

Northwest Portland Area Indian Health Board



2008 Legislative Plan

Prepared for the 110th Congress
Second Session

February 28, 2008



NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Suislaw &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinalt Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
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The Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization that has represented health-related issues of federally-recognized Tribes in Washington, Oregon, and Idaho for the last thirty-five years. The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts legislative and budget analysis, interprets regulations and policy issues related to health care, conducts health research, and offers health promotion projects.

Federal Responsibility for Health Care to American Indian/Alaska Native People

Many of our Northwest Tribes are among those who signed treaties with the United States that established the Federal responsibility to provide health care for Indian people. The Federal government has a unique legal and moral obligation to provide health care to Indian people--an obligation paid for with millions of acres of land and billions of dollars of resources. This obligation has been affirmed many times through treaties and executive orders, legislation, and by policy declarations of Presidential Administrations and Congress.

Northwest Tribes continue to exercise more control over their health care programs in all tribal communities, whether using contracting and compacting options provided by the Indian Self-Determination and Education Assistance Act (P.L. 93-638) or through IHS direct service. Tribes ensure that Federal funds reach the community level where they will be used to maximize care for patients. The diversity of the programs in the Northwest reflects this Nation's policy of tribal self-determination.

Indian Health Programs have achieved success despite chronic under-funding.

Over 98,000 Indian people in Oregon, Washington, and Idaho receive their primary health care from Indian health programs. Nationally, over 1.9 million American Indian/Alaska Natives receive care from Indian health programs. In many areas of the country, the Indian health care provider is their only option for health care. The partnerships forged among Congress, Tribal Governments, urban Indian health organizations, and the Indian Health Service over the last 60 years has resulted in significant improvements in the health status of Indian people. While American Indians continue to lag behind in a number of health status measurements, real progress has been achieved. Death rates of Indian people from infectious diseases, gastrointestinal diseases, and tuberculosis have decreased dramatically. In the Northwest, mortality from sudden infant death syndrome has declined significantly and other diseases have been prevented due to the increased emphasis on health promotion and disease prevention projects for diabetes, HIV/AIDS, cancer, and commercial tobacco use.

As the federal government moves to tie funding to performance, the nation's Indian Health Programs should stand out as worthy of increases. Indian health programs are models of what the Federal government can accomplish at its best.

**Northwest Portland Area Indian Health Board
2008 Legislative Plan**

Indian Health Service Appropriations

Indian Health Service

- The FY 2009 IHS Budget Request5
- Mandatory Costs, Critical Focus on CHS.....6
- Full Funding for Contract Support Costs.....6
- Office of Self-Governance7
- Permanent Funding for the Northwest Tribal Epidemiology Center.....8
- Increase Funding for Substance Abuse in the Mental Health
and Alcohol line items8
- Health Facilities Construction Funding9

CMS, Medicare, and Medicaid

- CMS, Medicare and Medicaid.....10
- Medicare Issues10
- Medicaid Issues.....11

Legislative Priorities

- Reauthorization of the Indian Health Care Improvement Act.....13
- Reauthorization of the Special Diabetes Program for Indians.....13
- Title VI Self Governance Legislation.....13
- Tribal Government Access to Federal Employee Benefits.....14
- Transfer IHS Indian Health Service Appropriations15

Other Health Priorities

- Special Appropriation for Northwest Regional Youth Treatment Program16
- Long Term Care and Elder Issues16
- Veterans Health Issues17
- Emergency Preparedness and Response17
- Funding for New Tribes18

Indian Health Service Appropriations

The FY 2009 IHS Budget Request

The President's budget proposes to provide the Indian Health Service (IHS) with \$3.325 billion in FY 2009, which is a \$21.3 million cut from last year's enacted level. Northwest Portland Area Indian Health Board (NPAIHB) estimates that in FY 2009 it will take at least \$486 million to maintain current services. The last time the IHS appropriation was decreased was in FY 1995 when the Agency's budget was cut by \$247 million during the Clinton Administration. President Clinton's subsequent budget requests did restore lost funding to the IHS by requesting some of the best increases that the Agency has received in the last twenty years. Unlike former President Clinton, this Administration will not have another opportunity to restore lost funding. It is unfortunate that this budget request may serve as President Bush's legacy to address the health care needs of American Indian people

The President's request includes \$56.3 million in cuts to various IHS budget accounts to fund \$25 million for staffing new facilities and provides \$10 million for the Indian Health Care Improvement Fund (IHCIF). The net loss to the IHS budget is \$21.3 million. The most notable cut is the Urban Indian Health Program (UIHP), which has been zeroed out for the third straight year by the Bush Administration.

Program increases and decreases for the health services line items account for \$32.8 million; equal to the funding of current services increases that include staffing at new facilities and the Indian Health Care Improvement Fund (IHCIF). Those budget line items that received decreases are as follows: \$11.3 million Alcohol and Substance Abuse, \$34.6 million UIHP, \$14.4 Indian Health Professions, and \$1 million Direct Operations. For the facilities accounts, there were \$23.5 million in program decreases as follows: \$20.8 million cut from Facilities Construction and \$2.7 million cut from Facilities and Environmental Health Support. Program increases for facilities include \$2.2 million for phasing in staffing at new facilities.

The Administration indicates that the IHS budget is indicative of Tribal Consultation and reflects Tribal priorities across Indian Country. These priorities are to maintain current services and fund pay costs, population growth, and inflation within the context of the **overall** Indian Health System- not fund them by eliminating the urban Indian health programs and other important programs. The urban and facilities cost savings has been redistributed to other IHS budget line items.

Indian health programs continue to face ever-increasing costs. Medical inflation in the Northwest exceeds 7%. Providing services to over 1.9 million patients residing in primarily rural areas, Indian health programs do not realize the same level of cost savings that managed care achieves in urban areas and costs continue to rise for Tribal health programs. Prescription drugs

alone have accounted for an increase of 36% since 1997.¹ It is unfair to hold the IHS budgets to 2-3%, while allowing true inflation and population adjustments for other federal health programs such as Medicaid and Medicare. In FY 2007, the Congressional Budget Office estimated that Medicaid expenditures grew by 8.3 percent. Meanwhile the IHS health care program increases of 2% never cover the true costs of inflation resulting in less than adequate care for Indian people.

Mandatory Costs, Critical Focus on CHS

In FY 2009 it is critical that funding be provided to cover all mandatory costs increases totaling \$486 million. These include medical inflation, mandatory payroll increases, and population growth (including new Tribes). In the Northwest, where Indian health programs must purchase all inpatient and specialty care from private providers, it is particularly important that inflationary cost increases for the Contract Health Services (CHS) program be funded. In past years deferred medical and dental services in the Northwest exceeded \$4 million annually.² CHS inflation alone in FY 2009 is estimated at \$57 million, while the President's increase for CHS is a mere \$8.8 million.

Recommendation: The IHS must receive an increase of \$480 million just to maintain current services. Anything less means a cut in health care services. The costs for maintaining current services are as follows: CHS inflation \$57.3 million; other health services accounts inflation \$208 million; Contract Support Costs \$158 million; and population growth \$62 million.

Full Funding for Contract Support Costs

The Indian Self-Determination and Education Assistance Act of 1975 authorize Tribes to enter into contracts or self-governance compacts to manage federal programs previously administered by the Departments of Interior and Health and Human Services. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and strengthened Tribal governments and institutions for Indian people. Every Administration from Nixon to Bush-I has embraced this policy and Congress has repeatedly affirmed it through extensive strengthening amendments to the Self-Determination Act enacted in 1988 and 1994. However, the current Congress and the President have failed to appropriate adequate Contract Support Costs to support the administrative functions of running Tribal health programs.

The FY 2008 final enacted budget eroded the base budget for the CSC line item due to the rescission. The President had requested a \$2 million increase for CSC, which the House and Senate approved. However after the rescission was applied the CSC line item lost \$2.3 million. This is the third time in five years that the CSC line item has had its base budget eroded due to rescissions. There is actually less money today to cover contract support costs than there was in

¹ U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index, Series Catalog I.D. CUUR0000SEMA, "Prescription Drugs and Medical Supplies".

² CHS deferred medical and dental services are those services that are within the CHS medical priorities; however there are no more funds available within the CHS budget to provide that service. It means patients go without care.

FY 2003. The \$272 million request for CSC is not adequate to fund past year's shortfalls or provide necessary resources for expanded Self-Determination opportunities for Tribes to manage health programs assumed from the Federal government. The damaging cuts to CSC are contrary to the Administration's principles of government outsourcing.

The IHS estimates a shortfall of approximately \$158 million in contract support costs. This year's allocation will continue the pattern of under funding this vital resource. Congress should appropriate adequate contract support cost funds to eliminate this ongoing shortfall. This continuing shortfall threatens to pit Tribe against Tribe as mature contractors are asked to absorb all inflationary increases in order to fund new contractors. Some Tribes are told they will receive no contract support cost funding if they take over new programs because their level of funding is greater than that of new contractors. As a matter of federal contracting principle, tribal contractors, like all other government contractors, should be promptly paid in full—payments not dependent on the politics of the budget process, the competing agency demands in OMB, or the willingness of tribal contractors to litigate.

Recommendations: (1) NPAIHB recommends a \$158 million increase in the appropriation for contract support costs; (2) The Department and IHS need to press OMB to increase the President's budget request for contract support cost funding; and (3) If large Tribes such as Navajo elect to contract or compact a special appropriation should make this possible without any reduction to existing self-determination Tribes, and; (4) the IHS should be exempt from paying back the DOJ Judgment Fund for settling outstanding CSC claims.

Office of Self-Governance

Five years ago, Congress reduced the Self Governance line item by \$4.7 million, a loss of 43% from the previous year. The final enacted FY 2009 budget for the Self-Governance program is \$5.8 million; a slight increase of \$73,000 over last year. This is significantly less than the \$9.8 million that this program was once established at and not enough to provide the levels of support for Self-Governance programs. The FY 2009 request only provides a \$92,000 increase and is not enough to cover the costs of administering these programs. The Self-Governance office supports compacted Tribes operating programs under the Tribal Self-Governance Amendments of 2000. This law, P. L. 106-260 established compacting as permanent, under the new Title V of P. L. 93-638. The Self-Governance process serves as a model program for federal government outsourcing, which builds Tribal infrastructure and provides quality services to Indian people. It is estimated that Tribes operate \$1.7 billion, or 54% of the total IHS budget, and it is imperative that they receive the necessary resources to develop and build their administrative infrastructure and allow for new and expanded programs.

Recommendation: The Self-Governance account should be restored to its FY 2002 level by providing \$5 million to adequately cover new and expanded Self-Governance projects and to fully fund the costs of inflation in order to protect current programs.

Permanent Funding for the Northwest Tribal Epidemiology Center

Tribal Epidemiology Center programs were authorized by Congress as a way to provide significant support to multiple Tribes in each of the IHS Areas. The President's only requests an increase of \$415,000 to cover the increased expense of operating twelve Epidemiology Centers. The twelve Epidemiology Centers provide critical support for tribal efforts in managing local health programs. Data generated locally and analyzed by Epi-Centers enable Tribes to evaluate tribal and community-specific health status so that planning and decision-making can best meet the needs of their tribal membership. Immediate feedback is provided to the local data systems which leads to improvements in Indian health data overall.

The Northwest Tribal Epidemiology Center (*EpiCenter*) serves the IHS Portland Area at the Northwest Portland Area Indian Health Board. The *EpiCenter* provides epidemiological and programmatic support on a variety of health issues designed to enable local Tribal sites to continue to work on projects independently. The Board recognizes the value of the *EpiCenter* as a model to replicate in other IHS areas, and is committed to assisting Tribes in this effort. The Board recommends that *EpiCenters* be funded at a level that will enable them to fully function as epidemiology centers.

Recommendation: The Northwest Portland Area Indian Health Board supports permanent funding for Tribal Epidemiology Centers.

Increase Funding for Substance Abuse in the Mental Health and Alcohol Line Items

The President's FY 2009 budget proposes to cut alcohol and substance abuse funding for the IHS by over \$11 million. More needs to be done to address the behavioral health needs of tribal communities. The circle of violence, depression, and substance abuse continues to plague tribal communities. The cost for treatment of alcohol and substance abuse is increasing at a rate that exceeds the availability of funds. Local tribal treatment centers and alcohol and substance abuse programs are forced to adjust priorities as a result. American Indian/Alaska Native communities are not receiving the latest information about "best practices" in the alcohol and substance abuse field. Without a system to share information from community to community, the development of effective models is more difficult. Tribes are active in this effort, but miniscule funding increases have made improvements difficult. Tribes want to address all forms of addictive behavior including gambling.

Methamphetamine use is on the rise throughout Indian Country resulting in tremendous costs to the Indian health care system. Studies show that to be effective Tribes pay as much as 180-day for quality inpatient treatment and provide significant aftercare treatment. Currently, there are no programs in the Northwest that provide for this type of treatment for adults. Tribes have identified substance abuse funding as a high priority, yet the Board has not achieved the success it would like in obtaining funds for behavioral health programs. The increase of Dual diagnosis patients necessitates a combination of mental health and alcohol treatment services. There must be a larger appropriation for these services. An increase in mental health programs provides the best hope in reducing the epidemic of suicides in Indian country. There must be more funding for Indian health programs to increase their aftercare rehabilitation services. Inter-agency transfers should be coordinated between the IHS and other HHS agencies that have responsibility for addressing alcohol and substance abuse concerns.

An increase in behavioral health services can also lead to an increase in improved health status for Indian people. By reducing the consumption of alcohol for Indian people, the rates of Type II diabetes will also decrease. Weight loss programs and positive behavior modification can lead to a decrease in cardiovascular disease, diabetes and depression.

Recommendation: The Congress must appropriate additional funding in the amount of \$12.1 million for the IHS alcohol substance abuse line item if we are to make a difference.

Health Facilities Construction Funding

Funding for Joint Venture Facility Construction and Small Ambulatory Care Projects

The Joint Venture and Small Ambulatory construction programs are an efficient way to maximize resources of the federal government. Although the IHS is working to improve the Health Facilities Construction Priority System (HFCPS), there are many tribal health facilities that will never be replaced or renovated under the current HFCPS. The current priority list was developed in 1991 and virtually locks out Tribes from much needed construction dollars unless they are one of the facilities on the current list.

The commitment of Tribes to use their own resources and non-IHS resources to construct facilities with the commitment of Congress to staff and equip the facility provides an opportunity to address the critical facility construction needs of Indian health programs with the costs shared by Congress and Tribes. Northwest Tribes have joined with Tribes from around the country to advocate for the joint venture program as one way to supplement the under funded facilities budget. Congress should continue to support tribal joint venture and small ambulatory clinic projects and allow for staffing packages. The Board, along with the IHS Portland Area Office, has developed an innovative method for small facility construction that should be promoted with funds from the Indian Health Service budget. The Joint Venture and Small Ambulatory construction programs were provided \$9.8 million in FY 2005 and were not funded in FY 2006.

Recommendation: (1) If facilities construction is restored, it is recommended that the Joint Venture and Small Ambulatory programs each receive \$10 million in FY 2009. (2) Health Facilities construction should be provided \$5 million to fund current projects on the facilities construction priority list and the agency must finalize its revision of the priority system to reflect the true facilities needs of all Indian Tribes.

CMS, Medicare and Medicaid

The Medicare and Medicaid programs will continue to see changes in the second session of the 110th Congress. The President's FY 2009 budget proposal includes many provisions that will shift costs from federal programs to the state, which will have a direct effect on Indian health programs. It is expected that Congress will look to programs where savings can be reduced in order to curtail spending and reduce the deficit. This means the Medicare and Medicaid programs will be scrutinized for cost savings.

The most significant Medicare/Medicaid concern for Indian health programs is that the unique status of Indian people as members of Tribes has been challenged by the Executive branch. The Centers for Medicare and Medicaid (CMS) has informed states that it will not approve waiver amendments containing special provisions for American Indian and Alaska Native participation in Medicaid. This is a departure from past CMS policy, in which American Indian people were allowed special provisions for participation in the Medicaid and SCHIP programs. CMS indicated that such treatment would have consequences related to the Civil Rights Act of 1964. The former CMS policy is one that acknowledges the federal government's unique legal responsibilities under the trust obligation to provide recognized privileges to American Indians and Alaska Natives. In recognition of the trust obligation, the Indian Health Care Improvement Act of 1976 states:

"federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."

This standard holds that the federal government's unique legal responsibilities under the trust obligation provide recognized privileges to American Indians and Alaska Natives. It is a standard that permits American Indians and Alaska Natives to be treated differently in federal programs because of the political status of Tribes as sovereign nations and is the standard that should be followed by CMS in determining eligibility, access to services and cost sharing issues for American Indian and Alaska Native people.

Moreover, Congress acknowledges the Federal trust responsibility for Indian health on a continuing basis through annual appropriations to the Department of Health and Human Services for the operation of Indian Health Service programs, in FY 2008, a total of \$3.3 billion was provided for health services in Indian Country. This budget is supplemented by \$785 million collected by Indian health programs from Medicare, Medicaid and other third-party insurance sources. By including Medicare and Medicaid collections in the IHS appropriations, Congress expects that these resources will be available to IHS and Tribes in order to provide health services to American Indian and Alaska Native people.

Medicare

It is estimated there are over 120,000 American Indians and Alaska Natives over the age of 65 years. Many of these elders live in rural areas and rely heavily upon federal and tribal assistance for housing, health care and transportation. Medicare is an important program for health care to

many of these Indian elders and an important funding source for IHS programs. There continues to be a number of unresolved issues stemming from the passage of the Medicare Modernization Act (MMA) and the DRA that have had an adverse effect on Indian elders. These issues must be resolved so that Indian elders can participate equally as other Americans in this important health program.

The MMA and DRA failed to adequately incorporate Indian issues into the policy changes that affected the Medicare and Medicaid programs. There were unintended consequences that failed to protect the right of elderly and disabled Indian people to receive prescription drug coverage and new program changes that raise significant issues of access and cost-sharing which impact how and where elderly and disabled Indians get coverage. The new Medicare Part D program also reduced reimbursements to Indian health programs for prescription drugs provided by IHS and Tribally-operated programs.

Recommendations: (1) CMS must continue to work with the Tribal Technical Advisory Group to develop regulations to improve Indian participation in the Medicare Part D program; (2) American Indians should be exempted from premiums, deductibles, and co-payments in the new Medicare program; (3) Congress should introduce legislation to allow Tribal resources to be applied to “true out-of-pocket” (TROOP) costs and be applied toward catastrophic coverage (i.e. donut-hole) and exempt Indians from Part D cost sharing requirements.

Medicaid

The Deficit Reduction Act (DRA) allows states greater flexibility to impose increased cost-sharing and premiums that could have a negative effect on Indian health programs. States may charge coinsurance payments as high as 10 to 20 percent of the costs of the medical service or drug; and for the first time, let providers turn away Medicaid clients who need care if they cannot afford the co-payment. The financial barriers of having to pay premiums and co-payments will simply mean that Indian people will quit enrolling in Medicaid. Why should they when they can receive their health services from the IHS at no cost? The decreases in Medicaid enrollment will deprive chronically under-funded Indian health programs of vital Medicaid revenues. The imposition of **co-pays** will not change utilization habits of Indian Medicaid beneficiaries because IHS and Tribal providers do not charge co-pays to their Indian patients. Co-pay amounts would be *cost-shifted* to the Indian health programs, causing a further reduction in the services they can offer, and reducing the resources that are used in the CHS program. These reductions in resources available to the Indian health system would decrease the health services they can provide and cause a further decline in the health status of Indian people.

The DRA also allows states greater flexibility in Medicaid benefits design that will mean fewer services to Indian people. The DRA also provides states the authority to expand services to certain eligibility groups if a state desires, thereby removing standards of comparability and state-wideness for Medicaid benefit packages. This new authority will allow states to reduce or expand the amount, duration and scope of Medicaid benefits to beneficiaries. The Indian health system is funded at less than 60% of need and is heavily dependent on Medicaid payments, would be devastated by any reductions in Medicaid-covered services. While states receive 100% FMAP for Medicaid services provided in an IHS or Tribal facility, those facilities have limited capabilities and are not able to supply all needed care. When the IHS or tribal facility must refer

an Indian Medicaid beneficiary to a private or public provider, the state must pay the regular state Medicaid match. Thus, states have an incentive to limit the benefits that Indians referred to outside providers would receive under the state Medicaid plan.

CMS has also issued regulations implementing a DRA provision requiring that persons applying for Medicaid must provide documentation of U.S. citizenship and identity. Although the CMS Tribal Technical Advisory Group urged CMS to recognize Tribal enrollment cards or Certificate of Degree of Indian Blood (CDIB) as satisfactory evidence of U.S. citizenship, Tribal concerns were not incorporated into the final regulations. Although, this DRA provision was enacted to address the concern of illegal immigrants receiving Medicaid benefits, it is ironic that the First Americans are required to prove U.S. citizenship and that the CMS will not recognize Tribal enrollment cards or CDIBs as legitimate proof of citizenship

Recommendations:

1. Since Medicaid enrollment is mandatory in the CHS program, Indian people need to be assured of the following when enrolling in Medicaid: (a) Indian people must be exempt from premiums and co-pays; (b) They will be able to choose an IHS program as their provider and that provider will be able to collect an equitable payment for services provided, and; (c) Their estate will not be subject to Estate Recovery proceedings;
2. The Executive Branch and the Congress should grant the necessary exemptions to American Indians/Alaska Natives to insure that Medicaid and Medicare programs not undermine the federal commitment to provide health care services to Indian people.
3. Tribes support the development of a uniform benefit package for American Indians/Alaska Natives under the DRA.
4. CMS should promulgate new regulations accepting Tribal enrollment documents and Certificate of Degree of Indian Blood as proof of U.S. Citizenship and identification.

Legislative Priorities in the 110th Congress

Indian Health Care Improvement Act

The Indian Health Care Improvement Act (IHCIA), along with the Snyder Act of 1921, serves as the key federal laws that authorize appropriations for Indian Health Service (IHS) programs. The IHCIA establishes the basic programmatic structure for delivery of health services to Indian people and authorizes the construction and maintenance of health care and sanitation facilities in Indian Country.

On February 5, 2008, the full Senate passed legislation to reauthorize the Indian Health Care Improvement Act (S. 1200) by an overwhelming vote of 83-10. A bill in the House (H.R. 1328) has been held at the Energy and Commerce Committee for at least six months. There are important provisions that modernize the Indian health care systems contained in the bills as well as important Medicare, Medicaid, and SCHIP provisions that extend services to Indian people. An important provision clarifies Medicaid documentation requirements required under the DRA and other provisions encourage Medicare and Medicaid enrollment by providing protections from cost sharing and estate recovery for Indian people. Now that a bill has been passed out of the Senate, the House leadership must find a way move this bill out of the Energy and Commerce Committee and get to the House floor prior to this legislative session ending.

Throughout the 108th, 109th, and now 110th Congresses, Tribes have negotiated in good faith to revise and delete certain provisions of the bill in order to accommodate Administration and Congressional concerns. For example, all significant Medicare provisions have been stripped from the bill, removal of FTCA coverage for urban programs, revisions to Medicaid and SCHIP provisions with the Senate Finance Committee, and other compromises with the HELP Committee.

Recommendations: (1) Since the IHCIA has yet to be reauthorized, all of the IHCIA programs and funding should be continued by Congress; (2) House leadership should immediately to pass the IHCIA legislation in this legislative session; and if it can not be passed as an entire bill, proposed programs should be considered for separate legislation.

Special Diabetes Program for Indians

Congress established the Special Diabetes Program for Indians (SDPI) in the Balanced Budget Act of 1997 to provide for the prevention and treatment services to address the growing problem of diabetes in Indian Country. The SDPI provides a comprehensive source of funding to address diabetes issues in Tribal communities by providing grants to 318 programs in 35 different states that successfully provide diabetes prevention and treatment services for AI/ANs and that have resulted in short-term, intermediate, and long-term positive outcomes.

Congress, in approving an extension of the State Child Health Insurance Program (SCHIP) through May 31, 2009, also included a one-year extension for the SDPI program at its current funding level of \$150 million through September 30, 2009. Senator Domenici and Representatives Kildee and DeGette have introduced bills in the 110th Congress that would seek to extend the SDPI through FY 2013 at a funding level of \$200 billion per year.

Recommendations: (1) Congress should work to pass the SDPI legislation introduced in the 110th Congress; (2) Legislative objectives identified by Tribes are to reauthorize the program at \$200 million a year for a period of five years (FY 2009 – FY 2013); (3) the funding allocations for the newly authorized program and any special set-asides should be made through Tribal Consultation, and; (4) that funding provided by the Special Diabetes Program for Indians be subject to contracting requirements of P.L. 93-638.

Title VI Self-Governance Legislation

When Congress enacted the Self-Governance legislation, it included a provision requiring the Department to carry out a study of the feasibility of Tribes and tribal organizations assuming responsibility for non-IHS programs of the Department of Health and Human Services. The Title VI Self-Governance feasibility study found that such a demonstration is feasible for eleven programs of the Department. In addition, the Secretary recommended he have authority to add as many as six additional programs during the course of the demonstration project. Tribal leaders have since developed draft language for a bill to authorize a non-IHS, HHS self-governance demonstration project.

Recommendations: (1) The Secretary should endorse and encourage the Administration and Congress to move swiftly to enact a non-IHS self-governance demonstration project; (2) It is imperative that the Secretary instructs HHS staff to sit down with tribal leaders to work through any objections the Administration may have to the tribal bill; and (3) The Department should begin to work with Tribes in the demonstration design of Self-Governance projects for some or all of the 11 programs identified in the feasibility study.

Tribal Governments to access certain Federal Employee Benefits when carrying out Federal functions under the Indian Self-Determination & Education Assistance Act

The Indian Self-Determination and Education Assistance Act (P.L. 93-638) authorizes the Federal government to contract with Indian Tribes to carry out certain federally funded programs and services that the federal government would otherwise provide. If Indian Tribes, as governmental entities, do not contract for these programs and services they must be carried out by employees of the Federal government. When Tribal governments assume these programs and services they incur the same administrative costs associated with operating programs that the Federal government would bear, and should be provided the same rights and privileges.

Congress recognized this when it determined that Tribal employees acting within the scope of their employment in carrying out Federally-authorized programs under P.L. 93-638 are deemed to be Federal employees of the Bureau of Indian Affairs (BIA) or Indian Health Service (IHS) with respect to claims arising under the Federal Tort Claims Act.³ Otherwise, Tribal governments carrying the same programs and services end up paying more for administrative services that ultimately end up costing the Federal government money. As is the case for liability coverage under FTCA; the same is true for purchasing employee benefits. In

³ P.L. 101-512, Title III § 314, Nov. 5, 1990, 104 Stat. 1959, *as amended*; P. L. 103-138, Title III § 308, Nov. 11, 1993, 107 Stat. 1416.

recognition of the vital role played by Tribal governments in carrying out Federal programs under P.L. 93-638, Tribal employees must be deemed employees of the BIA and IHS with respect to the Federal Employment Compensation Act and the Federal Employees Health Benefits provisions of Title 5, U.S. Code. This will provide Tribes the same benefits as its Federal partners when carrying out inherently Federal functions—that ultimately save the Federal government and American taxpayers' money.

Recommendation: Congress should enact legislation that would allow Tribal employees to be treated as a Federal employees in order to participate in Federal employee benefit programs under the Federal Employment Compensation Act and the Federal Employees Health Benefits laws.

Transfer of the IHS Budget from Interior Appropriations Committee to the Labor-HHS Education Appropriations Committee

Both, the National Congress of American Indians (NCAI) and the Affiliated Tribes of Northwest Indians (ATNI) support moving the IHS budget from the Interior Appropriations Sub-Committee to the Labor, Health and Human Services, and Education (LHE) Appropriations Sub-Committee. The LHE Committee handles health care related bills, and therefore understands the problems associated with health care delivery, such as medical inflationary rates. The Interior Appropriations Subcommittee is responsible for national parks, reclamation projects, mining activities, fish and wildlife, and other natural resource programs. It is reasoned that the IHS appropriation would benefit by being in the same pool of health expenditures that programs like Medicare, Medicaid, SCHIP, and other health programs appropriated out of the LHE Appropriations Subcommittee. The Labor-HHS-Education subcommittees have almost always been allocated appropriation increases that match or exceed health inflation indexes. While the Interior Appropriation Subcommittee allocations reflect natural resource program inflation rates, which generally fall below health inflation.

Recommendation: HHS and the Department of Interior should work to identify the feasibility and benefits/cons related to this transfer.

Other Health Priorities

Special Appropriation for Northwest Regional Youth Treatment Program

Regional Youth Treatment Centers provide drug and alcohol treatment for adolescents who are enrolled members of federally recognized Tribes. American Indian and Alaska Native Youth are at a considerably higher risk and suffer the effects of alcohol and substance abuse at a higher rate than other non-Indian youth. The Klamath Tribe of Oregon receives approximately \$1.2 million from the Indian Health Service (IHS) to operate the Klamath Alcohol Drug Abuse (KADA) program, and is the only dual diagnosis [mental health and drug and alcohol addiction] facility for Indian youth in the United States. KADA is currently located in a 6,500 square foot house that is over 30 years old and in considerable need of repair. The current facility is less than adequate for housing the youth services provided by KADA. The Klamath Tribe has had to lease an adjoining mobile trailer to house its administrative operations. The Klamath Tribe has recently purchased approximately 6 acres of land for a future KADA building at a cost of \$120,000--however does not have the necessary resources for construction of a new facility. A new facility is drastically needed to continue to provide a safe, compassionate, healing environment for the KADA program.

Recommendation: The NPAIHB requests Congress make a special appropriation of \$5 million to the Klamath Tribe for the construction of a new facility for the Klamath Alcohol and Drug Abuse program. This request is supported by a resolution of 43 Tribes passed by the Affiliated Tribes of Northwest Indians.

Long Term Care (LTC) and Elder Issues

As the population of American Indian/Alaska Native elders grows, there is a rising need for LTC facilities. The Indian Health Service does not fund long-term care (but it could), which is why there are few long-term care services in Indian communities. There are only 15 known tribal nursing homes in the nation. The Northwest Portland Area Indian Health Board supports the study of the long-term care needs of American Indians and Alaska Natives. Tribes need more case management funding and funding to allow Tribes to provide advice on long-term care needs to their elders.

Studies show that up to 90% of reservation families provide long-term care in their homes. The in-home care burdens are complicated and sometimes lead to increased elder abuse. With deteriorating economic and social conditions in much of Indian Country, family members caring for elders often have to leave them alone while they work, putting the elders at risk for injury as they do not have caregivers to assist them with meal preparation, personal hygiene and taking daily medications. Funding for adult day care services on reservations would greatly assist in combating the unintentional neglect these elders suffer as well as provide them a safe environment to visit with their fellow Tribal members and be involved in stimulating activities. For those elders who are truly home bound, respite care is critical.

The Medicare and Medicaid programs could become important sources of funding for long term and home and community based care for elders with support from CMS. If Tribes had Long Term Care infrastructure, they could obtain resources from each of the CMS-funded programs, but unfortunately this will not happen until the Indian Health Service receives the necessary

resources to develop this capacity.

Recommendation: The IHS should receive a line-item appropriation to fund long-term care programs in Tribal communities. Elder issues and Long Term Care (LTC) are a growing concern for Tribes across the country.

Veterans Health Issues

The Board has long recognized the growing concerns and frustrations of American Indian and Alaska Native veterans in obtaining health services from the Indian Health Service (IHS) and Veterans Administration (VA). The Board has passed previous resolutions supporting improved communication, information sharing, and data exchange in order to improve the quality of health services provided to veterans by the IHS and VA. Often there are redundancies in treatment when veterans obtain health services at an IHS or VA facility. American Indian veterans have advocated that the VA and IHS accept one another's diagnoses without the requirement of additional diagnoses for referrals. These conditions cause an undue burden on veterans when seeking services and are causing unnecessary costs to both the IHS and VA. This stress often serves as a barrier to seeking health care and illness goes untreated. Recognizing the growing importance of addressing Veteran's health issues the VA and IHS recently signed a memorandum of understanding. There is much work that can be done under the VA/IHS Memorandum of Understanding. Indian Veterans have requested that the VA look at the feasibility of satellite clinics located on reservations, possibly working through the IHS to serve as a host.

Recommendations: (1) Working under the auspices of the VA/IHS MOU, the agencies should work to identify needs and gaps in services and develop and implement strategies to provide care to Indian Veterans; (2) The agencies should work to develop strategies for information sharing of patient records and data exchange so patients do not have to undergo a duplication of service for referrals; and (3) Finally, an interagency workgroup of representatives from the IHS, VA, and tribal health programs should be developed to oversee the implementation of the MOU. (4) The Northwest Portland Area Indian Health Board reiterates its strong opposition to the closing of the Walla Walla VA hospital.

Emergency Preparedness and Response

There are more than 25 Indian Tribes that have primary jurisdiction over lands, on or near the Canadian or Mexican borders that comprises 260 miles of international borders. Tribes also have jurisdiction over waters that provide direct access by boat to lands within the United States. Tribal governments are crucial in the emergency response and preparedness system as state, local, and county governments. Yet when federal funding to support public health planning, preparedness, and response activities was provided to the states, very little of this money went to Tribal governments and Indian health programs. Tribes like states require funding to support efforts in assessing resources and needs in preparing an effective public health infrastructure to support emergency preparedness. Tribal health systems will play an important role as first responders, particularly in rural parts of the county, where Indian health programs may be the only health care provider. NPAIHB supports legislative measures that further incorporate Tribal programs for emergency preparedness and response.

Recommendations: (1) The Congress should work to correct the inequitable treatment of Tribes in the Homeland Security Act; (2) The Department of Homeland Security must develop a tribal consultation policy pursuant to Presidential Executive Order No. 13175, and; (3) Emergency preparedness funding provided by CDC to the states must include Tribal Governments.

Funding for New Tribes

Congress needs to provide new funds for the health care needs of newly recognized Tribes at the time of restoration and at the level of need identified by IHS. Congress should recognize that reducing funds from existing tribal contracts for newly recognized Tribes is disruptive to ongoing health care delivery. The obligation to provide health care rests with the federal government not other federally recognized Tribes. Newly restored or newly recognized Tribes in the Northwest may need funding for as many as 2,000 new users.