



**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 Shoshoni Tribe  
Port Gamble S'Klallam Tribe  
Puyallup Tribe  
Quileute Tribe  
Quinalt 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

527 SW Hall  
Suite 300  
Portland, OR 97201  
☎ (503) 228-4185  
FAX (503) 228-8182  
www.npaihb.org

**SENT VIA TELEFAX: (202) 228-2589**

November 13, 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 applaud and support your efforts to include S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (IHCA), as an amendment to the health reform bill.

We want you to know that our organization generally supportive of the provisions contained in S. 1790, however recommend that prior to it being included in the health reform legislation that the following items be addressed:

Section 131: For the reasons clarified in our November 5, 2009 letter to the Committee, we recommend striking this provision from the bill.

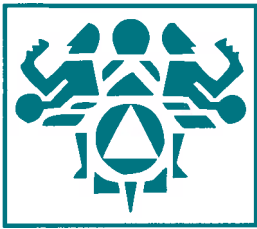
Section ###: We recommend that you include the area distribution fund provision for facilities construction funding that passed in S. 1200 at Section 301(f). Again, our letter of November 5<sup>th</sup> clarified why we believe this provision should be included as an alternative for facilities construction.

We have attached a letter that has been sent to the Majority Leader requesting that S. 1790 be included in the health reform legislation. We further recommend that the Leader ensure that the facilities item discussed above be included in S. 1790 when it is brought to the floor. We respectfully request that that Committee strike Section 131 in the bill. If the above items are addressed we are fully supportive of the provisions contained in S. 1790.

Thank you for your support!

Sincerely,

Andrew J. Joseph, Jr.,  
Chairperson of the Board and  
Colville Tribal Council Member



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**SENT VIA TELEFAX: (202) 224-7327**

November 13, 2009

The Honorable Harry Reid  
Majority Leader  
United States Senate  
522 Hart Office Building  
Washington, DC 20510

Dear Senator Reid,

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 the current efforts to include S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (IHCA,) as an amendment to the health reform bill. As you're aware, a similar effort to include the House version of the IHCA (H.R. 2708) in the health reform legislation was successful with the passage of H.R. 3962.

Generally, we are supportive of Senator Dorgan's efforts to include S. 1790 in the health reform legislation currently making its way through the Senate. Senator Dorgan's bill to reauthorize the IHCA is consistent with past efforts to improve the IHS and Tribal health system. While the bill is a marked improvement over S. 1200 that passed in the Senate last year, we are concerned that one very important provision was not included in the bill. A facilities provision was excluded (S. 1200, Section 301(f)) that would 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 to address health facilities construction needs in Indian Country. This provision would provide an alternative for facilities construction funding and bring some level of fairness to the current facilities construction funding process.

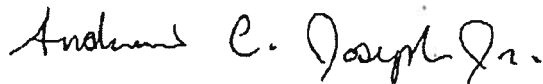
This provision is supported by over 500 Tribes nationally who are represented in seven of the twelve IHS Areas that include Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada Tribes) and Portland. The Indian Health Board of Nevada and its 26 member Tribes supported this provision in a letter dated January 16, 2008 (see attached). This provision was brought as an amendment to S. 1200 which passed by a comfortable margin (56-38) and included your vote to support.

There are new provisions in S. 1790 beyond what were included in S. 1200 that would greatly improve the efficiency of IHS and Tribes to manage health programs, which will improve access and quality of health care for Indian people. Therefore we urge you to support S. 1790 to be included in the health reform package. Indian Country has worked too hard and long to get this legislation passed. We have worked for over ten years now, attaching it to the health reform legislation may be the only way to get this legislation passed.

We further urge you to ensure that S. 1790 includes the Area Distribution Fund language included in S. 1200 at Section 301(f). This provision will not only be beneficial for Nevada Tribes, it will benefit Tribes nationally.

Thank you for your support!

Sincerely,

A handwritten signature in black ink that reads "Andrew J. Joseph, Jr." in a cursive script.

Andrew J. Joseph, Jr.,  
Chairperson of the Board and  
Colville Tribal Council Member

Enclosures: IHBN Letter, dated January 16, 2008  
Joint Area Health Board letter, dated February 28, 2008  
TSGAC Letter, dated October 29, 2007  
Area Fund FAQs

Indian Health Board of Nevada



**Executive Committee:**

President: Alvin Moyle, Chair  
Fallon Paiute-Shoshone Tribe  
Vice President: Arlan Melendez,  
Chair, Reno-Sparks Indian  
Colony  
Secretary: Genia Williams, Chair  
Walker River Paiute Tribe  
Treasurer: Diana Buckner, Chair  
Ely Shoshone Tribe  
Sergeant-at-Arms: Lloyd Hanks,  
Councilman, Duck Valley  
Shoshone Paiute Tribe

**Larry Curley, Executive Director**

680 Greenbrae Dr., Suite 265  
Sparks, NV 89431  
Phone: (775) 355-0600  
FAX: (775) 355-0648  
[www.ihbn.org](http://www.ihbn.org)

**Member Tribes**

Duckwater Reservation  
Duck Valley, Shoshone Paiute  
Tribe  
Ely Shoshone Council  
Fallon Paiute-Shoshone Tribe  
Ft. McDermitt Paiute-Shoshone  
Tribe  
Goshute Business Council  
Las Vegas Paiute Tribe  
Lovelock Paiute Tribe  
Moapa River Reservation  
Pyramid Lake Paiute Tribe  
Reno-Sparks Indian Colony  
Summit Lake Paiute Tribe  
Te-Moak Tribe of Western  
Shoshone Indians  
Battle Mountain Band Council  
Elko Band  
South Fork Band  
Wells Band Council  
Walker River Paiute Tribe  
Washoe Tribe of NV & CA  
Carson Colony  
Dresslerville  
Stewart  
Woodfords Washoe Community  
Council  
Yomba Shoshone Tribe  
Yerington Paiute Tribe  
Nevada Urban Indians, Inc.

January 16, 2008

Senator Harry Reid  
528 Hart Senate Office Building  
Washington, DC 20510

Dear Senator Reid,

We, the Indian Health Board of Nevada, want to take this opportunity to thank you for the leadership you've taken in ensuring that S. 1200, the *Indian Health Care Improvement Act Amendments of 2007* becomes a focus of Senatorial discussions and approval by placing it in on the Senate agenda January 22, 2008. As you know, Indian Country has looked to the passage of this legislation for over five years.

As this legislation nears passage, we know that there continues to be concerns related to some of its provisions. Indian Tribes in Nevada have waited patiently to have new healthcare facilities constructed in Nevada for over twenty-five (25) years. Most notably, since the closure of the Schurz Service Unit Hospital in 1986, Nevada tribes have had to wait as the priority list has been expanded and left smaller tribes out of the funding picture. Therefore, when the SMITH/CANTWELL Amendment was proposed which would authorize the DHHS Secretary to establish a Area Distribution Fund that inject equity into the distribution of funds, we realize that it would benefit tribes in Nevada.

Nevada tribes, through its representatives to the Indian Health Board of Nevada, wish to express its support for the SMITH/CANTWELL Amendment and we look forward to your support for this amendment. Its provisions will decrease the healthcare disparities in Nevada which has been a concern of yours and moreover, it will assist smaller tribes throughout the country to finally have access to facilities construction funds. We thank you for your continued support.

Respectfully,

Alvin Moyle, President  
Indian Health Board of Nevada



Northwest Portland Area  
Indian Health Board



United South and Eastern Tribes



California Rural Indian  
Health Board

February 21, 2008

Dear Senators:

We are writing to you about the Indian Health Care Improvement Act (S. 1200) that is scheduled to come to the floor on Monday or Tuesday of next week. Our organizations are P.L. 93-638 Tribal organizations<sup>1</sup> that represent 177 federally recognized Tribes that provide health care services to American Indian and Alaska Natives across 33 different states.

We are writing to request your support of an Amendment 3897, which Senators Smith/Cantwell will be offering to address a facilities construction funding disparity in S. 1200. Amendment No. 3897 would clarify the authority for the HHS Secretary to create an Area Distribution Fund for facilities construction projects within the Indian Health Service (IHS). The amendment addresses a funding issue that provides a disproportionate share of facility construction funding to a limited number of tribes within the twelve IHS regions. The amendment is a compromise to a controversial issue that is supported by Tribes from seven of the twelve IHS regions that represent 501 of 560 (90%) federally recognized Tribes in the United States. The amendment is further supported by the Tribal Self-Governance Advisory Council that represents 325 Self-Governance Tribes nationwide.

The Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada), and Portland Areas have worked very hard to reach a compromise on this issue. Amendment No. 3897 does nothing more than 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 as a possible alternative; it neither *creates* nor does it *require* the Secretary to do so.

Given the effort by the IHCIA National Steering Committee (who has guided the direction of this bill) to reach a compromise on this issue and the broad based support by an overwhelming majority of Tribes that provide services to Indian people throughout 41 different states, we urge your support of Amendment No. 3897.

Thank you for your support!

Sincerely,

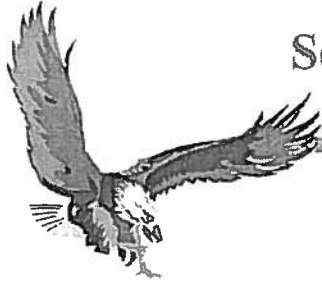
Linda Holt,  
NPAIHB Chairperson

Michael Cook,  
USET Executive Director

Jim Crouch  
CRIHB Executive Director

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<sup>1</sup> As defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638), 25 U.S.C. Section 450(b), a Tribal organization is a legally established governing body of any Indian Tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designed to act on their behalf.



## Self-Governance Communication & Education Tribal Consortium

Iowa Business Center ♦ 1768 Iowa Street ♦ Bellingham ♦ WA ♦ 98229-4702  
Phone: 360-752-2270 ♦ Fax: 360-752-2192 ♦ Email: [mkinley@tribalsegov.org](mailto:mkinley@tribalsegov.org)  
Web Site Address: <http://www.tribalsegov.org>

Original Sent Via USPS  
Copy Sent Via Fax 202.228.3997

October 29, 2007

The Honorable Gordon Smith  
U.S. Senate  
404 Russell Senate Office Building  
Washington, DC 20510  
ATTN: Matt Hill, Legislative Assistant

Re: Section 301 of S. 1200, Reauthorization the Indian Health Care Improvement Act

Dear Senator Smith:

Thank you for supporting the Indian Health Care Improvement Act (IHCA) and working with us to address the issue of facilities construction. On behalf of the Self-Governance Communication and Education Tribal Consortium (SGCETC), I am assuring you that we remain supportive of the proposed language in Section 301 (f) to S. 1200, the Indian Health Care Improvement Act Amendments of 2007. The proposed language in Section 301 (f) remains the best alternative to address facilities construction at this stage of the process that will allow the legislation to move forward and not be impeded by allegations of division among the Tribes.

The Self-Governance Communication and Education Tribal Consortium is representative of more than 325 Tribes who have chosen to be self-governing and to make the decisions for our people that benefit our people at the reservation level. We have been in the struggle with all Tribes for more than a decade to get the IHCA reauthorized and we are assuring you that we remain firm in our support for the proposed language in Section 301 (f).

The proposed language in Section 301 (f) was modified by the National Steering Committee (NSC) technical workgroup, at the charge of the members of the NSC and is supported by more than 60% of the representatives on the NSC. In addition, this language is supported by the United South and Eastern Tribes (USET), the Affiliated Tribes of Northwest Indians (ATNI) and it was unanimously supported by Self-Governance Tribal

Leadership at the 2007 Annual Self-Governance Conference in Orange County, California, May 8-10, 2007. The proposed language states:

*"301 (f) Development of Innovative Approaches- The Secretary shall consult and cooperate with Indian Tribes, Tribal Organizations, and Urban Indian Organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, that may include an area distribution fund and those provided for in other sections of this title and other approaches."*

Section 301 (f) was developed to clarify and expand Section 301 (c)(1)(D) in S. 1200 and to diffuse negative interpretations that were abound due to the lack of consensus by the NSC on the Section 301 issue. Our focus at this time is to continue to advance the IHClA and not to hinder the progression of the activities underway. Activities such as your support and the work of the Tribes all deserve to be applauded for the accomplishments to date in the Senate Indian Affairs and the Senate Finance Committees.

It is our hope that there is still a chance for S. 1200 to be addressed on the Senate floor. We look forward to continuing our alliance with you on this initiative and offer our assistance and commitment to getting the IHClA passed in the 110<sup>th</sup> Congress.

Sincerely,



W. Ron Allen  
Tribal Chairman/Chief Executive Officer  
Jamestown S'Klallam Tribe  
Chairman  
Self-Governance Communication and Education Tribal Consortium

Cc: The Honorable Jay Inslee (D-WA)  
IHClA National Steering Committee  
SGCETC  
USET  
ATNI  
NIHB

**Area Distribution Fund FAQ's  
Indian Health Care Improvement Act (S. 1200)  
Amendment No. 3897**

The Indian Health Care Improvement Act (IHCIA) is a key Federal law that authorizes appropriations for Indian Health Service (IHS) programs. It 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. These frequently asked questions are intended to clarify the issues associated with Amendment No. 3897, which is offered by Senators Smith, Cantwell, Wyden, Murray, and Crapo.

**1. What is the purpose of Amendment No. 3897**

This amendment would modify Section 301(f), which authorizes the Secretary, in consultation with tribes, to develop innovative approaches for construction of health care facilities. The amendment does nothing more than 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.

**2. To what extent is there support for Amendment No. 3897?**

The amendment is supported by 501 of the 560 federally-recognized Tribes in the United States. The Tribes represent seven of the twelve IHS regions. The amendment is also supported by seven IHS Area Health Boards or organizations that include the Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada), and Portland Areas. These Tribes provide health services to Indian people located throughout 41 different states as follows:

- Alaska Area (231 Tribes): AK
- Oklahoma Area (40 Tribes): OK, KS, TX
- Bemidji Area (30 Tribes): MN, WI, MI
- California Area (109 Tribes): CA and HI
- Nashville Area (25 Tribes): ME, NH, VT, MA, RI, CT, NY, NJ, PA, DE, MD, VA, WV, KY, TN, NC, SC, OH, IN, IL, MO, AR, LA, TX, MS, AL, GA, FL
- Portland Area (43 Tribes): ID, WA, and OR
- Phoenix Area: NV (23 Tribes)

**3. What is an Area Distribution Fund (ADF)?**

The FY 2000 Interior Appropriations bill required the IHS to revise its Health Facilities Construction Priority System (HFCPS). The Agency has completed its preliminary recommendations. One of the recommendations for the new priority system is an ADF that would take a portion of IHS facilities construction funds and allocate it to the twelve IHS Areas for high priority construction projects. The IHS position is that this innovative construction method can only be initiated when Congress provides the authority and funding; thereby implying that the Agency does not believe it has the authority to implement an ADF. Amendment No. 3897 clarifies this authority.

The ADF, unanimously supported by all twelve of the IHS FAAB Tribal representatives (see below), is complimentary to the HFCPS. It was developed as a compromise to allow existing priority system projects to be "grandfathered" into the new HFCPS, while allowing a method for new construction proposals to be submitted and funded. An annual distribution would allow each Area to improve, expand, or replace existing health care facilities. An ADF would provide a limited staffing and equipment package.

**4. What is the Health Facilities Construction Priority System (HFCPS)**

The HFCPS serves as the mechanism to evaluate and rank the facility construction projects for the IHS. Projects that score high enough are provided funding for construction and a recurring staffing package by Congress. The current priority system was developed in 1991 and has been *locked* ever since. Because the HFCPS has been *locked* it has prohibited Tribes nationally from accessing important facilities construction funding on the same basis as priority system projects. This has resulted in health services disparities for those Tribes not able to access facilities construction funding.

**5. Who developed the ADF?**

The Facilities Appropriations Advisory Board (FAAB), a joint federal and Tribal advisory body, developed the ADF as a recommendation for revising the new priority system. The FAAB developed the ADF as a compromise to allow existing projects to be "grandfathered" into the new HFCPS, while at the same time allowing a method for new construction proposals to be submitted and funded. An annual distribution would allow each Area to improve, expand, or replace existing health care facilities.

**6. What are the benefits of an ADF?**

An ADF would benefit all 12 IHS Areas by providing resources to address the unmet need for health services and facilities on a recurring basis. It restores some equity for funding the provision of new healthcare facilities and services. It will improve health care services and facilities for a greater number of Tribes and communities—much more effectively than the current system. The current system funds limited line item projects at the expense of all other Tribes nationally. The ADF encourages comprehensive and dynamic planning for health services and facilities construction. It encourages development and utilization of partnerships by leveraging limited IHS appropriations with many other sources of funding.

**7. Why did Congress direct the IHS to revise its HFCPS?**

Facilities construction funding has been a concern of Tribes nationally for a very long time. Recognizing this concern, Congress directed the IHS to "work closely with the Tribes and the Administration to make needed revisions to the facilities construction priority system." Specifically, Congress directed the Agency to address projects "...funded primarily by tribes; anomalies such as extremely remote locations; recognition of projects that involve minimal increases in operational costs; and options for alternative funding and modular construction." The recommendations for the new system are complete and have been provided to the IHS Director to make a decision on implementation. If the Section 301 bill language was to pass today, it would seriously hamper the ability of the IHS Director to implement the new system.

**8. Will an ADF displace current priority system projects?**

No. The ADF will not displace any current priority system projects. In fact, if implemented, it may allow some current projects to move up on the list, and be built sooner. Those IHS Areas that have projects on the priority list get the best of both worlds. They get to keep their project on the list and get access to funding that will benefit Tribes in their Areas that have existing renovation and expansion needs.

**9. How many projects are on the current priority system and how long will they take to complete?**

There are 16 pending projects on the priority list estimated to cost approximately \$3 billion. Based on a five year average of past facilities construction appropriations, it will take between 25-30 years to clear the backlog of pending projects. This means that unless an alternate process is implemented, over 550 Tribes will never be able to apply for facilities construction funding with staffing and equipment packages, until the projects are completed.

**10. Is the ADF a vague, ill-defined, or foreign concept?**

No. The ADF has been discussed in many of the FAAB deliberations when revising the new construction priority system. The ADF is described in many of the FAAB documents (i.e. July 21, 2005, March 10, 2006 FAAB letters to Gary Hartz; November 27, 2007 HFCPS document). There is broad based consensus for an ADF and it is *unanimously* supported and was developed in complete *consensus* with FAAB members.

**11. Is there precedence for ADF in other IHS facility construction programs?**

Yes. The IHS Sanitation Deficiency System (SDS) used in the Sanitation Facilities Construction Program currently uses an area distribution for funding projects. This funding methodology alleviated similar funding controversies in the sanitation program. The SDS uses an Area distribution for allocating funds for water and waste facilities, as authorized under the Indian Health Care Improvement Act (25 USC, Part 1632). It uses a methodology "developed by the Secretary... and applied uniformly to all Indian tribes and communities" to address an identified inventory of needed sanitation facilities. The success of this program has minimized complaints and concerns from Tribes over access to funds to meet needs in their communities. The facilities construction ADF is modeled on this program.

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