Statement by Mim Dixon[1]
to
Senate Committee on Indian Affairs
Hearing on Reauthorization of the
Indian Health Care Improvement Act

July 23, 2003

Senators, Tribal Leaders, Honored Guests. I thank you for the invitation to offer my observations about Title IV of the Indian Health Care Improvement Act currently proposed for reauthorization.

It has been my privilege to serve tribes as a health care administrator, researcher and policy analyst for more than 30 years. I have seen many changes during this time, including the emergence of tribally-operated health care delivery systems. At the same time, the private and public insurance programs in our country have changed from predominantly fee-for-service to managed care.

There is a lot of talk recently about "modernizing Medicare." In a way, the proposed Title IV of the Indian Health Care Improvement Act and the proposed amendments to Medicare and Medicaid could be considered "modernizing Indian health care." As we know, this is not an appropriations bill and it will not provide the funding to bring programs and facilities up to the standards that would truly modernize Indian health care. It is interesting to me that the Federal Employee Benefit Package has been cited by the Bush Administration as a benchmark for Medicaid and Medicare reform. As you know, Indian Health Service has conducted a comparison of Indian health funding and the Federal Employee Benefit Package which shows that Congressional funding for IHS is only 52 percent of the level of need.[2] While S. 556 includes attempts in Title IV to address the huge funding gap that has resulted in health disparities among American Indians and Alaska Natives, most of those provisions have been stripped out of H.R.2440, thereby reducing the cost of Title IV by 70 percent.

So, when I talk about "modernizing Indian health care," I am not talking about the delivery of services. Rather, I am talking about modernizing the legal and regulatory framework that allows the Indian health programs to bill Medicaid, SCHIP, Medicare and private insurance and to be paid for the covered services that are provided to their mutual beneficiaries. Title IV and the technical amendments to the Social Security Act codify some administrative decisions that are already in effect and make changes in the law to allow the IHS and tribes to operate in a manner that creates a rational interface with Third Party Payers.

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[1] Mim Dixon, Ph.D., is a consultant with Mim Dixon & Associates, 1618 Spruce Street, Boulder, CO 80302.

[2] FY 2003 IHCIF – Area Summary. Posted on the website www.ihs.gov. March 28, 2003.

To better understand why I call Title IV "modernizing Indian health care," consider some of the changes that have happened in the past 25 years.

Many of you have been involved in Indian health policy longer than I have. And you will remember that the Indian health system was not permitted to bill Medicaid or Medicare until 1976 when the first Indian Health Care Improvement Act amended the Social Security Act, to create section 1880 (Medicare) and section 1911 (Medicaid). It took a long time for the Indian Health Service and tribes to figure out how to bill third parties.

This effort was frustrated by the development of IHS computer software for patient care management that did not even have a billing component. The persistent underfunding of the Indian Health Service has resulted in prioritizing services, such that the acquisition of computer software for billing purposes has necessarily been a low priority. So, third party revenues grew very slowly at first.

The growth in Medicaid and Medicare collections in Indian health facilities has paralleled the growth in tribal contracting and compacting. A survey of tribes in 1998 found that one of the first things tribes did when they starting operating their own health care delivery systems was to develop billing systems to increase their revenues.[3] Between 1993 and 1997, the third party income to the IHS increased by 80 percent.[4] A significant factor in the growth of Medicaid income was the 1996 agreement between the IHS and the Health Care Financing Administration (now called Centers for Medicaid and Medicare Services) that changed the payment policies for tribally-owned and operated facilities to enable them to receive Medicaid payments at the IHS "all-inclusive" rate, and provided a 100 percent Federal Medicaid Assistance Percentage (FMAP) for services provided in those facilities.[5]

Just about the time that the Indian health facilities figured out how to collect Medicaid and Medicare for beneficiaries who used Indian health services, the whole system changed. Medicaid began to emulate the changes in the private insurance industry, shifting to managed care. In most states, tribes were not included in the planning for changes in the Medicaid program, or the development of the SCHIP programs.[6] It was only six years ago, in 1997, that the Kaiser Family Foundation funded NIHB to do a series of case studies of

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[3] Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith CM. *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management. Vol 4.* Denver, CO: National Indian Health Board. 1998.

[4] Mather D. Chapter 4: IHS Financial Trends during Self-governance (Title III) Compacting, FY 93 to F 97. In: Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith CM. *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management. Vol 4.* Denver, CO: National Indian Health Board. 1998.

[5] Indian Health Service and the Health Care Financing Administration. Memorandum of Agreement (MOA) signed December 19, 1996.

[6] Dixon M. *Indian Health in Nine State Medicaid Managed Care Programs.* Denver, CO: National Indian Health Board. 1998b.

managed care in Indian communities.[7] At that time, tribes and the IHS were trying to figure out what managed care was and how they fit into this new system of organizing and paying for health care.

It is difficult for Indian health care to interface with the Medicaid, SCHIP and Medicare of today. Indian health programs are unique in many ways, including tribal sovereignty, the federal trust responsibility and the government-to-government relationship that has existed since before the U.S. Constitution was written and has a long tradition in federal law.[8] Indian health program are also unique because they embody certain legally-established attributes that are expressly prohibited in other government-funded health programs, such as Indian preference in hiring and restricting services to enrolled members of federally-recognized tribes. Perhaps most unique is a health care delivery system so underfunded that it would not be able to stay in business in the private sector, that rations health care according to a priority system, and that does not include the cost of facilities in its rate structure for billing for services.

All of these attributes make it impossible for many Indian health facilities and programs to meet the usual requirements to serve as contracted providers for managed care programs under Medicaid, SCHIP and Medicare programs. In addition, many Indian health facilities cannot meet requirements such as having physicians on-call 24-hours per day, and having modern facilities that meet safety and accessibility codes. Furthermore, Indian health programs usually cannot take the risk involved in managed care contracts.

Despite all the short-comings of the Indian health programs, American Indian and Alaska Native people usually prefer to use them.[9] These programs are more accessible for AI/AN communities and offer care that is more responsive to cultural needs. Furthermore, these programs provide much needed employment for AI/AN communities. AI/AN beneficiaries who are enrolled in managed care plans under Medicaid or SCHIP will go off plan to seek care at their Indian health care facility. It is essential that they have that unrestricted choice and that the Indian health facility can bill and be paid for the services they provide. These policies are included in the IHCIA (section 406 of S. 556, Section 403 of H.R. 2440).

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[7] Dixon M. *Managed Care in American Indian and Alaska Native Communities.* Washington, D.C: American Public Health Association. 1998b.

[8] Shelton, Brett Lee. Chapter 1: Legal and Historical Basis of Indian Health Care in *Public Health Policy for American Indians and Alaska Natives in the 21st Century,* Mim Dixon and Yvette Roubideaux (eds). Washington, DC: American Public Health Association. 2000.

[9] Dixon M, Lasky PS, Iron PE, Marquez C. Factors Affecting Native American Consumer Choice of Health Care Provider Organizations. In: *A Forum on the Implication of Changes in the Health Care Environment for Native American Health.* Washington, DC: The Henry J. Kaiser Family Foundation. 1997.

In 1998, the National Indian Health Board conducted a study of managed care in nine state Medicaid programs.[10] NIHB held a national meeting where recommendations were adopted by the tribes. These recommendations attempted to respond to the growing managed care environment to assure that American Indian and Alaska Native people would have access to culturally competent care through their tribal, urban and IHS clinics. In 2001 there was a follow-up study with ten state Medicaid programs.[11] It showed that the CMS had implemented some of the recommendations from the previous study. Many of the recommendations from both studies are included in the Senate and House bills.

Despite the increasing reliance of Indian health programs on Medicaid and other third party collections, many American Indians who are eligible for Medicaid and SCHIP are not enrolled in the program.[12] The proposed IHCIA reauthorization bills attempt to remedy this situation by authorizing funding for tribes for outreach services, including education regarding eligibility and benefits, translation services, and transportation to offices of eligibility workers (section 404 of S. 556, and section 402 of H.R. 2440).

The bills would also eliminate financial barriers to enrollment, such as premiums, deductibles and co-pays (section 419 of S. 556, and Section 412 of H.R. 2440). These provisions are extremely important because most AI/AN have no incentive to pay for additional health coverage when the Indian health services are provided to them with no out-of-pocket payments. The prohibition against the states charging AI/AN premiums and co-pays is already in place administrative for SCHIP, but it is important to codify this and make it consistent across Medicaid programs as well. It is troubling that the Medicare program deducts 20 percent from its already low payments to Indian health programs for the amount that the Medicare beneficiary is supposed to pay, despite the fact that Indian health programs are prohibited from collecting this amount from consumers. The proposed IHCIA does not address this problem for Medicare, but it does protect against this practice in Medicaid and SCHIP.

In the past five years, tribes have begun to work more closely with states and with the federal government to resolve issues related to Medicaid, SCHIP and Medicare. Putting these provisions into law will clarify areas of ambiguity, resolve problems that can only be resolved through changes in the law. It will

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[10] Dixon M. *Indian Health in Nine State Medicaid Managed Care Programs.* Denver, CO: National Indian Health Board. 1998.

[11] Kauffman JA, Hansen P, Paternoster V. Into the Future: Indian Health, Medicaid, Managed Care & SCHIP, a Ten State Medicaid, Managed Care and SCHIP Program Study. National Indian Health Board. Draft Report, December 20, 2001.

[12] Rosenbaum S. Medicaid and Indian Populations: Issues and Challenges. In: *A Forum on the Implications of Changes in the Health Care Environment for Native American Health Care.* Washington, DC: The Henry J. Kaiser Family Foundation. 1997.

"modernize" the law regarding third party collections for Indian health facilities by addressing issues that didn't even exist until the past decade.

Provisions in the proposed IHCIA Act also allow tribes to take advantage of some of the opportunities provided by managed care. For example, tribes, tribal organizations and urban Indian programs could use their funding from IHS to purchase managed care plans or other insurance coverage for their beneficiaries (Sec 408 of S. 556 and Sec. 405 of H.R. 2440). This may be particularly useful for small tribes that would not have enough resources to offer comprehensive health services on their own. It also may help to stimulate tribes and tribal organizations to own and operate health care plans. Furthermore, the bills would protect tribal sovereignty while promoting quality care, by eliminating any requirements that tribal health programs be licensed under state or local law if they meet accreditation standards recognized by the Secretary of DHHS (Section 411 of S. 556, section 408 of H.R. 2440). The measures would also require states to allow Indian health providers to serve as case managers for AI/AN Medicaid beneficiaries (section 423 of S. 556, section 413 of H.R. 2440).

Many of the issues relating to health care financing are extremely complicated. There are a handful of technical experts working for tribes as health directors, consultants and attorneys. Tribes have recognized that there is a need for these technical experts to work closely with CMS to resolve problems as they arise. NIHB, NCAI and TSGAC have called for a Tribal Technical Advisory Group (TTAG) for CMS. They have designated individuals to serve on an interim TTAG until such time as CMS can establish a formal TTAG. Once again, there is a disconnect between the unique role of tribes and the regulatory framework for advisory committees. To operate effectively, the TTAG must be authorized in law, as proposed in section 409 of H.R.2440 (which was revised and improved after section 425 of S. 556 was drafted). The need for this TTAG is urgent. The interim TTAG has already identified 65 issues that need resolution with CMS, and the TTAG will be essential to helping CMS write regulations for the proposed Medicare reform, proposed Medicaid reform, and the new provisions in the IHCIA.

In summary, Title IV and the Social Security Act amendments are needed to respond to changes that have occurred in health care delivery in our country in the past decade. Just a few years ago, there was no Medicaid managed care, there was no SCHIP, there was no Medicare Part C or D or E. The complexities of health care financing can be overwhelming. So, it is important to remember the purpose of this legislation. At the heart of the provisions in Title IV is enhancing access to care for American Indians and Alaska Natives, protecting their rights to choose their health care providers, and assuring that Indian health facilities get paid when they provide covered services to Medicaid, SCHIP and Medicare beneficiaries.