S. HRG. 106–204

ELEVATE THE POSITION OF DIRECTOR OF THE INDIAN HEALTH SERVICE TO ASSISTANT SECRETARY FOR INDIAN HEALTH

ALASKA NATIVE AND AMERICAN INDIAN DIRECT REIMBURSEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

ON

S. 299

TO ELEVATE THE POSITION OF DIRECTOR OF THE INDIAN HEALTH SERVICE WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ASSISTANT SECRETARY FOR INDIAN HEALTH

AND

S. 406

TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO MAKE PERMANENT THE DEMONSTRATION PROGRAM THAT ALLOWS FOR DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS, AND TO EXPAND THE ELIGIBILITY UNDER SUCH PROGRAM TO OTHER TRIBES AND TRIBAL ORGANIZATIONS

AUGUST 4, 1999
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ELEVATE THE POSITION OF DIRECTOR OF THE INDIAN HEALTH SERVICE WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ASSISTANT SECRETARY FOR INDIAN HEALTH; AND ALASKA NATIVE AND AMERICAN INDIAN DIRECT REIMBURSEMENT ACT

WEDNESDAY, AUGUST 4, 1999

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10:29 a.m. in room 485, Senate Russell Building, Hon. Daniel K. Inouye (vice chairman of the committee) presiding.

Present: Senators Inouye, Reid, Murkowski, McCain, and Gorton.

STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Senator INOUYE. Good morning. On behalf of Chairman Campbell and the members of the committee, I am pleased to welcome the witnesses who are here to testify this morning on two measures.

The first bill, S. 299, would elevate the position of the director of Indian Health Service to that of Assistant Secretary for Indian Health.

Ever since the enactment of the Indian Health Care Improvement Act in 1976, various members of the House and Senate have proposed elevating the position of the Indian Health Service director. I believe the rationale for doing so now is as compelling as it was then. Health care needs in Indian country remain acute. So does the need for advocacy for Indian health programs at the highest levels within the Department of Health and Human Services.

The second bill on which we will receive testimony this morning is S. 406. This bill would authorize tribal governments and tribal organizations to directly bill Medicare, Medicaid, and third-party payers. It will also make permanent the program that has demonstrated the health benefits that can be realized by tribes and tribal organizations that have direct billing authority.

Enactment of these two bills would further empower Indian tribes in their long struggle to achieve levels of health status and health care comparable to the best of the rest of the Nation.

[Text of S. 299 and S. 406 follow:]

II

106TH CONGRESS
1ST SESSION

S. 299

To elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 22, 1999

Mr. MCCAIN (for himself, Mr. INOUYE, and Mr. CONRAD) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

---

A BILL

To elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. OFFICE OF ASSISTANT SECRETARY FOR INDIAN**
4 **HEALTH.**

5 (a) ESTABLISHMENT.—There is established within
6 the Department of Health and Human Services the Office
7 of the Assistant Secretary for Indian Health in order to,
8 in a manner consistent with the government-to-govern-

1 ment relationship between the United States and Indian
2 tribes—
3 (1) facilitate advocacy for the development of
4 appropriate Indian health policy; and
5 (2) promote consultation on matters related to
6 Indian health.
7 (b) ASSISTANT SECRETARY FOR INDIAN HEALTH.—
8 In addition to the functions performed on the date of en-
9 actment of this Act by the Director of the Indian Health
10 Service, the Assistant Secretary for Indian Health shall
11 perform such functions as the Secretary of Health and
12 Human Services (referred to in this section as the "Sec-
13 retary") may designate. The Assistant Secretary for In-
14 dian Health shall—
15 (1) report directly to the Secretary concerning
16 all policy- and budget-related matters affecting In-
17 dian health;
18 (2) collaborate with the Assistant Secretary for
19 Health concerning appropriate matters of Indian
20 health that affect the agencies of the Public Health
21 Service;
22 (3) advise each Assistant Secretary of the De-
23 partment of Health and Human Services concerning
24 matters of Indian health with respect to which that
25 Assistant Secretary has authority and responsibility;

1 (4) advise the heads of other agencies and pro-
2 grams of the Department of Health and Human
3 Services concerning matters of Indian health with
4 respect to which those heads have authority and re-
5 sponsibility; and
6 (5) coordinate the activities of the Department
7 of Health and Human Services concerning matters
8 of Indian health.
9 (c) REFERENCES.—Reference in any other Federal
10 law, Executive order, rule, regulation, or delegation of au-
11 thority, or any document of or relating to the Director
12 of the Indian Health Service shall be deemed to refer to
13 the Assistant Secretary for Indian Health.
14 (d) RATE OF PAY.—
15 (1) POSITIONS AT LEVEL IV.—Section 5315 of
16 title 5, United States Code, is amended—
17 (A) by striking the following:
18 "Assistant Secretaries of Health and Human
19 Services (6)."; and
20 (B) by inserting the following:
21 "Assistant Secretaries of Health and Human
22 Services (7).".
23 (2) POSITIONS AT LEVEL V.—Section 5316 of
24 title 5, United States Code, is amended by striking
25 the following:

1 "Director, Indian Health Service, Department
2 of Health and Human Services.".
3 (e) DUTIES OF ASSISTANT SECRETARY FOR INDIAN
4 HEALTH.—Section 601(a) of the Indian Health Care Im-
5 provement Act (25 U.S.C. 1661(a)) is amended—
6 (1) by inserting "(1)" after "(a)";
7 (2) in the second sentence of paragraph (1), as
8 so designated, by striking "a Director," and insert-
9 ing "the Assistant Secretary for Indian Health,";
10 and
11 (3) by striking the third sentence of paragraph
12 (1) and all that follows through the end of the sub-
13 section and inserting the following: "The Assistant
14 Secretary for Indian Health shall carry out the du-
15 ties specified in paragraph (2).
16 "(2) The Assistant Secretary for Indian Health
17 shall—
18 "(A) report directly to the Secretary concerning
19 all policy- and budget-related matters affecting In-
20 dian health;
21 "(B) collaborate with the Assistant Secretary
22 for Health concerning appropriate matters of Indian
23 health that affect the agencies of the Public Health
24 Service;

1 "(C) advise each Assistant Secretary of the De-
2 partment of Health and Human Services concerning
3 matters of Indian health with respect to which that
4 Assistant Secretary has authority and responsibility;
5 "(D) advise the heads of other agencies and
6 programs of the Department of Health and Human
7 Services concerning matters of Indian health with
8 respect to which those heads have authority and re-
9 sponsibility; and
10 "(E) coordinate the activities of the Depart-
11 ment of Health and Human Services concerning
12 matters of Indian health.".
13 (f) CONTINUED SERVICE BY INCUMBENT.—The indi-
14 vidual serving in the position of Director of the Indian
15 Health Service on the date preceding the date of enact-
16 ment of this Act may serve as Assistant Secretary for In-
17 dian Health, at the pleasure of the President after the
18 date of enactment of this Act.
19 (g) CONFORMING AMENDMENTS.—
20 (1) AMENDMENTS TO INDIAN HEALTH CARE IM-
21 PROVEMENT ACT.—The Indian Health Care Im-
22 provement Act (25 U.S.C. 1601 et seq.) is amend-
23 ed—
24 (A) in section 601—

(i) in subsection (c), by striking "Director of the Indian Health Service" both places it appears and inserting "Assistant Secretary for Indian Health"; and

(ii) in subsection (d), by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health"; and

(B) in section 816(c)(1), by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health".

(2) AMENDMENTS TO OTHER PROVISIONS OF LAW.—The following provisions are each amended by striking "Director of the Indian Health Service" each place it appears and inserting "Assistant Secretary for Indian Health":

(A) Section 203(a)(1) of the Rehabilitation Act of 1973.

(B) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377 (b) and (e)).

(C) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)).

○

II

106TH CONGRESS
1ST SESSION

S. 406

To amend the Indian Health Care Improvement Act to make permanent the demonstration program that allows for direct billing of medicare, medicaid, and other third party payors, and to expand the eligibility under such program to other tribes and tribal organizations.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 10, 1999

Mr. MURKOWSKI (for himself, Mr. LOTT, Mr. BAUCUS, Mr. INHOFE, Mr. COCHRAN, Mr. CAMPBELL, and Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

---

A BILL

To amend the Indian Health Care Improvement Act to make permanent the demonstration program that allows for direct billing of medicare, medicaid, and other third party payors, and to expand the eligibility under such program to other tribes and tribal organizations.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Alaska Native and
5 American Indian Direct Reimbursement Act of 1999".

1 **SEC. 2. FINDINGS.**

2 Congress finds the following:

3 (1) In 1988, Congress enacted section 405 of
4 the Indian Health Care Improvement Act (25 U.S.C.
5 1645) that established a demonstration program to
6 authorize 4 tribally-operated Indian Health Service
7 hospitals or clinics to test methods for direct billing
8 and receipt of payment for health services provided
9 to patients eligible for reimbursement under the
10 medicare or medicaid programs under titles XVIII
11 and XIX of the Social Security Act (42 U.S.C. 1395
12 et seq.; 1396 et seq.), and other third-party payors.

13 (2) The 4 participants selected by the Indian
14 Health Service for the demonstration program began
15 the direct billing and collection program in fiscal
16 year 1989 and unanimously expressed success and
17 satisfaction with the program. Benefits of the pro-
18 gram include dramatically increased collections for
19 services provided under the medicare and medicaid
20 programs, a significant reduction in the turn-around
21 time between billing and receipt of payments for
22 services provided to eligible patients, and increased
23 efficiency of participants being able to track their
24 own billings and collections.

25 (3) The success of the demonstration program
26 confirms that the direct involvement of tribes and

1 tribal organizations in the direct billing of, and col-
2 lection of payments from, the medicare and medicaid
3 programs, and other third payor reimbursements, is
4 more beneficial to Indian tribes than the current
5 system of Indian Health Service-managed collec-
6 tions.

7 (4) Allowing tribes and tribal organizations to
8 directly manage their medicare and medicaid billings
9 and collections, rather than channeling all activities
10 through the Indian Health Service, will enable the
11 Indian Health Service to reduce its administrative
12 costs, is consistent with the provisions of the Indian
13 Self-Determination Act, and furthers the commit-
14 ment of the Secretary to enable tribes and tribal or-
15 ganizations to manage and operate their health care
16 programs.

17 (5) The demonstration program was originally
18 to expire on September 30, 1996, but was extended
19 by Congress, so that the current participants would
20 not experience an interruption in the program while
21 Congress awaited a recommendation from the Sec-
22 retary of Health and Human Services on whether to
23 make the program permanent.

24 (6) It would be beneficial to the Indian Health
25 Service and to Indian tribes, tribal organizations,

1 and Alaska Native organizations to provide perma-
2 nent status to the demonstration program and to ex-
3 tend participation in the program to other Indian
4 tribes, tribal organizations, and Alaska Native
5 health organizations who operate a facility of the In-
6 dian Health Service.

7 **SEC. 3. DIRECT BILLING OF MEDICARE, MEDICAID, AND**
8 **OTHER THIRD PARTY PAYORS.**

9 (a) PERMANENT AUTHORIZATION.—Section 405 of
10 the Indian Health Care Improvement Act (25 U.S.C.
11 1645) is amended to read as follows:

12 "(a) ESTABLISHMENT OF DIRECT BILLING PRO-
13 GRAM.—

14 "(1) IN GENERAL.—The Secretary shall estab-
15 lish a program under which Indian tribes, tribal or-
16 ganizations, and Alaska Native health organizations
17 that contract or compact for the operation of a hos-
18 pital or clinic of the Service under the Indian Self-
19 Determination and Education Assistance Act may
20 elect to directly bill for, and receive payment for,
21 health care services provided by such hospital or
22 clinic for which payment is made under title XVIII
23 of the Social Security Act (42 U.S.C. 1395 et seq.)
24 (in this section referred to as the 'medicare pro-
25 gram'), under a State plan for medical assistance

1 approved under title XIX of the Social Security Act
2 (42 U.S.C. 1396 et seq.) (in this section referred
3 to as the 'medicaid program'), or from any other
4 third party payor.

5 "(2) APPLICATION OF 100 PERCENT FMAP.—
6 The third sentence of section 1905(b) of the Social
7 Security Act (42 U.S.C. 1396d(b)) shall apply for
8 purposes of reimbursement under the medicaid pro-
9 gram for health care services directly billed under
10 the program established under this section.

11 "(b) DIRECT REIMBURSEMENT.—

12 "(1) USE OF FUNDS.—Each hospital or clinic
13 participating in the program described in subsection
14 (a) of this section shall be reimbursed directly under
15 the medicare and medicaid programs for services
16 furnished, without regard to the provisions of section
17 1880(c) of the Social Security Act (42 U.S.C.
18 1395qq(c)) and sections 402(a) and 813(b)(2)(A),
19 but all funds so reimbursed shall first be used by the
20 hospital or clinic for the purpose of making any im-
21 provements in the hospital or clinic that may be nec-
22 essary to achieve or maintain compliance with the
23 conditions and requirements applicable generally to
24 facilities of such type under the medicare or medic-
25 aid programs. Any funds so reimbursed which are in

1 excess of the amount necessary to achieve or main-
2 tain such conditions shall be used—
3 "(A) solely for improving the health re-
4 sources deficiency level of the Indian tribe; and
5 "(B) in accordance with the regulations of
6 the Service applicable to funds provided by the
7 Service under any contract entered into under
8 the Indian Self-Determination Act (25 U.S.C.
9 450f et seq.).
10 "(2) AUDITS.—The amounts paid to the hos-
11 pitals and clinics participating in the program estab-
12 lished under this section shall be subject to all audit-
13 ing requirements applicable to programs adminis-
14 tered directly by the Service and to facilities partici-
15 pating in the medicare and medicaid programs.
16 "(3) SECRETARIAL OVERSIGHT.—
17 "(A) QUARTERLY REPORTS.—Subject to
18 subparagraph (B), the Secretary shall monitor
19 the performance of hospitals and clinics partici-
20 pating in the program established under this
21 section, and shall require such hospitals and
22 clinics to submit reports on the program to the
23 Secretary on a quarterly basis during the first
24 2 years of participation in the program and an-
25 nually thereafter.

1 "(B) ANNUAL REPORTS.—Any participant
2 in the demonstration program authorized under
3 this section as in effect on the day before the
4 date of enactment of the Alaska Native and
5 American Indian Direct Reimbursement Act of
6 1999 shall only be required to submit annual
7 reports under this paragraph.
8 "(4) NO PAYMENTS FROM SPECIAL FUNDS.—
9 Notwithstanding section 1880(c) of the Social Secu-
10 rity Act (42 U.S.C. 1395qq(c)) or section 402(a), no
11 payment may be made out of the special funds de-
12 scribed in such sections for the benefit of any hos-
13 pital or clinic during the period that the hospital or
14 clinic participates in the program established under
15 this section.
16 "(c) REQUIREMENTS FOR PARTICIPATION.—
17 "(1) APPLICATION.—Except as provided in
18 paragraph (2)(B), in order to be eligible for partici-
19 pation in the program established under this section,
20 an Indian tribe, tribal organization, or Alaska Na-
21 tive health organization shall submit an application
22 to the Secretary that establishes to the satisfaction
23 of the Secretary that—
24 "(A) the Indian tribe, tribal organization,
25 or Alaska Native health organization contracts

1 or compacts for the operation of a facility of the
2 Service;
3 "(B) the facility is eligible to participate in
4 the medicare or medicaid programs under sec-
5 tion 1880 or 1911 of the Social Security Act
6 (42 U.S.C. 1395qq; 1396j);
7 "(C) the facility meets the requirements
8 that apply to programs operated directly by the
9 Service; and
10 "(D) the facility is accredited by an ac-
11 crediting body designated by the Secretary or
12 has submitted a plan, which has been approved
13 by the Secretary, for achieving such accredita-
14 tion.
15 "(2) APPROVAL.—
16 "(A) IN GENERAL.—The Secretary shall
17 review and approve a qualified application not
18 later than 90 days after the date the applica-
19 tion is submitted to the Secretary unless the
20 Secretary determines that any of the criteria set
21 forth in paragraph (1) are not met.
22 "(B) GRANDFATHER OF DEMONSTRATION
23 PROGRAM PARTICIPANTS.—Any participant in
24 the demonstration program authorized under
25 this section as in effect on the day before the

1 date of enactment of the Alaska Native and
2 American Indian Direct Reimbursement Act of
3 1999 shall be deemed approved for participa-
4 tion in the program established under this sec-
5 tion and shall not be required to submit an ap-
6 plication in order to participate in the program.
7 "(C) DURATION.—An approval by the Sec-
8 retary of a qualified application under subpara-
9 graph (A), or a deemed approval of a dem-
10 onstration program under subparagraph (B),
11 shall continue in effect as long as the approved
12 applicant or the deemed approved demonstra-
13 tion program meets the requirements of this
14 section.
15 "(d) EXAMINATION AND IMPLEMENTATION OF
16 CHANGES.—
17 "(1) IN GENERAL.—The Secretary, acting
18 through the Service, and with the assistance of the
19 Administrator of the Health Care Financing Admin-
20 istration, shall examine on an ongoing basis and im-
21 plement—
22 "(A) any administrative changes that may
23 be necessary to facilitate direct billing and re-
24 imbursement under the program established
25 under this section, including any agreements

1 with States that may be necessary to provide
2 for direct billing under the medicaid program;
3 and
4 "(B) any changes that may be necessary to
5 enable participants in the program established
6 under this section to provide to the Service
7 medical records information on patients served
8 under the program that is consistent with the
9 medical records information system of the Serv-
10 ice.
11 "(2) ACCOUNTING INFORMATION.—The ac-
12 counting information that a participant in the pro-
13 gram established under this section shall be required
14 to report shall be the same as the information re-
15 quired to be reported by participants in the dem-
16 onstration program authorized under this section as
17 in effect on the day before the date of enactment of
18 the Alaska Native and American Indian Direct Re-
19 imbursement Act of 1999. The Secretary may from
20 time to time, after consultation with the program
21 participants, change the accounting information sub-
22 mission requirements.
23 "(e) WITHDRAWAL FROM PROGRAM.—A participant
24 in the program established under this section may with-
25 draw from participation in the same manner and under

1 the same conditions that a tribe or tribal organization may
2 retrocede a contracted program to the Secretary under au-
3 thority of the Indian Self-Determination Act (25 U.S.C.
4 450 et seq.). All cost accounting and billing authority
5 under the program established under this section shall be
6 returned to the Secretary upon the Secretary's acceptance
7 of the withdrawal of participation in this program.".
8 (b) CONFORMING AMENDMENTS.—
9 (1) Section 1880 of the Social Security Act (42
10 U.S.C. 1395qq) is amended by adding at the end the
11 following:
12 "(e) For provisions relating to the authority of cer-
13 tain Indian tribes, tribal organizations, and Alaska Native
14 health organizations to elect to directly bill for, and receive
15 payment for, health care services provided by a hospital
16 or clinic of such tribes or organizations and for which pay-
17 ment may be made under this title, see section 405 of the
18 Indian Health Care Improvement Act (25 U.S.C. 1645).".
19 (2) Section 1911 of the Social Security Act (42
20 U.S.C. 1396j) is amended by adding at the end the
21 following:
22 "(d) For provisions relating to the authority of cer-
23 tain Indian tribes, tribal organizations, and Alaska Native
24 health organizations to elect to directly bill for, and receive
25 payment for, health care services provided by a hospital

1 or clinic of such tribes or organizations and for which pay-
2 ment may be made under this title, see section 405 of the
3 Indian Health Care Improvement Act (25 U.S.C. 1645).".
4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall take effect on October 1, 2000.

○

The CHAIRMAN. Our first witness today is the deputy director of the Indian Health Service, Michel Lincoln.

Mr. Lincoln, welcome, sir. We have received your statement, and your full statement will be made part of the record.

STATEMENT OF MICHEL LINCOLN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD, ACCOMPANIED BY ADMIRAL GARY HARTZ, ACTING DIRECTOR OF THE OFFICE OF PUBLIC HEALTH

Mr. LINCOLN. Thank you.

Mr. Chairman, we very much appreciate this hearing on S. 406 today. It is a critical issue, a step that the Congress and the administration can take together that very clearly will benefit tribal governments, very clearly benefit their health programs, as we move into the next century.

I'm accompanied today by Admiral Gary Hartz, who is our acting director of the Office of Public Health. It is within this office that the managed care program and the Medicare, Medicaid, and private insurance components of that program are carried out. Admiral Hartz is to my left.

Dr. Trujillo sends his regrets today that he is unable to be with you; however, in preparing the testimony, he has had an opportunity to have full input into the testimony, and this, in essence, is his testimony.

I would like to comment that the administration's position, the Indian Health Service, the Department of Health and Human Services, the Health Care Financing Administration, and the OMB all support this bill. It is a strong bill. It is one that will clearly allow tribal governments and Indian health programs to improve the health of people that they serve.

I would like to point out that Indian people continue to suffer disproportionately from 1 dozen or more kinds of health indicators. Indian people suffer from alcoholism deaths 730 percent more than non-Indian people. The ratio is 1 to 7.3. The same can be said for diabetes, at 350 percent more. Motor vehicle collisions impact on Indian communities 3.3 times more than they do in non-Indian communities.

The mission and goal that the Indian Health Service and Indian health programs have established is critical to this particular piece of legislation.

Our objectives have been developed, and are primarily health objectives. This bill will primarily benefit the program and the services that will be provided to people. Our goals are: Improve health status, provide health services, assure partnerships in consultation with the tribes, and perform core functions in advocacy.

I believe this bill has all of those functions in mind as we move forward.

In 1988, Congress amended the Indian Health Care Improvement Act by adding the provision that would authorize a demonstration program in the Indian Health Service to four qualified tribes, tribal organizations, Alaska Native health organizations. In this demonstration, these organizations, these four groups, would be able to directly bill and receive payments for health services pro-

vided under the Medicare law and provided under the Medicaid law, titles 18 and 19 respectively.

A report on the direct billing demonstration project was prepared by the Indian Health Service in December 1997, and presented to the Congress by the Secretary of Health and Human Services in June 1998.

Within this report, we documented that those four participants—the Southeast Alaska Regional Health Corporation in Sitka; the Bristol Bay Area Health Corporation in Dillingham, AK; the Choctaw Nation of Oklahoma in Durant, OK; and the Mississippi Band of Choctaw Indians in Philadelphia, MS, were the four tribal groups that participated in the demonstration program.

They were to demonstrate these priorities: No. 1, to achieve or maintain accreditation or certification; No. 2, to improve the health resource deficiency; and, No. 3, to achieve and maintain compliance with regulations of the service.

We are here, and in that report, to tell you that this demonstration project has been an overwhelming success. The demonstration sites during this period of time had collection rate increases that ranged from a low of 152 percent to a high of 364 percent, while the Indian Health Service, working through its systems and processes for the same period of time, averaged an increase of 152 percent.

It is very clear to us that the rapid increase for tribal participants can be attributed to ownership of the system, improved billing and collection practices, easier reconciliation between invoices and accounts, and improved staffing.

It is this link that we would like to make for you today with health services. As the collections have increased, it is clear to us that the tribes have invested those increased collections in the delivery of health service programs and the development of preventive health programs.

During this last year, when both the IHS and the Health Care Financing Administration consulted with tribes on health-related issues, tribes were unanimous in their request for the department to support extension and expansion of this authority to authorize any tribe to participate in this program if they so chose to do that.

Mr. Chairman, Admiral Hartz and myself are here to answer any questions. We offer this committee strong support for a very successful program, and we look forward to the expansion of this program to other tribes that choose to participate.

Thank you, Mr. Chairman.

Senator INOUYE. Thank you very much, Mr. Lincoln.

[Prepared statement of Mr. Lincoln appears in appendix.]

Senator INOUYE. You have testified that the demonstration projects involving the two Alaska corporations and the two tribes have been an overwhelming success. Those were the words you used. But yet, in your prepared statement you say you support the "proposed intent of S. 406." Does it mean that you have some question as to the bill language?

Mr. LINCOLN. Mr. Chairman, this bill language has been reviewed within the administration, and we believe this bill language is acceptable.

Senator INOUYE. And you also testified that the proposal should be implemented in a fiscally-responsible manner. Are you suggesting that it may not be?

Mr. LINCOLN. No; we're not, Mr. Chairman. That phrase within the last sentence of almost the last paragraph in the bill is one where we're just acknowledging that funding would need to be set aside for the increases that were anticipated as we implement this bill and as we expand to other tribes. And so it is a matter of making sure that we've accounted for the availability of funding, primarily, through, the Medicare and Medicaid program.

What we're talking about here are Indian people who are eligible and entitled to participate in the Medicare and the Medicaid program. This is a mechanism to certainly have them enrolled. This is a mechanism to receive additional resources associated with their entitlement.

Senator INOUYE. Admiral, do you wish to add anything to the testimony?

Admiral HARTZ. Sounded like a good response to me. Thank you, sir.

Senator INOUYE. Senator Reid, do you have any questions?

Senator REID. No; I do not, Mr. Chairman.

Senator INOUYE. Senator Murkowski.

STATEMENT OF HON. FRANK H. MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Mr. Chairman, let me thank you for conducting the hearing this morning. As you and I know, along with Senator Campbell, we believe the bill will substantially reduce the redtape associated with the bureaucracy which is inherent in any government agency, including the Indian Health Service. In particular it will relieve the Medicare and Medicaid reimbursement difficulties.

We think it is a commonsense approach. As you know, the act is an expansion of current demonstration projects which I think challenge the innovation of our American Indian people. Particularly inclusive will be two Alaska locations—the Bristol Bay Health Corporation in Dillingham and the Southeast Alaska Regional Health Corporation. I guess we're going to have a videotape testimony of Frank Sutton for the Southeast Region Health Consortium.

I'm told by Mr. Sutton that previously the hospital had to wait four to nine months to collect reimbursement for Medicare or Medicaid, and after the demonstration project the length of time between billing and collection was 30 days. I think this has made the collections for the Southeast Alaska Region Consortium nine times faster, and that's a time saving factor which means more Medicaid and Medicare dollars to the Native health facilities to use for improving health care.

Last, I want to note that all participants in this demonstration program, as well as the HHS and IHS, report that the program is a success, and I'm pleased that the witnesses are here and have spoken so far in support of the legislation.

I want to thank you and the professional staff for expediting this process.

Senator INOUYE. Thank you very much.

Senator MURKOWSKI. Thank you for the opportunity to address it.

Senator INOUYE. Before proceeding, a statement in support of the measure by the chairman of this committee will be made part of the record at the appropriate place.

[Prepared statement of Senator Campbell appears in appendix.]

Senator INOUYE. I thank you very much, Admiral and Mr. Lincoln.

Our next panel is made up of the chief of the Choctaw Nation of Oklahoma, Greg Pyle; the chairman of the National Congress of American Indians, Ron Allen; and the chairman of the National Indian Health Board, Buford Rolin.

Chief Pyle, welcome, sir.

STATEMENT OF GREGORY E. PYLE, CHIEF, CHOCTAW NATION OF OKLAHOMA, DURANT, OK

Mr. PYLE. Thank you, Senator. I appreciate it.

Mr. Chairman, it is my pleasure to come before the committee in support of S. 406 to allow tribes to bill directly for Medicare and Medicaid, and S. 299, to elevate the director of Indian Health Service to Assistant Secretary for Indian Health within the Department of Human Services.

I'd like to take this brief moment to also introduce our speaker of our Choctaw Nation Tribal Council, Bob Pate, who is in the audience.

Question—should we go over just the Medicare and Medicaid bill first? Is that all?

Senator INOUYE. That would be fine, sir.

Mr. PYLE. Okay. I, of course, represent the Choctaw Nation of Oklahoma. We're the third-largest tribe in the Nation, and we manage our hospital and five health centers under a self-governance compact.

The Choctaw Nation was one of the four tribes selected by the Indian Health Service to participate in a demonstration project for direct billing of Medicare and Medicaid, which was a result of the 1988 amendment of the Indian Health Care Improvement Act.

Choctaw Nation has been direct billing Medicare and Medicaid for almost 10 years, with very great success. The direct billing process allowed us to decrease our processing claims from 3 to 4 months to about 2 weeks, on average. It has allowed us to reduce our administrative staff from eight positions down to four positions. Also, our ability to direct bill has provided us the opportunity to develop an electronic interface with respective fiscal intermediaries and to reduce our recordkeeping time.

Reimbursements have improved about 159 percent since we started direct billing, and the proposed permanent legislation would not only provide all tribes with the necessary tools to make them more efficient and effective, but it would also reduce the administrative cost of the Indian Health Service, which would free up money to go to what it is meant for, for health services, just like we've directed our eight to four. That all goes into more health services for Indian people. I think that's why we're here today.

Without question, this bill is a certain win/win situation for the tribes and the Indian Health Service, both. It has no down side, whatsoever, other than just helping out the Indian people, as a whole.

At this time I'll relinquish my time, and we can also go into the other bill later. I do appreciate it and ask any questions we have.

Senator INOUYE. If you may, you may speak on S. 299, also.

Mr. PYLE. Okay. Well, of course, the Indian Health has responsibility for about 1,300,000 people throughout the United States. The budget exceeds $2.3 million [sic]. It is the responsibility of the director of Indian Health Service to interact with all the other Federal health care programs on a direct basis, as well to work directly with the Secretary of the Department of Human Services.

The direct working relationship can only be accomplished by elevating the director of the Indian Health to an Assistant Secretary so he can work directly with the Secretary without going through the various bureaucratic levels of the Department.

The elevation of the director of Indian Health would also give tribes a much better opportunity to access the other programs administered by HHS. This elevation would then put the director at the same level as the Assistant Secretary of the Bureau of Indian Affairs, and they would then be equal.

We certainly support the director of Indian Health Service to Assistant Secretary level, and it would certainly be much, much more effective for the Indian people throughout the United States.

We would thank this committee for allowing us to testify today, and any questions you have I'll certainly try to answer. Thank you very much.

Senator INOUYE. Chief, I thank you very much for your statement.

[Prepared statement of Mr. Pyle appears in appendix.]

Senator INOUYE. May I now call on the chairman of the NCAI. Mr. Chairman.

STATEMENT OF W. RON ALLEN, CHAIRMAN, NATIONAL CONGRESS OF AMERICAN INDIANS, WASHINGTON, DC

Mr. ALLEN. Thank you, Mr. Chairman.

Members of the committee, it is always an honor to be able to be here to testify before this committee on important matters to Indian country.

We have submitted to you our testimony for the record, and I'd just like to be able to highlight what I think are some of the main issues with regard to these two bills that you are entertaining.

On the first bill, the elevation of the IHS director to Assistant Secretary level, it is a proposition that the National Congress of American Indians and our member tribes have been advancing for some time now.

As you are well aware, it is the largest direct care health agency in HHS, and, as Chief Pyle has pointed out, you know, it serves well over 1.3 to 1.4 million Indians, and we believe that there are another 500,000 or 600,000 Indians out there that also need health care services that we are very concerned about.

But, in order for us to advance the health care needs within the administration and advance those agendas, we firmly believe that

the director does need to have a more direct relationship with the Secretary as the Secretary deliberates on what are the priorities of that particular Department with regard to its agenda to be incorporated in the President's budget.

Too often in the past the director has not had the opportunity to be able to champion the issues that we have to address health care services, everything from direct health care services to facility needs, dealing with contract support issues that we have been wrestling with for some time, and many other issues, and we believe that they are very, very important.

We think that this issue is a reflection on the implementation of the self-determination and self-governance legislation where the Congress and the Administration is advancing the empowerment of tribal governments.

As we move that forward, not only would this position allow that individual to advance it within the health care arena, but also within the whole Department, and continue to champion it in the other arenas.

As you are well aware, we have been advancing the title V with self-governance, which encompasses other programs and agencies in HHS. Then this individual would have a better position to discuss that matter and champion that cause within the administration to make those agendas of empowering tribal governments more fluid and more successful.

So we really believe that this is an important step. We do not believe that it is creating unnecessary bureaucracy. We think it is going to help streamlining the bureaucracy and do the reverse of what many people's perceptions are.

On the second issue of the S. 406 on the Medicare/Medicaid proposal, this is another arena where the tribes have become more capable of handling their own programs.

In this area of the health care services, without a doubt the four demonstration projects have proved, in our judgment conclusively, that tribes can better manage the systems if they are provided the authority to collect the third-party rates from the Medicare and Medicaid, through the States. If it is coming straight from the Federal Government to the tribes, we can better improve it. We eliminate a whole lot of bureaucracy. It does not need to go back to the Federal Government then back to the tribes.

These demonstrations have shown that it can happen. It can happen very effectively.

And, quite frankly, we believe that these bills actually coincide or complement each other, because here the director of IHS or the Assistant Secretary would be working with his counterparts within the Administration to show why it is more effective and more efficient use of Federal dollars if the tribes can collect these rates themselves directly.

The bottomline is improvement of the efficacy of Federal dollars.

We believe that this is all part of our empowerment. This is all part of the success of the self-determination and self-governance movement. We think, as we go into the 21st century, that these two bills will help us move forward more effectively and more efficiently and more cooperatively with the Federal Government.

Thank you, and I look forward to working with you on both of these matters.

Senator INOUYE. Thank you very much, Chairman Allen.

[Prepared statement of Mr. Allen appears in appendix.]

Senator INOUYE. Now may I call on Chairman Rolin.

STATEMENT OF BUFORD ROLIN, CHAIRMAN, NATIONAL INDIAN HEALTH BOARD, DENVER, CO

Mr. ROLIN. Thank you, Mr. Chairman.

Mr. Chairman and members of the Senate Committee on Indian Affairs it is a pleasure for me to testify on behalf of the National Indian Health Board in support of S. 299 and S. 406, the elevation of the director of the Indian Health Service and the tribal Medicare/Medicaid direct billing project.

As you know, the National Indian Health Board represents 558 tribal governments. Our membership is elected throughout the various areas as membership of the board.

The National Indian Health Board strongly supports enactment of S. 299 and S. 406. We believe, through the enactment of S. 299, the government-to-government relationship between the United States and each tribal government will be better fulfilled if the director of the IHS is elevated to an Assistant Secretary level.

What this will do, it would definitely promote better relations within the Federal Government, within the director of the Indian Health Service.

With the enactment of S. 406, the NIHB is convinced that permanent establishment of direct Federal billing under Medicaid and Medicare will reduce the bureaucracy involved between agencies and will enhance third-party collections for all tribes.

Now, each of these two health bills will significantly improve the quality and quantity of health care services at the grassroots level within the tribes.

With specific regards to S. 299, despite new technological advances, Indian people are suffering and dying premature death, as you heard from Mr. Lincoln this morning, due in large part to underfunding from the Indian Health Service.

Now, no doubt that affects the overall health of all our American Indians and Alaska Native people, but in the last few years it has substantially improved, and we are appreciative of that. However, with new epidemiological information, as we heard earlier, throughout Indian Country, diabetes, heart disease, and cancer are very strong. There is a problem of the issue of infectious diseases, such as AIDS and pneumonia. There is also a high prevalence of violence and intentional injuries, as well as alcoholism and drug abuse.

These are health disparities which cry out for public attention yet remain largely unattended to due to a lack of funding.

One of the key reasons for limited funding is an inability of the Indian Health Service to get the attention and support of budgetary concerns within the Office of Management and Budget.

In the review of Indian country, this translates into the lack of respect. With the enactment of S. 299, the Assistant Secretary for Indian Health will be able to advocate more directly on its funding

priorities, and the Assistant Secretary for Indian Health will have access to other agencies within the Department.

With the elevation of the IHS director to the position of Assistant Secretary for Indian Health, the IHS will be able to provide a direct line of communication with Secretary Shalala and other Agency leaders on the unmet need of Indian people.

This bill certainly will provide the IHS with organizational independence and the capacity to advocate for itself at the highest level with more authority.

With regards to S. 406, it is our understanding that S. 406 amends the Indian Health Care Improvement Act to make permanent the demonstration programs and would allow other tribes and tribal organizations, including self-governance compacts, Indian self-determination contracts, to participate in direct billing programs and receive payment directly from Medicare, Medicaid, and from other third parties.

When Congress authorized the demonstration project for direct billing of Medicaid, it raised tribal expectations that the demonstration would develop a mechanism to bypass the government. Instead, the demonstration project bypasses the Indian Health Service so that tribes and tribal organizations can receive Medicaid payments directly from the State.

Now, we have long recognized the success, and you heard this morning of the Bristol Bay Health Corporation, the Southeast Alaska Regional Health Corporation, the Mississippi Band of Choctaw Indians, and the Choctaw Indians of Oklahoma in their demonstration projects of direct billings.

It has been our desire at the National Indian Health Board to secure—and we are still working on this—funding from private foundations to evaluate the demonstration project and the tribes' ability to increase their collections and decrease turn-around time between billing and payment.

It is our understanding that within the improvements that have been made, as we heard earlier, is the improvement of the JCHO accreditation process and ratings of quality, as well as the level of health care available to the patients.

In 1998, the National Indian Health Board completed a nine-State study on the practices of Medicaid and managed care. We understand from the study on Medicaid and managed care that the demonstration project has been successful and there is demand to increase the number of tribes and tribal organizations that can receive payments in this way.

For purpose of today's hearing, I am happy to make available—and it is included as a part of our written testimony—the executive summary that the National Indian Health Board completed on funding with that project.

As you are well aware, tribal governments are working very closely with the Indian Health Service to draft a new bill to reauthorize the Indian Health Care Improvement Act. Title 4 of that draft reauthorization bill provides a variety of changes to the Indian health provisions within Medicaid, Medicare, and State child health insurance programs which serve the capacity of tribes and tribal organizations to improve their reimbursements.

While we have not recommended specific changes to the bill language contained within S. 406, we respectfully request that the committee consider adoption of the draft provisions recommended within title four of the new Indian Health Care Improvement Act.

In conclusion, on behalf of the National Indian Health Board I thank the committee for considering our testimony on S. 299 and S. 406. In previous hearings, we have supplied the committee with resolutions which indicate our unequivocal support of the formal measures of S. 299.

Our views in support of S. 406 are shaped by studies in Medicaid and managed care. We believe the demonstration project has enhanced the capacity of the four tribes who participated in the project to increase their revenues and improve the quality of health among their people in their communities.

The capacity to improve Medicaid and Medicare reimbursements in all tribal communities is a worthy goal and will be certainly appreciative of our tribal communities.

Thank you very much.

Senator INOUYE. Thank you very much, Chairman Rolin.

[Prepared statement of Mr. Rolin appears in appendix]

Senator INOUYE. I have a few questions, if I may.

First, to Chief Pyle, you have testified that direct billing has reduced administrative costs. Can you give us some idea as to how much this reduction has been?

Mr. PYLE. The eight people that we used to have to have—and that was before we were able to increase it by 159 percent—these generally average about $120,000 saved each year, along with Indian Health Service. If they are able to reduce their staff by that much, we're talking a savings of approximately a quarter of a million dollars a year. Now, under a compact that money automatically goes back in the budget, and basically it goes into more services for the Indian people, and that's just one tribe. So we do appreciate that question.

Senator INOUYE. Has direct billing led to any improvements in your facilities and services?

Mr. PYLE. Yes, sir; to be able to use third party we'd be able to upgrade facilities. We have our clinics with average age of about 30 years of age. Our hospital was built in the 1930's. We are now—construction completion of a hospital. We are able to buy a large amount of equipment, particularly with third party.

In our area there is not such a thing as a CAT scan, and, because of the obviously-increased money we are able to collect, we were able to even get a CAT scan. We share this with other tribes.

We have about 115,000 members in the Choctaw Nation, and, simply, the children—we couldn't afford to send them to get a CAT scan, and with this we were able to purchase one, and various other pieces of very, very badly-needed equipment to replace old, existing equipment.

Even in our clinics that were 30 years old and very, very crowded situations, we were able to take this money and replace equipment.

We are attempting now to even upgrade how we can do our better facilitation of all data. And when I say "data," we're going to go to a central bank, use this information and even our CHRs out there now will be able to connect into a data, where if the patient

goes to the hospital one day, the next day they'll have information over the phone, and we're going to use third-party dollars to upgrade this.

It will double the efficiency, we think, of our community health representatives out there.

Senator INOUYE. Thank you very much.

Chairman Allen, as you know, the matter of elevating the director to the Assistant Secretaryship has been advocated for the past 15 years or so. Is there any urgency that it be done right away?

Mr. ALLEN. We believe there definitely is an urgency. In these trying times of budget austerity that the Congress is deliberating on, the issue is within the HHS' priorities that IHS has to be able to be in a position to negotiate with the Secretary and their senior budget officials with regard to what their priorities are. Otherwise, their agenda gets submitted into that senior level forum and there is no champion unless they call upon them to give them further explanation about their request.

And so when they have their debate and deliberation with OMB in terms of how this can be submitted into the President's budget, that level of relationship with the Secretary is critical——everything that falls underneath the budget, whether it is a special initiative such as the diabetes initiatives or whether it is other agendas that are advancing the Self-Determination Act.

Senator INOUYE. And you believe that the interests and concerns of Indian country would be better presented with the Assistant Secretary?

Mr. ALLEN. Absolutely. We believe, because of the very unique historical, legal, and moral relationship of the Indian nations to the United States, there is a need to have the person who represents our interests with regard to health care services have a direct relationship to the senior official of the agency that presides over those programs, and if they don't, then essentially it is relegating the Indian issues down into the system. As you well know, within any bureaucracy, your voice starts to lose its strength and influence of advancing those priorities.

Senator INOUYE. I have one more question.

As you are well aware, there are large tribes and small tribes, some with great efficient government structures, others that do not have such efficiencies. Would this measure have any impact on the difference between those tribes?

Mr. ALLEN. In terms of advocating for those various tribes' interest?

Senator INOUYE. No; for opportunities provided by S. 406.

Mr. ALLEN. No; I don't think it makes a difference. The 406 opportunity is really relative to the tribes' capacity to recover those resources directly and become more efficient.

As you are probably well aware, the sophistication of the tribes, of the 557 tribes across the United States, varies. Some are, without a doubt, very sophisticated, like the Choctaw Nation of Oklahoma. But, on the other hand, there are some who are still growing. They are probably not going to take advantage of it right away. But well over half of the tribes are going to take advantage of it, if not substantially more than that, and I think Buford may even know the number more accurately than I do.

But I have been able to observe the sophistication of our programs, and I know that the small tribes will take advantage of it. It's just that the magnitude of the recovery of those reimbursements won't be as important or as big, but the use of it is every bit as important to advance the same objectives that Chief Pyle had articulated.

Senator INOUYE. I thank you very much, Chairman.

If I may now call upon Chairman Rolin, you have indicated that by providing authority for direct billing and reimbursement tribes have been able to improve quality and level of health care. Can you tell us how these improvements have been brought about? Do we have anything that we can see in numbers?

Mr. ROLIN. Not with me today, but certainly I can provide those. But I can tell you that within the tribes and within their own sophistication is what has happened, their own abilities to utilize their data system, working within the Indian Health Service, and then the RPMS systems certainly have enhanced our ability, all of our tribes, to collect third party.

The one problem with that, Senator, is that within the Medicare collections the tribes have to still work through a fiscal intermediary. Of course, we have been working with HCFA on these very issues, and it is our goal to have tribes, as I testified, to be able to collect directly.

Of course, I know that's very ambitious, and certainly—but we feel that if tribes were able to collect directly, enhance their own billing process, then certainly the third party collection aspect would be much more valuable to us, and utilize that resource more adequately for providing services to our tribal members.

Senator INOUYE. You noted a very interesting argument in favor of the measure by saying that if we elevate the director to Assistant Secretary it will bring about greater respect for Indian Country. I thought the was very interesting.

Mr. ROLIN. Thank you. We certainly feel that it will, and within the Department now is the director. It's quite a difference when he attends meetings, as opposed to whether or not he was assistant secretary, so we feel very strongly in that aspect, sir.

Senator INOUYE. Senator Gorton.

Senator GORTON. I have no questions.

Senator INOUYE. Senator McCain.

STATEMENT OF HON. JOHN McCAIN, U.S. SENATOR FROM ARIZONA

Senator MCCAIN. Mr. Chairman, I thank you and I thank the witnesses for being here, and I thank them for their support of this legislation that has become something of a sisyphean task. This is the fourth effort to designate the IHS director to Assistant Secretary, and I'm sure that the Senate will probably report it out again. I hope we can prevail on our friends on the other side of the Capitol.

I'm not sure it will have significant and profound change in the way we treat the issue of Indian health care, but I think it is obvious, from the testimony of the leaders in the Native American community, that it is important to them. It is a very small step. I am sometimes amazed at how difficult it has been.

For a couple of years, as you know, Mr. Chairman, it was opposed by the administration. We had to overcome that.

I hope that no one has any illusions that what is really needed is attention, funding, and focus on the problems of Indian health care in America, but I think this may be some small way of bringing that attention and priority to it.

I thank you, Mr. Chairman, for your continued and many year-long support, and I hope we can markup this bill and other legislation before the committee as soon as possible.

Thank you, Mr. Chairman.

Senator INOUYE. It will be done today, and I thank you very much.

There is a 3-minute video prepared by the Southeast Alaska Regional Health Corporation we would like to be shown at this time.

We need to call a recess at this time. There is a vote. We will vote and return. This committee will stand in recess for a few minutes.

[Recess.]

Senator INOUYE. May we now view the video?

[Videotape presentation.]

Senator INOUYE. Thank you very much.

I hope this does not set a precedent, testifying by video. I cannot ask him any questions.

Alaskans, very innovative.

[Whereupon, at 11:22 a.m., the committee proceeded to further business.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Every year, Congress deliberates on how best to raise the standard of health care for all Americans. Yet, in nearly every debate, the health care needs of Indian people are ignored.

More than 1.3 million Indian people are served every year by the Indian Health Service, which is the principal advocate for Indian health care both on the reservation and for urban populations. Under the current structure the Indian Health Service Director's authority to set and implement health policy for American Indians is limited.

At its current capacity, the Indian Health Service estimates that it can only meet 62 percent of tribal health care needs. The Indian Health Service will continue to be challenged by a growing Indian population as well as an increasing disparity between the health status of Indian people as compared to other Americans. Thousands of Indian people continue to suffer from the worst imaginable health care conditions at a rate that exceeds other segments of our society.

Key legislation we will consider today, S. 299, will elevate the Indian Health Service Director to the Assistant Secretary for Indian Health. This bill is to establish the Office of the Assistant Secretary for Indian Health within the Department of Health and Human Services (HHS). This elevation is necessary to facilitate advocacy for the development of appropriate Indian health policy, and promote consultation on matters related to Indian health care.

Another bill, S. 406, is an expansion of a current demonstration project that includes two tribes and two Alaska tribal organizations. This demonstration program dramatically increases collections for Medicare and Medicaid services, significantly reduced the turn-around time between billing and the receipt of payment for Medicare and Medicaid services, and increased the administrative efficiency of the participating health facilities. All of the participants in the demonstration program—as well as the Department of Health and Human. Service and the Indian Health Service—report that the program is a great success.

S. 406 will make permanent the demonstration program and will end much of the red tape and bureaucracy for Indian Health Service facilities involved with Medicare and Medicaid reimbursement. The bottom line is that it will mean more Medicaid and Medicare dollars to Indian healtli care facilities to use for improving health care for their citizens.

I am hopeful that these two bills will be enacted into law in this session of Congress.

PREPARED STATEMENT OF MICHEL E. LINCOLN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee: Good Morning. I am Michel E. Lincoln, Deputy Director, Indian Health Service (IHS). Our Director, Dr. Michael Trujillo sends his regrets that he is not available to be here with you today. Today, I am accompanied by Gary Hartz, P.E., Assistant Surgeon General, Acting Director, Office of Public Health. We welcome the opportunity to testify on S. 406, Alaska Native and American Indian Direct Reimbursement Act of 1999, a bill to amend the Indian Health Care Improvement Act to make permanent the demonstration program that allows for the direct billing of Medicare, Medicaid and other third party payors, and to expand the eligibility under this authority to other tribes and tribal organizations.

The IHS has the responsibility for the delivery of health services to federally recognized American Indians and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (I/T/U/) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The Mission of the agency is to raise the physical, mental, social and spiritual health of AI/AN to the highest level, in partnership with the population served. The Agency goal is to assure that comprehensive, culturally acceptable health services are available and accessible to the service population. The mission and goal are addressed through four Strategic Objectives, which are: (1) Improve health status; (2) Provide health services; (3) Assure partnerships and consultation with I/T/U's; and (4) Perform core functions and advocacy.

The Federal commitment is to raise AI/AN health status in full partnership with tribal governments. Congress reaffirmed the obligation of the United States Government under treaties, executive orders and Federal statutes to provide health services to, and to improve the health status of, members of federally recognized Indian tribes through passage of the Indian Health Care Improvement Act in 1976. In 1988, Congress amended the Indian Health Care Improvement Act by Public Law 100–713 to establish a demonstration program in the Indian Health Service authorizing four qualified Indian tribes, tribal organizations, and Alaska Native health organizations to directly bill for and receive payments for health services provided under the Medicare and Medicaid (M&M) programs or any other program.

Prior to this legislation, M&M collections for all IHS facilities were placed in a special IHS fund account and subsequently allocated back to the IHS facilities by the IHS headquarters. Collections were placed in the special fund account to ensure that each facility met the requirements for participation in the Medicare and/or Medicaid programs. The demonstration program was authorized to determine whether collection activities could be improved through more direct involvement of the tribal health providers as compared to the old practice of channeling M&M collections through IHS after they were billed by the facility providing the reimbursable health care service.

A report on the Direct Billing Demonstration was prepared by IHS in December 1997 and presented to Congress by the Secretary, DHHS in June 1998. This report provides documentation of the successes and further recommendations. I will provide some highlights from this report.

IHS began implementation of the Demonstration in 1990 with the selection of four participants: The Southeast Alaska Regional Health Corporation in Sitka, AK; the Bristol Bay Area Health Corporation in Dillingham, AK; the Choctaw Nation of Oklahoma in Durant, OK and the Mississippi Band of Choctaw Indians in Philadelphia, MS. Each of the participants was receiving reimbursements by the end of 1991.

The funds obtained by tribes in this Demonstration were to be used in the following priority: (1) to achieve or maintain Accreditation or Certification; (2) to improve the health Resource deficiency; and (3) to achieve or maintain compliance with regulations of the Service.

Four tribal participants have seen their collections increase more rapidly than did the IHS as a whole over the period fiscal years 1990–96. The Demonstration sites had collection rate increases that ranged from a low of 152 percent to a high of 364 percent, while IHS averaged an increase of 152 percent. The more rapid increase for the tribal participants can be attributed, in part to a local feeling of ownership of the system, improved billing and collections practices, easier reconciliation between invoices and accounts, and improved staffing. By allowing tribal health programs to directly bill the State for M/M reimbursable services, they were able to by-pass several administrative requirements that they would have been required to follow without this demonstration authority. They would have had to bill the IHS Area Office and then the Area Office would seek reimbursement from the State Medicaid Office.

There were other benefits derived by the Demonstration participants. There was a major reduction in the time between billing and collection of Medicare and Medicaid funds The range was from zero to 8 months, with most billings occurring within the range of 3–4 months. With collections returning within a matter of weeks from billing, management planning for the use of collections was improved.

The other benefits noted were an across the board increase in the JCAHO ratings attributed in part to the increased funds available to enhance staff, to make medical equipment purchases, and to make necessary repairs and renovations to the hospitals. The demonstration also was cited as assisting in improving the quality and level of care.

The demonstration has been a success. The participating tribes are satisfied with the process and unanimously support the effort to make this demonstration a permanent authority. During the last year, when both the IHS and the Health Care Finance Administration (HCFA) consulted with tribes on health related issues, tribes were unanimous in their request for the Department to support extension and expansion of this authority to authorize any tribe to participate in this program if they chose. In general, these tribes have increased their collection rates above that of the IHS facilities, have experienced a significantly decreased turn-around time for collections that enhances cash flow, and have increased the efficiency of tracking the receipts of billings against collections. Direct billing for and receipt of M&M payments provide additional flexibility to tribes while ensuring that the participating facilities continue to meet the criteria for M&M participation.

The four tribes who participate in the demonstration now have derived significant benefits and the accountability for the funds has continued to be met. In brief summary, the administration and IHS supports the proposed intent of S. 406 to make the direct M&M billing authority permanent and make it available to other eligible Indian tribes and tribal organizations. This proposal should be implemented in a fiscally responsible manner and considered in the context of the President's Fiscal Year 2000 budget.

Mr. Chairman, this concludes my statement. We will be pleased to answer any questions you may have. Thank you.

PREPARED STATEMENT OF GREGORY E. PYLE, CHIEF, CHOCTAW NATION OF OKLAHOMA

Mr. Chairman, it is my pleasure to come before this committee in support of S. 406, to allow tribes to bill directly for Medicaid and Medicare and S. 299, to elevate the Director of the Indian Health Service to an Assistant Secretary for Indian Health within the Department of Health and Human Services.

I represent the Choctaw Nation of Oklahoma which is the third largest tribe in the Nation. The Choctaw Nation manages their own hospital and five health centers under a Self-Governance Compact.

The Choctaw Nation was one of the four tribes selected by the Indian Health Service to participate in the Demonstration Project for Direct Billing of Medicare and Medicaid which was a result of the 1988 Amendment, (P.L. 100–713), of the Indian Health Care Improvement Act.

The Choctaw Nation has been direct billing Medicare and Medicaid for almost 10 years with great success. The direct billing process has allowed us to decrease our processing time of claims from three (3) or four (4) months to about two (2) weeks and we do not have any findings with Medicare and Medicaid.

It has also allowed us to reduce Our administrative overhead from eight (8) positions to four (4) positions to process claims and manage the accounts receivable. Our ability to bill direct has provided us the opportunity to develop an electronic interface with the respective fiscal intermediaries to reduce our processing and recordkeeping time.

Our reimbursements have improved by 159 percent since we started billing direct. These reimbursements have allowed the Choctaw Nation to improve our health care facilities and services.

This proposed permanent legislation would not only provide all Tribes with the necessary tools to make them more efficient and effective but it would also reduce the administrative costs within the Indian Health Service which are presently handling all of the claims after they are processed by the Tribes and indirectly trying to keep up with the accounts receivable and accounts payable.

Without question Senate Bill 406 is a win win situation for the Tribes and the Indian Health Service and has no down side what so ever. The Choctaw Nation request the support of the Senate to make direct billing of Medicare and Medicaid a reality for all Indian tribes by passing bill S. 406.

The Indian Health Service is responsible for the health care of about a 1.3-million Indian people throughout the United States with an annual budget exceeding 2.3 billion dollars. This responsibility requires the Director of the Indian Health Service to interact with all of the other Federal health care programs on a direct basis as well as to work directly with the Secretary of the Department of Health and Human Services (HHS).

This direct working relationship can only be accomplished by elevating the Director of the Indian Health Service to an Assistant Secretary so he can report directly to the Secretary without going through the various bureaucratic levels of the department.

The elevation of the Director of the Indian Health Service would also give the Tribes a much better opportunity to access the other programs administered by the Department of HHS thus maximizing all resources for health services.

The elevation of the Director of the Indian Health Service would put him on the same administrative level as Assistant Secretary for the Bureau of Indian Affairs.

The Choctaw Nation supports the elevation of the Director of Indian Health Service to the Assistant Secretary level which will provide for a more affective and efficient Indian Health Service and requests the Senate to pass bill S. 299.

The Choctaw Nation of Oklahoma would like to thank the Committee for this opportunity to provide testimony and appreciates the support the committee has shown for Indian tribes and tribal programs.

W. Ron Allen, President
National Congress of American Indians

Testimony on
S. 299, to Elevate the Director of the Indian Health Service within the Department of Health and Human Service to Assistant Secretary for Indian Health,
And S. 406, the Alaska Native and American Indian Reimbursement Act of 1999
Before the Senate Committee on Indian Affairs
Washington, DC

August 4, 1999

I. INTRODUCTION

Good morning Chairman Campbell, Vice Chairman Inouye and distinguished members of the Senate Committee on Indian Affairs. My name is W. Ron Allen. I am President of the National Congress of American Indians (NCAI) and Chairman of the Jamestown S'Klallam Tribe located in Washington State. On behalf of NCAI, the oldest, largest and most representative Indian organization in the nation, I would like to thank you for the opportunity to present testimony in support of S. 299 and S. 406. NCAI was organized in 1944 in response to termination and assimilation policies and legislation promulgated by the federal government which proved to be devastating to Indian Nations and Indian people throughout the country. NCAI remains dedicated to the exercise of tribal sovereignty and the continued viability of tribal governments. NCAI also remains committed to advocating aggressively on behalf of the interests of our 250 member tribes on a myriad of issues including enhancing the performance of inherent federal functions operated by the Director of the Indian Health Service (IHS) and improving the current system of IHS-managed collections.

II. ELEVATION OF THE IHS DIRECTOR TO ASSISTANT SECRETARY FOR INDIAN HEALTH

Since the passage of the Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDA), the fundamental policy of the federal government with respect to Indian nations has been to encourage tribal self-determination and self-governance based on a government-to-government relationship between tribal governments and the federal government. This involves the interaction of tribal leaders and federal agency representatives at the highest levels. The Director of IHS holds a position of extreme importance for the health of Indian people and deserves a rank commensurate with the responsibilities of such a position.

The IHS, the largest direct health care provider within the Department of Health and Human Services (HHS), should answer directly to the HHS Secretary to insure that the issues that impact tribes are addressed. There are many legal and cultural issues that are unique to Indian health programs, and tribes look to the IHS Director to insure that these are taken into consideration when Department policy and regulation are developed. In order to do this effectively, the Director should report directly to the Secretary and serve at the top policy making level within the Department. Assistant Secretary for Indian Health is an appropriate rank for the head of the IHS since this agency is responsible for the health care services of over 1.4 million American Indians and Alaska Natives.

Mr. Chairman, the member tribes of NCAI have overwhelming supported every effort to elevate the position of the Director of the IHS to the rank of Assistant Secretary for Indian Health. Most recently, our member tribes unanimously provided support for the passage of S. 299 and H.R. 403, the House companion bill (see attached Resolution #VAN-99-048).

III. THE IMPACT OF SELF-DETERMINATION AND SELF-GOVERNANCE ON THE INDIAN HEALTH CARE DELIVERY SYSTEM

As this Committee is well aware, the needs in Indian Country are many; however, the improvement of the health status of Indian people must be of primary concern to the federal government as well as tribal leaders. According to a recent study[1], the following three epidemiological trends define the current health status of Native people:

- Tuberculosis and gastroenteritis, once major cause of death among Native populations, have been reduced to levels very close to the levels of all other races. However, Native people are at disproportionally high risk of such infections as meningitis, acute respiratory infections, viral hepatitis, sexually transmitted diseases and intestinal infections.

- The incidences of end-stage renal disease is three times higher among Native populations than white populations, with six times higher due specifically to diabetes. Diabetes is a particular problem to older Native Americans, and its incidence among the youth is increasing. For Native people 55 to 64 years of age, diabetes is the third greatest cause of death.

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[1] T. Kue Young, Changing Numbers, Changing Needs: American Indian Demography and Public Health, 1996.

> Injuries, intentional and unintentional, represent the second most predominant cause of death among all Native people, but the leading cause of death for ages 5 to 24. The second major cause of death for those 5 to 24 is homicide; for ages 15 to 25, the second major cause of death is suicide, followed by homicide. Indian youth are more likely than youth in the general population to die from accidents, homicide, and suicide. The alcoholism death rate for Native youth ages 5 to 24 is more than 17 times the comparable rate for all races.

In light of these statistics, any effort to improve the health care delivery system in Indian Country should be fully explored by Congress. Given the success of tribal self-determination and self-governance programs throughout the BIA and the IHS, expansion of these opportunities within other federal agencies is the next logical step in the process of improving tribal health care through tribal government assumption of federal health delivery systems.

The passage of Public Law 93-638, the Indian Self-Determination and Education Assistance Act in 1975, marked the beginning of a fundamental turning point in modern federal Indian policy. This new law allowed for tribes to operate federal programs on their reservations through a process known as self-determination "contracting." However, while the process of returning decision-making and funds to local tribal governments had begun in earnest by the mid -1980's, many tribes were frustrated with a federal bureaucracy that was still reluctant to change its role from that of a service provider and manager of tribal affairs to that of an administrator of government contracts.

In 1988, the concept of tribal self-governance was implemented with the passage of Title III to the Indian Self-Determination Act. Through the development of self-governance "compacts", tribal governments were provided greater authority to exercise their inherent self-governing powers. Through self-governance "compacting," tribes can administer and manage programs, services, activities and functions previously managed by the Bureau of Indian Affairs (BIA) and are provided the authority and flexibility to redesign programs and re-program funding to meet the needs of their respective tribal communities. In 1993, the self-governance initiative was extended to include the Indian Health Service (IHS).

Since the initiation of self-determination and self-governance policies, tribes have successfully demonstrated that the concept of redirecting resources based on local priorities and needs has resulted in more effective use of those resources. Tribal governments have repeatedly reported on the numerous benefits of tribal control and decision-making to better meet the health care needs of their people. These benefits include: 1) less regulation; 2) increased financial flexibility; 3) consolidation and redesign of health programs; and, 4) ability to access new programs and funds.

In a study of the National Indian Health Board entitled, "Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management", issues regarding the quality of health care under tribal control and assumption are examined. This study also considers the opportunities and barriers to self-determination "contracting" and self-governance "compacting." This is the first large-scale review that specifically asks tribal leaders and health directors about their perceptions of the quality of care in the health systems that serve their tribes.

In its findings, the study concludes that:

- Tribally-managed programs have a better track record than IHS in the addition of new programs, services and facilities;
- When tribes assume control of health care, they care a high priority to prevention programs; and,
- As the federal system of Indian health care changes, integration of services is occurring through tribally-controlled organizations.

In summary, the study states that self-determination and self-governance is working, and that tribes that have chosen to manage their health care programs are very successful. Despite the success of tribal self-determination and self-governance, barriers such as inadequate contract support cost funding are preventing some tribes from exercising their option to choose whether to enter into a contract or compact with the IHS for the assumption of their health care programs.

Unmet health care needs and inadequate funding are also major barriers to tribal contracting and compacting. Unmet health care needs in Indian Country have been as perpetual as the federal appropriations process itself. These growing needs have been documented and testified in countless hearings before congressional appropriators, with adequate funding levels rarely, if ever, provided. The IHS Service population alone is increasing at a rate of 2.1 percent per year, with tribal and urban Indian service area populations keeping pace.[2] The past four fiscal years (FY1996-99) are examples of the de minimis increases in federal Indian health care programs, which, when compared to rising unmet health care needs throughout Indian Country, are truly token in nature. The

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[2] INDIAN HEALTH SERVICES, U. S. DEPT. OF HEALTH AND HUMAN SERVICES, TRENDS IN INDIAN HEALTH – 1996. (This figure excludes the impact of new tribes, or new member participation rates stemming from welfare reform migration of Indian people back to tribal communities).

expanded authority of tribes to direct bill Medicaid and Medicare would assist tribes in stretching existing funding through increased collections.

IV. EXPANDED TRIBAL AUTHORITY TO DIRECT BILLING OF MEDICAID AND MEDICARE

In examining recommendations for addressing the unmet health care needs in Indian Country, NCAI looks toward a holistic concept of healthy Indian communities, including the expansion of self-determination contracting and self-governance compacting of the Indian health care delivery system. The role and capacity of tribal governments today have changed dramatically over the last century and even more so over the last few decades. Whether providing fundamental services, or programmatic functions that reach out into the community, tribes have learned to overcome the historical impediments to self-sufficiency established and propagated by the federal government. The increased capacity of a tribal governments to administer programs and services independent of federal government intervention breaks historic federal paternalism over the day-to-day management of an Indian tribe's operations and activities. Tribal governments are perfectly capable of assuming federal resources, authorities and responsibilities over federal government programs and services that benefit Indian tribes, including the direct billing of major entitlement programs such as Medicaid and Medicare.

S. 406 authorizes tribes and tribal organizations to directly bill and be reimbursed by Medicare, State Medicaid programs and other third-party payors. This bill makes permanent and extends to all tribes and tribal organizations authority that has been granted to four tribes and tribal organizations under a demonstration project authorized by Section 405 of the Indian Health Care Improvement Act. This project is vitally important to achieving efficiencies in the delivery of and reimbursement for health care services provided by tribes and tribal organizations. Without passage of this bill, the payments due tribes and tribal organizations will continue to be paid first to the IHS, then, after many months, will be transfered back to the tribal health program.

The experience of the four tribal health programs that participated in the demonstration has proven unequivocally that tribal health programs are capable of managing their own billing and collections. Moreover, they have demonstrated that direct access to these important funds lead to improvement in facilities – all of which are now accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Once again, tribes and tribal organizations have proven that the conversion of federal programs and services from federal control to tribal control has led to a far greater level of efficiency in administering those programs and services at the tribal level. In fact, in most instances, tribal health programs now exceed the capacity of the IHS.

As Chairman of one of the original self-governance tribes, I have had the privilege of being able to observe our own effort at streamlining the federal system based on what we refer to as tribally driven initiatives. Since 1988, there are also many other tribes who have enjoyed a great deal of success in implementing such initiatives and feel that their progress shows the Congress and the Administration that tribes can take a federal bureaucratic system and reshape, modify and downsize it into an increasingly effective and efficient system. More important, those federal resources identified in the streamlining process can be transferred directly to the tribes to further increase program and service deliveries. Economic and governmental self-sufficiency has increased throughout Indian Country, due in large part to the enactment of self-determination and self-governance initiatives[3] over the past several years. Increased tribally-controlled government functions, however, created a natural tendency for tribes to begin critically analyzing the service delivery system. This increased tribal autonomy has encouraged sharper criticism of the function of the IHS, specifically that the administration of many federal Indian programs has been consistently both inefficient and ineffective. This charge has come from not only tribal governments, but by members of both the House of Representatives and the Senate.

Although NCAI supports S. 406, it should be noted that the objectives of this measure are not the ultimate goal. Tribes fully believe that the government-to-government relationship between themselves and the federal government is one that for too long has been limited to just the BIA and the IHS. The SCIA is urged to take the lead in expanding this relationship to all cabinet-level departments and their agencies, including the Health Care Financing Administration (HCFA) that oversees this country's major entitlement programs such as Medicaid, Medicare, Supplemental Security Income (SSI) and the Children's Health Insurance Program (CHIP). Until this relationship is expanded, the total capabilities of tribal governments over the management and delivery of federal programs and services in the health care arena will not be fully realized.

V. CONCLUSION

Mr. Chairman, we urge the Congress to fulfill its fiduciary duty to American Indians and Alaska Natives and to uphold the federal trust responsibility as well as preserve the government-to-government relationship, which includes the fulfillment of health care needs of all Indian tribes in the United States. We ask that Congress take into consideration the unique legal and cultural issues at all levels of decision making and service provision in order to fulfill tribal health care needs and improve the health status of

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[3] *See generally,* The Indian Self Determination and Education Assistance Act, 25 U.S.C. §§ 450a - 450n.

all Indian people. This can partially be accomplished by elevating the Director of the Indian Health Services to Assistant Secretary for Indian Health.

Additionally, as the process of amending and further implementing the Indian Health Care Improvement Act (IHCIA) continues through this Congress, NCAI will continue to serve as a lead advocate on eliminating barriers to tribal self-determination in the area of Indian health care. Furthermore, NCAI looks forward to working with the Senate Indian Affairs Committee to develop legislation, such as S. 406, as a way to insure the protection and support of tribal sovereign rights aligned with the provision of Indian health care and its delivery systems to its members.

Mr. Chairman, this concludes my statement. Thank you for allowing me to present for the record, on behalf of our member tribes, the National Congress of American Indians' initial comments on S. 299 and S. 406.

* * * * *

ATTACHMENT

NATIONAL CONGRESS OF AMERICAN INDIANS

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Jamestown S'Klallam Tribe

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PORTLAND AREA
Henry Cagey
Lummi Nation

SACRAMENTO AREA
Cheryl A. Seidner
Table Bluff Reservation/Wiyot

SOUTHEAST AREA
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Lumbee Tribe

EXECUTIVE DIRECTOR

JoAnn K. Chase
Mandan, Hidatsa & Arikara

THE NATIONAL CONGRESS OF AMERICAN INDIANS

RESOLUTION # VAN-99-048

Title: Support For Senate Bill 299 And House Bill HR 403: The Elevation of the Directors of the Indian Health Service to Assistant Secretary of the Department of Health and Human Services

WHEREAS, we, the members of the National Congress of American Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants the inherent sovereign rights of our Indian nations, all rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish and submit the following resolution; and

WHEREAS, the National Congress of American Indians (NCAI) is the oldest and largest national Indian organization, established in 1944 and comprised of representatives of and advocates for national, regional, and local Tribal concerns; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of NCAI; and

WHEREAS, the Indian Health Service (IHS) is the federal agency responsible for funding the delivery of health services to Indian people; and

WHEREAS, the IHS is administratively located in the Department of Health and Human Services; and

WHEREAS, over twenty percent of all Department of Health and Human Services employees are employees of the Indian Health Services; and

WHEREAS, in 1996 the Department of Health and Human Services eliminated one of the seven secretaries of HHS, the Assistant Secretary for Health, most recently held by a strong advocate for Indian health, Dr. Philip Lee; and

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WHEREAS, the Director of the IHS, the top administrative official charged with carrying out the federal responsibility for Indian health, does not report directly to the Secretary of HHS; and

WHEREAS, the NCAI believe that Indian health needs are best served when the Secretary of HHS hears directly from the lead advocate for Indian Health programs; and

WHEREAS, the Congressional Budget Office has determined that the cost of elevation to the level of Secretary of HHS would have negligible costs; and

WHEREAS, Senator John McCain has introduced Senate Bill 299 and Representative George Nethercutt Jr. has introduced House Bill HR 403, both titled, "A bill to elevate the position of Director of the Indian Health Service to Assistant Secretary of Health and Human Services, to provide for the organizational independence of the Indian Health Service within the Department of Health and Human Services, and for other purposes."

NOW THEREFORE BE IT RESOLVED, that NCAI does hereby support the passage of Senate Bill 299 and House Bill HR 403 which would elevate the Director of the Indian Health Service to Assistant Secretary of the Department of Health and Human Services.

CERTIFICATION

The foregoing resolution was adopted at the 1999 Mid-Year Session of the National Congress of American Indians, held at the Vancouver Trade and Convention Center, in Vancouver, British Columbia, Canada on July 20-23, 1999 with a quorum present.

W. Ron Allen, President

ATTEST:

Lela Kaskalla, Recording Secretary

Adopted by the General Assembly during the 1999 Mid-Year Session held at the Vancouver Trade and Convention Center in Vancouver, British Columbia, Canada on July 20-23, 1999.

NATIONAL INDIAN HEALTH BOARD
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Statement of Buford L. Rolin
Chairman
National Indian Health Board
on
S. 299, a bill to elevate the Director of the Indian Health Service (IHS)
to
Assistant Secretary for Indian Health
within the Department of Health and Human Services,
and
S. 406, a bill that would allow tribes to bill directly for Medicaid and Medicare.
August 4, 1999

Chairman Ben Nighthorse Campbell, and distinguished members of the United States Senate Committee on Indian Affairs, I am honored to offer testimony on behalf of the National Indian Health Board (NIHB) in support of S. 299, a bill to elevate the Director of the Indian Health Service (IHS) to Assistant Secretary for Indian Health within the Department of Health and Human Services and S. 406, a bill to make permanent and expand the Tribal Medicare/Medicaid direct billing project.

The NIHB serves all 558 Tribal Governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Indian Health Service Areas, and are generally elected at-large by Tribal Governmental officials within their respective regional Areas. The NIHB has a duty to represent the sovereign right of all Tribal Governments to promote the highest levels of health for American Indians and Alaska Natives, and to advise the federal government in the development of responsible health policy.

The National Indian Health Board strongly supports enactment of S. 299 and S. 406. We believe through enactment of S. 299, the Government-to-Government relationship between the United States and each Tribal Government will be better fulfilled if the Director of the IHS is elevated to a position of higher authority thereby promoting greater consultation on matters related to Indian health within the federal government. With enactment of S. 406, the NIHB is convinced that permanent establishment of direct Federal billing under Medicaid and Medicare will reduce the bureaucracy involved between agencies and will enhance third party collections for all Tribes. Each of these two health bills will significantly improve the quality and quantity of health care services at the grassroots, tribal level.

S. 299, a bill to elevate the Director of the IHS to Assistant Secretary for Indian Health.

Mr. Chairman, I am here today to impress upon the Senate Committee on Indian Affairs, as to why they should pass S. 299 and why the Administration should move to enact this important legislation into public law.

Before, I proceed, I want to express our sincere appreciation to this Committee for its long-standing support for legislation to elevate the position of the IHS Director, and to thank the cosponsors of S. 299, Senators Conrad, Inouye, and McCain. We especially want to thank Senator John McCain for his willingness to persevere on this most important legislative proposal.

The National Indian Health Board upholds the right of Tribal Governments in their legal position regarding the United States Government to live up to its Treaty obligations and their desire to have comprehensive health care provided to all American Indian and Alaska Native citizens, at a level which should be comparable to the care provided to any other American.

Despite new technological advances, Indian people are suffering and dying premature deaths, due in large part to under funding of the Indian Health Service. While there is little doubt that the overall health status of American Indians and Alaska Natives has substantially improved in the second half of the 20th century it is also unfortunate, as we prepare to enter a new millenium, that new epidemiological data on the American Indian and Alaska Native population detect increased areas of concern. Throughout Indian Country there is a rise in chronic diseases, especially diabetes; there is the persistence of infectious diseases, and there is also a high prevalence of multiple "social pathologies" such as violence, unintentional injuries, and the ill effects of alcohol and drug abuse. Under an Assistant Secretary for Indian Health, American Indians and Alaska Natives will be provided with representation which will include functions specific to ensuring comparable health care by eliminating health care disparities within the Department of Health and Human Services.

In America, as in no other industrial nation, the health of an individual is linked to their wealth. Access to health care is only limited to those who have the means to pay for it. For American Indians and Alaska Natives, who are three times more likely to live in poverty than people of all other races, private health insurance is generally unavailable. This places American Indians and Alaska Natives on the lowest rung of the insurance ladder, in a nation with greater gaps in the health care safety net than all other industrial nations. The Indian Health Service and Tribal Health Systems narrow this gap. In FY 1998, the IHS made health services available to 1.46 million American Indians and Alaska Natives. Programs funded by the IHS provide a range of health delivery systems, including hospitals, outreach programs, referral stations and comprehensive outpatient health clinics.

Because the IHS is not an entitlement program but one dependent on annual appropriations, IHS and Tribal health beneficiaries bear the burden of inadequate funding. Shortfalls limit access to health services and restrict the types of health services they may obtain. When Congress enacts legislation to balance the national budget, the IHS is not spared. Without necessary cost of living adjustments and an effort to lift the spending caps, we predict that health services will be severely affected. This year, thousands of people may be denied hospital admission, nearly half a million outpatient visits may be reduced, dental services may be cut, mental health and social services could be decreased, public health nursing home visits may not be performed and CHR visits may be severely impacted.

A concern which has been raised repeatedly by tribal leadership this past year is the tremendous financial blow on an already inadequately funded IHS as compared to other programs within the Department of Health and Human Services (DHHS) who did not suffer similar consequences. Clearly Indian Health Service and tribal programs are loosing further ground this year, and the people who will suffer are Indian people back in our tribal communities.

One of the key reasons for limited funding is the inability of the Indian Health Service to get the attention and support within the Department and the Office of Management and Budget. In the view of Indian Country this translates into lack of respect.

With enactment of S 299, the Assistant Secretary for Indian Health will have access to other agencies within the DHHS system to help shape policies and initiatives that will make the Indian Health Service a stronger ally for Indian country.

Although tribal leadership was pleased with the Departments effort this past year to implement the Tribal "Consultation" policy, legislative mandates, and Executive Orders issued by the President, there continues to be unfinished business regarding the elevation of the Director of the Indian Health Service to the position of Assistant Secretary of Indian Health. Since IHS still bears much of the burden of providing health services to American Indians and Alaska Natives it makes no sense to us to not have the key player at the table when issues pertinent to tribal populations are being determined. In review of the Departments implementation effort a more comprehensive approach in the consultation process could have been accomplished through the position of an Assistant Secretary for Indian Health.

With the elevation of the IHS Director to the position of Assistant Secretary for Indian Health, the IHS will be able to provide a direct line of communication to

Secretary Shalala, and other Agency leaders, on the unmet needs of Indian people. This bill certainly will provide the IHS with organizational independence and the capacity to advocate for itself at a higher level with more authority.

If S. 299, is enacted into law, Dr. Michael Trujillo would have greater influence in ensuring that other DHHS funding is available to meet the health needs of Indian communities.

On May 12, 1999, Tribal leaders from the Dakotas and Montana met with the President of the United States, William Jefferson Clinton. In their meeting they discussed nine topics, one of which included disparities in health care among American Indians and Alaska Natives. They reminded the President of his Executive Order dated May 14, 1998, and his Policy Statement issued on April 29, 1994, on Government-to-Government relationships between the United States and Tribal Governments. In the presence of Dr. Trujillo and Deputy Secretary Kevin L. Thurm, they noted the necessity of allowing Tribal Governments to move forward on these policies by eliminating the levels of bureaucracy within the DHHS by elevating Dr. Trujillo to the position of Assistant Secretary for Indian Health.

S. 406, the Alaska Native and American Indian Direct Reimbursement Act of 1999

It is our understanding that S. 406, amends the Indian Health Care Improvement Act to make permanent the demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the operation of a hospital or clinic of the Indian Health Service may directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under Medicare or Medicaid or from any other third party payor. In addition to permanently authorizing this program, the National Indian Health Board understands that S. 406 would allow other tribes and tribal organizations, including those operating under Indian Self-Determination Contracts or Self-Governance compacts, to participate in the direct billing program and receive payment for services provided in their hospitals and clinics for Medicare, Medicaid and other third party payors.

Because of the federal trust responsibility and the government-to-government relationship between tribes and the federal government, many tribes would prefer to deal with a federal agency directly rather than going through their state governments for Medicaid and Medicare payments. This makes sense since the 100 percent federal match, under the IHS/Health Care Financing Administration Memorandum of Agreement, makes Medicaid a federally funded program for American Indians and Alaska Natives. Furthermore, there is a precedent in the Medicare program. Currently when providers bill Medicare, they send the billings to the federal government through a fiscal intermediary.

When Congress authorized the demonstration project for "direct billing of Medicaid," it raised tribal expectations that the demonstration would develop a

mechanism to bypass state government. Instead the demonstration project bypasses the Indian Health Service so that tribes and tribal organizations can receive Medicaid payments directly from the state. We have long recognized the success of the Bristol Bay Health Corporation, the Southeast Alaska Regional Health Corporation, the Mississippi Band of Choctaw and the Choctaw Tribe of Oklahoma in their demonstration of direct billing. It has been our desire to secure funding from private philanthropic foundations to evaluate the demonstration project and the tribes ability to increase collections and decrease turnaround time between billing and payment. We have long understood that by expediting direct reimbursement, the tribes have also been able to improve their JCAHO Accreditation ratings and the quality, as well as the level, of health care available to their patients.

In 1998, the National Indian Health Board completed a nine state study on best practices in Medicaid and Managed Care. We have found that as Indian health facilities and programs are becoming increasingly dependent upon Medicaid funding, they are affected by the current trend by states to provide Medicaid services through managed care plans. Our study conducted in the states of Arizona, California, Michigan, Minnesota, New Mexico, New York, Oklahoma, Oregon and Washington provided us with an opportunity to understand how Managed Care approaches are affecting Indian health and assess which provisions work best for American Indian and Alaska Native consumers and Indian health providers. While the scope of the study focused on Medicaid, we believe there are similar concerns within Medicare which will be the subject of study later this fall.

We understand from our studies of Medicaid and Managed Care, that the demonstration project has been successful and there is demand to increase the number of tribes and tribal organizations that can receive payments in this way, so that they can improve their cash flow and reconcile payments with their billings promptly. For purposes of today's hearing, I am happy to make available a copy of the Executive Summary which recommends in it's findings that, "Congress should reauthorize the current demonstration project for 'direct billing of Medicaid' and expand it to allow more tribes to participate."

As you are well aware, this past week, more than 450 representatives of Tribal Governments, the Indian Health Service and urban Indian programs participated in a national forum on the reauthorization of the Indian Health Care Improvement Act which is due to expire on September 30, 2000. We have undertaken an unprecedented step to provide the key authorizing Committees in Congress with a consensus bill drafted by the Tribes for your consideration during the remainder of the 106th Congress. Numerous comments were made about the draft bill and we are expecting final recommendations to be integrated into the bill for your introduction when the Senate re-convenes after the August recess.

Title IV of the draft reauthorization bill provides a variety of changes to the Indian health provisions within the Medicaid, Medicare and State Child Health Insurance Programs, which serve to strengthen the capacity of tribes and tribal organizations to improve their reimbursements. While we have not recommended specific changes to the bill language contained within S. 406, we respectfully request that the Committee consider adoption of the draft provisions recommended within Title IV of the new Indian Health Care Improvement Act reauthorization bill. This particular Title is now undergoing review by the Health Care Financing Administration and the Indian Health Service, who will provide technical assistance to the National Steering Committee on Reauthorization on changes that might improve the bill. These changes will be considered by the Tribes and recommended for integration into the draft reauthorization bill prior to its September introduction.

Conclusion

On behalf of the National Indian Health Board, I thank the Committee for considering our testimony on S. 299 and S. 406. We have supplied the Committee with resolutions which indicate our unequivocal support of previous measures similar to S. 299. On July 22, 1999, we joined in support and recommended that the National Congress of American Indians (NCAI) pass a new resolution in support the elevation of the Director of the Indian Health Service to Assistant Secretary for Indian Health. I believe my colleague, NCAI President W. Ron Allen will present this resolution which indicates our support.

Our views on S. 406, a bill to make permanent and expand the ability of Tribes to seek direct reimbursement of Medicaid and Medicare from the Federal Government, are shaped by our studies on Medicaid and Managed Care. We believe the demonstration project has enhanced the capacity of the four Tribes who participated in the project to increase their revenues and improve the quality of health care within their communities. The capacity to improve Medicaid and Medicare reimbursements in all Tribal communities is a worthy goal and will certainly lead to improvements in the quality of care.

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Indian Health in Nine State Medicaid Managed Care Programs

Mim Dixon

September 30, 1998

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Part 1. Executive Summary:

Medicaid Managed Care Issues and Recommendations[1]

Principles for the Development of Medicaid Managed Care Provisions Related to Native American Consumers and Indian Health Providers

As states develop their Medicaid managed care programs and as the Health Care Financing Administration (HCFA) exercises its federal trust responsibility with regard to federally-recognized tribes in the approval process for Medicaid state plans and waivers,[2] the following principles should guide decisions:

1. In recognition of the inherent sovereignty of Indian tribes and nations, the requirements and goals set forth by Congress in the Indian Health Care Improvement Act (P.L. 94-437) and the Indian Self-Determination and Education Assistance Act (P.L. 93-638), and the special status and programs for American Indians in federal law, states should consult with tribes in the development of their health programs and make special provisions for American Indian and Alaska Native consumers and Indian health system providers in Medicaid and other health programs that receive federal funding.

2. Because there are cultural, geographic, financial and historic barriers to accessing health care, special health care delivery systems have been developed for American Indians and Alaska Natives. States should design their Medicaid and other programs to protect and enhance Indian health facilities and services so that they can provide the highest possible level of care to people both when they are Medicaid beneficiaries and when they are not receiving Medicaid.

3. American Indian and Alaska Native individuals who are Medicaid beneficiaries should have access to their customary Indian health providers, as well as providers that are available to other Medicaid beneficiaries.

4. The Indian health facilities should be paid by Medicaid for every visit in which Medicaid-covered services are provided to a Medicaid beneficiary. This applies to

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[1] This version presented to the National Indian Health Board Consumer Conference in Anchorage, AK, October 6-8, 1998, has been revised to include comments offered by participants in the national meeting, "Indian Health, Medicaid and Managed Care: A Call to Action," held in Denver, CO, September 2-3, 1998.

[2] While this project and recommendations focus on Medicaid managed care programs, tribes also would like HCFA to consult with them on Medicare and other programs administered by HCFA.

the Indian Health Service (IHS) direct service facilities, tribally-operated facilities, and urban Indian clinics, collectively known as the I/T/U.

5. The I/T/U should be paid by Medicaid at a rate that covers the cost of delivering services, considering that there is little opportunity to shift costs to other third party payers.

6. Barriers to participation should be eliminated for American Indians and Alaska Natives for health care programs that receive any federal funding.

7. Recognizing the limitations in funding, resources should be used to the maximum extent for direct patient care and prevention activities while keeping administrative functions as efficient as possible.

Issue 1. Balanced Budget Act Protections

Summary of Issue: When Congress passed the Balanced Budget Act of 1997 (BBA), they recognized the need to protect American Indians from mandatory enrollment in managed care. Language was included in that Act that gives states the opportunity to include in their state plans mandatory enrollment in managed care plans; however, states can only require Native Americans in Medicaid to receive services through a Managed Care Organization (MCO) or Primary Care Case Management (PCCM) if the MCO or PCCM is the IHS, a tribally operated program or an urban Indian health program. Most states that have managed care Medicaid programs have used the waiver process. Until HCFA publishes the regulations related to the BBA, states in this study are taking a wait-and-see approach regarding whether to continue to use the waiver process or to include mandatory managed care in their state plans. Using the waiver process with approval from HCFA, some states are requiring American Indians to enroll in Medicaid managed care plans.

Recommendation: The same protections that Congress provided for American Indians in the BBA should be provided under state waivers that limit freedom of choice. Federal law should be amended to prohibit HCFA from granting waivers that include mandatory enrollment in managed care plans unless those waivers exempt American Indians and Alaska Natives from mandatory enrollment in plans that are not operated by the I/T/U.

Issue 2. IHS/HCFA MOA

Summary of Issue: The IHS/HCFA MOA is an important agreement. However, states are not signers on this agreement. Various states and HCFA regional offices have interpreted it differently. Some areas that need clarification are the definition of an encounter, the number of encounters per day, the situations in which the 100 percent Federal Medical Assistance Percentage (FMAP) applies, and the state role in assuring that licensing standards are met.

Recommendations:

1. The provisions for 100 percent FMAP and the IHS encounter rate for tribally-operated facilities should be specified in law.
2. Regulations should be developed by a joint tribal-federal rulemaking committee that includes HCFA and IHS, using the negotiated rulemaking model that was used for P.L. 93-638. This process should be used to address the following:
    a. The formula used to develop the encounter rate.
    b. The definition of an encounter and the types of services to which the encounter rate is applied.
    c. The situations in which more than one encounter can be billed for an individual on the same day, recognizing that access barriers are reduced, including transportation and child care, when a patient can receive different types of visits on the same day.
    d. Situations in which the 100 percent Federal Medical Assistance Percentage (FMAP) applies.
    e. The state role in assuring that licensing standards are met.
3. The IHS/HCFA MOA should be expanded to include urban Indian clinics.

Issue 3. I/T/U Billing for Medicaid

Summary of Issue: Managed care has created complicated billing practices that have increased the need for office staff in I/T/U facilities and this has diverted resources from direct patient care. Under Medicaid managed care, virtually all IHS and tribally-operated facilities are paid on a fee-for-service or encounter rate basis. Capitation is generally not feasible due to several factors including the federal Anti-Deficiency Act; some I/T/U clinics are small and serve a low number of patients, they lack other third party payers to absorb cost-shifting, and the population has a high need for health services and relatively few healthy people to absorb the risk. The OMB rate is higher than the Medicaid fee for service rates for outpatient visits in all states and this

necessitates complex billing practices when Indian health providers are required to bill health plans.

Recommendations:

1. A fee for service option, that includes the IHS encounter rate or FQHC rate, should be retained in all state Medicaid programs and available to American Indian and Alaska Native consumers and Indian health providers.
2. Indian health providers should receive payment for services to IHS beneficiaries who are also Medicaid recipients from states or their fiscal intermediaries directly and not be required to bill health plans.
3. States should intervene to assist I/T/U providers in collecting outstanding Medicaid payments from health plans.

Issue 4. Payment for Off-Plan Services

Summary of Issue: When American Indians and Alaska Natives enroll in health plans, either by choice or through mandatory enrollment, they may still seek services from I/T/U providers that are not in the plan's network and they will not be turned away. However, some state Medicaid programs do not have provisions for paying for these off-plan services. The Indian Health Care Improvement Act creates a legal basis for the IHS and tribes to collect from both Medicaid and commercial plans for off-plan services they provide.

Recommendation: HCFA should require all state Medicaid managed care programs or Medicaid managed care contractors to have provisions to pay the I/T/U for off-plan services provided to IHS beneficiaries who are also Medicaid beneficiaries at rates specified by the IHS/HCFA MOA.

Issue 5: FQHC Rates

Summary of Issue: In the Balanced Budget Act of 1997 (BBA), the Federally Qualified Health Center (FQHC) rate is scheduled to be reduced each year and eliminated by the year 2003. While tribally-operated clinics can use the IHS rate for American Indian Medicaid consumers, they may not be able to use this rate for non-Indians and the FQHC rate is a better alternative than the Medicaid fee-for-service rates. Most urban Indian clinics do not have access to the OMB rate. The FQHC rate provides reasonable cost reimbursement which is necessary since Indian health providers do not have sufficient third party resource to absorb costs shifting and the population seeking care is generally sicker than the population as a whole. While the payment process under FQHC is based on cost reporting that is clear and defensible, it can take years to

receive payment and it is costly to administer for tribes that do not receive Medicare reimbursement.

Recommendations:

1. Congress should develop an alternative to the current process for FQHC reimbursement that provides an enhanced rate to assure the viability of Indian health providers. The following options should be considered:
   a) Expand the IHS/HCFA MOA to include urban Indian clinics and non-Indians served in I/T/U facilities.
   b) Create another methodology that provides reasonable cost reimbursement that is tied to measurable information.
2. In waivered states, the full cost reimbursement for FQHCs should be maintained at the 100 percent level until at least the year 2003.

Issue 6: Increasing Native American Participation in Medicaid, Child Health Insurance Programs (CHIP) and Other Health Programs Receiving Federal Funding by Eliminating Cost Sharing and Other Barriers

Summary of Issue: Consumer cost sharing creates a barrier to participation by eligible American Indians. Because Indian health services are free of charge to the consumer, and eligible Native Americans cannot be turned away, there is little incentive for IHS beneficiaries to pay the consumer cost sharing to enroll in expanded Medicaid programs, CHIP and other federally-funded programs. Consumer cost sharing not only reduces participation by Native Americans, but also reduces revenues for Indian health facilities.

Other barriers to participation in Medicaid, CHIP and other health programs include lengthy application forms, the requirement for a face-to-face interview at an office that is difficult to access and producing documentation related to income. These barriers can be reduced by providing eligibility workers at I/T/U facilities and making the applications more user-friendly.

Furthermore, in states that have not used CHIP to expand Medicaid, but rather developed a separate program that contracts with managed care plans, there are barriers to the I/T/U becoming providers under those plans and they generally do not pay for off-plan services. The result is that American Indian consumers and I/T/U providers do not benefit from these federally-funded CHIP programs.

While QMB and SLIMB are two Medicaid programs designed to increase access to Medicare Part B, there is little participation by American Indians. More needs to be done to remove barriers, inform American Indian and Alaska Native consumers and providers about these programs and to assist them in the enrollment process.

Recommendations:

1. The federal government should mandate that states waive consumer cost sharing for American Indians and Alaska Natives in Medicaid programs, CHIP and other programs with federal funding.
2. The federal government should mandate that state Medicaid and CHIP managed care programs pay for services to AI/AN enrolled in managed care plans who go off-plan to receive services from I/T/U providers.
3. State Medicaid programs should provide eligibility workers in I/T/U facilities and Indian schools, and find other ways to make the application process more user-friendly.
4. HCFA and the states should provide resources for appropriate training and outreach on QMB and SLIMB to Indian health providers and consumers, and various subdivisions of state government.
5. The federal government should provide an Indian set aside for the Child Health Insurance Programs.
6. The IHS/HCFA MOA should be expanded to assure that states receive the 100 percent Federal Medical Assistance Percentage (FMAP) for the State Child Health Insurance Program services to American Indians and Alaska Natives.
7. States that have already expanded their Medicaid to the extent provided by the Child Health Insurance Program should be allowed to submit 1115 waivers to cover the remaining uninsured children and use the federal allocation for CHIP to accomplish this goal.

Issue 7. Medicaid Waiver Renewals

Summary of Issue: HCFA grants 1915(b) waivers for a two year period, while 1115 waivers are for a period of five years and subject to extension. Prior to the renewal of waivers, an independent assessment is done to determine the affect of waivers on Medicaid populations. Currently, HCFA does not explicitly require these assessment to address American Indian consumers and providers, nor do they require tribal consultation. Many I/T/U providers are concerned that special provisions for Native American consumers and Indian health providers will be eliminated in the waiver renewal process. At the same time, the waiver renewal process provides an opportunity for states to assess their policies and procedures with regard to Indian health and to make any needed improvements.

Recommendation: In addition to requiring tribal consultation in the 1915(b) and 1115 waiver application, HCFA should institute procedures for tribal consultation in the renewal assessment process and renewal application review for 1915(b) and 1115 waivers.

Issue 8. Access to Medical Specialists Under Medicaid Fee for Service Options

Summary of Issue. As an incentive for everyone to participate in managed care programs, state Medicaid programs have kept their fee for service rates paid to medical specialists so low that it creates access problems in some places for American Indians who opt to remain in a fee for service Medicaid program.

> Recommendation: HCFA should enforce its current regulations regarding accessibility by reviewing state Medicaid rates under both fee for service and managed care to assure that American Indians access to necessary specialty medical care is not being restricted.

Issue 9. Allowing Tribes to Bill the Federal Government for Medicaid

Summary of Issue. Because of the federal trust responsibility and the government-to-government relationship between tribes and the federal government, many tribes would prefer to deal with a federal agency directly rather than going through their state governments for Medicaid payments. This makes sense since the 100 percent federal match makes Medicaid a federally funding program for American Indians and Alaska Natives. Furthermore, there is a precedent in the Medicare program. Currently when providers bill Medicare, they send the billings to the federal government through a fiscal intermediary. When Congress created a demonstration project for "direct billing of Medicaid," it raised tribal expectations that the demonstration would develop a mechanism to bypass state government. Instead the demonstration project bypasses IHS so that tribes and tribal organizations can receive Medicaid payments directly from the state. The demonstration processes has been successful and there is a demand to increase the number of tribes and tribal organizations that can receive payments in this way, so that they can improve their cash flow and reconcile payments with their billings. Many tribes would like to see a demonstration project for billing HCFA or its fiscal intermediary directly for Medicaid covered services, without going through either the IHS or state governments.

> Recommendations:
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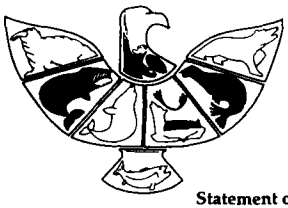
> 1. Congress should reauthorize the current demonstration project for "direct billing of Medicaid" and expand it to allow more tribes to participate.
> 2. HCFA should approve a research and demonstration project for tribes to bill HCFA or its fiscal intermediary directly for Medicaid without going through IHS or state governments, similar to the billing process for Medicare.

Issue 10. Monitoring the Effects of Managed Care Medicaid Programs on American Indian and Alaska Native Consumers and Indian Health Providers

Summary of Issue. This project has identified a number of issues that affect American Indian and Alaska Native Medicaid beneficiaries and Indian health providers. These issues require further evaluation and monitoring efforts on a national basis.

Recommendations: Congress should provide an annual appropriation of new funding, not to be subtracted from current IHS appropriations, for evaluation of Medicaid Managed Care and Indian Health to include the following oversight activities:

1. A Medicaid Managed Care and Indian Health Monitoring Committee should be formed with participation from tribes, urban Indian programs, the Indian Health Service, the Health Care Financing Administration, and states, to prioritize evaluation and monitoring needs and provide oversight for on-going studies.
2. An annual meeting should be held for researchers to share their findings about managed care and Indian health.
3. A newsletter should communicate findings to Indian health providers and state and federal agencies involved with Medicaid and managed care.
4. The Medicaid Managed Care and Indian Health Monitoring Committee should provide a annual report to Congress on the impact of Medicaid managed care on Indian health facilities and access to care for IHS beneficiaries.



Alaska Native Health Board

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Statement of the Alaska Native Health Board
H. Sally Smith, Chairman

Testimony Submitted by Andrew Jimmie
Executive Board Member
Alaska Native Health Board

On S. 299 and S. 406

Submitted to the
Senate Committee on Indian Affairs
August 4, 1999

Mr. Chairman and Members of the Committee, I am Andrew Jimmie, a member of the Alaska Native Health Board. I am also the current President of the Tanana Chiefs Conference Health Board, and have in the past served on the Minto Village Council and with the Village Minto Village Corporation. I am pleased to present this testimony on behalf of the Alaska Native Health Board (ANHB) on S. 299, a bill to elevate the position of the Director of the Indian Health Service to Assistant Secretary for Indian Health (ASIH) and on S. 406, a bill to expand the Tribal Medicare/Medicaid direct billing project. We strongly support both of these bills.

The ANHB represents Alaska Native tribes and tribal health organizations that provide health services through the Alaska Tribal Health Compact with the Indian Health Service. We have been working with the Alaska Area Health Service since 1968 to promote and implement programs to improve health services to Alaska's 110,000 Native residents.

Elevation of the Position of Director of the Indian Health Service. We thank this Committee for its long-standing support for legislation to elevate the position of the IHS Director, and thank especially the cosponsors of S. 299, Senators McCain, Inouye, and Conrad.

We would like to address what may be a misperception among some on Capitol Hill about the effect, or lack of effect, of this bill on the IHS-funded Alaska Native Health program. It is thought that because our program is now largely operated by

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
EASTERN ALEUTIAN TRIBES
KODIAK AREA NATIVE ASSOCIATION
MANILAQ ASSOCIATION
METLAKATLA INDIAN COMMUNITY
MT. SANFORD TRIBAL CONSORTIUM
NATIVE VILLAGE OF EKLUTNA
NATIVE VILLAGE OF TYONEK
NINILCHIK TRADITIONAL COUNCIL
NORTH SLOPE BOROUGH
NORTON SOUND HEALTH CORPORATION
SELDOVIA VILLAGE TRIBE
SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION
VALDEZ NATIVE TRIBE

tribal consortia under the Alaska Tribal Health Compact pursuant to Title III of Public Law 93-638, we do not need to be concerned about the status and role of the IHS Director. Nothing could be further from the truth. We are still heavily dependent on the performance of inherent federal functions operated by the IHS Director. These include the development of the annual budget request to the Congress and many other residual federal functions which are spelled out in a memorandum of agreement on continuing services between the Alaska Tribal Health Compact co-signers and the IHS, including highly significant financial management and funding allocation functions, functions related to federal employees on assignment for ATHC co-signers, significant responsibilities relating to the sanitation facilities program and other facility and environmental health functions. All these continuing responsibilities of the IHS mean that we Alaska Natives have a pressing concern as to the status and authority of the IHS Director within the Department of Health and Human Services. Our statement below points out the importance of the elevation of the IHS Director relative to non-IHS health matters within the Department of Health and Human Services (HHS).

Our support for the proposal to elevate the IHS Director to the position of Assistant Secretary also stems from our long acknowledgement of the need for a government-to-government relationship between the United States and Native Tribes. We view elevation of the IHS Director position as being reflective of the spirit of the well-established policy of government-to-government relationship and of President Clinton's 1994 Memorandum to Executive Agencies and his 1997 Executive Order regarding consultation and coordination with Indian tribes. If we can have an Assistant Secretary for Indian Health participating in the type of day to day working relationship with HHS that other Assistant Secretaries enjoy, the HHS will have a better awareness of Indian health needs. We agree with Mr. Thurm, the Deputy Secretary of Health and Human Services, who, when speaking of the same "awareness", noted in his July 22, 1998 testimony before this Committee that *"we do not underestimate the importance of increased awareness, because heightened awareness is the first step toward meaningful action"*.

The Assistant Secretary for Indian Health would ensure that the concerns of Native people were brought to the table along with the needs of the general population. This would bring the disparity between the two groups to the table and facilitate a better means to achieve direct action in correcting the disparity. HHS statistics already show that death of Indians from alcoholism is 579% greater than the general population, tuberculosis is 475% greater, diabetes is 231% greater, and that suicide is 400% greater. The disparities do not end here. On May 20, 1998, the Assistant Secretary for Health reported to the Committee on Indian Affairs that Indians have the second highest infant mortality rate in the United States, the lowest prenatal care rate and lower breast and cervical cancer and screening rates because of limited access to screening and treatment. An ASIH would benefit the HHS by

ensuring that the health needs of all Americans are considered at the table when the health policy of this country is being considered.

We expect that that the ASIH will have more clout that an IHS Director in influencing the Administration's proposed IHS budgets. The Administration's budget requests affect tribally-administered and IHS-administered health programs equally. The same can be said of IHS policy directives.

The pending legislation would give responsibilities to the ASIH for Native health matters which are beyond IHS-funded programs. The Department of Health and Human Services is a huge agency whose non-IHS programs dramatically affect health services for Native people, whether those services are administered by tribes or by the IHS. Policy and funding decisions affecting Medicare, Medicaid, the Children's Health Improvement Plan (CHIP), and managed health care all directly affect the availability of health services for Native people through tribal and IHS health programs.

Many agencies within HHS have great potential to assist in improving the health of Native people --among them, the Centers for Disease Control, National Center for Health Statistics, Substance Abuse and Mental Health Services Administration, Office of Rural Health Policy, and the National Institute on Drug Abuse.

Congress has often, through directives included in its Labor-HHS-Education Appropriations reports, encouraged non-IHS agencies within HHS to pay specific attention to Native health needs. If there were an ASIH, the coordination and implementation of these non-IHS Native health activities would be improved. Examples of such directives from the FY 1999 HHS appropriations reports are:

• Directive for HHS to review its methodology of collecting data on Indian and other minority populations, including review of types of data the agencies collect on members of racial/ethnic minority groups, including life expectancy, morbidity, mortality and health behavior.

• Directive to the National Institute of Nursing Research to establish an additional research center "which focuses on problems of rural populations, such those residing in Alaska and Hawaii."

• Directive to the National Institute on Drug Abuse to "work with existing native American and native Hawaiian organizations to assess and to increase their effectiveness."

• Directive to the Centers for Disease Control to work on targeted prevention and treatment diabetes programs for Native Americans.

• Directive to the Substance Abuse and Mental Health Services Administration to place more focus on projects to increase knowledge about effective ways to deliver substance abuse services to native and rural communities.

• Directive to the Office of Minority Health to assist programs which focus on training and recruitment and retention of Indians and Alaska natives as family practice physicians.

• Also of note is that the Health Professions Education Partnerships Act (P.L. 105-392), which was signed into law last November, requires the National Center for Health Statistics to collect data on American Indians and Alaska Natives. That same Act also directed that a national task force on Fetal Alcohol Syndrome/Fetal Alcohol Effect be established. FAS/FAE are, as we all know, prevalent among many tribes.

Having a position of Assistant Secretary for Indian Health would ensure that that appropriate attention is paid to these matters as well as any others that impact Native American health.

The Alaska Native and American Indian Direct Reimbursement Act

ANHB strongly supports the passage of S. 406, the Alaska Native and American Indian Direct Reimbursement Act, and we thank the Committee members – especially Chairman Campbell, Vice Chairman Inouye, and Senator Murkowski – for working to advance this important legislation as quickly as possible.

Currently, two Alaska Native health care organizations participate in the section 405 Medicare and Medicare demonstration program that S. 406 would make permanent and expand. The Bristol Bay Area Health Corporation (BBAHC) and the Southeast Alaska Regional Health Corporation (SEARHC) both have had unequivocal success with the demonstration project, as outlined below:

Increased Collections --- Medicare and Medicaid collections increased 364 percent for BBAHC and 152 percent for SEARHC

Decreased Turnaround Time Between Billing and Payment --- Medicare claim processing for SEARHC dropped from four-nine months to one month. For BBAHC, Medicare claim processing time decreased from eight months to approximately one month. Medicaid claim processing fell from four-six months to approximately one month for both entities.

Improved JCAHO Accreditation Ratings --- SEARHC's accreditation rating improved from 78 to 100, and BBAHC's rating climbed from 62 to 86.

Higher Health Care Quality and Levels of Patient Care --- SEARHC and BBAHC report that they have been able to hire additional nurses and other health care personnel as a result of the M&M demonstration program. These new employees have had a direct impact on the quality of care for its service population.

It is clear that the demonstration program participants have seen tangible and highly positive results. We recommend that Congress enact S. 406 as soon as possible so that all other Alaska Native health organizations that provide services under P .L. 93-638 compact or contract can see these types of benefits for themselves. After all, the demonstration program has shown us a very simple and proven way to reduce the bureaucracy involved with Medicare and Medicaid collections for Indian Health Service facilities that also allows us to significantly improve the quality of health care services at the local level.

Thank-you for your consideration of our testimony on S. 299 and S. 406, initiatives which we believe hold great potential to increase the resources devoted to improving the health of Native people.

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