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Senate Committee on Indian Affairs

Oversight Hearing on Access to
Contract Health Services in Indian Country

June 26, 2008

Chairman Dorgan, Vice-Chair Murkowski, and members of the Committee, I thank you for this opportunity to testify today on, "Access to Contract Health Services in Indian Country."

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 a number of 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

[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.

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 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 more alarming than these 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. A caution in using AI/AN data is that, due to small numbers, death rates are more likely to vary from year to year compared to rates for the general population. 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.

Despite widely documented health disparities, the federal government spends less per capita on AI/AN health care than on any other group for which it has this responsibility. This includes Medicaid recipients, prisoners, veterans, and military personnel. Each year, IHS spends 60 percent less on its beneficiaries than is spent on the average American for health care. What frustrates Tribal leaders is that each year, public health programs such as Medicare and Medicaid accrue annual interest to keep pace with inflation, while IHS programs do not. The disparity in funding is amplified by the poorer health conditions of AI/AN people. The Indian health system has done remarkably well with limited resources in carrying out health programs however, if funded sufficiently it could do more to stem the health crisis in Indian Country.

III. The Indian Health Service

[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.

The Indian health system is comprised of a network of programs operated directly by the Indian Health Service (IHS) or by Tribal health programs and urban clinics. The IHS, directly and through Tribal governments, carry out programs under the Indian Self-Determination and Education Assistance Act (P. L. 93-638). These programs provide health services to more than 2.3 million AI/AN people in the United States.[5] These services are provided to members of 567 federally-recognized tribes located in 35 different states.

Currently, IHS provides access to healthcare services for AI/ANs through 31 Hospitals, 50 health centers, 31 health stations and 2 school health centers. Tribes also provide healthcare access through an additional 15 hospitals, 254 health centers, 166 Alaska Village Clinics, 112 health stations, 18 school health centers, and 34 urban Indian health clinics that provide outreach and referral services in addition to direct medical care. Nineteen of the hospitals have operating rooms while health centers and health stations vary in their scope of services and in hours of operation.

Health services not available through direct care must be purchased through the Contract Health Service (CHS) program. In most cases, the facility that provides a patient's direct care services also authorizes payment under the CHS program. The use of contract care services varies considerably. For example, in two areas (California and Portland) all hospital-based services are purchased through contract care. In the other ten Areas, some hospital-based services are provided at IHS-funded facilities, while others are purchased through contract care. Tribes have the option of operating their own direct care facilities and contract care programs. Tribes operate 27 percent of the 49 hospitals and 70 percent of the 364 health centers and health stations. The remaining facilities were federally operated. For fiscal year 2005, approximately 50 percent of the IHS budget was allocated to Tribes to deliver services.

IV. Portland Area Tribes

The 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

[5] Indian Registrants, Active Indian Registrants, and User Population data are all referenced in this testimony are from the "IHS Final User Population Estimates – FY 2007," accessed December 27, 2007, available at www.ihs.gov.

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.

Of the health centers, twenty-nine are tribally operated and ten are federally operated. One of the health stations is federally operated, while the remaining thirteen are tribally operated. There were 954,375 direct care outpatient visits provided in the Portland Area in FY 2006. There are no hospitals in the Portland Area, therefore inpatient care and specialty care services that are not available in health facilities must be purchased through the CHS program. This important distinction makes Portland Area Tribes dependent on CHS funding for all specialty care services. Those Areas that do not have inpatient hospitals and must purchase all specialty care services under the CHS program are often referred to as "***CHS Dependent***" Areas.[6]

V. 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

[6] ***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.

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 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. If they do not begin the year at Priority One, they will move to this status by the second or third quarter of the fiscal year. These priorities are categorized into four Priority Levels described as follows:

Priority One - Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. Priority One represents those diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

Priority Two - Preventive Care Service: Primary health care that is aimed at the prevention of disease or disability. This includes services proven effective in

avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention).

Priority Three - Chronic Primary and Secondary Care Services: Inpatient and outpatient care services that involve the treatment of prevalent illnesses or conditions that have a significant impact on morbidity and mortality. This involves treatment for conditions that may be delayed without progressive loss of function or risk of life, limb, or senses. It includes services that may not be available at many IHS facilities and/or may require specialty consultation.

Priority Four - Chronic Tertiary Care Services: Inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis or therapy, (2) have less impact on mortality than morbidity, or (3) are high cost, elective, and often require tertiary care facilities.

VI. CHS Budget Concerns

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 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 line item for Portland Area Tribes.

Our estimates indicate that the CHS program has lost at least $778 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 (see Priority levels discussed above). In FY 2007, 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 these services do not go away. The

[7] "The FY 2009 IHS Budget: Analysis and Recommendations," p. 22, March 17, 2008, 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.

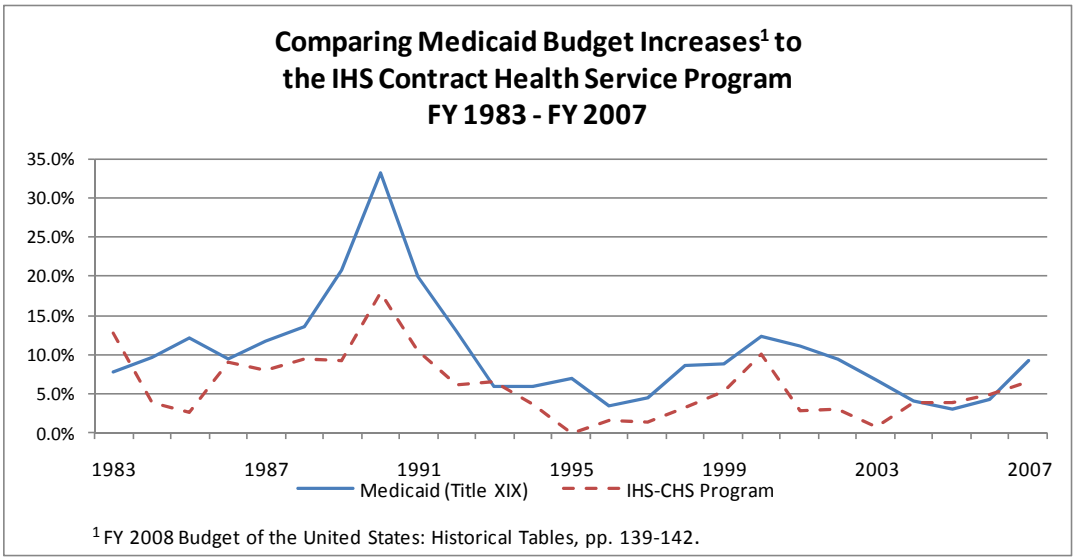
patients are put onto a "denied/deferred" services status and when health programs receive funding for the new fiscal year, most health programs begin clearing this backlog of service. This process puts almost all Portland Area Tribes into a Priority One status at the beginning of each fiscal year. Furthermore, postponing treatment of these services results in higher costs once a patient is finally able to receive care.

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	$ 588,161	$ 636,688	$ 48,527	$ 12,166	$ 60,693
		Seventeen Year Total:	**$ 625,924**	**$ 152,520**	**$ 778,444**

There are at least two ways to calculate the amount of additional funding needed in the CHS program. The first would be 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 2007. Adding this amount to the FY 2008 CHS budget indicates that minimally, the CHS program needs at least $912 million per year. The second 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 ($625.9 million) and population growth ($152.5) and that the CHS budget should be at least $1.3 billion.[9]



The reason the CHS budget has eroded so badly is due to the fact that the Administration and Congress—or the IHS—have not adequately provided inflation increases. 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 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 is expected to grow 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 10 percent in FY 2009. 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 increase annually.

[9] The FY 2008 CHS budget is $579.3 million, our estimates for unfunded inflation $625.9 million, and population growth $152.5 million equate to a CHS budget of $1.3 million in FY 2009.

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

VII. 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 may include 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. The result of this is that 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

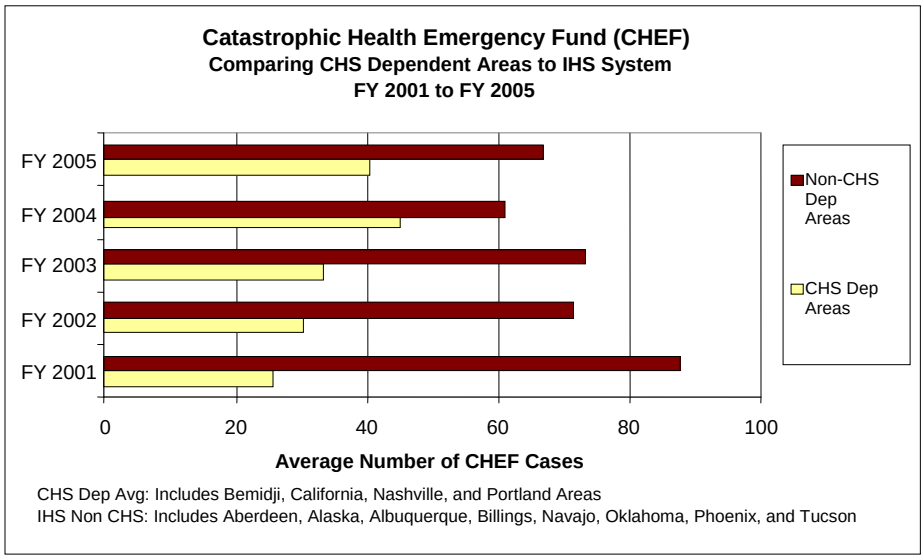
IHS AREA	A Deferred Services Within Med Priorities	Denied Service Categories: B Eligible But Care Not Within Med. Priority	C Eligible But Alternate Resource Available	D Patient Ineligible for CHS	E Emergency-Notification Not Within 72 Hours	F Non-Emergency No Prior Approval	G Patient Resides Outside 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 may not be counted in IHS User Population or workload reports. This is an important issue, because User Population and workload data are used in many formulas to allocate IHS funds, including the CHS program. Those Areas with inpatient hospitals can 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 services as those Areas that have inpatient care. This special concern should require an updated formula to allocate CHS funding.

VIII. 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. The CHEF is available until it has been depleted, generally between March and June of each fiscal year. In FY 2007, the CHEF program provided funds for 738 high cost cases totaling $18 million. For FY 2008, the CHEF fund has been increased to $27 million.

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 above 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.

To address this issue, it is recommended that Congress consider establishing an intermediate risk pool for CHS dependent Areas of Bemidji, California, Nashville, and Portland using a portion of the CHS or existing CHEF budgets.

IX. CHS Dependency Concerns

There is a wide range of dependency on the CHS program as part of the overall Indian health system, however, some IHS Areas are more dependent on the CHS program for inpatient, and specialty care services than other Areas. These Areas include the California, Bemidji, Nashville, and Portland Areas. CHS dependent Areas with no access to IHS or Tribal hospitals for inpatient care justify increased consideration in CHS funding. CHS dependent Areas do not take for granted the fact that severe under-funding of the Hospital & Clinic budgets over previous years have undermined the ability to provide adequate health care services and that CHS funds are very important even in Areas with inpatient facilities. However, CHS funding is less problematic for those Areas that have hospital based systems since recurring staffing packages provide funding for medical staff to provide health care services through existing inpatient facilities. This is not the case for CHS dependent Areas identified above, who must purchase such care under the CHS program.

The quote, “don’t get sick after June,” is often used by some Indian health advocates and is a misnomer for CHS dependent Tribes. The quote speaks to an administrative issue in which the CHS program moves into a Priority One status. This means that unless life or limb tests apply, patients may not receive health care according to CHS regulations. The quote is associated with Areas that have inpatient care and that generally move into Priority One status sometime in June. Having to be placed into Priority One status sometime in June is an option that CHS dependent Areas never have. Most Tribes from CHS dependent Areas begin the year in a Priority One status. CHS dependent Area Tribes begin the new fiscal year by clearing the backlog of denied and deferred services from the previous fiscal year. This immediately puts them into a CHS funding crisis and they must begin the year in a Priority One status. This process has repeated itself annually for many Tribes from CHS dependent Areas. So for Tribes from CHS dependent Areas, the quote is “don’t get sick at all” as most begin the year in Priority One status.

CHS Distribution Methodology

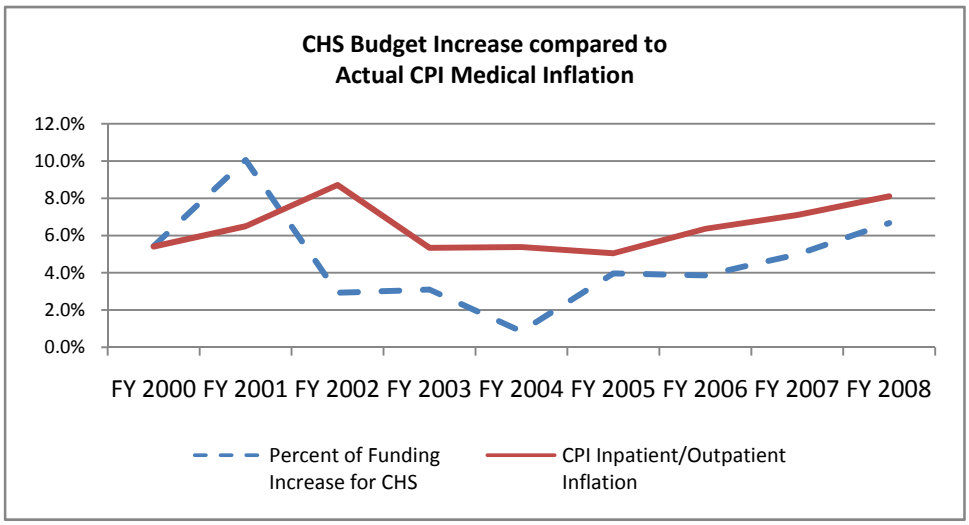
Perhaps the most critical concern for CHS dependent Areas is the distribution methodology used to allocate CHS resources. The basic framework of the CHS distribution methodology is that: (1) Congressional earmarks, new Tribes funding, and CHEF requirements must be met first; (2) any remaining amount is used to fund CHS inflation requirements, and; (3) if there is a balance after funding inflation, it is to be distributed using the new formula recommendations.

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 more funding for CHS dependent Areas. The new CHS dependence component was adopted because it was felt that the former component was not related to the population being served, did not recognize that all Areas have some degree of CHS dependence, did not consistently measure for CHS dependence, and was distorted when applied to the operating unit level data.

The new formula resulted in significantly less funding for CHS dependent Areas due to the fact that there is less weighted value given to the new variable to measure CHS dependence. If this formula continues to be utilized, Portland Area Tribes recommend that this same level of scrutiny be applied to the Hospitals & Clinics budget line items and for the method in which facilities construction funding and staffing packages are allocated.

Another concern with the formula is the manner in which inflation is determined. This component is just as important as CHS dependency. The new formula requires that inflation be funded prior to allocating any remaining funds under the new requirements. If an inadequate inflation factor is used, it can result in a surplus of CHS funds being allocated under the new formula, and is not fair for any Tribe receiving less than had a true inflation factor been used. The new formula uses the OMB medical inflation rate which has averaged around 4 percent over the past ten years. This year, the Consumer Price Index for hospital outpatient care is estimated to be 9.9 percent.[10] This is 5.5 percentage points higher than the average used by OMB! The graph above compares CHS budget increases to inpatient/outpatient inflation for hospital care. The OMB inflation factor is not the amount that is necessary to fund true medical inflation.

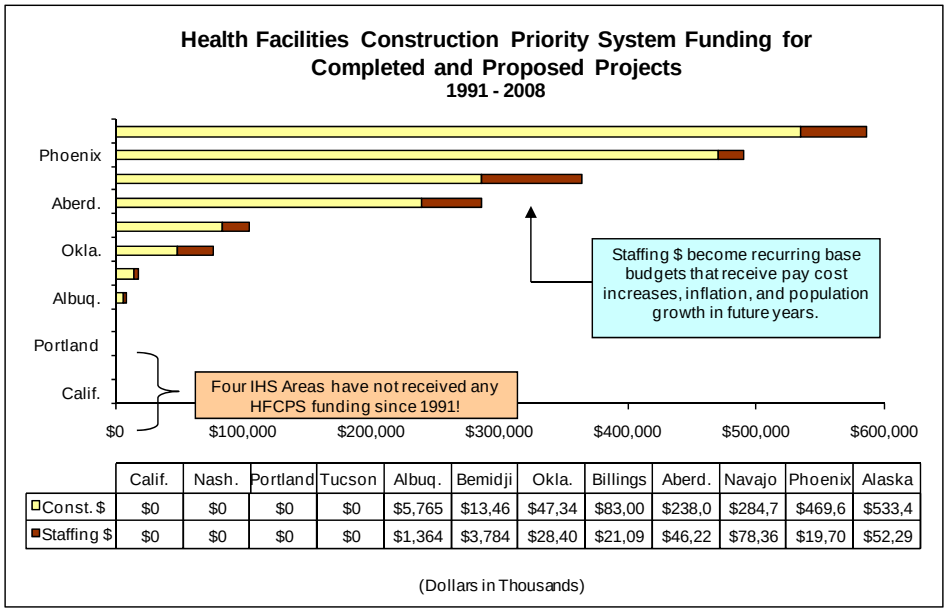
[10] Consumer Price Index Series CUSR00000S5703 available at: www.bls.gov



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. The IHS and Tribal workgroup that developed the new formula also recommended that future refinements for this component in the formula should be considered. The workgroup recommended that additional items related to the formula should continue to be addressed. We urge Congress to direct the IHS to appoint a technical workgroup to develop recommendations to address these on-going concerns.

CHS and Facilities Construction

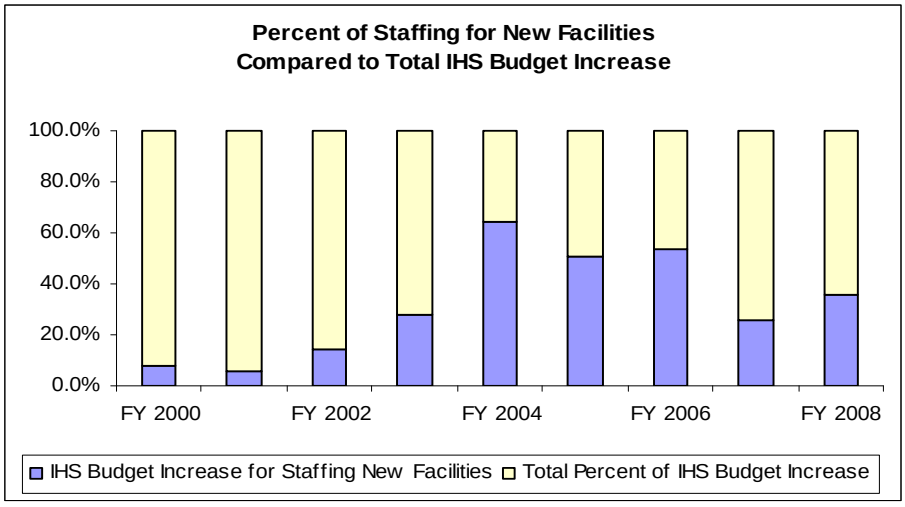
CHS dependent Areas have long been concerned with the methodology to prioritize facilities construction projects. This is very true in the case of constructing hospitals that are provided significant staffing packages to provide health services. A portion of phasing-in staff at new facilities includes additional funding for CHS services. This is inconsistent with the purpose of providing a staffing package. With a new facility and staffing package, the facility should be able to internalize costs associated with providing certain health services. To provide these same services, CHS dependent Areas must use contract care funds, as they do not have the benefit of new facilities and staffing. This is completely unfair to those Tribes from CHS dependent Areas that do not get an opportunity to compete for facilities construction resources on an equal basis as other Areas with inpatient hospitals.



	Calif.	Nash.	Portland	Tucson	Albuq.	Bemidji	Okla.	Billings	Aberd.	Navajo	Phoenix	Alaska
Const. $	$0	$0	$0	$0	$5,765	$13,46	$47,34	$83,00	$238,0	$284,7	$469,6	$533,4
Staffing $	$0	$0	$0	$0	$1,364	$3,784	$28,40	$21,09	$46,22	$78,36	$19,70	$52,29

(Dollars in Thousands)

The graph above and below demonstrates the inequities associated with facilities construction funding for CHS dependent Areas. In addition to the recurring staffing packages that are able to provide health services despite the level of funding for CHS services, the facilities and staff are also able to bill for services provided to patients eligible for Medicare, Medicaid, SCHIP, and private insurance. This in effect provides the facility—that is provided additional funding for staffing over and above CHS funds—to collect additional third party reimbursements that can further be used to provide additional services beyond the initial IHS funding. This dichotomy between CHS dependent Areas and those Areas that receive facilities with staffing funds is that there now begins to emerge a system within the Indian health care program that provides disproportionately more services when compared to CHS dependent Areas. This process is creating a health care system of "haves and have nots."



The graph above illustrates the impact that staffing new facilities has on IHS budget increases. Staffing packages for new facilities are like pay act costs in two respects: (1) They come 'off the top,' (i.e. they are distributed before other increases), and; (2) They are recurring appropriations. CHS dependent Tribes frequently ask, "Why did our health program receive a 1 percent increase in funding this year when Congress provided a 5 percent increase for the IHS budget? The answer is that once funding for phasing-in staff at new facilities is factored, the balance of the increase is distributed among 560 or more Tribes.

X. CHS and the Medicaid Program

The major trend in the financing of Indian health over the past ten years has been the effective stagnation of the IHS budget and a greater reliance on the Medicare, Medicaid, and SCHIP programs. The payor of last resort rule in the CHS program requires patients to exhaust all health care resources available from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. As IHS and Tribes have experienced a growing reliance on Medicaid reimbursement to sustain clinic services, a less obvious benefit has resulted from Medicaid coverage for services the Indian health system cannot provide. The CHS budget has limited capacity to pay for care outside of Indian health facilities. Medicaid coverage is the most important alternate resource to pay for this care. Medicaid helps protect CHS budgets from unpredictable catastrophic medical occurrences, especially for Tribes with small populations and very limited CHS allocations—thereby avoiding rationing of health care.

The IHS Federal Disparity Index (FDI) is often used to cite the level of funding for the Indian health system relative to its total need. The FDI compares actual health care costs for an IHS beneficiary to those costs of a beneficiary served in mainstream America. The FDI uses actuarial methods that control for age, sex, and health status to price health benefits for Indian people using the Federal Employee Health Benefits (FEHB) plan, which is then used to make per capita health expenditure comparisons. It is estimated by the FDI, that the IHS system is funded at less than 60 percent of its total need.[11]

In light of this chronic under-funding, Medicare and Medicaid collections are now a growing and critical component to providing basic health care services for Northwest Tribes and the Indian health system. While Medicare and Medicaid have become critically important to the health of AI/AN people, the expenditures constitute a very small share of overall costs in these programs. For example, it is estimated that Medicaid accounts for

[11] Level of Need Workgroup Report, Indian Health Service, available: www.ihs.gov.

almost 20 percent of the IHS budget but less than 0.5 percent of the overall Medicaid expenditures go to Indian health.

Unfortunately, we are now seeing changes to the Medicaid program, aimed at bringing about cost savings at the federal and state levels. AI/AN exemptions from cost-sharing and estate recovery rules are currently being challenged by the Centers for Medicare & Medicaid Services (CMS). In the Northwest, the effects on the general population of recent cost-cutting measures have been both instructive and alarming. In Oregon, modest cost sharing resulted in effectively cutting 50,000 of the most vulnerable and poorest participants from the state Medicaid rolls. In Washington and Idaho, much-needed services have been cut from the State Medicaid Plans. Nationwide, it appears that Medicaid entered a period of stagnation about four years ago, as state budgets adapted to the effects of the 2001-2003 recession. Looming changes at the federal level can only exacerbate that trend, with potentially disastrous results for the Indian health system.

If AI/ANs are not exempted from cost sharing, if they will fear loss of property due to estate recovery proceedings, and they will not sign up for Medicare and Medicaid services. Those that are currently enrolled will begin to disenroll from the programs in order to avoid administrative remedies associated with estate recovery. These costs will be borne by IHS and Tribal CHS programs. This will have a negative impact on the Indian health system, as it will be forced to cut services and incur increased costs in the CHS program, and result in a predictable decline in health status and increasing disparities.

We strongly urge the Congress to take action to protect AI/AN participation in the Medicare, Medicaid, and SCHIP programs. AI/AN participation programs are vital to maximizing the CHS budgets for IHS and Tribal health programs.

XI. Conclusion

In light of the duty owed to Tribal Governments under the Federal Trust Relationship, the United States and the federal government have an obligation to provide adequate funding to address the health needs of AI/AN people. Despite this duty, the Indian health system has been chronically and persistently under-funded by the United States Congress. This under-funding has resulted in a CHS program that is forced to ration health care that denies even the most basic types of health services that most Americans enjoy. Even the minimal level of funding that the CHS program has received has remained flat or actually lost ground due to unfunded population growth and medical inflation, including mandatory pay cost

increases. This rationing of health care has caused the deaths of many AI/AN people or caused many to live with needless pain.

It is time to stop the practice of delivering health care under a Priority One status and begin to have the United States Congress provide the necessary resources to address the significant health disparities that Indian people face. While the issues associated with the Contract Health Service program are complex, many are manageable with adequate funding.

In closing, I want to thank the Committee again for all the work it has done to hold this very important hearing and to thank you for your continued leadership to address the health care needs of American Indian and Alaska Native people.

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