NATIONAL CONGRESS OF AMERICAN INDIANS OVERSIGHT HEARING ON CONTRACT HEALTH SERVICE

Testimony of
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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:

1) 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;
2) 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;
3) The "don't get sick after June" phenomenon in Indian Country – or in some cases earlier – due to the underfunding of CHS programs; and
4) 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% decline in the American Indian population enrolled in the Oklahoma State Medicaid program, of which 60% 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% 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% 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.