Northwest Portland Area Indian Health Board
Briefing Document

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization that represents health care issues of 43 federally-recognized Tribes in WA, OR, and ID. The priorities outlined in this statement have been adopted through a formal resolution of the NPAIHB delegates.

Issue: Contract Support Cost Settlements and future payments

Background: The Administration's recent actions dealing with Contract Support Costs (CSC) are fundamentally altering the nature of Indian Self-Determination and stand to reverse the most successful federal-Indian policy in the history of the United States. In June 2012, the Supreme Court ruled in the Ramah and Artic Slope tribal contracting cases, and held that the federal government is required to pay Tribes their full Contract Support Cost (CSC) funding. The Court rejected the Government's defense to their breach of contract claims, and ruled that the Government acted illegally in failing to pay Tribes and tribal contractors the full contract price due under their ISDEAA contracts. This breach covers thousands of contracts by the BIA and IHS extending back over more than 20 years. There are estimated 1,600 past year's claims affecting the IHS alone.

Rather than the IHS and BIA acting quickly to resolve these claims and to make amends to Tribes and tribal contractors who have had to litigate their claims every step of the way, the agencies have instead engaged in administrative and accounting tactics that will further delay settlement in a very slow, expensive and unnecessary accounting process. The Administration has also proposed has sought to overrule the Supreme Court's Ramah and Arctic Slope rulings by proposing damaging anti-tribal provisions in the FY 2014 appropriations and continuing resolution measures. These budget proposals are intended to eliminate all future contract claims—essentially converting mandatory bilateral contracts into discretionary unilateral grants.

The current IHS system for resolving these claims is broken. In the 16 months since the Supreme Court held the government liable for underpaying the contracts, the IHS Director has only settled 16 out of 1,600 claims. That is just 1% of the pending claims. The Administration has shown leadership in settling several historic Indian-related cases when there were no court rulings holding the government liable. These include settlement of individual Indian claims (Cobell), tribal trust claims (Nez Perce), and Indian farmer claims (Keepseagle). There is no excuse for failing to promptly settle all outstanding claims where the Supreme Court has spoken and Tribes deserve justice.

Recommendations:

Tribal leaders respectfully urge the President to take immediate corrective action so that justice can finally be done for hundreds of Indian Tribes and tribal contractors who were the victims of massive contract breaches by the United States by doing the following:

1. Appoint a Special Master to resolve all outstanding tribal contract claims pending against the IHS and BIA, so that those claims can finally be settled and paid through the Judgment Fund.
2. Direct the IHS and BIA to reconvene their CSC Workgroup who are composed are technical and legal experts on ISDEAA contracting to work with the Special Master to address accounting and to develop recommendations for settlement.
3. Consult with Tribes on settlement recommendations
4. The OMB proposal contained in the FY 2014 budget proposals should be promptly withdrawn, and the Administration should re-commit to honoring in full all tribal contracts and compacts.

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Issue: Extend Medicare-like Rates to all Medicare providers and suppliers

Background:

Beginning on June 4, 2007, all Medicare-participating and critical access hospitals that furnish inpatient hospital services are required to provide services to IHS Contract Health Service authorized patients at no more than Medicare-like rates and to accept the CHS reimbursement as payment in full for such items and services. Currently, this Medicare-Like Rate cap applies only to hospital services, which represent only a fraction of the services provided through the CHS system. This means that non-hospital based charges such as radiology, professional and physician fee charges, laboratory fees, and other non-facility based charges are not subject to Medicare-like rates. CHS programs continue to routinely pay full billed charges for non-hospital services. Other federal purchasers of health care like the Department of Defense and Veterans Health Administration (VA) do not pay full billed charges for health care from outside providers.

On April 11, 2013, the Government Accountability Office (GAO) issued a groundbreaking report that concluded that the IHS CHS program routinely pays full billed charges for non-hospital services, resulting in needless waste of government and CHS funds. The GAO Report concludes that expanding the Medicare-Like Rate Cap to cover all services purchased under the CHS program would result in hundreds of millions of dollars in savings to Contract Health Service programs across the country. The GAO Report notes that the VA has already implemented a Medicare-Like Rate for the services it contracts for outside the VA system, and recommends that Congress enact legislation that would allow the IHS to do the same. Implementing Medicare-Like rates on all non-hospital services is budget neutral to the federal government and will not cost any money. It would greatly increase the level of care that Indian health programs can purchase and provide to American Indians and Alaska Natives at no additional cost to the government.

The GAO Report found that the vast majority of IHS's federal CHS program payments were made at non-negotiated rates, and that these rates cost on average nearly 70 percent more than negotiated rates. This resulted in federal CHS programs paying non-contracted physicians two and half times more than what it estimates Medicare would have paid for the same services, and that federal CHS programs alone would have saved an estimated $31.7 million annually if Medicare-Like Rates applied to non-hospital services. These savings would result in IHS being able to provide approximately 253,000 additional physician services annually. The GAO estimates that tribal CHS programs could have saved an additional $68.2 million for services provided in 2010 alone. Thus, the combined tribal and federal CHS program savings would be $126.4 million in 2010 alone if Medicare-Like Rates had been in place for non-hospital services.

RECOMMENDATION:

Tribal leaders should request the Administration to request the Congress to introduce legislation that will extend Medicare like rates to all Medicare providers and suppliers and to support passage of the legislation.

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Issue: IHS Budget and Sequestration

Background:

The provision of health services to American Indians and Alaska Natives (AI/AN) is the direct result of treaties and executive orders that were made between the United States and Indian Tribes and over two centuries judicial precedent. This forms the foundation of the federal trust responsibility for the United States to provide for health care services to AI/ANs.

Although the Obama Administration and Congress have proven over the last few years that they are willing to take steps to address Indian health care issues, the federal government has never fully met this obligation in a manner consistent with providing health care to other Americans. The Administration must do more to meet its obligations to fully fund the urgent healthcare needs of AI/ANs. Indian healthcare is not measured in dollars but in lives. Sequestration has had a tremendous burden on Indian health programs. Due to historic and chronic underfunding, Indian health programs cannot afford to lose any resources.

Tribes are still assessing the true impact of these cuts for FY 2013 and are beginning to plan for cuts for future years if IHS is not protected from sequestration. In FY 2013, it was estimated that the IHS and Tribal hospitals and clinics would be forced to provide 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits. These figures will likely be higher when other priorities and health needs are factored. In addition, the billions in lost funding for other key health agencies, such as Centers for Disease Control & Prevention, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration will further increase the impact on Indian health programs.

The stakes are high for tribal governmental services and programs in the federal budget that support the trust responsibility. Any reductions in IHS funding to meet trust obligations to tribal nations will result in negative health impacts. Tribal leaders throughout Indian Country believe that the IHS and BIA appropriations should be exempt from the requirements of the Balanced Budget Control Act of 2011 Congress; and that at the very least IHS should be limited to the 2 percent sequestration reduction consistent with Section 256 of the BBECA, consistent with other federal health agencies and programs. Most importantly, while deficit reduction may be targeted at discretionary spending and recognizing that IHS and BIA appropriations fall within this appropriation classification, funding provided to Indian Tribes is not "discretionary" by its mere nature, and is provided in fulfillment of the United States federal trust obligations to fulfill treaty obligations.

RECOMMENDATIONS:

1. Tribes urge the President to uphold the solemn promises of the trust responsibility throughout the federal budget in FY 2015 and future years.
2. Tribes recommend that OMB and the Administration support restoring the $228 million in lost IHS funding due to sequestration in FY 2013 and base future budget increases on this base budget.

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Issue: Indian Health Service Advance Appropriations

Background:

Since FY 1998 there has been only one year (FY 2006) when the Interior, Environment and Related Agencies budget, which contains the funding for Indian Health Service (IHS), has been enacted by the beginning of the fiscal year. Late funding provides significant challenges to tribes and IHS provider budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts. Providing sufficient, timely, and predictable funding is needed to ensure the federal government meets its obligation to provide health care for American Indian and Alaska Native people.

An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. For instance, if FY 2015 advance appropriations for the IHS were included in the FY 2014 Interior Appropriations bill, those advance appropriations would not be counted against the FY 2014 funding allocation but rather would be counted against the FY 2015 allocation caps. It would also be counted against the ceiling in the FY 2015 Budget Resolution, not the FY 2014 Budget Resolution. To begin the process, there would be an initial two year transition appropriation contained in the year in which the bill was enacted (for instance, FY 2014 and FY 2015). Thereafter, Congress would revert to making appropriations on a one year advance cycle. If IHS funding was on an advance appropriations cycle, tribal health care providers, as well as the IHS, would know the funding a year earlier than is currently the case and would not be subject to Continuing Resolutions.

Healthcare services directly administered by the federal government, such as the Department of Veterans Affairs, are funded by advance appropriations to minimize the impact of late and, at times, inadequate budgets. The decision of Congress to enact advance appropriations for the VA medical program provides a compelling argument for the effectiveness of advance funding a federally-administered health program which could easily be applied to the IHS. Beyond the efficiency inherent to advance appropriations, providing timely and predictable funding helps to ensure the federal government's Trust responsibility if carried out.

In October 2013, Rep. Don Young (AK) and Rep. Ray Lujan (NM) introduced H.R. 3229; and Senators Lisa Murkowski (AK), Mark Begich (AK), Brian Schatz (HI), and Tom Udall (NM) introduced S. 1570, both bills would amend the Indian Health Care Improvement Act to authorize a two year appropriation fo the Indian Health Service.

RECOMMENDATIONS:

1. Request the Administration to meet with Tribal leadership to address any concerns they may have with an advance appropriation and with H.R. 3229 and S. 1570 and work with Tribes and Congress to address those concerns in order to improve the bills.

2. Tribal leaders respectfully request the Administration to support H.R. 3229 and S. 1570.