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

AT THE OVERSIGHT HEARING ON ADVANCING INDIAN HEALTH CARE
BEFORE THE
SENATE COMMITTEE ON INDIAN AFFAIRS
February 5, 2009

Good Morning Chairman Dorgan, Vice-Chairman Barrasso and distinguished Members of this Committee. On behalf of Chief Gregory Pyle, of the Great Choctaw Nation of Oklahoma, I offer congratulations on this inaugural hearing to you Mr. Barrasso as the new Vice-Chairman, and new Members of the Committee Senators Udall, Crapo and Johanns. 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 Choctaw to provide testimony on advancing Indian health care.

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 bounded 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. The western boundary generally follows a line slightly west of Durant, then due 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 implementing its own programs and building a strong economic base, the Choctaw Nation 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.

In 2003, the Commission on Civil Rights prepared an extensive report on the Federal Funding and Unmet Needs in Indian Country. Again, in 2004, as a follow-up, the Commission reported more extensively on health care disparities in the report, Broken Promises: Evaluating the Native American Health Care System. We all applauded the attention that both of these reports received and the level of education they provided to the novices on the topics of need and disparity that plague Indian communities in all venues, on all levels, in all areas each and every day. More importantly, these reports shared what is real and what continues to deprive Indian people of the basic pleasantries of life and benefits that most Americans enjoy that is so inaccessible at the reservation level.

The health care needs that were identified in the sequel Commission report have consistently increased the level of need in our Tribal communities because of a plethora of shortfalls and rescissions. In fiscal year 2008, total funding for the Indian Health Service (IHS) was $4.3 billon, some 48% short of the need identified by the Tribal/IHS Budget Formulation Committee. The Choctaw Nation has been aggressive in addressing the need of our people, as well as those who live in proximity to our reservation. We have become impatient with the current system of health care service delivery that is the responsibility of the IHS. It is the directive of the Tribal Council at the Choctaw Nation to move forward in advancing and addressing the needs of our communities through outreach, alliance building and partnerships to accomplish our health care goals.

The Indian Health Service authority should be reviewed to determine the effectiveness of the Service in response to the needs of Indian beneficiaries and whether it is in the best interest of Indian people to change how IHS provides primary health care. It is the sense of the Choctaw Nation that given the current status of health care in this country, health care for Tribes should be targeted more at the Tribal/community levels for the best return on the investment using best practices as a key denominator in the equation for health care service delivery, management and accountability.

The Choctaw Nation Health Services is the leader in health care in southern Oklahoma and continues to expand to meet the ever-changing needs of our people. The Choctaw Nation and Senior Health Officials from other Tribes and the Urban Program recently convened a meeting with the Oklahoma Hospital Association. We feel the need to reach across the aisle to share best practices, learn about the health needs of our neighbors and forge partnerships to improve and expand the health care services that are being provided in Oklahoma. We are not seeking to just serve the Indian community but rather to identify the needs of others while offering Tribes access; knowledge and choices about what other services and types of facilities are available to them in our state.

The Choctaw Nation currently provides the following health services to the Choctaw people and surrounding communities:

- Choctaw Nation Health Facilities
- Community Health Representative
- Eyeglasses, Dentures and Hearing Aid Program
- Office of Environmental Health
- Recovery Center
- Women's & Children Residential Treatment Program
- Diabetes Wellness Center
- Drug & Alcohol Testing
- Mail Order Pharmacy
- Behavioral Health
- Youth Advisory Board

For the past decade, Indian Country has rallied behind and supported the reauthorization of the Indian Health Care Improvement Act (IHCIA). Tribes remain vigilant in their quest to make the bill a product that will bring health care for Indian people into the 21st Century. Unfortunately the previous Administration and Congress fell short of getting the job done. The most critical Indian health legislation has been rewritten, renegotiated and dissected so much since 1999 that we are left to question if it is sufficient to make a dent in the needs of the intended beneficiaries today. How have we allowed something that is so important to the lives of 1.5 million Indian people to become so bare-boned at a time when the current economic crisis has nothing better to offer? Now is as good a time as any to look at overhauling the overall health package; to redesign a health system that meets the needs of Indian people locally in our communities. The IHCIA bill can serve as the foundation on which to build a more comprehensive and responsive plan to address the financial and service needs of the Tribal communities. The Choctaw Nation asks that the SCIA gives every consideration to reassess the contents of this bill and to do what is necessary to restructure it to meet the needs of and provide the quality of benefits that Indian people are entitled to receive.

While it is not easy to design and overhaul a health care system, the greatest need we are confronted with is funding. We are denied full funding to operate contracts and compacts with the Indian Health Service and yet we are expected to perform as any and all other vendors in the delivery of goods and services. Contract support costs (CSC) has not fully been paid under P.L. 93-638. Therefore, we ask that Congress work with Tribes and the IHS to design a mechanism that will allow for an administrative cost rate rather than CSC. For smaller tribes, the administrative cost rate could be as great as 30%, and for larger Tribes possibly 18-20%. While these percentages are random, such a concept supports the need to consider an alternative to what does not currently work. This could stabilize the outlay and allow Tribes to recover cost associated with performing the services under the contracts and compacts. In addition, an administrative cost rate would eliminate litigation fees.

MEDICARE LIKE RATES

The Centers for Medicare and Medicaid (CMS) issued Section 506 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. This section generally provided authorization for contract health services and urban Indian programs to pay ***"no more than Medicare-like rates"*** for referred services (inpatient) furnished by Medicare-participating hospitals upon the effective date of enacting regulations. On June 4th the Department of Health and Human Services published regulations in the Federal Register effective July 5th to implement Section 506. The regulations describe the payment methodologies and other requirements covered providers must adhere to when processing claims for services authorized for purchase by a Contract Health Service or urban Indian program. Regulations require hospitals that participate in the Medicare program to accept Medicare-like rates as payment in full when providing services to Indian patients. The rules place a cap on the amount hospitals may charge for patients referred by the IHS, tribal and urban Indian organization Contract Health Service (CHS) programs. The new law will provide IHS and Tribally-operated CHS programs with similar benefits to those enjoyed by other Federal purchasers of health care.

The Choctaw Nation is requesting that Section 506 be amended to include ambulatory services.

FACILITIES CONSTRUCTION

The Health Facilities Construction Priority System (HFCPS) is a two-tiered priority process that has been the culprit of conflict among the Tribes and the IHS for years. The IHS Backlog of Essential Maintenance and Report (BEMAR) survey for October 2007 estimates that there is a backlog of $371 million in needed repairs to Indian health facilities. The replacement value of facilities eligible for Maintenance and Improvement (M&I) is $2.42 billion. The current priority list was developed in 1991 (nearly two decades ago) and embargoes Tribes from access to construction dollars unless they are one of the facilities on the list. The current rate of health facilities appropriations will keep the health facilities construction priority system locked for at least another decade.

There is yet another priority list from previous years that demonstrates the complacency of the IHS in acknowledging the enormous level of need that exists for replacement and construction of health facilities. Many Tribes support a moratorium on facilities construction until IHS, in consultation with Tribes, develops an equitable funding methodology. The Choctaw Nation is requesting that you make an inquiry about the status of the funding methodology. Tribes would support a study on this issue that will update the inventory, the level of need and provide recommendations on how to address the backlog. However, as I've stated previously, the facilities improvement and construction backlog is primarily attributed to the lack of funding.

The Joint Ventures and Small Ambulatory construction programs are an efficient way to maximize resources of the federal government and the Choctaw Nation supports both. Tribes have been able to build more health care space than IHS at a 3-1 ratio with the Joint Venture Program and the Small Ambulatory Program. The Joint Venture program was an amendment to the IHCIA under Section 818 and authorizes Congress to appropriate recurring funds for increased staffing, operations and equipment for new or replacement facilities constructed with non-IHS funding acquired by Tribes. Self-Governance Tribes have been the primary applicants for Joint Venture and Small Ambulatory programs but due to the lack of funds, applications continue to gather dust as the need for alternative facilities increases on a daily basis.

The Choctaw Nation entered into a Joint Venture Construction Project and constructed the Idabel Clinic in 2005. The Idabel Health Care Center provides a wide range of services in the 53,262-square-foot building. The Choctaw Nation built the $11 million clinic with tribal funds, and is named in honor of Charley Jones, a former Councilperson. Services include dental, a diabetes component, general medicine, optometry and a full lab and pharmacy.

In addition to Idabel, Choctaw has health facilities at the following locations:

- Talihina Hospital
- McAlester Clinic
- Hugo Clinic
- Broken Bow Clinic
- Poteau Clinic
- Atoka Clinic (Opened in 2008)
- Stigler Clinic
- Hospitality House in Talihina
- Choctaw Nation Diabetes Clinic
- Children & Family Services – McAlester
- Children & Family Services – Atoka
- Recovery Center
- Chi Hullo Li

On behalf of the Choctaw Nation we appreciate the opportunity to offer our views on some of the needs and changes to the health care service delivery system for Indian people.

Thank you for allowing me to testify this morning.