

**TESTIMONY OF JULIA DAVIS  
CHAIR OF  
THE NORTHWEST PORTLAND AREA  
INDIAN HEALTH BOARD  
BEFORE THE  
SENATE COMMITTEE ON INDIAN AFFAIRS  
HEARING ON DRAFT LEGISLATION TO REAUTHORIZE THE  
INDIAN HEALTH CARE IMPROVEMENT ACT  
(TITLES I, II AND III)**

**MAY 10, 2000**

I am Julia Davis, recently reelected member of the Nez Perce Tribe's Executive Council. I am also Vice Chair of the National Indian Health Board and Chair of the Northwest Portland Area Indian Health Board. Thank you for this opportunity to testify on behalf of the National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act. The NSC Committee appointed a Reauthorization Leadership Group and I am one of its six members. Today I would like to talk to you about Title III, the facilities section of the draft bill on the Reauthorization of the Indian Health Care Improvement Act (PL 94-437).

As others will mention today the draft bill is the Senate version of the consensus bill developed by tribes last May through October in what was a good example, or perhaps model is a better word, of a good consultation process. This bill was developed by tribes and urban Indian groups and reviewed and commented on by American Indians and Alaska Natives nationwide.

I was the Co-Chair of the Facilities workgroup within the National Steering Committee. I was pleased with the cooperative spirit that attended the development of Title III. I want to acknowledge the hard work of those who contributed to this section of the bill including my Co-Chair Robert Nakai of the Albuquerque Area. Tribes donated valuable staff time and the Indian Health Service provided additional technical support. I think it is a strong section that, if passed as proposed, would vastly improve the sorry condition of the facilities infrastructure of Indian health programs.

Before I review the bill 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 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? Their clinics, with notable exceptions are old, on an average more than 30 years old. My clinic in Lapwai, Idaho is over 40 years old. The clinic director has her office in a windowless basement room. Many of our clinics are really mobile homes. Often, when one of our tribal members becomes eligible for Medicaid they choose to drive 20 miles to Lewiston to see a doctor in a modern facility, not in our Nee Mee Poo clinic.

The clinics are not just old. They are inadequate. They are 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. My tribe just lost a native doctor to an urban clinic. Who can blame someone for not wanting to work up to their potential in a modern facility with state of the art equipment?

### **WHAT EXPLAINS THE POOR CONDITION OF SO MANY INDIAN CLINICS?**

Unfortunately, it is the budget process itself that annually under funds the Indian Health Service budget that is the cause of the poor condition of our facilities. There is no doubt that again this year little progress will be made to address our backlog of facilities need. As a discretionary program, the Congress will ask tribes the annual question: Do you want this year's proposed \$229 million increase to go to health services programs or facilities? This choice is unfair. No one asks Medicare recipients if they want facilities or programs---they get both. The health plans that deliver care to Medicaid and Medicare patients take out a portion of each dollar paid by these programs to provide adequate facilities. It is bad health care and bad business to have poor facilities. The idea of slicing off a portion of our inadequate health services dollars for facilities is not realistic. There is nothing to slice. Because the Indian Health Service is a discretionary program our funding is limited and proposals for facilities construction are the low hanging fruit that is chopped off every year. In fact, I think it is wrong that we don't ask for more than we do each year.

### **WHAT IS NEW IN TITLE III OF THE DRAFT BILL?**

Our general goal was to grant authority to tribes and the Indian Health Service to meet our needs. I have little hope that these authorities will produce the funding needed to meet our needs, however. We reaffirmed our support for existing alternative financing mechanisms like joint venture and proposed new ones like a revolving loan fund to finance facilities construction. In the Northwest, we believe innovative financing of facilities will reduce that gap between our current facilities and our need.

The new title requires the Secretary to develop a new priority system for construction through negotiated rulemaking with tribes, tribal organizations and urban Indian organizations. The consensus bill does include a provision that recognizes that many tribes have waited a long time under the existing system and states that the existing priority list will be used for projects in phase 1 and 2 of construction. An annual report would be required of the need for new facilities; inpatient, outpatient and specialized care facilities. Northwest tribes have expressed the desire that this report take a close look at the need for new inpatient facilities as opposed to alternatives such as clinic construction and expanded contract health dollars to meet the need.

The Sanitation section also tries to promote aggressive cooperation between agencies to maximize revenues to meet the need. It also encourages closer cooperation between the Indian Health Service and tribes to understand and meet sanitation needs. It gives the Indian Health Service the authority to enter into inter-agency agreements with State and Federal agencies to maximize funding opportunities.

For Maintenance and Improvement the new act requires a report to the Congress and President on the backlog of maintenance, as well as the expansion and renovation needs of health program facilities. The new section also allows Management and Improvement funds to be used to build new facilities if the cost is less than 80 % of what would be spent on repairs.

The staff quarters section allows tribes to set the rental rates for the quarters and authorizes tribes to directly collect rents from federal employees.

I think the proposed Title III section has widespread support. In the Northwest, we have presented the title to our Board and at two special meetings, one on December 15, 1999 and at another meeting of direct service tribes on April 14, 2000. I can report to you that our tribes have not expressed any serious reservations about Title III, however, I would understand if some tribes would like to have more time to fully understand this section of the bill.

Thank you and I would be happy to answer any of your questions.

S:\general\2000hrgs\ihcia\_0510\davis.wpd