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Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

Portland Area Position Papers on IHS Tribal Consultation Issues Prepared for the IHS Tribal Consultation Summit Washington, D.C.

July 6-7, 2011

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(Position papers are organized chronologically by agenda items for the Consultation Summit)

Wednesday, July 6, 2011:

Thursday, July 7, 2011:

10. Consultation Topic: Indian Health Care Improvement Act (refer to Item No. 3 above)

11. Workgroup: Director's Workgroup on Improving CHS (refer to Item No. 6 above)

12. Consultation Topic: Suicide Prevention – (see January 12, 2011, NPAIHB Talking Points prepared for the Federal Agency Listening Session on Suicide Prevention held in Portland, OR)

Miscellaneous Northwest Position Papers:

13. October 27, 2010, NPAIHB letter concerning Sec. 157, Access to Federal Health Heath Benefit Plan.

14. December 31, 2010, NPAIHB letter responding to Director's request for input on the IHS-VA Memorandum of Understanding.

15. May 20, 2011, NPAIHB letter to Roselyn Tso recommending that IHS mitigate reductions in CSC funding to Tribes and Tribal organizations as a consequence of the FY 2011 rescission.

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Direct Service Tribes

As Long as the Grass Grows and the Rivers Flow.

January 7, 2007

Yvette Roubideaux, M.D.
Obama-Biden Presidential Team
Health and Human Services

Dear Dr. Roubideaux:

Thank you for providing the Direct Service Tribes Advisory Committee (DSTAC) the opportunity to share with you and the Obama-Biden Transition Team the health care issues and priorities of American Indians who receive health care services directly from the Indian Health Service (IHS). These tribes are referred to in the IHS as Direct Service Tribes (DST).

Listed below are the three top DST Priority Issues for FY 2009:

1. Contract Health Services
   - Full funding to meet deferred services
   - Full funding to meet above priority level 1 in all IHS Areas
   - Recommend and support a review and evaluation of the IHS Contract Health Service Program policies for revisions to improve use of funds and health
2. Health Care Facilities
   - New and replacement facilities
   - Full funding for equipment/staff
   - Environmental health infrastructure
3. Behavioral Health
   - Coordinate Tribal/Federal program efforts to deal with suicide, domestic violence, substance abuse, and sexual abuse of children
   - Treatment/prevention focus on methamphetamine abuse and suicide
   - Holistic medicine approach incorporated with Traditional and Western approach

In addition to the above, DSTAC members raised additional concerns during our conference call. We hereby request that the following concerns also be noted:

1. Funding.
   - This is an over arching issue that permeates each of our priorities above and impacts the effectiveness of all IHS funded programs whether operated directly by the IHS or through compacts and contracts by Tribes and Tribal Organizations. Many DSTAC members related to you their concerns over being funded at less than half of what it costs to provide basic health care for Federal government employees. Without adequate funding, IHS facilities cannot hire the staff necessary to ensure adequate health care resulting in continued disparities for Indian people. The Obama Administration must make increasing funding to the Indian Health Service a priority over the next four years. A one billion dollar increase in

each of the next four years is necessary to bring IHS funded programs up to a level comparable to that provided to Federal Government employees.

2. Tribal Co-pays.
   - American Indians and Alaska Natives have sacrificed greatly for this nation. Indian Tribes have exchanged millions of square acres of land for an assurance that their education and healthcare needs would be met. As a result of inadequate funding and support, some Tribes are considering charging co-pays to Tribal members as a way of enhancing revenues. This practice is more likely going to result in eligible American Indians and Alaska Natives failing to seek care when needed and could result in a shift of the patient workload away from Tribal programs who charge a co-pay to IHS (DST) facilities, further diminishing their ability to serve local Tribal members. The Obama Administration should prohibit the practice of charging co-pays for services that have already been paid for in land and blood.

3. Indian Healthcare Improvement Act
   - Failing to pass the Indian Healthcare Improvement Act (IHCIA) is a blemish on both Congress and this past Administration. The DSTAC believes the Obama Administration should work actively to assure passage of the IHCIA within the first 100 days of the new Administration.

4. Elevation of the IHS Director
   - Several DSTAC members spoke about the importance of elevating the Director of the Indian Health Service to the Assistant Secretary level in the Department of Health and Human Services. Such an elevation would ensure that this important position for American Indians and Alaska Natives can be an office with responsibility to advocate forcefully for increases in IHS appropriations and to ensure tribal input and timely publication of Federal regulations that affect Indian health programs.

Thank you for your time and interest in the health care issues of American Indians and Alaska Natives. If I can answer any questions or provide additional information, I can be contacted at (918) 762-3621 or by e-mail at VWills@pawneenation.org

Sincerely,

George E. Howell
Chairman
Direct Service Tribes Advisory Committee

cc: DSTAC Members
Robert McSwain, IHS Director
Randy Grinnell, IHS Deputy Director of Management Operations
IHS Area Directors
Ron Demaray, Acting Director, IHS-OTP
Hankie Ortiz, Director, IHS-OTSG

EXTRACT FROM THE:

National Tribal Self-Governance Strategic Plan & National Priorities for the Obama Administration and the112th Congress 2011-2013

Updated - March 2011

(Note: Only includes HHS and IHS prioritie)

Department of Health & Human Services & Indian Health Service (IHS)

TOP PRIORITIES:

Goal #1: Advocate for Full Funding Contract Support Costs (CSC)
Goal #2: Advocate for IHS Mandatory Funding (Current Services)
Goal #3: Appoint an Office of Management and Budget (OMB) Assistant Director for Native American Programs

OTHER PROGRAM AND BUDGET ISSUES:

Goal #4: Advance Self-Governance Budget Priorities & Improve Tribal Involvement in Budget Strategy, Formulation and Development
Goal #5: Improve and Strengthen Communication with DHHS & IHS to Support and Increase Sovereign Governmental Authority
Goal #6: Support and Urge the Transfer of the Annual Appropriations for IHS from the Interior, Environment & Related Appropriations Subcommittee to Labor, Health and Human Services, Education and Related Appropriations Subcommittee

LEGISLATIVE PRIORITIES ISSUES:

Goal #7: Implementation of Affordable Care Act and the Indian Health Care Improvement Act (IHCIA)
Goal #8: Advance Self-Governance under a Demonstration Project - Title VI Amendment to the Indian Self-Determination and Education Assistance Act (ISDEAA)
Goal #9: Implementation of the Special Diabetes Program for Indians (SDPI)

PROCESS FOR IMPLEMENTATION:

In order to successfully implement and advance the Self-Governance Strategic Plan, it will require the on-going active involvement and advocacy of Tribal leadership to:

1. Advance the Self-Governance Vision and Priorities including Tribal examples of how Self-Governance works at the local level and identify challenges. Tribes should include quotes, excerpts and slogans to strengthen our message;
2. Advance Self-Governance goals identified in the Strategic Plan, including budget and legislative priorities;
3. Request meetings with the Administration and Congress and present Self-Governance priorities in a unified message; and
4. Report back to the Self-Governance Communication and Education (SGCE) office and share with other Self-Governance Tribes on-going outreach and feedback.

Self-Governance Tribes have identified what they consider to be key elements to this Plan and this draft is an attempt to capture their recommendations. This Plan is only as good as the implementation design and the collective input of Self-Governance Tribes, Department of the Interior and the Indian Health Service. To ensure that the results and long-term effects of the Plan accomplish the goals, there must be a system of checks and balances to monitor the:

- implementation of the Strategic Plan;
- effectiveness of the Strategic Plan communications outreach; and,
- overall results of the collective outreach and communication efforts of the Strategic Plan.

Direct Service Tribes

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Warm Springs Tribe
Yakama Nation

2121 SW Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

SENT BY TELEFAX: (301) 443-4794 – Hardcopy via Federal Express

July 1, 2010

Yvette Roubideaux, M.D., M.P.H
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Re: Comments regarding P.L. 11-148 PPACA and IHCIA

Dear Dr. Roubideaux:

Established in 1972, the Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization that represents forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington on health care issues. We are writing to provide our comments and recommendations to your May 12, 2010, "Dear Tribal Leader" letter, in which you and Paul Dioguardi, Director HHS-IGA, invited input to implement various provisions of the Patient Protection and Affordable Care Act (P.L. 111-148) and the reauthorization of the Indian Health Care Improvement Act (IHCIA).

As you may be aware, the NPAIHB played in critical role in the development of the IHCIA legislation and many of the provisions that were included in the Affordable Care Act. Northwest Tribes understand that the Affordable Care Act and amendments to the IHCIA will have lasting implications in developing the Indian health system. Because of this it is imperative that Indian Health Service (IHS) and other federal agencies carefully evaluate the impact that implementing health reform will have on providing services to American Indian and Alaska Native (AI/AN) beneficiaries and the Indian health system. It is the IHS' responsibility along with the Department's to ensure that the Indian health system is protected from any unintended consequences and promote the highest level of health care for Indian people.

Because of the reasons articulated above, Portland Area Tribes expect the IHS and Department to actively involve Tribes in the implementation efforts of the Affordable Care Act and the IHCIA amendments. In this regard, we are pleased to provide our comments and recommendations to your May 12th letter, which are organized around as follows: (1) Preamble to NPAIHB Comments; (2) IHCIA priorities and how to implement; (3) Affordable Care Act priorities and recommendations on how to implement, and; (4) How to consult with Tribes on an on-going basis as provisions are implemented.

I. Preamble to NPAIHB Comments

As a preliminary matter, Northwest Tribes urge the HHS Secretary and IHS Director to formally acknowledge that the IHCIA amendments are effective on the date of enactment of the Affordable Care Act, March 23, 2010. Northwest Tribes further recommend that the request for input to identify "priorities for implementation" shall not delay the immediate implementation of any new authorities allowed by law. While some new IHCIA provisions expressly require the Secretary to issue regulations, no provision contains language which delays its effectiveness until regulations are promulgated. Thus, issuance of regulations or agency guidance may be undertaken to help make utilization of new authorities more effective and efficient, but this activity should not delay their immediate applicability.

II. IHCIA priorities and how to implement

Provisions for which regulations, guidance or administrative action is required or needed

1. Establish a Negotiated Rulemaking Committee. For any rules that may need to be promulgated, the most efficient and effective way to develop regulations or other administrative guidance is to establish a Negotiated Rulemaking Committee comprised of tribal and IHS representatives. While the new law does not require the Secretary to use negotiated rulemaking, this procedure is available through the Negotiated Rulemaking Act, 5 U.S.C. 561, et seq. This procedure has been successfully used for development of recommended regulations for many Indian laws since it was first employed after enactment of the Indian Self-Determination and Education Assistance Act (P.L. 93-638, ISDEAA) amendments of 1994. It is an effective manner to obtain expertise from tribal representatives, while working together with IHS personnel, to produce regulations, guidance, and procedures that both the agency and tribes can support.

2. Section 409: Access to Federal Insurance. This is a ***"high priority"*** item for Portland Area Tribes. Sec. 409 allows a tribe/tribal organization operating any ISDEAA program to enroll its employees in the Federal Employee Health Benefit Program, provided it pays the premiums. This is a significant new opportunity for tribes to acquire more economical coverage. While the law does not *expressly* require regulations, it is clear that some form of guidance, procedures or regulations from the Office of Personnel Management will be needed to enable tribes to access the FEHBP. OPM has asked IHS to take the lead in implementing this provision, and tribes should be involved. Please see attached NPAIHB letter sent to OPM Director, John Berry, dated May 10, 2010.

3. Section 405: Sharing Arrangements with Federal Agencies. Sec 405(c) requires the Departments of Veterans Affairs and Defense to reimburse IHS and tribal health programs when they provide services to beneficiaries eligible for DVA and DoD services. IHS should take the lead in arranging with DVA and DoD an efficient billing/payment system. This should be a high priority for implementation attention.

4. Section 301: Health Care Facility Priority System. Requires IHS, in consultation with tribes/tribal organizations, to develop a health care facilities construction priority system which allows IHS and tribes/tribal organizations to nominate projects at least every 3 years. While *regulations* are not expressly required, the priority system developed will be applied throughout the IHS system.

5. Section 311: Other -Funding, Equipment and Supplies for Facilities. Requires IHS to "establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians under this Act."

6. Section 202: Catastrophic Health Emergency Fund (CHEF). This section requires issuance of CHEF regulations. The predecessor Sec. 202 did likewise, but IHS has never issued CHEF regulations. Unless there are issues about whether CHEF program operations comply with the law, regulations at this point are probably not needed.

7. Section 309: Tribal Management of Federally Owned Quarters. No regulations are required to implement this provision (Sec. 309); it should be considered in effect now. But IHS should update its personnel manuals to assure that IHS employees know of and comply with this new statutory authority for tribes.

Existing regulations that should be reviewed as a result of revisions to the IHCIA

8. Contract Health Services definition. Sec. 3(5) of the new law sets out a revised definition of contract health services. The existing regulation at 42 CFR 136.21(e) should be revised to conform.

9. Section 405: Sharing Arrangements with Other Federal Agencies (Payer of Last Resort). New Sec. 405(c) requires DoD and DVA to reimburse IHS and tribal programs for services provided to Indians eligible for DoD or DVA services. The POLR regulation at 42 CFR 136.61 should be updated to reflect this requirement. In addition, Sec. 2901(b) of the PPACA codifies in law the POLR status of IHS, tribal and urban Indian organizations. The IHS regulation should reference this statutory directive.

New Provisions for which tribes may want to be involved in development of regulations, guidance, eligibility criteria or other administrative action

10. Section 119: Community Health Aide Program (CHAP) expansion. Authorizes establishment of a CHAP program for tribes in the Lower 48 states, subject to the appropriation of new funds for this purpose. Tribes may want to be involved in deciding whether to use the Alaska CHAP criteria or to develop different criteria for the Lower 48 program.

11. Section 221: Licensing of Health Care Professionals. This provision would exempt Tribal Health Professionals from being licensed in the state of which they are practicing as long as they are licensed in another state. This is a priority to Portland Area Tribes as it would aid in the recruitment and retention of health professionals in rural areas and gives Tribes parity with IHS professionals. NPAIHB requests that the Center for Medicaid and Medicare services (CMS) issue a letter to State Medicaid Directors informing States they can no longer deny Medicaid provider status to a Tribal health care professional who is not licensed in the State, but does hold a license in another State.

12. Section 226: Contract Health Services Administration. The Secretary is authorized (but not required) to use Negotiated Rulemaking to develop a CHS distribution formula if, after receiving an ordered GAO report on the CHS program, she finds inequities in the current formula or problems with CHS administration.

13. Section 407: Eligible Indian Veteran's Services. This section authorizes the use of certain IHS-appropriated funds to pay expenses incurred by eligible Indian veterans who receive services from the Department of Veterans Affairs providers in IHS or tribal facilities. The Secretary is required to "establish such guidelines as the Secretary determines to be appropriate regarding the method of payments" to DVA. To the extent these guidelines would also apply to tribes, a tribal role in development may be desirable.

14. New Demonstration Programs. Several new demonstration programs are authorized in the new law. In some cases, funding will be needed before these authorities can be utilized. Criteria will be needed for selection of recipients and tribes may want to have input in their development.

15. New/revised Grant Programs. Tribes may want to have an integral role in developing eligibility criteria for new/revised grant programs, especially if new statutory language impacts existing similar programs. Title VII in particular will require some careful thought, as that Title's focus on substance abuse programs has been expanded to encompass wider behavioral health needs; it also creates new activities such as an Indian Youth Suicide Prevention program.

III. Affordable Care Act priorities and recommendations on how to implement

The sheer size and extent of the PPACA make it challenging for us to identify every provision that will impact our Northwest Tribes. An enormous number of new regulations will be required to implement the PPACA, as that law establishes a host of new programs and adds major new provisions to existing laws such as the Social Security Act and the Internal Revenue Code. HHS has already begun issuing regulations for provisions which become effective later this year and next year. In many cases, the law itself dictates implementation "priorities" by establishing specific timelines.

The National Indian Health Board's met in Denver last week to begin discussion of desired PPACA outcomes for Indian health, and to identify provisions in whose implementation it is important to assure that tribal leader input is obtained at the earliest stages of development. NPAIHB and its member Tribes has been an active participant in this process and endorse and support the recommendations submitted by the NIHB in follow up to your May 12th letter.

Desired Outcomes. For PPACA to fulfill the Administration's promise to American Indians and Alaska Natives, its implementation must:

- Significantly increase the rate of health coverage for American Indians and Alaska Natives, both on and off reservations.
- Financially strengthen Indian health providers so programs can expand service capacity and access to health care.
- Significantly reduce the glaring health disparities that plague American Indians and Alaska Natives.
- Ensure that Tribal leaders and Indian health program staff receive training in order to understand how PPACA works and are supplied with adequate resources to educate and enroll community members in new or expanded health programs.

- Ensure that all Indian communities directly benefit from new funding opportunities, grants and initiatives in a way that compliments the cultural context of their existing health programs.
- Implement Indian specific provisions as effectively and efficiently as possible.
- Recognize that the Indian health system is very different from the mainstream health delivery system and, therefore, assure that it is protected from any adverse consequences not intended by the statute, and receives express mention in regulations in order to achieve this outcome.
- Require all Department of Health and Human Services agencies with implementation responsibilities to engage in meaningful Tribal Consultation that respects the federal trust responsibility and Government-to-Government relationship with Tribes.

In order to accomplish these outcomes, PPACA must begin by implementing policies and actions in the following areas. The comprehensive and coordinated nature of PPACA will require an ongoing dialogue with Tribes and Indian communities in order to understand and accommodate the unique aspects of Indian health programs across the country. The following is not comprehensive list of PPACA items affecting Indian Tribes nationally, however represent the immediate issues from the perspective of Northwest Tribes, which should be addressed by the IHS and HHS:

A. Indian exemption from individual mandate penalty – PPACA Sec. 1501(b) creates a new Sec. 5000A in the Internal Revenue Code which exempts members of Indian Tribes from the tax penalty for failing to obtain acceptable insurance coverage.

The Secretary is charged with issuing certification attesting that the individual is entitled to the exemption. This process must be designed in a way that makes it easy for American Indians and Alaska Natives to obtain the certification in an expeditious and user-friendly manner.

B. Exchanges and subsidies, especially Indian provisions. Special Exchange rules for Indians: Sec. 1402(d) and Sec. 2901(a); Monthly enrollment window for Indians: Sec. 1311(c)(6)(D)

Regulations developed to implement the Exchanges must carefully set out the special treatment the law provides for IA/AN access to insurance products listed on the Exchanges. These includes: eligibility of AI/ANs to insurance products in the individual market; special enrollment period for AI/ANs; and cost-sharing protections for AI/ANs at/below 300% of the FPL and for all Indians served by an IHS, tribal or urban Indian organization health program. If HHS regulations implementing these provisions are not sufficiently explicit, AI/ANs could be denied the special considerations Congress intended.

C. Premium and cost sharing payment on behalf of eligible Indian people

Premium payment is a significant barrier to Indian enrollment in Exchange plans or high risk pools. To overcome this barrier, the regulations should establish an administratively simple mechanism which allows IHS, Tribes, Tribal organizations and Urban Indian programs to group-pay premiums on behalf of individual beneficiaries. Such group payment mechanisms are now used for enrolling individual beneficiaries in Medicare Part D plans. Since Exchanges will likely be operated by the states, the HHS regulations must expressly require the availability of such group pay options in order to assure the state systems will include them.

D. Use of high risk pools

Sec. 1101. For American Indians and Alaska Natives with pre-existing conditions, whether or not they use an Indian health program, purchasing insurance through a temporary high risk pool may be the only way to get affordable health coverage. In order to qualify, HHS should clarify with entities providing high risk pool coverage that IHS eligibility does not constitute "acceptable coverage" as defined in the PPACA, and, therefore, AI/ANs without other insurance coverage are eligible to acquire coverage from the high risk pools. Furthermore, ITU programs need a simple way to provide document that AI/AN beneficiaries have a pre-existing condition that would qualify them for coverage.

E. Modified Adjusted Gross Income – treatment of Indian income

Sec. 2002 of PPACA and Sec. 1004 of Health Care and Education Reconciliation Act. MAGI will be used as the basis for means tested eligibility for (among others) Medicaid and for Exchange plan premium subsidies. Regulations implementing the MAGI must expressly recognize Indian income exemptions provided by other Federal laws and assure that those exemptions also apply to MAGI calculations. HHS also has the responsibility to provide comprehensive outreach and education to Indian beneficiaries so they are informed about the types of Indian-specific income that are excluded in making MAGI calculations.

F. Exchange plan and high risk pool reimbursement for Indian health programs

PPACA Sec. 1311(c)(1)(C) requires the Secretary to include within Exchange health insurance plan provider networks "essential community providers" that serve predominately low-income, medically-underserved individuals. The HHS regulations should expressly include IHS, tribal and urban Indian organization programs in the definition of "essential community providers". Experience has demonstrated that private insurers often do not admit I/T/U providers to their provider networks. Thus, Exchange regulations should set out participation and payment requirements for I/T/U providers (as "essential community providers") modeled on the recent amendment to Sec. 1932 of the Social Security Act regarding participation of I/T/U providers in Medicaid and CHIP managed care entities.

Such express payment requirements are also needed to fully implement the revised IHCIA Sec. 206. This revised section gives IHS, tribal and urban Indian organizations providers a right of recovery from all third parties "the reasonable charges billed" by such providers, "or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities".

G. Medicaid expansion

The PPACA expands Medicaid to all individuals at/below 133% of FPL, effective in 2014, unless sooner expanded by a State Medicaid plan. Medicaid reimbursement is critically important to Indian health programs. PPACA Medicaid provisions will have a profound impact on access to health services for Indian people. CMS will have primary responsibility for most federal implementation. Priorities include how the HHS website and Exchange portals will convey information specific to

Indian provisions. The Coordinated Health Care Office must begin working with TTAG to make sure policies work to improve access for dually eligible Indian people. Indian specific directives to States will also be essential to implement.

H. Identifying and verifying Indian individuals eligible for special provisions

HHS regulations should include specific definitions as to individuals who are eligible for the special treatment the PPACA grants to Indians. These regulations should use the comprehensive definition of "Indian" set out in the final rule issued by CMS regarding Medicaid program premiums and cost-sharing. *See* 42 CFR 447.50(b)(1), as printed in 75 Federal Register 30261 (May 28, 2010).

I. Express Lane Agency status

PPACA Sec. 2901(c) adds IHS, tribal, and urban Indian organizations to the list of entities that have "express lane agency" status on whose determinations of eligibility a state may rely for purposes of Medicaid and CHIP eligibility. HHS must insure that states are aware that I/T/Us now have express lane agency status, and require them to provide I/T/Us with information on eligibility requirements, document processing and any necessary personnel training to enable them to perform their express lane agency functions.

J. "TrOOP" fix for I/T/U pharmacies

Effective January 1, 2011, PPACA Sec. 3314 requires Medicare Part D plans to count the cost of drugs dispensed by I/T/U pharmacies toward the true out of pocket expenses incurred by an individual Indian enrolled in a Medicare Part D plan. CMS must inform I/T/U pharmacies and Part D plans of this change so that all mechanisms are in place in advance of the January 1, 2011 effective date to implement this provision. In addition, IHS and the TTAG should revise the Indian Health Addendum which CMS requires to be included in Part D plan pharmacy provider agreements to reflect this revision to the "TrOOP" rules.

K. Tax exemption for tribally-provided benefits

Rapid implementation and education of PPACA Sec. 9021 is important to be sure American Indians and Alaska Natives understand that effective March 23, 2010, health benefits (including premiums) provided by IHS or tribes are not taxable income to individual AI/ANs.

L. Maternal, Child Home Visitation Program (HRSA and ACF)

PPACA Sec. 2951 establishes a new Maternal and Child Home Visitation Program for families at risk of poor maternal and child health. Tribes, tribal organizations and urban Indian organizations are eligible for competitive grants funded through a 3% set-aside at Sec. 2951(j)(2)(A).

While Indian Country is grateful for this express set-aside, the funds provided will not be sufficient to enable all at risk AI/AN communities. Thus, HHS must assure that States are required to include Indian communities in the needs assessments they must perform and services they must provide under the State grants made available under this Section.

M. Data collection for Federally-supported health programs

PPACA Sec. 4302 requires the Secretary to collect data for all federally-supported health programs according to race, ethnicity, sex, primary language and disability status of participants and to analyze these data to monitor trends in health disparities. It is vital that the data collection system includes categories for AI/ANs generally, and disaggregates data for AI/ANs served by I/T/U programs. It is well-known that AI/ANs suffer from the greater health disparities than other components of the American population. The data collection system should also be constructed to enable HHS to track the number of AI/ANs enrolled in Medicare, Medicaid and CHIP.

To successfully implement this provision, the Agency for Healthcare Research and Quality should be required to work with knowledgeable I/T/U and Indian researchers and Tribal Epidemiology Centers.

N. Workforce Development grant programs

Titles IV and V of Act: Many different HHS agencies will be involved and ITU access to these resources is important for successful implementation of PPACA and capacity building. Although some provisions explicitly list ITU or Tribes as eligible applicants, there should be a way to insure all programs are available in Indian Country and that application information is available at the earliest date possible.

O. Negotiated Rulemaking for Medically Underserved Populations and Health Professions Shortage Areas

Sec. 5602 requires the Secretary to utilize Negotiate Rulemaking for re-defining the terms medically underserved populations and health professions shortage areas. Indian Country is grateful that Indian organizations have been identified as entities to be represented on the Negotiated Rulemaking Committee.

P. Behavioral Health

In addition to Behavioral Health provisions in the IHCIA, PPACA includes: Sec. 1302; Sec. 2703; Sec. 2707; Sec. 2952; Sec. 3012; Sec. 3107; Sec. 3205; Sec. 3502; Sec. 4001; Sec. 4004; Sec. 4101; Sec. 4103; Sec. 4106; Sec. 4201; Sec. 4202; Sec. 5101; Sec. 5203; Sec. 5301; Sec. 5306; Sec. 5315; Sec. 5403; Sec. 5405; Sec. 5507; Sec. 5604; Sec. 10306; Sec. 10408; Sec. 10410.

The underlined Sections have specific references for Indian Country. The behavioral health features of the PPACA are numerous and complex. The Act offers significant opportunities to begin to ameliorate the impact of mental illness, drug abuse, and other behavioral issues commonly referred as "Behavioral Health" in Indian Country (consistent with Title VII of the IHCIA). Behavioral health issues have been profoundly underestimated and culturally undefined in the AI/AN population.

There are a variety of different opportunities in the Section above, that can impact or begin to ameliorate the profound needs in Indian Country, but only if ITUs can successfully find ways to tap into the various programs. Accessing new behavioral health programs under PPACA is complicated

by the fact that they will be administered by numerous federal agencies making an integrated strategy difficult to accomplish.

IV. How to consult with Tribes on an on-going basis as provisions are implemented

Portland Area Tribes want to be proactive – not just reactive. We understand that there are many internal implementation teams and some policy decisions are moving forward quickly. The provisions in PPACA are complexly intertwined and will impact Tribes in their roles as employers, health care providers and governments responsible for the health and wellbeing of their members. For these reasons, we strongly advise that Tribal representation be integrated into this process so that the critical voice of Tribes is reflected in all policy making processes which will impact them.

We also recommend that the Department convene a series of "All Tribes" calls to ensure that all of Indian Country has a chance to weigh in throughout this process. Because the role of IHS is limited, HHS and the Administration must effectively engage Tribes in both formal and informal consultation on a variety of PPACA policies which are beyond the expertise of IHS.

It seems that two consultation mechanisms are needed—one for the IHCIA, and one for the PPACA (described below). Whatever the process, it is imperative that Tribal leaders have a seat at the table with HHS and IHS as implementation of PPACA and IHCIA occur. Tribes as major stakeholders in the health reform process, we want to ensure that Tribal leaders are included in any major workgroup, advisory committee or consultation process that is used by HHS and IHS. We advise that the Department work with the NIHB and TTAG when it needs technical assistance on policies and implementation strategies that effect Indian people or Tribal and Urban Indian providers.

1. IHCIA tribal consultation. The implementation task facing IHS is three-fold: (i) identifying the new IHCIA provisions that do and do not require regulations; and (ii) identifying the few existing IHCIA regulations which must be updated as a result of the recent amendments; and (iii) preparing the new or up-dated regulations. Tribal leaders should be involved in all of these activities.

   As explained above, we believe the most efficient way to proceed is for the Secretary and the Director to establish a Negotiated Rulemaking Committee comprised of tribal representatives and IHS officials, and assign it to perform these three activities. While the Secretary retains final regulatory decision-making authority, the Negotiated Rulemaking Committee process can be greatly strengthened if the Secretary commits in advance to seriously consider the recommendations of the Committee. Negotiated Rulemaking has proved to be the most efficient and effective method for expeditiously producing regulations that can be supported by both the IHS and tribes.

2. PPACA tribal consultation. While several PPACA provisions are Indian-specific, far more of them have no express Indian language but will impact the Indian health care delivery system. Thus, as advised above, HHS implementation teams must accept first-line responsibility for evaluating the impact of each regulatory policy on the Indian health system, and assuring that mechanisms are put in place to protect and enhance that system. The process must provide an opportunity for early and on-going interaction between tribal leaders and their technical representatives and the HHS

implementation teams. Perhaps a channel of communication can be established by Mr. Dioguardi through the HHS Office of Intergovernmental Affairs.

In closing, we want to thank you and Mr. Dioguardi for reaching out to Indian Country for input on important PPACA and IHCIA priorities and recommendations to consult with Tribes over these important items. Your continued effort to engage and consult with Tribes over important health care issues is to be commended. To this end, Northwest Tribes stand ready to assist you and Secretary Sebelius to work on the implementation of the Affordable Care Act and the reauthorization of the IHCIA.

If you should have any questions concerning our recommendations, feel free to contact Jim Roberts, NPAIHB Policy Analyst, at (503) 228-4185 or by email at jroberts@npaihb.org.

Sincerely,

Andy Joseph, Jr.,
NPAIHB Chairperson,
Colville Tribal Council Member

Joe Finkbonner, RPh, MHA
Executive Director

cc: Paul Dioguardi, Director, HHS-IGA
Stacy Ecoffey, Tribal Affairs, HHS-IGA
Doni Wilder, Area Director, IHS Portland Area Office

Enclosure: NPAIHB Letter to John Berry, OPM Director, May 10, 2010

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT VIA ELECTRONIC TRANSMISSION: consultation@ihs.gov

March 22, 2011

Yvette Roubideaux, MD, MPH, Director
Indian Health Services
801 Thompson Avenue, Suite 440
Rockville, MD 20852

REF: Implementation of Section 130 of the Indian Health Care Improvement Act – Tribal Epidemiology Centers

Dear Dr. Roubideaux,

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington.[1] We provide the following comments in response to the IHS Director's request for comments regarding the Draft Data Sharing Contract proposed between the Tribal Epidemiology Centers (TECs) and the Indian Health Service.

As you are aware, NPAIHB (or the Board) through the Northwest Tribal Epidemiology Center (EpiCenter) receives a grant from the Indian Health Service (IHS) to perform the Agency's statutorily required function to establish and operate an epidemiology center in each IHS Area (25 U.S.C. §1621m). In order for the EpiCenter to comply with the statutory and grant requirements for epidemiology centers, the EpiCenter must collect data relating to the health status objectives described in 25 U.S.C. § 1602(b) to carry out its role. This means that the EpiCenter must have access to the IHS data included in the Resource and Patient Management System (RPMS). Therefore, the proposed IHS Data Sharing Contract (DSC) is very important to Tribal EpiCenters and their ability to serve Tribes in their respective Areas.

I. Lack of Tribal Consultation in development of the Data Sharing Contract

The provision of health services to American Indians and Alaska Natives (AI/ANs) stems from a unique trust relationship between the United States and Indian Tribes. The Federal government's trust responsibility provides the legal justification and moral foundation for Indian specific health policymaking – with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

segment of the American population. This special trust relationship recognizes Tribes as sovereign nations with the inherent right to self-govern, and to interact with the Indian Health Service (IHS) on a government-to-government basis on matters affecting their programs and health services.

The Patient Protection and Affordable Care Act (Pub. Law 111-148; or ACA) included amendments to the Indian Health Care Improvement Act (IHCIA) at section 214(e), a provision was included that gives epidemiology centers "public health authority" status (as defined at 45 CFR §164.501) under the Health Insurance Portability and Accountability Act (HIPAA). This provision was included on behalf of TECs in order to facilitate acquisition of data. This new provision requires the HHS Secretary, acting through the IHS Director, to grant epidemiology centers access to data and protected health information in the possession of the Secretary.

The fact that TECs assist IHS to carry out its statutory responsibilities to operate an epidemiology center in each IHS Area (25 U.S.C. §1621m) and the new IHCIA provision deeming TECs as "public health authorities" should have required more Tribal consultation with Tribes and TECs in the development of such an important document as the Data Sharing Contract, which will become critically important to the ability of TECs—and ultimately the Agency—to meet their mission. We do not concur with the reference to consultation in your letter in which you state:

> *"The IHS has worked with the TECs, in [Tribal?] consultation with the Office of the General Counsel, Area Directors, and Chief Medical Officers, to develop a draft Data Sharing Contract (DSC) to enable the exchange of health data." [Emphasis added]*

The Tribal EpiCenter Directors (TEC) had seen earlier drafts of the Data Sharing Contract. At the EpiCenter Directors meeting in Albuquerque, October 28, 2010, the TEC Directors were allowed to review this document and make minimal suggestions. The Directors reviewed the document for approximately one hour and were unable to remove the document from the room to take back to their respective places of employment to solicit further review.

Both, the IHS and Department of Health and Human Service (HHS) Tribal Consultation Policies require "meaningful and timely input by Indian Tribes in the development of policies that have Tribal implications."[2] It is the position of the Board and Northwest Tribes that this DSC does meet the definition of a "critical event" that will have a direct effect on the ability of TECs to provide services to Indian Tribes or Indian communities and should have undergone a more structured Tribal consultation process.

While we understand that the IHS and HHS consultation policies apply directly to Tribes, we want to recognize the fact that NPAIHB is established as a tribal organization under the Indian Self-Determination and Education Assistance Act (Pub. Law 93-638; or ISDEAA). Pursuant to the definitions of this Act, a P.L. 93-638 tribal organization is:

> "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes

[2] U.S. Department of Health and Human Services, Tribal Consultation Policy, Section 4(A), December 14, 2010.

the maximum participation of Indians in all phases of its activities." (see 25 U.S.C. §1603(e))

Portland Area tribes have organized the Board as a "tribal organization" under the ISDEAA to carry out certain functions in the provision of their health care services and programs. This includes acting as a grant recipient, through the EpiCenter, to carry out the responsibilities of a tribal epidemiology center with the IHS. As such, we believe the IHS and HHS consultation provisions apply to us in operation of the EpiCenter.

The DSC was vetted with the IHS Office of General Counsel and through the internal Indian Health Services offices, but appears not to have been vetted with Tribal leadership prior to its release for comment. In spirit of true Tribal consultation the development of such an important document that impacts Tribal governments and their epidemiology centers should occur in the in conjunction with Tribal leadership, health directors, and epidemiology staff. To receive a document after it has been become an official document of the Agency is not appropriate or in accordance with the IHS or Department's Tribal consultation policy.

RECOMMENDATION: We recommend that the IHS Director not implement or enforce this DSC contract until a joint Federal/Tribal work group is established to review the comments received through this comment seeking process. Additional input should be gathered from TECs about their concerns related to the DSC. The Federal/Tribal workgroup should then work to address the concerns received to improve the DSC so that it is mutually acceptable to both the IHS and Tribes and TECs. The final draft agreement should then be sent out for a formal tribal consultation using the recommended venue by the joint Federal/Tribal workgroup.

II. No Definition included for TECs as "Public Health Authorities"

The development of this agreement provides an opportunity for the Agency to clarify the role of TECs as "public health authorities" in the definitions section of the document. While we believe that HIPAA allows the EpiCenter access to the IHS' RPMS data for its Indian Health Program members while carrying out the statutory functions of the Secretary, we also would hope that the IHS would be supportive of TECs and clarify this fact in the Data Sharing Contract. This would support TECs to access other data with States in carrying out the IHS statutory function for epidemiology centers to monitor and report on required health status objectives.

As you know, in order to implement HIPAA, the Secretary promulgated regulations regarding the uses and disclosures of individual protected health information (hereinafter "PHI").[3] PHI is included in the RPMS data sets and covered in the Board's data sharing agreement with IHS-PAO in order to carry out its functions under the EpiCenter grant. PHI may be used or disclosed without patient authorization or opportunity to agree or object to use or disclosure of PHI pursuant to 45 CFR §164.512.

Furthermore, 45 CFR §164.512 (b) states:

"Standard: uses and disclosures for public health activities.

[3] "Protected Health Information" is defined at 45 C.F.R. § 160.104.

(1) Permitted disclosures. A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

i. A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; ... "

For purposes of the HIPAA, both the IHS and the TECs are covered entities, as defined by the HIPAA.[4] A public health authority is defined to mean:

> "an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate."[5]

The EpiCenter while acting under contract with the IHS, a public health authority, to perform the statutory obligations of the Secretary under 25 U.S.C. § 1621m, is a public health authority under the definition cited above. Furthermore, the IHCIA, at Section 214, (25 U.S.C. §1621m) designates TECs as "public health authorities", a special recognition that allows the EpiCenter to discuss and respond to public health issues on behalf of their constituents. Taken together, the above discussion clearly conveys that TECs are "public health authorities" and this should be included minimally in the definitions section of the Data Sharing Contract.

In order for this authority to be exercised, methods of data sharing and communication should be expeditious and allow for timely response to public health issues. Clarifying TECs as "public health authorities" in the DSC will assist them to meet this mission.

RECOMMENDATION: IHS should fully recognize and support that Tribal Epidemiology Centers as public health authorities by defining TECs as public health authorities in the definitions section of the Data Sharing Contract.

III. COMMENTS ON THE ABILITY TO PROVIDE SURVEILLANCE AND COMMUNITY HEATLH STATUS

There is a surveillance benefit for the Northwest Tribes by allowing access to the National EpiCenter Data Warehouse. The EpiCenter will be able to provide area wide reports much like the Indian Health Service Trends reports.

However, by allowing only de-identified data sets, the EpiCenters will be unable to fully execute community health profiles. We would be solely able to produce area wide reports, which are of limited use to individual Tribes. Tribes in the Northwest have requested individualized reports which we have

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[4] 45 C.F.R. § 160.102(a).
[5] 45 C.P.R, § 164,501.

been able to currently provide through the use of data with identifiers, as approved by the Portland Area Office of Indian Health Service Institutional Review Board.

The DSC as it currently stands will not allow the EpiCenter to fully execute all of the projects currently in operation at the Board. If this DSC is adopted, there must be a method identified which will allow access to user population and tribal identifiers, through negotiations between individual EpiCenters and their respective Area Office. Access to this data is needed to allow individual tribal reports to be developed and to perform linkages with registries such as cancer, trauma, hospital discharge, immunization, sexually transmitted diseases, as the NPAIHB EpiCenter currently is able to do. These linkages lead to the more accurate identification and quantification of health disparities for AI/AN residing in the Northwest Portland Area and respond to Tribal requests.

The DSC does not fully execute the intent of the Board resolution passed in January 2011, through which the Tribes of Idaho, Oregon and Washington resolved to allow access to identifiers to further work of the EpiCenter.

RECOMMENDATION:

NPAIHB recommends execution of the DCS for the purposes of area wide surveillance.

Execution of the Data Sharing Contract for the National EpiCenter Data Warehouse should not preclude additional negotiations with area offices for data with identifiers which can be used for tribally specific community health profiles and data linkage studies to more accurately identify health disparities.

Conclusion

In closing, this DSC for the National Epicenter Data Warehouse is a good start to improving surveillance. It should not however, preclude additional area agreements that would allow access to identified information to allow data linkage work and specific community health profiles to be developed.

We thank you in advance for consideration of our recommendations and the opportunity to provide our comments!

Sincerely,

Andrew C. Joseph Jr.

Andrew Joseph, Jr., NPAIHB Chairperson
Colville Tribal Council Member

cc: Portland Area Tribal Chairs
Tribal Health Directors
Dean Seyler, PAO Acting Area Director
Clark Marquart, Chief Medical Officer

PURPOSE AND AUTHORITY

Section 1.01 Purpose of Contract. This Contract is made between the Indian Health Service ("IHS") and XXX Health Board, on behalf of the XXX Epidemiology Center ("Epidemiology Center"). The Contract establishes requirements for the retrieval of Limited Data Sets from the IHS Epidemiology Data Mart to carry out activities authorized under 25 U.S.C. § 1621m and 45 CFR § 164.514(e) but only to the extent such activities are identified in this Contract.

For purposes of IHS internal administrative needs, this Contract will carry the following identification number _____.

Section 1.02 Grant of Authority. The Epidemiology Center is acting under a grant from the Indian Health Service to conduct activities authorized by 25 U.S.C. § 1621m. In accordance with 25 U.S.C. § 1621m, the Epidemiology Center collects data relating to, and monitors progress made toward meeting health status objectives identified at 25 U.S.C. § 1602 using the data sets of the Indian Health Service.

Section 1.03 Consideration. The IHS agrees to provide the Epidemiology Center with access to Data as defined below and identified in this Contract. In exchange, the Epidemiology Center agrees to use the Data to support the Epidemiology Center's studies, research or projects referenced in this Contract, which have been determined by the IHS to provide assistance to the IHS in monitoring, managing, and improving the IHS programs and services provided to its beneficiaries; and Epidemiology Center agrees to ensure the integrity, security, and confidentiality of the Data by complying with the terms of this Contract. The Parties acknowledge that the aforementioned consideration is both adequate and sufficient to render the Contract legally binding between the Parties.

DEFINITIONS

Section 2.01 Authorized User. The term "Authorized User" shall mean a person with written approval by IHS (1) to access the Epidemiology Data Mart ("EDM") on behalf of the Epidemiology Center; or (2) to access Limited Data Sets extrated from the EDM and maintained at the Epidemiology Center.

Section 2.02 Contract. The term "Contract" shall mean this document between the IHS and the Epidemiology Center.

Section 2.03 Data. The term "Data" means any information obtained from theEpidemiology Data Mart.

Section 2.04 EDM. The term "EDM" shall mean the Epidemiology Data Mart. The EDM is a subset of the NDW and maintained on a separate server.

Section 2.05 HIPAA. The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d-2 and 1320d-4, and its implementing regulations as may be revised from time to time.

Section 2.06 Limited Data Set. The term "Limited Data Set" shall mean sets of one or more categories of Data obtained from the EDM. A Limited Data Set may contain: (a) dates of admission and discharge, as well as dates of birth and death; and (b) nine-digit zip code, city, and state information. A Limited Data Set is composed of PHI that excludes the following direct identifiers of the patient or relatives, employers, or household members of the patient: (a) names; (b) postal addresses (may retain city, state, and nine-digit zip code); (c) telephone numbers; (d) FAX numbers; (e) electronic mail addresses; (f) social security numbers; (g) medical record numbers; (h) health plan beneficiary numbers; (i) account numbers; (j) certificate/license numbers; (k) vehicle identifiers and serial numbers, including license plate numbers; (l) device identifiers and serial numbers; (m) web Uniform Resource Locators (URLs); (n) Internet Protocol (IP) address numbers; (o) biometric identifiers, including finger and voice prints; and (p) full face photographic images and/or any comparable images.

Section 2.07 Interconnection Security Agreement. An agreement established between the Parties to document the technical requirements of the interconnected IT systems. The Interconnection Security Agreement shall be attached to this Contract.

Section 2.08 NDW. The term "NDW" shall mean the National Data Warehouse (formerly known as the National Patient Information Reporting System). The "NDW" stores Data provided by the IHS and by the tribes, tribal organizations and urban Indian organizations.

Section 2.09 Parties. The term "Parties" shall mean the IHS and the Epidemiology Center.

Section 2.10 Privacy Act. The term "Privacy Act" means the Federal Privacy Act of 1974, 5 U.S.C. §552a, as amended.

Section 2.11 Privacy Rule. The term "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, as amended.

Section 2.12 Protected Health Information ("PHI"). The term "Protected Health Information" and the abbreviation "PHI" have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103. This term shall include Electronic PHI.

Section 2.13 Security Rule. The term "Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Parts 160 and 164, as amended.

EPIDEMIOLOGY CENTER ACCESS TO DATA

Section 3.01 Limited Data Set Accessable under this Contract. Access under this Contract will include only Data from the Area or facilities that the Epidemiology Center represents.

Section 3.02 Permissible Uses of the Data by the Epidemiology Center.

(a) The Epidemiology Center shall use the Limited Data Set only for the permitted activities described in this Contract.

(b) The Epidemiology Center may develop, with prior written approvals from each affected tribe, tribal-specific health status reports and disseminate these reports to the respective tribal communities, IHS service units, and Area Office.

(c) Reports will only be published outside IHS if prior written approvals have been obtained by Epidemiology Center pursuant to Section 5.12.

(d) The Epidemiology Center shall not use Data accessed under this Contract for any purpose or in any manner that is prohibited by Federal law or, if applicable, the laws of the State of XXX or any other applicable state's laws.

(e) The Epidemiology Center shall not disclose, use, or reuse, sell, rent, lease, loan, or otherwise grant access to the Data covered by this Contract except as specified in this Contract or as IHS shall authorize in writing. In addition, all information derived from the Data shall be subject to the same terms and conditions that apply to Data in this Contract, including Section 3.07.

(f) The Epidemiology Center shall make every reasonable effort to limit Authorized Users' access to the Data covered by this Contract to the minimum amount of Data and minimum number of individuals necessary to achieve the purposes set forth in this Contract (i.e., individuals' access to the Data shall be on a role-based, need-to-know basis, under conditions appropriate for such access).

(g) The Epidemiology Center agrees that the Data shall not be physically moved, transmitted, or disclosed in any way from the location of the Epidemiology Center without written approval of IHS, unless such movement, transmission or disclosure is required by law and the Epidemiology Center has previously notified IHS in writing.

Section 3.03 Access to EDM by Epidemiology Center. Epidemiology Center must obtain prior written approval from IHS for each Authorized User under its control who may access the EDM. An Interconnection Security Agreement ("ISA") between the Epidemiology Center and IHS must be in place before the Epidemiology Center's Authorized Users may access the EDM. Consistent with the ISA and based on the information provided by the Epidemiology Center, IHS shall issue a user name and password to each Authorized User who will have access to the EDM. IHS shall provide each such user name and password to the Epidemiology Center and the Epidemiology Center shall be responsible for communicating that information to the appropriate Authorized User. When the Epidemiology Center removes an individual from its list of Authorized Users, the Epidemiology Center must immediately inform IHS of the change and IHS shall cancel the user name and password of such individual as soon as reasonably possible.

Section 3.04 Epidemiology Center's Responsibility for Authorized Users. The Epidemiology Center shall be solely responsible for all of its acts and omissions and/or its Authorized Users, with respect to the EDM and/or any confidential and/or other information accessed in connection therewith, and all such acts and omissions shall be deemed to be solely the acts and omissions of the Epidemiology Center. The Epidemiology Center shall agree and ensure that:

(a) The Data is protected in accordance with the provisions of the Privacy Rule, all applicable laws, and this Contract;

(b) Its Authorized Users have received training, approved by IHS, regarding the confidentiality of PHI under the Privacy Rule and all applicable Federal and state laws and agree to protect the Data in compliance with the Privacy Rule, such laws and this Contract;

(c) Its Authorized Users shall only access the EDM and use the Data for purposes as provided in this Contract;

(d) Its Authorized Users have agreed to hold any passwords, or other means for accessing the Network, in a confidential manner and to release them to no other individual;

(e) Its Authorized Users are informed that failure to comply with the terms of this Contract may result in exclusion from access to the EDM and use of the Data;

(f) It has restricted access to the EDM to only the Authorized Users that the IHS has approved pursuant to Section 3.03.

Section 3.05 License. IHS grants to Epidemiology Center, and Epidemiology Center shall be deemed to have accepted a non-exclusive, nontransferable, limited right to have access to and to use the EDM, subject to the Epidemiology Center's full compliance with this Contract. IHS retains all other rights to the EDM and all the components thereof. The parties agree that the Epidemiology Center does not obtain any right, title or interest in any of the Data furnished by IHS or any information derived therefrom. IHS may condition, restrict, or cancel Epidemiology Center's access to the EDM at anytime, with or without notice.

Section 3.06 Data Disclaimer. All Data to which access is made through the EDM originates from IHS and the tribes, tribal organizations, and urban clinics. All such Data may be subject to change arising from numerous factors, such as, changes to patient PHI made at the request of the patient, changes in the patient's health condition, the passage of time, and other factors. Without limiting any other provision of this Contract, the Epidemiology Center shall be responsible for all of its actions taken or not taken resulting from or related to the use of the EDM or the Data made available thereby.

Section 3.07 Use and Disclosure of Data After Termination. When this Contract terminates, the Epidemiology Center, at the IHS' option, shall return to the IHS, or destroy, all of the IHS' Data in Epidemiology Center's possession, and keep no copies of such Data except as requested or permitted by the IHS. The IHS shall notify Epidemiology Center whether Epidemiology Center must return or destroy any Data in its possession. If the Epidemiology Center destroys any Data, then Epidemiology Center will provide the IHS with documentation evidencing such destruction. Any Data maintained by Epidemiology Center shall continue to be extended the same protections set forth in this Contract for as long as it is maintained.

Section 3.08 Reporting of Disclosure. The Epidemiology Center agrees to notify the IHS within [one day] of any uses or disclosures of the Data that are not in accordance with this

Contract and any security incidents involving the Data of which it becomes aware and to fully cooperate in the investigation of such use or disclosure. If IHS determines that the risk of harm requires notification of affected individual persons of the security breach and/or other actions, the Epidemiology Center agrees to carry out this Section without cost to IHS.

CONFIDENTIALITY AND SECURITY

Section 4.01 Confidentiality. The Epidemiology Center agrees that it shall keep all Data obtained from the EDM confidential, in compliance with all applicable Federal and state laws, including but not limited to the Privacy Act of 1974, 5 U.S.C. 552a; Privacy Act Regulations, 45 CFR Part 5b; and Confidentiality of Alcohol and Drug Abuse Patients Records, 42 CFR Part 2.

Section 4.02 Enforcement of Confidentiality.

(a) The Epidemiology Center shall report within one day to the IHS any breach of the confidentiality of the Data of which it becomes aware in accordance with Section 3.08.

(b) The Epidemiology Center shall enforce the confidentiality provisions of this Contract by, among other possible actions, appropriately disciplining individuals within its organization who violate the confidentiality of the Data pursuant to its respective confidentiality and disciplinary policies. Such disciplinary actions may include, but not be limited to, warnings, suspensions, or termination.

Section 4.03 Access to Confidential and Proprietary Information. The Epidemiology Center shall not provide confidential and/or proprietary information obtained from the EDM to any tribe, tribal organization, person, or entity, and shall not publish any such information.

Section 4.04 Security. The Epidemiology Center shall implement security measures for the Data obtained from the EDM. Such security measures shall be no less stringent than those required by the Security Standards promulgated pursuant to HIPAA (45 CFR Parts 160 and 164).

Section 4.05 Malicious Software, Viruses and Other Threats. The Epidemiology Center shall ensure that its connection to and use of the EDM will not introduce any program, routine, subroutine, or data (including without limitation malicious software or "malware," viruses, worms and/or Trojan Horses). The Epidemiology Center shall not disrupt, cause a disruption in, or permit a disruption in the proper operation of the NDW, EDM, or any part thereof or any hardware or software used by IHS in connection with the NDW and EDM.

Section 4.06 EDM Equipment. The Epidemiology Center shall be responsible for procuring all software, hardware, equipment, communication lines/web access, and software necessary to access the EDM. The Epidemiology Center shall be responsible for ensuring that all of its computers for interfacing with the EDM are properly and securely configured.

Section 4.07 Connectivity. The Epidemiology Center acknowledges that access to the EDM is to be provided over various utilities and communications lines, and Data will be transmitted over local exchange and internet carrier lines and through routers, switches, and other devices owned and maintained by third-party carriers and service providers, all of which are beyond IHS'

control. IHS assumes no liability for or relating to the integrity of any Data while it is transmitted on the connectivity lines.

Section 4.08 Use of Equipment. The equipment used by the Epidemiology Center shall not be used in any way that interferes with NDW activity. The Epidemiology Center shall be solely responsible for any damage to hardware, software, or a computer system, loss of data, and any damage to the NDW caused by it or its Authorized Users.

Section 4.09 Safeguards. The Epidemiology Center shall implement all reasonable and appropriate administrative, physical and technological safeguards to prevent use or disclosure of the Data other than as provided for by this Contract. The Epidemiology Center further shall implement all administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Data that it receives, maintains or transmits.

Section 4.10 Security Obligation. As part of its security measures, IHS will conduct periodic audits at least quarterly to confirm that the Epidemiology Center's access to the EDM corresponded with the terms of this Contract and 25 U.S.C. §1621m. Access to the EDM by the Epidemiology Center that does not correspond to this Contract or 25 U.S.C. §1621m shall be considered an unauthorized disclosure.

Section 4.11 Contact/Identification. The Epidemiology Center shall ensure that all Authorized Users agree to not identify or attempt to identify the information in the Data or contact or attempt to contact any individual who is a subject of the Data or his/her relatives, employers or household members.

GENERAL OPERATIONS

Section 5.01 System Administration. IHS shall administer the NDW and EDM and may delegate any of its functions set forth in this Contract. The IHS permits the Epidemiology Center the right to retrieve Data from EDM consistent with the terms of this Contract. However, IHS retains all other rights to the NDW and all the components thereof.

Section 5.02 Indemnification. The Epidemiology Center shall indemnify, hold harmless and defend the IHS from and against any and all claims, losses, liabilities, costs and other expenses resulting from or relating to any acts or omissions of the Epidemiology Center in connection with the Data provided to the Epidemiology Center under this Contract.

Section 5.03 No Guarantees or Warranties. IHS in no way guarantees Data pursuant to this Contract and makes no warranties, express or implied, regarding the quality of any product produced under or Data provided pursuant to this Contract. Access to the EDM and the Data obtained are provided "as is" and "as available." The Epidemiology Center is responsible for any and all acts or omissions taken or made in reliance on the EDM or the Data in the EDM, including inaccurate or incomplete Data. IHS disclaims any and all liability for erroneous transmissions and loss of service resulting from communication failures by telecommunication service providers or the EDM.

Section 5.04 Compliance with Laws. The Parties to this Contract intend and in good faith believe that this Contract complies with all Federal and state laws. The Parties agree that Federal law shall apply to any problem or dispute arising out of the Contract.

Section 5.05 Severability. If any provision of this Contract is declared void by a court or arbitrator, or rendered invalid by any law or regulation, that portion shall be severed from this Contract, and the remaining provisions shall remain in effect, unless the effect of the severance would be to substantially alter the Contract or obligations of the Parties, in which case the Parties agree to attempt in good faith to renegotiate the Contract to comply with such law(s) to the satisfaction of the Parties.

Section 5.06 Relationship of the Parties. The Epidemiology Center is acting under a grant from IHS. The Parties mutually understand and agree that in performing their respective duties and obligations hereunder, the Parties are at all other times acting as separate entities with respect to each other. Nothing in this Contract shall constitute or be construed to create a business associate arraignment, partnership, joint venture, an agency relationship, or any form of organized health care arrangement between the Parties.

Section 5.07 Force Majeure. Neither Party shall be deemed in violation of this Contract if it is prevented from performing any of its obligations by reason of: (a) severe weather and storms; (b) earthquakes or other natural occurrences; (c) power failures; (d) nuclear or other civil or military emergencies; (e) acts of legislative, judicial, executive, or administrative authorities; or (f) any other circumstances that are not within its reasonable control.

Section 5.08 Disputes. The Parties acknowledge that this Contract is not a contract or any other form of agreement entered into under the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, and is not subject to the dispute procedures identified therein.

Section 5.09 Criminal Penalties. The Epidemiology Center acknowledges that criminal penalties under §1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), including a fine not exceeding $10,000 or imprisonment not exceeding 5 years, or both, may apply to disclosures of information that are covered by § 1106 and that are not authorized by regulation or by Federal law. The Epidemiology Center further acknowledges that criminal penalties under the Privacy Act (5 U.S.C. § 552a(i) (3)) may apply if it is determined that the any person designated as an Authorized User by the Epidemiology Center, knowingly and willfully obtained data under false pretenses. Finally, the Epidemiology Center acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if it is determined that its Authorized User, has taken or converted to his own use Data Set(s).

Section 5.10 Breach. The Epidemiology Center acknowledges that any breach of this Contract, including unauthorized use of the Limited Data Set(s) identified herein, may, at the discretion of IHS, result in immediate termination of this Contract. The Epidemiology Center also acknowledges that any breach of this Contract could result in further action up to and including the termination of the grant awarded under the Epidemiology Grant Program for American Indians/Alaska Natives and Urban Indian communities.

Section 5.11 No Third Party Beneficiaries. Nothing express or implied in this Contract is intended or shall be deemed to confer upon any individual or entity other than the Parties, any rights, obligations, remedies or liabilities. The Epidemiology Center does not have the right to assign or transfer their rights to any third party, including agents and subcontractors, under this Contract.

Section 5.12 Publication. IHS may require approval for any publication by the Epidemiology Center. If IHS informs the Epidemiology Center that a specific topic requires approval, any proposed publication shall be provided to the IHS for review at least sixty (60) days prior to the submission. In the event written approval is obtained, published materials shall clearly state that the opinions or assertions contained therein are those of the author and do not reflect any official or unofficial view or opinion of the IHS. Additionally, no such materials shall infringe upon, violate, or otherwise compromise patient's rights to privacy under the Privacy Act, the Privacy Rule and any other applicable Federal or state law. In no event will approval be given unless all identifiers as outlined in 45 CFR 164.514(b)(2)(i) are removed. Publications that specifically name a Tribe must receive prior approval from that Tribe.

Section 5.13 Publicity. Neither Party shall use the name of the other Party in any publicity, advertising, or new release without the prior written approval of the authorized representative of the other Party.

Section 5.14 Contact information: The designation contact point for each Party under this Contract shall be:

For the Indian Health Service:

_____
_____
_____
_____
Telephone _____

For the Epidemiology Center:

_____
_____
_____
_____
Telephone _____

Section 5.15 Non-waiver. Any failure or delay by IHS to enforce a provision of this Contract shall not be deemed a waiver of any provision of this Contract and any remedies thereto.

Section 5.16 Amendment. This Contract may be amended only by mutual written agreement, signed by an authorized representative of each Party.

Section 5.17 Entirety of Contract. It is expressly agreed that this written Contract represents the entire understanding between the Parties and supersedes any and all prior agreements or understanding with respect to the subject matter herein.

Section 5.18 Term and Termination of the Contract. This Contract will be effective upon the latest signatory date below and shall remain in effect for one (1) year or until terminated in writing, by an authorized representative of either Party, with or without cause. This Contract shall hereafter automatically renew annually for one year only if the Epidemiology Center grant remains in effect, the projects set forth herein are still active/ongoing, and the Data will continue to be used for the original project purpose. Otherwise, this Contract must be modified or a new contract must be negotiated.

IN WITNESS WHEREOF: the Parties hereto have duly executed this Contract in accordance with the terms and provisions contained herein. The persons signing this Contract warrant that they have full authority to do so and that their signatures shall bind the Parties for which they sign.

For the EPIDEMIOLOGY CENTER:

By: _____

Name: _____

Title: _____

Date: _____

For the INDIAN HEALTH SERVICE:

By: _____

Name: Director, or Designee

Title: _____

Date: _____

By: _____

Name: _____

Title: Area Director

Date: _____

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 Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault 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
Yakama Nation

2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

May 27, 2011

Yvette Roubideaux, M.D., M.P.H.
Director
Indian Health Service
801 Thompson Ave, Suite 440
Rockville, MD 20852

RE: Comments on updated MOA - DOI

Dear Dr. Roubideaux:

The Northwest Portland Area Indian Health Board (NPAIHB) appreciates the opportunity to provide comments on the updated *Memorandum of Agreement* with the Indian Health Service and the Department of Interior.

The NPAIHB is a P.L. 93-638 Tribal organization that represents health service issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. The commitment of the United States government to meaningful consultation with Indian tribes has been affirmed in Presidential Memoranda, Executive Orders, directives from the White House, and in recommendations from various federal agencies all designed to improve tribal relations and most importantly improve the ability of tribal governments to self-determine and advocate for the citizens they represent.

We acknowledge the *MOA* requires a significant amount of interagency coordination and collaboration among IHS and DOI (as stated in *Section 703 of the Indian Health Care Improvement Reauthorization and Extension Act of 2009*), however it would seem that a vital "third" agency, the Department of Justice (DOJ), should also be included. The Tribal Law and Order Act of 2010, has a Proposed Memorandum of Agreement that includes HHS (IHS, SAMHSA), DOI (Bureau of Indian Education), and DOJ (Office of Justice Programs). This addition would be an innovative, effective, and efficient action to reduce redundancy of programs and staff to introduce a more "systemic" approach for local communities to holistically address alcohol and substance abuse prevention and treatment. Consideration of merging these two MOAs would reduce duplication of superfluous efforts including meeting times, staff support, policy development, and consultation efforts.

It is important to ensure all efforts committed to this very important *Memorandum* are not in vain and not duplicative. We applaud the effort to coordinate data collection between IHS and BIA (specifically BIE), and increase collaboration among tribes and tribal organizations. It is vitally important that the tribal voice be present, and heard, during the development of all activities of the *Memorandum* (e.g. interagency meetings, policy and procedure development, and any regulatory issues).

Following are comments directed toward the information provided in the March 8, 2011, Dear Tribal Leader correspondence:

Section IV A.: Consider adding language the supports reimbursement for residents who do not reside in the states where the Youth Regional Treatment Centers are located (across state border issues).

Section IV A. Coordination Efforts (c): Please elaborate on how the determination of unmet needs for additional services will be determined, (i.e. local needs assessments, review of RPMS data, etc.)

Section IV A. Coordination Efforts (f)(i): Consider the following rewording of the paragraph to reflect actual issues with co-occurring and dual diagnosis individuals:

> (i) the coordination of alcohol and substance abuse programs of IHS, BIA, and Indian tribes and tribal organizations developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act with behavioral health initiatives, particularly with respect to the referral and treatment of dually diagnosed individuals and individuals with co-occurring (physical and behavioral) disorders requiring behavioral health, and substance abuse treatment, and physical health, and;

Section IV B. (3)(a)(b)(c) Organizational Responsibility: The assumption of IHS's responsibilities should be more definitively stated. It is understood that the purpose of the MOA is to address alcohol and substance abuse, the section as written tends to infer a limitation of IHS's responsibilities, which are inclusive of all Behavioral Health activities as noted in Title VII of the PPACA. The following change is suggested:

> *(a) the determination of the scope of the problem behavioral health issues which include of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;*

Additionally, paragraph (b) should be more definitive of the scope of an assessment, e.g. what methods would be used to determine needs, how this would be achieved, how will tribal collaboration be utilized.

Paragraph (c) should define what costs would be used as the comparison. If historical IHS expenditures were to be used, the result would be a gross underestimate of actual reasonable costs in the current health reform environment.

Following are comments based on the original MOA which were not proposed by IHS in the Dear Tribal Leader letter. The following changes are suggested:

III. BACKGROUND

> *Substance abuse, including alcohol, illegal drugs, and controlled substances, impact the whole community. Probable consequences include exasperation of physical health conditions (e.g. diabetes), depression, domestic violence, child neglect and abuse, elderly abuse, low educational outcomes, unemployment, property damage, gang activity, and violent crime. It increases the burden on communities and on those Federal, state, and tribal governments attempting to assist these communities.*

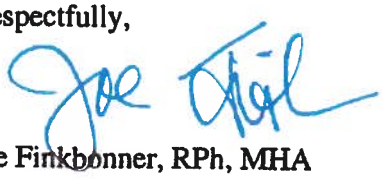
The production, distribution, importation, and use of substances such as methamphetamine (meth) are not a new problem. Substance abuse threatens not only the user but threatens the well-being and safety of the community. Related illicit acts encourage gang activities as well as organized crime on Indian lands. The production of meth results in toxic by-products that are left in buildings, fields, and waterways. Some of these chemicals can cause disfigurement, illness, or death.

International relations are being challenged as a result of importation of illegal substances. Community safety is being challenged, law enforcement is being overwhelmed in their efforts to protect their communities, and the school systems are besieged with children who have special needs, e.g FAS, FAE.

The last request is to add more educational components that are inclusive of BIA and tribally operated K-12 schools. Youth need to be involved in this MOA as well as utilizing the strengths of educational systems.

Once again, thank you for this opportunity to comment on this critical document. It truly has the potential to directly save lives. Should you have any questions or concerns about these comments and suggestions, please do not hesitate to contact Mr. Jim Roberts (503-416-3276 or Dr. Linda Bane Frizzell (503-313-3254).

Respectfully,



Joe Finkbonner, RPh, MHA
Executive Director
Northwest Portland Area Indian Health Board

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
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Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
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Spokane Tribe
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Portland, OR 97201
(503) 228-4185
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www.NPAIHB.org

SUBMITTED VIA EMAIL: *summer.king@samhsa.hhs.gov*

June 6, 2011

Summer King
SAMHSA Reports Clearance Officer
Room 8-1099
One Choke Cherry Road
Rockville, MD 20857

REF: Proposed Project, Unified Application for the Community Mental Health Services Block Grant and Substance Abuse and Prevention Treatment Block Grant FY 2012-2013

Dear Ms. King:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. NPAIHB appreciates the opportunity to provide comments on the proposed unified application for the Community Mental Health Services Block Grant and Substance Abuse and Prevention Treatment Block Grant programs, FY 2012-2013 (Proposed Project).

We also understand that the National Indian Health Board (NIHB) will also be submitting comments on this solicitation. NPAIHB has had an opportunity to review the NIHB comments and our organization endorses and supports the concerns expressed in the NIHB comment letter. We encourage SAMHSA to address the NIHB concerns.

Prior to discussing our comments on the Proposed Project, we want to underscore the commitment of the United States government to meaningful consultation with Indian tribes has been affirmed in Presidential Memoranda, Executive Orders, directives from the White House, and in recommendations from various federal agencies all designed to improve tribal relations and most importantly improve the ability of tribal governments to self-determine and advocate for the citizens they represent. Only through Tribal consultation can effective Indian health policy making occur. We applaud SAMHSA for this effort.

We applaud the inclusion of specific language for Tribal governments in the Proposed Project. This respect is appreciated and a positive step for Tribes to address the behavioral health needs of their populations. However, it is unclear from the Federal Register notice, how 45 CFR 96, Subpart D, Direct Funding for Indian Tribes, has been applied to the Proposed Project.

> *Sec. 96.41 General determination.*
>
> *(a) The Secretary has determined that Indian tribes and tribal organizations would be better served by means of grants provided*

directly by the Secretary to such tribes and organizations out of the State's allotment of block grant funds than if the State were awarded its entire allotment. Accordingly, where provided for by statute, the Secretary will, upon request of an eligible Indian tribe or tribal organization, reserve a portion of a State's allotment and, upon receipt of the complete application and related submission that meets statutory requirements, grant it directly to the tribe or organization.

(b) An Indian tribe or tribal organization may request direct funding under a block grant program included in this subpart regardless of whether the State in which it is located is receiving funds under the block grant program.

An explanation should be provided as to why the terminology in the Proposed Project does not include Tribes, (e.g. States, Tribes and Territories).

Following are comments directed toward the information provided in the Federal Register, Vol. 76, No. 69, Monday, April 11, 2011:

In regards to States following a four-step planning process consisting of: (1) Assessing the strengths and needs of the service system; (2) identifying the unmet service needs and critical gaps within the current system; (3) prioritize the State planning activities, and; (4) develop goals, strategies and performance indicators, there will be unintended consequences for Tribal population unless:

1. Tribes are consulted to address the strengths and needs of the population they serve. It would be impossible for a State to provide a comprehensive assessment of strengths and needs of the service system without the assistance of Tribes in their respective States.

   Additionally, non-Medicaid encounter data from Tribal systems is often reported directly to the Federal government, (via Indian Health Service), and is not included in State databases. Furthermore, Tribal populations often do not access State services due to historical discrimination and mistreatment, resulting in an unrealized "silent need".

2. The unmet service needs are difficult to identify. States have various methods for gathering data, as do the 565 Federally Recognized Tribes. Currently, most policy for service provision is driven from encounter data. This results in a fatal flaw – no valid method to determine unmet service needs when there is no access or limited access to behavioral health services. As noted in numerous publications, including the Report on State Responses to the FY 2011 Block Grant Addendum on Health Care Reform, there is a current shortage of behavioral health professionals. This shortage is projected to amplify in the implementation of health reform legislation, thus the intense need to determine actual levels of need.

   This Proposed Project needs to clearly define how population needs will be assessed for people that do not have access to behavioral health services. There should be a specific section that elaborates on a method to not only determine this for Tribal populations but all rural populations as identified by the Health Professional Shortage Areas.

If this measure is not taken there will be a gross underestimate of service needs from populations that are never "counted" until they self-terminate or suffer catastrophic consequences.

3. States must be required to consult with Tribal representatives (specifically elected Tribal leaders or individuals formally appointed to represent their Tribal government) for any prioritization of State planning activities. Tribal population will go unserved without this requirement.

4. Only Tribes know their population's attainable goals, strategies and performance indicators that are culturally applicable. This responsibility is accepted by Tribes for their constituents and not transferable. All Tribes, which have territories within State boundaries, should be consulted for any development of goals and performance indicators.

In regard to the paragraph Description of State's Consultation with Tribes, the following comments are provided:

We would suggest some additional language to fortify the government to government relationship that Tribes have with the Federal government. State relations history and Tribes as noted by Administrator Hyde in the Alcoholism and Drug Abuse Weekly, "...(Tribes) neither consulted with nor are their needs addressed when the state gets the dollars"..., needs to be definitively improved and required.

While we have been advised that SAMHSA "cannot require" State to consult with Tribes, there should be required reporting components in the State reports that tracks the dollars spent. A suggested list of those components should at a minimum include:

- Name of Tribe(s)
- Date of Consultation
- Duration of Consultation (e.g. hours, days)
- List of Tribal Representatives
- Topic of Consultation

Required Topics of Discussion must include:

- Scope of service provision (amount and need)
- Strategies for service provision
- Utilization of services
- Time frame for State implementation of Proposed Project
- involvement of "Dashboard" development (key performance indicators
- Suicide prevention
- Technical assistance needs
- Involvement of individuals and families
- Use of technology
- Collaboration

(* please note this is not an all-inclusive list, more components could be required)

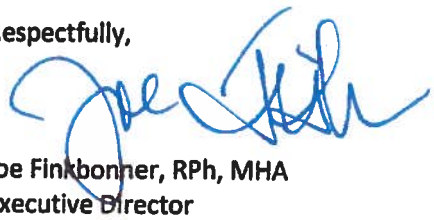
The list above should be strongly considered as a reporting requirement. Without such a requirement, history and experience has clearly shown that Tribal populations will be neglected/excluded from access

to federal dollars that are appropriately designated for the needs of American Indians and Alaska Natives (AI/AN).

Lastly, SAMSHA should require States to include official Tribal representatives (from all Tribes in the State) to be a voting member of State Behavioral Health Advisory Councils (council names may vary by State). This is critical, and important that each Tribe be invited to name a representative for State level councils. It is not enough nor appropriate just to have AI/AN individuals, they must be Tribal elected officials or their designee to maintain the required government to government relationship.

Once again, thank you for this opportunity to comment on this critical document. It truly has the potential to directly save lives. Should you have any questions or concerns about these comments and suggestions, please do not hesitate to contact Mr. Jim Roberts (503-416-3276 or Dr. Linda Bane Frizzell (503-313-3254).

Respectfully,

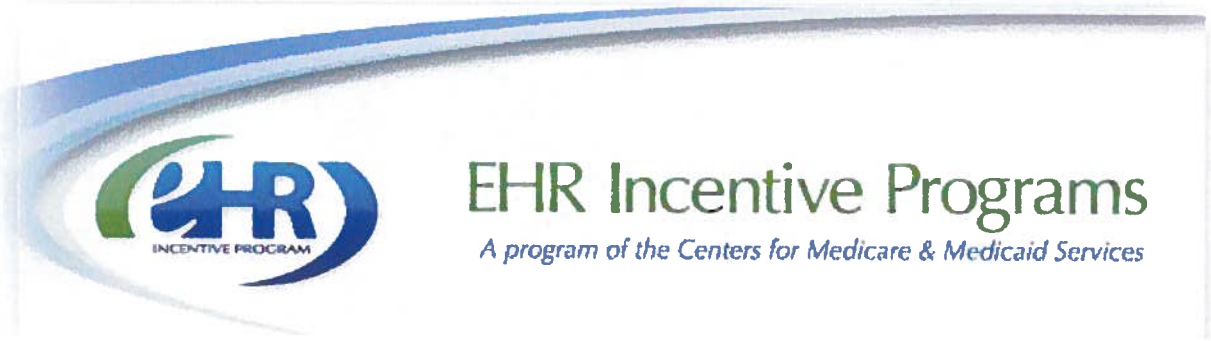


Joe Finkbonner, RPh, MHA
Executive Director

From: Turbert, Michele I. - Medicaid [mailto:TurbertM@dhw.idaho.gov]
Subject: FW: Earn CME Credit with EHR Medscape Modules

FYI: CMS has created some new tools for preparing for receiving EHR incentive payments. Please see information below and share with all who may be interested.

Michele Turbert
Idaho Medicaid



News Updates | June 29, 2011

Medscape Modules are Available on the CMS EHR Incentive Programs

CMS is pleased to announce that through Medscape Education, you now have the opportunity to achieve CME credits by learning more about the Electronic Health Records (EHR) Incentive Programs.

On Medscape's EHR Learning Center website, leading physician experts in medical informatics provide information, resources, and tools to help providers determine eligibility for the EHR Incentive Programs, understand the requirements for participating, take steps to participate, and recognize the immediate benefits of participation and future consequences of not participating.

By completing the module From Meaningful Use to Meaningful Care, providers can earn CME credit while gaining a better understanding about the purpose of the EHR Incentive Programs, the stages of meaningful use, a timeline of key dates, and most importantly, how patients will benefit.

Providers can also use the Medscape Learning Center to determine their comprehension of the EHR Incentive Programs by taking the Participant Self Assessment: Medicare and Medicaid EHR Incentives: What Do You Know and Do You Know Enough? By completing the assessment, providers can help to shape the content of future CME activities to best address the educational and clinical performance gaps identified.

The site also offers interviews, where physician EHR experts explain why it's important to register for the programs and the significance of EHRs to health care overall. Expert interviews include:

- Registering for the EHR Incentive Program -- Ready, Set, Go: An Expert Interview With Jason M. Mitchell, MD, and Richard Paula, MD
- Are You an Eligible Professional Who Hasn't Registered for the EHR Incentive Program? What Are You Waiting For? -- An Expert Interview With William F. Bria II, MD

In the next few weeks, new CME modules on meaningful use will be available. Look out for for a listserv message to announce these new learning resources.

Want more information about the EHR Incentive Programs?

Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

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Yakama Nation

2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT EMAIL VIA: dennis.romero@samhsa.hhs.gov

February 18, 2011

Dennis O. Romero, Director (Acting)
Substance Abuse & Mental Health Service Administration
Office of Indian Alcohol and Substance Abuse
1 Choke Cherry Road, Room 7-1079
Rockville, Maryland 20857

REF: Comments on Tribal Law and Order Act of 2010, Memorandum of Agreement and the Tribal Action Plan

Dear Mr. Romero:

The Northwest Portland Area Indian Health Board (NPAIHB) appreciates the opportunity to provide comments on the *Memorandum of Agreement* and the *Tribal Action Plan* as they relate to the *Tribal Law and Order Act* of 2010 (TLOA). NPAIHB is a P.L. 93-638 Tribal organization that represents health service issues of forty-three federally-recognized Tribes in Idaho, Oregon, and Washington.

The commitment of the United States government to meaningful consultation with Indian tribes has been affirmed in Presidential Memoranda, Executive Orders, directives from the White House, and in recommendations from various federal agencies all designed to improve tribal relations and most importantly improve the ability of tribal governments to self-determine and advocate for the citizens they represent. In this regard, it is an honor to provide you with our recommendations on the SAMHSA responsibilities of the TLOA and comment on the proposed MOA and Tribal Action Plan.

We acknowledge the *Act* requires a significant amount of interagency coordination and collaboration among DHHS, DOI, DOJ, and other federal agencies. However, it is important to ensure all efforts committed to this very important *Memorandum* are not in vain. We certainly understand the "interagency coordination" principles, but are suggesting that since this *Memorandum* directly impacts tribal governments, there be meaningful consultation during all interagency development and coordination activities. It is vitally important that the tribal voice be present, and heard, during the development of all activities of the *Memorandum* (e.g. interagency meetings, policy and procedure development, and any regulatory issues).

One area of concern is the proposed 90 days to enter into an agreement under the *Memorandum* or the federal agency will intervene in behave of a tribal government? Why does there need to be a time constraint? Secondly, tribal governments have the right and authority to self-govern. While a minimum time

requirement for federal stakeholders may be desired, it should not unilaterally be imposed on Tribal governments.

It is also noted that the *Memorandum* will be developed and conducted without tribal representation. It would seem to be appropriate at a minimum, to have a representative from organizations such as the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB), and at urban Indians have seats on the "agency" list of participation. In fact American Indian and Alaska Native (AI/AN) representation should have the majority membership (51%), since this *Memorandum* is directly applicable to AI/ANs.

Next, there is a substantial concern about the requirement of tribes to provide their data for federal scrutiny? This is based on historical attempts about means testing, lack of understanding of the importance of tribal programs, and lack of uniformity of data across Indian Country.

The requirement of tribes to provide their data should be determined by each tribe, and the *Memorandum* should only focus on what the federal agencies can control. Without this measure of reliability, data correlations would be nearly impossible to uniformly analyze.

Page 2 #1 and 4. The paragraphs talk about *established by federal law*, which would provide review of programs by the Secretaries of Interior and HHS, and the Attorney General. But the clause: *...and tribal, state, local and private health resources...*, is a problem. We recommend removing "tribal" since tribal resources are their own governance.

Page 2, #3. Who would be seated on this *Tribal Coordinating Committee*? The representation of this body should be clearly stated.

Tribal Action Plan Template, Components of the Tribal Action Plan: The *Action Plan's* first action should be to conduct a needs assessment. This would be consistent with the *Purpose* section that talks about *"what communities want, and an ability to analyze information"*, this action would be nearly impossible without community participation. An effective and sustainable plan cannot be determined by *conducting a profile of population needs.* That would amount to once again chasing bad to poor data.

Some tribes will have their strategic information from their own needs assessment, so would be ahead of the rest, but it is important to know the state of behavioral health data in tribal communities, which is a challenge to acquire and validate. Not even the Resource Patient Management System (RPMS) which accrues national behavioral health data has accomplished this. One example shows the Albuquerque Area as having an extremely high rate of methamphetamine encounters. Comparing the same variables nationally shows the rest of the country has a lower impact from methamphetamine. This data is reflective of the capacity of the health system, which is representative in the number of providers and the RPMS system, (atient Care Component (PCC). This data is captured by the Indian Health Service Areas

then complied in a national repository. However, reports from this aggregate data results in skewed results. In fact, numerous discussions with tribal leaders across the country report major issues with methamphetamine use everywhere in Indian Country, not just the Albuquerque Area. Currently, no system exists that validly and reliably gathers behavioral health data in Indian Country.

The *Tribal Action Plan* needs to have core components that have the flexibility and ability to build on existing programs. The *Plan* needs to be responsive to the stakeholders and their tribes. Tribal EpiCenters should be a serious consideration to tie into any plan. SAMHSA has done so with its Strategic Prevention Framework State Incentive Grants (SPF-SIGs). This program requires association with an epidemiologic service.

Once again, thank you for this opportunity to comment on this critical document. It truly has the potential to directly save lives. Should you have any questions or concerns about these comments and suggestions, please do not hesitate to contact Mr. Jim Roberts (503-416-3276 or Dr. Linda Bane Frizzell (503-313-3254).

Respectfully,

Joe Finkbonner, RPh, MHA
Executive Director

cc: Julia Wheeler, Portland Rep. SAMHSA Tribal Advisory Committee
Cassie Reck, Portland Alternate, SAMHSA Tribal Advisory Committee
Sheila Cooper, SR. Advisor Tribal Affairs, SAMHSA
Dr. Linda Frizzell, Project Manager, NPAIHB
Jim Roberts, Policy Analyst, NPAIHB

United States Department of the Interior

BUREAU OF INDIAN AFFAIRS
Washington, DC 20240

JUN 24 2011

Memorandum

To: All BIA Regional Directors
All BIA Regional Social Workers

From: Deputy Bureau Director, Field Operations

Subject: IHS/BIA/BIE/SAMHSA Action Summit for Suicide Prevention

On September 10, 2011, the National Action Alliance for Suicide Prevention was initiated to encourage government-wide partnerships to develop effective public awareness and increase suicide prevention. In support of the National Action Alliance, the Bureau of Indian Affairs (BIA) partnered with the Bureau of Indian Education (BIE), Indian Health Service (IHS), and Substance Abuse Mental Health Service Administration (SAMHSA), to hold ten Tribal Suicide Listening Sessions across the nation to gather information on the needs, concerns, and current programs from tribes to assist in the development of the national comprehensive suicide summit. It is my pleasure to announce the jointly sponsored ***Action Summit for Suicide Prevention*** - *Partnering to Protect the Circle of Life,* to be held in Scottsdale, Arizona, August 1 – 4, 2011.

I strongly support Regional, Agency and Tribal attendance at this important summit since many are often engaged in suicide prevention efforts. Moreover, social services staff serves people on a daily basis and have intervened in suicide gestures and attempts, and aftercare may be required upon completion. Attendance at this conference will be educational, as training opportunities are available to enhance knowledge to better prepare individuals and organizations to combat suicide and handle the underlying causes of suicide in Indian Country.

Regional Directors should encourage Agency Superintendents to assess their Human Services personnel to ensure that staff members have an opportunity to travel to Scottsdale, Arizona, and participate in this important initiative.

This summit will provide a forum for collegial dialogue within and across many disciplines; and will provide an excellent opportunity to meet with colleagues and shape the future of our strategies in protecting our youth and Indian communities as a whole. I strongly urge you to provide your staff with resources to attend this valuable training, particularly social workers, justice services' personnel, education and those front line first responders in your employment. I cannot impart the importance of their participation.

I, wholeheartedly, expect your cooperation in support of this unique training and educational summit on behalf of Indian Country.

Attachment

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 Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault 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
Yakama Nation

2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT BY TELEFAX: (301) 443-4794 – Hardcopy via Federal Express

March 19, 2010

Yvette Roubideaux, M.D., M.P.H
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Dear Dr. Roubideaux:

We are writing to provide you with our response to your letter dated, January 15, 2010, in which you request recommendation to improve the Contract Health Service (CHS) program. We were prepared to submit our recommendations as requested on March 15th, but wanted to offer our Tribe's additional time to submit their recommendations following your offer at last week's meeting with Portland Tribes, in which you offered additional time to develop recommendations. Your generosity to provide additional time is appreciated and did allow for additional comments to be received.

The attached position paper represents the views of Portland Area Tribes and was developed from previous Portland Area position statements, congressional testimony, and IHS Director Letters conveying concerns in the CHS program. This position paper will be adopted by a formal resolution of Portland Area tribes at our upcoming NPAIHB board meeting to be held on April 22, 2010.

We acknowledge your effort to address many longstanding issues in the CHS program. I believe you will find that Portland Area Tribes are willing to work hard on very difficult and complex issues to improve health programs for Tribes nationally. In this course, Portland Tribes only want their fair share while at the same time doing what is in the best interest of Indian health programs nationally. In this regard, our Board stands ready to assist you in this effort and we commend you for consulting with Tribes over these very complex issues.

If you should have any questions concerning any of our recommendations, feel free to contact me or Jim Roberts, NPAIHB Policy Analyst, at (503) 228-4185.

Sincerely,

Joe Finkbonner, RPh, MHA
Executive Director

Portland Area Tribes' Position Paper
Contract Health Service Program

March 19, 2010

Introduction

This position paper is prepared for the consideration by Portland Area Tribal leaders, Health Directors, and others to submit comments the Indian Health Service (IHS) Director's, Dr. Yvette Roubideaux, January 15, 2010 letter in which she announced a Tribal consultation process for the Contract Health Service (CHS) program. Dr. Roubideaux has requested Tribal input on issues affecting the CHS program, the CHS funding methodology, and ways to improve the way CHS programs conduct business.

Background

Between 2001 and 2010, there has been approximately $250 million in program funding increases in the Contract Health Service (CHS) program. The CHS increases are distributed using a CHS formula that takes into consideration such things as workload, inflation costs, and CHS dependency.[1] In 2001, IHS Director, Dr. Michael Trujillo formed a workgroup to provide recommendations to improve the formula and potential improvements to how CHS funding is allocated. The CHS formula is very important to those *CHS Dependent* Areas that do not have hospitals and must purchase all specialty and inpatient care from private sector hospitals and other providers. The 2001 workgroup formula has been controversial since it gives a lower weight for *CHS dependency* than the previous formula.[2]

The previous CHS formula (also referred to as the 1994 formula) was a response to the need to recognize the unique situation of *CHS Dependent Areas* in the same manner that facilities-dependent areas are recognized with funding from the hospital and clinic line items. Portland Area Tribes were unified in their position to retain the 1994 CHS formula. The position of Portland Tribes was that the 2001 workgroup formula did not have a strong enough factor for CHS dependency. The manner in which cost is measured is also suspect and was likely chosen because it was readily available. The 2001 workgroup formula uses the American Chamber of Commerce Research Association (ACCRA) Cost of Living Index. The location points used in the ACCRA index may not correlate with the locations of Portland Area Tribes, nor may they be indicative of costs in reservation settings.

The controversy around the formula is evident when in FY 2001 and FY 2002, there were CHS funding increases of $34.9 million and $15 million respectively, and the IHS Director decided to use a *blended formula* to allocate the increases. This was done in order to alleviate many of the "fairness" concerns associated with the 2001 workgroup formula.[3] The IHS Director allocated on a non-recurring basis one-

---

[1] The 1994 formula also included Years of Productive Life Loss, however was removed by the 2001 Workgroup since it did not relate to cost of treating disease, but rather reflected cost of disease to society (lost wages & taxes).

[2] The previous CHS distribution formula was made up of three components, and a percentage of the appropriated funding was allotted on each component as follows:(a) Workload/Cost - 20 percent; (b) Years of Product Life Loss – 40 percent, and; (c) CHS Dependency – 40 percent. The new CHS formula lowered the weighting for CHS dependency by applying a 25% weighting to user population.

[3] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated June 7. 2001 and December 31, 2001.

half of the funding using the old CHS formula and the other half using the new 2001 workgroup formula. Below are concerns of Portland Area Tribal leaders and Health Directors regarding the CHS program and the CHS formula:

1. The CHS Formula Must be Reconsidered

It is the position of Portland Area Tribes that the 2001 CHS Workgroup proposed funding methodology has never been officially adopted through tribal consultation by IHS. This is evident following the development of the proposed methodology when in FY 2001 and FY 2002, there were CHS funding increases of $34.9 million and $15 million respectively, and the IHS Director (Dr. Michael Trujillo) decided to use a *blended formula* to allocate the funding increases. This was done in to alleviate many of the "fairness" concerns associated with the new proposed methodology. The IHS Director allocated on a non-recurring basis one-half of the funding using the existing CHS formula (1994 formula) and the other half using the 2001 workgroup recommendations.

In FY 2003, the IHS Director (Dr. Charles Grim) continued this funding decision by allocating the $49.9 on a recurring basis using the "2002 blended formula."[4] Dr. Grim also announced that in the future, "he planned," to use the 2001 workgroup formula. A decision that Portland Area tribes feel was made without adequate Tribal consultation, especially given the fact that in the last three fiscal years a *blended formula* was used to make CHS allocations. While this letter indicated the IHS Director's intention, IHS did not explicitly adopt the formula as a final policy for future use. Certainly, Dr. Trujillo never officially adopted it in light of his use of a blended formula when allocating funding increases in FY 2001 and FY 2002.

Portland Area Tribes do not believe that the 2001 CHS formula has been officially adopted through the use of a "Dear Tribal Leader" letter, which is the common practice of the IHS when making substantive policy changes. In fact the IHS Director's decision letters in FY 2001 and FY 2002 states the following:

> *"I support the Workgroup's strong recommendation to convene a follow-up Workgroup to address these issues," and; "..the decision regarding recurring allocation can be deliberated more comprehensively with contemporary and agreed upon data. By using this approach, it is my hope that we will continue our dialogue on the outstanding issues related to the disparity between need and the resources available for CHS."* [5]
>
> *Dr. Michael Trujillo, IHS Director*

These statements indicate that the previous IHS Director intended to continue to refine the CHS formula. Because the formula has never officially been adopted, the IHS should have conducted Tribal Consultation to determine if the Tribes would prefer to use the blended formula implemented by previous IHS Directors when there were CHS funding increases in 2001, 2002, and 2003 or adopt the new Workgroup proposal. Thus, we recommend that additional Tribal consultation occur before any continued use of the 2001 workgroup formula.

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[4] See "Dear Tribal Leader Letter", by Dr. Charles Grim, IHS Director, dated April 10, 2003.

[5] See "Dear Tribal Leader Letter", by Dr. Michael H. Trujillo, IHS Director, dated June 7. 2001 and December 31, 2001.

2. CHS Funding and Formula Considerations

It is the position of Portland Area Tribes that funding issues associated with the CHS program should not be evaluated without addressing the overall funding received from the Hospitals and Clinics line item. The reason for this has to do with *CHS dependency*. The previous 1994 CHS formula was a response to the need to recognize the unique situation of *CHS dependency* in the same way that facilities-dependent areas are recognized. This type of formula should have been retained. The Portland Area has always recognized that its share of the Hospitals and Clinics line item is less than its user population would predict. For example, the Alaska Area makes up 9% of the total IHS user population, while receiving over 16% of the hospitals and clinics funding.[6] Comparatively, the Portland Area with 7% of the IHS user population receives less than 4% of the hospitals and clinics funding. As well, *CHS dependent* Areas cannot generate third party reimbursements on the same level as those areas that have inpatient care with greater medical staff.

The lower operating efficiencies of smaller health programs associated with *CHS dependent* Areas also predicts that they should receive a higher than user share percentage of total CHS spending. Smaller health systems do not have the same capacity as larger sized systems nor do they have the critical staffing packages that can generate third party collections. Those IHS Areas that have hospital based health systems (Aberdeen, Alaska, Phoenix, Oklahoma) can often provide specialty care and inpatient health services that *CHS dependent* Area (California, Bemidji, Nashville, Portland) must purchase from private sector hospitals. Moreover, those Areas with hospitals have staffing packages that can bill Medicare and Medicaid thereby preserving critical CHS funding for those patients that do not have public or private health coverage or in cases where the IHS hospital may not be able to provide the service.[7] In turn, hospital based Areas are then able to use the third-party collections to expand health services. *CHS dependent* Areas cannot internalize the same costs that inpatient systems can, nor can they bill for such services to expand care, thus increasing their need for CHS funds.

CHS Dependency: Portland Area Tribes do not believe that the 2001 workgroup formula has a strong enough factor for dependency. The Portland Area must insist that any CHS formula include a stronger factor for *CHS dependency*. The 2001 workgroup was too quick to give up on this concept and the decision to weight user population by a 1.25 factor as a measure of CHS dependency is not valid and distorts the reality that Areas such as Portland and California are far more dependent than this factor indicates. If it were true, then the Portland Area would certainly have a greater than 4% share of the Hospitals and Clinics line item. It is not clear that the access factor can be corrected by adding to the 1.25 factor for "access." Perhaps the 50% referral threshold could be changed so an operating unit with greater in-house hospital care is not treated the same as Portland or California programs that purchase 100% of hospital care. Not properly or accurately weighing CHS dependency is grossly unfair.

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[6] Based on FY 2009 Final IHS User Population Report, December 18, 2009; and FY 2010 IHS National Apportionment Tables 1-14.

[7] It is established that 60% of the IHS User Population over the age 55 are enrolled in Medicare; and that approximately 58% of AI/AI children and 28% of AI/AN adults are Medicaid enrollees that reside in IHS Areas. See *American Indian and Alaska Native Medicare Program and Policy Statistics*, (p. 24), October 31, 2009 and *American Indian and Alaska Native Medicaid Program and Policy Data*, (p. 14-15), February 28, 2010, both reports prepared for the Centers for Medicare & Medicaid Tribal Technical Advisory Group, prepared by the California Rural Indian Health Board.

User Population: *CHS dependent* Areas are particularly disadvantaged since they are not able to capture all of their potential active users relative to those Areas that have inpatient hospitals. Consequently, *CHS dependent* Areas like California and Portland suffer from an undercount in user population. For example, some areas, such as Alaska, Phoenix and Oklahoma, capture nearly all of their urban Indian population in their user counts, the Portland Area does not. Some areas, again such as Alaska and Oklahoma capture every resident in the state in a CHSDA, the Portland, Bemidji, and Nashville Areas do not. Adjustments that account for uniqueness in determining user population must be considered in any CHS formula.

Third Party Collections: Third party collections available from Medicare, Medicaid, and CHIP must also be factored in the CHS formula. The availability of revenue from third party collections alleviates CHS dependency when compared to those Areas that do not have hospital based staffing packages to provide services and generate revenue through Medicare, Medicaid, and other private collections. Medicare, Medicaid, and CHIP collection data are available from the states and from CMS and should be utilized in determining CHS need. Recent reports completed by the California Rural Indian Health Board document AI/AN participation in the Medicare, Medicaid, and CHIP programs and the glaring disparity in third party collections associated with hospital based IHS Areas and those that are *CHS dependent*. The Agency and IHS Director can no longer ignore these glaring data disparities in resource allocation in either FDI used to allocate the IHCIF or in the CHS formula.

3. CHS Workgroup Process

Any workgroup that examines proposed changes for the CHS program and formula should include equal representation from each of the twelve IHS Areas. The decision making process should also be based on a consensus process that is not bound by any time limitations. The process used by the 2001 workgroup was terribly flawed as it pitted Areas against Areas and was based on a majority rule. Since those IHS Areas classified as *CHS dependent* were usually in the minority, the outcome of the vote resulted in the damaging changes that were made in the CHS formula.[8] There was not consistent representation in the number of voting members participating in the process, meeting announcements and materials were not consistently shared, and when materials were shared time constraints prohibited due diligence in reviewing and developing positions—all which contributed to an unfair and unequal process in 2001. This underscores the Portland Area position that any decision to use the 2001 workgroup formula should be revisited and continued use of the 2001 workgroup formula requires additional Tribal consultation.

4. Establish a Workgroup to examine the distribution of funding for Hospitals & Clinics

The Portland Area gets less than its fair share of the $1.8 billion in Hospital and Clinics funding; and far less than its share of facilities construction and facilities support funding. The CHS formula should not have been changed unless the method of distributing Hospital and Clinics, Facilities Construction, and other support line items were also changed. Portland Area Tribes support

[8] See NPAIHB letter to IHS Director, Dr. Michael Trujillo, dated March 22, 2001.

establishing a workgroup to conduct a comprehensive review of all funding received by the IHS that would also include a gap analysis in the levels of health care provided across the IHS system. These gaps are a direct result of the varying levels of IHS funding, facilities infrastructure, staffing packages, and third-party collections that result in varying levels of basic, intermediate, tertiary health care in the IHS system. The workgroup would be charged with providing recommendations to reallocate resources so that consistent levels of care can be provided to Indian people across the IHS system. This recommendation is consistent with the health reform goals currently being deliberated by Congress and the Administration to increase access to health care and improve the quality to care for all Americans. This should also extend to AI/AN people served by the IHS system.

5. CHS Budget and Medical Inflation

It is generally accepted that the main challenge in the CHS program is that there is not enough funding. The CHS budget is the most important IHS budget line item for Northwest Tribes since there are no hospitals in the Portland Area and that the CHS program represents 40 percent of the Portland Area's health services budget. Nationally, the CHS program represents 19 percent of the total health services account. Because of this, Northwest Tribes have tracked the CHS budget over a long period of time. Portland Area Tribes estimate that the CHS budget has lost over $600 million in unfunded medical inflation and population growth since FY 1992.[9] This has resulted in rationing of health care services using the CHS medical priority system, in which most patients in the Portland Area cannot receive care unless they are in a Priority One status. In FY 2009, this resulted in over 100,000 denied or deferred services nationally in the CHS program.[10]

One of the reasons that the CHS budget has eroded so badly is due to the fact that the Agency, and/or the Department, and/or the Administration, and/or the Congress have all failed to either request or appropriate adequate CHS funding to cover mandatory inflation and population inflation increases. The CHS program is more vulnerable to inflation pressures than any other program in the Indian health system. CHS budget increases have averaged 4.5 percent over the last ten years, despite the fact that medical inflation has exceeded 10 percent in many of these years. Similar public insurance programs like Medicaid obtain budget increases that are based on actual medical inflation. The Medicaid program has averaged an annual budget increase of 7.5 percent over the same period.

The IHS Director must stress with the Department, OMB, and the Administration that the CHS program should receive medical inflation adjustments equal to the Medicaid program since both provide similar services and purchase care from the private sector. Surely, the relatively small Indian Health Program is not able to secure better rates from providers than the Medicare and Medicaid programs. It is reasonable to expect that Medicaid program inflation rates will exceed 10 percent in FY 2010. It seems clear that CHS, while an efficient alternative to building hospitals and

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[9] See *NPAIHB 21st Annual FY 2011 IHS Budget Analysis & Recommendations* (page 24), March 12, 2010. Available at: www.npaihb.org.

[10] See FY 2009 IHS Denied, Deferred, CHEF Services report, available from the IHS Headquarters CHS Program, Rockville, MD.

specialty clinics, is subject to higher rates of inflation than the rest of the IHS budget and should be provided with an appropriate increase annually.

In summary, this paper represents the position of Northwest Tribes who stand ready to assist the IHS Director to work to bring positive changes to the CHS program and funding methodology. Northwest Tribes are confident that the IHS Director will follow the practice of being sure that true consultation is obtained prior to making final decisions affecting the CHS program.

The last two years and the President's proposed FY 2011 budget mark positive changes for Indian health funding. We all share in that success if we distribute the record increases fairly. For the Portland Area, where over 40% of the funding for actual health care delivery comes from the 'contract care' line item; the IHS Director's decisions will be critical. The previous developed 2001 workgroup formula does not meet the test of fairness in the way it was developed or the results that it produces. The Northwest Portland Area Indian Health Board is ready, willing, and able to work on a new formula that will meet the needs of all tribes. Until an acceptable formula is developed, the current formula should be used to distribute CHS dollars.

###

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
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2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT BY TELEFAX: (301) 443-4794 – Hardcopy via Federal Express

March 1, 2011

Yvette Roubideaux, M.D , M.P.H
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Dear Dr. Roubideaux:

The Northwest Portland Area Indian Health Board is a P.L. 93-638 Tribal organization that represents health care issues of forty-three federally recognized Tribes in Idaho, Oregon, and Washington. We are responding to your December 30, 2011 letter, in which you have initiated Tribal consultation on the Indian Health Care Improvement Fund formula.

The Indian Health Service (IHS) has always been challenged by Tribes for its inequitable distribution of resources for health services and facilities. This distribution controversy reached a head in Rincon Band of Mission Indians vs. Harris, when a group of California Indians sought redress for disparate funding levels for Indian health care in the California Area.[1] Consequently, the Indian Health Care Improvement Fund (IHCIF) was established to correct IHS funding disparities by raising the level of funding and services provided to the neediest tribes. Since its inception, the system used to measure and rank tribal needs has often been criticized for its weaknesses and inability to know whether the IHCIF is truly being distributed according to tribes' relative needs.

Portland Area Tribes also have concerns about the IHCIF and whether it has been effective at eliminating funding and services disparities that exist across the Indian health system. To this end, we appreciate the opportunity to address the four items outlined in your December 30th letter.

1. **Should we change the IHCIF formula?**

   Our answer to this question is, *yes*. Portland Area Tribes position on this question is that the IHCIF should be changed to address the technical weaknesses unveiled by the IHCIF Data Workgroup. The Data Workgroup recommended making technical improvements in six key areas of the formula: (1) User Counts; (2) Cost Benchmark; (3) Health Status; (4) Facility Differences; (5) Data Procedures, and; (6) Alternate Resources. It is the position of Portland Area Tribes that the aforementioned areas must be improved in order to achieve the Congressional intent of the IHCIF and to effectively address funding and service inequities in the Indian health system.

[1] Rincon Band of Mission Indians v. Harris, 618 F.2d 569 (9th Cir. 1980).

Section 121 of the Indian Health Care Improvement Act (IHCIA) sets forth the authority to establish the IHCIF. Section 121 was amended to provide that funds appropriated for the IHCIF may be supplied to IHS or ISDEAA programs, with the apportionment of funds to be determined by IHS in consultation with affected tribes and tribal organizations. The amended Section 121 now states that one of the functions of the IHCIF is to eliminate inequities in funding for direct and Contract Health Service (CHS) programs. Section 121 also updates the requirement for IHS to file a health status and resource deficiency report to Congress and directs that, to the extent available, the report shall include information on waiting lists and the number of Indians turned away for services due to lack of resources.

One of the important changes for Section 121 is that it now defines ***"health status and resource deficiency."*** Section 121(d)(2) now requires that for the purpose of determining health status and resource deficiencies that the IHS must take into account all available resources.

> Section 121(d)(2) – "AVAILABLE RESOURCES-The health resources available to an Indian tribe or tribal organization include *[health resources]* provided by the Service as well as *[health resources]* used by the Indian tribe or tribal organization, including services and *[financing systems provided by any Federal programs, private insurance, and programs of State or local governments]*." [Emphasis added]

Because the law now requires IHS to consider *"financing systems provided by any Federal programs, private insurance, and programs of State and local governments"* we believe that alternate resources must now be included in calculating the Federal Disparity Index (FDI) for Tribes. While the IHCIF Data Workgroup did not concur about the reliability of alternate resources data we believe this data can readily be made available through the Centers for Medicare & Medicaid Services (CMS) and state Medicaid programs. There is no denying the fact that these alternate resources do provide an advantage over those tribes that may not have the same capacity to provide similar levels of care and also generate third party reimbursements. Ignoring this fact in the IHCIF will only perpetuate funding and health service inequities that the IHCIF was established to address.

2. Should we make technical improvements to the current formula?

The IHCIF Data Workgroup has proposed technical improvements for some of the data elements used in the IHCIF formula. We agree that the formula components should be refined as recommended by the Workgroup. We also provide the following recommendations based on concerns expressed by Portland Area Tribes:

<u>User Counts</u>. The IHCIF Data Workgroup supports retaining user population as an approach to determine the FDI scores. We support this recommendation with the condition that the formula develop a system to un-duplicate user counts across all IHS Areas. Currently, user population is only unduplicated within respective IHS Areas. We also recommend that the IHS take into consideration CHS dependency factors. For example, if a person lives outside a CHSDA they often will not seek care and do not show up in a Tribe's user population. Comparatively at a direct care facility many services may be provided and result in the patient being included in that facility's user population.

The result is that user population at CHS dependent programs is restricted and held artificially low compared to those direct care facilities. This inequity should be compensated in the IHCIF.

Cost Benchmark. We support continuing the use of benchmark per capita funding comparisons relative to the average per capita costs of a blend of Federal Employee Health Program insurance plans. We recommend improving the services included in the benchmark package to reflect changing services provided in the private sector and recognize the new authorities included in the reauthorization of the IHCIA. Our recommendation is consistent with that of the Workgroup, who concurred that IHS should make technical improvements to fine tune the benchmark to reflect evolving health care delivery system. The integration of behavioral health into primary care should also be factored in this process.

Health Status. We recommend additional work be put into refining the health status indicator in the formula. We believe that an index constructed from more relevant and current health status data would better reflect cost variations among the IHS Areas or operating unit sites. We agree with the Workgroup that IHS should evaluate substituting morbidity data, if practical, as an alternative to mortality data now used to scale funding estimates. Reliable morbidity data that measures occurrence of disease and lack of health would be a more direct indicator of cost variations than mortality data.

Data Procedures. The Workgroup recommended no important changes in the data collection methods, but suggested that IHS refine and update technical manuals. We concur with this recommendation.

Alternate Resources. We do not support counting resources contributed by Tribal governments to their health programs. Please also see our discussion included above in Item No. 1. The measurement of alternate resources is the most critical issue that must be addressed in the IHCIF formula. We support replacing the25 percent flat rate used in the formula with the actual collections data from Medicare, Medicaid, and CHIP. Alternatively, we are supportive of developing a new statistical index of alternate resources that could be created through an IHS-CMS expenditure data linkage.

3. Should we make changes in the basic methodology of the formula?

Please see our discussion included under Items No. 1 and No. 2 above.

4. How should we consult with Tribes on the questions above?

We recommend that the IHS continue to use the IHCIF Data Workgroup to review the comments received through this Tribal consultation. The Workgroup should refine their recommendations based on the Tribal consultation comments and prepare a final report to the IHS Director. We recommend that the findings of this report be used to conduct Area or national listening sessions,

which can serve as the basis for the IHS Director to make her decision concerning changes in the IHCIF.

Thank you for the opportunity to provide our comments on the IHCIF formula. If you should have any questions, please feel free to contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email at jroberts@npaihb.org.

Respectfully,

Andrew C. Joseph Jr.

Andrew Joseph, Jr., Chairperson
Northwest Portland Area Indian Health Board,
Colville Tribal Council Member

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2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT BY TELEFAX: (301) 443-4794 – Hardcopy via Federal Express

February 21, 2011

Yvette Roubideaux, M.D., M.P.H
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Dear Dr. Roubideaux:

The Northwest Portland Area Indian Health Board is a P.L. 93-638 Tribal organization that represents health care issues of the forty-three federally recognized Tribes in Idaho, Oregon, and Washington. We are responding to your January 25, 2011 letter, in which you have initiated Tribal Consultation in response the recent extension of the Special Diabetes Program for Indians (SDPI).

First, we want to emphasize that the following comments and recommendations represent the position of the forty-three tribal governments in Idaho, Oregon, and Washington – the Portland Area – and not the position of only one tribal entity. We are aware that federal agencies often have interpreted the comments from Tribal organizations as representing the position of only one tribe. The Northwest Portland Area Indian Health Board (NPAIHB) is one of few tribal organizations nationally that represent all federally recognized tribes in their IHS Area. As such, we ask that you recognize that our comments represent the position of all forty-three Tribes in the Portland Area.

The NPAIHB member Tribes discussed the details of your January 25, 2011 letter during our Quarterly Board Meeting held in Lincoln City, Oregon, on January 25-27, 2011. A significant portion of our consultation focused on our response to the issues of your letter. Our representatives also discussed the details of your letter at the conference of the Affiliated Tribes of Northwest Indians (ATNI) held in North Bend, Oregon on January 31 – February 1, 2011. Thus, our Quarterly Board Meeting and ATNI conference have provided appropriate venues for consultation resulting in the following recommendations.

1. **Maintain Current Distribution & Tribal Consultation**

   While the NPAIHB understands and appreciates the initial position put forward by the Tribal Leaders Diabetes Committee (TLDC), we do not agree with its preliminary recommendation to maintain the current funding distribution of the program, nor do we concur with their decision to not conduct Tribal consultation.

Portland Tribes understand completely that the evaluation of the SDPI over the past thirteen years has proven very effective with positive outcomes. However, a number of Tribes in the Portland Area as well as across the country, do not agree with the current distribution methodology and would like an opportunity to address those issues through Tribal consultation. During the TLDC teleconference the rationale for maintaining the current program and not conducting Tribal consultation was due to the urgency needed to make a decision for FY 2012 and FY 2013.

During FY 2009 (H.R. 2499, Medicare, Medicaid and SCHIP Extension Act of 2007) and the FY 2010 and FY 2011 (H.R. 6331, Medicare Improvements for Patients & Providers Act of 2008) we also faced similar timing and urgency issues and for each of these SDPI extensions and there was Tribal consultation on the SDPI funding distribution. To not conduct Tribal consultation on this SDPI reauthorization is inconsistent with past policy practice of the Indian Health Service (IHS). We were under very similar time constraints during the reauthorizations approved under H.R. 2499 and H.R. 6331, and this should not be a barrier to conducting Tribal consultation on this reauthorization of the program.

Tribal consultation has been instrumental in the success of the SDPI and should always be conducted whenever possible. We hope that you will always seek tribal leader input into programs affecting Indian people no matter what the circumstance or timing. Tribal consultation is one of your top priorities in renewing and strengthening IHS' relationship with Tribes and **we urge you to conduct a full Tribal consultation on the distribution of the FY 2012 and FY 2013 SDPI funds.**

If it is absolutely essential that a decision be made soon, than at a minimum an extension of the current program requirements could be made for FY 2012; and Tribal consultation would be utilized for FY 2013.

2. FY 2012 & FY 2013 SDPI Funding Distribution

You requested our input to maintain the current funding distribution for the additional two years that H.R. 4994, the Medicare and Medicaid Extenders Act of 2010, has reauthorized the SDPI program. Due to the reasons explained above, Portland Area Tribes do not support maintaining the current distribution of SDPI funding in FY 2012 and FY 2013. Portland Area Tribes continue to support our position on the SDPI distribution communicated to Robert McSwain, former IHS Director, outlined in our January 31, 2009 letter (see attached). We summarize those issues below and have included our 2009 letter for a detailed explanation and the Portland Area Tribes' continued position on these issues.

Basic Distribution Formula: Our January 31, 2009 letter described weaknesses in the Basic Distribution Formula (BDF) that should be addressed. Portland Area Tribes recommended the following changes to the BDF:

a. Decrease the weight of the tribal size adjustment from 12.5 percent to 8 percent;
b. Increase the weighting on the user population criteria from 30 percent to 42 percent;
c. Decrease the disease burden criteria from 57.5 percent down to 50 percent;
d. Delete the hold harmless and inflation amounts as these elements were intended to be funded once rather than becoming recurring funds as has happened from FY 2004 - FY 2009;
e. Increase the Tribal size adjustment factor from 300 to 1,200 users;
f. Use only Active User Population for calculating diabetes prevalence; we do not support using Service Population in the prevalence calculation.

Competitive Set-Aside: Portland Area Tribes are not fully supportive of a competitive grant set-aside (what has become known as the "special demonstration") in the SDPI program. Portland Area Tribes agree that there have been benefits to this program and that future efforts should be directed to translate the findings into community directed programs. Thus, Portland Area Tribes recommend returning 90 percent of the set-aside amount to the Community Directed Grant Program. The remaining 10 percent should be made available to the IHS Areas to translate the findings and best practices of the special demonstration program (competitive grant program) into the community directed grants. If this is not done, then Portland Area Tribes recommend a new competition for the special demonstration program. Other Tribes want to be able to benefit from the same opportunity that the special demonstration has provided a few select tribal communities.

Administrative Set-Aside: Portland Area Tribes support an appropriate level of funding for the administrative requirements of carrying out the SDPI, however we do not support such funding at the previous level. Our justification is that if the special demonstration funding is reduced per our recommendation, then the level of workload and administrative oversight will be greatly reduced. This cost savings should be returned to the community directed programs. We recommend decreasing the administrative set-aside from $4.1 million to $3 million due to a reduction in the administrative costs.

Data Set-Aside: Portland Area Tribes recommend that the data set-aside be discontinued and the $5.2 million be provided to the community directed program. During the past four Tribal consultations, Indian Country has been divided on recommendations to continue support for this set-aside. The Portland Area's position on this issue is that costs associated with information technology are a residual function and the responsibility of the IHS or Tribes if they take their shares. Portland Tribes are concerned that a preponderance of SDPI data funds has enhanced information technology at direct federal sites with little funding provided to Title I contracting or Title V compacting Tribes.

Urban Set-Aside: Portland Area Tribes support and recommend the continuance of a five percent set-aside (currently $7.5 million) to fund diabetes grants for the 34 Urban Indian Health Programs.

Native Diabetes Wellness Program: Portland Area Tribes do not support the $1 million set-aide for the CDC Native Diabetes Wellness Program and recommend that the funding be provided back to the community directed program. If this funding is continued, then a process should be put in place that ensures the services provided benefit the priorities of each IHS Area.

It is the position of Portland Area Tribes that our recommendations provide sound guidance to improve this very important program. Our recommendations are based on the principle that the SDPI funds should provide the greatest opportunity to reduce the burden of diabetes for Indian people. In fact, some of our recommendations would result in less overall funding to the Portland Area. On this same note, some of our recommendations would enhance the ability of small and disadvantaged Tribes to access additional funding to address diabetes issues in their communities. During the discussion on our initial recommendations we balanced these unique circumstances with what was in the best interest of Indian Country. To this end, we support building on the strength of the Community Directed grant programs with lessons learned from the special demonstration grantees.

I want to personally thank you for the opportunity to provide our comments on the SDPI and look forward to the continued success of this program. If you should have any questions concerning our recommendations, please contact Jim Roberts, Policy Analyst, at (503) 228-4185 or email at jroberts@npaihb.org.

Sincerely,

Original Sent signed.

Andrew Joseph, Jr., Chairperson
Northwest Portland Area Indian Health Board and
Colville Tribal Council Member

cc: Dean Seyler, Acting Area Director, IHS-PAO
Kelly Action, IHS-NDP Director
Lorraine Valdez, IHS-NDP
Buford Rolin, TLDC Chairperson
43 PAO Tribal Leaders and Tribal Health Directors
PAO SDPI Grantees

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527 SW Hall
Suite 300
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☎ (503) 228-4185
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SENT VIA TELEFAX: (301) 480-2991

January 31, 2009

Robert G. McSwain, MPA
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Dear Mr. McSwain:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization that represents forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington on health related issues. We are writing in response to your invitation to your October 23, 2008 letter concerning revisions to the Indian Health Service (IHS) Information Technology Support Packages. A Tribal consultation session was held in Phoenix, AZ on December 17, 2008, and again with our Board Delegates on January 21, 2008 in Suquamish, WA. We understand that the comment period on the proposed changes has been extended to January 31, 2009.

We have adopted the concerns discussed at the consultation sessions into a formal resolution that was passed by the Northwest Portland Area Indian Health Board on January 22, 2009. We respectfully request that you act upon our resolution by: (1) withdrawing the proposed IT support package reconfiguration, and; (2) convene a Federal/Tribal workgroup to address escalating IT costs in order to develop a solution that is amicably acceptable to both the IHS and Tribes. We further request that the workgroup include a Tribal representative from each of the twelve IHS Areas.

In addition to the above, the following outline concerns that were expressed by Portland Area Tribes during the consultation sessions. Dr. Theresa Cullen, Chief Information Officer, attended our Board meeting on January 21st, and heard firsthand the concerns expressed by Northwest Tribes. While Northwest Tribes expressed their concerns, they also offered to work collaboratively with the Agency to develop solutions to the challenges conveyed by IHS and address funding issues associated with implementing the rising costs associated with information technology.

Your October 23rd letter outlined a proposed restructuring the Office of Information Technology (OIT) activities into three packages that included: (1) National Data Warehouse, (2) Infrastructure Service Support Plans, and; (3) RPMS Service Support Plans. The intent of the proposed changes is to develop a direct financial relationship between Tribal shares and the proposed packages. The objective of the proposed change is to require Tribes to retain their Tribal shares with the IHS-OIT in order to receive any services for a particular package; or to assume completely the responsibilities of that package by contracting under the Indian Self-Determination and Education Assistance Act (P.L. 93-638. The proposed changes would result in a *"take it or leave it"* approach that is inconsistent with the ISDEAA. This change would remove

the option of contracting or compacting for "programs or portions thereof" that the ISDEAA allows. Initially, the IHS-OIT proposed that the changes become effective in the FY 2010 negotiation cycle.

In a letter dated November 14, 2008, C. Bryant Rogers explained on behalf of a number of Tribes—which like our member Tribes—operate health programs under the ISDEAA (P.L. 93-638) who would be impacted by the Agency's decision to redesign Information Technology Support Packages. Furthermore, in Mr. Roger's letter to IHS, he explained how the IHS lacked clear authority to require Tribes to contract for all or none of a program under P.L. 93-638. The Indian Self-Determination and Education Assistance Act (ISDEAA) stipulates that Tribes are entitled to contract for "programs or portions thereof."[1] We concur with the analysis explained in Mr. Roger's letter and conclude that P.L. 93-638 makes it a Tribe's decision—not an IHS decision—to decide what programs, functions, services, activities (PFSAs) or portions thereof a Tribe may chose to leave with the Agency or have performed through a retained services or buy-back arrangement.

In addition to the legalities explained above, Portland Area Tribes have additional concerns related to how the proposed changes will impact them programmatically, which include:

- The IHS has proposal departs from past Agency practice to consult and work with Tribes in a deliberative process to address an issue of mutual concern. Many Tribal leaders felt this was a significant step backward from the progress that Tribes have made with IHS and a very paternalistic approach to working with Tribes.
- Tribes that have taken a portion of their information technology shares have developed their internal capacity to support their health programs under the current circumstance and such radical change without much lead time to plan accordingly could seriously disrupt the delivery of health care services.
- Tribes are placed in a compromising position of being forced to decide to accept the IHS proposal under a "take it or leave it" option.
- Northwest Tribes are very concerned about the precedence of tying the restructuring proposal to the Programs, Services, Functions, and Activities (PSFAS) manual for future contracting/compacting opportunities. Tribes are not bound by the PSFA manual.
- What happens if IHS does not deliver the PFSAs in a timely fashion or by the fourth quarter of the fiscal year, will IHS be able to reimburse the share amounts because they have been expended?
- The Agency must develop an alternative "a la carte" buy back pricing (based on hourly rate, prorated licensing rates, and a la carte rate for other services) for individual Tribal programs who do not want to retain tribal shares but prefer to purchase services on a as needed basis.

We were also troubled that there was no one from the Office of General Counsel to present on behalf of the IHS, its position on the legal issues associated with restructuring the information technology packages. We are pleased to hear that IHS-OIT has decided to hold off implementing the proposed

[1] P.L. 93-638 Indian Self-Determination and Education Assistance Act, U.S.C. § 450 f (a)(1).

Information Technology Support Packages until the FY 2011 negotiation cycle and that the Agency will be appointing a technical workgroup to address the Tribal concerns expressed during the consultation sessions. We would encourage the IHS to implement a recommendation conveyed in Mr. Bryant's letter, that an individual cross walk of current OIT services be prepared which include price and historical data on the level of support (programming, training and other support hours) provided for RPMS and NDWS to Portland Area Tribes over the past two years. This would allow Tribes to become more acquainted with providing information technology support, costs, and service expectations for the various packages. The process would allow for the development of baseline service information that could be used to evaluate performance and identify areas for improvement. It would also build the foundation for the IHS and Tribes engage in a more deliberative process concerning these issues.
We thank you for our attention to our recommendations and for this opportunity to provide comments on behalf of our forty-three Northwest Tribes!

Sincerely,

Andy Joseph, Chairperson
Colville Tribal Council Member

cc: Doni Wilder, Portland Area Director
Theresa Cullen, IHS-OIT, Chief Information Officer
Samuel Berry, IHS, IT Program Specialist

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527 SW Hall
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RESOLUTION #09-02-01
Opposition to Restructuring IHS-OIT Support Packages and Recommend that the IHS Withdraw its Pending Proposal

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents forty-three federally recognized Tribes in Idaho, Oregon, and Washington and is dedicated to assisting to promoting the health needs and concerns of Indian people in the Northwest; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the Indian Health Service (IHS) has proposed a reorganization of the IHS Office of Information Technology (OIT) Support Packages; and

WHEREAS, all Northwest Tribes receive OIT services from the Agency on a direct service or as retained services or per buy-back arrangements (under P.L. 93-638) basis; and

WHEREAS, the IHS reorganization proposes a reconfiguration of the OIT packages into three menu options that include: (1) National Patient Information Reporting System (NPIRS); (2) Infrastructure, Office Automation, and Telecommunications, and; Resource and Patient Management System (RPMS) that would require all shares associated with a support package to be retained with the IHS-OIT in order to receive any services associated with the package; and

WHEREAS, the consequence of this reconfiguration will affect all Tribes by eliminating the option of contracting or compacting for portions of IHS-OIT support packages to become effective in the FY 2011 negotiation cycle; and

WHEREAS, the proposed reconfiguration is not fair to direct service tribes who may decide to pursue Self-Determination opportunities since they will be limited to fully assuming or retaining Information Technology (IT) support packages; and

WHEREAS, those Tribes that have assumed or retained portions of the IHS-OIT support packages prior to the FY 2011 contract or compact negotiation cycle will be expected to fully assume or retain the proposed IHS-OIT support packages effective FY 2011; and

WHEREAS, the proposed reconfiguration represents a significant change in the manner for which Tribes contract/compact for IHS-OIT support packages and is inconsistent with the Indian Self-Determination and Education Assistant Act (P.L. 93-638), which bar the HHS Secretary or IHS from precluding Tribes from choosing what portions of IHS administrative support services they elect to assume

or leave with the Agency as retained services or per buy-back arrangements under P.L. 93-638 (Title I or Title V) arrangements; and

WHEREAS, Tribes understand that the escalating costs associated with carrying out information technology (IT) functions on behalf of the Agency and in order to address these issues, that the IHS should initiate this work in collaboration and not in the manner that the Agency has dictated.

THEREFORE BE IT RESOLVED, that the Northwest Portland Area Indian Health Board oppose any changes to the IHS-OIT support packages and recommend that the IHS withdraw its pending proposal to configure IHS-OIT support packages.

BE IT FURTHER RESOLVED, in follow-up to a Tribal Consultation session conducted by IHS on December 17, 2008, the OIT has reported that it will appoint a workgroup to revamp the IT proposal, and that the Northwest Portland Area Indian Health Board recommend that the workgroup include a Tribal representative from each of the twelve IHS Areas to be included with the Information Systems Advisory Committee (ISAC) members that will be appointed to the workgroup.

BE IT FINALLY RESOLVED that the NPAIHB recommend that the comment period be extended 45 days after the first meeting of the workgroup.

CERTIFICATION

NO. 09-02-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 31 for, 0 against, 0 abstain on January 22, 2009

Chairman

1-22-09
Date

Secretary

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2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

Federal Agency Listening Session on Suicide Prevention

Northwest Region - January 12, 2011
Prepared by NW Portland Area Indian Health Board

Background

Suicide is a sensitive issue, but one that is of great concern to many American Indian and Alaska Native (AI/AN) communities. The Portland Area has one of the higher suicide death rates for AI/AN among Indian Health Service (IHS) Areas. The IHS reported that, from 1996-1998, the age-adjusted suicide death rate for the Portland Area was 22.0 per 100,000, a rate that was exceeded only by Aberdeen, Alaska, Bemidji, and Tucson.

At the state level, annual suicide rates for AI/AN tend to fluctuate widely because the actual number of deaths each year is relatively small. In 2005, for example, 12 AI/AN suicides occurred in Washington, 3 took place in Oregon, and 5 in Idaho. While males typically *complete* suicide more often that women, studies suggest that women actually *attempt* suicide more frequently than men. This pattern is also present among AI/ANs in the Pacific Northwest.

Data suggest that suicide is a significant problem throughout Indian Country, particularly among Native youth, males, veterans, and elders. From 2000-2005, the average suicide death rate was highest among AI/AN youth aged 15-24 (at 18.7 cases per 100,000, compared to 10.7 per 100,000 for White youth and 7.1 for Black youth). Nationwide in 2005, suicide was the second leading cause of death for AI/AN youth in that age range.

Data on suicide risk factors and attempts, as opposed to mortality, are available from a variety of sources, including the CDC's Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS). Data from these sources and other studies have found that several factors can put a person at higher risk for attempting suicide, including:

- Previous suicide attempt(s)
- History of depression
- Alcohol or drug abuse
- Family history of suicide or violence
- Physical illness
- Feeling alone.

Additional research is needed to identify and explore the culturally unique factors that affect AI/ANs. The following is a list of considerations to address with federal partners at the joint IHS, DOI-BIA, SAMHSA

Prepared by the Northwest Portland Area Indian Health Board, 2121 SW Broadway, Suite 300, Portland OR 97201. For additional information please contact Jim Roberts, Policy Analyst, at jroberts@npaihb.org; or Stephanie Craig-Rushing, MPH, PhD, Project Director, at scraig@npaihb.org or by phone at (503) 416-3290. www.npaihb.org.

Tribal Leader Talking Points

1. Federal agencies need to assist and collaborate to focus efforts to address cultural competency issues and problems associated with delivering behavioral health services.

    - There needs be an improved understanding by federal and state officials/employees and other local governments about tribal government legal status.
    - There will be tribal legal status training for non-tribal providers, local governments and State employees.
    - There needs to be an increase in culturally competent behavioral health service providers.
    - Cultural and traditional services should viewed as an equal service when compared to western/European behavioral health practices; and will be equitably reimbursed and recognized as legitimate services.
    - There needs to be an increase in culturally competent behavioral health service programs.
    - There should be an increase in research activities, with tribal government approval, to increase the body of knowledge (best practices) for Indian specific programs.

2. There should be regular and meaningful tribal consultation meetings with all federal partners to work with tribal leaders on a government to government basis when developing approaches to address behavioral health issues and suicide prevention.

    - Consultation meetings should be meaningful, with each government contributing representatives that have "administrative authority" to make decisions about:
        - Behavioral health issues
        - Communication
        - Waivers and policy development
        - Collaborations to making services seamless
        - Assessment and evaluation of programs.
    - In terms of dealing with implementation of health reform, there needs to be tribal representation on all of the ACA planning and advisory councils.
    - There should be a process developed to ensure tribal representation on all respective commissions, planning committees, and other groups established that would have an impact on tribal populations.

3. Mental Illness, chemical dependency, abusive disorders, FAS/FAE, and co-occurring disorders are difficult to segregate (as is currently true in most state systems; but not in most tribal behavioral health programs) when the focus should be on the patient/client as a whole person who must be able to interact with multiple entities in their communities.

    - There should be comprehensives services that are delivered in a seamless system.

- Tribal Community Mental Health Centers should be developed to promote the seamless delivery of services based on the Community Mental Health Centers Construction Act (P.L. 88-164). These Centers provided five core elements of service: outpatient, inpatient, consultation/education, partial hospitalization, and emergency/crisis intervention, all critically needed by Indian Country.
  Indeed the term "community mental health center" is no longer recognized as an official federal designation – this system of providing access for much needed behavioral health services needs to be reauthorized.
- There must be a system developed that not only guarantees confidentiality and data ownership, but also has an ability to share HIPAA and provider approved medical record transactions, that will be non-duplicative for tribal providers.

4. License/certification criteria needs to be changed to deem tribally certified professionals and facilities as eligible to be reimbursed for services, including where desired, direct State contracts.

5. The law enforcement workforces and the court systems (all governments) need to be changed to adequately protect communities and become collaborators in the behavioral health service delivery system.

   - Law enforcement professionals will be trained in interventions that include: coordination procedures with mental health professionals, crisis intervention, dealing with people with mental illnesses (including patient confidentiality), and cultural competence.
   - The State and local governments will recognize tribal court orders with full faith and credit and accept tribal assessments.

6. CMS has a role in addressing suicide issues in Indian Country and should work with States and Tribes to allow state Medicaid plan to include more reimbursable services for prevention and for patients with behavioral health issues and co-occurring disorders.

   - Current programs are over burdened and consequently do not have the ability to cost-shift expenses to maintain programs and services without reimbursement.
   - Youth Regional Treatment Centers need additional assistance to be able to provide services under state Medicaid plans and be reimbursed for them. Often state Medicaid plans classify YRTC "in-patient" facilities that can't meet state requirements despite the fact that if the same service provided in an outpatient setting would be reimbursable to the program.

7. There is not enough emphasis on the impact of the K-12 and tribal college educational systems, economics, veteran services, community participation, and environmental issues in their role of behavioral health.

- Federal agencies also need to work in concert to begin to establish a "seamless array" of programs and services. (BIA, CDC, DOD, DOE, DOL, HHS [CDC, IHS, NIH,] HUD)

8. Resources need to be allocated to enable tribal participation in behavioral health policy and system changes.

    - This commitment must be progress toward improving the lives of Indian people and not just another pilot project that gets buried in the bureaucracy.

9. The *Indian Alcohol and Substance Abuse Prevention and Treatment Act* of 1986 should to be reviewed and utilized to develop behavioral health services. (see Title 25, Chapter 26, Subchapter at §2402 Purpose)

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 Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault 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
Yakama Nation

2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT VIA TELEFAX: (202) 606-0633 and via ian.hunter@opm.gov

October 27, 2010

John Berry, Director
U.S. Office of Personnel Management
1900 E Street Northwest
Washington, DC 20415

Yvette Roubideaux, M.D., M.P.H, Director
Indian Health Service
801 Thompson Avenue
Rockville, MD 20852-1627

Dear Directors:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington.[1] On October 5, 2010, the Office of Personnel Management (OPM) and the Indian Health Services (IHS) issued a joint "Dear Tribal Leader" letter initiating a consultation on Section 157, Access to Federal Insurance, authorized in amendments to the Indian Health Care Improvement Act (IHCIA) and passed in the recent health reform legislation. On behalf of our Tribes, we are pleased to offer our comments on this issue.

Your joint consultation letter requested input to seven questions which we have responded to on the attached questionnaire. In addition, due to the administrative complexity of implementing this particular provision, we also felt it important to provide additional feedback in several areas. The following issues were discussed during our recent quarterly Tribal Health Director Meeting, held on October 18, 2010. Following our meeting, this letter was prepared and shared with our Northwest Tribal leaders and health directors for their comment and approval. Thus, our comments have been vetted in a very structured process with broad-based support of Portland Area Tribes.

Eligibility for Sec. 157

The most important issue related to implementing Sec. 157 is who will be eligible for this benefit. The NPAIHB played key role in the development of the IHCIA legislation and the inclusion of this provision. Unlike other provisions that were included in past IHCIA bills (S. 1200, S. 1057, S. 557, H.R. 1328, H.R. 5312, H.R. 2440, etc), Sec. 157 was not included in past IHCIA bills and there are no bill reports that can be relied upon as to what Congress' intent was relative to who would be eligible for coverage under Sec. 157. NPAIHB participated on the National Steering Committee (NSC) for the reauthorization of the IHCIA. The NSC and NPAIHB understood that the intent of this

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

provision was to allow tribes and tribal organizations carrying out programs under the Indian Self-Determination and Education Assistance Act (ISDEAA) and urban Indian organizations authority to purchase health and life insurance benefits for their employees through the system available to Federal employees.
It provides an economical means for tribes and tribal organizations to purchase insurance coverage for its employees when carrying-out essential governmental functions of the IHS, Bureau of Indian Affairs or other federal agencies under an ISDEAA agreement. This provides Tribal employees' access to the same benefits that a federal employee enjoy when carrying out the same governmental functions. We believe that Sec. 157 also extends access to federal employee health benefits to other non-ISDEAA employees as included in the legislative language below:

> *"SEC. 409. ACCESS TO FEDERAL INSURANCE. Notwithstanding the provisions of title 5, United States Code, Executive order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an urban Indian organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights, and benefits [for the employees of such Indian tribe or tribal organization, or urban Indian organization], under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title." [Emphasis added]*

The intent of the statutory language above is clear. It directly states that an "Indian Tribe or tribal organization carrying out programs under the ISDEAA or an urban organization carrying out programs under Title V of the IHCIA shall be entitled to purchase coverage, rights, and benefits for the employees of such tribes or tribal organization..." The statute does not stipulate that the eligible employee must be working under the ISDEAA agreement. Thus, we believe and recommend that the eligibility of this statute must apply to all tribal and tribal organization employees. The only requirement is that they must be carrying out a program under the ISDEAA.

This benefit is consistent with other responsibilities associated with carrying out activities that might not be funded under the core ISDEAA agreement. Such activities—which are usually funded in whole or in part by Tribes—include administrative functions, security and law enforcement activities, public works, transportation, and other infrastructure requirements. These "indirect" activities support the objectives of ISDEAA agreements and may be carried out by non-ISDEAA employees. When such activities are carried out in the federal government, they are often covered other non-IHS or BIA government entities. These non-IHS and BIA employees are covered under the FEHB program. Thus, covering non-ISDEAA Tribal employees is consistent with benefits provided to other non-IHS or BIA employees that assist the IHS or BIA to meet their mission. This privilege should also apply to Tribal employees not associated with the ISDEAA agreement and normally covered by Tribe's "Indirect cost pool."

Finally, restricting eligibility to just ISDEAA employees would create an unnecessary burden for the Tribes and tribal organizations as well as the OPM to attempt to classify each employee eligible or ineligible. In some instances certain employees could be covered part-time as an ISDEAA and by another Tribal cost center for the remainder of the full time equivalent. This would be just too complicated for OPM and Tribes.

<u>IHS and BIA Role Implementing Sec. 157</u>

We acknowledge that the IHS has primary responsibility for implementation of Indian provisions in the Affordable Care Act and the IHCIA. We also recognize the important role that the BIA and IHS have in administering ISDEAA agreements with Tribes. While both of these functions are very important responsibilities, neither agency has a functional role in the implementation of this provision. Our concern is that including the BIA or IHS in this process will create inefficiencies that will only complicate the timing and implementation requirements to effectively carry out the requirements of Sec. 157. Tribes and tribal organizations interested in participating in the FEHB programs should have a direct relationship with OPM or the designated fiscal intermediary.

Crediting Reimbursements to Tribes

Section 125 of the IHCIA provides the IHS, an Indian Tribe, or Tribal Organization the right to recover from an insurance company, health maintenance organization, employee benefit plan, or any third party the reasonable charges associated with providing health services. Other non-governmental providers of such services would be eligible to receive reimbursement. In many instances Tribal and tribal organization employees that are covered by FEHP programs may choose to see an IHS or Tribal health provider. In these instances where an IHS or Tribal health program provides such services they should also be eligible to receive reimbursement for reasonable charges associated with providing this care.

There are many reasons why a tribal employee may choose to seek care from an IHS or tribal health provider. Most often it is associated with the fact that the IHS system is the medical home for many tribal employees who have an established relationship with their provider. In most instances, the IHS system provides more culturally competent health care, which is important to most Tribal employees. They may also be geographically isolated from the provider network of the insurance program and seeking care through the IHS system is more accessible. It is noted that not all health services can be provided by the IHS system and employees will continue to rely on the FEHP insurance program's provider network.

To avoid any disagreements with reimbursements to IHS or tribal health providers, it would be most effective if OPM establishes a formal policy with the insurance programs participating in the FEHP to be required to reimburse IHS and Tribal providers when they provide care to beneficiaries covered by their products.

Fiscal Intermediary & Administrative Fee

Your October 5th letter indicates that "tribes and urban Indian organizations" will purchase coverage directly from OPM through a fiscal intermediary. Again, we believe that the omission of "tribal organization" was accidental and that this provision applies to employees of "tribal organizations" under the definitions of the ISDEAA.

While we understand the need to establish a separate administrative entity, in this case a Fiscal Intermediary, to coordinate implementation of this provision and the need to charge an "administrative fee" to cover costs of implementation, we do not believe the law provides for OPM to do so. The employees that will be covered by this benefit would normally be employees of the federal government. If this same benefit was provided on behalf of those governmental employees there would not be an administrative fee or the need for a separate fiscal intermediary. This responsibility would be assumed by the OPM. ISDEAA agreements are unique and distinct and are not normal procurement instruments

that the federal government uses to obtain goods and services. They are agreements that allow Tribes and tribal organizations to "step into the shoes" of the federal government to carry out the United States' responsibilities under the federal trust relationship..

We are not aware of an administrative fee that OPM charges the BIA or IHS for administering their health benefits. These costs are included in calculating the premiums that are paid by the employer and employee. It is our position that OPM must internalize the costs associated with administering benefits of Sec. 157. We do believe it a good idea to establish an office within OPM to administer the functions that might be served by a fiscal intermediary. However, we also believe that establishing this responsibility outside of OPM will only serve to complicate implementation and cause undue burden and costs.

If there are inter-departmental or inter-agency assessments associated between OPM and HHS, IHS, or BIA, we would request further discussion around how these assessments are conveyed. It is likely that such assessments might be considered a residual function[2] of the BIA or IHS and such administrative costs might be retained in the budgets of the BIA or IHS. Thus, such administrative costs might already be covered by any assessments that HHS, IHS, or the BIA provides to OPM.

Implementation & Enrollment Periods

The amendments to reauthorize the IHCIA became effective on March 23, 2010, the date of enactment of the Affordable Care Act. We understand that implementation will not occur immediately and that a reasonable amount of time must be permitted to work out administrative procedures for implementation. We recommend that once the administrative process is developed for implementing Sec. 157, that OPM allow a one-year open enrollment period for Tribes, tribal organizations, and urban Indian programs to transition from their current contract health plans to this new benefit. Thereafter, the open enrollment period could resort back to the regular contract enrollment period of the various FEHB plans.

The contract enrollment periods for Tribe and tribal organization health plans will vary across the system. The challenge for Tribes and tribal organizations will be to align existing coverage options with the enrollment periods of the FEHB program. There could be overlap with employees covered by more than one insurance program, or there could be a lapse in health coverage while employees wait for the new contract period to begin. Neither would be financially prudent or beneficial to providing health coverage. If there was an overlap in coverage this would create confusion and costs for the beneficiaries and insurance programs to coordinate benefits. If there was a lapse in coverage Tribes might have to purchase expensive insurance binders to bridge the time between their former insurance products with the FEHP program, or go without coverage. Neither is acceptable and can be resolved by allowing a special one-year open enrollment period.

Tribal Consultation

We understand that this will be a very complicated undertaking for OPM and Tribes, tribal organizations, and urban Indian health programs. We commend you for reaching out to Indian Country to elicit

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[2] Residual is oftentimes inter-changed with Inherent Federal Functions, which stated simply are Federal Government functions which cannot legally be delegated to Indian Tribes and funding associated with these responsibilities is retained by the Federal Government.

comments on how to establish this program. It is important to underscore the fact that the ISDEAA and access granted to the FEHP program comes in recognition of the United States' treaty obligations under the federal trust relationship. This establishes a government-to-government relationship with Tribes and a foundation for Tribal consultation. The recommendations that we have included in our letter are consistent with fulfilling the requirements under the federal trust relationship. Such issues as charging administrative fees and establishing fiscal intermediaries are inconsistent with this relationship and are not unacceptable.

Because we are at the beginning of setting this system up it is important Tribes and tribal organization continue to be consulted with over the operational aspects of establishing this program. We believe this should happen directly with Tribal governments and tribal organizations and not the BIA or IHS. We do understand the agencies play a vital role within the internal discussions of federal agencies. However their role is limited to the specific authorities they are granted and further bound by the constraints of their existing system and personnel. We will always be strong partners with the federal agencies that we work with however we believe that setting this program up can best be achieved by consulting and working directly with Tribal governments. In summary, we recommend continued tribal consultation to establish the administrative process to implement this very important program.

On behalf of our forty-three Portland Area Tribes, we thank you for this opportunity to provide our comments and look forward to continue to work with OPM to carry-out Sec. 157. This provision will not only save Tribes and tribal organizations money, it will save the federal government money as well.

If you should have questions concerning our comments, feel free to contact Jim Roberts, NPAIHB Policy Analyst, at (503) 228-4185 or by email at jroberts@npaihb.org.

Thank you for your consideration!

Sincerely,

Joe Finkbonner, RPh, MHA
Executive Director

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Chehalis Tribe
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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
Quinault 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
Yakama Nation

2121 S.W. Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

SENT BY TELEFAX: (301) 443-4794 – Hardcopy via Federal Express

December 31, 2010

Yvette Roubideaux, M.D., M.P.H
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Dear Dr. Roubideaux:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal Organization that represents forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington. On behalf of our tribes, we are responding to your November 12, 2010, "Dear Tribal Leader" letter requesting input to implement the new "Memorandum of Understanding Between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS)," (hereafter "2010 MOU").

We commend the efforts of the Department of Veterans Affairs and the IHS to negotiate a new MOU for the coordination, collaboration, and resource-sharing between VA and IHS/Tribal health programs. The activities to be arranged under this agreement will improve the access to health care for many American Indian and Alaska Native (AI/AN) veterans who have served their country valiantly. As you are well aware, AI/AN men and women have the highest rate of military service of any ethnic group, and it is vital that their sacrifice is rewarded with fully coordinated and accessible health care services.

NPAIHB joins other Tribes and national Indian organizations to raise the concerns outlined in this letter. In particular we would like to stress the problems and unnecessary oversights that are apparent in this MOU which is a direct result of IHS's failure to engage Tribal representatives during the negotiation process or drafting the MOU. We want to underscore the effort made by the IHS to undertake tribal consultation on a number of other matters affecting Tribes. However in the development of this very important instrument that will impact tribes nationally, tribal consultation was completely absent. We believe the 2010 MOU could have been improved with adequate tribal consultation at the beginning of the process rather than simply seeking input in the implementation. We encourage both the Department of Veterans Affairs and the IHS to consider re-opening the 2010 MOU and making necessary revisions for its improvement.

Our comments are built on two fundamental principles. The first is that the United States has special trust responsibilities and legal obligations to AI/ANs to ensure their highest possible health status and all resources necessary to effect that policy.[1] The second is that AI/ANs who have chosen to give even more to our country by serving in the armed forces should be entitled to receive services consistent with the mission of the Department of Veterans Affairs:

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[1] Section 3 of the IHCIA, as amended by Sec. 103 of S. 1790.

> To provide veterans the world-class benefits and services they have earned – and to do so by adhering to the highest standards of compassion, commitment, excellence, professionalism, integrity, accountability, and stewardship.[2]

In our view this mission cannot be fulfilled without facilitating the enrollment of all AI/AN veterans in VA benefit programs for which they are eligible, ensuring them access to health programs that are both culturally competent and knowledgeable about their special health issues as veterans, ensuring that resources are made available to support access to care. These goals must be achieved; ensuring that they can be provides the underpinning of our analysis of the 2010 Memorandum and the comments in this letter.

RELEVANT PROVISIONS OF THE IHCIA

The 2010 MOU identifies the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. 1645 and 1647 and 38 U.S.C. 523(a), 6301-6307, and 8153, as authority. 2010 MOU, Section II. The IHCIA authority for IHS and VA to share facilities and services has been in place since 1988.[3] Although the ACA did not amend the previous authority, it addressed similar issues in the new Section 405 of the IHCIA.[4] The principal differences between the new provisions in Sections 405 and 816 are that the newer Section 405—

- expanded the participants to the authorized sharing arrangements from just VA and IHS to also include Indian Tribes and Tribal organizations[5] and the Department of Defense ("DoD");
- required consultation by the Secretary with any Indian tribes that will be significantly affected by the arrangement prior to finalizing such arrangement;
- provided for reimbursement to the IHS, Tribe or Tribal organization (hereafter "Indian health program") by VA and DoD "where services are provided through the Service, an Indian Tribe, or a Tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law";[6] and
- did not include provisions affecting certain specific Service Units and requiring certain reports to Congress.

Congress also added a new Section 407 to the IHCIA[7] regarding eligible Indian veteran services. This new section is intended to encourage collaborations between VA and IHS regarding treatment of Indian veterans at facilities of the Service and increased enrollment for services of the VA by Indian veterans. Section 407 seeks to reaffirm the goals in the February 25, 2003, Memorandum of Understanding between the VA/Veterans Health Administration and HHS/Indian Health Service" (hereafter "2003 MOU"). The principal vehicle it relies upon is negotiation of Local MOUs, which is defined to mean

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2 http://www.va.gov/about_va/mission.asp.

3 The authority was enacted as Section 716 and added to the IHCIA on November 23, 1988. It was redesignated as Section 816 on October 29, 1992, and codified at 25 U.S.C. 1680f. Section 816 was not amended by the reauthorization and amendment of Pub. L. 94-437, as amended most recently pursuant to Sec. 10221 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 ("ACA") (incorporating by reference S. 1790 as reported by the Committee on Indian Affairs of the Senate in December 2009.

4 *See*, Sec. 154 of S. 1790. Section 405 is codified at 25 U.S.C. 1645.

5 Section 405(a)(1).

6 Section 405(c).

7 *See*, Sec. 155 of S. 1790.

> a memorandum of understanding between the Secretary (or a designee, including the director of any area office of the Service) and the Secretary of Veterans Affairs (or a designee) to implement the document entitled 'Memorandum of Understanding between the VA/Veterans Health Administration and HHS/Indian Health Service'. . ..

Section 407(b)(2). The HHS Secretary is required to consult with Tribes that would be affected by the Local MOU. Section 407(d). Subsection (c)(1) appears to impose a duty on the Secretary of HHS to provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B), which defines "eligible Indian veteran" as an Indian or Alaska Native veteran who receives any medical service that is:

> (A) Authorized under the laws administered by the Secretary of Veterans Affairs; and
> (B) Administered at a facility of the Service (including a facility operated by an Indian tribe or tribal organization through a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq)) ["ISDEAA"] pursuant to a local memorandum of understanding.

Section 407(b)(1). With regard to the funding to cover expenses incurred under subsection (c)(1), subsection (e) provides that such expenses shall not be considered contract health service ("CHS") expenses and that funds appropriated for the IHS (excluding funds for facilities, CHS, and contract support costs ("CSC") shall be used.

We believe that Sections 405 and 407 are reconciled by recognizing that both VA and IHS have duties to fulfill to AI/AN veterans. Section 405 amends existing authority to share resources between IHS and VA with one very important difference –that VA is obligated to pay for services provided through Indian health programs to AI/ANs who are eligible for VA or DoD services. Section 407 restates the basic obligation of IHS to provide services to AI/ANs who are also veterans and encourages local MOUs to be developed between IHS and VA to assure appropriate services and define the IHS's funding responsibilities (and, presumably, given the language of Section 405(c), the VA's responsibility).

COMMENTS ON THE 2010 MOU.

Inclusion of Tribes and Tribal Health Programs as Partners. We appreciate the effort that IHS and VA made to develop the 2010 MOU. We are concerned, however, that Tribes and Tribal health programs were not represented in the team that undertook the work and that many provisions address the relationship between IHS and VA with no specific reference to Tribes and Tribal and urban Indian health programs. IHS is a direct service provider for fewer than half the Tribes. Even those Tribes IHS serves directly carry out certain Indian health programs and have very decided and unique views about the needs of their veterans and how they can best be met.

Since the 2003 MOU the participation of Tribes and Tribal and urban health programs in all aspects of the delivery of Indian health services has grown consistent with the intent of Congress expressed in both the ISDEAA and, more recently, in the IHCIA. ISDEAA Section 3(b) includes a commitment to establishment of meaningful Indian self-determination policy and "orderly transition

from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services." More recently, in the Declaration of National Indian Health Policy found in Section 3 of the IHCIA[8] Congress expressly imposed new policies in fulfillment of the Nation's special trust responsibility and legal obligations:

> (3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
> . . .
> (6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; [and]
> (7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

These policies cannot be achieved unless Tribes[9] are at the table during negotiations, afforded all the benefits and opportunities contemplated under the MOU, and allowed to negotiate their own sharing arrangements on terms mutually acceptable to the Tribe or Tribal health program and VA.

We are concerned that while the purpose and actions set out in the 2010 MOU are apparently intended to lead to better results for all AI/AN veterans critical players are left out. For instance in Section I Purpose there is no reference to Tribal health programs until the last sentence when there is an acknowledgement that implementation "requires local adaptation to meet the needs of individual tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and Urban Indian health programs." Although in Section IV.A.3 there is a reference to "sharing agreements" with Tribal and Urban health programs, throughout most of the 2010 MOU where specific actions are described there are no references to those health programs.

We believe that IHS should have found a way to include representatives of Tribes and Tribal health programs in its deliberations with VA. Had it done so, we believe that many of the comments we have now would have been addressed and not be left outstanding. The opportunity is not lost, however.

To relieve these concerns, we recommend that the 2010 MOU be amended to fully address the status and needs of Tribes and Tribal health programs as full partners. We recommend that representatives of Tribes and Tribal health programs be included in any IHS and VA teams that are formed for that purpose or to otherwise carry out the amended MOU. Finally on this topic, we recommend specific amendments to the MOU be considered. We are not wedded to the particular language here, but believe that the intent is more clearly expressed when shown in the context of the

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[8] As amended by Sec. 103 of S. 1790.

[9] We assume that urban Indian health programs will be submitting their own comments and do not uniformly make reference to them. Failure to include a reference should not be interpreted as an effort to restrict a provision only to Tribes and Tribal health programs unless such restriction is expressly stated.

particular provisions of the MOU. As noted above, we believe Tribal representatives should be included in a team with IHS and VA representatives to negotiate amendments to this 2010 MOU to assure that it fully reflects the changed focus from sharing only between IHS and VA to sharing among IHS, VA, Tribes and Tribal organizations.[10]

IV.A.1 amend, as follows:

> Increase access to and improve quality of health care and services to the mutual benefit of both agencies and Tribal and Urban Indian health programs. Effectively leverage the strengths of the VA, ~~and~~ IHS, Tribes, and Tribal and Urban Indian health programs at the national and local levels to afford the delivery of optimal clinical care.

If Indian health programs provided by Tribes and Tribal and urban Indian health programs are to be able to fully participate, there needs to be direct reference to them in the goals.

IV.B.3.c and d amend the reference to "VA and IHS" to read: "VA and IHS in direct collaboration with Tribes and Tribal and Urban Indian health programs,". This change will assure that the agreements reached between VA and IHS are adequate to address unique issues faced by other Indian health providers with regard to health information technology.

IV.B.5.a amend the introductory language, as follows:

> Sharing of contracts and purchasing agreements that may be advantageous to ~~both~~ IHS, ~~and~~ VA, and Tribes and Tribal and urban Indian health programs, supported by the development of

Without this amendment, the 2010 MOU may be interpreted to limit the benefits of sharing contracts and purchasing agreements only to VA and IHS directly-operated programs. This would undermine the opportunities for improving access and efficiencies in those areas where Tribes (or urban Indian health programs) are operating IHS programs.

IV.B.6.a amend, as follows:

> Support care delivered to eligible AI/AN Veterans served at VA facilities and through IHS, Tribes or Tribal health programs.

Section 405(c) expressly provides for reimbursement by VA "where services are provided through the Service, an Indian tribe, or a tribal organization . . .." The express inclusion of references to Tribes and Tribal organizations was one of the most significant changes to the statutory authority regarding sharing arrangements and should be reflected affirmatively in these provisions of the

[10] The statute uses the term "tribal organization." Following the convention of the MOU, we refer to Tribal health programs, which, of course, may be serving a single Tribe or may be serving multiple Tribes through a Tribal organization, as that term is defined in Section 4(26) of the IHCIA (as amended by Sec. 104 of S. 1790).

2010 MOU regarding development of payment and reimbursement policies and mechanisms.[11]

IV.B.12 amend, as follows:

12. To accomplish the broad and ambitious goals of this agreement through the development of a joint Implementation Task Force (to include Tribal representatives from each IHS Area) to identify the strategies and plans for accomplishing the tasks and aims of this agreement, including:
    a. Development of joint workgroups (including Tribal representatives) for both short-term and ongoing work necessary to accomplish the aims of this agreement.
    b. Regular meeting of IHS, ~~and~~ VA, and Tribal leadership at multiple levels ~~in the organizations~~ to review progress and set priorities.
    c. An annual report by IHS and VA of activities accomplished under the auspices of the agreement, which shall be submitted prior to final publication to Tribes and Tribal and urban Indian health programs for comment and which shall include the comments submitted in the final publication.

IV. insert a new subsection C, as follows:

C. To fulfill the policies of the United States, as stated in the IHCIA and ISDEAA, the VA and IHS agree to collectively and individually actively engage with Tribes and Tribal or urban Indian health programs through individual interactions and negotiations and through consultation. To assure this MOU is interpreted and implemented consistent with the policies of the United States, the following terms will apply to all provisions of this MOU.

1. A Tribe or Tribal or urban Indian health program, in its sole discretion, may include, in any sharing agreement between it and VA and/or IHS any standard, pre-approved language agreed upon by VA and IHS.

2. Neither VA nor IHS may refuse to negotiate a sharing agreement with a Tribe or Tribal or urban Indian health program because the Tribe or Tribal or urban Indian health program does not exercise the right under subsection C.1 to include "standard pre-approved language," or because such entity rejects language that would have the effect of limiting rights and authority granted it under the IHCIA or ISDEAA.

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[11] We discuss issues about reimbursement and payment in greater detail in a later section of these comments.

3. Representatives of Tribes and Tribal and urban Indian health programs shall be included in all negotiations between IHS and VA of any standard pre-approved language for sharing agreements between the IHS and VA and in other collaborative activities, such as those described in Section 7.b of this MOU.

4. Tribes and Tribal and urban Indian health programs may enter into sharing agreements among themselves (with or without the direct participation of IHS or VA) if doing so will enhance their ability to improve services to AI/AN veterans.

The reasons for the new subsection should be obvious from the content. Without provisions that reflect these points, there is substantial risk that the 2010 MOU and terms negotiated for sharing agreements between IHS directly-operated programs and VA would be read as binding on Tribes and Tribal health programs, notwithstanding the unique circumstances of the Tribes and Tribal health programs and the policies adopted by Congress to encourage Tribal program autonomy and a government-to-government relationship between Tribes and Tribal health programs and agencies of the United States.

Practically, these provisions are also important. Many Tribal health programs are using non-RPMS based electronic health records and other health information technology. Terms relevant to IHS may not be relevant to them. The IHCIA and ISDEAA grant many Tribes and Tribal health programs, and even urban Indian health programs, privileges and exemptions from laws that might otherwise generally apply. A Tribe or Tribal or Urban Indian health program should not be compelled to exchange one set of rights for another.

The proposed new C.4 is intended to recognize the fact that cooperation among Tribal and urban Indian health programs regarding services to AI/AN veterans may also expand access, particularly to specialty services.

V.A. This subsection imposes a requirement on VA and IHS to comply with applicable laws. We agree this is important, but are concerned that it may be read as if all of the laws applicable to IHS are equally applicable to Tribes and Tribal health programs. That is not the case. For instance records of an Indian Tribe (including medical records) are not Federal records for purposes of chapter 5 of title 5 of the United States Code, which includes the Privacy Act.[12] To address this concern, we recommend amending this section by adding at the end:

> To the extent Tribes and Tribal health programs are not subject to one or more of the laws applicable to VA or IHS nothing in this MOU shall be interpreted to make participation in this MOU contingent on agreeing to comply with such law or regulation.

We also note that this Section fails to include the new Section 805 of the IHCIA, "Confidentiality of Medical Quality Assurance Records; Qualified Immunity for Participants." It is codified at 25 U.S.C. 1674. We recommend that it be added to the list of laws since it provides specific protections for IHS, Tribal and urban Indian health programs.

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[12] 25 U.S.C. 450j(o)(1) and 458aaa-5(d)(1).

V.B. This subsection requires VA and IHS approval for care rendered under the MOU that is part of a study, research grant, or other test and subjects such approval on all IHS and VA research protocols. No mention is made of Tribal approval or protocols where the care is being rendered in a Tribally-operated health programs. We recommend the following amendment:

> Care rendered under this MOU will not be part of a study, research grant, or other test without the written approval of ~~both~~ IHS, ~~and~~ VA, and the Tribe or Tribal health program (as applicable) subject to all appropriate IHS, ~~and~~ VA, and Tribal research protocols (as applicable). Approval and protocols shall be applicable only to the extent that the care is provided by one of the named entities or in a program operated by one of the named entities.

V.C. This subsection requires cooperation between VA and IHS in the event of claims, complaints or suits relating to care rendered under the MOU. There is no mention of cooperation with Tribes and Tribal health programs. We recommend the following amendment:

> VA and IHS agree to cooperate fully with each other in any investigations, negotiations, settlements or defense in the event of a notice of claim, complaint, or suit relating to care rendered under this MOU. This same cooperation will be extended to Tribes and Tribal and urban Indian health programs that may be providing or receiving services under this MOU.

V.D. This subsection provides assurance that this MOU will not result in reduction of services or priorities for care "provided to the Veteran population or IHS service population." Although it may be implicit, we recommend adding "or Tribal" after "IHS" so that the protection of Tribal service populations is explicit in the MOU.

V.E. This subsection says VA to provide IHS employees with access to VA automated patient records and for IHS to reciprocate. Both are subject to applicable Federal confidentiality and security laws and policies. There is no mention of tribal health program employees who would have the same need as IHS in locations where a Tribe or Tribal organization is carrying out the IHS program. We recommend the following amendment to the first sentence:

> VA will provide IHS and Tribal health program employees with access to VA automated patient records maintained on VA computer systems to the extent permitted by applicable Federal confidentiality and security laws and policies.

We also urge that VA and IHS identify any confidentiality or security laws or policies that they believe would act as a barrier to making records available under this section of the MOU. Seamless access to health records is an important cornerstone to assuring comprehensive, consistent care for AI/AN veterans who receive some of their care in the Indian health system and some through VA.

V.F. This subsection addresses FTCA coverage. We recommend that it be amended as follows:

> The IHS and VA, which ~~Both parties to this MOU~~ are Federal agencies, and Tribes and Tribal organizations carrying out programs of the IHS and their employees are covered by the Federal Tort Claims Act, 28 U.S.C. 1346(b), 2671-2680, in the event of an allegation of negligence. It is agreed that any and all claims of negligence attributable to actions taken by IHS or VA pursuant to this MOU will be submitted to legal counsel for both parties for investigation and resolution. Claims of negligence attributable to actions taken by a Tribe or Tribal organization pursuant to this MOU will be tendered for Federal Tort Claims coverage according to applicable statutes and regulations.

VII. Effective Period. This section addresses annual review by IHS and VA. As we have commented earlier we believe Tribal representatives need to be active participants. We recommend that it be amended, as follows:

> VA and IHS, with participation by representatives of Tribes and Tribal and urban Indian health programs, will review the MOU annually to determine whether terms and provisions are appropriate and current.

Reimbursement by VA for Services Provided by an Indian Health Provider. **Section IV.B.6** of the MOU provides the barest acknowledgement and framework for fulfilling the new duty of VA to reimburse the IHS, an Indian Tribe or Tribal organization "where services are provided through the Service, an Indian Tribe, or a Tribal organization to beneficiaries eligible for services from [VA], notwithstanding any other provision of law."[13] The responsibility to provide reimbursement became effective March 23, 2010, with the passage of the ACA. To date it has not been implemented.

The failure to implement the reimbursement provision of the law is troublesome on at least two levels. First, it deprives Indian health providers of the resources necessary to expand the scope of services they can provide to AI/AN veterans. Secondly, it raises potential compliance issues. Medicaid is generally the payer of last resort, except for Indian health programs. Typically, Medicaid programs require providers to bill all other potential payers, such as Medicare and VA, prior to billing Medicaid. For example, the Alaska Medicaid program provider billing manuals spell out expressly how claims for Medicaid enrollees who are also veterans eligible for VA benefits are to be handled. It requires the provider to "[b]ill VA first and receive a formal denial (in writing) from VA or receive a Medicaid Denial Letter."[14] Failure to comply with billing requirements can lead to serious audit and compliance issues for providers, including Indian health providers.

Development of the payment and reimbursement policies should be an extremely high priority and Tribes and Tribal health programs should be involved in the effort. We recommend certain principles be considered to guide the work.

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[13] Section 405(c), 25 U.S.C. § 1645(c).

[14] Alaska Medical Assistance Program, *Physician Provider Billing Manual*, I-22 (downloaded December 28, 2010, http://medicaidalaska.com/Downloads/Providers/BillingManual_Physician.pdf.

- AI/AN veterans should have the option to obtain care from either the VA or an Indian health program. If the Veteran chooses an Indian health program, that program should be reimbursed even if the service could have been provided by a VA facility or program in the same community.

- AI/AN veterans should never be *required* to delay care or travel to another community to obtain care if there is an Indian health program provider able to provide the care, and reimbursement should be provided to the Indian health program.

  This is a critical concern given that AI/AN reservations, villages, and other communities are often extremely isolated and may not be located anywhere near a VA facility. Requiring AI/AN veterans to travel far from home to receive VA-reimbursed care is extremely costly for the VA, can exacerbate medical problems due to delayed diagnosis and care, and may be medically prohibitive altogether based on an individual's condition. Further, such geographically distant facilities will rarely, if ever, offer the kind of culturally appropriate care that AI/AN veterans require, a necessity which is specifically noted in Section IV(B)(8) of the MOU. This cultural unfamiliarity alone can result in AI/AN veterans failing to seek services through the VA system and does a tremendous disservice to our veterans.

- Reimbursement should be made by VA for services provided by any licensed or certified provider, including certified community health aides, including behavioral health aides and practitioners and dental health aides and dental health aide therapists,[15] in order to assure the availability of services to veterans living in the most remote communities and to address shortages in the number of providers.

- Reimbursement should be made for services delivered through telehealth and telemedicine applications (live and store-and-forward) in order to reduce unnecessary travel costs and provide for greater access to all levels of care in the most remote communities and specialty care in a much broader range of Indian health programs.

- Any prior authorization or other VA policies that limit reimbursement to non-VA providers should be expressly waived so long as the AI/AN veteran is obtaining medically necessary care in an Indian health program.

- Reimbursement for services provided by Tribal health programs should be made without requiring any prior agreement between the Tribal health program and the VA.

- Reimbursement should be made according to the Medicaid rates published annually in the *Federal Register* for Indian health programs. Section 401(d) of the IHCIA allows Tribal health programs to directly bill for, and receive payments for, health care items and services provided by such programs for which payment is made under titles XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.[16] Under Section 401(d)(3)(A), the Secretary shall implement any administrative changes that may be necessary to facilitate any such direct billing and reimbursement.

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[15] *See*, Section 119 of the IHCIA, as amended by Sec. 111 of S. 1790 and further amended by Sec. 10221(b) and (e).

[16] 42 U.S.C. § 1641.

These provisions, as well as sections 321(a) and 322(b) of the Public Health Service Act,[17] and Public Law 83-568,[18] invest the IHS director with the authority to set payment rates for inpatient and outpatient medical care provided by Indian health facilities for Medicare and Medicaid beneficiaries and beneficiaries of other Federal programs. These rates are published annually in the federal register.[19] As there is no authority suggesting that the VA reimbursement payments required under IHCIA Section 405(c) are meant to deviate from these carefully determined fee schedules, VA should adhere to these rates when making reimbursement payments to Tribal health programs.

Fully and immediately implementing section 405(c) will not only reduce VA transportation costs and help avoid delays in treatment, but will ultimately create significant efficiencies that will positively affect VA and Indian health providers. Ultimately, reimbursement could diminish or eliminate the need or desire for duplicative health programs and facilities between IHS and VA. Although some Tribes and AI/AN veterans may wish to maintain separate IHS and VA facilities, a decision that VA and IHS should respect, that should be the Tribes' choice, and not their burden.

Improved AI/AN Veteran Enrollment and Screening for VA Benefits and Services. A critical issue facing AI/AN veterans is their persistent under-enrollment in the VA benefits programs to which they are entitled. Stated goals of the MOU include increasing access to services and benefits, improving coordination of care, and training benefits coordinators. To combat the problem of under-enrollment and achieve the goals of the 2010 MOU, in **Section IV.B.1** actions are proposed to expand the Tribal Veterans Representative program into the Indian health system and to provide cross-training in eligibility. We endorse these improvements and appreciate IHS and VA's current efforts to further these goals and the various pilot projects and special agreements among VA, IHS, and Tribes and Tribal health programs that specifically target VA-eligible AI/ANs in order to enroll them in VA health programs. However, they are insufficient to overcome the problem. We recommend more specific actions be considered.

- VA should work with Area Indian Health Boards and Tribes to publish simplified eligibility enrollment explanations that are culturally and linguistically tailored to the Tribal member audiences. The pamphlets should clearly identify who is eligible for VA benefits, how eligibility is determined, how an eligible AI/AN veteran can apply for VA benefits, and any applicable appeals process in the event that enrollment is denied.

- VA should develop standard, uniform documentation that identifies an individual as eligible for VA benefits. Should VA policies or regulations differ between types or levels of eligibility, the documents should clearly differentiate between the different service levels. VA should also fund any necessary training that Indian health providers require to be able to quickly and accurately intake VA-eligible AI/ANs seeking services at Indian health facilities.

- VA should fund outreach and enrollment efforts by Tribes and Tribal health programs willing to carry out such activities on behalf of the VA.

- VA should provide written materials and training that can be used by AI/AN Veterans and Indian

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17 42 U.S.C. §§ 248, 249(b).

18 42 U.S.C. § 2001(a).

19 The rates for FY 2010 are found at 75 Fed. Reg. 33,890, 34,147 (June 16, 2010).

health providers to determine the range of services that VA facilities and programs provide to VA beneficiaries, as well as services that are reimbursable by VA even if performed by a third party provider. This will improve coordination of care and referral from IHS and Tribal health programs to VA programs when the AI/AN Veteran chooses the VA system for care or the Indian health system cannot provide the services needed by the AI/AN Veteran.

Cultural Awareness and Competence. "Attention to cultural issues" is certainly a first step in achieving improved cultural awareness and competence, however more is needed. VA facilities and programs where AI/AN veterans are being served need to have specific training. We recommend amending **Section IV.B.8** by adding a new paragraph, as follows:

> c. Orientation and training for VA personnel in cultural awareness and competence, preferably by members of the Tribes being served by the VA personnel.

Training and Sharing. A number of the actions proposed in Section IV are intended to promote cross-training, innovations, improvements in models of care and other practices that will support optimal care for AI/AN Veterans whether they are receiving care in a VA, IHS or Tribal health program. In addition to the cultural awareness training discussed above regarding Section IV.B. 8 of the 2010 MOU, we recommend:

- VA should provide specialized training to Indian health programs in health problems particularly prevalent among veterans, such as screening, diagnosis and treatment of post-traumatic stress disorder and brain trauma, and treatment and physical rehabilitation of veterans who have suffered physical injuries that create temporary or permanent limitations. These programs are especially important where there are behavioral health components of the AI/AN veteran's condition that affect not only the veteran, but others in the family or community.

- VA should seek training for its behavioral health providers from specialists in serving AI/ANs with mental health or substance abuse issues, including how to work with the family and community in a culturally appropriate way to provide support for the veteran and his or her family.

Temporary Assignment of Commissioned Officers to the VA. **Section IV.B.10.f** provides for temporary assignment of Commissioned Officers to the VA. We are somewhat concerned about this. While we recognize the cross-training opportunities presented in clauses i and ii, reassignment of Commissioned Officers for "service delivery," as provided in clause ii could exacerbate the staffing problems experienced in both IHS directly-operated and Tribally- operated health programs, by reducing the pool of Commissioned Officers available to provide services in Indian health programs.

Similarly, we are concerned about the standards under which assignments to VA for rapid force deployments and other Public Health Service emergency staffing may occur under clause iii. We appreciate that VA has special responsibilities to respond to regional and national public health crises. However, AI/AN populations are often particularly vulnerable due to their generally poorer health status and limited access to alternative resources for health care. Shifting Commissioned Officers away from

Indian health programs to assist VA in meeting its responsibilities may have the unintended consequence of creating other health delivery issues or leaving an Indian health program unable to respond adequately to the public health emergency. We believe such assignments should only be made after a finding by the Secretary that the health delivery needs of the Indian health program will not be compromised and that such assignments should be of time-limited duration.

Requirement for Consultation. As our substantive comments show, the implementation measures of this MOU have the potential to profoundly impact the operation of Indian health programs. As VA and IHS proceed in carrying out any specific activities identified in the MOU, these agencies should be sure to develop Tribal work groups or other processes by which Tribal representatives can actively participate in the actual development of any programs or regulations. While we appreciate the opportunity to comment on the implementation of the MOU, mere post-implementation commenting will not suffice with regard to the planning of any formal programs and policies or official regulations. Tribes and Tribal organizations and their representatives must be actively involved from the outset.

Specifically, Section IV(B)(12) of the MOU calls for the creation of a Joint Implementation Task Force to identify the strategies and plans for accomplishing the tasks and aims of this agreement. This task force should include at least one representative selected by each of the twelve IHS areas. Task force members should be included in all meetings between IHS and VA leadership involving the determination of priority areas within the MOU and any actions regarding implementation.

Finally, we recommend that VA ensure that it integrates information gathered from its various pilot and focus groups, and other such outreach programs, to help inform and guide the implementation of the MOU. While we commend IHS and VA for their collaboration, completing the goals of the MOU accomplishes little if those responsible for its administration in the various IHS areas are not engaged directly with Indian health providers and VA regarding outreach, enrollment, services, and payment.

Thank you for the opportunity to make these comments. We look forward to being able to be even more directly involved in future work between IHS and VA.

Sincerely,

Andrew C. Joseph Jr.

Andy Joseph, Jr.,
NPAIHB Chairperson and
Colville Tribal Council Member

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 Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
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Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
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Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

2121 SW Broadway Drive
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.NPAIHB.org

SENT BY TELEFAX: (301) 443-4794 – Hardcopy via Federal Express

May 20, 2011

Roselyn Tso, Acting Director
Office of Direct Service & Contracting Tribes
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Dear Ms. Tso:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization that represents health care issues of forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington.[1]

We are writing to you about the details of the Indian Health Service (IHS) FY 2011 spending plan recently provided to Congress. The FY 2010 enacted level for CSC funds is $398,490,000 with no increase provided for FY 2011. The final FY 2011 year-long continuing resolution contained an across-the-board rescission of .2%; and when this is applied to the enacted FY 2011 level it results in a net loss of $797,000. This will erode the FY 2011 CSC line item down to $397,693,000 and could mean reducing the level of CSC funds provided in Tribal contract and compact agreements.

In previous fiscal years the IHS has taken great care to mitigate the impact of rescissions on Indian Self-Determination and Education Assistance Act (P.L. 93-638) contracts and compacts. While CSC's may not be construed as funding available for direct health care services, CSC funding does affect the availability of resources for direct care. If CSC's are not funded, Tribes ultimately must cut health care services to absorb the mandatory costs covered by CSC funds. Over the last three years, Tribes have advocated vehemently about the need to fund CSCs in the budget development process, in tribal consultation and with the Congress. Tribes have made great progress with Congress to fund CSC as a priority item. From a practical policy standpoint, we would hope the Agency would be supportive of this Tribal priority and demonstrate its support for Indian Self-Determination by considering our request so that Tribal contracts and compacts would not be negatively affected in these tough budget times. While it might

[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C. §405(b), a Tribal organization is a legally established governing body of any Indian Tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

be too late to have CSCs funded by the Congress there is an administrative solution for this issue.

As we indicated previously, IHS in recent years has taken great care to mitigate the impact of rescissions on P.L. 93-638 contracts and compacts. This was addressed by first applying any available CSC funding at the Headquarters level to off-set the rescission before applying those funds to Pool 1 or Pool 3. This was a policy practice put in place to alleviate the need of reducing CSC funds in annual funding agreements with Tribes.

In FY 2010 the IHS received a substantial increase in CSC funding and over $6.8 million of that appropriation was provided to Tribes as non-recurring pre-award and startup funding. This funding does not recur to those Tribes or Areas but instead, pursuant to IHS CSC Policy, after annualizing any requests, this funding is then to be allocated by the IHS as a part of Pool 3. We estimate that after annualizing the FY 2010 requests, the IHS will have in excess of $4.0 million to reallocate to Tribes. It is our recommendation that the IHS consider using $797,000 of this funding and offset the rescission so that no P.L. 93-638 contracts or compacts are reduced. The remaining $3.2 million can still be allocated to Pool 3 and a national distribution be made in accordance with IHS CSC Policy.

We appreciate your consideration of this request and look forward to a prompt response so that Tribal programs will not have to undergo unnecessary reductions in their P.L. 93-638 contracts and compacts. If you should have any questions, please follow-up with Jim Roberts, Policy Analyst, at (503) 228-4185 or email at jroberts@npaihb.org.

Sincerely,

Joe Finkbonner, RPh, MHA
Executive Director