

**TESTIMONY PRESENTED BY
MICKEY PEERCY, EXECUTIVE DIRECTOR OF HEALTH SERVICES
(ON BEHALF OF CHIEF GREGORY E. PYLE)
CHOCTAW NATION OF OKLAHOMA**

**AT THE OVERSIGHT HEARING ON PROMISES MADE, PROMISES BROKEN: THE
IMPACT OF CHRONIC UNDERFUNDING OF CONTRACT HEALTH SERVICES
BEFORE THE
SENATE COMMITTEE ON INDIAN AFFAIRS
December 3, 2009**

Good Morning Chairman Dorgan, Vice-Chairman Barasso and distinguished Members of this committee. On behalf of Chief Gregory E. Pyle, of the Great Choctaw Nation of Oklahoma, I extend to you the support of the people of the Choctaw Nation to work with you in addressing the priority issues of Native American peoples. Thank you for inviting the Choctaw Nation to provide testimony on the desperate need for contract health services funding.

The Choctaw Nation of Oklahoma is an American Indian Tribe organized pursuant to the provisions of the Indian Reorganization Act of June 26, 1936-49. Stat.1967. and is federally recognized by the United States Government through the Secretary of the Interior. The Choctaw Nation of Oklahoma consists of ten and one-half counties in the southeastern part of Oklahoma and is bordered on the east by the State of Arkansas, on the south by the Red River, on the north by the South Canadian, Canadian and Arkansas Rivers, and on the west by a line slightly west of Durant that runs north to the South Canadian River.

We have been operating under a compact of Self-Governance since 1995 in the Indian Health Service/Department of Health and Human Services and in the Bureau of Indian Affairs/Department of the Interior since 1996. The Choctaw Nation of Oklahoma believes that responsibility for achieving self-sufficiency rests with the governing body of the Tribe. It is the Tribal Council's responsibility to assist the community in its ability to implement an economic development strategy and to plan, organize and direct Tribal resources in a comprehensive manner which results in self-sufficiency. The Tribal Council recognizes the need to strengthen the Nation's economy, with primary efforts being focused on the creation of additional job opportunities through promotion and development. By planning and developing its own programs and building a strong economic base, the Choctaw Nation of Oklahoma applies its own fiscal, natural, and human resources to develop self-sufficiency. These efforts can only succeed through strong governance, sound economic development and positive social development.

Issue:

Contract Health Service (CHS) is the most complex and dysfunctional service delivered by the Indian Health Service, Tribally Operated Health Program (IT) health care delivery program. CHS is designed to refer patients and reimburse providers outside the IT system for medical services provided to American Indians/Alaska Natives (AIAN) patients. CHS services consist of those services not provided by the IT hospitals and clinics. The Congress is aware of what CHS is designed to do. The question is how it can be improved.

The most logical way to fix the contract health problem is to provide adequate funding for the IT system. The Congress is also aware of the marginal funding level for ITs overall, and specifically in this line item. 2010 appropriations level for CHS is a positive step and needs to be continued, with that type of increase for the next 5 years. At this point, we know that some tribal health programs receive assistance in their health programs budget, some specific to CHS, from their tribal governments. Not all tribes have the developed and economic development base that allows this support. Also, in most cases these tribal funds are not recurring and cannot be counted on long term. Significant federal funding over the next several years is critical.

An important aspect of CHS that has been difficult for the Indian Health Service to work with is the private sector relationship. Administrators and Providers must work in a collaborative effort with hospitals, clinics, imaging services, diagnostic labs and doctors who provide services in a whole different world than the IT system. As much as providing quality service, they are driven by the bottom line, the reimbursement. They expect to be paid for their service.

Federal employees in the Indian Health Service do not, and will not ever, fully understand the private sector concept. They have always had the ability to fall back on the federal system. In most cases federal employees do not concern themselves with the private sector providers who refuse to see our patients because they are either not getting paid or have to wait as much as a year for payment. The anti-deficiency act is always there. This is not to say that federal staff are bad, they are just always going to err on the side of the government. It is in their DNA.

Whether you receive, in some cases, a life or limb saving procedure should never be determined on the basis of if you called in within 72 hours of an incident or hospitalization, or whether the committee could not meet on a certain day, or if it is after July 1, and the funds are gone. We must provide case management.

Many Tribally Operated Health Programs have reached out to private sector specialty care facilities and providers and have formed strong partnerships with them to include: quality of care issues, authorization/referrals, and expectation of payments. In addition, Tribally Operated Programs own the

responsibility of the patient. The patient is family, a community member and a voter. It is imperative that they are treated with respect, even if the funds are not available for a service; the way this is conveyed to a patient is important. We are changing the scope of work for our staff members that work in the CHS environment. It not acceptable to just say 'No'. This staff will be trained in Case Management. All staff must be trained to work with outside vendors and most importantly with our patients.

There are “best practice models” for CHS out there within the Tribally Operated Programs. They are not perfect, as we are all underfunded. We need to share those models, and others have to be ready to listen.

Recommendations:

2010 appropriations for CHS was a good faith beginning for Congress. Additional fiscal support of at least at the 2010 level should continue for the next 5 years.

Strongly encourage the Indian Health Service to explore some “best practice models” of tribal programs around the areas of customer service, collaboration with referral sources, case management and fund management.

Currently the Senate Committee on Indian Affairs is working on S.1790, Reauthorization of the Indian Health Care Improvement Act. There are two sections within that legislation that are controversial. Section 131, proposes a negotiated rule-making process to develop a distribution formula for the CHS program. The Choctaw Nation of Oklahoma strongly recommends that this provision be deleted. A funding formula was developed in 1999 through consultation with Tribal leaders. It is ironic that 2010 is the first year that a CHS increase has contained enough resources to trigger this funding methodology. Section 192 of S.1790 proposes establishing a new Contract Health Service Delivery Area (CHSDA) for North and South Dakota. We fear that if this happens the result could be an attempt to shift funds from one Area to another which will have a tendency to pit tribe against tribe. We ask that this provision not be allowed to proceed.

Establish a regular hearing before this Committee to ensure progress.

The Choctaw Nation of Oklahoma strongly requests that Congress respect the sovereignty of Tribal Governments in defining their citizens. We are defined by the Dawes Commission and our Constitution.

Conclusion:

There is no ‘magic bullet’ fix for the underfunding of Contract Health. The issue critically affects all Tribes. The Choctaw Nation of Oklahoma strongly urges this Committee, and the entire Congress to work with Tribes and with each other to remedy this long-standing problem. We stand ready to assist the Committee in any way we can.

On behalf of the Choctaw Nation of Oklahoma, and Chief Gregory E. Pyle, I appreciate the opportunity to offer our Tribe’s views on the needs of the Contract Health Services system.

Thank you for allowing me to testify today.