



**Gregory E. Pyle**  
Chief

## **Choctaw Nation of Oklahoma**

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**TESTIMONY PRESENTED BY  
MICKEY PEERCY, EXECUTIVE DIRECTOR OF HEALTH SERVICES  
CHOCTAW NATION OF OKLAHOMA  
ON THE FISCAL YEAR 2013 BUDGET  
BEFORE THE U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON APPROPRIATIONS  
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES  
PUBLIC HEARING ON THE INDIAN HEALTH SERVICE PROGRAMS  
March 27, 2012**

On behalf of Chief Gregory E. Pyle, of the Great Choctaw Nation of Oklahoma, I bring greetings to the distinguished Members of the Committee. I am Mickey Peercy, the Executive Director of Health Services. I appreciate this opportunity to provide testimony to the Committee on our top budget priorities for FY2013 in the Indian Health Service.

The Choctaw Nation of Oklahoma is the third largest Native American Tribal government in the United States, with over 208,000 members. The Choctaw Nation territory consists of all or part of 10 counties in Southeast Oklahoma, and we are proudly one of the state's largest employers. The Nation operates numerous programs and services under Self-Governance compacts with the United States, including but not limited to: a sophisticated health system serving over 33,000 patients with a hospital in Talihina, Oklahoma, eight (8) outpatient clinics, referred specialty care and sanitation facilities construction; higher education; Johnson O'Malley program; housing improvement; child welfare and social services; law enforcement; and many others.

Appropriations for Indian Country remain severely deficient for each of these programs, and it is simply not acceptable for such programs to be further debilitated by budget cuts. Thus, it is essential that programs impacting Indian Country be exempted from any sequestration for Fiscal Year 2013 and forward.

In my testimony today, I will focus on Indian health and related programs, appropriations which are critical in order to address the health disparities of Native Americans as compared to other Americans. The current funding levels have created a system of rationed health care and perpetuate these health disparities for Native people.

**Joint Venture – Increase to \$90 million**

The Joint Venture program, although a relatively small program, remains the most innovative, timely and cost-effective means within the Indian Health Service (IHS) to acquire new or replacement health facilities for Indian Country. The IHS Joint Venture program demonstrates the shared commitment of Tribal Nations and the IHS in providing additional health facilities within the Indian health system and the staff necessary to support the facilities. This strategy has been especially effective in the Oklahoma City Area, allowing us to replace some antiquated facilities and extending health care to underserved Tribal citizens in our communities. However, the need for adequate health facilities remains great. We request that funds continue to be appropriated for the Joint Venture program on an annual basis, including the associated contract support costs and adequate operational funds.

**Contract Health Services – Increase of \$200 million**

Contract Health Services (CHS) remain a high priority for the Choctaw Nation and many other Tribes in the Nation. CHS funds all of the referrals from Tribal and IHS facilities for specialty care that cannot be delivered at the Tribal/IHS clinic or hospital site. Referrals are often deferred or denied, due to lack of funds, despite the determination of medical need by our health providers. The Oklahoma City Area and the Choctaw Nation suffer some of the highest deferral/denial rates of CHS cases in the Nation. For example, denied or deferred cases in our health system resulted in some of our patients not receiving necessary diagnostic tests, cancer treatment or neurology services last year.

**Contract Support Costs – Increase of \$100 million over FY 2013 President’s Request**

One of the most important appropriation issues facing Indian Country is the underfunding of contract support costs (CSC), which negatively affects nearly every single Tribal Nation. This issue is especially significant for Self-Governance/Self-Determination Tribes because it protects direct service operations from sharing in overall funding reductions and limitations. Every dollar in unfunded contract support costs is a direct reduction in health care or other services to our Tribal citizens.

Contract Support Costs appropriations go directly to the Tribal Nations at the local level, with immediate positive impact on health care and other critical programs. CSC funds mandatory costs for which the federal government is legally and contractually responsible to provide. Failing to adequately fund CSC defeats the very program that has most improved health conditions for American Indian and Alaska Natives.

Tribal programs have significantly increased the quality and level of services in our health systems compared to direct service programs. Since contract support costs are fixed costs that a contractor must incur, Tribes are required to either (1) reduce funds budgeted for critical healthcare or other services under contract to cover the shortfall; (2) divert Tribal funds to subsidize the federal contract (when such Tribal funds are available); or, (3) use a combination

of these two approaches. For every \$1 million that the Choctaw Nation would be required to divert from direct patient care to cover contract support costs, the Nation's health system must forego an estimated 5,800 patient visits.

The reported CSC shortfall is nearly \$5.5 million annually for the Choctaw Nation alone. The President's Budget Request for Fiscal Year 2013 includes only a \$5 million increase in IHS CSC funds for all 567 Tribes in the country, an amount insufficient to fund even the Choctaw Nation's shortfall for one year. This current budget request is woefully inadequate to not only address the present shortfall, but to prevent the shortfall from growing in future years. We urge you to consider the total unfunded need for CSC, which we estimate for FY 2013, will approach \$100 million within the IHS.

**Special Diabetes Program for Indians – Support 5 Year Reauthorization at \$200 million/Year**

The Special Diabetes Program for Indians (SDPI) was authorized in 1997 in response to an alarming and disproportionate high rate of type 2 diabetes in American Indian and Alaska Native people. Tribal advocacy has contributed greatly to changing the course of this once devastating health menace in Indian Country. Continued innovation and increased funding are required to further arrest the disparity and achieve equity. SDPI funding has been at \$150 million since it was reauthorized in 2004. During this time nearly 400 Indian Health Service, Tribal and Urban (I/T/U) Indian health programs have assisted in developing innovative and culturally appropriate strategies, vital resources and tools to prevent and treat diabetes. Congressional funding remains the critical factor in the battle against diabetes which translates into documented improvements in blood glucose control, reduced amputation rates and decreased cases of kidney failure, just to name a few of the maladies associated with this disease. The Choctaw Nation has been an aggressive soldier in the fight against diabetes and we ask this Committee to support the crusade to ensure the continuation of the SDPI. We also request that you urge your colleagues on the Labor, Health and Human Services and Education Appropriations Subcommittee to increase funding for the SDPI program, which is administered by the Indian Health Service. Without the SDPI, the epidemic status of Type 2 diabetes will once again be a serious life-changing disease to future generations of our people.

**Indian Health Care Improvement Fund – Request \$45 million increase**

Overall funding for the IHS remains at less than 60% of need; using the benchmark of the federal employee benefit package. Deplorably, IHS average funding per patient remains less than that expended on federal inmates. In addition to the well-documented disparate funding between the IHS and other federally funded health programs, funds among the IHS Areas are distributed inequitably. The Oklahoma City Area, specifically, suffers a funding level even below that of the average within the IHS. In order to address such inequities and resulting health disparities, the Indian Health Care Improvement Fund (IHCIF) was created to direct funding to the most severely underfunded programs first. Tribal Nations have previously recommended that the federal government implement a time-limited plan to bring all IHS Operating Units to the 80% level, and the Choctaw Nation supports that position.

In addition, the Choctaw National supports these **National Indian Program Priorities**

- **Mandatory Costs – Provide \$304 million increase to maintain current services**  
Mandatory cost increases are necessary to maintain the current level of services. These “mandatories” are unavoidable and include medical and general inflation, pay costs, phasing in staff for recently constructed facilities, and population growth. I
- **Alcohol and Substance Abuse Programs – Provide \$40 million increase**  
Alcohol and Substance Abuse Programs (ASAP) and community-based prevention activities are an integrated part of behavioral health programs needed to reduce the incidence of alcohol and substance abuse in American Indian and Alaska Native communities and to address the special needs of Native people dually diagnosed with both mental illness and drug dependency. Youth Region Treatment Centers are also funded by this line item.
- **Funding for Implementation of the Indian Health Care Improvement Act (IHCA)**  
Implementation of the IHCA remains a top priority for Indian Country. IHCA provides the authority for Indian health care, but does NOT provide any funds to IHS. The American health care delivery system has been revolutionized while the Indian health care system waited for the reauthorization of the IHCA. Resources are needed to implement all provisions of the IHCA.
- **Office of Tribal Self-Governance - Increase \$5 million to the IHS Office of Tribal Self-Governance**  
In 2003, Congress reduced funding for this office by \$4.5 million, a loss of 43% from the previous year. In each subsequent year, this budget was further reduced due to the applied Congressional rescissions. As of 2012, there are 337 Self-Governance (SG) Tribes managing approximately \$1.4 billion in funding. This represents almost 60% of all federally-recognized Tribes and 33% of the overall IHS funding. The Self-Governance process serves as a model program for federal government outsourcing, which builds Tribal infrastructure and provides quality services to Indian people.

We also support the testimony presented by:

- The National Indian Health Board
- The National Congress of American Indians

**In closing**, on behalf of the Choctaw Nation of Oklahoma, and Chief Gregory E. Pyle, thank you for the honor to provide this testimony and we respectfully urge your consideration and support of these program funding requests in the FY2013 budget for the IHS.