RESOLUTION # 11-04-03
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 287-07-11
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

Support for an Actuarial Analysis of the IHS Hospital & Clinics and Contract Health Service Programs to determine the equity of health care services provided across the Indian Health System

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization under P.L. 93-638 that represents 43 Federally-recognized Indian tribes in Oregon, Washington and Idaho and is dedicated to assisting and promoting the health needs and concerns of Indian people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California; is a tribal organization in accordance with Public Law 93-638, is a statewide tribal health organization representing 31 Federally recognized tribes in 21 counties through its membership of 12 Indian Health Programs throughout California's Indian Country; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of Indian people; **AND**

WHEREAS, the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member tribes; **AND**

WHEREAS, Indian Health Services (IHS) facilities and resources continue to be uneven among the twelve IHS Area Offices and is a longstanding concern among those Tribes that receive an uneven distribution of resources relative to the rest of the IHS system and which results in disparities in the level of health services available to Indians from Contract Health Service (CHS) dependent areas; **AND**

WHEREAS, at least three General Accounting Office (GAO) studies[1] have documented that the health service disparities across the Indian health system are due to the fact that a broader array of on-site services at hospitals compared with health centers increase the overall availability of health care services and that many routine types of services are not available in CHS dependent Areas; **AND**

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[1] See General Accounting Office Studies, "IHS Health Care Services Are Not Always Available to Native Americans", GAO-05-789, August 2005;IHS Basic Services Mostly Available; Substance Abuse Problems Need Attention", GAO/HRD-93-48, April 1993, and; "IHS Not Yet Distributing Funds Equitably Among Tribes", GAO/HRD-82-54, July 2, 1982;

WHEREAS, this disparity in the levels of care across the IHS system is the result of a decades old construction process that prioritizes large populations in remote areas over small populations in mixed population areas and the fact that IHS allocations are based primarily on the level of funding each area received in previous years, with the largest portion of the budget dedicated to clinical services delivered through the IHS hospitals and clinics budget line item, which for this reason, provides a greater proportion of IHS appropriations for distribution at direct-care facilities and less funding to those IHS Areas that are considered to be CHS dependent; **AND**

WHEREAS, the core issue related to the disparity in the levels of health care services is that IHS hospital level care can substitute for CHS purchased services in some Areas but not in others, yet the annual distribution of CHS funds does not effectively take this fundamental exchange into consideration in resource allocation in the IHS system; **AND**

WHEREAS, in many instances where hospital level care is substituted for CHS purchased services those facilities can often generate additional third party revenue from Medicare, Medicaid and other private insurance, which further contributes to the disparity in the levels of health care services; **AND**

WHEREAS, this problem and the resulting reductions in access to care will continue as long as access to CHS funds are considered in isolation from access to directly provided hospital level care and the impact of this problem will be further compounded under the Affordable Care Act for CHS dependent Areas as more American Indian and Alaska Natives obtain health coverage under Medicaid expansion or qualify for insurance subsidies; **AND**

WHEREAS, the CHS Workgroup appointed and charged with reviewing input on how to improve the CHS program and address funding issues failed to recognize the funding dichotomy between the levels of health care services provided through hospitals and clinics resources compared to the levels of care and financing delivered through the CHS program and refused to address resource allocation issues associated with these facts due to the political volatility of the issues; **AND**

WHEREAS, in order to address access to care issues associated with varying levels of health service capacity and infrastructure the IHS Director should commission an actuarial analysis of the IHS hospital and clinics and the CHS programs to collect data evaluating the levels of care provided, which can be used to design a distinct benefit package for the Indian health system, which in turn can be used to measure health services and funding parity; **AND**

WHEREAS, such analysis will measure the ability of IHS operating units to provide a uniform level of health services and can be used to measure resource deficiencies in the hospital and clinics and CHS budget line items in order to improve IHS funding allocation policies.

THEREFORE BE IT RESOLVED, that we do hereby recommend that the IHS Director commission an actuarial analysis of the IHS Hospital & Clinics and Contract Health Service Programs to determine the equity of health care services provided across the Indian Health System and use the findings to improve IHS resource allocations for health services.

BE IT FURTHER RESOLVED, that the Senate and House Interior Appropriations Committees, the House Resources Committee, and the Senate Committee on Indian Affairs should all direct the IHS Director to undertake this study to address the inconsistent levels in access to health care services and to improve health service parity in the Indian health system.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of Northwest Portland Area Indian Health Board and California Rural Indian Health Board (***NPAIHB*** *vote* 25 *For and* 0 *Against and* 0 *Abstain;* ***CRIHB*** *vote* 20 *For and* 0 *Against and* 0 *Abstain*) held this 21st day of July 2011 in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
527 SW Hall, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD
4400 Auburn Blvd, 2nd Floor
Sacramento, CA 95841
(916) 929-9761

Chairperson of the Board

Attest