaid expenditures go to Indian health.

Unfortunately, we are now seeing changes to the Medicaid program, aimed at bringing about cost savings at the federal and state levels. AI/AN exemptions from cost-sharing and estate recovery rules are currently being challenged by the Centers for Medicare & Medicaid Services (CMS). In the Northwest, the effects on the general population of recent cost-cutting measures have been both instructive and alarming. In Oregon, modest cost sharing resulted in effectively cutting 50,000 of the most vulnerable and poorest participants from the state Medicaid rolls. In Washington and Idaho, much-needed services have been cut from the State Medicaid Plans. Nationwide, it appears that Medicaid entered a period of stagnation about four years ago, as state budgets adapted to the effects of the 2001-2003 recession. Looming changes at the federal level can only exacerbate that trend, with potentially disastrous results for the Indian health system.

If AI/ANs are not exempted from cost sharing, if they will fear loss of property due to estate recovery proceedings, and they will not sign up for Medicare and Medicaid services. Those that are currently enrolled will begin to disenroll from the programs in order to avoid administrative remedies associated with estate recovery. These costs will be borne by IHS and Tribal CHS programs. This will have a negative impact on the Indian health system, as it will be forced to cut services and incur increased costs in the CHS program, and result in a predictable decline in health status and increasing disparities.

We strongly urge the Congress to take action to protect AI/AN participation in the Medicare, Medicaid, and SCHIP programs. AI/AN participation programs are vital to maximizing the CHS budgets for IHS and Tribal health programs.

XI. Conclusion

In light of the duty owed to Tribal Governments under the Federal Trust Relationship, the United States and the federal government have an obligation to provide adequate funding to address the health needs of AI/AN people. Despite this duty, the Indian health system has been chronically and persistently under-funded by the United States Congress. This under-funding has resulted in a CHS program that is forced to ration health care that denies even the most basic types of health services that most Americans enjoy. Even the minimal level of funding that the CHS program has received has remained flat or actually lost ground due to unfunded population growth and medical inflation, including mandatory pay cost

increases. This rationing of health care has caused the deaths of many AI/AN people or caused many to live with needless pain.

It is time to stop the practice of delivering health care under a Priority One status and begin to have the United States Congress provide the necessary resources to address the significant health disparities that Indian people face. While the issues associated with the Contract Health Service program are complex, many are manageable with adequate funding.

In closing, I want to thank the Committee again for all the work it has done to hold this very important hearing and to thank you for your continued leadership to address the health care needs of American Indian and Alaska Native people.

NPAIHB POLICY BRIEF

CHS Unfunded Need in FY 2007

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Issue No.05, June 24, 2008

The Indian Health Service Contract Health Service Program: An Assessment of Unfunded Need

(This brief updates Policy Brief No. 15 published on August 18, 2006)

Overview

The Indian healthcare system, which is comprised of the Indian Health Service, Tribes or Tribal Organizations, and Urban Indian Organizations (I/T/U), provides direct primary and preventive health care services to eligible patients. The Indian health system must routinely purchase specialized health services for their beneficiaries from public and private providers through the Contract Health Services (CHS) program. It is estimated that the unmet need for CHS resources is at least $333 million based on FY 2007 data and this figure could be significantly higher if all CHS data from Tribal programs were available. Many Tribally-operated health programs no longer report deferred or denied services because of the expense associated with tracking and reporting. More disturbing is that many IHS users do not even visit health facilities because they know they will be denied services due to funding shortfalls. Thus, the $301 million estimate is quite conservative and when added to the current IHS budget line item the CHS budget should be at least $800 million.

IHS Contract Health Service Program
Summary of Unfunded Need in FY 2007

Category	Number of Services	Estimated CHS Resource Need
Deferred Services within Medical Priorities	161,751	$179,058,357
Eligible But Care not within Medical Priorities	35,155	$38,916,032
Eligible But Alternate Resources Available	66,045	$73,111,262
Emergency Notification Not within 72 Hours	8,033	$8,892,531
Non-Emergency No Prior Approval	19,259	$21,319,713
Patient Resides Outside CHSDA	9,642	$10,673,694
Unfunded CHEF Cases (actual amount)	895	$990,765
TOTAL:	300,779	$332,962,353

In order to budget the CHS resources so that as many services as possible can be provided, the agency applies stringent eligibility rules and uses a medical priority system. The regulations at 42 Code of Federal Regulations (CFR) Part 136 require that CHS services must be authorized or no payment will be made. Non-emergency services must be pre-authorized and emergency services are only authorized if notification is provided within 72 hours of the patient's admission for emergency treatment. The agency also has adopted the financial position that it is the Payer of Last Resort. This requires patients to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. The IHS also negotiates contracts with providers to ensure competitive pricing for the services provided; however, there may be only one or a limited number of providers or vendors available to the local community. The CHS authorizing official from each I/T either approves or denies payment for an episode of care. If payment is approved, a purchase order is issued and provided to the private sector hospital.

CHS Priority System

CHS regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of care needed. Because of insufficient funding in the CHS program, most IHS and Tribal health programs often begin the year at a Priority One level. If they do not begin the year at Priority One, they will move to this status by the second or third quarter of the fiscal year. These priorities are categorized into four Priority Levels and described as follows:

Priority One - Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. Priority One represents those diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

Priority Two - Preventive Care Service: Primary health care that is aimed at the prevention of disease or disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention).

Priority Three - Chronic Primary and Secondary Care Services: Inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment-for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It includes services that may not be available at many IHS facilities and/or may require specialty consultation.

Priority Four - Chronic Tertiary Care Services: Inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, elective, and often require tertiary care facilities.

Estimating Resources for CHS

The IHS maintains a deferred and denied services report that is updated each year. The report is inclusive of CHS data from IHS direct operated health programs and may include limited data from Tribally-operated health programs. Unfortunately, the deferred/denied services report **understate** the true need of CHS resources due to the data limitations and the fact that many tribes no longer report deferred or denied services because of the expense involved in reporting. More disturbing is that many IHS users do not even visit health facilities because they know they will be denied services due to funding shortfalls. Although there are limitations with CHS data, an analysis can be conducted using the data that are available to assess the need for additional CHS resources. The effort of this analysis will under estimate need for additional CHS resources since the data are incomplete because not all tribally operated facilities report denial data to IHS headquarters, and not all requests for care are documented at the facilities that do report.

IHS FY 2007 CONTRACT HEALTH SERVICE PROGRAM
DEFERRED & DENIED SERVICES REPORT
ALL AREA OFFICES
January 22, 2008

IHS AREA	A Deferred Services Within Med Priorities	Denied Service Categories: B Eligible But Care Not Within Med. Priority	C Eligible But Alternate Resource Available	D Patient Ineligible for CHS	E Emergency-Notification Not Within 72 Hours	F Non-Emergency No Prior Approval	G Patient Resides Outside CHSDA	H IHS Facility Available & Accessible	I All Other Denials	TOTAL
Aberdeen	*7,895*	9,116	17,463	2,409	774	3,357	2,565	3,989	1,398	41,051
Alaska	*2,785*	*1,463*	5,472	802	129	3,459	464	1,389	478	13,456
Albuquerque	*3,383*	2,078	4,448	223	220	66	1,180	186	256	8,657
Bemidji	*2,278*	572	1,909	872	984	1,930	617	626	1,611	9,301
Billings	*14,319*	6,707	4,740	1,227	236	3,577	1,529	3,118	187	21,321
California	*2,123*	318	1,308	352	303	274	25	13	7,532	10,125
Nashville	*1,927*	2,650	237	234	362	412	137	218	103	4,353
Navajo	*75,673*	2,654	16,247	229	1,311	523	602	2,026	2,779	26,371
Oklahoma	*45,159*	*5,069*	1,313	89	1,262	2,961	856	2,869	8,381	22,798
Phoenix	*2,720*	1,941	9,457	546	922	906	1,307	1,536	922	17,539
Portland	*3,389*	*2,562*	1,916	1,525	1,425	3,440	187	500	0	11,555
Tucson	*100*	25	1,535	93	125	14	173	1	11	1,977
TOTALS	***161,751***	***35,155***	***66,045***	***8,401***	***8,033***	***20,919***	***9,642***	***16,453***	***23,858***	***188,504***

Column A – Deferred Services: Last year, the IHS deferred payment for 161,751 recommended cases totaling $179 million. This amount is computed by multiplying the average CHS outpatient cost of $1,107.00 times the number of deferred services. Deferred services that are those within the CHS medical priorities (usually Priority One or Two) however there simply was not enough funding the cover the costs of care. This is the highest amount that deferred payments in the CHS program have ever been.

Column B – Denied Services: In 2007, IHS programs denied care to 35,155 eligible cases, because they were determined not to be within medical priorities (Priority One). This is a 10% since 2005. Every year tribes simply do not submit claims since they know that in the last quarter claims are not likely to be approved. Thus, this number could be significantly higher.

Columns C, E, F, and G: Represent denied service categories that are generally not reflected in denied service reports by the IHS. These categories represent policy and procedural decisions that typically disqualify an individual from 'covered care', however they would be eligible if the CHS program was funded at an adequate level.

Column C – Alternate Resources: Represents individuals that were denied services because of the CHS payer of last resort or alternate resources rule. This simply means that an individual was eligible for services under another health program like Medicaid or another source; and does not mean that the individual would have received services had the resource not been available. The estimated funding to cover the CHS costs these individuals is $73 million.

Column E – No Emergency Notification: Represents individuals that needed to receive emergency or urgent care within the CHS medical priorities from a non-IHS provider however did not report their visit within the required 72 hours to the IHS or Tribal CHS program. Thus, payment authorization was denied. The estimated

funding to cover the CHS costs of these individuals is $9 million.

Column F – No Prior Approval: Represents individuals that received non-emergency services from a non-IHS provider and were within the medical priorities, however were denied payment authorization since they could have been delivered by an IHS provider. The estimated funding to cover the CHS costs of these individuals is $23 million.

Column G – Resides Outside CHSDA: Represents those individuals that requested CHS services but were denied because they reside outside of the Contract Health Service Delivery Area (CHSDA).[1] These are individuals that require services within the CHS medical priorities however may have been away from the reservation for more than 6 months or may not qualify for CHS funding for other reasons. The estimated funding to cover the CHS costs of these individuals is $11 million.

Finally, the Catastrophic Health Emergency Fund (CHEF) is intended to protect CHS programs from overwhelming expenditures for catastrophic health cases and ensure their financial stability. In FY 2007, there were 738 CHEF claims totaling $18 million. There were 895 cases totaling $20 million that went unpaid and were absorbed by local CHS budgets. The actual unfunded need is at least $20 million because the fund is usually depleted by the third quarter of the fiscal year and many Tribes stop making application to the CHEF once it has been depleted.

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NPAIHB Policy Brief is a publication of the Northwest Portland Area Indian Health Board, 527 S.W. Hall, Suite 300, Portland, OR 97140. For more information visit www.npaihb.org or contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email jroberts@npaihb.org.

February 15, 2001

Dear Dr. Trujillo:

We are pleased to present to you a recommended CHS distribution methodology for your consideration and, if acceptable, for presentation to the Tribal Leaders National Consultation meeting in March. We extend our appreciation for your leadership and support for the workgroup and assistance in this consensus-building process. Your comments and words of encouragement in our meeting in San Diego, California, are appreciated and have indeed given us the needed direction in completing this important charge.

The CHS Allocation Work Group and the Technical Sub-Work Group have worked extensively in the short time that they have collaborated through a consensus building process. There was extensive discussion concerning this resource allocation methodology which should not be considered as a tool for budget projections to meet the health needs of the Indian population. It was determined that as an allocation methodology, the use of a health status indicator was not as critical as if used in a budget projection tool focused on particular health needs.

The input and contributions made by each member have been invaluable. Throughout the development process the Work Group members continually demonstrated a focus on services and dedication in meeting the health care needs of all American Indian and Alaska Natives. Many issues and concerns that impact CHS were discussed. However, there are still some matters that were not resolved simply because of limited time and data resources. The Work Group has made recommendations for future review and these are contained in the report. This process has indeed opened our eyes and caused us to realize that there is still a great deal of work to be done by the IHS and Tribal leadership.

We appreciate your comment, "This is not the end but a beginning in building a future process." Again, thank you for your support. We are proud to have been a part of this process. We believe we are providing you with a CHS distribution methodology that is both acceptable and workable.

Sincerely yours,

Vern Donnell
IHS Co-Chair
CHS Allocation Work Group

Lydia Hubbard-Pourier
Tribal Co-Chair
CHS Allocation Work Group

Recommended
FY 2001 Contract Health Service (CHS) Formula

Introduction

Contract Health Services (CHS) is a line item in the Indian Health Service (IHS) budget intended for purchasing health care services from the private sector for eligible beneficiaries. Use of CHS funding is governed by special regulations that are more restrictive than other IHS services. For example, CHS can only be used for eligible beneficiaries who live in a Contract Health Service Delivery Area (CHSDA) and alternate resources must be used first. Prior authorization is required for all referred care and emergency services must be reported within 72 hours. Historically, CHS funding has been so limited that a priority system has been developed to ration CHS resources.

In some cases, CHS is used to contract for services that are delivered in an Indian health facility. For example, it may be more cost effective to contract for a physician in private practice to hold a cardiac clinic in an IHS facility once a week, rather than referring patients to a cardiologist for appointments at the physician's office. Therefore, the distinction between the CHS and Hospitals and Clinics (H&C) line items is often blurred. Tribes that have P.L. 93-638 contracts and self-governance compacts have the authority to reprogram funds between line items in order to meet their service requirements.

There is a wide range of dependency on CHS as part of the overall personal medical services provided through the IHS. In most places, CHS is used to augment services that are provided by the IHS and/or tribes. For example, CHS is typically used to procure specialized medical services beyond the scope of the IHS/Tribal (I/T) services, such as cancer treatment. American Indians/Alaska Natives (AI/AN) rely on CHS for all of their inpatient care in the California and Portland Areas, and for nearly all their inpatient care in the Bemidji and Nashville Areas. Newly-recognized tribes currently receive all of their initial funding through the CHS line item. Some tribes rely exclusively on CHS and do not operate any outpatient or inpatient services. In a few cases, IHS funding is used to purchase a managed care plan for tribal members.

Over the years, various formulas have been used to distribute CHS funds. In response to tribal requests, Dr. Michael Trujillo, Director of the IHS, formed a CHS Work Group to solicit tribal input and recommend how the new CHS funds should be distributed. (Letter of charge is attached) This paper summarizes those recommendations from the Work Group to Dr. Trujillo and are subject to further tribal consultation and comment.

Process for Developing Recommendations

The CHS Work Group (WG) developed the following basic design principles:

- The formula should be designed based on principles rather than showing the results of the formula first.
- Common factors will be applied across the IHS and tribal programs.
- While scarce resources mean that unmet needs exist at all CHS locations, the challenge is to describe the CHS need from one program to another.
- The CHS formula should be rational, reasonable, defensible, manageable, fair and equitable.
- Population size should be considered in the CHS distribution formula.
- Growth factors should be considered.
- Total dependence on CHS for ambulatory and inpatient services should be considered.
- The most current and complete data should be used, in most cases current or prior fiscal year only.
- The simplest data driven formula possible should be used.
- The formula will have multiple factors.
- The formula should maintain buying power and be inflation proof to the extent possible.
- The formula should incorporate differences in health care costs at the point of service.
- CHS funding for new tribes should come from new CHS appropriations, and non-CHS funding for new tribes should not come out of the CHS appropriations.

A Technical Work Group (TWG) was formed to consider the availability of data and to develop approaches that would meet the criteria set forth by the WG. The TWG evaluated six different options using the above criteria. These options included:

1. Distribute CHS "Program Increase" using the "Percentage of Historical Base" method.
2. Distribute the new funds using the same allocation formula as last year.

3. Distribute using a direct allocation to the operating units in greatest need of CHS resources.

4. Distribute the new funds using the same allocation as last year, except revising or "tweaking" the three variables.
(Workload, Health Status, and CHS Dependency).

5. Distribute based on a mixture of historical and a new formula.

6. Distribute on a whole new formula using cost and demand for services.

When the options were evaluated using the principles developed by the WG, Option 5 was selected as the approach that was most responsive to the direction provided by the WG. This option was further developed by designing a conceptual framework, identifying possible data elements, and selecting and combining the data elements into a formula.

Background Information Regarding the Old Formula

The FY 2000 CHS distribution formula was made up of three components, and a percentage of the appropriated funding was allotted to each component as follows:

	Relative Weight	FY 2000 Allotment
a) Workload/Cost	20%	$2,632,000
b) Years of Productive Life Lost (YPLL)	40%	$5,264,000
c) CHS dependency	40%	$5,264,000

Workload/Cost

The Workload/Cost component accounted for the volume of CHS services produced within each IHS Area. Services counted included dental, outpatient, inpatient, and patient/escort travel costs. The volume of services produced in each of the first three categories was taken from numbers reported to the IHS, multiplied by an average cost calculated from IHS fiscal intermediary data. Patient & Escort travel was based on actual reported costs.

The total values for each of the four sub-categories were added together, and then multiplied by a cost index factor based on the HCFA wage index for each IHS Area. The adjusted cost for each IHS Area was compared to the actual recurring base for each Area to determine a shortfall amount for each Area. These shortfall amounts were added together, and a proportional percentage of the total shortfall was assigned to each Area as the amount to be received from the funds available for distribution under the Workload/Cost component of the formula.

This approach was found to be problematic because:

- Workload was limited by available funding, which is not a good measure of CHS need.
- Data was incomplete, due to utilization data from the Fiscal Intermediary (FI) only. Many tribes do not use the FI.

Years of Productive Life Lost (YPLL)

The YPLL component of the formula calculated a value of excess years of productive life lost for each IHS area in relation to the U.S. rate. Funding available for this component was allotted based on a proportional percentage of the total excess YPLL for each Area.

This approach was found to be problematic because:

- It does not relate to the cost of treating illness, but rather reflects the cost of disease to society in terms of lost wages and taxes.
- It assigns much greater weight to disease that occurs in youth, which does not actually cost CHS more to treat than disease that occurs in elders.
- It relies on death statistics that are not accurate for AI/AN in some states.

CHS Dependency

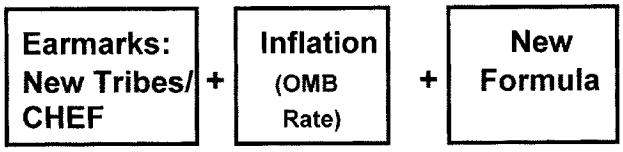
Inpatient admissions were used to calculate dependency for each Area, the number of CHS inpatient admissions was divided by the total admissions (CHS and IHS). The IHS average percentage for CHS dependency was 23.9%. The five Areas below this average did not receive any allocation for this component of the formula. A proportional amount of the total above the average was recalculated and allotted to the remaining seven Areas.

This approach was found to problematic because:

- The dependency factor in no way related to the population to be served. For example, certain Areas having large inpatient CHS workloads received none of this funding.
- It did not recognize that all Areas have some degree of dependency on CHS.
- It relied on a distorted scale that had only limited validity in describing the differences in scope of CHS services. Using this approach, the amount allotted per admission was $1,826 in one Area and $42 in another Area. Five Areas had $0 per admission.
- The data became distorted when applied to an Operating Unit (OU) level.

Overview of the Recommended Distribution Plan

The FY2001 budget for the IHS provides an increase of $40 million in the CHS line item. The new CHS funding is divided into three parts: I. Congressional earmarks, II. Inflation funding; and III. New formula.



The mandatory funding for CHEF, Ketchikan Indian Corporation (KIC), and new tribes is specified in legislative intent. These funds should be determined first and the remaining amount will be available for inflation funding and the new formula. The WG recommends that IHS reserve the minimum amount necessary to meet the needs for new tribes. If too much funding is reserved for new tribes, the excess will be distributed at the end of the year using the new formula. However, there is a general consensus that allocation of CHS funding is desperately needed as soon as possible.

For FY 2001, it is estimated that about $4.1 million will be needed for CHEF, KIC and new tribes. That leaves about $35.8 million for distribution using inflation adjustment and the new formula. The division in funding between inflation adjustments and the new formula presents several challenges:

- Inflation funding preserves the historic base, which some Areas believe is not equitable. The more that is allocated for inflation, the less that is available for the new formula, which is presumed to be more equitable.

- The $40 million in new funding for CHS in FY2001 is sufficient to allocate funding for both the recommended inflation adjustment and the new formula. However, if new CHS funding is less and/or the inflation rate increases in future years, the entire amount may be absorbed by the inflation adjustment. In that event, there would be no funding available for the new formula unless inflation funding was constrained to a specific portion of the available funding.

The WG could not agree on a percentage distribution of the inflation adjustments and the new formula. The WG recommendation is to fully fund the inflation adjustment at the OMB medical inflation rate and to use the remaining amount for the new formula for FY2001. The WG further recommends that allocation percentages be reconsidered in FY2002.

The new formula has three basic factors that are multiplied together: (a) user population; (b) relative cost of purchasing services; and (c) access to care. The result of this computation is a number that is used to calculate the proportion of the allocation that goes to each operating unit.

New Formula:

Operating Units

The WG recommends that calculations be made at the operating unit (OU) level, as defined in the Level of Need Funded (LNF) methodology. However, funding for all operating units in an Area are also added together to determine the Area funding level which would include funding for medical centers, which may not be recognized as OUs. In consultation with tribes, Areas may decide to redistribute funds using a different approach.

Now that we have presented an overview of the recommended distribution plan, we will provide more details about each part of the formula.

I. Congressional Earmarks

Legislative report language for FY 2001 earmarks a portion of the new CHS funding for CHEF, Ketchikan Indian Corporation and unfunded tribes[1].

Catastrophic Health Emergency Fund (CHEF)

In the 2001 Interior Appropriations Conference Report 106-914, September 29, 2000, the following language appears:

> Language is included raising the amount for the Catastrophic Health Emergency Fund from $12,000,000 to $15,000,000 ...

Therefore, $3 million of the new funding is reserved for CHEF.

[1] Unfunded tribes include restored/reinstated tribes, newly federally recognized tribes and existing federally recognized tribes that did not previously receive funds.

Ketchikan Indian Corporation (KIC)

In the 2001 Interior Appropriations Conference Report 106-914, September 29, 2000, the following language appears with regard to KIC:

> *Within the funding provided for contract health services, the Indian Health Service should allocate an increase to the Ketchikan Indian Corporation (KIC) recurring budget for hospital-related services for patients of KIC and the Organized Village of Saxman (OVS) to help implement the agreement reached by the Indian Health Service, KIC, OVS and the Southeast Alaska Regional Health Corporation on September 12, 2000. The additional funding will enable KIC to purchase additional related services at the local Ketchikan General Hospital. The managers remain concerned that the viability of Alaska Native regional entities must be preserved. The accommodation by the managers of the September 12, 2000 agreement in no way is intended to imply that similar requests for similar arrangements will be encouraged or supported elsewhere in Alaska.*

The agreement referenced in the above language commits $140,000 from CHS funds.

Unfunded Tribes

Recent IHS policy has been to request funding for newly-recognized tribes from the Contract Health Services fund. This approach was taken for several reasons; one being that a newly-recognized tribe would not likely have access to an IHS facility from which to receive health services, but would be required to purchase health care. It appears that this approach also may have been beneficial in order for the agency to retain the funding availability should the tribe not commence services in the year in which funds were appropriated. There was a concern that if funding were requested in another category of the IHS budget, those funds appropriated would not retain their availability beyond one year.

Senate Report 106-312 stated, "The Committee notes that within the contract health services activity, funds will be available to the Cowlitz Tribe for the provision of health care, if the tribe is recognized within the coming year." There was no language in the Appropriations Act itself regarding funding newly-recognized tribes in FY 2001.

Recommendations for Unfunded Tribes

1. Estimate for unfunded tribes should be reserved from the FY 2001 CHS appropriation increases to the IHS. Although the report language of the Senate does not carry the force of law, it does express the understanding of the Congress and the terms under which the increases were appropriated to the IHS for FY 2001.

In order for the agency to act within the probable intent of the Congress, it is recommended that CHS increases be utilized to fund tribes that commence health services in FY 2001.

2. The process for requesting budgetary needs for unfunded tribes for FY 2002 and forward should be changed. Justifying unfunded tribal needs along with the funding needs of existing CHS programs is not congruent and confuses the purposes for the increase. Resources for unfunded tribes should be approached in a manner similar to that of inflationary, pay cost and other "uncontrollable" increases to the budget and addressed as a separate line item. The language accompanying the unfunded tribes budget request should provide for "no year" or similar designation, and that such funds may be reprogrammed to the appropriate sub-sub activity(ies) of the IHS once the tribe becomes active in the system. In its meeting of January 18, 2001, the CHS Work Group was informed by a representative of IHS Headquarters that a different method of pursuing appropriations for unfunded tribes would be employed for FY 2002.

3. The process for estimating amounts for unfunded tribes requires revision. For FY 2001, the planning figure utilized by IHS Headquarters for unfunded tribes was approximately $7 million, which could be "set aside" from the appropriation increase of $40 million. Since this set aside affects the amount of new CHS funds to be distributed to existing programs, the CHS Work Group believes it necessary to make recommendations regarding the process for determining planning estimates that are used for this purpose. The Work Group received information from the IHS Office of Tribal Programs (OTP) regarding the existing process to provide resources to unfunded tribes. Based on this information, the Work Group makes the following recommendations regarding any "set aside" of funds from CHS in FY 2001, as well as the process for developing these estimations in general:

   A. *The prior estimate of $7 million should be revised to be more realistic.* Due to information that the OTP now has concerning the recognition status of several tribes and the requisite appellate processes, it is anticipated that the tribes that may be funded for the first time in FY 2001 are:

	IHS Estimated Funding
➢ Cayuga Nation (Nashville	$426,813
➢ Onondaga Nation (Nashville):	$1,350,675
➢ Graton Rancheria (California):	$331,931
➢ Kodiak (Alaska):	no estimated amount
➢ King Salmon (Alaska):	no estimated amount
➢ Lower Lake Rancheria (California):	no estimated amount
➢ Loyal Shawnee (Oklahoma)	no estimated amount
TOTAL:	$2,109,419

The population numbers and per capita costs for the Kodiak, King Salmon, Lower Lake Rancheria and Loyal Shawnee tribes are unknown at this time, and a projected dollar amount has not been estimated by OTP.

B. *The planning estimate for unfunded tribes should utilize an estimated user population, rather than tribal enrollment.* All existing tribes must use user population in distribution of funding. User population is generally substantially lower than tribal enrollment. For consistency in funding, it is more appropriate to use a projected user population for the first year, which may be adjusted in 1-2 years once an actual count is known. To achieve such an estimate, the IHS may use a national or Area ratio of user population to total tribal enrollment, applied to the tribe's enrollment.

C. *Any resources for unfunded tribes made available from CHS appropriations should not include Area/HQ residual funds.* Currently, funds are reserved from CHS for IHS residual funds for these tribes. It was noted by some Area representatives that CHS funding may not be used for residual purposes. In addition, it is inadvisable to utilize CHS funds for residual, in order to justify further increases to the Congress.

D. *Resources for unfunded tribes should not duplicate existing IHS services.* It was determined by the Work Group that many of the unfunded tribes being monitored by OTP were currently being served by the IHS, and had user population numbers already in the system. When OTP estimates a population for purposes of new funding, it does not account for services already being provided in the IHS system. The Work Group recommends that any existing user population of an unfunded tribe be considered in estimating the new funding required.

E. *Resources for unfunded tribes should be accurately prorated to reflect the actual period that the funding is to cover.* In practice, allocation to new tribes is often delayed and funding is not needed to cover the entire year. The Work Group felt the IHS should accurately pro rate the new funding to cover the actual period needed from approval of a new tribe to the end of the fiscal year.

Given the issues above, the CHS WG recommends that only $1 million be set aside at this time for unfunded tribes, with up to an additional $1 million distributed to OUs non-recurring in FY 2001 to be utilized for annualized funding in future years, should it become necessary.

4. Any reserved resources for unfunded tribes not expended should be redistributed according to the new CHS formula. The IHS should establish a reasonable "cut-off" date to redistribute unused funds on a recurring basis. This redistribution of resources reserved for unfunded tribes should be implemented with sufficient time for tribal and IHS programs to put the funds to good use.

II. Inflation Funding

Inflation has consistently eroded the purchasing power of CHS funds for all IHS and tribal programs over the past decade. This problem has been particularly acute for the CHS program as medical inflation rates in the early part of the decade were rising 2 to 3 times faster than the increases provided by Congress to the CHS program.

Several different inflation rates were considered and it was acknowledged that there may be regional variations in the medical inflation rate. Although the OMB medical inflation rate usually understates the true rate of inflation of medical costs, the WG recommends using the OMB medical inflation rate in the formula for the following reasons:

- This rate was approved by OMB for the federal budget so it has legitimacy for the administration and Congress. If Congress had funded inflation for CHS as a specified line item, this is the rate they would have used.

- This rate is more consistent with the rate the IHS uses for the Hospitals and Clinics portion of the budget, so inflationary increases will be reasonably consistent across CHS and directly operated programs

The OMB medical inflation rate for the FY2001 budget is 3.9 percent. This is multiplied by the FY2000 OU base budget for CHS of $389,922,579 for a total of $15,206,981 to be distributed for this portion of the allocation. This leaves about $20.5 million to be distributed using the new formula.

The Work Group also discussed at length whether the amount of funding for inflationary costs should be capped at some portion of the overall appropriation. Although the Work Group did not recommend this cap for the FY2001 distribution, it did recommend that this issue be revisited in subsequent years. The importance of this cap is directly related to the size of the future year appropriations. To the extent that these appropriations fall below the OMB approved medical inflation rate, there may be no funds left to distribute using the second portion of the formula if there is no cap.

III. New Funding Formula

The new funding formula starts with active user population. This number will be adjusted by multiplying by two modifying factors. The first factor will be a cost adjustment factor derived from the American Chamber of Commerce Researchers Association (ACCRA) cost of living index[2] which provides regional comparative costs for dental, doctor visits and hospital days. The second factor provides an additional upward adjustment for operating units that do not have access to a IHS or tribal hospital.

Active Users

A basic assumption is made that as more people are served, more funding is needed for CHS. The formula is to be based on the number of active users that reside in a CHSDA in the operating unit. The data are to be the most recent available from the IHS data system when the distribution is made.

Cost Adjustment Factor

The Work Group recognizes that it cost more to purchase medical care in some parts of the country than in other places. Thus, the formula recognizes the relative cost of purchasing care in different geographic areas of the country. The formula takes into account the relative costs of inpatient care and outpatient care. Several indices were considered, including the composite cost index utilized by LNF formula and the ACCRA Regional Cost of Living Index published by the ACCRA. The Work Group selected the ACCRA index because it is independently maintained and because it has costs of care for physician visits and hospital day for over 317 geographic areas.

The cost adjustment factor is a composite of the relative costs of a doctor visit and hospital day. Each factor will be weighted by the relative proportion of this type of service that is purchased by CHS funds nationally using FI data from FY 1999. This weighting is:

Inpatient	65%
Outpatient	35%
	100%

There was active discussion in the Work Group regarding the inclusion of travel and dental in the cost adjustment category. However, both the inpatient and outpatient service represent the major expenditures for the CHS program, thereby excluding consideration for dental and patient/escort costs. The Work Group chose not to include travel costs[3] in the formula due to difficulties in obtaining accurate data on travel in time for the FY2001 distribution.

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[2] ACCRA Cost of Living Index, Comparative Data for 308 Urban Areas, Vol. 33. No.3, published January 2001

[3] The Alaska representative asked to go on record in opposition to this decision.

The cost adjustment factor is constructed as follows:

Cost Factor = **.65**(Inpatient Cost) + **.35**(Outpatient Cost)

Where:

Inpatient Cost = cost of hospital day in referral location compared to national average.

Outpatient Cost = cost of doctor visit in referral location compared to national average.

The cost factor is determined by combining a percentage of the relative cost of each component. The weight should reflect the current national percentage of the contract health funds expended in each category (the percentages provided are estimates based on the FY99 distribution data). The Work Group also agreed that the cost factors selected are the CHS referral locations for the operating unit. Or if data in ACCRA was not available, the closest location to the OU in the ACCRA report was used.

Access to Hospitals Operated by IHS or Tribes

The Work Group also felt it was important to recognize that some operating units rely solely or more heavily on CHS funding for all inpatient care. The group had some difficulty clearly defining exactly what variables could be used in the formula to accurately describe this access.

After discussion the Work Group agreed that operating units without access to IHS or Tribal hospitals should receive an additional adjustment factor in this portion of the formula. This factor of 1.25 would be multiplied by the number of active users in the qualifying operating units.

The OUs will qualify for the 1.25 adjustment if they meet the following criteria:

- There is no IHS/Tribal hospital in the OU with an Average Daily Patient Load (ADPL) of 5 or more; and,

- The OU does not have an established referral pattern to an IHS/Tribal hospital. The established referral pattern means that more than 50% of inpatient admissions go to an IHS/Tribal hospital.

Several Work Group members felt that the adjustment should be more complex and take into account the full range of dependency on CHS or access to direct facilities. Virtually all Work Group members felt that this adjustment factor should be refined in future allocation methodologies to more fully reflect the complexities of the IHS delivery system. For the current year, however, the Work Group could not provide a more accurate adjustment factor that they felt was understandable and based on scientifically accurate and valid data.

Final Calculation of the New Formula

The user population, cost adjustment, and the access factor are multiplied together to obtain a numeric value for each OU. These values for each OU are added together for a total for the entire system. Each OU number is divided by the total to create a percentage of the total. This percentage is applied to the remaining resources (after subtracting the amounts for earmarks and inflation adjustments from the initial appropriation).

Effects of the Rescission

In the FY 2001 budget, there was a 0.22% rescission to balance the federal budget in accordance with P.L. 106-554. This 0.22% was taken against the entire recurring base of the agency. The work group recommends that the formula be calculated on the entire appropriation prior to the rescission. This means that after the formula is applied, each OU allotment will be reduced by 0.22% of each OU's recurring CHS base, which must result in a total reduction of $949,863.

Summary of the Distribution Plan

After the funding for earmarks is reserved from the appropriation the remaining CHS funding increases will be distributed as new funding. These funds will be distributed on a recurring basis. This formula is expressed mathematically as follows:

Inflation Funding = CHS Base for OU x 3.9% (OMB inflation rate, 2001)

New Formula Funding = Active Users for OU x Cost Factor x Access Factor (Converted to proportionate percentage)

Process for Tribal Review of Data

Once the formula is approved for use, it is important that the accuracy of the data be verified by Areas and the Tribes on an annual basis. The WG recommends that the Tribes receive the opportunity to review data in the formula and make corrections prior to distribution of funds. The WG thinks it is also important to distribute the new funds in the first quarter of each fiscal year. If this formula is used for FY 2002 the only data that must be updated is active user data and the inflation rate. If the formula is going to be revised in any future year once it's approved, it should be done prior to the beginning of the fiscal year to ensure a distribution in the first quarter.

The following dates are submitted for consideration, to insure adequate time is allowed for tribal review of data for FY 2001 and in future years.

2001 Tribal Consultation Process

March 8-9	Tribal Consultation
March 12	Dr. Trujillo decision
March 13-25	Tribe Review Data
March 30	2001 Distribution

Future Year Allocations

July	Form WG, if necessary
August -September	Review formula, including cap on inflation
September-October	Tribes review data
10 days after apportionment	Distribute Funds

Suggestions for Future Refinements in the Formula

The formula presented for 2001 represent the best effort given available data and timeframe. The WG recommends refinements of the formula in future years. Some of the issues that have been identified for review are:

- Review the cap on inflation
- Seek verifiable data on patient and patient escort travel for inclusion in the formula and determine what cost index to use, including reasonable costs.
- Review and refine access to care factor.
- Representatives from all the Area be selected on an equal basis
- Review definition/designation of OUs
- Insure equal representation in future Work Groups

Questions and Answers

1. Why didn't the WG use the Level of Need Funded (LNF) formula?

The TWG and WG did discuss using the LNF formula. This could have been accomplished by subtracting the hospitals and clinics (H&C) appropriations from the LNF to determine the unmet need for CHS, and then allocating proportional share to all operating units. However, this idea was rejected for two reasons:

- The charge to the WG was to develop a formula that is independent of other formulas.

- While the LNF tribal consultation process has not yet been completed, it appears that consensus was forming to use the LNF formula only for the Indian Health Care Improvement Fund.

2. *Why is health status not a factor in the CHS allocation formula?*

Health status indicators are important for the Indian health system as a whole to help Congress understand the extraordinary needs for health care funding. The TWG believes that this additional funding for CHS is essential to improve the health status for American Indians and Alaska Natives in all IHS Areas. Specific measures of health status are not included in the allocation formula for the following reasons:

- Health status by itself is not an indicator of CHS need. Two tribes with similar health status with different delivery systems may vary widely in their CHS funding needs.

- The CHS distribution methodology is not a measurement of budgetary needs. The LNF process, which is designed to be a valid estimate of overall budgetary needs, includes CHS. LNF does fully factor in health status among Areas in the funding methodology.

- Health status measures based on mortality are not accurate at the operating unit level. The populations are so small that calculating rates of death due to specific diseases would be misleading and fluctuate wildly from year to year.

- Mortality statistics come from states. They often do a poor job of identifying AI/AN, which results in undercounting in some Areas.

- There is no tribe that believes its tribal members have good health status. Different tribes suffer from different types of health problems. Deciding how to weight health problems (i.e., which type of health status deficiency is most important) should be a matter of tribal sovereignty.

- Measures of health status used in the CHS formula should relate to costs borne by the CHS. Some high cost diagnoses are predominantly paid by alternate resources. For example, Medicaid pays for a high percentage of deliveries and neonatal intensive care, Medicare pays for dialysis, and CHEF pays for complicated injuries. Furthermore, special funding is available to some extent to address some of the health status disparities in AI/AN populations, including programs for injury prevention, tobacco cessation, mental health, substance abuse, and diabetes.

- Previous CHS formulas used Years of Productive Life Lost (YPLL), but this is not a good health status indicator to use in the distribution of IHS funds. It does not relate to the cost of treating illness, but rather reflects the cost of disease to society in terms of lost wages and taxes. Also, it assigns much greater weight

to disease that occurs in youth, which does not actually cost CHS more to treat than disease that occurs in elders.

- Research and better data on disease prevalence are needed to accurately select health status indicators that relate to the cost of CHS.

- Health status is meaningful in comparing the AI/AN population to the general U.S. population for justification of new funding, but less meaningful in allocation of funds within the IHS among Areas and Tribes.

3. Why was 1.25 chosen as the factor for OU's without hospitals?

The Work Group felt that "dependency" or access to care in IHS/Tribal facilities should be an important consideration in developing a formula for distribution of CHS funding. There is a wide diversity in how CHS resources are used and how OUs are organized. There was not a clear consensus of how this "access" or "dependency" was to be defined and no objective indicators could be found.

Despite this lack of empirical data the Work Group felt it was important to provide an adjustment for access to care in IHS/Tribal facilities. After some discussion, the somewhat subjective decision was reached to provide the 25% modifier to facilities not able to access IHS or tribal inpatient facilities.

4. Why was an Average Daily Patient Load (ADPL) of 5.0 chosen as a cut off in the "access to care" factor?

The Work Group examined services provided by very small hospitals and determined that very small hospitals did not offer a range of services that would substitute for CHS expenditures. Specifically, in the smaller hospitals, there are no or few deliveries, no anesthesiology services, and no surgeries. A total of fourteen (14) of forty-nine (49) IHS/Tribal hospitals were not considered "access to care" due to the limited scope of services provided. Furthermore, the limit of 5.0 ADPL is consistent with the threshold established in the IHS facility planning methodologies.

5. Why were ACCRA data utilized and not CHS fiscal intermediary (FI) data?

ACCRA is the most commonly recognized and used database to describe geographic differences in costs. Conversely, the FI data are not complete because some Tribal health data are not included. The FI data do not provide comparable unit costs across geographic areas. Furthermore, the expenditure data in the FI system have inconsistencies of provider rates obtained through contractual arrangements at locations throughout the country.

6. *How was the 65/35 weight for the cost factor determined?*

The Work Group based this weight upon the FY99 cost data from the F.I. Total inpatient and outpatient billed charges were compared, and the resulting percentages for inpatient and outpatient were determined to be 65% and 35%, respectively. These national averages were used consistently across OUs to weight the cost factor. Although the F.I. data do not include all tribes, they are expected to be representative of the system. There is significant variation between operating units in the utilization of CHS resources between inpatient and outpatient resources. Despite these shortcomings, the index does reflect a significant percentage of the cost variation experienced in the CHS program. Furthermore, data to reflect the actual conditions in each operating unit are not readily available, and is relatively insensitive to the changes in this ratio. Dental CHS costs, which reflect less than 3% of all CHS costs are not included.

7. *Why were travel costs excluded from the relative cost adjustment in the 2001 formula?*

Travel costs were excluded from the formula because the data available on CHS travel costs was incomplete. In addition, travel cost cannot be indexed for cost like other elements of the formula, and there are no valid sources for this index. This is because travel costs vary due to location, distance and mode of transportation, not in relationship to the unit cost of travel. For example, travel costs may be much higher because of long distances, not because it costs more per mile. A valid cost index for travel should compare relative cost per trip for patient and patient escort travel and no such index is available.

8. *Why didn't the WG recommend taking the rescission "off the top" before distributing the $40 million increase?*

Congress legislated a government-wide recission in P.L. 106-554. This rescission is a reduction to the entire IHS recurring budget (across the board). This means that the 0.22% must be applied to not only the $40 million increase, but also to the recurring CHS OU base of $389,922,579 that has already been distributed. The rescission rate must be applied to the recurring CHS base, as well as to the new CHS funding. The IHS should also avoid a "pay back" of funds already allocated to the local level. To accomplish this, the rescission should be deducted from each OU's increase after the formula is applied, but before funds are distributed. In this way, the $40 million is allocated and the 0.22% rescission is accurately applied to all CHS allocations.

APPENDIX A

CHARGE TO WORKGROUP

The charge to the Workgroup is to provide a formal written recommendation to the Director of Indian Health Services on a CHS distribution methodology that considers a variety of complex factors such as but not limited to: 1) Inflation, 2) separation of CHS from direct service formulas/methodologies; 3) CHS dependent environments; 4) utilization of CHS funding for provision of services provided at IHS facilities; 5) variables in cost allocations; and 6) access to health care providers and services. The Workgroup will consider options for forecasting resources and costs that are widely recognized in the health industry and Federal government and are also practical to apply. The workgroup will advise on means to measure available resources that are necessary to compute a CHS percentage that is equitable. Areas in consultation with tribes will have the authority to further develop distribution methodologies according to the I/T program needs.

WORKGROUP COMPOSITION

The Workgroup will be composed of tribal and IHS representatives and from selected from Area. Representative to the workgroup may be comprised from the Tribal Self-Governance Advisory Committee, the National Indian Health Board, the Indian Health Leadership Council, tribes and the IHS. A Federal and a tribal co-chair will be elected at the initial meeting. Indian organizations, other Federal agencies, and various institutions may be sought from time to time, with supplemental work by IHS staff.

LOGISTICS AND SUPPORT

The Workgroup will meet as necessary, with logistical support provided by IHS Headquarters. The budget authorized for the support of the Workgroup will be determined on a quarterly basis and travel expenses for the Workgroup for no less than three meetings will be authorized. Consultant services if needed will be funded as appropriate.

EXPECTED PRODUCTS

The CHS Allocation Workgroup is expected to complete its charge by February 28, 2001.

APPENDIX B

Mathematical Description of recommended formula:

$$\Delta CHS_{OU} = (CHS_{base} \times INFLATION_{omb}) + \left[\frac{(ACTIVE\ USERS_{OU} \times COST_{adj.} \times ACCESS_{dir.\ hosp.})}{\Sigma_{IHS}(ACTIVE\ USERS_{OU} \times COST_{adj.} \times ACCESS_{dir\ hosp})} \right] \times APPROP._{remaining}$$

Where:

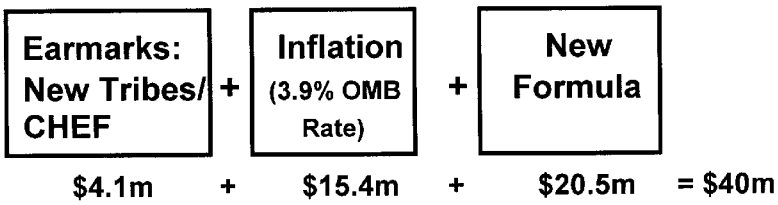
ΔCHS_{OU}	= the increase in CHS funds for each operating unit
CHS_{base}	= the base CHS recurring funds for each operating unit (excludes CHEF funds which are NR)
$INFLATION_{omb}$	= The inflation rate for medical programs as defined by the Office of Management and Budget
$ACTIVE\ USERS_{OU}$	= The most recently available number of active users for each operating unit that reside in a CHSDA
$COST_{adj.}$	= cost adjustment factor based on the ACCRA regional cost data
$ACCESS_{dir\ hosp.}$	= a "yes/no" variable which indicates whether an OU has access to an IHS funded hospital
$APPROP._{remaining}$	= the remaining portion of the CHS increase after funds for CHEF, New tribes, and inflation adjustments have been removed from the total new funding.

APPENDIX C

FY 2001 Estimated Distribution

$40,000,000	New CHS Funding
(140,000)	Ketchikan Indian Corporation agreement
(3,000,000)	CHEF increase
(1,000,000)	New Tribe Funding (ESTIMATED)
$35,860,000	Remaining to Distribute
$15,395,484	Distributed According to Inflation Funding
$20,464,516	Distributed With New Formula (remaining approp.)

Rescission is deducted after calculation but before funds are distributed.



APPENDIX D

CHS Allocation Work Group Members
Vern Donnell, Co-Chair, Pine Ridge Service Unit, IHS
Lydia Hubbard-Pourier, Co-Chair, Navajo Health Systems Corp.
Everett Enno, NIHB, Aberdeen Area Indian Health Board
Don Kashevaroff, Alaska Native Tribal Health Consortium
Linda Cortez, Ysleta Del Sur Tribe
Deanna Bauman, Oneida Nation of Wisconsin
Gregg Duffek, Stockbridge Munsee Tribe
Kathy Annette, MD, Bemidji Area IHS
Anna Sorrel, Confederated Salish and Kootenai Tribe
Garfield Little Light, Billings Area IHS
Jim Crouch, California Rural Indian Health Board
Alternate: Rachel Joseph, Lone Pine Reservation
Brenda Commander, Houlton Band of Maliseet Tribe
Alternate: Tom John, Brenda Shore-Fuller, United South & Eastern Tribes
Douglas Peter, MD, IHS Chief Medical Officers, Navajo Area
Mickey Peercy, Oklahoma Area Tribal Health Board
Wanda Stone, Kaw Nation, Tribal Self-Governance Advisory Committee
Gloria Holder, IHS Contract Health Officers
Mariddie Craig, White Mountain Apache Tribal Council
Alternate: Judy Cranford, Paiute Indian Tribe of Utah
Eric Metcalf, Coquille Tribal Health Center
Julia Davis, National Indian Health Board
Richard Ramirez, Tohono O'Odham

CHS Technical Sub-Work Group Members
Vern Donnell, Co-Chair, Pine Ridge Service Unit IHS
Flora Odegaard, Aberdeen Area IHS
Dave Mather, Alaska Tribal Health Compact
Maria Clark, Albuquerque Area IHS
Gregg Duffek, Stockbridge Munsee Tribe
Garfield Little Light, Billings Area IHS
Tom John, United South & Eastern Tribes
Gloria Holder, Contract Health Officer Oklahoma Area IHS
Dan Cameron, Oklahoma Area IHS
Melanie Knight, Cherokee Nation
Mim Dixon, Cherokee Nation
Elvin Willie, Schurz Service Unit, IHS
Ed Fox, Northwest Portland Area IHB
Clayton Old Elk, IHS Headquarters

HQ Support

Craig Vanderwagen, MD	Carol Littlefield	John Yao, MD
Jim Bresette	Brenda Jeanotte	

The CHAIRMAN. Thank you very much, Ms. Holt.

Finally, we will hear from Ms. Brenda Shore, the Tribal Health Program Director at the United South and Eastern Tribes in Nashville, Tennessee. You may proceed.

STATEMENT OF BRENDA E. SHORE, DIRECTOR OF TRIBAL HEALTH PROGRAM SUPPORT, UNITED SOUTH AND EASTERN TRIBES, INC. (USET)

Ms. SHORE. Thank you and good morning, Mr. Chairman, members of the Committee, and tribal leaders. My name is Brenda Shore. I am an enrolled member of the Seminole Tribe of Florida and I am also one-half Cheyenne River Sioux from South Dakota. It is a pleasure to have you here, Mr. Johnson.

My career as an advocate for the rights, health and welfare of Indian people spans 13 years, the last 11 of which have been spent as the Director of Tribal Health Program Support for the United South and Eastern Tribes. USET is a coalition of 25 federally recognized tribes located in States from Maine, south to Florida, and west to Texas, that are served by the Nashville Area Office of the Indian Health Service.

I would like to acknowledge the USET tribal leaders in the audience, including our President directly behind me, Mr. Brian Patterson, Principal Chief of the Eastern Band of Cherokee Indians, Mr. Michell Hicks, to my left, as well as Mr. Buford Rolin, Chairman of the Poarch Band of Creek Indians, again to my left.

I commend the Chairman and the Committee for embarking on an in-depth scrutiny of the Contract Health Service Program. We all share the goal of raising the health status of Indian people "to the highest possible level." You and I both know that we have a long, long way to go to get to that goal.

The fundamental question is what can we do to improve the health status of American Indian people and finally achieve the goal as articulated in the Indian Health Care Improvement Act 32 years ago. Unfortunately, there is no easy answer, but looking at the Contract Health Services Program is a very good start.

To prepare this testimony, I consulted with my own panel of experts, the USET member tribes' health directors. One of them is sitting directly behind me, Casey Cooper, from the Eastern Band of Cherokee Indians. What I found was that all USET member tribes are heavily dependent on CHS to purchase in-patient care. There are only two facilities in the Nashville Area that offer in-patient care, and even they are very limited in what they can provide to their own population, let alone somebody presenting from another area or another tribe.

The highest portion of CHS funding is used to purchase out-patient care, including specialty care. Most tribes confirmed the widely known fact that CHS funds run out before the 12-month period that they are expected to cover. We had nine tribes report that their funding is gone before nine months, and three of those even before seven months.

There are dramatic differences between the per capita funding for CHS among our tribes. Some tribes are forced—and this is a quote from one of our tribes—to "cannibalize" their direct-care programs in order to purchase the outside care that their members need.

Only a small percentage of the tribes' CHS funds can be devoted to rehabilitative services such as physical therapy. Tribal leaders subsidize their health care programs when health care funding is

insufficient where they can. However, many tribes are not able to do this.

I urge this Committee to be a strong and persistent advocate for a substantial increase to the CHS funding appropriation. There are three fundamental reasons for doing so. First, this segment of the Indian health budget is essential to fulfilling the United States' trust responsibility to provide the quantity and quality of health services needed to raise the health status of Indian people to the highest possible level.

Second, this is the humane thing to do. Every American deserves access to decent and comprehensive health care. As an Indian and an American, it is very painful for me to see Indian people forced to live with untreated ailments. An example of this exists within my family. I have an uncle on the Cheyenne River Reservation who is 55 years old, but nearly immobile because of a knee injury suffered as a youth, a sports-related injury. This man lives with chronic pain day to day, but does not meet the priority-one level to receive a proper diagnosis or treatment. Our family thinks he needs a knee replacement, but we don't know that because he can't even get an MRI to tell us if that is what the case is.

With that situation, I implore you to think of the CHS review committees, which every day are forced with making these kinds of decisions about which tribal members will be forced to live with pain and who will get relief. I doubt that any of you would want to have to make those choices, especially when they affect your family, friends and community members. You have the power to eliminate the need for these hard choices.

Third, supplying funds for CHS is a good investment that benefits local economies. Mr. Chairman, I challenge you and anybody else in this room to dispute that fact. CHS dollars purchase medical services from non-Indian providers in near-reservation communities. This spending makes valuable contributions to the economic health of these communities.

In an April, 2008 Trend Watch report, the American Hospital Association pointed out that nationally, each hospital job supports almost two additional jobs and every dollar spent by a hospital supports more than $2 of additional business activity. You have a report attached to my testimony to that effect. They refer to this as the "ripple effect." Each additional dollar appropriated for CHS produces benefits at several levels. It improves the physical and mental health of Indian beneficiaries. It creates local health care provider jobs, and through the ripple effect, it contributes to enhanced business activity in the community and, of course, to its tax base.

By the same token, the local community is vulnerable to adverse consequences when an Indian health program is not funded sufficiently. An Indian beneficiary who cannot get CHS-funded care and has no additional resources is likely to present to a local hospital seeking treatment as an indigent patient. But no hospital, especially a small community hospital, can absorb an unlimited number of uncompensated cases without damaging its economic viability. The entire community, Indian and non-Indian alike, suffers when a hospital fails for economic reasons. Ms. Krein's testimony supports this theory.

Although IHS seeks an $8.8 million increase for CHS in fiscal year 2009, the resulting budget would actually enable us to purchase less care in every category. In my view, the overwhelming deficiency of the CHS program is that it is woefully under-funded.

I promise I am almost done.

I am not going to cover anything regarding the fact that the estimate 50 percent level of need is probably optimistic. Chairwoman Smith and Councilwoman Holt did an excellent job of that. The one thing I would like to mention, though, is Medicare-like rates and the way that tribes have been using those. As we approach the first anniversary of the implementation of that legislation, we will be in a better position to evaluate the extent to which CHS buying power has been increased, or if it has been increased.

Continued vigilance regarding improving the CHS program and extending its reach must be continued, while assuring that IHS budget requests for CHS do not attempt to offset any of the savings we have realized from Medicare-like rates by a reduction in or smaller than needed requested increases to the CHS appropriation. We hope that this Committee will share this oversight responsibility with us.

I am very grateful to have had the honor to address this Committee and to discuss the vital CHS program that Indian people depend on, but cannot count on. I thank you for the opportunity in my Native languages: [phrase in Native tongue].

I hope that I am invited to testify on behalf of my people again in the future. I am happy to take any questions that you have.

Thank you.

[The prepared statement of Ms. Shore follows:]

PREPARED STATEMENT OF BRENDA E. SHORE, DIRECTOR OF TRIBAL HEALTH PROGRAM SUPPORT, UNITED SOUTH AND EASTERN TRIBES, INC. (USET)

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Testimony of
Brenda E. Shore, Director of Tribal Health Program Support
United South and Eastern Tribes, Inc. (USET)

Senate Committee on Indian Affairs
regarding the
IHS Contract Health Services Program

June 26, 2008

Mr. Chairman and Members of the Committee:

My name is Brenda E. Shore. I am an enrolled member of the Seminole Tribe of Florida and am also one-half Cheyenne River Sioux. My career as an advocate for the rights, health and welfare of Indian people has spanned 13 years, the last eleven in my current position as the Director of Tribal Health Program Support for the United South and Eastern Tribes -- USET. USET is a coalition of 25 Federally-recognized tribes served by the Nashville Area Office of the Indian Health Service.[1] The USET tribes have reservations in 12 eastern and southern states extending from Maine to Florida and west to Louisiana and eastern Texas.[2]

I commend the Chairman and the Committee for embarking on an in-depth scrutiny of the Contract Health Services Program. This demonstrates that you recognize how vital the CHS program is to the goal we all share of raising the health status of Indian people to the "highest possible level" -- the aspiration recited 32 years ago in the Indian Health Care Improvement Act.

We have a long, long way to go to meet that goal. You know that and I know that. I will not here recite the extensive – and depressing – list of health measures that demonstrate that the health status of Indian people falls shockingly below that of every other racial, ethnic and social group in our nation. You know these statistics as well as I do.

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[1] The USET member tribes are: Eastern Band of Cherokee; Mississippi Band of Choctaw; Miccosukee Tribe of Indians of FL; Seminole Tribe of FL; Chitimacha Tribe of LA; Seneca Nation of Indians; Coushatta Tribe of LA; St. Regis Mohawk Tribe; Penobscot Indian Nation; Passamaquoddy Tribe Pleasant Point; Passamaquoddy Tribe Indian Township; Houlton Band of Maliseet Indians; Tunica-Biloxi Indians of LA; Poarch Band of Creek Indians; Narragansett Indian Tribe; Mashantucket Pequot Tribe; Wampanoag Tribe of Gay Head; Alabama-Coushatta Tribe of TX; Oneida Indian Nation; Aroostook Band of Micmac Indians; Catawba Indian Nation; Jena Band of Choctaw Indians; Mohegan Tribe of CT; Cayuga Nation; Mashpee Wampanoag Tribe.

[2] USET tribes are located in the states of Maine, Massachusetts, Rhode Island, Connecticut, New York, North Carolina, South Carolina, Mississippi, Alabama, Florida, Louisiana and Texas.

The fundamental question for all of us is: What can we do to improve the health status of Indian people and finally achieve the goal articulated in the IHCIA?

There is no single, easy answer. But focusing a long-overdue spotlight on the deficiencies of the Contract Health Services program and fashioning ways to cure those deficiencies are laudable steps toward achieving that goal.

Contract Health Services Program is Underfunded

In my view, the overwhelming deficiency of the CHS program is that it is woefully underfunded. By many accounts, it is funded at less than 50% of the level of need. Even that conclusion may be overly optimistic for several reasons: Measuring the extent of need necessarily requires *estimating* the cost of services which have **not** been provided – those which have to be deferred due to insufficient funds or denied because they do not meet stringent IHS medical priorities. I know that not all USET tribes track and report services that had to be deferred or denied, and suspect this is true of other tribes as well. Some tribes do not track these statistics as doing so requires expenditure of scarce administrative resources for accumulation of case information that has little likelihood of being funded. So, the extent of all tribes' CHS needs is not fully known.

Plus, to produce an up-to-date valuation of deferred or denied services, one must factor-in the appropriate increase in the Medical Consumer Price Index (CPI). A service needed in 2006 but which had to be deferred to a subsequent year will very likely cost more when it is finally delivered. And to the extent the condition of the patient has worsened over the period of deferral, he/she will need more extensive care at a greater cost.

The extent to which the Medical CPI is outpacing available resources cannot be understated. The FY09 IHS budget request for CHS starkly demonstrates this. Although IHS seeks an $8.8 million increase for CHS, the resulting budget would actually enable us to purchase less care in every category – average daily patient load for general medical and surgery hospitalization; outpatient visits; patient and escort travel; and dental services.[3] While we are grateful that an increase is recommended, this one is so insufficient that it will not even maintain the status quo. Please consider requiring IHS to report annually on the Medical CPI and to demonstrate that the full value is factored into the CHS budget request. Of course, the resulting figure should be a **floor**, not a ceiling, on CHS funding.

Estimates of need may not reflect all care that is actually needed. For example, it would not surprise me if an Indian beneficiary does not bother to seek care from his/her IHS or tribal facility because the patient believes there is little chance it will be funded.

Finally, any true estimate of need must necessarily reflect expected increases in the Indian health service population. This includes projecting new births among Indian people (who have traditionally had one of the highest birth rates in the nation), as well as the health program needs for newly-recognized tribes. The members of the Mashpee Wampanoag Tribe, the newest

[3] IHS Budget Justification, Fiscal Year 2009, at p. CJ-97.

USET member tribe which achieved Federal recognition in 2007, are not yet represented in the IHS service population calculations and the Tribe is still awaiting initial IHS funding to establish a health program on its reservation. IHS does not expect to supply funding until 2010.

USET Tribes' CHS Programs

In preparing for this testimony, I consulted with my own panel of experts – the health directors who operate the reservation-based programs of the USET member tribes – to learn more about their CHS program details and issues. Thirteen tribes responded to our survey. I want to share with you some of what I learned.

- Inadequacies in CHS funding create hardships for all tribes' programs, especially those which provide a limited array of services in their direct care facilities. For example, in the Nashville Area, there are only two facilities equipped to provide in-patient care, and even there in-patient services are extremely limited: The Mississippi Choctaw, with a service population of nearly 9,800 beneficiaries, has only 18 in-patient beds in its Health Center. The Eastern Band of Cherokee hospital in North Carolina has a mere 12 in-patient beds for its service population of more than 15,000 beneficiaries. Thus, **all** USET tribes are heavily dependent on CHS to purchase in-patient hospital care. In fact Choctaw reports that 25% of its CHS allotment is spent on hospital care. At Cherokee that figure is 34%.

- By far, the highest portion of any USET tribe's CHS funding is used to purchase outpatient care, including specialty care that cannot be provided by the limited medical staff available at a direct care facility.

- Most tribes responding to our survey confirmed the widely-known fact that CHS funds run out before the end of the 12-month period they are supposed to cover. Nine tribes said their funds are exhausted in nine months or less, including three who reported theirs last for fewer than seven months.

- There are dramatic differences in the per-capita amount of CHS funding. Doubtless there are some rational reasons for these differences, such as a tribe which has no health care facility must supply all/most of the care for its members through CHS. In other cases, a tribe may have elected to direct more IHS dollars to direct care, thus reducing the per-capita amount for CHS. But even if these reasons are taken into account, it still does not fully explain the wide differences in the per-capita amounts received by the tribes. Most likely, these wide differences are historical in nature and have been carried forward each year. The IHS formula for the apportionment of CHS funds should be re-examined.

- I know that some tribal programs are so desperate for CHS funding that they have to "cannibalize" their direct care programs in order to purchase the outside care their members need.

- It was disappointing to learn that only a small percentage of most tribes' CHS funds can be devoted to rehabilitation services such as physical and occupational therapy. Patients

recovering from surgery or injury need such services to make their recuperation complete.

- Tribal leaders are keenly aware of the hardship and suffering caused when health care funding is insufficient. Where tribes have the resources to do so, they subsidize their health care programs, especially CHS, with tribal resources. But only a few tribes are able to help in this way.

Reason why CHS Funding should be Enhanced

I urge this Committee to be a strong -- and persistent -- advocate for substantial increases in CHS funding. I want to describe three reasons why you should do so:

First, fully funding this segment of the Indian health budget is fundamental to fulfilling the United States' **trust responsibility** to "to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level", as articulated in the Indian Health Care Improvement Act.

Second, this is the **humane** thing to do. Every American deserves access to decent and comprehensive health care. As an Indian woman and an American, it is very painful for me to see the many thousands of Indian people who are forced to live with untreated ailments, a reduced quality of life and the prospect of a shorter life span because IHS health care is severely rationed and they came out on the short end of that rationing.

Think also of the CHS review committees which every day are faced with making heart-wrenching decisions about which tribal members will receive treatment and which ones will not; who will be forced to live with pain and who will get relief; whose condition will be allowed to worsen until his/her life or life function is endangered. I doubt that any of you would want to have to make these choices, especially when they affect your family, friends and community members. But you have the power to eliminate the need for these hard choices to be made at all. You can see to it that Congress properly funds CHS. We intend to share this testimony with the 24 Senators who represent USET states – nearly ¼ of the entire Senate membership – to ask them to support this effort.

Third, supplying funds for CHS is a **good investment** that benefits local economies.[4] Remember that CHS dollars purchase medical services from non-Indian providers such as hospitals, physicians, pharmacies, rehabilitation centers and dialysis facilities in near-reservation communities. This spending makes valuable contributions to the economic health of these communities. In its April, 2008 *TrendWatch* report, the American Hospital Association pointed out that, based on 2006 survey data, "[n]ationally, each hospital job supports almost two additional jobs and every dollar spent by a hospital supports more than $2 of additional business activity." The AHA describes this additional activity as the "ripple effect" that flows from local health care spending.

---

[4] I want to acknowledge the valuable contribution Mr. Casey Cooper, CEO of the Cherokee Indian Hospital, made to this portion of my testimony.

Thus, each additional dollar appropriated for CHS produces benefits at several levels: It improves the physical and mental health of the Indian beneficiaries whose care it purchases; it creates local health care provider jobs; and through the ripple effect, it contributes to enhanced business activity in the community and, of course, to its tax base.

By the same token, the local community is vulnerable to adverse consequences when an Indian health program is unable to provide the care needed by its service population. An Indian beneficiary who cannot get CHS-funded care and who has no alternative resource such as Medicare, Medicaid or private insurance is likely to present at the local hospital seeking treatment as an indigent patient. This presents a dilemma to the hospital: It presumably wants to fulfill its moral (and often legal) responsibility to provide aid to a person with a pressing health care need, but no hospital, especially a small community hospital, can absorb an unlimited number of uncompensated cases without jeopardizing its economic viability. Should a hospital fail for economic reasons, the entire community – both Indian and non-Indian – suffers.

Tribal Pro-Active Efforts

Tribes are always vigilant for ways to reduce pressure on their CHS budgets. We reach out to Indian beneficiaries who are eligible for Medicare, Medicaid and SCHIP, encourage them to enroll in those programs and actively assist with the enrollment process. Indeed, in order to qualify for CHS care, an Indian beneficiary eligible for an alternate resource must apply for that resource. We are also conscientious about billing a beneficiary's private insurance carrier where such coverage exists. When the new Medicare Part D Prescription Drug Benefit was enacted, tribes which operate pharmacies worked hard to enroll their Medicare patients in Part D plans and to achieve network status for those pharmacies in order to bill the plans for the drugs dispensed.

Indian tribes were the most vigorous advocates for enactment of "Medicare-like rates" legislation. Under the sponsorship of Senator Bingaman, this goal was finally achieved with passage of the Medicare Modernization Act in 2003. This law requires all Medicare hospital providers to accept no more than the Medicare rates for services provided to Indian beneficiaries through CHS referrals and thereby enable CHS programs to purchase more care with the scarce funds appropriated. To our dismay, our savings opportunities were delayed, as it took HHS more than three years to promulgate regulations to implement the law. These regulations did not become effective until July, 2007. As we approach the first anniversary of their implementation, we will be in a position to evaluate the extent of additional CHS buying power they permit.

Continued vigilance regarding Medicare-like rates is required in two ways: We must assure that CHS hospital providers fully comply with the these rate caps as the law directs, and we must assure that IHS budget requests for CHS do not attempt to offset the savings achieved by a reduction in or smaller-than-needed increases for the CHS appropriation. We hope this Committee will share this oversight responsibility with us.

I am very grateful to have had the honor to address this Committee and to assist in its efforts to make the vital CHS program fulfill its proper role of providing needed health care to Indian people. I am happy to answer your questions.

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April 22, 2008

Dear Colleague:

Health care is too often viewed as an economic drain when, in fact, it is an economic driver. Hospitals not only provide vital health care services to millions of people, they also play a critical role in supporting a strong and stable economy – a role that is not widely understood.

The enclosed *TrendWatch* report, Beyond Health Care: The Economic Contribution of Hospitals, tells this story. This report provides national and state level data on jobs and economic activity supported by hospitals. It shows that nationally hospitals employ more than 5 million people, rank second as a source of private-sector jobs and, if one includes the "ripple effects" of hospital and hospital employee purchases of goods and services from other businesses, annually support nearly $1.9 trillion dollars of economic activity.

The economic contribution of hospitals is a message that resonates well with policymakers and the business community. We hope you will use the enclosed materials to help you tell your story. A link to the electronic version of the report, as well as PowerPoint charts, can be found by clicking on "Research and Trends" at www.aha.org. If you have any questions or comments, please contact AHA Member Relations at (800) 424-4301.

Sincerely,

Rich Umbdenstock
President and CEO

Enclosure

AMERICAN HOSPITAL ASSOCIATION
APRIL 2008

TRENDWATCH

Beyond Health Care: The Economic Contribution of Hospitals

In 2006, America's hospitals treated 118 million people in their emergency departments, provided care for 600 million outpatients, performed 27 million surgeries, and delivered 4 million babies.[1] Every year, hospitals provide vital health care services like these to millions of people in thousands of communities. However, the importance of hospitals to their communities extends far beyond health care.

Hospital care is the largest component of the health sector, which itself is a growing segment of the U.S. economy. In 2006, this sector represented about 16 percent of the Gross Domestic Product (GDP) – a measure of economic output – or approximately $2.1 trillion.[2] Hospitals accounted for $648 billion of that total.[3] The health sector is an economic mainstay providing stability and growth, even during times of recession.[4]

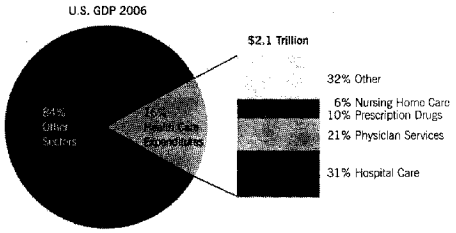
In 2006, community hospitals employed more than 5 million people and spent about $286 billion on goods and services in addition to employee wages. Nationally, each hospital job supports almost two additional jobs and every dollar spent by a hospital supports more than $2 of additional business activity.[5] With these "ripple effects" included, hospitals support nearly $1.9 trillion of economic activity.

A strong health care network, in which hospitals play a key role, also adds to the attractiveness of a community as a place to settle, locate a business or retire.

American Hospital Association

Health care and hospitals are major contributors to the economy...

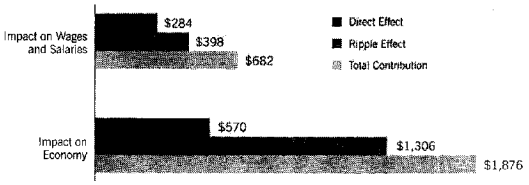
Chart 1: National Health Expenditures as a Percentage of Gross Domestic Product and Breakdown of National Expenditures on Health, 2006



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released January 7, 2008.

...supporting other businesses and jobs in communities across the U.S.

Chart 2: Impact of Community Hospitals on U.S. Economy (in billions), 2006

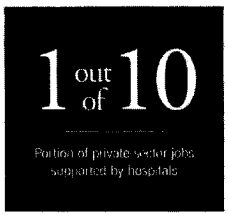


Source: Avalere Health, using BEA RIMS-II (1997/2005) multipliers applied to 2006 American Hospital Association Annual Survey data.

Hospitals Are Among the Largest Employers in Many Communities

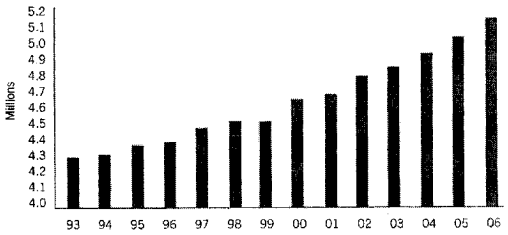
More than half of hospital expenses are salaries, wages and benefits. In 2006, U.S. hospitals paid about $284 billion in employee compensation. Hospitals rank second as a source of private-sector jobs, behind only full-service restaurants.

Hospitals regularly rank among the top 10 employers in large urban areas such as Boston, New York and Detroit. The hospitals in the Chicago metropolitan area directly employ more than 140,000 full-time employees.[6] In Minnesota, the Mayo Clinic is the state's largest private employer, with a staff of more than 30,000 in Rochester and several thousand more in the regional health system.[7] Regionally, hospitals can account for more than 4 percent of employment.



Nationwide, hospitals employ over 5 million people...

Chart 3: Number of Full-time and Part-time Hospital Employees, 1993-2006



Source: Avalere Health analysis of 2006 American Hospital Association Annual Survey data for community hospitals.

...making them the second-largest employer in the private sector...

Chart 4: Hospital Employment versus Employment in Other Industries, 2007*

Source: Department of Labor, Bureau of Labor Statistics, Current Employment Statistics Survey, customized tables. Data released 2008. http://www.bls.gov/ces.
*2007 annual projections based on data as of November 2007.

Impact of Rural Hospitals

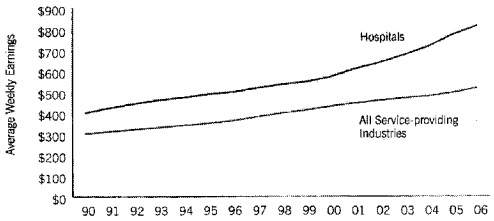
In rural areas, hospitals are often either the largest or the second-largest employer, behind the school system.[8] In these communities, which often struggle to attract and retain college graduates, rural hospitals provide a source of high-tech jobs for young people who might otherwise leave communities heavily dependent upon agriculture. Rural hospitals also provide an anchor for other health care jobs, such as physicians and pharmacists that, in the absence of the hospital, may not be available. Total direct and indirect employment generated by health care is often 10 to 20 percent of a rural community's employment.[9]

Additionally, in 2007, the health care sector overall added approximately 367,000 jobs, comprising 45 percent of all private-sector jobs added over the year.[12]

Facing a shortage of skilled workers, hospitals are investing in workforce development and retention activities – another way hospitals contribute to the economic base of communities. Some hospitals offer tuition reimbursement programs, partner with local colleges to provide training programs for employees to update or develop their skills, or implement mentoring programs for less experienced staff.

Hospital jobs provide higher pay than other service sector jobs.

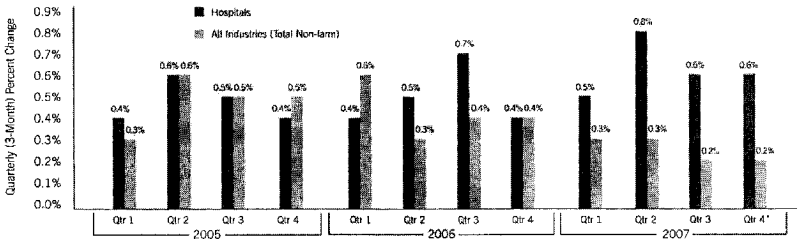
Chart 7: Average Weekly Earnings of Workers, Hospitals* versus All Service-providing Industries, 1990-2006



Source: Department of Labor, Bureau of Labor Statistics, Current Employment Statistics (CES) Survey, customized tables. Data released 2008. http://www.bls.gov/ces.
*Includes physicians employed by hospitals.

Hospitals provide a consistent source of jobs.

Chart 8: Percent Change in Employment, Seasonally-adjusted: Hospitals versus All Industries (Total Non-farm), 2005-2007



Source: Department of Labor, Bureau of Labor Statistics. http://www.bls.gov/bls/employment.htm.
*2007 Qtr 4 data are preliminary.

"Creating greater opportunities in the allied health professions will not only improve patient care, it will spur job growth and help boost our economy. Training people to fill these openings could create more than 40,000 jobs."[13]

Senator Maria Cantwell (D-WA)

from the field

Hospitals Support their Communities in Many Additional Ways

In addition to providing traditional health care services and supporting their local economies, hospitals offer an array of special programs and activities to help meet communities' broader health and social needs.

Hospitals offer services that aid in disease prevention, promote health awareness, contribute to advances in medicine and address other societal needs. Examples of the types of community programs hospitals offer include:

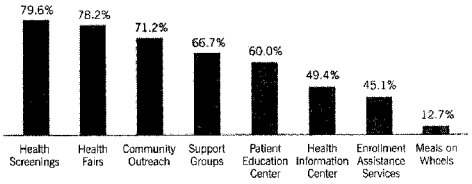
- Health programs such as educational outreach, health screenings and support groups;
- Subsidized health services (e.g., free clinics, vaccinations);
- Programs to address the social needs of communities (e.g., Meals on Wheels, various shelters);
- Health professions training programs for physicians, nurses and technical staff;
- Continuing education for health professionals; and
- Clinical research.

Hospital charity care programs provide care for free or on a sliding scale for patients with limited financial means. Hospitals have specific criteria to identify patients eligible for this care. In 2006, hospitals provided more than $31 billion in uncompensated care – a mixture of charity care and other care for which payment was expected but not received.

Hospitals also offer services to needy patients through Medicaid, a federal-state program that does not fully reimburse community hospitals for the services provided to these patients. In 2006, Medicaid payments fell short of the actual costs of care by $11.3 billion, a number that includes disproportionate share payments intended to subsidize the costs of caring for other low-income populations.

Hospitals offer an array of community services...

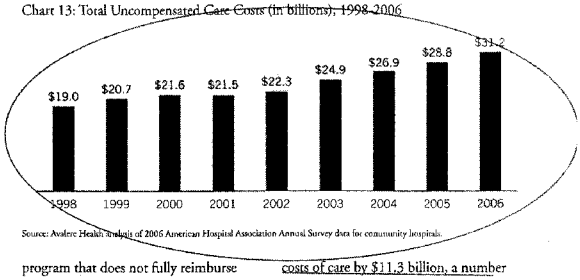
Chart 12: Percent of Community Hospitals Offering Selected Community Outreach Services, 2006



Source: Health Forum. (2006). *AHA Hospital Statistics*

...and provide charity care and other care for which no payment is received.

Chart 13: Total Uncompensated Care Costs (in billions), 1998-2006



Source: Avalere Health Analysis of 2006 American Hospital Association Annual Survey data for community hospitals.

"These hospitals not only sustain and contribute to the region's economic viability through local spending, job creation and research, they also have a huge community and social impact by partnering with local agencies to address unmet social and health care needs and providing care to those in need regardless of their coverage or means." [16]

from the field

James Mandell, Conference of Boston Teaching Hospitals Chair and President and CEO of Children's Hospital Boston

Summary and Conclusions

Hospitals contribute to the economic viability of local and regional communities by serving as the anchors of local health care networks and stimulating demand for goods and services produced by local businesses. Hospitals continue to provide jobs and job growth during recessions. However, when investors, policymakers and the public think about industries that promote economic stability and growth, most do not think about hospitals. Indeed, increases in expenditures on manufacturing or technology inspire optimism about the nation's fiscal health, while increases in expenditures on health care are typically viewed with concern. But, the fact remains that hospitals are strong contributors to the U.S. economy.

Hospitals create a steady source of employment even in economic downturns:

- High pay relative to other service sectors;
- Jobs across a wide spectrum of skill levels; and
- Jobs not easily "outsourced" abroad.

Hospital – and hospital employee – purchases of goods and services support other community businesses. With "ripple effects" included, hospitals:

- Support nearly one of 10 jobs in the U.S.; and
- Support more than $1.9 trillion in economic activity.

ENDNOTES

1 Health Forum. (2008). *AHA Hospital Statistics.*
2 Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Data released January 2008.
3 Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Data released January 2008.
4 Department of Labor, Bureau of Labor Statistics, Current Employment Statistics Survey.
5 Avalere Health, using BEA RIMS-II (1997/2005) multipliers applied to 2006 American Hospital Association Annual Survey data.
6 The Metropolitan Chicago Healthcare Council. (July 2006). *The Economic Impact of Chicago's Hospitals on the Metropolitan Chicago Area.* Chicago, IL.
7 The Economist. (February 2008). *Mayo with Everything.* Access at: http://www.economist.com/world/na/displaystory.cfm?story_id=10743347.
8 Doekson, G.A., & Schott, V. (2003). The Economic Importance of the Health Care Sector on a Rural Economy. *Rural and Remote Health*, 3(135). Access at: http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=135.
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American Hospital Association

Avalere

TrendWatch, produced by the American Hospital Association, highlights important trends in the hospital and health care field. Avalere Health supplies research and analytic support.

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The CHAIRMAN. Ms. Shore, thank you very much.

All of you have provided testimony from different directions and different perspectives about exactly the same problem, and that is the lack of funding and the issue of priority-one requirements excluding people who live in pain.

Ms. Shore, you described I think a relative with a knee problem. We have had testimony before this Committee by a doctor who saw a patient who had a knee problem, the kind of problem that represents excruciating pain—bone-on-bone, every day, debilitating—and went to a doctor at Indian Health Service and was told to wrap

the knee in cabbage leaves for four days. Well, that is not health care.

I don't think this represents what the Indian Health Service does routinely, but I say that there are a lot of people who live in constant pain, who are not priority one, and who in many cases if they show up, they don't get the kind of health care they need. A knee, in many cases, would be just completely out of reach for someone who is trying to confront this Indian health care system. So you have all given us a lot to think about.

I have a couple of questions, but let me turn to my colleague, Vice Chairman Murkowski, if you have questions, and then my colleague, Senator Johnson.

Senator MURKOWSKI. I do. Thank you, Mr. Chairman.

Thank you all for your testimony, your comments.

I want to ask a question to the entire panel about the Medicare-like rates. But before I do that, I want to ask you, Sally, a question about just kind of the sustainability. I will use the Bristol Bay Area Health Corporation as an example. In my opening, I mentioned the fact of the transportation costs exceeding $2 million, and that isn't even recognizing the expenses that are involved there.

Bristol Bay is looking at a situation where well over $1 million with third-party reimbursements, including Medicare and Medicaid last year. How long can you sustain? How long can Bristol Bay sustain a situation like this, where they are faced with a requirement to supplement, and supplement at an enormous rate and amount? First of all, how long can they do this? And I know that that is a vague question and you are just guessing, but what other factors can potentially affect the ability to collect third-party reimbursements that we know are so critical here?

So kind of a general question about the sustainability aspect and what other factors may be in play there.

Ms. SMITH. Thank you, Senator Murkowski. At every board meeting, the board sits down and wrestles with this particular issue. What we do is we look back into our budget and we know that the costs are going to be coming out of program dollars. How long can we take from program dollars to sustain a system that is so—as one board member said, Sally, this is terrible; you must fly to D.C. and tell them how terrible this is.

Earlier today, we were talking about costs. You mentioned costs from various points in Alaska. On June 18, I received an e-mail, a copy of an e-mail. The e-mail says, I called PenAir to get some prices for our budget and was blown away. The one-way from Dillingham where Kanakanak Hospital is, to the Chigniks and to Port Heiden, which is even shorter than any of the lines you demonstrated this morning, Senator, is by Cherokee, which is a single-engine, low-wing aircraft, to the Chigniks is $2,150.

Senator MURKOWSKI. From Dillingham?

Ms. SMITH. From Dillingham, by Caravan, which is a high-wing cargo passenger plane, one-way, and you can only charter, is $4,953.60. Using that as the fulcrum for how long can we sustain, three days ago the barge landed in Aniak, Alaska. The price of fuel, for gas, went to $7.92 a gallon.

Senator, you asked me, how long can we sustain this? I beg of the panel here that what is going to happen in Dillingham, what

is going to happen in Indian Country across our Nation, is that we are going to not only be scrambling, but we are going to start lining up our beneficiaries, and it is going to be a random toss as to whom we are going to offer the services to, because monies are going to get so tight that every day in every meeting the big question on the table is: How much longer can we sustain the ever-increasing costs to be able to provide limited health care to our beneficiary population?

It is very scary. What is also happening is we are trying to help ourselves, too. Earlier, we talked about the Medicare-like rates. I know you know that the tribes are really seeking savings for their Contract Health Service dollars as a result of the implementation. So let me give you a few examples.

At the Alaska Native Medical Center, we have roughly a $17 million CHS budget, and the Medicare-like rates are expected to save ANMC approximately 20 percent to 30 percent of CHS dollars. So we are not being inactive. We are trying to make the dollars stretch. In Knik, which is down on the Kenai Peninsula, the emergency room costs that were $1,500 are now $500, using the Medicare-like regulations.

At the Southeast Alaska Regional Health Consortium, there are huge savings. For example, a hospital bill of $55,000 was dropped to $5,000 on average. To date, SEARHC has saved $400,000. And one more: At the Tanana Chief's Conference in the interior, medevac costs of $10,000 dropped to $5,000 under the rates.

Senator MURKOWSKI. So that really is making a difference around the State, the Medicare-like rates?

Ms. SMITH. Yes, Senator, it is.

Senator MURKOWSKI. Let me ask the others on the panel if you are seeing the same savings? Or what problems, if any, have you noticed with the Medicare-like rates? Does anybody like to speak? Ms. Shore?

Ms. SHORE. Thank you. One of the things that we are seeing are very wide fluctuations already between the kind of savings our tribes are receiving. We realize we have tribes in 12 different States, so they are dealing with 12 different hospital systems. We see anywhere from 40 percent savings down to 20 percent savings. What we can see so far is that there seems to be a lot of difference if you refer a patient to a teaching hospital versus just a general public hospital. That is something that we would like to look at further once we can have more data from the Medicare-like rates implementation.

Mr. KEEL. Senator, the savings that are realized from being able to pay at the Medicare-like rates allows tribes to extend some of those services to other providers. We would ask that those Medicare-like rates be extended to other providers to pay for fees and other things that are not necessarily covered under the normal rates.

But yes, they have been very beneficial in allowing tribes to negotiate for more services. Some of the tribes in the Oklahoma City area, are revising some of their software in order to do more third-party collections. Because of the resulting savings, we are able to offer more services, which amounts to a savings in other ways. The information on tele-medicine, those types of services that we have

not been able to provide in past, we are able to provide because we have more resources.

You know, it is a matter of looking at the resources that we have and making them go as far as we can, extending those to other providers, to getting other types of services that have not traditionally been available. The providers that are being negotiated with now, see that we are paying our bills, that we do pay them in a timely manner, so it is not as hard to negotiate a rate with them to provide services. So it has been very beneficial.

Senator MURKOWSKI. Ms. Krein?

Ms. KREIN. I can speak from the other side of the Medicare-like rates. Coming from North Dakota, our payment is the lowest in the Nation, number one. So from my perspective, it is less payment, which adds to the unpaid bills in the emergency department.

Senator MURKOWSKI. Again, just so that I am understanding. Ms. Shore, you mentioned that there is a differential there, basically dependent on where you go for the services.

Ms. SHORE. Yes.

Senator MURKOWSKI. But that is different than what you are talking about, Ms. Krein.

Ms. KREIN. I am talking about the payment for us.

Senator MURKOWSKI. Right.

Ms. KREIN. Yes.

Senator MURKOWSKI. You mentioned, Ms. Shore, the ripple effect and the positive benefit that the CHS dollars generate throughout the communities. I think that that is an important factor as we talked about how we get the most bang for the buck, if you will, in health care dollars. When we talk about funding, it is not just funding to, whether it is Bristol Bay, but how that translates out into the communities as well, so it is a good point to raise.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Murkowski, thank you very much.

I promised that I would have the Director of the Indian Health Service on, and I will do that in just a couple of minutes.

Ms. Krein, how much un-reimbursed cost has your hospital experienced as a result of serving the Native American population?

Ms. KREIN. Over the years, in the last few years, it has been several million dollars. That doesn't count the charity that we do not count.

The CHAIRMAN. And you are not turning patients away, are you?

Ms. KREIN. We never turn anybody away, but I can tell you how I have changed what we have done is before when Native Americans have come to our emergency department, I would know that they needed medication and we would give them maybe four or five days of antibiotics. What I have done now is give them enough medication until the pharmacy at Fort Totten opens, so that is how I have kind of reduced some of the things that we have done for them.

I think the other thing that I would like to say is that meeting with the people from the Spirit Lake Nation, one lady said to me, she said, "I do know that we use your emergency room in an inappropriate way, but I have to tell you that when I have someone who is ill and I put them in a car, the closer to Mercy I get, the safer I feel."

The CHAIRMAN. My understanding is you don't bill the individuals that show up for uncompensated services.

Ms. KREIN. No, we do not.

The CHAIRMAN. Many other providers do.

We have a system that is broken. We need to fix it. But in the meantime, the providing of care that you do is exemplary.

Let me ask the witnesses, we have heard this issue, "don't get sick after June"; I assume many of you see that on the ground, at a time when Contract Health funds have expired. I have spoken on the floor about a woman who was taken by ambulance to a hospital, suspected of having a heart attack, with a piece of paper taped to her thigh. As she entered the hospital, the hospital professional saw the paper, which was an admonition that if this woman was admitted, the hospital would likely not be able to bill and get Contract Health funds because they were out of funds.

So here is a sick woman suspected of a heart attack being wheeled into a hospital with a piece of paper on the leg that says, "take this patient at your own risk, Contract Health funds are out."

Have you all experienced that? Tell me, does anybody here go through the full year with sufficient Contract Health funds? Ms. Holt?

Ms. HOLT. No, we don't. As I testified earlier, Senator Dorgan, in CHS-dependent areas such as Portland, California, Nashville, Bemidji, we face that at the beginning of the year.

The CHAIRMAN. At the beginning of the year, do you allow priority twos?

Ms. HOLT. A lot of our tribes are on priority one at the beginning of the year. Because they are working the deferred and denied services, they start the year working those cases and push themselves into priority one right away.

The CHAIRMAN. Are there circumstances where cancer is not a priority one?

Ms. HOLT. Yes. And I think that seriously needs to be looked at.

The CHAIRMAN. That is unbelievable to me. How can cancer, almost any kind of cancer, with perhaps the exception of the more common basal cell skin cancers, not be considered "life or limb"?

Ms. HOLT. We also run into the issue of misdiagnosis in IHS clinics. I just lost my sister-in-law a year ago to bladder cancer that was diagnosed for two years as a bladder infection and treated as a bladder infection until it was too late.

The CHAIRMAN. It is always a fine line when we have hearings and talk about these issues, a fine line to walk because Senator Murkowski and myself go to places and we see some unbelievably dedicated men and women working in the health area on reservations, some people that I deeply admire.

It is also the case that we go places where we think that the health care is inadequate, and so we never want to have some sort of blanket tarnishment of the wonderful work a lot of people are doing out there in understaffed locations, trying everything they can to get by with far too little funding.

Ms. Smith, did you want to comment on that?

Ms. SMITH. I just wanted to add two things. First, that using Bristol Bay as an example again, the amount that Senator Murkowski mentioned that we receive, 100 percent of that is used in

transportation. The cost of medevac is so high and the cost of transportation is so high, all of our Contract Health Service dollars actually go to there.

What happens, then, is the patient is referred to Alaska Native Medical Center, and the cost shift goes to Alaska Native Medical Center, so it goes. This is a huge issue. I am so thankful that we are having these hearings. I want to thank you very much for inviting the Direct Service Tribes. I know that you will hear from them as well. I urge again that we have these similar-type hearings across Indian Country because you need to hear the stories.

Senator Murkowski, again, I have a half-dozen stories here. I will send those on to you. They are stories that are universal across Indian Country.

The CHAIRMAN. Ms. Smith, I will be on the Turtle Mountain Indian Reservation next Monday or Tuesday. I guess it is probably next Tuesday, at a hospital there that is having very significant problems. I have asked the regional director, from Aberdeen, South Dakota, to meet us. I am going to be hearing from the clinic professionals directly as well.

I have run out of time, because I promised Director McSwain to have him up, and he has other things as well to be attending to.

I want to thank all of you. You have come from far distances to provide us information. It has been very good information. Your testimony is really very helpful to this Committee. So thank you very much for your testimony today.

We will dismiss you and ask Mr. McSwain, then, to come to the witness table.

Thank you very much.

[Applause.]

The CHAIRMAN. Director McSwain, you may come to the witness table. I again commend you. It is generous of you to be willing—and we will not do this at the next hearing—but it is generous of you today to be willing to listen to six witnesses from different parts of our Country. You are thoughtful to be willing to do that.

We are interested in having your testimony today on the Contract Health Service issue and the things that you have heard. If you would like to introduce those who have accompanied you from the Indian Health Service, we would appreciate it.

Again, your entire statement will be made a part of the record. You may summarize as you wish.

STATEMENT OF HON. ROBERT G. MCSWAIN, DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY DR. RICHARD OLSON, DIRECTOR, OFFICE OF CLINICAL AND PREVENTIVE SERVICES, AND CARL HARPER, DIRECTOR, OFFICE OF RESEARCH ACCESS AND PARTNERSHIPS

Mr. MCSWAIN. Thank you, Mr. Chairman and Vice Chairman Murkowski. I want to thank you both for supporting certainly my nomination, successful as it was, and in fact supporting it all the way to the floor. I was surprised at the speed at which it went through. So with that, thank you so much for that.

And I also thank you for shining a light on this program. I certainly have been around Indian Country enough to also hear the

same kinds of stories that you are. But let me just summarize my statement.

I am Robert McSwain, the Director of Indian Health Service. Today, I am accompanied by Dr. Richard Olson, Director of the Office of Clinical and Preventive Services, and Mr. Carl Harper, the Director of the Office of Research Access and Partnerships.

I say that because I think that these two gentlemen will need, as we walk away from this table, Dr. Olson actually was a clinician in the field, and has had to be the ordering physician for ordering care for Contract Health Services. So now he is in headquarters providing oversight on the clinical side of the house. And of course, Mr. Harper literally runs and oversees not only collections, but also the Contract Health Service Program for the agency.

As you know, the Indian Health Service provides services to nearly 1.9 million American Indians and Alaska Natives. In carrying out this responsibility, we certainly have a relationship with all the tribal folks that you heard from today, plus about 555 other tribal leaders out there. I think that they have talked about the challenges, in a word, in the rural areas. We are isolated. We are remote. And certainly Alaska is a classic example of remoteness and access. So these are challenges that we have in dealing with available health care services that are out in the areas.

And then we have a couple of facilities that are in heavy metropolitan areas, Anchorage being one, ANMC, and of course the medical center in Phoenix.

I would just like to be able to share with you very quickly, I know that the time is late, and I will run through this rather quickly. But the fact is, our health system in total is direct in what we can provide. I think it is important to know as much as we can provide care means we don't have to buy the care. So it is a capacity. I think Senator Murkowski talked about vacancy rates and the fact that that is a big challenge for us to fill the positions so that we can in fact provide the care through our existing direct service system, both tribal and indirect. But I think it is important to point out that all of the services we provide are within our total control. We staff the facilities. We staff the programs, and we provide all that care.

Now, when we have to buy care, now the control is lost. We have to deal with the private sector. We have to deal, and in order to make the $579 million go as far as we can, not only calendar-wise, but just in terms of services, we have structured a series of policies and requirements that result in a very highly structured program. Even though we talk about CHS and direct service programs being complementary, they really are complementary because it is the physician who needs to have the care provided, as when they are seeing a patient, do they need to order some diagnostic care.

And I think it is important to point out that in a word, we provide care at nearly 700 locations, tribal and IHS. Emergency room and in-patient care is provided in 46 locations. A limited number of our largest medical facilities provide secondary medical care.

So on the medical side, on the direct side, it is important to know that the capacity varies across the Country. You heard from Chairwoman Holt talking about they don't have any in-patient care, so they are having to buy all of their in- patient and a great number

of certainly their primary care. But I think that of all the hospitals we have, only 20 of the hospitals have operating rooms. I pause there, because we are going to have to go out and buy much of that care as well. And 20 of the hospitals have operating rooms, but I think that we should point out also that our average daily patient load in some of the hospitals, we only have two facilities that have more than 45 patients per day. So in a word, all of our facilities are in fact CHS-dependent, some more than others.

What is CHS? I think that, as I mentioned, we have a number of very careful strictures around how we manage the Contract Health Service Program. It starts with regulatory eligibility, a wholly different narrow eligibility for CHS. We are the payer of last resort. It means that we exhaust all other possible benefits the Indian patient has before we pay for care. We have something referred to as medical priorities. We have five priorities, and you have noted those in a chart.

The important thing is what CHS isn't. CHS isn't an insurance program. Therefore, we have to manage it. We have to gate-keep it, and we have to make referrals in order to ensure that the care that is being provided is in fact authorized and that we have the appropriations to back up the authorization.

The efforts that we have been going on for the last few years certainly, and I won't go through all of them, but we are maximizing resources. We are talking about the CHEF fund. That is the one that used to end by May and June. But with the additional appropriations and a combination of Medicare- like rights, we are seeing the actual CHEF fund go into August now, and we are hopeful—this is our first year—and perhaps it will even go further.

With that, and the fact that we have just introduced this year a unified financial management system, and I am sure you have been hearing around Indian Country that the Indian Health Service is not paying its bills. We are working through that, and I think with the department, we will see not only good data—I think there was a question about data—but also financial management reports and our ability to pay timely.

With that, I will conclude my summary and thank you for this opportunity, Mr. Chairman, and answer any questions that you might have.

[The prepared statement of Mr. McSwain follows:]

PREPARED STATEMENT OF HON. ROBERT G. MCSWAIN, DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee:

Good Morning. I am Robert McSwain, Director of the Indian Health Service. Today I am accompanied by Dr. Richard Olson, Director of the Office of Clinical and Preventive Services, and Mr. Carl Harper, Director of the Office of Resource, Access and Partnerships. We are pleased to have the opportunity to testify on the Indian Health Service's Contract Health Services program.

Overview of Indian Health Service Program:

The Indian Health Service provides health services to nearly 1.9 million American Indians and Alaska Natives (AI/ANs). In carrying out this responsibility, the IHS maintains a unique relationship with more than 560 sovereign Tribal governments located in the most remote and harsh environments within the United States as well as in modern metropolitan locations such as Anchorage and Phoenix. This geographic diversity and major health disparities offer extraordinary opportunities and challenges to managing and delivering health services.

The IHS and Tribal programs provide a wide array of individual and public health services, including clinical, preventive, and environmental health services. In addition, medical care services are purchased from outside the IHS system through the Contract Health Services (CHS) program when the care is otherwise not available at IHS and Tribal facilities.

The IHS is committed to its mission to raise the physical, mental, social, and spiritual health of all AI/ANs to the highest level.

In FY 2008, the CHS program is funded at $579 million, and over 50% is administered by Tribes under Indian Self Determination contracts or compacts. Of the total funding the Tribal programs manage $302.9 million and the federal programs manage $276.4 million. CHS programs are administered locally through 163 IHS and Tribal Operating Units (OU). The funds are provided to the Area Offices which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to Federal and Tribal OUs (local level) and health care facilities providing care.

CHS payments are made to community healthcare providers in situations where:

- There is a designated service area where no IHS or Tribal direct care facility exists;
- The direct care facility does not provide the required health care services;
- The direct care facility has more demand for services than it has capacity to provide; and/or
- The patient must be taken to the nearest Emergency Services facility

Many of our patients have no health care coverage outside of that received from the IHS or tribal health programs. These patients often access needed care through local community hospital emergency rooms. The CHS program covers emergency services if they meet eligibility criteria. If the services do not meet eligibility criteria or CHS funds are not available, the patient is responsible for the cost of care. Some patients are unable to pay for these services. Although these patients are eligible for direct IHS care, they may not meet the CHS eligibility regulations and many do not have an alternate resource to pay for their services.

The CHS and direct care programs are complementary; some locations with larger IHS eligible populations have facilities, equipment, and staff to provide more sophisticated medical care. IHS and Tribes provide medical care at nearly 700 different locations. Emergency room and inpatient care is provided in 46 locations, and a limited number of our largest medical facilities do provide secondary medical services. With the exception of a hospital in Alaska, IHS and Tribal hospitals have an average daily patient census of fewer than 45 patients. Twenty of the hospitals have operating rooms. In locations where there is no access to inpatient, emergency or specialty care in IHS or tribal healthcare facilities, patients are dependent on CHS for most of their health care needs. Those direct care programs with the most sophisticated capabilities have, per capita, the smallest CHS programs and visa versa. However, all of our facilities and programs are dependent on CHS for the medical services that they are unable to provide. The CHS program covers medical services on a priority system with the highest priority medical needs funded first.

It is important to understand that the CHS program does not function as an insurance program with a guaranteed benefit package. When CHS funding is depleted, CHS payments are not authorized. The CHS program only covers those services provided to patients who meet CHS eligibility and regulatory requirements, and only when funds are available. Many facilities only have CHS funds available for more urgent and high priority cases and utilize a strict priority system to fund the most urgent cases first.

In some instances AI/AN patients go directly to community healthcare providers for care rather than through the CHS referral system for required prior authorization. Because community healthcare providers assume that IHS provides coverage and/or payment for AI/ANs, it is not uncommon for community healthcare providers to expect payment from the IHS or tribal CHS program regardless of eligibility, regulatory requirements, and/or CHS medical priorities. Patients who access non-emergency care without prior authorization/referral are responsible for payment for those services, regardless of CHS eligibility status.

Eligibility

In general, to be eligible for CHS, an individual must be of Indian descent from a federally recognized Tribe and belong to the Indian community served by a Contract Health Services Delivery Area (CHSDA). If the person moves away from their CHSDA, usually to a county contiguous to their home reservation, they are eligible for all direct care services available but are generally not eligible for CHS.

When the individual is not eligible for CHS, the IHS cannot pay for the referred medical care, even when it is medically necessary, and the patient and provider must be informed that CHS funds are not available. The CHS program educates patients on the eligibility requirements for CHS, by interviewing them, posting the eligibility criteria in the patient waiting rooms, and in the local newspapers. The CHS program assists these patients by trying to find the needed healthcare services within the community at no cost or minimal cost to them. Patients who are not CHS eligible are responsible for their health care expenses. Some non-IHS providers have expectations that IHS will be the primary payer for all AI/AN patients, which has led to strained relationships with local community healthcare providers when patients are denied CHS which often leaves them without compensation.

Payor of Last Resort Rule

By regulation, the Indian Health Service is the payor of last resort (42 C.F.R. 136.61), and therefore the CHS program must ensure that all alternate resources that are available and accessible such as Medicare, Medicaid, SCHIP, private insurance, etc. are used before CHS funds can be expended. IHS and Tribal facilities are also considered an alternate resource; therefore, CHS funds may not be expended for services reasonably accessible and available at IHS or tribal facilities.

Maximizing Alternate Resources

The CHS program maximizes the use of alternate resources, such as Medicare and Medicaid which increases the program's purchasing power of existing dollars. The IHS works closely with CMS to provide outreach and education to the populations we serve to ensure that eligible patients are signed up for Medicare, Medicaid, and SCHIP. Recently, the IHS launched a nationwide awareness initiative entitled "Resource Smart." This is an outreach program that trains staff and patients to maximize the enrollment of eligible AI/ANs in CMS and private insurance programs. By enrolling in these programs, this frees up existing funds to be used for CHS referrals/payments. An important component of this initiative is to increase the placement of State Medicaid eligibility workers at IHS health care facilities instead of our patients having to travel great distances to apply for Medicaid.

Medical Priorities

CHS regulations permit the establishment of medical priorities to rank which referrals or requests for payment will be funded. Area-wide priorities and routine management of funds are used to try to maintain an equivalent level of services throughout the year and take into consideration the availability of services and accessibility to a facility within the Indian healthcare system. There are five categories of care within the medical priority system: ranging from Emergency (threat to life, limb and senses) to chronic care services.

I. Emergency—threat to life, limb, senses e.g., auto accidents, cardiac episodes

II. Preventive Care Services e.g., diagnostic tests, lab, x-rays

III. Primary and Secondary Care Services e.g., family practice medicine, chronic disease management

IV. Chronic Tertiary and Extended Care Services e.g., skilled nursing care

V. Excluded Services—unless determined to be a Medicare covered service the program would pay for the services

Services not Covered by CHS:

Payment for contract health care services may be denied for the following reasons:

1) Patient does not meet CHS Eligibility requirements;

2) Patient eligible for Alternate Resources;

3) No Prior Approval for non-emergency services;

4) No notification within 72 hours of emergency services or 30 days in some cases;

5) Services could have been provided at an IHS or Tribal facility

6) Not within medical priority. When the services are not within the medical priority levels for which funding is available they must be denied.

If the medical condition does not meet medical priorities the care is captured as a CHS deferred service. In the event funds become available the care may be provided at a later date. The IHS cannot incur costs which would exceed the amount of available resources.

Distribution of CHS Funding Increases

The IHS works hard to ensure fairness in distributing CHS funding increases. In FY 2001 the IHS Director formed a CHS Allocation Workgroup that included IHS and Tribal representatives to develop a distribution methodology for increases in appropriations of CHS funds. The workgroup's focus was on distributing any potential CHS funding increases in an equitable manner.

The CHS allocation methodology emphasizes four main elements:

- Inflation funding based on each Area's base at the prevailing OMB inflation rate
- User Population
- Relative regional cost of purchasing services
- Access to care—those Areas with or without I/T/U facilities

Catastrophic Health Emergency Fund (CHEF)—Purpose and Intent

The CHS program also includes a Catastrophic Health Emergency Fund which pays for high cost cases over $25,000, which is capped by Statute. Prior to FY 2008, the CHEF was funded at $18 million and typically was depleted before the end of the fiscal year. The CHEF is funded at $27 million in FY 2008. The CHEF cases are funded on a "first-come-first served" basis. In FY 2007, the CHEF program provided funds for 738 high cost cases in amounts ranging from $26,000 to $1,000,000.

When CHEF cannot cover a particular high cost case, the responsibility for payment reverts back to the referral facility for payment purposes.

Unified Financial Management System

The IHS is successfully implementing a new accounting system (UFMS) in accordance with Departmental policy. In the past, the CHS program has experienced some challenges in paying providers but we expect the implementation of UFMS will mitigate these issues. Making timely payments to community healthcare providers is a priority for us, and we continue to look for ways to improve the process. We provided training on this new system prior to implementation and continue to train our staff in not only this system but the overall management of the CHS program.

Medicare-Like Rates (MLR)

The passage of Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a requirement that Medicare participating hospitals accept IHS, Tribal and Urban Indian Health programs' reimbursement at the "Medicare-like Rates." These rates are about 60–70% of full billed charges. The individual physicians and other practitioners paid under Medicare Part B are not included in this provision. The savings derived from the Medicare-like rates allow Indian healthcare programs to purchase additional health care services for AI/ANs, than would otherwise be the case. Since the regulation became effective in July of 2007, I have heard from several Tribes experiencing increased purchasing power due to payment savings, and expect the Medicare-like Rate payment savings to continue. However, the Federal programs have experienced less savings as most already had negotiated provider contracts with payment rates at, or near, the level of the Medicare rates, but benefit from the guarantee of reasonable rates that the regulation provides. Area Office CHS staffs continue their efforts to negotiate contracts with providers with the most cost-effective payment rates possible.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to report on Contract Health Services programs serving American Indians and Alaska Natives. We will be happy to answer any questions that you may have.

The CHAIRMAN. Dr. McSwain, thank you very much.

I will first call on the Vice Chairman.

Senator MURKOWSKI. Thank you, Mr. Chairman.

And thank you, Mr. McSwain. We, too, are glad that the process went quickly for your confirmation.

So how do you respond to Sally Smith and the present-day reality of medivac flights not even 100 miles away costing $4,000 a flight? With $7.95 gas up in a village that isn't even that remote, really, our costs are accelerating at an unprecedented rate. What do we do in the short term? Do we do, as Mrs. Smith suggested, where you line them up and you see who gets care?

Mr. MCSWAIN. Senator, that is one of the most difficult questions when we talk about the fact that we may have to make choices. Those choices are who gets served and who does not get served. As I said during my confirmation, I think the question about why aren't we asking for more resources, we haven't made the best case possible. I think that out——

Senator MURKOWSKI. How can we make the best case? What more do we need?

Mr. MCSWAIN. We need to bring those particular stories, particularly the ones in Alaska and other parts of the Country. I am hearing more and more that it is not that the CHS budget is not going as far, but they are having to pay a great deal of transportation. It is not just in Alaska. We are transporting patients in the Lower 48 long distances for that priority-one care.

So how do we capture that? We need to capture it and tell the story much better than we have. I think we have been doing some things such as worrying about are we staying up with inflation, are we doing comparisons. We should be telling a story that really talks about the needs in the program and quite frankly the growing needs that we have in purchasing care.

What we are doing is buying a lot more care, and I think the line in the graphs that we showed earlier is indicative of the fact that we are buying much more care today than we did 10 years ago.

Senator MURKOWSKI. Well, we want to help you be able to present that best case.

I guess, Mr. Chairman, I would ask those that were present at the hearing, gave testimony, or those that are listening, let's get these stories out there because the stories are compelling, and the stories are very immediate. If that is what you need to present the case, I think you would have a roomful of people that are happy to provide you with the requisite story to give the data that you need.

Let me ask, when I presented the question to the panel about how the Medicare-like rate regulations are working and what benefits they are seeing or what problems they are seeing, of course the suggestion is that it would be beneficial to expand these Medicare-like rates to cover other things like the ambulatory facilities and professional fees. What is your comment on that?

Mr. MCSWAIN. I think right now we have just elapsed a year, but the results are rather mixed. I think for Indian Health Service direct, the direct side of the house, we have been under scrutiny for developing good contracts, very cost-effective contracts with providers and hospitals and other provider groups, for a number of years.

So when the Medicare-like rates came out, our biggest concern now is whether or not the Medicare-like rates is a cap. On our direct side, we are experiencing whether or not if we go to renew those contracts, that the hospital will say, well then, you negotiated this rate; we would like to go at Medicare-like rates because it is higher. That is how well we have done on the direct side.

The tribal sites obviously are experiencing some different results. Obviously, the Alaska results, and I have heard many of these stories as I have traveled around, asking the question of how are you doing with Medicare-like rates. Without exception, tribes are expe-

riencing some good reductions relative to being able to spend more of their Contract Health Services on more people, as opposed to just straight rates.

Now, about the expansion. I don't think we are in a position to talk about the expansion of the current one. We would like to see how it is working right now. Now, Ms. Krein indicated, and I have also heard a lot of stories on that side of it. The small hospitals out in the rural areas are seeing the rates, causing them some budget difficulties as well. So that is the other part of the story.

So I think we will wait and see how this is working all the way through, and perhaps report at a future date as to how we are doing.

Senator MURKOWSKI. And then one last question for you. In terms of outreach, what is IHS doing in reaching out to ensure that Indian patients are enrolled in the alternative resources, whether it is Medicare or Medicaid?

Mr. MCSWAIN. Yes, we have actually started a program this year on that very issue. I want to refer to it as—in fact, let me ask—the Resource Smart program, it is actually in his shop. What we are doing is we are running a campaign that literally tells not only the patient, but the providers as well, that particularly for Indian people, that enrolling in Medicaid-Medicare and private insurance is such that that brings more resources into the system, and increased collections means more services.

So we have actually had an internal campaign going on and expanding that Resource Smart campaign. It is low cost, but I think actually having some results, but that is our internal campaign. We have shared the same campaign brochures and the like with our tribal programs as well.

Senator MURKOWSKI. Thank you.

Thank you, Mr. Chairman.

Thank you, Mr. McSwain.

The CHAIRMAN. Director McSwain, you saw the chart I used at the start of the hearing. Obviously, we are short of the funds necessary for Contract Health. My first question would be, as you survey the landscape here, you will be making recommendations this year for the construction of a new budget. What kind of recommendations will you be making, generally speaking, for Contract Health Service? Do you think substantial additional funds are needed to fill the gap that I describe?

Mr. MCSWAIN. It will all certainly depend on the rules that come back to us as to how we actually prepare the budget. But I can assure you that, as we talked about, building the capacity on the direct side for providing direct care for both tribal and IHS, but the next-highest priority is Contract Health Service because that is the bundle of services we provide. We provide it or we buy it. So CHS will continue to be at least—and I have been pushing for much higher requests and will continue to do so.

The CHAIRMAN. You are pushing for a higher request? I understand you have to follow the rules.

Mr. MCSWAIN. Right.

The CHAIRMAN. You are appointed and you work in a circumstance where when the rules come to you from OMB and the White House, you are bound to follow those rules. But it seems

pretty self-evident to me that we are desperately short of funds here. So your position is that you believe more funds are needed and you will push for more funds?

Mr. MCSWAIN. That is correct.

The CHAIRMAN. Let me ask you, the tribes and others who described to us that because we are so short of funds, we are limited in many cases to priority-one cases. And yet there are people with cancer who are not priority one. Describe that to me. Do you know the circumstances of that? It seems to me that in most cases, someone with cancer who needs diagnosis, treatment, chemotherapy, surgery, would be priority one.

I described at the opening the situation with a young woman who went in for a certain kind of treatment, ended up having surgery, ends up with $200,000 in debt because it wasn't approved. They end up taking out a cancerous tumor, but it wasn't pre-approved.

Describe that to me. Are there circumstances where cancer is not "life and limb"?

Mr. MCSWAIN. Let me ask our good doctor here. My first thought is that if it is cancer, and for example I know that we do screenings that are priority one. I find it interesting that we have not declared that priority one.

Dr. Olson?

Dr. Olson. I don't know any of the circumstances of this case, but I agree with you. I don't understand why it wouldn't be priority one. I was the Medical Director of one of our small rural hospitals for 11 years, and I managed our CHS program directly. At our location, we did run out of funds every year.

The CHAIRMAN. And when do you run out of funds normally?

Dr. Olson. Usually in August.

The CHAIRMAN. In August.

Dr. Olson. But after that time, we could pay for absolutely nothing. It didn't matter whether there was priority one or not.

So I don't know the circumstances of this case at all, but in general I agree with you, that certainly sounds like a priority-one case.

The CHAIRMAN. Tell me, because you mention this, you are running a health facility, there is a health delivery that is necessary from a responsibility we have; and all of a sudden you have no money, and somebody shows up in a desperate situation.

Dr. Olson. Well, if we can't handle the case directly, as Mr. McSwain was talking about, CHS and direct services are complementary to each other. Some of our locations are very small and have very few direct services, and some have a moderate amount of direct services. But at every location we have, we are CHS-dependent. As Ms. Smith talked, Alaska Native Medical Center has a CHS budget because there are many things that they can't handle there either.

But what we do from a medical perspective is that we will refer the patient. We just cannot pay for it if we are out of funds.

The CHAIRMAN. And then what happens is the patient shows up, sometimes at the medical facility. They accept the patient, and sometimes they may not. If they accept the patient and perform the medical service that was necessary, and bill the patient, the patient ends up having a destroyed credit rating. Isn't that the case?

Dr. Olson. Yes, sir.

The CHAIRMAN. That is devastating. The fact is, we have 500-plus Indian tribes around this Country, and in many cases they are, as you said Director McSwain, in remote areas. So they have various forms of clinics or very small hospitals, and in most cases, you don't have the full range of medical services that can be delivered. Someone has a devastating ailment with a knee, excruciating pain, can't walk. Well, that orthopedic care is not going to come from that area. In most cases, that person, to the extent that they are viewed as priority one, will be referred.

But I know of cases where it is not priority one that someone would be unable to walk, unfortunately. And that describes the absurdity of what we are doing here, with only about half the money needed being available for people who in many cases are very, very sick and have very serious health problems.

I offered an amendment to the budget process of $1 billion additional funds for IHS. We are spending a lot of money on health care in Iraq and elsewhere. We need to fund IHS. If we are going to make promises, we have to keep the promises with the funding.

So, Director McSwain, I hope as you put the budget together this year you review what is going on around the Country because you have a doctor here who was running a place that ran out of money every year. I hope you will be very vocal and very insistent.

We need two things to happen: One, we need budgets to come from the White House that have much more aggressive funding for Contract Health. Number two, we need a Congress that is much more willing to provide funding as well. Both are necessary.

There are a lot of other priorities. There are a lot of reasons for people to say, well, this or that or this is a priority. But I ask them to look in the eyes of people who are desperately sick and say to them, "I know we made a promise, but we can't afford it."

And then look at all the other things we are spending money on.

So your tenure here is going to be very important in the coming six or seven months as you put together your recommendations. I hope you will take some professional risks. By that, I mean that we had a person on the third floor, directly below us, show up at a Committee hearing one day and said, you know, the fact is my account is desperately under-funded; we need more money. The next morning, he was fired because he was not following the President's budget recommendations.

But I am asking you to take some risks as you go through this because we need, you need, I need, Senator Murkowski needs, all of us, to recognize we have a responsibility here.

When Ms. Shore was describing circumstances in her family and circumstances in her tribe, I understand the emotion that chokes you up when you describe it because people out there are suffering and need to get this help.

I have a whole series of questions that I want to send to you, about six or seven, dealing with SCHIP outreach and Medicare reimbursement rates on services. I think what I will do is send those to you, Director McSwain, and tell you that Senator Murkowski and I are waiting very anxiously for the House to work on the Indian Health Care Improvement Act. The House needs to get that

done so we can get to conference with them and get that bill finished this year.

We also will be continuing to put a magnifying glass over this issue of Contract Health because no matter what else we do, if we don't find a way to fix and fund contract health, this system doesn't work the way it is expected and promised to work. So we intend to do that as well.

Do you have any final statements, Director McSwain?

Mr. MCSWAIN. Just that I will work. We have done this in the past and done it very well, and that is work with our tribal partners to put together the story. I really believe that if we tell the story clearly, my bosses and my superiors would agree and would support that. I think that the Administration would like a clear compelling story in particular on CHS.

The other comment is I know it is floating around, sort of an elephant in the room, is this whole business of billing and charging Indian people. In fact, there is a piece of press out there on me right now that says that I said that I would terminate contracts with programs who were in fact billing.

No. In fact, what we are doing is we are having a dialogue with them to see the extent and why are they doing it, so we can have a discussion about where we go next. There is no decision made at this point, excepting the fact by law the Indian Health Service cannot bill, and our position is as tribes take over the programs, they should do likewise, which is not to bill. And that is our position until the law changes. We will see the outcome.

But I just wanted to clarify. I noticed that came up, and I fully appreciate tribes trying to make it work, trying to look at co-pays as an answer to addressing the health needs that they are trying to deal with. We will continue to work with them on those issues.

The CHAIRMAN. Dr. McSwain, would you have your staff describe for us, if you could, and submit to our Committee the issue of what is determined specifically as you can to be priority one? Especially relating to what I just asked about with respect to cancer and other issues. Clearly, there is confusion and there ought not be.

We ought not be confused about two things: One, how do you define the priorities; and number two, is there adequate funding? The answer to that is no, we are not confused.

Director McSwain, thank you for being here.

This Committee hearing is adjourned.

[Whereupon, at 11:55 a.m., the Committee was adjourned.]

A P P E N D I X

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SENATE COMMITTEE ON INDIAN AFFAIRS
June 26, 2008 Hearing on
"Access to Contract Health Services in Indian Country"

STATEMENT OF THE HONORABLE JOHN E. ANTONIO, SR.
GOVERNOR OF THE PUEBLO OF LAGUNA

Introduction. This statement is submitted by the Pueblo of Laguna ("Pueblo" or "Laguna") to inform the Committee of the Pueblo's concerns about the way the Congress and the Indian Health Service ("IHS") have funded and administered the Contract Health Service ("CHS") program.

The Pueblo of Laguna is a federally recognized Indian tribe located 45 miles west of Albuquerque, New Mexico, and has approximately 8,200 tribal members who are affiliated with six (6) different villages. The Pueblo's lands consist of 560,000 acres in Cibola, Sandoval, Bernalillo and Valencia Counties.

Direct Service Tribe. The IHS serves the health care needs of the Pueblo and its members through the Acoma-Canoncito-Laguna ("ACL") Service Unit and the ACL Hospital, which provide services to three tribes. This makes Laguna a direct service tribe, meaning the IHS administers the facility at which our tribal members receive health care.

Laguna Is Suffering Sharp Cutbacks. As a direct service tribe, Laguna is increasingly receiving less and less funding and administrative attention from the IHS. As the Governor of the Pueblo, I regularly hear from our tribal members about the deteriorating level of health care that they and their families receive at the hands of the IHS. Many, especially our elders, recall times in the past when the

health care they received was of a better quality and quantity. They remember when waiting lists were shorter, when IHS providers were more attentive, and when people did not die as frequently from lack of appropriate health care. Today, the complaints are of insufferably long waiting lists, rude provider behavior, and patients suffering from misdiagnosis or inappropriate health treatment.

Pub.L. 638 Operations Receive Greater Attention. Over the past decade or more, federal Indian policy has increasingly favored those service units which are operated by tribes under Pub.L. 93-638, the Indian Self-Determination and Education Assistance Act of 1975, as amended ("ISDA"). New initiatives, new funds, court judgments (e.g., *Ramah Navajo, Cherokee Nation*) and the funding protections built into Pub.L. 93-638 have combined to leave direct service programs like our ACL Service Unit far behind. In other words, the meager advantages that tribally-administered ISDA programs have managed to claw out of the federal system have not been shared by direct service programs. As a result, our tribal members have suffered an even greater deterioration in health care services than tribes who administer ISDA health programs. These disproportionate cutbacks are caused, at least in part, by the following factors.

Unfunded Pay Cost Increases Reduce Direct Services. Direct service facilities like our ACL Hospital must pay their professional and non-professional staff at federal pay rates. Some of these employees are subject to collective bargaining agreements. The law requires that all IHS staff receive annual federal pay cost increases. However, rarely does the Administration request or Congress fund the full amount of these required pay costs. As a result, IHS must "absorb" the funds needed to meet the pay cost increases, which is doublespeak for reducing program expenditures in order to increase payroll expenditures. This means fewer supplies, shorter hours, fewer staff, less replacement equipment, less facility maintenance, and on and on. In sum, it means the overall quantity and quality of service delivery goes down, year after year.

Unfunded Administrative Increases Reduce Direct Services. Direct service facilities like our ACL Hospital must buy supplies and equipment in a health care market in which the rate of price inflation has far outpaced the increases in overall IHS funding. And, unlike an ISDA-administered facility, our direct service hospital cannot renegotiate its indirect cost rate to recover the actual costs of rising administrative expenses. So while ISDA facilities are partially protected by a statutorily-required funding floor, and can sometimes recover greater indirect costs, an IHS-administered, direct service facility like our ACL Hospital is subject to funding cutbacks and no adjustment for increased administrative costs.

CHS Cannot Meet Growing Demand. As the number and type of direct services is reduced, our patients are forced to go elsewhere for basic health services. CHS is supposed to cover services provided by the private sector that IHS direct care services cannot. Either this is because the IHS-funded facility is temporarily overwhelmed by patient demand or specialty care is required that is not offered at that particular IHS-funded facility.

However, in recent years, the only type of CHS care that IHS will fund is "Priority #1" emergency care, and even that goes unpaid for lack of funds in the 3rd or 4th quarter of each year. As a result, basic services are denied our tribal members.

For years now, CHS care has been approved only in the direst of circumstances, leaving our members without reliable health care for all but the most life-threatening health needs. Laguna tribal members complain to me and other tribal leaders that the quality and quantity of health services have been steadily declining.

More Funding Required For CHS. For all of these reasons, the Pueblo of Laguna urges this Committee to redouble your efforts to appropriate more funds for Indian health care, and for CHS specifically. Given budget constraints, we also urge this Committee to work with the Pueblo and other tribes to develop new and innovative ways to deliver funding for health care that is both adequate and culturally appropriate. This is part of the trust responsibility the federal government owes to Indian tribes and tribal members.

In its 2009 Budget Justification, IHS writes that the CHS budget supports essential health care services, including such necessary services as inpatient and outpatient care, routine and emergency ambulatory care, medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy, as well as treatment and services for diabetes, cancer, heart disease, injuries, mental health, domestic violence, maternal and child health, elder care, refractions, ultrasound examinations, dental hygiene, orthopedic services, and transportation. IHS says it is currently replacing its hospitals with outpatient care facilities, which will require an even greater reliance on CHS to provide in-patient as well as specialty services. In other words, IHS is relying more and more on CHS to provide basic health services at the same time that IHS buying power is going down because CHS services purchased in the private sector market are increasing in cost.

From A Patient Perspective, CHS Funding Is Critical. In human terms -- which is what I and other tribal leaders must always deal in because these patients are our

beloved people -- fewer and fewer tribal members are getting the health care they need despite the federal obligation to provide it.

When our tribal members do receive health services outside of the CHS priority system, IHS will not pay the costs. This leads to hospitals or other nearby service providers charging individual tribal members for this care, even though payment is not their responsibility. As IHS haggles with these providers, the bills mount up unpaid, which can then result in poor credit ratings and financial difficulties for our tribal members. Over time, as the health providers realize that IHS may never pay them for Indian patients, there is a growing temptation on the part of providers to begin to give Indian patients lower quality service or turn them away. All this means tribal members suffer both financially and health-wise. This is unconscionable. The burden is borne by our most vulnerable tribal members: our elders, our people with chronic health issues, those without employer-provided health care, and all others who lack the means to shoulder IHS's burden to provide health care.

An Alternative IHS Health Structure Is Needed. The Pueblo of Laguna seeks assistance from the Committee as we explore how we can reverse the decline of health care being provided to our people.

Negotiated Fee Agreements. We need IHS assistance, not obstruction, in our efforts to negotiate fee arrangements with local medical systems in our region. Our bargaining leverage, in theory, should be fairly strong if IHS permits us to combine the purchasing power we have as a fairly major employer in our region with the purchasing power we have as a tribe with approximately 8,200 IHS-eligible members.

Replacement Facilities Are Needed. We need the IHS to stop ignoring direct service regional facilities like ours in its capital needs budget planning.

Regional Services For Indians and Non-Indians. We need IHS to right-size and market-size facility and provider options that utilize economies of scale and cost efficiencies that reflect the reality that the larger society is beginning to move toward our previously isolated Pueblo. With that emigration come people who need health care and can pay for it. That market should be captured by IHS-funded facilities like our ACL Hospital so that we can serve both non-Indians on a fee-generating basis and Indians eligible for IHS-funded care.

Managed Care. We need IHS to work with us to explore providing CHS-funded care more in the form of a managed care system through a health management organization arrangement with a regional provider in order to stretch scarce dollars. To do this, we will need, however, for CHS to be administered transparently and CHS bills paid timely.

IHS Flexibility and Creativity. All of these new ideas will require flexibility and creativity on the part of an IHS bureaucracy to which these are alien concepts.

Conclusion. In closing, thank you for allowing the Pueblo to present this statement to the Committee. We respectfully request the Committee's favorable consideration of our requests. If you have any questions, please do not hesitate to contact me at (505) 552-6654. You may also contact our legal counsel, Philip Baker-Shenk, of the Holland & Knight law firm in Washington D.C. at (202) 955-3000.

Thank you for your consideration and support.

Sincerely,

PUEBLO OF LAGUNA

John E. Antonio
Governor

PREPARED STATEMENT OF HON. MICHAEL E. MARCHAND, CHAIRMAN, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

On behalf of the Confederated Tribes of the Colville Reservation ("Colville Tribe" or the "Tribe"), I appreciate the opportunity to provide to the Senate Committee on Indian Affairs this statement on access to Contract Health Services (CHS) in Indian country, a topic of great interest to the Tribe and our citizens. The Colville Tribe applauds the Committee's attention to this issue and hopes that this hearing will illuminate some of the issues and concerns with the CHS program that the Tribe and other tribes face on a daily basis.

The Tribe knows that the Committee is well aware that many Indian Health Service (IHS) units, including our Colville Service Unit, are in "priority one" status for much of any given year. We truly appreciate the Chairman's and the Committee members' efforts to address these issues in the budget and appropriations process. Today, I would like to share the Colville Tribe's experiences on how shortfalls in direct care services, specifically, facilities and staffing, have strained tribes' already insufficient CHS dollars even more. I would also like to share some of the steps that the Colville Tribe has taken to address the chronic CHS funding shortfalls and to identify other CHS related issues our members have encountered.

Background on the Colville Tribe and IHS Services on the Colville Reservation

Although now considered a single Indian tribe, the Confederated Tribes of the Colville Reservation is, as the name states, a confederation of 12 smaller aboriginal tribes and bands from eastern Washington State. The Colville Reservation encompasses nearly 2,300 square miles (1.4 million acres) and is in north-central Washington State. The Colville Tribe has more than 9,300 enrolled members, making it one of the largest Indian tribes in the Pacific Northwest. About half of our members live on or near the Colville Reservation.

The Tribe's CHS program is operated by IHS from the Tribe's main IHS clinic in Nespelem, Washington. The Tribe's CHS delivery area includes Okanogan, Grant, Ferry, Chelan, Douglas, Lincoln, and Stevens Counties, some of which are among the largest counties in Washington State. Because the Tribe's Nespelem clinic is the primary source of IHS health care delivery, many tribal members, particularly those living in the Omak area, must travel long distances to receive any direct service health care.

Facility and Staffing Shortcomings Strain CHS Dollars

Like many Indian tribes with large service delivery areas that are heavily dependent on CHS, the Colville Tribe faces a health delivery crisis. As the Committee is aware, a significant issue for tribal communities is the lack of funding for adequate health facilities in Indian country, both for construction and for on going staffing needs. The Colville Tribe is an unfortunate and all-too-familiar example of how funding limitations for facilities have a corresponding impact on CHS funding.

The Tribe's original IHS clinic in Nespelem, Washington, was constructed in 1934. In the 1980s, the Tribe hoped to have constructed a new facility utilizing the IHS priority list system. The Tribe understands that at one point, its request would have been ranked highly on the IHS priority list but was not considered because of concerns that the existing facility was a historical site. That priority list has been closed since 1991 and some IHS Area Offices, including the Portland Area Office, have never had any facility constructed under the priority list system.

Because the Tribe's need for a new facility was so great and the priority list was no longer an option, the Tribe ultimately was forced to utilize a variation of IHS's small ambulatory program to replace its aging facility in Nespelem. Of a total contract amount of nearly $4.7 million for the Nespelem facility, the Tribe funded $3.3 million and IHS funded $1.3 million in equipment costs, with no additional staffing package. Although the new clinic is larger than the 1934 building it replaced and can accommodate additional patient visits, the lack of additional staff makes full utilization of this new facility impossible.

This lack of staff and the resulting long, often futile waits by patients to receive treatment at the Tribe's Nespelem facility have created a disproportionate strain on the Colville Tribe's already insufficient CHS dollars by discouraging preventive care. If a patient cannot receive care because of facility or staffing shortages, problems that could have easily been addressed become emergencies and may ultimately lead to emergency care. Ironically, given the "priority one" rationing of CHS resources, it is only when a problem becomes an emergency that a patient becomes eligible for CHS services.

Adding to this strain is the lack of inpatient IHS facilities, such as hospitals. Neither the Colville Tribe nor any other Indian tribe in the Portland Area has an inpatient hospital. This is significant because inpatient hospitals are able to provide services that outpatient clinics cannot. This gap in services is otherwise borne by a tribe's CHS funds.

The Colville Tribe's Efforts to Secure Supplemental Resources

The Colville Tribe strongly believes that the United States' trust responsibility requires nothing less than adequate funding for Indian health care, including CHS. The strains on CHS funding, however, have required Indian tribes to do whatever they can to secure alternative funding or to establish other programs in their attempts to preserve precious CHS resources.

IHS has adopted "a payer of last resort rule" that requires patients to exhaust all health care resources available to them before IHS will pay for services from the CHS program. Medicare and Medicaid are among the most critical alternative resources to CHS funds. The more CHS eligible beneficiaries that can utilize those programs, the farther CHS funds can be stretched. Using tribal and other funds contracted from IHS under P.L. 93–638, the Colville Tribe dedicates staff in ongoing outreach and educational efforts to ensure that eligible tribal members are enrolled in those programs.

Preventive care is another area in which the Colville Tribe provides supplemental resources, specifically for cancer patients, an issue of great concern to our Tribe. Approximately 800 Colville tribal members are currently being treated by IHS for cancer. The Tribe has been fortunate to have obtained a grant during the past year from the State of Washington for cancer awareness and other preventive services. Our cancer patients include young women being treated for breast cancer, and the Tribe has been able to secure a grant through a private foundation that allows one part-time staff member to provide outreach and preventive care, specifically for breast cancer. These services are provided to supplement the shortfall in CHS funding for what would otherwise be preventive health care.

Other Issues Relating to Access to CHS

In our Tribe's efforts to ensure that our tribal members have at least some access to health care, other issues have arisen relating to access to CHS. One example is the complexities in partnering with IHS on initiatives to relieve the burden on the CHS system. In Omak, Washington, which is 30 miles from the Tribe's IHS clinic in Nespelem and where there is no IHS facility, the Tribe went to extraordinary lengths to lease a tribally owned building to IHS to allow IHS to station a doctor from the Nespelem clinic there on a satellite basis. More flexibility would have made this process much easier.

Another issue that has arisen locally is the need for more tribal input on the use of CHS funds. We have noted that breast cancer awareness has been a priority for our Tribe. CHS used to fund a mammogram coach that came to Colville Reservation from Spokane to perform on-site mammograms. Now, CHS will not pay for this service, but it will pay for mammogram referrals. Although some explanation may exist, the referrals would appear to cost much more than onsite mammograms.

Thank you for the opportunity to provide this testimony and for your consideration of these issues. The Colville Tribe looks forward to continuing to work with the Committee and the respective appropriations committees to ensure that the CHS program serves the needs of Indian country and is adequately funded.

PREPARED STATEMENT OF CASEY COOPER, CHIEF EXECUTIVE OFFICER, CHEROKEE INDIAN HOSPITAL

The Effects of Inadequate Funding for Contract Health Services in Indian Health Care on the Eastern Band of Cherokee Indians and North Carolina

The U.S. Congress, the General Accounting Office, and the U.S. Commission on Civil Rights have all concluded that American Indian and Alaska Native communities suffer from significant health disparities and inadequate federal funding of Indian health care.[1–4] Current federal funding levels for Indian health represents approximately 60 percent of the level of need in Indian country and is significantly less, per capita, than other federally funded populations, including federal employees, immigrants, and prisoners.[5]

Contract Health Service Funding

Funding for Contract Health Services (CHS), a line item in the Indian Health Service budget that allows Indian health providers to purchase health care services when they cannot directly do so, is grossly insufficient. The annual need for CHS has been estimated to be in excess of $1 billion per year, and is currently funded at approximately half that amount.[6] As a result, most tribes, including the Eastern Band, are forced to ration health care to Indians, funding only those services for conditions that pose an immediate threat to life or life function.[1]

As medical inflation continues to outpace routine inflation and chronic disease rates continue to increase, insufficient funding will accelerate the disparities in the health of American Indians and Alaska Natives. For example, without adequate funds it is certain that there will be missed opportunity to diagnose, treat, and in some cases cure pre-malignant or early malignant lesions of the skin and colon. Malignancies of the prostate, or ovaries, uterus, or breast will go undiscovered in numerous patients without specialty consultation in urology and gynecology respectively. Blindness will result from unidentified retinal disease hidden behind cataracts that are not removed in a timely manner. Early cardiac or other vascular intervention will not be possible without indicated cardiac stress testing and other vascular testing. Without proper intervention, critical vascular lesions will almost certainly continue their inevitable progression to infarction of the heart (heart-at-

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[1] United States Government Accountability Office, Report to Committee on Indian Affairs, U.S. Senate, Indian Health Services: Health care services are not always available to Native Americans, August 2005.

[2] Sally Smith 2007 Testimony, *http://www.nihb.org/article.php?story=20070216120829197* (1 of 5) [7/31/2007 5:02:10 PM].

[3] U.S. Commission on Civil Rights, A Quiet Crisis: Federal funding and unmet needs in Indian country, July 2003.

[4] U.S. Commission on Civil Rights, Broken Promises: Evaluating the Native American health care system, September 2004.

[5] I.H.S. Appropriations Per Capita Compared to other Federal Health Expenditure Benchmarks, March 2003.

[6] HHS, Indian Health Service "Justification and Estimates" 2005.

tack) or brain (stroke). Unfortunately, these needs have already outpaced even these supplemental funds provided by tribes.

Rationing of health care has immediate and secondary consequences. Untreated conditions result in progressive deterioration of health, and delayed intervention leads to a worsening prognosis for recovery and more expensive treatment. Patients will be subjected to avoidable pain and suffering, and delays in treatment will likely increase rates of depression and stress resulting in higher rates of chronic disease and suicide.

Regional Economic Impact

To the extent that resources are available, tribal Contract Health Service programs are a significant referral channel for non-tribal health systems. In 2008, the Indian Health Service and tribal health programs will refer $579 million of federal Contract Health Services dollars into the public and private sectors.[7] This does not include referrals from Indians with alternate funding sources, such as private health insurance, Medicare, and Medicaid. The Eastern Band alone will refer over $15 million of care to North Carolina health care providers, with $3.5 million of these referrals from Contract Health Service dollars. The American Hospital Association has estimated the economic ripple effect of health care to be approximately two dollars for every dollar spent and every hospital job represents approximately two additional jobs.[8] Tribal health systems also provide a safety net for beneficiaries who have no health insurance coverage. The failure of tribal CHS programs will compromise this safety net, exacerbating the economic challenges of uncompensated care for non-tribal health systems in neighboring health care markets.

In North Carolina, the Eastern Band is forced to cannibalize direct care services and other programs like economic development, housing, and infrastructure, to mitigate the adverse health and economic effects of inadequate CHS funding. CHS funding represents approximately ¼ of the annual emergent and urgent needs. Thus, continuing to fund this unmet need will erode access to primary care, and undermine economic and community development.

Innovative Solutions

The appropriation of more federal dollars for Contract Health Services is the only real solution to the serious health disparities in Indian country. Until Congress fulfills its treaty and trust obligations to Indians and tribes, the Eastern Band and other tribes have sought to innovate through aggressive tribal programs to get Indians better health care opportunities.

For example, the Eastern Band aggressively encourages its tribal members to enroll in alternate health services they are eligible for and assists with the costs of those alternate programs. After visiting the Mille Lacs Band of Ojibwe Reservation, the Eastern Band established a Supplemental Health Insurance Program (SHIP) that funds Medicare Part B premiums. So if a tribal member is eligible for Part B, which covers physician and other non-hospital services, the Tribe reimburses the Indian beneficiary for the cost of enrolling in the program. While the cost of the tribal program to reach Indian beneficiaries costs approximately $1 million per year, the savings to the Tribe and the Indian Health Service is significant. The Tribe can then bill Medicare for service provided at the Cherokee Indian Hospital and only pays for co-payments rather than the full cost of specialty care.

To ensure that the Tribe reaches the maximum number of tribal members that it can, it has combined several sources of tribal data—enrollment, per capita distribution, and hospital information—to create a database for outreach to community members. When an Eastern Band member is about to become eligible for Part B, the database alerts the Tribe so it can specifically reach out to the individual. This also allows decreases the cost of enrolling in Part B, which increases as the age of the eligible recipient increases.

As a part of the targeted outreach, Eastern Band hospital staff communicate with tribal members by letter, visits to the Senior Center (called Tsali Manor), and various community meetings to assist tribal members with enrollment in Part B.

Conclusion

The Congress should adequately fund Contract Health Services in accordance with the treaty and trust responsibilities of the United States to Indians and tribes. Not doing so compromises Indians' quality of life, results in avoidable suffering, promotes inefficiency, and perpetuates the economic challenges of both tribal and non-tribal communities.

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[7] See 2008 I.H.S budget.

[8] American Hospital Association, "Trendwatch" April 2008.

PREPARED STATEMENT OF TRACIE REVIS, SECOND YEAR LAW STUDENT, UNIVERSITY OF KANSAS

Mr. Chairman and distinguished members of the committee, my name is Tracie Revis. I am Yuchi and Muscogee Creek from Tulsa, Oklahoma. I am a second year law student at the University of Kansas and recent cancer survivor. My entire life, starting from my birth I have received services from Indian Health Services (IHS). I am all too familiar with the process of IHS, and contract health services (CHS) and how long it takes to get services, if you are fortunate to receive them at all. I am excited to submit testimony on this matter of IHS-Contract Health Services. I am excited because I believe that stories like mine need to go on record so that perhaps something in the future will change. IHS has been a double edged sword for me. It has been the system that hurt me the most, but yet saved me at other times.

Diagnosis

In 2005, I graduated with my Masters degree from the University of Oklahoma and began law school at the University of Kansas. During my first semester of law school I became very fatigued and my lymph nodes became painful. I was losing weight, became very pale, and was experiencing night sweats. I went to the Haskell Indian Nations Indian Health Services clinic in Lawrence, Kansas where the doctor ordered a chest x-ray and diagnosed me with walking pneumonia. He prescribed antibiotics but my symptoms persisted. For three weeks the doctor repeated x-rays and treated my illness as walking pneumonia. There was some discussion about ordering a CT scan, however, because Oklahoma was my home area and I was in Kansas, we had difficulty getting authorization for a referral to the local Lawrence facility.

Finally, in November, a year after I started going to the doctor for my symptoms, I had become too ill and the doctor at Haskell ordered the CT Scan at Claremore Indian Hospital in Oklahoma. The doctor at Claremore did a full workup and CT Scan. He immediately reviewed the CT films and informed me that I had a large mass above my heart area and that I would need to have a biopsy immediately. His inclination was that I either had a form of cancer or a thymoma. He wanted me to meet with a thoracic surgeon to discuss the possibilities and have him review my films.

The Referral

My referral "for evaluation" with the thoracic surgeon "and a biopsy if necessary and any additional treatment if necessary" were sent to my tribal contract health department. However, I ran into several complications and was deferred, denied and then mysteriously approved. The process was unclear and confusing, and I was not contacted by CHS if there was missing documentation. I had to constantly call my tribe's area clinic and the main tribal complex contract health services office to get information on my referral status. Upon receiving the approval for the biopsy I had to call and schedule the appointments myself and then coordinate with the local clinic's caseworker. The surgeon's office informed me that until I could confirm payment that they could not discuss the possible dates for surgery with me. In December, a month after the mass was discovered, I went in for the biopsy.

The thoracic surgeon decided to biopsy a tissue sample from the mass instead of biopsying the lymph nodes. I was informed that that there would be a small incision below my collar bone to take the tissue sample but, if the thoracic surgeon could determine with certainty that the mass was a thymoma then he would perform a sternotomy and remove the mass. After the biopsy began the thoracic surgeon could not get a good tissue sample and consequently performed the sternotomy which ultimately removed 75% of the tumor. I was in the hospital for six days following the procedure. I became completely dependent on others to assist me.

On Christmas day, I was given the official diagnosis of Hodgkins Lymphoma. At that time there was one tumor and it was at an early stage 2 (since it was only in the chest area and not below the diaphragm).

Getting Treatment

In January 2006, I was told that there were some concerns about my referral originating from Haskell Health (because it was in Kansas) and concern because I did not have a utility bill in my name within my tribal boundaries. Because of these concerns, my tribal CHS requested a verification of my residence. Again, I explained that I was a student when I was diagnosed and that upon moving back to Oklahoma I had to move back to my grandmother's residence and therefore all of the bills were in her name. During the address verification period in February, I developed a bad cough and went to Claremore IHS to see the doctor that had performed the CT scan.

He ordered another chest x-ray which showed that the mass appeared to have doubled in size since pre-surgery. He inquired about my progress with getting an oncology appointment and I explained to him what I had been told by my tribal CHS that my referral was approved pending residence verification.

My doctor was very concerned and decided to call the main tribal CHS to find out when I would be able to schedule an appointment. He spoke with my caseworker at the tribe, who informed him that my referral had been denied. He inquired about the appeal process and asked if I had been notified of the denial. The caseworker responded that I had not been informed and that I would not be informed for at least 4 weeks, then I would receive a letter in the mail telling me that I had been denied. Also, that if he (as my referring physician) wanted to send another referral he would have to wait 4 weeks and then we could appeal with a new referral. He asked about why I had been told that it was "approved pending verification" and had the CHS office received Haskell's letter stating that my address on file was listed as Oklahoma. She said that it was denied because they did not have any money and then she read him the policy of denying a referral and policy about waiting 4 weeks before notifying the patient. I was in the room for the entire call which was on speakerphone.

Advocating for the urgency of treatment, my doctor inquired whether the CHS caseworker understood how important it was that I see an oncologist right away. She said she could not do anything and that I needed to speak with the local caseworker at my tribal clinic. My doctor was very upset and decided to call the tribal CHS director, unfortunately she was unreachable that day. My doctor advised me that my health could not wait, and that I needed immediate treatment. He decided to call other caner facilities within the state to see if they were willing to take me as an uninsured patient. Every hospital that he called said they were at their fill of uninsured patients and that they could not take me on financially. At that point my doctor suggested possibly seeking treatment out of state.

After the denial from IHS, I called the State Department of Health Services inquiring about state assistance and was told that I had the "wrong type of cancer". I did not qualify for any assistance because I did not have children and was not disabled. It did not matter that I did not have an income. Frustrated by the system, I called state representatives, tribal officials, and anyone who knew someone that might be able to offer suggestions. I followed up with the CHS Director and was informed that I was "approved pending verification of my residency".

Three months after my biopsy, I finally had approval for treatment and had an appointment with an oncologist. My new oncologist reviewed all of the previous medical records and ordered more tests to determine the final staging of my tumor size before I began treatment. Upon initial review he presumed my staging was stage 2 because of the location of the tumor above the diaphragm. However, because of the time it took for me to get approval to begin treatment, the tumor had grown and I now had 3 tumors in my chest and neck. Also, I had enlarged lymph nodes in the groin and in areas surrounding the aorta and an enlarged spleen and liver. My final staging was a 3(B)(E).

I tolerated the treatment well. However, because of my anemia and weight loss my oncologist recommended red and white blood cell boosters. Unfortunately, the cost of the injections was $4,000 for one and $6,000 for the other. My oncologist knew that CHS would not and could not afford that amount so he put me in a clinical trial. Earlier this year, the FDA released a report on one of the drugs that noted that it should not be given to young patients with chest, neck, or breast cancer; it should not be given to patients that have a high chance of recovery, or to young patients. I met all three criteria.

Remission

Through it all, I overcame the obstacles and struggles and finished treatment in July 2006. In September, I accepted a full time job working in cancer research at a University Health Center Institutional Review Board away from my tribal community but within an IHS urban service area. While filling out my insurance forms, I inquired about pre-existing conditions. The insurance provider said that if I could verify continued coverage with no lapses in service then they would cover the pre-existing condition. I explained that I was always eligible for direct service through IHS. They accepted it and I had insurance coverage.

Relapse

In November 2006, I began to show symptoms that my cancer had returned. Because of the problems that I experienced at the former cancer center I decided to change oncologists. I spoke with the IHS service area office's CHS and they agreed to be the secondary provider to what my insurance company did not cover even

though my new doctor was not a doctor they contracted with. The plan of treatment was for extensive salvage chemotherapy and an autologous stem cell transplant. My transplant would consist of 30 days in the hospital and more high-dose chemotherapy.

I began salvage chemotherapy in January 2007. The treatments were much more intense and longer. It took two different types of salvage chemotherapy treatments which was four total rounds to get my tumor to respond. By May, my tumor had decreased enough to begin transplant procedures.

Transplant

I had been speaking with CHS and my insurance company to try to coordinate what services would be covered. CHS advised me that they would try to cover the costs that the insurance provider would not. The dilemma came when the insurance provider said that my hospital, where I was working and where I was planning to have the transplant procedure, was not in the insurance provider's network and that I would have to go out of state. CHS said that in order for me to have a chance of their office covering the remaining costs then I would need to stay in-state (even though it was a higher cost). The CHS worker informed me that I had a high chance of having my costs covered because I was a good candidate. She [CHS caseworker] said that it is not common to cover most transplants because of the follow-up costs that are associated with them and that often patients do not adhere to the follow-up treatment. Ultimately, after I had already scheduled the transplant and began the transplant procedures (stem cell harvesting, heart and lung tests) my referral was denied and my health could not afford the wait to reschedule at another facility out of state.

I was released from the hospital in June 2007 and had plans to return to Lawrence to restart law school. In July, my doctor called to say that the transplant did not remove all of the cancer cells, and I was still showing active uptake in my cells. I was immediately sent to a radiation oncologist.

Radiation

I had plans to return to law school in the Fall of 2007 and because of my current obstacles with IHS and CHS I decided to not let "the wait" for referrals and approvals be the deciding factor. This "wait" for referrals may or may not produce services, and I felt that my health could not afford that gamble of getting an approval. I started school and radiation at the same time. As a result of my previous struggles, I chose to not go through IHS. The debt is 100% on me. However, I maintained contact with my area office regarding my decision to go back to school and my doctor is in Oklahoma.

Currently, I am in remission for a second time. I have outstanding medical debt as well as my credit rating has been greatly impacted. I receive CT and PET scans every six weeks to monitor any growth in the tumor, and full blood panel tests. CHS has covered two of my five scans since radiation. My biopsy bill has been paid, even though after the procedure, CHS claimed that they had not authorized the hospital stay. It took over a year to get it paid, but it has now been paid. While, IHS covered my chemotherapy, I still incurred several other costs associated with cancer. My total cancer debt is around 200,000.

Other problems

Getting the referrals and approvals was not the only problem that I encountered with IHS and the CHS system. When I was deferred and then denied the first time, I asked what the process was so that I may appeal it. I was told that I was not allowed to see the policy for approvals or denials. There was not one person who could tell me how the process worked, or how often the committee met, or explain the criteria for approvals.

At the cancer center where I was referred the financial manager informed me of her issues of dealing with me because I was from "the Indian Clinic". I corrected her and told her that I was not referred from a clinic but from a Hospital and it was actually my tribe, not the hospital that was the payor. She proceeded to tell me how "the Indian clinic likes for us to treat their patients, but they don't want to pay us." I was frustrated by her attitude, dislike for IHS, and blatant racism; however, it was not my issue to deal with. I was a patient like every other patient, battling cancer and fighting for my life. I was very concerned that perhaps I would be treated differently and would not receive the highest standard of care because I was an "Indian patient". Each time that I went in for treatment the front desk would ask me for my "Indian authorization" or my "Indian papers" before they could treat me. They did this very loudly, and I often felt embarrassed by the scene that they caused.

During treatment I often needed to get CT scans to monitor the size of my tumors. I would go to Claremore IHS to get the scans and often during the scans the CT machine would overheat and would have to be shut down for a while to let it cool it off. It has been suggested by other doctors that I may not have had adequate scans because the machine at Claremore IHS was older and probably did not show the true picture of my cancer. Therefore, it is likely that I may have never truly been in remission.

Purpose of my Testimony

Through all of the struggles, I understood that I was fortunate to have access to what health care I did receive. Having worked on IHS contracts in prior jobs, I understood the budget process and that there is never going to be enough money to meet the entire medical need of the community. But, I truly believe that had someone been more willing to walk me through the process in the beginning I may have had a different experience. I, like so many others was very disillusioned by the true nature of the system. Never throughout my entire experience did I feel empowered or in control of my own health. If I would have had a choice on what my options were in the beginning I may not have had to suffer so much. Since then, I have been told by several doctors, oncologists, and surgeons that I should have never had my chest cracked open in the first place. I did not have a choice and since then my struggles with the system lead to longer treatment time for a tumor that was even larger than was originally noticed. I will forever bear the scar and at 30 years old I have already been through menopause as a result of my treatment. I am happy to be alive and have the opportunity to share my story, but, I cannot help but to wonder what would be different if I had only known.

Thank you

DR. JOE SHIRLEY, JR.
President

BEN SHELLY
Vice President

April 30, 2008

VIA EMAIL: comments@indian.senate.gov

The Honorable Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, DC 20510

RE: Indian Health Service Contract Health Service Program

Dear Senator Dorgan:

Thank you for inviting input on the Indian Health Service Contract Health Service program. First, the Navajo Nation is pleased with the final regulations of Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 which places a cap on the amount a Medicare participating hospital will be reimbursed for services provided under the IHS Contract Health Service program. The Navajo Nation serves on the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group which was consulted during the development of Section 506—Medicare Like Rates. Since the implementation, the Navajo Area IHS has reported a 19 percent reduction as a percent of total billed charges in Fiscal Year 2008 resulting in more buying power for the Navajo Area IHS Contract Health Service program.

The Indian Health Service provides healthcare services directly through its facilities and indirectly through contract health services delivered by a non-IHS facility or provider through contracts with the IHS. There are six federal and two tribally operated service units on the Navajo Nation. Specialty services are limited and there is an increasing demand for Contract Health Service program funds to access specialty or emergency care.

Of the twelve IHS areas, the Navajo Area represents the largest direct care program provided by IHS. In Fiscal Year 2007, the Navajo Area's user population was 237,981 or 12.5 percent of the entire IHS user population with a total of 16,000 hospital admissions and 1.2 million ambulatory care visits.[1]

We are appreciative and grateful for increased IHS Contract Health Service program funding in Fiscal Year 2008; however, the overall funding for the Contract Health Service program including Catastrophic Health Emergency Fund (CHEF) remains severely inadequate. Until Fiscal Year 2008 the funding for CHEF had been flat since Fiscal Year 2003. The CHEF set-aside funding remains underfunded by an estimated $15 million nationally. Across the IHS including the Navajo Nation, the CHEF funds are usually depleted by June of each year and it is all too common to hear "don't get sick after June" in tribal communities. Underfunding CHEF is unacceptable.

[1] NAIHS Profile, January 2008.

Several of our Contract Health Service issues involve the IHS eligibility criteria. Although there is a national IHS Contract Health Service program eligibility criteria, each IHS area has its own medical priority list modeled after IHS National medical priority guidelines. There are five eligibility factors that one must meet to access the Navajo Area IHS Contract Health Service program:

1. Indian Decent: 42 CFR 136.23—one must show proof of being an enrolled member or descendent of an enrolled member of a federally recognized tribe;
2. Residency: 42 CFR 136.23—permanent residence on a reservation or one must have permanent residence in a Contract Health Service Delivery Areas (CHSDA) and as a member of that tribe. If one is not a member of that tribe—he/she must have close social and economic ties to that tribe or have certification of eligibility by that tribe. If one has been away from their CHSDA or reservation for more than 180 days, he/she is no longer eligible. Exception is students, transients, children placed by the tribe or through court orders outside of their CHSDA;
3. Medical Priority: 42 CFR 136.23—"Not all services are covered" referrals from the Indian Health Service for further care will be in accordance with established National CHS Medical Priorities and/or Area specific Medical Priorities. Occasionally, IHS providers refer cases outside of IHS facilities that are not necessarily covered, such as reconstructive surgeries, orthodontics, bridges/crown, root canals, durable medical equipment, etc.;
4. Notification/Prior Authorization: 42 CFR 136.24—Emergency care, the patient or someone on behalf of the patient must notify an IHS facility within 72 hours of admission and/or outpatient services. Non-Emergency, one must obtain prior authorization prior to getting medical care. If one has a follow up care to the initial referral, one must go back to their primary care provider at the IHS to see whether he/she need to go back to the private hospital/physician for care or IHS may take care of that care in-house. Exception is 30 day notification for disabled and elderly; and
5. Alternate Resources: 42 CFR 136.23 (f) states that IHS will not authorize payment for Contract Health Service to the extent that the patient/family is eligible for Alternate Resources, upon application or would have been eligible if they applied or made an effort to apply. IHS is a payor of last resort. There are various categories of alternate resources that a person may apply to and qualify for and depending on the circumstances.

There are 320,000 Navajo people of whom about 205,000 live on the reservation and the remaining reside off the reservation.[2] Due to strict eligibility requirements for the IHS Contract Health Service program, Navajo individuals who reside off the reservation for more than 180 days and who require health care that is unavailable at a nearby direct care facility will not be able to qualify for IHS Contract Health Service funds. For example, if an enrolled member of the Navajo Nation was living in Phoenix, Arizona for more than 180 days and requires medical care at the Phoenix Indian Medical Center it will be provided to the extent that it is available at PIMC. But, access to Contract Health Service program will be denied if the individual requires specialty care such as heart surgery not available at PIMC. The reason for denial would be due to the residency requirement. The Navajo Nation proposes to solve this problem by funding the entire State of Arizona as a Contract Health Service Delivery Area similar to the State of Oklahoma.

[2] Estimated. 2007, Navajo Division of Economic Development; Window Rock, AZ.

Overall, there is a general misunderstanding by many patients on the types of services provided through IHS including direct care and Contract Health Service program. Provision of health care is a federal trust responsibility and for that reason an enrolled member of a federally recognized tribe should be eligible for healthcare at any IHS or tribally operated facility. The Navajo Nation proposes to streamline the eligibility requirement for the IHS Contract Health Service program with adequate and appropriate tribal consultation, and requests that eligibility requirements for the IHS Contract Health Service program be the same as for IHS direct care. The Navajo Nation further urges Congress to adequately fund the overall Indian Health Service, including Contract Health Service program and CHEF.

Another issue affecting the Navajo Area IHS is the Contract Health Service program funding distribution. According to the IHS Fiscal Year 2007 Resource Distribution Report of April 3, 2008, the Navajo Area IHS had the second largest user population of 237,981 and it ranked 11th among twelve areas with regards to Contract Health Service program resources available. Unlike the Navajo Nation, tribes served by several other Areas have more immediate geographic access to emergency and/or specialty care. The Navajo Nation proposes that the IHS Contract Health Service program funding distribution take into consideration the uniqueness, user population and vastness of the reservation.

Contract Health care needs budget increases to keep up with transportation costs. The Navajo Area IHS spent eleven percent of its Contract Health Service program funds on transportation costs. Many of our contract health service patients live in such isolated and remote areas without immediate access to specialty hospital care and often times they must be air-evacuated by airplane or flown out by helicopter for emergency or specialty care. Seventy-eight percent of our roads on the Navajo Nation are dirt and unpaved.[3] Most of these unpaved roads are rutted and barely passable which becomes increasingly difficult and dangerous to travel on during inclement weather. Our ambulance services must travel these roads which takes its toll on the vehicles.

Unlike some other IHS regions, specialty care is not available in the immediate area because of our isolation and our health and emergency personnel cannot travel on well-maintained state and county roads to transport our specialty patients. Our contract health care allocations and those of other isolated, large land based tribes' budget should be increased to cover our transportation-related costs.

Covered medically eligible services should be expanded. The top ten diagnoses the Navajo Area IHS Contract Health Service program has covered from Fiscal Year 2007 paid claims to date include:

[3] 2000 U.S. Census.

Inpatient Diagnosis	Outpatient Diagnosis
Fractures and sprains	Kidney/urinary tract disease
Heart disease	General symptoms
Infectious diseases	Nervous system disorders
Gallbladder/pancreas disease	Heart disease
Neoplasms	Fractures and sprains
Liveborn infants	Injuries and wounds
Artery/vein/lymphatic disease	Neoplasms
Kidney/urinary tract disease	Back disorder
Congenital disorders	Aftercare
Injuries and wounds	Connect tissue/musculoskeletal

The Senate Committee on Indian Affairs must understand that the IHS Contract Health Service program denied a total of 177,480 claims in Fiscal Year 2006. Of which, nearly 23,000 claims were in Navajo Area IHS. About 10 percent of the Navajo patients were eligible but the care they were seeking was not within funded medical priorities and therefore the care was deferred, in other words "denied", for which the Congress must adequately fund the IHS Contract Health Service program.

Lack of Contract Health Service program funds causes the IHS Areas to limit the amount of health care services. The lack of funds causes rationing of health care. Here is a list of non-delivered health care: Medicare level skilled care in a certified extended care facility, durable medical equipment, preventative care which enables a person to maintain optimum daily living including immunization, high prevalence health condition screening, diagnosis and treatment, periodic health examination for infants and children, eye care services designed to prevent the onset of ocular disease/visual impairment at all ages and services to advance the quality of life, and the list goes on. Increased funding for Contract Health Service program would provide these types of essential healthcare services.

In conclusion, on behalf of the Navajo Nation, thank you for introducing an amendment to increase funding for the Indian Health Service by $1 billion which overwhelmingly passed by the full Senate in March. This funding increase is a step in the right direction to begin addressing the health and funding disparities of American Indians and Alaska Natives.

Thank you for your time and deepest consideration of the Navajo Nation's input on the IHS Contract Health Service program.

Sincerely,

Dr. Joe Shirley, Jr., President
THE NAVAJO NATION

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INDIAN PUEBLO
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OFFICE OF GOVERNOR

June 23, 2008

Senator Byron L. Dorgan
Chairman
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

SUBJECT: Indian Health Service Contract Health Service (CHS) Program

Dear Honorable Senator Dorgan:

On April 14, 2008, I had sent you my comments in regards to the matter on the Indian Health Service Contract Health Services (CHS) program. After further consultation with your staff, the recommendation was to also include statements from tribal members regarding their denials.

Enclosed are both a copy of the letter, comments I submitted and the denial statements from our tribal members. I hope our information will provide some fuel on the urgency and need to not only assist and support the CHS program, but to provide the "real need" funding. Additionally with the support that Tribe's are providing, all of our information should justify the need for additional funding as part of the Indian Health Care Improvement Act S. 1200.

Additionally, in consultation with both the Santa Fe Service Unit and the Albuquerque Area Office Indian Health Service we offer these comments and concerns that face the premise from which we include our statement:

- The Indian Health Service, even with its limited resources, is the first line of defense against poor health in Indian Country. Without these services, our health status would be significantly worse that it is. Lack of adequate funding is the primary factor in addressing the health care needs in Indian Country.
- With ever decreasing funding and ever increasing health care costs, the CHS program operates on a priority schedule that restricts almost all care, with the exception of life or death circumstances, in most cases, less

- serious illnesses or injuries must get significantly worse before it can be covered under CHS guidelines.
- All parts of the Indian Health Service delivery system must be addressed for overall improvements. CHS is only one part of this system, and other parts must be funded to not only fund illnesses and injuries but prevention.
- Not all provider organizations are bound by the Federal Medicare-like rates legislation; this includes most physician provider groups and air ambulance services; as a result, these services have high costs which greatly impact on the CHS budget. Congress should take action that would include all providers of health service in the Medicare-like rates legislation for the Indian Health Service and tribal health care facilities that are operated under P.L. 93-638.
- Chronic care requires long term commitment of CHS dollars, especially for those patients that do not qualify for Medicare. It is recommended that another long term care CHS fund be appropriated by Congress to meet the needs of chronic care patients (rehabilitative care, cancer care, dialysis, head trauma and other diseases or injuries.
- The CHS Delivery Areas (CHSDA) are confusing to patients, non federal providers, Indian Health Service staff as well as other rules of eligibility that are complex and confusing.
- Annual CHS expenditures consistently exceed allowances.
- Medical priorities used to ration care; are not applied uniformly across the Indian Health Service; and, cause further severity of illness by delay of treatment.

Throughout the course of the funding made available to the Indian Health Service, we have seen and experience first hand the massive dwindle ling of services and funding. I do not understand why the richest Country in the word cannot take care of our people. It is a shame and hurtful. I hope something will come out from this Hearing and that the Congress of the United States place a priority to meet the unmet health needs of our people. Many of them do not have a choice, many are on fixed income, and we get a continual reducing of service. I ask and plead on behalf of my People and Community, that something be done to correct this inhumane and injustice dire situation.

Senator Dorgan, again thank you to you and the other members of the Committee on Indian Affairs for championing this very vital and critical health care issue.

I can be reached at the following email address, governor@santaclarapueblo.org or you can call me at my office (505) 753-7330, or you can also contact Mr. Walter Dasheno, Director, Intergovernmental and Public Relations Office at his email address walterd@santaclarapueblo.org or his office at (505) 692-6312.

Sincerely,

J. Michael Chavarria, Governor
Santa Clara Pueblo

Enclosure(s)

(1) Letter and Testimony from Governor J. Michael Chavarria dated April 14, 2008

(2) Letter's from Tribal Members on denial of services or concerns

Cc: Santa Clara Pueblo Tribal Council
The Honorable Senator Pete V. Domenici, United States Senate
The Honorable Senator Jeff Bingaman, United States Senate
Chairman Joe Garcia, All Indian Pueblo Council
Mr. James Toya, Director, Indian Health Service, Albuquerque Area

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INDIAN PUEBLO
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OFFICE OF GOVERNOR

April 14, 2008

Senator Byron L. Dorgan
Chairman
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Dear Honorable Senator Dorgan:

I can't tell you how much my Pueblo appreciates and supports the effort you are making as Chairman for the Senate Committee on Indian Affairs. We have talked with you and met you personally on various occasions and the issues that you have articulated and promised to champion for Indian Country are now becoming a reality. My Pueblo wishes to thank you for taking a pro-active direction in addressing the multitude of Indian issues and concerns that have been brought before this Committee.

Today, we submit our position document regarding the issue of Contract Health Services as it relates to our Pueblo and the many injustices that have happen to our People not only for lack of funding, but the inadequacies that continues to haunt the Indian Health Services because the Congress and in particular, the White House does not make funding a major priority for this Department.

The information provided is a cooperative effort between our Pueblo and the Santa Fe Service Unit through Mr. Robert J Lyon, the Chief Executive Officer. This provides just a small window of information that is available, there are many more windows that could show more, maybe in time.

Senator Dorgan, again thank you, to you and the Committee for championing this vital and critical health care issue.

I can be reached at the following email address, governor@santaclarapueblol.org or you can all me at my office (505) 753-7330 or you can also contact Mr. Walter Dasheno, Director, Intergovernmental and Public Relations at his email address, walterd@santaclarapueblo.org or at his office (505) 692-6312.

Sincerely,

J. Michael Chavarria

J. Michael Chavarria, Governor
Santa Clara Pueblo

Enclosure(s)

(1) Healthy People, Healthy Community – A Profile of the Health of Santa Clara Pueblo – October 2007
(2) Letter from SFSU, CEO, Mr. Robert J. Lyon w/Supplemental IHS Information

cc: Santa Clara Pueblo Tribal Council
Chairman Joe Garcia, All Indian Pueblo Council
Mr. James L. Toya, AD, AAO
Mr. Robert J. Lyon, CEO, SFSU
Mr. Walter Dasheno, SCP

Position Statement
Prepared by Governor Joseph Michael Chavarria
Santa Clara Pueblo
April 2, 2008

"When something happens, people are there to share and help. We are a community. We help each other out in many ways as much as we can. We are there. We are a community"
-Wisdom about Health shared by an Adult

"Healthy People, Healthy Community: A profile of the Health of Santa Clara Pueblo – October 2007

Dear Chairman Dorgan and Members of the Indian Affairs Committee, my name is Joseph Michael Chavarria and I am the Governor for the Pueblo of Santa Clara. A Tewa Pueblo located in North Central New Mexico. My reservation encompasses over 57,000 acres of what was once pristine land's.

We have inhabited this land since time immemorial and will continue to do so into the future.

Our Pueblo's government is unique and has been recognized by three different sovereign governments over the past 400 years: Spain, Mexico and the United States of America. Our tribal government consists of 6 annually-elected tribal officials; Governor, Lt. Governor, Secretary, Treasurer, Interpreter and Sheriff and 8 Tribal Council Representative appointed by the 4 recognized tribal parties. Today we have 34 programs and over 200 employees, the Santa Clara Pueblo tribal government provides a full-range of services to our community members and continues to meet the many challenges facing our community.

Just recently, our Pueblo completed and adopted the following document entitled **"Healthy People, Healthy Community: A Profile of the Health of Santa Clara Pueblo – October 2007".** This profile was develop with support

by the Santa Clara Pueblo Governor and Tribal Council, the Governor's Task Force on Youth and Families and was compiled and edited by Mr. Greg Tafoya a Santa Clara Pueblo Tribal Member and a Masters' Program candidate at the University of New Mexico and Ms. Christine Chavez-Trujillo a Member of the Cochiti Pueblo and Coordinator for this project.

I will be using language from this Profile to make and articulate my statement.

The inside cover of this document begins with a **"Message from the Governor and Task Force Chairman"** and the first paragraph is appropriate to this issue. It reads **"Santa Clara community members face many challenges in this generation, as documented in this first-ever Health Profile of our community. Stagnant funding for the Indian Health Service is a central reason for the tremendous health disparities we experience....."**.

On page 1, the document states **" The Santa Clara Pueblo Community Health Profile (Profile) aims to describe the health of the community by providing information on health status and community strengths and needs. The data provided within this document illustrates the health conditions and issues that require improvements....This document also identifies those areas where more information is needed, such as gaps in services, quality of health care, and community resources....."**

It further states, **"The Profile is the basis for public health planning and may be used for a variety of purposes such as:**

- **Justifying program development and funding needs;**
- **Planning and evaluating community health programs;**
- **Documenting health-related activities in the community;**
- **Ensuring accountability by agencies and programs for services provided and required;**
- **Reporting on important health outcome measures;**
- **Obtaining technical assistance to other agencies;**
- **Developing funding proposals and applications;**
- **Guiding research and informing policymakers; and**
- **Identifying professional training needs.**

On page 5, the Executive Summary states **"Santa Clara Pueblo began a Community Health Assessment (CHA) in 2006 to secure for our community member the quality of life and healthcare they deserve. The assessment is designed to;**

1. **Identify the major health problems affecting Santa Clara people based on existing data sources and community perceptions;**

2. **Prioritize health concerns for action by conducting interviews with community leaders, service providers and key stakeholders; and**
3. **Identify resources, programs and funding to address those health concerns.**

continuing.... **"At this time there are many sources of health data about Santa Clara Pueblo in the Indian Health Service (HIS), U.S. and New Mexico Department of Health, and in other locations. The CHA process has enabled Santa Clara Pueblo organize and analyze this data so that it can be used to justify funding requests and grants to help the Pueblo develop new programs and activities address the most critical health needs of the community".**

And the following statement is probably the most crucial to this issue of contract services within the Indian Health Services and more specifically as it relates to the Santa Clara Pueblo Health Clinic, the Santa Fe Service Unit, and the Albuquerque Indian Health Service Unit where the majority of our people receive health care services. **"It will also help the Pueblo hold IHS accountable and help us to work with IHS to get funding for the Santa Clara Health Clinic and the Santa Fe Indian Hospital to meet our people's most serious health needs".**

Following this section, I would like to take some of the statements again from the "Profile" made on pages 63, 64 , 65 and 66. P. 63 - **"Indian Health Service Units The Santa Fe Service Unit also known as the Santa Fe Indian Hospital, has a 35-Year tradition of providing local tribal communities with primary medical care and services. The Santa Fe Indian Hospital is a United States Public Health Service facility. It is a 39-bed hospital with an ambulatory care center located in the hospital. Santa Fe Service Unit Services (SFSU) SFSU offers inpatients services for general medical, prenatal, gynecology, and surgical and pediatric patients. Urgent Care is open 24 hours a day for urgent problems. SFSU also offers the following outpatient clinical services: Dental, Pharmacy, Women's Health, Radiology,** etc. (a total of 24 programs)

Santa Clara Health Clinic Services: (located within the Santa Clara Pueblo) Santa Clara Health Clinic provides services to many of the surrounding tribes, not just Santa Clara Pueblo alone" . (a total of 12 programs).

P. 64 – **"Health Care Funding Crisis Faced with many immediate health concerns as illustrated in the Community Health Profile, there is strong concern around healthcare quality and care received by Santa Clara residents. The Indian Health Service (Santa Fe Indian**

Hospital and Santa Clara Clinic) is the primary healthcare option for the community. Over the past 10 years IHS Santa Fe Service Unit has experienced increasing outpatient visits while receiving decreased federal appropriations. Disturbingly, the Indian Health Service receives about one-third of the nation average for per capital health expenditure and about half of the amount federal prisoners receive per capita for healthcare (see Chart 11-4). Compounding HIS funding and service issues is the rate of medical expense inflation through increased healthcare costs".

P. 65 – **Chart 11-4. 2005 HIS Expenditures Per Capita (Source: Indian health Service, Health Disparity Index Report 2005).**

This chart illustrates the disparity between "**Medicare ($6,784), National Health Expenditures ($5,670) Veterans Administration ($4,653) Medicaid ($4,328) Medicaid for Federal Prisoners ($3,242) FEHB Medical Benchmark ($2,980) 2005 IHS Expenditures ($2,130)**

In consultation with the Santa Fe Service Unit Director, we received the following attached information that determines the criteria for our Santa Clara Pueblo people receiving or not receiving Contract Health Services (CHS) within this Service Unit area. **Although the information we receive denotes availability of some of the necessary information to identify our concerns, it does not necessarily include all the information.**

During FY-2006 the Santa Fe Service Unit had to issue 474 denials because a patient either received services that didn't fall with the Medical Priority 1 or didn't reside on or near their home reservation. The average CHS referral for FY-2006 cost SFSU $921; therefore to cover these visits, the SFSU would have needed an additional $436,554.

During FY-2005 the Santa Fe Service Unit had to issue 272 denials because a patient either received services that didn't fall within the Medical Priority 1 or didn't reside on or near their home reservation. The average CHS referral for FY-2005 costs SFSU $1,298; therefore to cover these visits, the SFSU would have needed an additional $353, 056.

During FY-2004 the Santa Fe Service Unit had to issue 502 denials because a patient either received services that didn't fall within the Medical Priority 1 or didn't reside on or near their home reservation. The average CHS referral for FY-2004 costs SFSU $874; therefore to cover these visits, the SFSU would have needed an additional $438,748.

These numbers do not include patients who don't even ask HIS for help with the bills because they already know that we don't have the funds to help them.

In many of the above cases, the dollar amounts identified was an average cost and would not have taken into account some of the other factors such as follow up visits, specialist and therapeutic care, surgery, and other related or associated costs. We also know that CHS funds become available each Fiscal year, but also relate to the comment that this funding is exhausted by February and sometimes if not to many patients need CHS funds, it could be stretched till June.

Attached is the SFSU letter dated April 14, 2008, Albuquerque Area Indian Health Service letter dated December 18, 2007 from the Chief Medical Officer, Subj: Contract Health Service Medical Priorities – FY 2008 and the Sections listed in the Federal Regulation, Subpart C – Contract Health Services. Source: 64 FR 58320. Oct. 28, 1999 unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

136. 21 Definitions.
136.22 Establishment of contract health service delivery areas.
136.23 Persons to whom contract health services will be provided.
136.24 Authorization for contract health services.
136.25 Reconsideration and appeals

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

May 10, 2008

Dear Honorable Senator Byron L. Dorgan,

It is with great respect that I am writing to you, Senator Dorgan, today to express my concerns regarding the Indian Health Service (IHS) and contract health services. We, Native Americans, are a people who share our lives with each other through our songs, dances, traditions, culture, and language on a daily basis. Because we are interconnected in our village in a daily basis, I know that all women share my same concerns. We are all very concerned about the health, welfare, and happiness of our husbands, children, mothers, fathers, uncles, aunts, relatives, and friends. We all share the pain and the sadness when someone we know is not well and in need of medical services which are unavailable at our Santa Fe Indian Hospital. We worry about our future generations and what will happen to them when they need medical services.

Currently the Contract Health Services Program for Indian Health Care at the Santa Fe Indian Hospital is in shambles. With all the funding cuts for Indian health care services, mental health services, and health care facilities thousands of Indian people are not being served. Many are being denied health care and many are being placed in enormous debts by contract health service providers. Most often due to being denied payment by Indian Health Service to pay for medical or health care services. In many incidents there are no clear directions on what IHS accepts as Indian health service claims. I have seen many parents and grandparents that have a sick child selling raffle tickets to purchase medication, and medical equipment for their sick child. On top of that they are burdened by the incoming enormous medical bills for services rendered by public hospitals. As a result parents and families are left feeling hurt, very depressed, and hopeless.

I have seen and heard of many Native American patients having to be serviced and kept at St. Vincent Hospital who are very sad, depressed, and feeling out of place having to be there instead of at our own Santa Fe Indian Hospital.

I recommend that instead of sending Native American people to other hospitals for service, that our own Santa Fe Indian Hospital be fully funded so that we will have a

more cost efficient, very professional medical "State of the Art" facility for Native Americans. It is my understanding that it would be more cost efficient to serve our native people at our own "State of the Art" medical facility and bring in specialists in as needed. This would alleviate the high costs of sending our native people to other hospitals for services resulting in having to pay high medical bills to other public hospitals.

It is a federal trust responsibility that needs to be honored by the United State Government. We need to honor our ancestors who sacrificed and made agreements with the government.

It is with proper physical, mental, and emotional health care that we will all be able to move forward and become productive people and have an excellent quality of life to continue our traditional ways.

Senator Byron L. Dorgan, I thank you very much for bringing to light the U.S. Government's legal trust responsibility based on treaties, statutes, and long standing practice to provide health care for all Native Americans.

I will keep you in my prayers and ask our Lord God to bless you with guidance and strength for your dedication in helping all Native American people.

Respectfully,

Rebecca Ortega

Ms. Rebecca Ortega
P.O. Box 2305
Espanola, NM 87532
(505) 747-1548

RECEIV
MAY 12 200
SANTA CLARA PUEBL
GOVERNOR'S OFFICE

5-6-08

To whom it may concern,

I am writing this letter on behalf of myself Reyann D. Tafoya. I recieved the note about the health care provide outside of the IHS.

Of course I have recieved services at the Espanola Presby Farian Hospital 10-2-06 and at Radiology in Santa Fe 2-01-07. I have proof that later IHS (Indian Health Service) sent me a letter denying payment for those dates.

What happens if I have another accident? and the IHS cant provide?

Hopefully we will come to a conclusion to handle this. I am a mother of and these days its hard enough to afford Health Care for them.

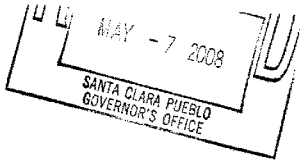
Sincerely

Reyann D Tafoya

REYANN D. TAFOYA

RECEIVED
MAY - 6 2008
SANTA CLARA PUEBLO
GOVERNOR'S OFFICE

May 7, 2008



Intergovernmental and Public Relations Office
Santa Clara Pueblo

Dear Mr. Walter Dasheno,

This letter is in response to Senator Dorgan's letter to the tribal leaders, March 27, 2008, regarding the current Contract Health Services program.

My name is Marian Naranjo, a Santa Clara tribal member, a senior citizen, with an annual income of $12,000.00 per year. Since I am self employed, I had to pay close to $400.00 in taxes (1040 application, 2007).

My son, Ernest, 27 years of age, who was born and raised here at the Pueblo of Santa Clara, and lives with me, broke his forearm during the summer of 2007. He had to undergo three surgeries to date, because of complications that the bones were not healing properly. We went to the Espanola Hospital Emergency unit and were then referred to Indian Health Services (IHS) in Santa Fe. He was then contracted to St. Vincent's Hospital where he had the surgeries. Each facility that we went to were hesitant when asked who the primary care physician is. When we stated that the primary care physician was IHS, several phone calls had to be made to IHS and several trips to IHS and then back to the hospitals before IHS agreed to approve the contract services needed. The distance to Santa Fe from Santa Clara is approximately 60 miles roundtrip, my income is such that these long distant phone calls and trips have caused a hardship financially to make ends meet with the monthly living expenses. Besides the financial burden, and more important is that this process prolonged the immediate health care that Ernest needed.
For this last surgery, Ernest was denied physical therapy because IHS does not offer this service any more and refused to approve this service as a contract service as requested by the surgeon. The surgeon is most concerned about the physical therapy and has stated that if the bones are not healing this time, he will be referred to specialists in Albuquerque to undergo special tests and possibility of a forth surgery.

Even though IHS has approved the contract services, the bills for these services have not been paid. As a result, I receive phone calls from the credit collectors daily, daily stress because of unpaid bills and for a young man who can not use his arm, the need to be useful and productive is leading to depression. He has also been denied Social Security and Disability. Attached are the current bills that we have received and have not been paid by IHS Contract Health Program. These bills are not inclusive of the debts incurred to the Espanola Hospital for emergency services, which were also approved by IHS Contract Health Program for treatment.

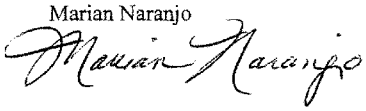
For myself, as a senior citizen who has made a lifetime living as a self employed potter, I pray that I do not become ill and require hospitalization because at this time I know the bills will not be paid, I fear the denial of proper health care, I can not afford health

insurance and I do not qualify for Social Security. I have hesitated to go to the Santa Clara Clinic or Santa Fe IHS for relief of allergies, flu, and/or pain or yearly check ups because of the budget cuts and out of consideration that there are others whose illnesses are far more critical than mine.

As a Native American, we often hear about trust responsibilities with the United States government and tribes on every level of federal agencies and laws. I am feeling mistrust and a direct impact of the IHS contract program and the need for medical services to be rendered.

Sincerely,

Marian Naranjo



P.O BOX 12000
SANTA FE, NM 87504-7000
1617
PHONE: (505) 820-5220

SI PAGA CON MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, LIENE LA INFORMACION MAS ABAJO.

MASTERCARD DISCOVER VISA AMERICAN EXPRESS

CARD NUMBER AMOUNT $

SIGNATURE EXP DATE

0101

ADDRESS SERVICE REQUESTED

Make sure your SVH account number appears on your check

STATEMENT DATE	PAY THIS AMOUNT	SVH ACCT. #
03/18/2008	27260.62	

PLEASE PAY PROMPTLY

SHOW AMOUNT PAID HERE
CANTIDAD PAGADA $

PAGE: 1 of 1

RT 5 BOX 474
ESPANOLA, NM 87532-8911

ST. VINCENT HOSPITAL
P.O. BOX 12000
SANTA FE, NM 87504-7000

1617*SB00J4AB4000020

☐ Please check box if address is incorrect or insurance information has changed, and indicate changes on reverse side.

STATEMENT PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMEN

RT 5 BOX 474
ESPANOLA, NM 87532-8911

ACCT #:
Admit Date: 02/05/08 Discharge Date: 02/06/08
Attending Physician: VON STADE,ELEANOR

SUMMARY CHARGES	AMOUNT
PHARMACY	697.03
IV SOLUTIONS	163.20
DRUGS/OTHER	103.90
MED-SUR SUPPLIES	0.00
STERILE SUPPLY	383.90
SUPPLY/IMPLANTS	21046.95
LAB/BACT-MICRO	624.00
PATH/HYSTOL	476.95
DX X-RAY	478.70
OR SERVICES	7125.30
ANESTHESIA	1861.65
RECOVERY ROOM	759.00
OBSERVATION ROOM	355.20
TOTAL CHARGES	34075.78
TOTAL PAYMENTS	
TOTAL ADJUSTMENTS	-6815.16
BALANCE DUE	27260.62
AMOUNT DUE	27260.62

Thank you for choosing St. Vincent Hospital for your services. We have billed PHS for the charges you incurred. To d we have not received payment. Please be advised if payment is not received within 30 days of this notice, you will responsible for the charges.

Please contact PHS/Contract Health at (505) 946-9206 to expedite payment.

1617PHS1 (06

SANTA FE REGIONAL MEDICAL CENTER
ST. VINCENT HOSPITAL

P.O BOX 12000
SANTA FE, NM 87504-7000
1617

PHONE: (505) 820-5220

0101

ADDRESS SERVICE REQUESTED

Make sure your SVH account number appears on your check

SI PAGA CON MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, LLENE LA INFORMACION MAS ABAJO.

MASTERCARD DISCOVER VISA AMERICAN EXPRESS

CARD NUMBER AMOUNT $

SIGNATURE EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	SVH ACCT. #
03/18/2008	3039.83	

PLEASE PAY PROMPTLY

SHOW AMOUNT PAID HERE
CANTIDAD PAGADA $

PAGE: 1 of 1

RT 5 BOX 474
ESPANOLA, NM 87532-8911

ST. VINCENT HOSPITAL
P.O. BOX 12000
SANTA FE, NM 87504-7000

1617*SBQ0J4A84000019

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STATEMENT PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

RT 5 BOX 474
ESPANOLA, NM 87532-8911

ACCT #:
Admit Date: 02/08/08 Discharge Date: 02/10/08
Attending Physician: OLDHAM,JACOB B

SUMMARY CHARGES	AMOUNT
ROOM-BOARD/PVT	577.50
PHARMACY	466.81
IV SOLUTIONS	75.20
DRUGS/OTHER	49.44
IV THERAPY	483.15
LAB/IMMUNOLOGY	91.00
LAB/HEMATOLOGY	153.50
LAB/BACT-MICRO	217.80
DX X-RAY	242.82
EMERG ROOM	1368.85
DRUGS/DETAIL CODE	73.72
TOTAL CHARGES	3799.79
TOTAL PAYMENTS	
TOTAL ADJUSTMENTS	-759.96
BALANCE DUE	3039.83
AMOUNT DUE	3039.83

Thank you for choosing St. Vincent Hospital for your services. We have billed PHS for the charges you incurred. To da we have not received payment. Please be advised if payment is not received within 30 days of this notice, you will b responsible for the charges.

Please contact PHS/Contract Health at (505) 946-9206 to expedite payment.

1617PHS1 (05/05

Patient Name

Santa Fe Pathology Services PA

Your Pathology Service Provider

Account #	Statement Date
CHS-	03/24/2008

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

Due Date	Amount Due
04/08/08	80.00

IMPORTANT MESSAGE

FINAL NOTICE, PLEASE REMIT PROMPTLY.

PLEASE PAY OR CONTACT US BY THE DUE DATE SHOWN OR YOUR ACCOUNT MAY BE SENT TO A COLLECTION AGENCY. THANK YOU.

www.pathologybilling.com
e-mail: psabilling@psapath.com

Servicio en espanol, por favor llame

TOLL FREE: 1-877-268-1012
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 6am-7pm MT
Fri 6am-6pm

Referring Physician:
CAESAR M URSIC MD

DATE	PROC. CODE	DECRIPTION	QUANTITY	AMOUNT
02/04/08	8830426	MICROSCOPIC ANALYSIS, III	1	80.00

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

10000

SANTA FE PATHOLOGY SERVICES PA
Do Not Mail - For Undeliverable As Addressed Only
c/o DICLT Return Mail Processing
PO Box 29 Mooresville NC 28115-0029

Patient Name: ERNEST HARRINGTON

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

STATEMENT DATE	DUE DATE	ACCOUNT #
03/24/2008	04/08/08	CHS-

AMOUNT DUE
$ 80.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at:
or call: 1-877-268-1012

ePAY 24/7
www.pathologybilling.com

ADDRESSEE:

01-A 20080324 T041 S 10000

RR 5 BOX 4/4
ESPANOLA NM 87532-8911

MAKE CHECKS PAYABLE TO & REMIT TO:

SANTA FE PATHOLOGY SERVICES PA
PO BOX 52990
GREENWOOD, SC 29649-0048

Santa Fe Pathology Services PA

Your Pathology Service Provider

Account #	Statement Date
CHS-	03/24/2008

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

Due Date	Amount Due
04/08/08	300.00

IMPORTANT MESSAGE

SECOND NOTICE, PLEASE REMIT PROMPTLY.
YOUR PROMPT ATTENTION IS NEEDED. SEND BALANCE SHOWN BY DUE DATE.
THANK YOU.

www.pathologybilling.com
e-mail: psabilling@psapath.com
Servicio en espanol, por favor llame
TOLL FREE: 1-877-268-1012
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 6am-7pm MT
Fri 6am-6pm

Referring Physician:
ELEANOR VONSTADE MD

DATE	PROC. CODE	DECRIPTION	QUANTITY	AMOUNT
02/05/08	8830526	MICROSCOPIC ANALYSIS, IV	1	125.00
02/05/08	8833126	FROZEN SECTION	1	175.00

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

STATEMENT DATE	DUE DATE	ACCOUNT #
03/24/2008	04/08/08	CHS-

AMOUNT DUE
$ 300.00

9999

SANTA FE PATHOLOGY SERVICES PA
Do Not Mail - For Undeliverable As Addressed Only
c/o DICLT Return Mail Processing
PO Box 29 Mooresville NC 28115-0029

Check # ____
(please do not staple)

AMOUNT ENCLOSED $

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at:
or call: 1-877-268-1012

ePAY 24/7
www.pathologybilling.com

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

ADDRESSEE:

01-A 20080324 T041 S 09999

RR 6 BOX 474
ESPANOLA NM 87532-8911

MAKE CHECKS PAYABLE TO & REMIT TO:

SANTA FE PATHOLOGY SERVICES PA
PO BOX 52990
GREENWOOD, SC 29649-0048

P.O BOX 12000

SANTA FE, NM 87504-7000

1617

PHONE: (505) 820-5220

0101

ADDRESS SERVICE REQUESTED

Make sure your SVH account number appears on your check

CHECK CARD US NO FOR PAY

☐ MASTERCARD ☐ DISCOVER VISA

CARD NUMBER

SIGNATURE

STATEMENT DATE	ACCT #	PAY THIS AMOUNT
04/28/2008		27260.62

PLEASE PAY PROMPTLY

PAGE: 1 of 1

RT 5 BOX 474
ESPANOLA, NM 87532-8911

ST. VINCENT HOSPITAL
P.O. BOX 12000
SANTA FE, NM 87504-7000

1617*SCVOLDW170000019

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

RT 5 BOX 474
ESPANOLA, NM 87532-8911

ACCT #:
Admit Date: 02/05/08 Discharge Date: 02/06/08
Attending Physician: VON STADE,ELEANOR

SUMMARY CHARGES	AMOUNT
PHARMACY	697.03
IV SOLUTIONS	163.20
DRUGS/OTHER	103.90
MED-SUR SUPPLIES	0.00
STERILE SUPPLY	383.90
SUPPLY/IMPLANTS	21046.95
LAB/BACT-MICRO	624.00
PATH/HYSTOL	476.95
DX X-RAY	478.70
OR SERVICES	7125.30
ANESTHESIA	1861.65
RECOVERY ROOM	759.00
OBSERVATION ROOM	355.20
TOTAL CHARGES	34075.78
TOTAL PAYMENTS	
TOTAL ADJUSTMENTS	-6815.16
BALANCE DUE	27260.62
AMOUNT DUE	27260.62

Thank you for choosing St. Vincent Hospital for your services. We have billed PHS for the charges you incurred. To dat we have not received payment. Please be advised if payment is not received within 30 days of this notice, you will b responsible for the charges.

Please contact PHS/Contract Health at (505) 946-9206 to expedite payment.

1617PHS1 (05/05)

May 12, 2008

Dear Honorable Senator Byron L. Dorgan,

This is in reference to Indian Health Service at the Santa Fe Indian Health Unit. Let me introduce myself. I am Desiderio Gutierrez, a tribal member of Santa Clara Pueblo, NM. I am glad to hear that you are checking into the Indian Health Service. I am 82 years old, in 2 months I will be 83 years old.

Santa Fe Indian Health Service is a good hospital but what we want to do is make good better. I have seen when I am at the Santa Fe Indian Hospital after being checked by the doctor I have to wait 2-3 hours to get my perciption. Another question I have is I don't know why we are being sent to St. Vincent's Hospital or other public hospital. In the old days, we were at our own hospital. We felt very well taken care of and if a specialist was needed, then the Specialist was contracted to come to our Santa Fe Indian Hospital. It makes no sense to send our Native American people to other hospitals to see Specialists, because then we not only pay for the Specialist, but also for the room and board, medication, staff, and equipment used.

It is my wish that we will have a much needed, well-funded, state of the art medical facility to meet our needs today and into the future. I hope and pray that we here in New Mexico will receive a state of the art medical facility as well as all other Native Americans across the United States of America.

Senator Byron L. Dorgan thank you for working for us, the Native American People.

Respectfully,
Desiderio Duffers Sr.
Rt. 5, Box 451
Espanola, NM 87532

Joseph and Terrie Baca
064 South Santa Clara
Espanola, New Mexico 87532
(505)231-6783

RECEIVED
MAY - 9 2008
SANTA CLARA PUEBLO
GOVERNOR'S OFFICE

May 9, 2008

Santa Clara Governor
P.O. Box 580
Espanola, NM 87532

Dear Governor J. Michael Chavarria,

In June 2007, I was went in for a routine check up at the Santa Clara Health Clinic and after a regular tests, I was called back and diagnosed with renal disease with kidney failure. I was referred to a kidney specialists in Santa Fe and continued with regular check ups at Santa Clara and at Santa Fe Indian Hospital.

It was then when I started to receive bills from the kidney specialists. I took these bills to Santa Fe Indian Hospital and was told that they would not be paid and I would have to find other means to have these paid for.

I have just been put on the kidney transplant list in Albuquerque and was told that they had received notice that PHS/IHS would ***NOT*** be paying for the transplant.

Due to my recent illness, I have had to resign from employment and begin disability. My wife has had to stay home to take care of my children and myself as I have begun dialysis 3 days a week. So we are financially unable to pay for these medical bills. We have had to resort to having fund raisers and food sales to pay for medical expenses. This also leaves me wondering how I am to pay for a kidney transplant that will help me to be here for my family.

These are bills that should be taken care of by PHS/IHS, Especially since I was referred to these specialists by PHS/IHS doctors.

PHS/IHS will bill Medicaid or other insurance before they take responsibility to pay for services. This also causes patients to have poor reports to their credit, and causes unfair and unnecessary credit rating, causing hardship on the patients for illness and financial stresses.

I feel it is unfair that we as Native Americans have to pay out of pocket expenses for medical care when it should be provided to us.

Thank You for your time,

Sincerely,
Joseph and Terrie Baca
Tribal Members Santa Clara Pueblo

Dear Patient:
After many attempts on our part, we have been unable to obtain a purchase order from the Santa Fe PHS Contract Health Office for the services rendered in October 2006. At this time we have no other recourse but to bill you directly.

You may want to contact the Contract Health Office and seek direct resolution of the matter with them. We appreciate your understanding.

Catalina G Voinescu MD
1650 Hospital Dr Suite 200
Santa Fe NM 87505-4788

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
4/10/2008	580.00	
TAX ID NUMBER		SHOW AMOUNT PAID HERE $

100

Rt 5 Box 317C
Santa Fe, NM 87506

REMIT TO:

1650 Hospital Dr Ste 200
Santa Fe NM 87505-4788

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT
Charges audited and subject to change.

Santa Fe Internal Medicine

DATE	PATIENT	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	CHARGE	INSUR RECEIPT	PATIENT RECEIPT	ADJUST	INSUR BALANCE	PATIEN BALANC
6/8/07	Joseph	Dr. Voinesc	99245	Office Cons Comp	350.00				0.00	350.0
6/8/07	Joseph	Dr. Voinesc	81000	Urinalysis, Nonauto, W/scope	15.00				0.00	15.0
7/2/07	Joseph	Dr. Voinesc	81000	Urinalysis, Nonauto, W/scope	15.00				0.00	15.0
7/2/07	Joseph	Dr. Voinesc	99215	Office/outpatient Visit, Est	200.00				0.00	200.0

ACCOUNT NBR	CHARGES	PAYMENTS	REFUNDS/ ADJUSTMENTS	BALANCE DUE FROM PATIEN
	580.00	0.00	0.00	580

MESSAGE
INTERNAL MEDICINE SPECIALISTS For billing inquiries, please call (505) 462-2900 or toll free at 1-800-888-6642 between 9:00 a.m. and 4:00 p.m MST, Monday-Friday. Thank you.

PLEASE PAY THIS AMOUNT >> >> >> >> 580.00

** PAYMENT DUE UPON RECEIPT * THANK YOU **

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Rt 5 Box 317C
Santa Fe, NM 87506

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM 05 DD 06 YY 1969 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) ROUTE 5 BOX 317 C

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) ROUTE 5 BOX 317 C

CITY SANTA FE STATE NM

8. PATIENT STATUS Single [ ] Married [X] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY SANTA FE STATE NM

ZIP CODE 87506 TELEPHONE (Include Area Code) (505) 670-6903

ZIP CODE 87506 TELEPHONE (Include Area Code) (505) 670-6903

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM 05 DD 06 YY 1969 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME SANTA FE INDIAN HOSP

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 08 02 2007

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE CARRIE WALKER

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

1. 780.2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 21 2006	11 21 2006	22		95819	26	1	110 00	1			NPI
2 PHS has never issued Purchase Order on which we base											
3 to clear account. Please remit balance shown											
4 account is past due.											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back) YES [X] NO [ ]

28. TOTAL CHARGE $ 110 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 110 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED 08 02 2007 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST VINCENT HOSPITAL
455 ST MICHAELS DRIVE
SANTA FE, NM 87505

a. b.

33. BILLING PROVIDER INFO & PH # (505) 983-8182
SANTA FE NEUROLOGICAL ASS
531 HARKLE RD STE C
SANTA FE, NM 87505

a. b.

NUCC Instruction Manual available at www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/

SANTA FE PATHOLOGY SERVICES, P.A.

MEDICAL - DENTAL CENTER
465 ST. MICHAELS DRIVE, SUITE 115
SANTA FE, NEW MEXICO 87505

:LEPHONE: (505) 986-8620

FICE HOURS:
ONDAY THRU FRIDAY
AM - 12 NOON
PM - 5 PM

FEDERAL ID#
H. CLARK ANDERSON, M.D.
JACK E. ZWEMER, M.D.
F. PIERR JOHNSON, M.D.
SANDRA P. LOWRY, M.D.

STATEMENT

CCOUNT #

DATE OF STATEMENT: 09/20/07

THE PATHOLOGY SERVICES LISTED BELOW WERE PERFORMED FOR YOU AT THE REQUEST OF DR. EIENIEK

RT 5 BOX 317C
SANTA FE NM 87506

INSURANCE
INSURANCE
Please call immediately if insurance is incorrect

DATE OF SERVICE	CPT CODE	DESCRIPTION OF SERVICES	AMOUNT
DETACH AT PERFORATION AND RETURN TOP PORTION WITH YOUR PAYMENT			
		*** NOTICE	
		PAYMENT HAS NOT BEEN RECEIVED ON YOUR ACCOUNT. PLEASE REMIT BALANCE DUE OR MAKE ARRANGEMENTS FOR PAYMENT WITH OUR OFFICE.	
		PAST DUE Please remit TODAY!	
SERVICE DATE: 10/17/06			
AMOUNT LAST PAID			0.00

PLEASE SEE REVERSE SIDE FOR EXPLANATION OF CHARGES.

PATIENT NAME: ACCOUNT #: TOTAL PLEASE PAY THIS AMOUNT 155.00

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO SANTA FE PATHOLOGY SERVICES, P.A. SORRY, WE DO NOT ACCEPT CREDIT OR DEBIT CAF

SANTA FE PATHOLOGY SERVICES, P.A.

MEDICAL - DENTAL CENTER
465 ST. MICHAELS DRIVE, SUITE 115
SANTA FE, NEW MEXICO 87505

ELEPHONE: (505) 986-8620

FFICE HOURS:
ONDAY THRU FRIDAY
AM - 12 NOON
PM - 5 PM

STATEMENT

FEDERAL ID#
H. CLARK ANDERSON, M.D.
JACK E. ZWEMER, M.D.
F. PIERR JOHNSON, M.D.
SANDRA P. LOWRY, M.D.

CCOUNT #

DATE OF STATEMENT: 08-23-07

RT 5 BOX 3170
SANTA FE NM 87506

THE PATHOLOGY SERVICES LISTED BELOW WERE PERFORMED FOR YOU AT THE REQUEST OF DR. BIENIEK

WE DID NOT RECEIVE INSURANCE INFORMATION FOR YOU.
PLEASE CALL US IMMEDIATELY IF YOU WISH FOR US TO ASSIST YOU
IN FILING A CLAIM WITH YOUR PRIMARY INSURANCE CARRIER.

INSURANCE
INSURANCE
Please call immediately if insurance is incorrect

DATE OF SERVICE	CPT CODE	DESCRIPTION OF SERVICES	AMOUNT
DETACH AT PERFORATION AND RETURN TOP PORTION WITH YOUR PAYMENT			
10/17/06	88305-26	SURGICAL PATHOLOGY; GROSS&MICRO, LEV IV	125.00
	88311-26	SURGICAL PATHOLOGY; DECALCIFICATION	30.00

PLEASE SEE REVERSE SIDE FOR EXPLANATION OF CHARGES.

PATIENT NAME: ACCOUNT #: TOTAL PLEASE PAY THIS AMOUNT 155.00

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO SANTA FE PATHOLOGY SERVICES, P.A. SORRY, WE DO NOT ACCEPT CREDIT OR DEBIT CARDS

Statement

SANTA FE NEUROLOGICAL ASSOCIATES
531 HARKLE ROAD STE C
SANTA FE, NM 87505

FROM 8/1/2007 **TO** 8/28/2007

MICHAEL BATEN, M.D.

(505) 983-8182
(800) 425-8182

PAST DUE

Date 8/27/2007
Account

Amount Enclosed

ROUTE 5 BOX 317 C
SANTA FE, NM 87506

We accept Visa/Mastercard, please provide your card information and sign below

Card Number _____ Exp. ____

Signature _____

Date	Ticket	Description	Patient	Fee	Payment/Adj	Balanc
11/21/2006	105732	REG-WAKE/SLEEP-INTER		110.00		110.(
08/02/2007		TRANSFER - PHS TO P			110.00	

Amount filed with your insurance company: .00

Due from patient 110.

Current	Over 30	Over 60	Over 90	Over 120
110.00	.00	.00	.00	.00

Date

ROUTE 5 BOX 317 C
SANTA FE, NM 87506

Patient

Statement

SANTA FE NEUROLOGICAL ASSOCIATES
531 HARKLE ROAD STE C
SANTA FE, NM 87505

FROM 9/1/2007 **TO** 9/25/2007

MICHAEL BATEN, M.D.

(505) 983-8182
(800) 425-8182

PAST DUE

Patient:

Date 9/25/2007
Account 40956

Amount Enclosed

ROUTE 5 BOX 317 C
SANTA FE, NM 87506

We accept Visa/Mastercard, please provide your card information and sign below

Card Number _____ Exp. ____

Signature _____

Date	Ticket	Description	Patient	Fee	Payment/Adj	Balanc
11/21/2006	105732	REG-WAKE/SLEEP-INTER		110.00		110.0
08/02/2007		TRANSFER - PHS TO P			110.00	

Amount filed with your insurance company: .00

Due from patient 110.0(

Current	Over 30	Over 60	Over 90	Over 120
.00	110.00	.00	.00	.00

Date

ROUTE 5 BOX 317 C
SANTA FE, NM 87506

Patient 40956

Statement

SANTA FE NEUROLOGICAL ASSOCIATES
531 HARKLE ROAD STE C
SANTA FE, NM 87505

FROM 1/1/2008 **TO** 1/28/2008

MICHAEL BATEN, M.D.

(505) 983-8182
(800) 425-8182

PAST DU

Patient:

Date 1/29/2008

Account

ROUTE 5 BOX 317 C
SANTA FE, NM 87506

Amount Enclosed

We accept Visa/Mastercard, please provide your card information and sign below

Card Number _____ Exp. ___

Signature _____

Date	Ticket	Description	Patient	Fee	Payment/Adj	Balar
11/21/2006	105732	BEG-WAKESLEEP-INTER		110.00		110
08/02/2007		TRANSFER - PHS TO P			110.00	
12/05/2007		TRANSFER - TO P			110.00	

Amount filed with your insurance company: .00

Due from patient 110.0(

Current	Over 30	Over 60	Over 90	Over 120
.00	110.00	.00	.00	.00

Date

ROUTE 5 BOX 317 C
SANTA FE, NM 87506

Patient

PRESBYTERIAN

Presbyterian Hospital
1801 Randolph SE
Albuquerque, NM 87106

00626

Hr 5 Box 317c
Santa Fe, NM 87506-2622

Hospital Billing Statement

Important Message

Thank you for choosing Presbyterian Healthcare Services.

Presbyterian Healthcare Services introduces our new Online Patient Billing Manager

Do you have access to a computer and the internet?

Presbyterian Healthcare Services offers a simple, yet secure, way to view and pay your hospital bills online 24 hours a day, seven days a week, with our Online Billing Manager. Signing up is easy and free. Just go to www.phs.org and click on "Visit Presbyterian Online" and select "Online Hospital Billing". The Web site allows patients to manage account information or make a payment.

Account Summary

Statement Date	01/22/08
Account Number	
Visit Type	Radiology
Dates of Service	01/11/08
Total Charges	$557.00
Balance Pending With Insurance	$557.00
Patient Payments	$0.00
Insurance Payments	$0.00
Insurance Adjustments	$0.00
Applied Discounts	$0.00
Total Amount Due	$0.00

Patient Services Provided

Summary of Charges

Description	Amount
OTHER IMAGING SERVICES	557.00
Total Charges	557.00

Insurance Information

Please confirm that information is correct.

Primary Insurance	PRES TRANSPLANT SVS KD AC
Secondary Insurance	
Tertiary Insurance	

Questions

Patient Accounting Customer Service
Customer Service is 1-505-923-6400
or Toll free at 1-800-251-9292
Office hours are 8:30 a.m. to 5:00 p.m. M-F
Our e-mail address is : pfscustomer@phs.org

Write to us at:
Presbyterian Patient Accounting
P.O. Box 26268
Albuquerque, NM 87125-7845

Presbyterian serves to improve the health of individuals, families and communities.

INFORMATION UPDATE

Account Number:
Statement Date: 01/22/08

Complete the reverse side of this form only if your address or insurance information has changed.

Presbyterian Healthcare Services
P.O. Box 27822
Albuquerque, NM 87125-7822

Want to find updated information on your account?

Online Billing Manager

- Simple and easy account access 24 hours a day, 7 days a week
- Pay your bills online
- Helpful hints on billing issues

Click on Billing & Insurance
www.phs.org

PRESBYTERIAN

Presbyterian Hospital
1801 Randolph SE
Albuquerque, NM 87106

Hospital Billing Statement

00477

Rr 5 Box 317c
Santa Fe, NM 87506-2622

Account Summary

Statement Date	01/09/08
Account Number	
Visit Type	Lab
Dates of Service	11/12/07
Total Charges	$950.00
Balance Pending With Insurance	$950.00
Patient Payments	$0.00
Insurance Payments	$0.00
Insurance Adjustments	$0.00
Applied Discounts	$0.00
Total Amount Due	$0.00

Patient Services Provided

Summary of Charges

Description	Amount
LABORATORY	950.00
Total Charges	950.00

Important Message

Thank you for choosing Presbyterian Healthcare Services.

Presbyterian Healthcare Services introduces our new Online Patient Billing Manager

Do you have access to a computer and the internet?

Presbyterian Healthcare Services offers a simple, yet secure, way to view and pay your hospital bills online 24 hours a day, seven days a week, with our Online Billing Manager. Signing up is easy and free. Just go to www.phs.org and click on "Visit Presbyterian Online" and select "Online Hospital Billing". The Web site allows patients to manage account information or make a payment.

Insurance Information

Please confirm that information is correct.

Primary Insurance	PRES TRANSPLANT SVS KD AC
Secondary Insurance	
Tertiary Insurance	

Questions

Patient Accounting Customer Service
Customer Service is 1-505-923-6400
or Toll free at 1-800-251-9292
Office hours are 8:30 a.m. to 5:00 p.m. M-F
Our e-mail address is : pfscustomer@phs.org

Write to us at:
Presbyterian Patient Accounting
P.O. Box 26268
Albuquerque, NM 87125-7845

Presbyterian serves to improve the health of individuals, families and communities.

INFORMATION UPDATE

Account Number:
Statement Date: 01/09/08

Complete the reverse side of this form only if your address or insurance information has changed.

Presbyterian Healthcare Services
P.O. Box 27822
Albuquerque, NM 87125-7822

Want to find updated information on your account?

Online Billing Manager

- Simple and easy account access 24 hours a day, 7 days a week
- Pay your bills online
- Helpful hints on billing issues

Click on Billing & Insurance
www.phs.org

P.O. BOX 15618, DEPT 38
WILMINGTON, DE 19850

NCO FINANCIAL SYSTEMS, INC.
2340 MENAUL BLVD NE SUITE 100
ALBUQUERQUE, NM 87107

April 27, 2008
OFFICE HOURS:
MONDAY & WED: 8:00AM - 8:00PM
TUE, THUR & FRI: 8:00AM - 6:00PM

11956-2623

PHONE: 1-800-688-6553
505-889-8730

RR 5 BOX 317C
SANTA FE NM 87506-2622

SANTA FE PATHOLOGY SERVICES PA

RE:
BALANCE: $ 155.00

Your Credit Rating May be In Jeopardy

This may be reported to all national credit bureaus, if you: a) do not notify this office within 30 days after receiving this notice that you dispute the account or any portion thereof, or b) the account is not paid in full or otherwise resolved after 30 days from receiving this notice. It is our intention to work with you to resolve this matter. However, if payment or an acceptable resolution has not occurred, your account will be subject to further collection.

To assure proper credit, please put our internal account number ! on your check or money order.

Calls to or from this company may be monitored or recorded for quality assurance.

You may also make payment by visiting us on-line at www.ncofinancial.com. Your unique registration code is

This is an attempt to collect a debt. Any information obtained will be used for that purpose. This is a communication from a debt collector.

^line33^
^line34^

Please See Reverse Side For Important Information
PLEASE RETURN THIS PORTION WITH YOUR PAYMENT (MAKE SURE ADDRESS SHOWS THROUGH WINDOW)

Creditor Reference #: , JOSEPH BACA
NCO Financial Systems, Inc.
2340 MENAUL BLVD NE SUITE 100
ALBUQUERQUE, NM 87107
PHONE: 1-800-688-6553
505-889-8730

Account #	Total Balance
	$ 155.00

Payment Amount

$.

Credit Card Number
(VISA and MasterCard only)

Make Payment To:
NCO Financial Systems Inc. - Dallas
P.O. Box 15393
Wilmington, DE 19850

CMS Medicare Summary Notice

March 21, 2008

SANTA FE NM 87506-2622

CUSTOMER SERVICE INFORMATION

Your Medicare Number:

If you have questions, write or call:
Medicare (00400)
please see the"General Information" section for 'mailing address'

CALL:1-800-MEDICARE (1-800-633-4227)
ask for Hospital Services
TTY for Hearing Impaired:1-877-486-2048

BE INFORMED: Protect your Medicare number as you would a credit card number.

This is a summary of claims processed on 03/05/2008.

PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS

Dates of Service	Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Control number						
Bma Dialysis Espanola						a,b,c
640 Riverside Drive						
Espanola, NM 87532						
Referred by: Charnes Chiu						
02/01/08-02/29/08	Syringe w/wo needle (A4657)	$0.50	$0.00	$0.12	$0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Syringe w/wo needle (A4657)	0.50	0.00	0.12	0.12	d
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e

(continued

THIS IS NOT A BILL - Keep this notice for your records.

Your Medicare Number:

PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS (continued)

Dates of Service	Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
This Claim was continued from the previous page.						
02/01/08-02/29/08	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Paricalcitol (J2501)	7.60	0.00	1.87	1.87	e
	Hepb vacc, ill pat 3 dose im (90740)	114.51	0.00	28.06	28.06	f
	Dialysis procedure (90999)	167.66	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	168.17	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.66	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.50	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.34	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.56	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.50	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.88	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.44	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.38	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.60	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.50	0.00	41.04	41.04	g,h
	Dialysis procedure (90999)	167.50	0.00	41.03	41.03	h,i
Claim Total		**$2,398.50**	**$0.00**	**$587.44**	**$587.44**	

Notes Section:

a The amount Medicare paid the provider for this claim is $1,803.50.

b This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.

c This information is being sent to Medicaid. They will review it to see if additional benefits can be paid.

d $0.03 of this approved amount has been applied toward your deductible.

e $0.43 of this approved amount has been applied toward your deductible.

(continue

Your Medicare Number:

March 21, 2008

General Information (continued):

Glaucoma may cause blindness. Medicare helps pay for a yearly dilated eye exam for people at high risk for Glaucoma. Afican-Americans over 50 and people with diabetes or a family history of glaucoma are at higher risk. Talk to your doctor to learn if this exam is right for you.

Medicare covers expanded benefits to help control diabetes. Benefits include your diabetes self-testing equipment and supplies, diabetes self-management training and medical nutrition therapy. Starting January 1, 2005, Medicare will cover screening to check for diabetes.

If you have not received your flu shot, it is not too late. Please contact your health care provider about getting the flu shot.

Want to see your latest claims? Visit MyMedicare.gov on the web any time, day, or night, and get the most out of your Medicare. Your personalized Medicare information is waiting for you online.

Please send written appeal requests to: P.O. Box 660155 Dallas, TX 75266-0155.

Send routine written inquiries to: General Medicare-BIC, P.O. Box 100297, Columbia, SC 29202-3297.

Planning to retire? Does your current insurance pay before Medicare pays? Call Medicare within the six months before you retire to update your records. Make sure your health care bills get paid correctly.

Appeals Information - Part B (Outpatient)

If you disagree with any claims decisions on either PART A or PART B of this notice, your appeal must be received by **July 24, 2008.**
Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Pag
(You may also send any additional information you may have about your appeal.)

3) Sign here _____ Phone number (____)_____

Robert J Kossmann MD
1650 Hospital Dr Suite 200
Santa Fe NM 87505-4788

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
4/10/2008	575.00	-----
TAX ID NUMBER	SHOW AMOUNT PAID HERE	$

98

Rt 5 Box 317C
Santa Fe, NM 87506

REMIT TO:

1650 Hospital Dr Ste 200
Santa Fe NM 87505-4788

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT
Charges audited and subject to change.

Santa Fe Internal Medicine

DATE	PATIENT	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	CHARGE	INSUR RECEIPT	PATIENT RECEIPT	ADJUST	INSUR BALANCE	PATIEN BALANC
2/1/08	[illegible]		90921	Esrd Related Services, Month ME	575.00	0.00		0.00	0.00	575.0

ACCOUNT NBR	CHARGES	PAYMENTS	REFUNDS/ ADJUSTMENTS	BALANCE DUE FROM PATIENT
	575.00	0.00	0.00	575.0

MESSAGE
INTERNAL MEDICINE SPECIALISTS For billing inquiries, please call (505) 462-2900 or toll free at 1-800-888-6642 between 9:00 a.m. and 4:00 p.m MST, Monday-Friday. Thank you.

PLEASE PAY THIS AMOUNT >> >> >> >> 575.00

** PAYMENT DUE UPON RECEIPT * THANK YOU **

May 9, 2008

Dear Honorable Senator Bryon P. Dorgan,

My name is Marie Genevieve Gutierrez and I am a Tribal Member of Santa Clara Pueblo. I have concerns about myself, my family and all the Native Americans of our country.

As an elder woman, at the age of 75, I want to be able to hear my children, grandchildren and great-grandchildren's voices, laughter, concerns and stories. I want to be able to communicate with my friends and family but the Santa Fe Indian Hospital has denied me and cannot help with eye glasses, hearing aids or dental work, which I am in need of desperately. There are a lot of other women and men my age who are in need and are complaining about it. Our children and babies also need help.

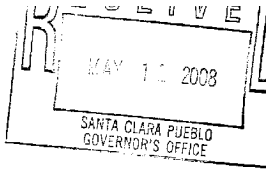
Our late elder men and women told us in accordance with the US Government treaties and federal responsibilities we were to be taken care. But, now it seems the Government is forgetting about us.

Thank you hearing me and May God Bless and take care of you and your work.

Respectfully,

M. Genevieve Gutierrez

M. Genevieve Gutierrez
Rt. 5, Box 451
Espanola, NM 87532



To: Walter Dasheno, Intergovernmental and Public Relations

From: Joseph L. Naranjo

Subject: Contract Health Service

Date: May 9, 2008

This is in response to the memorandum from Governor Chavarria regarding the above subject matter. My response, on behalf of my mother, Madeline Naranjo, is not in regard to denial of contract health service but is directly related to contract health.

The situation that I would like to address in regard to my mother and probably many other elders, is not denial of service but the lack of timely payment of those services which results in monthly invoices for payment, with threaten wording indicating that if payment is not received the invoices will be submitted to collection agencies. As anybody with experience in working with elders will acknowledge, this is terrifying for an elder with limited income to have to think about the possibility of having a collection agency coming after them for a bill that they think is being taken care of by the I.H.S. I know that they are in panic and are thinking about how they can manipulate their limited funds to try to pay for a portion of the bill to avoid having to deal with a collection agency. Once the anxiety and panic sets in, it is hard to convince them that the bills will be taken care of and that everything will be alright. This gets worse every month that this happens and I mean months, even years. I have had to deal with invoices that were six years over due. This is something that should not be allowed to continue and if collection agencies eventually get into the picture, it will ruin the credit rating for many individuals and contribute even further to the poor economic situation on Reservations.

The situation with contract health service needs to be investigated and addressed either in terms of additional funding or whatever else that may be needed to resolve the current situation. Senator Dorgan's oversight hearing is appreciated but it's the next step that would be appreciated even more and that is an overall solution to the dilemma that contract health services are in. When thought about in a broader sense, the whole I.H.S. funding should be included in the oversight hearing and if not there should be a hearing scheduled for just that purpose.

I hope that this information is useful in some way because elders are being impacted and at a time in their lives when they should not have to be worrying about finances for their health care.

SANTA CLARA PUEBLO
TRIBAL AND COMMUNITY MEMBER

FULL NAME: Edward MARTIN KENNEDY 201.407477 Blackfeet-Montana

ADDRESS: Santa Clara Pueblo

MEDICAL SERVICE DENIAL INFORMATION:
Related to Fractured Leg; ANKLE (49 BRONTS)

DOCUMENTS ATTACHED:
1. DEPARTMENT OF HEALTH & HUMAN SERVICES PHS SANTA FE
2. NORTHWEST ORTHOPEDIC & SPORTS MEDICINE MONTANA
3. NM MEDICAID UTILIZATION REVIEW ALBQ NM
4. ESPANOLA HOSPITAL ESPANOLA NM

SIGNED:

DATE:

DOCUMENTS ATTACHED CON'T:
ESPANOLA HOSPITAL ESPANOLA NM
SOCIAL SECURITY ADMINISTRATION RICAMOND CA

CONTRACT HEALTH

The Program as it has affected me is ponderous and slow. I was injured and permanently disabled in 2005. The accident necessitated a series of outpatient visits. Each of these visits had to be approved through three (3) Indian Health Service Staff Members plus a review committee. The Specialist involved was a Neophyte Doctor (Dr. Ryan Tingle). This doctor made serious mistakes in the initial surgery. I.H.S. Contract Health required me to continue to see this doctor because he was on their approved list for the Specialty Work that I needed. This doctor, knowing his mistake, repeatedly attempted to convince me that I should amputate my leg. This was done so as to cover up the fact that he had infected my leg with his "Strep" cells. As a direct result of this doctor's malfeasance I am permanently disabled and face the constant possibility of losing my leg. The leg is permanently broken, however I walk on it any way.

Competent Medical Advocacy

As the patient I did not and to this day, do not, have a competent medical doctor who would and should advocate for Patient Protection in cases of Doctor Mal-Practice.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Santa Fe Service Unit
1700 Cerrillos Road
Santa Fe, New Mexico 87505

CONTRACT HEALTH SERVICE

Apr 25, 2006

Document number: 063-QSFH-591

TO: EDWARD M KENNEDY
RT 5 BOX 472-A
ESPANOLA, NM 87532

Re: Patient: EDWARD M KENNEDY CHART: 28589 SANTA FE HOSPITAL
Contract Health Services request for services on Apr 10, 2006.
Date request received: Apr 10, 2004
Provider of services: ORTHOPEDIC ASSOC OF NNM

Dear EDWARD M KENNEDY,

We have been requested to authorize payment for services received from the above provider(s). Regretfully, we must advise you the Indian Health Service (IHS) will not pay for charges for the following reason(s):

Care Not Within Medical Priority
The medical care you received is not within the CHS medical priorities. Medical priorities must be established when funding is limited. [Per 42 Code of Federal Regulations 36.23(e) (1986)].

Primary Denial Comments:
CONTRACT HEALTH DOES NOT COVER 2ND OPINIONS.

If you have additional information that may be helpful in reconsidering our decision, please submit, in writing, within 30 days of receipt of this letter to:

Robert J. Lyon, CEO
1700 Cerrillos Road
Santa Fe, NM 87505
(505) 988-9821

EDWARD M KENNEDY

If you do not have additional information, you may appeal in writing, within 30 days of receipt of this letter:

James L. Toya
5300 Homestead Road, NE
Albuquerque, NM 87110
(505) 248-4510

C R E D I T S Y S T E M S
P.O. Box 875 2525 Colonial Dr.
Helena, MT 59624

1-800-223-8112 1-406-442-3728
FAX 406-442-8067

November 28, 2007

LTR#32-#063400215
Edward Kennedy
RR 5 BOX 472A
Espanola NM 87532-8911

RE: NORTHWEST ORTHOPEDICS & SPORTS MEDICINE 236.98

BAL: $236.98

Were you denied credit because this owing account is listed on your credit record? Will you be denied credit in the future?

Credit grantors do check your credit record and owing collections can lead to a credit denial.

Payment can be made with cash, money order, personal check, visa, or mastercard. We also can accept a check by phone free of charge.

Remember it is your credit record!

Sincerely,
COLLECTION DEPARTMENT

This notice has been sent to you by a debt collector.

This is an attempt to collect a debt. Any information obtained will be used for that purpose.

Interest on this account shall accrue in accordance with Montana State Law.

New Mexico Medicaid Utilization Review
P.O. Box 27950 Albuquerque, NM 87125-7950

12/18/2007

EDWARD KENNEDY
RT 5 BOX 472A
ESPANOLA, NM 87532-0000

Dear Medicaid Recipient:

This letter is to let you know that New Mexico Medicaid Utilization Review received and reviewed a request for the following service(s):

"Fee for Service" - Durable Medical Equipment and Supplies (Prosthetics/Orthotics)

The information your provider submitted to establish medical necessity for the services has been reviewed. The requested services have been denied because:
The information does not show that you meet the medical necessity criteria that would allow you to receive the service(s) requested. See the Medical Assistance Division Manual section 8.302.5.10

The policy(ies) or regulation(s) in the New Mexico Medicaid Program Policy Manual that explain(s) why this decision has been made is/are: 8.302.5.10 NMAC
Medical necessity determinations are made by professional peers based on established criteria, appropriate to the service(s) that are reviewed and approved by MAD.

The basis for this decision is:

New Mexico Medicaid does not cover orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics [8.324.8.13, A].

Your provider can request a re-review of this decision within ten (10) calendar days of the date on this letter.

You have a right to request a fair hearing if you disagree with this decision.

You can also ask for a hearing if you think HSD or its agent made an error or did not act promptly. Within ninety (90) days from the date on this notice, you may request a fair hearing. To be on time, the request must be received by the Human Services Department (HSD) Hearings Bureau, your local Income Support Division office or the Medical Assistance Division no later than the close of business on the ninetieth (90th) day. Hearings are completed and a written decision is made within ninety (90) days from the date that the HSD Hearings Bureau receives the hearing request. 8.352.2.12 (C) NMAC.

You can represent yourself at a hearing or you can have a friend, relative, attorney or other person represent you. You have the right to look at your case record and other proof used to make the decision.

In order to continue to receive the same Medicaid services while the hearing process goes forward, the request for a fair hearing must be received by the HSD Hearings Bureau, your local Income Support Division office, or the Medical Assistance Division no later than the close of business on the thirteenth (13th) calendar day from the date on this notice. If you ask for a hearing within thirteen (13) days and continue to receive the same Medicaid services but the final hearing decision favors HSD or the contractor, you will have to repay HSD for the cost of those services. 8.352.2.16(B) (2) NMAC.

You can write to the Medical Assistance Division or the HSD Hearings Bureau at the following address:

New Mexico Human Services Department
Hearings Bureau or Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348

If you need more information about the services this letter talks about, please contact your provider. If you want to request a fair hearing, please contact the Hearings Bureau of the Human Services Department at (505) 827-8164 or 1-800-432-6217, option 6.

Sincerely,

New Mexico Medicaid Utilization Review

Espanola Hospital
1010 Spruce St
Espanola, NM 87532

January 12 , 2007

Hello, my name is Dolores Vigil and I am a Financial Counselor for Presbyterian Healthcare Services. According to the hospital's records, our system indicates that your visit **is not financially** covered for service.

I would like to help you resolve your current medical bills by determining if we have your insurance incorrectly entered into our system, or if you may qualify for Medicaid or other financial assistance programs and/or payment arrangements.

Sincerely,

Dolores D. Vigil

Dolores D Vigil
Financial Counselor
(505) 753-1523

ESPANOLA HOSPITAL
1801 RANDOLPH RD SE
ALBUQUERQUE NM 87106

TEMP-RETURN SERVICE REQUESTED

Patient Name	
Service Date(s) 2006-01-17 00:00:00	Statement Date 02/05/2007

If paying by CREDIT CARD, please complete this section.	CHECK/M.O.
☐ [redacted] ☐ [redacted] ☐ [redacted] ☐ [redacted]	AMOUNT ENCLOSED
Card # _____	
Exp. Date ___ / ___ AMT AUTHORIZED $ _____	
Signature _____	

D3-PRESB
*A-02-NDO-AM-02874

RR 5 BOX 472 A
ESPANOLA NM 87532-8911

11

ESPANOLA HOSPITAL
PO BOX 27822
ALBUQUERQUE NM 87125-7822

ESPANOLA HOSPITAL
PO BOX 27822
ALBUQUERQUE NM 87125-7822

DATE: 02/05/2007

PATIENT ACCOUNT #.
PATIENT NAME: EDWARD KENNEDY
AMOUNT DUE: $ 336.00
SERVICE DATE: 2006-01-17 00:00:00

SECOND NOTICE

YOUR ACCOUNT IS NOW DUE. PLEASE SELECT ONE OF THE OPTIONS DESCRIBED BELOW AND RETURN THIS LETTER TO US WITHIN FIVE DAYS. IF YOU NEED ASSISTANCE, PLEASE CALL 888-708-6020.

___ MY CHECK FOR THE FULL AMOUNT IS ENCLOSED.

___ PLEASE CHARGE THE FULL AMOUNT TO MY VISA, MASTERCARD, DISCOVER, AMEX
TO EXERCISE THIS OPTION, YOU MAY EITHER CALL OUR OFFICE OR FILL IN THE FORM AT THE TOP OF THIS LETTER.

IF YOU WOULD PREFER TO MAKE MONTHLY INSTALLMENTS, PLEASE CONTACT OUR CUSTOMER SERVICE DEPARTMENT TO DISCUSS PAYMENT TERMS. FAILURE TO RETURN THIS NOTICE OR CONTACT OUR OFFICE COULD RESULT IN YOUR ACCOUNT BEING REFERRED FOR FURTHER COLLECTION ACTIONS. PLEASE SELECT AN OPTION AND RETURN THIS LETTER TO US OR CONTACT OUR OFFICE TODAY TO DISCUSS YOUR ACCOUNT. WE WILL DO OUR BEST TO WORK WITH YOU IN THIS REGARD.

SINCERELY,

PATIENT FINANCIAL SERVICES
ESPANOLA HOSPITAL

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Disapproved Claim

Western Program Service Center
P.O. Box 2000
Richmond, California 94802-1791
Date: June 26, 2006
Claim Number:

000697 MCSM75 N1 1.360

EDWARD M KENNEDY
RT 5 BOX 472A
ESPANOLA, NM 87532-8911

We are writing to tell you that you do not qualify for disability benefits.

Why We Cannot Pay You

You do not qualify for disability benefits because you have not worked long enough under Social Security.

We figure work under Social Security in credits. Please read the enclosed pamphlet, "How You Earn Social Security Credits," which explains how the credits are earned and how many a person must have to receive benefits.

Since you do not have enough work credits to qualify for benefits, we did not make a decision about whether you are disabled under our rules.

Other Social Security Benefits

You are not entitled to any other Social Security benefits based on the application you filed. In the future, if you think you may be entitled to benefits, you will need to apply again.

Need Help Getting A Job?

If you want counseling, training, and other services to help you in going to work, contact the nearest State vocational rehabilitation office to ask about getting services. The telephone number is in the blue pages of your telephone directory under State Government or access the Social Security Administration, Office of Employment Support Programs' website at www.socialsecurity.gov/work/ServiceProviders/rehabproviders.html. Click on the State where you live and it will provide your local vocational rehabilitation agency's address and telephone number.

Enclosure(s):
Pub 05-10072
Pub 05-10058

If You Want Help With Your Appeal

You can have a friend, lawyer or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a lawyer, we will withhold up to 25 percent of any past due benefits to pay toward the fee.

If You Have Any Questions

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-505-473-3707. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
1922 FIFTH STREET
SANTA FE, NM 87505

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Stephen Breen

Stephen Breen
Assistant Regional Commissioner,
Processing Center Operations

SANTA CLARA PUEBLO
TRIBAL AND COMMUNITY MEMBER

FULL NAME: David Lloyd Naranjo

ADDRESS: P.O. Box 861
Espanola, NM 87532

MEDICAL SERVICE DENIAL INFORMATION:

New Mexico Heart Institute
services rendered 12/28/06 - 12/29/06
1) Card Cons Ext - ofc/op
2) Eca Int & Rep
3) Color Flow Doppler
4) Doppler Echo Exam Heart
5) 2d Echo

DOCUMENTS ATTACHED:

1. Bill from New Mexico Heart Institute
2. RCIS Active Referrals
3.
4.

SIGNED: [signature]

DATE: 5/09/08

N E W M E X I C O
HEART INSTITUTE
A PROFESSIONAL ASSOCIATION
P.O. Box 8387
Albuquerque NM 87198-8387

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
11/30/2007	1,338.00	

TAX ID NUMBER | SHOW AMOUNT PAID HERE $

IF PAYING BY CREDIT CARD, FILL OUT BELOW
☐ AMERICAN EXPRESS ☐ DISCOVER ☐ MASTERCARD ☐ VISA

CARD NUMBER | AMOUNT
SIGNATURE | EXP. DATE

3965

**********AUTO**3-DIGIT 875

REMIT TO:
New Mexico Heart Institute
Department 1905
Denver CO 80291-1905

PO BOX 861
ESPANOLA NM 87532-0861

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT
Charges audited and subject to change.

DATE	PATIENT	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	CHARGE	INSUR RECEIPT	PATIENT RECEIPT	ADJUST	INSUR BALANCE	PATIENT BALANCE
12/28/06		Dr. Webber	99244	Card Cons Ext-ofc/op	386.00				0.00	386.00
12/28/06		Dr. Webber	93000	Ecg Int & Rep	60.00				0.00	60.00
12/29/06		Dr. Stamm	M93325	Color Flow Doppler	258.00				0.00	258.00
12/29/06		Dr. Stamm	M93320	Doppler Echo Exam Heart	194.00				0.00	194.00
12/29/06		Dr. Stamm	M93307	2d Echo	440.00				0.00	440.00

ACCOUNT NBR	CHARGES	PAYMENTS	REFUNDS/ ADJUSTMENTS	BALANCE DUE FROM PATIENT
	1,338.00	0.00	0.00	1,338.00

MESSAGE
NEW MEXICO HEART INSTITUTE For billing inquiries, please call (505) 462-2900 or 1-800-888-6642 between 9:00 a.m. and 4:00 p.m MST, Monday-Friday. Thank you.

PLEASE PAY THIS AMOUNT >>>>>>>> 1,338.00

JRPOSE: MRI
AGNOSTIC CATEGORY: OTOLARYNGOLOGICAL DISORDERS

12/28/06 8:30

GIN DOS: 04/04/06 E 4/4/06 DISCHARGE CONSULT DT:
TE REFERRED: 4/4/2006 CHS STATUS: APPROVED
FERRED BY: WALKER,CARRIE REFERRED TO: NEW MEXICO HEART INSTITUTE PA
JRPOSE: CARDIAC EVALUATION/CONSULTATION
AGNOSTIC CATEGORY: CARDIOVASCULAR DISORDERS

GIN DOS: 04/03/06 E 4/3/06 DISCHARGE CONSULT DT:
TE REFERRED: 4/3/2006 CHS STATUS: PENDING
FERRED BY: CHAVEZ,EVELYN M REFERRED TO: X-RAY ASSOC OF NM
JRPOSE: MRI BRAIN
AGNOSTIC CATEGORY: CEREBROVASCULAR DISRDERS

GIN DOS: DISCHARGE CONSULT DT:
TE REFERRED: 2/14/2006 CHS STATUS: APPROVED

May 7, 2008

To whom it may Concern;

I am sending this correspondence in reference to Contract Health. My name is Mary L. Sisneros and I am an enrolled tribal member from Santa Clara Pueblo. I am in poor health and have received numerous amounts of hospital bills. At this time, I have no means to pay out of pocket for them.

I have in the past few years been living on a fixed income and have taken in my two young granddaughters. I have no extra money at all. I have been turning in all my hospital bills to Contract Health and hope these bills will be paid in full.

I need all the help I can get in repaying my hospital bills. The closest hospital we have to Santa Clara is Espanola Hospital, and this is the only emergency room I can make it to. I appreciate your time and effort in this matter.

If you have any questions please feel free to contact me at (505) 753-7379.

Sincerely,

Mary L. Sisneros

Mary L Sisneros

LINCARE

LINCARE INC
P O BOX 23078
OKLAHOMA CITY OK 73123-2078

INVOICE # Q5986653 DATE 4/27/08

ACCOUNT #

WE HEREBY CERTIFY THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTION 6, 7 AND 12 OF THE FAIR LABOR STANDARDS ACT AS AMENDED AND OF REGULATIONS AND ORDERS OF THE U.S. DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF.

PO BOX 207
ESPANOLA NM 87532-0207

FEDERAL ID #

Billing Inquiries: (877)879-9852 Service Inquiries: (888)753-5585

DATE	DESCRIPTION	QUANTITY	AMOUNT BILLED	AMOUNT ALLOWED	INSURANCE AMOUNT DUE	CUSTOMER AMOUNT DUE
	CUSTOMER BEGINNING BALANCE:					121.40

TOTAL INSURANCE PENDING ►	.00	PAY AMOUNT NOW DUE ►	121.40

DETACH HERE

RETURN THIS PORTION WITH YOUR PAYMENT. PLEASE WRITE ACCOUNT NUMBER ON CHECK.

☐ Check Here For Address Change (Note New Address Below)

Account #

Account Name

Primary Insurance

Secondary Insurance

Invoice # Q5986653

Date 4/27/08

Payments received after invoice date will appear on your next invoice

AMOUNT DUE ► 121.40

AMOUNT ENCLOSED ►

WE ACCEPT

Check one ☐ MasterCard ☐ VISA ☐ DISCOVER

Card No. Exp. Date

Card holder signature

LINCARE

LINCARE INC
P O BOX 23078
OKLAHOMA CITY OK 73123-2078

PRESBYTERIAN

Espanola Hospital
1801 Randolph SE
Albuquerque, NM 87106

Hospital Billing Statement

Important Message

Thank you for choosing Presbyterian Healthcare Services.

The balance on your account is now past due. To avoid further collection activity, please forward your payment in full immediately.

Presbyterian offers a variety of payment options and financial assistance is available for qualified applicants. We encourage you to contact our Customer Service Department for more information.

02775

Po Box 207
Espanola, NM 87532-0207

Account Summary

Statement Date	04/19/08
Account Number	
Visit Type	Inpatient
Dates of Service	09/19/07
Previous Amount Due	$1,502.00
New Charges/Adjustments	$0.00
Self Pay Discount	$0.00
New Payments/Credits	$0.00
Current Account Balance	$1,502.00
Balance Pending With Insurance	$0.00
Please Pay This Amount	$1,502.00

Financial Assistance

As an important part of our charitable mission, Presbyterian Healthcare Services is committed to providing benefits to the community. Financial assistance may be available to those who are uninsured or under insured and do not have other resources. Please complete an application to determine eligibility. Please contact our Customer Service department for additional information.

Questions

Try our On-Line Billing Manager. A simple and secure way to view and pay your bill on-line. Visit us at www.phs.org and follow the easy steps to get registered.

Patient Accounting Customer Service
Customer Service is 1-505-923-6400
or Toll free at 1-800-251-9292
Office hours are 8:30 a.m. to 5:00 p.m. M-F
Our e-mail address is : pfscustomer@phs.org

Write to us at:
Presbyterian Patient Accounting
P.O. Box 26268
Albuquerque, NM 87125-7845

Presbyterian serves to improve the health of individuals, families and communities.

Detach Here and Return

Account Number	Patient Name	Date of Service	Due Date
	Mary Lillian Sisneros	09/19/07	05/19/08

Send Payment to:

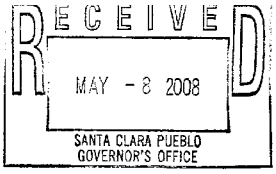
Presbyterian Healthcare Services
P.O. Box 27822
Albuquerque, NM 87125-7822

Card Account Number	VIN #	Exp. Date

Signature X

Payment Amount:

Please check here if address or insurance information h changed and indicate changes on back of this page.



May 7, 2008

Walter Dasheno Sr., Inter Tribal Public Relations
P.O. Box 580
Espanola, NM 87532

Dear Walter Dasheno Sr.,

This is in reference to the Indian Health Service, Contract Health. I would like to advise you of my current experience I had with Contract Health.

I was involved in a motor vehicle hit and run accident on July 30, 2007. The accident location was on State Road 30 Santa Clara Pueblo Tribal land. I had to be transported via ambulance to the local hospital (Espanola Hospital). There I was taken to the emergency room, and was check by the doctor, I also had to have x-rays done. Upon arrival at the hospital which was in the evening. My brother called Santa Fe Indian Hospital and left a message with Contract Health to advise them that I had to receive emergency services at Espanola Hospital due to the hit and run accident. Upon leaving the hospital I was advised by the doctor that I had my left tibia platue broken, as well as sever cuts on my left hand and left arm. I was also advised by the doctor that I had to have a follow-up conducted with the doctor that I see. I was also given a referral to be seen by an orthopedist. I currently don't have health insurance so my only choice is the Santa Fe Indian Hospital or Santa Clara Pueblo Health Clinic. On July 31, 2007 I went to the S.C.P. Health Clinic. Prior to my going to the clinic my brother once again attempted to get a hold of Contract Health in Santa Fe, another message was left. While I was at the clinic I had x-rays done of both my ankles, which were not broken but severely sprained. My right knee was also looked at to find out that I have nerve damage. I submitted my referral to the doctor at the clinic, he stated he would submit it to Contract Health, I had advised the doctor that messages were left pertaining to my accident and my services at Espanola Hospital. The doctor was able to get a hold of Contract Health and forwarded the referral as an emergency at this time he also advised of the messages that were left. An appointment was made for the following day with the Orthopedist. On August 1, 2007 I met with the Orthopedist and was advised by his office that no referral was received and that I need that before I went in or I would have to pay for the office visit fee. The office administrator was able to get a verbal confirmation from contract health. The orthopedist referred me to have an MRI done to see exactly what else was wrong with my left leg other than the break. This same day, I went to the Indian Hospital and was seen by a doctor to have another x-ray of my right ribs, also to submit the referral for the MRI. The doctor submitted the referral to Contract Health who advised they would contact me with a date for MRI. This same day late in the afternoon I received a call from Contract Health advising I could be seen at the clinic were MRI's are conducted. The following week I had another appointment with the orthopedist that looked at the MRI results. I was advised that my left ACL was torn, which meant I had to have surgery. The orthopedist did not want to conduct the surgery until my break was healed. Contract Health was advised of this and I was advised to submit the referral when I was going to have surgery. I had several appointments with the orthopedist. After two and a half months my break healed. I advised Contract Health that I was able to go through with the surgery, the referral was submitted to Contract Health. At this point there was no money to have my procedure done, I was advised I had to wait for the new fiscal year to start and then resubmit

my paperwork which had to go through the whole approval process once again. The new fiscal year was in placed and I was approved to have surgery which was on January 30, 2008. However, I still needed to go through physical therapy. At this time after my surgery there was no physical therapist at Santa Fe Indian Hospital. So this meant I had to ask Contract Health for another referral for physical therapy. On February 25, 2008 I received a call from Contract Health advising that my **referral was denied due to no funds available**. The last time I checked there was still no physical therapist at the Santa Fe Indian Hospital, because of this I have to pay out of my own pocket for physical therapy, which is very expensive. I was referred by the orthopedist to go every week however, due to my budget I am only able to go once a month. So I am no where near recovery from the surgery.

I hope that there is help soon for those who can't afford something such as my situation. Also I would like to add that personnel at Contract Health are very hard to get in contact with. No phone calls are ever retuned. Thanks to my brother working next to the hospital he was able to do a lot of the leg work for me. I also made numerous trips to Santa Fe just to speak with Contract Health.

Sincerely,

Josephine Naranjo

Josephine Naranjo, Santa Clara Pueblo Tribal Member

SANTA CLARA PUEBLO
TRIBAL AND COMMUNITY MEMBER

FULL NAME: MARGARET Gutierrez

ADDRESS: P.O. Box 1409, Espanola, NM 87532

MEDICAL SERVICE DENIAL INFORMATION:

SEE Attachments

DOCUMENTS ATTACHED:

1. Public Health Service (1 page)
2. Health + Human Services (2 pages)
3.
4.

SIGNED: Margaret Gutierrez

DATE: May 8-2008

5-8-08

To whom It may Concern:

I am writing you on behalf of one of my seniors who is very concerned about the denials of Indian Health Service Contracts.

She had been going for Therapy for a Joint Disease she has on both hands. The Therapy was helping her, but now she is being denied services because of monies being limited at Indian Health.

Mrs. Margaret Gutierrez also mentioned that her husband is also being denied services for treatment he had been recieving before.

They feel it is wrong not to be able to recieve these services that were very helpful to them.

I also feel it is wrong not to be able to serve our Native Elders where their Health is of great concern. Something has got to be done to remedy this problem.

I have enclosed copies of her denial letters.

Thank you,

Florence Jorgensen

Florence Jorgensen
Activity Coordinator
Santa Clara Pueblo Senior Center

RECEIVED
MAY -7 2008
SANTA CLARA PUEBLO
GOVERNOR'S OFFICE

May 5, 2008

MEMORANDUM

TO: **SANTA CLARA PUEBLO TRIBAL AND COMMUNITY MEMBERS**

FROM: **GOVERNOR J. MICHAEL CHAVARRIA**

SUBJECT: **INDIAN HEALTH SERVICE – SFSU CONTRACT HEALTH SERVICE DENIAL**

On April 14, 2008 I sent a written statement to the Honorable Senator Byron L. Dorgan, Chairman for the Senate Committee on Indian Affairs regarding information he requested from Tribes and Indian organizations regarding the denial of contract health service by our people from Santa Clara Pueblo.

Senator Dorgan was at this time in the process of considering an oversight hearing on this matter in Washington, D.C. with the United States Senate Committee on Indian Affairs. Today, we receive notification that this hearing will take place at 9:30 a.m. on Thursday, May 15, 2008.

For this reason, I am requesting your assistance to this matter.

This is a direct quote from Senator Dorgan's letter to tribal leaders on March 27, 2008.

"In response to complaints and comments by tribal leaders, individual Indians and health care providers, I plan to hold a hearing soon on the Contract Health Services Program. This program allows Indian health clinics and hospitals to obtain services from outside contractors when the clinics and hospitals cannot provide these services. However, the program is not working

well, and many individual Indians are often faced with having to pay enormous bills that are supposed to be covered by the federal government.

In preparation for this hearing, I would greatly appreciate any input or comments you or your members can provide. Thoughts about how the current Contract Health Services program is working and any problems that your community faces regarding health care will be beneficial"

If you, a member of your family or extended family or friend have been denied payment by the Indian Health Services to pay for your medical or any health care services from other than a Indian Health Service medical and health facility, I would like to have you record this, so I may submit this as additional information and concerns from our Pueblo.

I am requesting that you please submit your document to my office no later that Friday, May 9, 12 noon, I will then include this as part of our additional statement to Senator Dorgan the following Monday, May 12, 2009.

If you have any questions, please do not hesitate to contact my office at (505) 753-7330 or Mr. Walter Dasheno, Director, Intergovernmental and Public Relations Office at (505) 692-6312 or (505) 753-7326, ext. 1273.

Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Santa Clara Health Center
RR. 5, Box 446
Espanola, New Mexico 87532-9614

January 16, 2008

Mrs. Margaret Gutierrez
P. O. Box 1409
Espanola, NM 87532

RE: Orthopedic Services/UNM Hospital

Dear Mrs. Gutierrez,

I'm sorry I am getting back to you so late. I am writing to give youinformation at the University of New Mexico Hospital (UNMH) for services to address the joint disease in your hands.

You will need to obtain a denial letter for services from Contract Health Services (CHS) in Santa Fe. I did see on the computer IHS-CHS did deny orthopedic services for you, as it was not considered a high priority. If you already received a letter on denial of services, youwill need to take this with you to UNMH.

First, you will have to contact the UNMH Out of County indigent program-- call (505) 272-1612 and ask to speak to a Financial Counselor for the Native American program. You will have to tell them you live in Rio Arriba County. You should also tell them you have Medicare (the red/white/blue card) parts A & B.

Ask about an appointment for the Orthopedic clinic. When you show for clinic, be sure you take your tribal enrollment identification with you. So they will know you are Native American and not be charged for your outpatient visit.

I would recommend a family member helping you. You will also need to ask if you might have to pay anything out of your own pocket. The out of county indigent program is based on income; so you will be asked questions about your social security payments and if you receive any other benefits.

If you don't want to look at obtaining services at UNM Hospital, you might want to consider looking at the Gallup Indian Medical Center or going back to Santa Fe and asking to place you back on the list to see an Orthopedic doctor. I'm sorry that Indian Health has limited dollars and that we are not able to address your needs immediately. I hope this process, information I am giving you is of help.

Sincerely,

Sharon F. Martinez

Sharon F. Martinez/Patient Advocate

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Santa Fe Service Unit
1700 Cerrillos Road
Santa Fe, New Mexico 87505

CONTRACT HEALTH SERVICE

May 17, 2007

Document number: 073-QSFH-601

TO: MARGARET GUTIERREZ
PO BOX 1409
ESPANOLA, NM 87532

Re: Patient: MARGARET GUTIERREZ CHART: 8353 SANTA FE HOSPITAL
Contract Health Services request for services on Apr 24, 2007.
Date request received: Apr 24, 2007
Provider of services: ST VINCENT'S ORTHOPAEDIC GROUP
Other resources:
MEDICARE
Other resources paid: $0.00

Dear MARGARET GUTIERREZ,

We have been requested to authorize payment for services received from the above provider(s). Regretfully, we must advise you the Indian Health Service (IHS) will not pay for charges for the following reason(s):

Care Not Within Medical Priority
The medical care you received is not within the CHS medical priorities. Medical priorities must be established when funding is limited. [Per 42 Code of Federal Regulations 36.23(e) (1986)].

Primary Denial Comments:
THIS REFERRAL PERTAINS TO A REQUEST FOR AN ORTHOPAEDIC EVALUATION OF YOUR THUMBS.

If you have additional information that may be helpful in reconsidering our decision, please submit, in writing, within 30 days

of receipt of this letter to:

Robert J. Lyon, CEO
1700 Cerrillos Road
Santa Fe, NM 87505
(505) 988-9821

If you do not have additional information, you may appeal in writing, within 30 days of receipt of this letter:

James L. Toya
5300 Homestead Road, NE
Albuquerque, NM 87110
(505) 248-4510

Sincerely,

Robert J. Lyon, CEO
1700 Cerrillos Road
Santa Fe, NM 87505
(505) 988-9821

1203 North 24th St.
Billings, MT 59101

June 22, 2008

RECEIVED
JUL 2 2008

IHS Director
801 Thompson Ave.
Rockville, Maryland 28052

Dear Sir:

I am requesting from you reconsideration of IHS denial of payment for services following the procedure outlined to me by Mr. Pete Conway, Director, Indian Health Service, Billings Area Office. I am enclosing copies of the documents regarding this denial for your consideration.

I am an enrolled member of the Crow tribe and meet the requirements for contract care. I received emergency medical treatment at the Saint Vincent Hospital in Billings, MT on January 10, 2008. I routinely receive medical treatment at the IHS at Crow agency. However in this case, after an extremely intensive and thorough questioning in regards to my symptoms, I was advised by the nurse with the Ask-a-Nurse helpline to seek IMMEDIATE medical attention and to go directly to the local hospital. Travel to Crow agency for help did NOT fall within the immediate nature of the instructions I was given as it would have required an hour's drive just to reach the facility and my pain made transport even to the local facility extremely difficult. Incidentally, it is my experience that the Ask-a-Nurse program does not suggest immediate or extreme care lightly. Often times I have used the service to obtain answers to medical questions, and I have known them to routinely seek the least extreme medical option available. The Billings Ask-a-Nurse program has considerable experience with the IHS at Crow, and has advised me in the past on temporary care so that I could travel to the hospital at Crow. In this situation, however, I was advised to seek immediate care and to go directly to the hospital. I followed that medical advice, but did go to Crow for all follow-up care.

I am appealing to you because CHS and the Billings area IHS has denied payment of the charges I incurred at Saint Vincents even though I was following explicit medical advice. The denial is based on the fact that I did not postpone diagnosis and treatment for the hour drive to Crow to obtain medical help. In other words, the decision leaves an Indian person with a medical emergency in a situation where they must go against medical advice in deference of IHS or CHS funding criteria policy. I recognize that CHS is poorly funded, but I find it hard to believe that we who must depend on IHS for health care are routinely asked to ignore emergency medical advice. I ask for your reconsideration of this situation. I am enclosing documents pertaining to this case for your review.

Sincerely,

Benjamin S. Takes Horse

cc: Senator Byron Dorgon
Committee on Indian Affairs
838 Hart Office Bldg.
Washington DC 20510

Senator Lisa Murkowski
Committee on Indian Affairs
838 Hart Office Bldg.
Washington DC 20510

Senator Jon Tester
204 Russell Senate Office Bldg.
Washington, DC 20510

Senator Max Baucus
511 Hart Senate Office Bldg.
Washington, DC 20510

Robert G. McSwain, Director
Indian Health Service (HQ)
The Reyes Building
801 Thompson Avenue, Ste. 400
Rockville, MD 20852-1627

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Billings Area
Indian Health Service
2900 4th Avenue North
P.O. Box 36600
Billings, MT 59107

MAY 23 2008

Our Reference: CHS

Benjamin Takes Horse
1203 North 24th Street
Billings, Montana 59101

Dear Mr. Takes Horse:

This is in response to your lettered dated April 18, 2008, requesting a reconsideration of the decision issued by the Public Health Service (PHS) Indian Hospital, Crow Agency, Montana, to deny payment of medical expenses you incurred on January 10, 2008, at Saint Vincent Hospital, Billings, Montana.

We have thoroughly and carefully reviewed all the information on file associated to the medical care you received and our review revealed the care did not meet the medical priority level the Contract Health Service (CHS) is operating at and the PHS Indian Hospital was available and accessible to provide the medical care you required. The decision issued was in accordance with Indian Health Service (IHS) and CHS regulations which require individuals utilize an IHS facility when one is available and accessible within a 90 minute driving distance prior to authorization of CHS funds. Therefore, the decision was appropriate.

In response to your question about following medical advice, we are not recommending patients disregard medical advice, however, when the care received does not meet CHS funding criteria then the patient must assume financial responsibility.

CHS regulations were followed in the decision to deny payment and we must sustain the decision.

We regret we cannot provide a more favorable response, however, if you disagree with this decision, you may request reconsideration from the IHS Director, 801 Thompson Avenue, Rockville, Maryland, 20852. Any appeal must be received in writing within 30 days of receipt of this letter.

Sincerely,

Pete Conway
Director, Billings Area

cc: Acting Chief Executive Officer, PHS Indian Hospital, Crow Agency, MT

Triage Detail Report

Call Information

Master Contract/Sub Contract "Name": ST VINCENT HEALTHCARE / St. Vincent Healthcare-Triage
Call Start Date & Time: 1/10/2008 4:57:26AM
Call End Date & Time: 1/10/2008 5:36:43AM
Call Length (minutes): 39.3
Caller Name: Takeshorse, Benjamin
Relationship to Patient: Not Recorded
Operator Name: Stockwell, Gloria

Patient Information (Current as of 2/26/2008)

Name:
MRN:
Contract Id:
SSN :

Gender: Male
Date of Birth: 11/4/1978
Address: 1203 N 24TH ST
Billings, MT 59101
UNITED STATES
Age: 29 yr.
Phone: 1 (406) 8615813

Call Details

***Plan Name:**
***Patient Plan Id:**

***PCP Name:** Out Of Net, Pcp
PCP Phone(s):
PCP Fax(es):

***Person Profile Notes:**

***Presenting Problem:** gstockwell.RN. "I am having really bad stomach pain. I think it is gas. Should I go in." Caller seems to be having difficulty talking due to pain. Unable to stand up. At times unable to walk when pain at its worse. Caller is referred to emergency room now.

Assessment:	Triage Nurse Assessment	**Version:** 2
	Symptom:	Severe abdominal pain
	Onset/duration:	9 PM. almost 9 h ours
	Location:	mid epigastric pain
	Severity:	10
	Associated Symptoms:	unable to stand straight up
	What have you tried so far:	calling for what to do
	Effect on activities of daily living:	no sleep tonight due to pain

***Encounter Notes:**

***Triage Notes:**

Guideline Title: Abdominal Pain / Discomfort , Version: C00428

Guideline Title
Question (All questions, regardless of response) **Response** **Question Note**

Abdominal Pain / Discomfort , Version: C00428

*Information is accurate as of the time the call was taken.

New or worsening signs and symptoms that may indicate shock	No
Any other cardiac signs/symptoms for more than 5 minutes, now or within last hour	No
Over 50 years of age AND new onset (first episode) unbearable back or abdominal pain	No
Known abdominal aneurysm (swollen or ballooning aorta) AND sudden onset of unbearable abdominal pain	No
Injury to abdomen	No
GI bleeding, more than streaks of blood or scant amount	No
Food or foreign body stuck in esophagus	No
Rectal symptoms or pain associated with constipation	No
Painful spasms or cramping of large muscle groups (back, legs or abdomen) associated with heat exposure	No
Recent childbirth or miscarriage	No
Pregnant, less than 20 weeks gestation AND vaginal bleeding	No
Pregnant, more than 20 weeks gestation AND vaginal bleeding	No
Pregnant, 20-37 weeks gestation AND signs of labor	No
Pregnant, gestation more than 37 weeks AND signs of labor	No
Pregnant AND injury to abdomen	No
Pregnant AND abdominal pain/cramping OR back pain	No
Pregnant AND heartburn	No
Pain described as deep, boring, or tearing	Yes

Recommended Disposition **Original Inclination** **Intended Action**

See ED Immediately

Physician Contacted: No **Physician Instructions:** N/A

Care Advice Text:

Another adult should drive.
Do not give the patient anything to eat or drink.
Do not push on abdomen.

Access Instructions:

Emergency Department: SVH Open 24/7

Primary Care Provider

*Information is accurate as of the time the call was taken.

ELKO BAND COUNCIL
1745 Silver Eagle Drive • Elko, Nevada 89801
775-738-8889 • Fax 775-753-5439

RECEIVED
MAY 01 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Honorable Senator Dorgan:

In reference to your letter dated March 27, 2008, we highly appreciate the opportunity to address the health care needs of the Elko Band Council population of the Te-Moak Tribe of Western Shoshone Indians of Nevada. The Te-Moak Tribe of Western Shoshone is composed of four (4) constituent bands consisting of Elko Band Council located in Elko, NV; Battle Mountain Band Council located in Battle Mountain, Nevada; South Fork Band Council located in Lee, Nevada and Wells Band Council located in Wells, Nevada.

The Southern Bands Health Clinic is located in Elko, in Northeastern Nevada. The Clinic serves a great population which spreads over a vast geographical area, reaching up to 75 miles east and west and 30 miles south of the City of Elko. The Southern Bands Health Center is under the direction of Don Davis, Area Director, Phoenix Area Indian Health Service. Southern Bands Clinic is strictly an outpatient facility with limited services. Currently, the services available are pharmacy, dental, outpatient clinic and diminutive mental health services.

STAFFING:

- For the past year and a half the clinic has been operating with a temporary Chief Executive Officer (CEO) because the Indian Health Services has yet to fill the position permanently. This has caused major problems with communication between the Clinic and Elko Band Council. Numerous requests have been made to upgrade clinical services and the needs that are pertinent to patient care but unfortunately, it has been unsuccessful. The only answer given for the inconsistencies is "once we get a permanent CEO hired we will look at the situation".

- One of many concerns of the Elko Band Council is the budget. Southern Bands Clinic is functioning off limited funds and a majority of the budget is spent on salaries for administration and clerks. The funds would be better utilized by obtaining a full time doctor on a permanent status. Elko Band Council would like to see these types of positions filled and a reduction in administration and clerks. The Elko Band Council has continuously requested the budget on Contract Health Services in the approximate amount of $1,361,954.00 for FY' 2008 and have yet to receive a working budget.

- Elko Band Council would like to have a professional audit done to the clinic. With all the added administrative/clerk positions, it has caused extra expenses with no exact reason for the additional personnel. Patient visits to employee ratios should be considered. These positions have been incorporated with no assessment to the actual need of the clinic.

FUNDING:

- The Southern Bands Health Center has an operating budget for Contract Health at $2,087, 044.00. According to the most recent budget received from the Acting CEO, it shows $557,295.00 under funded. The Contract Health Services in our service unit is responsible for Catastrophic Care, Diagnostic testing and any other specialty services that are not available within the walls of the clinic. Obviously, this is not enough funds to cover all the services needed causing lack of care to patients and delay of referrals. The Southern Bands Clinic has expended $95,000 to install an automated phone system. The goal of the installation was to assist the community more effectively and efficiently. Consequently, it has caused more havoc resulting in countless complaints from patients. When patients call they get a recorded directory, this system is very complicated for the elderly patients served in the clinic. Furthermore, patients have observed the clerks ignoring phone calls to allow the automated system to answer. The system has become more of an inconvenience to patients within the clinic and those trying to call the clinic. In addition, patients who try to reach the pharmacy only receive the answering machine and have difficulty trying to get the staff to return their calls. Elko Band is in favor of upgrades in technology only if it will benefit the patient population. It is apparent this upgrade has no benefits because it is utilized improperly.

THIRD PARTY:

- Third party billing is highly important to the Southern Bands Health Clinic. The additional funding saved by billing third party resources can be utilized to improving care that is greatly needed. Instead, these funds are being used to offset deficits in the Contract Health Budget mainly salaries. Third party billing can assist the clinic in achieving higher qualities of health care. For instance, it could provide actual dental care rather than extracting teeth for quick fixes. It could also assist in more pharmaceuticals and increase overall improvement by employing specialty physicians and providers.

REFFERALS:

- One of the major challenges for patients is obtaining referrals to visit a specialty physician. Many patients will see a doctor at Southern Bands Clinic and need specialty treatment or a more thorough examination from a specialist but because referrals are delayed, patients are waiting for this care. This care ranges from having diagnostic testing to a much needed oncology appointment. This is detrimental to the quality of care that should be provided for our people. We understand that budgeting is a major factor but when patient lives are in jeopardy, the clinic should do its sole purpose and provide adequate health care so our people live healthy lives. For example, a Native American elder could not get a referral for over thirty (30) days and had serious ongoing medical problems. It was later diagnosed as throat cancer and the patient is currently going through chemotherapy. This is not preventative.

- Every Tuesday a Case Manager Group meets for referrals. This meeting closes down Southern Bands Clinic for half a day cutting services for patients to 36 hours a week. This group reviews, recommends and approves referrals and overrides the recommendations made by the attending physician. The employees who form the Case Manager Group are not qualified physicians and should not be allowed to make any type of medical decision when the lives of the patients are in jeopardy. This process has been disputed mainly by physicians because the boundaries are being overstepped, resulting in Doctors and Clinical directors leaving and being placed in other Clinical facilities. This issues has been ongoing and yet to be resolved.

DRUG FREE WORKPLACE:

- In 1988 the Drug Free Workplace Act came into law. In most facilities today and most Tribal Organizations across the nation, this law is adhered to through employee drug testing. Presently, the Southern Bands Health Center employees are not tested under this law. In fact, it is refused due to their union affiliations and protection. Elko Band Council is concerned with this practice and would like this issue to be addressed and resolved. Southern Bands Clinic is a tribal facility leased from the Elko Band Council of the Te-Moak Tribe of Western Shoshone which promotes a drug free workplace.

EMERGENCY ROOM VISITS:

- Patients visit Southern Bands Clinic to receive medical services. Due to lack of professional services of a physician many patents end up in the emergency room to obtain a correct diagnosis or for further examinations. This does not only cause an increased burden on the patient and their family but costs to visit the emergency room are drastically high. These visits cause a major strain on the already limited budget affecting Contract Health Services. And a majority of the time patients are left to pay the high cost of the emergency room visit. These incidents also need to be reviewed and investigated by a peer review organization and recommendations made to be acted upon.

DENTAL:

- Dental services are very limited in Southern Bands Health Clinic. The limitations we are told are due to lack of funds. The only services provided are extraction of teeth and partial cleanings. This is not acceptable when you have minor dental problems and the only conclusion is to extract the tooth. Many individuals have had root canals partially done only to find they must find another dentist to finish the work. Many procedures do not get completed due to the financial burden placed on the patient. Contract Health is limited to priority 1 status. Therefore, follow through care is not done. Elko Band Council has requested additional dental positions and is in the process of locating funding to expand the dental department so that services may be provided to improve a serious needed dental program. To be successful in this plan of expansion, funding for a new modular is greatly needed.

NEED TO KNOW VS PRIVACY ACT:

- The Te-Moak Tribe of Western Shoshone participates in the Special Diabetes Program for Indians. There are approximately 210 diabetics. This is a prevalent number being around 11% of the tribal population. In the past we have not had the access to the exact number of patients or listing of patients from Phoenix Area control patient records, due to the Privacy Act. We believe that a program which is funded by Indian Health Services (Special Diabetes Program for Indians) has a need to know and access this information to comply with regulations. Most recently, names were received from diabetic patients themselves by offering the NIKE N7 shoe. This is hardly an effective way to obtain statistics. We plead with you to investigate this issue.

We believe these issues outlined in this letter exist because of the Phoenix Area directives. Elko Band is looking forward to hearing your ways of improving Indian Health Services and more importantly your assistance to improving the Southern Bands Health Clinic which service the Elko and surrounding areas directly. Your much needed support is greatly appreciated and will undoubtedly give the health care of the Elko Band Council and others a great deal of enhancement. Again, thank you for your concern and assistance.

Respectfully,

Lynette Piffero, Chairperson
ELKO BAND COUNCIL

cc: Elko Band Council Members
Te-Moak Adminstration

SOUTHERN INDIAN HEALTH COUNCIL, INC.
4058 Willows Road • Alpine, CA 91901-1620
Mailing: P.O. Box 2128 • Alpine, CA 91903-2128
(619) 445-1188 • FAX (619) 445-4131

RECEIVED
APR 24 2008

April 14, 2008

Re: Contract Health Program

Honorable Byron L. Dorgan, Chairman
Senate Committee on Indian Affairs
United States Senate
322 Hart Senate Office Building
Washington, D.C. 20510-6450

Dear Chairman Dorgan:

I write in response to your letter dated March 27, 2008 to tribal leaders seeking input on the current Indian health care system. I write on behalf of the Southern Indian Health Council, Inc. (SIHC). SIHC is a health care consortium of the following tribes in southern San Diego County: the Barona Band of Mission Indians, the Campo Kumeyaay Nation, the Ewiiaapaayp Band of Kumeyaay Indians, the Jamul Indian Village, the La Posta Band of Mission Indians, the Manzanita Band of the Kumeyaay Nation, and the Viejas Band of Kumeyaay Indians. SIHC operates clinics on the lands of certain of its Member Tribes.

I wish to recognize your hard work on behalf of the reauthorization of the Indian Health Care Improvement Act and congratulate you on the passage of S. 1200, the Indian Health Care Improvement Act Amendments. The provisions in that bill are important for addressing critical issues in Indian health care.

I also wish to address the questions that you raise regarding the Contract Health Care program. SIHC provides contract health care to its patients. Such services provide critical specialty and other health care which we cannot provide in our clinic.

Unfortunately, the amount of funding which SIHC receives from Indian Health Service for contract health care is vastly insufficient to meet our patients' needs. For example, typically our funding for contract health care is exhausted between six months and eight months into each fiscal year. That occurs even though we fund only Priority One health care services, which are the IHS-defined category of most urgent and critical need. This is also a very dramatic statistic because many of our patients have private insurance and thus do not need contract health care services. Thus, even for the relatively smaller number of SIHC patients who require contract health care, the amount of funding which IHS provides is not sufficient.

Accordingly, we support any effort by Congress to increase the funding provided for contract health care services.

Sincerely,

Ralph Goff, Chairman
SIHC Board of Directors

OFFICE OF THE GOVERNOR

ROUTE 1 BOX 117 – BB* NAMBÉ PUEBLO* NEW MEXICO 87506*PHONE 505-455-2036* FAX: 505-455-2038
NP2008-144

April 16, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, DC 20510

Re: Contract Health Services Program

Our Community Health Representatives are a big help in assisting our tribal community members with the information on current procedures and by keeping up to date on a regular basis. There are some that just are not willing to work with our CHR's until they have obtained the bill so it them becomes a learning experience for those individuals in which the CHR's will do all that can possibly be done to avoid any out of pocket expenses. Awareness in our communities is essential. The Health Boards for both Santa Fe and Santa Clara are not functioning properly due to the lack of participation and interests by each of the tribes in the surrounding area. Awareness to new Governors' and Tribal Administration is essential to maintain an established board, which currently does not exist.

The Preference in Employment seems to play a big factor in delaying hiring process to bring our clinics up to par in staffing. The current situation has several people working double or triple duties to cover the areas and positions open. The positions are open too long which means needs are not being met, overworked staff, and confusion in stability of those covering positions until filled. This really needs to be reviewed and revised to accommodate the current needs in the service units. I do commend Commander Lyons and Albert Bowie for doing an excellent job in maintaining the structure to its best ability, but could and would do so much more if their hands were not tied in the hiring process. They have great ideas in planning for efficiency and accountability and put several into place, but are capable of doing so much more which will in turn provide improvement in services.

It is imperative that more funding become available to meet the increasing needs and that those who are eligible and are members from tribes outside of our service unit areas be reimbursed for providing services for them from their service units because they receive funding for them, yet deplete our service units funding by providing them services as they can not be denied. Balance is needed so that all the service units through out the USA can begin billing for services provided to those outside their areas and maintain their budgets for the members they are funded for.

The RPM's system is a vital tool in providing Congress documentation of what our tribes are providing as an extension the care they provide to our tribal members. However, it has not yet been set up at our tribal offices for one reason or another. I would like to see that this is given priority so that it documented of all that is done at the grass roots level. I also do not understand the EPI and RPM's differences, as I see it as

a conflict in putting out the correct information when it comes to diabetic care and prevention program initiatives. They should both work together to get a true number of services and activities being administered to prove our efforts are there and are working so that we can begin working towards increasing our funds provided for us through Congress vs. the continued decrease we have witnessed over the years. We can prove our worth through consistent documentation.

These are some of our current concerns that are in need of change. If you have any questions, you may contact our Health & Human Services Department Manager, Venus Montoya-Felter at (505) 455-2036 ext. 112.

Sincerely,

Ernest Mirabal

Ernest Mirabal, Sr., Governor
Pueblo of Nambe

Cc: Venus Montoya-Felter, HHSD Manager
Irene Tse-Pe, Tribal Administrator

-WOHEHIV-
The Morning Star

NORTHERN CHEYENNE TRIBE
ADMINISTRATION
P.O. BOX 128
LAME DEER, MONTANA 59043
(406)477-6284
FAX (406)477-6210

RECEIVED
MAY 21 2008
I. A.

-WOHEHIV-
The Morning Star

By E-Mail to comments@indian.senate.gov and Facsimile to (202) 228-2589
Original by U.S. Mail

May 5, 2008

The Honorable Byron L. Dorgan, Chairman
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Re: Indian Health Service Contract Health Services program

Dear Senator Dorgan:

This letter responds to your request for comments regarding the Indian Health Service ("IHS") Contract Health Services program. We appreciate the opportunity to submit comments regarding this critically important IHS program.

As background, members of the Northern Cheyenne Tribe receive medical services from the IHS in Lame Deer, Montana, and through programs contracted by the Northern Cheyenne Tribal Health Department. The IHS-operated Northern Cheyenne Health Center provides outpatient ambulatory and 24-hour urgent care services. Optometry, Dental, Physical Therapy, Behavioral Health, Laboratory and Radiology services are also provided. No hospital services are available in Lame Deer. The Northern Cheyenne Tribal Health Department provides Community Health Services, such as Public Health Nursing, Community Health Representative, Health Education, Recovery, and Behavioral Health services under an Indian Self-Determination Act contract with the IHS.

The direct services available at Lame Deer are supplemented by Specialty Clinics, where select specialists come to Lame Deer once or twice a month to provide limited specialty care, and the Contract Health Service ("CHS") program, under which patients are referred out to non-IHS providers to receive care which is not available at Lame Deer. The CHS program is critically necessary due to the remoteness of the Northern Cheyenne Service Unit and the lack of local hospital services. Very limited hospital services are available at the Crow Hospital – about 50 miles from Lame Deer. Any acute condition must be referred to Billings, Montana – over 100 miles away, and the nearest specialty hospitals (heart, pediatrics) are in Denver, Colorado. In addition, the Northern Cheyenne Service Unit experiences a high level of traumatic injury cases requiring hospitalization. Many of these cases must be sent by medical helicopter to Billings or other locations, at a

minimum cost of $10,000 per flight. Thus, several factors contribute to the high level of need for services which cannot be provided directly by IHS and which must be obtained from private providers through the CHS and Castastrophic Health Emergency Fund ("CHEF") programs.

The IHS Northern Cheyenne Service Unit received $2.5 million in Fiscal Year 2008 for its CHS program. In Fiscal Year 2007, the Northern Cheyenne Service Unit received $2.5 million, and exhausted these funds by August. The Service Unit's allocation of CHS funds does not last a full fiscal year, and even operating at the highest level of medical priority, the CHS program operates in a deficit for part of each fiscal year. After funds are exhausted in any given fiscal year, the Service Unit attempts to continue providing referral services through supplemental funds provided by the Billings Area Office, or through attempts to obtain authorization to use third party collections for CHS purposes. In the event the Service Unit does receive additional CHS funds from the Area Office, however, these funds must be paid back the following fiscal year, which perpetuates a vicious cycle in which current year CHS funds are never adequate. When CHS funds are depleted at the local level and supplemental funds cannot be obtained from the Area, the Service Unit must refer patients out for critically needed care, and request authorization to use carryover funds, if any are available, to cover the deficit. While these authorizations are usually eventually granted, vendors sometimes go for months without receiving payment for services provided. Based on IHS's resultant poor payment history, some providers refuse to provide services without a purchase order in advance which results in patients being denied or delayed care, and others simply refuse to contract with IHS.

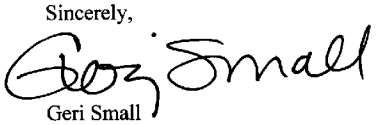
Tragically, but of necessity, the Northern Cheyenne Service Unit must follow IHS medical priorities in its use of CHS funds. The Service Unit's allocation of CHS funds does not cover a full year of CHS needs at the highest level of medical priority (emergent care), much less allow providers to routinely send patients for preventive screenings and care, that are recommended and the medical standard of care in a non-IHS setting. For each of the past few years, the Northern Cheyenne Service Unit has issued between 300 and 500 denials of needed referral care, another 300-500 deferrals of needed care. Examples include 1) there are insufficient funds to send patients for routine mammograms and other preventative screenings; 2) there are insufficient funds to refer patients for cancer screenings when medically indicated; 3) specialty services such as rheumatology are deferred leading to increased patient morbidity; and 4) orthopedic procedures for chronic conditions are delayed resulting in severe patient limitations and suffering, as only the most urgent of cases can be approved for CHS referral. As another example, many Cheyenne people have rheumatoid arthritis and are on prednisone, which is known to cause osteoporosis. The DEXA scan is the standard of care to monitor osteoporosis. Due to limited funds, this test is not offered at the IHS Lame Deer or Crow facilities. As a result, there is no way to effectively monitor the effectiveness and effects of prednisone treatment. As a result, you will see elderly grandmothers stooped over with a humped back, which is the classic sign of the progression of osteoporosis.

Practicing medicine in this way also takes its toll on the Service Unit's efforts to recruit and retain providers. The Service Unit has lost good providers because they know what our patients need but are unable to access the services they need through the current system. After relocating to Billings, one provider commented on the relief he felt at no longer having to deny patients needed care. Another provider refuses to attend CHS meetings because it torments him to be involved in denying needed care to patients. Community members comment that the IHS Health Center has "killed family members" because it has delayed cancer treatment and other services for six months and longer after the care is medically indicated.

As shown through the examples above, the deficiencies in the CHS program adversely affect efforts at Health Promotion and Disease Prevention, one of IHS's proclaimed three main health initiatives. CHS funds are simply not available to provide preventive tests, such as mammograms and early cancer detection screenings, which are the standard of care in a non-IHS setting. The shortcomings in the CHS program are primarily due to the wholly inadequate funding of the program. The Administration's requested increase of $8.8 million in the FY2009 budget request is not sufficient to begin to remedy the problems. A realistic review of the CHS needs of the Northern Cheyenne Tribe, and all tribes, needs to be conducted to arrive at a funding amount which will realistically address the health needs of Indian people.

Thank you for the opportunity to submit these comments regarding the Indian Health Service Contract Health Service program.

Sincerely,



Geri Small
President

TULE RIVER INDIAN HEATH CENTER, INC. (TRIHCI)
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June 23, 2008

RECEIVED
JUL 07 2008

Senator Byron Dorgan, Chairman
Committee on Indian Affairs
United States Senate
838 Hart Office Building
Washington, DC 20510
FAX: 202-228-2581

RE: Opposition of Proposed Funding Reductions to the Indian Health Service (IHS) in 2009

Dear Senator Dorgan:

On behalf of the Tule River Indian Health Center, Inc. (TRIHCI) and the Indian population of Tulare County, I am writing to express concerns regarding proposed reductions in the President's tentative budget for Fiscal Year (FY) 2009 for the Indian Health Service (IHS) of the Department of Health and Human Services (DHHS). Specifically, the proposed $11 million dollar funding reduction to the Alcohol & Substance Abuse Services line item, elimination of the Urban Indian Health Programs' entire budget of $35 million dollars, and a $14.4 million dollar decrease in funds for Indian health professions would place an enormous burden on Indian Health Service, Tribal, and Urban (I/T/U) health programs to meet the growing needs of our Indian people. I therefore appeal to your sense of historical and ethical responsibility to exercise your voice in opposition to these reductions.

IHS provides a comprehensive health service delivery system for over 1.9 million American Indians and Alaska Natives across the United States. In many cases, I/T/U facilities provide the only means of access to healthcare for Indian people, and thus the President's budget cuts to critical components of the health care delivery in Indian Country is distressing. Consider the following information:

The Prevalence of Alcohol and Substance Abuse in Indian Country

Recent statistics demonstrate that American Indians die a higher rate than other Americans from alcoholism and substance abuse. Indeed, some studies report this mortality rate as high as 550%, and consequently an $11 million dollar budgetary loss would devastate the efforts to provide alcohol & substance abuse services, including preventive and treatment-based care efforts in Indian Country. In their current state, these services have been developed out of a holistic and culturally-based approach to reduce dependency on drugs and alcohol.

We are also concerned that the elimination of $14 million dollars for Methamphetamine and Suicide Prevention Program in the IHS, as found in the FY 2008 appropriations, will have serious impact on the agency's ability to address related problems in Indian Country, including suicide prevention, mental health, and behavioral issues involving methamphetamine.

Indian Health Professions Program

The Indian Health Professions program was created for the purpose of promoting the recruitment and retention of qualified health professionals in IHS through scholarship and loan repayment incentives. With growing competition from the private sector, programs and incentives such as these are needed to attract and retain

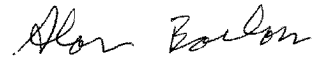
quality Indian health professionals to Indian Country. Moreover, in a society where cultural relevance is important, it is critical to retain dedicated health professionals who have earned the trust of the community. A reduction of over $14 million dollars to the Indian health professions line item will inevitably result in substantial reductions in the number of scholarships and loan repayments awarded. Based on the information presented for FY 2009, only an estimated 188 scholarships would be awarded compared to 442 scholarships awarded in 2007. This equates to a reduction of over 60% in the funding of health profession scholarship and loan repayment programs, and this is unacceptable when reduced applicant pools, increased tuition costs, and rising costs of living contribute to the hard realities of recruitment and retention of high-quality providers.

Reduction in Urban Indian Health Program:

The President's budget proposes the elimination of $35 million dollars for the urban Indian program. 36 Urban Indian Health Organizations currently provide culturally-appropriate healthcare to over 150,000 American Indians and Alaska Natives (AI/ANs) residing in urban centers. Many of these AI/ANs and their descendants reside in urban areas as a result of Federal relocation programs of the 1950s, as a result of employment, or as a result of attending institutions of higher education. This is the third year that this Administration has "zeroed" out the urban Indian program despite compelling evidence of growing needs in these areas. The IHS budget justification indicates the urban Indian funding was reallocated to tribal communities on or near the reservation. However, this Administration has failed to conduct any related studies, nor has it consulted with Tribes and Tribal organizations, regarding the impact the elimination of the urban program would have on tribal health delivery systems and whether this reallocation of funding would be sufficient to provide services to a potentially new population. The elimination of funding to the urban Indian programs is an extension of this Administration's belief that its trust responsibility to AI/ANs—codified in numerous treaties, supported by the Constitution of the United States, and reinforced by numerous Supreme Court decisions—is limited to the reservation. Even the language of the Snyder Act authorizes appropriations for the "benefit, care, and assistance of Indians throughout the United States." Consequently, the elimination of the urban Indian program could be interpreted as an initial step of regression from historical fidelity to the Federal government's trust responsibility to provide these services to AI/ANs, regardless of where they might reside.

In conclusion, although there were some increases to a few IHS programs, these tokens do not address the difficulties within an agency which finds itself perpetually under-funded despite evidence of growing needs and explicit calls to honor trust responsibilities as intended. Moreover, the proposed cuts to the specific programs mentioned herein serve only to widen disparities between the need for healthcare and its provision. We therefore urge you to not only protect all existing IHS programs, but to also increase the funding that flows into these vital services insofar as you are able.

Respectfully,



Alan Barlow, MS, MSHR, SPHR
Chief Executive Officer

Cc: Neil Peyron, TRIHCI Health Advisory Board Chairman
Yolanda Gibson, TRIHCI Health Advisory Board Member
Gayline Hunter, TRIHCI Health Advisory Board Member

July 7, 2008

Robert G. McSwain
Director
Indian Health Service

Dear Director McSwain:

I visited the Indian Health Service facility in Belcourt, North Dakota on the Turtle Mountain reservation last week.

Frankly, nothing has changed there with respect to physician recruitment.

I had been led to believe by you and others that substantial activity was taking place to remedy the shortage of health care professionals, etc.

The Director of Physicians has indicated to me that he has had no contact and nothing has happened on the matter.

The Director of the Aberdeen Indian Health Services office was there. She indicated that she has only been in her role only a few short months. But there was no evidence from my standpoint that something was happening that is going to fix this.

She indicated they are taking a look at a pilot program for "direct hire." I was a little surprised that a health facility of the type that exists in Belcourt with the problems that they have do not have direct hire authority. The absence of direct hire authority means that by the time they run these issues through the regional office they lose time and candidates.

But, at any rate, I was led to believe that things were happening to correct the problems at Belcourt and having met with the professionals at Belcourt in a roundtable discussion for an hour, it appears to me almost nothing has happened. Can you give me a response to what is underway that is going to help solve those problems? And also why I was led to believe something was happening when it appears almost nothing has happened?

Sincerely,

Allison
John
Eb
Ben
Amber

NORMAN J. COOEYATE
Governor
DANCY SIMPLICIO
Lt. Governor
SHELLY C. CHIMONI
Head Councilwoman
DIXIE J. TSABETSAYE
Councilman

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CARLETON P. ALBERT SR.
Councilman
ARDEN KUCATE
Councilman
WINONA S. PEYNETSA
Councilwoman
CHARLOTTE T. BRADLEY
Councilwoman

Officially known as the Zuni Tribe of the Zuni Indian Reservation

June 24, 2008

RECEIVED
JUL 07 2008

Honorable Byron Dorgan, Chairman
United States Senate
Committee on Indian Affairs
Washington, DC 20510

Re: Oversight Hearing on "Access to Contract Health Services in Indian Country"

Dear Chairman Dorgan:

On behalf of the Zuni Tribe, I am writing this correspondence to the Committee on Indian Affairs in regards to the hearings that have been scheduled about how the Indian Health Service Contract Health Service (CHS) is working within their health delivery areas and its impacts to Native American communities.

It should be noted that IHS, with its limited resources, is the first line of defense against poor health within all Native American communities. Without these services, the health status of NA populations would be worse than it is now. The lack of adequate funding is the primary factor impacting the health status and delivery of health care services within Indian county. Thus it is our understanding, CHS is a separate line-item budget appropriated by Congress to help pay for medically necessary services from a non-IHS hospital, doctor, or other type of provider when services are not available with IHS healthcare facilities. Payments for these non-IHS services are dependent upon availability of funds and other CHS eligibility criteria, which have their own set of rules that are somewhat complex and confusing to patients and to IHS staff. IHS Service Units constantly struggle to meet the needs of their patients as CHS cases are unpredictable from one year to the next. During the good years less trauma and/or high risk acute or chronic cases are experienced, while in the bad years the opposite is the case. In the good years, CHS funding allocation can be stretched to pay for all eligible non-IHS services; however, in the bad years it becomes a struggle even paying for some the high priority cases.

The inadequate allocated CHS funds have made it necessary for IHS to establish the following medical priority levels. **Priority I** is services required to prevent immediate death or serious impairments. **Priority II** is services for potentially life-threatening or severe handicapping conditions. **Priority III and IV** is services to better aid patient functioning, but not necessarily leading to death or serious impairment.

Zuni-Ramah IHS Service Unit (ZRSU), serving the Zuni community and the Ramah Band of Navajos, because of inadequate funding, primarily restricts payments to **Priority I and II** when access to other IHS facilities is exhausted. Payment for Priority II (diagnostic tests, etc.) are necessary to prevent potentially life-threatening or severe handicapping conditions, for our community populations which are considered high risk for diabetes and its complications; end stage renal disease; heart failure and other conditions such as high risk pregnancies and neonatal; trauma due to motor vehicle accidents; and mental health/substance abuse. In most cases, less serious illnesses or injuries must get significantly worse before they are covered under CHS guidelines.

Currently, the ZRSU annual CHS recurring budget is $2,765,525 for FY2007. ZRSU's annual CHS expenditures have been consistently exceeded the recurring budget allocated by Congress. The following is what ZRSU paid out in CHS expenses for each fiscal year (includes hospital, physician and other cost associated with the care):

Fiscal Year	Amt. Paid	# Patients	Avg. per Patient	Recurring Budget	Budget Deficit
2004	$3,298,466	869	$ 3,796	$ 2,465,683	**-$ 832,783**
2005	2,874,097	787	3,652	2,465,683	**- 408,414**
2006	2,971,117	623	4,769	2,573,398	**- 397,719**
2007	3,194,262	761	4,197	2,765,525	**- 428,737**

In addition to the inadequate CHS funding, community members are denied payment for health services, by the strict CHS eligibility criteria. The following table illustrates each fiscal year how many and why payment for non-IHS services were denied (this does not include other CHS denial categories, alternate resource available, not CHS eligible, availability of IHS facility):

FY	ER Notification Not Within 72 Hrs.	No Prior Approval for Non-ER	Eligible But Care Not Within Medical Priority	Lives Outside Z-RSU CHSDA	No ER Notification Within 30 Days for Elderly or Disabled	Total
2004	22	3	43	163		231
2005	28	9	46	156	1	240
2006	21	11	22	144	1	199
2007	14	10	36	147		207

As illustrated, a majority of annual denials are due to Zuni tribal members not residing on or near their CHS Delivery Area (CHSDA). When a Zuni tribal member who resides within the Albuquerque Area (Bernalillo or Sandoval County) and are not full-time student attending a higher education institute, they are not CHS eligible because Zuni Tribe's Reservation does not border Bernalillo County. The Zuni tribal member would not be eligible for Albuquerque IHS Health Center (AIH) either because Zuni tribal members are not part of AIH's CHS delivery area. They are responsible for payment of their own healthcare received from non-IHS providers and hospitals. Other Zuni tribal members that live throughout the United States are also ineligible since they do not reside on or near their CHS Delivery Area. In order to allow coverage of all tribal members, a request could be made in accordance with IHS regulations to make the state of New Mexico a CHS delivery area, particularly for Zuni since Ramah Navajo would be deemed eligible for AIH's CHS if patients register and apply for CHS with them.

However, huge amount of additional funding will be required to cover all of our community members residing within the State of New Mexico.

ZRSU would have needed additional CHS funding, as noted below, to cover the annual deficits plus the denied visits had all cases been considered for payment. Fortunately ZRSU was able to cover its annual CHS deficits from other sources (e.g. private insurance, Medicaid/Medicare, other 3rd party collections); however, it took away from meeting other operational needs. Requests to purchase clinic items/equipment, to hire additional staffing, to consider facility improvements and others had to be deferred or denied. The following table illustrates the total CHS needs:

FY	# Denials	X Avg. Cost Per Patient	Sub-Total	+ Deficit	= Total Need
2004	231	$ 3,796	$ 832,876	$ 832,783	**$ 1,709,659**
2005	240	3,652	876,480	408,414	**1,284,894**
2006	199	4,769	949,031	397,719	**1,346,750**
2007	207	4,197	868,779	427,737	**1,296,516**

Other than the known "additional and adequate CHS funding," there is a concern regarding clarity on CHS regulations or eligibility criteria. CHS regulations are not consistently applied due to misinterpretation or misunderstanding of IHS policy, which creates confusion amongst CHS staff from one Service Unit to another Service Unit. Perhaps a review of the Contract Health Service policy (under the IHS Manual, Services to Indians and Others, Chapter 3) regulation language is warranted to include examples, in aide in the correct understanding or interpretation of the regulations. Some areas misinterpreted are as follows:

1. Residency – CHS eligibility requirements cites "To be eligible for CHS, an individual must: (1) reside within the U.S. and on a reservation located within a CHSDA; or (2) reside within the U.S., and within a CHSDA, and be a member of the tribe or tribes located on that reservation or maintain close economic and social ties with such tribe or tribes." This is being misinterpreted by some to mean that only tribal members of that reservation are eligible for that CHSDA and exclude other tribal members residing on their reservation. First example: A Zuni tribal member residing on another tribe's reservation and part of a household member in that tribe is denied CHS coverage because the facility's CHS program cite that the Zuni tribal member must be legally married into the other tribe. It is difficult to require tribal members to marry within their tribe or to others from another tribe, when the practice of marriage is a foreign concept for most Native Americans. Common law practices have been in existence for generations of Native Americans, knowing that receipt of benefits requires a marriage license, and has been continued to be practice by Native Americans prior to the arrival of Columbus. Why do we continue to penalize those that choose to maintain a marriage based on traditional practice? Second example, a tribally run health facility operated under P.L. 93-638 Indian Self-Determination Act would deny a different tribal member residing on their reservation access to CHS citing the same – that the NA is not a tribal member of that reservation similar the example noted above. Why deny services when the intent of P.L. 93-638 was to allow tribal governments the ability to determine how best to provide

services to their community members. All NA within a reservation should be eligible to receive services regardless of whether they are tribal members of that reservation or not.

2. Social and Economic Ties versus Residency – Under Social and economic ties criteria regulations cite that the basis for determining close, economic and social ties are established by: "(i) employment with a tribe whose reservation is located within a CHSDA in which the applicant lives; (ii) marriage to, or being a 'child of an eligible member of the tribe, or (iii) determination by the tribe, including certification from the tribe or tribes near where they live that have close economic and social ties with the tribe whose reservation is located with a CHSDA in which the applicant lives." An individual claiming eligibility under social and economic ties is responsible in furnishing documentation to substantiate their claim.

   This is often unclear to CHS staff, particularly when a tribal member has permanently moved away from their reservation for more than 180 days and has established physical residency elsewhere (e.g. Albuquerque), nor are they a full-time student at a higher educational institute. The relocation might have been for employment purposes, since most rural tribal communities lack adequate economy to provide employment to all members. Tribal members return to their reservations citing their need to participate in tribal religious activities, to visit when traditional activities occur, or may return to their reservation on the weekends even though they have established residency off reservation. Clarity is needed in this area. If the official residency is off reservation, and the tribal member returns home for the weekend, does this mean that the tribal members reestablishes residency for CHS eligibility once they enter their tribal reservation. A clear definition of "establish residence" needs to be provided, especially when a tribal member returns to their reservation for 1 hour, 1 day, week, month or more/less than 180 days.

Additional concerns related to CHS include:

1. All parts of the IHS delivery system must be evaluated and/or addressed for overall improvements. CHS is only one part of this delivery system, and other parts of the system must receive adequate funding not only for illnesses and injuries, but for prevention type services.

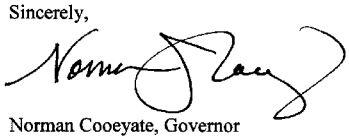
2. Not all non-IHS provider organizations are bound by the legislation for Federal Medicare-like rates. Private or non-IHS physician provider groups and air ambulance services charge very high rates that greatly impact local CHS budgets. Congress should take action to change legislation for Federal Medicare-like rates to include all providers of health service to HIS and tribal health care facilities that are operated under P.L. 93-638.

3. A know fact is that chronic illnesses or conditions require long term commitment of CHS dollars, especially for those individuals who do not qualify for Medicare. Congress should appropriate another long term care CHS fund to meet the needs of chronic care patients requiring: rehabilitative care due to head trauma, injury or other diseases, cancer care, dialysis or debilitating birth effects.

In closing, I want to thank you for giving me this opportunity to provide this documentation as part of the discussion on IHS CHS funding and services, and its impacts to the Zuni Tribe. I hope that our experiences with the CHS regulations, eligibility criteria, our understanding and confusion of such will assist the committee making the appropriate recommendations to improve the health status and delivery of IHS services throughout Indian country, especially for the Zuni Tribe.

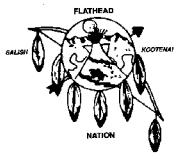
If you have any more questions or require additional information, you can reach me at (505) 782-7023 or via e-mail at ncooey@ashiwi.org. With all our prayers and blessings for good health and prosperous year from our village to you and your family and staff, I bid you a good day.

Sincerely,



Norman Cooeyate, Governor

Cc: Senator Lisa Murkowski, Vice-Chairman (R-AK)
Senator Pete Domenici (R-NM)
Senator Daniel Inouye (D-HI)
Senator John McCain (R-AZ)
Senator Kent Conrad (D-ND)
Senator Tom Coburn (R-OK)
Senator Daniel Akaka (D-HI)
Senator John Barrasso (R-WY)
Senator Tim Johnson (D-SD)
Senator Gordon Smith (R-OK)
Senator Maria Cantwell (D-WA)
Senator Richard Burr (R-NC)
Senator Claire McCaskill (D-MO)
Senator Jon Tester (D-MT)



THE CONFEDERATED SALISH AND KOOTENAI TRIBES
OF THE FLATHEAD NATION
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A Confederation of the Salish, Upper Pend d'Oreilles and Kootenai Tribes

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Steve Lozar – Secretary
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Charles L. Morigeau
Terry L. Pitts

JUN 12 2008
Indian Affairs

May 29, 2008

Honorable Byron L. Dorgan
Chairman, Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington DC 20510
VIA FAX: 202-228-2589

Re: Contract Health Services Program of the Indian Health Service, U.S. Department of Health and Human Services

Dear Senator Dorgan:

On behalf of the Salish, Kootenai, and Pend d'Oreille people of The Confederated Salish and Kootenai Tribes (CSKT), it is my duty to provide comments regarding the Contract Health Services Program of the Indian Health Service. The CSKT extends its appreciation to you for providing this opportunity, and we commend you and the Committee for your commitment to improve health care services and health status for American Indians and Alaska Natives.

The CSKT's homeland is the Flathead Indian Reservation in northwestern Montana. Under the 1855 Hellgate Treaty, the Salish, Kootenai, and Pend d'Oreille people ceded over 20 million acres of indigenous territory in exchange for a permanent homeland of 1.3 million acres. At present, there are approximately 7,200 enrolled CSKT members of which two-thirds reside on the Reservation.

Since October 1993, the CSKT has operated its health care delivery system through funding agreements with the Indian Health Service under the Indian Self-Determination and Education Assistance Act, as amended. At present, the CSKT is serving an estimated user population of 11,085 (as of FY 2007) with total annual expenditures of approximately $16.5 million (IHS funding, grant funding, and third-party collections). ***This is an average of $1,500 annually per user, and is far below the amount per user spent by Medicaid, Medicare, Veterans Administration, mainstream health insurers, and for persons incarcerated in federal prisons.***

Since the establishment of the Reservation, health care has been provided to our Indian people largely by the private sector. By 1955 when the Indian Health Service was established, it

continued the trend of purchased care through Contract Health Services (CHS). There has never been an Indian Health Service hospital on the Flathead Reservation and perhaps never will be under the current funding and methodology for construction of health care facilities. Therefore, the majority of the Indian Health Service user population has received primary, specialty, and hospital care through CHS-purchased services from the private sector. There are two hospitals on the Reservation (St. Luke's Hospital in Ronan, Montana and St. Joseph's Hospital in Polson, Montana) and four hospitals near the Reservation (Kalispell Regional in Kalispell, Montana; St. Patrick's Hospital and Community Medical Center in Missoula, Montana; and Clark Fork Valley Hospital in Plains, Montana).

In October 1993 the CSKT began operating all programs, functions, services, and activities that had been carried out by the IHS Flathead Service Unit, including Contract Health Services. However, the demand for CHS-purchased services and the continual increase in CHS expenditures—which was not matched by increased funding—forced the CSKT to return the CHS program to IHS in October 2005. By that time the CSKT was spending twice as much for CHS—$17 million—as was allocated. For several years the CSKT attempted to resolve the issue with the Indian Health Service but ultimately, retroceding the CHS program was the only option. To date, CHS remains the only program ever returned to federal management by the CSKT after we had assumed it under self-determination or self-governance.

Some of the specific examples of how Contract Health Services is not adequately serving our user population are described below:

- **Sleep apnea untreated (50 cases)** – The Indian Health Service, CHS does not pay for sleep studies nor the C-pap therapy prescribed after the sleep study. This would save lives – patients would not need to wait until their situation became "life threatening".

- **Denial of MRI's and CT scans (450 cases)** – The IHS, CHS has denied payment of MRI's and CT scans leaving the patient without a diagnosis and leaving the patient in pain; and for some patients, the inability to go back to work because of the pain and the inability to use their limbs. Many times, the patient is prescribed pain medication and some become addicted to the pain medicine. This in itself has caused many problems and additional funding is needed to take care of this addiction problem. Surgery may be required, but without the appropriate testing this cannot be determined.

- **Denial of cholecystectomies (30 cases)** – The IHS, CHS continues to deny these because they are not "life threatening" conditions, but IHS, CHS will pay for the inpatient hospitalizations and emergency room visits related to this condition that the patient requires to mitigate the condition and the dollars expended amount to more than the amount that the surgery would have cost. In the meantime the patient's health and well-being is compromised because this truly can be a debilitating disease. Patients lose many hours of work because of being sick.

- **Denial of cardiac rehabilitation, physical therapy, and occupational therapy (25 cases)** – The IHS, CHS won't pay for therapy before surgery to prevent surgery, nor after surgery, leaving the patient in a situation whereby he could lose his life or limb. Surgeons are telling us they are very concerned with 'quality of care' issues and for the well-being of the patient without these therapies. In fact, surgeons don't want to care for these patients if the patient cannot get the full spectrum of care. The CSKT's Tribal Health Department was recently notified by an orthopedic provider off the Reservation that they would no longer accept any new patients whose primary insurance is IHS or Tribal Health, noting "It has become apparent through conversations with staff at Tribal Health as well as IHS that orthopedic care is not a priority for IHS" and "...given our physicians do not feel that they have been allowed to exercise their best clinical judgment in caring for these patients, we have no choice but to suspend working with IHS and Tribal Health as health care payers." (April 13, 2008 letter from Missoula Bone & Joint Surgery Center)

- **Denial of diagnostic testing if not "life threatening" (125 cases)** – Without testing, many cases of life threatening circumstances have gone undiagnosed until it is too late and the patient either passes on or lives a very short, painful time. Colonoscopies are recommended, nationwide, for individuals age 40 and over. The IHS, CHS has denied payment for these diagnostics.

- **Denial of minor surgical procedures (25 cases)** – The IHS, CHS won't pay for tonsillectomies, adenoidectomies, or ear tubes for children and adults. As a result, the children are sick often and they cannot function at school nor can they join in activities that other children are doing. With all the programs that exist to encourage our children to stay in school and to do their best, chronic tonsillitis can be very debilitating and does cause a lot of absenteeism. Also, there are many documented cases of children with speech delays due to abnormal tonsils and adenoids which further cause problems with development.

- **Denial of specialty care services (1,150 cases)** – With healthcare becoming specialized, the primary care physicians (PCP) increasingly refer patients to specialists for further testing, diagnoses and treatment. The IHS, CHS has denied payment for such referrals.

- **Denial of Skilled Nursing Home Care** – The IHS, CHS does not pay for and will not supplement Medicare with Skilled Nursing Home Care days, leaving our most fragile population, our elders, in an unsafe environment. In the past, families took care of their parents and grandparents, but in this new day families have had to rely on nursing homes to help with the care of their elders. These elders do not have alternate resources, i.e., Medicaid, available to them because of over-resource and/or income. With every hospital admission our elders can potentially become a skilled nursing home patient so this number constantly varies.

Between April 2007 and January 2008, the CSKT underwent a long-term strategic planning process in order to effectively plan for health care needs for the next decade. The results of the planning process recommended that we expand the primary care services we deliver in our Tribally-operated program because we have a better opportunity to serve our population's needs rather than the current CHS-dependent scenario. However, the strategic concept requires over $80 million to construct, equip, and staff two facilities. The concept is successful if third-party collections can increase to offset the cost of providing more health care services. But until that concept can be implemented, the CSKT must continue under the current inadequately funded health care delivery system. In that respect, we strongly advocate for substantial increases in the amount of CHS funding appropriated by Congress. The enacted FY 2008 amount of $579 million is only half of the need. For the last seven years, Contract Health Services has been the number one priority expressed by the tribes served by the Billings Area as part of the annual IHS Budget Formulation process. These tribes are located on the seven Reservations in Montana and the one Reservation in Wyoming. In this two-state region, only two Indian Health Service hospitals are in operation—at Crow Agency, Montana and at Browning, Montana. For that primary reason, there is a significant need for CHS-purchased services for the more than 70,000 eligible Indian users in the Billings Area.

The CSKT thanks you and the Committee for your consideration of our comments. We look forward to continued dialogue and discussion to resolve the urgent issue of health care needs for all of Indian country. Please contact us if you have any questions.

Sincerely,

THE CONFEDERATED SALISH AND KOOTENAI TRIBES

James H. Steele, Jr., Chairman
Tribal Council

Copied to:
Senator Max Baucus
Senator Jon Tester
National Indian Health Board
Montana-Wyoming Tribal Leaders Council
Self-Governance Communication and Education Project
IHS-HQ – Mr. Robert McSwain, Director, Indian Health Service
IHS-BAO – Mr. Pete Conway, Area Director, Billings Area
CSKT – Kevin Howlett, Tribal Health Department Head

MAY 29 2008

May 7, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20052

Re: Pueblo of Jemez Comments on Contract Health Services (CHS)

Dear Chairman Dorgan:

On behalf of the Pueblo of Jemez, I am submitting the following comments regarding the CHS program in response to your solicitation of comments dated March 27, 2008. The Pueblo of Jemez, pursuant to P.L. 93-638, contracts with the Indian Health Service (IHS) for a major part of CHS for our tribal members. Our CHS budget is approximately $648,517. We are currently in a transitional situation with our contracting of CHS in that we are responsible for management of referrals for our eligible tribal members to outside medical providers and the processing of purchase orders for those referred services. The Pueblo of Jemez administers the CHS process up to the point that the Albuquerque Service Unit's (ASU) CEO applies electronic signatures for committing funds and making payments to providers. Further, Jemez currently cooperates with the Indian Health Service to utilize IHS provider and fiscal intermediary contracts. Through this cooperative working relationship with IHS, Jemez plans to complete transition to full tribal responsibility for CHS in the next fiscal year.

General CHS Resource Issues

Having become involved in the management of CHS funds for our Jemez people, we are acutely aware of the limitations of CHS resources and the need to enroll our people in any alternate resource program that might relieve the need to use CHS funds for referrals to outside providers; however, the need in Jemez for CHS is still significant. Since contracting its management, we approach the end of each fiscal year with some anxiety regarding whether or not our CHS funds will cover our obligations. We are acutely aware of the prospect that one or two catastrophic cases could deplete our entire CHS budget. In addition, the Albuquerque Area will generally notify Jemez that CHEF funds are exhausted well before the fiscal year. Therefore, this relief, in cases that exceed $25,000, may not always be there when we need it. As no real "management cushion" exists for CHS, the appropriation of additional dollars for both CHS and CHEF by the Congress is a standing request from the Pueblo of Jemez.

Office of the Governor
5517 Highway 4, Box 100 • Jemez Pueblo • New Mexico • 87024
(505) 834-0056 • Fax (505) 834-0136

Medicare-like Rates and Non-contracted Providers

In our limited experience with CHS and the implementation of Medicare-like rates, we believe they have helped in our conserving the dollars we pay out, ***except*** in cases where professional hospital fees must be paid to providers who do not have contracts with IHS. In the Albuquerque Area, no Air Ambulance services are contracted and flights can run $10,000 and more for billed charges. These air ambulance companies attempt to tack on significant interest charges for balances not paid in 30 days. Jemez experiences 2-4 air ambulance bills each year. This has significant impact on our limited CHS resources. Also, the large hospital systems in Albuquerque utilize physician groups most of whom are not contracted by the IHS/FI, and do not offer discounts. These provider organizations are not bound by the federal Medicare-like rates legislation, and this has significant impact on our limited resources. The Pueblo of Jemez requests that Congress take action to apply the Medicare-like rates legislation to all medical provider organizations that provide services to patients referred by the IHS or tribally operated programs pursuant to P.L. 93-638.

Critically Ill Patients

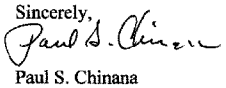
Each year Jemez experiences cases of critically ill patients with a diagnosis such as cancer with long medical stays and intensive treatments sometimes leading to death, or a long recovery period. When these patients do not qualify for Medicare for two years, and if we cannot get them on some type of disability coverage or Medicaid, CHS funds in these cases are rapidly consumed. These cases continue to concern us in the light of our limited CHS resources.

Conclusion

It is the opinion of the Pueblo of Jemez that while many details of the CHS process can be improved, the major contributing factor to the problems faced by individual Indian patients in the CHS system, whether IHS operated or tribally operated, is the limited CHS funding available.

We thank you for your continued advocacy for Indian health issues and your attention to this most critical of programs. We support your advocacy efforts to increase the Indian Health Service Contract Health Services budget.

Sincerely,



Paul S. Chinana
Governor

Sac and Fox Nation

Route 2, Box 246 Stroud, OK 74079

Principal Chief GEORGE THURMAN
Second Chief CHERYL L. McCLELLAN TOFPI
Secretary GWEN McCORMICK WILBURN
Treasurer MICHAEL W. HACKBARTH
Committee Member STELLA NULLAKE NANAETO

RECEIVED
MAY 21 2008

D-A-

May 06, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D. C. 20510

Dear Senator Dorgan:

The Sac and Fox Nation would like to extend our appreciation for you acknowledging the important issues surrounding Indian health care. The Nation would also like to thank you for actively listening to, and your willingness to work with Indian Tribes across the United States.

The Sac and Fox Nation is fortunate in it has an excellent ambulatory health clinic; furthermore, the Nation also has an excellent wellness center which is dedicated to the prevention and treatment of diabetes. The Nation's health care center is an access point for many people with a diversity of illnesses and diseases. However, having nice facilities and good professional staff does not eliminate suffering. The Sac and Fox Nation, as with most tribes, continue to struggle with inadequate funding to address the issues of chronic illnesses, disease patterns, behavioral health issues, and premature death.

The health disparities of American Indians/Alaskan Natives have been discussed and described and discussed again, at every opportunity, whenever and wherever someone would listen.

One such disparity every Tribe and Tribal health facility deals with on a daily basis is the Contract Health Service Program (CHS). If a patient needs specialty health services outside of the treatment available at a tribal facility, the patient must request a "referral." Once the patient's request is received it must go through a priority ranking process.

Questions must be answered to address the seriousness of the illness and/or injury. The tribal facility then must make an actual decision on which patients need the referrals the most. If the patient meets the highest priority, a life or death situation, then the patient will be referred to an outside provider, provided the tribal facility has the funding available. In short, referrals are based on a priority level and if the tribal facility has the

funding to support the required specialty services. Patients with low priority levels may get suspended to the next fiscal funding cycle or may be denied services altogether.

The Sac and Fox Nation has policies in place ensuring our CHS dollars are used only as a last resort. Patients must have private insurance or apply for Medicare and/or Medicaid before applying for Contract Health Services. Whenever CHS services are extended, the Nation uses its CHS funding only for whatever Medicare and/or Medicaid does not pay. In the case of cardiovascular disease or cancer, a single case would likely deplete the Nation's entire CHS funds, if the Nation does not use private insurance or Medicare and Medicaid resources.

Inadequate funding, prioritizing referrals and chronic disease patterns are all central components of insufficient patient care. The Nation understands the federal funding process is complicated. The Nation also fully realizes it is Native American issues and programs, which often take funding cuts. Nevertheless, the Sac and Fox Nation strongly supports an increase in funding for the Contract Health Services Program in order to ensure each individual Native American receives all the health care services needed to live a long healthy life. Thank you for your continued support on these serious issues facing Indian Country.

Sincerely,

George Thurman, Chief

Cheryl L. McClellan Tofpi, Second Chief

Gwen McCormick Wilburn, Secretary

Michael W. Hackbarth, Treasurer

Stella Nullake Nanaeto, Committee Member

SOUTHERN UTE INDIAN TRIBE

May 23, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

RECEIVED
JUN 4 2008

Re: Contract Health Services program

Dear Senator Dorgan:

This letter responds to your invitation of March 27, 2008, asking that tribal leaders provide comments regarding how the Contract Health Services (CHS) program is working and any problems that tribal communities face regarding health care. I appreciate the opportunity to submit these comments on behalf of the Southern Ute Indian Tribe (Tribe).

The Tribe is a federally recognized tribe with approximately 1400 members, most of whom reside on its reservation in southwestern Colorado. The medical needs of the Tribe's members are primarily served by the Indian Health Service (IHS), which operates the Southern Ute Health Center in Ignacio, Colorado. The Tribe's experience with IHS has been largely unfavorable.

Years ago, the Tribe recognized that chronic underfunding of IHS medical services directly contributed to tribal members being forced to needlessly suffer with illnesses that were either untreated or poorly treated and, in at least one case, the lack of CHS funds caused the death of a tribal member. In that case, a tribal member was not referred to an oncologist because IHS lacked the necessary CHS funds. When the funds finally did become available, the tribal member's cancer had progressed to the point that it was untreatable and she passed away. This seems to have been the result of the policy that reserves CHS funds for emergent cases, where life or limb is immediately threatened (Medical Priority I) and places all other cases on a deferred services list. Here, a death was the result of deferring services.

The Tribe considered this tragic situation to be intolerable, but realistically expected that neither Congress nor the Administration would address the situation by providing much needed funding for Indian health care services, including CHS. The history of federal indifference to Indian health care serves as dismal proof that the Tribe accurately predicted the federal commitment, or, more correctly, lack of any commitment, to concrete improvements to Indian health care.

P.O. Box 737 ✦ Ignacio, CO 81137 ✦ Phone: 970-563-0100

The Tribe is in the unique and fortunate position of being financially able to make a financial commitment to healthcare, despite the unwillingness of the United States to meet its trust obligations to provide adequate health care for Indians. The Tribe established a Tribal Member Health Benefits (TMHB) Department and a tribally-funded health resources pool. This funding pool pays the cost of health care referrals for tribal members when IHS does not have CHS funds available to cover the cost of a timely referral. While the Tribe is proud of what it has done with its TMHB system, the Tribe was compelled to take this step because Congress and the Administration consistently refused to meet its trust obligations to Indians, including the Tribe, in the area of health care services. In short, this was your job, not ours, but we stepped up to the plate when the United States would not.

Even with the Tribe filling the void of inadequate CHS funding, the situation at the Southern Ute Health Center is unacceptable. During FY2006, the Southern Ute Health Center issued 450 denials primarily because the services did not fall within Medical Priority I. The average CHS referral in FY2006 cost $664.00; therefore, to cover the cost of these referrals, the Health Center would have needed an additional $298,800. During FY2007, the Southern Ute Health Center issued 393 denials primarily because the services did not fall within Medical Priority I. The average CHS referral in FY2007 cost $417.00; therefore, to cover the cost of these referrals, the Health Center would have needed an additional $163,880.

Consequently, the Tribe's primary comment concerning the CHS program is simple and obvious: CHS has always been chronically under-funded and, for once, Congress should meet its trust obligations by approving a realistic level of CHS funding that meets actual needs in Indian Country for quality health care services. As you may be aware, Congress does not provide the same level of health care funding for Indians as it spends for federal prisoners. Until Congress makes actual funding commitments to the improvement of Indian health care, the words of such documents as the Indian Health Care Improvement Act, which nobly state that the United States has a responsibility "to assure the highest possible health status for Indians," are little more than political window-dressing designed to hide the ugly truth that Congress could really care less about the health status of Indians.

The Tribe understands that, realistically and to its bitter disappointment, it is unlikely there will be any new funding for Indian health care. Nonetheless, there are other measures that Congress could take that would eliminate pressure on limited CHS funds without requiring new funding. Section 506 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003,* Pub. L. 108-173, 117 Stat. 2066 (2003) (MMA), requires hospitals that participate in Medicare to not charge Indian health care facilities more than Medicare rates for contract health patients referred to them by Indian facilities. While this is helpful, it does nothing to contain or limit charges by individual health care practitioners. Most health care practitioners are not in-house employees of hospitals. Instead, hospitals provide a location for health providers to deliver health care services to patients. Consequently, the MMA rate limitations do not apply to the individual practitioners who deliver contract health-related services, regardless of whether those practitioners are Medicare participants. The Tribe suggests that the MMA rate limitations for hospitals were a good first-step toward managing the costs that are charged to contract health dollars and that an appropriate follow-up would be to now apply those limitations to *all* Medicare participants.

The Tribe also suggests that the tribal programs eligible for the MMA rate limitations be more inclusive. As discussed above, the Tribe has made up for CHS funding shortfalls by creating its own resource pool to cover the cost of tribal member referrals to facilities outside IHS. However, the Tribe does not presently operate its own health care facility. Local hospitals and health care practitioners bill TMHB for full charges of the health care services rendered to a tribal member patient who is covered by the tribal resource pool because the MMA limitations only apply to referrals made from a *facility* run by a Tribe or a tribal organization. The Tribe believes that you should explore also extending the MMA rate limitations to *any* tribally-funded *program* that pays the cost of tribal member contract health services.

There are other changes that could be made, short of amending the MMA, that would help reduce the cost of CHS referrals. At present, IHS Service Units, including the Southern Ute Health Center, are prohibited from entering into referral contracts with local health care providers. Instead, only the IHS Area offices are permitted to enter into such contracts. However, because, in the case of the Southern Ute Health Center, the Albuquerque Area Office has never established such contracts with local health care providers, the Health Center ends up spending more of its limited CHS funding on non-contracted providers who have not agreed through contract to limit their charges. Local IHS facilities should have the authority to enter into referral contracts with local health care providers in order to contain referral costs.

Your letter suggests that you may have a greater interest in addressing the problems created by the five eligibility criteria for contract health reimbursement. ("However, the program is not working well, and many individual Indians are often faced with having to pay enormous bills that are supposed to be covered by the federal government.") This appears to be a reference to problems such as the denial of eligibility when, for example, a patient fails to give notice of a potential contract health claim within the 72 hours prescribed by the regulations. 42 C.F.R. § 136.24. Before considering the eligibility criteria, the Tribe has one comment concerning a purely regulatory fix to CHS problems. If it is the goal of the Senate Indian Affairs Committee to address CHS inadequacies by such means as extending the 72-hour notification period, such changes *must* be accompanied by additional funding. As harsh as it may seem, the current eligibility criteria have the effect of allowing limited CHS funds to be stretched. If the regulations are revised to ensure that a greater number of cases are to be covered, then a larger pool of funds must be provided, otherwise the revisions would do little more than shift the impact of limited funding from patients at the front-end of the fiscal year to patients at the end of the fiscal year (whose claims will be denied when appropriated funds are exhausted).

There are six eligibility criteria that are a frequent source of disqualification for CHS coverage. These eligibility criteria, which are taken from federal regulations at 42 C.F.R. §§ 136.12, 136.23, 136.24 and 136.61, are as follows:

1. The patient must be person of Indian descent (§136.12);
2. The patient must reside on an Indian reservation within the contract health service delivery area of the facility responsible for payment *and* be a member of the tribe located on that reservation or maintain close ties with that tribe (§136.23(a));
3. The patient must meet medical priorities for the use of CHS funds (§136.23(e));

4. Because CHS is designated as a payor of last resort, the patient must not be eligible for any other alternative resources, such as Medicare or Medicaid (§136.61);
5. Notice has been provided to the facility responsible for payment for CHS services within 72 hours after admission or the beginning of treatment, which may be extended in emergent situations (§136.24); and
6. A purchase order for the use of CHS funds has been issued by the facility responsible for payment for CHS services to the outside health care provider (§136.24(a)).

These criteria are the source of confusion on both the part of patients and the outside health care facilities to which patients are referred. The Tribe is aware of patients being denied CHS coverage because it turned out that they were eligible for an alternative source of payment, but which they failed to actually access because of a lack of understanding regarding their eligibility or the procedure for obtaining coverage through that alternative resource. The Tribe is aware of patients who, because of their own lack of sophistication or the failure of the outside health provider to do so, did not provide 72-hour notice and who were therefore denied CHS coverage. The Tribe is aware of patients who have been denied services at the Southern Ute Health Center because they live close to, but not within, the Southern Ute Indian Reservation. The Tribe is aware that many patients are denied CHS coverage because their cases are not emergent or do not meet the highest level of medical priority.

The medical priorities that *are* covered are often questionable. Because of CHS funding limitations, the Southern Ute Health Center currently only considers Medical Priority I cases. The Tribe finds it deeply disturbing that gynecological tubal ligations, that is, sterilizations of Indian patients, fall within Medical Priority I, while other procedures (that do not have the taint of genocide) are lower priority.

Certainly, nearly all of these eligibility criteria could be revised to make them more humane and understanding of the problems facing patients with serious medical problems. The 72-hour notification period could be extended. A patient with alternative resources could be ineligible for CHS only where those alternative resources actually pay the patient's medical bill, rather than denying coverage when there is only theoretical eligibility for alternative resources. CHS coverage could be extended to lower levels of medical priority.

In making any of these changes, however, you must face the fact that the eligibility criteria are fundamentally designed to cut off claims in order to enable spreading already inadequate CHS funds to a greater number of cases. Realistically, none of these eligibility criteria can be made less draconian unless Congress first agrees to provide greater CHS funding. Discussion of revisions to the eligibility criteria is simply an exercise in futility until such a funding commitment is made.

In summary, therefore, the Tribe hopes that the federal government will finally put some action and funding behind what have thus far been only empty promises and words. The failure to adequately fund CHS has led to tragedy for the Tribe's members and we hope that, like the Tribe has done in response to that tragedy, Congress will finally live up to its commitment to stop the disastrous underfunding of healthcare services for Indian Country.

Sincerely,

Clement J. Frost, Chairman
Southern Ute Indian Tribe

the Chickasaw Nation HEALTH SYSTEM

Bill Anoatubby
Governor

Jefferson Keel
Lieutenant Governor

JUN 4 2008
RECEIVED

May 13, 2008

Honorable Byron L. Dorgan
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Dear Senator Dorgan:

Subject: Indian Health Service (IHS) Contract Health Services Program

Thank you for the opportunity to comment on the Contract Health Services Program for the Indian Health Service.

The Contract Health Services Program has been a problem for the last 20 years due to poor management and inadequate funding levels.

When the Chickasaw Nation took over the IHS program in the Ada Service Unit in Oklahoma under Self-Governance in 1995, the Indian Health Service owed millions of dollars for contract care to local physicians and hospitals. This problem was caused because the IHS would not pay its bills and would not refuse authorization of services due to lack of funds. Credit collection companies were taking Indian people to court and the local health providers were upset and taking it out on the Indian people.

The Chickasaw Nation recognized the challenges and has made some corrections that were administratively correctable. These corrections include developing a set of operating policies that are understood by the Indian patient and the contract provider. These include authorizing or disapproving services and paying the provider claims within a short period of time. We have also developed the policy of not approving any self-referred care, including emergencies. This policy allows the utilization of the limited contract health services resources to be utilized for specialty referred medical services for patients seen in the tribal clinics and hospital. This policy was required due to the lack of adequate contract health care funding, but the providers will see the Indian patients and they know that they will receive payment when the referred patient is seen.

The negative result of this policy is the shifting of the responsibility of payment for the emergency health services to the individual Indian patient and the local hospitals who see the patients and are not reimbursed for the services. This results in lots of Indian people being hounded for payments and their credit totally destroyed. The only good thing is the health services are provided to the Indian patients because the hospitals can not refuse the emergency services; however, it then becomes a matter of payment. In this case the hospitals know the Chickasaw Nation will not approve payment and the individual Indian patient knows the Chickasaw Nation will not pay for the service.

CARL ALBERT INDIAN HEALTH FACILITY
1001 N. Country Club Rd.
Ada, OK 74820
(580) 436-3980

FAMILY PRACTICE CLINIC
1001 N. Country Club Rd.
Ada, OK 74820
(580) 436-4585

OEH
1001 N. Country Club Rd.
Ada, OK 74820
(580) 436-3160

HEALTHY LIFESTYLES
3115 E. Arlington
Ada, OK 74820
(580) 332-6345

ARDMORE CLINIC
2510 Chickasaw Blvd.
Ardmore, OK 73401
(580) 226-8181

DURANT CLINIC
1600 N. Washington
Durant, OK 74701
(580) 924-7141

TISHOMINGO CLINIC
815 E. 16th
Tishomingo, OK 73460
(580) 371-2362

The current contract service program is obviously a very poor way to provide emergency health services but it is necessitated due to the totally inadequate funding level.

Improvements in the Contract Health Services Program should include the adequate funding of contracted services and the reduction of administrative overhead within the IHS. This reduction in administrative cost should include the departmental-imposed administrative paperwork, systems, programs, etc., as well as a limit on the dollar amount of resources that may be utilized for administrative costs versus health care costs.

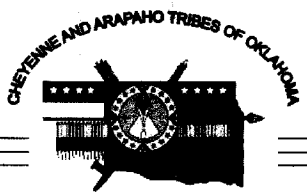
Thank you for the opportunity to comment and your interest in improving the health services for Indian people.

Sincerely,

Bill Anoatubby

Bill Anoatubby, Governor
The Chickasaw Nation

Office of Health Programs



P.O. Box 38
Concho, OK 73022
(405) 262-0345
Fax (405) 262-3423
1-800-247-4612

Date: April 25, 2008 (Revised May 12, 2008)

To: Darrell Flyingman, Governor
Cheyenne and Arapaho Tribes

RECEIVED
MAY 21 2008

From: Executive Director
Health Programs
Cheyenne and Arapaho Tribes

Subject: Public Hearings

Attached are the results of the Public Hearings held throughout the Cheyenne and Arapaho Tribal Service Area for your review. Included are recommendations based on these attachments:

- Schedule of public hearings
- Documented concerns submitted by attendees in Graph form
- Information from notes taken at each meeting
- Complaint/Concern Form developed for documentation by individuals
- Clinton Service Unit Complaint Policy
- US Public Health Service Commissioned Corps Standards of Conduct
- Civil Service Standards of Conduct
- Contract Health Services Policy
- Sample Letter of CHS Denial
- Summary of Meetings
- Recommendations based on results of meetings, documented and verbal complaints/concerns regarding the Clinton Service Unit to the Cheyenne and Arapaho Tribal members and other eligible recipients of services.

Thank you

Minita T. RunningWater, RN, MSN

Attachments (11)

Cc:
Minerva Rodriguez, Director, CHR Program
Cheyenne and Arapaho Tribal Health Board Members (5)
Senator Byron L. Dorgan, Senate Committee on Indian Affairs
Senator Tom Coburn, United States Senate

REPORT

SUMMARY:

I. Based on the documented concerns that are interpreted in graph form, the highest number of complaints/concerns are "Administrative". According to the individual complaints, this includes:
- management of the Clinton, El Reno and Watonga Health Centers
- Medical Records,
- Nursing triage system
- Phone System at Clinton Health Center,
- Concern about services for/to non-Tribal members,
- rudeness
- blatant discourteous and disrespectful attitudes toward patients, often mentioned was Kim Bower, a nurse who repeatedly turns away sick patients
- low employee morale
- Favoritism – some patients get in quicker than you, such as staff children and other family members
- No walk-in clinic
- No Inpatient unit
- No Emergency Room Services

II. The next highest documented concern is the Contract Health Services System operated by the Clinton Service Unit:
- Primarily, CHS bills do not get paid (Many, many complaints regarding this)
- When at a clinic visit the Physician says "a referral is needed, completed, appointment made", then when the bill arrives, CHS will not pay as it has been denied, many times the patient has not received a denial letter and unaware the referral was denied
- Patients will call in within the specified time period of notification of an emergency but will still be denied payment (this also refers to the telephone system).
- Credit is ruined if patient does not or cannot pay the bill and name is sent to "Collection Agency"
- Many patients unaware of Appeal Process which should be mentioned in the denial letter

III. The next highest complaint has to do with the Doctors/Providers regarding services, prescriptions, diagnoses, several patients mentioned that "How do the Doctors know how to treat you when they don't examine or touch you, they have your chart and with pen in hand say "What do you want?" (prescription or treatment wise, I presume).

IV. The remainder of the complaints, both documented and verbal, concern Nurses, Dental, Pharmacy, Appointments, and Mental Health. The complaints/concerns from the Cheyenne and Arapaho Tribal Members are numerous concerning the Clinton, Watonga and El Reno Health Centers, the primary area of concern is the Clinton Health Center.

Many of the complaints, both written and verbal have to do with discourteous behavior from the staff of the Clinton Health Center, one often mentioned individual is Kim Bower, a nurse who does triage at the Clinton Health Center and very often turns away sick individuals and has the support of the CEO according to staff from the Health Center. The other often mentioned is the Supervisor of Medical Records, these complaints from staff. The Health Center employs both Civil Servants and Commissioned Corps Officers and the policy regarding "Conduct" in both these systems is attached.

RECOMMENDATIONS:

- Thorough investigation of Clinton, El Reno and Watonga Health Centers by Indian Health Service and Office of Personnel Management and other regulating agencies regarding:
  1. infractions of unprofessional conduct by staff both Civil Servants and Commissioned Corps Officers with appropriate action
  2. Nepotism at the Clinton Health Center
  3. Favoritism at the three Health Centers, particularly the Clinton Service Unit Medical Records Department, i.e. employees who take leave during the week but are approved to work the week-end for overtime pay—suggest review of their ITAS in conjunction with overtime documentation
- Customer Service, Cultural and Sensitivity Training for all staff
- Review of the Nursing Triage System
- Implement a Walk-in Clinic or
- Implement an Urgent Care Clinic
- Extended evening Urgent care hours
- Extended appointment hours in evening to accommodate working individuals and/or parents
- Have a "real" person available to answer questions as they are sent to an "information" line in your department. Have an Operator available to determine where calls should go.
- Install an 800 toll-free line to all three Health Centers
- Staff should readily answer their phones, this is a health facility and there are serious questions patients may have regarding their health.
- Review the Contract Health System Services, re-educate staff, provide Customer Service Training
- Set timelines as to when to notify patients of denial of services
- Contact Oklahoma City Area Office regarding the additional $3.7 Million that was promised to the Clinton Service Unit as a result of the closure of their Inpatient Unit
- Review Personnel Policies and Procedures with All Employees and the expectation that the policies and procedures will be followed.
- Hire or designate a Patient Advocate who is physically located at entrance to ensure patient questions and/or concerns are answered in a timely manner
- Hire Case Managers to provide Exit interviews to ensure their appointments are made, medications received, understand their medications, require transportation for next scheduled visit, etc., etc.

The Cheyenne and Arapaho Tribal members have a long and proud history and the employees who commit the infractions of disrespect, rudeness, and unprofessional conduct should be reprimanded and or removed as it is apparent they are unaware of our history and the right to healthcare, quality health care. The Cheyenne and Arapaho Tribal members have a right to healthcare as indicated by our history. The results of the Public Hearings conducted throughout the Cheyenne and Arapaho Tribal Communities in the nine county area indicates the overall general concern that the CEO and a hand-picked few staff have lost their concern and compassion and the patients receive the horrific end of this these actions which appears to be common place in the Clinton Service Unit. The process of the provision healthcare, or lack thereof, at the Clinton Service Unit is viewed as paramount mismanagement which affects the overall health and quality of healthcare the Cheyenne and Arapaho Tribal members. Your additional comments are requested for submission to all who receive copies of this report.

Respectfully Submitted,

Minita T. RunningWater, RN, MSN

CHEROKEE NATION®
P.O. Box 948 • Tahlequah, OK 74465-0948 • (918) 453-5000

Chad "Corntassel" Smith
Principal Chief

Joe Grayson, Jr.
Deputy Principal Chief

May 6, 2008

Senator Byron Dorgan, Chairman
U.S. Senate Committee on Indian Affairs
838 Hart Office Building
Washington, DC 20510

Re: Indian Health Service Contract Health Services Program

Dear Chairman Dorgan:

On behalf of the Cherokee Nation, I applaud your continued efforts to address the disparate health conditions in Indian Country. In response to your Tribal Leader letter dated March 29, 2008, the Cherokee Nation would like to provide the following information regarding the Indian Health Service (IHS) Contract Health Services Program and how it affects the delivery of health care in northeastern Oklahoma.

As you are well aware, Tribes have consistently advocated for additional funding to address the serious unmet needs that exist in Indian Country and to bring funding for the Indian Health Service to a level comparable to other federally funded health programs. In 2003, the per capita personal health care expenditures for IHS population totaled **$1,914**, while the per capita amount for the total U.S. population totaled **$5,085**. The $1,914 represents only 56.8% of the actual need according to the Federal Disparity Index.

In addition to the disparate funding between the IHS and other health programs, funds among the IHS Areas are distributed inequitably. In order to address the inequities within the IHS system, the Indian Health Care Improvement Fund was created to achieve parity among the IHS Areas. The Oklahoma City Area is funded at $976 per capita, which is the lowest funded area in the system and represents only 44% of the actual need according to the Federal Disparity Index. In addition to the funding disparities identified through the Federal Disparity Index, contract health services funds are distributed inequitably among the Areas.

In Fiscal Year 2007, the per capita contract health services expenditures for the IHS population totaled **$358**. However, the Oklahoma City Area only receives **$207** per capita, which ranks last among the twelve areas. While the entire contract health services program desperately needs additional funds, special attention should be directed towards reaching equity among the Areas.

Due to the chronic under funding of the Indian health system, the Cherokee Nation, as well as other Tribes within the Oklahoma City Area of the Indian Health Service (IHS), must rely heavily on the contract health program to attempt to provide specialty care for its service population. As you know, the shortfall for contract health funding is so severe that typically only life-threatening conditions can be funded and most other requests for treatment are denied.

Within the Cherokee Nation, adequate funding does not exist to make specialty services readily available such as urology, oncology, neurology, neurosurgery, orthopedics, nephrology and cardiology. Therefore, scarce contract health service funds must be utilized for such services. It should be noted that the national Contract Health Services (CHS) funding shortfall is approximately $120 million, of which $59 million represents the shortfall in the Oklahoma City Area. In order to realize a net increase to the CHS program, IHS would need a minimum of $40 million in FY 2009, in which the first $18 million would address inflation under the present methodology. If the entire Indian health system were properly funded, regularly used specialists that are now provided through the CHS program could be provided within the Indian health system and CHS resources could be utilized for other services.

The Cherokee Nation is served by two service units of the Indian Health Service, Claremore and Tahlequah. Currently, the Cherokee Nation operates the CHS program within the Tahlequah Service Unit, while the CHS program for the Claremore Service Unit is operated in portion by the Indian Health Service, the Cherokee Nation, and the Muscogee (Creek) Nation.

In Fiscal Year 2007, the two service units within the Cherokee Nation denied over $20.7 million in desperately needed inpatient and outpatient health services due to lack of funding. During the first half of Fiscal Year 2008, over $7 million in health services have already been denied. The Cherokee Nation believes the number of denials at the Claremore Service Unit is actually higher in FY 2008; however the Claremore Service Unit typically experiences delays in reporting denials due to inadequate staffing.

For those patients denied services, they are forced to consider three difficult options: 1) Do nothing; 2) Seek care at a facility outside of the Indian health system, where they may or may not be able to get treatment. If they are able to receive treatment, they are burdened with costs that they are most likely unable to pay, which creates a financial loss for the facility; 3) Wait until the condition worsens in order to become eligible for contract health services at a higher priority level.

In addition to funding shortfalls within the CHS program, the program can be an extremely complicated process that often leads to confusion and miscommunication among the Indian health system, outside health care providers, and patients. As a result, instances have occurred where payments have been delayed, services have been provided without adequate authorization, and misunderstandings as to which CHS program was responsible for payment. In instances where services have been provided without adequate authorization, the IHS or Tribal CHS program is not responsible for payment

and leaves the burden of payment on the outside health care provider and patient. It would be very beneficial to the Indian Health Service, Tribes, outside health care providers, and patients if the CHS program was presented in a much more user-friendly format. A more user-friendly program could be achieved through technological upgrades to the Indian Health Service website that would assist in navigating through the CHS system.

In closing, an important item of note is the provision within the Medicare Modernization Act (MMA) that requires hospitals participating in the Medicare program to accept Medicare-like rates as payment in full when providing inpatient services to individuals under the CHS program. While the Cherokee Nation advocated for this provision and applauds Congress for its passage, it does not have a substantial impact on the Cherokee Nation because most Cherokee Nation provider contracts already have rates similar to Medicare. However, the Cherokee Nation remains concerned that the federal government and Congress may view the potential savings (estimated at $75 million annually) as a justification to reduce overall CHS funding.

The Cherokee Nation seeks the commitment of the federal government and Congress that this does not occur. Additionally, the Cherokee Nation would like to see the extension of Medicare-like rates for all Medicare payees including physicians, ambulatory care facilities (non-hospital), and all service providers participating in Medicare reimbursement. Data within the Oklahoma City Area indicates an increase in CHS usage for ambulatory services as opposed to inpatient/facility based care, which is based on national trends of moving toward shorter inpatient stays and one-day surgical procedures.

The Cherokee Nation is supportive of this effort and stands ready to provide further information to assist the Senate Committee on Indian Affairs in addressing the insufficiencies within the American Indian/Alaska Native health care delivery system. Should you require additional information, please feel free to contact Paula Ragsdale at the Cherokee Nation Washington Office at (202) 393-7007, or by e-mail at paula-ragsdale@cherokee.org. Thank you for your consideration in this matter.

Sincerely,

Chad Smith
Principal Chief

FY 2007 Contract Health Services Appropriations by Area

AREA OFFICE	FY 2007 Recurring Base for CHS Funds	FY 2007 User Population	Per Capita based on User Pop	Rank by Area
	(1)	(2)	(2)/(3)	
ABERDEEN	$ 61,057,469	119,379	$ 511.46	4
ALASKA	$ 55,178,362	134,743	$ 409.51	6
ALBUQUERQUE	$ 25,833,463	85,671	$ 301.54	9
BEMIDJI	$ 36,093,969	100,243	$ 360.06	7
BILLINGS	$ 44,719,430	70,196	$ 637.07	1
CALIFORNIA	$ 26,386,313	75,010	$ 351.77	8
NASHVILLE	$ 21,339,338	47,438	$ 449.84	5
NAVAJO	$ 60,418,257	237,981	$ 253.88	11
OKLAHOMA	$ 65,096,289	313,901	$ 207.38	12
PHOENIX	$ 45,112,454	153,607	$ 293.69	10
PORTLAND	$ 60,484,666	100,784	$ 600.14	2
TUCSON	$ 13,363,305	24,708	$ 540.85	3

Rank	Area	Per Capita for CHS
1	Billings Area	$ 637.07
2	Portland	$ 600.14
3	Tucson	$ 540.85
4	Aberdeen	$ 511.46
5	Nashville	$ 449.84
6	Alaska	$ 409.51
7	Bemidji	$ 360.06
8	California	$ 351.77
9	Albuquerque	$ 301.54
10	Phoenix	$ 293.69
11	Navajo	$ 253.88
12	Oklahoma	$ 207.38

Total CHS Budget	/Total User Pop	=	Total Per Capita for Total CHS Budget
$ 525,099,000	1,463,661		$ 358.76

Based on FY 2007 Appropriation and User Population

RECEIVED
MAY 12 2008

Ohkay Owingeh
P.O. Box 1099
San Juan Pueblo, NM 87566
Phone: (505) 852-4400
Fax: (505) 852-4820

May 1, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Dorgan,

In response to your letter dated March 27, 2008, here is a list of problems that our community has been faced with.

1) Contract Health Services delivery areas are confusing to patients and exclude patients who live close to their home reservation. The majority of denials issued by Santa Fe Service Unit because of not meeting the residency requirement for New Mexico Tribes.
2) Medical priorities are established because Contract Health Services funding is inadequate to fund all needs.
    - The Santa Fe service unit is restricted to paying for life and limb threatening emergencies (Medical Priority 1); therefore if an elderly patient needs cataract surgery, the patient has to pay for that service.
    - If a patient needs arthroscopic knee surgery, the patient has to pay for that service.
    - If a patient needs dentures, the patient has to pay for that service.
    - If a patient needs dermatology, allergy, or podiatry services, the patient has to pay for that service.
3) Due to these medical priorities, many community members have been denied service.
    - During FY-2006 the Santa Fe Service Unit had to issue 474 denials because a patient either received services that didn't fall within the Medical Priority 1 or didn't reside on or near their home reservation. The average CHS referral for FY-2006 cost SFSU $921; therefore to cover these visits, the SFSU would have needed an additional $436,554.
    - During FY-2005 the Santa Fe Service Unit had to issue 272 denials because a patient either received services that didn't fall within the Medical Priority 1 or didn't reside on or near their home reservation. The

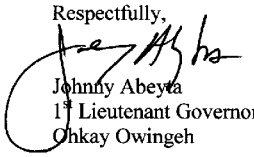
average CHS referral for FY-2005 cost SFSU $1,298; therefore to cover these visits, the SFSU would have needed an additional $353,056.

- During FY-2004 the Santa Fe Service Unit had to issue 502 denials because a patient either received services that didn't fall within the Medical Priority 1 or didn't reside on or near their home reservation. The average CHS referral for FY-2004 cost SFSU $874; therefore to cover these visits, the SFSU would have needed an additional $438,748.

4) Elderly patients must notify IHS within 30 days of emergency room visits and receive prior authorization for non-emergency visits.

Thank you for the opportunity to express the concerns of our community. If you have any questions or need further assistance, I could be reached at (505) 852-4400.

Respectfully,



Johnny Abeyta
1st Lieutenant Governor
Ohkay Owingeh

Oneida Tribe of Indians of Wisconsin
BUSINESS COMMITTEE

Oneidas bringing several hundred bags of corn to Washington's starving army at Valley Forge, after the colonists had consistently refused to aid them.

UGWA DEMOLUM YATEHE
Because of the help of this Oneida Chief in cementing a friendship between the six nations and the colony of Pennsylvania, a new nation, the United States was made possible.

RECEIVED
MAY 02 2008

P.O. Box 365 • Oneida, WI 54155
Telephone: 920-869-4364 • Fax: 920-869-4040

April 23, 2008

Senator Byron Dorgan
838 Hart Senate Office Building
Washington, DC 200510

Dear Senator Dorgan:

This correspondence is in response to your request for input on the current Indian Health Care System and specifically the Contract Health Services Program. The Indian Health Service Contract Health Service Program operated by the Oneida Tribe of Indians of WI is an alternative resource coverage for specific services which can not be provided on-site by the Oneida Comprehensive Health Division Community Health Center providers. Contract Health Resources are based upon eligibility established through the Federal Register for eligible Native people residing within our Contract Health Service Delivery area of Brown and Outagamie counties within the State of Wisconsin. These are two of the largest counties within the State and include the highest concentration of tribal members. The Oneida Tribe is also one of the largest tribes within the State of Wisconsin.

The Oneida Contract Health Services Program (CHS) requires the patient to obtain a referral from one of our health center providers and then services are purchased by our CHS program for eligible persons with funds provided by the Indian Health Services. CHS is defined as a payer of last resort by federal regulations, therefore our patients are required to exhaust all other resources of payment before CHS can pay for any of their contracted care.

Fortunately, the leadership of the Oneida Tribe has been financially able to supplant the CHS program funds on a regular basis since 1996 through the success of the Tribe. This additional funding of the CHS program has prevented the Health area from having to implement a Priority 1A requirement since 1996. Without the additional financial support from the Tribe, the CHS program would have been required to implement a severe restriction to services through the Priority 1A which permits only life threatening injuries and or life threatening emergency service to the membership. At present, the CHS program funding from the Indian Health Service is severely under funded as is the rest of the Indian Health Service. Based upon our current level of need for the Oneida Tribe which is within the Bemidji, MN Service Area, we are one of the

lowest funded areas of the IHS. Our current level of IHS funding for the number of patients served within the Oneida Comprehensive Health Division meets approximately 1/3 of the need. The funding level specific for Contract Health Services is even lower! Based upon our expenditures for CHS care for Fiscal Year 2007, Indian Health Service CHS funding would have only permitted our facility to provide CHS funding for approximately 3.5 months of the fiscal year. The remaining 8 months of the year, patients would have been required to pay for their own services unless it was a life threatening situation. There would have been no CHS funding available to provide care based upon the IHS Contract Health Service funding levels. Our expenditures on CHS for FY 2007 were $9,232,525.00. Our CHS funding from IHS was $2,602158.00! The Oneida Tribe of Indians of Wisconsin has determined that Health is one of their number one priorities and opted to infuse tribal contribution dollars into the CHS budget to avoid having to limit care throughout the year and have continued to supplement the IHS dollars so that no eligible patient will have to delay their health care based upon funding limitations.

Were it not for the success of the Oneida Tribe of Indians of Wisconsin, we would also be one of those Tribes that are forced to limit care to their membership resulting in routine types of illnesses ending in needless tragic loss of life for things such as cancer. Early detection of cancers can prolong life but early diagnosis is necessary. Based upon many priority lists within Tribes, they only have the ability to provide for life threatening illness and early cancer screening and detection does not fall into this priority. Simple procedures such as gallbladder surgery can not be performed if it doesn't occur within the "right" month and patients are forced to wait until "monies" are available within Tribes. With the assistance of additional funding to the Indian Health Service, health disparities such as these could be eliminated!

If you have any specific questions regarding this matter, please contact me at 920-869-4428.

Sincerely,

Kathy Hughes

Kathy Hughes, Vice-Chairwoman
Oneida Tribe of Indians of Wisconsin

Fort Belknap Indian Community

R.R. 1, Box 66
Fort Belknap Agency
Harlem, Montana 59526
PH: (406) 353-2205
FAX: Council - (406) 353-4541
FAX: Departments - (406) 353-2797

Fort Belknap Indian Community
(Tribal Govt.)
Fort Belknap Indian Community
(Elected to administer the affairs of the community and to represent the Assiniboine and the Gros Ventre Tribes of the Fort Belknap Indian Reservation)

April 30, 2008

Senator Bryon L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, DC 20510

Dear Senator Dorgan:

As President of the Fort Belknap Indian Community Council, I would like to address the issues relating to the Indian Health Service's Contract Health Services program and its impact on the Tribal members and the eligible Indians that we serve. Like most federal and tribal facilities in the Billings Area (Montana and Wyoming) and the Nation, the Fort Belknap Little River Health Center is a critical access hospital. Fort Belknap's Contract Health Service Delivery Area (CHSDA) serves approximately 5,000 eligible Indian users.

Issue 1: Access to Contract Health Services Providers (Specialty care Providers)

As described by the Indian Health Service (IHS), Contract Health Services (CHS) are services that the Indian Health Services is unable to provide in its own (IHS or Tribal) facilities. Contract Health Services are provided by non-Indian Health Services (or Tribal) healthcare providers and facilities. The Fort Belknap Tribes CHSDA encompasses two counties (as designated by the Rural Health Institute) – Blaine and Phillips Counties. The nearest local specialty care providers are Northern Montana Hospital in Havre, MT (45 miles from Fort Belknap) and Benefis Hospital in Great Falls, MT (160 miles from Fort Belknap), and Billings, MT hospitals, Deaconess and St. Vincent's (224 miles from Fort Belknap).

Though the cost of medical care is lower in Montana than other states, availability of certain specialty care (i.e. severe burns) is a challenge. Tribes are more likely to purchase that care out of state where it is more costly.

Problem Areas: Because of the lack of access to specialty care providers in rural Montana, Fort Belknap often buys the only available care from providers in Salt Lake, UT (700 miles) Denver, CO (822 miles), and Seattle, WA (800 miles) at an even greater cost for care and the additional cost of transportation. Transportation usually becomes a

Tribal obligation as the IHS budget does not provide for it nor can the individual Tribal member afford the expense (Billings Area Tribes have the third highest population below the poverty level [44.6%], Billings Area Tribes have the highest percent of unemployment – males 29.8% [compared to US All races 6.4%] and females 21% [compared to US All races 6.2%]).

Recommendation 1:

Montana Tribes need additional funding for transportation costs for CHS.

Recommendation 2:

IHS and Tribes facilities need to be able to fund recruit and retain health providers that fill their specific need for specialty care, such as a provider for orthopedic services.

Recommendation 3:

IHS and Tribal facilities need to have the resources to build partnerships within the area Indian healthcare system and the private sector for "sharing" specialty care providers.

Issue 2: Contract health Services Funding vs. Tribal Need

Each year the Billings Area Tribes have exhausted their CHS budgets by April of that fiscal year. The Billings Area Tribes have the 2nd **highest disease burden** in the 12 Indian health Service Areas. Tribes in the nation are seeing not only an **increase in chronic disease** within the age groups most commonly affected but in the younger populations as well. Tribes in the Nation are developing chronic disease at a younger age. Tribes are asking, "What stress will this add to our strained healthcare system knowing we may be supporting, at greater costs, an individual at a younger age for a potentially longer time?"

Severe health problems/treatments related to chronic disease i.e. cardiovascular disease, gastrointestinal disease, cancer and diabetes take a toll on the annual Fort Belknap CHS budget. The most debilitating to many Tribal communities are motor vehicle accidents. Often there is more than 1 individual who will need emergency (i.e. life flight – for Fort Belknap is a cost of $9,000) specialty care (i.e. surgery, brain injury, severe burns), lengthy recovery time in a hospital and may need rehabilitation services as well. One multiple car/multiple person accident can wipe out a Tribe's annual CHS budget within a short time. This leaves the IHS/Tribal facility struggling to manage the Tribe's CHS needs for the remainder of the year.

Recommendation:

The tribal CHS budget must be funded to fulfill need. Under funding the budget will only prolong access to healthcare for Tribal members causing further deterioration with an increased cost for care.

Issue 3: Contract Health Services Program Management

"The Indian Health Service is funded each year through appropriations by the U.S. congress. The Indian Health Service is not an entitlement program, such as Medicare or Medicaid. The Indian health Service is not an insurance program. The Indian Health Service is not an established benefits package.

CHS payments are authorized based on clearly defined guidelines and are subject to availability of funds. The Indian Health Service cannot always guarantee that funds are always available. Funds appropriated by the U.S. Congress currently cover an estimated 60% of health care needs of the eligible American Indian and Alaska Native people."

"Questions Most Asked",
Indian Health Service website

In Order to responsibly manage a limited CHS budget, Montana Tribal and IHS clinics must "ration healthcare" utilizing the CHS medical priority rating system. For the Billings Area tribes, this system rates from 1-12 the severity of your condition (within a menu of conditions that are allowable). Because of a limited budget, currently only those rated at 12 ("life or limb"), the most severe, qualify for payment of a referral. Those individuals that do not rate a 12 are **"deferred"** payment of a referral until funding is available to address those rated under 12 (or until their condition deteriorates to be rated a 12). Those individuals whose condition is not within the medical priority are **"denied"** payment of a referral due to inadequate funds to address conditions not within the medical priority.

In FY 2007, the Billings Area deferred data is as follows:

- Medical Referral Procedures – 2,203
- Orthopedic – 831
- Elective Surgeries – 481

These individuals have been rated 1 -11 and are "deferred" payment of a referral until funding becomes available. Often by the time their condition warrants a 12 rating their condition will cost significantly more that when they first were given a referral.

From FY 2004 to FY 2007, payments deferred for contract health services referrals due to inadequate funds or not within the medical priority was 692 patients. A total of $2,087,194. would have paid for these referrals, provided needed care and prevented further health deterioration and additional costs for care.

If your condition warrants, the IHS is obligated to give you a referral for contract health services BUT if there is no funding available or your condition does not fall in the medical priority then you could be deferred/denied payment of that referral. This is a big issue for

Fort Belknap and the rest of the Montana Tribal people who cannot afford to pay for those services themselves if "denied". For those individuals who are "deferred", it gets more confusing for them. They are provided the referral for services, thinking that IHS will be paying for them, and then are billed for them after. When these bills are not paid; they go to credit bureau for collection. This further burdens Tribal people who are unemployed and struggling to meet daily basic needs.

Recommendation 1:

CHS is to be fully funded at the true level of need.

Recommendation 2:

IHS and Tribal clinics need to have the resources to fund categories besides the 12 – "life and limb" category. The 12 category is not even funded to fulfill total need. After funding the 12 category in full, a secondary category needs to be specifically funded to be preventative (so that there is no further health deterioration).

Recommendation 3:

IHS and tribal clinics need funding opportunities for health systems redesign to develop a more effective and meaningful healthcare system.

Senator Dorgan, the Fort Belknap Indian Community would like to thank you and the other members of the Senate Committee on Indian Affairs for your commitment to improving the Indian healthcare system. The Fort Belknap Indian Community Council also appreciates your work in gaining the reauthorization of the Indian health Care Improvement Act. The Gros Ventre and Assiniboine Nations look forward to continued discussion to create solutions for improving the Indian healthcare system and the Indian Health Services' Contract health Services program.

Should you have any questions please call me at 406.353.8303 or Loren 'Bum' Stiffarm, Chief Administrative Officer, 406.353.8448 or Ms. Velva Doore, Tribal Health director at 406.353.8486.

Sincerely,

Julia doney
President

cc: Montana Congresional Delegation
Fort Belknap Little River Health Care Unit

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APR 21 2008

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POST OFFICE BOX 580
(505) 753-7326
(505) 753-7330

INDIAN PUEBLO
ESPANOLA, NEW MEXICO
87532

OFFICE OF GOVERNOR

April 14, 2008

Senator Byron L. Dorgan
Chairman
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Dear Honorable Senator Dorgan:

I can't tell you how much my Pueblo appreciates and supports the effort you are making as Chairman for the Senate Committee on Indian Affairs. We have talked with you and met you personally on various occasions and the issues that you have articulated and promised to champion for Indian Country are now becoming a reality. My Pueblo wishes to thank you for taking a pro-active direction in addressing the multitude of Indian issues and concerns that have been brought before this Committee.

Today, we submit our position document regarding the issue of Contract Health Services as it relates to our Pueblo and the many injustices that have happen to our People not only for lack of funding, but the inadequacies that continues to haunt the Indian Health Services because the Congress and in particular, the White House does not make funding a major priority for this Department.

The information provided is a cooperative effort between our Pueblo and the Santa Fe Service Unit through Mr. Robert J Lyon, the Chief Executive Officer. This provides just a small window of information that is available, there are many more windows that could show more, maybe in time.

Senator Dorgan, again thank you, to you and the Committee for championing this vital and critical health care issue.

I can be reached at the following email address, governor@santaclarapueblol.org or you can all me at my office (505) 753-7330 or you can also contact Mr. Walter Dasheno, Director, Intergovernmental and Public Relations at his email address, walterd@santaclarapueblo.org or at his office (505) 692-6312.

Sincerely,

J. Michael Chavarria

J. Michael Chavarria, Governor
Santa Clara Pueblo

Enclosure(s)

(1) Healthy People, Healthy Community – A Profile of the Health of Santa Clara Pueblo – October 2007
(2) Letter from SFSU, CEO, Mr. Robert J. Lyon w/Supplemental IHS Information

cc: Santa Clara Pueblo Tribal Council
Chairman Joe Garcia, All Indian Pueblo Council
Mr. James L. Toya, AD, AAO
Mr. Robert J. Lyon, CEO, SFSU
Mr. Walter Dasheno, SCP

Position Statement
Prepared by Governor Joseph Michael Chavarria
Santa Clara Pueblo
April 2, 2008

"When something happens, people are there to share and help. We are a community. We help each other out in many ways as much as we can. We are there. We are a community"
-Wisdom about Health shared by an Adult

"Healthy People, Healthy Community: A profile of the Health of Santa Clara Pueblo – October 2007

Dear Chairman Dorgan and Members of the Indian Affairs Committee, my name is Joseph Michael Chavarria and I am the Governor for the Pueblo of Santa Clara. A Tewa Pueblo located in North Central New Mexico. My reservation encompasses over 57,000 acres of what was once pristine land's.

We have inhabited this land since time immemorial and will continue to do so into the future.

Our Pueblo's government is unique and has been recognized by three different sovereign governments over the past 400 years: Spain, Mexico and the United States of America. Our tribal government consists of 6 annually-elected tribal officials; Governor, Lt. Governor, Secretary, Treasurer, Interpreter and Sheriff and 8 Tribal Council Representative appointed by the 4 recognized tribal parties. Today we have 34 programs and over 200 employees, the Santa Clara Pueblo tribal government provides a full-range of services to our community members and continues to meet the many challenges facing our community.

Just recently, our Pueblo completed and adopted the following document entitled **"Healthy People, Healthy Community: A Profile of the Health of Santa Clara Pueblo – October 2007"**. This profile was develop with support

by the Santa Clara Pueblo Governor and Tribal Council, the Governor's Task Force on Youth and Families and was compiled and edited by Mr. Greg Tafoya a Santa Clara Pueblo Tribal Member and a Masters' Program candidate at the University of New Mexico and Ms. Christine Chavez-Trujillo a Member of the Cochiti Pueblo and Coordinator for this project.

I will be using language from this Profile to make and articulate my statement.

The inside cover of this document begins with a **"Message from the Governor and Task Force Chairman"** and the first paragraph is appropriate to this issue. It reads **"Santa Clara community members face many challenges in this generation, as documented in this first-ever Health Profile of our community. Stagnant funding for the Indian Health Service is a central reason for the tremendous health disparities we experience....."**.

On page 1, the document states **" The Santa Clara Pueblo Community Health Profile (Profile) aims to describe the health of the community by providing information on health status and community strengths and needs. The data provided within this document illustrates the health conditions and issues that require improvements....This document also identifies those areas where more information is needed, such as gaps in services, quality of health care, and community resources....."**

It further states, **"The Profile is the basis for public health planning and may be used for a variety of purposes such as:**

- **Justifying program development and funding needs;**
- **Planning and evaluating community health programs;**
- **Documenting health-related activities in the community;**
- **Ensuring accountability by agencies and programs for services provided and required;**
- **Reporting on important health outcome measures;**
- **Obtaining technical assistance to other agencies;**
- **Developing funding proposals and applications;**
- **Guiding research and informing policymakers; and**
- **Identifying professional training needs.**

On page 5, the Executive Summary states **"Santa Clara Pueblo began a Community Health Assessment (CHA) in 2006 to secure for our community member the quality of life and healthcare they deserve. The assessment is designed to;**

1. **Identify the major health problems affecting Santa Clara people based on existing data sources and community perceptions;**

2. **Prioritize health concerns for action by conducting interviews with community leaders, service providers and key stakeholders; and**
3. **Identify resources, programs and funding to address those health concerns.**

continuing.... **"At this time there are many sources of health data about Santa Clara Pueblo in the Indian Health Service (HIS), U.S. and New Mexico Department of Health, and in other locations. The CHA process has enabled Santa Clara Pueblo organize and analyze this data so that it can be used to justify funding requests and grants to help the Pueblo develop new programs and activities address the most critical health needs of the community".**

And the following statement is probably the most crucial to this issue of contract services within the Indian Health Services and more specifically as it relates to the Santa Clara Pueblo Health Clinic, the Santa Fe Service Unit, and the Albuquerque Indian Health Service Unit where the majority of our people receive health care services. **"It will also help the Pueblo hold IHS accountable and help us to work with IHS to get funding for the Santa Clara Health Clinic and the Santa Fe Indian Hospital to meet our people's most serious health needs".**

Following this section, I would like to take some of the statements again from the "Profile" made on pages 63, 64 , 65 and 66. P. 63 - **"Indian Health Service Units The Santa Fe Service Unit also known as the Santa Fe Indian Hospital, has a 35-Year tradition of providing local tribal communities with primary medical care and services. The Santa Fe Indian Hospital is a United States Public Health Service facility. It is a 39-bed hospital with an ambulatory care center located in the hospital. Santa Fe Service Unit Services (SFSU) SFSU offers inpatients services for general medical, prenatal, gynecology, and surgical and pediatric patients. Urgent Care is open 24 hours a day for urgent problems. SFSU also offers the following outpatient clinical services: Dental, Pharmacy, Women's Health, Radiology, etc.** (a total of 24 programs)

Santa Clara Health Clinic Services: (located within the Santa Clara Pueblo) Santa Clara Health Clinic provides services to many of the surrounding tribes, not just Santa Clara Pueblo alone" . (a total of 12 programs).

P. 64 – **"Health Care Funding Crisis Faced with many immediate health concerns as illustrated in the Community Health Profile, there is strong concern around healthcare quality and care received by Santa Clara residents. The Indian Health Service (Santa Fe Indian**

Hospital and Santa Clara Clinic) is the primary healthcare option for the community. Over the past 10 years IHS Santa Fe Service Unit has experienced increasing outpatient visits while receiving decreased federal appropriations. Disturbingly, the Indian Health Service receives about one-third of the nation average for per capital health expenditure and about half of the amount federal prisoners receive per capita for healthcare (see Chart 11-4). Compounding HIS funding and service issues is the rate of medical expense inflation through increased healthcare costs".

P. 65 – **Chart 11-4. 2005 HIS Expenditures Per Capita (Source: Indian health Service, Health Disparity Index Report 2005).**

This chart illustrates the disparity between **"Medicare ($6,784), National Health Expenditures ($5,670) Veterans Administration ($4,653) Medicaid ($4,328) Medicaid for Federal Prisoners ($3,242) FEHB Medical Benchmark ($2,980) 2005 IHS Expenditures ($2,130)**

In consultation with the Santa Fe Service Unit Director, we received the following attached information that determines the criteria for our Santa Clara Pueblo people receiving or not receiving Contract Health Services (CHS) within this Service Unit area. **Although the information we receive denotes availability of some of the necessary information to identify our concerns, it does not necessarily include all the information.**

During FY-2006 the Santa Fe Service Unit had to issue 474 denials because a patient either received services that didn't fall with the Medical Priority 1 or didn't reside on or near their home reservation. The average CHS referral for FY-2006 cost SFSU $921; therefore to cover these visits, the SFSU would have needed an additional $436,554.

During FY-2005 the Santa Fe Service Unit had to issue 272 denials because a patient either received services that didn't fall within the Medical Priority 1 or didn't reside on or near their home reservation. The average CHS referral for FY-2005 costs SFSU $1,298; therefore to cover these visits, the SFSU would have needed an additional $353, 056.

During FY-2004 the Santa Fe Service Unit had to issue 502 denials because a patient either received services that didn't fall within the Medical Priority 1 or didn't reside on or near their home reservation. The average CHS referral for FY-2004 costs SFSU $874; therefore to cover these visits, the SFSU would have needed an additional $438,748.

These numbers do not include patients who don't even ask HIS for help with the bills because they already know that we don't have the funds to help them.

In many of the above cases, the dollar amounts identified was an average cost and would not have taken into account some of the other factors such as follow up visits, specialist and therapeutic care, surgery, and other related or associated costs. We also know that CHS funds become available each Fiscal year, but also relate to the comment that this funding is exhausted by February and sometimes if not to many patients need CHS funds, it could be stretched till June.

Attached is the SFSU letter dated April 14, 2008, Albuquerque Area Indian Health Service letter dated December 18, 2007 from the Chief Medical Officer, Subj: Contract Health Service Medical Priorities – FY 2008 and the Sections listed in the Federal Regulation, Subpart C – Contract Health Services. Source: 64 FR 58320. Oct. 28, 1999 unless otherwise noted. Redesignated at 67 FR 35342, May 17, 2002.

136. 21 Definitions.
136.22 Establishment of contract health service delivery areas.
136.23 Persons to whom contract health services will be provided.
136.24 Authorization for contract health services.
136.25 Reconsideration and appeals

MESCALERO Apache TRIBE

Carleton Naiche-Palmer, President

Mescalero New Mexico 88340

RECEIVED APR 18 2008

April 9, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

RE: Current Indian Health Care System Response/Contract Health Care Program

Dear Senator Dorgan:

First, let me thank you for taking the time and the initiative to focus attention on one of the matters of greatest concern in Indian country. The health care system and health status of American Indian people have long been ignored, under-funded and continue to deteriorate every single day. I and the Mescalero Apache Tribe applaud your efforts and intent and pledge and offer our assistance in addressing this issue.

Let me start by saying that the Indian Health Service, even with its limited resources, staffing and ability to provide a full range of services, is the first line of defense against poor health in Indian country, and without the services provided by IHS, our health status would be significantly worse than it is. The IHS provides health services across Indian country and strives for excellence, but is severely handicapped by a lack of funding and the ability to recruit and retain competent and culturally sensitive providers and staff. **Lack of adequate funding is the primary factor in addressing the health care needs in Indian country.**

The Contract Health Service (CHS) program is a referral care system intended to provide access to specialty care not provided by in-house IHS care providers. The continuum of care model employed by IHS implies a complete package of routine, chronic, acute and emergency care services provided in the most economically feasible manner, but lack of CHS funding hinders the ability to deliver intended services. With ever decreasing funding and ever increasing health care costs and inflation, the CHS program operates on a priority schedule that restricts almost all care, with the exception of life-and-death circumstances. In most cases, less serious illnesses or injuries must get significantly worse before it can be covered under CHS guidelines. Waiting for a problem to become an emergency is ludicrous, negatively and unfairly impacts personal health, and is not within the intention of health prevention approaches. In the long run this only adds to the poor health status of Indian people and costs the IHS even more money.

It is projected that the CHS funding levels should be four (4) times current levels just to meet today's current needs. The funding levels, if ever increased to the level of need, also need to increase annually to keep pace with increasing levels of need and costs. Although this would be a godsend, it still would not be enough. All funding types and levels must be increased with planned increases if we are to ever truly address the poor health status of Indian people. The H&C funding levels, which funds basic operations, must also be increased so that more prevention and awareness can be effected. We must address all

parts of the delivery system if we hope to make improvements overall. Only if we approach health care holistically will we ever begin to meet levels of need. The CHS program is only one part of the IHS delivery system, and all other areas must be fully funded to effect improvements in health across Indian country. If we are ever to make the paradigm shift to health prevention, we must proactively spend money to prevent illnesses and injuries. It is a well know fact that prevention is more cost-effective than reactionary measures associated with ongoing reactions to health care needs.

In summary, I urge you to look at the total health care delivery system and strive to affect levels of funding that are consistent with addressing current needs, preventing illnesses and injuries, and minimize the impact of failing health across Indian country. Taking a holistic approach to problem solving dictates that we strengthen the system at all levels, and that prevention and earlier diagnosis and treatment of routine illnesses before they escalate to a level of emergency is the route we should strive to take.

Again I personally thank you for your efforts and assure you that I and the Mescalero Apache Tribe stand as partners with you in improving health care services to Indian country. Please do not hesitate to contact me at (575) 464-4494 if further information or assistance is needed.

Sincerely Yours,

Carlton Naiche-Palmer, PhD

Dr. Carlton Naiche-Palmer
President

RECEIVED
APR 24 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, DC 20510

LETTER TRANSMITTED VIA FAX TO: 202-228-2589

April 9, 2008

Dear Senator Dorgan:

I am writing this letter on behalf of the Red Cliff Band of Lake Superior Chippewa. I appreciate the opportunity to give comment on the need for reform within the Contract Health Services (CHS) Program. As you know, this program is vital to the overall healthcare delivery system within the Tribal setting. I would like to focus on four specific challenges faced by our Tribe.

Red Cliff is located in northern Wisconsin, in rural Bayfield County. We currently operate an outpatient clinic providing primary care for a service population of 1,689. There are no IHS Federal hospitals in the state of Wisconsin. Therefore, we rely solely on contract health dollars to purchase outside specialty and hospital services. The funding levels for the CHS program have not kept pace with need or medical inflation. Need continues to grow as the eligible population has increased and alternate resources have decreased. These result in further pressure on and competition for limited resources. The impact is felt not only on the CHS Program and the population it directly serves, but also on the entire Tribal health system and Tribal government.

The Contract Health Service program is operated on a priority system. The highest level is priority 1A, urgent and acutely emergent care services. When funding is limited, Tribes are forced to limit services to this level only; Red Cliff has been at this priority level for the past ten years. Reliance on a priority system, which is based upon a limited view of the appropriate interventions that are applicable to acute care, compromises the effectiveness of such interventions and may stand in the way of early identification and intervention. This not only results in increased costs in the long run, it also results in increased morbidity and mortality. The recommendation would be for the CHS program to acquire the financial resources and programmatic structure to be able to authorize

88385 PIKE ROAD, HWY 13 • BAYFIELD, WISCONSIN 54814 • (715) 779-3700 • FAX (715) 779-3704

payment for routine screenings (e.g. colonoscopies) and rehabilitative services (e.g. cardiac rehabilitation and physical therapy).

There is a need for increased behavioral health resources. According to the Resource Patient Management System (RPMS) in 2007, 26% of all clients accessing care at the Health Center did so for a mental health diagnosis. Tribal behavioral health programs simply do not have the needed array of specialty services. The CHS program needs to be able to purchase these services from community providers. Tribal populations are often relatively small and not able to support Tribally organized specialty care programs. Tribal primary care practitioners need consultative support for the specialty management of psychiatric and substance abuse disorders just as they have come to rely upon the assistance of the other medical specialties. Mental health services may not only be life saving in their own regards, but these services may also reduce the frequency and severity of need for other health care interventions for both acute and chronic conditions. Local units of state government have traditionally served as a significant source of behavioral health care services either directly or through purchase. The limitations, both fiscal and programmatic, now being placed on these agencies and programs has resulted in reduced resources available to the entire community, both Tribal and non-Tribal.

The implementation of the Medicare like rates (July 2007) is a significant change to the CHS program. This change will have a positive impact on the ability to provide increased services. The CHS program is in need of program support to assist with this transition. In order to complete this much delayed transition, Tribal Health and CHS programs need a variety of resources: staff training, access to Center for Medicare and Medicaid Service (CMS) resources, and legal advocacy/representation. Very modest Tribal programs must interact with a host of providers, some of which are very complex and sophisticated institutions, who can bring significant resources to bear to rightfully protect their own interests.

Again, I wish to thank for the opportunity to share our concerns. You have fought for the passage of legislation that improves the health and general welfare of Indian people. On behalf of the Red Cliff Band of Lake Superior Chippewa, I urge your continued leadership.

Thank you,

Rose Gurnoe-Soulier
Tribal Chairperson

Cc: Tribal Council

BENEWAH MEDICAL CENTER
P.O. Box 388 • PLUMMER, IDAHO 83851
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WELLNESS CENTER
P.O. Box 700 • PLUMMER, IDAHO 83851
(208) 686-9355

April 22, 2008

RECEIVED
MAY 08 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Dorgan,

Thank you for requesting input for the Indian Health Care Improvement Act and the current Contract Health Services. I have worked for the Coeur d'Alene Tribe for 16 years and I have assisted in trying to find ways to stretch the Contract Health dollars to meet the healthcare needs of all tribal patients. It is heartbreaking to tell patients that their healthcare issues cannot be met or are deferred due to funding shortages. Sometimes these procedures/surgeries can mean the difference between a person being able to return to work so they can support their family or not.

It is demoralizing to all to hope that any major accidents or illnesses happen before June each year when CHEF funds are maxed out. When accidents do happen after CHEF funds are expired, the impact on the Tribe by picking up these medical costs is felt by all tribal members due to the need for shifting funding for these catastrophic cases. The result is that the health needs (care, procedures, and surgeries) for other Tribal members is then delayed and put off for another year or sometimes longer. The consequence is rationed and fragmented care.

The American Indians gave up their land and trusted the United States in their promise to provide for their basic healthcare needs. That healthcare should be complete and comprehensive. Thank you for all your hard work to bring about meaningful reform in the area of Indian health.

Sincerely,

Ginger C. Carpenter

Ginger Carpenter, MSN
Executive Director
Benewah Medical & Wellness Center / Coeur d'Alene Tribe
PO Box 388
Plummer, Idaho 83851

CC: Leta Campbell, Health Board Chair, Coeur d'Alene Tribe
Jim Roberts, Policy Analyst, Portland Area Indian Health Board

April 22, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Dorgan:

This is in response to your letter dated March 27, 2008, seeking input from the tribes on the current inadequate Indian Health Care System. As President of the Flandreau Santee Sioux Tribe (FSST), I am focusing on healthcare funding for our patients.

On June 27, 2007, I had the opportunity to meet with Dr. Grim, Director, Indian Health Service (IHS), in Denver, Colorado, at the Direct Services Tribes meeting. We discussed our grossly underfunded Behavioral Health and Alcohol Substance Abuse Programs. Dr. Grim indicated at this meeting that there may be a possibility that Congress may allocate funding, to the tune of $5-15M, for methamphetamine treatment and prevention and suicide prevention in FY-08. Dr. Grim also suggested we submit a document justifying our needs should these funds become available. We submitted a proposal to Dr. Grim on September 17, 2007, however, Dr. Grim left office soon after our meeting and Robert McSwain was appointed as Acting Director. Our request seemed to have gotten lost in the transition.

On January 09, 2008, I and our Health Administrator met with Mr. Robert McSwain , Acting Area Director, and his IHS Delegates. We again provided the documents to the team in support of our meeting. We not only discussed Behavioral Health, CHS, and Alcohol and Substance Abuse shortfalls, but also the Medicaid issue. The attached document spells out the details of non-payment/non-enrollment with Medicaid. We actually left the meeting feeling confident that we would receive assistance from the Indian Health Service, however, we have not received any written response to our initial request nor to the January 09 meeting.

In the interim, we called Mr. McSwain, but he was out of the office. We were referred to another individual, so we explained we were following up on the meeting we had in January, regarding funding and Medicaid coverage for our students. We were assured the information would be relayed to Mr. McSwain upon his return. Currently, we have not received a response from anyone.

FLANDREAU SANTEE SIOUX TRIBE
FUNDING REQUEST FOR THE FSST COMMUNITY AND FLANDREAU INDIAN SCHOOL STUDENTS

CONTRACT HEALTH SERVICES UNMET NEED:

Listed below are the Contract Health Services funds for each fiscal year (FY-05 – FY-08) for the Flandreau Santee Sioux Tribe Clinic (FSSTC) Community.

FY-2005: $714,906.00

Priority I – Paid: 39% - 683 Patient Referrals
Priority II, III, IV, V – Not paid: 61% - 1,072 Patient Referrals

FY 2006: $734,684.00

Priority I – Paid: 39% - 573 Patient Referrals
Priority II, III, IV, V - Not Paid: 61% - 895 Patient Referrals

FY-2007: $749,946.00

Priority I Paid: 39% - 580 Patient Referrals
Priority II, III, IV, V - Not Paid: 61% - 891 Patient Referrals

***FY-2008:** $781,649.00

Priority I – Paid: 31% - 249 Patient Referrals
Priority II, III, IV, V – Not Paid: 69% - 547 Patient Referrals

*The data provided for FY-08 – October 01, 2008 through April 15, 2008.

CHS funds are not spent for Behavioral Health and Alcohol and Substance Abuse treatment unless they meet all the CHS requirements, plus they must be an **immediate** threat to self or others.

FLANDREAU INDIAN SCHOOL:

For several years the Flandreau Indian Boarding School (FIS) has enrolled approximately 300 - 500 high school students from over fifty tribes and thirty different states. The FIS employees accept the parental responsibilities in accordance with the "**loco parenti**" (local parents) document that is signed by the parent and/or guardian. Unfortunately, the majority of the students are either court-ordered or they are involved

in drug and alcohol activities, so the parents enroll them in our school with the understanding their child will receive an education and adequate healthcare.

The school is funded through the Bureau of Indian Affairs (BIA), however, the BIA does not provide funding for Behavioral Health and Alcohol and Substance Abuse treatment for the students. When the Flandreau Santee Sioux Tribe (FSST) initially contracted outpatient healthcare services under P.L. 93-638 Indian Self Determination and Education Act (ISDEA), these services for the FIS students were not included in our base funding.

The 2005 school year, FIS enrolled 505 students – 62 dropped out, 65 were expelled, 142 abused alcohol, 204 abused drugs, 70 displayed violent behaviors, 10 stealing incidents, and 9 were caught with weapons. In support of these statistics, documents are available that will clearly identify and justify the Behavioral Health and Alcohol and Substance Abuse needs: 1) Needs Assessment; 2) Student Statistics; 3) Therapeutic Student Profiles.

The FSST Clinic provides direct healthcare services to all FIS students when they present, and should a healthcare emergency arise; our staff make special arrangements to ensure the students receive the appropriate healthcare. It is our practice to utilize Indian Health Service Facilities (IHS) offering behavioral health and alcohol and substance abuse treatment; however, these facilities routinely have a long waiting list or they are unable to provide the special services needed.

Contract Health Service (CHS) is provided to the FIS students only if they meet all CHS eligibility criteria. The majority of the FIS students come from urban areas and reservations throughout the United States, so they do not meet the eligibility criteria at our clinic. This is due to the alternate resource requirement per the Federal Regulations, (42CFR, Parts 36 and 36a). Staff is required to contact the student's home agency for payment if they live within the Aberdeen Area. This process has proven to be ineffective because the home agencies do not respond in a timely manner or not at all. Unfortunately, the students outside the Aberdeen Area are not provided this service by our staff because it is not a requirement.

A majority of the students are ineligible for South Dakota Medicaid in Moody County because they are not considered permanent residents of Moody County; though they do live in Moody County nine (9) months out of the year.

We are also experiencing problems with the out-of-state Medicaid/CHIPS Programs. They are alleging their policies and laws do not permit them to pay for services outside their given state area. All students who do not have any type of healthcare coverage are required, by most private referral facilities, to pay $50 - $75.00 before they can be seen. There have been instances when our students have traveled 52 miles to an appointment and they were denied services because they did not have the money to pay up front. The Tribe, FIS and Clinic staff will continue to collaboratively work with the out-of-state

Medicaid\CHIPS Program(s) and referral facility(s); however, it seems to be a losing battle.

As noted in the Student Profile document, the previous four school years average the same statistics. It is evident these students are begging for Behavioral Health and Alcohol and Substance Abuse services; and they are not receiving it due to lack of funding. Our students are falling through the cracks and our hands are tied because we are unable to provide these badly needed services.

In the continuum of care, Behavioral Health and Alcohol and Substance Abuse are integral parts of a total and comprehensive healthcare program. Additional funds will allow the tribe to hire trained staff in mental health and physical medicine. Given the number of FIS students with severe behavioral health problems, it is imperative that a Psychologist, two Counselors and a psychiatrist be added to our medical team. It is evident that our FIS students are treated like stepchildren in the IHS healthcare arena. Without this needed care, the students eventually get into negative situations that will warrant expulsion from the school. This type of action place students back into the negative environment that the parents want to avoid, and also does not project well for the students' future. These students deserve no less than what is available to the general public.

I understand Congress allocated $14 for methamphetamine treatment and prevention and suicide prevention activity in FY-2008. I am pleading, on behalf of the FIS Students, for additional recurring funds to provide Behavioral Health and Alcohol and Substance Abuse treatment to our students, so they may live healthy and fruitful lives.

The FIS obviously would qualify for additional funds - the school is not only a unique situation, but also a first class example of a special needs program. The additional funding will play a major role in breaking the negative cycle for these Indian students, and can eventually provide them with the bright future they deserve.

Joshua O. Weston
President, FSST

HEALTH PRIORITIES APPENDIX 5
ABERDEEN AREA IHS
FY 1999-2010

FY 1999	FY 2000	FY 2001	FY 2002
1. Diabetes 2. Alcoholism 3. Healthy Heart and Cancer 4. CHS Funds for Prevention Services 5. Mental Health 6. Tobacco 7. Obesity 8. Health Status/Data Collection 9. Dental Disease	1. Alcohol/Substance Abuse 2. Mental Health 3. Diabetes 4. Healthy Heart and Cancer 5. Contract Health Services 6. Maternal & Child Health 7. Wellness/Prevention 8. Environmental Health	1. Alcohol/Substance Abuse 2. Mental Health 3. Injury Prevention 4. Diabetes 5. Contract Health Services 6. Maternal & Child Health 7. Dental 8. Cancer	1. Diabetes 2. Alcohol/Substance Abuse 3. Respiratory/Pulmonary 4. Mental Health 5. Heart Disease 6. Cancer 7. Injuries 8. Maternal Child Health 9. Dental Disease
FY 2003	**FY 2004**	**FY 2005**	**FY 2006**
1. Diabetes 2. Alcohol/Substance Abuse 3. Mental Health 4. Injury Prevention 5. Heart Disease 6. Contract Health Services 7. Cancer 8. Dental 9. Maternal & Child Health 10. Emergency Medical Services	1. Diabetes 2. Alcohol/Substance Abuse 3. Mental Health 4. Injury Prevention 5. Heart Disease 6. Contract Health Services 7. Cancer 8. Dental 9. Maternal & Child Health 10. Emergency Medical Services	1. Diabetes 2. Alcohol/Substance Abuse 3. Mental Health 4. Injuries 5. Heart Disease 6. CHS 7. Cancer 8. Dental 9. Maternal Child Health 10. Emergency Medical Services	1. Diabetes 2. Mental Health 3. Alcohol/Substance Abuse 4. Cancer 5. Contract Health Services 6. Dental Disease 7. Heart Disease 8. Maternal Child Health 9. Emergency Medical Services 10. Injuries
FY2007	**FY2008**	**FY2009**	**FY2010**
1. Diabetes 2. Cancer 3. Dental Disease 4. Mental Health 5. Alcohol/Substance Abuse 6. Heart Disease 7. Contract Health Services 8. Emergency Medical Services 9. Maternal Child Health 10. Injuries	1. Diabetes 2. Mental Health 3. Cancer 4. Alcohol/Substance Abuse 5. Heart Disease 6. Dental Disease 7. Maternal Child Health 8. Injuries 9. Emergency Medical Services 10. Respiratory/Pulmonary	1. Diabetes 2. Behavioral Health 3. Cancer 4. Heart Disease 5. Dental Disease 6. Injuries 7. Maternal Child Health 8. Respiratory/Pulmonary 9. Emergency Medical Services 10. Elder Health	1. Diabetes 2. Behavioral Health 3. Cancer 4. Heart Disease 5. Dental Disease 6. Injuries 7. Maternal Child Health 8. Respiratory/Pulmonary 9. Emergency Medical Services 10. Elder Health

Bruce S. Bozsum
Chairman/CEO
Mohegan Tribal Council

May 5, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, DC 20510

Dear Senator Dorgan:

The Mohegan Tribe would like to offer input to your office in preparation for the upcoming Contract Health Services (CHS) hearing. The following describes our experiences with our Tribal health care system in as much detail as we can provide, and should convey the special circumstances that apply to the Mohegan Tribe.

- The importance of CHS cannot be understated. This is an incredible benefit to the members of the Mohegan Tribe. Without it, many tribal members might find their health in serious jeopardy. The CHS system allows for the tribal members to have good access to medical professionals in our region, while allowing the Tribe to continue to operate without the need for charitable donations. The Mohegan Tribe does not maintain a health clinic on its reservation. Tribal members living near the reservation land can visit one of three area hospitals, and our densely-populated Northeastern region offers many options.

- The Tribe spends an average of $3.1 million on health care for all of its members (approx. 1,700 persons) per year. Our IHS funding, which only covers Tribal members living within the State of Connecticut, amounts to $1.7 million. The Tribe's business enterprises help to support the shortfall amount.

- Thus far, the Mohegan Tribe has been very fortunate not to have to tap into the CHEF program. Although the Tribe has members who face some considerable health issues, the program which covers catastrophic health events has not been necessary in any situation.

THE MOHEGAN TRIBE
5 Crow Hill Road • Uncasville, CT 06382 • Telephone (860) 862-6100 • Fax (860) 862-6153

- We have had no issues with IHS criteria for the CHS program. Without the additional funds from CHS, the Tribe might only be able to offer emergency/preventive care. Currently, the cost of providing pharmaceutical benefits for tribal members, especially our Elders, is extremely high, with no sign of coming down to a more reasonable level.

- We have saved approximately $20,000 for in-patient care through the Medicare rates. The Tribe is still waiting to implement the software necessary for out-patient care. Because of the lack of this software, we are paying the full rate rather than the Medicare rate for out-patient care.

- All of our health-care providers maintain billing systems that are not affiliated with IHS. In many cases, CHS/IHS funds are used as "the payer of last resort," with Mohegan tribal members using an alternative resource as the primary method of reimbursement for medical treatment. Many tribal members who work for either the Tribal government of Mohegan Sun, the Tribe's business enterprise, are primarily covered by the Anthem or Lumenos program.

The Mohegan Tribe thanks you for your leadership in addressing the important issue of health care in Indian Country. If we can be of any more assistance, or if you would like us to directly participate in the forthcoming hearing on May 15th, please let us know.

Sincerely,

Bruce S. Bozsum
Chairman/CEO, Mohegan Tribal Council

Alamo Navajo School Board, Inc.
P. O. BOX 907
MAGDALENA, NEW MEXICO 87825
(505) 854-2543 Voice (505) 854-2545 Fax

President
Earl Apachito
Vice President
Genevieve Apachito

Members:
Burton Apache
Clayton Monte
Alvino Sandoval

Friday, April 11, 2008

RECEIVED
APR 23 2008

The Honorable Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, DC 20510

Reference: Contract Health Services Program

Dear Senator Dorgan:

The Alamo Navajo School Board, Inc. is a PL 93-638 contractor with the Indian Health Service. While we have withdrawn many if not most of the health functions and activities through tribal shares at the Albuquerque Area Indian Health Service and Albuquerque Service Unit, we have left our Contract Health Services tribal shares at the area office.

Until the last 24 months or so, contract health services coordination at the Area level had been adequate and met the needs of our community. However, Alamo community members have been experiencing problems with both services and payments for services. Specifically, there are problems with bills not being paid, payments are very late when bills are finally paid, and some specialty facilities such as the Heart Institute in Albuquerque do not accept CHS patients. As a consequence, our community members are being hounded by billing officers and then even being turned over to collection agencies. When Contract Health Service staff is contacted regarding these problems, their response is that they are short-staffed and cannot keep up with the workload. As a result, the Alamo Navajo School Board, Inc. is currently assessing contract health issues and the process for providing that service in order to make a decision to withdraw its tribal shares in the contract health services program. This would present a significant decrease in administrative funds to run the area office CHS program. So, how are our CHS program funds being utilized if they are not being used to provide services and pay for services that are provided? What is being done by the CHS program to address problems of payments to service providers? What arrangements are being made to negotiate contracts with specialty service providers? The CHS Program will have to provide adequate answers to these questions if the Alamo Navajo School Board, Inc. is to leave its tribal shares in the Area Office.

Thank you for your interest in the Indian health care system and for allowing the Alamo community the opportunity to provide input on the Contract Health Program and its service delivery system. Should you have any questions, or need further clarification, I can be reached at (505) 854-2543 ext. 1303.

Sincerely,

Michael A. Hawkes
Executive Director

CALIFORNIA VALLEY MIWOK TRIBE
10601 Escondido Pl., Stockton CA 95212 Bus: (209) 931-4567 Fax: (209) 931-4333
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RECEIVED
APR 16 2008

April 9, 2008

Hon. Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, DC 20510

Re: Comments regarding the current Indian Health Care System

Dear Senator Dorgan,

In general, the concerns I have with the current Indian Health Care System is that the Tribal Elder's "Long Term Care" is not being addressed, health care for Native American's who are mentally ill, and many Native American Indians being billed for medical services when the bill is supposed to be covered by the federal government.

The elder population is growing rapidly and although there are some tribes that can afford to pay for insurance to care for their elderly, most tribes have limited resources to properly contribute to the Long Term Care that many elderly members need.

The other health care concern is, mental illness. The Indian Health Care System needs to seriously address the mental illness issue. There are many alcohol and substance abuse programs but little is being done to treat Native American Indians that have mental illnesses. There is a great need for funds and programs to be implemented into the Indian Health Care System that fully address these concerns.

In closing, I have personally known Native Americans who have received bills from collection agencies for past due medical bills that were suppose to be covered by the federal government. These actions cause enormous problems and embarrassment for the patient. They shy away from getting the medical care that they desperately need or are hassled about the bill until the problem is finally resolved and that is usually very time consuming and extremely stressful, especially now that the economy is in such a slump with people having to decide what bills to pay and what food and clothing needs they can do without that month.

Thank you, on behalf of the California Valley Miwok Tribe, for allowing me to bring these matters to your attention.

Sincerely,

Silvia Burley, Chairperson

Dot Lake Village Council
PO Box 2279
Dot Lake, Alaska 99737
907-882-2695
Fax: 907-882-5558

March 31, 2008

Senator Byron L. Dorgan, Chairman
United States Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Dear Senator Dorgan,

We are in receipt of your March 27, 2008 letter regarding current Indian health care system. We support your efforts in making improvements in the Indian health care system as it is badly needed. Currently Dot Lake and the villages of Northway, Tanacross, Tetlin and Tok are being provided Indian health care from Tanana Chiefs Conference, Chief Andrew Isaac Health Center. CAIHC is located approximately over 200 miles from Northway, Tanacross and Tetlin. It is about 150 miles from Dot Lake. We have Health Aides who are equivalent in their training similar to EMT's I - IV in all the villages however some of the villages have only one Health Aide. If additional more advance medical care is needed then patients are transferred to Alaska Native Medical Center in Anchorage, Alaska which is 400+ miles depending on where the patient is from or referred to Chief Andrew Isaac Health Care Center or to a private doctor in Fairbanks.

Medical care and services have declined due to lack of funding at Chief Andrew Isaac Health Care Center. Staffing shortages are being worked on however this area needs improvement in all levels: Medical Doctors, nurses, dentists, support staff as well as qualified specialized services.

In reviewing the S. 1200: Indian Health Care Improvement Act Amendments of 2007: Section 101 specifies two goals: (1) raise the health status of Indians and

Urban Indians by 2010 or successor objectives; and (2) allow Indians, to the greatest extent possible, to set their own health care priorities and establish goals that reflect their unmet needs. We do need to set our own health care priorities and be able to take care of our unmet needs as we believe we know our people and what is mostly needed: travel Cost, Psychology care, more medical doctors and to meet salary cost comparable to private companies, more dental, eye and ear doctors, prevention care in tobacco, diabetes, heart disease, cancer, and other infectious disease such as tuberculosis which is on the rise again in Alaska.

We need more trained Behavioral Health Professionals in our villages to provide mental and psychological help. We hope University of Alaska: Anchorage, Fairbanks, and the Rural Educational Centers (there are currently six in Alaska) will be one of the nine universities that will be considered for the $300,000.00 grant for American Indians into Psychology Program. Alaska has the highest per capita suicide rate in the entire nation: "19.6 per 100,000 according to a report published by the Alaska Statewide Suicide Prevention Council in April 2005. This is nearly twice the incidence of suicide in the rest of the United States." This was published in 2005 and I am sure that the rate has increased since then.

There is one Village Counselor in all Upper Tanana villages that worked only six hours a day; are on call literally 24/7. These counselors need additional training and really should have one other person working with them. Alcohol/drug abuse is high in Rural Alaska therefore we need more preventive education in the schools and villages. The consequences of any type of abuse are seen in the high rate of Alaska Natives who are incarcerated and whom are serving their sentences outside the state of Alaska. The Amendment states "Revises requirements for substance abuse counselor educational curricula demonstration programs. Extends the initial grant period from one year to three years and the renewal periods from one year to two years." Some of our Counselors are Traditional Counselors who practice our traditional methods and are not "trained, educated so to speak in the westernized method of structured classroom education." There has to be a way to recognize these individuals and to give them credit for their many years of commitment and service. Why not, continue to provide them additional training in the Athabascan method of traditional counseling? It also converts mental health to behavioral health training and community education programs making Indian Tribes and Tribal Organizations participants. I believe this

would mean, regional tribal consortium such as Tanana Chiefs Conference? I hope you also meant individual Tribes.

It also authorizes appropriations through FY2017 for Indian health, human resources, and development. I see a great need for more of our own Indian people in all these areas. Our elders who are transferred to Alaska Native Medical Center are sometimes "lost" in the great city of Anchorage. We need to see that they are comfortable and can communicate with the medical personnel, travel agent, and whoever they are in daily contact with. In short, we need bi-lingual people who they can communicate with. They also need hospice care when released. Funding is short and the fundamental concept of processing paperwork for one client is almost a burden. How can one bathe a patient in 15 minutes, or prepare food and feed a patient in 15 minutes? These requirements need drastic changes. They also need to be more realistic and reasonable.

It also states "Eliminates the Office of Indian Women's Health Care....." I need to disagree with that as Alaska Native Medical Center has one of the best Women's Health Care center. The rate of cancer, heart diseases and diabetes is increasing among Alaskan Native women. I urge you to reconsider this part.

And then, it states "Authorizes the Secretary to establish within IHS an Office of Indian Men's Health to coordinate and promote the health status of Indian men." This is needed for Indian men as well as the women who need Women's Health Care.

The sometimes extreme cold weather in Alaska makes it difficult to repair existing sanitation facilities when they break down. The high cost of fuel drives up other cost such as parts needed to fix a simple water & sewer line break. This can be a health hazard if not fixed in a timely manner therefore additional funding for emergency repairs and operation and maintenance can be useful.

These comments come from a rural perspective and not Urban. These are the problems that we face daily as a people in our small villages in Alaska. I'm sure others in the urban organizations in the medical field have a different perspective.

We applaud your efforts and would like to be kept informed when this goes before the President for his signature.

We also thank you for your consideration and recognizing that there are problems which you are trying to correct.

Sincerely,

Charles Miller
Vice President

Cc: Upper Tanana Villages of Northway, Tanacross, Tetlin, Tok Native Association
Roselyn Isaac, Tanana Chiefs Conference, Upper Tanana Board Member
Victor Joseph Director, Tanana Chiefs Conference, Health Services

KEWEENAW BAY INDIAN COMMUNITY

Keweenaw Bay Tribal Center
16429 Beartown Road
Baraga, Michigan 49908
Phone (906) 353-6623
Fax (906) 353-7540

2008 TRIBAL COUNCIL

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RECEIVED
APR 25 2008

April 14, 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Senator Dorgan:

On behalf of the Keweenaw Bay Indian Community, we appreciate your interest in addressing improvements needed in the Contract Health Service program.

A summary of concerns that Keweenaw Bay Indian Community (KBIC) has about the Contract Health Service program is presented as follows:

- Lack of funding to meet the actual Contact Health Service spends that tribes incur.

In fiscal year 2007, the funds earmarked for KBIC's Contract Health Services (CHS) out of the total Indian Health Services (IHS) grant to cover our CHS program would have covered only 2/3rds of the actual costs for CHS services for FY 2007.

In fact, the whole KBIC Health Department was under funded by about 1/3 in FY 2007, meaning that the amount received in KBIC's IHS grant only covered 2/3 of the actual operating costs of the KBIC Health Department, which includes a medical clinic, dental clinic, mental health clinic, community outreach, and the contract health service program. The difference for all programs was made up through third party revenue and a tribal subsidy.

The above picture is presented, because it is difficult to just take the Contract Health Services program out of the whole funding package, and assess it individually. To provide appropriate care for the Indian people in our area, we must have direct service providers, which, in turn, assess and make appropriate referrals for the Contract Health Services program. It is difficult to provide for all the medical needs of the Indian population, when all program components are under funded.

- Lack of funding for the Catastrophic Health Emergency Fund (CHEF).

When a patient is involved in a catastrophic medical occurrence (total cost is over $25,000), it is a financial hardship for the Tribe that covers that catastrophic occurrence out of the CHS program.

To alleviate this financial hardship, Indian Health Services has the Catastrophic Health Emergency Fund (CHEF), which can be applied for if the tribal program has provided more that $25,000 worth of CHS funds toward one specific patient's catastrophic occurrence. The CHEF reimburses for any amount over the $25,000 threshold. Example: If a patient incurs a $100,000 bill at a hospital, and the CHS program still has funds and covers that occurrence, the CHS program pays the $100,000 in full, applies for CHEF, and may get reimbursed $75,000, if CHEF still had funds.

Unfortunately, CHEF also runs out of money. There may be CHEF funds available at the beginning of the fiscal year, but the funds will likely be depleted by the end of the fiscal year.

As stated above, a catastrophic medical occurrence is a financial hardship for CHS programs, but it is even more of a financial hardship for an Indian patient who may bear the cost of that catastrophic occurrence, if the tribe has run out of CHS funds for the year and cannot cover the cost of the occurrence.

An additional issue for an Indian patient whose CHS program has been depleted is that the Indian person cannot benefit from the CHEF program, either. CHS programs are the entities that apply for CHEF, and the application will only be accepted after the CHS program has paid for the occurrence in full. If a CHS program is out of funds, and cannot cover the occurrence, that Indian patient is responsible for the whole bill, and cannot access CHEF, even if there is still money in the CHEF program. Example: A patient incurs a $100,000 bill a hospital. The Tribe's CHS fund is depleted, thus leaving the patient responsible for the total $100,000 bill. That patient cannot access CHEF, even to potentially reduce their bill amount to $25,000, because that $100,000 bill has not been paid in full by a CHS program. Oftentimes, patients incur exorbitant medical bills that they will never be able to pay off.

If you've dealt with a CHS program, you've likely heard the saying "...don't get sick after June...". This is because CHS funds get depleted. CHEF funds get depleted. It is even worse for an Indian person if the CHS funds for their tribe get depleted early.

- The lack of Contract Health Services coverage for Indian patients.

Some tribes elect to cover tribal members of all federally recognized tribes per the Indian Health Service Contract Health Services guidelines, and some tribes elect to cover only tribal members from their own tribes, also per IHS CHS guidelines that allow tribes to define "social and economic ties to the local tribe". Thus, Indian people are excluded not only from CHS, but also from the ability to access CHEF. If an Indian person happens to fall in the CHSDA of a tribe that does not cover Indians from other tribes, that Indian person will never be able to access CHEF because they have already been excluded from

CHS at the tribal level. Even if that Indian person's own tribe paid the medical bills for him or her out of tribal generated funds, that tribe also cannot access CHEF as the Indian patient does not reside in that Tribe's CHSDA.

KBIC is not advocating for the Federal Government to "take over" and not allow self-governance tribes to make the rules and regulations for their communities. But, when the IHS funds do not cover the vast medical needs of Indian Country, tribes do what they can to ensure that their members have health care. It is unfortunate for those Indian people who do not have insurance and cannot access health care.

- Calculation of CHS/CHEF unmet need does not reflect the total unmet need.

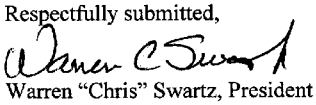
In cases where Indian people do not meet the requirements of the local CHS programs guidelines, those Indian people familiar with the guidelines are not going to apply for CHS, just to get a denial letter. So even if the patient numbers from CHS programs are utilized to generate unmet need due to lack of funding, there are populations within communities that are not being considered.

This same issue happens with the CHEF program. If a patient with a catastrophic medical occurrence is already considered ineligible for a local CHS program, that patient will never be considered as an unmet need for purposes of CHEF.

In closing, the bottom line is lack of funding. When CHS funds deplete, and CHEF funds deplete, Indian people often go without services, end up in financial ruin, or end up responsible for medical bills for the duration of their lives, which, in many cases, will never be paid off.

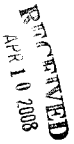
KBIC wants to continue to be an active participant as you progress with addressing concerns about the Contract Health Services program. Ideally, we would like to see interaction with tribes, with a focus on adequate funding and problem solving versus divisiveness and tribes scrambling for "a piece of the pie" that gets smaller with each successive year.

Respectfully submitted,



Warren "Chris" Swartz, President
Keweenaw Bay Indian Community

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.



April 1, 2008

Senator Bryon L. Dorgan, Chairman
Committee on Indian Affairs
United States Senate
838 Hart Office Building
Washington, DC 20510

RE: Addressing the problem of severely limited CHS funding in California

Dear Chairman Dorgan,

Thank you for sending a letter to Indian Country dated March 27, 2008 asking for input on Contract Health Services and recognizing the unmet funding need in the program. You are correct in noting that this program allows for medical care and urgent health care services to be purchased from public and private non-IHS providers when the Indian Health Service or tribal health facilities are not able to provide it. You also correct in noting that early in the fiscal year, the Indian Health Service runs out of funding for Contract Health Services.

The California Rural Indian Health Board Inc., (CRIHB) is a Tribal organization established in 1969 and operating under the authority of the Indian Self Determination Act to provide health and health related services to eleven member Tribal Health Programs serving 35 federally recognized Tribes across seventeen rural counties in the state. CRIHB has begun assisting Tribes and Tribal Health Programs in Nevada, Utah, Oregon, and Washington through projects funded by SAMHSA and the Centers for Disease Control.

There are over 620,000 American Indians and Alaska Natives living in California, according to the 2000 U.S. Census; this is the largest Indian population of any state. This population is comprised of members of indigenous California tribes as well as members of tribes from throughout the U.S. There are more than 109 indigenous California tribes, representing about 20 percent of the nation's approximately 500 tribal groups. Approximately 50% of the population fall below the Federal Department of Health & Human Services poverty guidelines and 30% of Indian households receive general assistance.

The California Rural Indian Health Board requests that Congress provide $2,000,000 in FY 2009 Contract Health Service funds under the authority of section 211 of the Indian Health Care Improvement Act to address the inability of Tribal Health Programs in California to provide inpatient and specialty care for Indians in our Area. California is deferentially under funded by the Indian Health Service (IHS) and our most critical short fall is in CHS funding. This lack of CHS funds is compounded by a lack of access to the Catastrophic Health Emergency Funds which is limited by our general under funding and lack of service capacity associated with IHS constructed facilities which are generally available in other IHS Areas.

4400 Auburn Blvd., 2nd Floor, Sacramento, CA 95841
Phone: 916-929-9761 • 800-274-4288 • Fax: 916-929-7246 • www.crihb.org • firstname.lastname@ihs.gov

Due to federal termination policy all IHS funded services were withdrawn from California in the 1950's. In 1972, services were reestablished through direct Congressional action. Initially these new Tribal Health Programs were operated under the provisions of the Buy Indian Act and became a model for what is now known as the Indian Self Determination Act. At the time the IHS had no "New Tribes" funding policy resulting in a funding dispute between Tribes in California and the Department of Health and Human Services. This dispute, known as the Rincon Case, was found in favor of the Tribes and ultimately lead to the establishment of what is now known as the Indian Heath Care Improvement Fund. Tragically the under funding of the IHS program in California has continued. Today, the California Area of the Indian Health Service has an active user population of 77,000 American Indians and Alaska Natives. Uniquely, only half of these IHS eligible clients are members of one of the 109 federally recognized tribe's within the state. About 30% of the active users are members of Tribes located outside of California and 20% are California Indians documented as descendants of Tribes resident in California in 1852 and listed on the California Judgment Rolls. IHS eligible clients in California are served by 30 Tribal Health Programs which operate one or more primary care clinics under the Indian Self Determination Contracts and Compacts. Collectively these Tribal Health Programs provide services within 37 contiguous counties of mostly rural California running from the Mexican border to the Oregon Border. An area of over 123,510 square miles of which less than 7% is land held in trust. The largest Tribal Health Program serves 13,000 active users the smallest serves less that one hundred. To date, there are no IHS constructed facilities of any kind in the California Area of the IHS. Most significantly there are no IHS funded Hospitals. This makes California one of four IHS areas termed "Contract Health Service Dependent." Two of the four CHS Dependent Areas have at least one IHS funded Hospital facility. California's lack of Hospital capacity comes with a concomitant lack of Pharmacy, Diagnostic Laboratory, and X-Ray capacity. There are only seven Tribal Health Programs that operate licensed Pharmacies', there is only one CLEA certified laboratory and only two operate limited X-ray services. The lack of infrastructure compounds the shortage of CHS funds by expanding the range of services that must be purchased from non-Indian providers. Many Tribal Health Programs are spending as much as 60% of their allotted CHS funds to cover prescription costs for individual clients.

The Tribally Operated IHS funded health care system in California has been very effective at utilizing all of the resources that are available to them. Aggressive measures are used to ensure enrollment of American Indian and Alaska Native clients into alternative coverage such as Medicaid, Medicare and S-CHIP. Many locations services are also provided to insured non-Indians. All programs have active, long standing and creative prevention programs focused on diet, exercise, nutrition and high risk behaviors.

Published research on IHS clients in California documents that very few hospitalizations are funded with IHS funds, but over the entire hospitalization rate is among the highest in the IHS system. Specifically 15.7 per 10,000 were funded with CHS funds compared an all sources hospitalization rate of 980 per 10,000. This study identifies major sources of payment were Medicaid funded 40% of the discharges followed by Medicare which accounted for 25% and private pay at 19%.

Today, with 77,000 active users we can expect 2800 hospital discharges annually of which 700 are identified as having no source of pay creating $19,355,000 in bad debt at licensed hospital facilities in California.

Understanding the IHS program is not new information. For over a decade the IHS Indian Health Care Improvement Fund methodology has shown California to be generally underfunded with an Area wide level of need funded at 55%. However, only recently the complexities and multiple impacts of the under funded CHS program in California have begun to be understood.

The central role of constrained CHS funding in California can best be addressed by providing funding to the California CHS Demonstration Project as authorized in Section 211 of the Indian Health Care Improvement Act. The IHCIA establishes an innovative intermediate risk pool that would target CHS costs below the threshold amount needed for reimbursement by the IHS operated Catastrophic Health Emergency fund (CHEF). The operation of such a fund by the California Rural Indian Health Board would increase access to inpatient and specialty care and reduce financial risk to local tribal health programs. It would also afford California an equitable opportunity to obtain funding through the IHS operated CHEF fund and help establish a more complete continuum of care.

Our analysis indicates that there is currently $19,355,000 in unfunded hospital costs from 700 unfunded hospital discharges for IHS Active Users in California. The requested $2,000,0000 for the California CHS Demonstration Project which would fund approximately 72 cases, given that the average cost of a hospital discharge in California is $27,650. Additionally, there could be as many as 20 high cost cases that would be newly eligible for CHEF reimbursement. A Congressional commitment to fully fund such an intermediate risk pool over a multi year period could easily serve as a model to address the issue of CHS dependency in other IHS Areas including Portland, Nashville and Bemidji. Initial funding for the California CHS Demonstration project should be in the range of $2,000,000 to allow for administrative efficiency. This sum is small compared to the "staffing packages" that routinely accompany the opening of new hospitals in other areas, a benefit that will never accrue to hospital rich California.

IHS CHS program management statistics document that the California Area consistently has fewer CHS resources even when compared to the other CHS Dependent Areas.

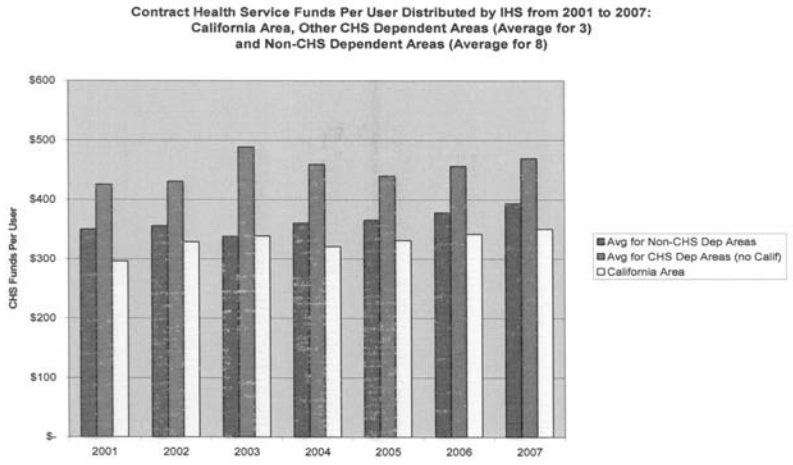
Similarly the California Area has had less access to the Catastrophic Health Emergency Fund of all the IHS Areas even when compared to the other "CHS Dependent Areas."

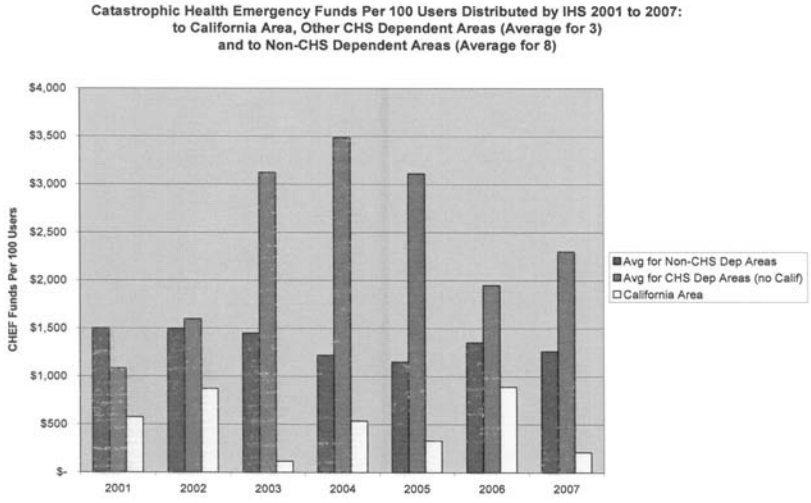
Attached are two charts that are useful to further understanding the challenges we face in maintaining the CHS program and related health services.

In closing, thank you for allowing me to share information on CHS in California. I hope that you will further support this vital program.

Sincerely,

James Allen Crouch, MPH
Executive Director


Contract Health Service Funds Per User Distributed by IHS from 2001 to 2007:
California Area, Other CHS Dependent Areas (Average for 3)
and Non-CHS Dependent Areas (Average for 8)
CHS Funds Per User
$600
$500
$400
$300
$200
$100
$-
2001
2002
2003
2004
2005
2006
2007
Avg for Non-CHS Dep Areas
Avg for CHS Dep Areas (no Calif)
California Area


Catastrophic Health Emergency Funds Per 100 Users Distributed by IHS 2001 to 2007:
to California Area, Other CHS Dependent Areas (Average for 3)
and to Non-CHS Dependent Areas (Average for 8)
CHEF Funds Per 100 Users
$4,000
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$-
2001
2002
2003
2004
2005
2006
2007
Avg for Non-CHS Dep Areas
Avg for CHS Dep Areas (no Calif)
California Area

FALLON PAIUTE-SHOSHONE TRIBE
FALLON TRIBAL HEALTH CENTER

April 11, 2008

RECEIVED
APR 30 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Dorgan,

This letter is to provide the input on problems and concerns related to the current Contract Health Services program. The Fallon Tribal Health Center issues referrals to Tribal members and their families for outside providers for over 15 years. On average there are over 2,000 referrals for Fallon Tribal Health Center patients issued within the year. In 2007 there were 2,146 referrals approved and 601 referrals denied. The table below presents statistics for last four month indicating the number of referrals approved, denied, or pending:

Table1

	December 2007	January 2008	February 2008	March 2008
# of referrals approved by IHS	123	119	129	203
# of referrals denied by IHS	40	30	42	50
# of referrals pending approval from IHS	25	23	30	38

It can be seen from the table above that on average 29% of referrals are denied by Indian Health Services. Indian Health services have established medical priorities for contract health services medical care that determine which referrals are approved or denied. They are the following:

I. Emergency/Acutely urgent care services
II. Acute primary and preventive care services
III Chronic primary and secondary care services
IV Chronic tertiary care services
V Excluded Services

For the last several years only priority I, Emergency/Acutely urgent care services, is approved, which includes such services as emergency room care, emergency psychiatric care, life threatening condition, acute prenatal care, etc. As a result, preventive care services, primary and secondary care services, etc. are not being approved. The reason that only first Contract Health Services Medical Care Priority is approved is due to the

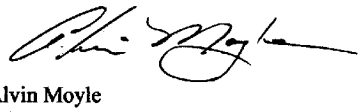
1001 Rio Vista Drive • Fallon, Nevada 89406-9408 • Tel 775-423-3634 • Fax 775-423-1453

lack of funds available to cover all Contract Health Services expenses. In 2007 fiscal year Schurz Service Unit (manages Contract Health Services for several Northern Nevada Health Clinics including Fallon Tribal Health Center) overspent Contract Health Services funds $4,000,000 and this is taking into account that only medical priorities I, Emergent/Acutely urgent care services, are being approved for Contract Health Services. Major complaints from the patients are that pain management is not covered by Contract Health Services. In addition, durable medical equipments such as wheelchairs are not being approved by Contract Health Services.

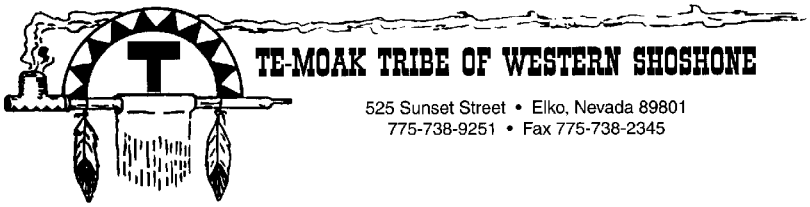
Obviously, the funding for Contract Health Services is not sufficient to cover all expenses for all priorities (including preventive services, pain management, etc), which results in poor health coverage for Indian population. We hope that with the passage of the new bill the health care coverage for Native Americans and Alaskan Natives will drastically improve. If more information or statistics is needed, please do not hesitate to request it.

If you have any questions regarding this matter, please call Dr. Virginia Sutter, Fallon Tribal Health Services Director at (775) 423-3634.

Sincerely yours,



Alvin Moyle
Tribal Chairman
Fallon Paiute-Shoshone Tribe



TE-MOAK TRIBE OF WESTERN SHOSHONE

525 Sunset Street • Elko, Nevada 89801
775-738-9251 • Fax 775-738-2345

April 10, 2008

RECEIVED
APR 18 2008

Senator Byron L. Dorgan
Senate Committee on Indian Affairs
838 Senate Hart Office Building
Washington, D.C. 20510

Honorable Senate Dorgan:

In reference to your letter dated March 27, 2008, we appreciate the opportunity to address the health care needs of the Native American population of the Te-Moak Tribe of Western Shoshone. The Te-Moak Tribe of Western Shoshone serves the population of four (4) communities consisting of the Elko Band Council, Elko, Nevada, Battle Mountain Band Council, Battle Mountain, Nevada, South Fork Band Council, Lee, Nevada and Wells Band Council, Wells, Nevada.

The Southern Band Health Center under the direction of Don Davis, Area Director, Phoenix Area Indian Health Service located in Elko, Nevada, which is located in northeastern part of Nevada and serves this population which is spread over a large geographical area reaching up to 75 miles east and west and 30 miles south of the City of Elko. The Southern Bands Health Center is strictly an outpatient facility with limited services. Currently the services available are Pharmacy, Dental and Outpatient Clinic and limited Mental Health Services.

STAFFING:

- For the past one and half years the clinic has been operating with a temporary (CEO) due to the lack of hiring from the Indian Health Services. This in itself has caused problems with communications with the Tribe. There have been numerous requests for upgrading of clinical services and needs that are pertinent to the population but to no avail. The answer is always when we get a permanent position hired we will look at this situation.

- The Tribe's concern is the budget that is spent on salaries for administration and clerks instead of utilizing funds to obtain a fully fledged doctor on a permanent status. Our Tribe is concerned of the professional positions that should be filled and a reduction in the administration and clerical positions. The Te-Moak Tribe has continuously requested the budget on Contract Health Services is

approximately $1,361,954.00 for FY'2008 and as of this date the Te-Moak Tribe has still not received a budget.

- The tribe would like to have a professional desk audit done to this clinic. Positions added have caused much extra expenses. The tribes are concerned with the ability to add positions without consulting with the actual need of the clinic. Patient visits to employee ratios should be considered for workload standards.

FUNDING:

- The Southern Bands Health Center has an operating budget for Contract Health at $2,087.044.00. The amount of ($557,295.00) under funded according to the most recent budget received from the Acting CEO. The Contract Health Services in our service unit is responsible for Catastrophic Care, Diagnostic Testing and any other specialty services that are not available within the walls of the clinic. Obviously, this is not enough funds to cover all services needed causing lack of care to patients and delay of referrals. The Southern Bands Health Clinic has expended $95,000.00 to install a phone system, which has been in operation for approximately 15 months. This installation has resulted in numerous complaints from the public. Patients will call and will only receive a directory and some of the elders have no idea of which button to push to get the information they were calling for. Many times the people within the clinic can listen to the phone ring and ring and the refusal of the staff to pick up the phone has become totally ridiculous and irritating to patients because the staff is aware that if they don't answer it will switch to automatic attendant. Many patients call the pharmacy and receive the answering machine and leave messages but staff not returning their calls. Thus this phone system has become a hindrance rather than an improvement and has cost thousands of dollars. We are in favor of upgrades to technology, but those that are beneficial to all those involved.

THIRD PARTY:

- In the Indian Health Services it is important to bill Third Party resources, which includes Private Insurances, Medicaid and Medicare. These funds are being used to offset the deficits in the Contract Health Budget, instead of supplementing or improving the care that is needed. These improvements in our clinics would be more beneficial could include a Dental Clinic that did actual needed Dental work rather than just pull teeth for easy fixes, receive more pharmaceuticals on the formularies and a need for increase in overall improvement of care which is extremely important for specialty physicians and providers.

REFERRALS:

- Referrals to specialty physicians are always a challenge. Many patients will see a doctor and need to have specialty treatment or a more thorough examination from a specialist but these referrals are

delayed causing patients to wait for care. This care could range from having a Diagnostic Test for diagnosing to a much needed oncology appointment. This is detrimental to the quality of care that should be provided for our people. We know that budgeting is a major factor but when a patient lives are in jeopardy, this is serious. For example, a Native American elder could not get a referral for over thirty (30) days and had an ongoing serious medical problem in which a diagnosis resulted in throat cancer and is currently undergoing chemotherapy. This is not preventative.

- On every Tuesday a committee meets for referrals, which results in the Southern Bands Health Center is being closed down half days and services for the patients are only 36 hours a week. This committee reviews, recommends and approves for referrals and whenever recommendations are made by the attending physician his/her decision is overrode by employees in the contract health services office who are not qualified physicians and should not be allowed to make any type of medical decisions when it comes to the lives of our patients. This process has been disputed mostly by physicians because of the overstepping of boundaries. Once again, this has never been solved. Resulting in Clinical Directors leaving because of this development.

DRUG FREE WORKPLACE:

- In 1988 the Drug Free Workplace Act came into law. In most facilities today in and most Tribal Organizations across the nation, this law is adhered through employee drug testing. Currently, the Southern Bands Health Center Employees are not tested under this law. In fact, they refuse to due to their union affiliations and protections. We as a tribe are concerned with this practice and would like to have this issue resolved. As a footnote, the Southern Bands Clinic is a tribal facility that is leased from the Elko Band Council of the Te-Moak Tribe of Western Shoshone and is employed with Indian Health Service Employees.

EMERGENCY ROOM VISITS:

- Patients go into the Southern Bands Clinic to receive medical services but due to the lack of professional services of a physician many of these patients end up having to go to emergency for a correct diagnosis or for further examinations. This not only causes increased burden for the family but emergency room visits and costs are extremely high which is affecting the Contract Health Budgets. These incidents should be reviewed and investigated by a Peer Review Organization and recommendation made need to be observed and acted upon.

DENTAL:

- Our dental services have become very limited. These limitations have been implemented due to lack of funding we are told. The services are restricted to extracting of teeth, partial cleanings and care that is quite

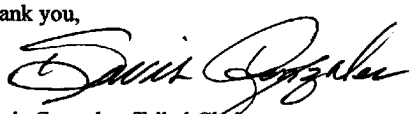
useless. We have many individuals who have had root canals temporarily done and then asked to find their own dentist to finish the procedure. Many of these procedures do not get completed due to the financial burden placed on the patient. Contract Health responsibility is limited because of the priority 1 placing. Therefore, care is not complete. The Te-Moak Tribe has requested an additional dentist position and is in the process of trying to receive funding for expansion of the dental department and provide services to a seriously needed dental program. To succeed in this expansion funding for a modular is greatly needed to provide these services.

NEED TO KNOW VS PRIVACY ACT

- The Te-Moak Tribe of the Western Shoshone participates in the Special Diabetes Program for Indians. We currently have approximately 210 diabetics. This is a prevalence level of about 11%. In the past we have not had access to the exact number patients or listing of patients from the Phoenix Area control patient records, due to what is told is the Privacy Act. We believe that a program which is funded by the Indian Health Services (Special Diabetes Program for Indians) does have a need to know and in order to comply with regulations should have access to this information. Most recently, we actually received names from individuals themselves by offering the NIKE N7 shoes. This is a sad way to get statistics. We plead with you to investigate this issue. We believe this strictly exists in the Phoenix Area.

Finally, we are looking forward to hearing of your improvements to the Indian Health Service but most importantly to the Southern Bands Health Clinic that services our area directly. Your much needed support is appreciated and definitely will give the health care of the Te-Moak Tribe a great deal of needed enhancement. Thank you once again, for your concerns.

Thank you,



Davis Gonzales, Tribal Chairman
Te-Moak Tribe of Western Shoshone Indians of Nevada

CONTRACT HEALTH SERVICES—A GROWING CRISIS IN HEALTH CARE FOR AMERICAN INDIANS AND ALASKA NATIVES

A Discussion Paper

Prepared for the
Southwest Oklahoma Intertribal Health Board
Of the
Lawton Service Unit of the
Oklahoma City Area IHS

By the
Task Force Group on Contract Health Services
May 4, 2008

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BACKGROUND

The need for Contract Health Services (CHS) is a result of the tremendous growth in medical technology and tertiary care during the past several decades, along with an aging population. These advances have come with ever increasing costs. The Indian Health Service (IHS) has not escaped these costs and the growth of medical care has resulted in the need for IHS to purchase ever increasing care from the private sector. As a result of these increases, the IHS has implemented a new program, which now has its own line in the budget: the Contract Health Services (CHS) program. Further, the rapidly escalating costs, particularly for "purchased" care, have exceeded the resources available to the IHS to such a degree that establishment of priorities of care that will be funded first has been necessary. The end result has been a crisis in CHS care.

This discussion paper has been prepared to respond to the request for information by the honorable Byron Dorgan, Chairman of the Senate Indian Affairs Committee (letter to Tribal Leaders, March 27, 2008). We express our thanks to the Chairman for undertaking this task and are happy to provide our perspective on the CHS program as it affects services for Indians residing in southwest Oklahoma.

Analysis of CHS is made more difficult by the extraordinary complexity of providing health care services to the more than 500 sovereign Indian Nations of widely varying size, location, and morbidity. The necessity for providing an equitable distribution of resources within this complex situation is a major challenge and one that also requires attention. It is not presently possible to provide a comprehensive analysis of CHS. In this presentation we will discuss some of the major considerations related to operation of CHS, especially those most affecting the approximately 25,000 Indians residing in southwest Oklahoma (i.e. served by the Lawton Service Unit).

One sometimes hears the expression that the IHS is "broken". We do not believe that that assertion can be made in the face of the serious under funding that exists throughout the IHS. Use of the term, "broken" implies that there is some inherent deficiency in policy, philosophy, or operations. We reject this assertion. Certainly such a judgment can only be made when and if adequate resources are first made available to fulfill the federal government's responsibility to Indian people. It is necessary to keep in mind the overall inadequacy of resources for the entire IHS programs. A discussion of these needs is beyond the scope of this paper but the document entitled "GAO Report to the Committee on Indian Affairs, U.S. Senate – Indian Health Service – Health Care Services Are Not Always Available to Native Americans. August, 2005" provides much useful recent information.

THE OKLAHOMA CITY (OKC) AREA, IHS

Inadequate and Inequitable Funding Experienced by the OKC Area

The overall unsatisfactory situation in regard to resource allocations to the OKC Area were very well described in a 1989 publication entitled "Status of Indian Health Service Funding in Oklahoma. Report prepared by the Chickasaw Nation Office of Public Affairs, revised March 1989". The following information is extracted from the above referenced publication.

> The OKC Area Indian population accounts for 23 % of the total Indian population of the United States but receives only 11% of IHS allocations. The current (i.e. 1989) OKC Area recurring *Hospital and Clinics and Contract Health Services* funding in the amount of $82,432,700 represents funding of $379/person. This compares to an IHS average of $688/person. In order to bring funding for the OKC Area up to the national average, would require additional funding of $68 million for the OKC Area.

The inequities described in that document persist to the present time. As shown in Table 1, which displays a ranking of IHS Areas by per capita CHS allocations for FY 2007, the OKC Area occupies the lowest level ($207.38). An increase of $11.2 M (73 per cent) would be necessary *to bring the OKC Area to the national average of $358.76.* Presently and historically the OKC Area has consistently ranked at the lowest funded of the 12 Areas. This inequity, with its effect on the OKC Area in general and the Lawton SU, specifically, demands correction. As noted below, the per capita CHS funding for the Lawton SU of $137.66 is well below that of the OKC Area.

The Interrelationship of Contract Health Services and Direct Services

Part of the complexity of Indian health care is the extensive interrelationship between direct health care and that provided through the CHS. It is not possible to describe what an ideal interconnectedness should be but IHS personnel can attest to the many challenges of dealing with the many complexities on a daily basis. The significance of the interrelationship is that one cannot consider one program without attention to the other. In simplest terms, attention must be given to providing adequate resources to both the Direct and the CHS components. CHS cannot be operated effectively without concomitant attention to adequate support for "in-house" services.

In the case of the Lawton Service Unit (SU), to cite a ready example, a lack of resources for adequate in-house services has consequences for the CHS program. For example, staff shortages are such that much care that could and should be provided in-house must of necessity be "farmed out" to the private sector. Not only does this place undue pressure on the CHS program, but it has a compounding effect in that we are therefore not able to bill third party payors for services that could otherwise be provided in-house. Thus, we not only lose resources in the form of collections, but must then pay for care provided in the private sector that could more economically be provided in-house. Providing adequate support for CHS must rest upon adequate support for in-house care.

One aspect of this interrelatedness is that patients referred to private vendors for care remain the responsibility of the local Service Unit throughout the course of care, following referral for outpatient care and post hospital discharge. Improved management of care and improved satisfaction of referred patients would occur if a case manager were employed by the IHS to work with the private facility in order to coordinate care between the two systems. Questions such as location of service, payment for various procedures and expedited communication

between the IHS and vendors would all be greatly facilitated if funds were available for case management.

The Contract Health Services Office is severely understaffed due to limitation of positions and funding to support the positions. Although the Lawton Service Unit CHS workload supports the need for 10 FTE's plus a manager, current staffing is only 4 full time FTE's. Similarly, there is great need for a benefits coordinator to assist patients in navigating the often labyrinthine courses now existing in health care. Finding one's way in the many channels of care is a problem for many Indian patients who have no prior experience with the "mainstream" health care system and who often need assistance in applying for benefits, such as Medicaid and Medicare. Thus, two categories of staff should be added to the in-house facility to ensure proper care obtained from private vendors and to coordinate care between the latter and the IHS.

Fundamental Differences between In-House Health Care and Payment for Contract Health Services

Notwithstanding the complexities of program interrelatedness, a fundamental "structural" divide exists between providing in-house services and paying for services provided outside the IHS or Tribal programs. The IHS is faced with the challenge of operating two fundamentally different systems of care, adding to an already complex situation. When providing direct care to individuals, one can always do something to ameliorate the situation or at least to render aid. In contrast, with CHS, a fundamental difference exists. With CHS, the IHS has become a mini-health care financing agency, a fundamentally different approach to health care. The primary concern in the latter instance is making decisions about what can be paid for with insufficient funds. The denial of payment for many services has created yet another barrier to access to care.

In addition, the growth of the CHS program has created an administrative nightmare for overworked staff. Health care professionals find that serving on CHS committees not only interferes with seeing patients, but is extremely unpleasant because of the necessity of denying payment.

We must point out the extreme interference with adequate administration at the Area and SU level when sweeping policies and procedures are imposed from higher authority. The IHS is unlike any other agency within the Department of Health and Human Services and many of the centrally planned procedures simply do not fit the distinct mission carried out by the IHS. Two problems are causing major disruptions in administering the program and these disruptions necessarily ultimately result in denial of access to care. The first of these is the misguided imposition of regionalization of the OKC Area Human Resources Management (Personnel) function. With the concomitant reductions in Area Office personnel that have occurred in recent years, it is presently almost impossible to process the paperwork necessary for bringing staff on board, particularly medical staff to address immediate needs. The second barrier is the federally mandated conversion of IHS to "United Financial Management System" (UFMS) in FY 2008. This new financial management system, already implemented with limited success with other agencies, is essentially incongruent to the unique financial requirements of the IHS system. As a result, we have experienced numerous delays in payments to vendors and have effectively lost multiple contractors, and critically needed contracted medical providers as a result. We do not

believe the application of this system can be satisfactorily conducted within the IHS, certainly not at the SU level where "the rubber meets the road". We request that the IHS be permitted to utilize its previously existing system, or a modification that it finds useful rather than the mandated UFMS. We further recommend that the Congress address these types of ill-conceived organizational change mandated from higher authorities with little or no idea of the consequences for local Indian communities.

Estimating Unmet Need. Difficulties in Accurately Measuring That Which Does Not Take Place

A major difficulty experienced by the IHS is the inability to accurately measure the extent of denial of access to care provided either in-house or through CHS. It is not possible to accurately identify each person who, for whatever reason, does not get to even be considered for care. Many physicians do not refer a patient for CHS payment when they already know funds are not available to say nothing of having to refer a patient to a private facility while pointing out that the IHS does not have the funds to pay for that care. Similarly, patients also quickly learn that it is futile to seek CHS and so do not appear for care. Calculating the extent of such lack of access is virtually impossible. However, attempts to estimate the extent of this lack of access are helpful in analyzing the need for additional funds.

THE LAWTON SERVICE UNIT (SU)

Background

The Lawton SU encompasses ten counties in southwestern Oklahoma, home of approximately 25,000 members of seven tribes: Apache, Caddo, Comanche, Delaware, Fort Sill Apache, Kiowa, and Wichita tribes (see map in Figure 1). In addition, about one-third of all admissions are by members of other tribes residing in the service area. Health care is essentially rural with commonly reported difficulties experienced by patients because of lack of transportation. Technical and other support is provided by the OKC Area Office located in Oklahoma City, 90 miles away.

To date, the tribes comprising the Service Unit have regularly exercised their self-determination through decisions to receive their health services directly from the Indian Health Service. Advice and guidance are provided through the Southwest Oklahoma Indian Health Board (SWOIHB). The health facilities of the Service Unit are the Lawton Indian Hospital, the Anadarko Health Center, the Carnegie Health Center, and a health station at the Riverside Indian School located in Anadarko, Oklahoma, which serves students from across the US.

Lawton Indian Hospital

The present facility was constructed in 1967 with 80 beds. However, because of resource constraints, only 28 beds are presently utilized. When the hospital was constructed, it did not receive the usual increased funding for staff and operating expenses. As a result, within a short time, staffing constraints forced closure of 20 of the beds, and a vicious downward spiral of lost services commenced that has not entirely stopped.

Existing staff vacancies reflect the loss of services experienced by the Lawton SU through lack of funding for the Lawton Indian Hospital (LIH). For example, we have positions for 29 physicians, but have only 17 on board. This represents a *deficiency* of 41 per cent. Further, we have positions for 18 primary care physicians with 11 on board; positions for three pediatricians and one on board; positions for four internists and two on board; positions for two OB/GYN physicians and one on board. Inability to adequately staff the LIH has resulted in closure of the Obstetrics Delivery Department. Deliveries must now be referred to local OB providers and hospitals. The loss of these services translate to additional demand on CHS and loss of potential revenue from billing third party payors for OB services that could have otherwise been provided in-house.

Through efforts of SU staff and the Board, the Congress has taken initial steps to stop the continuing decline in services. In 2004, the Congress provided $ 3 M in recurring funds and directed the IHS to submit a request for additional funds if such were considered to be needed. As a result, the IHS requested approximately $11 M in additional funds for the FY 2009 appropriation, and this increase has been included in the president's budget request. The point in regard to the LIH is that, unlike any other present inpatient facility constructed with IHS funds, it is necessary to *restore services lost as a result of failing to provide basic funding* at the time the facility was constructed in 1967. This puts the LIH in a situation unlike any other in the IHS.

The FY 2009 request was based upon a quick assessment of the most urgent needs and was therefore primarily based upon the need for additional staff. It did not contain an amount that would have accumulated through the years if the hospital had been appropriately funded at the time of its construction. We note that this amount was well below the actual operating needs, and in particular *did not take into account the need for substantial increases in funding for CHS.*

History of CHS Allocations to the Lawton Service Unit

In Table 2 below is shown the annual allocations for CHS for the Lawton Service Unit for the five year period 2001-2006. Except for a one time non-recurring allocation in 2005, it is clear that the average annual increases in CHS allocations for the Lawton SU of 2.2 percent is far below estimates of annual increases in the cost of medical care. With a recent annual increase in the actual cost of CHS care of 8 percent (see *Health Care Costs – A Primer*. Kaiser Family Foundation. August 2007, p. 3), there has been an annual *erosion of support for CHS.* It is not surprising that CHS care has become a crisis. In FY 2007, the Lawton SU received $3,299,976.00 for CHS. With a conservatively estimated 25,000 beneficiaries, the calculated *per capita* allocation for that year was $ 132.00 (data provided by OKC Area staff). Experience indicates that this amount should be increased at a minimum by several fold.

Unmet Needs in Contract Health Services Care at the Lawton Service Unit.

As noted above, establishing a precise figure for additional funding required to adequately provide CHS for Indians throughout the US, including the Lawton SU, is virtually impossible. A door to door community survey would be necessary to provide some degree of quantification, but such surveys are very difficult and very expensive. As noted above, patients often do not

seek care because they know payment will be denied or because of prior denials of CHS. Many times such patients are sued; wages are often garnished; and tax returns often attached; patients are harassed and threatened by collection actions; and credit is ruined by negative reporting of unpaid medical debts. IHS/Tribal/Urban physicians too, knowing that payment will be denied, often do not bother to make a referral for clinically indicated care. There is presently no systematic way to record the numbers of individuals who do not get referred for CHS. However, CHS staff who deal with denials and deferrals on a daily basis have a very good sense of the magnitude of the problem. The extent of the overall problem is such that, even if there is a modest degree of error in the estimates, these errors do not appreciably affect the overall assessment of need. The estimates in this paper have been kindly provided by CHS staff at the Lawton SU, with assistance and guidance of Area Office staff, and are based upon existing data and their own extensive experience. The estimates are considered to be reasonable and conservative.

Three Categories of Unmet CHS Needs

The OKC Area operates under Medical Priorities for CHS, published October 6, 1988, and which was specifically designed to accommodate the limitation of CHS funding in two major areas. First, it is of necessity much more restrictive than IHS Headquarters CHS Medical Priorities; placing multiple IHS HQ Priority I services – such as preventive care – in Priority II. Second, it incorporates an approach to further manage resources by simply identifying specific services as "excluded" services, and by definition excluding certain categories from the need from any consideration for possible CHS payment.

1. Deferred Services. Services that might be provided, and authorized for payment, if funds were available, are termed "deferred" services. Authorization for CHS payment for such services are "deferred" but are essentially denied. Although the requests may be reconsidered in subsequent review weeks, most of these referrals never reach the level of priority for payment; and the services are usually never received by patients. Noteworthy, many of the "deferred" items would be extremely cost-beneficial to both the patient and IHS, as "denial" of access to preventive/diagnostic/early intervention type services often lead to acute, chronic, and emergency cases that are costly for CHS. The burden on the health status of the patient can not be measured. Estimates of deferred services are arrived at by CHS staff who have years of intense experience. We emphasize that our estimates are conservative. Of the three categories of CHS unmet need, that of deferred services can be most readily quantified. Many of these conditions are within the highest priority (Priority I of the IHS and OIC Area), but cannot presently be covered because of lack of funds. The Lawton SU deferred services for 2007 are shown in Table 3. We emphasize that the figures shown are presented only for the IHS *Deferred Services matrix*. It does not address the "excluded" services of the OKC Area CHS Medical Priorities. The array of services that require payment but for which no funds are available is staggering. Attention is directed to the need for cardiovascular procedures, dealing with the leading cause of death of OKC Area Indians. *In the Lawton SU, as in the rest of the OKC Area, funds are not available to provide all of the necessary services in Priority I* of the OKC Area *CHS Medical Priorities; funds are not available to comply with the IHS National CHS Medical Priorities*.

2. Excluded Services. Excluded services are services that are presently simply unavailable. That is, they are not referred nor authorized for CHS care because of absence of funds. CHS staff at the Lawton SU, again with the support and guidance of Area Office staff, have provided a listing of services that are presently excluded in the CHS Medical Priorities because of a limitation of CHS funds at the Lawton SU. This list is shown in Table 4. Attention is directed to the critical importance of rheumatology, a serious and prevalent condition among our service population. Multiple publications reflect the need for analysis of the prevalence of rheumatology, arthritis, Lupus and related conditions, with attention to diagnosis and early intervention. With the present level of our funding, both diagnosis and treatment are often delayed until the condition has deteriorated to urgent or acute status. The availability of CHS for these, and similar conditions, would greatly improve the health status of the population.

3. Denied Services. This category is based upon an estimate of denials of CHS payment for Indians served by the Lawton Service Unit. It is an adjustment of the recorded data. The actual number of denials is adjusted by a factor of 2 and the cost is adjusted by a factor of 2.5. The volume of denied services includes 3,564 denials at a total cost of $16,171,460.

DISCUSSION

While our SU experiences problems of access to health care shared by tribes throughout the country, it has certain distinctions that require specific attention. These include the loss of CHS capability occasioned by inadequate resources resulting from the special circumstances that particularly affect the LIH mentioned above. The special needs experienced by the LIH have been repeatedly described by us, primarily through a series of budget requests and Congressional testimony offered during the past decade and a half. The downward spiral experienced by the LIH with its effects on the rest of the SU reached the point of crisis several years ago. This crisis has been partially responded to through actions of the Congress and the IHS, but we are far from reaching parity with similar SU. The compounding effect of inadequate care in our facility has uniquely created an interconnected series of denials of access to care affecting both in-house and CHS services. As we have noted, while it is important to direct one's attention to CHS, its deficiencies ultimately cannot be separated from overall funding shortages.

Because of the lack of funding for the LIH noted above, we have not been able to employ an appropriate number of specialists to provide in-house care in our clinics and hospitals. Thus, we not only have to refer many patients to private vendors (at great cost) but we have not had the opportunity to provide this care, which should be available in our own facility, and for which we should be able to bill third party payors. The resulting compounded loss of services, to say nothing of the loss of third party collections, creates its own self-defeating circumstances. We emphasize that attention to the needs of adequate specialty care in our own facility would be a significant advance towards correcting lack of access to services through the CHS program.

Another situation illustrates the loss of economies of scale by the present inadequate level of support available for CHS. For example, we regularly deny payment for corrective procedures that are necessary for a given patient *to remain employed*. This loss of employment is often accompanied by loss of private insurance so that the patient appears at one of the IHS clinics for attention to other health matters previously covered by private insurance. It is not unusual for

such a circumstance to arise because of injuries that go untreated. Such conditions are necessarily denied payment because of inadequate funding. This is another example of the complicated interconnectedness of Indian health care and illustrates the compounding that results from inadequate resources, not only for CHS but for in-house care.

We would be remiss if we failed to address the impact of insufficient CHS funding on the local non-IHS health care community. Denial of payment for services provided to IHS patients does not adversely affect only the Indian patient. It adversely affects the revenues of all health care providers, who often must absorb the costs of uncompensated care.

Finally, we commend the often heroic efforts of our Area and Service Unit staff to "manage" the limited funds we do receive. We have, by necessity, developed and adhered to an Area CHS Medical Priorities System that *further restricts the IHS CHS Medical Priorities*. We have, since 1983, aggressively pursued contracts at Medicare or lower rates (staff have achieved the highest levels of CHS payments at Medicare rates). The magnitude of our concerns is expressed in the fact that we have consistently represented approximately one-half of the CHS contracts recorded by Blue Cross/Blue Shield of New Mexico, the IHS Fiscal Intermediary who processes CHS claims payment. We have continually developed innovative service delivery models that are cost effective and service-efficient and that are designed to optimize the efficiency with which all categories of IHS resources are managed.

RECOMMENDATIONS

We believe that all individuals who have dealt with the difficult problems of CHS care agree that the basic problem is one of dramatic underfunding of the entire IHS system itself. In the case of the OKC Area, and specifically, the Lawton SU, attention to CHS requires attention to the level of care that is provided in-house and that additional resources are mandatory for the latter as well as for CHS.

We recommend great caution in making a judgment that the IHS is "broken" before taking into account that this opinion is basically an acknowledgement that the program is very seriously under financed. To the contrary, the IHS regularly provides numerous examples of creative and effective models of services that often serve as models for other countries. We are not opposed to exploring other, perhaps radical, systems of care but caution that doing so is unwise without first correcting for the dramatic under funding that now exists.

We request that the IHS be permitted to utilize its previously existing financial management system, or a modification that it finds useful, rather than the mandated UFMS. We further request that the Congress address such types of ill-conceived organizational change mandated from higher authorities possessing little or no understanding of the consequences for local Indian communities.

Based upon the most recent estimate of *only deferred* services, we request the addition of $27,000,000 for CHS funding for the Lawton SU.

We request that the Congress provide for an in-depth analysis of the overall allocation of CHS funds by Area in order to determine inequities of resource allocation inherent in the present system.

We request funding that will bring the *overall* OKC Area per capita level of funding (presently $207.38/person) to at least the IHS average.

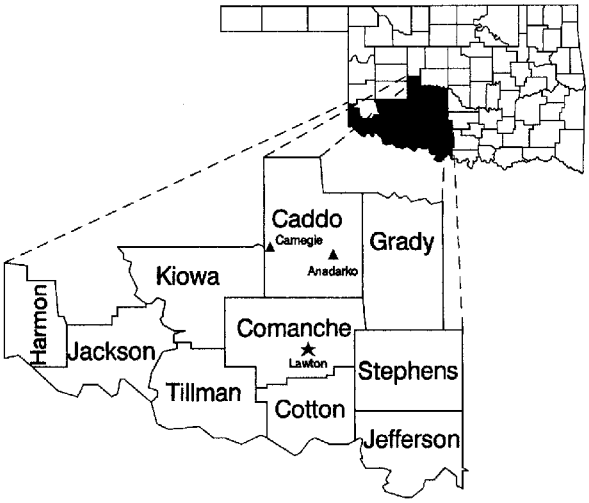
We request funding for CHS Program staff, Physician/Nurse case managers and benefits coordinators for the SU. A relatively modest investment would provide for greatly improved individual services.

We request funding and authorities for the support of Area consultants in Cardiology, Oncology, Rheumatology, Infectious Diseases, Nephrology, and Wound Care, some of the specialties that are seriously lacking for our tribal members.

Acknowledgements

We are very grateful for the dedicated special efforts by the Staff of the Area and Service Unit in gathering data and information utilized in this report and in providing guidance relative to its interpretation. We especially thank Dr. John Farris the Area Chief Medical Officer who generously supported our efforts. Special thanks also go to Gloria Holder of the Area Office who provided many extra hours of support along with her unusual expertise and knowledge of CHS, at the national and local levels. In addition, Tina Isham-Amos and Marjorie Rogers of the Area Office; and Kathy Red Elk and staff of the Lawton Service Unit were invaluable in assisting with completing this report. These individuals made special efforts to respond to requests and spent time outside their usual working hours in order to assist in the completion of this report.

Figure 1. The Lawton Service Unit



The Headquarters of the Service Unit is in the Lawton Indian Hospital with clinics located in Anadarko and Carnegie.

Table 1. Ranking of IHS Areas According to Per Capita Distribution of CHS Funds. FY 2007

AREA	FY 2007 Recurring Base for CHS Funds	FY 2007 User Population	Per Capita based on User Pop	Rank
ABERDEEN	$61,057,469	119,379	$511.46	4
ALASKA	$55,178,362	134,743	$409.51	6
ALBUQUERQUE	$25,833,463	85,671	$301.54	9
BEMIDJI	$36,093,969	100,243	$360.06	7
BILLINGS	$44,719,430	70,196	$637.07	1
CALIFORNIA	$26,386,313	75,010	$351.77	8
NASHVILLE	$21,339,338	47,438	$449.84	5
NAVAJO	$60,418,257	237,981	$253.88	11
OKLAHOMA	$65,096,289	313,901	$207.38	12
PHOENIX	$45,112,454	153,607	$293.69	10
PORTLAND	$60,484,666	100,784	$600.14	2
TUCSON	$13,363,305	24,708	$540.85	3

Source: OKC Area Office of Planning and Partnership Development

Table 2. Allocations for CHS, Lawton Service Unit. 2001-2006

Year	Amount	Increase	Percent Change
2001	3,095,407		
2002	3,172,937	+ 77,530	+ 2.5
2003	3,254,271	+ 81,334	+ 2.6
2004	3,306,452	+ 52,181	+ 1.6
2005*	3,875,582	+ 569,130	+ 17.2
2006	3,441,442	- 434,140	- 11.2
Net Increase 2001-2006**		+ 346,035	+ 11.2
Avg. Annual Inc. 2001-2006			+ 2.2

* In FY 2005, the IHS received a one time, non-recurring increase for CHS
** Net increase, recurring funds (e.g. Year 2006 minus Year 2001)

Source: Area and Service Unit CHS staff.

Table 3. Estimates of Unmet Need for CHS; Lawton Service Unit; 2007

Category of Service	Est. Avg. Cost	Units	Estimated Cost
ENT	100	1040	10,400
Other GYN Elective Procedures	250	750	187,500
Dermatology	150	260	3,900
Nephrology/Evals./Follow-up	150	2600	390,000
Nephrology/IVPs	250	250	62,500
Hematology	100	1040	104,000
Oncology	250	1040	260,000
GI/Gastroscopy	250	2080	520,000
Pulmonary	200	780	156,000
CT Scans/Nuclear Med./MRI	500	1300	650,000
Rheumatology	200	1560	312,000
Podiatry	100	1300	130,000
Genetic Counseling	300	40	12,000
Other Referrals/Procedures	250	5000	1,250,000
Cataract Surgery	3000	520	1,560.000
Other Ophthalmologic	2000	520	1,040,000
Orthopedic Surgeries	6000	1300	7,800,000
Orthopedic Follow-Up/PT	150	780	117,000
Cardiac Procedures	15000	780	11,700,000
Other Cardiac Dx/Tests/Mgt	500	1500	750,000
Dental Basic*	200	2600	520,000
Dental Advanced*	1500	1040	1,560,000
Total		28,080	29,095,300

Source: Area and Service Unit CHS staff.

Table 4. Excluded Services. Conditions that are urgently needed but presently excluded from CHS because of insufficient funds.

CONDITIONS	UNITS	EST. COST
Durable Medical Equipment		
Prescription Drugs		
Eyeglasses		
Hearing Aids-Cochlear Implants		
Rehabilitation-Medical Inpt & Outpt		
Rehabilitation-Chem Dep-Inpt & Outpt		
Rheumatology-		
Prevention -Early Intervention		
Pain Management		
Sleep Studies-Apnea Mgt		
Cataract Surgery		
Home Health Care		
Hospice Care		
Skilled Nursing Care		
TOTAL		

Source: Area and Service Unit CHS staff.

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