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Testimony of United South and Eastern Tribes Sovereignty Protection Fund
Submitted to the United States Senate Committee on Indian Affairs
For the record of the Hearing on,
"Reexamining the Substandard Quality of Indian Health Care in the Great Plains"
and the Listening Session on, "Putting Patients First: Addressing Indian Country's Critical Concerns Regarding Indian Health Service"
February 17, 2016

The United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) is pleased to provide the Senate Committee on Indian Affairs with the following testimony in pursuit of solutions to the systemic challenges facing the Indian Health Service (IHS) and Tribally-Operated facilities. Following the unacceptable and devastating failures of the Indian Health System in the Great Plains, that is in part responsible for the unfortunate loss of lives, it was vital that the Committee investigate the state of Indian health care regionally and beyond. USET SPF thanks the Committee for hosting the hearing on the quality of health care within the IHS Great Plains Area and the subsequent listening session on "Putting Patients First: Addressing Indian Country's Critical Concerns Regarding Indian Health Service."

USET SPF is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine.[1] Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the IHS, which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-Operated facilities operated under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

We echo the comments of many Members of the Committee, as well as witnesses, highlighting the financial obstacles facing the Indian Health Service and Tribal Nations, as they seek to provide quality health care to American Indians and Alaska Natives (AI/AN). While the issues surrounding the deplorable conditions in the Great Plains are multi-faceted, much of the problem can be attributed to the persistent underfunding of IHS. With this in mind, USET SPF is hopeful that Congress will take necessary actions to fulfill its Federal Trust responsibility and obligation to provide quality health care to Tribal Nations, including providing adequate funding to the IHS. In addition, we urge this Congress to introduce and approve no-cost legislation that will stabilize and extend the limited resources of the IHS.

[1] USET member Tribes include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

Uphold the Federal Trust Responsibility and Obligations to Tribal Nations

As this Committee is well aware, many of the systemic inequities in the Indian Health System and strikingly high health disparities[2] in Indian Country result from the chronic underfunding of the IHS budget. The IHS is the primary agency tasked with ensuring the federal government fulfills its promise to provide health care to AI/AN. However, the IHS is consistently underfunded, meeting just around 59% of the demonstrated financial need to deliver care to AI/AN patients. As a result, IHS health expenditure per capita for patients is just $3,099, which is approximately 61.7% less than health spending for the total U.S population at $8,097 per capita[3]. Although Congress has appropriated additional funding for IHS in recent years, the costs of health care continue to increase. Current levels of funding are barely able to meet non-medical inflation rates and is completely unable to meet the medical inflation rate. As a result, major barriers to accessing care exist due to the lack of resources in the Indian health system. These barriers lead to poor health outcomes and severe health disparities.

Through the permanent reauthorization of the Indian Health Care Improvement Act, "Congress declare[d] that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy[4]." As long as the IHS is so dramatically underfunded, Congress is not living up to its own stated policy and responsibilities. USET SPF urges this Committee to consider carefully the level of funding for IHS it will support as it makes requests of appropriators for Fiscal Year (FY) 2017 and beyond. Fulfillment of the Federal Trust responsibility, both from a fiduciary and moral perspective, means fully funding the Indian Health Service.

Extend PRC Resources by Passing Legislation to Extend Medicare-Like-Rates Payment Methodologies to Non-Hospital Services.

One of the most severely underfunded line items within the IHS budget is the Purchased/Referred Care (PRC) account (formerly known as Contract Health Services). PRC resources allow Indian Health programs to purchase care that is furnished by outside, non-Indian health care providers (non-IHCPs) in the private sector. PRC funding is essential for AI/AN patients to access primary care, specialty care, and other services not readily available at their Indian Health Facility. At current funding levels, many IHS and Tribally operated programs are only able to cover Priority I[5] services to preserve life and limb and are often unable to fully meet patients' needs at even this restrictive PRC service category. In FY 2015, IHS estimates that it denied 132,000 necessary services to AI/AN patients due to lack of funds.

Compounding and contributing to this challenge are the rates PRC programs pay to non-IHCPs. Non-IHCPs routinely charge, and expect to be paid, full-billed charges to PRC programs. According to an April 2013 Government Accountability Office (GAO) report, federal PRC programs paid non-contracted physicians two and a half times more than what it estimates Medicare would have paid for the same services. The PRC program may be the only program in the federal government that pays rates above the Medicare rate. Neither the VA nor the DOD pay full billed charges for health services furnished by outside providers. Nor do insurance companies, including those with whom the federal government has negotiated favorable rates through the Federal Employee Health Benefits program. IHS and Tribally-Operated Health Programs' regular payment of full billed charges is both a major barrier to accessing necessary care for AI/AN patients, and an inefficient use of taxpayer dollars.

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[2] Tribal Nations face disproportionately high rates of mortality from diabetes, major heart disease, chronic liver disease and injuries, when compared with all other races in the United States (U.S.).

[3] Indian Health Service "Year 2015 Profile" December, 2015.

[4] 25 U.S. Code § 1602

[5] For a breakdown of IHS Medical Priority Levels see: http://www.ihs.gov/chs/index.cfm?module=chs_requirements_priorities_of_care

The 2013 GAO report concluded that paying a Medicare-like Rate (MLR) for services purchased by PRC programs would allow the IHS to provide approximately 253,000 additional physician services annually. Payment under this rate would have resulted in hundreds of millions of dollars in new federal health care resources being made available to AI/ANs in 2010 alone. Furthermore, the implementation of this payment mechanism would be achieved at no cost to the federal government.

Over the past year, IHS has been working to implement a regulation that would provide Tribal Nations with the option to apply MLR to their PRC programs. The rule, however, does not include an enforcement mechanism, namely, conditioning participation in the Medicare program on the acceptance of MLR. A lack of enforcement could lead non-IHCP to refuse to AI/AN patients due to the decrease in payments. Particularly for USET Tribal Nations that reside in areas with few specialty care providers, this rule could create additional barriers to accessing health services. This is why legislation is necessary. The Administration, in its FY 2017 Budget Request, recognized the need for legislation over regulation, stating in its Congressional Justification, "unlike the legislative proposal, the regulation cannot require that providers participating in Medicare accept the capitated PRC rate from IHS."

USET SPF urges this Committee to support and work toward the passage of legislation extending MLR to non-hospital services that includes an enforcement mechanism to ensure AI/AN patients' continued access to care. Doing so would be a more efficient use of taxpayer dollars, dramatically improve AI/AN patient access needed care, and be an important step toward improving the health inequities between AI/AN and the U.S. population.

Provide Advance Appropriations for the Indian Health Service

In addition to the more efficient spending of IHS dollars, Congress should work to ensure funding is received on time by approving legislation that would authorize advance appropriations for IHS. Advance appropriations is funding that becomes available one year or more after the appropriations act in which it is contained, allowing for increased certainty and continuity in the provision of services.

On top of chronic underfunding and drains on precious dollars, IHS and Tribes face the problem of discretionary funding that is almost always delayed. In fact, since FY 1998, there has only been one year (FY 2006) in which appropriated funds for the IHS were released prior to the beginning of the new fiscal year. The FY 2016 Omnibus bill was not enacted until 79 days into the Fiscal Year, on December 18, 2015.

Late funding has severely hindered IHS and Tribal health care providers' ability to administer the care to which AI/AN are legally entitled. Budgeting, recruitment, retention, the provision of services, facility maintenance, and construction efforts all depend on annual appropriated funds. Many of our USET SPF member Tribal Nations reside in areas with high Health Professional Shortage Areas and delays in funding only amplify the challenges with salary and hiring of qualified professionals which are systemic across the IHS System. IHS and Tribal facilities must continue to operate while Congress engages in philosophical debates about federal spending. However, they are forced to do so at a severely reduced capacity. In a world where it is not unusual to exhaust funding before the end of the Fiscal Year, surgeries are delayed, services are reduced, and employment is in jeopardy.

Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle. When it became clear that our nation's veterans were not able to receive the quality health care earned in the protection of this country due to funding delays, advance appropriations were enacted for the Veterans Administration (VA) medical care accounts. Advance appropriations

serve to mitigate the effect of delayed and, at times, inadequate funding for the VA. As the only other federal provider of direct health care and a consistently underfunded agency, IHS should be afforded this same consideration and certainty. USET SPF urges this Committee to support legislation that would extend advance appropriations to the IHS.

Conclusion

As the February 3rd hearing revealed, the chronic underfunding of the IHS has life or death consequences for many of the AI/AN patients from our USET SPF member Tribal Nations. Any loss of life resulting from failure to fulfill trust responsibilities and obligations is unacceptable. The rationing of care through the PRC program, and major obstacles with the recruitment and retention of providers are examples of the direct result of Congress' failure to meet its Trust responsibilities and obligations to adequately fund the IHS. In recognition of the political climate that enables the underfunding for Indian Health Care, we offer the preceding solutions to extend and stabilize IHS resources. We hope that Members of the Senate Committee on Indian Affairs will join us, and others in Indian Country, in advocating for the introduction and passage of these two common-sense proposals, in addition to increased funding for IHS.

We thank the Committee for holding both the hearing and the listening session to examine the quality of care delivered through IHS. USET SPF is a willing partner in your efforts to address systemic problems at IHS and improve the health outcomes of AI/AN patients.

"Because there is strength in Unity"