IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE
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National Indian Health Board

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Sent electronically to: millerb@gao.gov

November 8, 2018

The Honorable Gene L. Dodaro
Comptroller General of the United States
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Re: GAO-18-652, "Indian Health Service: Considerations Related to Providing Advance Appropriation Authority"

Dear Mr. Dodaro:

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee, the National Indian Health Board, the Self-Governance Communication & Education Tribal Consortium, the Northwest Portland Area Indian Health Board, and the Tribal nations we represent, we are writing to you today to provide some comments following the release of GAO-18-652, *Indian Health Service: Considerations Related to Providing Advance Appropriation Authority*, and to request that GAO create a Tribal Advisory Committee. In general, we believe that GAO can benefit from additional context in its reports that uniquely affect Indian country, as demonstrated in the comments below. Tribal leaders are in the best position to work with GAO on a government-to-government basis to provide this information.

Background

Through a series of treaties between the United States and Tribal nations, Tribes ceded significant portions of their lands to the United States and, in exchange, the United States assumed a responsibility to provide certain benefits to American Indians (AI) and Alaska Natives (AN), including health care services. Since its creation in 1955, the IHS has worked toward fulfilling the federal promise to provide health care to AI/ANs. In passing the Affordable Care Act, Congress reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). In the IHCIA, Congress reaffirmed the duty of the federal government to AI/ANs, declaring: **"it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."**

In February 2017, GAO added Federal administration of health care programs that serve Tribal nations and their citizens to its high-risk list. In its high-risk report, GAO recognizes the failure of the United States to fulfill its special trust responsibilities to AI/ANs. However, GAO's report and subsequent testimonies fail to highlight the primary factor hindering the IHS's ability to provide adequate health care to AI/ANs—wholly inadequate funding. Rather, the report focuses on challenges that are not as consequential to the overall operation of the IHS. The simple fact is that the IHS continues to be chronically underfunded with a budget that only meets about half of its need. In 2017, the IHS per capita expenditure for patient health services was just **$3,322**, compared to at least **$9,990** per person for health care spending nationally.[1]

In addition to a lack of resources, funding delays contribute significantly to the challenges the IHS and Tribes face when they seek to provide health care to AI/ANs. For nearly two decades, there has been only one year when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year. Funding delays make it very difficult for Tribal health providers and IHS to adequately address the health needs of AI/ANs. **Congress can address this problem by authorizing advance appropriations for IHS.**

Congress Requested GAO Review the Use of Advance Appropriation Authority

In response to a Congressional request, GAO reviewed the use of advance appropriations authority and applications to IHS. GAO reported many benefits associated with advance appropriations authority. We are very appreciative that GAO documented what many Tribal leaders have been reporting for years—if Tribally

[1] Figures on congressional appropriations for IHS include funding for health care delivery as well as sanitation and facilities. Source: *2017 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita*," February 26, 2018, available at: https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/2017_IHS_Expenditures.pdf, last accessed 10/15/2018.

administered and IHS programs had advance appropriations, they could better plan their patients' care over a longer period of time.

Nothing underscores the need for advanced appropriations authority more clearly than the federal government shutdown at the start of FY 2014. Not only did this period prevent Tribal and IHS facilities from providing adequate care, it came at a time when programs were already operating with minimal budgets due to the fiscal year 2013 across-the-board sequestration cuts—which were not applied to any other federally-funded health program. This two-week government shutdown forced some Tribally-operated health programs to only treat "life or limb" cases due to the lack of an operating budget. Others had to borrow funding at additional cost to the Tribe in order to continue delivery of these federal services.

In addition to identifying the benefits of this advance appropriations authority, GAO reported several considerations for lawmakers. Unfortunately, based on the information identified in the report, GAO drew conclusions that do not consider or lay out the full context of the situation. These conclusions may raise doubts with lawmakers that the IHS should be provided advance appropriations authority—authority that is already provided to the Veteran's Administration and the Corporation for Public Broadcasting. We address a few of our concerns associated with the considerations presented in the report below:

Amount of Funding to be provided in IHS Advance Appropriations

GAO reported: "*If Congress were to grant IHS advance appropriation authority, it would need to make operational decisions regarding what amount of IHS funding would be provided in advance appropriations, with input from OMB and IHS as appropriate."*

While the logistics of implementing the advance appropriation should be developed by Congress and IHS in consultation with Tribal nations, it is the position of Tribal leaders that the full appropriation should be added to advance appropriations. The IHS receives only three main appropriations—services, facilities, and contract support costs (CSC). The CSC appropriation is indefinite, and would not be impacted by advance appropriations, but it is clear from the data presented in the previous pages of the report that both services and facilities would significantly benefit from the advance appropriation authority.

Advance Appropriations for IHS Will Not Unduly Reduce Flexibility

GAO reported: "*Advance appropriation authority reduces flexibility for congressional appropriators, because it reduces what is left for the overall budget for the rest of the government—meaning the total available for appropriations for a budget year is reduced by the amount of advance appropriations for that year, when budgets have caps."*

The federal trust responsibility to Tribal nations and AI/ANs is not "discretionary" and this information should have been identified to ensure the statement is read within the appropriate context. Tribes prepaid for health services. GAO's assertion that IHS funding—which is currently far below the actual need—might somehow take away from other programs is irrelevant. In addition, the $5.5 billion in the fiscal year 2018 IHS budget is miniscule when compared with discretionary appropriations, and any increases given to IHS (if looking at historical trends) would have a nominal impact on the federal budget. We believe Congress can plan accordingly if it decides to increase the IHS budget. Perhaps most critically, Congress providing advance appropriations, whether it be for IHS or the Veterans Health Administration, does not in any way constrain the federal budget: it is just that we and Congress will know one year in advance what will be attributed to the Interior Subcommittees' allocation for the year in which the IHS funds are available.

IHS Leadership's Ability to Manage an Advance Appropriation

GAO reported: "*IHS still does not have permanent leadership—including a Director of IHS—which is necessary for the agency to demonstrate its commitment to improvement."*

GAO identified the lack of IHS permanent leadership as a consideration for advance appropriations. Current IHS leadership retains the full authority to make decisions on all funding issues so they should also have the full authority to manage advance appropriations processes. The agency is funded at $5.5 billion in FY 2018 and there is no reason to believe that the same staff could not responsibly carry out its duties related to these funds if the funding were allocated a year ahead of time. [2] Finally, the lack of permanent leadership is because a nominee for IHS Director has not been named by the Administration. Political appointment decisions should not be the basis for preventing major policy changes that improve the health care for AI/ANs, including the implementation of advance appropriation authority.

GAO Does Not Identify the Effect of Linking Its High-Risk Designation to Advance Appropriation Authority on Tribally-Operated Health Programs

GAO reported: *"While not directly related to consideration of advance appropriations, IHS's high-risk designation and continuing challenges in mitigating the deficiencies in its program point to questions about the agency's capacity to implement such a change to its budget formulation process."*

The IHS's high-risk designation should not be a factor in the consideration of whether advance appropriations authority is a good or bad idea for the IHS. IHS officials stated

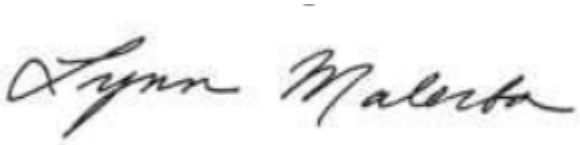
[2]Other federal agencies with larger budgets—such as the Centers for Disease Control and Prevention—do not have a Senate confirmed leader.

that they would have little difficulty making this change and we found no evidence in the report that the IHS officials' statement should be put in doubt.

GAO reported that a significant portion of IHS funding and programs are administered by Tribal nations that participate in Self-Governance initiatives—specifically, over 60% of the IHS budget is administered directly by Tribal nations through Self-Governance compacts and Self-Determination contracts.[3] However, GAO's linkage of the IHS high-risk designation to advance appropriation authority could have negative implications for the Tribal nations that have taken over administration of healthcare programs from the federal government. Decades of evidence show that when Tribal nations assume the administration of health care programs from the federal government, Tribes are more successful in the administration and financial management of health programs than the federal government. This has resulted in the ability of Tribes to be more effective at meeting the health needs of their communities. In summary, GAO deemed it appropriate to place IHS management challenges on its high-risk list. IHS management challenges should not be transferred to Tribal nations that elect to manage their own health programs.

In closing, thank you for taking the time to consider the concerns raised in this letter and we look forward to working with GAO to create a Tribal Advisory Board. Should you have any questions regarding this matter or if you would like to discuss it further, please contact Chief Lynn Malerba at (860) 862-6192 or lmalerba@moheganmail.com; Stacy Bohlen, Chief Executive Officer, National Indian Health Board, at sbohlen@nihb.org; or Jay Spaan, Executive Director, Self-Governance Communication & Education Tribal Consortium, at jays@tribalselfgov.org.

Sincerely,

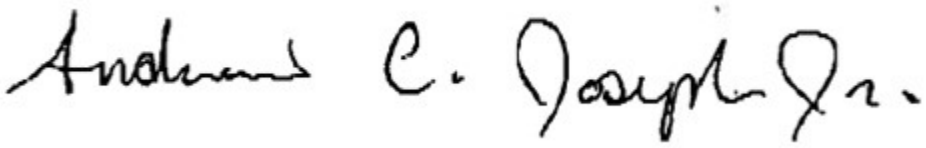


Chief Lynn Malerba
Mohegan Tribe of Connecticut
Chairwoman, IHS TSGAC

[3] "FY 2019 IHS Justification of Estimates for Appropriation Committees", p. CJ-13.

Vinton Hawley
Chairman
National Indian Health Board

W. Ron Allen
Tribal Chairman/CEO, Jamestown S'Klallam Tribe
Board Chairman, Self-Governance Communication & Education Tribal Consortium



Andrew C. Joseph, Jr.
NPAIHB Chairperson
Confederated Tribes of Colville Vice Chairman

cc: Tribal Self-Governance Advisory Committee
A. Nicole Clowers, Managing Director, Health Care, U.S. GAO
Jessica Farb, Director, Health Care, U.S. GAO