Fiscal Year 2016 and Fiscal Year 2017 Report to Congress on the Administration of the Indian Health Service Tribal Self-Governance Program

(Includes FY 2016 and FY 2017 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) 2016 Report to Congress on the Administration of the Indian Health Service Tribal Self-Governance Program and FY 2017 Report to Congress on the Administration of the Indian Health Service 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 Indian Health Service (IHS or Agency) Tribal Self-Governance Program for fiscal years 2016 and 2017, and provides an accounting of the level of need being funded for each Indian tribe or tribal organizations under self-governance compacts[1] and funding agreements[2] authorized under Title V of the ISDEAA.

In FY 2016, approximately $1.9 billion of the total IHS annual appropriation was transferred to tribes and tribal organizations under (89) ISDEAA self-governance compacts and (115) funding agreements.[3] In FY 2017, approximately $2 billion of the total IHS annual appropriation was transferred to tribes and tribal organizations under (94) ISDEAA self-governance compacts and (120) funding agreements.[4]

In 2016, the Spirit Lake Tribe, which is located in North Dakota (Great Plains Area IHS), and the Tohono O'odham Nation, which is located in Arizona (Tucson Area IHS), entered into the IHS Tribal Self-Governance Program. This was a notable accomplishment as these two IHS Areas previously had no tribes and tribal organizations participating in the IHS Tribal Self-Governance Program. Currently, all 12 IHS Areas now have at least one tribe or tribal organization participating in the IHS Tribal Self-Governance Program.

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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 and 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 (2018). Self-Governance. *Department of Health and Human Services, Fiscal Year 2018. Indian Health Service: Justification of Estimates for Appropriations Committees*. Retrieved from https://www.ihs.gov/budgetformulation/congressionaljustifications/

[4] Department of Health and Human Services (2019). Self-Governance. *Department of Health and Human Services, Fiscal Year 2019. Indian Health Service: Justification of Estimates for Appropriations Committees*. Retrieved from https://www.ihs.gov/budgetformulation/congressionaljustifications/

In 2017, five additional tribes entered into the IHS Tribal Self-Governance Program: (1) the Fort McDermitt Paiute and Shoshone Tribe, located on the borders of Nevada and Oregon; (2) the Quapaw Tribe of Oklahoma; (3) the Seminole Nation of Oklahoma; (4) the Salt River Pima-Maricopa Indian Community, located in Arizona; and (5) the Ho-Chunk Nation, located in Wisconsin.

B. Background

Title V of the ISDEAA allows tribes and tribal organizations 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 2016 and FY 2017, approximately one-third 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 (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 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 and tribal organizations.

This report 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 and tribal organizations related to this report, as required by 25 U.S.C. § 5394(a)(2) (previously codified as § 458aaa-13(a)(2)) of the ISDEAA.

C. Linkage with other reports to Congress

[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 non-exhaustive list of examples 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.

The Indian Health Service Fiscal Year (FY) 2016-2017 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards (Includes Fiscal Year 2016-2017 Data).[6]

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.

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

Examples of Successful and Innovative Tribal Self-Governance Health Programs

The Citizen Potawatomi Nation Health Services (CPNHS). The CPNHS administered and operated by the Citizen Potawatomi Nation (CPN) is one example of a successful and innovative tribal aelf-governance health program, located in Shawnee, Oklahoma. The CPNHS utilizes a comprehensive approach to healthcare, providing: high quality, evidence-based, culturally-suitable primary medical care, optometry services, physical therapy, dental services, public health services, pharmacy, behavioral health and substance abuse counseling and services, and a wellness center focused on preventive services to members of the CPN and other federally recognized American Indian tribes. The CPNHS also provides ultrasound service, mammography, and Joslin Vision Network (JVN) retinal imaging. Additionally, in 2016, CPNHS reported it was building a Diagnostic Imaging/Specialty Services Clinic, to be equipped

[6] The FY 2016 CSC amounts are identified and reported in the *Fiscal Year (FY) 2016-2017 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards* (Includes Fiscal Years 2016-2017 Data), which is available online at https://www.ihs.gov/newsroom/reportstocongress/

with Computed Tomography scan, Magnetic Resonance Imaging (MRI) and extra exam rooms for specialty providers. The CPNHS employs approximately 210 employees and contractors.

Focusing on the goal of expanding medical care for their community, the CPNHS's user population almost doubled in FY 2016 (11,106 total patients with a visit), as compared to FY 2012 (6,027 total patients with a visit). Additionally, the total number of visits increased by two-fold in FY 2016 (147,306 total number of patient visits), when compared to FY 2012 (72,859 total number of patient visits). The CPNHS' innovative Insurance Sponsorship Project was very successful in FY 2016, enrolling 125 patients. While premiums increased drastically in 2016, the CPNHS returns on investment came out ahead at $7.71 per $1.00 invested, taking into consideration revenue collected and Purchased/Referred Care (PRC) dollars saved. For example, reimbursement by third party payers for services provided to CPNHS patients and clients increased by almost $2 million in FY 2016 (collections from all sources in FY 2016 totaled $6,862,467) from FY 2015.[7]

The Fond du Lac Band of Lake Superior Chippewa (hereafter referred to as Fond du Lac Band). The Fond du Lac Band with approximately 4,200 tribal members, has also developed an innovative and successful Self-Governance health program, in Minnesota. In 2013, the Fond du Lac Band's Tribal Council approved a tribal sponsorship program called FDL Total Coverage mostly for people under 300 percent of the federal poverty level (FPL)[8] who enrolled in MNsure, the marketplace set up by Minnesota under the Patient Protection and Affordable Care Act (ACA) of 2010 (Pub. Law 111-148). With approximately 500 new enrollees in Medicaid and careful attention to billing, FDL's income from Medicaid increased by $1.62 million in 2014, an increase of 11 percent over the previous year. After the first enrollment period, less than 10 percent of the Tribe's 7,309 user population remained uninsured. During the second year open enrollment period, FDL staff focused on re-enrolling people and reducing the list of uninsured.[9]

The Indian Health Care Improvement Act, reauthorized under ACA, specifically authorizes that tribes may use funds made available under ISDEAA to purchase health insurance, such as coverage through a Marketplace, for IHS beneficiaries. A tribal sponsorship program provides self-governance tribes with an opportunity to expand access to healthcare for tribal members, as well as increased resources available to the tribal health program. For those formerly uninsured IHS beneficiaries who now have insurance under the Marketplace, tribes can reduce

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[7]Citizen Potawatomi Nation Health Services (2016). Citizen Potawatomi Nation Health Services Annual Report FY 2016 (10/01/15-09/30/16). The CPNHS submitted the report to IHS in 2016.

[8] The tribal sponsorship programs are permitted, but not required, to purchase coverage based upon the financial needs of the IHS beneficiaries. *See* 25 U.S.C. § 1642(b) (found on the Internet at: https://www.gpo.gov/fdsys/pkg/USCODE-2015-title25/pdf/USCODE-2015-title25-chap18-subchapIII-A-sec1642.pdf), and the CMS guidance letter dated February 7, 2014 (found on the Internet at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf).

[9] Self-Governance Communication and Education Consortium (2017). Success Stories: Tribal Sponsorship Helps Fond du Lac Band Reach Goal of Providing Health Insurance for All. Retrieved from Success Stories - Tribal Self-Governance (tribalselfgov.org)

expenditures for services authorized through PRC by accessing substantial federal premium and cost-sharing assistance provided through the Marketplace.[10]

The Chickasaw Nation Medical Center (CNMC). The CNMC, located in Ada, Oklahoma, is another example where a self-governance tribe has developed an innovative health program and maximized resources to provide more comprehensive community-wide services. The Chickasaw Nation's Department of Health provides services to approximately 31,000 Chickasaw Nation tribal members.[11] The IHS reports a service population of 41,414, including individuals of other tribal affiliations, for the Ada Service Unit in 2016.

The CNMC developed best practices in tobacco treatment to promote healthier lifestyles and address tobacco-related illness and disease, among Native and non-Native populations. In 2016, the Centers for Disease Control and Prevention (CDC) reported that 33.9 percent of American Indians and Alaska Native people consume tobacco.[12] According to the 2014 Oklahoma State's Health Report, tobacco related illness and disease kills over 6,000 Oklahomans, and is Oklahoma's leading cause of preventable death, costing the state $1.16 billion in health care costs annually. The CNMC facility adopted best practices in tobacco treatment as recommended by the Oklahoma Hospital Association (OHA), Tobacco Settlement Endowment Trust and Joint Commission. The tobacco treatment assistance ranges from therapy to interactions with a "quit coach" and tobacco cessation classes. In 2014, the CNMC partnered with OHA to offer the nicotine replacement therapy program to patients who wish to quit using tobacco products.[13]

In 2016, the CNMC reported they were having tremendous success referring patients to receive services from the Oklahoma Tobacco Helpline, which greatly increases a patient's chances of successfully quitting. Patients referred by their inpatient or outpatient health providers are contacted by the 1-800-Quit-Now hotline for counseling support and over-the-counter medications to improve their chances of success. The Chickasaw Nation reported that over 1,000 individuals received assistance from the Oklahoma Tobacco Helpline after being referred by the CNMC. The CNMC was also the first health system in Oklahoma, and among a handful of hospitals in the nation, to fully integrate clinical tobacco treatment into its electronic health records system.[14]

Village of Kivalina. Completed in 2016, the Portable Alternative Sanitation System (PASS) demonstration project, a non-piped in-home sanitation system, was designed and retrofitted into nine homes to address immediate water and sanitation needs in the village of Kivalina, in northwest Alaska. Kivalina's PASS demonstration project is an example of increased

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[10] Self-Governance Communication and Education Consortium (2017). *Tribal Sponsorship Overview. Health Care Reform in Indian Country*. Retrieved from https://www.tribalselfgov.org/health-reform/health-q-a/sponsorship-overview/.

[11] Chickasaw Nation Department of Health (August 19, 2020). Information provided by Chickasaw Nation Department of Health staff via email communique.

[12] Centers for Disease Control and Prevention (CDC) (2016). Smoking & Tobacco Use. *American Indians/Alaska Natives and Tobacco Use*. Retrieved from https://www.cdc.gov/tobacco/disparities/american-indians/index.htm

[13] Chickasaw Nation Media Relations Office (April 1, 2016). *Tribal Health Care Helps Community Members Quit Smoking.* Retrieved from https://www.chickasaw.net/News/Press-Releases/Release/Tribal-health-care-helps-community-members-quit-sm-1982.aspx

[14] *Ibid.*

community engagement, program design driven by the needs and priorities of a Tribal community, and the development of innovative health programs and services. The PASS demonstration project was a collaboration between the Tribal and city councils of Kivalina, the Alaska Native Tribal Health Consortium (ANTHC), the Cold Climate Housing Research Center, the Northwest Arctic Borough, and the IHS.

According to the State of Alaska, the majority of the more than 3,000 rural Alaska homes that lack running water and flush toilets are located in 30 'unserved' Alaska Native villages, and many of the homes and villages with in-home water and sewage services rely upon "deteriorating piped and haul systems."[15] Insufficient in-home water and sewage service in rural Alaska can result in numerous health issues, such as, respiratory illnesses (e.g., influenza and pneumonia), infectious disease (e.g., COVID-19) and severe skin infections.

Due to the lack of running water and flush toilets, many of Kivalina's approximately 442 residents[16] need to haul clean water from melted ice, rainwater catchments, or rivers to their homes, and dispose of waste from a honey bucket (a plastic lined bucket that serves as a toilet) in a seepage pit or a landfill area.[17] Kivalina is situated at the tip of an 8 mile barrier reef island in the Chukchi Sea, which is susceptible to ongoing flooding, wind driven ice, and erosion. Plans are in place to relocate the village to an area 2.5 miles away from its current location in the near future. For this reason, building a new water and wastewater system for the entire village of Kivalina is not an option. Also, once the relocation occurs, it will be costly to construct a new piped water and sanitation system that could take years to build. Some of the benefits of the PASS demonstration project, include, that the units are:

(1) low cost - Costing $47,726 for installation in each home, and averaging $30 in monthly operating fees for homeowners. Also, it takes less time to build the PASS units, than to build a piped sanitation system;
(2) transportable - the PASS units can be moved to a new village site when a community relocates;[18] and
(3) increased accessibility to water – creating healthier and more sustainable communities.

Upon completion, the PASS demonstration project monitored and evaluated homeowner acceptance and health benefits, as well as feasibility to expand the PASS demonstration project to other homes in Kivalina and northern coastal communities. Initial results indicate that PASS has the potential to improve the quality of life and health for rural Alaska Natives living without in-home piped water systems. The ANTHC also emphasized the importance of "partnering with the community to ensure homeowner buy-in, to develop good rapport to facilitate successful user training and address the human factors."[19] With at least 12 other Alaska Native communities, comprised of more than 1,000 households, considering or advancing with relocation, as a

[15] Alaska Department of Environmental Conservation/Department of Water (2020). Alaska Water and Sewage Challenge. The Problem. Retrieved from https://dec.alaska.gov/water/water-sewer-challenge/
[16] Northwest Artic Borough (2018). Kivalina. Retrieved from https://www.nwabor.org/village/kivalina/
[17] Alaska Native Health Consortium (2016). *Portable Alternative Sanitation System/Kivalina, Alaska. Final Report.* Retrieved from https://anthc.org/clean-water-and-sanitation/portable-alternative-sanitation-system-final-report-kivalina-alaska/
[18] *Ibid.*
[19] *Ibid.*

consequence of erosion and flooding caused by climate change, the usability and need of PASS for these affected communities is underscored.[20]

Cherokee Nation. The Cherokee Nation, with a Tribal membership over 370,000 world wide and 141,000 Cherokee Nation citizens residing in their service area, is located in northeastern Oklahoma, in a 9,000 square mile area that includes all or parts of 14 counties.[21] The Cherokee Nation (CN) Diabetes Prevention Program, funded largely by an IHS Special Diabetes Program for Indians (SDPI) grant, has received national recognition as a successful evidence-based practice targeting and reducing type 2 diabetes.[22] The prevalence of diagnosed diabetes is highest among American Indian and Alaska Native populations (14.7 percent), as compared to Hispanics (12.5 percent), African Americans (11.7 percent), Asians (9.2 percent) and Caucasians (7.5 percent).[23]

The CN Diabetes Prevention Program operates under the umbrella of the CN Health Services, which administers the W.W. Hastings Hospital and eight health centers and provides treatment for approximately 10,000 diabetes patients per year.[24] The CN Health Services refers patients who are diagnosed with prediabetes, who have a high risk for prediabetes or a history of gestational prediabetes to the CN Diabetes Prevention Program. In the year 2017, to prevent diabetes, and mitigate other chronic illnesses, the CN Diabetes Prevention Program began offering weekly, biweekly, and monthly Healthy Native classes at nine sites to encourage participants to lose weight and provide weight loss tools.

Approximately 293 individuals who participated in the CN Diabetes Prevention Program and Healthy Native classes, from the years 2017 to 2019, lost a total of nearly 1,300 pounds. Participants who completed the program experienced an average weight loss of 6.6 percent after a year. The CN Diabetes Prevention Program is at the forefront of diabetes prevention and has set a national precedent, serving as a model diabetes program for other tribes, as well as non-Native organizations (e.g., YMCAs and hospitals) that want to offer similar preventative programs to address the diabetes epidemic.[25]

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

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[20] *Ibid.*

[21] Cherokee Nation (2020). Frequently Asked Questions. Common Questions: Where is Cherokee Nation? Retrieved from https://www.cherokee.org/about-the-nation/frequently-asked-questions/common-questions/

[22] Cherokee Phoenix (2019). CN Diabetes Prevention Program Earns CDC Recognition. Retrieved from https://cherokeephoenix.org/Article/index/62991

[23] U.S. Department of Health and Human Services (2020). National Diabetes Statistics Report (2020): Estimates of Diabetes and Its Burden in the Unites States. Retrieved from https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

[24] *Ibid.*

[25] Tahlequah Daily Press (2019). CN Diabetes Prevention Program Earns CDC Recognition. from https://www.tahlequahdailypress.com/news/lifestyles/cn-diabetes-program-earns-recognition/article_bbe60a9c-df1a-54f3-a160-a3983108ee2b.html

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 2016 and FY 2017, respectively.

FY 2016 Data:

(1) IHS, Office of the Director, Office of Tribal Self-Governance line item, FY 2016 appropriation (Dollars in Thousands) $ 5,735

(2) IHS, Area Offices, total of FY 2016 budgets for self-governance activities $ 0

(3) Amount available for current self-governance tribes[26] $ 1,540,732
(Dollars in Thousands)

IHS Area Office	All Funds
Alaska	$ 559,990
Albuquerque	16,661
Bemidji	76,982
Billings	22,243
California	79,532
Great Plains	5,393
Nashville	94,931
Navajo	76,088
Oklahoma City	422,184
Phoenix	69,833
Portland	106,256
Tucson	10,639
Total	$1,540,732

(4) Total funds related to the provision of services and benefits to self-governance tribes (Dollars in Thousands) $ 1,546,467

FY 2017 Data:

(1) IHS, Office of the Director, Office of Tribal Self-Governance line item, FY 2017 appropriation (Dollars in Thousands) $ 5,786

(2) IHS, Area Offices, total of FY 2017 budgets for self-governance activities $ 0

[26] Please note the following: Contract Support Costs (CSC) are not included in this report. The FY 2016 CSC amounts are identified and reported in the *Fiscal Year (FY) 2016-2017 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards* (Includes Fiscal Years 2016-2017 Data), which is available online at https://www.ihs.gov/newsroom/reportstocongress/

(3) Amount available for current self-governance tribes[27] in FY 2017 (Dollars in Thousands) $ 1,634,447

IHS Area Office	All Funds
Alaska	$ 570,526
Albuquerque	16,796
Bemidji	80,305
Billings	32,587
California	81,002
Great Plains	11,857
Nashville	96,809
Navajo	77,517
Oklahoma City	422,773
Phoenix	72,983
Portland	108,218
Tucson	43,074
Total	$1,634,447

(4) Total funds related to the provision of services and benefits to self-governance tribes (Dollars in Thousands) $ 1,640,233

F. Funds transferred to each Self-Governance Indian tribe in FY 2016 and FY 2017, and the corresponding reduction in the Federal bureaucracy[28] (Dollars in Thousands)

(1) Funds transferred to Tribes for PSFAs assumed under Title V of the ISDEAA for FY 2016 and FY 2017 respectively.

(a) FY 2016

$ 1,419,941

IHS Area Office	Funds Transferred
Alaska	$ 473,214
Albuquerque	12,480
Bemidji	73,085

[27] Please note the following: Contract Support Costs (CSC) are not included in this report. The FY 2017 CSC amounts are identified and reported in the *Fiscal Years (FY) 2016-2017 Report to Congress on Contract Funding of Indian Self-Determination and Education Assistance Act Awards* (Includes Fiscal Years 2016 - 2017 Data), which is available online at https://www.ihs.gov/newsroom/reportstocongress/.

[28] Note: For amounts by tribe, please see Exhibit A "FY 2016 Funds Transferred to Each Self-Governance Tribe" and Exhibit B "FY 2017 Funds Transferred to Each Self-Governance Tribe."

Billings	21,521
California	76,927
Great Plains	3,906
Nashville	91,831
Navajo	74,266
Oklahoma City	417,591
Phoenix	66,960
Portland	102,589
Tucson	5,571
Total	$1,419,941

(b) FY 2017 $ 1,487,348

IHS Area Office	**Funds Transferred**
Alaska	$ 455,998
Albuquerque	12,668
Bemidji	76,371
Billings	32,229
California	78,197
Great Plains	11,241
Nashville	94,079
Navajo	75,684
Oklahoma City	438,340
Phoenix	71,372
Portland	104,137
Tucson	37,032
Total	$1,487,348

(2) Corresponding reduction in the Federal bureaucracy

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

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

Tribes may elect to assume responsibility for PSFAs formerly administered by the IHS. A tribe 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 items.

(1) Tribal Size Adjustment Formula

The IHS transferred $28,738 (Dollars in Thousands) in FY 2016 and $33,796 (Dollars in Thousands) in FY 2017 to self-governance tribes for their individual tribal shares of all IHS Headquarters funds. For most IHS Headquarters 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" Headquarters 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.[29]

(2) Special Program Formulas

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

(a) Purchased/Referred Care,[30] Fiscal Intermediary Formula

Using the Purchased/Referred Care (PRC) Fiscal Intermediary formula, the IHS provided $994 (Dollars in Thousands) in FY 2016 and $1,009 (Dollars in Thousands) in FY 2017 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, $959 (Dollars in Thousands) and $1,102 (Dollars in Thousands) were provided to self-governance tribes, in FY 2016 and FY 2017, respectively. Headquarters 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.

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[29] Indian Health Service (June 2002). *HEADQUARTERS, PROGRAMS, SERVICES, FUNCTIONS AND ACTIVITIES (PSFA Manual),* Updated: June 2002, which is available online at https://www.ihs.gov/sites/selfgovernance/themes/responsive2017/display_objects/documents/2002-PSFA-Manual.pdf

[30] In January 2014, the Consolidated Appropriations Act of 2014 changed the name of the Contract Health Services program to the Purchased/Referred Care program.

H. Total residual[31] amount identified in the preceding fiscal year (FY 2015) for FY 2016 and (FY 2016) for FY 2017 to carry out inherent federal functions. HQ Residual amounts were historically determined after consultation with and recommendation by a Tribal/Federal 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;
- Legal Counsel - Legal advice and related services; and
- Property Oversight – Control of acquisition, use and disposition of federal property, records management

(1) In 2015, IHS Headquarters identified a Headquarters residual amount of $ 29,720,509 million.

FY 2015 HQ Residuals

HQ PSFA	Sub-category	Residual
01-Hospitals and Clinics	0146 - Records Mgmt., Property & Supply	$ 1,095,803
13-Direct Operations	1301 - Direct Operations - Rockville	23,565,646
24-Facilities & Envr. Hlth.	2401 - San. Facilities Constr. Support	1,316,987
	2402 - Environ. Health Services Support	1,212,543
	2403 - Facilities Operations Support	1,003,628
	2404 - Facilities and Engineering Support	1,525,902
Grand Total		**$**29,720,509

(2) In 2016, IHS Headquarters identified a Headquarters residual amount of $ 30,013,900 million.

FY 2016 HQ Residuals

HQ PSFA	Sub-category	Residual
01-Hospitals and Clinics	0146 - Records Mgmt., Property & Supply	$ 1,099,150

[31] "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)

13-Direct Operations	1301 - Direct Operations - Rockville	23,805,592
24-Facilities & Envr. Hlth.	2401 - San. Facilities Constr. Support	1,330,028
	2402 - Environ. Health Services Support	1,224,551
	2403 - Facilities Operations Support	1,013,567
	2404 - Facilities and Engineering Support	1,541,012
Grand Total		**$30,013,900**

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

By letter dated August 2, 2023, the IHS initiated Tribal Consultation with Tribal Leaders to request comments on this FY 2016-2017 (Combined) Report to Congress on the Administration of the Tribal Self-Governance Program. The IHS received two letters with comments and recommendations, from one Tribe and one IHS Tribal Advisory Committee. Both the Tribe and Tribal Advisory Committee requested that the IHS be more responsive to the statutory requirements under ISDEAA, 25 U.S.C. § 5394, for this report. The following summarizes the comments and recommendations provided by these two entities:

1. **Annual Report** (25 U.S.C. § 5394(a)(1)). Both the Tribe and Tribal Advisory Committee request that the IHS adhere to statutory requirements for providing the information annually to Congress, emphasizing that this report is overdue by more than 5 years.

   IHS response: The IHS acknowledges that the report is overdue and has assigned more staff to calculate the amounts needed for this report and future reports. The IHS is committed to completing the past due Reports.

2. **Inherent Federal Functions** (25 U.S.C. § 5394(b)(2)(E)). The Tribe and Tribal Advisory Committee both recommend that the IHS clarify and include in this report and future reports the inherently federal functions carried out by the Agency and the amount of residual resources associated with them. The Tribe commented that despite sharing the residual total, it is not clear what functions the IHS continues to provide to self-governance tribes using the IHS Headquarters residual amount, nor is the report specific about how this amount is determined annually. Additionally, the Tribe said that this number does not accurately reflect the amount of funding the IHS Area Offices retain to conduct inherent federal functions.

   The Tribe also recommends that this Report reference criteria for identifying inherent Federal functions, such as:

   a. "those Federal functions which cannot lawfully be delegated to Indian tribes" (25 U.S.C. § 5381(a)(4)) and
   b. "inherently governmental function" as meaning "a function that is so intimately related to the public interest as to require performance by Federal Government

employees" (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).

IHS response: The IHS has provided a table with the amounts of residual for inherent federal functions at Headquarters programs, in section H above. However, the IHS does not have the actual Area residual amounts readily available for Area programs, and would need to perform a data call to obtain this information, which would require time. The IHS will consider this request for future reports to Congress on the Administration of the Tribal Self-Governance Program.

Regarding defining "inherently federal functions," the initial version of this report that was issued for tribal comments included the definition of "inherent federal functions," in a., above (footnote 5 on page 4). However, the citation, under ISDEAA, has been added. The definition for b., above, was also included in footnote 5 on page 4, but per the tribal recommendation, the citation to the FAIR Act was added. Examples of inherent federal functions have also been added to section H of this report.

3. **Level of Need Funded and Unfunded** (25 U.S.C. § 5394(a)(2)). The Tribe and Tribal Advisory Committee requested that the IHS provide detailed analysis and more comprehensive information for the "level of need funded and unfunded." In their letter, the Tribe commented that during FY 2016, the national average health spending per user for healthcare was $9,990, and the IHS spending per user was $3,337. The Tribe and Tribal Advisory Committee both recommended that at a minimum, the IHS should add "user population" and "funding per user population" data to Exhibit A and B of the reports. The Tribe indicated that such information would show that funding per user varies significantly across self-governance tribes. To demonstrate how this data could be used/calculated and displayed in this report or future reports, the Tribe provided the following table with information for the Citizen Potawatami Nation as an example:

Tribe	Funds Transferred (Dollars in Thousands)	User Population (UP)	Funds Transferred/UP
Citizen Potawatomi Nation	$14,511	19,536	$743

(Note: $14,511,000/19,536 = 742.782 rounded off to 743)

IHS response: The IHS has conformed to the requirements in 25 U.S.C. 5394(b) and this type of work is occurring elsewhere in the Agency. Specifically, the IHS Indian Health Care Improvement Fund (IHCIF) Workgroup has analyzed the level of need funded and their work continues. Information on the IHCIF Workgroup is available at INDIAN HEALTH CARE IMPROVEMENT FUND (IHCIF) WORKGROUP FINAL REPORT (ihs.gov).

In response to the Tribe and Tribal Advisory Committee recommendation that, at a minimum, the IHS should add "user population" and "funding per user population" data to Exhibit A and B of the reports, it should be noted that the IHS user population is estimated by Service Unit and not by tribe or facility. The IHS is unable to provide user population data by tribe, as the user population is calculated by Service Unit. While some Service Units only serve one tribe, many Service Units serve multiple tribes. Additionally, while the table reflects funds transferred to Title V tribes, it does not reflect total funds allocated to individual tribes. This figure does not show funding for retained IHS services or third-party reimbursement that the tribe receives.

4. **Reduction of Federal Bureaucracy** (25 U.S.C. § 5394(b)(2)(C)). The Tribe and Tribal Advisory Committee acknowledged that Section F of this report summarizes funds transferred to each tribe in Exhibit A, but point out that there is no analysis or illustration of any corresponding reduction in the Federal bureaucracy as required by the ISDEAA at 25 U.S.C. § 5394(b)(2)(C). The Tribe stated that the corresponding reduction in federal bureaucracy can be demonstrated quantitatively and qualitatively. The Tribe recommends that the IHS provide a more detailed description, and add a year-to-year comparison to measure reductions in federal bureaucracy and further illustrate the Tribal Self-Governance Program success. They stated that this is an opportunity to inform Congress of specific examples of program successes and why it is important to invest in self-governance tribes. The Tribe and Tribal Advisory Committee also encourage the IHS to reach out to tribes and tribal organizations for more success stories to include in this report.

   IHS response: The ISDEAA at 25 U.S.C. § 5394(a)(2), states that, "In compiling reports pursuant to this section, the Secretary may not impose any reporting requirements on participating Indian tribes or tribal organizations, not otherwise provided in this chapter." Therefore, the limited number of published self-governance success stories, evidenced-based practices, or qualitative data has hindered the Agency's efforts to provide more examples of success stories for this report. Qualitatively, Section D. of this report references some tribal success stories. The IHS looks forward to working with tribes and tribal organizations, such as the IHS Tribal Self-Governance Advisory Committee, that may be willing to share success stories for the purposes of this report, as stated above. As for providing quantitative data to demonstrate a reduction in federal bureaucracy, the IHS would like to hear more from tribes on what type of data elements they would like to be reported on in a year-to-year comparison to demonstrate a reduction in federal bureaucracy.