National Indian Health Board
926 Pennsylvania Ave, SE
Washington, DC 20003
www.nihb.org

Testimony of the National Indian Health Board Before the U.S. Senate Committee on Indian Affairs Hearing on Access to Contract Health Services in Indian Country June 26, 2008

562 Dirksen Senate Office Building
Washington, DC

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

[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.

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 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

[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

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

---

[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.

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.

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.

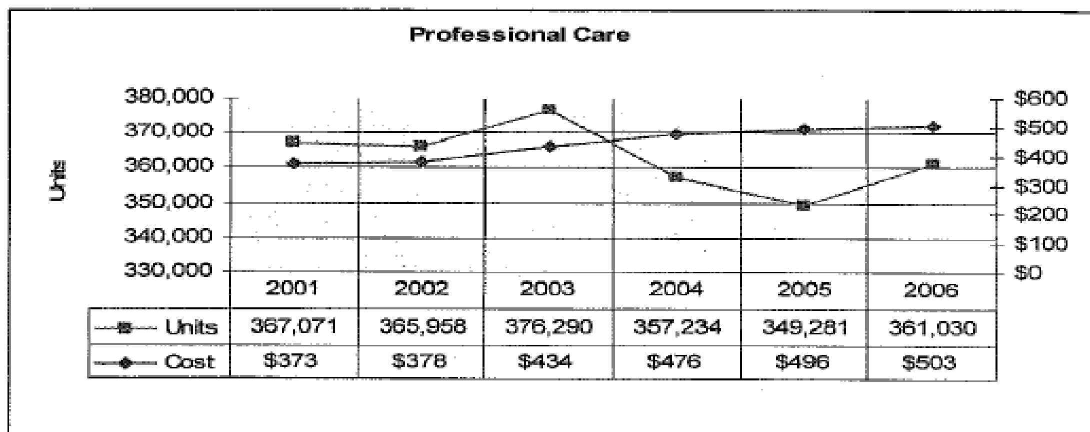
Priority V: Excluded Services such as cosmetic procedures and experimental services.

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.

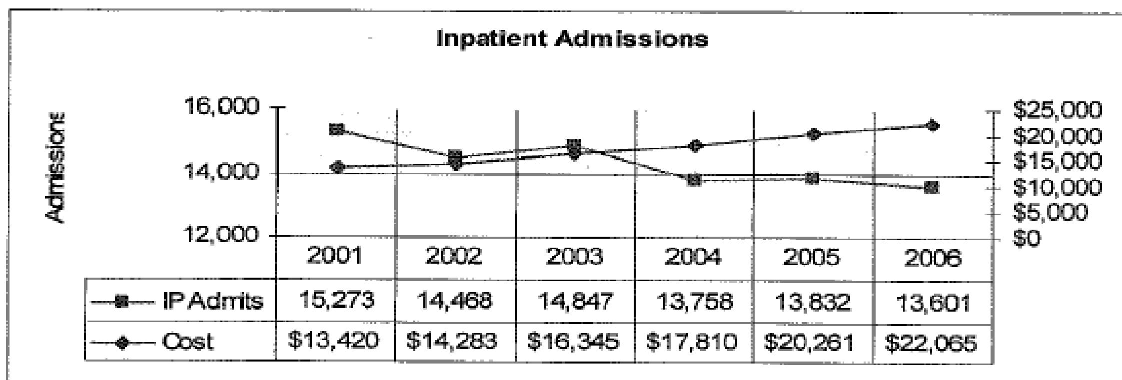
The Reality:

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:



	2001	2002	2003	2004	2005	2006
Units	367,071	365,958	376,290	357,234	349,281	361,030
Cost	$373	$378	$434	$476	$496	$503

- 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.



	2001	2002	2003	2004	2005	2006
IP Admits	15,273	14,468	14,847	13,758	13,832	13,601
Cost	$13,420	$14,283	$16,345	$17,810	$20,261	$22,065

- 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

[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.

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 accurate, 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

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

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 determination 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 reapply. This can be burdensome, especially for the elderly. Tribal members have expressed concerns that CHS claims are denied or payment is delayed due

---

[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.

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.

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 (see the attached map of our service area where clinics are identified). 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.