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CITIZEN POTAWATOMI NATION

September 26, 2023

Via email to: consultation@ihs.gov

Ms. Roselyn Tso, Director
Indian Health Service
5600 Fishers Lane
Mail Stop: 08E37A
Rockville, MD 20857

Re: IHS Tribal Self-Governance Report – FYs 2016 and 2017

Dear Director Tso,

On behalf of the Citizen Potawatomi Nation (CPN, Tribe, Nation), we provide these comments and recommendations in response your Dear Tribal Leader Letter dated August 2, 2023 regarding the Indian Health Service's (IHS') Fiscal Years 2016 and 2017 Report to Congress for the Administration of the Tribal Self-Governance Program.

As you reference in the agency's draft report, this information is required by law annually under the Indian Self-Determination and Education Assistance Act (ISDEAA) U.S.C 25 §5394. Specifically, section §5394(a) requires the report and §5394(a)(2) and §5394(b)(2) together outline the eight main elements required for each annual report to Congress as follows:

1. Detailed analysis of the level of need being presently funded or unfunded for each Tribe, either directly by the Secretary, under Self-Determination Contracts, or under Self-Governance Compacts and Funding Agreements (§5394(a)(2))
2. Relative costs and benefits of self-governance (§5394(b)(2)(A))
3. (With particularity) all funds that are specifically or functionally related to the provision by the Secretary of services and benefits to self-governance Indian tribes and their members (§5394(b)(2)(B))
4. Funds transferred to each self-governance Indian tribe and the corresponding reduction in the Federal bureaucracy (§5394(b)(2)(C))

5. Funding formula for individual tribal shares of all headquarters funds, together with the comments of affected Indian tribes and tribal organizations, developed under subsection (c) of this section (§5394(b)(2)(D))
6. Amounts expended in the preceding fiscal year to carry out inherent Federal functions, including an identification of those functions by type and location (§5394(b)(2)(E))
7. Description of the method or methods (of any revisions thereof) used to determine the individual tribal share of funds controlled by all components of IHS (including funds assessed by any other Federal agency) for inclusion in Self-Governance Compacts or Funding Agreements (§5394(b)(3))
8. Separate views and comments of the Indian tribes or tribal organizations (§5394(b)(3))

Overall, CPN believes this draft provided is a good report and that the IHS has improved the report content since its last publication. One significant improvement includes five tribal examples of the innovation and benefits of Tribal Self-Governance. We were especially honored that IHS highlighted the Citizen Potawatomi Nation's successes with managing our health programs under our self-governance authority. However, it appears that the Indian Health Service has missed an opportunity to provide Congress with the kind of detailed analysis required to determine the level of need being presently funded, which would be helpful to the authorizers of our funding. Additionally, we hope that future Congressional reports are more responsive to each statutory requirement and thus more helpful to Congress as they address health needs across Indian Country. As such, CPN provides the recommendations discussed below for revision to the FYs 2016 and FY2017 report.

Include an analysis of level of need funded and unfunded. IHS references that the report provides "...an accounting of the level of need being funded for each Indian Tribe..." on page three. However, it does not contain an analysis "...of the level of need funded or unfunded for each Indian Tribe, either directly by the Secretary, under self-determination contracts under subchapter I of this chapter, or under compacts and funding agreements authorized under this chapter" as specifically referenced in §5394(a)(2).

This is a critical oversight that needs to be corrected. IHS's chronic underfunding is no secret to Congress. In FY2016 the Indian Health Service's annual appropriation was about $5 Billion. During that time, IHS spending per user was $3,337; yet the national average health spending per user for FY2016 was $9,990. IHS has the data to evaluate the level of need funded and unfunded for Tribes and Service Units. But this information is simply omitted from the Report.

The IHS should add a more robust level of need discussion to this report. In the least, "user population" and "funding per user population" data should be added to Exhibit A. Using the Citizen Potawatomi Nation as an example, this information could be displayed as outlined for 2016:

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

Such information would show that funding per user varies significantly across self-governance tribes. Congress cannot make effective funding decisions without this detail.

Provide a corresponding analysis of reduction in Federal bureaucracy. While Section F of the Report does show funds transferred to each Tribe in Exhibit A, there is no analysis or illustration of any corresponding reduction in the Federal bureaucracy as required by ISDEAA. The simplistic answer provided that concludes a "separate trend analysis will need to be conducted to capture the actual rate of reduction in Federal bureaucracy" does not provide valuable or informative data to Congress that Title V is achieving one of its stated goals, "to provide for a measurable parallel reduction in the Federal bureaucracy as programs, services, functions, and activities (or portions thereof) are assumed by Indian tribes." CPN suggests a more detailed description as required by §5394(b)(2)(C) and adding a year-to-year comparison to measure reductions in Federal bureaucracy and further illustrate the Tribal Self-Governance Program success.

The corresponding reduction in federal bureaucracy can be demonstrated quantitatively and qualitatively. Self-governance Tribes have reduced Federal administration of health care in Tribal communities while providing culturally competent care, expanding local services, and strengthening Tribal economies. This report is an opportunity to tell Congress how Tribes participating in Self-Governance have redesigned programs, leveraged other Federal resources, and created partnerships with the private sector to expand services and improve care for their communities. For example, because the CPN has not been successfully funded through a joint venture facility construction project, it turned to other federal agencies for health facility construction grants to expand access to care for its user population. This is an opportunity to inform Congress of specific examples of program successes and why it is important to invest in self-governance tribes; as such, the report on page 12 leaves much to be desired.

Clarify inherent Federal functions by type and location. ISDEAA requires that IHS include the "amounts expended in the preceding fiscal year to carry out inherent Federal functions by type and location." Despite sharing the residuals 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. This number also does not accurately reflect the amount of funding IHS Area Offices retain to conduct inherent Federal functions. There are criteria for identifying inherent Federal functions, which the Report could reference. The term "inherent Federal functions" is defined in §5381(a)(4) as meaning "those Federal functions which cannot lawfully be delegated to Indian tribes." 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, defines an "inherently governmental function" as meaning "a function that is so intimately related to the public interest as to require performance by Federal Government employees."

This draft report to Congress is a unique opportunity for IHS to share the success of Self-Governance as well as the level of funding needed. However the Agency must provide increased detail to prudently inform Congress. We hope you will carefully consider the Nation's recommendations and ultimate incorporate them into the IHS's Fiscal Years 2016 and 2017 Tribal Self-Governance Report. Please do not hesitate to contact Kasie Nichols- Director, Office of Self-Governance at kasie.nichols@potawatomi.org or 405-271-3121 for any questions or comments.

Sincerely,

John A. Barrett
Tribal Chairman

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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314 West 14th Place - Tulsa, Oklahoma 74119
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Sent electronically via consultation@ihs.gov

September 29, 2023

Roselyn Tso Director
Indian Health Service
Mail Stop: 08E86
5600 Fishers Lane Rockville, MD 20857

SUBJECT: Tribal Self-Governance Report – FYs 2016 and 2017

Dear Director Tso:

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), I write to provide our comments to FYs 2016 and 2017 Tribal Self-Governance Reports in response to your Dear Tribal Leader Letter (DTLL) dated August 2, 2023.

The Indian Self-Determination and Education Assistance Act (ISDEAA) requires IHS to submit an annual report to Congress focused on the implementation of Self-Governance authority. ISDEAA requires the report to include information on, among other things, the level of need being presently funded or unfunded for each Tribal Nation, relative costs and benefits of Self-Governance, and an identification of inherent federal functions and the amounts expended by the agency to carry out those functions.

The two reports that IHS shared for Tribal consultation are both over 5 years old. TSGAC appreciates the submission of the report, but we believe the information has a more significant impact when the information is reflective of current conditions. IHS is also required to submit the report annually and we ask IHS to adhere to all statutory requirements. TSGAC urges the IHS to adhere to statutory requirements for providing the information annually to Congress. Tribal Nations are facing new challenges daily and having timely reports will help Congress better understand the current situation and needs for Indian health care.

TSGAC offers the following comments related to the FYs 2016 and 2017 reports:

1. Inclusion of Tribal Success Stories. Tribal Nations have negotiated Self-Governance agreements with IHS to reduce Federal administration of health care in Tribal communities while providing culturally competent care, expanding local services, and strengthening Tribal economies. This report shows Congress how Tribal Nations participating in Self-Governance have used flexibilities offered in ISDEAA to make scarce IHS resources more effective by redesigning programs, leveraging other Federal resources, and partnering with the private sector. As a result, Tribal governments have successfully expanded services and improved care for their communities. We appreciate and are supportive of the specific examples of successful Tribal health programs that are included in the Reports. We encourage you to continue reaching out to Tribal Nations and highlight these success stories. Please also let us know how the TSGAC can assist you in this effort going forward.

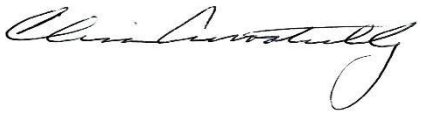
2. Clarify inherent federal functions. ISDEAA requires that IHS include the "amounts expended in the preceding fiscal year to carry out inherently federal functions by type and location." Despite sharing the residuals total, it is not clear what functions the IHS continues to provide using the IHS Headquarters residual amount, nor is the report specific about how this amount is determined annually. This number also does not reflect the amount of funding IHS Area Offices retain to carry out inherently federal functions. TSGAC recommends IHS include in the FYs 2016 and 2017 reports, as well as future reports, inherently federal functions retained by the agency and the amount of residual resources associated with them.

In addition, we believe IHS has missed an opportunity to provide the level of detailed analysis required to meet the intent of the report requirements. TSGAC is uncertain of the benefit that could be realized by going back to conduct a detailed analysis of information that is 6-7 years old, but we do believe IHS should provide significantly more information and improved analysis in future reports. This is particularly true when it comes to reporting on the level of need and reduction in federal bureaucracy.

In the FYs 2016 and 2017 reports, IHS states that they provide " ... an accounting of the level of need being funded for each Indian Tribe." However, the reports do not contain a sufficient level of detail to meet the ISDEAA requirements. In FY16, the Indian Health Service's annual appropriation was about $5 billion. At that time, IHS spending per user was $3,337; yet the national average health spending per user for FY2016 was $9,990. IHS has the data to evaluate the level of need funded and unfunded for Tribal governments and Service Units. TSGAC requests that future reports provide more comprehensive information. At a minimum, IHS should add "user population" and "funding per user population" data to Exhibit A of reports.

Thank you for allowing us to provide these comments. If you have any questions or wish to discuss further, please do not hesitate to contact me at (508) 272-5160; or via email: chris.anoatubby@chickasaw.net.

Sincerely,



Chris Anoatubby
Lieutenant Governor, Chickasaw Nation, and
Chairman, IHS TSGAC

cc: Jennifer Cooper, Director, Office of Tribal Self-Governance
Jay Spaan, Executive Director, Self-Governance Communication and Education
TSGAC Members and Technical Workgroup