The Confederated Tribes of the Colville Reservation

Prepared Statement of the Honorable Mel Tonasket, Council Member
Confederated Tribes of the Colville Reservation

House Committee on Appropriations
Subcommittee on Interior, Environment and Related Agencies

Public Witness Hearing—Native Americans

April 8, 2014

Good morning Chairman Calvert, Ranking Member Moran, and members of the Subcommittee. On behalf of the Confederated Tribes of the Colville Reservation ("Colville Tribes" or the "CCT"), I thank you for this opportunity to provide testimony today. I am here today to discuss the challenges that the Colville Tribes and other Indian tribes face in getting needed health care facilities constructed under the existing programs administered through the Indian Health Service ("IHS"). These issues are of great importance to the CCT and to other Indian tribes in other IHS areas where IHS facility construction dollars have not traditionally been available.

The CCT recommends that the Subcommittee (1) provide an additional $15 million in the Health Care Facilities Construction Account for IHS to implement the Area Distribution Fund construction program; and (2) provide at least a $10 million increase to the Criminal Investigations and Police Services account to allow for deployment of more police officers in Indian country.

BACKGROUND ON THE COLVILLE TRIBES

Although now considered a single Indian tribe, the Confederated Tribes of the Colville Reservation is, as the name states, a confederation of twelve smaller aboriginal tribes and bands from all across eastern Washington State. The Colville Reservation encompasses approximately 1.4 million acres and is located in north central Washington State. The CCT has nearly 9,500 enrolled members, making it one of the largest Indian tribes in the Pacific Northwest. About half of our tribal members live on or near the Colville Reservation.

THE AREA DISTRIBUTION FUND WOULD PROVIDE FLEXIBILITY IN HEALTH FACILITY CONSTRUCTION

When Congress reauthorized the Indian Health Care Improvement Act in 2010, it included a new Section 301(f) that requires IHS to consult with Indian tribes and tribal organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities. That section also provides that IHS may consider establishing an Area

Distribution fund ("ADF") in which a portion of health facility construction funding could be devoted to IHS service 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 in to 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 Agency 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 12 IHS areas, including Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada tribes), and Portland. Most recently, the National Tribal Budget Formulation Workgroup unanimously recommended $30 million in FY 2015 to implement Section 301(f), including $15 million for the ADF. That Workgroup's recommendations are based on consensus. Despite the tribes' support, IHS has not taken steps to implement Section 301(f).

The CCT tried unsuccessfully in the 1980s and early 1990s to construct a new health facility through the IHS priority list system. The CCT was told that at one point, it ranked near the top of the priority list but for reasons unknown to the CCT it was never included in the final list. Because the CCT's need for a new facility was so great, it was ultimately forced to utilize a variation of the Small Ambulatory Program to replace its 1930s era clinic in Nespelem, WA. Of the $4,693,000 needed to construct the clinic, the CCT provided $3,324,000 and IHS provided $1,369,000, with no staffing package. Although the Nespelem clinic was completed in 2007, the CCT has a severe staffing shortage, despite the costs that the CCT paid to construct the facility.

The CCT remains in need of a permanent clinic in Omak, the largest population center on the Colville Reservation. The CCT strongly supports implementation and funding of Section 301(f) as a path forward for its facility construction needs. Other tribes nationally are in similar circumstances.

The FY 2015 request does not contain any funding to implement the ADF. The CCT requests that the Subcommittee fund the ADF at the $15 million level in FY 2015 as recommended by the Workgroup.

Suggested Language:

"Changes to the Request include $15 million for the Indian Health Service to implement the Area Distribution Fund under Section 301(f) of the Indian Health Care Improvement Act."

LAW ENFORCEMENT

There is a constant need for additional funding for the Criminal Investigations and Police Services account within the BIA's budget. This account funds tribal and BIA police officer salaries. There are occasions when there is only one or two tribal officers on duty for the entire 1.4-million-acre Colville Reservation.

The much heralded passage last year of the Violence Against Women Act reauthorization will provide those tribes with sufficient resources, and the ability to prosecute non-Indians for domestic violence offenses. But for the majority of tribes, this new authority will mean little if there are not enough police officers on the ground in the first place.

The FY 2015 request includes a modest $1.67 million increase for this account, but the CCT hopes that the Subcommittee can provide at least a $10 million increase to help bridge this gap.

This concludes my testimony. At this time I would be happy to answer any questions that members of the Subcommittee may have.