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Testimony of
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Senate Committee on Indian Affairs
regarding the
IHS Contract Health Services Program

June 26, 2008

Mr. Chairman and Members of the Committee:

My name is Brenda E. Shore. I am an enrolled member of the Seminole Tribe of Florida and am also one-half Cheyenne River Sioux. My career as an advocate for the rights, health and welfare of Indian people has spanned 13 years, the last eleven in my current position as the Director of Tribal Health Program Support for the United South and Eastern Tribes -- USET. USET is a coalition of 25 Federally-recognized tribes served by the Nashville Area Office of the Indian Health Service.[1] The USET tribes have reservations in 12 eastern and southern states extending from Maine to Florida and west to Louisiana and eastern Texas.[2]

I commend the Chairman and the Committee for embarking on an in-depth scrutiny of the Contract Health Services Program. This demonstrates that you recognize how vital the CHS program is to the goal we all share of raising the health status of Indian people to the "highest possible level" -- the aspiration recited 32 years ago in the Indian Health Care Improvement Act.

We have a long, long way to go to meet that goal. You know that and I know that. I will not here recite the extensive – and depressing – list of health measures that demonstrate that the health status of Indian people falls shockingly below that of every other racial, ethnic and social group in our nation. You know these statistics as well as I do.

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[1] The USET member tribes are: Eastern Band of Cherokee; Mississippi Band of Choctaw; Miccosukee Tribe of Indians of FL; Seminole Tribe of FL; Chitimacha Tribe of LA; Seneca Nation of Indians; Coushatta Tribe of LA; St. Regis Mohawk Tribe; Penobscot Indian Nation; Passamaquoddy Tribe Pleasant Point; Passamaquoddy Tribe Indian Township; Houlton Band of Maliseet Indians; Tunica-Biloxi Indians of LA; Poarch Band of Creek Indians; Narragansett Indian Tribe; Mashantucket Pequot Tribe; Wampanoag Tribe of Gay Head; Alabama-Coushatta Tribe of TX; Oneida Indian Nation; Aroostook Band of Micmac Indians; Catawba Indian Nation; Jena Band of Choctaw Indians; Mohegan Tribe of CT; Cayuga Nation; Mashpee Wampanoag Tribe.

[2] USET tribes are located in the states of Maine, Massachusetts, Rhode Island, Connecticut, New York, North Carolina, South Carolina, Mississippi, Alabama, Florida, Louisiana and Texas.

The fundamental question for all of us is: What can we do to improve the health status of Indian people and finally achieve the goal articulated in the IHCIA?

There is no single, easy answer. But focusing a long-overdue spotlight on the deficiencies of the Contract Health Services program and fashioning ways to cure those deficiencies are laudable steps toward achieving that goal.

Contract Health Services Program is Underfunded

In my view, the overwhelming deficiency of the CHS program is that it is woefully underfunded. By many accounts, it is funded at less than 50% of the level of need. Even that conclusion may be overly optimistic for several reasons: Measuring the extent of need necessarily requires *estimating* the cost of services which have **not** been provided – those which have to be deferred due to insufficient funds or denied because they do not meet stringent IHS medical priorities. I know that not all USET tribes track and report services that had to be deferred or denied, and suspect this is true of other tribes as well. Some tribes do not track these statistics as doing so requires expenditure of scarce administrative resources for accumulation of case information that has little likelihood of being funded. So, the extent of all tribes' CHS needs is not fully known.

Plus, to produce an up-to-date valuation of deferred or denied services, one must factor-in the appropriate increase in the Medical Consumer Price Index (CPI). A service needed in 2006 but which had to be deferred to a subsequent year will very likely cost more when it is finally delivered. And to the extent the condition of the patient has worsened over the period of deferral, he/she will need more extensive care at a greater cost.

The extent to which the Medical CPI is outpacing available resources cannot be understated. The FY09 IHS budget request for CHS starkly demonstrates this. Although IHS seeks an $8.8 million increase for CHS, the resulting budget would actually enable us to purchase less care in every category – average daily patient load for general medical and surgery hospitalization; outpatient visits; patient and escort travel; and dental services.[3] While we are grateful that an increase is recommended, this one is so insufficient that it will not even maintain the status quo. Please consider requiring IHS to report annually on the Medical CPI and to demonstrate that the full value is factored into the CHS budget request. Of course, the resulting figure should be a **floor**, not a ceiling, on CHS funding.

Estimates of need may not reflect all care that is actually needed. For example, it would not surprise me if an Indian beneficiary does not bother to seek care from his/her IHS or tribal facility because the patient believes there is little chance it will be funded.

Finally, any true estimate of need must necessarily reflect expected increases in the Indian health service population. This includes projecting new births among Indian people (who have traditionally had one of the highest birth rates in the nation), as well as the health program needs for newly-recognized tribes. The members of the Mashpee Wampanoag Tribe, the newest

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[3] IHS Budget Justification, Fiscal Year 2009, at p. CJ-97.

USET member tribe which achieved Federal recognition in 2007, are not yet represented in the IHS service population calculations and the Tribe is still awaiting initial IHS funding to establish a health program on its reservation. IHS does not expect to supply funding until 2010.

USET Tribes' CHS Programs

In preparing for this testimony, I consulted with my own panel of experts – the health directors who operate the reservation-based programs of the USET member tribes – to learn more about their CHS program details and issues. Thirteen tribes responded to our survey. I want to share with you some of what I learned.

- Inadequacies in CHS funding create hardships for all tribes' programs, especially those which provide a limited array of services in their direct care facilities. For example, in the Nashville Area, there are only two facilities equipped to provide in-patient care, and even there in-patient services are extremely limited: The Mississippi Choctaw, with a service population of nearly 9,800 beneficiaries, has only 18 in-patient beds in its Health Center. The Eastern Band of Cherokee hospital in North Carolina has a mere 12 in-patient beds for its service population of more than 15,000 beneficiaries. Thus, **all** USET tribes are heavily dependent on CHS to purchase in-patient hospital care. In fact Choctaw reports that 25% of its CHS allotment is spent on hospital care. At Cherokee that figure is 34%.

- By far, the highest portion of any USET tribe's CHS funding is used to purchase outpatient care, including specialty care that cannot be provided by the limited medical staff available at a direct care facility.

- Most tribes responding to our survey confirmed the widely-known fact that CHS funds run out before the end of the 12-month period they are supposed to cover. Nine tribes said their funds are exhausted in nine months or less, including three who reported theirs last for fewer than seven months.

- There are dramatic differences in the per-capita amount of CHS funding. Doubtless there are some rational reasons for these differences, such as a tribe which has no health care facility must supply all/most of the care for its members through CHS. In other cases, a tribe may have elected to direct more IHS dollars to direct care, thus reducing the per-capita amount for CHS. But even if these reasons are taken into account, it still does not fully explain the wide differences in the per-capita amounts received by the tribes. Most likely, these wide differences are historical in nature and have been carried forward each year. The IHS formula for the apportionment of CHS funds should be re-examined.

- I know that some tribal programs are so desperate for CHS funding that they have to "cannibalize" their direct care programs in order to purchase the outside care their members need.

- It was disappointing to learn that only a small percentage of most tribes' CHS funds can be devoted to rehabilitation services such as physical and occupational therapy. Patients

recovering from surgery or injury need such services to make their recuperation complete.

- Tribal leaders are keenly aware of the hardship and suffering caused when health care funding is insufficient. Where tribes have the resources to do so, they subsidize their health care programs, especially CHS, with tribal resources. But only a few tribes are able to help in this way.

Reason why CHS Funding should be Enhanced

I urge this Committee to be a strong -- and persistent -- advocate for substantial increases in CHS funding. I want to describe three reasons why you should do so:

First, fully funding this segment of the Indian health budget is fundamental to fulfilling the United States' **trust responsibility** to "to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level", as articulated in the Indian Health Care Improvement Act.

Second, this is the **humane** thing to do. Every American deserves access to decent and comprehensive health care. As an Indian woman and an American, it is very painful for me to see the many thousands of Indian people who are forced to live with untreated ailments, a reduced quality of life and the prospect of a shorter life span because IHS health care is severely rationed and they came out on the short end of that rationing.

Think also of the CHS review committees which every day are faced with making heart-wrenching decisions about which tribal members will receive treatment and which ones will not; who will be forced to live with pain and who will get relief; whose condition will be allowed to worsen until his/her life or life function is endangered. I doubt that any of you would want to have to make these choices, especially when they affect your family, friends and community members. But you have the power to eliminate the need for these hard choices to be made at all. You can see to it that Congress properly funds CHS. We intend to share this testimony with the 24 Senators who represent USET states – nearly ¼ of the entire Senate membership – to ask them to support this effort.

Third, supplying funds for CHS is a **good investment** that benefits local economies.[4] Remember that CHS dollars purchase medical services from non-Indian providers such as hospitals, physicians, pharmacies, rehabilitation centers and dialysis facilities in near-reservation communities. This spending makes valuable contributions to the economic health of these communities. In its April, 2008 *TrendWatch* report, the American Hospital Association pointed out that, based on 2006 survey data, "[n]ationally, each hospital job supports almost two additional jobs and every dollar spent by a hospital supports more than $2 of additional business activity." The AHA describes this additional activity as the "ripple effect" that flows from local health care spending.

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[4] I want to acknowledge the valuable contribution Mr. Casey Cooper, CEO of the Cherokee Indian Hospital, made to this portion of my testimony.

Thus, each additional dollar appropriated for CHS produces benefits at several levels: It improves the physical and mental health of the Indian beneficiaries whose care it purchases; it creates local health care provider jobs; and through the ripple effect, it contributes to enhanced business activity in the community and, of course, to its tax base.

By the same token, the local community is vulnerable to adverse consequences when an Indian health program is unable to provide the care needed by its service population. An Indian beneficiary who cannot get CHS-funded care and who has no alternative resource such as Medicare, Medicaid or private insurance is likely to present at the local hospital seeking treatment as an indigent patient. This presents a dilemma to the hospital: It presumably wants to fulfill its moral (and often legal) responsibility to provide aid to a person with a pressing health care need, but no hospital, especially a small community hospital, can absorb an unlimited number of uncompensated cases without jeopardizing its economic viability. Should a hospital fail for economic reasons, the entire community – both Indian and non-Indian – suffers.

Tribal Pro-Active Efforts

Tribes are always vigilant for ways to reduce pressure on their CHS budgets. We reach out to Indian beneficiaries who are eligible for Medicare, Medicaid and SCHIP, encourage them to enroll in those programs and actively assist with the enrollment process. Indeed, in order to qualify for CHS care, an Indian beneficiary eligible for an alternate resource must apply for that resource. We are also conscientious about billing a beneficiary's private insurance carrier where such coverage exists. When the new Medicare Part D Prescription Drug Benefit was enacted, tribes which operate pharmacies worked hard to enroll their Medicare patients in Part D plans and to achieve network status for those pharmacies in order to bill the plans for the drugs dispensed.

Indian tribes were the most vigorous advocates for enactment of "Medicare-like rates" legislation. Under the sponsorship of Senator Bingaman, this goal was finally achieved with passage of the Medicare Modernization Act in 2003. This law requires all Medicare hospital providers to accept no more than the Medicare rates for services provided to Indian beneficiaries through CHS referrals and thereby enable CHS programs to purchase more care with the scarce funds appropriated. To our dismay, our savings opportunities were delayed, as it took HHS more than three years to promulgate regulations to implement the law. These regulations did not become effective until July, 2007. As we approach the first anniversary of their implementation, we will be in a position to evaluate the extent of additional CHS buying power they permit.

Continued vigilance regarding Medicare-like rates is required in two ways: We must assure that CHS hospital providers fully comply with the these rate caps as the law directs, and we must assure that IHS budget requests for CHS do not attempt to offset the savings achieved by a reduction in or smaller-than-needed increases for the CHS appropriation. We hope this Committee will share this oversight responsibility with us.

I am very grateful to have had the honor to address this Committee and to assist in its efforts to make the vital CHS program fulfill its proper role of providing needed health care to Indian people. I am happy to answer your questions.