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TESTIMONY
BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE HEARING ON
ACCESS TO CONTRACT HEALTH SERVICES IN INDIAN COUNTRY

June 26, 2008

Good morning. Thank you for the opportunity to be here today. My name is Stacy Dixon. I am the Chairman Susanville Indian Rancheria, a Federally-recognized Indian tribe whose reservation is located in Susanville, California, a small community located about 85 miles from Reno, Nevada. I am pleased to testify about a topic of great importance to my Tribe: the severe underfunding of Contract Health Services in Indian country.

Let me begin by providing a little background on my Tribe's health care delivery system. Health care to eligible beneficiaries who reside in our geographic area is provided out of the Lassen Indian Health Center (LIHC), a small rural health care facility located on the Susanville Indian Rancheria. The Tribe has been providing health services through the LIHC to tribal members and other eligible beneficiaries under an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement since 1986. In 2007 the Tribe and the Indian Health Service (IHS) entered into a self-governance agreement under Title V of the ISDEAA. Like most other tribes, we have struggled to achieve and maintain a high level of health care services despite chronic underfunding, especially of Contract Health Services (CHS) funds.

As you are aware, CHS funds are used to supplement and complement other health care resources available at IHS or tribally operated direct health care facilities. Under the CHS program, primary and specialty health care services that are not available at IHS or tribal health facilities are purchased from private and public health care providers. For example, CHS funds are used when a service is highly specialized and not provided at the IHS or tribal facility, or cannot otherwise be provided due to staffing or funding issues, such as hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services.

CHS, like the rest of IHS funded programs, is extremely under-funded.[1] Based on FY 2007 data, the Northwest Portland Area Indian Health Board (NPAIHB) conservatively estimates that Congress would need to appropriate an additional $333 million per year to meet unmet CHS needs nationally. When added to the current IHS budget line item ($588,161,000 million is requested for FY09) for CHS, the CHS budget should be no less than $900 million. The CHS program is also greatly affected by

[1] U.S. Comm'n on Civil Rights, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country* at 49 (July 2003) (concluding that "the anorexic budget of the IHS can only lead one to deduce that less value is placed on Indian health than that of other populations").

medical inflation, as the costs are not controlled by the IHS or by tribal health care providers, but are determined by the private sector health care environment.

The lack of adequate CHS funding has led to health care rationing and barriers to access to care because there are simply not enough appropriated funds to meet all needs. In expending limited CHS resources, the IHS and tribal health care providers use a strict medical priority system. Most IHS Areas lack enough CHS funds to even pay for medical priority one – emergent and acutely urgent care services. These services are ones necessary to prevent the immediate death or serious impairment of health – so called "life or limb emergencies." Any medically-necessary health care services that are needed but do not reach that priority status, such as priority two preventive care, priority three chronic primary and secondary care or priority four chronic tertiary care, are put on a deferred list and are not approved for payment unless funding becomes available. If no funding becomes available, payment is denied and the patient's condition goes untreated unless he/she has an alternate resource such as Medicare or Medicaid, or can afford to pay for the care him/herself.

According to the IHS in its FY 2007 CHS Deferred and Denied Services report, IHS programs denied care to 35,155 eligible cases because they were not within medical priority one, representing a 9% increase in denials over the previous year. Many tribally operated health programs no longer track deferred or denied CHS services because of the expense of doing so, meaning that figure is understated, particularly in California where there are no direct care programs operated by IHS, and would be higher if all CHS data from tribal programs were available.

Patients eligible for CHS but who do not get approved for funding are left with an unconscionable choice between having to pay for the service themselves (many cannot afford to even consider that option) or not getting the services they need. In the Susanville Indian Rancheria's experience, many tribal beneficiaries do not even visit health facilities when they expect CHS to be denied, which adversely impacts their overall health status.

The impact of CHS underfunding on access to health care has had a particularly devastating impact in California. To fully grasp the extent of CHS under-funding in our state, it is helpful to first understand the history of health services in California and tribes' efforts to bring about equity in funding. This history is unique within the U.S. Indian Health Service system.

In the 1950's, as part of the termination of tribes' special status across the United States, the Bureau of Indian Affairs (which was responsible for health care until that responsibility was transferred to the U.S. Public Health Service in 1954) withdrew all federal health services from Indians in California. Studies of the health status of California Indians in the late 1960s revealed that their health was the worst of any population group in the State. The routine health services available to Indians through the IHS in other states were not accessible or available to Indians in California. At the urging of the tribes in California through the work of the California Rural Indian Health

Board and the State of California, at the direction of Congress the IHS began to restore federally provided health care services for Indians living in California in 1968 – but through tribally owned and managed health programs rather than direct services from the federal government. Funding was insufficient and the programs grew slowly.

Indians in California were left out of the IHS's growth that occurred between 1955 – when the U.S. Public Health Service began discharging its responsibility for Indian health care – and 1969 – when the IHS again assumed responsibility for Indian health care services in California. To address that shortfall and force the issue of equitable care, Tribes filed a class action against the IHS. In *Rincon Band of Mission Indians v. Harris*,[2] the Ninth Circuit Court of Appeals ordered the IHS to provide California Indians with the same level and scope of services that it provides to Indians elsewhere in the United States. Despite winning this victory, California tribes continued to be short-changed: the IHS distributed only $13.7 million to California tribes out of the $37 million in additional funding Congress originally appropriated to address IHS funding inequities following the *Rincon* decision. The IHS never fundamentally altered its funding allocation method, and California tribal health programs have remained chronically under-funded.

According to the Advisory Council on California Indian Policy (ACCIP), in a report and recommendations made to Congress in September 1997, IHS service population figures for 1990 to 1995 show that California was the fifth largest Area out of the twelve IHS Areas, but ranked third lowest in per capita IHS funding levels.

Today, many tribes in California have taken on the responsibility for developing and operating health care facilities pursuant to the ISDEAA. None of the tribal facilities and programs in California originated as facilities and programs previously operated by the IHS, as is the situation in most of the other IHS Areas. California tribal health programs were never built or staffed under the IHS system, there are no IHS inpatient facilities in California and the IHS provides no direct care services in California. Without having had such infrastructure and services in place, IHS was unable to base the amount of funds for tribally-operated health care in California on the amount IHS itself had spent. This is the funding calculation methodology used in many other Areas and is required by the ISDEAA.

There are no IHS hospitals in California. Thus, tribal providers rely heavily on the CHS program to fund specialty and inpatient care. When CHS resources are exhausted, Indian beneficiaries in California have no recourse. IHS facilities can rely on their specific Area Offices to assist them with a major crisis that requires additional CHS, where in a true emergency the Area Offices can shift funds or ask IHS Headquarters for assistance. The California Area Office, however, does not have reserves or other ability to shift funds between and among already inadequately funded tribal programs.

[2] *Rincon Band of Mission Indians v. Harris*, 613 F.2d 569 (9th Cir. 1980).

In its September 1997 report, ACCIP determined that the California CHS budget as of that time was the lowest in the entire IHS system at $114 per user, compared to $388 per user in the Portland Area, which also lacks IHS hospitals. California received $7,085,200 in CHS funds for FY 1995 compared to $16 million and $28 million provided to the Bemidji Area and the Billings Area, respectively, which have similar user populations to that of California. ACCIP determined that the CHS funding shortfall for California was $8 million in 1997. Now more than ten years later, that figure is no doubt considerably higher. Recently, research done by the California Rural Indian Health Board which matched data for the IHS Active User population in California with data from the California Hospital Discharge Data set identified $19,355,000 in unfunded hospital care for the year 2007. That number does not address other needs such as diagnostic services, specialty care and pharmacy services.

With respect to California beneficiaries, the IHS's FY 2005 CHS Deferred and Denied Services report shows that IHS programs deferred payment for services for 2,611 eligible cases and denied care to 519 eligible cases that were not within the medical priority. The report for 2006 indicates that the number of eligible cases denied care in 2006 in the California Area rose to 841. As mentioned above, these figures understate the problem given that there are no IHS direct care providers in California and tribal programs do not all track this type of data.

In 1995, the Susanville Indian Rancheria undertook a comparison analysis to look at three IHS Indian Health Centers – one each in Arizona, Utah and Oregon – to review similarities and differences between them and the tribally operated LIHC in California, with respect to CHS and other IHS funding. The comparison facilities were all IHS-operated and had similar staffing, workloads and service populations (one facility had a service population slightly lower than the LIHC's). By doing that comparison, we discovered that the IHS health facilities had considerably more resources. For example, the LIHC had a CHS budget in FY 1994 of $93,000, compared to the much higher budgets for the comparison facilities in the same period: $770,125, $629,224 and $1,371,156. Even taking into account differences in the service population, the funding levels should have been somewhat similar for similar workload and number of active users. Our comparison showed what we already knew, which is that the IHS resource allocation methodology has consistently demonstrated a bias toward larger facilities and toward IHS facilities rather than tribally operated facilities.

In 1986, when the Tribe took over the responsibility to deliver health care services, our goal was simple: provide the best possible health care to our people. One important aspect of that goal was to provide a continuum of care, including as many possible health services in one location so that care provided by physicians and other providers could be integrated and coordinated. We firmly believe that the continuum of care approach provides the highest quality health care for the patients served.

Key to our continuum of care approach is the provision of on-site pharmacy services. This allows our patents to obtain direct counseling on the use of prescription drugs being dispensed and to obtain necessary drugs at a low cost as part of an integrated

health program. The challenges that we have faced with our pharmacy program provide a vivid illustration of the impact that CHS under-funding - and the IHS's under-funding in general – on tribal health programs and barriers to access to care problems.

Historically the IHS has never provided the Tribe with any funds specifically to operate its pharmacy program or, for that matter, to purchase pharmacy supplies. In fact, the Tribe receives today only about one-half the funds from the IHS that are needed to carry out the Tribe's health programs. To compensate for this chronic lack of funding the Tribe has made decisions to reallocate available funds, redesign programs, and seek additional resources (thought third party reimbursements, Medicare and Medi-Cal reimbursements, and even through tribal contributions from its own funds) to fund the health care needs of its beneficiary population.

For many years, the Tribe attempted to operate its pharmacy program using a substantial amount of funds diverted from other health purposes at a significant cost to the Tribe. The Tribe had to close the pharmacy between January 2004 and June 2005 because it concluded that it could not afford to operate the pharmacy any longer. During this time, prescription drugs had to be obtained from a local pharmacy, where the Tribe's patients experienced long waiting lines to receive their medications, errors in prescribing the correct drug, and prescriptions being given to the wrong patients. The Tribe also experienced a drop in patient visits, which was directly related to the Tribe having no on-site pharmacy and the disruption of services through its continuum of care.

To pay for these retail pharmacy services while the LIHC on-site pharmacy was closed, the Tribe used its already limited CHS funds. Obtaining prescription medications outside of the Tribe's facility was not only more inconvenient for the Tribe's patients and interfered with the continuum of care, but the cost for billing and administration in working with retail pharmacies was significant. The Tribe did not (and still does not) have enough CHS resources to pay for pharmaceuticals through retail pharmacies.

Each dollar of CHS funds used for pharmacy services is a dollar that cannot be used for other critically needed CHS-funded services. When using CHS for pharmacy services, the cost of the pharmaceuticals is higher than it would be in a direct care environment, because outside retail pharmacies do not want to provide federal discount pharmaceutical pricing to the Tribe. Moreover, given the dramatic rise in the cost of pharmaceuticals over the past several years, and the continuing trend of substantial increases in price, we concluded that in a short time all of the CHS dollars available to the Tribe would have been spent on pharmaceuticals, meaning no CHS dollars would have been available for other critical CHS services.

While the Tribe was providing pharmacy services through CHS, it had to make significant cuts in other CHS services that it had been providing. For example, the Tribe could only cover CHS priority level one for medical and CHS priority levels one through four for dental. In 2005 the tribe decided that the problems associated with not having a pharmacy on-site could only be corrected by re-opening the on-site pharmacy. When the Tribe resumed pharmacy operations in July 2005, the Tribe was able to once again use

CHS funds to meet the growing backlog of needed CHS services for medical and dental care.

In CY 2006, the Tribe supplemented approximately $908,458 of tribal third-party funds to operate its IHS programs. The Tribe operated its pharmacy that year at a net loss of $18,007.08. In many of the previous years, the losses were greater than $100,000. Because the IHS provides the Tribe with no funds specifically for its pharmacy program and the Tribe's other health programs are severely under-funded by the IHS, every dollar the Tribe receives through its ISDEAA agreements and through third-party resources such as Medicare and Medi-Cal, are very carefully managed. There are no excess revenues or available funds the Tribe can reallocate to provide pharmacy services without hurting other health programs.

After much study and analysis, the Tribe determined that the only way to run a viable in-house pharmacy program without jeopardizing the CHS needed for other critical services was to charge a small co-payment ($5.00) along with the acquisition cost of the medicine to those patients who could afford it. Indigent members and elders are exempt from this charge. The Tribe implemented this policy in July 2006.

The Tribe's Pharmacy Policy, made necessary by chronic CHS underfunding, became the focus of a lawsuit between the IHS and the Tribe and remains a lightning rod today in a legal and policy debate about the means available to tribes to supplement their health care funding. The decision in *Susanville Indian Rancheria v. Leavitt* upheld our Pharmacy Policy and affirmed a tribe's right to determine for itself whether to charge beneficiaries for services at a tribally-operated program. Disturbingly, this decision in favor of tribal self-governance has led the IHS in recent weeks to threaten to revoke the ISDEAA funding of other tribes that decide to charge beneficiaries.

Despite the fact that the IHS had never provided the Susanville Tribe with funds specifically for pharmacy services, for many years the Tribe had included a pharmacy services program in its ISDEAA agreement. In 2006, after the Tribe was admitted into the Title V self-governance program, it began negotiating with the IHS for a self-governance compact and funding agreement for Calendar Year 2007.

The Tribe's proposed agreement included pharmacy services, but said nothing about its co-pay policy. IHS negotiators, however, learned of the Pharmacy Policy, and informed the Tribe of the IHS's position that the Tribe could not charge eligible beneficiaries for pharmacy services. The IHS gave the Tribe two choices: (1) delete pharmacy services from the agreements entirely, or (2) include language in the contract stating the Tribe would not charge eligible beneficiaries for pharmacy services. The Tribe refused to accept either of these options and presented IHS with a final offer that included pharmacy services.

The IHS rejected the Tribe's proposal on two primary grounds. First, the IHS argued that the Secretary lacks authority to enter an agreement to do something that the Secretary cannot do — namely, charge beneficiaries for services. Second, the IHS

argued that the Tribe's co-pay policy would result in a "significant danger or risk to public health".

The Tribe appealed the IHS rejection decision to federal district court in the Eastern District of California. The court found that the IHS's public health argument failed because the agency cited only speculative risks that did not meet the agency's burden of proof under the ISDEAA. The court then addressed the IHS's argument that the Tribe could not charge because the IHS cannot charge. This issue turned on the interpretation of Section 515(c) of Title V of the ISDEAA, which provides as follows:

> The Indian Health Service under this subchapter shall neither bill nor charge those Indians who may have the economic means to pay for services, *nor require any Indian tribe to do so*.[3]

The Court decided that this provision prohibits the IHS from charging — for good reason, as it would directly violate the federal trust responsibility – but that it does not prohibit tribes from doing so.

The court also rejected the IHS argument that the agency cannot approve an ISDEAA agreement under which a tribe will conduct activities (such as billing) that the IHS itself has no legal authority to carry out. The court pointed out that, "[a]s Title V makes clear, the Tribe is not required to operate a [program] in the same manner as the IHS." Tribes are not federal agencies, which can only do what Congress authorizes them to do. Tribes retain inherent authority beyond that delegated by Congress.

Events subsequent to the *Susanville* decision are troubling and bring into question the IHS's understanding of tribal rights to self-governance. Despite the *Susanville* decision—and the plain language of the ISDEAA on which the decision was based—the IHS has sought to prohibit tribes (other than our Tribe) from charging eligible beneficiaries. The IHS did not appeal the *Susanville* decision, yet the agency insists the court was wrong and has not heeded its ruling. In a series of recent "consultation" sessions with tribes in various regions, the IHS has stated that the *Susanville* decision is limited to one tribe, and does not constitute binding precedent. The agency made clear that "the existing IHS policy, which prohibits Tribes from charging eligible beneficiaries, remains unchanged."

In fact, the IHS has threatened to cut the funding of any tribe that charges beneficiaries (again, except for Susanville). As quoted in an article last week in *Indian Country Today*, an IHS official called tribal billing "inappropriate" and said the IHS is "contemplating terminating relationships with tribes that have been discovered to be doing so."[4]

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[3] Pub. L. 93-638, Title V, § 515(c), as added Pub. L. 106-260, § 4, Aug. 18, 2000, 114 Stat. 711, *codified at* 25 U.S.C. § 458aaa-14(c) (emphasis added).

[4] Rob Capriccioso, *IHS Considers Stopping Funds for Tribe Requesting Patient Copays*, INDIAN COUNTRY TODAY (June 20, 2008).

But the IHS and tribes agree on at least one thing: When the federal government fails to meet its trust responsibility, as it has by chronically underfunding CHS (and other areas of the IHS budget), it is inappropriate to force Indian beneficiaries to shoulder part of the burden by allowing the IHS to charge the very people to whom it owes the trust duty. Recognizing that this is so, Congress has flatly prohibited the IHS from billing or charging in the Title V provision at issue in the *Susanville* case and quoted above. Congress also recognized the flip side of this coin, however: Tribes are sovereign governments that have the right to decide how best to carry out health care programs for their people and to supplement inadequate federal funding by any and all reasonable means. While the decision whether to charge tribal members and other beneficiaries is not appealing, it is a choice Congress has left to Tribes in the exercise of their right of self-governance.

The Susanville Indian Rancheria – just like many other tribes – would prefer not to charge eligible beneficiaries for any portion of the cost of providing health care to them. Doing so forces hard choices for individuals and tribes alike, and should be unnecessary given the federal government's trust responsibility to provide the highest possible level of health care services to Native peoples, or provide sufficient resources for tribes to do so.

Many, perhaps most, tribes have no plans to charge beneficiaries for health care services under any circumstances. Nonetheless, the tribal leaders I have heard from strongly support the right of Tribes and tribal organizations to make that decision themselves rather than have it made for them by the IHS. We believe that the IHS should abandon its contrary position, which comports neither with the law nor the policy of self-governance, and instead work with Tribes to find ways to ensure that sufficient funds are provided to tribal programs so that they do not need to consider billing beneficiaries. Even more important, we urge Congress to address the larger crisis of chronic CHS underfunding so that tribes do not even have to consider charging beneficiaries in the first place.

Thank you for the opportunity to testify on these important issues vital to the well-being of Indian country.