



Northwest Portland Area Indian Health Board

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2015 Legislative Plan & 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 *2014 Legislative Plan & Regulatory Priorities* available at www.npaihb.org

Indian Health Service Appropriations:

The past year's Indian Health Service (IHS) budgets have experienced a heavy burden of neglect. The IHS budget from FY 2002 to FY 2007 saw less than 2.5 percent increases for health service accounts. Recent year's budgets have allowed increases to address a growing population and medical inflation. However given the tremendous health needs of Indian people, and the programs that serve them, funding is still not adequate. Tribes are forced to redirect funding from their economic development or other initiatives to supplement health programs. Past year's decline in state Medicaid programs are just now starting to recover in as states implement the second year of Medicaid expansion under the Affordable Care Act (ACA), but this is limited to states that expand Medicaid. There continues to be a great resource gap for Indian health programs that results in greater health care disparities between Indian people and the general population.

The Budget Control Act of 2011 (BCA) requires the federal deficit to be reduced by \$2.3 trillion over 10 years. The BCA sets spending targets and if they are not met require budget sequestration by the Administration to make across the board spending cuts. 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 IHS appropriation 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 in future years, the IHS budget will be subject to across the board spending reductions. **Following the final FY 2013 sequestration, the IHS appropriation of \$4.34 billion was reduced by \$217 million.** This lost funding will take years for the Administration and Congress to make Tribal governments whole and in turn the AI/AN people they serve.

The BCA disproportionately targets discretionary spending and Tribes underscore to Congress that the IHS appropriations are not "discretionary" by their mere classification in the 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 federal trust responsibility and the chronic and severe underfunding of the Indian health system—along with the significant health disparities of Indian people—the Congress and Administration should exempt the IHS appropriation from discretionary funding budget reductions, and; enact an Amendment to the Budget Control Act of 2011 to fully exempt the IHS budget from future sequestrations.

FY 2016 IHS Budget & Mandatory Costs

The President’s FY 2016 budget request will provide \$5.1 billion to Indian Health Service (IHS) programs, a very respectful increase of \$460.6 million (an increase of 9.9% over FY 2015). Tribal health programs acknowledge the Administration for requesting such respectful increase for Indian health programs but are also cautious about whether Congress will approve the amount of funding requested by the President. The request if funded will go a long way to restore the \$217 million that was lost in the FY 2013 budget cycle. This funding was lost due to the Administration having to sequester the IHS budget because annual spending exceeded the spending caps contained in the Budget Control Act of 2010. If Congress funds the President’s request the FY 2016 budget cycle could be a funding year for Tribes but only if there are changes to the distribution of the proposed increase.

The President’s budget proposes \$19.4 million for pay costs, \$71.2 million for inflation, and \$56.8 million for population growth (total of \$147.3 million). The President’s budget also requests an addition \$313.3 million for program increases to fund staffing at new facilities, business office functions to improve third party reimbursements, increases for the Purchased and Referred Care (PRC) program, as well as increases for health information technology, behavioral health, contract support costs, and the facilities program. NPAIHB estimates that it will take \$297.2 million to fund the actual inflation costs associated with operating medical programs. However the President’s budget only requests \$147.3 million for these costs, which means after the program increases are factored, that tribes will have to absorb over \$149 million of unfunded inflation and population growth. While the overall budget increase is good for IHS programs, the distribution of the overall increase within the IHS budget line items is not.

Analysis of FY 2016 President's Request for the Indian Health Service: The Economic Effect of Absorbing Unfunded Inflation & Population growth on Tribal health budgets (Dollars in Thousands)			
Current Services Amounts: Inflation and Populaton Growth	NPAIHB Estimates	President's Proposed Budget	President's Budget is Short:
President's Proposed Increase for FY 2016 IHS Budget	\$460,604	\$460,604	
Amount needed for Inflation based on actual medical inflation components from the Consumer Price Index	\$215,191	\$71,150	(\$124,636)
Amount needed to fund Pay Act increases (NPAIHB estimate is included in the inflation amount above)*	*	\$19,405	
Amount needed for population growth based on 1.5% population growth	\$82,032	\$56,726	(\$25,306)
Balance after funding Current Services	<u>\$163,381</u>	<u>\$813,323</u>	
President's Propose Program Inceases:		<u>\$313,323</u>	
Tribal budgets would have to absorb unfund inflation and population costs in order to fund the President's Proposed Program Inceases:			<u>(\$149,942)</u>

The Northwest Portland Area Indian Health Board (NPAIHB) analysis of the President’s request indicates that the allocation of the increase will result in Tribes having to absorb over \$149 in unfunded inflation and population growth unless the budget is reallocated among the line items or unless the Congress provides additional funding to cover these costs. NPAIHB estimates that it will take \$297.2 million to fund inflation and populations growth in FY 2015. This is the minimum amount of funding based on

actual medical inflation indices that it will take to maintain the current levels of health care provided by the Indian health system.

Contract Support Costs

The Congress and Administration now agree that Tribes must be paid full contract support costs (CSC). The funding provided to the Indian Health Service (IHS) is still insufficient to fund these requirements. Tribes and the IHS Contract Support Cost Workgroup are working cooperatively with the IHS to develop a solution to short term CSC issues as well as develop an approach to address long term CSC funding issues. Congress has passed a Continuing Resolution (CR) for operation of federal programs through December 11, 2014. It is likely that another CR will be passed to fund the federal government through the beginning of next year.

In September, the IHS identified at the high end an estimated \$48 million to fully fund CSC in FY 2014. This amount was adjusted downward for a final figure of \$25 million. This was difficult because the amount needed to be reprogrammed at the end of the IHS fiscal year came from IHS' remaining discretionary appropriations. The IHS reported that it reprogrammed this out of the IHS Services account – first from Headquarters, then from Area Offices and then from Service Units. Shifting these funds from services to CSC obligations will reduce the funding available for health programs. Given this anomaly, the amount requested in the President's FY 2015 request that Congress is forecasting its budget recommendations on is insufficient to fully fund CSC need for FY 2015 unless additional funding is requested by the Administration.

Short Term Appropriations for CSC:

- Urgent action is needed to ensure that Appropriations made for FY 2014 after December 11th include enough funding to fully fund CSC and avoid reducing any funds for health care services.
- Some Tribes have requested that OMB and Congress consider CSC an “anomaly” for purposes of making the needed full CSC funding available for FY 2014.
- Tribes have also requested that unobligated funds anywhere in the HHS be considered for transfer to fund required CSC.

Long Term Appropriation Solution:

- The Tribes have recommended that the long-term solution to fund CSC is to make it a mandatory, permanent appropriation. This would separate the CSC account and provide sufficient funds to pay these required, mandatory costs; no matter when they are identified during the Fiscal Year.
- However, it is likely that such a solution will take considerable time for Congress to consider and enact, if at all – perhaps years. Tribes will continue their advocacy on this ultimate solution.
- Request the President to support legislation that would make CSC funding an entitlement (see discussion under legislative priorities).

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 requests an increase of \$360,000 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 a \$7.4 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 \$17.5 million for the IHS alcohol substance abuse line item.

Increase Mental Health funding due to staffing and new Tribes funding

The President's budget reduces mental health funding by \$8.5 million to phase in staffing and fund new Tribes. The reprogramming of mental health funds will result in budgets being reduced for all Tribes because the President's requested increase of \$4 million is not sufficient to cover the costs of IHS reprogramming mental health funds.

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 continues to be funded, it is recommended that the SAP programs each receive \$10 million in FY 2015.

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 (IHCA), which establishes the basic programmatic framework for the Indian health care system. The ACA and IHCA can work together fundamentally to 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 IHCA 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 IHCA. 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 IHCA 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.

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.

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).

Amend IHCA to authorize Dental Health Aide Therapists

Tooth decay in children is one of the major health problems in the United States – especially among low-income and minority populations. The prevalence of tooth decay in AI/AN children ages 2 to 5 is nearly three times the U.S. average, and more than two-thirds of AI/AN children ages 2 to 5 have untreated dental cavities. Too many children live in pain, have trouble concentrating in school, or miss school altogether and, in extreme cases, risk life-threatening infections because there are not enough dentists

where they live or because they cannot afford dental care. Minor problems often escalate, leading to repairs that must be performed under anesthesia in a surgical suite. There are simply not enough dental professionals to meet the huge backlog of dental disease in Indian Country. For example, 17% of the dentist positions within the Indian Health Service are vacant, and IHS dental providers carry a patient load nearly twice as high as dental providers in the general population. Per capita spending for IHS dental services is \$50 per patient, while \$300 is spent in the general population.

We can expand the reach and capacity of the dental care workforce safely, effectively and quickly to address these deplorable oral health disparities. NPAIHB recommends expanding the Alaska Dental Health Aide Therapist (DHAT) program to the rest of Indian Country. DHATs are part of a dentist-led team. They educate patients about oral health and prevention, perform dental evaluations, give fluoride treatments, place sealants, clean teeth, place fillings, and perform simple extractions. Like nurse practitioners and physician assistants in the field of medicine, dental therapists expand the reach of dentists and free them to perform advanced treatments. Dental therapists who come from and return to their communities bring immeasurable strengths. They have excellent technical skills and the cultural understanding, and personal connections to their communities. Dental therapists will help provide access and quality oral health care to AI/AN people who need it badly.

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 they 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 Purchased and Referred Care (PRC) authorized patients at no more than Medicare-like rates. The hospitals are also required to accept the PRC 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 PRC 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. PRC 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-PRC program routinely pays full billed charges for non-hospital services, resulting in needless waste of government and PRC funds. The GAO Report concludes that expanding the Medicare-Like Rate Cap to cover all services purchased under the PRC program would result in hundreds of millions of dollars in savings to PRC programs across Indian Country.

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 for the Indian Health Service.

Make CSC Funding an Entitlement

Tribal leaders have begun to advocate for a change in the manner in which contract support costs (CSC) are appropriated now that the U.S. Supreme Court has affirmed the payment of CSCs under the Indian Self-Determination and Education Assistance Act (ISDEAA) are a legal and binding obligation owed to Tribes carrying out ISDEAA contracts and compacts. The Indian Health Service (IHS) and Bureau of Indian Affairs (BIA) have also begun to pay full CSC payments beginning in FY 2014. The agencies have requested similar action in the President's FY 2015 budget request. Despite the mandatory nature of CSC obligations they are currently paid from annual discretionary appropriations.

Tribal leaders, Indian health advocates and even some Congressional members assert that CSC obligations should be made an entitlement and not funded from discretionary appropriations. The result of CSC obligations in the appropriations process has caused decades of conflict over the underfunding of CSC payments to Tribes. This has resulted in numerous lawsuits between the federal government and Indian Tribes. There were over 1,500 past year's claims that totaled over one billion dollars filed by Tribes over CSC underfunding. To put this into perspective, the damages owed to Tribal governments for unpaid contract support costs are comparable to recent landmark settlements of the *Cobell*, *Nez Perce* and *Keepseagle* court cases.

A proposal supported by Tribal leaders to address the fundamental disconnect between the legal binding CSC requirements of the ISDEAA and the appropriations process would be for Congress to pass a simple statutory amendment that would appropriate contract support costs on a permanent, indefinite basis like other legal entitlements. Tribal leaders and other Indian health advocates support changing the contract support cost appropriations process to be into line with the entitlement required in the ISDEAA. Congress recently called for "long-term accounting, budget, and legislative strategies" to address the challenge of full contract support cost funding. This proposal would not solve all of these challenges but it would represent a major step forward to address such issues.

The appropriation process has failed to reflect the status of contract support costs as such, however, and that failure is ultimately at the root of the persistent funding problems that have loomed over the otherwise largely successful efforts to diminish "federal domination of Indian service programs" under

bold new self-determination and self-governance initiatives. Since contract support costs are already an entitlement under substantive law, Congress should align the appropriation process with the authorizing statute and the *Cherokee* and *Ramah* decisions by appropriating funding for contract support costs on a mandatory basis.

Medicaid Program

The Medicaid program provides critical health coverage for AI/AN people and has also become a very important source of financing for health care for Indian health programs. Because the IHS budget has not received adequate increases to maintain current services, Medicaid provides additional revenue for Indian health providers. Most of the IHS budget increases are directed toward staffing new facilities and minimally finance inflation and population growth for the I/T/U programs. Least to say that the allocation of scarce resources needed to support program increases have recently been directed to funding the IHS obligations for contract support costs.

The increased coverage and revenue associated with Medicaid expansion has had a very positive effect on Northwest Tribal health programs. However this positive impact has not been felt by Tribes in other States that have elected not to expand Medicaid. CMS should continue to hold states accountable to ensure AI/ANs have access to important Medicaid services whether that be in expansion states, States that submit 1115 Demonstration Waivers for Uncompensated Care (AZ, CA, OR), or if states pursue expansion opportunities under waivers like the Arkansas premium assistant model.

The ACA established the Center for Medicare & Medicaid Innovation (CMMI) to support the development and testing of innovative health care payment and service delivery models. This work has funded new initiatives in States to plan, design, test, and evaluate new payment and health service delivery models. These new models are aimed at lowering costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries. It is not entirely clear how these reforms will impact the Indian health system. Many of the reformation objectives are outcomes that the Indian health system has had in place for many years. These new models would be served well to study the Indian health system that has an integrated health model that combines medical, behavioral, and public health. Past experience demonstrates that unless I/T/U programs and policy experts are involved in the development of health system reforms, they will not effectively integrate with the Indian health system. It is critical that CMS involves Tribes in the development of any policy framework to reorient payment policy and health care delivery redesign.

NPAIHB commends CMS for its recent policy decision to support the uncompensated care waivers in Arizona, California, and Oregon. CMS has also enforced State Medicaid consultation requirements in waivers and managed care requirements. This action 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 in the following:

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. 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 to protect and promote 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 exceeds 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

Tribal Public Health Infrastructure

While Tribal health programs have public health and medical care infrastructure; it is often underfunded and may lack the capacity to respond effectively to health, 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 public health emergencies and disasters can and do occur on Indian reservations and in rural areas in proximity to Tribes, and that the impact of these emergencies 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.

The recent public health emergencies dealing with the Ebola outbreak in the United States is yet another example. Tribes expressed concerns regarding the cost of deployment of IHS Commissioned Corp officers to combat Ebola, protecting AI/AN communities from exposure to the Ebola virus, and communications with Tribal leadership. While IHS facilities may have established infection control procedures; IHS facilities are not equipped to deal with the Ebola virus. IHS and Tribal facilities in most cases do not have isolation rooms, full body protective gear, and other things necessary to contain the Ebola virus.

Recommendation: 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, resources and implementation must also occur at the local Tribal level.

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 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 a Regional Referral Specialty Care Center demonstration project in the Portland Area.

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.

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