Testimony of Valerie Davidson

Senior Director, Legal & Inter-Governmental Affairs,
Alaska Native Tribal Health Consortium
Chair, CMS Tribal Technical Advisory Group
Member, Medicaid Commission

Medicare, Medicaid and SCHIP and the Indian Health System

Senate Finance Committee

March 22, 2007

Good morning, Chairman Baucus, Ranking Member Grassley and Members of the Committee. I thank you for giving me the opportunity to testify today about the importance of Medicaid, Medicare and SCHIP funding in the Indian health system. I want to express my appreciation to the chairs of the National Steering Committee for Reauthorization of the Indian Health Care Improvement Act (NSC) and the other members for their tireless work over the past several years to draft a reauthorization bill that best meets the health needs of Indian country.

I especially want to express my gratitude to this Committee for its attention to this important issue. Even though the comprehensive reauthorization bill was stalled last year, this Committee considered and passed the Medicaid, Medicare, and SCHIP Indian Health Care Improvement Act of 2006, S. 3524, a stand-alone bill that contained many of the Social Security Act amendments being considered as part of the IHCIA reauthorization this year. This Committee's timely consideration and emphatic support for that legislation was a highlight in what has been a long and often disheartening reauthorization effort. It is especially encouraging to see a Committee not normally tasked with handling Indian issues reach out to Tribes in this way. I look forward to working with the Committee again this year.

I was privileged to work for many years for the Yukon-Kuskokwim Health Corporation, the Tribal health program that serves 58 Tribes in a region roughly the size of Oregon, of which Bethel is the hub. I now am honored to work for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 229 Tribes in Alaska, co-manages with Southcentral Foundation the Alaska Native Medical Center (ANMC), the tertiary care hospital for all American Indians and Alaska Natives (AI/ANs) in Alaska, and carries out all non-residual Area Office functions of the IHS that were not already being carried out by Tribal health programs as of 1994.

I also serve as the Chair of the Tribal Technical Advisory Group that advises CMS on policy relating to American Indians and Alaska Natives. In that capacity, I have worked closely on many of the policies that determine how Medicaid, Medicare and SCHIP funding is used by IHS and tribal clinics. I also had the opportunity to serve on the Medicaid Commission, which in its final Report endorsed the enactment of the provisions found in S. 3524.

The amendments to the Social Security Act contained in S. 3524, which we hope will be included in the IHCIA Reauthorization bill this year, are essential to improving access to Medicaid, Medicare and SCHIP by AI/ANs and the viability of the Indian health system. They are essential to reducing health disparities that plague AI/ANs and to the viability of struggling IHS and tribal health programs.

Senate Report 109-278, which accompanied S. 3524, provides an excellent section by section analysis of each of the provisions considered and approved in the last Congress. There is no need to walk you through each of them today. Instead, I hope through my testimony to reinforce your resolve to pass these improvements to Medicaid, Medicare and SCHIP and the balance of the IHCIA this year.

For those of you who have not visited Indian country, I will try to paint a picture. It will be incomplete. It is impossible to understand the diversity and challenges faced by Tribes without visiting them. However, not everyone can visit. So today, I hope to help you understand why Medicaid, Medicare and SCHIP are so important to the Indian health system.

The stories I will tell you come from my experience in Alaska, but also from the experience of other tribes across the country, where tribal members experience the same difficulties accessing health care, and tribal governments and clinics experience the same pain of having to deny health care to people in need because there just isn't enough money to pay for it.

I. The Indian Health Service System

The federal government has a duty – acknowledged in treaties, statutes, court decisions and Executive Orders – to provide for the health and welfare of Indian Tribes and their members.[1] In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to American Indians and Alaska Natives through a network made up of the Indian Health Service, tribal health programs and urban clinics.

The Indian Health Service (IHS), directly and through tribal health programs carrying out IHS programs under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended (ISDEAA), provides health services to more than 1.9 million American Indians and Alaska Natives. We are members of 562 federally-recognized tribes in the United States, located in 35 different states. According to the IHS, these services are offered from the following facilities:[2]

---

[1] See Federal Basis for Health Services, January 2007 (info.ihs.gov/Files/ BasisForServices-Jan2007.doc).

[2] Indian Health Service Fact Sheet, IHS/OD/PAS January 2007 (info.ihs.gov/Files/IHSFacts-Jan2007.doc).

	IHS Directly Operated	Tribally Operated
Hospitals	33	15
Health centers	54	229
Health stations	38	116
Alaska Community Health Aide (CHA) clinics		162

There are also an additional 600,000 AI/ANs who access health care through 34 urban Indian health programs funded by IHS under Title V of the IHCIA.[3] When health care cannot be provided through these facilities, IHS and tribal programs use funding to purchase contract health care from providers outside of the IHS system.

The number of facilities does not really tell the story though. The Indian health system is a real system of care. It is reflected in the IHCIA, which addresses health provider workforce issues, a full range of health care services from prevention through services needed at the end of one's life and from services to be provided on an out-patient basis to inpatient services, nursing home services, and purchased services, facility needs, safe water and sanitation systems, behavioral health, including a continuum of mental health and substance abuse services, and the infrastructure needed by IHS and Tribes to carry out this vast array of
services.

What this description covers up is how desperate the need continues to be. And, how much the system relies on Medicaid, Medicare and SCHIP to keep it viable.

---

[3] Indian Health Service Year 2007 Profile, January 2007 (info.ihs.gov/Files/ProfileSheet-Jan2007.doc).

II. Under-Funding the Indian Health System

The Indian health system is consistently, persistently under-funded. Worse yet, this minimal level of funding has remained flat or actually lost ground to population growth and medical inflation, including mandatory pay cost increases (arising from the annual Pay Act passed by Congress each year); the budget for Indian health care is losing pace. Last year, the Northwest Portland Area Indian Health Board (NPAIHB), which takes a leadership role in analyzing the funding for Indian health programs, estimated that it would take an increase of "at least $436 million to maintain current services in FY 2007."[4] Instead, under the continuing resolution, there is "a mere 13.5 million increase for IHS programs."[5] NPAIHB estimates that in FY 2008, the number needed to retain services has increased to $480 million.[6] Adequate direct appropriations for Indian health care is consistently absent from the federal budget.

The IHS Federal Disparities Index (FDI) illustrates the severe funding shortfall in Indian health care. The FDI compares health care costs for Indians to costs of typical mainstream health insurance plans. Actuarial methods controlled for age, sex, and health status were used to price a typical health benefits plan for Indian people using costs of the Federal Employees Health Plan. The FDI does not address public health deficiencies and needs for safe water and waste disposal.

"After discounting for Medicare, Medicaid, and private insurance coverage, the FDI results show that IHS funding fell $1.7 billion short of parity with the benchmark mainstream health plan. About 160 IHS and tribal health care delivery sites are funded at less than 60% of the benchmark cost."[7] Put another way, "[t]he average cost of mainstream health insurance plans is approximately 40% greater than the IHS funding level for [AI/ANs]." *Id.* More is spent in the Federal prison system per inmate than is available for each AI/AN.

---

[4] "NPAIHB POLICY BRIEF, President's FY 2008 IHS Budget Request," NPAIHB, February 9, 2007, p. 2 (found at: www.npaihb.org/images/policy_docs/IHS/).

[5] *Id.*

[6] *Id.* at 3.

[7] Personal Health Services Funding Disparities, IHS, January 2007 (info.ihs.gov/Files/FundingDisparity-Jan2007.doc). Emphasis added.

Enactment of the Indian Health Care Improvement Act in 1976 was an important step to address this unmet need. Recognizing the enormous need and the limited funding appropriated for Indian Health Service, Congress authorized IHS and tribal health programs to recover reimbursements from Medicaid, Medicare and SCHIP.[8] While AI/ANs are entitled to free health care through the IHS system because of treaty obligations and the trust responsibility, many also qualify for low-income programs such as Medicaid. It is galling to individual AI/ANs to have to apply for Medicaid in order to assure the access to health care promised to them through countless treaties, Executive Orders, and laws; however, the compelling need to do so is inescapable.

Today, Medicaid income is an indispensable part of the federal budget for Indian programs. Since the IHCIA was enacted, all appropriations have contained an estimate of Medicaid income. For example, the IHS Budget proposal for FY 2008 estimates that Indian health programs will generate $625 million in Medicaid revenue.[9] While these funds are crucial to the Indian health system, they constitute less than one-half of one percent of total federal Medicaid expenditures. And, most important, they do not begin to fill the gap between the need for funding Indian health services and the direct appropriations to IHS.

III. The Real Effects of Under-funding – Health Disparities and Personal Tragedy

In part because of this chronic under-funding and in part for many historical reasons that are almost too painful to recount, AI/ANs lag 20-25 years behind the general population in health status, and on the whole have the most severe health needs of any group in the United States. IHS describes the problem:

> The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower health expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.[10]

---

[8] Sections 401 and 402, codified at 42 U.S.C. §§ 1395qq and 1396j.

[9] Department of Health and Human Services FY 2008 Budget Justification, CJ-148.

[10] Facts on Indian Health Disparities, IHS, January 2007 (info.ihs.gov/Files/DisparitiesFacts-Jan2007.doc).

Diabetes, heart disease, alcoholism, teenage suicide and infant mortality rates are higher for American Indians than for any other minority, and far higher than for the general American population. AI/AN infants "die at a rate of nearly 10 per every 1,000 live births, as compared to 7 per 1,000 for the U.S. all races population (2001-2003 rates)."[11] Among adults,

> [AI/ANs] die at higher rates than other Americans from tuberculosis (500% higher), alcoholism (550% higher), diabetes (200% higher), unintentional injuries (150% higher), homicide (100% higher) and suicide (60% higher).[12]

But even these startling statistics do not fully capture the severity of the health crisis and the funding needs in Indian country.

On a reservation in Montana, a woman with a strange stomach growth was turned away from IHS clinics several times when she tried to seek treatment; she was told that she had simply gained weight. When she was finally examined, after several months, doctors removed a tumor that weighed more than 20 pounds. In telling you this story, I don't mean it as an indictment of the doctors and other health professional practicing at the clinics where she sought treatment. Having worked on American Indian and Alaska Native health issues for as long as I have, I know that these stories are the all-too-common result of a system that is quite simply over-burdened, a system in which doctors in under-staffed clinics do not always have the luxury of examining a non-emergency patient with the care they would like to use.

In a system that is systematically under-funded, meeting the health care needs of the beneficiaries forces unacceptable choices. Due to the limited number of hospitals in the Indian health system and the under funding that makes most specialty services merely a wish, IHS and tribal health programs must rely on contract health services (CHS) funding to acquire necessary hospital and specialty care. Yet even CHS funding falls far short of what is needed. To deal with the shortage, most tribes have adopted policies that only allow CHS funding to be used for "life or limb" emergencies. Other health care needs simply go unmet.

---

[11] *Id.*

[12] *Id.* Also see, United States Commission on Civil Rights, Broken Promises: Evaluating the Native American Health Care System (September 2004), 8 and Department of Health and Human Services FY 2008 Budget Justification, CJ-5-11.

Many throughout the system have coined a new name for this funding program: it is the "Don't get sick after June" program. One tribe typically runs out of CHS funds in January, leaving no money for health care for the rest of the year, making even the promise of services until June look good.

As desperately inadequate as the CHS funding is, the situation would be unimaginably worse, but for Medicaid, Medicare and SCHIP, which are considered prior resources. Patients with access to these health programs rely on them to cover the cost of their care, rather than CHS, thus allowing the limited dollars in CHS to go further for those without coverage. They also pay for care that the Indian health program may not be able to provide, but which does not meet the dreadful criteria of "life and limb".

IV. Medicare, Medicaid & SCHIP's Role in the Indian Health System

There are two critical roles Medicare, Medicaid and SCHIP play in the Indian health system. First, they provide a source of payment for health care that the Indian health system cannot supply. Secondly, they provide a critical source of revenue to support the Indian health system.

The importance of the first role – as a source of payment for services the Indian health system cannot provide – is critical, but in many cases it provides an illusory benefit addressed better by the second role – providing revenue to support the Indian health system. Indian health programs are not merely other providers. The IHS, directly and through tribal health programs, provides culturally appropriate, integrated health services. The value of this cannot be over-estimated. AI/ANs routinely make the choice to not seek care at all, if in order to get it, they must leave their communities.

My grandmother died two years ago. Our home, Bethel, does not have a nursing home – for no other reason than lack of financial resources. My grandmother made me and my mother and aunts promise that we would never send her away to Anchorage to a nursing home. She qualified for Medicaid; she could have been in a nursing home there when she finally needed it, but she would never have accepted it, even if her decision meant she would have to forego needed health care. She chose, like other elders in our villages, to die in her own community, rather than being transported to non-Indian nursing homes where she wouldn't understand the language, the food would be unfamiliar, and her family could only visit when they could afford a plane ticket from our region to Anchorage. Outside Alaska, the geographical distances may not be so great, but the cultural differences are just as large.

The Senate Indian Affairs Committee held a hearing on Indian health care two weeks ago, and Senator Dorgan recalled the story of a young girl who was a victim of suicide. Before she died, however, the warning signs were all there. She withdrew from school, stopped talking to people, and stayed in her room for three months; her family

had a history of alcohol and drug abuse and suicide. Despite all this, she never received mental health intervention. As Senator Dorgan pointed out, there was no clinic for several hundred miles around her home. There were no mental health professionals in the community where she lived. Even if there had been a clinic or a professional for her to see, her family had no car that could have driven her there. I tell this story to you for the same reason Senator Dorgan told it last week – the barriers American Indians and Alaska Natives face when seeking even the most basic and necessary health care can seem insurmountable. While funding alone is important, facilitating access to that funding and bringing quality care to remote communities is equally critical. The IHS and tribal health system have proven their ability to be effective interveners, but only when resources are available.

The new provisions that would be added to law if the provisions approved in S. 3524 are enacted are critical to expanding access and to making the Indian health system more viable, especially when taken in concert with other provisions of the IHCIA Reauthorization bill.

These provisions would ensure that IHS and tribal health programs can be reimbursed for all Medicaid covered services they provide, not just those that are facility-based. That is critical to ensuring that home- and community-based services can be expanded. The new provisions also ensure that the critically needed mental health and substance abuse services that desperately need to be expanded within the Indian health service can be supported.

The new provisions would increase outreach and improve cooperation between Indian health programs and the States under Medicaid and SCHIP. The geographic, cultural, and other barriers to enrollment in Medicaid and SCHIP are huge. Services to ensure AI/ANs have meaningful access to these programs are needed to overcome the barriers. Among these barriers is the requirement for proof of citizenship – a particularly cruel requirement to be imposed on the first Americans, many of whose elders cannot produce the kinds of records currently required since their parents either did not have or were denied access to hospitals where birth certificates might have been completed. Allowing tribal records to suffice for proof of citizenship will help remove this burden on applications.

Protection against estate recovery of certain classes of property of special significance to AI/ANs was also provided in S. 3524. Many elders will not apply without the assurance that they will not be buying their own comfort with their tribal patrimony. Protection of trust land, subsistence harvesting rights, and objects of religious and cultural importance is considered by most elders to be a sacred responsibility.

Protections against premiums and other cost sharing would also be provided. I cannot overstate the importance of this for AI/ANs who use IHS and tribal health

programs. Cost sharing requirements applied in such settings merely reduce the funds available to the Indian health program since, in recognition of the Federal responsibility for Indian health care, the IHS may not charge fees for services. This means that the IHS or Tribal health program must absorb any co-payment or premium required by Medicaid, further straining the limited resources of these programs.

Barriers to payments to Indian health programs under SCHIP would be removed to ensure that the health programs most likely to be able to offer services that will be acceptable to the child and family have the resources to provide them.

Other provisions address the operation of IHS and tribal health programs, including those that deal with licensing requirements and safe harbors when they relate to each other and their patients. These are important to protecting and expanding the viability of the Indian health system.

V. Conclusion

For those of you who deal with the complexities and size of the Medicare, Medicaid and SCHIP programs on a regular basis, the improvements we seek here may seem inconsequential. That could not be farther from the truth.

As American Indians and Alaska Natives, we are a people with painful legacies of forced removal – to boarding schools, to cities, to faraway hospitals – and rampaging epidemics that disrupted families for generations. Despite this, we still have very strong ties to our communities. As one of the younger members of my Tribe, with the privilege and opportunity to work in our health programs, it is my duty to try to overcome this history and to assure that no AI/AN will have to make the choice to forgo medical care entirely because culturally competent care is not available. It is my duty to be sure that we protect the health status improvements that have been made and that we accomplish more. I must leave a better system for my children and grandchildren than I inherited. It is for that reason that I am here today to testify before you.

The legislation we are discussing today will authorize many important steps toward the goal of quality health care in our home communities and in ways that respond to our needs and respect our way of life. I know that we cannot knock down all of these barriers overnight, but the provisions of S. 3524 will make a significant improvement.

In closing, I want to thank the Committee again for all the work you have done to pass this critical legislation and for your leadership in addressing such an important issue.