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August 3, 2009

The Honorable Byron L. Dorgan
Chairman, Committee on Indian Affairs
United States Senate
Washington, D.C. 205410-6450

Dear Chairman Dorgan:

We are writing to provide you with our comments and recommendations concerning the Senate Committee on Indian Affairs' concept paper in which the Committee offered ideas and proposals for reforming certain aspects of the Indian health care system.

On July 23, 2009, the California Rural Indian Health Board (CRIHB) and the Northwest Portland Area Indian Health Board (NPAIHB) held the 10th anniversary meeting of our Joint Board of Directors. Together, CRIHB and NPAIHB represent over seventy three federally recognized Tribes in the states of California, Idaho, Oregon, and Washington.

Our agenda included a discussion with Brenda Shore, Sr. Policy Advisor for the Committee, regarding the Concept Paper and recommendations from our joint Board of Directors. Generally, we are very pleased with the Committee's ideas for addressing Indian health disparities and ways to improve the quality of health care in Indian Country. We also noted additional recommendations for the Committee to consider in addressing important issues for California and Portland Area Tribes. For this purpose, we have shaped our recommendations around the seven priority areas that the Committee has organized its concept paper.

We hope you find our recommendations useful and are available to discuss any of the recommendations we present. To this end, if you should have any questions, please contact Jim Roberts, Policy Analyst, at (503) 416-3276, or by email at jroberts@npaihb.org.

Thank you for your consideration!

Sincerely,

Andy Joseph, Jr., Chairperson
Colville Tribal Council Member

NW Portland Area Indian Health Board
Recommendations to the Senate Committee on Indian Affairs
Indian Health Concept Paper issues July 6, 2009

Revised: August 3, 2009

I. Meet Indian Country Health Care Priorities

- a) Reauthorize the Indian Health Care Improvement Act (IHCIA). Reauthorization of the IHCIA means not only extending the Act, but also including Tribal recommendations to modernize and improve the Indian health care delivery system over current law.
- b) Any IHCIA reforms must address the Indian Health Service (IHS) structure so that consistent levels of primary¹, intermediate², and advanced services³ are available across the IHS system. In August 2005, the General Accounting Office (GAO) report, "Health Care Services are Not Always Available to Native Americans," concluded that the variations in the level of health care services across the IHS system meant that some Indian people were living with "deliberating conditions," in part due to the fact consistent levels of care were not provided across the IHS system. Because of the lack of inpatient facilities, these conditions tend to be worse in the California and Portland Areas since they are Contract Health Service (CHS) dependent. This means that all specialty care services that might normally be provided by IHS inpatient hospitals must be purchased under the CHS program. Because CHS funding is extremely limited, many patients may go without care. Factors that will need to be taken into consideration, but not limited to, include:
 - i. Address federal funding levels from all sources (Medicare, Medicaid, etc.).
 - ii. Account for all resources available to provide levels of care (i.e. facilities, staffing packages, reimbursements)
 - iii. Transportation factors associated with receiving care
- c) Include requirements that make the IHS accountable to Congress to implement reform changes recommended by Tribal leaders and IHS reform processes; without this mandate, IHS may not implement changes. In October 2002, an IHS Restructuring Initiative Workgroup (RIW) completed a report, "Transitions 2002: A 5-year Initiative to Restructure Indian Health," which included a number of recommendations to redesign and improve the IHS. A chapter in the RIW report titled, "Internal Restructuring Reforms," included a number of recommendations intended to streamline and improve the manner in which IHS administers its health programs. Many of the RIW concerns and recommendations were never addressed or implemented. The point here is that unless there is Congressional oversight and accountability, the IHS may not be willing to implement recommendations related to reforming and improving its bureaucracy. Congress must include this requirement.
- d) Include administrative and management improvements that address:
 - i. Recruitment and retention issues of health care professionals

¹ Primary Care Services: includes ambulatory, screenings, diagnostic and treatment services, basic preventive care, covered medications, some dental services, and some mental health and behavioral health services.

² Intermediate Services: includes professional services, more advanced ambulatory care screenings, diagnostic and treatment services, vision, hearing, physical therapy, orthopedic, and both non-complex ambulatory and inpatient surgery.

³ Advanced Services: includes complex and highly specialized diagnostic, surgical, and treatment services. These could include transplants and other sophisticated surgery treatments.

- ii. Inefficiencies associated with the IHS human resources system that hamper recruitment/retention. The grievance processes associated with federally operated sites result in a tremendous administrative burden and costs for those health programs directly operated by the IHS. This in turn has an affect on the quality of care that those Tribes receive. These issues are intrinsic with the Office of Personnel Management and IHS operated systems – consider providing IHS with an exemption of OPM requirements.
- iii. Expense associated with having health care professionals carrying out administrative and management functions. The IHS system has many health care providers serving as administrators and managers. This translates to higher costs of operating health care systems and contributes to health professional shortages. While some of these functions require a clinical background, many do not, and these health providers should be seeing patients. In many instances when Tribes have assumed programs under P.L. 93-638, they have been able to reassign these positions with comparable and effective managers and administrators, which have translated to substantive cost savings.
- e) Allow access to the Federal Employer Health Benefit Plan (FEHBP) for tribes carrying out governmental functions under the Indian Self-Determination and Education Assistance Act (ISDEAA). When Tribes step into the shoes of the federal government to carry out health programs that are normally managed by the IHS, they should also be able to purchase administrative requirements, like health insurance, at the same rates as the federal government. Tribes are carrying out federal responsibilities, and when they must purchase administrative requirements at a higher cost, it dilutes the availability of funding to provide health services to Indian people, and is not an efficient use of tax payer dollars since it costs more to carry out these responsibilities. Congress should allow Tribes access to the FEHBP when carrying out programs under the ISDEAA.

II. Increase Access to Care

- a) Implement structural and systematic improvements discussed in Item No. I(b) to make the Indian health system more efficient in order to provide more resources available for health care services on a consistent level across the IHS system.
- b) Revamp the IHS facilities construction program to construct health facilities based on need, health disparities, and on an equitable basis.
 - i. Develop alternative approaches to facilities construction other than the Health Facilities Construction Priority System.
 - ii. Implement an Area Distribution Fund (ADF) for facilities construction. This recommendation was included in S. 1200 when it passed the Senate. It is supported by seven of the twelve IHS Areas that include the Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada), and Portland Areas. These Areas represent 501 of the 560 federally recognized Tribes. The ADF was included as a recommendation to revise the Health Facilities Construction Priority System, however the IHS feels it cannot be implemented unless directed by Congress. Finally, the IHS Budget Formulation Workgroup has unanimously recommended funding for the ADF in FY 2010 and FY 2011.
 - iii. Pursue modular construction approaches for Indian health facilities construction that are being utilized in the military sector.
 - iv. Allow other federal funds (Department of Agriculture, HUD, HRSA, etc.) used to construct facilities to be transferred to IHS.

- c) Address personnel shortage issues by decentralizing the human resources functions, exempting IHS from the requirements of OPM, and tie high level executive merit pay to recruitment and retention incentives.
- d) Authorize Long Term Care and home and community based services.
- e) Provide tax incentives for IHS scholarship recipients similar to other federal programs like the Public Health Service Corps.
- f) Provide exemptions from state licensure requirements for health care professionals working for Tribal 93-638 programs consistent with federal sites.
- g) Extend FTCA for all services provided to all patients served by IHS and tribal health programs.
 - i. Expansion of health coverage availability may require an increase in health provider capacity. Some, but not all, Tribes are able to provide this extra capacity in their communities by extending services to Non-Indians. A significant barrier to this is malpractice insurance. While Tribal health programs are generally covered by FTCA for their Indian patients, there is controversy over whether this protection extends to Non-Indian patients. By explicitly allowing FTCA to cover Non-Indian patients seen by Tribal health programs, Congress could help provide additional capacity that will be needed after health reform is enacted.
 - ii. There have been misunderstandings about whether or not FQHC status could provide adequate coverage for Non-Indian patients. FQHC status will only cover Tribal health programs in very limited situations. Although Tribes do qualify for FQHC “look-alike” status, this does not confer malpractice coverage. In order to qualify for coverage, two things must occur. First a Tribe must receive a health professional shortage area (HPSA) designation through the regular HRSA process. There are no special rules deeming Tribes eligible for a HPSA designation. The HPSA designation allows a Tribe to be eligible to compete for “330” funding. Many Tribes cannot acquire either the HPSA designation or the FQHC 330 funding - both of which are required for coverage.
- h) Allow IHS funding to be used to purchase health care coverage.
- i) Authorize collaborative relationships with other federal health care providers like the Veterans Administration (or Community Health Centers) that allow Tribal beneficiaries to receive care from IHS and be reimbursed for them. This would include allowing non-VA beneficiaries to receive care from an IHS facility and be reimbursed for providing the care by VA. Also allow IHS eligibles to receive care from VA, and then have the IHS/Tribes reimburse VA for the services when beneficial (usually CHS related services). Both systems are federal providers of health care and it should not make a difference where the federal patient elects to receive care if it can be provided. This will reduce time to receive care, reduce costs, and improve quality.
- j) Expand authority for tele-health initiatives for IHS programs.
- k) Expand authority of mid-level providers such as the dental health aide therapy program to be carried out in all of Indian Country.
- l) Increase access to NHSC and make refinements to designate HPSA to address uniqueness of Indian Country.
- m) Under authorities of the ISDEAA allow Tribes to provide services to non-beneficiaries in order to increase third party collections, which expands capacity to provide additional health care services to eligible beneficiaries, and improves quality of care to its members.
- n) **Reforming the CHS Program**: We note that the Committee recommends improvements to the CHS program. The CHS program cannot be evaluated singularly on its own without considering all aspects of funding provided by IHS. Any challenges and changes in the CHS program must be

balanced with the overall direct care program and its financing. The NPAIHB strongly urges that any changes made in the CHS program to improve access must be balanced with funding and services provided by facilities infrastructure, staffing packages that CHS Dependent Areas are not direct beneficiaries, and other funding received from sources like Medicare, Medicaid, and private insurance. No CHS resources should be shifted without first addressing these issues and relate Sections I(c) and VI(a).

III. Expand prevention, intervention and treatment activities

- a) Make permanent the Special Diabetes Program for Indians and allow Tribes to contract SDPI funds under authority of the ISDEAA.
- b) Develop similar initiatives as the SDPI to address other types of chronic care diseases of AI/AN people.
- c) A model program that has been very beneficial in Indian Country to address cancer as a chronic disease is the Cancer Navigator Project currently being carried out in Indian Country. A navigator project allows professional assistance in understanding the chronic health conditions as well as coordinating services of the various health systems a patient becomes involved with when undergoing diagnosis and treatment. The Cancer Navigator Project addresses the lack of access to adequate cancer screening and treatment in Indian Country causing higher cancer morbidity and mortality in tribal communities. As a result of Navigation services, patients initiate treatment sooner and complete treatment on schedule resulting in better health outcomes and healthier communities. In addition, the efficiency of navigation services is likely to reduce the cost of managing chronic care. This model should also be expanded for other types of chronic disease management.
- d) Authorize systems of care approaches to behavioral health issues (NICWA recommendation & ATNI resolution)
- e) Deem Tribal EpiCenters as public health entities to ensure adequate data access to conduct surveillance and other public health activities.

IV. Increase access to alternate resources

- a) Clarify authority of IHS system to collect Medicare, Medicaid, CHIPRA and expand authorities (i.e. extend Medicare-like rates for all Part B related services, make permanent Section 1880(e) of the SSA to allow IHS/Tribes to collect for all Part B services—expires December 31, 2009, require 100% Medicare reimbursement to such facilities for Part A and B services)
- b) Continue the payer of last resort provision
- c) Allow reimbursements for mid-level practitioners, CHRs, PHNs.

V. Address the needs of urban Indian programs

We support fully the proposed solutions outlined by the Committee to address the significant health care needs of the urban Indian population.

VI. Provide a framework for an Indian health care delivery system that complements and benefits from any system designed to address national health care reform; and

- a) Establish an Indian Health Reform Task Force to conduct comprehensive research and a decision making process to redesign the Indian health system within the context of health reform goals. The Indian health system has evolved over time and by and large has been successful at recognizing and responding to the challenges of serving diverse and very poor populations with

health status that is unacceptable by any measure. Significant inroads have been hampered primarily by a serious lack of funding. Indian health has adopted a community based, public health model to provide services. Health reform activities are using a competitive, insurance based model, which will not work in many Tribal communities. To research the options and develop the most promising changes for the Indian health system will take time and money. It is important to preserve the strengths while ushering in new system changes that are specifically designed to improve the health of AI/AN in a culturally relevant way. The Task Force will:

- i. Review and analyze gaps in the levels of health care services provided across the Indian health system that are a result of the varying levels of IHS funding, facilities infrastructure, staffing packages, and third-party collections;
 - ii. Gather evidence on utilization, third party collection data;
 - iii. Identify conditions that have lead to the poor health of AI/AN across the country;
 - iv. Identify models of Indian health care delivery that are successful;
 - v. Identify and recommend actions for revising statutes and regulations that impede or restrict access to funding or services needed to systematically improve the health of AI/AN across the country.
 - vi. Submit a report back to the Secretary within 12 months of convening.
 - vii. The Secretary, acting through the IHS Director shall appoint members of the Commission and must include a majority membership of tribal representatives.
 - viii. The Task Force shall submit its recommendations to the HHS Secretary one year after enactment of the health reform bill.
- b) Exempt AI/ANs from mandates and penalties: AI/ANs 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 AI/ANs 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.
- c) 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.
- d) AI/ANs 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.
- e) Portability of health care is essential: In order to guarantee portability between health insurance and the Indian health system, include express language which allows an individual AI/ANs 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.
- f) 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 seek to exclude them from networks. This is why

Congress enacted Medicaid managed care protections which require plans to pay Indian providers as in-network providers (ARRA Sec. 5006(d)). This same type of protection and right of participation must be included in health care reform legislations to assure that Indian health care providers receive payment when they provide services to patients enrolled in an Exchange plan. Without such guarantees, the Exchange plan in which an Indian is enrolled receives a windfall: it is paid a premium but does not have to pay for care that enrollee receives from an Indian health care provider.

- g) Exclusion of Health Benefits as Income: Tribal governments have been trying to meet the challenge of addressing the health care needs in their communities. Some tribal governments have met this challenge by providing supplemental services above and beyond the limited IHS services while others are providing more comprehensive care through self insured funds or third-party plans. This type of universal health coverage for tribal citizens is similar to Medicare. However, some Internal Revenue Service field offices – in examining specific tribal governments for their compliance dating back to 2002 or 2003 – are asserting that this type of coverage, when provided by a tribal government, should be treated as a taxable benefit.

VII. **Provide authorities for essential miscellaneous provisions** – We provide recommendations to the Indian Self-Determination and Education Assistance Act (ISDEAA) here in order to improve and modernize the delivery of health care services for Title I Tribes:

- a) Amend section 102(e) of the ISDEAA to conform the Secretary's burden of proof on all Title I appeals to the standard in Title V. The amendment should use the same language as is presently included in section 518 of Title V, which places a clear and convincing standard on the Secretary, and would increase the ability of Tribes to assume programs under Title I to make improvements and efficiencies when carrying out health services.

"In any appeal (including civil actions) involving decisions made by the Secretary under this Title, the Secretary shall have the burden of proof of demonstrating by clear and convincing evidence: (A) the validity of the grounds for the decision made and (B) that the decision is fully consistent with the provisions and policies of this Title."

- b) We recommend that the Title V standard pertaining to the Secretary's interpretation of Federal laws, Executive orders and regulations be added to Title I as a new subsection (f) to section 102. This language is taken from section 512(a) of Title V.

"(f) Except as otherwise provided by law, the Secretary shall interpret all federal laws, Executive orders, and regulations in a manner that will facilitate (1) the inclusion of program, functions, services and activities (or portions thereof) and funds associated therewith, in self-determination contracts and funding agreements, (2) the implementation of self-determination contracts and funding agreements, and (3) the achievement of tribal health goals and objectives."

- c) We recommend that the following subsection be added to Title I as a new subsection (g) to section 102, to require the Secretary to negotiate in good faith, similar as Title V requirements:

"In negotiating self-determination contracts and funding agreements under this Title, the Secretary shall at all times negotiate in good faith to maximize the implementation of the self-determination policy. The Secretary shall carry out this Part in a manner

that maximizes self-determination consistently with the purposes specified in section 3 of this Act."

- d) In order to provide the same authority for Title I tribes to redesign programs as Title V tribes have now, we recommend replacing the redesign the ISDEAA language in subsection 105(j) with a provision based on subsection 506(e) of Title V:

"(j) Notwithstanding any other provision of law (including any regulation) a tribal organization (with the approval of any Indian tribe being served) may rebudget, redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a funding agreement in any manner which the tribal organization deems to be in the best interest of the health and welfare of the Indian community being served, provided that no redesign or consolidations shall have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable Federal law."

- e) We recommend amending section 4(j) by adding the following at the end thereof to make clear that the purpose of not treating self-determination contracts as procurement contracts is to exempt them from any federal procurement law or regulation:

"or subject to any federal procurement law or regulation."

- f) Title V Diabetes Amendment – Since 1997, Congress has provided significant funding (\$150 million in FY 2004 – FY 2011) for the Special Diabetes Program for Indians (SDPI). The program is administered by the DHHS grants office, not the IHS, and thus is not subject to the ISDEAA. This has created burdensome administrative complications for Tribes carrying out programs under ISDEAA. The problem can be solved by an amendment to section 505(b) of Title V of the ISDEAA, adding SDPI funds and associated activities to Title V agreements. This amendment would enhancing control over program design, increasing accountability to Tribal communities, and converting a grantee relationship with the DHHS grants office into a government-to-government relationship with the Secretary. Under this alternative, Section 505(b) of the ISDEAA (25 U.S.C. 458aaa-4(b)) would be amended to add a new subparagraph (3) providing:

"(3) At the option of an Indian Tribe grants for special diabetes programs for Indians awarded to Indian tribes under Section 330C(b)(2) of the Public Health Service Act (42 U.S.C. 254c-3(b)(2)) shall, after award, be added to the Title I or Title V funding agreements of any Indian tribe under this Act, and shall be administered and implemented in accordance with the provisions of this Act rather than the Secretary's grant regulations (including the regulations governing statutorily mandated grants codified at 42 C.F.R. Part 137, Subpart F). Subsections 106(a)(2), (3), and (5) of this Act providing for start up and contract support costs shall not apply to these grants."

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