HEARING BEFORE THE HOUSE SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES ON THE FY 2013 BUDGET
March 28, 2012

Testimony of Lloyd B. Miller, Counsel, National Tribal Contract Support Cost Coalition

My name is Lloyd Miller and I am a partner in the law firm of Sonosky, Chambers, Sachse, Endreson & Perry, LLP, of Washington, DC. I appear here today as counsel to the National Tribal Contract Support Cost Coalition, comprised of 20 Tribes and tribal organizations situated in 11 States and collectively operating contracts to administer over $400 million in IHS and BIA facilities and services on behalf of over 250 Native American Tribes.[1] Thank you for the opportunity to appear once again to discuss the legal duty and urgent need to fully fund the "contract support costs" that are owed these and other Tribes performing contracts and compacts on behalf of the United States pursuant to the Indian Self-Determination Act—specifically $571 million for IHS contract support cost requirements and $228 million for BIA contract support cost requirements.

No single enactment has had a more profound effect on more tribal communities than has the Indian Self-Determination Act. In just three decades Tribes and inter-tribal organizations have taken over control of vast portions of the BIA and IHS, including federal governmental functions in the areas of health care, education, law enforcement and land and natural resource protection. Today, not a single Tribe in the United States is without at least one self-determination contract with each agency, and collectively the Tribes administer over **$2.82 billion** in essential federal governmental functions, employing an estimated 35,000 people.

In the IHS Aberdeen Area, over 20% of the IHS budget is under contract to the Tribes. In Alaska, 100% of the IHS budget and most of the BIA budget has been contracted over to the Tribes. From the Navajo Nation to the Pacific Northwest to California, Tribes in 35 States have demanded their self-determination rights and secured control over IHS and BIA programs.

The ISDA employs a contracting mechanism to carry out its goal of transferring essential governmental functions from federal agency administration to tribal government administration. To carry out that goal and meet contract requirements, the Act requires that IHS and the BIA fully reimburse every tribal contractor for the "contract support costs" that are necessary to carry out the contracted federal activities. (Cost-reimbursable government contracts similarly require reimbursement of "general and administrative" costs.) Full payment of fixed contract support costs is essential: without it, offsetting program reductions must be made, vacancies cannot be

[1] The NTCSCC is comprised of the: Alaska Native Tribal Health Consortium (AK), Arctic Slope Native Association (AK), Central Council of the Tlingit & Haida Indian Tribes (AK), Cherokee Nation (OK), Chippewa Cree Tribe of the Rocky Boy's Reservation (MT), Choctaw Nation (OK), Confederated Salish and Kootenai Tribes (MT), Copper River Native Association (AK), Forest County Potawatomi Community (WI), Kodiak Area Native Association (AK), Little River Band of Ottawa Indians (MI), Pueblo of Zuni (NM), Riverside-San Bernardino County Indian Health (CA), Shoshone Bannock Tribes (ID), Shoshone-Paiute Tribes (ID, NV), SouthEast Alaska Regional Health Consortium (AK), Spirit Lake Tribe (ND), Tanana Chiefs Conference (AK), Yukon-Kuskokwim Health Corporation (AK), and the Northwest Portland Area Indian Health Board (43 Tribes in ID, WA, OR).

filled, and services are reduced, all to make up for the shortfall. In short, *a contract support cost shortfall is equivalent to a program cut*.[2]

For years the Administration failed to request full funding for its contract support cost obligations, and the resulting shortfalls grew. The first major effort to address this deficiency in the past 10 years occurred in FY 2010, when Congress enacted a $116 million increase to narrow the IHS contract support cost shortfall by about one-half, and a $19 million increase to address BIA contract support cost shortfalls. The IHS increase, alone, will eventually restore 2,820 health sector jobs in Indian country.

Today IHS refuses to disclose its shortfall projections for FY 2012 and FY 2013. Based upon our own projections, we believe the shortfall this year will be approximately $60 million, and that the shortfall in FY 2013 will approach $99 million. Our calculations and assumptions are attached to my testimony. (Unfortunately, IHS's failure to disclose data for the past two years means our projections are subject to change.) Unless remedied, we foresee *a $99 million cut in tribally-contracted programs next year*—not IHS-administered programs, but tribally-administered health programs *alone*—to cover the shortfall that will be left unaddressed.

In this context, IHS's request for a $5 million increase is shocking, all the more so given this Committee's instruction to IHS last year that the agency must prioritize fully funding these contracts before requesting other discretionary increases. In contrast, the BIA has responded to Indian Country, and it has heeded this Committee's instruction, by requesting $228 million—an amount the BIA says will fully fund all contract support cost requirements.

It is not acceptable for the agency to prioritize discretionary increases over its contract obligations. It is not acceptable to seek deficit reduction by cutting contract payments. It is not acceptable to treat tribal contractors differently from other contractors. And it is not acceptable to single out tribally-administered health programs for grave cuts in essential governmental services, while the agency seeks enhancements to the rest of its budget. Congress 24 years ago warned that the agencies "must cease the practice of requiring tribal contractors to take indirect costs from the direct program costs, which results in decreased amounts of funds for services," S. Rep. No. 100-274, at 9 (1987). At long last this practice must stop.

Last year we detailed for the Committee the extraordinary impact that addressing CSC shortfalls has on job creation across Indian country. Just as the shortfall costs jobs, eliminating the shortfall restores jobs. Addressing the IHS shortfall in contract payments is therefore not just a matter of legal obligation and sound policy; it is good economics at a time of terrible unemployment.

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[2] Contract Support Costs are the necessary costs of operating a federal program under contract. When the BIA and IHS operate these programs, the agencies are supported by their own bureaucracies and other federal agencies (*i.e.*, the General Services Administration, the Office of Personnel Management and the Department of Justice) to provide personnel and financial management systems, legal resources, procurement systems and the like. Tribal contractors require similar resources, as well as resources to meet mandatory federal requirements such as annual audits. They cover those requirements with contract support costs. Most fixed contract support costs are set by government-issued indirect cost rates, with the rates issued based upon certified independent audits and adjusted based upon post-year audits.

The National Tribal Contract Support Cost Coalition recommends the following:

1. The Coalition recommends that in FY 2013 (1) the IHS contract support cost line be increased to $571 million; and that (2) the BIA's request to increase its contract support cost line to $228 million be accepted.

2. The Coalition recommends that the Committee adopt language requiring IHS and BIA to promptly disclose each year all available contract support cost data—precisely as both agencies have historically done up until the past year. Language to address this issue accompanies my testimony. The agencies are suddenly claiming that, because CSC data is eventually wrapped up inside a formal Report to Congress, the otherwise disclosable data cannot be disclosed until the Report is fully cleared through each Department and through OMB. That is a sure way to keep the data secret and under wraps for years—witness the fact that only this month, March 2012, did IHS submit its Report detailing 2009 data, *three years too late*. Without data there is no way for Tribes, or Congress, to see how these tribal funds are being managed.

Such secrecy does not accompany any other agency funds, and only leads one to speculate that the agencies have something to hide. Indeed, last year's multiple IHS errors in projections that were furnished to Congress suggest that the agencies want to hide both their own errors and the magnitude of the shortfalls. This is unacceptable, and it should not require costly Freedom of Information Act lawsuits every year for Tribes and Congress to learn what is going on inside the agencies with appropriated funds.

This is a major issue. Today Tribes have been denied all access to 2011 data about how last year's appropriation—all of which belongs to the Tribes—was spent. They are also being told that they will not see how the 2012 funds, which Congress appropriated in December, will be spent this year—not until formal reports are sent to Congress years from now. They are being denied access to the critical information that would permit them to see if systemic errors are being made—a particularly acute problem given the wholesale loss of all CSC expertise within the agency. They are even being told that Tribes, themselves, favor this secrecy—notwithstanding that section 106(c) of the Indian Self-Determination Act *mandates* Tribe-by-Tribe disclosure, and notwithstanding that such diverse entities as the Great Plains Tribal Chairman's Health Board, the Northwest Portland Area Indian Health Board, the IHS Contract Support Cost Work Group (all attached), as well as this 11-State, 20-Tribe, Coalition, all have demanded disclosure.

3. The Coalition recommends that the Committee once again require both agencies to consistently project and budget the additional CSC requirements associated with new contracts and program expansions (on average, 13.5 cents for each new IHS program dollar, and 10.4 cents for each new BIA program dollar). The IHS did this in its FY 2012 budget, but ceased doing it in the FY 2013 budget. *This is the first time in some 25 years that IHS has not disclosed in its Budget Justification its projection of CSC requirements for the coming year*. Congress cannot do its work without this information.

4. Finally, the Coalition recommends that the Committee reconcile the different language used in the IHS and BIA portions of the bill, and that the Committee eliminate the old "section

314" language (a useless vestige after the Cherokee v. Leavitt case). Variations in language only raise unnecessary questions as to the Committee's intent. Suggested language accompanied our testimony to the Committee last year.

Thank you again for the opportunity to offer these recommendations.

Attachments (as stated)

INDIAN HEALTH SERVICE
CONTRACT SUPPORT COST PROJECTIONS
FYs 2010, 2011, and 2012
January 25, 2012

FY 2011

FY 2010 CSC Need (From FY 2011 CSC Shortfall Rpt.)	$520,715,103	1/			
Tribal Shares available for CSC (From FY 2010 CSC Shortfall Report)	$32,683,845				
IDC on unpaid DCSC in FY 2009 (Calculated from FY 2010 CSC Shortfall Report)	$1,756,818		**2011 Program Increases**	54%	25%
Base CSC Funding (FY 2010 Appropriation)	$398,490,000		Services	-	-
Inflation for FY 2010 at 1.5%	$5,977,350		Facilities	-	-
Estimated New and Expanded programs (ISD) in FY 2011	$0		Staffing of New Facilities	0	-
CSC for program increases in the FY 2010 Omnibus Budget	-		**TOTAL**	-	-
Total Funding Required in FY 2011	$495,765,425	2/			
Base Funding (FY 2010 Omnibus Budget)	$398,490,478				
Additional CSC Needed in FY 2011	**$97,274,947**				
Projected Average CSC Level of Need Funded	80.38%				

FY 2012

			2012 Program Increases	54%	25%
Total Funding Required in FY 2010	$495,765,425		Services	-	-
Inflation (1.5%)	$5,977,357		Facilities	-	-
Estimated New and Expanded programs (ISD) in FY 2012	$10,000,000		Staffing of New Facilities		-
CSC for program increases in the proposed FY 2012 President's Budget request (estimate)	17,500,000	3/	**TOTAL**	-	-
Total CSC Funding Required in FY 2011	$529,242,783		$33,503,709	Increase in CSC Need over Previous Fiscal Year	
Adjustment for additional Tribal Shares and IDC on DCSC Shortfall	$26,352				
Base Funding (FY 2011 President's Budget)	$473,490,478		75,000,000	Increase in CSC Funding available over Previous Fiscal Year	
Additional CSC Needed in FY 2011	**$55,778,657**				
Projected Average CSC Level of Need Funded	89.46%				

FY 2013

Total Funding Required in FY 2011	$529,242,783	
Inflation (1.5%)	$7,102,357	
Estimated New and Expanded programs (ISD) in FY 2013	$10,000,000	
CSC for program increases in the proposed FY 2013 budget request (Average of Previous 2 years)	-	4/

Total CSC Funding Required in FY 2012	$546,345,140	$17,129,105	Increase in CSC Need over Previous Fiscal Year
Adjustment for additional Tribal Shares and IDC on DCSC Shortfall	$26,748		
Base Funding (FY 2011 President's Budget)	$473,490,478	-	Increase in CSC Funding available over Previous Fiscal Year
Additional CSC Needed in FY 2012	**$72,881,409**		
Projected Average CSC Level of Need Funded	**86.66%**		

			Inflation [6/]	ISD Fund
Total CSC Funding Required in FY 2014	$559,540,317	**5/**	$8,195,177	$5,000,000
Total CSC Funding Required in FY 2015	$572,933,422	**5/**	$8,393,105	$5,000,000
Total CSC Funding Required in FY 2016	$586,527,423	**5/**	$8,594,001	$5,000,000

1/ Taken from the **Final** FY 2011 Indian Health Service Contract Support Cost Shortfall Report.

2/ CSC associated with the portion of the FY 2011 Appropriation increases that are to be included in Self-Determination awards. (54% of the increase, times 25% for CSC)

3/ CSC associated with the FY 2012 proposed budget increases that are anticipated to be included in Self-Determination awards. (54% of the increase, times 25% for CSC)

4/ CSC associated with the FY 2013 budget increases that are anticipated to be included in Self-Determination contracts and compacts. (Average of previous 2 years)

5/ This amount does NOT include any CSC based on program increases anticipated in the proposed Budget.

6/ Inflation is computed at 1.5 % of the prior fiscal year's total requirement.

INDIAN HEALTH SERVICE
CONTRACT SUPPORT COST PROJECTIONS
FYs 2011, 2012, 2013 and 2014
February 15, 2012

FY 2011

FY 2010 CSC Need (From FY 2010 CSC data collected from Tribes)	$520,715,103 1/				
Tribal Shares available for CSC (From FY 2010 CSC data)	$32,683,845				
IDC on unpaid DCSC in FY 2010 (Calculated from FY 2010 CSC data)	$1,756,818	**2011 Program Increases**		54%	25%
Base CSC Funding (FY 2010 Appropriation)	$398,490,000	Services	-	-	-
Inflation for FY 2011 at 1.5%	$5,977,350	Facilities	-	-	-
Estimated New and Expanded programs (ISD) in FY 2011	$0	Staffing of New Facilities	-	-	-
CSC for program increases in the FY 2010 Omnibus Budget	$0	**TOTAL**	**-**	**-**	**-**
Total Funding Required in FY 2011	$495,765,425				
Base Funding (FY 2010 Omnibus Budget)	$398,490,478				
Additional CSC Needed in FY 2011	**$97,274,947**				
Projected Average CSC Level of Need Funded	80.38%				

FY 2012

		2012 Program Increases		60%	25%
Total Funding Required in FY 2010	$495,765,425	Services	64,361,881	38,617,129	9,654,282
Inflation (DCSC at Medical Inflation (3.6%)/ IDC at regular Inflation (1.5%))	$8,069,432	Facilities	6,712,000	4,027,200	1,006,800
Estimated New and Expanded programs (ISD) in FY 2012	$10,000,000	Staffing of New Facilities	62,950,119	38,678,119	9,669,530
CSC for program increases in the FY 2012 Enacted Budget	20,330,612 2/	**TOTAL**	**134,024,000**	**81,322,448**	**20,330,612**
Total CSC Funding Required in FY 2012	$534,165,469	$38,426,396	<=== Increase in CSC Need over Previous Fiscal Year		
Adjustment for additional Tribal Shares and IDC on DCSC Shortfall	$26,352				
Base Funding (FY 2012 Enacted Budget)	$471,437,000	$72,946,522	<=== Increase in CSC Funding available over Previous Fiscal Year		
Additional CSC Needed in FY 2012	**$62,754,822**				
Projected Average CSC Level of Need Funded	88.25%				

FY 2013

		2013 Program Increases		60%	25%
Total Funding Required in FY 2012	$534,191,822	Services	62,998,000	37,798,800	9,449,700
Inflation (DCSC at Medical Inflation (3.6%)/ IDC at regular Inflation (1.5%))	$9,546,599	Facilities	2,259,000	1,355,400	338,850
Estimated New and Expanded programs (ISD) in FY 2013	$10,000,000	Staffing of New Facilities	49,236,000	49,236,000	12,309,000
CSC for program increases in the proposed FY 2013 budget request	22,097,550 3/	**TOTAL**	**114,493,000**	**88,390,200**	**22,097,550**
Total CSC Funding Required in FY 2013	$575,835,971	$41,670,897	<=== Increase in CSC Need over Previous Fiscal Year		
Adjustment for additional Tribal Shares and IDC on DCSC Shortfall	$26,748				
Base Funding (FY 2013 President's Budget)	$476,446,000	$5,009,000	<=== Increase in CSC Funding available over Previous Fiscal Year		
Additional CSC Needed in FY 2013	**$99,416,719**				
Projected Average CSC Level of Need Funded	82.74%				

FY 2014

		2014 Program Increases		60%	25%
Total Funding Required in FY 2013	$575,862,719	Services	-	-	-

Inflation (DCSC at Medical Inflation (3.6%)/ IDC at regular Inflation (1.5%))	$9,648,032		Facilities	-	-	-
Estimated New and Expanded programs (ISD) in FY 2014	$10,000,000		Staffing of New Facilities	-	-	-
CSC for program increases in the proposed FY 2014 budget request (Average of previous 2 Years)	21,214,081	4/	**TOTAL**	-	-	-
Total CSC Funding Required in FY 2014	616,724,831		$40,889,261	<=== Increase in CSC Need over Previous Fiscal Year		
Adjustment for additional Tribal Shares and IDC on DCSC Shortfall	$27,149					
Base Funding (FY 2013 President's Budget)	$476,446,000		$0	<=== Increase in CSC Funding available over Previous Fiscal Year		
Additional CSC Needed in FY 2014	**140,305,980**					
Projected Average CSC Level of Need Funded	77.25%					

			Inflation 6/	**ISD Fund**
Total CSC Funding Required in FY 2015	$634,087,019	5/	$12,335,040	$5,000,000
Total CSC Funding Required in FY 2016	$651,768,760	5/	$12,681,740	$5,000,000
Total CSC Funding Required in FY 2017	$669,804,135	5/	$13,035,375	$5,000,000

1/ Taken from FY 2010 Contract Support Cost Shortfall data collected from Tribes.

2/ CSC associated with the portion of the FY 2012 Appropriation increases that are to be included in Self-Determination awards. (60% of the increase, times 25% for CSC)

3/ CSC associated with the FY 2013 proposed budget increases that are anticipated to be included in Self-Determination awards. (60% of the increase, times 25% for CSC)

4/ CSC associated with the FY 2014 budget increases that are anticipated to be included in Self-Determination contracts and compacts. (Average of previous 2 years)

5/ This amount does NOT include any CSC based on program increases anticipated in the proposed Budget.

6/ Inflation is computed at 2.0 % of the prior fiscal year's total requirement.

Indian Health Service - Detail of Changes

Program Enacted Enacted Request	FY 2011	FY 2012	Difference	FY 2013	Difference
SERVICES	**Enacted**	**Enacted**	**2012 over 2011**	**Request**	**2013 over 2012**
Hospitals & Health Clinics	1,762,865	1,810,966	48,101	1,849,310	38,344
Dental Services	152,634	159,440	6,806	166,297	6,857
Mental Health	72,786	75,589	2,803	78,131	2,542
Alcohol & Substance Abuse	194,409	194,297	(112)	195,378	1,081
Contract Health Services	779,927	843,575	63,648	897,562	53,987
Total, Clinical Services	**2,962,621**	**3,083,867**	**121,246**	**3,186,678**	**102,811**
Public Health Nursing	63,943	66,632	2,689	69,868	3,236
Health Education	16,649	17,057	408	17,450	393
Community Health Reps.	61,505	61,407	(98)	61,531	124
Immunization AK	1,930	1,927	(3)	1,927	-
Total, Preventive Health	**144,027**	**147,023**	**2,996**	**150,776**	**3,753**
Urban Health	43,053	42,984	(69)	42,988	4
Indian Health Professions	40,661	40,596	(65)	40,598	2
Tribal Management Grants	2,581	2,577	(4)	2,577	-
Direct Operations	68,583	71,653	3,070	72,867	1,214
Self-Governance	6,054	6,044	(10)	6,044	-
Contract Support Costs	397,693	471,437	73,744	476,446	5,009
Total, Other Services	**558,625**	**635,291**	**76,666**	**641,520**	**6,229**
TOTAL, SERVICES	**3,665,273**	**3,866,181**	**200,908**	**3,978,974**	**112,793**
					-
FACILITIES					-
Maintenance & Improvement	53,807	53,721	(86)	55,470	1,749
Sanitation Facilities Construction	95,665	79,582	(16,083)	79,582	-
Health Care Facilities Construction	39,156	85,048	45,892	81,489	(3,559)
Facilities & Environmental Health Support	192,701	199,413	6,712	204,379	4,966
Equipment	22,618	22,582	(36)	22,582	-
TOTAL, FACILITIES	**403,947**	**440,346**	**36,399**	**443,502**	**3,156**
TOTAL, BUDGET AUTHORITY	**4,069,220**	**4,306,527**	**237,307**	**4,422,476**	**115,949**

From DHHS/IHS FY 2013 Justification of Estimates for Appropriation Committees

The FY-2012 staffing packages total was $62,950,119.	
Carl Albert	2,487,000
Lake Co HC	1,088,000
Elbowoods	7,315,000
Cheyenne River HC	24,272,000
Absentee Shawnee HC	8,981,000
Vinita HC	8,665,000
Undesignated (place holder two JV facilitie	**9,843,000**
	62,651,000
The FY 2013 Staffing was estimated at $49,236,000.	
Ardmore, OK	8,948,000
Vinita, OK	2,792,000
Tishomingo, OK	5,341,000
Wasilla, AK	13,462,000
Fairbanks, AK	8,074,000
Nome, AK	10,619,000
	49,236,000

Notwithstanding any other provision of law, the Bureau of Indian Affairs and the Indian Health Service shall, on or before April 1 of each fiscal year, circulate to every tribal and tribal organization engaged in contracting or compacting under Pub. L. 93-638, as amended, data from the preceding year showing (1) for each tribe and tribal organization, nationally, and by Area and Region, the total amounts of funds provided for the direct costs of contracted or compacted programs, and the total amounts of funds provided for the contract support costs associated with such programs; (2) for each tribe and tribal organization, nationally, and by Area and Region, any deficiency (or surplus) in funds needed to provide required contract support costs; (3) the indirect cost rate and type of rate that has been negotiated with the appropriate Secretary for each tribe and tribal organization; (4) the direct cost base and type of base from which the indirect cost rate is determined for each tribe and tribal organization; (5) the indirect cost pool amounts and the types of costs included in the indirect cost pool; and (6) for the current fiscal year, each agency's calculation of the estimated national contract support cost requirement for all tribes and tribal organizations, based upon the President's most recent Budget submitted to Congress.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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SENT VIA TELEFAX: (301) 443-4794

February 22, 2012

Yvette Roubideaux, M.D., M.P.H.
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Dear Dr. Roubideaux:

On behalf of the IHS Contract Support Cost (CSC) Work Group, I want to thank you for reconvening the Work Group to begin the evaluation process concerning the 2007 CSC Policy contained in the IHS Manual. As the Tribal Chair of the CSC Work Group, I write to follow up on the Work Group's initial recommendations made during our January 31-February, 2012 Rockville, Maryland meeting.

You charged the CSC Workgroup with reviewing and evaluating the 2007 CSC Policy changes, but to also make recommendations on how to improve other aspects of the Policy. You also requested that we consider technical revisions to clarify definitions, consider deadlines and dates that are referenced in the Policy, and engage in a discussion about whether Tribes remain open to having their data disclosed for purposes of reporting CSC requirements and deficiencies. In order to address this ambitious agenda, I believe it is important that we identify specific follow-up actions needed for the CSC Workgroup to complete its work in an efficient manner and to prepare for our next meetings.

As we explained during our exit meeting, the CSC Work Group cannot do an assessment of the 2007 CSC Policy until IHS complies with the existing Policy by releasing the data which the Policy currently requires be released. In substantial part, reviewing this data will permit the Work Group to assess how the 2007 changes which you have requested us to examine have worked over time. All of the data the CSC Work Group requested for FY 2009, FY 2010, and FY 2011 is required to be disclosed under IHS Manual, Chapter 6-3.5(B)(4). We expressly did not request the disclosure of congressional reports that are not yet cleared for disclosure. Again, absent disclosure of this raw data, the Work Group believes it cannot proceed with a full assessment of the 2007 Policy, as charged. I respectfully renew our request that this data be released.

The CSC Workgroup also requests additional information concerning the following items:

1. When were the Ch. 6-3.5(B) data reports certified by the IHS Chief Financial Officer for FY 2009, FY 2010 and FY 2011?
2. What specific provisions of the Manual does IHS propose be changed and how does IHS propose they be changed? (A redline of IHS's suggestions would expedite the Work Group's review and work.)
3. What provision of law or regulation has been relied upon by IHS to withhold disclosure of the data reports regarding the expenditure of closed appropriations? As we discussed, we believe these disclosures are not only necessary to comply with the Policy, but necessary to facilitate maximum tribal consultation on issues directly impacting federally recognized Tribes.
4. What is the allocation plan for the $74 million increase in contract support cost appropriations enacted for FY 2012? (The Manual requires the allocation by March 30, 2012, and the Work Group believes that disclosure of the allocation plan before allocations are made will maximize the President's commitment to tribal consultation.)
5. How were the FY 2010 and FY 2011 CSC appropriations allocated?

The forgoing information is essential for the CSC Work Group to fully and properly review the existing CSC Policy, consistent with the government-to-government relationship and the President's commitment to maximum tribal consultation.

With regard to dates and deadlines, I would note that, while some of the dates may initially be confusing, I understand that the dates and deadlines were specifically adopted to accommodate the declination and rejection deadlines that appear in the Indian Self-Determination Act. I also understand that other dates and deadlines were adopted by IHS to permit an orderly reporting process and a prompt allocation of appropriated funds based upon that data. It would be beneficial to the CSC Work Group to have IHS staff go through the Policy, to review the dates and logic behind them, and to propose other dates that might better achieve these goals consistent with the Act. The Work Group intends to do the same.

Similarly with regard to definitions and terms, efficiency in Work Group meetings will best be served if IHS would identify the terms or definitions that agency staff would like us to consider revising, again using a "redline" method. CSC Work Group members should also feel free to prepare "redline" amendments which they would like the full Work Group to consider. All such redline documents should be shared with one another prior to our next meeting.

Finally, I would like to accommodate the request of some CSC Work Group members for an orientation to CSC policy. Toward this end, I believe it would be most beneficial to arrange a joint Federal-Tribal panel that would provide a brief history of the CSC changes that have taken place over the years, and a discussion of how the key Policy provisions are being implemented. This will allow new Work Group members and IHS staff, alike, to see the evolution of the Policy

to its present form. I understand that the goal of each successive change has been to improve equity across Tribes while maximizing tribal self-determination. If so, the more Work Group members and IHS staff understand this evolution, the more likely we are to develop new recommendations consistent with those goals. I am committed to working with you to develop this joint Federal-Tribal presentation for the Workgroup.

I am hopeful that with assistance from IHS staff we can get these requests organized and addressed over the next two weeks, so that we prepare an agenda for our next CSC Work Group meetings. I believe our request is consistent with your priorities to strengthen the IHS' partnership with Tribes and to have the work of IHS be as transparent, accountable, fair, and inclusive as possible. Our request is consistent with your principles to improve the work of IHS.

I have directed my technical staff, Jim Roberts, NPAIHB Policy Analyst, to work with your office or designee to follow up on the details of this letter. You and your staff should feel free to contact Mr. Roberts at (503) 228-4185 or by email at jroberts@npaihb.org.

Respectfully,

Andrew C. Joseph Jr.

Andrew Joseph, Jr., Chairperson
Colville Tribal Council Member
Tribal Chair, CSC Workgroup

cc: IHS-CSC Workgroup Members
Randy Grinnell, IHS Deputy Director, Co-Chair CSCWG
Roselyn Tso, Acting Director, Office of Direct Service and Contracting Tribes

Enclosures: ATNI Resolution
GPTCHB Resolution

2012 Winter Convention
Shelton, Washington

RESOLUTION #12 - 09

"REQUESTING THE INDIAN HEALTH SERVICES (IHS) DIRECTOR TO DIVULGE CONTRACT SUPPORT COST (CSC) DATA PURSUANT TO THE IHS CONTRACT SUPPORT COST POLICY; AND SUPPORT FOR THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD (NPAIHB) FREEDOM OF INFORMATION ACT REQUEST FOR CSC DATA"

PREAMBLE

We, the members of the Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants rights secured under Indian Treaties, Executive Orders, and benefits to which we are entitled under the laws and constitution of the United States and several states, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise to promote the welfare of the Indian people, do hereby establish and submit the following resolution:

WHEREAS, the Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

WHEREAS, ATNI is a regional organization comprised of American Indians/Alaska Natives and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of the ATNI; and

WHEREAS, on October 11, 2011, the Indian Health Service (IHS) Director sent a Dear Tribal Leader Letter initiating Tribal consultation on the IHS 2007 Contract Support Cost (CSC) Policy, the purpose of the consultation is to review and evaluate policy changes made in 2007, and to make recommendations on whether to continue or change the IHS CSC Policy; and

WHEREAS, the 2007 CSC Policy revised the methodology associated with CSC funding for new or expanded awards under the Indian Self-Determination and Education Assistance Act (ISDEAA, P.L. 93-638, as amended), at Section 6-3.3A(3) and Manual Exhibit 6-3-D; this change was temporary and implemented only for Fiscal Years 2007-2010. The CSC Policy further states that:

> *"To ensure responsiveness to the needs of Tribes in administering their health programs, and continued support of the IHS's commitment to the Federal Government's policy of Indian Self-Determination, the change will be monitored and fully evaluated during the FY 2010 funding period to determine if the change should be made permanent."*

All other aspects of the CSC Policy were unchanged; and

WHEREAS, as part of the Tribal consultation process the IHS Director appointed a CSC Workgroup comprised of Tribal leaders or designees to act on their behalf who convened their first meeting in Rockville, Maryland on January 31 – February 1, 2012; and

WHEREAS, in order for the CSC Workgroup to evaluate the impact of the 2007 CSC Policy changes the Workgroup must have CSC data in order to assess the impact that the CSC Policy changes have had on the CSC shortfall, deficiencies, and to evaluate the impact of the policy change on new and expanded programs as well as the impact on current self-determination contractors and compactors; and

WHEREAS, during the CSC Workgroup meeting the IHS Director refused to divulge CSC data with the Workgroup, which resulted at an impasse between the IHS Director and the Workgroup and resulted in the CSC Workgroup not being able to complete its charge to evaluate the 2007 CSC Policy changes; and

WHEREAS, the CSC Workgroup acknowledges that prior year's CSC data has been regularly disclosed by IHS to Tribal leaders, the public and to Indian Tribes at meetings attended by the IHS Director and by representatives of the Office and Management and Budget; and

WHEREAS, the CSC Workgroup contends that there is no basis in law for withholding disclosure of the requested CSC data and documents; and

WHEREAS, absent the CSC data the CSC Workgroup cannot and should not evaluate the impact of the 2007 CSC Policy changes, and to do so would not be fiscally prudent nor in the best interest of Indian Tribes; and

WHEREAS, if IHS does not complete the evaluation of the 2007 policy changes, the Agency will be out of compliance with its CSC Policy; now

THEREFORE BE IT RESOLVED, that ATNI does hereby request that the Office of Management and Budget, the Secretary for the Department of Health and Human Services and the IHS Director make available and disclose CSC data prepared pursuant to the IHS Contract Support Cost Policy at Chapter 6-3.5(B)(4) for FY 2009, FY 2010, and FY 2011; and

BE IT FURTHER RESOLVED, that ATNI does hereby acknowledge and support the Freedom of Information Act (FOIA) request made by the Northwest Portland Area Indian Health Board for Contract Support Cost data for FY 2010, FY 2011, and FY 2012; and

BE IT FINALLY RESOLVED, that this resolution shall be the policy of ATNI until it is withdrawn or modified by subsequent resolution.

CERTIFICATION

The foregoing resolution was adopted at the 2012 Winter Convention of the Affiliated Tribes of Northwest Indians, held at Little Creek Casino Resort, Shelton, Washington on February 13 – 16, 2012, with a quorum present.

Fawn Sharp, President

Norma Jean Louie, Secretary

Great Plains Tribal Chairman's Health Board

Resolution 2012-02

WHEREAS, the Great Plains Tribal Chairmen's Health Board (GPTCHB) is comprised of the Chairmen/Presidents of seventeen (17)Tribes and one (1) Health organization in a four state area including North Dakota, South Dakota, Nebraska, and Iowa; and

WHEREAS, federally recognized Indian Tribes have an absolute right to health care from the United States federal government, based on treaty rights, on Congressional Acts, on Federal Court decisions, and on the Federal Government's trust responsibility to Indian Tribes; and

WHEREAS, the GPTCHB is primarily responsible for addressing the health concerns and needs of the American Indian Tribes in the Aberdeen Area; and

WHEREAS, the Great Plains Tribal Chairman's Association recognizes that over 20% of the Aberdeen Area IHS budget is currently operated by Tribes under self-determination contracts; and

WHEREAS, tribes cannot operate these contracts properly without full reimbursement of indirect costs and other contract support costs; and

WHEREAS, despite substantial increases in FY 2010 and FY 2012, IHS has historically failed (and continues to fail) to request full funding from Congress and failed (and continues to fail) to fully reimburse tribal contract support costs; and

WHEREAS, services to tribal members suffer when Tribes have to use program funds to cover the shortfall in IHS contract support cost reimbursements; and

WHEREAS, the law (25 U.S.C. 450j-1(c)) and the IHS Manual (IHS Manual Part 6, Chapter 3.5B) requires that IHS annually track and publish all indirect, contract support need and contract support shortfall data for every Tribe in the country;

WHEREAS, in violation of the IHS Manual (IHS Manual Part 6, Chapter 3.5B), IHS has failed and refused to distribute this data to all Tribes for FY 2010, FY 2011 and FY 2012, either nationally or on an Area basis (showing data for all Tribes within each Area); and

WHEREAS, due to this failure, Tribes cannot tell how IHS is handling and managing tribal contract support cost funds, either from Tribe to Tribe or from Area to Area, and also cannot tell how IHS is allocating its contract support cost appropriation and whether it is doing so in conformity with the law and the IHS Manual; and

WHEREAS, the law mandates the public disclosure of all contract support and related data for every tribal contract, and Tribes therefore do not object to this disclosure of financial data regarding contracted federal funds; and

WHEREAS, IHS's failure to share its data on a timely basis, as mandated by the IHS Manual, is unprecedented, is particularly inappropriate for an Administration committed to transparency, and has contributed to a lack of trust in the Indian Health Service;

NOW THEREFORE BE IT RESOLVED, that the Great Plains Tribal Chairman's Health Board calls upon the Director of IHS to immediately release all data specified in IHS Manual Part 6, Chapter 3.5B for FY 2010, FY 2011 and FY 2012 for every Tribe in the United States, including data showing how IHS calculated the distribution of contract support cost funds in FY 2010 and FY 2011, and data showing how IHS has calculated the distribution of contract support cost funds for FY 2012.

CERTIFICATION

This is to certify that the foregoing Resolution was adopted by the GPTCHB Board/Executive Committee by Meeting/Conference Call/Special session, February 6, 2012 by a vote of

__11_ FOR __0_OPPOSED _7_ NOT VOTING.

MOTION CARRIED/DENIED.

Rodger Trudell
GPTCHB Chairmen
Chairmen, Santee Sioux Nation

John Blackhawk
GPTCHB Vice-Chairmen
Chairmen, Winnebago Tribe of Nebraska