Northwest Portland Area Indian Health Board

2004 Legislative Plan

Prepared for the Second Session
of the 108th Congress

February 11, 2004

February 11, 2004

The Northwest Portland Area Indian Health Board is a tribal organization that for the past 31 years has represented the federally recognized Tribes (currently 43 Tribes) in Washington, Oregon, and Idaho on health-related issues. The Board facilitates consultation between Northwest Tribes and the Indian Health Service and state agencies; provides information to Tribes on legislation, federal budget matters, regulations and policy related to health care; and conducts health research and health promotion projects with Northwest Tribes.

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

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

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

Indian Health Programs have achieved success despite severe underfunding.

Over 93,000 Indian people in Oregon, Washington, and Idaho receive primary health care from Indian health programs. Nationally, over 1.6 million American Indian/Alaska Natives receive care from Indian health programs and, in many areas of the county, the Indian health care provider is the only health care available. The partnership forged among Congress, Tribal Governments, urban Indian health organizations, and the Indian Health Service over the last 50 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 fallen dramatically. In the Northwest, mortality from sudden death infant syndrome have declined significantly and other diseases have been prevented due to strong emphasis on health promotion and disease prevention projects for diabetes, HIV/AIDS, cancer, and tobacco.

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 at its best can accomplish.

Table of Contents

Status of FY 2004 Indian Health Service Appropriation

The $72 million increase for the FY 2004 IHS budget will not even cover the costs of pay act increases, nor the approved staffing for new facilities. The constant under-funding of the IHS continues to erode the agency's base-budget and impacts the ability to provide health care services to American Indian and Alaska Native people. Tribes are concerned about maintaining current services. Funding increases that do not cover inflationary costs and modest program expansions mean a cut in health services to Indian people.

The President signed the Interior Appropriations Bill (H.R. 2691) into law on November 10th, (P.L. 108-108). The Bill provided $2.96 to the IHS for FY 2004, an increase of $108.5 million over the previous year's enacted level. The Bill included a provision imposing a .646% across the board rescission or a $19.1 million cut to the IHS budget. On January 22, 2004 Congress passed the FY 2004 Omnibus Appropriations bill (H.R. 2673) that imposes another rescission of .59% on non-defense discretionary programs. The second rescission will result in an additional cut of $17.3 million to the IHS budget. This translates into a net increase of only 2.5% over the FY 2003 spending level.

FY 2005 Indian Health Service Budget

The President's budget request proposes an increase of just 1.6% for FY 2005. Since 1993 the IHS has absorbed approximately $2.2 billion in mandatory costs increases. This year's $45.6 million increase would leave another $351 million in unfunded mandatory costs. This lost purchasing power has lead to the diminishment of medical services to American Indians/Alaska Natives putting their health and lives at risk.

Indian health programs are facing ever-increasing costs. Medical inflation in the Northwest exceeds 10%. Providing services to over 1.6 million patients residing in primarily rural areas, Indian health programs do not realize the same level of cost savings that managed care achieves in urban areas and costs continue to rise for Tribal health programs. U.S. increased spending for prescription drugs alone averaged 14% annually from 1997 to 2002 (Source: CBO). It is unfair to freeze the IHS budget while allowing inflation and population adjustments for other federal health programs such as Medicaid and Medicare. Medicaid expenditures grew by 14% in FY 2002 and by 9% in 2003 (well IHS was 'frozen' at 2.5%). Medicaid is predicted to grow 7.2% annually from 2004 to 2014; Medicare by 9% annually. The Board, through the leadership of former Chair Julia A. Davis-Wheeler, as lobbied over the years to make Indian Health an entitlement in order to make these annual adjustment for inflation automatic.

Health Care programs make an important contribution to tribal economies. Health care jobs are typically 2 or 3 in importance in terms of payroll and number of employees on any reservation. While tax reductions do little for the average tribal member, funding for health care programs creates jobs and, more importantly, creates healthy tribal members who can keep the jobs they have. Tribes are very concerned about preserving their basic health care programs.

Recommended Action: (1) Fund IHS at a level to cover mandatory costs of inflation, population growth and administration; and (2) We request that the Congress and the Secretary recognize that one of the fastest growing populations in the U.S., with the greatest health care needs, should receive similar increases as other agencies within the Department.

Mandatory Costs, Critical Focus on CHS 2005

In FY 2005 it is critical that funding be provided to cover all mandatory costs increases totaling $397 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 program be funded. In past years deferred medical and dental services in the Northwest have been as much $4 million annually. This must not be allowed to happen again.

Recommendation: At a minimum, the IHS needs to receive this amount of funding just to maintain current services. Anything less means a cut in health care services. The costs for maintaining current services are as follow: CHS inflation $59.8 million; health services accounts inflation $161.8 million; facilities inflation $15.7 million; contract support costs $100 million, and; population growth $59.8 million.

Reauthorization of the Indian Health Care Improvement Act (IHCIA) PL 94-437

The Indian Health Care Improvement Act, along with the Snyder Act of 1921, serve as the policy basis for the provision of health services provided by the IHS and Tribal and urban Indian programs. Senator Campbell (R-CO) and Representative Young (D-AK) have introduced bills in the 108th Congress to reauthorize the IHCIA. The IHCIA Steering Committee has worked very closely with Representative Young's staff and House Legislative Counsel to draft H.R. 2440, which is a bill that has broad tribal consensus. Congress needs to act promptly to reauthorize this important legislation and reaffirm the federal commitment to Indian Health. If the bill is not reauthorized again in 2004, all programs should be continued and proposed programs should be considered for separate legislation.

Recommendations: (1) It is the consensus of the IHCIA Steering Committee that members of Congress support H.R. 2440. (2) If S. 556 is adopted it should incorporate the revisions contained in Title IV of H.R. 2440 in order to address previous concerns of the Administration.; and (3) It is recommended that the H.R. 2440 be scored by the Congressional Budget Office as soon as possible, and; (4) Leadership from the IHS, CMS, and others responsible for legislative review should be directed to meet with the IHCIA National Steering Committee and its technical and legal support staff to discuss any concerns the Administration may have concerning the pending legislation. It is critical to work together to identify and resolve any concerns and objections that the Administration may have with respect to the pending bills.

Elder Issues & Long Term Care

Elder issues and Long Term Care (LTC) are a growing concern for Tribes across the country. As the population of American Indian/Alaska Native elders grows, there will be 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). With deteriorating economic and social conditions in much of Indian country, elder abuse is also on the rise. Prevention programs for Tribes are desperately needed, yet no funds have ever been provided. Studies show that up to 90% of reservation families provide long-term care. The in-home care burdens are complicated and sometimes lead to increased elder abuse. Indian caregivers deal with daily diabetes management--the shots and dietary restrictions--as well as the amputations, blindness and kidney dialysis that diabetes brings. The Northwest Portland Area Indian Health Board Elders Committee has identified Elder Abuse as a growing area of concern. Northwest Tribes helped produce a video on elder abuse to assist Tribes in dealing with this issue. 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. Support of domestic violence is needed to assist tribal programs that have tried to address this issue.

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 bill each of the CMS-funded programs, but this won't happen until the IHS receives the necessary resources to develop it.

Recommendation: The IHS should be given authority to receive an appropriation to fund long-term care programs in Tribal communities.

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

More needs to be done to address the circle of violence, depression, intergenerational violence, and domestic abuse in 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. There is an increasing 'designer drug' problem for crack, ecstasy, and crank. Studies show that to be effective Tribes need to pay for 180-day treatment costs and provide transitional housing after treatment. 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 substance abuse treatment and mental health programs. Dual diagnosis patients needing a combination of mental health and alcohol treatment services would benefit from a larger appropriation for these services. Mental health programs are the best hope

to reduce the epidemic of suicides in Indian country. There must be more funding so Indian health programs can 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.

Recommendation: The Congress must appropriate additional funding in the amount of $7.6 million for the IHS alcohol substance abuse line item if we are to make a difference.

Funding for Tribal Health Information Systems

Actuarial data is not a reality within the Indian Health Service for revenue generation, cost containment, work efficiencies and benchmarking comparisons as an agency. GPRA measurements will be harder to refine utilizing present day methodologies and resources. Continuous technological improvements worldwide compound the deficiencies presently within the IHS. Information technology resources need to be addressed on the same level as health care programs.

The Indian Health Service has identified a need for $250 million in information infrastructure spending, yet the President's budget, although mentioning IT needs, does not fund them. Data collection is important to support the goals of DHHS and IHS. As tribal governments take on more responsibility for health care and welfare programs for Indian people, it is critical that they have up-to-date information and telecommunication systems to enable them to operate programs efficiently and effectively. Congress needs to recognize this need and provide funds to build and improve tribal telecommunication and information systems that support health and welfare programs in tribal communities.

Vast rural environments require frequent travel by a multitude of personnel within the IHS. Time efficiencies need to be pursued and maximized by increasing telecommunication infrastructure and expanded as a standard part of business to capture fundamental time efficiencies. The amount above is calculated at 5% of total operating costs and is consistent with--if not less than--industry standards for IT in health care.

Recommendation: The agency should be provided with $250 million to fund infrastructure necessary for developing adequate information systems.

Support for the Title VI Demonstration Project

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. This is commonly referred to as Title VI Demonstration project. A team of tribal leaders and technical and legal staff worked with HHS to design and carry out the feasibility study. This yearlong effort resulted in a report by the Secretary to the Congress finding 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 Homeland Security

There are more than 25 Indian Tribes that have primary jurisdiction over lands, on or near the Canadian or Mexican borders that comprises 260 miles of international borders. Tribes also have jurisdiction over waters that provide direct access by boat to lands within the United States. Yet American Indian/Alaska Native Tribes were omitted in the Homeland Security Act and the planning activities of many states. There is no doubt that tribal governments and tribal communities are at equal risk, and in some instances more vulnerable, to acts of terrorism than states, counties, and municipalities across this country. Indian Tribes will play a crucial role in providing for the health and safety of those who reside on tribal lands and are necessary components—very much like cities, counties, states—in developing a comprehensive system for homeland security. The Northwest Portland Area Health Board and the California Rural Area Indian Health Board (representing 79 Tribes) have passed a joint resolution recommending that the Secretary for the Department of Homeland Security establish an Indian Desk within the Department and work to implement a tribal consultation policy pursuant to Executive Order No. 13175, Consultation and Coordination with Indian Tribal Governments.

Recommendations: (1) The Congress should work to pass S. 578 and H.R. 2242 to correct the inequitable treatment of Tribes on homeland security matters created by the Homeland Security Act; and (2) The Department of Homeland Security must develop and implement a Tribal Consultation pursuant to Presidential Executive Order No. 13175.

CMS, Medicare and Medicaid

CMS has recently reversed it long-standing approval of special provision for American Indians and Alaska Natives in Medicaid programs. The agency has informed the State of Washington that it cannot exempt American Indians from copays citing violation of Title VI of the Civil Right Act. The Board has joined the state and the American Indian Health Commission of Washington State to challenge this recent ruling.

The Medicare and Medicaid programs have become an important part of funding for Indian health programs and we are pleased that the Centers for Medicaid and Medicare Services (CMS) have officially adopted the Tribal Technical Advisory Group (TTAG). For all the benefits

these programs provide, the complexity of the Medicare and Medicaid programs present operational challenges for IHS and tribal health programs. The TTAG is an advisory committee to CMS to address complex issues and improve access for Indian health programs to Medicare and Medicaid.

Our position has always been that CMS regulations should include a specific analysis of their impact on Indian health programs. The TTAG can provide this analysis. In 2002 CMS established a good working relationship with IHS and Tribes that resulted in an exemption from the requirement to use a proposed outpatient prospective payment system (OPPS). This will allow Tribes to continue to bill under the encounter rate and relieves our health programs of the burdens of setting up administrative and internal controls for implementing OPPS, which would have been very expensive. The cost savings from this exemption prevents cuts in health services to Indian people.

Medicare
Last year saw the Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This new legislation will mean sweeping changes for the Medicare program, which will undoubtedly impact IHS and Tribal health programs. The new legislation contains Indian specific provisions that will benefit Indian people enrolled in Medicare who receive services from the IHS and tribal health programs. A new expansion of the Medicare program promises not only to increase access to prescription drugs but may also increase Indian participation in the basic Part A and Part B Medicare programs. The result would be much needed resources for the under funded health program of Tribes, the Indian Health Service, and urban Indian health programs. Indian health programs need special resources and technical assistance to understand and negotiate contracts with the prescription drug plans. Some Tribes must still depend on off-reservation pharmacies for access to prescription drugs and this requires additional coordination.

Recommendations: (1) CMS must be instructed to work with the TTAG to develop regulations for implementing the new Medicare provisions often regulations are developed for federal programs without assessing their impact on Tribal programs. Working with the TTAG will avoid this mistake; and (2) The IHS and tribal health programs should be provided special resources for education, outreach, and enrollment for the new Medicare program.

Medicaid
Perhaps the single greatest threat to the viability of Indian Health Programs will be state efforts to contain costs with Medicaid programs. All three Northwest states (Idaho, Oregon, Washington) have implemented some form of benefits reduction and/or cost sharing. These cost cutting measures have had an adverse effect on IHS and tribal health programs. Costs previously paid by Medicaid will now go unpaid and Indian Health programs will suffer financially. When the Congress appropriates funds for the IHS, there is an expectation that Tribes will have access to funding provided through state Medicaid programs.

Oregon and Washington have both submitted requests to CMS to amend their state Medicaid plans in order to maintain benefits for American Indian people. In both cases, CMS has communicated that do not have the authority to make decisions on these types of matters because

they have civil rights implications. CMS' position on this issue is contrary to earlier guidance in which they have informed states and Tribes that, "...states cannot impose cost-sharing on children entitled to Medicaid," and further stating that it would no longer approve demonstration waivers that impose cost-sharing on AI/AN children, for both Medicaid and SCHIP (November 3, 2000, HCFA Tribal Leader). These types of decisions will have a detrimental effect on Indian health programs since they derive an important portion of their income from the Medicaid program. CMS decisions should be based on the government-to-government relationship and the unique health care obligation between AI/AN Tribes and the United States. This special relationship is one that is based on a "legal and political distinction" and not one based on race.

Indian people are eligible for both IHS services and Medicaid if they meet eligibility criteria. Since the IHS is the payer of last resort, many Indian people are required, often against their wishes, to enroll in the Medicaid program. The payer of last resort designation should never be used to abrogate the federal government's special trust responsibility to provide full funding for Indian health programs.

Recommendations:

1. Since this enrollment is mandatory, Indian people need to be assured of the following when they sign up for Medicaid: (a) They will not be charged premiums; (b) They will not be charged co-pays; (c) They will be able to choose an IHS program as their provider and that provider will able to collect an equitable payment for services provided, and; (d) Their estate will not be subject to Estate Recovery proceedings;
2. CMS and the Office of Civil Rights should meet with the TTAG to resolve this issue;
3. The payment methodology of the encounter rate must be preserved. There is a strong desire to continue the use of the encounter rate, but CMS insists on eliminating this simple, fair and effective payment mechanism; and
4. The Executive Branch and the Congress should grant the necessary exemptions to American Indians/Alaska Natives to insure that Medicaid programs not undermine the federal commitment to provide health care services to Indian people. Tribes support the development of a uniform benefit package for American Indians/Alaska Natives so they do not suffer from changes in state economies.

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 unnecessary causing additional 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. A recent Board meeting sponsored a veteran's health focus revealing a number of concerns by veterans in seeking services from the IHS and VA. Indian Veterans 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.

Make Cancer a National Indian Health Priority and Increase Funding for Cancer Prevention and Control Activities

The Affiliated Tribes of Northwest Indians and the National Congress of American Indians have both passed resolutions to make cancer a national health priority for Indian people. In 1997, a similar effort resulted in a Balanced Budget Act amendment providing $150 million for diabetes efforts in Indian Country. The Special Diabetes Program for Indians has since been reauthorized and provides $150 million per year for IHS and Tribal diabetes programs. Northwest Tribal leaders summon a similar effort to bring attention to cancer in Indian Country.

Cancer is the second leading cause of death for American Indian and Alaska Native people. In 1994-96, sixteen-percent of all deaths in the Portland Area were caused by cancer. Some cancer rates were once lower for American Indian and Alaska Natives, however that is not the case any longer. American Indian and Alaska Natives have the poorest survival rate from "all cancers combined" than any other racial group. National cancer mortality rates are on the decline, while American Indian mortality rates are increasing. A national response similar to that for diabetes is required to combat this leading killer of Indian people. Tribes have declared their support for sufficient cancer funding to provide treatment and control and prevention activities to meet this growing threat to the health status of Indian people. It is also believed that cancer rates are higher for Indian people due to radiation from government nuclear processing plants in the Northwest. Tribes support funding to provide for the health care needs of those people who have suffered from the impact of these activities. Indian people should not have to wait until studies are completed to receive adequate funding to meet the health care needs of people who cause of illness or disease is suspected to be from the many forms of radioactive exposure and other contaminants found in the Northwest.

Recommendation: It is recommended that $100 million be appropriated for cancer treatment, prevention, and control in the FY 2005 Department of Health and Human Service Budget.

Contract Support Costs

The President's budget does not include an increase for Contract Support Costs (CSC) for the second straight year and when the rescissions from FY 2004 are considered, the CSC line item actually has been cut by $1.6 million in the President's FY 2005 request! The Administration's request of $267 million is not adequate to fund past year's shortfalls or provide necessary resources for Tribes to assume health programs. CSC funds are required for Tribes to successfully manage health programs. The IHS has estimated a shortfall of $112 million in contract support costs. This year's allocation will continue the pattern of under funding this vital resource. Congress should appropriate adequate contract support cost funds to eliminate this ongoing shortfall. The Northwest Portland Area Indian Health Board, the Tribal Self-Governance Advisory Committee, the National Congress of American Indians, and the National Indian Health Board support full funding of contract support costs.

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.

Recommendations: (1) The NPAIHB recommends a $112 million increase in the appropriation for contract support costs; (2) The Department and IHS need to press OMB to increase the President's budget request for contract support cost funding; and (3) If large Tribes such as Navajo elect to contract or compact a special appropriation should make this possible without any reduction to existing self-determination Tribes.

Office of Self-Governance

The FY 2004 President's request attempted to restore $4.7 million to the Self-Governance account but was not successful. The FY 2004 enacted level is $5.6 million. The FY 2005 request of $5,672,000 is less than a one-percent increase and will only cover pay act increases. This 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 is an excellent method of outsourcing for the federal government, which builds Tribal infrastructure that provides quality services to Indian people. Each year's appropriations should contain funds to protect existing Self-Governance programs and allow for expanded programs by Tribes choosing to compact.

Recommendation: The Self-governance account of the IHS budget should be provided $5 million to adequately cover expanded Self-governance projects and to cover the costs of inflation in order to protect current programs.

Increase Funding for Community Health Representatives (CHRs)

Limited staff and the lack of coordinated efforts hinder the ability of Tribes to provide local communities with services related to: disease prevention, health education, substance abuse

counseling, mental health counseling, diabetes screening, etc. The long-term goal of the CHR program is to improve disease prevention in the communities. More community-based programs should be directed toward prevention and screening activities to improve the overall health of the community population. Having a designated coordinator for community and Indian Health Services activities improves services and reduces duplication of health care services. Transportation services for patients to be transported between the community and Indian Health Service activities should be improved. Community-based services for disease prevention and screening should be improved. Staffing increases would result in more patients being contacted.

Recommendation: CHRs require an annual increase $4 million just to keep pace with inflation and fund necessary training for CHRs.

Permanent Funding for the Northwest Tribal Epidemiology Center

The Tribal Epidemiology Center program was authorized by Congress as a way to provide significant support to multiple Tribes in each of the IHS Areas. The seven existing Epidemiology Centers provide critical support for tribal efforts in managing health programs. Data generated locally and analyzed by Epi-Centers enable Tribes to evaluate tribal and community-specific health status data so that planning and decision-making can best meet the needs of their tribal membership. Because these data are used at the local level, immediate feedback is provided to the local data systems which will lead 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 with activities designed to enable local Tribal sites to continue to work on projects on their own. 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. In addition, the work of the *EpiCenter* is critical to Government Performance and Results Act (GPRA) reporting requirements. The Board recommends that *EpiCenters* be funded at a level that will enable it to be a fully functional epidemiology center. There may be some merit in having an EpiCenter in each area, but this need must compete with others in the Indian Health Service budget.

Recommendation: The Northwest Portland Area Indian Health Board supports the President's request of a $2.5 million increase for Epi-Centers. Last year the Board passed a joint resolution with the California Rural Indian Health Board supporting an EpiCenter in California developed by California Tribes.

Increase Funding for HIV/AIDS Prevention Efforts

The Northwest Portland Area Indian Health Board's Project Red Talon is the only tribal effort in the Northwest to collectively combat HIV/AIDS. In the face of increasing HIV/AIDS infections among American Indians/Alaska Natives, there is a tremendous need to monitor data on the

HIV/AIDS infection rate to assure that prevention and treatment resource efforts are directed at those significant areas on and off reservations.

Recommendation: HIV/AIDs needs further funding in order to increase the awareness and prevention of this epidemic.

Increase Maintenance and Improvement Funding in FY 2005

Funding for the maintenance and repair of Indian health facilities is calculated on the basis of square footage. As new facilities have been built, M & I funding has not kept pace and Tribes have received less and less each year. The large investment (both Federal and tribal) to update medical facilities should not be jeopardized through inadequate funding. If it makes sense to build facilities, it also makes sense to maintain them. The IHS estimates over $472 million in Backlog of Essential Maintenance and Repair (BEMAR) needed for facilities.

Recommendation: It is recommended that Congress provide at a minimum, ten percent ($47 million) of this need in the IHS appropriation.

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. There are many tribal health care facilities that are not currently addressed for replacement through the current IHS Health Care Facilities Priority System. The commitment of Tribes to use their own resources and non-IHS resources to construct facilities with the commitment of Congress to staff and equip the facility provides an opportunity to address the critical facility construction needs of Indian health programs with the costs shared by Congress and Tribes. Northwest Tribes have joined with Tribes from around the country to advocate for the joint venture program as one way to supplement the under funded facilities budget.

Congress should continue to support tribal joint venture and small ambulatory clinic projects and allow for staffing packages. The Board along with the IHS Portland Area Office has developed an innovative method for small facility construction that should be promoted with funds from the Indian Health Service budget. The Joint Venture and Small Ambulatory constructions programs each received $5 million and $10 million respectively in FY 2002. Since this time, the programs have not received funding and the President's FY 2005 request again neglects this innovative program.

Recommendation: The Joint Venture and Small Ambulatory construction programs should receive an amount equal to the appropriation of FY 2002. This is $5 million for the Joint Venture program; and $10 million for the Small Ambulatory program.

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

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

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

Elevation of the Indian Health Service Director

Tribal leaders have long advocated for the elevation of the IHS Director to that of an Assistant Secretary. This position is supported by the National Congress of American Indian, the National Indian Health Board, and Affiliated Tribes of Northwest Indians and includes the support from members of Congress. The Department recently announced the re-establishment of the Inter-Departmental Council on Native American Affairs, which is co-chaired by the Administration for Native Americans Commissioner and the IHS Director. The purpose of the Council is to coordinate activities and encourage the cooperation of the Department's operating divisions in order to improve access to resources by Tribes. It has been indicated that the elevation of the IHS Director might not be in the best interest of the Tribes and that it might be more beneficial to maintain the current status of the position. This argument is centered on the re-establishment of the Council and the ability of the IHS Director to effectively advocate for IHS through his participation on the Council and working through the existing structure of the Department.

Tribal leaders believe that the elevation of the IHS Director to an Assistant Secretary level position within the Department would facilitate greater Consultation across HHS Operating Divisions and is respectful of the government-to-government relationship that Tribes have with the United States. The persistent whittling away of resources from within the Department, together with insufficient budget increases, casts doubt on the Department's ability and commitment to improve health care funding in Indian Country. It is clear the IHS does not have the same level of respect and advocacy as other agencies within the Department. The IHS Director, as an Assistant Secretary would commend the respect and advocacy necessary to bring funding to the unmet needs of Indian health.

Other Concerns

Sanitation and Environmental Surveys

Sanitation is slated for a $10 million increase in FY 2005. Environmental surveys should receive an increased appropriation to better document the need for increased funding for Sanitation. We recommend an additional $6.4 million for Sanitation.

Funding for New Tribes

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

Chemawa Boarding School

The Board supports efforts to secure additional funding to increase health care services for the Chemawa Boarding School, one of three boarding schools in operation nationwide. This school serves students from around the country who often need special health care services that the school's clinic currently does not provide. A review of its critical needs is in order and recommendations for improvements acted on before lives of our children are lost.