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Subcommittee on Indian, Insular and Alaska Native Affairs

Oversight Hearing on "Improving and Expanding Infrastructure in Tribal and Insular Communities"

March 9, 2017

Good morning Chairman LaMalfa, Ranking Member Torres, and members of the Subcommittee. On behalf of the Northwest Portland Area Indian Health Board ("NPAIHB" or the "Board") and the Confederated Tribes of the Colville Reservation ("Colville Tribes"), I thank you for this opportunity to provide testimony.

I am here today to discuss the challenges that the Colville Tribes, and other Indian tribes in the Indian Health Service ("IHS") Portland Area, face in getting health care facilities constructed under the existing programs administered through the IHS. These issues are of great importance to the Colville Tribes and to other Indian tribes in other IHS areas where IHS facility construction dollars have not traditionally been available. My testimony is on behalf of both the Board and the Colville Tribes.

The Board and the Colville Tribes urge the Subcommittee to do everything in its power to ensure that Congress addresses Indian health facilities needs when it drafts legislation to implement the expected Trump administration infrastructure initiative. In doing so, we also urge this Subcommittee to ensure that all IHS areas benefit from facilities construction and not just a handful of projects.

BACKGROUND ON THE NPAIHB AND THE COLVILLE TRIBES

Established in 1972, the NPAIHB is a P.L. 93-638 tribal organization that represents 43 federally recognized tribes in the states of Washington, Oregon, and Idaho on health care issues. The

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.

The present-day Colville Reservation is approximately 1.4 million acres and occupies a geographic area in north central Washington State that is slightly larger than the state of Delaware. The Colville Tribes has more than 9,500 enrolled members, about half of whom live on the Colville Reservation. In terms of both land base and tribal membership, the Colville Tribes is one of the largest Indian tribes in the Pacific Northwest.

Most of the Colville Reservation is rural timberland and rangeland and most residents live in one of four communities on the Reservation: Nespelem, Omak, Keller, and Inchelium. The Colville Tribes has a large IHS service area and these communities are separated by significant drive times. The CCT's primary IHS facility is located in Nespelem, WA, and residents from Inchelium that require care there must drive in many cases more than 90 minutes through two mountain passes.

HEALTH FACILITIES UNDER THE IHS SYSTEM

There are currently three IHS programs that allow Indian tribes to construct new health facilities. The first is the Health Care Facility Construction Priority List ("Priority List"), which has been in effect for more than two decades and provides funding for construction of the facilities included on the list, as well as 80 percent of the annual staffing costs. The projects on the Priority List have been locked since 1991 and in the intervening decades Congress has directed most of the IHS health facilities construction funding to projects on the Priority List.

The second is the Joint Venture (JV) program, which requires an Indian tribe to pay the up-front cost of constructing a facility in exchange for the IHS providing a portion of the annual staffing costs. Because the JV program provides for the possibility of recurring staffing for selected projects, it is extraordinarily competitive. The IHS has solicited applications for the JV program only twice over the past decade.

The third is the Small Ambulatory Health Center Grants program, which is the opposite of the JV program in that the IHS provides funds for the construction of the facility, but not for recurring staffing. Congress has not provided any funding to this program in more than a decade.

It is important to note that when new facilities are constructed under the Priority List and JV programs, it carries a budgetary commitment for staffing packages that must be funded on a recurring basis. The construction priorities in the Priority List were last updated 26 years ago. As the NPAIHB has noted in previous testimony, the current IHS funding for facilities construction is inequitable in that it provides a disproportionate share of funding to a few select Tribal communities based on decades-old data.

In many cases, the Priority List either did not reflect facilities needs at the time or do not reflect the current needs of tribal communities. For example, the Colville Tribes sought in the 1980s and the early 1990s to replace its Nespelem, WA facility with a new facility. The Nespelem facility was originally constructed in the 1920s as a U.S. Department of War building that was converted for use in the 1930s as a clinic for the U.S. Public Health Service and, later, the IHS. The Colville Tribes

were told by former IHS officials that at one point, its request for a new clinic in Nespelem was near the top of the priority list but was removed because of concerns that the facility was a historical site. None of the more than 40 tribes in the IHS Portland Area, of which the Colville Tribes is a part, have ever had a facility constructed under the Priority List system.

It has been more than 17 years since the Interior Appropriations Subcommittee directed the IHS to revamp its facilities construction system. The IHS, however, has ignored this request and has never provided an updated facilities construction Priority List system. Going forward, this Committee should direct the IHS to develop an updated Priority List methodology that accurately reflects current needs and allows for changed circumstances.

THE AREA DISTRIBUTION FUND WOULD PROVIDE A MECHANISM TO MORE EQUITABLY DISTRIBUTE FACILITIES CONSTRUCTION RESOURCES

When Congress reauthorized the Indian Health Care Improvement Act in 2010, it included a new Section 301(f) that requires the IHS to consult with Indian tribes and tribal organizations in developing innovative approaches to address all or part of the total unmet needs for construction of health facilities. That section also provides that the IHS may establish an Area Distribution Fund ("ADF") in which a portion of health facility construction funding could be devoted to all IHS areas.

The Facilities Appropriations Advisory Board, a joint federal-Tribal advisory committee, developed the ADF concept as a compromise to allow existing projects to be grandfathered into the health facilities Priority List, while at the same time allowing a method for new proposals to be considered and funded. The ADF is intended to allow each IHS area to improve, expand, or replace existing health care facilities. The IHS could extend the benefits of appropriated funds to a significantly larger number of tribes and communities throughout Indian Country than would be possible by relying solely on funding for line-item projects.

Section 301(f) was supported by more than 500 Indian tribes represented in seven of the twelve IHS Areas, including Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada tribes), and Portland. Since then, the National Tribal Budget Formulation Workgroup has recommended that Congress fund the ADF. That Workgroup's recommendations are based on consensus. Despite the tribes' support, the IHS has not taken steps to implement Section 301(f) in the intervening years since its enactment into law.

The Board and the Colville Tribes urge the Subcommittee to do everything in its power to ensure that Congress addresses Indian health facilities needs when it drafts legislation to implement the expected Trump administration infrastructure initiative. We specifically urge the Subcommittee to direct the IHS to distribute a significant portion of any facilities construction funds that may be available under an infrastructure initiative through the ADF to ensure that all IHS areas have an opportunity to address facility needs.

This concludes my testimony. I would be happy to answer any questions that the Subcommittee may have.