

# IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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## Testimony of

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**on behalf of the**

**Indian Health Service Tribal Self-Governance Advisory Committee  
12<sup>th</sup> Annual National Department of Health and Human Services  
Budget Formulation and Consultation Session on the 2012 Budget  
Washington, DC  
March 3-5, 2010**

## I. Introduction

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC), I am writing to formally submit the top budget and legislative priorities identified by the Self-Governance Tribes. Self-Governance is a Tribally-driven, Congressional legislative option, whereby Tribal governments are authorized to negotiate annual appropriated funding and assume management and control of programs, services, functions and activities that were previously managed by the federal government. Self-Governance allows Tribes, as sovereign nations, to exercise their right to be self-governing and to take federal program funds and manage them to best fit the needs of their citizens and Tribal communities.

Since initiation of the first Self-Governance agreement two decades ago, the number of Tribes operating their programs under this legislation has steadily increased. **As of 2010, there are 330 Self-Governance Tribes within the Department of Health and Human Services - Indian Health Service (HHS -IHS).** The Self-Governance Tribal leadership and representatives have held on-going meetings with the Administration and Congress regarding ways to improve and advance Self-Governance. The Self-Governance Tribes conduct an Annual Conference and meet each fall for a Strategic Planning Session to discuss and identify goals and priorities. The priorities identified in this testimony are the result of this process and have been included in the 2010-2011 National Self-Governance Strategic Plan.

## II. Top Budget Priorities

The TSGAC is supportive of the Indian Health Services I/T/U budget formulation process and priorities. Within that overall process, the TSGAC has identified the following top budget priorities:

- 1. Support IHS Mandatory Funding (maintaining current services) - \$ 397 million in FY 2012 and \$406.8 million in FY 2011**
- 2. Fully fund Contract Support Costs – \$145 million in FY 2012 (above President's FY 2011 Budget)**

**3. Appoint an Office of Management and Budget (OMB) Assistant Director for Native American Programs**

**III. Top Legislative Priorities**

The TSGAC has identified the following top legislative priorities for this Administration:

- 1. Support Tribal Health Amendments in the Health Care Reform Legislation**
- 2. Support Reauthorization of the Indian Health Care Improvement Act (IHCIA)**
- 3. Support legislation to Expand Self-Governance under a Demonstration Project, by amending Title VI of the Indian Self-Determination and Education Assistance Act (ISDEAA)**
- 4. Support legislation to amend Title V of the ISDEAA to authorize inclusion of diabetes funding in Title V funding agreements**

**IV. Description on Top Budget Priorities:**

**1. Mandatory Funding (Current Services) – in FY 2011 \$406.8 million and in FY 2012 \$397 million**

Current services calculate mandatory cost increases necessary to maintain those services at current levels. These “mandatories” are unavoidable and include medical and general inflation, pay costs, contract support costs, phasing in staff for recently constructed facilities, and population growth. If these mandatory requirements are not funded, Tribes have no choice but to cut health services, which further reduces the quantity and quality of health care services available to American Indian/Alaskan Native (AI/AN) people.

**Recommended Action:** We urge the Administration to fully fund the IHS Budget Formulation Workgroup recommendations for current services, which include:

<b>IHS Current Services Estimates</b>		
	<b>FY 2011</b>	<b>FY 2012</b>
General Inflation and Additional Medical Inflation for the CHS Program	\$ 70.9 million	\$118.1 million
Contract Support Costs (unfunded)	\$ 100.0 million	\$145.0 million
Population Growth	\$ 60.5 million	\$ 42.9 million
Federal & Tribal Pay costs		\$ 25.0 million
Health Facilities Construction		\$ 66.0 million
Health Services Account (not including CHS inflation)	\$ 175.4 million	
<b>Total</b>	<b>\$ 406.8 million</b>	<b>\$397 million</b>

**2. Contract Support Cost Funding – \$145 million in FY2012 (above President’s FY 2011 Budget)**

The FY 2010 final appropriation provides a \$116 million increase for Contract Support Costs (CSC) and signals an end to a sad chapter of neglect for Indian Self-

Determination and Self-Governance. The growth of Self-Governance compacting was seriously undermined from 2002 through 2009 by the failure to pass adequate funding increases to support not only existing contractors, but those who wanted to participate in Self-Governance opportunities. Self-Governance Tribes deeply appreciate the FY 2010 and FY2011 support of the Administration and Congress to address the CSC funding shortfall, and acknowledge the commitment to sustain and expand Indian Self-Determination. The well-documented achievements of Indian Self-Determination and Self-Governance policies have consistently improved service delivery, increased service levels, and strengthened Tribal governments, institutions and services for Indian people.

It is estimated that the CSC shortfall will be \$145 million in FY2012 (above the President's FY 2011 Budget request). Although it is significant and noteworthy that the President has requested a \$45.8 million increase for FY 2011, even this increase will leave significant shortfalls in FY2011 and FY2012.

The chronic underfunding of CSC represents the single greatest impediment to the expansion of Tribal Self-Governance. CSC funding is vital to support the infrastructure needed to operate IHS programs. The present shortfall creates a disincentive for Tribes to pursue Self-Governance compacts, and diminishes available health care funding as Tribal budgets must absorb the shortfall amounts. Adequate CSC funding assures that Tribes, under the authority of their IHS contracts and compacts, have the ability to deliver the highest quality health care services to their members. Tribal programs have significantly increased the quality and level of services in their health systems compared to direct service programs. Failing to adequately fund CSC defeats the very program that has most improved health conditions for Alaska Natives and American Indians. Finally, underfunding CSC disproportionately hurts Self-Governance/Self-Determination Tribes because it protects direct service operations from sharing in overall funding reductions and limitations. And again, underfunding CSCs costs jobs in Indian country.

**Recommended Action:** Fully fund all outstanding shortfalls. To the extent fully funding CSC in FY 2011 is deemed infeasible, the TSGAC recommends that a plan be developed by the Administration and implemented immediately to sustain CSC funding in the appropriations process by eliminating the IHS CSC shortfall over a defined period of time. The objective would be to (1) annually provide sufficient CSC increases to adequately cover expanded CSCs associated with program increases and inflation (\$45.8 million in FY 2011 and a similar sum in FY 2012, and (2) include an additional CSC increase to phase-out the overall shortfall in three years (such as by adding \$35 million to the \$45.8 million).

Pacing increases in this manner would permit the Administration to fulfill its commitment to support Indian Self-Determination and Self-Governance in a responsible manner that reflects the current difficult fiscal environment. It will allow Tribal governments to support the Administration and Congressional efforts currently underway to create jobs in the most severely impoverished parts of the country. If these increases begin in FY2012, it will eliminate the shortfall entirely in the FY2014 budget (after which annual increases would drop back to cover future inflationary, program increase and ISD requirements).

Finally, the Administration should budget for CSC requirements associated with future IHS budget increases. For instance, today any new program dollar requires a matching increase of 13.5 cents in contract support costs, because the CSC requirement is on average 25% of each direct service dollar that is under contract, and 54% of all IHS service dollars are presently under contract. Developing appropriations increases in the future along these lines will prevent any future expansion of the historic CSC shortfall. Once the shortfall is eliminated, as proposed above, this approach will guard against any recurrence of shortfalls in the future.

### **3. Office of Management and Budget (OMB)**

The Office of Management and Budget (OMB) continues to consult on only a very limited basis with Tribes, particularly in sharing budget information. Many years ago, OMB shared a "who-struck-john" table that allowed Tribes to understand where budget cuts were made. This allowed Tribes to direct their advocacy to key decision makers by providing them with information about the funding requirements of Indian health programs. This information is now embargoed and OMB generally refuses to meet directly with Tribal leaders (although a few notable exceptions have occurred in recent months). All budget information should be shared opening with Tribes, consistent with the government-to-government and trust relationship.

The OMB could open the process by (1) sharing the history of each budget from the agency up through final presentation by the President to Congress, (2) sharing budget information prior to the first Monday in February, and (3) sharing budget information during the passback process and permitting Tribes to weigh in during that process. The continued embargo of budget information allows the Administration to violate accepted standards of government-to-government consultation. **Tribes have specifically requested that OMB allow the Department of Health and Human Services to share the OMB pass-back information with Tribes so they can provide their comments to the Administration and the IHS to assist in the preparation of any appeals to the Department and OMB.** Sharing the final budget information with Tribes earlier would also allow them to prepare their testimony for the oversight committees in a timely manner and to target their advocacy where it is needed.

OMB also routinely uses non-medical inflation estimates to calculate budget increases for the IHS budget, vastly underestimating true health care inflation rates. To be consistent, OMB should use the same inflation rates for IHS as are applied to Medicaid and Medicare. It is estimated by some analysts that the IHS budget has lost close to \$1 billion dollars during the Bush Administration when the compounding effect of unfunded inflation, population growth, and unfunded CSC requirements is taken into consideration. Simply stated, the IHS has received insufficient funding to cover population growth and the increasing cost of medical salaries, medical equipment, facility maintenance, and service administration (i.e. contract support costs). This underestimation has seriously diminished the purchasing power of Tribal health programs.

**Recommended Action:** We strongly urge the Administration to prioritize the budget needs of Self-Governance Tribes by appointing an OMB Assistant Director for Native American Programs. We further recommend that OMB use real medical inflation rates when determining funding increases for the IHS budget consistent with those used in the Medicaid program. And we recommend that OMB open the budget process to Tribes as outlined here.

#### **IV. Description on Top Legislative Priorities:**

##### **1. Health Care Reform**

The Administration and Congress are actively engaged in trying to extend access to health care to all Americans, and to make insurance coverage more affordable and predictable, while controlling the total cost of health care expenditures. These are issues of tremendous importance to Tribes who continue to suffer from the underfunding of IHS and the failure of Congress to reauthorize the Indian Health Care Improvement Act, both of which are critical to modernizing IHS and clarifying authority of Tribal health programs. These problems impede the ability of the United States to fulfill its obligations to American Indian and Alaska Native people by making it impossible for IHS and Tribal health programs to provide the full range of needed health services. As a result American Indians and Alaska Natives continue to suffer poorer health status than all other Americans.

National Health Care Reform presents an opportunity for the United States to fulfill its obligations to the First Americans. Both the House and Senate have passed bills on Health Care Reform. Indian-specific provisions have been included in the House bill (H.R. 3962) and the Senate bill (H.R.3590). Both measures demonstrate that congressional policymakers have been mindful of their responsibilities to include specific language to assure that the unique Indian health system is not adversely affected by – and enjoy full rights of participation in – health care reform initiatives. Both bills would also reauthorize and up-date the Indian Health Care Improvement Act (IHCA), thereby bringing to fruition more than a decade-long effort of Indian Country.

##### **2. Reauthorization of the Indian Health Care Improvement Act.**

As noted above, versions of the IHCA reauthorization have been included in the House (H.R. 3962) and Senate (H.R.3590) health care reform bills. The United States has a longstanding trust responsibility to provide health care services to American Indians and Alaska Natives. This responsibility is carried out by the Secretary of Health and Human Services through the IHS. Since its passage in 1976, the Indian Health Care Improvement Act (IHCA) has provided the foundational programmatic and legal framework for carrying out the federal government's trust responsibility for Indian health.

It has been 18 years since the Congress last reauthorized and enacted a comprehensive review of the IHCA (since 1992). The reauthorization of the IHCA will modernize and improve Indian health care services and delivery, allow for programs to address the behavioral and mental health and well-being of Indian communities, and allow for in-home care for the Indian elderly population. Most importantly it will help address critical health disparities such as infant mortality, diabetes, alcoholism, suicide

and the inequity in health care expenditures for Indians compared to other citizens of the United States

### **3. Title VI Demonstration Project**

The expansion of Self-Governance within Title VI of the ISDEAA would greatly assist Tribes in serving their people. By such amendments Tribes would gain increased flexibility to redesign programs that are within the Administration on Aging (AOA), Administration for Children and Families (ACF), Substance Abuse and Mental Health Services Administration (SAMHSA), and Health Resources and Services Administration (HRSA). Tribes would also be able to reallocate program funding to better meet the needs of their citizens.

In 2000, Congress added Title VI to the ISDEAA, directing DHHS to study the feasibility of expanding Self-Governance to reach agencies within DHHS other than IHS. The DHHS March 2003 study concluded that expanding Self-Governance was feasible and identified several candidate programs for inclusion in Self-Governance agreements. The study also reaffirmed that Tribes are capable of overseeing essential health care programs and services, while maximizing responsiveness to the needs of Tribal citizens (particularly as compared to state-operated programs). In 2003, a Tribal bill to implement the study's recommendations on a demonstration basis was reported out of the Senate Committee on Indian Affairs (SCIA), but died in part due to opposition by President Bush's Administration.

The new Administration should help move this important legislation forward during the 111<sup>th</sup> Congress, so that Tribes can assume direct operation of such essential programs as Temporary Assistance for Needy Families (TANF), Community Services Block Grants, and Head Start. With Welfare Reform slated to be reauthorized in the 111<sup>th</sup> Congress, there is an excellent opportunity to include in such legislation amendments to Title VI of the ISDEAA.

### **4. Title V ISDEAA - Diabetes Amendment**

Since 1997, Congress has provided significant funding—\$150 million in FY 2008—for a Special Diabetes Program for Indians (SDPI). The program is administered by the DHHS grants office, not the IHS. For this reason, alone, this diabetes funding is not subject to being compacted by Tribes under Title V of the ISDEAA. This has created burdensome administrative complications for Self-Governance Tribes, who must separately secure and administer diabetes grants, even though the funded programs under these grants and ISDEAA compacts are interrelated and carried out together. The problem can be solved by an amendment to section 505(b) of Title V of the ISDEAA, adding SDPI funds and associated activities to Title V agreements. Such an amendment would enhance control over program design, increase accountability to Tribal communities, and convert a grantee relationship with a DHHS grants office into a government-to-government relationship with the Secretary. The reauthorization of Welfare Reform is an opportunity to pursue this much needed legislative amendment.

## **VI. Summary of Tribal Testimony Submission**

We are deeply appreciative of the Secretary's impressive, sincere and continuing outreach to Tribal governments and inter-tribal organizations. This continued dialogue does honor to President Obama's commitment to the government-to-government relationship. We look forward in the coming years to continuing this close collaboration in order to narrow, and hopefully to close, the gap in health care and health status within the framework of Tribal Self-Governance and Self-Determination.

Thank you.