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
Kalispell Tribe
Klamath Tribe
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Lummi Tribe
Makah Tribe
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Nez Perce Tribe
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NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
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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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SENT VIA TELEFAX: (202) 228-2589

November 5, 2009

The Honorable Byron Dorgan
Committee on Indian Affairs
United States Senate
838 Hart Office Building
Washington, DC 20510

Dear Chairman Dorgan,

The Northwest Portland Area Indian Health Board is a P.L. 93-638 tribal organization that represents health care issues of forty-three federally recognized Tribes in Idaho, Oregon, and Washington. We are writing to you about S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (IHCIA). We applaud you for your efforts to continue to work with Tribes to reauthorize the IHCIA. This legislation has lingered in the Congress far too long and must be passed and we support you in your efforts. Your work to pass S. 1200 in Senate last year and introduction of S. 1790 in this legislative session speak to your commitment to address health issues for American Indian and Alaska Native (AI/AN) people. Thank you for this!

While we are generally supportive of the S. 1790, we do have concerns with some of the provisions and also believe that other key provisions that were passed in S. 1200 should have been included. A summary of our concerns follows:

Section 102: Language developed by the IHCIA National Steering Committee (NSC) has been omitted from this section.

We recommend restoring "Indian tribes, have, through, the cessation of over 400 million acres of land to the United States in exchange for promises, often reflected in treaties, of health care secured a de facto contract that entitles Indians to health care secured a de facto contract that entitles Indians to health care in perpetuity, based on moral, legal, and historic obligation of the United States." This language is very important as it recognizes the resources that Indian Tribes conceded to the United States and acknowledges the duty to provide health care services under the federal trust relationship.

Section 131: Contract health service disbursement formula. This section would require the IHS to used negotiated rule-making procedures to develop a distribution formula for the Contract Health Services (CHS) program.

We have serious concerns with this provision, and believe as drafted, it would be more harmful than beneficial for several reasons. First, whenever funding or equity issues are addressed in the IHS system, it is imperative that the issue being evaluated (in this case CHS funding)

not be considered singularly on its own. Resource allocation in the IHS system is very complicated and must be balanced with the availability of other resources that come from hospitals and clinics budget line items. There are inconsistencies in the level of care provided across the IHS system and existing distribution formulas are intended to address these inequities. CHS dependent areas like the Portland, California, Nashville, and Bemidji Areas do not have inpatient or specialty care available to the same extent that the rest of the IHS system provides. CHS Dependent Areas must purchase inpatient and specialty-care from the private sector and are likely to receive a higher percentage of CHS funding. Likewise, those Areas that have inpatient and specialty care hospitals receive a higher percentage of the Hospitals & Clinics budget. Because of these variations in the IHS system, we must be careful that any formula changes do not harm this delicate funding balance.

Secondly, this provision when considered with Section 192 could result in shifting CHS resources between the IHS Areas. Under a negotiated rule-making proceeding it is likely that current CHS resources could be shifted to those states to phase in the newly created state-wide Contract Health Service Delivery Areas (CHSDAs). We recommend that the Committee address this issue by dropping the Section 131 or revising it to include a "*hold-harmless funding clause"* for those CHS Dependent Areas that include Bemidji, California, Nashville, and Portland. (Please see attached NPAIHB Resolution on this issue)

Section 192: Arizona, North Dakota, and South Dakota as contract health service delivery areas; eligibility of California Indians. This provision provides authority to continue to make Arizona a permanent contract health service delivery area and establishes a single contract health services delivery area consisting of the states of North Dakota and South Dakota.

We are supportive of Arizona, North and South Dakota Tribes to expand their states to become statewide CHSDAs. However we do have concerns that the requirements of this section have the potential to shift funding away from existing IHS and Tribal CHS programs to the newly established statewide CHSDAs. We recommend including a "*hold-harmless funding clause"* for existing CHS programs in this section. We further recommend that specific language be included in the bill that directs a special appropriation in order to implement new/expanded CHSDAs in Section 192. Future CHS budget increases should not be used to phase in the new/expanded CHSDAs, since the formulas in place address the previously discussed CHS Dependency issues. (Please see attached NPAIHB Resolution on this issue)

Subtitle C, Health Facilities: While we are supportive of the new provisions to establish a modular construction program and demonstration projects, we are disappointed that the Section 301(f) from S. 1200 was not included. The 301(f) provision would simply clarify that in considering any number of constructive, innovative approaches to address the unmet need for the construction of health facilities, the Secretary may consider an

Area Distribution Fund (ADF) as a possible alternative; it neither creates nor does it require the Secretary to do so. This provision is supported by over 500 Tribes nationally who are represented in seven of the twelve IHS Areas that include Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada Tribes) and Portland. We recommend that the 301(f) language that was passed in S. 1200 be included in the bill.

Thank you for this opportunity to provide comment on S. 1790 and believe that our recommendations will serve to strengthen the bill. If you should have any questions concerning our recommendations, please contact Jim Roberts, Policy Analyst, at (503) 416-3276, or by email at jroberts@npaihb.org.

Sincerely,

Andrew C. Joseph Jr.

Andrew Joseph, Jr.,
NPAIHB Chairperson
Colville Tribal Council Member

cc: Allison Binney, Majority Staff Director and Chief Counsel
David Mullon, Minority Staff Director and Chief Counsel
Senator Patty Murray
Senator Maria Cantwell
Senator Ron Wyden
Senator Jeff Merkley
Senator Mike Crapo
Senator Jim Risch
Portland Area Tribal Chairs

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RESOLUTION #10-01-03
Hold Harmless Protections at Section 192 of the Reauthorization of the Indian Health Care Improvement Act (S. 1790)

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization under P.L. 93-638 that represents forty-three Federally-recognized Indian tribes in Idaho, Oregon, and Washington on health related issues; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

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

WHEREAS, because of the absence of inpatient care facilities the Contract Health Services (CHS) budget line item is the most important budget item for CHS dependent Areas like Portland, California, Nashville, and Bemidji Areas; and

WHEREAS, Senator Byron Dorgan (ND) has recently introduced a bill (S.1790) to reauthorize the Indian Health Care Improvement Act (IHCIA) which includes two critical provisions that could be detrimental to CHS dependent Areas, which are:

(1) Section 131. CHS Disbursement Formula: would require the IHS to undertake a rulemaking proceeding – using negotiated rule-making procedures – to establish a distribution formula for the Contract Health Services program within the IHS, and
(2) Section 192. AZ, ND, and SD as statewide Contract Health Service Delivery Areas (CHSDAs): continues current law authority to make Arizona a permanent CHSDA and establishes a single CHSDA consisting of the states of North Dakota and South Dakota for the purposes of providing CHS services to members of Indian tribes located in those states;

WHEREAS, the legislation does not include any specific rules on how the negotiated rulemaking process would be implemented at Section 131 nor are there any protections or hold-harmless provisions for existing CHS dependent Areas when implementing the expanded CHSDAs at Section 192; and

WHEREAS, without specific rules or hold-harmless provisions in the legislation at Sections 131 and 192, these provisions could jeopardize the current CHS funding base for all Tribes, and risk of shifting resources away from CHS dependent Areas to those Areas like the Phoenix and Aberdeen Areas that have significantly more capacity to provide inpatient and outpatient care; and

WHEREAS, any concerns associated with the CHS program should not be addressed singularly by looking at the CHS program alone, but must be addressed comprehensively and systematically by reviewing and analyzing 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—the CHS program cannot be reviewed by itself and any changes in doing so will only result in perpetuating the inequities in the levels of care provided across the IHS system.

THEREFORE BE IT RESOLVED, that the NPAIHB strongly urge the Senate Committee on Indian Affairs to include hold-harmless provisions for currently funded CHS programs at Section 192.

BE IT FURTHER RESOLVED, that the NPAIHB recommend that if the Senate Committee on Indian Affairs does not include hold-harmless protections at Section 192 for existing CHS programs, than we recommend striking Section 131 from the bill.

CERTIFICATION

NO. 10-01-03

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 24 for, 0 against, 0 abstain on October 22, 2009.

Andrew C. Joseph Jr.
Chairman

Date

Stella M. Hawkins
Secretary