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For the House Committee on Appropriations
Subcommittee on Interior, Environment and Related Agencies
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Introduction

Chairman Simpson, Ranking Member Joyce, and members of the Subcommittee thank you for this opportunity to provide testimony on behalf of Tuba City Regional Health Care Corporation (TCRHCC), a 638 self-governance organization on the Navajo Nation that is the only provider of cancer treatment on any Indian reservation in the United States.

TCRHCC is a tribal health innovator that is led by a Community Board of Directors who represent the Navajo, Hopi and San Juan Southern Paiute communities within our 35,000 patient service area, and is steered by a Senior Leadership Team of mostly Navajo health care professionals who are supported by a nontechnical staff that is also 95% Navajo.

Four years ago, we built our Specialty Care Center without the benefit of any federal construction funds from the Indian Health Service (IHS). But that was not for a lack of trying. Both the IHS and the National Cancer Institute repeatedly told us that they don't do cancer treatment on Indian reservations. So, we did it ourselves with the help of private and philanthropic donations.

We've been to Capitol Hill before to share our story but yours is the first committee to invite testimony about why dedicated federal funding is needed to make cancer treatment locally accessible to American Indians. I am honored, but also pained, to have to be the one to tell you that not one federal dollar has ever been dedicated for cancer treatment on Indian reservations.

Issues

When the National Cancer Act of 1971 was passed to provide the funding and technical assistance needed to create the cancer treatment infrastructure most Americans now take for granted, tribes were forgotten.

More than 50 years later, the federal agencies with the trust responsibility to provide health care to Indian tribes now say they do not have the authority to do so for cancer, which just so happens to be the most complex, costly and deadly disease of all. Treatable cancers are killing American Indians simply because federal policies won't allow cancer treatment to reach them.

Challenges
Ten years ago, we committed to take this issue on because our mission is to provide safe, accessible, quality, and culturally sensitive healthcare.

Our first challenge was to build and equip a cancer treatment center without any federal construction funding dedicated to that purpose. We used our third-party resources and added to that donations from corporations, philanthropists and individuals. We even launched a GoFundMe campaign that we advertised on a donated billboard high above Interstate-40, the 21st century version of a bake sale. Our own employees took up a collection.

This may sound like the plot of an inspiring movie, but it is no way to have to fund a critically needed health care for IHS beneficiaries on federal trust land. Our Specialty Care Center has already provided chemotherapy infusions and other lifesaving treatments to about 800 cancer patients in just four years. We are already bursting at the seams.

Our second challenge is sustainability. The Centers for Medicare and Medicaid Services (CMS) refuses to pay us the same reimbursement for chemotherapy drugs that they pay non-tribal providers. About 50% of our claims are rejected by CMS. When that happens, CMS only allows us to bill Medicare the all-inclusive OMB rate for outpatient visits to a tribal health care facility, which last year was just $541.

The $541 OMB all inclusive rate for chemotherapy does not even cover our cost for the drugs.

If our two oncologists were administering infusion and oral therapies to our Navajo patients in a cancer treatment facility in Flagstaff or Phoenix instead of at Tuba City, then CMS would reimburse them based on the average sales price of the drug.

Chemotherapeutics are expensive and Medicare's refusal to fairly reimburse us for the raw cost of these medicines threatens our entire operation. About half of our costs for cancer drugs are never reimbursed. As a tribal non-profit organization operating under a Title V Compact with the IHS, we are required to use Medicare reimbursement for patient care. We cannot, and would not profit from patient disease, but we also cannot afford to continue to lose money every time we treat cancer.

The OMB all-inclusive rate captures the average cost all tribal health care providers incur for all services. It is unreasonable to expect it to reimburse the cost of lifesaving chemotherapy infusion and oral drugs. The OMB all-inclusive rate does not contemplate the cost of oncology because the IHS does not provide it.

Long before we opened our Specialty Care Clinic we reached out to CMS, meeting them at their Maryland headquarters to let them know of our intention to provide cancer treatment.

We thought reimbursement would not be an issue because their own policy sets out how Medicare reimburses IHS and tribally operated providers: Drugs provided by a physician in the office setting are paid using the Average Sales Price from the Medicare Part B Drug Pricing File supplied to all Medicare Administrative Contractors.[1]

When we launched the Specialty Care Center, we never imagined that CMS would essentially punish us for doing so. How could we have known that the agency would refuse to follow its own policy that would otherwise fairly reimburse us?

When we met CMS Director Seshamani this past January we brought this problem to her attention. Though she and her staff expressed their commitment to work on it, we have heard nothing since.

Recommendations

As this committee considers what is needed to fund health care for American Indians, we respectfully urge you to include language that directs CMS to reimburse chemotherapeutic drugs administered by a tribal health care provider that elects to do so the same way it reimburses other health care providers. Their failure to do so is a regressive health care practice that discriminates against American Indians by refusing to fully reimburse tribal health care providers for the chemotherapy they provide to American Indian and Alaska Native Medicare patients.

We also encourage you to consider how to fund the establishment and expansion of cancer treatment facilities on Indian reservations. There is currently no federally funded program to support such an effort. TCRHCC is proud to be the first cancer treatment facility in Indian Country, and we understand our unique accomplishment of building our Specialty Care Center without any federal funds dedicated to that purpose. But dedicated federal funding is urgently needed so we are not the last cancer treatment facility in Indian Country.

Conclusion

Tomorrow I will be at the White House to participate in the Cancer Moonshot Forum. This is a historic event because this is the first time any tribal representative has ever been included in the creation of our nation's cancer policy. This Administration's commitment to reauthorizing the National Cancer Act to increase access to care provides the opportunity to finally include us First Americans in the national cancer treatment system. TCRHCC welcomes this historic moment and humbly suggest you consider our little Specialty Care Center as being a cornerstone upon which our nation's first tribal center of excellence for cancer treatment could be built.

Don't forget us this time.

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[1] Medicare Claims Processing Manual Chapter 19 – Indian Health Services
80.1 - A/B MAC (B) - Medicare Part B Physician and Practitioner Services Paid Under the Medicare Physician Fee Schedule (MPFS) - Payment Policy
(Rev. 1040, Issued: 08-25-06, Effective: 09-11-06, Implementation: 09-11-06)

From July 28, 2022, through November 7, 2022

TCRHCC's total cost of cancer infusion medications was $212,513.60
$137,805 (65%) of this total was rejected by Part D insurance

$82,944 was reimbursed from Part D Insurance
$23,804 was reimbursed from OMB rate

$**105,766 (50%) was not reimbursed**.

Our Specialty Care Center Pharmacist spends an average of 25% of his annual time (52 days - 10hr/days) billing private insurance.

Our Specialty Care Center Prior Authorization personnel spend an average of 38% of their annual time (98 days - 8hr/day) working part D insurance.