Statement of Linda Holt, Chairperson
Northwest Portland Area Indian Health Board
Before:

House Natural Resources Committee Hearing on
Indian Health Care Improvement Act Amendments of 2007 (H.R. 1328)

March 14, 2007
10:00 a.m.

Good morning Chairman Rahall, Congressman Young, and members of the Committee, my name is Linda Holt, I am an elected Tribal Council Member of the Suquamish Tribe and serve as the Chairperson of the Northwest Portland Area Indian Health Board (NPAIHB). I serve in a variety of capacities on national Tribal committees for agencies within the Department of Health and Human Services and serve as the Portland Area representative on the National Steering Committee (NSC) for the Reauthorization of the Indian Health Care Improvement Act. In my role serving our 43 Northwest Tribes, I am quite familiar with the health care needs and challenges of Indian Country. It is an honor and a pleasure to offer my remarks concerning the Indian Health Care Improvement Act Amendments of 2007 (H.R. 1328).

Established in 1972, NPAIHB is a P.L. 93-638 tribal organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health related matters. The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts policy and budget analysis, and operates a number of health promotion and disease prevention programs. NPAIHB is dedicated to improving the health status and quality of life of Indian people and is recognized as a national leader on Indian health issues.

Background on IHCIA

In June 1999, then Indian Health Service Director, Dr. Michael Trujillo, convened a National Steering Committee (NSC) composed of representatives from tribal governments and national Indian organizations to provide assistance and advice regarding the reauthorization of the Indian Health Care Improvement Act (IHCIA). Over the course of five months, the NSC drafted legislation, which was based upon the consensus recommendations developed at four regional consultation meetings held earlier in that year. The consensus recommendations formed

the foundation upon which the NSC began to draft proposed legislation to reauthorize the IHCIA. In October 1999, the NSC forwarded their final proposed bill to the IHS Director and to each authorizing committee in the House and Senate and to the President. The House and Senate introduced legislation based on the tribal bill, but neither passed. Subsequent NSC meeting were hosted by the NPAIHB and held in Portland, OR in May 2002 and March 2003 to refine the proposed legislation that has served as the basis for bills introduced in the 108th, 109th, and now the 110th Congress.

As one can see, Indian Country has put a tremendous amount of time and resources into reauthorizing the IHCIA. The NSC process has served to develop bill that has broad based consensus and is generally supported throughout Indian Country. This act enacted in 1976 declared this Nation's policy to elevate the health status of our population to the highest possible level. Northwest Tribes believe this should be at parity with the general U.S. population. Today, 30 years later, we are no where near achieving this goal. The message from Indian Country is that it is time to pass this bill in the 110th Congress.

Indian Health Disparities

The IHCIA declares that this Nation's policy is to elevate the health status of the American Indian and Alaska Native (AI/AN) people to a level at parity with the general U.S. population. Over the last thirty years the IHS and Tribes have made great strides to improve the health status of Indian people through the development of preventative, primary-care, and community-based public health services. Examples are seen in the reductions of certain health problems between 1972-74 and 2000-2002: gastrointestinal disease mortality reduced 91 percent, tuberculosis mortality reduced 80 percent, cervical cancer reduced 76 percent, and maternal mortality reduced 64 percent; with the average death rate from all causes dropping 29 percent.

Unfortunately, while Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that other types of diseases are on the rise for Indian people. For example, a comparison of death rates for Indian people to the U.S. all races rates indicate they are 638 percent more likely to die from alcoholism, 400 percent greater to die from tuberculosis, 291 percent greater to die from diabetes complications, 91 percent greater to die from suicide, and 67 percent more likely to die from pneumonia and influenza. It can be demonstrated that 13 percent of AI/AN deaths occur in those younger than 25 years of age, a rate

three times higher than the average U.S. population. No other segment of the American population is more negatively impacted by health disparities than the AI/AN population. Many of these issues can be addressed with the enhancements included in H.R. 1328.

H.R. 1328 will allow Indian Country to modernize its health care systems. Since the enactment of the IHCIA in 1976, the health care delivery system in America has evolved and modernized while the AI/AN system of health care has not kept pace with these changes. For example, mainstream American health care is moving out of hospitals and into people's homes; focus on prevention has been recognized as both a priority and a treatment; and, coordinating mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Reauthorization of the IHCIA will facilitate the modernization of the systems of health care relied upon by 1.8 million AI/ANs. Finally, Indian people will get to enjoy the same modern benefits of receiving health care that most Americans receive today.

Construction of Health Care Facilities

I want to this opportunity to alert the Resources Committee to a provision of H.R. 1328 that is particularly concerning to all 43 Northwest Tribes in the states of Idaho, Oregon, and Washington. While I can only speak on behalf Portland Area Tribes, this issue is also a concern for a number of other Tribes nationally who have serious concerns related to the method in which the IHS allocates health facilities construction funds. Our former Chair, Julia Davis Wheeler, served as the Co-Chair of the NSC Facilities Workgroup that worked to develop the legislative language contained in the reauthorization bills, including H.R. 1328. This workgroup worked in a cooperative spirit to develop bill language that reflected the current needs for health facilities construction in 1999, however if the bill language at Section 301(c) passes as proposed, it is questionable whether it will vastly improve the sorry situation for facilities construction and infrastructure improvement for the Indian health system.

Before I review Section 301, I would like to say just a few words about federal funding for health facilities. Medicare and Medicaid provide tens of billions of dollars for facilities construction annually, but there is no discussion of facilities construction before the Congress and no separate appropriation for facilities construction in connection with the Medicare or Medicaid program. Yet most American seniors receive care in the most modern clinics and

hospitals in the world. Indeed it is remarkable, but true, that poor Americans who are eligible for Medicaid in Washington, Oregon, and Idaho now receive their care in the same facilities as other non-poor Americans, that's right, in the very same clinics and hospitals that are the envy of the world. What about Indian people? Our clinics in the Northwest are notable exceptions; most on average are more than 40-50 years old. A clinic on the Colville Indian reservation is over 70 years old; and in other Northwest Tribal communities, clinics are housed in mobile homes. The clinics are not just old, they are also inadequate. They are often too small, the equipment is often outdated, and the staff is forced to make do as best they can. That is, the staff that is willing to stay under these less than desirable conditions. Many tribes continually battle recruitment and retention of medical doctors and nurses because of the less than desirable working conditions. Who can blame someone for not wanting to work up to his or her potential in a modern state of the art facility?

Section 301(c): This section establishes the authority for the IHS to develop a Health Facilities Construction Priority System (HFCPS) that includes a "grandfathering" provision to protect all facility construction projects that are on the current priority list. The language contained in Section 301 was carried over from current law and developed through Tribal consultation, which responded to Tribal needs and concerns in 1999, however given recent changes in the construction priority system, **the language is now out of date**. It is estimated that at the current rate of appropriations for facilities construction, it would take 20-30 years to clear the current projects, thus prohibiting a new facilities construction priority system from ever being implemented and prohibiting the IHS from responding to a Congressional directive.

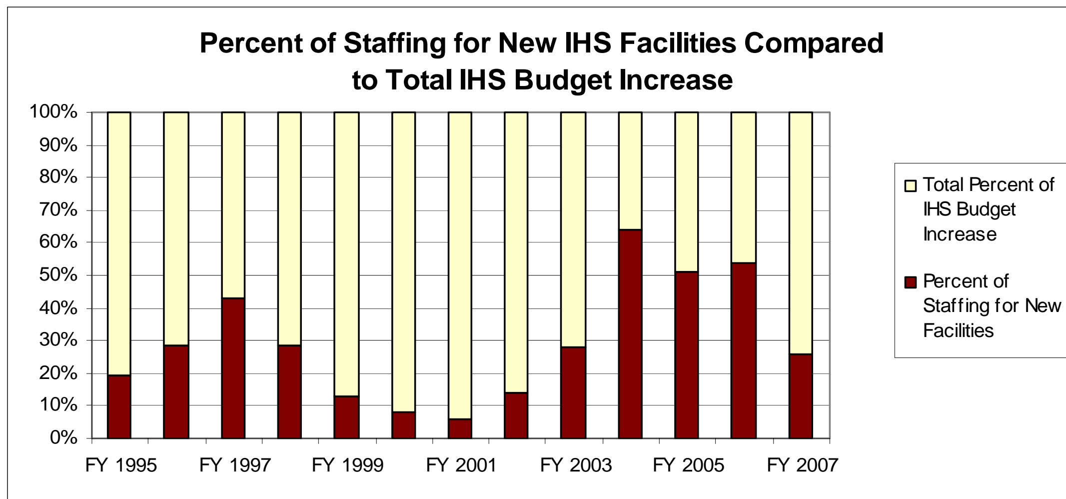
The reason the language at Section 301 is out of date is that over the last three years the IHS and Tribes have worked to develop a new and more equitable construction priority system. The FY 2000 Interior Appropriations Act directed the IHS to "work closely with the Tribes and the Administration to make needed revisions to the facilities construction priority system." Specifically, Congress directed the Agency to address projects "...funded primarily by tribes; anomalies such as extremely remote locations; recognition of projects that involve minimal increases in operational costs; and options for alternative funding and modular construction." The recommendations for the new system are complete and have been forwarded to the IHS Director to make a decision on the final implementation of a new HFCPS. If the Section 301 bill language was to pass today, it would seriously hamper the ability of the IHS Director to

implement the new system and continue the long-standing inequities in allocating facilities construction funds.

Just as the current bill language has gone through Tribal consultation, so too have the recommendations for revising the HFCPS**. In fact, the HFCPS recommendations have gone through much more rigorous Tribal consultation than language in H.R. 1328**. A review of this Tribal Consultation process follows. In June 2004, the IHS sent out for comment a draft of a revised HFCPS. The IHS received over 1,200 comments during the comment period. Because of the complexity of the issues, the IHS Facilities Advisory Appropriation Board (FAAB) established a workgroup to review the comments and address specific issues identified by Tribes. Like the NSC, the FAAB includes Tribal representatives from each of the twelve IHS Areas and two federal representatives. The workgroup met over six months in three meetings held in Portland, Oklahoma City, and Tucson and also conducted numerous teleconference meetings. The workgroup reported their recommendations to the full FAAB on May 11-12, 2005. Based on this report, the FAAB developed specific recommendations to make improvements in the facilities priority system and transmitted their recommendations to IHS on July 21, 2005. In October 2005, the workgroup met again in Rockville, MD to finalize their recommendations based on feedback from the IHS. The revised recommendations were transmitted to IHS on February 28, 2006. On June 26, 2006, the IHS Director sent a letter to Tribal leaders requesting additional facility data to assess the impact on projects under the new system. The full FAAB met in October 2006 in Minneapolis to review a "dry run" of facility construction project scores under the new system. There were concerns related to the project rankings, so the FAAB adjusted their recommendations that were transmitted to IHS on March 3, 2007. This process culminates over three years of work to revise the facilities construction priority system. If this bill passes as proposed it will prohibit the new system from being implemented today.

Tribal Concerns: There are many Tribal concerns associated with facilities construction. Many of these concerns have been addressed in the revision of the new priority system. Generally, Tribes are opposed to the old system because it has been locked since 1991 and allocates a disproportionate share of resources to a select few Tribal communities that results in gaps in the level of health services provided to AI/AN people. The staffing requirements for newly constructed health facilities have always been a concern for Tribes that are dependent on Contract Health Service (CHS) funding to provide health care. The inequities associated with

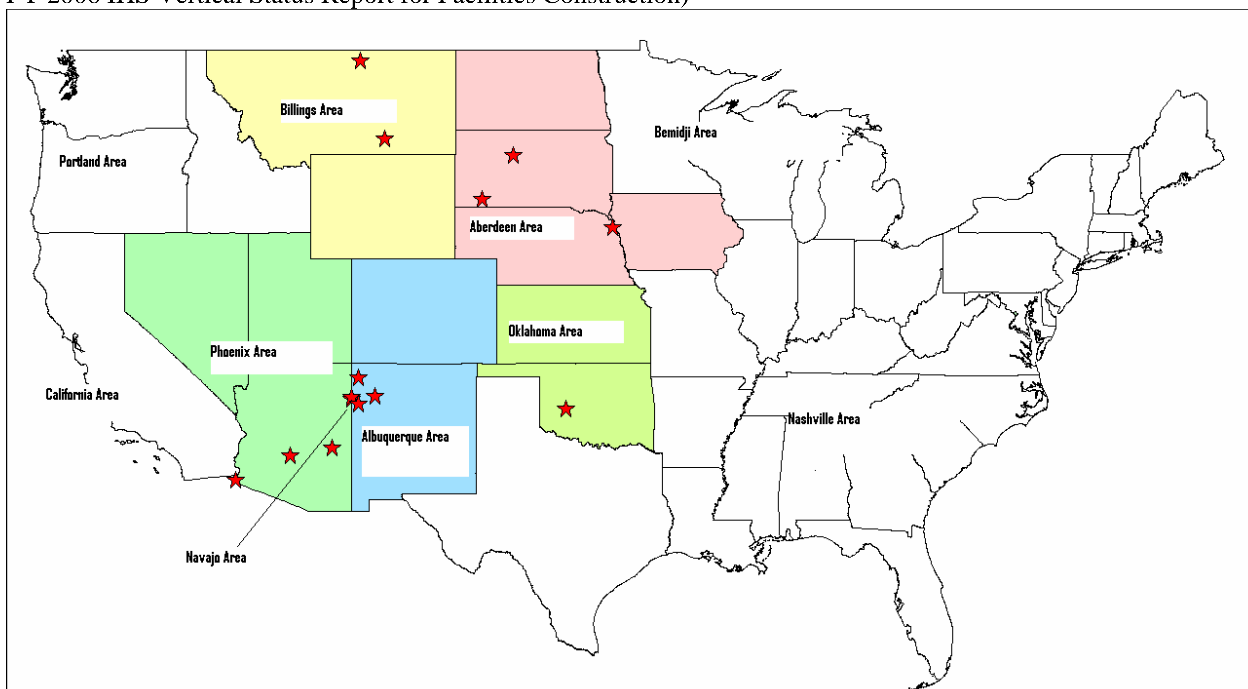
health facilities construction provide a significant amount of resources to one to three Tribes that are fortunate to score well under the priority system and receive a new facility—along with a new staffing package. The significance of staffing new facilities is that it removes funds necessary to maintain current services (pay costs, inflation, and population growth) from the IHS budget increase, which then become recurring appropriations. As the graph below illustrates, staffing packages for facilities construction cuts considerably into budget increases for the IHS.



The graph above demonstrates that phasing in staff at new facilities is a growing problem within the Indian health system. The decline in FY 2007 is a result of the pause in facilities construction in part due to the fiscal effects of the federal deficit. Otherwise, the percentage for staffing new facilities would be considerably more. In FY 2004, the new staffing was over 60% of the IHS budget increase. In FY 2005 and FY 2006, new staffing costs consumed over 50% of the increase. **It simply is not fair that one or two Tribes benefit by receiving 40-60 percent of the IHS budget increase, while 550 other Tribes must divide the remaining budget to fund its mandatory cost increases.**

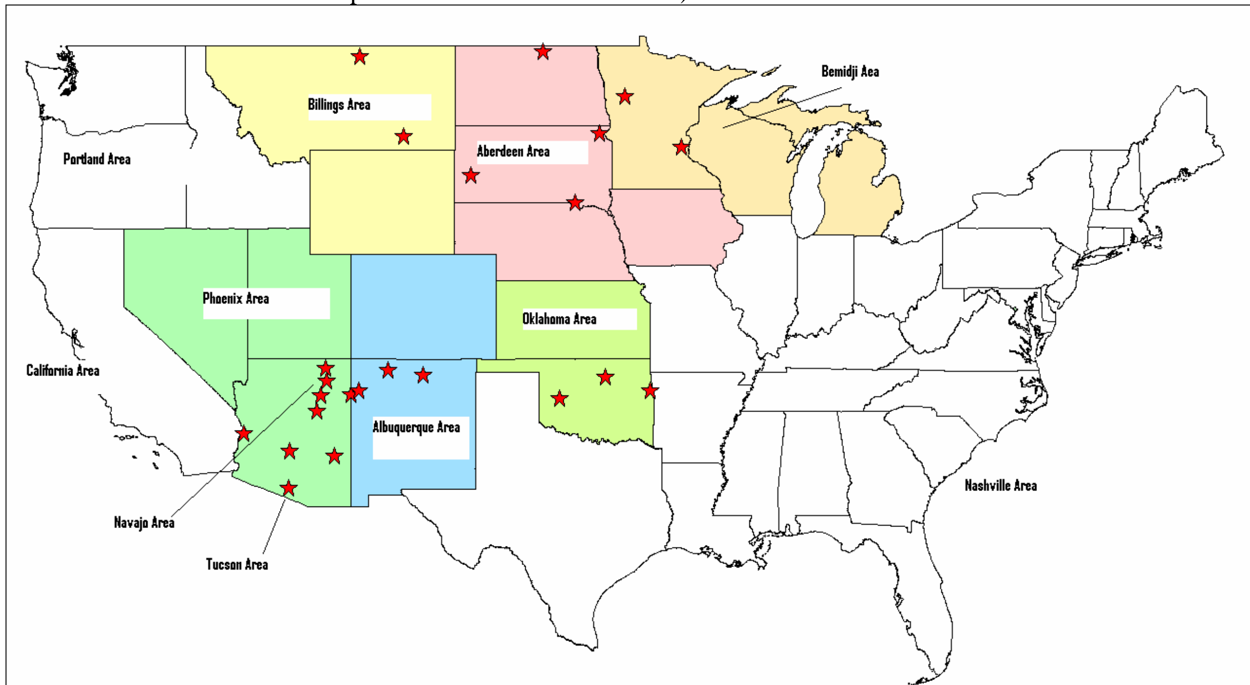
Inpatient Facilities Construction: The following map demonstrates the inequities in allocating facilities construction funding for inpatient hospitals. The map indicates that **there has not been one inpatient hospital built in the Bemidji, California, Nashville, and Portland Areas** under this system. It is important to note that there have been facilities built in these Areas under the joint-venture and small ambulatory program authorities. However, these authorities do not provide for a staffing package similar to those projects built under the HFCPS. This is critical as it provides those projects built under the HFCPS with a generous staffing package that recurs year after year. This in effect provides a disproportionate share of resources to projects built under this system. How can Congress implement a provision in the IHCIA that unjustly provides funding for facilities construction? The work that the FAAB has undertaken over the last three years will address the inequities of this system and levels the playing field for Tribes to compete for facilities construction funding.

Completed and proposed Inpatient Hospitals from the 1991 Health Facilities Construction Priority System. (Source: FY 2006 IHS Vertical Status Report for Facilities Construction)



Outpatient Facilities Construction: Again, the following map demonstrates the inequities in allocating facilities construction funding for outpatient clinics built under the current health facilities construction system. The map indicates that **there has not been one outpatient clinic built in the California, Nashville, and Portland Areas** under this system.

Completed and proposed Outpatient Clinics from the 1991 Health Facilities Construction Priority System. (Source: FY 2006 IHS Vertical Status Report for Facilities Construction)



What is important to note about the above maps is the concentration of facilities construction projects located in the Albuquerque, Navajo, Aberdeen, and Phoenix Areas. The continued funding of projects from the old priority list will perpetuate a Indian health care system that disadvantages those Areas like Bemidji, California, Portland, and Nashville that do not benefit from the facilities construction program. It is time to stop the inequities of this system by revising the language at Section 301(c). In keeping with the principles of this bill, it is highly recommended that the House Resources Committee work to address the issues in Section 301(c) so that it is consistent with H.R. 1328's Declaration of National Indian Health Policy. That policy states that it will, "...assure the highest possible health status for Indians and to provide all resources necessary to effect that policy and raise the health status of Indians." Addressing the inequities of health facilities construction is consistent with this principle.

Recommendation to address Section 301 concerns:

Being respectful of the work of the NSC and keeping with the consensus that has been developed with the IHCIA bill, Portland Area Tribes are supportive of retaining most of the bill language at Section 301(c). As a compromise, we propose that the House Resources Committee adopt one of the FAAB recommendations for revising the facilities construction priority system and revise the language in subsequent provisions of Section 301(c). The first recommendation is the establishment of an Area Distribution Funding methodology. This recommendation would add a provision at Section 301(c)(1)(A) that will allow those Areas that do not benefit from the construction priority system to receive funding to address the facilities construction projects in their Areas. We further recommend that the Committee adopt language changes at Section 301(c)(2)(B) and at 301(c)(1)(D). NPAIHB has provided House Resources staff with a copy of our proposed language for your consideration and we are happy to discuss our recommendations in detail with the Committee's staff.

I look forward to working with you to address the concerns that we have on Section 301 and am happy to make myself to meet with your staff if necessary. I want to thank the members of the Committee for allowing me the opportunity to provide remarks on the IHCIA bill and look forward to working with this new Congress on the passage of this very important bill!