Fiscal Year 2018 and Fiscal Year 2019 Report to Congress on the Administration of the Indian Health Service Tribal Self-Governance Program

(Includes FY 2018 and FY 2019 Data)

In Response to:
Section 5394 of the Indian Self-Determination and Education Assistance Act, as amended

Prepared by the
Department of Health and Human Services
Indian Health Service

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Report to Congress on the Administration
of the Tribal Self-Governance Program

A. Introduction

The Fiscal Year (FY) 2018 Report to Congress on the Administration of the Indian Health Service (IHS) Tribal Self-Governance Program and the FY 2019 Report to Congress on the Administration of the IHS Tribal Self-Governance Program are combined in this report and prepared as required in 25 U.S.C. § 5394 (previously codified as 25 U.S.C. § 458aaa-13) of the Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5301 et seq. (previously codified as 25 U.S.C. § 450 et seq.).

This combined report addresses the administration of the IHS (or Agency) Tribal Self-Governance Program for FYs 2018 and 2019, and provides an accounting of the level of need being funded for each Indian Tribe or Tribal organization under self-governance compacts[1] and funding agreements[2] authorized under Title V of the ISDEAA.

In FY 2018, approximately $2.3 billion of the total IHS annual appropriation was transferred to Tribes and Tribal Organizations (T/TO) under 101 ISDEAA self-governance compacts and 127 funding agreements.[3] In FY 2019, approximately $2.4 billion of the total IHS annual appropriation was transferred to T/TO under 104 ISDEAA self-governance compacts and 130 funding agreements.[4]

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[1] A "Self-Governance compact" is a legally binding and mutually enforceable written agreement that affirms the government-to-government relationship between a self-governance Tribe and the United States. A compact shall include general terms setting forth the government-to-government relationship, including such terms as the parties intend to control year after year. It is negotiated in a manner consistent with the federal government's trust responsibility, treaty obligations, and the government-to-government relationship between Indian Tribes and the United States. 25 U.S.C. § 5384 (previously codified as 25 U.S.C. § 458aaa-3); 42 C.F.R. §§ 137.30-31.

[2] A "funding agreement" is a legally binding and mutually enforceable written agreement that identifies the programs, services, functions, or activities (PSFAs), or portions thereof, that the self-governance Tribe will carry out, the funds being transferred from service unit, Area, and/or Headquarters levels in support of those PSFAs, and such other terms as are required or may be agreed upon pursuant to Title V, 25 U.S.C. § 5385 (previously codified as 25 U.S.C. § 458aaa-4); 42 C.F.R. § 137.40.

[3] Department of Health and Human Services (2020). Self-Governance. *Department of Health and Human Services, Fiscal Year 2020. Indian Health Service: Justification of Estimates for Appropriations Committees*. Retrieved fromhttps://www.ihs.gov/sites/ofa/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf.

[4] Department of Health and Human Services (2021). Self-Governance. *Department of Health and Human Services, Fiscal Year 2021. Indian Health Service: Justification of Estimates for Appropriations Committees*. Retrieved from https://www.ihs.gov/sites/ofa/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf.

B. Background

Title V of the ISDEAA allows T/TOs to assume operation of certain IHS programs and to receive not less than the amount that the Secretary, Department of Health and Human Services (HHS) (Secretary), would have otherwise provided for the direct operation of the programs for the period covered by the contract. For both FY 2018 and FY 2019, approximately 40 percent of the Agency's annual appropriation is compacted through Title V of the ISDEAA.

The following are specific elements of the annual report as required by statute [25 U.S.C. § 5394 (b) (previously codified as 25 U.S.C. § 458aaa-13(b)]:

- The relative costs and benefits of self-governance;
- Funds specifically or functionally related to the provision by the Secretary of services and benefits to self-governance participants;
- Funds transferred to each self-governance Indian Tribe and the corresponding reduction in the Federal bureaucracy;
- The funding formula for individual Tribal shares of all IHS Headquarters funds;
- Amounts expended in the preceding FY to carry out inherent Federal functions,[5] by type and location; and
- Comments on this report received from Indian Tribes or Tribal Organizations.

This combined report to Congress has been compiled using information contained in funding agreements, annual audit reports, and data from the Secretary regarding the disposition of Federal funds. No reporting requirements have been imposed on participating Indian Tribes or Tribal Organizations related to this report, as required by 25 U.S.C. § 5394(a)(2) (previously codified as 25 U.S.C. § 458aaa-13(a)(2)) of the ISDEAA.

C. Linkage with other reports to Congress

The Indian Health Service Fiscal Year (FY) 2018 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards (Includes FY 2018 Contract Support Costs Data).[6] *The Indian Health Service Fiscal Year (FY) 2019 Report to Congress on*

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[5] The Office of Management Budget (OMB) defines "inherently governmental function" as "a function that is so intimately related to the public interest as to require performance by Federal Government employees" *OMB; Publication of the Office of Federal Procurement Policy (OFPP) Policy Letter 11-01, Performance of Inherently Governmental and Critical Functions*, 76 *Federal Register* 56227, issued on Sept. 12, 2011; *see also* The Federal Activities Inventory Reform Act of 1998 (FAIR), P. L. 105-270 (112 Stat. 2382-2385), codified as a note to 31 U.S.C. § 501. Pursuant to the ISDEAA (25 U.S.C. §5381(a)(4)), "Inherent Federal functions means those Federal functions which cannot legally be delegated to Indian Tribes." Inherent Federal functions can be located at the Service Unit-, Area-, and/or IHS Headquarters-level. The following is a non-exhaustive list of examples that are functions within the exclusive province of the Agency: determination of Secretarial policy; formulation of the President's budget; the direction and control of federal employees; real property management; federal procurement activities; the conduct of administrative hearings and appeals; and resource allocation.

[6] Indian Health Service (2018). *The Indian Health Service Fiscal Year (FY) 2018 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards.* Retrieved from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/60407-1_2018_CSC_Report_to_Congress_10.18.19.pdf

Contract Funding of Indian Self-Determination and Education Assistance Act Awards (Includes FY 2019 Contract Support Costs Data).[7]

D. The relative costs and benefits of Self-Governance

The IHS Tribal Self-Governance Program strengthens the government-to-government relationship between the United States and Indian Tribes by enabling each Indian Tribe to choose the extent of its participation in self-governance, and by transferring full control and funding of certain IHS programs, services, functions, or activities (PSFAs), or portions thereof, to Tribal governments.[8]

Under Title V of the ISDEAA, Tribes have the discretion to plan, conduct, redesign, and administer PSFAs, or portions thereof, that they have assumed. As a result, significant variations exist among tribally administered health programs. These benefits can include:

- Creation of a comprehensive approach to health services;
- Increased community engagement;
- Program design driven by the needs and priorities of each Tribal community;
- Improvement in communication and coordination between Tribal programs, resulting in the reduction of service duplication and improved efficiency;
- The ability to leverage self-governance funding, maximize resources, and provide more comprehensive community-wide services; and
- Development of innovative health programs and services.

The costs associated with the Tribal Self-Governance Program are detailed in section E, "*Funds related to the provision of services and benefits to Self-Governance Tribes*."

In 2018, the following seven Tribes entered into the IHS Tribal Self-Governance Program: 1. the Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians of Michigan (Gun Lake Tribe) (Bemidji Area IHS); 2. the Nottawaseppi Huron Band of the Potawatomi, located in Michigan (Bemidji Area IHS); 3. the Lake County Tribal Health Consortium, Inc., located in California (California Area IHS); 4. the Pinoleville Pomo Nation, located in California (California Area IHS); 5. the Winnebago Tribe of Nebraska, located in Nebraska (Great Plains Area IHS); 6. the Samish Indian Nation, located in Washington State (Portland Area IHS); and 7. the Pascua Yaqui Tribe, located in Arizona (Tucson Area IHS). In 2019, the following three additional Tribes entered into the IHS Tribal Self-Governance Program: 1. the Paskenta Band of Nomlaki Indians - Rolling Hills Clinic, located in California (California Area IHS); 2. the Iowa Tribe of

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[7] Indian Health Service (2019). *The Indian Health Service Fiscal Year (FY) 2019) Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards.* Retrieved from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/FY_2019_RTC_Contract_Funding_Indian_Self_Determination.pdf.

[8] The PSFAs may include not only program operation, but may include start-up and/or preaward funding, under Contract Support Costs, which are not included in this Report, but are found in the annual IHS *Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards,* mentioned in Section C, above. Additionally, the 105(l) lease funds allocated to Tribes are not included in this Report.

Kansas and Nebraska, located in Kansas (Oklahoma City Area IHS); and 3. the Ak-Chin Indian Community, located in Arizona (Phoenix Area IHS).

Examples of Successful and Innovative Tribal Self-Governance Health Programs:

Bristol Bay Area Health Corporation. The Bristol Bay Area Health Corporation (BBAHC), a self-governance entity, provides comprehensive health care to a consortium of Bristol Bay Tribes, including Yup'ik, Dena'ina, and Supiak/Alutiiq, extending over 36,000 square miles in Southwest Alaska. In 2018, the total BBAHC population was 6,891 spread across the following five subregions: 1. Dillingham; 2. Nushagak River and Bay Central; 3. Southern; 4. Western; and 5. Kvichak Bay and North Side Peninsula.[9] The BBAHC operates Kanakanak Hospital, a critical access hospital, located in Dillingham, Alaska, and provides health services or support to 38 villages, including; 22 primary health care clinics; an emergency room; behavioral health services; ancillary health services; and dental health care. The BBAHC also operates a number of programs, including the following: Community Health Aide Program; Environmental Health and Injury Prevention Program; Diabetes Wellness Program; Emergency Medical Services; and Health Education.[10]

The BBAHC utilizes a number of best practices to improve health outcomes for the population served. For example, the BBAHC's Injury Prevention Program has been successful in reducing the number of injuries and deaths among Tribal members, ages 55 years and older, in the Bristol Bay region of Alaska. The success of the BBAHC's Injury Prevention Program is due to its partnership with community health aides who are instrumental in identifying the needs of elders, as well as facilitating follow-up activities and procedures. Partnering with community health aides also allows the program to serve rural communities more effectively, while keeping travel costs low.

The primary injury prevention activities includes visiting the homes of elders to identify hazards that increased the risk of falling and modifying the homes to decrease hazards and enhance safety. Some of the highlights of the BBAHC Injury Prevention Program, from 2015 to 2020, include the following: 1. checked 118 homes for fall hazards; 2. completed 374 changes to make homes safer for elders (e.g., provided shower and bath benches and toilets fitted with grab bars); 3. at a 6-month follow-up, reported zero falls in homes where home modifications were made; and 4. distributed more than 300 ice cleats to prevent falls.[11] The BBAHC also distributed gun safes to families, **which is considered another injury prevention best practice, to reduce** access to lethal means for suicide and injuries**.**

The success of the BBAHC's efforts to reduce injuries during 2018 and 2019 can also be attributed to partnerships with the Bristol Bay Native Association; Bristol Bay Economic Development Corporation; Village Public Safety Officers; Tribal entities; village and Tribal

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[9] McDowell Group (May 2019). Bristol Bay Area Health Corporation Community Health Needs Assessment. Retrieved from https://www.bbahc.org/.

[10] Bristol Bay Area Health Corporation (May 2019). Bristol Bay Area Health Corporation: Community Health Needs Assessment. Retrieved from https://bbahc.org/.

[11] Indian Health Service (2020). Bristol Bay Health Corporation Injury Prevention Program. Retrieved from https://www.ihs.gov/sites/injuryprevention/themes/responsive2017/display_objects/documents/tipcap-funded/Bristol_Bay_Area_Health_Corporation_Program_Profile_2020.pdf.

councils; and Alaska State Troopers, as well as awards from and participation in both the IHS Tribal Injury Prevention Cooperative Agreement Program, and the IHS Methamphetamine and Suicide Prevention Initiative grant program.[12]

Winslow Indian Health Care Center. The Winslow Indian Health Care Center (WIHCC), located in Winslow, Arizona, serves eight chapter communities (Birdsprings, Dilkon, Indian Wells, Jeddito, Leupp, Teesto, Tolani Lake, and White Cone) in the southwest region of the Navajo Nation reservation.[13] The Navajo Nation reservation is located in the four corners region of the United States (U.S.), which includes portions of northeastern Arizona, northwestern New Mexico, southeastern Utah, and southcentral Colorado. The WIHCC, an innovative ambulatory health care center operating on a family medical model, offers accessible, quality, and cost effective health care to an estimated 190,000 Navajo Tribal members and other American Indian and Alaska Native (AI/AN) people.[14] The WIHCC provides quality health care services, including: behavioral health, dental, health promotion and disease prevention, Hózhǫ́ógo Iiná Wellness Program (diabetes program), optometry, pharmacy/medication services, physical therapy, prenatal care, public health nursing, and women's health.

The WIHCC Women's Health program is another example of a Tribal self-governance program that uses best practices to prevent and treat health issues. The WIHCC Women's Health program is a comprehensive program designed to meet the needs of AI/AN women of all ages. Services include: full physical examinations; family planning services; screening for breast and cervical cancer; prevention, screening, and treatment of sexually transmitted infections; and screening for osteoporosis.[15]

Breast cancer is the most commonly diagnosed cancer among Navajo women, and AI/AN women often have a higher mortality due to a late diagnosis of breast cancer. Navajo women identified many barriers to cancer screening with transportation barriers most frequently reported.[16] The WIHCC is reducing the risks associated with breast cancer through activities such as education, prevention, and screening efforts.

The WIHCC Women's Health program has formed a partnership with the Navajo Nation Breast and Cervical Cancer Prevention Program (NNBCCPP), which has, for more than 20 years, utilized best practices to provide breast and cervical cancer screening services to Tribal women living on or near the Navajo reservation. The mission of the NNBCCPP is to reduce breast and cervical cancers by engaging communities and partners to promote, expand, and improve the quality of health outcomes, through on-site clinics provided through Assured Imaging (Mobile Mammography).[17] Additionally, the NNBCCPP coordinates with the Centers for Disease

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[12] *Ibid.*

[13] Winslow Indian Health Care Center (2020). Winslow Indian Health Care Center. Retrieved from https://www.wihcc.com.

[14] *Ibid.*

[15] Winslow Indian Health Care Center (WHICC) (2020). Women's Health. Retrieved fromWomans - Winslow Indian Health Care Center (wihcc.com).

[16] Robin Harris, Sallie Joe, Tomas Nuno, and Louise Canfield (2007). Survey of barriers to cancer screening among Navajo Nation women. *Cancer Epidemiology Biomarkers & Prevention* (2007). Retrieved from https://aacrjournals.org/cebp/article/16/11_Supplement/A107/174989/Survey-of-barriers-to-breast-cancer-screening.

[17] Navajo Nation (2020). Navajo Nation Breast and Cervical Cancer Prevention Program. Navajo Cancer Prevention Program. Retrieved from https://www.ndoh.navajo-nsn.gov/Department/Division-of-Public-Health-Service/Navajo-Cancer-Prevention-Program.

Control and Prevention National Breast and Cervical Cancer Early Detection Program and the IHS to host mobile mammography events and coordinate appointments with local IHS and Tribal health facilities in five IHS Service Units on the Arizona side of the Navajo Nation.

The WIHCC collaborates with NNBCCPP to provide mammography services to eligible patients through Assured Imaging, and a case manager to manage clinics and provide follow-up for patients with abnormal results. In 2019, 773 mammograms and ultrasounds were provided to patients on site at the WIHCC.[18]

Eastern Band of Cherokee Indians. The Eastern Band of Cherokee Indians (EBCI), a self-governance Tribe, provides health care services to approximately 12,000 of 16,000 enrolled Tribal members who live within the vicinity of its location on the Qualla Boundary, at the foothills of the Great Smoky Mountains National Park, in North Carolina. The EBCI is nationally recognized for providing best practices in health care. For example, in 2019, the ECBI was presented with the Redefining American Healthcare Award by the Healthcare Leadership Council, a coalition of chief executives representing some of the nation's leading health care companies and institutions. The award recognized the EBCI for demonstrating best practices in providing health care for high-need patients; and prioritizing work with patients in the areas of substance abuse, diabetes and depression, which were identified as three of the EBCI's 10 top priority areas, through an ECBI Tribal community health assessment, conducted in 2018.[19]

In 2019, the EBCI reported that they were successful in increasing the number of behavioral health visits almost two-fold, from 6,942 in 2014 to 13,239 in 2016, by raising awareness about substance abuse, and helping Tribal members access needed care and treatment.[20] The EBCI is at the forefront in mitigating the opioid epidemic and high rates of substance abuse, with a $14 million, 18-bed residential treatment facility and $46 million crisis stabilization unit that was constructed next to the Cherokee Indian Hospital, a 155,000 square-foot, 20-bed, state-of the-art facility that opened in 2015.[21] Over the past 20 years the Cherokee Indian Hospital's annual budget has grown exponentially, from $20 million to more than $80 million, primarily from third-party reimbursements, mostly Medicaid and Medicare ($27.4 million), followed by funding from the IHS and the ECBI.[22]

Among the reasons for the EBCI's success in the healthcare arena, is their adoption of best practices to improve patient health care and outcomes, such as the Nuka System of Care. Developed in Alaska by the Southcentral Foundation, the Nuka System of Care is an integrated care model that is customized to meet the health and cultural needs of Tribal members. The Cherokee hospital also uses a core team, consisting of a primary physician, a nurse practitioner,

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[18] Elizabeth Blackgoat, Coordinator, WIHCC Women's Health program. Provided information via email, on April 22, 2020.

[19] Smokey Mountain News (June 2019). Cherokees recognized for leadership in healthcare. Retrieved from Cherokee recognized for leadership in healthcare (smokymountainnews.com).

[20] Eastern Band of Cherokee Indians Public Health and Human Services Division (June 1, 2019). Eastern Band of Cherokees Indians Tribal Health Assessment, 2018, p. 68. Health Priority 1: Substance Abuse and Related Issues. Retrieved from https://phhs.ebci-nsn.gov/wp-content/uploads/2021/10/THA-2018-FINAL-060119.pdf.

[21] *Ibid.*

[22] Katja Ridderbusch (July 22, 2019). How the Eastern Cherokee Tribe Took Control of Their Health Care. Kaiser Health News. Retrieved from https://kffhealthnews.org/news/how-the-eastern-cherokee-took-control-of-their-health-care/.

and a scheduler. Three core teams share a nutritionist, a behavioral health specialist, and a pharmacist. In addition to primary and acute care, mental health, and substance abuse treatment, EBCI provides dialysis, acupuncture, massage therapy, and chiropractic care services.

The ECBI is also an IHS Special Diabetes Program for Indians Healthy Heart Program site, and utilizes best practices to improve diabetes prevention and treatment outcomes in clinics and communities. In 2013, 27.3 percent of the EBCI population were diagnosed with diabetes, and in 2015, 25 percent of the population were diagnosed with diabetes.[23] The diabetes rate in the EBCI community is reported to have leveled out over the 4 years preceding the year 2019. Additionally, the EBCI is also data driven, using quality measures, including the Healthcare Effectiveness Data and Information Set, to track and improve health outcomes.[24] Consequently, the hospital performed in the top quartile for blood pressure control, blood sugar control, and several cancer screenings.[25]

Muscogee Nation. The Muscogee Nation is a self-governance Tribe comprised of approximately 90,000 Tribal members, and is the fourth largest federally recognized Tribe in the U.S. The Muscogee Nation's land encompasses 4,811 square miles spanning the northwestern region in Oklahoma.[26] Established in 1977, the Muscogee Nation's Department of Health (DOH) is one of the largest Tribal health systems in Oklahoma, serving approximately 42,000 patients annually. The Muscogee Nation's DOH operates the Okemah Community Hospital, the Okmulgee Medical Center, and the Okmulgee Physical Therapy Center, which has a long-term acute care facility. These facilities are equipped with modern technology, each providing a number of different services to both Tribal members and non-beneficiaries, such as: emergency care; on-site laboratories; radiology services; 3-D mammography; inpatient care; 24 hour/7 days per week stroke care team; surgical services; respiratory therapy; cardiac rehabilitation program; and inpatient senior behavioral health services. The Muscogee Nation also operates the following clinics: Eufala Indian Health Center; Koweta Indian Health Center; Okemah Indian Health Center; Okmulgee Express Care Clinic; Salpulpa Indian Health Center; and Wetumpa Clinic.[27]

The Muscogee Nation owns and operates a hospital that serves both Tribal citizens and non-Tribal members, under the authority of 25 U.S.C. § 1680c(c), in a rural setting with few health resources. On May 10, 2018, the Muscogee Nation opened the new, state-of-the-art Okemah Community Hospital, a 110,000 square-foot, $55 million replacement facility located off of Interstate 40, near the Okehmah exit, to provide better access for patients.

The Okemah Community Hospital consists of two parts, with inpatient and emergency services located on one side of the facility, and the Okemah Clinic with traditional outpatient services for Tribal members who possess a Certificate of Indian Blood, located on the other side of the

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[23] Eastern Band of Cherokee Indians Public Health and Human Services Division (June 1, 2019). Eastern Band of Cherokees Indians Tribal Health Assessment, 2018, p. 78. Health Priority 3: Diabetes. Retrieved from https://phhs.ebci-nsn.gov/wp-content/uploads/2021/10/THA-2018-FINAL-060119.pdf.

[24] Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, and is maintained by the National Committee of Quality Assurance.

[25] *Ibid.* See footnote 21.

[26] Muscogee (Creek) Nation Department of Health (2020). About MCN. Improving the health of our communities. Retrieved from https://www.creekhealth.org/.

[27] *Ibid*.

facility. The emergency room is open to anyone needing emergency medical services, including radiology, lab work, and inpatient services. At the time the new facility opened, there were approximately 44,000 individuals using the Muscogee Nation's health system. The Muscogee Nation's DOH projected that the new facility would increase the number of patients 5 to 10 percent. [28]

The Muscogee Nation's DOH also encouraged new patients to meet with their benefit counselors, provided through a partnership with Resource Corporation of America, to assist them with enrolling in Marketplace Insurance, and other third-party benefits. Enrolling patients in benefits allows the Muscogee Nation's DOH to bill for health care services, and collect revenue from private insurance and other third parties. With third-party billing collections, the Muscogee Nation's DOH utilizes the revenue to improve and expand health care services.[29]

The Oneida Nation in Wisconsin. The Oneida Nation in Wisconsin (Oneida Nation) entered the IHS Tribal Self-Governance Program in 1997. The Oneida Nation has approximately 17,000 Tribal citizens globally. There are 7,737 Oneida Nation citizens living on or near the Oneida Nation reservation. The reservation covers about 65,400 acres and is located in northeastern Wisconsin. [30]

The Oneida Comprehensive Health Division (OCHD) of the Oneida Nation provides and coordinates health care services to approximately 12,578 patients, including, but not limited to, family health services, ambulatory medical services, mental health/substance abuse services, optical, dental, internal medicine, laboratory services, retail pharmacy, nurse services (population based), community health representative, physical therapy, long-term care, respiratory services, public health, and health promotion and disease prevention services. The Oneida Nation is actively engaged in various health care accreditation processes that will assure quality care, evidence-based care and best practices are incorporated into holistic healthcare services.

In November 2018, the Oneida Nation achieved initial public health accreditation from the Public Health Accreditation Board (PHAB) and became the second Tribal nation to achieve PHAB accreditation in the U.S.[31] The Community Health Services (CHS) department of the OCHD is recognized as the Tribal public health department and responsible for the coordination of public health accreditation. Comprised of five individual teams, the CHS works to assure the 10 Essential Public Health Services[32] are available, and these teams include the following: Community Health Case Management; Community Health Long-Term Care Case Management; Health Promotion/Disease Prevention; Nutrition Services; and Population-Based Programming. The Oneida Nation is actively engaged in the PHAB re-accreditation process, seeking to achieve PHAB reaccreditation for the next 5 years.

The Oneida Nation's achievement of national public health accreditation is another example of a self-governance Tribe's success story. Public health accreditation and standards help guide public health work to improve the health of the Oneida Nation. The PHAB accreditation

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[28] *Ibid.*
[29] Muscogee (Creek) Nation Department of Health (2020). Eligibility. Retrieved from https://www.creekhealth.org/eligibility/.
[30] Michelle Tipple, Community/Public Health Officer, Oneida Nation (February 22, 2024).
[31] Oneida Nation (2024). Retrieved from https://test.oneida-nsn.gov/community-health-services/.
[32] *Ibid.*

standards not only assure that Tribal health departments maximize their potential to protect and enhance the health of AI/AN populations in Tribal communities, but accreditation is also a successful program for routinely assessing performance and improving quality. Evaluation and quality improvement assist Tribes to assure the programs and services provided by the Oneida Nation are relevant and meet or exceed national standards.

Accreditation by the PHAB is one way that Tribes can demonstrate their dedication and accountability to the Tribal members and communities they serve.[33] Currently, there are six Tribal nations that have achieved PHAB accreditation. The Oneida Nation willingly shares experiences of their PHAB accreditation journey with other interested Tribes.

E. Funds related to the provision of services and benefits to Self-Governance Tribes

The funds specifically or functionally related to the provision, by the Secretary, of services and benefits to self-governance participants include the IHS budget for administration of the Tribal Self-Governance Program and the funds available to the Secretary to provide services for each Indian Tribe (as reflected by the amount each Tribe in a self-governance funding agreement is eligible to receive) for FY 2018 and FY 2019, respectively.

The FY 2019 budget included a significant change to the funding structure by changing the period of availability for a large portion of the IHS appropriation. Funds that were previously available for obligation by the IHS for one fiscal year (e.g., expiring on September 30, 2019) were made available for obligation by the IHS for two fiscal years (e.g., expiring on September 30, 2020).[34]

FY 2018 Data:

(1) IHS, Office of the Director, Office of Tribal Self-Governance line item, FY 2018 appropriation (Dollars in Thousands) $5,806

(2) IHS, Area Offices, total of FY 2018 budgets for Self-Governance activities $0

(3) Amount available for current Self-Governance[35] Tribes in FY 2018

[33] Public Health Accreditation Board (October 9, 2023). Retrieved from https://phaboard.org/stories-of-impact/wisconsin-tribal-health-departments-demonstrate-public-health-excellence-through-accreditation/.

[34] USCode.House.Gov (2019). PUBLIC LAW 116-06-FEB. 15, 2019, 133 STAT. 248. 116th Congress. Consolidated Appropriations Act, 2019. *DEPARTMENT OF HEALTH AND HUMAN SERVICES, INDIAN HEALTH SERVICE,* p. 246. Retrieved from https://uscode.house.gov/statutes/pl/116/6.pdf.

[35] Please note the following: FY 2018 105(l) lease amounts and Contract Support Costs (CSC) are not included in this report. The FY 2018 CSC amounts are identified and reported in the *Indian Health Service Fiscal Year (FY) 2018 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards (Includes Fiscal Year 2018 Data).* Retrieved from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/60407-1_2018_CSC_Report_to_Congress_10.18.19.pdf.

(Dollars in Thousands) $1,801,508

IHS Area Office	All Funds
Alaska	$573,416
Albuquerque	17,128
Bemidji	93,392
Billings	35,884
California	82,342
Great Plains	17,710
Nashville	97,262
Navajo	78,902
Oklahoma City	516,923
Phoenix	113,295
Portland	117,601
Tucson	57,653
Total	$1,801,508

(4) Total funds related to the provision of services and benefits to Self-Governance Tribes, in FY 2018 (Dollars in Thousands) $1,807,314

<u>FY 2019 Data</u>:

(1) IHS, Office of the Director, Office of Tribal Self-Governance line item, FY 2019 appropriation (Dollars in Thousands) $5,806

(2) IHS, Area Offices, total of FY 2019 budgets for Self-Governance activities $0

(3) Amount available for current Self-Governance[36] Tribes in FY 2019 (Dollars in Thousands) $1,847,911

IHS Area Office	All Funds
Alaska	$582,945
Albuquerque	17,277
Bemidji	89,101
Billings	35,983
California	107,004
Great Plains	32,352
Nashville	93,653
Navajo	78,470

[36] Please note the following: FY 2019 105(l) lease amounts and CSC amounts are not included in this Report. The FY 2019 CSC amounts are identified and reported in *the Indian Health Service Fiscal Year (FY) 2019 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards (Includes Fiscal Year 2019 Data)*. Retrieved from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/FY_2019_RTC_Contract_Funding_Indian_Self_Determination.pdf.

IHS Area Office	All Funds
Oklahoma City	518,323
Phoenix	124,153
Portland	111,787
Tucson	56,863
Total	$1,847,911

(4) Total funds related to the provision of services and benefits to Self-Governance Tribes, in FY 2019 (Dollars in Thousands) $1,853,715

F. <u>Funds transferred to each Self-Governance Indian Tribe in FY 2018 and FY 2019, and the corresponding reduction in the Federal bureaucracy</u>[37] (Dollars in Thousands)

(1) Funds transferred to Tribes for PSFAs assumed under Title V of the ISDEAA for FY 2018 and FY 2019, respectively.

(a) FY 2018 $1,663,134

IHS Area Office	Funds Transferred
Alaska	$465,888
Albuquerque	12,956
Bemidji	88,723
Billings	35,094
California	79,809
Great Plains	15,887
Nashville	94,634
Navajo	77,075
Oklahoma City	513,134
Phoenix	110,717
Portland	113,480
Tucson	55,737
Total[38]	$1,663,134

(b) FY 2019 $1,714,111

IHS Area Office	Funds Transferred
Alaska	$479,803
Albuquerque	12,925
Bemidji	84,524
Billings	35,191
California	103,830

[37] Note: For amounts by Tribe, please see Exhibit A, "FY 2018 Funds Transferred to Each Self-Governance Tribe," and Exhibit B, "FY 2019 Funds Transferred to Each Self-Governance Tribe."
[38] See footnote 35.

IHS Area Office	Funds Transferred
Great Plains	31,468
Nashville	91,115
Navajo	76,666
Oklahoma City	514,420
Phoenix	121,312
Portland	107,894
Tucson	54,963
Total[39]	$1,714,111

(2) Corresponding reduction in the Federal bureaucracy

Tribal participation in the IHS Tribal Self-Governance Program increased, resulting in an increased assumption of Tribal shares, and reduced IHS staffing levels, as Tribes hired their own staff to work in tribally operated facilities. However, a separate national trend analysis will need to be conducted, in the future, to capture any rate of reduction in Federal bureaucracy brought about by Tribal Self-Governance.

G. The funding formula for individual Tribal shares of all IHS Headquarters funds

A T/TO may elect to assume responsibility for PSFAs formerly administered by the IHS. A T/TO may negotiate a compact and funding agreement with the Secretary for its share of the funds associated with the PSFAs. The funds for each PSFA may be found in one or more budget line item or items.

(1) Tribal Size Adjustment Formula

The IHS transferred $36,057 (Dollars in Thousands) in FY 2018 and $36,038 (Dollars in Thousands) in FY 2019 to self-governance Tribes for their individual Tribal shares of all IHS Headquarters (HQ) funds. For most IHS HQ programs, eligible shares for each Tribe were determined using the Tribal Size Adjustment (TSA) formula developed in the mid-1990s. The amount calculated by the TSA formula was originally determined in proportion to the aggregate user population of each Tribe. A small supplemental amount was added for Tribes with fewer than 2,500 users in partial compensation for inefficiencies related to small size. The amount determined by the TSA formula is termed the Tribe's "base" IHS HQ shares in subsequent years and is not increased or decreased based on fluctuations in user population. Over time, the base Tribal shares have been adjusted proportionately for inflation or in response to congressional action.[40]

(2) Special program formulas

Some IHS programs determine Tribal shares based on special program formulas, including the following:

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[39] See footnote 36.

[40] Indian Health Service (April 19, 1995). *Indian Health Manual*. Special General Memorandum (SGM) No. 95-02. Policy Decisions for Self-Governance/Self-Determination Project Negotiations-Action. Retrieved from https://www.ihs.gov/IHM/sgm/1995/sgm-9502.

Some IHS programs determine Tribal shares based on special program formulas, including the following:

(a) Purchased/Referred Care, [41] **Fiscal Intermediary Formula**
Using the Purchased/Referred Care (PRC) Fiscal Intermediary formula, the IHS provided $1,046 (Dollars in Thousands) in 2018 and $1,046 (Dollars in Thousands) in 2019 to self-governance Tribes for the processing of PRC claims (health care purchased from non-IHS providers when an IHS beneficiary is eligible for PRC and the care is not reasonably accessible or available within the IHS system). The fiscal intermediary is an IHS contractor that calculates and pays the PRC claims according to applicable authorities.

Tribal Share = A x B
Where
A = Tribal percent of 1993 Total Claims
B = Current Fiscal Intermediary Expenditures

(b) Office of Environmental Health and Engineering (OEHE), OEHE Support
Using the IHS Office of Environmental Health and Engineering (OEHE) Environmental Health Services Support formula, $1,214 (Dollars in Thousands) and $1,135 (Dollars in Thousands) were provided to self-governance Tribes in FY 2018 and FY 2019, respectively.

IHS HQ Program funds for OEHE support are allocated to Tribes, when requested, based on each Tribe's pro-rata share of the applicable Area Facilities and Environmental Health Support workload.

H. Total residual[42] amounts for IHS HQ PSFAs and Budgets for Tribal Shares, identified in the preceding fiscal years (FY 2017) for FY 2018 and (FY 2018) for FY 2019 to carry out inherent Federal functions

Indian Health Service HQ residual amounts were historically determined after Tribal Consultation and recommendations provided by the Joint Allocation Methodology Workgroup (in the 1990s). Also annual incremental increases were added in proportion to funding identified for inflation and pay costs.

Some examples of inherent Federal functions include, but are not limited to:
- Budget and Strategic Planning – Budget Formulation, Budget Execution;
- Personnel Management – Appointment, oversight, control, and direction for Federal employees;
- Contracting – Control and oversight over all pre-award and post-award Agency contract functions;

[41] In January 2014, the Consolidated Appropriations Act of 2014 changed the name of the Contract Health Services program to the Purchased/Referred Care program.
[42] "Residuals" are portions of the budget linked to inherent Federal functions. (for definition of "inherent Federal function" - see footnote 5, page 4 of this report).

(1) In FY 2017, IHS HQ identified a HQ residual amount of $30,582,121.

FY 2017 IHS HQ Residual Amounts

IHS HQ PSFA	Sub-category	Residual
01 – Hospitals and Clinics	0146 – Records Management, Property & Supply	$ 1,109,376
13 – Direct Operations	1301 – Direct Operations - Rockville	24,317,140
24 – Facilities & Environmental Health	2401 – Sanitation Facilities Construction Support	1,343,252
N.A.	2402 – Environmental Health Services Support	1,229,850
N.A.	2403 – Facilities Operations Support	1,024,155
N.A.	2404 – Facilities and Engineering Support	1,558,348
Grand Total	N.A.	$30,582,121

(2) In FY 2018, IHS HQ identified a HQ residual amount of $32,153,537.

FY 2018 IHS HQ Residual Amounts

IHS HQ PSFA	Sub-category	Residual
01 – Hospitals and Clinics	0146 – Records Management, Property & Supply	$1,117,224
13 – Direct Operations	1301 – Direct Operations - Rockville	25,789,111
24 – Facilities & Environmental Health	2401 – Sanitation Facilities Construction Support	1,365,964
N.A.	2402 – Environmental Health Services Support	1,257,637
N.A.	2403 – Facilities Operations Support	1,040,952
N.A.	2404 – Facilities and Engineering Support	1,582,649
Grand Total	N.A.	$32,153,537

I. Comments on this report received from Indian Tribes and Tribal Organizations

On June 3, 2024, the Director, IHS, initiated a Tribal Consultation inviting Tribal Leaders to submit comments and recommendations on the combined FY 2018 and FY 2019 Report to Congress on the Administration of the Indian Health Service Tribal Self-Governance Program through a Tribal Leader letter posted on IHS.gov. The ISDEAA at 25 U.S.C. § 5394 requires that, prior to submitting the report to Congress, the IHS seek comments and views from Tribes. The Tribal Consultation comment period was for 60 days and closed on August 2, 2024. The IHS did not receive any comments or recommendations from Tribes, Tribal organizations, or anyone else, for this Report during the comment period.