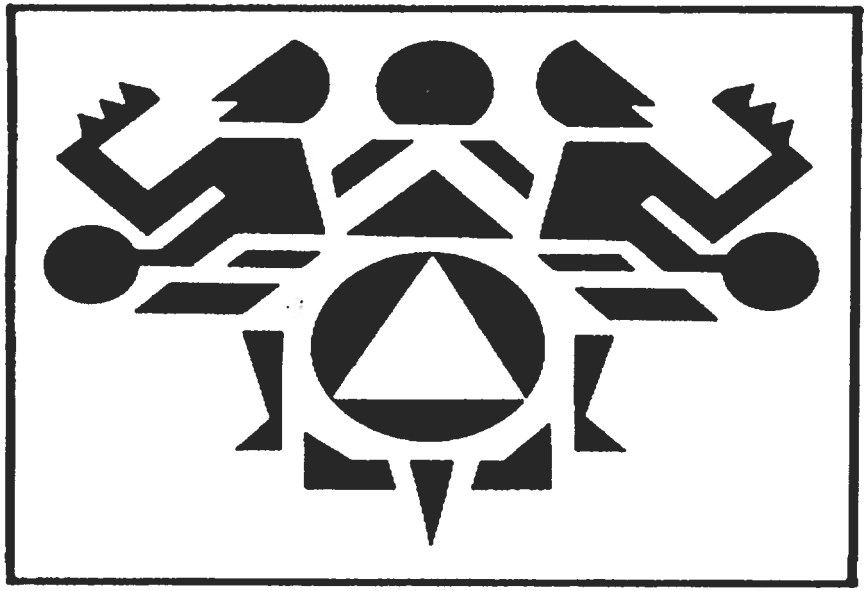
SUMMARY OF MINUTES



12TH JOINT BOARD OF DIRECTORS MEETING

CALIFORNIA RURAL INDIAN HEALTH BOARD & NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

JULY 9-11, 2013

NORTHERN QUEST CASINO RESORT

AIR WAY HEIGHTS WA

July 2013 Quarterly Board Meeting
Summary of Minutes

Issue	Summary	Action	Follow-Up
Area Director Report	Area Meetings: Have met with 3 direct service tribes' tribal councils; Colville, Spokane & Shoshone-Bannock. As soon as I meet with the other two direct service tribes I am going to call a PAFAC meeting to then discuss what the next steps are. The Direct Service Tribes 10th annual national meeting will be July 23-24, 2013 in Minneapolis MN	There are some travel restrictions that are in place and they are in the final stages of determining who the 30 federal travelers are.	
Area Director Report	Chief Medical Officer position has been filled by Dr. Stephen Rudd for the Portland Area. He is also Chairman of the IHS National Pharmacy & Therapeutic Committee. The Western Region Commission Corps Liaison was finally filled; it has been about 2 years vacancy.	The new person is Amanda Treat and she is in the Alaska Area Office. The Western Region makes up Portland, Alaska & California Areas. Alaska has 300 officers in Alaska alone; it made sense to have this liaison physically located in Anchorage	
Area Director Report	Fund Distribution Workgroup; have listed 4 dates and from the list of existing members whichever day has the best result will be the day for the face-to-face meeting in the Area Office	Took the charter that has been in place since 1996 and was updated in 1998 – we now need to update it to what the Federal Regulations guidelines of the Circular are. We need to talk about how we move forward with the changes of the ACA.	
Area Director Report	VA/IHS MOA for reimbursement update – all 6 federal sites have signed agreements completed. There has been successful electronic transmissions of invoice and receipt of funds at the Warm Springs Service Unit.	Hard problems with the electronic submission because the VA has their own system and they have different payment centers. They are working on this. The reason Warm Springs worked is because Warm Springs zip code is within the VISN 20 area.	

July 2013 Quarterly Board Meeting
Summary of Minutes

Area Director Report	Diabetic Retinopathy screening is one of those objectives, as far as the GPRA, that all of our clinics will be using as performance measures as to how well we are serving the people. Joslin Vision Network (JVN) – making sure that all IHS hospitals and tribal sites that have more than 500 patients on their diabetes registry have JVN available.	Key issue from the Area standpoint is to look at productivity and actual utilization of JVN to improve the number of diabetic retinopathy exams that were being performed. We initiated monthly calls with the federal Clinical Directors to make sure JVN is current. Donnie Lee provides sites with monthly goals for the number of exams that they should be doing each month. It is recommended that every patient with diabetes get an annual eye test to screen for the early signs of this sort of eye disease.	
Executive Director	2013 Board Member of the Year: Cheryle Kennedy 2013 Employee of the Year: Mike Feroglia		
Legislative Update	Sequester – IHS Budget loss was $228 million for FY13. President's 2014 budget proposal includes $124 million increase for IHS; which is about 2.9% over the FY12 mark. Contract Support Cost Summit will be July 31-August 1, 3024 in Portland. We have all the lawyers that agrued the Supreme Court cases on CSC. The White House Council on Native American Affairs has been created; it includes a rep from every Executive Agency/Department within the Federal Government; also requires somebody from OMB be present. It will be coordinated through the White	The deficit reduction process will be dealt with in the budget resolution process, so we will not see any more across the board cuts that we saw in 2013. Meeting will address 1) the Administration's proposal that is included in the 2014 appropriations process, which is their attempt stop tribe's ability to pursue underpayment through litigation; 2) to develop some policy positions on how to deal with IHS-BIA settlement offers that are currently underway right now; 3) developing consensus on moving forward about how to tract CSC underpayments and how to deal with them. The Chair will be the Secretary of Interior. The requirement is that they meet at least 3 times a year	

July 2013 Quarterly Board Meeting
Summary of Minutes

	House Domestic Policy Council		
Financial Report	Indirect Cost Proposal for FY14 was submitted and will be 35.9%	It was recommended by the Board to have the finance report consists of all projects/programs as has been done in the past.	It will occur at the next quarterly board meeting
MOTION	**Motion by Cheryl Sanders, Lummi Nation; seconded by Shawna Gavin, Umatilla Tribe to approve the financial report. Motion carried.**		
RESOLUTION #13-04-01	**Native American Research Centers for Health (NARCH) VIII** – Motion by Greg Abrahamson, Spokane Tribe; seconded by Shawna Gavin, Umatilla Tribe to approve this resolution.		
MOTION Minutes	**Motion by Shawna Gavin, Umatilla Tribe; seconded by Cassandra Sellards-Reck, Cowlitz Tribe to approve the April 2013 minutes. Motion carried**		
SDPI	SDPI Update – NIHB SDPI website has been developed. SDPI was signed into law 1/2/13 as part of the fiscal cliff package. SDPI Toolkit helps develop our relationship with grantees and they provide information to be used when visiting Congress	Bipartisan deal authorized for 1 more year; ends 9/30/14	
CHS Strategy Session	After group discussion the list of recommendations are: 1. Support MLR for outpatient services 2. Recommend CHS study to derive average CHS services cost to demonstrate CHS dependency issues (others are buying secondary/tertiary care while CHS dependent are buying primary care)		

July 2013 Quarterly Board Meeting
Summary of Minutes

	3. Study CHEF: a. to determine why one Area has historically received more of the CHEF pool than other Areas; b. provide training on processing CHEF claims, use information from item A to develop curriculum.		
Indian Managed Care	Reviewed the letter regarding ARRA Protection for Indians in Medicaid & CHIP. Defined as a managed care entity are hospital, a tribe, a tribal organization or an urban Indian organization.	There is not enough information on Indian Managed Care. When becoming a managed care entity, you need reserves to do it.	
IHS Update	Sequestration was discussed; President's FY2014 budget request; FY2015 now in the HHS budget formulation process. ACA is gearing up for 10/1/13 open enrollment IHCIA Implementation – VA, we are billing have received payments for national reimbursement agreement. Facilities Appropriations Advisory Board – notification has gone out to all the new members of the committee and our first meeting will be via conference call. CHS – CHS workgroup met and recommended that the formula remain the same. CSC – 2014 President's budget did not totally fund CSC. With regards to CSC settlements, we are making progress. Our challenge is to fully fund CHS & CSC.		

July 2013 Quarterly Board Meeting
Summary of Minutes

Contract Support Cost Discussion	After the Ramah case was decided the number of claims increased significantly. Originally there were 25 tribes and now close to 200 tribes. In the last 13 months since the Supreme Court decision, they are settling 1 claim per year per tribe.	Fully funded CSC is within reach for the BIA, but not IHS. The Agency has now taken a different approach: they no longer say the tribe has an absolute entitled cost, now they say the tribes incur overhead costs and it's a radically different approach There is a statute of limitations of 6 years; so 2007-2013 is as far back as you can go.	
Health Equity: Actuarial Approaches to Indian Health Reform	Conclusions • Use actual IHS, Medicaid & Medicare data for Operating Unit (OU) Data managers and analysts agree that there are no technical barriers to providing data now available on an annual basis • Replace the "current services" approach to budget development with an actuarial approach for all Clinical Services Builds equity through two sources; Congressional increases and prevented misallocations • Motivation to support this change exists in all IHS Areas because funding disparities exist in all Areas		
JOINT RESOLUTIONS	**#13-04-02 300-07-13 IN Support of the Contract Health Service Allocation Formula – Motion by Cassandra Sellards-Reck, Cowlitz Tribe; seconded by Cheryl Sanders, Lummi Nation; CRIHB – Motion by Clois Erwin, seconded by Farrel Starr to approve the resolution. Motion carried** **#13-04-03 302-07-13 – Contract Support Cost -**		

	Motion by Cassandra Sellards-Reck, Cowlitz Tribe; seconded by Sharon Stanphill, Cow Creek Tribe; CRIHB – Motion by Michael Thom, seconded by Andrea Cazares-Diego to approve the resolution. Motion carried **#13-04-04 303-07-13 – In Support of Data-based Resource Allocation – Motion by Cassandra Sellards-Reck, Cowlitz Tribe; seconded by Leslie Wosnig, Suquamish Tribe; CRIHB – Motion by Andrea Cazares-Diego, seconded by Gayline Hunter to approve the resolution. Motion carried** **#13-04-05 29907-13 – In Support of the US Congress & Administration Adopting the Definition of Indian at 42 C.F.R. § 447.50 Uniformly in Implementing the Affordable Care Act – Motion by Marilyn Scott, Upper Skagit Tribe; seconded by Frances delosAngeles, Snoqualmie Tribe; CRIHB – Motion by Farrel Starr, seconded by Fern Bates to approve the resolution. Motion carried** **#13-04-06 301-07-13 – Indian Managed Care Entity – Motion by Cheryl Sanders, Lummi Nation; seconded by Leslie Wosnig, Suquamish Tribe; CRIHB – Motion by Belinda Brown, seconded by Clois Erwin to approve the resolution. Motion carried** **#13-04-07 304-07-13 – DHHS Support for the Twelve Tribal Epidemiology Centers to Perform Mandated Public Health Function – Motion by**		

	Leslie Wosnig, Suquamish Tribe; seconded by Marilyn Scott, Upper Skagit Tribe; CRIHB – Motion by Gayline Hunter, seconded by Farrel Starr to approve the resolution. Motion carried **#13-04-08 305-07-13 – Dental Support Centers – Motion by Steve Kutz, Cowlitz Tribe; seconded by Leslie Wosnig, Suquamish Tribe; CRIHB – Motion by Andrea Cazares-Diego, seconded by Fern Bates to approve the resolution. Motion carried**		
MOTION ADJOURN	**Motion by Frances delosAngeles, Snoqualmie Tribe; seconded by Leslie Wosnig, Suquamish Tribe - CRIHB Motion by Farrel Starr; seconded by Joseph Waddell to adjourn at 3P. MOTION CARRIED**		

Resolution #13-04-01
Native American Research Centers for Health (NARCH) VIII

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 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

2121 SW Broadway
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; 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, the Native American Research Centers for Health (NARCH) program has announced an eighth round of funding to support NARCH centers in order to continue to develop partnerships between American Indian Tribes and tribally based organizations for the purposes of conducting intensive academic-level biomedical, behavioral and health service research; and

WHEREAS, the NPAIHB has established a strong training program to support future academic careers for American Indian / Alaska Natives in health research; and

WHEREAS, a preliminary needs assessment will be conducted to guide the development of the projects submitted for funding under this mechanism; and

WHEREAS, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the *EpiCenter*.

THEREFORE BE IT RESOLVED that the NPAIHB endorses and supports efforts by staff of the *EpiCenter*, under the guidance of the Executive Director, to pursue the eight round of NARCH funding.

CERTIFICATION

NO._13-04-01_

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; ___28_____for, _____0__against, ___0____abstain on __July 9___ ,2013.

Andrew C. Joseph Jr.

Chairman

Cheryle A. Kennedy

Secretary

_____

Date

RESOLUTION # 13-04 -02
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION #300-07-13
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION
In Support of the Contract Health Service Allocation Formula

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 Indian Health Service (IHS) has designated a Contract Health Service (CHS) Workgroup Chartered on May 29, 2012 which has reviewed many of the issues related to the accessibility, management, quality, and resource needs of the Contract Health Service program; **AND**

WHEREAS, On May 6, 2013 IHS Director Yvette Roubideaux, MD issued a Dear Tribal Leader Letter which identifies seven outcomes to date from this "Tribal Consultation" and identifies eight new recommendations; **AND**

WHEREAS, Recommendation one is to continue the current CHS distribution formula for FY2014; a formula which has been consistently rebuked by the General Accounting Office as being inadequate to address the long standing and well documented disparities in funding and access to inpatient and specialty care of the various operating units; **AND**

WHEREAS, it is unclear that the IHS will complete the CHS Workgroup recommended update and redesign of the CHS allocation methodology in a timely manner for use in FY 2015; **AND**

WHEREAS, The current formula addresses the funding of medical inflation before other factors in the formula are utilized and the funding level necessary to cover medical inflation equals $39 million; **AND**

WHEREAS, The current formula includes a fourth co-factor to address CHS dependency that distributes a portion of the increased CHS funds to those Operating Units which are located more than 30 miles from an IHS funded or operated hospital; **AND**

WHEREAS, the level of funding requested by the IHS for what is now termed Purchased and Referred Care for FY 2014 is a mere $35 million increase and is therefore insufficient to trigger any distribution of funds through the CHS Dependency Co-factor in the current CHS Distribution formula thus continuing the long established IHS practice of claiming to address funding disparities without actually doing so; **AND**

WHEREAS, the current CHS Distribution formula if implemented does not meet the standards established for IHS resource allocation under the Rincon v. Harris law suit which held that IHS resource allocations processes must be reasonable, rational and defensible in order to meet the Constitutional requirement of equal access under the law.

THEREFORE BE IT RESOLVED, that the IHS be directed to distribute all new CHS funds on the basis of CHS dependency alone until such time as the IHS is ready to implement a new CHS allocation methodology that takes into account regional variations in cost, operating unit variations in IHS resource availability per active user and regional variations in Medicare and Medicaid payments for IHS eligible American Indians/Alaska Native Services, as well as operating unit level variations in access to IHS direct or funded hospital services.

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 # 13-04-03
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

RESOLUTION # 302-07-13
CALIFORNIA RURAL INDIAN HEALTH BOARD

JOINT RESOLUTION

Contract Support Costs

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 Indian Self-Determination and Education Assistance Act (ISDEAA) allows Tribal governments to assume operation of federal health programs managed by the Indian Health Service (IHS) and Bureau of Indian Affairs (BIA) and to receive contract support costs (CSC) to cover the reasonable costs of activities which must be carried out by Tribes in order to ensure compliance with the terms of the contract and prudent management of the program, but normally are not carried on by the Federal government's direct operation of the program or are provided by other resources than those under the contract; **AND**

WHEREAS, due to CSC shortfalls tribally administered IHS and BIA programs end up with less funding and fewer personnel than non-contracted IHS and BIA programs that provide the same services; **AND**

WHEREAS, Tribes have been litigating CSC issues with IHS and BIA for over twenty years; **AND**

WHEREAS, the Supreme Court has ruled that the Federal government is liable for these CSC underpayments. In *Cherokee Nation v. Leavitt* the Supreme Court held the United States liable for IHS's failure to pay full CSCs in 1994-1997; and

WHEREAS, in *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012), the Supreme Court reached the same conclusion over the BIA's 1994-2001 CSC underpayments, notwithstanding "caps" on aggregate CSC spending in each year's appropriations act, and the *Ramah* decision was held to apply to IHS in *Arctic Slope v. Sebelius*, No. 2010-1013 (Fed. Cir. Aug. 22. 2012); **AND**

WHEREAS, the *Salazar v. Ramah Navajo Chapter* case affirmed that Tribes carrying out federal programs under the ISDEAA are entitled to full CSC, the reasonable costs of administering those programs and services, just like any other federal contractor, and are entitled to be paid what the statute and its contract promise; **AND**

WHEREAS, in response to *Ramah,* the Administration has proposed a statutory 'amendment-by-appropriation' to eliminate all future contract rights of Tribes by proposing to give legal effect to a "table" which each Secretary has provided to the appropriators, specifying the maximum amount each tribal contractor would be entitled to be paid; **AND**

WHEREAS, since each tribal contract is "subject to the availability of appropriations," the Administration hopes this language will limit what is "available" to the amount in the "table" and would limit the ability of Tribes to seek legal remedy for funding that the Supreme Court has ruled is due to Tribes. This policy of subjection to the availability of appropriations for Tribes is a detrimental policy, which is not supported by case law because the Administration is proposing that the agencies, and not Congress, will specify how much each Tribe would be paid—but just in contract support costs—and the agencies would do so only after the contract support cost appropriation is enacted, and after the agencies have made an assessment about how they wish to divide up that appropriation' **AND**

WHEREAS, the Administration's proposed policy has not been formally discussed or consulted with Tribes and is in violation of the President's Executive Order (13175) on Tribal Consultation and the IHS own Tribal Consultation policy.

THEREFORE BE IT RESOLVED that the NPAIHB and CRIHB recommend that the Congress reject the Administration's restructuring of the annual appropriations Acts.

BE IT FURTHER RESOLVED, that NPAIHB and CRIHB recommend that Congress should either eliminate the current earmarking caps on contract support cost payments (as was the case with the IHS appropriation until FY 1998, and with the BIA until FY 1994), or raise the IHS cap to $617 million and the BIA cap to $242 million.

BE IT FINALLY RESOLVED, that Congress should not deny Indian Tribes the very same contract remedies that every other government contractor possesses; which the Supreme Court in the Ramah and Cherokee cases confirmed protect Indian contractors too; and which Congress put into law 25 years ago.

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 # 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 # 13-04-05
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 299-07-13
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

In Support of the U.S. Congress & Administration Adopting the Definition of Indian at 42 C.F.R. § 447.50 Uniformly in Implementing the Affordable Care Act

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 Patient Protection and Affordable Care Act (ACA) contains numerous favorable procedural rules, cost-sharing protections, and mandatory enrollment exemptions that apply specifically to American Indians and Alaska Natives (AI/ANs), referred to generally as "Indians" in the ACA; **AND**

WHEREAS, these Indian specific provisions do not uniformly define the term "Indian," and in many cases do not include any definition at all, creating enormous confusion in the implementation of the ACA; **AND**

WHEREAS, this confusion will result in many AI/ANs not receiving the benefits and special protections intended for them in the law; **AND**

WHEREAS, effective July 1, 2010, the Centers for Medicare and Medicaid Services adopted a definition of "Indian" in its implementation of the Medicaid cost sharing protections enacted in Sec. 5006 of the American Recovery and Reinvestment Act (codified at 42 U.S.C. § 1396o(j)) and this regulation, 42 C.F.R. § 447.50, broadly defines the term "Indian" consistent with the Indian Health Services' (IHS) regulations on eligibility for IHS services; **AND**

WHEREAS, use of this definition of Indian at 42 C.F.R. § 447.50 will end the confusion and result in AI/ANs receiving the benefits and special protections intended for them in the ACA; **AND**

WHEREAS, the NPAIHB, the CRIHB, the National Indian Health Board, the National Congress of American Indians, the Tribal Technical Advisory Group to CMS, the Tribal Self-Governance Advisory Committee, Area Indian Health Boards, and many individual Tribes have officially endorsed amending the definition of Indian in the ACA provisions affecting cost sharing (ACA 1402), special enrollment (ACA 1311) and tax penalties (ACA 1501/IRC 5000A) to correspond to the definition of Indian adopted by CMS in regulation at 42 C.F.R. § 447.50.

THEREFORE BE IT RESOLVED, that the NPAIHB and the CRIHB request that the United States Congress and Administration adopt the definition of Indian at 42 C.F.R. § 447.50 uniformly in implementing the ACA, including for the Exchange Plans, Medicaid expansion, and the specific AI/AN provisions.

BE IT FURTHER RESOLVED, that adopting the definition of Indian at 42 C.F.R. § 447.50 will avoid administrative mistakes and facilitate ease of enrollment, as well as advance fulfillment of the federal government's special trust responsibility toward AI/ANs, promote the ACA's objectives of making healthcare coverage more accessible to the uninsured, and address the alarmingly inadequate access to health services by AI/ANs due to underfunding of the IHS.

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 # 13-04-06
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 301-07-13
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION
Indian Managed Care Entity

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 American Recovery and Reinvestment Act (ARRA, P.L. 111-5) provides important protections for American Indians and Alaska Natives (AI/AN) in Medicaid and Children's Health Insurance Program (CHIP) managed care; **AND**

WHEREAS, these Indian specific protections will apply consistent rules governing the treatment of AI/ANs and Indian health providers participating in Medicaid and CHIP managed care and also create an opportunity for Indian health programs and urban Indian health organizations to become and function as an "Indian Managed Care Entity" (IMCE) in state Medicaid programs; **AND**

WHEREAS, becoming an IMCE may provide an opportunity for IHS, Tribes, and urban Indian health organizations to integrate with each other by forming an IMCE to provide services under a State Medicaid Plan that are culturally competent and which accrue the greatest possible benefit to Tribes, Tribal Organizations and Urban Indian Health Programs ; **AND**

WHEREAS, no formal policy guidance has been issued on the requirements to become an IMCE with exception of limited information contained in the State Medicaid Director Letter (SMDL #10-001/ARRA #6) issued on January 22, 2010; **AND**

WHEREAS, state Medicaid programs and Indian health programs both require additional policy guidance on what the ARRA statute means and how IHS, tribal and urban Indian

health programs can become an IMCE in order to implement the ARRA protections and authority.

THEREFORE BE IT RESOLVED, that the NPAIHB and the CRIHB request that the Centers for Medicare and Medicaid Services (CMS) consult and work in collaboration with the CMS-Tribal Technical Advisory Group (TTAG) to develop policy guidance for IHS, Tribal and urban Indian health programs to become Indian Managed Care Entities as authorized under P.L. 1115.

BE IT FURTHER RESOLVED, that NPAIHB and CRIHB recommend that CMS issue a new State Medicaid Director Letter or new Federal Regulations that communicates the CMS and TTAG recommendations to implement and operationalize IMCEs in state Medicaid and CHIP programs.

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 # 13-04-07
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION #304-07-13
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION
DHHS Support for the Twelve Tribal Epidemiology Centers to Perform Mandated Public Health Functions

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, 25 USC Section 1621m(a)(1) of the Federal Code establishes Tribal Epidemiology Centers (TEC) in each Indian Health Service Administrative Service Area; **AND**

WHEREAS, 25 USC Section 1621m(e)(1) of the Federal Code establishes the functions of TEC, including that they "shall be treated as a Public Health Authority(s) for the purpose of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; PL 104-191; 110 Stat. 1936); **AND**

WHEREAS, 25 USC Section 1621m of the Federal Code states, "the Secretary [of Health] shall grant to each TEC... access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary"; **AND**

WHEREAS, the Secretary of the Department of Health and Human Services (DHHS) and the Director of the Centers for Disease Control and Prevention have not adequately provided TEC with technical assistance to access DHHS health data; **AND**

WHEREAS, TEC, while designated as Public Health Authorities, have not been able to properly perform this important and critical role for the health and wellness of American

Indian/Alaska Native (AIAN) peoples and communities due to data access limitations.

THEREFORE BE IT RESOLVED, the DHHS Secretary be directed to provide technical assistance to Tribal Epidemiology Centers as is required by Federal law and through a Data Sharing Agreement to allow access to the Behavioral Risk Factor Surveillance System; Behavioral Health Services Information System; Drug Abuse Warning Network; Indian Health Service Patient Registry and Clinical Data Systems; National Vital Statistics System; National Notifiable Diseases Surveillance Systems; National Health and Nutrition Examination Survey; National Nursing Home Survey; National Health Interview Survey; National Hospital Discharge Survey; National Ambulatory Medical Care Survey; National Hospital Ambulatory Medical Care Survey; National Survey on Drug Use and Health; Pregnancy Risk Assessment Monitoring System; Youth Risk Behavior Surveillance System and other data systems.

BE IT FURTHER RESOLVED, that TEC should serve as data repositories for AI/AN data found in DHHS public health and administrative datasets by virtue of tribal sovereignty and ownership of these data. The purpose of the data repository shall be to allow for appropriate data stewardship for projects completed under the auspices of the TEC, and other data that each Tribe, collaboration of Tribes, Urban Indian Health Organizations or Tribal Colleges may desire to have held on their behalf. Technical assistance shall be provided by relevant DHHS offices with the expertise to assist in the development of repositories that meet or exceed HIPAA standards. Technical assistance may be requested in but not limited to areas such as: physical data security; compliance with all human subjects and data privacy regulations, including HIPAA; data archiving to protect from loss; compliance with strong, tribally focused IRB requirements; and protections from data misuse.

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 # 13-04-08
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 305-07-13
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION
Dental Support Centers

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 NPAIHB and CRIHB is to improve the health and quality of life of its member Tribes; **AND**

WHEREAS, 66% of 2-5 year olds have experienced dental caries and 44% have untreated tooth decay (2010 IHS Survey) and 83% of 6-9 year olds have experienced dental caries and 47% have untreated tooth decay (IHS 2011 survey); **AND**

WHEREAS, AI/AN populations are disproportionately impacted by dental caries creating a significant health problem for AI/AN populations; **AND**

WHEREAS, oral health is essential to overall health of AI/AN populations; **AND**

WHEREAS, the goals of the Dental Support Centers are consistent with the goals and objectives of NPAIHB and CRIHB.

THEREFORE BE IT RESOLVED, that NPAIHB and CRIHB endorse and support the Dental Support Centers.

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