



National Indian Health Board 



September 3, 2021

The Honorable Xavier Becerra
Secretary
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave SW
Washington, DC 20201

Sent via email: consultation@hhs.gov

Re: Mandatory Appropriations Dear Tribal Leader Letter

Dear Secretary Becerra:

On behalf of the undersigned organizations, I write to you in response to the August 12, 2021, Dear Tribal Leader Letter (DTLL) seeking comments regarding Mandatory Appropriations for the Indian Health Service (IHS). We greatly appreciate President Biden’s commitment to ensuring the stability of the Indian health care system. Secretary Becerra, we applaud your leadership and “call for a challenge” in addressing this multi-faceted and extremely complicated funding and health care system.

Overview

This dialogue is a first step in determining the potential for full entitlement funding for the Indian health care system. Common themes have emerged from this consultation, including the need for a comprehensive, Tribally-driven study on the needs of the Indian health system and support for reclassifying costs associated with Contract Support Costs (CSC) and Section 105(l) leases as mandatory as soon as possible.

These issues are complex and have vexed the IHS and Tribal leaders for years. Therefore, two weeks of consultation is not sufficient to reach a firm consensus on these issues. For example, this matter arose when considering the reauthorization of the *Indian Health Care Improvement Act* (IHCA). A draft bill (H.R. 1662, introduced in the 107th Congress) included language regarding the need for a Commission study, a process far more extensive than a two-week

consultation. While Congress did not address the matter in the final passage of the IHCA reauthorization, we commend your willingness to take up this challenge once again.

As we assess the mandatory funding issues, we urge the Administration to continue to work diligently and expeditiously with Congress and Tribes to reclassify the Contract Support Costs (CSC), and Section 105(l) leases as mandatory funding, beginning no later than FY 2023. Congress must reclassify CSC and Section 105(l) leases *without reprogramming or reducing funding* for other Indian health programs or services. The reclassification of CSC and 105(l) lease accounts as mandatory funding and achieving Advance Appropriations for the IHS are critical first steps to full mandatory appropriations.

Additionally, we recommend the Administration work with Tribes to better understand the long-term goal of full mandatory appropriations for IHS services and facilities accounts. Consultation and deliberation on full mandatory appropriations must be intentional and thorough to ensure the funding mechanisms address all needs of the Indian health care system

To that end, we believe that the Administration must fund a **Tribally driven study feasibility study** to accurately assess the full scope of the Indian health system's needs and develop a path forward on an appropriate schedule.

Trust Responsibility

Over the course of a century, sovereign Tribal Nations and the United States signed over 350 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises – which exist in perpetuity - collectively form the basis for what we now refer to as the federal trust responsibility. During permanent reauthorization of the Indian Health Care Improvement Act, Congress declared that, “...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.”¹

The Indian Health Service (IHS) is the principal federal entity charged with fulfilling the federal trust responsibility for healthcare; however, every branch and agency of the federal government is required to honor and uphold the trust obligations for health to sovereign American Indian and Alaska Native (AI/AN) Tribal Nations and Peoples. These trust obligations are owed to AI/AN peoples because of their status as American Indian and/or Alaska Native, and do not have an expiration date.

Tribally-driven Study

The Indian health care system is a complex mechanism consisting of medical, preventive, and rehabilitative services and facilities run directly by IHS, Tribes, and Urban Indian Organizations. It also serves a variety of populations in a variety of locations, all with different needs.

¹ 25 U.S.C. § 1602

Most importantly, it also involves 574 sovereign Tribal governments. These sovereign governments are in the best position to examine and determine the needs of their communities and the people this Indian health system intends to serve. The United States must defer to Tribal governments to lead a study about the needs of their people.

The IHS Budget Formulation Workgroup (the Workgroup) has estimated full funding to be approximately \$49 billion per year. However, the Workgroup has acknowledged that, while they base this figure on the best information available, the figure may still underestimate the full scope of the system's needs. We agree.

The Indian health system is still dealing with years of neglect from the Federal Government. As outlined in the U.S. Commission on Civil Rights' "Broken Promises" report, the Federal Government has chronically and substantially underfunded the Indian health system.² This underfunding has resulted in aging facilities, with little hope of receiving the necessary replacement or renovations. The average age of an IHS facility is greater than 37 years old, which compares highly unfavorably with nine to ten years in the private sector.³ At the current rate of appropriations, an IHS facility built today would not be replaced for **400 years**.

While receiving little funding, these same facilities are still required to provide top-notch patient care, even as health care delivery continues to evolve. This inequity will pose a challenge in the future. For example, throughout the COVID-19 public health emergency, telehealth has become an increasingly important component of the health care delivery system. Aging infrastructure creates a barrier to its adoption. Facilities need to be constructed and retrofitted with adequate telecommunications equipment and a broadband connection that enables sufficient interoperability and communications with patients and other providers within the system.

The failure of the Federal Government to provide adequate funding has contributed to this glaring disparity. **Determining the scope of the funding disparity and what it will cost to fully modernize and deliver the various types of Indian health care facilities is an example of the work that a Tribally-driven study must encompass.**

Funding must allow for the engagement of subject matter experts, as needed, to determine the full scope of need. This study must include experts such as health economists and actuaries. The study must also include a Tribally-driven analysis across all Areas to determine full need.

Given the scope of the questions involved and the complex evaluation required, a two-week consultation will not provide the level of detail that an in-depth Tribally-led study could provide to enable the Administration and Tribal leaders to make a fully informed decision. **We recommend a Tribally-driven study on an appropriate schedule to fully evaluate and determine the answer to these questions.** A Federal-Tribal workgroup must examine the results of that study to determine the best path forward. Any recommendations developed by the Workgroup should be subject to robust and ongoing Tribal consultation.

² U.S. Commission on Civil Rights. The Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans (2018).

³ See <https://www.hhs.gov/about/agencies/asl/testimony/2021/06/17/examining-federal-facilities-indian-country.html>

Section 105(l) Leases and CSC

Payments for Section 105(l) leases and CSC are contractual obligations to Tribal nations. These costs are not negotiable and must be paid to Tribes. However, these items are current discretionary funding line items in the IHS budget. Classifying these budget items as discretionary has created disastrous and inappropriate competition with facilities and services for funding. While CSC has received nearly full funding and more funding has been requested for Section 105(l) leases, the rest of the IHS budget falls below parity. Moreover, on an annual basis, these items impact the larger Interior, Environment, and Related Agencies Budget, which affects services essential to Tribal communities.

The President's Budget Request for FY 2022 has recommended:

In addition, the Budget proposes reclassification of the appropriations for Contract Support Costs and section 105(l) lease agreements beginning in FY 2023. Specifically, the Budget proposes that, beginning in FY 2023, these accounts will continue to be funded through the Appropriations process but will be reclassified as mandatory funding. At present, Congress provides funding for these costs through an indefinite discretionary appropriation. These costs are more appropriately funded from mandatory appropriations because they arise from the operation of law.

We recommend that the Administration work diligently and expeditiously with Congress and Tribes to reclassify this funding as most appropriate for Tribes, without reducing or reprogramming any other funding within the IHS budget.

Conclusion

The Indian health care system is a complex mechanism, borne out of a trust responsibility and treaty obligation that the Federal Government has so often failed to uphold. It has been chronically underfunded and often neglected. We appreciate the Department consulting on mandatory appropriations and urge the Federal Government to continue working with Tribes to fully evaluate and determine the appropriate amounts needed, how it will accommodate growing inflation, population, other costs, and other processes and issues involved.

Indian Tribal nations stand ready to work with the Administration to promptly find the right path forward on mandatory appropriations for the Indian health system. Thank you in advance for your consideration of our comments.

Sincerely,

National Indian Health Board
Alaska Native Health Board
Albuquerque Area Indian Health Board
Great Lakes Area Tribal Health Board

Lummi Nation
National Congress of American Indians
National Council of Urban Indian Health
Northwest Portland Area Indian Health Board