DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

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BEFORE THE

INDIAN AFFAIRS COMMITTEE

OF THE

UNITED STATES SENATE

HEARING

ON

S. 406, ALASKA NATIVE AND AMERICAN INDIAN DIRECT REIMBURSEMENT

ACT OF 1999

August 4, 1999

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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/Us; 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 reimburseable 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, Alaska; the Bristol Bay Area Health Corporation in Dillingham, Alaska; the Choctaw Nation of Oklahoma in Durant, Oklahoma; and the Mississippi Band of Choctaw Indians in Philadelphia, Mississippi. 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 1990-1996. 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 reimburseable services, they were able to bypass 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 eight 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.