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
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Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
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NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
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 EMAIL: yvette.roubideaux@ihs.gov;

October 10, 2014

Yvette Roubideaux, M.D., M.P.H
Acting Director
Indian Health Service
801 Thompson Avenue
Suite 440
Rockville, MD 20852

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dr. Roubideaux and Administrator Tavenner:

We are writing to you in follow-up to discussions held at the July CMS Tribal Technical Advisory Group (TTAG) and the recent HHS Secretarial Tribal Advisory Committee (STAC) meetings about the Office of Management and Budget (OMB) efforts to work with your agencies to compile Medicare, Medicaid, and CHIP provider and payment data.

During the July TTAG meeting it was reported by the Indian Health Service (IHS) that the agency was working with CMS and the Office of Management and Budget (OMB) to provide Medicare, Medicaid and CHIP provider data as required under the Indian Health Care Improvement Act (IHCIA). During our CMS-TTAG meeting there was a concern by Tribal representatives about the reporting of this information since OMB has not clearly defined how it will use this information. Consequently, it was generally implied that Tribes are not supportive of CMS and IHS providing this information until the use of this data can be more clearly defined. Similar discussions were also held at the recent STAC meeting in Washington, DC.

While we understand and share similar concerns, the Northwest Portland Area Indian Health Board (NPAIHB) and our 43 member Tribes support the collection and reporting of such data to OMB with conditions. For over thirty years the IHS has been challenged with an unfair facilities and resource allocation methodology that results in an uneven distribution of resources across the entire IHS system. This results in disparities in the level of personal health care services available to Indians from Contract Health Service (CHS) dependent areas. At least three General Accounting Office (GAO) studies have documented that the health service disparities across the Indian health system are due to the fact that a broader array of onsite services at hospitals compared with health centers increase the overall availability of health care services and that many routine types of services are not available in CHS dependent areas.

Both, California and Portland Area Tribes have continually urged IHS to develop an updated resource allocation methodology to identify and address the multiple inputs which provide support in the provision of personal health care services to the IHS service population including IHS funds, available Medicaid resources, available Medicare resources and newly emerging resources provided through the new marketplace health insurance exchanges. The collection of Medicare, Medicaid, and CHIP provider and collection data will allow the IHS and the tribal health system to conduct analysis and

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

While we understand that some Tribes may have concerns about the collection of such data we underscore that the IHCIA requires that an Indian health program receiving reimbursements or payments under Medicare, Medicaid, or CHIP provide to IHS a list of each provider enrollment number (or other identifier) under which the Indian health program receives such reimbursements or payments and requires the information be reported to Congress.[1]

We also emphasize that section 401(a) of the IHCIA prohibits the Administration and Congress from using Medicare, Medicaid, and CHIP collection data to offset the IHS appropriation. It is the intent of Congress that any Medicare and Medicaid funds received by the Indian Health Service program be used to supplement—and not supplant—current IHS appropriations. To this end, it is clear that Congress firmly expects that funds from Medicare and Medicaid will be used to expand and improve current IHS health care services and not to substitute for present expenditures.

We agree that IHS, CMS, and OMB should make every effort to ensure that the collection of this data is reliable and that the CMS-TTAG be involved to reconcile any discrepancies in the data. IHS and CMS must also consult with Tribes about the use of the data.

If you should have any questions concerning this letter, please contact Jim Roberts, Policy Analyst, at (503) 228-4185 or email jroberts@npaihb.org.

Sincerely,

Andrew C. Joseph Jr.

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

cc: Kitty Marx, CMS Tribal Affairs
Geoffrey Roth, IHS Special Assistant
Carl Harper, IHS Office or Resource and Partnerships
Dean Seyler, Portland Area Director
Office of Management and Budget, IHS Examiner

Enclosures: CRIHB/NPAIHB Joint Resolution 13-04-04
CRIHB/NPAIHB Joint Resolution 11-04-03
CRIHB/NPAIHB Joint Resolution 11-04-08

[1] 25 USC § 1641(d)(2)(C); 25 USC § 1643, and; 25 USC § 1671.

RESOLUTION # 13-04 -04
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION #303-07-13
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION
In Support of Data-based Resource Allocation

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

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

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

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

WHEREAS, the current US Congress is gridlocked and has acquiesced to the implementation of significant reductions in funding for the Indian Health Service (IHS) through a sequestration policy that if continued over several appropriations cycles will destroy the Indian Health Service as a viable provider of health care services; **AND**

WHEREAS, at best over the foreseeable future the IHS appropriations will continue to grow at a rate that continues to be less than the amount necessary to achieve sustained improvements in access and availability to high quality health care services necessary to elevate the health status of all American Indians and Alaska Natives to the highest possible level; **AND**

WHEREAS, under current IHS policy, large portions of all new clinical services funds are targeted to meet the expanded staffing needs of those operating units that have an active user population large enough to attract facilities construction funds thereby consistently marginalizing and reducing the availability of funds to the rest of the IHS funded health care system thereby perpetuating certain inequity; **AND**

WHEREAS, for the past thirty three years the IHS has been unwilling or unable to devise and fund a resource allocation methodology that is reasonable, rational and defensible and that results in funding equity and equal access to services across all segments of the IHS funded delivery system thereby perpetuating great disparities in funding from provider site to provider site; **AND**

WHEREAS, the implementation of the Affordable Care Act will expand coverage for many American Indians and Alaska Natives through both Medicaid and the new subsidized health coverage through the "Market Place" systems; **AND**

WHEREAS, some Congressional leaders may falsely assume that these new coverage opportunities will alleviate the need for vigorous funding for the Indian Health Service in spite of the fact that these forms of coverage will not be uniformly available throughout Indian country, thereby adding not only new resources but new complexity to the diversity of funding which currently exists.

THERFORE BE IT RESOLVED, that the IHS is urged to develop an updated resource allocation methodology to identify and address the multiple inputs which provided support in the provision of personal health care services to the IHS service population including IHS funds, available Medicaid resources, available Medicare resources and newly emerging resources provided through the new Market Place systems.

BE ITFURTHER RESOLVED, that the IHS is urged to update this methodology using the best available data on an annual basis and where necessary to invest in the development of new data sets necessary for the proper administration of this methodology.

BE IT FINALLY RESOLVED, that all annual increases to the IHS Appropriation provided by Congress for Clinical Services, not ear marked for specific new facilities, shall be distributed through a single resource allocation methodology as generally described above.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of Northwest Portland Area Indian Health Board and California Rural Indian Health Board (***NPAIHB*** *vote* 28 *For and* __ *Against and* __ *Abstain;* ***CRIHB*** *vote* 13 *For and* 0 *Against and* 0 *Abstain*) held this 11th day of July 2013 in Airway Heights, Washington and shall remain in full force and effect until rescinded.

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

Chairperson of the Board

Attest

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

Chairperson of the Board

Attest

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

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

JOINT RESOLUTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CERTIFICATION

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

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
527 SW Hall, Suite 300
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Chairperson of the Board

Attest

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Chairperson of the Board

Attest

RESOLUTION # 11-04-08
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 292-07-11
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

Recommendation for IHS Director to finalize decision on the IHCIF Consultation and that all federal resources be used in calculating the federal disparity index of IHS Operating Units

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

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

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

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

WHEREAS, the IHCIF was established to determine the overall level of need funded for Federal, Tribal, or Tribal organization health care facilities; **AND**

WHEREAS, on December 30, 2010, the IHS Director initiated a Tribal Consultation on the Indian Health Care Improvement Fund (IHCIF) and its formula; **AND**

WHEREAS, a technical data workgroup was also appointed by the IHS Director to review the IHCIF methodology and make recommendations to refine the formula. The workgroup made a number of recommendations to address user counts, the cost benchmark, health status, facility differences, data procedures and alternate resources; **AND**

WHEREAS, the Affordable Care Act included the reauthorization of the Indian Health Care Improvement Act (IHCIA), which includes a provision at Sec. 121 to establish the IHCIF, and specifically states that for the purpose of measuring resources deficiencies that all "available resources" available to an Indian tribe or tribal organization must be factored and include resources provided by the Service as well as resources used by the Indian tribe or tribal organization that are financed by any Federal programs such as Medicare, Medicaid, and private insurance. **AND**

WHEREAS, Sec. 121 also directs the HHS Secretary to establish a process for any Indian Tribe or tribal organization to review of any determination of the extent of the health status and resource deficiency of such Indian tribe or tribal organization.; **AND**

WHEREAS, the President's FY 2011 and FY 2012 budgets have requested approximately $100 million over a two year period. The longer a decision is delayed on making refinements to the IHCIF or addressing the clear statutory intent to include available resources—which include Medicare, Medicaid, and private insurance collections—is inefficient and ineffectively addresses resource equity, which is the very purpose of the IHCIF.

THEREFORE BE IT RESOLVED, we do hereby urge the IHS Director to make a decision as soon as possible regarding the Indian Health Care Improvement Fund and complete the consultation initiated on December 10, 2010.

BE IT FURTHER RESOLVED, we do hereby recommend that the IHS Director must include all available federal resources which include Medicare, Medicaid, and CHIP in calculating the federal disparity index of IHS and Tribal health programs consistent with the statutory intent of Sec. 121 of the IHCIA.

CERTIFICATION

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

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