S. HRG. 111–525

EXPANDING DENTAL HEALTH CARE IN INDIAN COUNTRY; PROMISES MADE, PROMISES BROKEN: THE IMPACT OF CHRONIC UNDERFUNDING OF CONTRACT HEALTH SERVICES

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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EXPANDING DENTAL HEALTH CARE IN INDIAN COUNTRY

THURSDAY, DECEMBER 3, 2009

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

The Committee met, pursuant to notice, at 2:41 p.m. in room 628, 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. We will now convene the hearings. We have two hearings, and as I indicated previously, we thank all of you.

The first hearing is on expanding dental health care in Indian Country. And what we are going to do is begin with the witnesses for that hearing.

Dr. Ronald Tankersley is with us, a dentist from the American Dental Association, President, actually; Ms. Evangelyn "Angel" Dotomain, the President and CEO of Alaska Native Health Board; Dr. Patricia Tarren, Staff Pediatric Dentist, Department of Dentistry at Hennepin County Medical Center in Minneapolis.

If the three of you will take your seats, we will begin testimony. When it is required for us to be present at the vote, we will go to the end of the first vote, then cast the beginning of the second vote and be back as quickly as we can.

We have two items on our hearing list today. The first is on dental health care and the second is on contract health services. So we want to try to get through these in reasonable time, and I appreciate the cooperation of everyone.

Dr. Tankersley, you are President of the American Dental Association. We are pleased that you are here and your entire statement will be a part of the permanent record, so you may summarize. Why don't you proceed?

STATEMENT OF RONALD L. TANKERSLEY, D.D.S., PRESIDENT, AMERICAN DENTAL ASSOCIATION (ADA)

Dr. TANKERSLEY. Mr. Chairman and Members of the Committee, I am Ron Tankersley, President of the American Dental Association, which represents 157,000 dentists across the Country. I am a practicing oral and maxillofacial surgeon in Newport News, Virginia.

Let me begin by thanking you for your efforts to reauthorize the Indian Health Care Improvement Act which contains so many important provisions to improve the health of American Indians and Alaska Natives. Enactment is long overdue.

I have been asked to appear before you to discuss our position on whether to expand the new dental health aide therapist position, which is currently being tested in frontier Alaska, into other areas of the Country.

You know from our previous testimony that the ADA does not support delegating surgical procedures to those without the comprehensive education of dentists. So we are opposed to Congress expanding the Alaska therapist model.

To us, it is not a matter of whether similar providers exist in other countries. The U.S. has higher education standards than many other countries, and currently in this Country, surgical services are not delegated to any health care provider with just two years of post-high school education. Even nurse practitioners who have six years of higher education and training are not given surgical privileges.

The real question is whether establishing such a position, with the attending challenges of recruiting, educating, training, supervising and regulating such providers, is the best solution for improving access to oral health in the tribal areas.

Furthermore, we believe that recent events make expanding that model even less necessary than in the past. Specifically, the drastic shortage of dentists in the Indian Health Services is finally being addressed. This year alone, there will be 70 additional dentists providing care in tribal areas. With one more year of similar recruiting success, the shortage of dentists in IHS could actually be eliminated. No other action could have more significant impact upon increasing access to surgical oral health care in tribal areas with profound needs.

The ADA has played a critical role in this success. Working with the Indian Health Service to create a fund for dental summer extern programs and lobbying to increase student loan repayments for dentists hired by the Service or the tribes. Last year, over 300 dental students applied for 150 openings for the extern program.

This year, the ADA successfully advocated for increased funding to double the number of summer dental externs in 2010. We believe that this will lead to more young dentists choosing to work in tribal areas, reducing even further the need to look for other models to provide surgical dental care.

That said, we agree with many others that innovations in the dental team could help increase access to dental services in underserved areas, including tribal lands. For example, the expanded function dental assistant model has been used with great success in the United States military. We also strongly support the creation of new innovative dental workforce models that parallel that of medical community health aides.

The ADA is currently funding and pilot testing such a model, the Community Dental Health Coordinator. We call that the CDHC. Our initial classes of CDHCs will work in rural, urban and tribal areas. These allied dental personnel come from the under-served communities in which they will work. They are trained to provide

community-focused oral health promotion, prevention and coordination of care.

And importantly for this discussion, the CDHC Program will be independently evaluated during the pilot phase before the program is actually replicated in other areas.

We all agree that American Indians and Alaska Natives deserve access to the same oral health care as the rest of the population. Accordingly, the ADA asks Congress to focus on eliminating dentist shortages and supporting workforce innovations that increase efficiency and focus on prevention, while still ensuring that the people who need surgical care receive that care from fully trained dentists.

Thank you. I appreciate the opportunity to speak.

[The prepared statement of Dr. Tankersley follows:]

PREPARED STATEMENT OF RONALD L. TANKERSLEY, D.D.S., PRESIDENT, AMERICAN DENTAL ASSOCIATION (ADA)

Mr. Chairman and Members of the Committee:

I am Dr. Ron Tankersley, president of the American Dental Association (ADA), which represents 157,000 dentists around the country. I am a practicing oral and maxillofacial surgeon from Newport News, Virginia.

Let me begin by thanking you for your efforts to reauthorize the Indian Health Care Improvement Act. Enactment of this legislation, which contains so many important provisions to improve the health of American Indians and Alaska Natives, is long, long overdue.

I have been asked to appear before you to discuss our position on whether to expand the new dental health aide therapist position currently being tested in frontier Alaska into other areas of the country. You know from previous ADA committee testimony that the ADA does not support delegating surgical dental procedures to those without the comprehensive education of dentists. So, we are opposed to Congress expanding the Alaska therapist model.

To us, it's not a matter of whether similar providers exist in other countries. The United States has higher educational requirements than many other countries. Currently in this country, surgical services are not delegated to any healthcare providers with just two years of post-high-school training. Even nurse practitioners, with six years of education and training, are not given surgical privileges.

The real question is whether establishing such a position, with the attending challenges of recruiting, educating, training, supervising, and regulating such providers, is the best solution for improving access to oral health care in tribal areas.

Furthermore, we believe that recent events make expanding that model even less necessary than in the past. Specifically, the drastic shortage of dentists in the Indian Health Service (IHS) is finally being addressed—this year alone there will be 70 additional dentists providing care in tribal areas. With one more year of similar recruiting success, the shortage of dentists in the IHS could be eliminated. No other action could have a more significant impact upon increasing access to surgical oral healthcare in tribal areas with profound need.

The ADA has played a critical role in this success, working with the IHS to create and fund a dental summer extern program and lobbying to increase student loan repayments for dentists hired by the Service or tribes. Last year, over 300 dental students applied for 150 openings in the extern program. This year, ADA successfully advocated for increased funding to double the number of summer dental externs in 2010. We believe that this will lead to more young dentists choosing to work in tribal areas, reducing even further the need to look for other models to provide surgical dental care. [1]

We agree with many that innovations in the dental team could help increase access to dental services in underserved areas, including tribal lands. For example, the expanded function dental assistant model that has been used with great success by the U.S. military. We also strongly support the creation of new innovative dental workforce models that parallel that of medical community health aides. The ADA is currently funding and pilot testing one such model, the Community Dental Health Coordinator (CDHC).

[1] See attachment for additional ADA activities on behalf of IHS/tribal oral health.

Our initial classes of CDHCs will work in rural, urban, and tribal areas. These allied dental personnel come from the underserved communities in which they will work and who will provide community-focused oral health promotion, prevention, and coordination of dental care. And importantly, for this discussion, the CDHC program will be independently evaluated during the pilot phase before the program is replicated in other areas.

To qualify for a CDHC credential, an individual will have to be a high school graduate and complete a 12 month series of classes, with 3–6 months of on-site practice depending on the student's prior experience. The individual will have to be trained at a Commission on Dental Accreditation (CODA) approved training site. Working under a dentist's supervision in health and community settings (such as schools, churches, senior citizen centers, and Head Start programs) and with people who have similar ethnic and cultural backgrounds, CDHCs will:

- Provide individual preventive services, such as screenings, fluoride treatments, placement of sealants, and simple teeth cleanings.
- Place temporary fillings in preparation for restorative care by a dentist.
- Help patients and/or their caregivers navigate through the maze of health and dental systems to assure timely access to care and to help prevent reoccurrence of the Deamonte Driver tragedy.
- Collect information to assist the dentist in the triage of patients, which will enhance delivery system effectiveness and efficiency.
- Overcome the barriers to seeking care by working with community leaders to promote oral health literacy and nutritional literacy and to address additional social and environmental barriers, such as assistance with transportation issues and enrollment in publicly funded programs.

We all agree that American Indians and Native Alaskans deserve access to the same oral health care as the rest of the population. Accordingly, the ADA asks Congress to focus on eliminating dentist shortages and supporting workforce innovations that increase efficiency and focus on prevention while still ensuring that people who need surgical care still receive that care from fully trained dentists.

Thank you.

Attachment

American Dental Association's American Indian/Alaska Native Activities

The ADA is the founding member of the "Friends of Indian Health", which works to ensure adequate funding for the Indian Health Service and tribal health programs, including oral health care services. And each year the ADA aggressively lobbies the United States Congress to ensure the dental health programs funded by the Indian Health Service (IHS) receive adequate appropriations dollars. In addition:

American Indian/Alaska Native (AI/AN) Dental Placement Program

In 2005, the ADA hired a full time staffer to develop a volunteer dentist program for Indian Country. To date, volunteer dentists have served at 13 sites in eight states, including North Dakota.[2] In Minnesota we have sent 17 dentists on 19 trips. In November 2009, the ADA sponsored a team of eight prosthodontists, who travelled to Taos-Picuris Health Center (NM) for one week to provide full and partial dentures to local patients. The ADA continues to recruit, assign and coordinate volunteer dentists and dental students to serve at Indian Service (IHS) and/or tribal clinics.

Indian Health Service Externship Program Support

Since 2008, the ADA has financially sponsored 18 dental students who provided practical support for upper classmen who are participating in the IHS externship program. This provided the chance for more dental students to participate in the IHS dental extern program, a key recruitment activity. The current vacancy rate for IHS dentists has dropped from 140 last year to 67 today. We believe that some of that success is due to the IHS summer extern program. Last year over 300 dental students applied for 150 openings. The IHS has reported that their positive summer experience makes them great ambassadors to their dental school colleagues. As a

[2] Alaska (Bristol Bay Area Health Corporation/Togiak), Arizona (Hopi Health Care Center/Pollaca), Maine (Presque Isle), Minnesota (Cass Lake, Red Lake and White Earth Health Centers), New Mexico (Taos-Picuris Health Center), North Dakota (Belcourt and Fort Yates), South Dakota (Pine Ridge, Rosebud and Wagner) and Wisconsin (Menominee Tribal Clinic/Keshena).

result of this program the ADA successfully advocated for additional funding in FY 2010 to double the number of summer dental externs.

Summit on American Indian/Alaska Native Oral Health Access

In 2007, the ADA hosted the Summit, which included more than 100 participants, public and private interests, from tribal organizations, local communities, state dental societies, dental educators, specialty organizations, the U.S. Public Health Service, philanthropy and the Association.[3] The Summit focused around the question, "What are we going to do, both individually and collectively, to improve access to dental treatment and prevention strategies that address the oral health of American Indian and Alaskan Native people?"

At the conclusion of the Summit, all participants agreed to work on activities related to the following seven AI/AN oral health focus areas:

1. Creating a new paradigm for improving the dental workforce;
2. developing collaborative strategies for lobbying, funding, policy making, etc.;
3. designing research and implementing "best practices" for the prevention of oral disease, including early childhood caries;
4. fostering broader community involvement to identify oral health issues and their solutions;
5. advocating for a fully funded IHS/Tribal/Urban (ITU) dental program;
6. building trust among the partners/communities of interest; and
7. encouraging meaningful tribal empowerment in oral health policy making.

American Indian/Alaska Native Strategic Workgroup

The AI/AN Strategic Workgroup is comprised of leaders for the action team areas identified during the 2007 Summit. The Workgroup continues to meet two times per year to foster and maintain collaborations for effective advocacy, research, policies and programs at the local, regional and national levels, resulting in: (1) increased access to oral health care, (2) reduced oral health disparities, and (3) improved prevention of oral disease. One outcome of this continued effort was a FY 2009 joint appropriations request seeking $1 million for research into the unique causes and needed new treatments for tooth decay among AI/AN children. The Strategic Workgroup also identified a long term funding plan for the IHS dental program. The ADA conveyed that message in an April 2009 letter to President Obama. Tribal members of the AI/AN Strategic Workshop planned to work with their organizations to send similar letters to the Administration.

Symposium on Early Childhood Caries in American Indian and Alaska Native Children

In October 2009, the ADA co-hosted, with the IHS, the Symposium on Early Childhood Caries (ECC) in American Indian and Alaska Native (AI/AN) Children. The Symposium was attended by national and international ECC experts; Indian Health Service dental, pediatric and child development personnel; and local tribal representatives. There was a consensus among Symposium participants that early childhood caries among AI/AN children represents a different disease from that experienced by other populations of children: it starts earlier, follows a more aggressive course, results in a much higher burden of disease for the children and their families, and has been refractory to many years of determined efforts to control it using intervention strategies found effective in other populations. Control of ECC among AI/AN children thus requires new approaches which are likely to be multimodal in nature with an enhanced emphasis on the infectious etiology of the disease. It will also require development of new metrics with which we can better characterize the disease and measure the effectiveness of new prevention approaches. Symposium participants intend to present a research agenda to the National Institute of Dental and Craniofacial Research and similar entities.

Pathways Into Health

In 2008 and 2009, the ADA co-sponsored the Pathways Into Health (PIH) annual conference. PIH is a grassroots collaboration of more than 150 individuals and organizations dedicated to improving the health, health care and health care education of American Indians and Alaska Natives. PIH recognizes that an important factor

[3] Stakeholder Groups: (1) Indian Health Service Area Dental Officers and Headquarters Personnel, (2) State Dental Societies, (3) Local Tribal Health Programs, (4) American Dental Association, (5) Indian Health Service Dental/Clinical/Preventive Support Programs and Other Local Programs, (6) Specialty and Special Interest Oral Health and General Health Care Organizations, (7) Regional Health Boards and Philanthropic Organizations, (8) Dental Education.

to improving the number of health care providers serving in Indian country is to "grow your own" and has developed distance education and mentoring programs to ensure that AI/AN students succeed in becoming health care providers. ADA personnel serve on the PIH advisory committee.

Society of American Indian Dentists (SAID)

Dr. Lindsey Robinson, ADA CAPIR Council chair represented the ADA at the Society of American Indian Dentists' annual meeting, April 30-May 3, 2009 at University of California, Los Angeles. Dr. Robinson gave a presentation about ADA access to care activities, highlighting advocacy and programs for AI/AN populations.

ADA Institute for Diversity in Leadership

Two Summit participants; Dr. Alyssa York, dental director, Inter Tribal Council of Arizona and Ruth Bol, secretary/treasurer, SAID; were accepted to participate in the ADA's Institute for Diversity in Leadership, a three-part personal leadership training program designed to enhance the leadership skills of dentists who belong to racial, ethnic and/or gender backgrounds that have been traditionally underrepresented in leadership roles in the profession.

The CHAIRMAN. Dr. Tankersley, thank you very much.

Evangelyn Dotomain? Thanks for being here and you may proceed.

STATEMENT OF EVANGELYN "ANGEL" DOTOMAIN, PRESIDENT/CEO, ALASKA NATIVE HEALTH BOARD

Ms. DOTOMAIN. Good afternoon and thank you for the opportunity to testify today. I am honored to be here. My name is Angel Dotomain. It is much easier. I am President and CEO of the Alaska Native Health Board.

In response to extensive dental health needs and high dental vacancy rates, the Alaska Dental Health Aide Therapist Program began in 2003. It is part of the Community Health Aide Program, which is authorized under Section 119 of the Indian Health Care Improvement Act.

Following the CHAP model, the DHAT Program selects individuals from rural Alaska communities to be trained and certified to practice under general supervision of dentists in the Alaska Tribal Health System.

Alaska Native children and adolescents suffer dental caries rates at 2.5 times greater than the general U.S. child and adolescent population. This, combined with a vacancy rate of 25 percent and 30 percent turnover rates in dentists, has developed into a serious problem in Alaska dental care.

Indian Country, in fact, has about half the number of dentists per capita, at 33 per 100,000. With the number of dentists expected to decline, there is clearly not an adequate supply in the distribution of dentists to meet the basic dental health needs of America's first people. Dental therapists can help to fill the gap to provide desperately needed services where dental services are limited or do not exist at all.

At a time when Indian Country lags behind the rest of the Country in access to service, isn't it time for us to be at the forefront of the health care delivery model? The DHAT Program, if expanded, would allow for that to happen in our Country, and for the first time, American Indians and Alaska Natives would be the first to benefit from a positive health care change.

The Alaska DHAT Training Program is modeled after the New Zealand National School of Dentistry in Otago. New Zealand's den-

tal therapists have been highly valued for over 80 years. In fact, over 14,000 dental therapists operate in over 53 countries worldwide, including Canada, The Netherlands, Australia, Great Britain and Malaysia. The United States is the only industrialized nation without a mid-level dental provider available to its citizens.

Alaska's DHATs receive extensive training, certification, continuing education and clinical reviews to ensure that their skills are of the highest quality. In 2007, the Alaska Native Tribal Health Consortium and the University of Washington's MEDEX Program opened DENTEX, the first DHAT training center in the United States.

The DENTEX Program is extremely rigorous. Students receive 2,400 hours of training over two years, spending one year in Anchorage and one year in Bethel. They utilize the same textbooks as dental students. DHATs are trained with the same high quality level of care dentists would, within their limited scope.

DHATs are trained to provide oral health education, preventive services, fillings, and uncomplicated extractions to preserve function and address pain and infection. In addition to their two-year training, DHATs are required to perform at least a 400-hour preceptorship program with their supervising dentist.

Only after the DHAT completes that clinical preceptorship are they eligible for certification. Each DHAT must apply for and receive certification to the Indian Health Service Community Health Aide Program Certification Board. DHATs must be recertified every two years, which includes multiple direct observation of skills and complete 24 continuing education hours per two-year period.

There are currently 10 practicing DHATs who were trained in New Zealand, and three who were trained at the DENTEX Program. There are 14 in DENTEX training and on December 11th will graduate seven more.

In recent independent studies, DHAT skills were assessed to determine if they are on par with dentist-provided services and quality of care. The results of an early study noted that the program deserves not only to continue, but to expand. In a recent pilot study, there was found to be no significant difference between irreversible dental treatment provided by DHATs in comparison to dentists, and no significant difference in reportable events.

Like the community health aide, the DHAT has become an essential part of dental health delivery in the Alaska Tribal Health System. Their ability to provide culturally appropriate high quality care has increased Alaska Native access to proper dental services and prevention activities.

It is exciting to see that other parts of the United States are looking at a dental mid-level model. DHATs are an innovative solution to the inadequate numbers of licensed dentists practicing in under-served areas, not just in rural Alaska. Because of this, we respectfully recommend this Committee urge the Indian Health Service to include DHAT Program funding in their funding request for future years.

In addition to seeing DHATs provide services, the Alaska Native Health Board is excited to see upcoming preliminary results of a study commissioned by philanthropic organizations which will determine the DHATs Program implementation integrity and conduct

a health outcome assessment addressing safety, quality and patient-oriented outcomes. The study started in the spring of 2009 and preliminary results are expected in the summer of 2010.

It has come to our attention that the current philanthropic evaluation meets all but one evaluation request set aside for review by the Secretary of Health and Human Services. Thus, we also respectfully recommend that the Committee utilize the current study for all of the needs of evaluation noted, rather than commissioning a new study.

With that, I thank you for your time and I am open for questions.

[The prepared statement of Ms. Dotomain follows:]

PREPARED STATEMENT OF EVANGELYN "ANGEL" DOTOMAIN, PRESIDENT/CEO, ALASKA NATIVE HEALTH BOARD

Good afternoon and thank you for the opportunity to testify today. I am honored to be here. My name is Evangelyn "Angel" Dotomain and I am the President/Chief Executive Officer of the Alaska Native Health Board (ANHB). ANHB was established in 1968 and represents twenty-five tribal health organizations across the state of Alaska who collectively employ over 7,000 individuals and serve approximately 130,000 American Indians/Alaska Natives. Our purpose is to promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people.

I am of Cupik and Inupiaq descent from the villages of Mekoryuk, Shaktoolik, and Mary's Igloo. I have been blessed to have previously worked for the Alaska Native Tribal Health Consortium (ANTHC) for approximately nine years in Education & Development, Recruitment, and in the Alaska Native Medical Center Administration office.

My testimony will address expanding dental health care in Indian country and Alaska's dental health aide therapist program. I appreciate the privilege and opportunity to share the Alaska Tribal Health System experience with the DHAT program. The DHAT program has provided high quality care that meets all the standards of care as that of a dentist within their scope of practice and exists as another example of innovations to ensure access to high quality care in Alaska.

Background

In response to extensive dental health needs and high dental vacancy rates, the Alaska Dental Health Aide Therapy (DHAT) program began in 2003. The DHAT program is part of the Community Health Aide Program (CHA Program), which is authorized under Section 119 of the

Indian Health Care Improvement Act, 25 U.S.C. § 1616*l*. The CHA Program started in the 1960s by the Indian Health Service to provide emergency, clinical, and preventive services under general supervision of physicians. Following the CHA Program model, the DHAT program selects individuals from rural Alaska communities to be trained and certified to practice under general supervision of dentists in the Alaska Tribal Health System.

The Alaska DHAT program was created in part due to the high rates of dental caries and overall lack of access to dental services in rural Alaska villages. Alaska Native children and adolescents suffer dental caries rates at 2.5 times greater than general US children and adolescents.[1] This, combined with a vacancy rate of 25% and 30% annual turnover rates in dentists has developed into a serious problem in Alaska dental care.[2]

Nationally, with the number of dentists declining from 60 per 100,000 currently to an expected 54 per 100,000 in 2030 (ADA), there is clearly not an adequate supply and/or distribution of dentists to meet the basic oral health needs of America's First People. The great unmet need for dentists or other oral health providers in Indian Country, where there are, on the average, about half the dentist-to-population ratio of the national average, is well-documented.[3] According to the Indian Health Service: "The fact that dental decay affects more than 75 percent of AI/AN people presents a major challenge requiring a large-scale public health approach."[4] Based on our experiences in Alaska, we could not agree more. Dental Therapists can help to fill the gap to provide desperately needed services where dental services are either limited or do not exist at all.

Dental Therapists Worldwide

The Alaska DHAT training program is modeled after New Zealand's National School of Dentistry in Otago. New Zealand's Dental Therapists have been highly valued for over 80 years and are providing high quality care. In fact, over 14,000 dental therapists operate in over 53 countries worldwide. The United States is the only industrialized nation without a midlevel dental practice available to its citizens.

Dental therapists have been in practice for many years world wide especially in

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[1] Smith EB. Dental therapists in Alaska: addressing unmet needs and reviving competition in dental care. Alaska Law Review. 2007;24(1):105-43. Nash DA, Nagel RJ. Confronting oral health disparities among American Indian/Alaska Native children: the pediatric oral health therapist. Am J Public Health. 2005;95(8):1325-1329. One-third of school-age children in rural Alaska miss school because of dental pain, and a quarter report avoiding laughing or smiling because of the appearance of their teeth. Ibid. Oral Health disparities plague not only Alaska Natives, but all of Indian Country. According to the Department of Health and Human Service's Agency for Healthcare Research and Quality (AHRQ), AI/AN children between the ages of 2 and 4 have the highest rate of decay in the U.S.—five times the national average. http://www.innovations.ahrq.gov/content.aspx?id=1840. According to the Indian Health Service, 79 percent of AI/AN preschool children from 2 to 5 years old have a history of dental decay, 68 percent have untreated dental decay, and more than 50 percent have severe childhood cavities. http://www.ihs.gov/headstart/index.cfm?module=hs_providers_oral_health.

[2] Nash, DA. Ibid.

[3] Agency for Healthcare Research and Quality, http://www.innovations.ahrq.gov/content.aspx?id=1840.

[4] Indian Health Service, http://www.ihs.gov/headstart/index.cfm?module=hs_providers_oral_health.

children's oral health services and have shown they provide high quality care. For example, since 1963, Canadian dental therapists have been providing excellent care equal to or exceeding the quality of care of dentists and they have been more cost-effective.[5] In the Netherlands, there is greater investment in a dental therapist/dental hygienist combination and a 20% reduction in dental school numbers to improve access to care and decrease care cost.[6] With no litigation or malpractice suits in over 50 years, Malaysian dental therapists have proven their worth in the treatment of children's dental needs.[7] Dental therapists have proven their ability through high quality care worldwide.

DHAT Program Information

Alaska's DHATs receive extensive training, certification, continuing education, and clinical reviews to ensure their skills are of the highest quality. Alaska's first DHATs received their training New Zealand's National School of Dentistry in Otago. The first DHATs graduated in 2004. In 2007, the Alaska Native Tribal Health Consortium in partnership with the University of Washington's MEDEX Northwest Physician Assistant Training Program opened DENTEX, the first DHAT training center in the United States. The DENTEX goal is to provide culturally sensitive patient-centered care to optimize prevention to ensure that patients feel comfortable enough to return for continued care and treatment.

The DENTEX program is extremely rigorous. Students receive two years of training in biological science, social science, pre-clinic, and clinic training. The students receive 2400 hours of training and clinical experience during their first year in Anchorage and during their second year in Bethel, Alaska. Utilizing the same textbooks as dental students, DHATs in training are trained to provide the same high quality level of care a dentist would within their limited scope. The DENTEX faculty, most from dental schools, ensures that the students meet all skill requirements throughout their training. The training also consists of extensive clinic training. In fact, 20% of the first year of training and 78% of the second year of training consists of clinical components.

DHATs are trained to provide oral health education, preventive services, fillings, and uncomplicated extractions to preserve function and address pain and infection. DHATs are able to provide atraumatic restorative technique, placement of temporary restorations, simple restorations, simple extractions, lab processed crowns, pulpotomy, and pulp capping just to name a few. In addition, DHATs provide community education, many times in schools for young children and to families who visit the clinics.

An additional requirement of participating in the program is for each student to have a sponsor agreement with a tribal health organization for which they will work after graduation and certification. The sponsoring tribal health organization covers the costs of the student's training for the two year program in return for four years of service. In addition, the sponsoring organization provides a supervising dentist for the DHAT.

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[5] Nash, DA. Dental Therapists: A Global Perspective, Int'l Dental Journal, 58:61-70 (2008).
[6] Ibid.
[7] Ibid.

In addition to the agreement and extensive training, the student must complete a preceptorship of at least 400 hours with their supervising dentist. Since the DHAT will be practicing under the general supervision of the supervising dentist, it is during this preceptorship time that the supervising dentist and DHAT agree on the DHAT's scope of practice. The preceptorship time also allows the dentist and DHAT to develop a rapport as they will be in constant communication once the DHAT is at their permanent station many times talking telephonically three to six times per day, communicating via e-mail and/or telemedicine consultations regarding patient needs.

Only after the DHAT completes this clinical preceptorship are they eligible for certification. Each DHAT must apply for and receive certification to the Indian Health Service's Community Health Aide Program Certification Board. This independent federal board serves to credential providers and respond to issues and patient complaints. In addition, this board ensures standards for discipline, suspension or revocation of a certificate are met.

Once DHATs are trained, complete their preceptorship, and are certified, they begin work at their respective tribal health organization. However, their review and education does not stop there. DHATs must be recertified every two years and complete continuing education hours. A DHAT review consists of direct observation of each service performed eight times every 2 years. They are also required to complete 24 hours of continuing education per two year cycle.

Current DHATs

There are currently ten practicing DHATs who were trained in New Zealand and three who were trained at DENTEX. These DHATs work for the following tribal health organizations: Norton Sound Health Corporation (NSHC), Maniilaq Association (Maniilaq), Yukon Kuskokwim Health Corporation (YKHC), SouthEast Alaska Regional Health Consortium (SEARHC), Bristol Bay Area Health Corporation (BBAHC), Metlakatla Indian Community (MIC), and Mount Sanford Tribal Consortium (MSTC). In addition to these tribal health organizations having current DHATs practicing, the following tribal health organizations are sponsoring DHATs in their second clinical year of DENTEX: YKHC, BBAHC, Tanana Chiefs Conference (TCC), and Aleutian Pribilof Islands Association (APIA). The following tribal health organizations are sponsoring DHATs in their first year of DENTEX: Council of Athabascan Tribal Governments (CATG), YKHC, Eastern Aleutian Tribes (EAT), Maniilaq, and BBAHC. In total, there are thirteen DHATs currently practicing and fourteen in DENTEX training. Please see map of DHAT location information attached.

In recent independent studies, DHAT skills were assessed to determine if they are on par with dentist provided services and quality of care provided by DHATs.[8] The results of an early study noted that the "program deserves not only to continue by to expand" and that suggestions that dental therapists "cannot be trained to provide competent and safe primary care for Alaska Natives is overstated."[9] In a recent pilot study, there was found to be no significant difference between irreversible dental treatment provided by DHATs or dentists and no significant

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[8] Agency for Healthcare Research and Quality, http://www.innovations.ahrq.gov/content.aspx?id=1840.
[9] Louis Fiset. *A Report on Quality Assessment of Primary Care Provided by Dental Therapists to Alaska Natives* (Seattle, WA: University of Washington School of Dentistry, 2005).

difference in reportable events.[10] Dr. Bolin noted:

> One of the main objections to the solution of expansion of duties to nondentists was the issue of quality of care. Some who are opposed to treatment provided by DHATs have suggested that it is "second-class care" or, since DHATs do not have dental licenses, that they are practicing dentistry without a license and, therefore, could be "unsafe."
>
> . . .
>
> The opposition has occurred despite study results showing that DHATs can perform primary care procedures comparably to dentists, and that DHAT trainees perform equally well compared with dental students.

Id. (citations deleted).

Next Steps

Like the Community Health Aide, the DHATs have become an essential part of the dental health care delivery model in the Alaska Tribal Health System. Their ability to provide culturally appropriate, high quality care has increased Alaska Native access to proper dental services and prevention activities. In addition, these individuals have become role models for young people sharing and teaching them there are options and careers available to them. DHATs continue to thrive and prove their worth just as dental nurses and therapists have worldwide.

It is exciting to see other parts of the United States are looking at a dental mid-level model. The Alaska Native Health Board believes that dental therapists can be extremely helpful in combating dental disease and increase the level of oral health throughout Indian country and the nation. DHATs are an innovative solution to the inadequate numbers of licensed dentists practicing in underserved areas, not just rural Alaska. Recently, the Minnesota Legislature approved the Oral Health Practitioner consisting of the Dental Therapist and the Advanced Practice Dental Therapist with graduates expected in summer of 2011.[11]

In addition to seeing DHATs provide services, the Alaska Native Health Board is excited to see the preliminary results of a study commissioned by philanthropic organizations (Rasmuson, W.K. Kellogg, and Bethel Community Services Foundations) who are covering all costs of the evaluation which will determine the DHAT program's implementation integrity and conduct a health outcome assessment addressing safety, quality, and patient-oriented outcomes. The study is being conducted under extensive review by two advisory committees; one national and one state. The national advisory committee selected RTI International to conduct the evaluation. RTI International is the second largest non-profit research group in the United States and has experience in program evaluation and health services research. The study started in the Spring of 2009 and preliminary results are expected in Summer of 2010.

DHAT Program Needs

Major issues addressed include program funding shortfalls and evaluation needs. We respectfully recommend that this Committee urge the Indian Health Service include DHAT program funding in their funding requests for future years. It has come to our attention that the current philanthropic evaluation meets all but one evaluation request set aside for review by the Secretary of Health and Human Services. Thus, we also respectfully recommend that the Committee utilize the current study for all other needs of evaluation noted rather than commission a new study.

[10] Kenneth A. Bolin. *Quality Assessment of Dental Treatment Provided by Dental Health Aide Therapists in Alaska.* Paper presented at the National Oral Health Conference; 2007 May 1.
[11] Minnesota Board of Dentistry Newsletter 24:2 (September 2009).

The CHAIRMAN. Well, thank you very much, Ms. Dotomain. I perhaps should have asked Senator Murkowski whether she wanted to say a word because you are from Alaska, I know.

All right. We have I think about four minutes left to the end of this vote. So I think what we should do is go vote and come back. I want to recognize Senator Franken, who wishes to make a comment as he introduces a colleague from Minnesota.

We will stand in recess for about 15 minutes, no more than 15 minutes.

[Recess.]

The CHAIRMAN. I will call the hearing back to order.

Senator Franken?

Senator FRANKEN. Thank you, Mr. Chairman.

I want to introduce Dr. Patricia Tarren.

Thank you, Dr. Tarren, for traveling all the way from Minnesota. I know it is a great hardship. I am kidding about that. It is not so bad and I do it all the time.

Dr. Tarren is a pediatric dentist at the Hennepin County Medical Center, which is a great safety net hospital about four blocks from my house. And you have first-hand experience supporting mid-level dental providers and serving patients who face serious barriers to dental care, and we thank you for being here today.

STATEMENT OF PATRICIA TARREN, STAFF PEDIATRIC DENTIST, DEPARTMENT OF DENTISTRY, HENNEPIN COUNTY MEDICAL CENTER

Dr. TARREN. Good afternoon, Chairman Dorgan, Members of the Committee. My name is Patricia Tarren. I am a pediatric dentist at Hennepin County Medical Center.

I am here to testify regarding the amendment that Senator Dorgan had proposed restricting further expansion of dental therapists on Indian lands and prevent the Indian Health Services from providing or covering dental therapist services.

I am really glad to hear that he is going to be working with Senator Franken on the amendment that he had proposed, but is now withdrawn, to remove that restriction.

Hennepin County Medical Center is a large safety net hospital in Minneapolis, Minnesota. We provide dental care for patients who are medically compromised, those with special needs, and the socio-economically disadvantaged. We see the medical complications that arise from dental neglect, causing considerable pain, suffering, as well as costly hospitalizations.

When I graduated from dental school in England in 1974, I worked with four dental therapists and recognized their ability to provide safe, high quality dental treatment for our patients. I was a member of the Oral Health Practitioner Work Group that reported to the Minnesota legislature to facilitate enactment of Minnesota's dental therapy law this year.

I serve on the Curriculum Advisory Committee for Metropolitan State University's Advanced Dental Therapy Program. In my hospital position, I observe the professionalism of the dental hygienists I have trained in expanded functions, delivering local anesthetic and placing fillings.

Since the inception of the dental therapist in 1921, they have been evaluated worldwide. Dozens of peer-reviewed studies have shown that they improve access, reduce costs, provide excellent quality of care, and do not put patients at risk.

They provide commitment to their community and can work under general supervision of the dentist, who need not be present. Their scope of practice is limited to certain procedures which they are trained to perform to the same level of clinical competence as a dentist.

The benefit of a dental therapist improving access to care may well depend on them working in places impossible to recruit and staff permanently with dentists. This is particularly evident on Indian lands. For example, on the Red Lake Indian Reservation in

Minnesota, the dental hygienist struggles to find care for children with extreme dental neglect. Various intermittent volunteer and training programs using private dentists and dental students have not provided an effective solution.

Further, it has been demonstrated that American Indians have better health outcomes when culturally appropriate services are available. The dental health aide therapists, DHATs, who provide dental care in the bush for Alaska tribes have had a positive impact on oral health and are appreciated by their patients. They triage patients so the neediest are prioritized for the dentist's arrival. They are instrumental in directing patients who need evacuation by air for emergency care.

Dr. Bolin, a consultant and instructor with the DENTEX Anchorage Training Program, supervises DHAT students in the bush where he continues to see very good technical work as they perform simple procedures within a narrow scope of practice. The results of his pilot study are reported in the Journal of the American Dental Association. A full evaluation of the DHAT Program is currently underway, funded by the Kellogg Foundation.

So, given the successful introduction of the Alaska DHATs, tribes in other States should be allowed to evaluate the data when published, and determine for themselves whether to utilize DHATs, rather than using this restrictive legislation to deny them that possibility.

For the benefit of all members of society, the mark of a true medical professional is to advance the science of their profession. We should, therefore, be open to the possibility of different models of allied dental professionals, just as our medical colleagues have done with nurse practitioners and physician assistants, for example.

In conclusion, to increase access for under-served patients, allow us to follow our medical colleagues and expand our dental workforce to include well trained professional dental therapists who will provide appropriate care within their scope of practice, and allow their supervising dentist to practice at the top of their license. Please do not perpetuate the status quo where the best care is reserved for those with means and there is little or no care for the rest.

I urge you to support Senator Franken's amendment to remove the restrictive language and allow the option of dental therapists to improve dental care in Indian Country.

And thank you for this opportunity to testify.

[The prepared statement of Dr. Tarren follows:]

PREPARED STATEMENT OF PATRICIA TARREN, STAFF PEDIATRIC DENTIST, DEPARTMENT OF DENTISTRY, HENNEPIN COUNTY MEDICAL CENTER

Good afternoon Chairman Dorgan, members of the committee. My name is Patricia Tarren. I am here to testify regarding an amendment by Sen. Dorgan which restricts further expansion of dental therapists on Indian lands and prevents the Indian Health Service (IHS) from providing or covering dental therapist services.

I support Sen. Franken's amendment to remove this restriction from the legislation thus allowing potential expansion of the dental therapist's important and cost-effective role in improving oral health on Indian lands.

I am a staff pediatric dentist at Hennepin County Medical Center, a large safety net hospital in Minneapolis, Minnesota. We provide dental care for patients who are medically compromised, those with special needs, and the socioeconomically disadvantaged. We see the medical complications that arise from dental neglect, causing considerable pain, suffering, as well as costly hospitalizations.

When I graduated from dental school in England in 1974, I worked with four dental therapists, and recognized their ability to provide safe, high quality dental treatment for our patients. I was a member of the Oral Health Practitioner Work group that reported to the Minnesota legislature to facilitate enactment of Minnesota's Dental Therapy Law this year. I serve on the curriculum advisory committee for Metropolitan State University's Advanced Dental Therapy Program. In my hospital position, I observe the professionalism of the dental hygienists I have trained in expanded functions – delivering local anesthetic and placing fillings.

Since the inception of the dental therapist in 1921 they have been evaluated worldwide. Dozens of peer-reviewed studies have shown that they improve access, reduce costs, provide excellent quality of care and do not put patients at risk. They provide commitment to their community, and can work under general supervision of the dentist who need not be present. Their scope of practice is limited to certain procedures which they are trained to perform to the same level of clinical competence as a dentist.[1, 2, 3]

The benefit of the dental therapist – improving access to care – may well depend on them working in places impossible to recruit and staff permanently with dentists. This is particularly evident on Indian lands: For example on the Red Lake Indian Reservation in Minnesota the dental hygienist struggles to find care for children with extreme dental neglect. Various intermittent volunteer and training programs using private dentists and dental students have not provided an effective solution. Further, it has been demonstrated that American Indians have better health outcomes when culturally appropriate services are available.

The dental health aide therapists (DHATs) who provide dental care in the bush for Alaska tribes have had a positive impact on oral health and are appreciated by their patients.[4] They triage patients so the neediest are prioritized for the dentist's arrival. They are instrumental in directing patients who need evacuation by air for emergency care. Dr. Bolin, a consultant and instructor with the DENTEX Anchorage training program, supervises DHAT students in the bush where he continues to see very good technical work as they perform simple procedures within a narrow scope of practice. The results of his pilot study are reported in the Journal of the American Dental Association.[5] A full evaluation of the DHAT program is currently underway, funded by the Kellogg Foundation.[6]

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For the benefit of all members of society, the mark of a true medical professional is to advance the science of the profession. We should therefore be open to the possibility of different models of allied dental professionals, just as our medical colleagues have done with nurse practitioners and physician assistants, for example.

In conclusion, to increase access for underserved patients, allow us to follow our medical colleagues and expand our dental workforce to include well trained, professional dental therapists who will provide appropriate care within their scope of practice and allow their supervising dentist to practice at the top of their license. Please do not perpetuate the status quo where the best care is reserved for those with means and there is little or no care for the rest.

I urge you to support Sen. Franken's amendment to remove restrictive language and allow the option for dental therapists to improve dental care in Indian Country.

Thank you.

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The CHAIRMAN. Ms. Tarren, thank you very much. We appreciate your coming to testify.

Let me just say at the outset, my notion of this is that we have responsibilities to provide health care for Native Americans. I have never been very interested in saying to the IHS it is okay if you don't provide full dental service. You can do something less because we are short of money, so hire people that aren't qualified to be dentists to do bona fide dental work. So that has been my notion. Why let them off the hook? Why not say let's spend the money necessary to give the First Americans the kind of dental treatment that we have said that they would get in trust agreements and treaties and so on?

On the other hand, I recognize that in Alaska, you won't find a dentist around population centers, so they have created a separate kind of dental health aide therapist and apparently quite successful for providing services in the areas where there would be no service.

So the question I have is this. The testimony by Dr. Tankersley, you talk about your support of the creation of a new innovative

dental workforce that parallels the medical community health aides. You are pilot testing a community dental health coordinator. How does that particular position that you are now training, how does that relate to the DHAT, the dental health therapist that exists in Alaska? What might be the difference between those two levels?

Dr. TANKERSLEY. Well, the community dental health coordinator is more like a medical model. You know, like a physician's assistant or whatever. In other words, they are not doing surgical services, but there are many, many services that they do which are preventive, triage, and that sort of thing.

The DHAT model in Alaska, and once again, one of the problems is with multiple DHAT models. But the DHAT model in Alaska is doing surgical services. They are extracting teeth and doing things like that, and that is the problem.

As a surgeon, I can tell you there is no such thing as a routine extraction until it is done. You just never know what you are going to run into. You know, you can run into the area around a nerve. You can get excessive bleeding and that sort of thing. So that is our concern is having unsupervised surgery done by someone, you know, who admittedly could have good technical training.

The CHAIRMAN. All right.

Let me call on Senator Murkowski and then call on Senator Franken.

Senator Murkowski?

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

Senator MURKOWSKI. Thank you, Mr. Chairman. I appreciate the hearing.

I want to welcome you, Angel. It is good to see you and I appreciate your leadership on this issue and your leadership as the CEO of the Alaska Native Health Board.

Some of the comments that have been made here today, Dr. Tankersley has indicated that the effort that is underway now within the ADA is to help eliminate the shortage that we all acknowledge exists out there in terms of the dentists, the practitioners. And you have indicated that as many as 70 additional dentists may be in the pipeline coming into IHS.

Angel, I am going to ask you this question because so much of our problem is not that there not dentists that are being trained on a daily basis coming out of dental school. It is our ability to get them into these villages on a more than once a year for one week or two week basis. And this has been our challenge and how we as a very remote, very large State have come to this mid-model that has been developed, the DHAT model.

Your family comes from Shaktoolik. How many folks live in Shaktoolik now?

Ms. DOTOMAIN. As of last week, probably about 212.

Senator MURKOWSKI. About 212. How often do the people of Shaktoolik see a dentist come to the village?

Ms. DOTOMAIN. Once a year.

Senator MURKOWSKI. And how long would that individual be there to care for the residents?

Ms. DOTOMAIN. One week.

Senator MURKOWSKI. So you get one week. So your five-year-old child or your 23-year-old young woman or you are an elder, and you have dental care that is provided to you for one week. I shouldn't say dental care provided for one week because you get your time slot with the dentist that is there. Our challenge has always been how we get these professionals.

Now, earlier in the audience there were three friends from Kotzebue, and I was asking them as we took our break. I said, how many DHATs do we have in Kotzebue now? And I am told that we have two, and I was also reminded that both of these individuals were born and raised in Kotzebue. We have now trained them and they have come back home.

I have had a chance to visit with the DENTEX program and the individuals there that are going through there. You ask them where they are from, and one is from Chevak and one is from Hooper and one is from Quinhagak. And their desire is to go back to their village.

So what we are doing is we are not sending people out to a dental school in Oklahoma or Minnesota, and hoping that they come back home. We are growing our own. And I think this is one of the facets of the DHAT Program that I think is resulting in a level of success.

Dr. Tankersley, you mentioned the concern about the unsupervised surgery. And I think we have all recognized that that is kind of where the angst comes. When you are extracting teeth, that is a permanent issue, as opposed to putting fluoride on a child's teeth.

Can you explain, Angel, how the mentoring process works within the program? If you have a DHAT in a village who does have to work a procedure, are they totally on their own? Can you just explain for the panel here?

Ms. DOTOMAIN. Absolutely not. They are in constant contact and communication with their supervising dentist.

Senator MURKOWSKI. And what does that mean? Tell us.

Ms. DOTOMAIN. What happen is the dental health aid therapist actually works under the license and supervision of their supervising dentist, usually someone located, for instance, in Unalakleet, which is 40 miles from my home town of Shaktoolik, there is a dental health aide therapist, Aurora Johnson. Born and raised in Unalakleet, she was able to go to the program in New Zealand and come home.

And she works under the license of a dentist in Nome, with the Norton Sound Health Corporation. They are in constant communication with their supervising dentist, and the agreement between the supervising dentist and the dental health aide therapist actually can sometimes limit the already limited scope of practice of the dental health aide therapist.

So they come out of the DENTEX Program with a certain scope of training, and then they spend at least 400 hours with their supervising dentist in the preceptorship program. And during that time, they can either continue to limit the scope of practice so there is an agreement between the supervising dentist and the DHAT of what their scope of practice will be, based on how the supervising dentist feels their skills are.

Aurora Johnson could be in contact with her supervising dentist three to six times a day, either on the phone, via email, or through the Alaska Federal Health Care Axis Network Telemedicine Program. She is able to send films to her supervising dentist if she is unsure of or wants to just refer, consult with her supervising dentist. She has the option and opportunity to do that at any point in time during her day.

Senator MURKOWSKI. Thank you.

Dr. Tarren, I think you used the words "culturally appropriate" services, and you indicated that you think American Indians have better outcomes, and you have also cited to the DHAT Program in Alaska, where we have seen the benefits.

How significant do you feel that is as we are trying to develop these mid-levels to respond to what clearly is a need in my State and in the Lower 48 with American Indians?

Dr. TARREN. I think it is extremely important for the practitioner to develop the trust of their patients. And for example, if I came into Alaska and worked for two weeks in one of the villages, I would probably be viewed with some suspicion, and I know that my giving, for example, advice to a family about diet and their child would not be received as well as if Angel were giving them the exact same information.

And in our hospital at Hennepin County Medical Center, we see many patients of different ethnicities. For example, I have learned to speak Spanish so that I can more readily gain the trust of my Spanish-speaking families so that they will believe me when I am trying to divert their dietary practices from harmful practices, for example.

Senator MURKOWSKI. I appreciate you bringing that up because I think one of the things that we have recognized, particularly with children, is that if it is somebody that is in your village, someone that is in your community who is giving you guidance, giving you counsel, telling you, you know, are you brushing, who sees you in your school or in the store, that is kind of a constant reminder.

You mention the issue of trust, which is so important, but I think also just having that presence within the community on a daily basis, somebody that lives there, someone that is one of us I think makes such a big difference.

And Dr. Tankersley, I so appreciate what the American Dental Association is doing and their efforts. And I truly believe that there has been a greatly stepped up effort to get more dentists out into all aspects of rural America, and I applaud you on that.

I think that the example that is underway in Alaska does demonstrate that we can be working cooperatively to fill in some of these gaps, so I appreciate your willingness to work with us on that.

I have well exceeded my time, Mr. Chairman. I appreciate your indulgence.

The CHAIRMAN. Thank you very much.

Senator Franken?

STATEMENT OF HON. AL FRANKEN,
U.S. SENATOR FROM MINNESOTA

Senator FRANKEN. Thank you, Mr. Chairman.

Thank you, Senator Murkowski, for talking about the DHAT Program in Alaska and a lot of the successes of it.

I would like to ask Dr. Tarren, in your career as a dentist, and I knew you were a pediatric dentist. I just said pediatrician. Have you seen a dental therapist give substandard care?

Dr. TARREN. I have not. I was in England last year and visited two training programs, and continue to be very impressed by the level of education that is received, the competence, the commitment, the dedication among the students, who are learning dental therapy, and then going out in to the community to a practice situation, a community clinic, and again seeing the high level of professionalism.

And the fact that their patients really appreciate the standard of care that they are getting to the point where a dental therapist who recognizes that a procedure would be beyond her scope of capability and wants to refer that patient to the supervising dentist, the patient is a little bit disappointed and would rather have the dental therapist provide the care.

Senator FRANKEN. And I think that I would argue the most substandard is offering no care at all. Would you agree with that?

Dr. TARREN. Completely.

Senator FRANKEN. Now, have you worked on Red Lake Reservation?

Dr. TARREN. Unfortunately, no.

Senator FRANKEN. Do you know anyone who has?

Dr. TARREN. I know the dental hygienist that works there, and I know that they are desperately short of access to dental care. For example, they send patients down to the Twin Cities, children who need care, who have extensive dental needs and would most benefit from care under general anesthesia. And that is 250 miles. It is a long way to bring a small child.

Senator FRANKEN. Ms. Dotomain, do you see any reason why other locations that are suffering from a lack of dental care shouldn't use a mid-level dental provider model similar to what you use in Alaska?

Ms. DOTOMAIN. No, none at all.

Senator FRANKEN. Dr. Tankersley, shouldn't everyone have access to dental care?

Dr. TANKERSLEY. We believe they should.

Senator FRANKEN. Okay. In your testimony, you said something interesting. You said this year alone, there will be 70 additional dentists providing care in tribal areas. That was your recruitment. And then you went on to say, with one more year of similar recruiting success, the shortage of dentists in the IHS could be eliminated.

Dr. TANKERSLEY. Yes.

Senator FRANKEN. Do you know how many dentists there are in the IHS?

Dr. TANKERSLEY. I don't know the total, but I think the number that the IHS, you know, wants is low, as it is in some military situations.

Senator FRANKEN. I am sorry. I didn't understand.

Dr. TANKERSLEY. Yes, I don't know the total of dentists in IHS. No, I don't.

Senator FRANKEN. Well, the numbers don't seem to make any sense to me. Do you know what the shortage is?

Dr. TANKERSLEY. Well, the IHS has a quota just like military does for how many posts they have. And for years, there has been an inability to recruit dentists in IHS. In the last short period of time, we have been much more successful because of some of these programs that we have instituted in getting dentists to——

Senator FRANKEN. Okay. Well, if you don't know how many dentists there are in the IHS, and you said that recruiting 70 more could eliminate the shortage, I don't know how you could make that statement.

Dr. TANKERSLEY. Because there are——

Senator FRANKEN. There are 600 dentists in the IHS. Do you how much of a shortfall there is?

Dr. TANKERSLEY. Yes, the shortfall at this point is about another 70 dentists, and they have——

Senator FRANKEN. No, it is not. The shortfall that I have seen is about 25 percent.

And do you know what the turnover rate is?

Dr. TANKERSLEY. I don't know the statistics, but the turnover rate is high.

Senator FRANKEN. So when you said that with one more year of similar recruiting success, the shortage of dentists in the IHS could be eliminated, why did you use the word "could"?

Dr. TANKERSLEY. Because there is no way we know that it will be eliminated.

Senator FRANKEN. Why did you even bother to say it? Because the turnover rate is about 30 percent, sir.

Dr. TANKERSLEY. Yes, but because there is a—for the first time in many years, there is a positive trend to actually get dentists into the Indian Health Service.

Senator FRANKEN. Well, your positive trend was 70, which to my calculation is like 11 or 12 percent. And if we have a 24 percent shortfall and we have a 30 percent turnover, I don't see how 70 new recruits can possibly eliminate the shortage. And so it just bothers me that—I mean, I think we agree that people need dental care.

Dr. TANKERSLEY. We do.

Senator FRANKEN. And I understand that the ADA represents dentists and you want people who you represent to do this work, and I applaud dentists who do this. But we have a model here that seems to be working, and we have a shortfall in Indian Country. And it could do a lot of people a lot of good. And I wouldn't mind if you could meet that shortfall. I would love it. But it doesn't seem to me that from your testimony that your testimony is convincing at all.

And what I want to do is make sure that kids in Indian Country don't have rotting teeth. That is my responsibility.

Thank you.

Thank you, Mr. Chairman.

[The prepared statement of Senator Franken follows:]

PREPARED STATEMENT OF HON. AL FRANKEN, U.S. SENATOR FROM MINNESOTA

Thank you Mr. Chairman. It is an honor to be here today, and I thank you for holding this hearing on such a critical and timely topic for our nation and particularly Minnesotans.

Last summer, Minnesota became the first state to pass legislation to create a training option for mid-level dental health practitioners to be licensed. The goal was providing more basic services to underserved rural populations in the state. Underserved areas including reservations where there are teeth literally rotting in the mouths of children because they don't have dentists to take care of them.

Physician assistants and nurse practitioners have become accepted and valuable parts of the health care model. There is no reason that areas other than Alaska shouldn't have the option to add dental health aid therapists to the dental care model. Particularly in locations where there has been such a historically hard time in getting dentists to work. The bill we craft today should be permissive to reasonable options, not dictating because of special interests.

Over 50 countries, such as England, Canada and Australia are using mid-level dental practitioners to improve access and lower costs. Research has shown these programs are both safe and effective. Not a single study has shown these programs to be unsafe. Yet the American Dental Association has repeatedly tried to block efforts to have mid-level providers help Americans improve their dental health. The ADA fought the Alaska program. When the program was implemented they filed a lawsuit to stop it. The ADA was vehemently against the Minnesota legislation. And now they are lobbying to take away the chance to duplicate a good program in places where it's needed most.

We are talking today about teeth rotting in the mouth of children because of a lack of dental care. How can this possibly be acceptable?

I am looking forward to hearing from the people who have come here to testify on this crucial topic, particularly Dr. Patricia Tarren, from the Hennepin County Medical Center in the great state of Minnesota. But I'd also like to point out that we won't be hearing today from the people who have the most to lose. People on the reservations who have some of the worst dental health of anyone in our country. People who, at the same time, have some of the worst access to dental care. Those are the people who would most benefit from a mid-level dental provider. Those are the people that will continue to have poor dental health and poor access to dental care if we deny them this opportunity.

The CHAIRMAN. Senator Franken, thank you very much.

This is an issue that has had some previous attention by this Committee, again thanks to the work of Senator Murkowski and others. Senator Franken has brought the issue to us again, and I think caused us to have a discussion that is probably long overdue.

I appreciate the testimony by all three of you. We are going to work on this Committee to think our way through this in a way that reaches a good result.

My interest, I think the interest of everyone on this Committee, is for good dental care for American Indians who have been promised good dental care. I have seen circumstances myself of one dentist working in an old trailer house serving 5,000 people on an Indian reservation. That is not good dental care. Most of the dental care there was to simply have a patient show up and pull the tooth. So we expect better, demand better, and I think this discussion will be helpful going forward.

And Senator Franken, I appreciate you requesting this hearing.

Senator MURKOWSKI. Mr. Chairman?

The CHAIRMAN. Yes, Senator Murkowski?

Senator MURKOWSKI. Can you let me ask one quick question of Dr. Tankersley?

Is there an effort within the ADA to specifically recruit American Indians, Alaska Natives into the dental profession? Do you have a specific outreach to them, and if so could you speak to that?

Dr. TANKERSLEY. You know, we have pipeline projects, and that is difficult and there is an effort to do that, and it is meeting with some success.

Senator MURKOWSKI. Can you define when you say it is meeting with success? How far along are you in the process?

Dr. TANKERSLEY. Well, you know, it is a low percentage. I don't know, do you know the percentage? We can supply it. I know it is an——

Senator MURKOWSKI. I would be curious to know what that is.

Dr. TANKERSLEY. The reason I know is because our Board of Trustees deals with this all the time, and it is a major issue, not just with Indians, but with other ethnic groups, too.

And if I have permission to say something, I would like to say most of the conversation of what has been done is exactly what our community dental health coordinator does—you know, the cultural competence, the prevention, they can get people out of pain. And the difference in approach probably is that we would like to see the Indian Health Service have better resources so that they could have dentists to come in to do the actual surgical procedures.

Now, we are aware of stories like a dentist shows up once a year, but that is not necessary. I mean, if you have proper resources in medicine and dentistry, there are lots of people that can come into areas once a week or once a month. And so it is just a matter of having the appropriate resources to get the dentist in to do the surgical procedures.

Thank you.

The CHAIRMAN. Dr. Tankersley, thank you.

Angel Dotomain, thank you.

Patricia Tarren, we appreciate your being here.

That closes this portion of the hearing.

[Whereupon, at 3:48 p.m., the Committee was recessed, to reconvene the same day.]

A P P E N D I X

PREPARED STATEMENT OF THE PEW CHILDREN'S DENTAL CAMPAIGN

The Pew Children's Dental Campaign would like to thank the Committee Chairman for holding this important and timely hearing.

The Pew Children's Dental Campaign is working to ensure that more children receive dental care and benefit from policies proven to prevent tooth decay. We are mounting a national campaign to raise awareness of the problem, recruit influential leaders to call for change, and showcase states that have made progress and can serve as models for pragmatic, cost-effective reform.

Pew believes children should see a dentist when needed, and when possible. However, we recognize it is not always possible. Therefore, Pew supports state innovations that show promise in improving access to preventive and restorative services for children who cannot access care. Pew supports state efforts to expand the existing dental health care team with new providers, as well as using current providers to the extent of their training.

The Campaign supports dental workforce innovations based on five key principles:

1.) Proposals for new workforce models should be **based on research and evidence.**

2.) Models should be based on a **careful analysis** of the state's particular experience and needs.

3.) The **duties and scope of practice** of new providers should be designed to address the needs and problems identified in the state's analysis.

4.) New dental providers should be **adequately educated** to perform their scope of services competently.

5.) States should adopt the **least restrictive level of supervision** that maintains patient safety.

The DHAT program in Alaska meets each of these criteria.

To prevent tribes in the other 49 states—who have the legal standing as sovereign nations—from even assessing the viability of this model as a solution to their lack of access to dental care is counterproductive.

Our country is facing a critical lack of access to dental care. A shortage of dentists—especially in low-income, inner-city and rural communities—constitutes a national crisis, particularly for children.

There is a consistent shortage of dentists in rural and underserved areas, including tribal lands. The ADA has acknowledged a geographic maldistribution of dentists, with too few locating in rural, isolated, and underserved areas.

During economic downturns, it is always easier to recruit dentists for the IHS and other safety net settings. However, once the economy improves, the vacancy rate always goes up. Generally speaking, about one quarter of rural safety net clinic openings for dentists are unfilled, and the percentage is higher in rural areas.

Expanding the dental workforce to include therapists is a cost-effective investment that can help extend essential health services to all Americans. Therefore, the Pew Children's Dental Campaign supports the DHAT program and does not support preemptively restricting the tools available to communities in the other parts of the United States to address their dental health needs.

Attachment

MAY 2009

Help Wanted:

A Policy Maker's Guide to New Dental Providers

THE PEW CENTER ON THE STATES

NATIONAL ACADEMY for STATE HEALTH POLICY

W.K. KELLOGG FOUNDATION

By Shelly Gehshan, Mary Takach, Carrie Hanlon and Chris Cantrell

Access to oral health care is becoming an increasingly serious problem for many people in the United States, particularly for children. The tragic death of 12-year-old Deamonte Driver in 2007 from complications of untreated tooth decay gave the nation a sobering reminder of the grim consequences that can result from a lack of dental care availability.[1] The National Academy for State Health Policy and the Pew Center on the States, with funding from the W.K. Kellogg Foundation, conducted a comprehensive literature review and interviewed leading experts in several states to learn about options for expanding available care.

Limited provider supply and increased demand for care are combining to create the growing national problem. Shortages of private dentists—especially in low-income, inner-city, and rural communities—and limited availability of government-supported dental care restrict patient access. The supply of private dentists who participate in public health insurance programs and who serve young children, the elderly, people with disabilities and immigrants is also acutely constrained. Dentists are also poorly distributed, with too few in many communities that need them and too many in others. At the same time, Americans are living longer and doing so with more of their natural teeth than past generations, putting additional strain on an already taxed system of care.[2]

It is not surprising that dental problems disproportionately affect low-income families, children, and racial and ethnic minorities. Nearly 80 percent of dental caries occur among 25 percent of children, many of whom are from lower income families.[3] While states are required to provide dental care to Medicaid-enrolled

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1 Deamonte Driver, a 12-year-old Maryland boy, died from a tooth abscess that spread to his brain. He spent six weeks in the hospital prior to his death, accumulating bills totaling over $250,000. See "For Want of a Dentist," *The Washington Post*, February 28, 2007. Available at: http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html

2 R. L. Ettinger, "Oral Health and the Aging Population," *Journal of the American Dental Association* (Sept. 2007), 138.

3 L. M. Kaste, et al., "Coronal caries in the primary and permanent dentition of children and adolescents 1–17 years of age," *Journal of Dental Research* 76 (1996), 631–641.

low-income children, only one in three of these children received services in 2006.[4] Racial and ethnic minorities, independent of income, have more serious problems accessing dental care than whites and have poorer oral health as a result.[5]

The current economic crisis likely will further limit access to dental health services but, at the same time, the crisis gives states an opportunity to explore new, cost-effective models that can safely provide the care patients need. As a result, many states are considering adding new types of dental providers such as community dental health coordinators, dental therapists and advanced dental hygiene practitioners to the existing oral health care team.

Recognition is growing in the United States that such alternative providers can competently and safely deliver basic dental care. These additional providers can supply urgently needed oral health services, especially essential preventive care in areas and settings where dentists are scarce. By improving access to primary care for all patients, not only those in underserved communities, these new providers can potentially reduce the overall demand for care, actually making it easier for patients needing more complex treatment to get in to see a dentist.

Many other countries, including Canada, Great Britain, Australia and New Zealand, have had alternative dental providers for decades who function similarly to nurse practitioners and physician assistants. A substantial body of research exists that establishes the quality of care, cost effectiveness and health outcomes associated with the use of alternative providers, and this extensive research can guide the United States in looking at similar models.[6]

This guide is intended to provide policy makers with objective information and the tools they need as they consider developing new providers. It reviews three proposed providers—dental therapist, community dental health coordinator and advanced dental hygiene practitioner—along with implementation steps policy makers can consider.

Why Develop New Providers?

A number of factors have spurred interest in developing new dental providers.

- **Shortages of private dentists persist.**[7] By the year 2014, the number of dentists reaching retirement age will outpace new dentists entering the workforce, and the ratio of dentists to population (a common measure of supply) will begin to decline.
- **People who cannot afford private dentists have limited options.** Community health centers and clinics operated by dental and hygiene schools, hospitals and public schools comprise the dental safety net for individuals who cannot afford private care. Community centers and clinics, however, have the capacity to serve only about 10 percent of the 82 million low-income people who need them.[8] Hospital emergency rooms—often a last resort for uninsured patients—can treat only for pain and infection, not underlying dental problems.

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4 Centers for Medicare and Medicaid Services, *Annual EPSDT Participation Report: Form CMS-416 (National), 2006* (Baltimore, MD: U.S. Department of Health and Human Services, 2008). Retrieved January 29, 2009. http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp

5 GAO. Oral Health, Factors Contributing to Low Use of Dental Services by Low-Income Populations, GAO/HEHS-00-149, September, 2000, 6.

6 Minnesota Safety Net Coalition, Highlight of the Research Literature Review on Mid-Level Oral Health Practitioners, January, 2009, 107-111 http://www.health.state.mn.us/healthreform/oralhealth/FinalReport_OHP.pdf

7 B.Mertz and E. O'Neill, "The Growing Challenge of Providing Oral Health Services to All Americans," *Health Affairs*, v. 21, no. 5 (2002), 73.

8 H. Bailit, et al., "Dental Safety Net: Current Capacity and Potential for Expansion," *Journal of the American Dental Association* 137, no. 6 (June 2006), 807-815.

- **Expanding public dental coverage alone will not sufficiently increase access.** In fact, coverage expansions might lead to growing waiting lists for providers who participate in Medicaid and Children's Health Insurance Program (CHIP).[9] Public insurance programs rely primarily on private practitioners to deliver care. The majority of dentists, however, do not participate in Medicaid and the CHIP.[10] Extending public dental coverage under the current inadequate Medicaid financing structure will not address the core problem of limited provider supply and could exacerbate access problems, putting additional pressure on the delivery system.

Proposals for New Providers

In the United States, most dental care is delivered in private practices by a dental team that consists of dentists, dental hygienists and dental assistants. Recognizing the successes of other models throughout the world, innovative proposals for new providers have emerged that would expand the dental team and increase access to care. Currently, three principal proposals for new dental care providers are being discussed by policy makers, dental professionals and other stakeholders: the dental therapist, community dental health coordinator and the advanced dental hygiene practitioner. Key characteristics of these three providers are highlighted below.

Dental Therapist

Dental therapists deliver basic educational, preventive and restorative services. For cases that require more extensive care, dental therapists refer patients to a dentist. In other countries, dental therapists focus on care for children in schools and public health settings. Many, however, also work in private practices with dentists.

The dental therapist model has not been adopted in the United States, with the exception of the Alaska Native Tribal Health Consortium, which introduced what the Consortium called dental health aide therapists (DHATs) as a way to deliver care to some of the most isolated tribal regions.

In the Alaska model, dentists who supervise DHATs are not usually on-site. DHATs practice under standing orders issued by their supervising dentist that spell out what treatment DHATs can provide and when they must refer

> As of 2007, 10 dental therapists have provided care to thousands of residents in 20 Alaskan villages, many of whom might never have received care otherwise. Since dental therapists are not under the direct supervision of dentists, they are able to practice in remote areas not often visited by dentists. Two initial studies found that the care provided by dental therapists in Alaska is of high quality.[11]

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9 K. Lazar, "Dental Benefits Widen, Waiting Lines Grow, Some Balk at Giving Care, Call Subsidized Rates Too Low," *Boston Globe*, August 7, 2008.

10 P. Cunningham and J. May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health System Change, Tracking Report no. 16, August 2006.

11 K. Bolin, "Assessment of Treatment Provided by Dental Health Aide Therapists in Alaska: A Pilot Study," *JADA* 2008; 139, no. 11, 1530-1535; L. Fiset, "A Report on Quality Assessment of Primary Care Provided by Dental Therapists to Alaska Natives," University of Washington School of Dentistry (September, 2005).

TABLE 1

NEW DENTAL PROVIDERS — HOW DO THEY COMPARE?

	PROPOSED COMMUNITY DENTAL HEALTH COORDINATOR	DENTAL THERAPIST	PROPOSED ADVANCED DENTAL HYGIENE PRACTITIONER
History	First proposed by the American Dental Association in 2006 First 12 CDHC candidates began training in 2009	Introduced in 1921 in New Zealand Now used in 53 countries and Alaska.	Developed by the American Dental Hygienists' Association to be a new licensed dental provider
Post-secondary education	Twelve months of training program followed by a six-month internship	Two years of training followed by clinical training in practice sites (Other countries are moving toward a three-year program that combines dental therapy and dental hygiene)	A 2-year master's degree for people with a 4-year degree in dental hygiene
Regulation	Certification	Certification Recertification required every two years	Licensure
Supervision	Direct supervision by a dentist for clinical services; general supervision for education	General supervision under standing orders by a dentist	General supervision under standing orders by a dentist or collaborative agreement with a dentist
Practice settings	Private practices, WIC offices, Head Start programs, community clinics, schools, churches, nursing homes, federally qualified health centers	Private practices, community-based clinics, rural settings, Indian Health Service (IHS) clinics in Alaska, schools, nursing homes	Private practices, community-based clinics, rural settings, IHS, schools, nursing homes
Scope of services	Assist patients in locating providers who accept the patients' insurance, perform education, preventive services, and limited restorations	Perform basic preventive, diagnostic and restorative services	Perform basic preventive, diagnostic and restorative services

patients elsewhere. These orders can vary depending on the dentist and dental therapist. Typically, the dentist practices in a "hub clinic" while providing supervision to dental therapists at satellite clinics in remote areas.

Dental therapists undergo training that is designed to resemble the last two years of dental school but includes more hours of education and experience treating children than dentists receive.[12]

12 D. Nash and R. Nagel, "Confronting Oral Health Disparities Among American Indian/Alaska Native Children: The Pediatric Oral Health Therapist," *American Journal of Public Health* 95 no. 8 (August 2005), 1325-1329. Retrieved March 17, 2009. http://www.ajph.org/cgi/reprint/AJPH.2005.061796v1

Community Dental Health Coordinator (CDHC)

Following the model of community health workers, the community dental health coordinator position (CDHC) is designed to supplement the services already provided by dentists, dental hygienists and dental assistants. CDHCs will act most often as a facilitator in communities by helping patients navigate the health care system and obtain access to oral health care, but CDHCs may also perform preventive and restorative services, such as applying fluoride varnish. Direct supervision by a dentist would be required when performing clinical procedures, while general supervision would be necessary for community and educational support.

CDHC candidates must have a high school education. The first group of CDHC candidates is in training at press time, so a fully implemented model is not yet available for evaluation. CDHCs may undergo voluntary certification but are not required to be licensed under the current proposal. This is controversial considering the proposed CDHC model includes performing temporary restorations. All other providers who perform restorations are licensed, which is a stricter process.

Advanced Dental Hygiene Practitioner (ADHP)

The advanced dental hygiene practitioner would be able to perform basic preventive, diagnostic and restorative services. This model is comparable to a nurse practitioner in the ADHP's function and relationship to dentists. Under the proposed model, the ADHP would work under general supervision with standing orders from a dentist. This would allow ADHPs to provide basic services and case management with a high degree of autonomy while still reserving the more complex procedures for the expertise of the dentist.

The American Dental Hygienists' Association has developed a master's degree curriculum for training these new providers. The program is intended to recruit existing dental hygienists who would like to further their education and qualify as an ADHP. Upon completion of the program, ADHPs will be licensed by states. While no ADHP program is currently in place, training programs are being planned by hygiene education programs at community colleges in several states.

Developing a New Type of Dental Provider

Mid-level providers such as nurse practitioners and physician assistants have existed in the medical community for years and have been successfully integrated into the health care workforce. State policy makers looking to introduce similar providers in dentistry to their states require thorough data to determine what types of professionals would best integrate with the existing dental workforce. Policy makers need to:

- **Collect baseline data** to document the extent to which people have untreated oral health problems or difficulty accessing routine dental care and to determine which populations, institutions or communities the new provider could serve. Data sources include: State Dental Directors,[13] State Oral Health Coalitions, State Health Policy Institutes,[14] and the U.S. Department of Health and Human Services, Health Resources and Services Administration.[15]

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13 An overview of information provided to the Centers for the Disease Control and Prevention (CDC) by state dental directors is available at http://apps.nccd.cdc.gov/synopsis/index.asp.

14 National Network of Public Health Institutes, "National Network of Public Health Institutes" (2008) Retrieved December 23, 2008 http://nnphi.org/home/

15 Health Resources and Services Administration, "Shortage Designation: HPSAs, MUAs & MUPs," 2008. Retrieved December 23, 2008. http://bhpr.hrsa.gov/shortage/muaguide.htm

TABLE 2

KEY CHARACTERISTICS OF PROPOSED AND CURRENT PROVIDER MODELS

	PROPOSED COMMUNITY DENTAL HEALTH COORDINATOR	DENTAL THERAPIST	PROPOSED ADVANCED DENTAL HYGIENE PRACTITIONER
Unique features	**Educators, community health workers** focused on supporting the proper use of dental services by low-income populations.	**Primary care providers** focused on delivering basic preventive and restorative care to isolated and underserved populations.	**Case managers and primary care providers** who could assess risk, educate, provide preventive services and basic restorations.
Potential political/ implementation challenges	• Training to do temporary restorations with a hand instrument is controversial for an unlicensed practitioner. • Although the CDHC model is designed to increase access to care by helping patients find dental providers, it does not address the fact that most dentists do not accept Medicaid patients.	• Trained to perform restorative procedures under general supervision, which is controversial among segments of organized dentistry in the U.S.	• Trained to perform restorative procedures under general supervision, which is controversial among some members of organized dentistry. • Training may be excessive and expensive, given the limited expansions gained in scope of practice. • Salaries would be higher than that of dental therapists for a similar scope of practice. • It may be difficult to persuade dentists to collaborate with and accept referrals from ADHPs.
Potential limitations of the scope of service	• Includes a mix of skills and services that may not be realistic. • Very limited clinical services would make them difficult to support through reimbursements and of limited use in most practice settings. • To perform clinical procedures, CDHCs must be under a dentist's supervision and so could not help in the many areas where there are no dentists.		• Recruiting from current pool of hygienists would limit cultural competence since most are white women.
Advantages	• Could be useful in prevention programs. • Supported by the American Dental Association. • Candidates would be drawn from the communities they will serve, increasing their ability to provide culturally competent care and overcome barriers.	• A proven model, with a solid research base on quality of care from Alaska and other countries. • Ability to practice under general supervision makes them useful in many areas without dentists. • Two-year education makes them cheaper to train, reimburse, and employ. • Can mirror, and be sensitive to, the population served.	• The public is familiar with dental hygienists and might feel comfortable receiving care from them. • A higher education level may help gain the confidence of dentists that they can perform restorative functions. • ADHPs could perform case management for underserved patients and help staff safety net clinics, which lack sufficient dentists.

- **Assess the current dental workforce and educational infrastructure** to determine: which dental providers currently work in the state; where provider shortages exist; how many providers are enrolled in Medicaid; how many providers serve patients with special needs; and whether existing educational institutions can be expanded to train new providers or if new institutions need to be created. Data sources include: state medicaid agencies, state dental associations, and dental schools.

- **Identify potential funding streams**, such as Medicaid and CHIP, to ensure that the new provider model will be sustainable and supported by reimbursement policies linked to the populations and settings to be served. State Medicaid and CHIP agencies are good places to obtain information regarding financing questions. Also, comprehensive information on each state's economic, budget, demographic and uninsured rate can be found at Kaiser State Health Facts.[16]

- **Appraise the political landscape and identify who is likely to support and oppose the plan and why**—and include both sides in stakeholder discussions. The political landscape may present opportunities to advance a new model. For instance, tight state budgets or state health goals promoting dental homes for all children may give policy makers the opportunity to take a fresh look at potentially less costly and more accessible dental provider options. Policy makers will also need to determine if any statutory or regulatory changes are needed to establish a new dental provider.

Implementation Steps for Developing New Provider Models

Experiences from states show that developing new dental providers requires careful planning. Implementation steps include:

- **Create a strong, broad-based partnership of stakeholders.** The group's leader must keep stakeholders focused on the central, mobilizing objective—improving access to oral health for the underserved—and away from perceived limits or threats to any professional group's practice.[17] Involving and developing leadership roles for dentists who serve Medicaid patients or practice in safety net settings have also proven helpful.[18] Other stakeholders to consider are: dental, dental hygiene and medical professional associations; state colleges and universities with public health programs; oral health coalitions; local and national experts; legislative champions; organizations serving vulnerable populations, such as consumer advocacy groups and federally qualified health centers; state policy makers; and Medicaid and state health agency representatives. Transparency in the process builds trust and collaboration among stakeholders.

- **Obtain legislative approval** (required in most states for a new dental provider). Where possible, work with the state Board of Dentistry to permit implementation of a new provider under existing regulations.[19] States also can amend the dental practice act to explicitly

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16 See http://www.statehealthfacts.org/

17 Many lessons about consensus-building, particularly adhering to the group objective, were evident in North Carolina's experience with physician assistants. See E. Harey Estes, Jr. and Reginald D. Carter, "Accommodating a New Medical Profession: The History of Physician Assistant Regulatory Legislation in North Carolina," North Carolina Medical Journal 66, no. 2 (March/April 2005), 103-107

18 For discussion about the importance of support among dentists for new dental workforce models see L. Nolan et al., *The Effects of State Dental Practice Laws Allowing Alternative Models of Preventive Oral Health Care Delivery to Low-Income Children* (Washington, DC: Center for Health Services Research and Policy, School of Public Health and Health Services, The George Washington University, January 17, 2003).

19 Ibid. Although the authors discuss the option to "reinterpret" law, it is unclear whether any states have done it.

allow for the new provider or enact legislation to establish the new provider scope of practice and supervision level.

- **Handle regulatory issues.** After legislation has been passed, state regulatory agencies (e.g., health professions' boards) write and enforce the regulations that implement the law.[20] Regulations are needed for credentialing or licensing new provider types, licensing exams and renewal and continuing education requirements. States must determine whether an existing board will be responsible for regulating the new provider or if a new committee must be established. Most states regulate dental practice through a dental board; a few states have separate dental hygiene committees that make recommendations to the dental board.[21] Consensus stakeholder group involvement will help ensure that regulations are not designed to block competition.

- **Develop an appropriate educational framework** so that students can obtain the licensing or credentialing required for the new provider type. A curriculum must be developed and faculty must be hired or trained. Funding may be required for program courses, faculty and equipment. Consideration should be given to joint education and training with dentists to foster constructive working relationships. An educational institution within the state (or region) will need to create a program that incorporates the curriculum, and the program will need to be accredited by the Council on Dental Accreditation, which provides accreditation to dental and hygiene education programs.[22] If the Council declines, it is the state's responsibility to provide accreditation. This process takes time, but it can be undertaken concurrently with consensus building and legislative initiatives.

- **Identify and make necessary systemic modifications.** Consider whether the ways oral health care is delivered and providers are supervised and/or reimbursed will need to be changed for the new provider type to be successful. States must determine where new providers will work and what types of assistance they may need. For specific settings, such as nursing homes or schools, leaders of those systems need to be involved in the planning. Clinical rotations to those sites can be built into the curriculum and funding and reimbursement plans can be made. New providers may require help marketing their services to patients, dentists and institutions; negotiating contracts; or developing collaborative agreements with dentists. States may consider adding case review or consulting fees to reimbursement rates to compensate dentists for their time providing supervision.

Tools for Developing New Providers

States' experiences, such as those in California, Colorado, Iowa and Minnesota, also show that several tools can facilitate progress in implementing new types of dental providers. To help policy makers assess needs and make informed decisions related to workforce changes, states can:

- create a department or unit that enables new workforce models to be piloted;
- develop regulations and review processes to ensure that workforce changes are based on evidence and in the best interests of the public; and/or
- carry out workforce planning either across all health professions or specific to oral health professions.

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20 C. Dower, S. Christian and E. O'Neil, *Promising Scope of Practice Models for the Health Professions*, (San Francisco: Center for the Health Professions, University of California, San Francisco, 2007), 1.

21 Ibid, 14.

22 The Council is technically independent of the American Dental Association, but organized dentistry does exert some indirect influence over the Council's functions.

Piloting New Approaches: California

The California legislature established the Health Workforce Pilot Projects Program (HWPP) in 1972 to allow organizations to demonstrate and evaluate new provider models before requesting changes in professional practice laws.[23] Pilot projects are intended to help the state avoid spending the money and time on legislative battles over untested models.[24] Through the HWPP, the Registered Dental Hygienist in Alternative Practice (RDHAP) model—specially trained hygienists working in underserved communities—was tested in 1980. And, after a protracted process that highlights the need to include all stakeholders throughout the planning stages, legislation to create these providers was passed in 1997. Approximately 230 licensed RDHAPs now practice in California.

Independent, Evidence-Based Review Policies: Colorado[25]

To mitigate the impact of lobbyists and interest groups in the process, several states have established independent mechanisms to review proposals for changing scopes of practice for the health professions and then summarize that evidence for legislators or other policy makers.[26] The governor of Colorado issued an executive order in 2008 commissioning the study of the evidence for and value of expanding the scopes of practice of advanced practice nurses, physician assistants and dental hygienists.[27] The Colorado Health Institute (CHI) systematically reviewed regulatory policies and relevant research in the state and produced an evidence-based study of the scopes of practice of the three health care professionals, their practice settings and the quality of care they provide. The report concluded that unsupervised dental hygienists can "competently" provide oral health care preventive services "within their scope of training, education and licensure in Colorado" and can do so with quality of care "at least comparable" to that of dentists.[28] The report also found that, as in other states, current Colorado statute prevents dental hygienists from making a diagnosis that falls within the full scope of their license and that some payers in Colorado do not directly reimburse dental hygienists for services authorized under their current scope of practice. The report calls for an evaluation of and recommendations for reimbursement policy options to "enhance the use of dental hygienists in areas where oral health access is lacking."[29]

Health Care Workforce Planning: Iowa[30]

Iowa has designated a single state entity to address overall health care workforce planning across the state: the Bureau of Health Care Access within the Iowa Department of Public Health (IDPH). Bureau programs have provided grants to communities and educational institutions for tuition reimbursement, loan repayment, training and recruitment, and mentoring programs for

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23 http://www.oshpd.ca.gov/hwdd/HWPP.html

24 http://www.oshpd.ca.gov/hwdd/HWPP.html

25 Unless otherwise noted, all information in this section comes from: Colorado Health Institute, "Colorado Collaborative Scopes of Care Study." Retrieved November 21, 2008. http://www.coloradohealthinstitute.org/resourceHotissues/hotissuesViewItemFull.aspx?theItemID=43

26 Dower, 10-13.

27 Governor Bill Ritter, Jr., Executive Order B 003 08 Commissioning the Collaborative Scopes of Care Study and Creating an Advisory Committee, February 7, 2008. Retrieved November 21, 2008. http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadername2=MDT-Type&blobheadervalue1=inline%3B+filename%3D784%2F835%2FB+003+08+%28Scopes+of+Care+Study%29.pdf&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobkey=id&blobtable=MungoBlobs&blobwhere=1228676288785&ssbinary=true

28 Colorado Health Institute, *Final Report of Findings: Executive Summary*. Prepared for the Scopes of Care Advisory Committee (December 20, 2008), 8. Retrieved January 23, 2009. http://www.coloradohealthinstitute.org/Documents/workforce/csoc/executive_summary.pdf

29 Ibid, 9.

30 Doreen Chamberlin, "Iowa Strategies on Health Care Workforce Planning," handout presented at the National Academy for State Health Policy's 21st Annual State Health Policy Conference, Tampa, Florida (October 7, 2008). Unless otherwise noted, all information from this section comes from this source.

health professionals. Programs also have funded online training and curriculum for health education programs and supported improvements to a state worker registry. Legislation in 2007 built on these efforts and directed IDPH to project future workforce needs, coordinate efforts, make recommendations and develop new strategies. After participating in a multi-agency workgroup, conducting a literature review and convening a summit, IDPH issued a final report with workforce recommendations for health professions, including dental providers. Short-term recommendations include establishing an Iowa Health Workforce Center to provide state-level coordination of recruitment and retention of health professionals.[31] Iowa passed legislation in 2008, which directs IDPH to take additional steps in workforce planning and development, such as seeing that relevant data is continuously collected and biennially delivering a strategic plan to the governor and legislature.[32]

Oral Workforce Planning: Minnesota

In May 2008, Minnesota enacted the Omnibus Higher Education Policy Bill, which established the position of an oral health practitioner, a provider similar to an ADHP.[33] The legislation instructed the Commissioner of Health and the Board of Dentistry to convene an Oral Health Practitioner Work Group to make recommendations and propose legislation regarding the education, training, scope of practice, licensure and regulation of oral health practitioners.[34] The work group's co-conveners served important roles: The Department of Health provided logistical and project support, while the Board of Dentistry offered technical expertise. The work group met several times throughout the fall of 2008. These facilitated meetings were open to the public, and information, materials and public feedback are available online.[35] The work group issued its report to the legislature in January 2009.[36] The report from the work group was used to develop legislation for a new provider that was amended, enacted and signed into law in May 2009.

Conclusion

New thinking and action is needed to respond to the serious dental access problems facing states. Demographic shifts are reducing the number and availability of dentists even as demand increases. As the most highly trained and educated dental providers, dentists will remain the leaders and experts in the field and the only providers who can perform the most complex and clinically difficult procedures. However, new dental providers offer a way for states to help ensure that vital primary dental care is accessible to constituents regardless of age, race, ethnicity, income, geographic location and/or insurance status. State examples and studies from around the world confirm that providers with a smaller scope of practice than dentists can efficiently and safely perform many components of dental care. States are working hard to gather data, build consensus, develop systems of care, and train and educate new types of providers who can join the dental team, supply basic primary dental care to underserved populations and expand the safety net.

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31 Iowa Department of Public Health, "The Future of Iowa's Health and Long-Term Care Workforce: Health and Long-Term Care Workforce Review and Recommendations," December 2007. Retrieved November 21, 2008. http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/hltcw_jan08.pdf

32 Page 8, http://iowahouse.org/wp-content/uploads/2008/04/bill-summ-house-health-care.pdf

33 Minnesota Laws 2008, Chaprer 298—S.F.No. 2942. https://webrh12.revisor.leg.state.mn.us/laws/?year=2008&type=0&doctype=Chapter&id =298 The Minnesota Dental Hygienists' Association (MDHA) describes the legislation as modeled after the ADHP model. See MHDA, "Legislative Reports." Retrieved November 5, 2008. http://www.mndha.com/Legislative.html.

34 Minnesota Department of Health, "Oral Health Practitioner Work Group 2008: Project Summary and Timeline." Retrieved November 5, 2008. http://www.health.state.mn.us/healthreform/oralhealth/projectsummary.pdf.

35 See Minnesota Department of Health, "Oral Health Practitioner Work Group." Retrieved 5 November 2008. http://www.health.state.mn.us/healthreform/oralhealth/index.html.

36 Minnesota Department of Health and Minnesota Board of Dentistry, *Oral Health Practitioner Recommendations: Report to the Minnesota Legislature 2009*, January 15, 2009. Retrieved January 23, 2009. http://www.health.state.mn.us/healthreform/oralhealth/FinalReport.pdf

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For a copy of the full "Help Wanted" report , visit *www.pewcenteronthestates.org/helpwanted* and *www.nashp.org.*

PREPARED STATEMENT OF THE SHOSHONE-BANNOCK TRIBES—FORT HALL BUSINESS COUNCIL, PREPARED STATEMENT

Fort Hall Indian Health Service Dental Department Needs

Guidelines for the development of the appropriate size for I.H.S. dental clinics for the purpose of this approximation are found in the 1998 I.H.S. Planning and Programming Manual, and from the I.H.S. Oral Health Program Guide. Appropriate size for an I.H.S. dental clinic is based on a workload projection formula that multiplies an estimated need for 95 Dental Service Minutes (DSM) per person in a user population per year. For the Fort Hall Indian Health Service, with an estimated user population of 6,100 the estimated workload projection is 6,100 (user pop) X 95 (service minutes) = 579,500 total service minutes provided annually.

Analysis of the construction program projected through the year 2005 foresaw the need for the development of 4 dental templates. The templates and their utilization/workload ranges are as follows:

SERVICE LEVEL	WORKLOAD RANGES
1) 8 Dental Treatment rooms	262,001 DSMs through 393,000 DSMs
2) 12 Dental Treatment rooms	393,001 DSMs through 588,000 DSMs
3) 16 Dental Treatment rooms	588,001 DSMs through 856,000 DSMs
4) 24 Dental Treatment rooms	856,001 DSMs through 999,999 DSMs

According to analysis template, the Fort Hall Service Unit Dental Clinic would have 12 Dental Treatment Rooms to accommodate the estimated workload projection of 579,500 service minutes. Currently, the Fort Hall Dental Clinic has 6 dental treatment rooms.

Referring to the I.H.S. Oral Health Program Guide page I-41, table 1, labeled Dental Staff and Facility Recommendations for Selected Ranges of Annual Service Minute Needs, a 12 dental treatment room facility should have 4 dentists, and 15 dental auxiliaries(includes dental hygienists, dental assistants, and clerks). Our current 6 chair facility has 3 dentists, and 5 dental auxiliaries. The additional staff for this model is obviously significant and the would require significant funding for salaries – far in excess of dental department budgeting which currently requires supplementation from third party collections to meet payroll on what is under the I.H.S. recommended 2:1 of dental assistant to dentist ratio.

I do not have accurate knowledge of what the actual construction cost of the physical expansion of the dental clinic to include 6 more treatment rooms would be. Some conceptual planning for expansion to a 10 chair clinic at the Fort Hall Service Unit has been done in the Portland Area Office, and Gene Kompkoff at the Area Office may be a resource for cost estimates on construction of additional treatment rooms. In 2005, loose estimates for this expansion included $80,000 for a Pre-design-concept study, $100,000 for actual design costs, and $1,000,000 for the construction phase of the dental expansion. This was for the addition of 4 dental treatment rooms, and some additional office space in the dental area.

Relative to equipping the treatment rooms, however, I can approximate from recent purchases for the current clinic. To provide delivery systems, and patient treatment chairs, comparable to those we installed in 2005, it would cost $13,000 to $15,000 per operatory, or between $78,000 and $90,000. Delivery and installation of comparable equipment in 2006 was $8,600, thus one could anticipate such cost would be closer to $10,000 at this time. Comparable X-ray systems for the each treatment room to those we installed in 2007 would cost approximately $3,000 per

room, with an additional $100 per room for wall plate mounts, and a one time installation fee in the range of $1500 to $2,000. Overhead treatment lights were not replaced in our operatories in 2006, so their cost would also need to be added as one per room at a cost of approximately $1,300 each totaling $7,800. Additionally, with the eventual need to initiate an Electronic Dental Record (EDR), each treatment room will need to be equipped with the appropriate Hardware (monitor/keyboards/mouse) to accommodate the use of EDR. The current cost to I.H.S. clinics for this hardware per treatment room is $1,689 for a total of $10,134. Thus, it could very easily cost in the neighborhood of $140,000 to equip 6 new dental treatment rooms. This would not include cabinetry necessary as part of the construction.

In relation to the question of Orthodontic needs in our community, we don't have a dental code in our RPMS package to track the number of children who are in need of orthodontic services, so we have to speculate averages from looking to other sources for information. One Orthodontic Journal article we referenced speculated that 15% of the overall population of children 10 to 18 years old was receiving orthodontic therapy, and that an additional 16% were in need of such treatment for a total of 31%. I Contacted the I.H.S. Orthodontic Consultant, Dr. Mark McCollough of the Western Oregon Service Unit, and his estimation in the American Indian Population of this age range was anywhere from 75% to 90% exhibit an orthodontic treatment need. It should be noted that the range of need ranges widely from mild to severe involving significant functional problems to those that are strictly mild aesthetic concerns.

Dr. McCollough also included appropriately that patients can not even be screened and considered for orthodontic therapy unless they are highly motivated, and have excellent oral hygiene. Historically, this would eliminate a significant number of patients who otherwise present with orthodontic needs.

Even if you estimated trying to provide approximately 30% of the orthodontic therapy in this age range to our local youth, you would be looking potentially at a number in the range of 300 patients annually according to a PCC Management Report Visit Count Summary of the dates 12/09/08 – 12/09/09 - which reported 976 patient encounters in this age range at the Ft. Hall Service Unit. With an average cost approximating $5,000 per case of comprehensive orthodontic therapy, an annual cost of 1.5 million dollars would be incurred for this number of patients. Orthodontic therapy is classified as a Level VI (6) service, a category of low priority due to the fact that many more critical and higher prioritized dental services are still not provided regularly due to lack of critical resources. This is why orthodontic services have historically been provided at very few locations nationally in the Indian Health Service.

PREPARED STATEMENT OF TERRY BATLINER, DDS, MBA

I am writing as a private citizen. The following opinions are strictly my own and not necessarily those of my employer, The University of Colorado Denver (UCD) or any other group with which I am affiliated.

I am a dentist and a member of the American Dental Association (ADA). I occupy the positions of Associate Dean at the UCD School of Dental Medicine and Associate Professor in the Colorado School of Public Health. More importantly, I am a member of the Cherokee Nation of Oklahoma and I care deeply about the health of Indian people. That is why I adamantly disagree with ADA's effort to thwart the expansion of the Dental Health Aid Therapist (DHAT) program outside of Alaska.

Earlier in my career I spent 8 years in the Indian Health Service, 5 years in South Dakota and 3 years in the Northwest. It was depressing to treat child after child with early childhood caries (ECC), knowing that there were at least 5 more kids needing care for every one we treated. My current work takes me back to the Pine Ridge reservation and to the Navajo Nation in Arizona. The situation has not improved and has, in fact, gotten worse. This is not merely my opinion. At a recent national meeting of ECC investigators it was agreed the problem has gotten far worse in Indian Country. The majority of kids at age 3 in Indian communities have significant and often severe untreated dental decay. Why? Well one reason is clearly the lack of access to preventive, restorative and even emergent dental services.

In the U.S., it is generally agreed that a child with a painful and abscessed tooth is a dental emergency. That is simply not the case in Indian Country. I recently

learned the following fact from some current IHS dentists: A dental emergency is defined differently because there are just too many kids with these problems and too few dentists to treat them. Only kids with severe facial infections are considered true emergencies because the risk of dire complications is very high. In Indian Country, a child in pain is not an emergency. This must change!

The Indian Health Service cannot fill the large number of dental vacancies they currently have and even if they could, there would still be too few dentists to serve the needs of Indian people. The DHAT provides some hope for Indian communities. If local people can be trained and supported, they will be more likely to stay in their communities and provide needed emergent, preventive and restorative care to their fellow community members. This would help to reduce the number of children in pain and perhaps lead to some leveling in the definition of a dental emergency. If the DHAT program expands, perhaps more Indian children will grow up free of dental pain.

I respectfully urge you to act now to remove the language in the present draft of the Indian Health Care Improvement Act that would effectively restrict the expansion of the DHAT program for Indian communities outside of Alaska. It is sad that the ADA has taken a stand that places the economic concerns of dentists over the severe dental needs of Indian people. Please help those in the most need, our Indian children.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO RONALD L. TANKERSLEY, D.D.S.

Question. Is there an effort within the ADA to specifically recruit American Indians, Alaska Natives into the dental profession? Do you have a specific outreach to them, and if so could you speak to that?

Answer. The ADA has been involved in a variety of activities to attract and recruit minorities, including American Indian/Alaska Native (AI/AN) students, to a career in dentistry. Knowing that just one approach is not enough, the ADA has employed a variety of strategies.

We formed the Committee on Career Guidance and Diversity Activities which is made up of representatives from the national and student chapters of the Society of American Indian Dentists (SAID), the National Dental Association (NDA), the Hispanic Dental Association (HDA), the American Dental Education Association (ADEA), the American Student Dental Association (ASDA), the National Association of Advisors to the Health Professions (NAAHP) and the Colgate-Palmolive Company.

Committee members collaborate on joint efforts to attract students from underrepresented groups including AI/AN students, such as:

- Attending and exhibiting at the annual SAID Conference to distribute career resources and materials aimed at attracting AI/AN students to careers in dentistry.
- Supporting and collaborating with community-based organizations such as Learning for Life Health Careers Exploring organization in their outreach activities promoting dentistry as a profession to students from diverse of backgrounds.
- Publicizing the need for a diverse profession. For example, Dr. George Blue-Spruce, former committee member and founder of the SAID, wrote an article titled, "The Need for American Indian Dentists", which is on the Career Resources landing page of ADA.org at *http://www.ada.org/public/careers/beadentist/index.asp#need.*

The ADA initiated the Student Ambassador Program which is made-up of representatives from the Society of American Indian Dentists (SAID) Student Chapter, National Association of Advisors to the Health Professions (NAAHP), the American Student Dental Association (ASDA), the Student National Dental Association (SNDA), the Hispanic Student Dental Association (HSDA), the American Dental Education Association (ADEA) Council of Students. The Ambassador Program is a student-driven recruitment process in which dental students take the lead in organizing and conducting introduction to dentistry get-acquainted programs with an emphasis on recruiting underrepresented students to the profession.

The five student representatives plan an annual meeting where they share information on their national student peer-to-peer recruiting outreach strategies and programs. Specifically, the 2009 SAID Student Chapter representative detailed the support and resources for AI/AN students interested in dentistry and encouraged other ambassadors (including AI/AN students) to model the best practices presented at

the meeting. A CD containing the recruiting programs presented at the 2009 Ambassador Meeting, including the information targeting AI/AN students, was made available to all participants at this year's program.

The ADA has established a mentoring program with information specifically for AI/AN students on the ADA webpage at *http://www.ada.org/public/careers/beadentist/college.asp* linking interested students with AI/AN students via the Arizona School of Dentistry and Oral Health SAID Student Chapter site. The site includes "A Day in the Life" series," a newly revised feature of ADA.org, which highlights an American Indian new dentist working at the Yukon-Kuskokwim Health Corporation Dental Clinic in Bethel, Alaska. A portrait of her day-to-day activities in working in the clinic and in the surrounding Alaskan villages is detailed at: *http://www.ada.org/public/careers/beadentist/day__*damon.asp. The ADA.org site also has information on IHS, scholarships and other resources to encourage AI/AK students to consider a career in dentistry.

In addition to peer—peer recruitment strategies, collaborative ventures with community organizations, dental societies are also encouraged to liaison locally with a variety of community resources/organizations across the country as exemplified in a resource kit highlighting "best practices" in dental society initiated outreach efforts.

The ADA is committed to these and future programs to increase the number of AI/AN dentists."

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO PATRICIA TARREN, BDS

Question. During the hearing, it was said that opposition to the dental health aide therapist program in Alaska was related to concern about therapists performing irreversible procedures without the proper training. Can you recommend or describe ways that programs for mid-level dental health providers could address this concern? Do you think that there are advantages to having access to mid-level dental health providers even if the providers cannot do surgical procedures?

Answer. There have been 5 years of positive experience with Dental Health Aide Therapists (DHATs) in Alaska (as well as utilization of a similar model in New Zealand since 1921) where the education and experiential training received by the graduates prepares them to practice in the Alaskan bush **including performing extractions, with the authorization of their supervising dentist.** They are educated in a certified program with professional supervision in a narrowly focused, competency based, primary care curriculum. The DHAT must meet the same standard of care for procedures they perform as that expected of a dentist. Following graduation, they have 400 hours of direct supervision in preceptorship with their supervising dentist, and their scope of practice is based on their demonstration of clinical skill. They undergo continued quality assessment and assurance by their supervising dentist and receive annual education and recertification. Ongoing, independent evaluation of DHAT clinical competency has shown that DHATs provide competent, safe care.[1,2,3,4,5,6] They are well received and appreciated in their communities as highlighted in an editorial by Elise Patkotak in the Anchorage Daily News, June 2005: "People need ongoing treatment to take care of long- and short-term problems. A dentist in a village for a couple of weeks doesn't meet that need."[7]

It must be emphasized that the DHAT works under the license and supervision of a dentist. They have the constant ability for daily contact, as frequently as needed, by telemedicine with the supervising dentist, who retains control over proce-

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[1] Nash, D et al. Dental Therapists: A Global Perspective. Int Dent J. April 2008 58 (2): 61–70.

[2] Support for the Alaska Dental Health Aide Therapist and Other Innovative Programs for Underserved Populations.Policy date: 11/8/2006 *http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1328*.

[3] Dental Health Aide Program Improves Access to Oral Health Care for Rural Alaska Native People. AHRQ Innovations exchange. June 2008, updated Nov. 2009; *http://www.innnovations.ahrq.gov/content.aspx?=1840*.

[4] Training New Dental Health Providers in the U.S.: Executive summary prepared for W.K.Kellogg Foundation, Burton L. Edelstein DDS MPH, Dec. 2009.

[5] Bolin K. Assessment of Treatment Provided by Dental Health Aide Therapists in Alaska: A Pilot Study. J Amer Dent Assoc. Nov. 2008; 139: 1530–1535.

[6] Evaluation to Measure Effectiveness of Oral Health Care Model in Rural Alaska Native Villages. W.K. Kellogg Foundation press release 7/15 2008 *http://www.wkkf.org/default.aspx?tabid=1147&CID=432&NID=259&newsitem=4*.

[7] Patkotak, E. Dental aides remedy lax care in villages. Anchorage Daily News (AK): Voice of the Times. June 8, 2005.

dures performed by the DHAT. Teledentistry, for example, utilizing intraoral cameras, digital x-rays, and electronic health records allow the dentist to view in "real-time" the patient's medical history, any lab results, clinical and radiographic findings and consult with attending dentist to confirm the diagnosis, treatment plan, and authorize treatment as well as offer guidance throughout the procedure. The usefulness in utilizing teledentistry to support the services and minimize complications of DHATs or a similar model of mid-level practioner, such as the dental therapist, is underscored by the published statement of RADM Halliday, chief dental officer USPHS, "The fact that many Indian Health Service dental facilities are in remote locations underscores the need for strong commitment to technology in delivering care. . . IHS has made large financial commitments over last several decades . . . in emerging technologies in the health field. . . IHS remote sites in Alaska often utilize telemedicine/teledentistry to consult with oral health providers. . . This is being increasingly integrated into remote facilities in the lower 48 states as well. All new clinics are equipped with digital imaging technology which IHS has used for many years." [8]

It was interesting to hear Dr Yvette Roubideaux's testimony (which followed ours), when questioned by Sen. Murkowski about **expanding the use of DHATs, she responded that the IHS "has not taken a formal position . . . but it is a great program."**

It is noteworthy that in his testimony, Dr Tankersley stated, "Performing surgical services.there's no such thing as a routine extraction until it's done, for example a root wrapped around the nerve or excessive bleeding. . ." This complication can be avoided by triaging the procedure with the supervising dentist, discussing potential complications before beginning the procedure, receiving authorization to carry out the procedure and having a robust system in place for management of any complication for example, stabilize the patient and transport them to a facility where treatment can be completed. **In his testimony Dr Tankersley stated, in regard to the DHAT, "Admittedly they could have good technical training."**

In my opinion, removing the ability of the DHAT to perform nonsurgical extractions will dilute their potential benefit but will not negate their usefulness. According to Burton Edelstein in his report to the Kellogg Foundation "the primary goal of instituting dental therapists is to expand the availability of basic dental services to socially disadvantaged subpopulations who are now inadequately served. A second goal is to establish a diverse cadre of caregivers whose social, experiential and language attributes are a better match for targeted underserved populations than those of current dentists. The proportion of procedures now delivered exclusively by dentists that could potentially be delegated to dental therapists is substantial: 75 percent for general dentists and 79 percent for pediatric dentists". [4]

A published on the IHS website, there are approximately 380 IHS dentists. As of 12/3/2009, there were 108 vacancies with 56 available for immediate employment now. [9]

According to Dr. Tankersley's testimony, "The number of dentists that the IHS wants is low, as in the military . . . the inability to recruit for years . . . turnover rate is high . . . but we are showing a positive trend recruiting new graduates." **In my opinion, this strengthens the argument for utilizing DHATs or other models of dental therapists in Indian country.** As Sen. Murkowksi stated, (in Alaska) "we are growing our own DHAT graduates who return to their community, high level of commitment to serve." They are a proven model providing safe, effective, culturally sensitive dental care for individuals who lack access to care.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. AL FRANKEN TO PATRICIA TARREN, BDS

Question. Dr. Tankersley said during questioning that their Community Dental Health Aide Coordinator (CDHC) model is a better option than the Dental Health Aide Therapist (DHAT) currently being used in Alaska for improving dental care through the Indian Health Service. As a dentist, do you agree with that assessment? Dr. Tankersley also asserted that the CDHC is more similar to the medical model of a Physician Assistant. Again, as a dentist, do you believe this is true?

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[8] Indian Health Service: IHS Impressions, Quarterly Newsletter Vol. 6, Issue 2. Public Health Dentistry—Creating Access for the Underserved: An interview with RADM Christopher G. Halliday, Chief dental Officer, USPHS.

[9] Indian health Service website: The Indian health Service Dental Program, and employment opportunities accessed 12/3/2009.

Answer. I disagree with Dr. Tankersley's assertions. While the Community Dental Health Coordinator (CDHC) may prove to be a useful adjunct in providing preventive dental services and coordination of dental care, it is **a new, untested model.** It is more comparable to the community health worker (CHW) and pales in comparison to the educational background and scope of services of the Physician Assistant (PA) which is a well proven model. **The CDHC cannot perform anywhere near the range of services of the PA or DHAT.** According to the ADA, the CDHC will work in health and community settings, assist the dentist in triaging patients, and address social, environmental and health literacy issues facing the community. They will educate community members on preventive oral health care and assist them in developing goals to promote and manage their personal oral health care. Helping patients navigate their way through the complex maze of health and dental care systems to obtain care will be an important role of the CDHC. **To date there have been no graduates of the ADA's CDHC program.** [10]

According to the U.S. Bureau of Labor Statistics PAs receive 2 years of training in accredited programs (admission to many programs requires at least 2 years of college and some health care experience. Most applicants have a bachelor or master's degree due to the competitive applicant pool). The PA passes a national exam to become licensed. Employment growth is high as PAs are increasingly utilized to contain costs. PAs practice medicine under supervision of physicians and surgeons: diagnostic, therapeutic, preventive. They treat minor injuries—suturing, splinting and casting, take medical histories, examine and treat patients, order and interpret lab tests, xrays and make diagnoses, record progress notes, instruct and counsel patients, order and carry out therapy. They have prescribing privileges. They may make house calls, work in hospitals and nursing homes. Also, those who specialize in surgery provide preoperative and postoperative care and may work as 1st or 2nd assistant during major surgery. **They may be the principle care providers in rural or inner city clinics** where the doctor is present 1 or 2 days/week. Their duties are determined by supervising doctor and state law. [11]

The DHAT more readily resembles the PA or the nurse practitioner than the CDHC. The CDHC is envisioned to provide limited preventive and palliative care and extensive care coordination services—which will be a useful member of the oral health care delivery team, but with a very much limited scope of practice compared to the DHAT.

[10] ADA website: The ADA CDHC Program: frequently asked questions. Sept. 2009.
[11] U.S. Bureau of Labor Statistics, Occupational Outlook handbook, 2008–2009 Edition.

PROMISES MADE, PROMISES BROKEN: THE IMPACT OF CHRONIC UNDERFUNDING OF CONTRACT HEALTH SERVICES

THURSDAY, DECEMBER 3, 2009

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

The Committee met, pursuant to notice, at 3:49 p.m. in room 628, Dirksen Senate 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 want to call to the dais Dr. Yvette Roubideaux.

Dr. Roubideaux, you have been extraordinarily patient and I appreciate that. I know you have taken much of your afternoon. Perhaps it was helpful as well to be here during the discussion of the Indian health care bill and dental health care.

I would like to ask your permission. I know that we normally don't do this, but I would like to ask your permission to bring the other two witnesses to sit at the table while you are there. That way we can go from you to the other two witnesses, then have questions of all three.

Would that be satisfactory to you?

Dr. ROUBIDEAUX. Sure.

The CHAIRMAN. All right.

Ms. Connie Whidden and Mr. Mickey Peercy, we will ask questions of Dr. Roubideaux first, but then I will be able to excuse her and let her be on her way.

Dr. Roubideaux is the Director of the Indian Health Service, and this discussion is on the impact of chronic underfunding of Contract Health Services. We want to revisit this issue because we are beginning to try to look at some more interesting ways to improve this Contract Health Service program.

So Dr. Roubideaux, what we will do is have you testify, ask you questions, and allow you to be on your way. You have been very generous with your time.

Following that, I will ask Connie Whidden to testify and Mickey Peercy.

Dr. Roubideaux, you may proceed.

STATEMENT OF YVETTE ROUBIDEAUX, M.D., M.P.H., DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY RANDY GRINNELL, DEPUTY DIRECTOR, AND CARL HARPER, DIRECTOR, OFFICE OF RESOURCE ACCESS AND PARTNERSHIPS

Dr. ROUBIDEAUX. Great. Thank you so much, Mr. Chairman and Members of the Committee.

Good afternoon. I am Dr. Yvette Roubideaux, the Director of the Indian Health Service. Today, I am accompanied by Mr. Randy Grinnell, the Deputy Director, and Mr. Carl Harper, the Director of the Office of Resource Access and Partnerships. I am pleased to have the opportunity to testify on the Indian Health Service's Contract Health Services program.

The Contract Health Services Program, or CHS Program, serves a critical function in the Indian Health Service since patients often have medical needs that cannot be met with available services in our facilities. IHS provides direct care in its systems of hospitals, clinics and health stations based on what resources, providers and equipment are available to each facility with our annual appropriation for direct services. The CHS Program was developed to purchase additional health care services for patients when the local facility is unable to provide needed services.

Our health care providers first identify the needs for referrals based on medical need, and then we review what resources might be available to pay for this referral, either through the Contract Health Services Program or through other third-party resources.

Many programs report that funding these referrals can be a challenge because their CHS annual budget does not cover all referrals. Therefore, the CHS Program has been designed to pay first for the most urgent medical referrals when funding is limited.

Based on preliminary area and service unit reports, we estimate that approximately 360 million services were denied and deferred in 2008. In fiscal year 2009, the Contract Health Services Program was funded at $635 million with over 50 percent administered by tribes under Indian self-determination compacts or contracts. In fiscal year 2010, the CHS budget is $779 million, and increase of $144 million or 23 percent.

CHS programs are administered locally through our IHS and tribal operating units, 163 of them. The funds are provided through the 12 IHS area offices which in turn provide resource distribution, program monitoring and evaluation activities, and technical support. Less than two percent of the CHS funds are retained at headquarters.

CHS payments within budget limitations may be made for referrals to community health care providers in situations where the direct care facility does not provide the required health care services, the direct care facility has more demand for the services than it has the capacity to provide, or the patient must be taken to the nearest emergency services facility.

Referring patients to the CHS Program depends on the direct services available. In a particular IHS or tribal facility in locations where there is limited or no access to in-patient emergency or spe-

cialty care in IHS or tribal health care facilities, patients must depend on CHS to address their health care needs.

However, all of our facilities and programs are dependent on CHS and third-party coverage among IHS beneficiaries for the medical services they are unable to provide.

It is important to understand that the CHS Program does not function as an insurance program with a guaranteed benefits package. The CHS Program only covers those services provided to patients who meet the eligibility and other requirements and only when funds are available.

Many facilities have CHS funds available only for more urgent and high-priority cases, and all utilize a priority system to approve the most medically urgent cases first. When CHS funding is depleted, CHS payments are not authorized.

It is also important to note that when CHS funding is not available to authorize payment for a referral, that does not mean that the referral is not medically necessary. If a medical provider identifies a need to refer a patient, we assume the referral is medically necessary. The challenge we have in many cases is finding funding to pay for these referrals with our annual appropriation for the CHS Program.

Some patients and community health providers often believe that IHS does or should provide coverage and payments for all American Indians and Alaska Natives that present for services. So it is not uncommon for providers to expect payment in cases where CHS requirements are not met or when funding is not available. We constantly have to work with our health care provider partners in the private sector and our patients to educate them on our CHS requirements and procedures so that they better understand and can work with us in our efforts to fulfill our mission within available resources.

In terms of the distribution of Contract Health Services funding, CHS funding is distributed to local service units in two ways. A fixed amount, called the base funding, does not change over the years except for adjustments in inflation and population growth if it is included in the annual appropriation; and second, by new increases in annual appropriations.

Now, in 2001, a work group called the CHS Allocation Work Group, comprised of IHS and tribal representatives from the 12 IHS areas, developed a new formula to distribute funding beyond the base amount made available for CHS in the annual appropriation. The formula emphasizes four factors: inflation, depending on the prevailing OMB inflation rate; user population to address population growth; regional and geographic cost variances; and access to care to the nearest health facility.

Any new CHS funding in the annual appropriation is distributed to the areas based on this methodology.

As the new Director of the Indian Health Service, I have heard from tribes that one of their top priorities for internal IHS reform is to discuss improvements in the Contract Health Services Program, which may include a discussion of how we distribute these resources and how we do business.

I plan to ask tribes if they want to continue to use this 2001 formula for new program increases or whether they would like to dis-

cuss changes in the formula, but I believe it is important to discuss any changes to the CHS Program and its funding distribution in consultation and partnership with tribes. Any formula or changes to it may be more advantageous to some areas compared to others. So my primary concern is to ensure that any proposed changes to the formula are as fair as possible to all our patients and health programs.

Now, the most common complaint we receive about the program is why do we not pay for all of our medical referrals. The most important principle that drives this policy is that IHS cannot incur costs which would exceed our available resources. So we follow a series of regulatory and other requirements to guide approval and payment.

Our medical providers first identify medically needed referrals. Then the CHS Program determines whether IHS can authorize payment for such referrals.

In my written testimony, I have included a number of reasons why payment for Contract Health Services may be denied or deferred, such as not meeting eligibility, patient has alternative resources, IHS is the payer of last resort, prior approval was not obtained, notification was not made, services could have been provided in IHS or tribal programs, or the services don't fall within medical priority levels when funding is limited.

So again, while our providers make medically needed referrals, IHS cannot incur costs which would exceed available resources. So unfortunately, the CHS annual budget does not cover all referrals.

Finally, we realize the importance of making maximum use of available CHS funding, and we are focusing on improvements in the ways we do business in the overall CHS program.

I also look forward to consulting with tribes on how to improve the CHS Program now that they have formally indicated to me that it is a priority for internal IHS reform.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify on the Contract Health Services Program serving American Indians and Alaska Natives. I would be happy to answer any questions you may have.

[The prepared statement of Dr. Roubideaux follows:]

PREPARED STATEMENT OF YVETTE ROUBIDEAUX, M.D., M.P.H., DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Overview of Indian Health Service Program

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Service because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and acts of Congress. This Indian health system provides services to nearly 1.5 million American Indians and Alaska Natives through hospitals, health centers, and clinics located in 35 States, often representing the only source of health care for many American Indian and Alaska Native individuals, especially for those who live in the most remote and poverty-stricken areas of the United States. IHS provides a wide array of clinical, preventive, and public health services, within a single system for American Indians and Alaska Natives. The purchase of health care from private providers through the Contract Health Services program is also an integral component

of the health system for services unavailable in IHS and Tribal facilities or, in some cases, in lieu of IHS or Tribal health care programs.

Overview of the Contract Health Services Program

The Contract Health Services (CHS) program serves a critical function in the IHS since patients often have medical needs that cannot be met with available services in our facilities. IHS provides direct care in its system of hospitals, clinics and health stations based on what resources, providers and equipment are available to each facility with our annual appropriation for direct services. The CHS program was developed to purchase additional health care services for patients when the local facility is unable to provide needed services. Our health care providers identify needs for referrals based on medical need, and then we review what resources might be available to pay for this referral either through the CHS program or through other third party resources. Many programs report funding these referrals, however, can be a challenge because their CHS annual budget does not cover all referrals. Therefore, the CHS program has been designed to pay first for urgent medical referrals.

Based on preliminary Area and Service Unit reports, we estimate that approximately $360 million services were denied and deferred in 2008. In FY 2009, the CHS program was funded at $635 million, with over 50 percent administered by Tribes under Indian Self Determination contracts or compacts. In FY 2010 the CHS budget is $779 million, an increase of $144 million or 23 percent. CHS programs are administered locally through 163 IHS and Tribal Operating Units (OU). The funds are provided to the 12 IHS Area Offices which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to Federal and Tribal OUs (local level). Less than 2 percent of CHS funds are retained at Headquarters to administer the Fiscal Intermediary contract and Quality Assurance Fund.

CHS payments, within budget limitations, may be made for referrals 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 with a valid medical emergency.

Referring patients to the CHS program depends on the direct services available in a particular IHS or tribal facility. 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 direct medical care at nearly 700 different locations. Emergency room and inpatient care is provided directly in 46 locations, and a limited number of our largest medical facilities do provide secondary medical services (such as family practice medicine) but none provide tertiary care (such as burn units or specialized care). With the exception of one hospital in Alaska, IHS and Tribal hospitals have an average daily patient census of fewer than 45 patients, most with a census of 5 or fewer 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 must depend on CHS to address their health care needs. Those direct care programs with the most sophisticated capabilities have, per capita, the smallest CHS programs and vice versa. However, all of our facilities and programs are dependent on CHS and third party coverage among IHS beneficiaries for the medical services that they are unable to provide.

It is important to understand that the CHS program does not function as an insurance program with a guaranteed benefit package. The CHS program only covers those services provided to patients who meet CHS eligibility and other requirements, and only when funds are available. Many facilities have CHS funds available only for more urgent and high priority cases and all utilize a strict priority system to approve the most urgent cases first. When CHS funding is depleted, CHS payments are not authorized.

It is also important to note that when CHS funding is not available to authorize payment for a referral that does not mean that the referral is not medically necessary. If a medical provider identifies a need to refer a patient, we assume the referral is medically necessary. The challenge we have, in many cases, is finding funding to pay for these referrals with our annual appropriation for the CHS program.

Many of our patients have no health care coverage outside of services received from the IHS or Tribal health programs, approximately 40 percent based on the Resource Patient Management System patient registration enrollment data. However, many of these patients access health care through local community hospital emergency rooms and in other ways. Some patients and community health care providers often believe that IHS does or should provide coverage and/or payments for all American Indians and Alaska Natives that present for services, so it is not uncommon for providers to expect payment from the IHS or Tribal CHS program even in cases where CHS requirements are not met or CHS funding is not available. Patients who access care without meeting CHS requirements are responsible for payment for those services. We constantly have to work with our health care provider partners in the private sector and our patients to educate them on our CHS requirements and procedures so that they better understand and can work with us in our efforts to fulfill our mission within available resources, including our CHS resources.

Distribution of CHS Funding Increases

CHS funding is used to maintain previously existing levels of CHS patient care services. This fixed amount is called "BASE" funding. This base funding was originally established based on health care needs and availability of resources for each designated population within an area and is not necessarily based on a funding formula. Consequently, the established historical funding base or "fixed amount" does not change over the years except for adjustments due to inflation and population growth if included in the annual appropriation.

In 2001, the CHS Allocation Workgroup (CHSAWG) comprised of IHS and Tribal representatives from the 12 IHS Areas developed a new formula to distribute funding beyond the base amount made available for CHS in the annual IHS appropriation. The Workgroup-developed formula for allocation of new CHS funding emphasizes the four following factors:

- Inflation funding based on each Area's base of the prevailing OMB inflation rate;
- User population to address population growth;
- Regional and geographical cost variances; and
- Access to care to the nearest healthcare facility

Any new CHS funding distribution to the Areas is based on this methodology, which is expressed mathematically as follows:

Inflation Funding = CHS Base for Operating Unit (OU) x % of OMB inflation rate

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

As the new Director of the Indian Health Service, I have heard from tribes that one of their top priorities for internal IHS reform is to discuss improvements in the CHS program, which may include a discussion of how we distribute CHS program resources. I plan to ask tribes if they want to continue to use this 2001 formula for new program increases or whether they would like to discuss changes to the formula. I believe it is important to discuss any changes to the CHS program and its funding distribution in consultation and partnership with tribes. Any formula, or changes to it, may be more advantageous to some Areas compared with others. My primary concern is to assure that any proposed changes to the formula are as fair as possible to all our patients and health programs.

Reasons Services are Not Covered by CHS

The CHS requirements and how we conduct the business of the CHS program are important but complex matters and I would like to discuss them now in greater detail. The most common complaint we receive about the program is why we do not pay for all medical referrals. The most important principle that drives policy in this case is that IHS cannot incur costs which would exceed available resources. The CHS program follows a series of regulatory and other requirements to guide approval and payment of CHS services. Our medical providers identify medically necessary referrals. The CHS program determines whether IHS authorizes payment for such referrals.

Payment for contract health care services may be denied (and the referral care may be denied or deferred) for the following reasons:

1.) Patient does not meet CHS eligibility requirements;

2.) Patient is eligible for alternate resources and IHS is the payer of last resort;

3.) Prior approval was not obtained for non-emergency services;

4.) Notification was not made to the IHS or tribal program within the required time frames after emergency services were received (generally within 72 hours, or within 30 days in certain cases);

5.) Services could have been provided at an IHS or Tribal facility; or

6.) Services do not fall within medical priority levels for which funding is available.

Eligibility

In general, to be eligible for CHS, an individual must be of Indian descent from a federally recognized Tribe, belong to and live in the Indian community served by the local facilities and programs, or maintain close economic and social ties with said Indian community in a Contract Health Services Delivery Area (CHSDA). If the person moves away from their CHSDA, even to a county contiguous to their home reservation, they are eligible for all available direct care services but are generally not eligible for CHS. Given the limited amount of funding available for CHS, the CHSDA rules were implemented to ensure that the funding for CHS was prioritized for patients that live in the specified areas.

When the individual is not eligible for CHS, the IHS cannot pay for referred medical care, even when it is medically necessary, and the patient and provider must be informed of this circumstance. The CHS program educates patients on the eligibility requirements for CHS, by interviewing them and by posting the eligibility criteria in the patient waiting rooms and in the local newspapers. The CHS program assists these patients by attempting to locate available healthcare services within the community at no cost or minimal cost to them. Patients who do not meet CHS eligibility requirements are responsible for their health care expenses from other providers. If patients have other healthcare resources, such as Medicare, Medicaid or private insurance, the third party insurer must pay for the services because IHS is the payer of last resort. CHS programs work with the patient to determine if those other resources can pay for referrals. Some non-IHS providers have expectations that IHS will be the primary payer for all American Indian and Alaska Native patients, whether or not they are eligible to receive care through the CHS program. This can lead to strained relationships with local community health care providers when payment for medical services are denied by the CHS program leaving the non-IHS providers without compensation if a patient does not have alternate healthcare resources such as insurance. While we do everything we can to inform local health care providers of the process for authorization of CHS payments for medical referrals from IHS, misunderstandings sometimes still occur.

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, Children's Health Insurance Program (CHIP), 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. As a part of our business practices, both patients and outside healthcare providers are informed of the payor of last resort rule, as well as other CHS requirements, and we work with all patients to identify any third party or alternate resources to help pay for their referrals. This is particularly important when we do not have CHS funding available—patients can still obtain referred services using their other health coverage. This is why we encourage our providers to identify the need for referrals based on medical necessity, not on availability of funding. Sometimes a patient can be scheduled for a referral by IHS with an understanding that their health insurance, Medicare, Medicaid, or the CHIP will pay for it when we don't have CHS funding or the patient is not eligible for CHS funding.

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 the Centers for Medicare & Medicaid Services (CMS) to provide outreach and education to the populations we serve to ensure that eligible patients are signed up for Medicare, Medicaid, and CHIP. On February 4, 2009 the President signed into law the Children's Health Insurance Program Reauthorization

Act of 2009 (CHIPRA, P.L. 111–3). CHIPRA provides $100 million over five years to fund outreach and enrollment efforts that increase coverage of eligible children in Medicaid and CHIP. Ten percent of these funds are set aside for grants to the IHS providers, Urban Indian Organizations, and certain Tribes and Tribal organizations that operate their own health programs for outreach to, and enrollment of, children who are Indians. The IHS trains staff and educates patients to maximize the enrollment of eligible American Indian and Alaska Natives in CMS and private insurance programs. Enrolling patients in these programs frees up existing funds to be used for CHS referrals/payments.

Medical Priorities

CHS regulations permit the establishment of medical priorities that rank referrals or requests for payment when funding is limited, as is frequently the case. There are five categories of care within the medical priority system: ranging from Emergency (threat to life, limb and senses) to chronic care services. Medical Priority V is considered Excluded Services and would not normally be funded. The medical priority categories are as follows:

1. Emergency—threat to life, limb, senses e.g., auto accidents, cardiac episodes.
2. Preventive Care Services e.g., diagnostic tests, lab, x-rays.
3. Primary and Secondary Care Services e.g., family practice medicine, chronic disease management.
4. Chronic Tertiary and Extended Care Services e.g., skilled nursing care.

It is important to note that this priority system is only used to rank referrals in order of medical priority for payment when resources are limited. It does not imply that these referrals are not medically necessary. It assures that we are targeting limited resources to the patients most in need of care based on their medical condition, not other factors.

If the medical condition does not meet medical priorities, the proposed care is identified as a CHS deferred service. In the event funds become available, the care may be provided at a later date. Again, the IHS cannot incur costs which would exceed the amount of available resources.

Unified Financial Management System (UFMS)

The IHS implemented the accounting system (UFMS) in accordance with HHS Departmental policy. Prior to implementation of UFMS, the CHS program experienced some challenges in paying providers for authorized referrals; but, we anticipate full 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. It is important to note that the issue of not paying for referrals that are not authorized is a separate issue.

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 a threshold of $25,000, as authorized by the Indian Health Care Improvement Act (Public Law 94–437), as amended. In FY 2007, the CHEF was funded at $18 million and was depleted before the end of the fiscal year. In FY 2009, the CHEF program was funded at $31 million and provided funds for 1,223 high cost cases and was depleted in August. The CHEF is funded at $48 million in FY 2010, an increase of over 100 percent from the FY 2007 level. The CHEF cases are funded on a "first-come-first served" basis. When CHEF cannot cover a particular high cost case, the responsibility for payment reverts back to the referral facility for payment purposes.

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 rates set forth in regulations and based on Medicare payment methodologies. As is the case for health programs of the Department of Defense and certain Department of Veterans Affairs health programs, rates are established by regulation based on what Medicare pays for similar services. These reimbursement rates are typically about 60–70 percent of full billed charges. These rates are established by regulation, based on what Medicare pays for similar services, and are typically about 60–70 percent 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 American Indians and Alaska Natives, than would otherwise be the case. Since the regulation became effective in July of 2007, we have heard from several Tribes experiencing increased purchasing power due to payment savings, and expect the Medicare-like rate payment savings to continue. IHS Federally-operated programs have experienced fewer saving because most had already negotiated provider contracts with payment rates at, or near, the level of the Medicare rates. However, the federally-operated programs benefit from the guarantee of reasonable rates that the regulation provides. Area Office CHS staff continue their efforts to negotiate contracts with other providers not covered by the MLR to achieve the most cost-effective payment rates possible.

We realize the importance of making maximum use of available CHS funding and we are focused on improvements in the ways we do business in the overall CHS program. We work to ensure that staff maximizes the use of alternate resources, assist eligible patient to enroll in other types of health coverage, apply the Medicare-like rates, negotiate lower reimbursement rates for services not covered under MLR, and apply medical priorities and other CHS requirements strictly and fairly. For many years, the program also has implemented managed care practices in an effort to maximize resources. We focus our efforts on cost-effective strategies for our CHS cases such as improved case management and utilization of telemedicine. We are working diligently to recruit and retain providers to provide more direct care in our facilities, thus reducing the demand on CHS. We are also working to improve the CHS systems and processes by utilizing the electronic health record and the new UFMS system. And, we continue to build partnerships with our non-IHS healthcare providers through local and national meetings. I also look forward to consulting with tribes on how to improve the CHS program now that they have formally indicated to me that it is a priority for Internal IHS reform.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify on the 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. Roubideaux, thank you very much. You described a couple of things: one, a shortage of money in the aggregate to cover all of the needs. I think you indicated in your testimony 360 million services were denied and deferred in 2008. And my guess is there are some American Indians out there whose credit is destroyed because likely they got the service, had no money, only to discover that Contract Health won't pay. They are supposed to pay. Their credit rating is trashed, and it goes to a collection service.

I mean, that is the awful part of this. The first part is the lack of funding generally to do what we have promised to do in Contract Health. And the second is the issue of the formula. And so you described what you are going to do with the formula. You are going to begin a consultation with tribes. I think that makes a lot of sense in terms of how you would distribute funding for Contract Health.

But let me ask you just a general question. If you had your will and your ability to do whatever you wanted to the Contract Health Service to make it work, to keep the promise to American Indians, what would that be?

Dr. ROUBIDEAUX. Well, personally if I had my wish, I would find funding so we could pay for all of the referrals. But you know, personally I don't have that much money.

In terms of the Indian Health Service, I think it is important for us to do two things, is to consult with tribes on how we distribute the funding, and the second thing is for us to look at how we do business.

I really think there is a lot of ways that we can improve the way we do our program. For example, we can better assist patients in

understanding why we have to look at the payment for the referral. We can do a lot of work with our local health care providers to make sure they understand the rules, so that there are no misunderstandings about who is going to pay. We can better look at how we are monitoring our costs and making sure that we are negotiating good rates, making sure that we are processing the claims in a timely manner, and making sure that we are trying to do what we can to get the patients their medically necessary referrals.

The CHAIRMAN. Let me ask you about the process. Let's assume that a woman on the Standing Rock Indian Reservation presents herself to the Indian Health Service clinic and she has a knee condition that is unbelievably painful, bone on bone, impossible to walk and so on. And I assume that that is referred because the referral would mean that they can't treat that at that Indian Health Service clinic at Fort Yates, North Dakota.

So the person is referred to an orthopedic surgeon in one of the hospitals in Bismarck, but I also assume that is not a priority one or two, right? It is not life or limb.

Dr. ROUBIDEAUX. Well, yes, if a patient comes in and is seen by the medical provider, the medical provider assesses them and makes a diagnosis of, you know, knee pain. And then if the facility doesn't have an orthopedic surgeon, then the medical provider writes out a referral to an orthopedic doctor. Then the patient is instructed to take the referral to our Contract Health Services office, and then our Contract Health Services office looks at that referral and tries to help figure out, okay, first does the patient have other resources that might be able to pay for that? And second, do we have enough funding to pay for it with our Contract Health Services Program? If we don't, then they have to consider that referral with all the other referrals according to medical priority.

The CHAIRMAN. But they are prioritizing their referrals. Is the situation I described, a desperate need for an orthopedic doctor to address this unbelievable pain of bone on bone in the knee, is that considered a priority one on most reservations?

Dr. ROUBIDEAUX. Well, it depends. If the person couldn't walk, it could be sort of life and limb. But if the person can still walk, it may be in a different priority category. And it depends on the availability of funding. If funds are not available for that category that it fits into, then it wouldn't be paid for.

The CHAIRMAN. And even if it is a priority one life and limb, if it is let's say June and the contract health funds are exhausted, then what happens?

Dr. ROUBIDEAUX. Well, it depends on the facility because in some facilities, the funds last longer or can pay for more referrals versus others, depending on all the other resources in terms of alternate resources like Medicare and Medicaid available. But it could be a case where funding is limited and this particular referral doesn't meet the highest medical priority that we can pay for. So in that fact, the patient would not be able to have a referral.

The CHAIRMAN. But my question is, this person shows up at the Contract Health office and it is June. Don't get sick after June because there is zero money. What happens at that point? If there is zero money, there is no referral?

Dr. ROUBIDEAUX. Well, if there is not funding available for the level of priority of that referral, then the case could either be denied or deferred. And what some facilities do is that they have these referrals and they meet weekly with medical providers and try to figure out which cases meet the highest priority. So unfortunately, some patients may have to wait to get that referral paid for.

The CHAIRMAN. We had testimony before this Committee. I know anecdotal testimony sometimes you can't draw a more general conclusion from it. A doctor, an orthopedic doctor testified before this Committee about a woman who came to him having been treated at the Indian Health Service, with an unbelievably painful knee condition, almost unable to walk because it was bone on bone. And the treatment at the Indian Health Service was to wrap the knee in cabbage leaves for four days.

Of course, that produced no pain relief at all, so she showed up then at the Bismarck Hospital to the person that came to testify. The person testifying said this is a woman who was living with pain that almost no one should have had to live with, and wrapping a knee in cabbage leaves is not going to address a serious orthopedic problem.

The reason I ask these questions is I think almost certainly someone at an Indian Health Service clinic someone with a serious orthopedic problem is not going to get help there. In most cases you don't have an orthopedic surgeon or orthopedic doctor at that clinic, so it gets referred. And the question is, who pays for it, under what conditions does it get paid for.

And I think the biggest issue for us is to try to figure out, not just how do you increase the aggregate amount of money, but how do you, on serious medical issues that must be referred. Because if they can't be handled by the Indian Health Service clinic, how do you keep the promise to that Native American who was promised health care. The Native American discovers that that promise means only optional health care if someone decides to give you the go sign as opposed to the stop sign when you stop at the Contract Health office?

And we are trying to work through, a number of us on this Committee, trying to work through a reform proposal on Contract Health or some sort of pilot project. We just can't continue doing this. It is not fair to say to somebody who is desperately ill or desperately in need of attention, it is June and your tribe has run out of Contract Health funds.

That is just not fair and that is, we have heard on the Floor of the Senate all kinds of discussion about rationing of health care. I know exactly rationing goes on and so do you. The rationing went on when 360 million worth of care that was required, necessary, was not able to be compensated, denied and deferred.

So, I mean, that is rationing. And it is not on the front pages because nobody pays very much attention, which I think is shameful. You have taken over this job. It is a big job. All of us want to work with you in every possible way because we want you to succeed. If you succeed, Native Americans will receive the full flower of the promise that was given to them.

So, Senator Murkowski?

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

Senator MURKOWSKI. Thanks, Mr. Chairman.

Interesting discussion about how it actually works, not in theory, but in practice. And as you say, I mean, this is rationing in action. This is one of our government-run health care plans, and when you don't fully fund it, as we do not within IHS, we see what happens.

To know that, well, if you get sick after June when those Contract Health funds have run out, you are out of luck, if not unlike what many veterans in the State of Alaska face within the V.A. system. If you happen to live in the right place, you can get those services. But if you are in a village and you have no way to get to town, so to speak, those services that were promised you, whether you are a veteran or whether you are an Alaska Native/American Indian, are not available to you. That is rationing in all-capital letters here.

Some of the Alaska Native health leaders have raised concerns with me about reopening the Contract Health Services distribution. I understand that the tribes are very much divided on this distribution formula, and as long as we have this chronic under-funding, they are going to be continue to be divided on the formulas.

We recognize that the negotiated rulemaking process is by nature a very contentious process, and I would hope that we don't put the tribes in the position of battling over limited or scarce funds.

I want to ask you, Dr. Roubideaux, whether or not the IHS keeps track of the chronic under-funding of Contract Health Services. How do you know what your unfunded balance is, I guess, if I can frame it that way? Do you keep track?

Dr. ROUBIDEAUX. Yes. In the Contract Health Services Program, we do track with the Indian Health Service programs what number of cases are denied and deferred, so that we can have an estimate of the numbers of cases that we were not able to fund.

Senator MURKOWSKI. And as you prepare for the budget coming up here, do you plan on requesting funds to address the shortfall?

Dr. ROUBIDEAUX. Well, it is clear that the amount of resources we have to pay for referrals is not adequate.

Senator MURKOWSKI. It doesn't work.

Dr. ROUBIDEAUX. Yes. So as we look at our budget formulation process, the first thing we look at is the recommendations from our tribes. And our tribes have indicated that more funding for Contract Health Services is a priority, so we do take that——

Senator MURKOWSKI. Is a priority or their number one priority? Have they specified?

Dr. ROUBIDEAUX. Yes, they do list the priorities in their budget formulation recommendations, and I know that it is in the top three, for sure. They also have other top priorities that include the Indian Health Care Improvement Fund and improve contract support costs. But Contract Health Services is indicated as one of their top priorities and we fully consider that as we develop our budgets.

Senator MURKOWSKI. Well, I would hope that you would. I would hope that you would take a very critical look and review as to what the chronic under-funding has been. We recognize that these are difficult budget times, but as the Chairman has noted not only today, but on many, many other occasions when I have sat at the

dais with him, this is an issue that would be unacceptable anywhere else, and yet somehow, some way in Indian Country it is just allowed to continue. The IHS budget is just, when it comes to Contract Health support costs, it just hasn't been funded. And we hear the stories of the consequences.

A little bit off-subject, but knowing that you were here during the discussion about the dental health therapists, has the IHS taken a position on the expansion of the DHAT Program?

Dr. ROUBIDEAUX. The Department of Health and Human Services has not taken a formal position on that issue, but we are reviewing the various positions.

Senator MURKOWSKI. Have you had a chance yourself to observe what we have been able to do with the DHAT Program in Alaska?

Dr. ROUBIDEAUX. Yes, I have. I think it is a great program.

Senator MURKOWSKI. Well, I appreciate your attention to it. I do think we recognize that we have worked hard to be out front in developing a model that will not only work in a very remote place like Alaska, but that can be used in other parts of the Country if we do it right. I think we have a pretty good model up there, and we are saying we are open to the rest of the world to take a look at it, review this, assess it. We are happy to share all that we know of it, but we think that we have something very good and very positive coming in and we would certainly encourage the support from IHS on this.

Dr. ROUBIDEAUX. Well, I look forward to traveling to Alaska and learning more about their programs. I actually was scheduled to be there this week until the hearing was scheduled. So I look forward to going there.

Senator MURKOWSKI. Oh, darn it. I was going to get her up there in December.

[Laughter.]

Dr. ROUBIDEAUX. So as soon as I can, I will go and visit Alaska. But I want to reassure all the Members of the Committee that related to the Contract Health Services Program, we believe that the referrals that are made are medically necessary and that our patients deserve the highest quality of care. And as the Director of the Indian Health Service, I am committed to working in partnership with our tribes to look in our budget formulation to make Contract Health Services a priority, as the tribes want us to, and also to look at how we do the business of the Contract Health Services Program to make sure that as many patients can get these referrals as efficiently as possible.

Senator MURKOWSKI. I appreciate that and look forward to your visit to Alaska. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Roubideaux, thank you very much. We will excuse you. I know you have other things to do, and we appreciate your patience today. Thank you for coming.

Dr. ROUBIDEAUX. Thank you very much.

The CHAIRMAN. Next, we will hear from Connie Whidden, who is the Health Director of the Seminole Tribe in Florida, Hollywood, Florida; and Mr. Mickey Peercy, the Executive Director of the Health Services of the Choctaw Nation of Oklahoma in Durant, Oklahoma.

Let me thank the two of you for your patience as well.
You may proceed, Ms. Whidden. Thank you.

STATEMENT OF CONNIE WHIDDEN, HEALTH DIRECTOR, SEMINOLE TRIBE OF FLORIDA

Ms. WHIDDEN. Thank you for the opportunity to be here today. My name is Connie Whidden. I am a member of the Seminole Tribe of Florida and have served as its Health Director for 15 years. I have been asked to provide testimony on the tribe's experience with Contract Health Service Program.

Under a self-governance compact with the IHS, the Seminole Tribe offers primary care programs at the ambulatory clinics located on our reservation. We also operate the CHS programs. CHS funding nationwide is extremely inadequate. Last year, the Seminole Tribe received approximately $1.9 million for its CHS Program. The tribe supplements these CHS funds significantly to ensure that eligible tribal members receive the care they need.

To address the unmet need, the tribe created and administers a supplemental self-funded CHS member health plan. Eligibility is limited to tribal members and descendants who are eligible for the CHS Program. Consistent with the IHS regulations, all beneficiaries must enroll in other programs for which they are eligible, such as Medicare and Medicaid, in order to be eligible for services.

After our supplemental plan was established, Medicare paid first for care to tribal members enrolled in Medicare. But approximately 18 months ago, Medicare began denying claims from patients covered by our supplemental plan. For example, one of our tribal members who is enrolled in Medicare is in end-stage renal disease and is undergoing dialysis treatment. Medicare approved the claim early in the treatment, but then started to deny payments, asserting that the patient has another resource, namely the tribe's supplemental plan which Medicare erroneously concluded was an employment-based plan. The patient has appealed the denied claims.

In the meantime, the tribe has paid the provider more than $500,000 to assure that the patient has continued access to dialysis service. Two weeks ago, tribal officials met with the Director of CMS Financial Services Group. We explained that the tribe's CHS supplemental health plan is not an employment-based group health plan, so the secondary payment rules are not a basis for denial of Medicare payments.

We explained that the tribe's plan supplements the CHS Program. Federal regulations require that all alternate resources must be used before the CHS Program will be responsible for any payment. The Director agreed to consult with IHS officials before making a final determination on the tribe's request to correct the denied Medicare claim. We understand that these conversations have begun.

Mr. Chairman, the real issue here is whether the Federal Government will honor its trust responsibility to pay for medically necessary services provided to tribal members through the CHS Program as administered by the Seminole Tribe. If Medicare fails to pay, it will be yet another broken promise to Indian people.

To truly fulfill the United States' trust responsibility to Indian people for health care, the CHS Program should be an entitlement

program. Until that happens, however, we urge Congress to assure that the Federal Government does not further abrogate its trust responsibility. If existing laws can be interpreted to allow CMS to deny Medicare benefits on this basis, then the law need to be clarified to assure that this practice does not continue.

I hope that CMS will quickly determine that Medicare is a primary payer for the Seminole tribal members whose claim has been denied. If it does not, I look forward to working with this Committee and Congress to address this issue.

Thank you for the opportunity to testify today. My staff and I will be happy to answer any questions you may have.

[The prepared statement of Ms. Whidden follows:]

PREPARED STATEMENT OF CONNIE WHIDDEN, HEALTH DIRECTOR, SEMINOLE TRIBE OF FLORIDA

Chairman Dorgan, Vice Chairman Barrasso, and Members of the Committee, good afternoon and thank you for the opportunity to be here today. My name is Connie Whidden. I am a Member of the Seminole Tribe of Florida and have served as the Health Director for the Tribe, which is headquartered in Hollywood, Florida, for 15 years. I have been asked to provide testimony on the Tribe's experience of having to supplement our Contract Health Service (CHS) program with tribal resources due to chronic underfunding from IHS. I have also been asked to describe the recent problems we encountered when Medicare began to deny claims of tribal members who receive this supplemental coverage despite Indian Health Service (IHS) regulations which make CHS the payer of last resort.

The Tribe's CHS Program

The Seminole Tribe of Florida currently has a compact of self-governance with the IHS under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA). For decades, the Tribe has directly operated its own health programs. We offer primary care programs at the ambulatory clinics located on our reservations, and we also operate the CHS program through which we purchase health care services that are otherwise not available to our patients at the Tribe's clinics. Based on patient eligibility for CHS, the Tribe authorizes CHS from certain specified providers, normally on referral, based on medical necessity, priority of need and funding availability for such services.

In the past, these outside health care providers have been paid first by private insurance or by Medicare and Medicaid when applicable, and thereafter by the Tribe's CHS program. The Tribe's CHS program is responsible for payment only after all of a patient's other alternate resources are exhausted.

Chronic CHS Under-Funding and Tribal Supplementation of CHS

The status of CHS funding nation-wide is woefully inadequate and many tribes – including the Seminole Tribe of Florida – struggle to provide CHS services when the funding runs out mid-way through the fiscal year. This past year, for example, the Tribe received approximately $1.9 million for its CHS program from IHS, excluding CHEF fund reimbursements. These funds are very limited and they failed to meet our members' CHS needs. In fact, if we had relied solely on these funds we would have had to stop providing CHS services by the end of the first quarter of the fiscal year. Instead, the

Tribe chose to supplement these IHS CHS funds with $36 million of its own to ensure that eligible tribal members receive the care they need through out the year.

Because the CHS unmet need is so great, the Tribe created a supplemental plan through which the Tribe annually funds the unmet need. The Tribe funds and administers the plan itself. Eligibility for this supplemental coverage is limited to tribal members and descendants who are eligible for the CHS program. Consistent with IHS regulations, all beneficiaries must enroll in other programs for which they are eligible – such as Medicare and Medicaid – in order to be eligible for services paid for by CHS, including the Tribe's supplement to CHS. The Tribe's plan is an integral part of our CHS program.

CMS Incorrectly Issues Denials of Payment

Under federal regulations,[1] the CHS program is residual to all other payers, including Medicare and Medicaid. This is the "payer of last resort rule," and is extremely important because CHS funding is so scarce. This rule also assures that Indian people enrolled in Medicare and Medicaid can fully utilize these benefits to the same extent as non-Indians enrolled in those programs – without having the value of those benefits diminished to secondary status by the rights and benefits they receive by virtue of their status as Indian people to whom the United States owes a trust obligation.

Because the Tribe's plan supplements its overall CHS program, we believe that Medicare should be the primary payer for services provided to a beneficiary enrolled in Medicare. In other words, the CHS program continues to be the payer of last resort and that rule does not change merely because the Tribe has supplemented its under-funded CHS program with tribal funds. The Tribe's plan explains that it is supplemental to and part of the Tribe's CHS program and that the plan will always act as the payer of last resort whenever a person has other insurance coverage, including Medicare and Medicaid.

After our supplemental plan was established, Medicare paid first for care to tribal members enrolled in Medicare. But approximately 18 months ago Medicare began denying claims from patients covered by our supplemental plan. The denials were primarily based on what is known as "Reason Code 34294," which means that the claims must be billed to an available employer group health plan. Upon inquiry, we learned that the denials were based on an erroneous view that the Tribe's CHS supplemental plan is an employee benefit plan to which CMS is a secondary payer.

For example, a Tribal member who is enrolled in Medicare is in end-stage renal disease and is undergoing dialysis treatments. Medicare approved the claims early in the treatment, but thereafter started to deny payment asserting that the patient has another resource – namely the Tribe's supplemental plan which Medicare erroneously characterizes as an employment-based plan.

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[1] 42 DFR §136.61.

The patient has appealed the denied claims, but in the meantime the Tribe has paid the provider more than $500,000 to assure the patient has continued access to dialysis services. The Tribe has also worked out temporary payment arrangements with other service providers with the understanding that the Tribe would be repaid once the problems are resolved with Medicare.

The Tribe's Efforts To Reverse Denials

The Tribe has tried to work with Medicare staff at the local level to reverse these erroneous denials. When our efforts to achieve correction at the local and regional level failed, we sought assistance from Jonathan Blum, the Director of the Center for Medicare Management. Tribal Chairman Mitchell Cypress wrote to Mr. Blum last August, providing a detailed explanation of the issue and rationale for why the CHS payer of last resort should continue to apply for Seminole Tribal members receiving care through the CHS program. He asked that Mr. Blum meet with Tribal representatives to resolve the issue. I have attached that letter to my statement and ask that it be included in the official hearing record.

After three months of phone calls and emails to follow up on our meeting request, Tribal officials recently met with Gerald Walters, Director of CMS' Financial Services Group, to pursue the matter Mr. Walters apologized for the delay in responding to the Seminole Tribe, and pledged to resolve the issue promptly. We explained to Mr. Walters that the Tribe's CHS supplemental health plan is not an employment-based "group health plan" as that term is defined in the MSP rules and in the Social Security Act, so the Medicare Secondary Payer (MSP) rules regarding group health plans are not a basis for denial of Medicare payments. "Group health plans," to which Medicare benefits are secondary, pertains primarily to insurance being provided in an employment-based context. Mr. Walters told us that CMS considers "group health plans" under the MSP rules to include a variety of relationships that are not limited to employer-employee types of plans, like the Tribe's member plan. We have not, however, been able to find any substantiation for this position in the applicable law or CMS regulations.

We explained that the Tribe's plan supplements the CHS program which is the payer of last resort under Federal regulations. These regulations require that all alternate resources must be accessed and used before the CHS program will be responsible for any payment. While it is generally unquestioned that Medicare is the primary payer when CHS is involved, applicable regulations are not being honored with respect to our supplemental plan.

Resolution of the problem was not achieved at the meeting with Mr. Walters, but he did agree to consult with IHS officials to learn more about the CHS program and the payer of last resort policy before making a final determination on the Tribe's request to correct the denied Medicare claims. We understand that CMS-IHS conversations have begun.

Conclusion

Mr. Chairman, the real issue we are confronting here is whether the federal government will honor its trust responsibility to pay for medically necessary services provided to Tribal members through the CHS program as administered by the Seminole Tribe pursuant to its self-governance agreement. The current discussions between CMS and IHS are taking place to reconcile apparent inconsistencies between CMS regulations governing Medicare and IHS regulations governing the CHS program.

We believe that the correct legal conclusion is that Medicare is the primary payer in the circumstances described above. If CMS reaches a different conclusion, we believe it is the responsibility of the Congress to consider the broader policy implications at stake. As part of its trust responsibility to Indian tribes the Federal government has the obligation to provide health care to Indian people. If Medicare will not pay for necessary medical care for Seminole tribal members because the Seminole Tribe has stepped in to supplement the CHS program, it will be yet another example of the United States failing to meet its trust responsibility to Indian people.

Our Tribe is not the only tribe that supplements inadequate CHS funding levels. All tribes who can afford to do this do it because they want to advance the health status of Indian people. Our efforts should be encouraged, not discouraged. We and other tribes should not suffer adverse consequences when we attempt to do the right thing. It goes without saying that if CHS were fully funded, tribes would not be placed in the position of having to do the Federal government's job for it. To ensure that the United States' trust responsibility to Indian people for health care is fully realized the CHS program should be an entitlement program.

Until that happens, however, we urge Congress to take whatever steps are necessary to assure that the Federal government does not further abrogate its trust responsibility to Indian people by denying Medicare benefits to tribal members because tribal governments take steps to supplement woefully inadequate CHS funding levels. If existing law can be interpreted to allow CMS to deny Medicare benefits on this basis, then the law needs to be clarified to assure that this practice does not continue.

I hope that CMS will quickly determine that Medicare is the primary payer for Seminole Tribal members whose claims have been denied. If it does not, I look forward to working with this Committee and the Congress as a whole to address this issue, which has significance not just for the Seminole Tribe, but for all of Indian Country.

Thank you for the opportunity to testify today. I will be happy to answer any questions you may have.

Attachments

SEMINOLE TRIBE OF FLORIDA

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6300 STIRLING ROAD
HOLLYWOOD, FLORIDA 33024

August 21, 2009

Via Telefax and U.S. Mail

Jonathan D. Blum, Director
Center for Medicare Management
DHS/CMS/OA
200 Independence Avenue
Washington, D.C. 20201

Re: Medicare As Primary Payer

Dear Mr. Blum:

The Seminole Tribe of Florida ("STOF") is seeking your assistance to resolve an outstanding issue involving coordination of benefits between the STOF and Medicare. The STOF believes that several Medicare claims have recently been denied by the Centers for Medicare and Medicaid Services ("CMS") based on an improper application of the Medicare secondary payor rules to the STOF's health care beneficiaries. The STOF thinks the law is clear that Medicare is the primary payer in the situations at issue and that the claims should not have been denied. Any help you could provide to resolve this matter would be greatly appreciated.

We begin by providing the background giving rise to our request and then outline our view of the relevant issues:

Background

As you know, the United States has a trust responsibility to provide health care to Indians. Generally, this responsibility is performed by the Indian Health Service ("IHS") which carries out Indian health programs with annual appropriations from Congress. But Federally-recognized tribes – such as the STOF – may elect to take over operation of their IHS health programs under agreements issued pursuant to the Indian Self-Determination and Education Assistance Act ("ISDEAA"), utilizing funding supplied by IHS.

The STOF has directly operated its health program for decades and currently does so under a compact of self-governance authorized by Title V of the ISDEAA. It offers primary care programs at the ambulatory clinics on its reservation, and operates the Contract Health Services ("CHS") program through which IHS and tribes purchase health care services that are not available in the Indian health care facilities.

Under federal regulations, the CHS program is residual to all other payers, including Medicare. This policy is extremely important because CHS funding is so scarce. Of equal importance, however, is the fact that these regulations assure that Indian people enrolled in Medicare can fully utilize their Medicare benefits to the same extent as non-Indians enrolled in that program without having the value of those benefits diminished to secondary status by the rights/benefits they received by virtue of their status as Indian people to whom the United States owes a trust obligation.

Because the CHS funding the STOF receives from the IHS is so limited and the unmet need is so great, the STOF determined that it had to supplement its meager CHS budget to assure that Tribal beneficiaries can receive the level of care to which they are entitled. The STOF created a self-funded supplemental plan for which its members and descendants are eligible (hereinafter "STOF self-funded member health plan"). It is intended to supplement the CHS program.

Since its self-funded member health plan is supplemental to CHS, the STOF believes that, like the CHS program itself, Medicare is the primary payer when a beneficiary is enrolled in Medicare. The STOF self-funded member health plan, as a supplement to the CHS program and consistent with the Tribe's Compact and Funding Agreement with the IHS, is responsible for payment only after all of a patient's other alternate resources are exhausted. The Plan Document for the STOF self-funded member health plan explains that whenever a person covered by the plan has other insurance coverage, including Medicare and Medicaid, the plan will always act as the payer of last resort.

Recently, however, CMS denied Medicare benefits to patients who received CHS services authorized by the STOF because those patients also happen to be covered by the STOF self-funded member health plan. The denials were based on the erroneous view that the STOF self-funded member health plan is an employee benefit plan to which CMS is a secondary payor. For example, one recent denial of Medicare coverage was based on "Reason Code 34294," where CMS said the "claim submitted as Medicare primary and a positive ESRD/EGHP record exists . . . claim should be billed to the employer group health plan."

The STOF believes the denials were incorrectly issued and that Medicare should be considered the primary payer when the STOF's CHS eligible beneficiaries receive CHS services. For the past few months Tribal staff has been engaged in discussions with CMS staff to seek resolution on this issue. The STOF has worked with Diane Thorton, the CMS Native American contact for the Atlanta Region, and Rodger Goodacre, a member of the CMS Tribal Affairs Group. While these individuals have provided helpful information, they and the STOF have to date not been able to resolve the outstanding denials. We understand the issue is being reviewed internally at CMS but without any input from the STOF.

Discussion

The STOF believes that its self-funded member health plan is residual to Medicare for two reasons: (1) The Tribe's self-funded member health plan is not a "group health plan," ("GHP") so the Medicare secondary payer rules regarding GHPs do not apply; and (2) The STOF's self-funded member health plan supplements the STOF's CHS program in which the STOF is the payer of last resort. We address each of these reasons in greater detail below.

1. The Medicare secondary payer rules do not require denial based on the STOF's self-funded member health plan.

Section 1862 of the Social Security Act makes Medicare the secondary payer for services to the extent payment has been made or can reasonably be expected to be made under a group health plan, large group health plan, workers' compensation plan, liability insurance or no fault insurance. 42 U.S.C. §§ 1395y(b)(1)(A)(i), (v), 1395y(b)(2)(A). The basic rule is stated in the CMS regulations as follows: "Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries." 42 C.F.R. § 411.32 (emphasis added). The term "primary payer" in the context of that regulation means an entity that is responsible for payment under a "primary plan," which in turn is defined as a group health plan, a worker's compensation law or plan, an automobile or liability insurance policy or plan, or no-fault insurance. 42 C.F.R. § 411.22

Because the STOF self-funded member health plan is not workers' compensation, liability insurance or no fault insurance, the question is whether it constitutes a GHP for purposes of applying the Medicare secondary payer rule. The answer is that the STOF self-funded member health plan is not a GHP.

The term "GHP" is defined at Section 1862 of the Social Security Act as follows: "[T]he term 'group health plan' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of Title 26." 42 U.S.C. § 1395y(b)(1)(A)(v). Section 5000(b) of the Internal Revenue Code in turn defines GHP as follows: "[A] plan . . . of, or contributed to by, an employer . . . or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families." 26 U.S.C. § 5000(b). Thus, to be a GHP, there must be an employment relationship where the insurance is being provided to employees (current or former) and/or employees' families.

This employment-related definition is carried-forward by CMS in its regulations implementing the secondary payer rules: "Group health plan (GHP) means any arrangement made by one or more employers or employee organizations to provide health care directly or

through other methods such as insurance or reimbursement, to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families . . . ." 42 C.F.R. § 411.101. See also Medicare Secondary Payer Manual § 20 (Rev. 65, 03-20-09) ("The term "GHP" means any arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.").

The STOF self-funded member health plan is not a GHP because eligibility for enrollment is not at all related to employment with the STOF. The plan is provided by the STOF solely to its Tribal members and descendants of Tribal members to supplement an inadequately funded federal program. The plan is not contingent on or related in any way to employment with the STOF.

The STOF self-funded member health plan thus is not a GHP as that term is defined in the Social Security Act, the Internal Revenue Code, or CMS's regulations or policies implementing the Medicare secondary payer rules. As the CMS's Medicare Secondary Payer Manual recognizes, "A plan that does not have any employees or former employees as enrollees . . . does not meet the definition of a GHP and Medicare is not secondary to it." Manual § 20 (defining "GHP"). Accordingly, the STOF believes that the Medicare denials at issue – based on erroneously treating the STOF self-funded member health plan as a GHP – are incorrect.

2. The STOF is the payer of last resort.

As explained above, the STOF's self-funded member health plan is provided to STOF members and descendants in order to supplement the STOF's CHS program, which the STOF carries out under its Title V compact of self-governance and funding agreement with the Indian Health Service. The STOF's CHS program is intended to pay for health care services that are outside of the scope of services provided within the STOF's own health care facilities. Based on patient eligibility for CHS, the STOF authorizes CHS from certain specified providers, normally on referral, based on medical necessity, priority of need and funding availability for such services. However, like many other tribes around the country, STOF does not receive nearly enough CHS funds from the IHS to meet the need for CHS services. The STOF thus developed its self-funded member health plan in order to supplement the CHS program for STOF members and descendants.

Under the ISDEAA and the Tribe's Title V agreements with the IHS, the STOF has authority to redesign the programs it has assumed from the IHS, such as the CHS program, "in any manner which the STOF deems to be in the best interest of the health and welfare of the Indian community being served," so long as STOF does not deny eligibility for services in doing so. STOF Title V Self-Governance Compact, Art. III, § 4 (Amended and Restated FY 2004) (hereinafter "Compact"); FY 2009 Funding Agreement, § 4(c); 25 U.S.C. § 458aaa-5(e). The

STOF may also consolidate its Title V programs and the associated funds it receives in its funding agreement from the IHS with the STOF's own funds or funds from other sources, provided the programs are allowable for inclusion in the STOF's funding agreement. Compact, Art. III, § 9; 25 U.S.C. § 458aaa-5(e). The STOF accordingly exercised such authority when it created the STOF self-funded member health plan to supplement the CHS program and inadequate CHS funding with STOF funds. STOF is thus carrying-out the STOF self-funded member health plan as part of the Title V self-governance compact and funding agreement.

The STOF self-funded member health plan, as part of the STOF's CHS program, is the payer of last resort. The IHS regulations provide that all alternate resources must be accessed and used before the CHS program will be responsible for any payment:

(a) The IHS is the payor of last resort for persons defined as eligible for contract health services under the regulations in this part, notwithstanding any State or local law or regulation to the contrary.

(b) Accordingly, the IHS will not be responsible for or authorize payment for contract health services to the extent that:

(1) The Indian is eligible for alternate resources, as defined in paragraph (c) of this section, or
(2) The Indian would be eligible for alternate resources if he or she were to apply for them, or
(3) The Indian would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for contract health services, or other health services, from the IHS or IHS funded programs.

(c) Alternate resources means health care resources other than those of the IHS. Such resources include health care providers and institutions, and health care programs for the payment of health services -including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, and private insurance.

42 C.F.R. § 136.61(b)-(c).

CMS recognizes its position as primary payor when CHS is involved. For example, Section 50.1.5 of the CMS Medicare Benefit Policy Manual (Rev. 102, 02-12-09) states that "[i]n the case of such contract health services to Indians and their dependents entitled under the Indian Health Service (IHS) program and Medicare, Medicare is the primary payer and the IHS the secondary payer."

The STOF thinks that for CHS eligible beneficiaries of the STOF, who are covered by the STOF self-funded member health plan as supplemental to the STOF's CHS program, Medicare

is the primary payer for CHS services. The STOF's CHS program and self-funded member health plan are the payers of last resort.

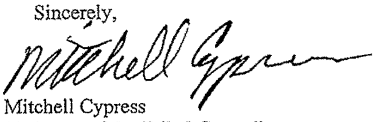
Any other outcome would essentially penalize the Tribe for its "good deed" of stepping in to augment a vital federal Indian health program which has never been funded at the appropriate level of need, and would put the STOF in the position of subsidizing the Medicare program.

Conclusion

Because the STOF self-funded member health plan is not a GHP and the STOF is a payor of last resort, the STOF asks that CMS reverse its previous decisions to deny payment of claims to STOF beneficiaries under the Medicare secondary payer rules. The STOF asks for your assistance in clarifying this issue with CMS staff. We would like to work together with you to revisit the various denials of Medicare payment as soon as possible. Many of the provider bills for which Medicare issued denials have been pending for several months and need to be quickly resolved.

The STOF would appreciate it if you and your staff could meet with us as soon as possible so that we can discuss and resolve these issues. We will be in touch with your office to schedule a mutually agreeable time to meet. Thank you in advance for your time and attention to this important matter.

Sincerely,



Mitchell Cypress
Chairman of the Tribal Council

cc: Connie Whidden, Director, Health Administration, Seminole Tribe of Florida
Jim Shore, General Counsel, Seminole Tribe of Florida
Geoff Strommer, Esq.
Diane Thorton, CMS
Rodger Goodacre, CMS
Kitty Marx, Director, Tribal Affairs Group, CMS Office of External Affairs
Yvette Roubideaux, Director, IHS
Hankie Ortiz, Director, Office of Tribal Self-Governance, IHS
Richie Grinnell, Director, NAO

SEMINOLE TRIBE OF FLORIDA

CONNIE WHIDDEN
Health Director

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February 4, 2010

The Honorable Byron Dorgan
Chairman
Committee on Indian Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

On December 3, 2009, I had the honor of testifying before the Committee on Indian Affairs at a hearing entitled "Promises Made, Promises Broken: The Impact of Chronic Underfunding of Contract Health Services." During that hearing I discussed a problem the Seminole Tribe of Florida was having with Medicare denying claims submitted by Seminole tribal members enrolled in our self-funded plan that supplements the Contract Health Services program. In my testimony I indicated that the Tribe had recently met with Mr. Gerald Walters, Director of CMS' Financial Services Group, and that he had agreed to look into the issue.

I am pleased to report that Tribal Chairman Mitchell Cypress recently received a letter from Mr. Walters notifying him that CMS agrees that Medicare is the primary payer when a tribe member receives health services under the self-funded plan. He indicated that he had instructed his staff to work to "ensure that any earlier incorrect denials are reversed and that denials do not occur in future similar situations." Indeed, Medicare has begun processing tribal member claims that previously were denied and Mr. Walters' staff has been responsive and helpful in expediting the process.

We very much appreciate the efforts of IHS Director Roubideaux and her staff, who met with CMS to explain the CHS payer of last resort rules. We also want to commend CMS Financial Services Group Director Gerald Walters for his responsiveness to our concerns. After 18 months of unanswered questions to CMS at the local, regional and national level, Mr. Walters turned around the incorrect Medicare denials in less than 60 days.

I understand that the official hearing record is no longer open, but I wanted to be sure to inform you of the positive resolution to this significant issue for the Seminole Tribe. Please feel free to contact me if you have any questions or would like more information.

Sincerely,

Connie Whidden, MSW
Health Director

The CHAIRMAN. Ms. Whidden, thank you very much for being here, and your testimony.

Mr. Peercy, you may proceed.

STATEMENT OF MICKEY PEERCY, EXECUTIVE DIRECTOR OF HEALTH SERVICES, CHOCTAW NATION OF OKLAHOMA

Mr. PEERCY. Thank you, sir. I have a voice problem so I am going to be sucking water as we go, but I wanted to thank the Committee for the invitation. I am Mickey Peercy, Choctaw Nation of Oklahoma, Executive Director of Health.

Choctaw Nation covers 10.5 counties in Southeast Oklahoma, very rural there. We have a 37-bed hospital and eight ambulatory

clinics that cover a space about the size of Vermont. We have about 200,000 primary patient visits per year, a user population of about 40,000, as well as about 520 births.

Today, I am going to speak to you as a clinical social worker, so it is not going to be a lot of empirical stuff, but it is, with 25 years of experience in working with tribal health programs and working with Indian Health Service, I am sorry that Dr. Roubideaux left. I think she had read my testimony and felt like I had insulted her in my testimony. That wasn't the intent at all, and she and I get along real well, so we will work through that.

I am not going to describe to you what Contract Health is. I think that Dr. Roubideaux did a great job of doing that. You folks on this distinguished panel know what CHS is. You know it is rationed care. You also know CHS is woefully under-funded, as well as all of IHS.

We applaud Chief Pyle. I wanted to make sure that you knew we applaud the movement that Congress is making this year and 2010 with the $144 million increase. We ask that that be done at least in a lump sum next year or in a five-year increment so at least that same amount of significant money. There has to be significant money put in the system.

I think what Dr. Roubideaux might have had an issue with is I wanted to contrast a little bit of what Indian Health Service, how they run CHS, and how tribal-operated programs, specifically Choctaw's, would run.

And my observation is that Government employees, not just Indian Health Service, have a real problem dealing with private sector individuals. Keep in mind, CHS is private sector-driven. It is outside of the Indian Health Service. It is outside of V.A. We go from our primary care facility to that next level, which is private sector. And when government and private sector get together, it doesn't hardly ever work out, the two different mind-sets. And that is what I think the issue is with, especially with Indian Health Service. And again, I have been around it for many years in terms of the issues that, you know, the staff in Indian Health Service, they are good people, but they have rules, regulations. They have this new USMF system that I guess all the Government has, that you can't, which is cumbersome, it takes forever, the rules, the regulations that take forever.

On the other side, and I guess just to talk a little bit about the private sector, those folks expect to be paid. You know, they are running their own business. They are running their own labs. They are running their own radiology services. They expect to be paid, and they don't want to wait for a year to be paid, and they don't want to wait six months. If you make a referral, they expect to be paid within a reasonable time.

It is really tough in the world of government to get something like that done, and I think that is a real drawback for the Service.

In most cases, in my experience, Federal employees always have, and I think you heard Dr. Roubideaux say, you know, it is Federal. We don't have deficit spending. If we run out of money, we run out of money. And Feds, in my experience, tend to use that, if you are dealing with private sector folks and payment folks, you always can say, we are the Government.

In contrast with the tribally-operated program, you know, if our system turned down somebody for CHS in McAlester, Oklahoma, I am probably going to see that person at the next community meeting. And I am probably going to see that person. They are family. They are community family and they are voters for the tribe.

So I do think that tribal programs are better able to operate CHS programs, have it easier because we can go out to that doc, and if I have a doc that needs to be paid within a short period of time, we can do a quick check in about three days. You know, so we can function better with the private sector, whether that be hospitals, diagnostic labs or anybody else, than the Indian Health Service. We have that advantage. Plus that is our family.

And I know my time has run out, so I will try to speed up real quickly, sir.

What we would like to see and what we are starting to do at Choctaw, instead of—I know Dr. Roubideaux mentioned the lady you mentioned would go to the CHS office—and a lot of what or would have been in CHS offices are those clerks who take that information and they look at it. What we try to do and what we are trying to do is turn our people into case managers, instead of saying no and writing the letter and sending the letter out.

We are trying to case manage, make sure that we sit down with them, make sure we explore those resources, make sure we get back to them. There is a way of saying no to someone without sending a letter. And there is a way of putting somebody on a list and continuing to work with them.

So we are trying to change the scope of our Contract Health Service to a case management, and try to change the name of it. And I would like to see us work, tribes with IHS, in maybe taking a look at developing that model.

One thing I also wanted to mention, when Dr. Roubideaux was talking about, I think the question was asked about deferred and denials. That is a list, but in my experience over the years, when doctors don't think that service is going to be paid, they don't send a referral. So you don't have a denied and referral. So I think the number of denieds and deferrals are probably under-tabulated.

And with that, I will just make quick recommendations. The finance piece, encourage Indian Health Service and tribes to look for best practices and let us work together not on the funding methodology, but on how we deal with best practices in taking care of our patients, and how we deal with the private sector. I think the funding methodology was put in place, I worked on that work group in 2001, and it was put together. But this is the first year that that methodology ever hit. There was never ever enough funding to make that methodology work. So I would suggest we leave that in place.

And I would just answer questions.

[The prepared statement of Mr. Peercy follows:]

PREPARED STATEMENT OF MICKEY PEERCY, EXECUTIVE DIRECTOR OF HEALTH SERVICES, CHOCTAW NATION OF OKLAHOMA

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 peo-

ples. 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 and 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.

The CHAIRMAN. Mr. Peercy, you just indicated that doctors, I assume you are talking about doctors at the IHS.

Mr. PEERCY. At the clinic.

The CHAIRMAN. The IHS clinics, will decide not to defer if they think it is going to be turned down anyway. Is that correct?

Mr. PEERCY. True.

The CHAIRMAN. So you think that perhaps we are getting less than accurate information about how much Contract Health Services are denied because some was just not referred that probably should be just because the doctor says this isn't going to happen.

Mr. PEERCY. Yes, sir.

The CHAIRMAN. Tell me about your notion of case management. I mean, you are talking about case management. Describe what you mean by that. I mean, if someone comes in with a medical condition and there is no money in Contract Health Service, what does case management mean to a pain?

Mr. PEERCY. Case management has to do with really doing an assessment on the socioeconomic side of that patient in terms of are there really any resources out there? Is there, if it is a medication, is there a needy meds number you can call? There are many pharmaceutical companies who will provide medications. That may not be in our formulary. There are many foundations out there. There

is St. Jude's. There are many places that people can sit with and say, well, we can't go this way; let's go this way.

And you know, Choctaw CHS folks weren't trained that way until a couple of years ago, and we are trying to start training them. The thing comes in, do they meet the eligibility, are they living in our geographical area, did it come within 72 hours of when it was supposed to, was a phone call made. And I heard Dr. Roubideaux, it is right—mention A, B, C, D, C. How many things kept people out?

Well, we are trying to look for things that get people in.

The CHAIRMAN. All right. I mean, case management is not a substitute for the health care. Your case management is a way to try to find a road into the health care system.

Mr. PEERCY. Yes, sir.

The CHAIRMAN. Ms. Whidden, how many members of the tribe that you represent?

Ms. WHIDDEN. We have approximately 3,500 enrolled members and another 200 descendants of the Seminole Tribe that we provide services to.

The CHAIRMAN. You described that the tribe set up a supplemental system that would be available to assist those who need help when the Contract Health money is not available. And then you indicated those who are Medicare-eligible would have Medicare billed, which I understand. Medicare would be billed for the procedure first, and Medicare was paying that, and then decided, no, we are not going to pay it. This is because the supplemental system the tribe set up means that Medicare doesn't have to pay it. The supplemental system should be called upon first.

Has anyone done a legal analysis of that? I mean, tell me, how did you discover this? They just began denying claims?

Ms. WHIDDEN. Yes, it did. We worked at the local, when it was first denied, we worked at the local and regional offices trying to resolve this and trying to see why it had been paid, and now all of a sudden it was being denied. And I think in my presentation, they said something about reason such-and-such number, which turned out to be they thought that our tribal members had insurance which was employment insurance, and that was not the case.

So after 18 months of back and forth, a couple of weeks ago we came up to Baltimore, met with the CMS people and that is when we began to see what the differences were and we did tell them that it is not an insurance plan; that it is a supplement to CHS.

The CHAIRMAN. Is it now resolved or not?

Ms. WHIDDEN. No. It is not.

The CHAIRMAN. Okay. Does your tribe run out of Contract Health Service money in the year?

Ms. WHIDDEN. Yes.

The CHAIRMAN. When?

Ms. WHIDDEN. By the end of the first quarter.

The CHAIRMAN. So at the end of the first three months of the year, you are out of Contract Health Service money?

Ms. WHIDDEN. Yes.

The CHAIRMAN. And then someone who goes to, do you have a clinic, the IHS clinic on the reservation?

Ms. WHIDDEN. Yes.

The CHAIRMAN. And someone goes to that clinic tomorrow morning and they have any number of problems that cause them great pain. It is likely the doctor onsite would want to refer to a specialist, perhaps, and that referral would then probably go to a contract health office on your reservation?

Ms. WHIDDEN. Yes.

The CHAIRMAN. And they would show up and the contract health office would say no money here on contract health; that is exhausted.

Ms. WHIDDEN. No, we don't even let our patient know that CHS funding has been exhausted.

The CHAIRMAN. You immediately grab them in the supplemental program?

Ms. WHIDDEN. Yes.

The CHAIRMAN. And if they are Medicare-eligible, you move them——

Ms. WHIDDEN. Yes, and he talked about case management. We have medical social workers who know when our elder population will turn 65 and they start working with our clients or our patient to make sure that they are enrolled with Medicare.

The CHAIRMAN. Now, why do you think that you run out of money at the end of the first quarter? I mean, that is pretty dramatic under-funding, isn't it, on contract health?

Ms. WHIDDEN. Yes.

The CHAIRMAN. Mr. Peercy, when do you run out of money, or don't you?

Mr. PEERCY. We are fairly fortunate with economic development. We get about $5 million from the line item of CHS, and then the tribe supplements $7 million. So we have about $12 million. And we would run out of money without the tribal improvement.

We are fortunate also where we are at. It is about 87 percent to 90 percent Choctaw, and so those $7 million from the tribal side are specific to Choctaw members, and the Federal money certainly takes care of Choctaws and other members.

The CHAIRMAN. How many members of the Choctaw Nation? Do you have an enrolled——

Mr. PEERCY. Yes, nationwide there is about 200,000. Within the 10.5 counties, there is probably 60,000.

The CHAIRMAN. Is that recognized, 60,000?

Mr. PEERCY. Yes, sir.

The CHAIRMAN. That is recognized as a separate tribe, a separate tribal entity?

Mr. PEERCY. It is all Choctaw Nation.

The CHAIRMAN. Okay.

Mr. PEERCY. Yes, 200,000, and only about 60,000 live in the 10.5 counties.

The CHAIRMAN. I understand.

Well, what we are trying to think through is how to do this differently. I mean, clearly contract health is a process by which if we have provided a guarantee, and we have actually signed treaties to say we promise, and have trust responsibilities to say we are going to take care of this population with respect to their health care.

We put together an Indian health system, IHS. They establish clinics. Those clinics are staffed with certain health professionals,

and then the tribal member will go to that clinic. And if that clinic is not able to address that health care need, there would be a referral to some other facility, and that will be paid by contract health. That is the purpose of contract health, to be the facilitator, the funding facilitator to move to a specialist or another facility where the health care they need would be made available to them.

The dilemma is if we have reservations that are running out of funding at the end of the first quarter. Some reservations don't have extra revenues and can't put together a supplemental program, Mr. Peercy, you have described.

Mr. PEERCY. True.

The CHAIRMAN. That means that the person that comes in is going to be told no. Or perhaps the person will find their way nonetheless to a hospital thinking it is going to be paid, and then have their credit rating ruined because they get the health care and it doesn't get paid. This happens all too often, where a person's credit rating is ruined.

And so we have got to find some reform approach to Contract Health. This is the purpose of this discussion with Dr. Roubideaux and to hear your perspectives as well, to try to evaluate.

If you know what doesn't work, and we know what doesn't work, and that is dramatically under-funding Contract Health. Then what is it that can work other than just funding up to a certain level? Are there other ways? You mentioned case management and other efforts that could improve the system. I agree, and certainly the Indian Health Service itself can be improved in many ways.

But can this particular piece of public policy, Contract Health Services, be reformed and improved? Or do we just continue with the model we have and continue to under-fund it? This means there is actual deliberate rationing going on. Notwithstanding, I am not suggesting that people at the start of the year say, you know what? Let's ration health care. But deliberate in the sense that everyone knows it is under-funded. If it is under-funded, then we have a population in this Country that are recipients of full-scale health care rationing. I find this abominable, especially inasmuch as the entire government has made a written promise.

So we are just trying very hard to address this.

Mr. Peercy?

Mr. PEERCY. Yes, sir. I think so. I think with funding and with additional funding and being able to deal with the private sector on a closer basis, more collaboration, knowing that we are always going to have rationed care. I don't see the day ever there that we are going to pay for heart and lung transplants. You know, but I don't know how many private sector insurance things pay for that, either.

But there ought to be a way that we can get through priorities one and two.

The CHAIRMAN. Yes.

Mr. PEERCY. You know, we don't want to do orthodontics. You know, we are not talking orthodontics. We are talking that basic priorities one and two, and not the cosmetics, not the orthodontics, but what we consider the——

Ms. WHIDDEN. The very basic health care of Indian people.

Mr. PEERCY. The very basic health care. But I do think with a combination of adequate funding and, you know, we are not talking breaking the bank, but I mean better case management of individual Indian patients who come in. Have enough staff to, when a doc in my clinic makes a referral, that person goes right to them, and some of what Dr. Roubideaux mentioned, but also make sure you have done everything that you can to make sure that person has looked for those alternate resources and let them know right up front. Don't let them go out to that doc with the assumption that it is going to get paid for when it is not.

The CHAIRMAN. Well, let me thank both of you for traveling to Washington, D.C. and for having the patience to spend most of your afternoon with us. We are going to work on, as you witnessed today, we passed out the Indian Health Care Improvement Act. The next step for us is to work on some reform pieces that follow it.

The Health Care Improvement Act does make some positive, constructive changes, but it is not the major reform. We are now working on reform, and some reforms for the Contract Health Services. Your contributions and your testimony will be very helpful.

So we thank you very much for being here.

Mr. PEERCY. Thank you, sir.

Ms. WHIDDEN. Thank you.

The CHAIRMAN. This hearing is adjourned.

[Whereupon, at 4:48 p.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Chairman Dorgan, Vice-Chair Barrasso, and members of the Committee, thank you for this opportunity to provide our testify for the record and for conducting this very important hearing on "Promises Made, Promises Broken: The Impact of Chronic Underfunding of Contract Health Services."

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 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 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

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[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.

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 alarming about this 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. 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.

III. Portland Area Tribes

The IHS 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 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.

Twenty-nine of the health centers are tribally operated, while ten are federally operated. One of the health stations is federally operated, while the remaining thirteen are tribally operated. There has been a decline in direct care outpatient visits in the Portland Area falling from 954,375 visits reported in FY 2006, down to 736,025 in FY 2007. This decline is attributed to the meager CHS budget increases as many services were likely reduced to absorb costs of inflation and population growth. There are no hospitals in the Portland Area, therefore inpatient and specialty care services that are not available in health facilities must be purchased through the CHS program. This is an important distinction that

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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.

makes IHS Areas like the California, Bemidji, Nashville, and Portland Areas highly reliant on the CHS budget—and are commonly referred to as "***CHS Dependent***" Areas.[5]

IV. The IHS 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 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

[5] ***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.

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.[6]

V. **CHS Funding**

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 inpatient and 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 budget line item for Portland Area Tribes. Our estimates indicate that the CHS program has lost at least $732 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. In FY 2008, 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 CHs services continue to need care. The 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 immediately puts many Portland Area Tribes into a Priority One status at the beginning of each fiscal year. Postponing treatment often results in higher costs once a patient is finally able to receive care. In other instances patients will quit reporting to Tribal health facilities because they know that the health program is in a Priority One status and funding is limited. They know their required health care services may be denied or deferred, so they don't seek health care. Because of this, the data used to estimate denied/deferred services is often incomplete and can never accurately estimate the complete level of unfunded CHS need.

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[6] CHS Prioritized Levels of Care available at: www.ihs.gov/NonMedicalPrograms/chs/index.cfm

[7] "The FY 2010 IHS Budget: Analysis and Recommendations," p. 25, June 10, 2009, 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.

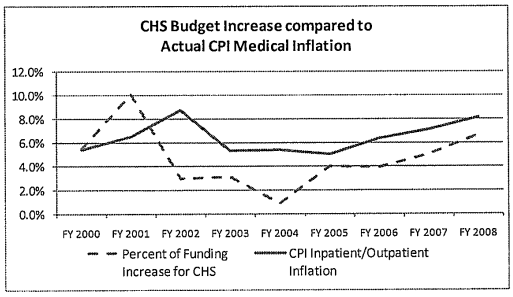
Table 12: Contract Health Services (CHS) Lost Purchasing Power 1993 - 2009 (Dollars in Thousands)					
Year	Approved Budget	Required CHS Budget with Medical Inflaton	Un-funded Medical Inflation	Un-funded Population Growth	Total Unfunded
FY 1992	$ 308,589	(Base Year)			
FY 1993	$ 328,394	$ 331,425	$ 3,031	$ 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	$ 634,477	$ 636,688	$ 2,211	$ 12,166	$ 14,377
		Eighteen Year Total	$ 579,608	$ 152,520	$ 732,128

There are at least two ways to calculate the amount of additional funding needed in the CHS program. The first is to 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 2008. Adding this amount to the approved FY 2010 CHS budget indicates that minimally, the CHS program needs at least $1.1 billion. Another 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 ($579.6 million) and population growth ($152.5 million) and that the CHS budget should be at least $1.5 billion in FY 2010.[9]

The reason the CHS budget has eroded so badly is due to the fact that the Administration—or IHS—has not requested adequate increases; or that the Congress have failed to provide adequate increasese to cover inflation and population growth. 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

[9] The FY 2010 CHS budget is $779.3 million + our estimates for unfunded inflation $579.6 million + unfunded population growth $152.5 million equals a CHS budget of at least $1.5 million in FY 2010.

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 grew 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 12 percent in FY 2010. 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 budget increase annually.



Almost all Tribes in the Northwest contribute Tribal resources to complement 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.

VI. 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 includes 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. Thus, 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*	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	1,538	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***

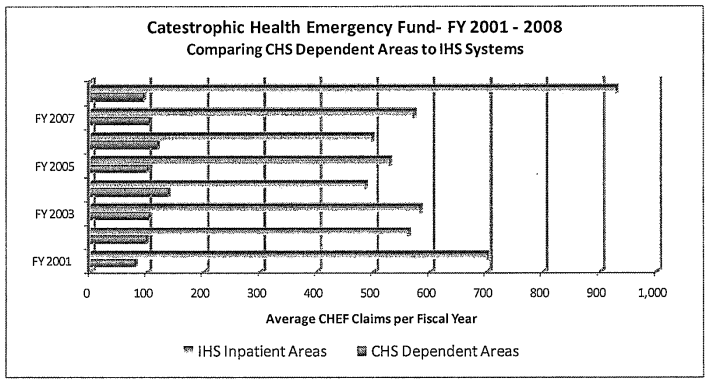
The denied/deferred service issue is a special concern for CHS dependent Areas. When a patient is not authorized to receive care; or does not report to a health clinic because they will be denied care, their visit will not be counted in IHS user population or workload reports. This is important, because user population and workload data drive many funding formulas to allocate IHS resources, including CHS funding. Those Areas with inpatient hospitals can generate more workload and users and 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 care as those Areas that have inpatient care.

VII. 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. In FY 2008, the CHEF program provided funds

for 1,084 high cost cases totaling $26.7 million. For FY 2010 the CHEF fund has been increased to $48 million and should cover a higher level of catastrophic CHS claims.

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 below 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.

CHS Funding Distribution Methodology

The most important issue for CHS dependent Areas is the distribution methodology used to allocate CHS resources. In 2001, a CHS Workgroup proposed a new distribution methodology that arguably has never been officially adopted by previous IHS Directors. 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 slightly more funding for CHS dependent Areas to deal with the unique circumstances of not having access to inpatient or specialty care. The previous formula's CHS dependency component was not adopted by the CHS Workgroup because it was felt that it did not adequately relate to the population being served, nor did it recognize that all Areas have some degree of CHS dependence, and was reportedly distorted when applied to operating unit level data. This position was not unanimous within the CHS Workgroup that developed the formula, with the previous formula components supported by those CHS Dependent Areas. Because the workgroup did not use a consensus process, the new changes were accepted based on a of majority support. Since there are only four CHS dependent Areas, defending the former CHS methodology was a losing proposition. The effect of the revised formula is that it will result in significantly less funding for CHS dependent Areas.

In 2001, understanding the contention of the newly proposed CHS funding methodology, the IHS Director decided to distribute the $34.9 million CHS funding increase on a non-recurring basis using a blended formula. One half of the funding was distributed using the existing formula at the time, and the other half was distributed using the Workgroup's *proposed* formula.[10] The following fiscal year (2002), the IHS Director again allocated on a non-recurring basis the FY 2001 increase ($34.9 million) and the FY 2002 increase ($15 million) "using the FY 2001 blended formula", which was *based on a blend of the*

[10] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated June 7. 2001.

former formula and the formula recommended by the 2001 CHS Workgroup.[11] Finally, in FY 2003, Dr. Charles Grim, IHS Director, made final the $49 million distribution by allocating the funds on a recurring basis using the "FY 2002 formula".[12] The slight increase of $10 million that was provided by Congress in FY 2003 was not adequate to fully fund medical inflation; therefore the new formulary portion was not applied. While the IHS Director indicates his "plan was to distribute increases in the future" using the proposed formula, it leaves in question whether the CHS Workgroup proposed formula has ever been officially adopted by the IHS. Certainly, the previous IHS Directors never officially adopted it in light of their use of a blended formula when allocating funding increases in FY 2001, FY 2002, and FY 2003.

It is the position of Portland Area Tribes that new CHS formula has never been officially adopted through the use of "Dear Tribal Leader" letter that that is the common practice of the IHS when making substantive policy changes. In fact the IHS Director's decision letters in FY 2001 and FY 2002 state the following:

> "I support the Workgroup's strong recommendation to convene a follow-up Workgroup to address these issues," and; "..the decision regarding recurring allocation can be deliberated more comprehensively with contemporary and agreed upon data. By using this approach, it is my hope that we will continue our dialogue on the outstanding issues related to the disparity between need and the resources available for CHS."

The statements above indicate that then IHS Director, Dr. Michael Trujillo, intended to continue to work to refine the CHS formula. There has not been a CHS funding increase sufficient until FY 2009 for the IHS to apply the new formulary components, in which the Agency allocated a $20.1 million increase using the proposed 2001 Workgroup formula. Because the formula has never officially been adopted by the IHS, the IHS should have conducted Tribal Consultation to determine if the Tribes would prefer to use the blended formula adopted by previous IHS Directors when there were CHS funding increases in 2001, 2002, and 2003; or use the 2001 Workgroup proposal. It is the position of Portland Tribes that this is not a closed case and the IHS Director should consult with Portland Area Tribes over this matter.

Another concern related to the CHS funding methodology is the use of inflations rates that are not indicative of actual medical inflation. 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.

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[11] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated December 31, 2001.
[12] See "Dear Tribal Leader Letter", by Dr. Charles W. Grim, IHS Director, dated April 10, 2003.

VIII. Recommendations

1. It is the position of Portland Tribes that the proposed formula developed by the 2001 CHS Workgroup has not been officially adopted by the IHS and that the Agency should continue to consult with Tribes over its continued use. The IHS Director should also convene a new CHS Workgroup to revisit the CHS formula to consider the following:
   a. Alternate resources (Medicaid, Medicare, Private Insurance, and changes under health reform) when making CHS distributions.
   b. CHS Dependency
   c. Use of actual medical inflation when allocating CHS funding.

2. The unique circumstances of CHS Dependent Areas must be addressed by the IHS and Congress in national and internal health reform, otherwise these systems will continue to be plagued with chronic underfunding and may not be able to capitalize on health care coverage expansions that will come with health reform.

3. To address the lack of access to the CHEF, it is recommended that Congress consider establishing an intermediate risk pool for CHS dependent Areas.

Prepared Statement of Dr. Joe Shirley, Jr., President, Navajo Nation

Navajo has an estimated total population of 320,000 tribal members. Approximately 205,000 Navajos reside within the boundaries of the Navajo Nation and over 100,000 Navajos reside outside of Navajo land and in surrounding "border towns" or metropolitan areas. As the largest tribal government, the Navajo Nation has geographical barriers and real infrastructural needs that limit access to quality health care for hundreds of thousands of Navajo people. As such, chronic underfunding of Contract Health Services (CHS) is a significant concern for our people. The Navajo Nation appreciates opportunity to comment on the Senate Indian Affairs Committee's December 3, 2009 hearing, "Promises Made, Promises Broken: The Impact of Chronic Underfunding of Contract Health Services."

There are six Indian Health Service (IHS) units and four tribally operated facilities on the Navajo Nation. Specialty services are limited and there is an increasing demand for CHS program funds to access specialty and emergency care. Of the twelve IHS areas, the Navajo Area represents the largest direct care program provided by IHS. In 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. In 2006, a total of 177,480 claims for CHS program were denied. Of which, nearly 23,000 claims were specific to the Navajo Area IHS.

The Navajo Nation supports full funding of CHS, as advocated for in Dr. Yvette Roubideaux's written statement to the Committee. In addition, we wish to call your attention to the proposals we most strongly support, along with areas in which the proposals do not adequately address our needs. Additionally, the Navajo Nation has provided comments to the Committee on April 30, 2008 regarding the IHS CHS program. A copy of these comments is attached since many of the same issues remain relevant and reflect our position.

The Navajo Nation strongly supports:

- Full funding of the current CHS system. Elements of the CHS can be improved, but overall revamping of existing CHS formulas should be carefully considered.
- This increased funding should include an express expansion of funded medical priority cases.
- Full funding of the Catastrophic Health Emergency Fund (CHEF).

The Navajo Nation has the following concerns:

- Any reformulation of CHS delivery should go out to tribes for full tribal consultation. The effects of chronic underfunding of CHS are significant. More often, tribes are left to compete with each other for limited resources. Again, efforts should primarily focus on fully funding CHS, rather than changing the formula and altering tribes' expectations. Legislative efforts should also incorporate hold harmless language for future CHS reform efforts.
- Under the current strict eligibility requirements for the CHS program, Navajos residing outside the Nation's boundaries for more than 180 days who require the type of health care that is unavailable at a nearby direct care facility are not eligible for CHS program funds. The Navajo Nation proposes to solve this problem by funding the entire state of Arizona as a Contract Health Service Delivery Area, (CHSDA) and has supported Chairman Dorgan's legislation in S.1790 that would authorize this designation.
- S.1790 also included language for a Navajo Medicaid feasibility study. As legislative efforts for this study move forward as part of the process for designating Navajo as a separate entity for Medicaid reimbursement, the Nation recommends that in addition to Arizona, New Mexico and Utah also be considered for CHSDA designation.

The Navajo Nation respectfully submit these comments on this issue that is so important to American Indians and Alaska Natives impacted by the chronic underfunding of the Indian Health Care system. We thank you for your service and work you do on behalf of the Navajo people. If you have additional questions about the Nation's position on this issue, please contact Novaline Wilson at the Navajo Nation Washington Office at 202-271-4976 or nwilson@nnwo.org.

cc: NNWO file

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.

[1] 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.

PREPARED STATEMENT OF HON. CHERYLE KENNEDY, CHAIRWOMAN, CONFEDERATED TRIBES OF THE GRAND RONDE COMMUNITY OF OREGON

Chairman Dorgan, Vice Chairman Barrasso, Members of the Senate Indian Affairs Committee, my name is Cheryle Kennedy and I am the Chairwoman of the Confederated Tribes of the Grand Ronde Community of Oregon.

I appreciate the Chairman holding this hearing to focus attention on such a significant issue to Indian Country. Contract Health Services (CHS), a critical line item in the Indian Health Service budget that pays for hospital and specialty care, is severely under-funded. Under-funding CHS not only impacts the more than 5,000 Grand Ronde tribal members, but Indian Country as a whole.

First, I want to thank you Chairman Dorgan for your leadership in addressing the many issues facing Indian Country. Your commitment to increasing funding for health care, economic and infrastructure development, crime and gang prevention and other Native priorities is very much welcomed and appreciated.

Notwithstanding the significant increase in funding provided to CHS in FY 2010, there is still much to be done. I come from a restored tribe. I was a young girl when Congress passed the Western Oregon Indian Termination Act ending the federal recognition of all western Oregon tribes, including Grand Ronde. For most Grand Ronde people, termination meant a loss of home, identity, and services from the Federal Government. After 30 years of hard work and perseverance by tribal members, the Grand Ronde people convinced Congress in 1983 to reverse its ill-fated termination decision and restore Grand Ronde's federal recognition.

My testimony today is shaped in part by a 30-year career as a health administrator working to improve the access and quality of health care to native people and,

more importantly, as someone who personally experienced the immediate injustices of termination and has lived long enough to witness and chronicle its long-term consequences.

I will focus my testimony today on a topic of great importance to me and my tribe, the severe under-funding of CHS and the significant impacts of this under-funding on terminated tribes.

As you would expect, termination forced the vast majority of Grand Ronde tribal members to leave the reservation in search of work and sustenance. While today many tribal members are returning to the reservation, Grand Ronde has tribal members living across the United States and around the world.

Health care to eligible beneficiaries who reside in our six-county service area is provided out of the Grand Ronde Health and Wellness Center, a health care facility built, financed, and owned by the tribe on the Grand Ronde Reservation. The tribe first contracted with the Indian Health Service (IHS) in 1986 and began running a CHS program. In 1995, the tribe and IHS entered into a self-governance agreement under Title V of the Indian Self-Determination and Education Assistance Act. Like many other tribes, we have struggled to achieve and maintain a high level of health care service, despite chronic under-funding, especially of CHS funds.

The CHS budget is the most important budget item for the Grand Ronde Health and Wellness Center as there are no hospitals in the Portland Area, unlike most other IHS areas. 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. Due to the lack of facilities to deliver health services, Grand Ronde has no choice but to purchase specialty care from the private sector. 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. 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.

When tribes run out of CHS funds during the fiscal year, many tribal members put off important medical care and procedures until funding is again available. Sadly, this creates undue illness and members are sometimes lost due to untimely diagnoses, due solely on the lack of funding. This process also creates a huge burden at the beginning of the fiscal year on the CHS budget and in many cases cost more money as the delay in care magnifies the problems associated with most diseases. The good news is that the solution is simple: fund the IHS at a needs-based level.

When Grand Ronde 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 in one location as possible so that the care provided by physicians who are providers that could be integrated and coordinated. The challenge Grand Ronde has faced in providing health services to its members is an illustration of the impact that CHS under-funding and IHS under-funding in general has on tribal health programs and tribal sovereignty.

Since restoration, the tribe has worked diligently to develop the foundation necessary to sustain a viable community. We have invested in excess of one hundred million dollars to date toward this effort. However, to accomplish our ultimate objective requires an additional investment of hundreds of millions of dollars in areas such as: health care, land acquisition, physical infrastructure, support services for children and families, and other resources which promote a sustainable community and provide a reasonable opportunity for our people to realize social and economic stability and progress.

Through treaties, the tribes of this nation pre-paid for health care with their land and resources. I request the members of this Committee and all of Congress to fulfill the treaty obligations of this nation by establishing the funding levels of the Indian Health Service based on the true health care needs of Indian people.

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