Northwest Portland Area Indian Health Board

2010 Legislative Plan

Prepared for the Second Session
of the 111th Congress

February 23, 2010

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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

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The Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization that has represented health-related issues of federally-recognized Tribes in Washington, Oregon, and Idaho for the last thirty-seven years. The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts legislative and budget analysis, interprets regulations and policy issues related to health care, conducts health research, and offers health promotion projects.

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

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

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

Indian Health Programs have achieved success despite chronic under-funding

Over 104,000 Indian people in Oregon, Washington, and Idaho receive their primary health care from Indian health programs. Nationally, over 2.1 million American Indian/Alaska Natives receive care from Indian health programs. In many areas of the country, the Indian health care provider is their only option for health care.

The partnerships forged among Congress, Tribal Governments, urban Indian health organizations, and the Indian Health Service over the last 60 years has resulted in significant improvements in the health status of Indian people. While American Indians continue to lag behind in a number of health status measurements, real progress has been achieved. Death rates of Indian people from infectious diseases, gastrointestinal diseases, and tuberculosis have decreased dramatically. In the Northwest, mortality from sudden infant death syndrome has declined significantly and other diseases have been prevented due to the increased emphasis on health promotion and disease prevention projects for diabetes, HIV/AIDS, cancer, and commercial tobacco use.

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

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Health Care Reform Recommendations

On June 2-3, 2009, in Portland, Oregon, Northwest Tribes participated in a "Roundtable on Health Care Reform Policy Options for the Indian Health System," in which Tribal leaders and health directors developed key recommendations for the Congress and the Administration as they develop national health reform legislation. Those recommendations were with the following principle:

> *There is a special legal obligations Involving American Indians: It is the policy of the nation, in fulfillment of its legal obligation to Indian Tribes, to meet the national goal of providing the highest possible health status to American Indians and Alaska Natives (AI/AN) and to provide existing health services with all resources necessary to affect that policy. Indian Tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. Because of this, Tribes must be included and consulted with in the development of any health reform legislation.*

The Northwest Portland Area Indian Health Board recommends six general policies to make sure the promise of health reform reaches American Indian and Alaska Natives across the country.

Exempt AI/ANs from mandates and penalties. American Indians and Alaska Natives have already paid for their health care coverage. Failure to acknowledge that Native people are different from other groups needing health care coverage will result in either an abrogation of the federal trust responsibility or denial of their right to fully participate in health reform. It is not appropriate to subject American Indians and Alaska Natives to the individual mandate, especially the penalty for failing to acquire or purchase health insurance. We recommend the House bill, like the Senate HELP Committee draft, expressly exempt Indians from individual mandate penalties.

Tribal government exemption from employer penalties. The employer mandate provisions must also exempt Indian tribes, as employers, from penalties. Indian tribes are sovereign nations and should not be subject to federal penalties in their roles as employers.

AI/AN people should be eligible for insurance subsidies. Permit American Indian and Alaska Natives to participate in subsidized insurance and explicitly permit tribes to pay premiums and cost sharing on their behalf. This concept is no different than how Medicare, Medicaid, CHIP, state subsidized insurance plans or employer based insurance work right now.

Portability of health care is essential. In order to guarantee portability between health insurance and the Indian health system, include language which allows an individual American Indian or Alaska Native to enroll in an insurance plan at any time without assessment of late enrollment penalties or other negative consequences. Without this protection Indian people may be denied options to which they are entitled as United States citizens. Indians should not be forced to choose between the Indian health system and other options; both should be available to them.

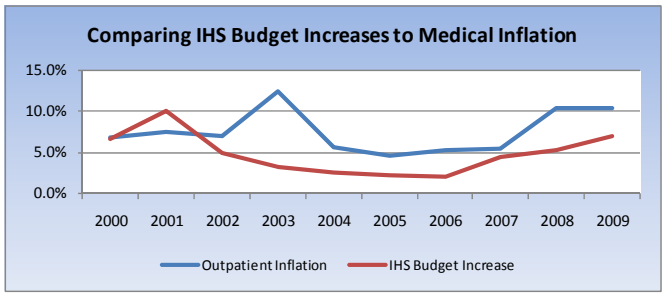
Indian Health Provider Protections. Indian health care providers, who form a crucial system of care in some of the most remote communities in the country, must be explicitly included in health reform policies so they are able to participate as network providers for health benefits plans offered through the Exchange. Indian health care providers have enormous experience with the variety of ways insurance plans

NPAIHB supports health insurance market reform so that the Indian health care delivery system is strengthened and improved so that AI/AN people benefit from the proposed reform changes. In order to accomplish these objectives, it is essential that the Administration and Congress include above fundamental protections to make health insurance market reform work in Indian Country. We urge the President and Congress to include the above recommendations.

Indian Health Service Appropriations

The FY 2011 IHS Budget Request

The President released his FY 2011 budget request includes $4.4 billion for the Indian Health Service (IHS). This marks the second year of remarkable support by the Obama Administration to fund Indian health programs. Last year's enacted FY 2010 budget included a $471.3 million increase (13.2%) increase for the IHS that began with a generous President's request. This year's FY 2011 President's request for the IHS includes a $354.1 million increase (8.7%) and will come close to maintaining current services. The Northwest Portland Area Indian Health Board estimates and recommends that an additional $111 million will be provided to maintain current services for the Indian Health Service (IHS).



Despite last year's positive increase, and the President's generous request for FY 2011, there continues to be a tremendous unfunded need for IHS and Tribal health programs. This unmet need stems from years of chronic underfunding that has plagued the IHS and Tribal health programs. It has resulted in over $6 billion in lost purchasing power due to unfunded inflation and population growth.[1] Tribes understand that this Country is in a deep recession and that it is going to take a strong commitment to fiscal responsibility to turn the U.S. economy around.

This has already begun with a freeze on non-security discretionary spending. As with the rest of America, Indian country is also dealing with the effects of the recession and in fact the economic crisis has been detrimental on Tribal communities. The economic conditions in Indian Country are among the worst found anywhere in the United States. Tribal communities do not have the same economic infrastructure or capital needed to create job opportunities and stimulate economies as the rest of the country. *Investing in Indian health programs is vital for job creation and economic growth.* On many reservations the IHS and Tribal health system is the major employer and these programs must be sustained.

[1] *NPAIHB FY 2010 Budget Analysis and Recommendations*, (p. 6-7), June 10, 2009.

Mandatory Costs, Critical Focus on CHS

In FY 2011 it is critical that funding be provided to cover all mandatory costs increases totaling $465.4 million. These include medical inflation, mandatory payroll increases, and population growth (including new Tribes). In the Northwest, where Indian health programs must purchase all inpatient and specialty care from private providers, it is particularly important that inflationary cost increases for the Contract Health Services (CHS) program be funded. In past years deferred medical and dental services in the Northwest exceeded $4 million annually.[2] CHS inflation alone in FY 2011 is estimated at $80.3 million, there is over a $300 million backlog of denied and deferred services annually in the CHS program.

Recommendation: The IHS must receive an increase of at least $465 million to maintain current services. Anything less means a cut in health care services. The costs for maintaining current services are as follows: CHS inflation $80.3 million; other health services accounts inflation $178 million; Contract Support Costs $146.1 million; and population growth $60.4 million.

Full Funding for Contract Support Costs

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

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

Support Costs to support the administrative functions of running Tribal health programs.

The FY 2002 began an erosion of the CSC base budget line item due to the lack of adequate inflation increases requested by the Administration and the effect of budget rescission imposed by the Congress. The result of this is that over a five year period, the CSC budget lost funding in three of those budget years due to lack of increases and the effect of rescissions. In FY 2009, there was actually less CSC funding than there was available in FY 2003. Because of this, Tribes are appreciative to the $115 million CSC increase that was provided in FY 2010.

Because of the considerable program increase that was provided in FY 2010 appropriation, and the fact that Tribes administer over one-half of the IHS program under P.L. 93-638 contracts and compacts, it has driven up the need for additional CSC funding needed in FY 2011. This is compounded by the fact that IHS has never provided 100% of CSC funds needed. The Supreme Court has held that the IHS is responsible to fund 100% of a Tribes CSCs associated with carrying out P.L. 93-638 contract and compacts and when CSCs are not funded Tribes invariably have to reduce the levels of health care to absorb these unavoidable costs.

The estimated IHS-CSC shortfall will be approximately $146.1 million in FY 2011. This year's allocation will continue the pattern of under-funding this vital resource. Congress should appropriate adequate contract support cost funds to eliminate this ongoing shortfall. This continuing shortfall threatens to pit Tribe against Tribe as mature contractors are asked to absorb all inflationary increases in order to fund new contractors. Some Tribes are told they will receive no contract support cost funding if they take over new programs because their level of funding is greater than that of new contractors. As a matter of federal contracting principle, tribal contractors, like all other government contractors, should be promptly paid in full—payments not dependent on the politics of the budget process, the competing agency demands in OMB, or the willingness of tribal contractors to litigate.

Recommendations: (1) NPAIHB recommends a $146.1 million increase in the appropriation for contract support costs; (2) The Department and IHS need to press OMB to increase the President's budget request for contract support cost funding; and (3) NPAIHB supports a financing plan by the Administration to reduce completely the IHS CSC shortfall over a three year period, by providing $75 million a year in FY 2011, FY 2012, and FY 2013.

Office of Self-Governance

Six years ago, Congress reduced the Self Governance line item by $4.7 million, a loss of 43% from the previous year. The final enacted FY 2010 budget for the Self-Governance program is $6 million; a slight increase of $62,000 over last year. This is significantly less than the $9.8 million that this program was once established at and not enough to provide the levels of support for continued expansion of Self-Governance programs. The FY 2011 request only provides a $135,000 increase and is not enough to cover the costs of administering these programs. The Self-Governance office supports compacted Tribes operating programs under the Tribal Self-Governance Amendments of 2000. This law, P. L. 106-260 established compacting as permanent, under the new Title V of P. L. 93-638. The Self-Governance process serves as a model program for federal government outsourcing, which builds Tribal infrastructure and provides quality services to Indian people. It is estimated that Tribes operate $1.7 billion, or 54% of the total IHS budget, and it is imperative that they receive the necessary resources to develop and build their administrative infrastructure and allow for new and expanded programs.

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

Permanent Funding for the Northwest Tribal Epidemiology Center

Tribal Epidemiology Center programs were authorized by Congress as a way to provide significant support to multiple Tribes in each of the IHS Areas. The President's budget requests an adequate increase of $138,909 (8%) to cover the increased expense of operating twelve Epidemiology Centers. The twelve Epidemiology Centers provide critical support for tribal efforts in managing local health programs. Data generated locally and analyzed by Epi-Centers enable Tribes to evaluate tribal

and community-specific health status so that planning and decision-making can best meet the needs of their tribal membership. Immediate feedback is provided to the local data systems which leads to improvements in Indian health data overall.

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

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

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

The President's FY 2011 budget proposes to increase alcohol and substance abuse funding for the IHS by over $11.3 million. This increase is to be commended, however, more needs to be done to address the behavioral health needs of tribal communities. The circle of violence, depression, and substance abuse continues to plague tribal communities. The cost for treatment of alcohol and substance abuse is increasing at a rate that exceeds the availability of funds. Local tribal treatment centers and alcohol and substance abuse programs are forced to adjust priorities as a result. American Indian/Alaska Native communities are not receiving the latest information about "best practices" in the alcohol and substance abuse field. Without a system to share information from community to community, the development of effective models is more difficult. Tribes are active in this effort, but miniscule funding increases have made improvements difficult. Tribes want to address all forms of addictive behavior including gambling.

Methamphetamine use is on the rise throughout Indian Country resulting in tremendous costs to the Indian health care system. Studies show that to be effective Tribes pay for 180-day quality inpatient treatment and provide significant aftercare treatment. The IHS has initiated an initiative that provides $16.4 million to combat methamphetamine and suicide issues, however in FY 2011, the President's budget does not provide an increase for this very important program.

There is only one program in the Northwest that provides methamphetamine related treatment for adults. Likewise services for youth are also extremely limited. Tribes have identified substance abuse funding as a high priority, yet the Board has not achieved the success it would like in obtaining funds for behavioral health programs. The increase of Dual diagnosis patients necessitates a combination of mental health and alcohol treatment services. There must be a larger appropriation for these services. An increase in mental health programs provides the best hope in reducing the epidemic of suicides in Indian country. There must be more funding for Indian health programs to increase their aftercare rehabilitation services. Inter-agency transfers should be coordinated between the IHS and other HHS agencies that have responsibility for addressing alcohol and substance abuse concerns.

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

Recommendation: The Congress must appropriate additional funding in the amount of $100,000 for the IHS alcohol substance abuse line item if we are to make a difference.

Health Facilities Construction Funding

Funding for Joint Venture Facility Construction and Small Ambulatory Care Projects

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

construction dollars unless they are one of the facilities on the current list.

The commitment of Tribes to use their own resources and non-IHS resources to construct facilities with the commitment of Congress to staff and equip the facility provides an opportunity to address the critical facility construction needs of Indian health programs with the costs shared by Congress and Tribes. Northwest Tribes have joined with Tribes from around the country to advocate for the joint venture program as one way to supplement the under funded facilities budget. Congress should continue to support tribal joint venture and small ambulatory clinic projects and allow for staffing packages. The Board, along with the IHS Portland Area Office, has developed an innovative method for small facility construction that should be promoted with funds from the Indian Health Service budget.

Despite over $481 million being recommended in the IHS budget formulation process for facilities construction, very little funding has been provided consistent with the Tribal consultation recommendations. In FY 2011, the IHS budget consultation recommendations included $281 million for facilities construction, $60 million for the Joint Venture program, and $140 million for an Area Distribution Fund. Northwest Tribes have received little funding consistent with what other IHS Areas have received for facilities construction and urge the Congress to support alternative forms of construction including funding an Area Distribution Fund.

Portland Area Tribes have been very innovative in developing alternatives for facilities construction. The Portland Area IHS, with oversight by a Tribal advisory committee, has recently completed a Pilot Study to evaluate the means for determining the demand for regional referral centers in the IHS system. This effort is consistent with the objectives of bring reform to the IHS system that the new IHS Director has embarked.

The Pilot Study concludes that the demand for a Regional Specialty Referral Centers, when strategically placed, to offer specialty care, diagnostics, and ambulatory surgery care are economically feasible and should be further explored and funded. This effort demonstrates the viability of Regional Specialty Referral Centers using a "market erosion" methodology that factored user-population data of participating Tribes, reasonable travel distances, health care competitors (providers), and economics of payer groups to derive utilization rates for a regional specialty referral center. The Study further recommends that a demonstration project be completed in the IHS.

Recommendation: (1) If Health Facilities construction funding is provided, 50% should be directed to establish an Area Distribution Funds, and; (2) $4 million be provided out of the Facilities Construction budget to for planning, site surveys and selection, architectural and engineering design, and to assist in developing a governing structure for the regional specialty referral health facility.

Medicare, Medicaid, and SCHIP

CMS Programs

In 1976 Congress authorized Medicare and Medicaid (CMS) payment for services delivered in Indian health facilities (whether operated by the IHS or Tribes) through amendments to the Social Security Act made in the Indian Health Care Improvement Act of 1976 (P.L. 94-437) (IHCIA). The statutory language clearly indicates that Congress intended Indian health programs to access Medicaid and Medicare revenues. This funding was expected to provide critical resources to improve the quality of health care for AI/ANs to reduce existing disparities and facility deficiencies.

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

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

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

Moreover, Congress acknowledges the Federal trust responsibility for Indian health on a continuing basis through annual appropriations to the Department of Health and Human Services for the operation of Indian Health Service programs. In FY 2010, a total of $4 billion was provided for health services in Indian Country. This budget is supplemented by $734 million collected by Indian health programs from Medicare, Medicaid and other third-party insurance sources. By including Medicare and Medicaid collections in the IHS appropriations, Congress expects that these resources will be available to IHS and Tribes in order to provide health services to American Indian and Alaska Native people.

Medicare

It is estimated there are over 120,000 American Indians and Alaska Natives over the age of 65 years. Many of these elders live in rural areas and rely heavily upon federal and tribal assistance for housing, health care, and transportation. Medicare is an important program for health care to many of these Indian elders and an important funding source for IHS programs. There continues to be a number of unresolved issues stemming from the passage of the Medicare Modernization Act (MMA) and the DRA that have had an adverse effect on Indian elders. These issues must be resolved so that Indian elders can participate equally as other Americans in this important health program.

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

Recommendations: (1) CMS must continue to work with the Tribal Technical Advisory Group to develop regulations to improve Indian participation in the Medicare Part D program; (2) Congress should introduce legislation to allow Tribal resources to be applied to "true out-of-pocket" (TROOP) costs and be applied toward

catastrophic coverage (i.e. donut-hole) and exempt Indians from Part D cost sharing requirements.

Medicaid

Congress provided the states with $87 billion in Medicaid assistance as part of the economic stimulus package. This aid will increase the federal matching assistance percentage (FMAP) and will target states with particularly high unemployment rates. The FY 2011 President's Budget proposes to provide this increased match rate to States through June 2011, providing an additional $25.5 billion in Federal support to States.

This is very important for IHS and Tribally operated health programs as Medicaid reimbursements provide additional funding to provide health services to their members. Unfortunately, during tough economic times states often cut health services as a cost savings measure to balance deficit budgets. This is an important point to make since states receive 100% FMAP for Medicaid services provided in an IHS or Tribal facility. The costs of providing health care to an AI/AN in a IHS or Tribal facility does not cost state governments any money whatsoever.

In 1976, Congress amended the Social Security Act to authorize Medicare and Medicaid payments to Indian health programs. When Congress provided this authority, its intent was clear: to enable AI/ANs *full access* to Medicare and Medicaid benefits in health programs operated by the IHS and Tribes, to enhance the quality of care provided, and to improve the substandard conditions of Indian health facilities. In light of these circumstances, the federal government must do more to encourage states to expand services for AI/AN people. The expectation of full and fair access to programs operated by the Centers for Medicare & Medicaid Services (CMS) has not been realized because policies have failed to include mechanisms needed to make Medicare and Medicaid work in the unique Indian health delivery system.

To address the issues above, the CMS Tribal Technical Advisory Group (TTAG) developed the *CMS 2010-2015 American Indian and Alaska Native Strategic Plan* with the goal of improving AI/AN access to Medicare, Medicaid, and State Children's Health Insurance Programs (SCHIP), while supporting the vital role Indian health programs in their delivery of health services. This strategic plan provides five goals to improve CMS Tribal consultation, policy and regulatory recommendations, increase access to Medicare and Medicaid, improve data to evaluate AI/AN participation in CMS programs, and establish and improve long term care services in Indian Country.

Recommendations:

(1) CMS should work with the TTAG to implement the recommendations included in the *CMS 2010-2015 American Indian and Alaska Native Strategic Plan;* (2) Those recommendations that cannot be implemented administratively by CMS should be addressed by the Congress.

Legislative Priorities in the 111th Congress

Indian Health Care Improvement Act

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

On February 5, 2008, the full Senate passed legislation to reauthorize the Indian Health Care Improvement Act (S. 1200) by an overwhelming vote of 83-10. Subsequent bills have been introduced in the 111th Congress. A bill in the House (H.R. 2708) has introduced by Rep. Frank Pallone and Sen. Byron Dorgan has worked to get a bill (S. 1790) passed out of the Senate Indian Affairs Committee. As the House and Senate have worked to pass their health reform legislation, each chamber has included a number of provisions from the IHCIA legislation, while not entirely H.R. 2708 and S. 1790. Many important provisions that modernize the Indian health care systems were contained in the health reform bills as well as important Medicare, Medicaid, and SCHIP provisions that extend services to Indian people.

Recommendations: (1) Since the IHCIA has yet to be reauthorized, all of the IHCIA programs and funding should be continued by Congress; (2) Senate and House leadership should immediately pass the IHCIA as part of the larger health reform legislation, and; (3) if the IHCIA does not move on the health reform legislation, Congress should immediately move to pass the legislation in the 111th Congress as a stand-alone bill.

Title VI Self-Governance Legislation

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

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

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

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

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

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

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

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

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

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

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

Other Health Priorities

Special Appropriation for Northwest Regional Youth Treatment Program

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

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

Long Term Care (LTC) and Elder Issues

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

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

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

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

Veterans Health Issues

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

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

Regional Referral Specialty Care Centers

Portland Area Tribes have been very innovative in developing alternatives for facilities construction. The Portland Area Tribes have recently completed a Pilot Study to evaluate the feasibility of regional referral centers in the IHS system. This effort is consistent with the IHS Directors initiative to bring reform to the IHS. The Pilot Study concludes that the demand for a Regional Specialty Referral Centers, when strategically placed, to offer specialty care, diagnostics, and ambulatory surgery care are economically feasible and should be further explored and funded. This effort demonstrates the viability of Regional Specialty Referral Centers using a "market erosion" methodology that factored user-population data of participating Tribes, reasonable travel distances, health care competitors (providers), and economics of payer groups to derive utilization rates for a regional specialty referral center. The Study further recommends that a demonstration project be completed in the IHS.

Recommendation: Request the appropriations committees include $3.4 million for planning and design of regional referral specialty care center demonstration project in the Portland Area.