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**TESTIMONY BEFORE HOUSE COMMITTEE ON NATURAL RESOURCES,  
SUBCOMMITTEE ON INDIAN AND ALASKA NATIVE AFFAIRS  
HEARING ON  
FY 2013 BUDGET REQUEST FOR INDIAN HEALTH SERVICE**

**March 6, 2012**

Good afternoon, Mr. Chairman and members of the Committee. My name is Robert McGhee. I am a council member and the Treasurer of the Poarch Band of Creek Indians and sit as an at-large member of Secretary Sebelius's Tribal Advisory Committee.

My testimony will focus on a few IHS budget issues of particular importance to Poarch Band and other tribal health contractors across the nation: Contract Health Services, built-in costs, and contract support costs. First, however, a word about the need to maintain the recent gains IHS and tribes have made. We firmly believe that the IHS budget should be held harmless in terms of budget reductions, including across-the-board rescissions and sequestration. Health care is not something that can be reduced, delayed or withheld without real damage to people. Congress and the public have rightly supported maintaining health care funding for members of the military and veterans, and we feel the same should be true of the Indian health care system. IHS and tribal budgets are suffering the consequences of the past two years' lack of funding for inflation and population growth; the FY 2013 budget proposal is no improvement in this regard.

The trust obligation of the Federal government to Native peoples is fundamentally different from ordinary discretionary spending. Unlike other areas, this legal obligation is deeply rooted in the U.S. Constitution, treaties, statutes, case law, and other commitments made to Native peoples, largely in return for huge land cessions. A 1977 U.S. Congress/American Indian Policy Review Commission Report stated:

*The purpose behind the trust is and always has been to ensure the survival and welfare of Indian tribes and people. This includes an obligation to provide those services required to protect and enhance Indian lands, resources, and self-government, and also includes those economic and social programs that are necessary to raise the standard of living and social well-being of the Indian people to a level comparable to the non-Indian society.*

The President's FY 2013 budget proposal essentially provides for a small increase to the Indian Health Service budget and flat-funds the Bureau of Indian Affairs. After inflation, these agencies would, overall, lose purchase power from FY 2012, even if some individual programs received additional funding. The health care rate of inflation, in more years than not, is greater than the increased rate of funding to the Indian Health Service. To the extent they can, Tribes use their own funds to supplement this trust

obligation, but in some cases, ironically, have had the Internal Revenue Service question whether such tribal funding and programs might actually be taxable.

Moreover, Federal law also provides for an across-the-board cut for nearly all domestic and defense programs of about 8.5% starting January 1, 2013. Federal budget problems should not be addressed on the back of Native peoples. We would ask the Subcommittee to support the concept that funding increases should consistently exceed the health care rate of inflation in order to achieve real progress in closing the health care services gap for Natives.

Although we have been asked to focus on the Indian Health Service, we would like to take the opportunity at the end of this testimony to emphasize the importance of passage of the Carcieri Fix, which the Subcommittee has long supported.

Contract Health Services. We appreciate the recognition by Congress and the Administration of the importance of the Contract Health Services program, as evidenced by the FY 2012 increase in appropriations and the Administration's request for a \$54 million increase in FY 2013. While even this amount would not fully meet the need for Contract Health Services, we recognize the difficult fiscal environment, and urge Congress to appropriate at least the amount requested. The CHS program is of particular importance to many tribes, as much of our health care is done on a referral basis.

Built-In Costs. We are very concerned about the cumulative effects of deficiencies in the past several years for built-in costs – namely, population growth, inflation, and required pay increases. The Administration and Congress do consistently request and provide funding for staffing and operation of new facilities, although not always in the amount the tribal health care providers feel is needed. In FY 2010 Congress provided \$169 million for built-in costs for pay raises, inflation, population growth, and staffing for new facilities. But in *FY 2011* the only increases enacted were for a pay increase to Commissioned Officers and staffing of new facilities. The Administration had also requested \$60 million for inflation and \$52 million for population growth and funding for civilian pay increases for that year. And in *FY 2012* the Administration requested \$255 million for pay costs, inflation and population growth, none of which was appropriated. All these costs must be absorbed by health programs. In *FY 2013* there is no request for funding for population growth, inflation (except for Contract Health Services) or pay increases. Funding is requested for staffing and operation of new facilities.

Contract Support Costs. We appreciate the steps Congress has taken in the last few years to reduce the crippling contract support cost shortfalls suffered by tribal health care providers. Contract support costs are the administrative and overhead expenses tribes and tribal organizations incur in providing health care under Indian Self-Determination Act agreements. When contract support costs are not fully funded, as has been the case for almost twenty years, tribes are forced to slash administrative capacity, divert program resources to cover administrative expenses, subsidize federal programs with their own scant tribal resources, and/or curtail or forgo self-determination and self-

governance altogether. In effect, tribes are shortchanged and treated as second-class government contractors.

Substantial increases in CSC appropriations in fiscal years 2010 and 2012 have reduced the shortfalls significantly, saving and creating jobs in tribal health care. More progress needs to be made, however. Underfunding of contract support costs continues to impose major hardships on tribal health care providers and patients around the nation. Last year, in H.R. 2584, the House proposed funding IHS for contract support costs at \$574,761,000, which would have reduced the CSC shortfall dramatically. Ultimately, however, Congress appropriated just over \$471 million, requiring tribes to divert close to \$100 million from health care services to fixed administrative expenses.

We urge this Committee to continue to press for full funding of contract support costs. The requested increase of \$5 million is not sufficient. Given the increase in program funding requested, we estimate that a CSC appropriation of at least \$580 million would come close to eliminating the shortfall, allowing tribal providers to use all health care program funds for the purposes Congress intended.

A word of appreciation is due to IHS for its advocacy and approach to contract support cost issues. During this Administration, IHS has engaged in good faith negotiations resulting in the settlement of many claims for past CSC shortfalls. Recently IHS initiated tribal consultation on the agency's CSC policy, convening a workgroup of tribal leaders and technical experts. The process has gotten off to a rocky start due to IHS's refusal to share CSC data for the last three years. Once IHS releases this data, however, we anticipate that the tribal consultation will help the agency strengthen its contract support cost policy.

*Timely Funding.* We feel the time is ripe for a serious discussion about whether IHS funding should be put on an advance appropriations or biennial basis. As you know, in FY 2010 three of the Veterans Administration's medical accounts were put on an advance appropriations basis – those are very large accounts totaling approximately \$50 billion. Going back to 1998, the only year in which an Interior and Related Agencies appropriations bill has been enacted prior to the beginning of the fiscal year was FY 2006. Even if an appropriations bill is enacted just prior to October 1, it still takes time for OMB and IHS to apportion and allocate the funds. Receiving funds under a series of Continuing Resolutions, without knowing how much funding will be available in the fiscal year, makes planning and delivery of services very difficult.

*Carciere "Fix."* Poarch Band is very thankful to this Subcommittee for its strong support of the Carciere "fix." The President has, for the third year in a row, included the "fix" in his proposed budget. If the Congress is serious about stimulating the economy and is also serious about assisting Tribes, than the "fix" must be passed. The uncertainty caused by this decision is stopping or delaying many projects across Indian country as tribes and financiers try to figure out if there is a Carciere-related issue that they need to be concerned with.

As you know, the Supreme Court held in *Carcieri v. Salazar* that the Secretary of the Interior has authority to take land into trust under the Indian Reorganization Act of 1934 (IRA) only for those tribes that were "under federal jurisdiction" in 1934. The Court's opinion is inequitable because it creates two classes of federally recognized tribes that would be treated differently under federal law – those that were "under federal jurisdiction" in 1934 and those that were not. The decision also opens the door to considerable confusion and potential inconsistencies concerning the status of tribal lands, tribal businesses, and important civil and criminal jurisdictional issues. The *Carcieri* Fix would restore the *status quo ante*. For nearly 75 years before the *Carcieri* decision, DOI and tribes throughout Indian Country consistently interpreted the IRA as applying to all federally recognized tribes. This proposal found strong support in the 111th Congress. Importantly, this same language was unanimously approved by that House Interior Appropriations Subcommittee late last year and included in the House-passed continuing resolution (H.R. 3082). The language is vigorously supported by tribal organizations across the country. Indeed, Congress amended the IRA in 1994 to clarify that all federal agencies must provide equal treatment to all Indian tribes regardless of how or when they received federal recognition. See 25 U.S.C. § 476(f)-(g).

In closing, Poarch Band appreciates this Committee's leadership in securing recent appropriations increases for IHS, and urge that this progress be continued. We also appreciate IHS's recent efforts to work with tribes on contract support costs and other issues. We look forward to working with Congress and the Administration to improve health care services to Indian peoples.

Thank you for your time.