

# National Indian Health Board



February 4, 2022

The Honorable Brian Schatz  
Chairman  
Senate Committee on Indian Affairs  
838 Senate Hart Office Building  
Washington, DC 20510

The Honorable Lisa A. Murkowski  
Vice Chair  
Senate Committee on Indian Affairs  
838 Senate Hart Office Building  
Washington, DC 20510

## ***Re: Indian Health Service Contract Support Costs Legislative Fix***

Dear Chairman Schatz and Vice Chair Murkowski:

On behalf of the 574 federally-recognized Indian Tribal nations and Member Organizations, the National Indian Health Board (NIHB) serves,<sup>1</sup> we write to you regarding a legislative fix to correct a recent judicial decision which could potentially destabilize the Indian health system serving Tribal communities. Your support is respectfully requested to amend the *Indian Self-Determination and Educational Assistance Act* (ISDEAA) to clarify and restore the status quo for Contract Support Costs (CSC) administration for Indian health care systems.

A recent D.C. Circuit Court of Appeal case, *Cook Inlet Tribal Council, Inc. v. Dotomain*<sup>2</sup>, wrongfully decided how CSC should be defined, contrary to Congress' direction on CSC. This decision is now being applied in federal-Tribal contract negotiations to deny millions of dollars for necessary health care operational support. Congress authorized this type of funding in the ISDEAA and, in the absence of a clarifying amendment, the direction and intent of Congress will continue to be contravened – to the detriment of health care for American Indians and Alaska Native people.

On January 24, 2022, the NIHB Board of Directors took formal action to support a legislative fix to this judicial decision. We stand ready to work with Congress to advance legislation clarifying the ISDEAA as Congress intended for the benefit of Indian health care.

### **Background – ISDEAA and CSC**

The federal government has a trust responsibility to Tribal nations to provide health care services for American Indians and Alaska Native people. In carrying out that responsibility, the federal government through the Indian Health Service (IHS), an agency within the Department of Health and Human Services, provides those services either 1) directly or, 2) pursuant to the ISDEAA, enters contracts and compacts with Tribes which then provide the health care services.

The ISDEAA governs the processes, mechanisms, and policy for Tribal administration of federal programs. The principles and hallmarks of the ISDEAA are flexibility, efficiency, and effectiveness.

---

<sup>1</sup> Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). Whether Tribes operate their entire health care program through contracts or compacts with IHS under the *Indian Self-Determination and Education Assistance Act* (ISDEAA) or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

<sup>2</sup> 10 F.4th 892 (D.C. Cir. 2021).

Although the health care services remain severely underfunded, the ISDEAA has resulted in a significant improvement in Indian health care delivery through Tribal administration.

Congress amended the ISDEAA to authorize funding for 1) costs for the operation of programs or portions thereof for the contract or compact period<sup>3</sup> and 2) CSC, such as worker’s compensation and overhead.<sup>4</sup>

In enacting these provisions, Congress recognized the importance and necessity of the CSC to the “prudent management” of Indian health programs. Moreover, Congress has supported a flexible administration of CSC which would enable Tribes to effectively operate health care programs.<sup>5</sup> As a matter of law, Congress has authorized full funding of these costs as well.<sup>6</sup> These principles reflect the cornerstones of Tribal self-determination and self-governance policy and set forth a clear direction from Congress to bolster, not arbitrarily restrict, CSC.

### **The Impact of the Cook Inlet Decision**

The *Cook Inlet* case sets a troubling precedent for Tribal health programs. In *Cook Inlet*, the Court found that certain facility costs may not fall under the umbrella of items that are reimbursable as CSC. Because these facility costs are “normally” incurred by IHS in their administration of a program, they should be considered secretarial operational costs and not eligible for reimbursement as a CSC.<sup>7</sup>

The Court recognized, however, that “perhaps nuances or exceptions may arise” in determining what qualifies as CSC.<sup>8</sup> While Congress did not refer to such costs as “nuances or exceptions”, flexibility was clearly intended for Tribes in the ISDEAA. Congress knew that Tribes justifiably needed

---

<sup>3</sup> 25 U.S.C. § 5325(a)(1).

<sup>4</sup> For CSC, the ISDEAA provides in pertinent part:

(2) There shall be added to the amount required by paragraph (1) contract support costs which shall consist of an amount for the reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract and prudent management, but which—

- (A) normally are not carried on by the respective Secretary in his direct operation of the program;
- or
- (B) are provided by the Secretary in support of the contracted program from resources other than those under contract.

(3)(A) The contract support costs that are eligible costs for the purposes of receiving funding under this chapter shall include the costs of reimbursing each tribal contractor for reasonable and allowable costs of—

- (i) direct program expenses for the operation of the Federal program that is the subject of the contract; and
- (ii) any additional administrative or other expense incurred by the governing body of the Indian Tribe or Tribal organization and any overhead expense incurred by the tribal contractor in connection with the operation of the Federal program, function, service, or activity pursuant to the contract, except that such funding shall not duplicate any funding provided under subsection (a)(1) of this section.

25 U.S.C. § 5325(a)(2) and (a)(3)(A).

<sup>5</sup> See S.Rep. 103-374.

<sup>6</sup> 25 U.S.C. § 5325(a)(2), (g). See also *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012).

<sup>7</sup> However, the IHS CSC Manual includes certain facility support costs as eligible for CSC reimbursement. Indian Health Service Contract Support Cost Manual (IHM) § 6-3.2D. Available at <https://www.ihs.gov/IHM/pc/part-6/p6c3/#6-3.1G> (last reviewed February 3, 2022).

<sup>8</sup> *Cook Inlet Tribal Council, Inc. v. Dotomain*, 10 F.4th 892 (D.C. Cir. 2021) at 6.

flexibility in determining and tailoring how programs and their supporting costs should be addressed and managed. As a result, Tribal decisions on what costs (including the so-called “nuances or exceptions”) are involved and qualify for CSC take on a greater significance and weight. That would include costs for programs that have expanded and grown over the years.

But the opposite appears to be the result of the *Cook Inlet* case. In December, 2021, citing the *Cook Inlet* decision, the IHS denied one Tribal organization \$16,627,268, **or 90%**, of its CSC support for Fiscal Year 2022. We are concerned that without Congressional action, these denials and funding reductions will continue. Congress cannot allow this to happen.

Tribes are concerned about this case impacting their ability to administer their health care services and programs and treat their patients. Indian health care services are chronically underfunded. Tribal health care providers already stretch limited resources to overcome significant health disparities and inequities among the Tribal population. This task is made even more complicated by funding reductions and instability.

Without the CSC funding, Tribes will not be able to pay for these costs and, instead, be forced to divert funding from patient care to pay for the overhead and other CSC. These reductions will result in diminished access to care across the Indian health system. Congress specifically authorized CSC in the ISDEAA to avoid this situation.

### **Conclusion**


We urge Congress to fix this problem and preserve the CSC for its intended purposes. Restoring the ***status quo for CSC administration*** would help ensure that Tribes can receive their CSC and not be forced to reprogram health care services funding to cover the overhead and other CSC. Tribal providers do not have the flexibility to divert millions of dollars to cover such costs.

We urge Congress to legislatively correct the *Cook Inlet* Court decision and ensure that Tribal programs can continue operating their programs and treating their patients without any CSC and programmatic funding reductions. If you have any questions or need more information, please do not hesitate to contact the NIHB Chief Executive Officer, Stacy A. Bohlen at [sbohlen@nihb.org](mailto:sbohlen@nihb.org). Thank you for your consideration in this matter.

Sincerely,



William Smith, *Valdez Native Tribe*  
Chairman  
National Indian Health Board



Stacy A. Bohlen, *Sault Ste. Marie Chippewa*  
Chief Executive Officer  
National Indian Health Board

Cc:

Nickolaus Lewis, NIHB Vice Chairman and Portland Area Representative  
Lisa Elgin, NIHB Secretary and California Area Representative  
Sam Moose, NIHB Treasurer and Bemidji Area Representative

Marty Wofford, NIHB Member-at-Large and Oklahoma City Area Representative  
Beverly Coho, NIHB Albuquerque Area Representative  
Timothy Davis, NIHB Billings Area Representative  
Victoria Kitcheyan, NIHB Great Plains Area Representative  
Beverly Cook, NIHB Nashville Area Representative  
Jonathan Nez, NIHB Navajo Area Representative  
Amber Torres, NIHB Phoenix Area Representative  
Sandra Ortega, NIHB Tucson Area Representative  
Alberta Unok, President/CEO, Alaska Native Health Board  
Ayn N. Whyte, M.S., Executive Director, Albuquerque Area Indian Health Board  
Will Funmaker, Executive Director, Great Lakes Area Tribal Health Board  
William Snell, Executive Director, Rocky Mountain Tribal Leaders Council  
Mark LeBeau, PhD, Executive Director, California Rural Indian Health Board  
Jerilyn Church, Executive Director, Great Plains Tribal Leaders' Health Board  
Kitcki Carroll, Executive Director, United Southern and Eastern Tribes, Inc.  
Jill Jim, PhD, MHA, MPH, Executive Director, Navajo Nation Department of Health  
Nic Barton, Executive Director, Southern Plains Tribal Health Board  
Maria Dadgar, Executive Director, Inter-Tribal Council of Arizona  
Laura Platero, Executive Director, Northwest Portland Area Health Board