Northwest Portland Area Indian Health Board

2121 S.W. Broadway, Suite 300 • Portland, OR 97201 • Phone: (503) 228-4185 • www.npaihb.org

2013 Legislative & Regulatory Priorities

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization that represents health care issues of 43 federally-recognized Tribes in WA, OR, and ID. The priorities outlined in this statement have been adopted through a formal resolution of the NPAIHB delegates. This *2013 Legislative Plan & Regulatory Priorities* available at www.npaiihb.org.

Indian Health Service Appropriations:

On August 2, 2012, President Obama signed into law the Budget Control Act of 2011 (BCA). The BCA allows the President to increase the debt ceiling by up to $2.8 trillion, but also requires that the federal deficit be reduced by $2.3 trillion over 10 years. The fiscal cliff deal reached by Congress on January 3, 2013, delays budget sequestration until March 1st, at which point the Congress and Administration will need to address over $85 billion (originally $109 billion under the BCA) in FY 2013 budget cuts required under the new deal.

This is important for Indian health programs because at least $26.4 billion of the proposed cuts must be made from non-defense discretionary programs. Since the Indian Health Service (IHS) budget comes entirely from discretionary funding, the BCA sequestration will have an adverse impact IHS programs. If Congress fails to enact legislation negating the government-wide sequestration of FY 2013 appropriations, the IHS budget will be subject to an 8.2 percent reduction.

Initially, the Administration and IHS Director reported that it under the Budget Control Act any sequestration for IHS programs would be limited to two percent pursuant to a reference contained in the BCA, section 256 of the Balanced Budget and Emergency Deficit Control Act of 1985. On September 14, 2012, the Office of Management and Budget (OMB) submitted to Congress a report indicating that the IHS would be subject to a full sequestration which they estimate to be 8.2 percent. At the time, the estimated budget reduction for the IHS programs is approximately $353 million. The Special Diabetes Program for Indians (SDPI) would not be subject to an 8.2 percent cut, but will be held harmless up to 2 percent, and would be reduced by $3 million.

The past year's IHS budgets have experience a heavy burden of neglect. The IHS budget from FY 2002 to FY 2007 saw less than 2.5% increases for health service accounts. A growing population and medical inflation eroded the purchasing power of Indian health programs. Tribes were forced to redirect funding from economic development initiatives to supplement their health programs. Unfortunately, declining Medicaid programs in the wake of state fiscal crisis have further eroded resources available for Indian health care programs. There is no denying that a huge and growing resource gap resulted in greater health care disparities between Indian people and the general population over the past ten years.

Most importantly, the IHS appropriations are not "discretionary" by the mere nature of their classification in the federal appropriations process. IHS funding is provided in fulfillment of the United

States federal trust responsibility based on treaty obligations that the United States Congress entered into with Indian Tribes. It is important to remind the Administration and Congress that it passed a Declaration of National Indian Health Policy, in which the Congress declares it the policy of the United States—"in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and *to provide all resources necessary* to effect that policy." [Emphasis added] To reduce IHS funding would be in contradiction of this policy passed by this Congress and signed by this President and makes it appropriate to exempt IHS programs from sequestration.

RECOMMENDATION: Because of the chronic and severe underfunding of the Indian health system—along with the significant health disparities of Indian people—the IHS should be exempt from any discretionary funding budget reduction targets, and; enact an Amendment to the Budget Control Act of 2011 to fully exempt the IHS budget from sequestration.

FY 2013 IHS Budget & Mandatory Costs

The President's FY 2013 budget will provide $4.4 billion to Indian Health Service (IHS) programs, an increase of $115.9 million (2.7%) over this year's enacted level. The Northwest Portland Area Indian Health Board (NPAIHB) estimates that the President's request will fall short by over $287 million just to maintain current services. NPAIHB estimates that it will take at least $304 million in FY 2013 to maintain the current levels of health care provided by the Indian health system. Anything less will result in Indian health programs having to absorb the mandatory costs of inflation, population growth and increased administrative costs.

The FY 2013 IHS Congressional Justification reports that the President's budget provides a $115.9 million to support activities identified by the Tribes as budget priorities including increasing resources for the Contract Health Services (CHS) program; funding Contract Support Costs (CSC) shortfall; funding for health information technology activities, and; providing routine facility maintenance. Unfortunately, this increase will not be adequate to "sustain the Indian health system, expand access to care, and continue to improve oversight and accountability" as the Agency reports to Congress. This statement defies simple accounting logic and is contrary the IHS' own data released for the FY 2013 budget consultation process.

NPAIHB projections estimate that it will take an additional $287 million to maintain the IHS program at the current levels of care. Inflation and population growth alone using actual medical inflation rates extrapolated from the Consumer Price Index (CPI) and IHS user population growth predict that at least $304 million will be needed to maintain current services (see attached worksheet). Compound this with the fact that nearly half of the proposed increase is directed to staffing and operation of six new facilities ($49 million), will only leave $66 million to cover current services. Estimates developed by the IHS for the FY 2013 budget formulation consultation process estimate the FY 2013 current services need to be $136.8 million for pay act costs, inflation and population growth.[1]

Full Funding for Contract Support Costs

P.L. 93-638 authorizes Tribes to manage programs previously administered by federal agencies. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and strengthened Tribal governments and institutions for Indian people. Tribal estimates using IHS data predict a shortfall of approximately $146.1 million in

[1] See IHS FY 2013 Budget Formulation Electronic Worksheets used for Area and National Budget Consultation Sessions.

contract support costs. NPAIHB recommends a $146.1 million increase in the appropriation for contract support costs.

Permanent Funding for Epidemiology Centers
Tribal Epidemiology Center programs were authorized by Congress as a way to provide significant support to multiple Tribes in each of the IHS Areas. The President's only requests an increase of $38,344 to cover the increased expense of operating twelve Epidemiology Centers. The twelve Epidemiology Centers provide critical support for tribal efforts in managing local health programs. The Northwest Portland Area Indian Health Board recommends permanent funding for Tribal Epidemiology Centers.

Increase Funding for Substance Abuse in the Mental Health and Alcohol Line Items
The President's budget proposes only a $1 million increase for alcohol and substance abuse funding programs. More needs to be done to address the behavioral health needs of tribal communities. The circle of violence, depression, and substance abuse continues to plague tribal communities. Methamphetamine use is on the rise resulting in tremendous costs to the Indian health care system. Currently, there are no Tribal programs in the Northwest that provide for this type of treatment for adults. NPAIHB recommends an additional $5 million for the IHS alcohol substance abuse line item.

Health Facilities Construction Funding
Although the IHS is working to improve the Health Facilities Construction Priority System (HFCPS), there are many tribal health facilities that will never be replaced or renovated under the current HFCPS. The Joint Venture (JV) and Small Ambulatory (SAP) Programs are an efficient way to maximize resources of the federal government. The current priority list was developed in 1991 and virtually locks out Tribes from much needed construction dollars unless they are one of the facilities on the current list. If facilities construction funding is restored, it is recommended that the JV and SAP programs each receive $10 million in FY 2013.

AI/AN Health Reform Implementation

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The ACA included a permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), which establishes the basic programmatic framework for the Indian health care system. The ACA and IHCIA can work together fundamentally change and improve access to health care services for most American Indian and Alaska Native (AI/AN) people. It can also help to address the deplorable health disparities that AI/AN people face, but only if the new law adequately integrates the Indian health care delivery system.

The ACA can have a beneficial and profound impact for AI/AN people to participate in Medicaid, access health insurance, and change the Indian health care delivery system. The dramatic expansion of insurance coverage and Medicaid will mean AI/AN people can afford to seek the primary and preventive health care services. The IHCIA can provide the necessary backbone of support for many of those people that will now have health care coverage. In order to maximize this opportunity, it is imperative that implementation efforts by state and federal government adequately integrate the Indian health care delivery system. There are Indian specific provisions intended to protect AI/AN participation in the new health reform programs that will be created by states and the federal government.

Indian Definition: The ACA includes three Indian-specific sections that provide special protections and benefits to AI/ANs. The Federal government has ruled that the eligibility standards for the Indian-

specific provisions under the ACA are slightly different. To address this key policy issue, the state exchanges and Indian Tribes have requested that uniform operational guidance be issued through HHS and IRS guidance or regulations regarding eligibility determinations for Indian-specific benefits and protections under Medicaid and the ACA. This guidance should rely on the CMS regulations, 42 C.F.R. § 447.50, in order to permit a uniform application across Medicaid, state and federal Exchanges and IRS (for the exemption for AI/ANs from the tax penalty for not maintaining minimum essential coverage).

QHP Contracting & Payments: Indian Health Providers are the Indian Health Service (IHS), Tribes and Tribal Organizations carrying out programs of the IHS, and urban Indian organizations receiving funding from the IHS pursuant to Title V of the IHCIA. To ensure compliance with the Indian-specific provisions of law and simplify administrative interaction of qualified health plans (QHPs) with Indian health providers, the federal government should require the following: (1) require compliance with IHCIA Sections 206 and 408 as a condition of certification and recertification; (2) require QHPs to offer to contract with all Indian Health Providers in the QHP's service area as in-network providers, and; (3) require QHPs to use the Centers for Medicare and Medicaid Services (CMS) approved "QHP Model Indian Addendum" when contracting with Indian Health Providers. Without such requirements the Indian health system lacks the bargaining power to negotiate with large insurance carriers and will not be included in carrier networks doing business on or near Indian reservations.

Individual Mandate: (Title I, Section 1501(b)). The ACA makes most Americans responsible to carry some form of health insurance coverage. Compliance with this requirement will be enforced through the use of tax penalties by the Internal Revenue Service. IHS coverage must meet requirement of "essential health benefits." The law exempts members of Indian Tribes on the basis of the federal trust relationship.

Payer of Last Resort: (Title II, Section 2901(c)). The new law makes health programs operated by IHS, tribes/tribal organizations and urban Indian organizations (I/T/Us) the payer of last resort for persons eligible for services through those programs. This key provision removes any doubt that other health coverage - e.g., Medicare, Medicaid, or private insurance - carried by an IHS eligible person is required to pay before IHS or a Tribe is required to pay. ACA rules must be developed so that payer of last resort requirements apply to health plans in the insurance exchanges.

Insurance Exchange: (Title II, Section 1402). Individuals who do not have health coverage through their employer would be able to purchase coverage through state-based insurance exchanges by 2014. Three Indian specific provisions will protect Indians from cost sharing requirements at or below 300% of FPL, a second protects Indians from any cost sharing for service delivered through an IHS program, and Indians will be allowed to enroll in Exchange plans on a monthly basis.

Tribes as Express Lane Agencies: (Title II, Section 2901(c)). Effective March 23, 3010, the new law adds the Indian Health Service, Indian tribes, tribal organizations and urban Indian organizations to the list of public agencies who have "express lane agency" status for purposes of making eligibility determinations for Medicaid and CHIP.

Tax Exemption on Tribal Health Benefits: (Title IX, Section 9021). Effective March 23, 2010, the law excludes from an individual Tribal member's gross income the value of health benefits, care, or coverage provided by IHS programs, a Tribe, or tribal organization.

RECOMMENDATION:
Federal and state agencies responsible for implementing the above ACA issues must continue to consult with Tribes to implement the provisions so that they do not adversely impact AI/AN people.

Legislative Priorities

ACA Indian Definition Fix

The ACA includes three Indian-specific sections that provide special protections and benefits to AI/ANs. The Federal government has ruled that the eligibility standards for the Indian-specific provisions under the ACA are slightly different. To address this key policy issue, the state exchanges and Indian Tribes have requested that uniform operational guidance be issued through HHS and IRS guidance or regulations regarding eligibility determinations for Indian-specific benefits and protections under Medicaid and the ACA. This guidance should rely on the CMS regulations, 42 C.F.R. § 447.50, in order to permit a uniform application across Medicaid, state and federal Exchanges and IRS (for the exemption for AI/ANs from the tax penalty for not maintaining minimum essential coverage).

Permanent Reauthorization of the SDPI

Congress established the Special Diabetes Program for Indians (SDPI) in the Balanced Budget Act of 1997 to provide for the prevention and treatment services to address the growing problem of diabetes in Indian Country. Congress recently extended the Act through FY 2014 however should permanently extend the Act. The SDPI provides a comprehensive source of funding to address diabetes issues in Tribal communities that successfully provide diabetes prevention and treatment services for AI/ANs and have resulted in short-term, intermediate, and long-term positive outcomes.

Extend Medicare-like Rates to all Medicare providers and suppliers

All Medicare-participating and critical access hospitals that furnish inpatient hospital services are required to provide services to IHS Contract Health Service authorized patients at no more than Medicare-like rates and to accept the CHS reimbursement as payment in full for such items and services. Currently, this Medicare-Like Rate cap applies only to hospital services, which represent only a fraction of the services provided through the CHS system. This means that non-hospital based charges such as radiology, professional and physician fee charges, laboratory fees, and other non-facility based charges are not subject to Medicare-like rates. CHS programs continue to routinely pay full billed charges for non-hospital services. Other federal purchasers of health care like the Department of Defense and Veterans Health Administration (VA) do not pay full billed charges for health care from outside providers. On April 11, 2013, the Government Accountability Office (GAO) issued a groundbreaking report that concluded that the IHS CHS program routinely pays full billed charges for non-hospital services, resulting in needless waste of government and CHS funds. The GAO Report concludes that expanding the Medicare-Like Rate Cap to cover all services purchased under the CHS program would result in hundreds of millions of dollars in savings to CHS programs across Indian Country.

Contract Support Cost Oversight Hearing: Legislation

The Indian Self-Determination Act and Education Assistance Act (ISDEAA) allow Indian Tribes to carry out health care services on behalf of the Federal government and IHS. Almost every federally-recognized Tribe in the United Stated operates one or more self-determination contracts. Not only has this process increased access to and improved quality of health care, it has served to strengthen tribal institutions, increased local employment, and reduced the federal bureaucracy. Recently, the Supreme Court ruled that the ISDEAA "mandates that the Secretary [of the Interior] shall pay the full amount of 'contract support costs' incurred by tribes in performing their contracts." Id. at 2186. CSC funds are equivalent to "general and administrative costs" required by government procurement contractors. These costs are generally set by indirect cost rates that are issued by the federal government.

Tribes have been litigating CSC issues with the IHS and Bureau of Indian Affairs for over twenty years with many owed outstanding CSC funds. The Supreme Court's ruling should bring an end to this

litigation. Since the decision, IHS has been reviewing how it should proceed to settle outstanding CSC claims. The IHS recently communicated to Tribal Leaders that it believes that the amount due each tribal claimant is limited to CSC "actually incurred" as opposed to the amount previously obligated by the contract and ISDEAA statute. This approach would punish Tribes for fiscal prudence in the face of CSC underfunding and reward the Government for its chronic underfunding of tribal health programs. More fundamentally, it treats ISDEAA agreements as cost-reimbursable contracts, for which the price is determined retrospectively, while the ISDEAA requires that Tribes be paid in advance the funds they use to carry out the programs.

Because of the Agency's reluctance to share CSC shortfall data as in past practice, and their decisions communicated in past Dear Tribal Leader Letters about settling outstanding claims and sharing data, there is an atmosphere of distrust among Tribes with the IHS; and the Agency's relationship with tribally-operated programs is deteriorating over it. NPAIHB has on-going litigation with IHS over their reluctance to share CSC data pursuant to the ISDEAA statute and IHS-CSC Policy. In light of these issues, we urge the Senate Committee on Indian Affairs to convene an oversight hearing on "Contract Support Cost issues in Indian Country". Portland Area Tribes recommend that any outstanding CSC claims should be compensated from the federal Judgment Fund maintained by United States Department of the Treasury, Financial Management Service. This fund is a permanent and indefinite appropriation available to pay judicially and administratively ordered monetary awards against the United States, this includes IHS. Finally, we urge Congress to require IHS/HHS to request adequate CSC funds and such requests should be open, honest and transparent with Tribes.

IHS Advance Appropriations

Since FY 1998 there has been only one year (FY 2006) when IHS appropriations have been provided at the beginning of the fiscal year. Late funding results in administrative challenges related to budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts. This affects access to care and the quality of health care provided. Providing sufficient, timely, and predictable funding is needed to ensure the federal government meets its obligation to provide health care for AI/AN people. Healthcare services directly administered by the federal government, such as the Department of Veterans Affairs, are funded by advance appropriations to minimize the impact of late and, at times, inadequate budgets. The decision of Congress to enact advance appropriations for the VA medical program provides a compelling argument for the effectiveness of advance funding a federally-administered health program which could easily be applied to the IHS. Beyond the efficiency inherent to advance appropriations, providing timely and predictable funding helps to ensure the federal government's Trust responsibility if carried out.

In October 2013, Rep. Don Young (AK) and Rep. Ray Lujan (NM) introduced H.R. 3229; and Senators Lisa Murkowski (AK), Mark Begich (AK), Brian Schatz (HI), and Tom Udall (NM) introduced S. 1570, both bills would amend the Indian Health Care Improvement Act to authorize a two year appropriation fo the Indian Health Service.

Medicaid Program

The most significant trend affecting Indian programs are declining Medicaid reimbursements attributed to state fiscal crisis. As states curtail Medicaid services to balance budgets it impacts third party collections for Tribal health programs despite the fact that states are reimbursed at 100% FMAP for services provided at IHS and Tribal facilities. This could be addressed with special waivers based on the unique legal and political status of Indian people. In at least one instance, CMS has informed at least one state that they could provide additional benefits delivered through the Indian health system.

NPAIHB commends CMS for this policy decision and it is one that acknowledges the federal government's unique legal responsibilities under the trust obligation to provide recognized privileges to American Indians and Alaska Natives. In recognition of the trust obligation, the Indian Health Care Improvement Act of 1976 states:

> *"federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."*

This standard holds that the federal government's unique legal responsibilities under the trust obligation permits AI/ANs to be treated differently in federal programs because of the political status of Tribes as sovereign nations and is the standard that should be followed by CMS in determining eligibility, access to services and cost sharing issues. NPAIHB recommends that CMS provide the technical assistance to states requesting similar action in order to develop waiver programs to accomplish the policy objective of exempting AI/ANs from Medicaid benefit reductions.

Optional Benefits: State Medicaid programs have historically eliminated optional Medicaid services during difficult budget times in order to balance state budgets despite that when such services are provided to eligible AI/ANs and delivered by IHS and tribally operated health programs the eliminated services are completely budget neutral to the states since the Federal government reimburses these services at 100% Federal Medical Assistance Percentage (FMAP). Many AI/ANs experience severe access to care issues in Medicaid and suffer significantly higher rates of health disparities than most other Americans and providing access to the full range of Medicaid benefits will help to improve the quality of care, prevent chronic health conditions and lower health care costs for AI/ANs served by state Medicaid programs. Tribes nationally have requested that the states and CMS explore options to exempt AI/AN from benefit reductions and/or explore opportunities to be able to provide optional services that have already been reduced in the Medicaid program.

Medicaid ACO Protections: Medicaid Accountable Care Organizations (ACOs) are gaining momentum as the health care system learns from the Medicare experience of care integration. Many state Medicaid agencies, managed care plans, and providers are in the process of transforming the Medicaid program to coordinate care as ACO models. Some of the key issues that will be considered in designing Medicaid ACOs include new financial and reimbursement models, care coordination and system design issues, mandatory enrollment requirements, and how to fit the current provider, purchaser, and health plans into the new ACO system. The role of IHS, Tribal and urban Indian health programs will need to be considered in this new Medicaid ACO process. The Medicaid program includes a complex set of regulatory requirements intended protect and romote AI/AN participation in Medicaid. There are cost sharing and estate recovery protections, payment requirements, and requirements for Tribal consultation. It is imperative that the States and CMS comply with these requirements in the development of these new Medicaid care models.

Medical Health Homes: AI/AN people face high rates of illness, disability and death from chronic and preventable diseases. An innovative approach to providing comprehensive primary care services to this population and children, youth, and adults are through the Patient-Centered Health Home (PCHH) model. The PCHH is a health care encounter that facilitates partnerships among individual patients, their personal providers, and when appropriate the patient's family and significant others. In 2008, IHS and Tribes launched the Improving Patient Care (IPC) program to address health disparities. The IHS is adopting a primary care medical home model to focus on delivery of patient-centered care. If the IHS model meets or exceed that standards developed by state Medicaid PCHH models, the IHS program should be deemed to have met state requirements and allowed to be reimbursed as other PCHH providers.

Title VI Self-Governance Legislation

When Congress enacted the Self-Governance legislation, it included a provision requiring the HHS to carry out a study of the feasibility of assuming responsibility for non-IHS programs. A Title VI Self-Governance feasibility study found that such a demonstration is feasible for eleven programs. The HHS Secretary should encourage the Administration and Congress to move to enact a non-IHS self-governance demonstration project. HHS should also work with Tribes to design a Self-Governance demonstration for the 11 programs identified in the feasibility study.

Support transfer of IHS Appropriations from jurisdiction of Interior, Environment & Related Appropriations to Labor, Health and Human Services, Education and Related Appropriations.

Both, the National Congress of American Indians (NCAI) and the Affiliated Tribes of Northwest Indians (ATNI) support moving the IHS budget from the Interior Appropriations Sub-Committee to the Labor, Health and Human Services, and Education (LHE) Appropriations Sub-Committee. The LHE Committee handles health care related bills, and therefore understands the problems associated with health care delivery, such as medical inflationary rates. The Interior Appropriations Subcommittee is responsible for national parks, reclamation projects, mining activities, fish and wildlife, and other natural resource programs. It is reasoned that the IHS appropriation would benefit by being in the same pool of health expenditures that programs like Medicare, Medicaid, SCHIP, and other health programs appropriated out of the LHE Appropriations Subcommittee. The Labor-HHS-Education subcommittees have almost always been allocated appropriation increases that match or exceed health inflation indexes. While the Interior Appropriation Subcommittee allocations reflect natural resource program inflation rates, which generally fall below health inflation.

Other Health Priorities

Special Appropriation for Northwest Regional Youth Treatment Program

Regional Youth Treatment Centers provide drug and alcohol treatment for adolescents of federally recognized Tribes. AI/AN youth are at higher risk and suffer the effects of alcohol and substance abuse at a higher rate than other non-Indian youth. The Klamath Tribe operates the only dual diagnosis [mental health and drug and alcohol addiction] facility for Indian youth in the United States. The program is located in a 6,500 square foot house that is over 35 years old and in considerable need of repair. It is less than adequate to house youth and for providing services. The tribe has purchased six acres of land for a future building however does not have the capital to build a new facility. NPAIHB requests Congress make a special appropriation of $5 million to the Klamath Tribe for construction of a new facility for the Klamath Alcohol and Drug Abuse program.

Long Term Care (LTC) and Elder Issues

The IHS does not fund long-term care, which is why there are few long-term care services in Indian communities. There are only 15 known tribal nursing homes in the nation. NPAHB supports the study of the long-term care needs of AI/AN people. Tribes need more case management funding and funding to allow Tribes to provide advice on long-term care needs to their elders. Medicare and Medicaid programs could become important sources of funding for long term and home and community based care for elders with support from CMS. The IHS should receive a line-item appropriation to study long-term care programs in Tribal communities. Elder issues and Long Term Care (LTC) are a growing concern for Tribes across the country.

The ACA strengthens and expands the "Money Follows the Person" (MFTP) Program so that more states can participate and rebalance their long-term care systems to transition people with Medicaid from institutions to the community. Today, forty-three states have implemented MFP Programs who are all eligible for a new "MFTP Tribal Initiative (TI) to offer states and Tribes resources to build sustainable community- based long term services and supports specifically for Indian country. In order for Tribes to be eligible for these resources, states that are current MFTP grantees must apply. There will be federal and state administrative challenges to implementing this new opportunity. We strongly urge CMS and States to continue to consult with Tribes in the development of this new and important program.

Veterans Health Issues

Indian Country has long recognized the growing concerns and frustrations of AI/AN veterans in obtaining health services from the IHS and Veterans Administration (VA). Often there are redundancies in treatment when veterans obtain health services at an IHS or VA facility. AI/AN veterans have advocated that the VA and IHS accept one another's diagnoses without the requirement of additional diagnoses for referrals. These conditions cause an undue burden on veterans when seeking services and are causing unnecessary costs to both the IHS and VA. This stress often serves as a barrier to seeking health care and illness goes untreated. Congress should direct the IHS and VA to identify needs and gaps in services and develop and implement strategies to provide care to AI/AN Veterans. The agencies should work to develop strategies for information sharing of patient records and data exchange so patients do not have to undergo a duplication of service for referrals.

Regional Referral Specialty Care Centers

Portland Area Tribes have been very innovative in developing alternatives for facilities construction. The Portland Area Tribes have recently completed a Pilot Study to evaluate the feasibility of regional referral centers in the IHS system. This effort is consistent with the IHS Directors initiative to bring reform to the IHS. The Pilot Study concludes that the demand for a Regional Specialty Referral Centers, when strategically placed, to offer specialty care, diagnostics, and ambulatory surgery care are economically feasible and should be further explored and funded. This effort demonstrates the viability of Regional Specialty Referral Centers using a "market erosion" methodology that factored user-population data of participating Tribes, reasonable travel distances, health care competitors (providers), and economics of payer groups to derive utilization rates for a regional specialty referral center. The Study further recommends that a demonstration project be completed in the IHS.

Recommendation: Request the appropriations committees include $3.4 million for planning and design of regional referral specialty care center demonstration project in the Portland Area.

Tribal Emergency Preparedness

While Tribal health programs have public health and medical care infrastructure it is often underfunded and may lack the capacity to respond effectively to both natural and manmade disasters. Too often population density is often a primary consideration in the allocation of emergency preparedness resources, it is important to recognize that disasters can and do occur on Indian reservations and in rural areas in proximity to Tribes, and that the impact of these disasters can be felt on all Americans regardless of geography. One need only consider the far reaching impacts of natural disasters, agricultural blight, and infectious diseases to realize the interconnectedness of our reservation, rural and urban citizens. In order to ensure the readiness of the Tribal governments in times of crisis, an important consideration is that, while the federal and state governments need to be financial partners in this endeavor, implementation must also occur at the local Tribal level.

Implementation of IHCIA Priorities

The reauthorization of the IHCIA makes improvements to or adds new provisions that will improve the Indian health care system in several ways. The legislation sets to improve workforce development and recruitment of health professionals, it also provides new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs, and creates opportunities to improve access and financing of health care services for American Indian and Alaska Natives.

For example, the law now allows IHS to carry out long term-care related services and be reimbursed for them, such as home and community based services. The bill makes a marked improvement at modernizing the delivery of health services provided by IHS, but this can only happen if the new provisions are implemented in a timely and effective manner.
IHS should not have unilateral authority to interpret specific provisions in the law or to drive key policy decisions that will have a direct impact on Tribal governments and the members they serve.

While IHS plays a vital role within the federal agencies' internal discussions, their role is limited to the very specific authorities they are granted and further bound by the constraints of their current system and personnel. Northwest Tribes have always been strong partners with IHS within the context of their mission; however, both ACA and IHCIA go far beyond the current capacity of IHS policy and regulatory expertise.

In those areas, IHS should not be tasked, alone, with representing Tribal interests. In fact, there have been times when IHS has been unable to appreciate the importance of Tribal innovations to provide more appropriate and effective health services to their American Indian and Alaska Native beneficiaries. In order for ACA and IHCIA to have a positive impact in Tribal communities, the Administration must involve Tribes in implementation discussions immediately**.**

Prepared by the Northwest Portland Area Indian Health Board, 2121 S.W. Broadway Ave., Suite 300, Portland, OR 97201. For questions or additional copies, contact Jim Roberts Policy Analyst, at (503) 228-4185 or email jroberts@npaihb.org, or visit www.npaihb.org.