TESTIMONY OF BUFORD ROLIN

CHAIRMAN, POARCH BAND OF CREEK INDIANS,
VICE CHAIRMAN, NATIONAL INDIAN HEALTH BOARD,
CO-CHAIRMAN, TRIBAL DIABETES LEADERS COMMITTEE &
CO-CHAIRPERSON OF THE NATIONAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

TO THE HOUSE INTERIOR APPROPRIATIONS SUBCOMMITTEE

FY 2011 INDIAN HEALTH SERVICE BUDGET PRIORITIES
MARCH 23, 2010

Mr. Chairman, and Members of the Subcommittee:

My name is Buford Rolin. I serve as Chairman of the Poarch Band of Creek Indians and Vice-Chairman of the National Indian Health Board (NIHB). In these capacities and others, I have been fortunate to work with Tribal Leaders from across the country to address issues that affect the Indian health delivery system and the health status of Indian people.

The NIHB was very pleased to learn that, for the FY 2011 IHS budget, the Obama Administration is proposing a $354 million increase over the FY 2010 enacted IHS appropriations. This 8.7% increase is particularly noteworthy in light of the fact that the Administration has proposed an overall freeze on discretionary funding. The request represents the continued commitment of the Administration to engage with Indian Country on a government-to-government basis, and that the Administration understands the critical needs of our communities. I thank Congress, specifically this committee, for also championing our issues through increased appropriations.

In addition, NIHB is mindful that, despite the federal government's legal obligation and sacred trust responsibility to provide health care to American Indians and Alaska Natives (AI/AN), to date IHS funding remains a discretionary line and thus susceptible to cuts. The trust obligation to provide health care is, however, paramount, and it is upon this foundation that the IHS Tribal Budget Formulation Workgroup built its recommendations for the FY 2011 IHS budget.

The IHS Tribal Budget Formulation Workgroup consists of tribal representatives from each of the 12 IHS Areas. Each year the Workgroup consolidates all the Area recommendations and, working with IHS Headquarters and national Indian organizations, develops a consensus national tribal budget and health priorities document. For FY 2011, the Workgroup's detailed recommendations are described in its paper titled "*Standing on Principals: A New Era in Tribal Government Relation*" which is attached as an addendum to this written testimony. The Workgroup's focus here is on investing in a new partnership between the Federal Government and Tribes to advance the health of AI/ANs. The Workgroup's proposal centers on a ten-year phase-in to eventually achieve full funding for IHS. As a first step, the Workgroup recommends increases in the IHS Budget totaling $2.1 billion above FY2010 funding levels.

These recommendations focus on two types of needed increases:

Current Services Increases are those budget increments needed to enable the Indian health system to continue operating at its current level of service. This category contains such items as pay cost increases; inflation; contract support costs; funding for population growth; and facilities construction and staffing. Without these increases to base funding, the Indian health system would experience a *decrease* in its ability to care for the service population. The Workgroup recommends an increase of $947 million for these items to maintain the existing level of services.

Program Services Increases refer to the recommended increases in key IHS budget accounts to enable our programs to improve and expand the services they provide to Indian patients. As you know, the IHS has long been plagued by woefully inadequate funding in all programmatic areas, a circumstance which has made it impossible to supply Indian people with the level of care they need and deserve, and to which they are entitled by treaty obligation. The Workgroup recommends $1.14 billion be added to identified program and facilities accounts for these purposes.

Specific Increases. I would like to highlight a few programs targeted by the Tribal Workgroup for vital increases. Similar to the President's proposal, the Tribal Workgroup focuses the largest increases on the following program areas.

Contract Support Costs. Since 1975, Indian Tribes, under the Indian Self-Determination and Education Assistance Act, have exercised the right that the law provides to take over the direct operation of IHS programs. All Tribes in all Areas operate one or more such contracts. The ability of Tribes to successfully operate their own health care systems, from substance abuse programs to entire hospitals, depends centrally upon the proper appropriation of Contract Support Costs (CSC) – the audited and fixed general and administrative costs required to administer these programs. The present underfunding of CSC creates a disincentive for Tribes to take on such endeavors. Worse, it *penalizes* Tribes when they do, because it diminishes available health care funding by forcing contracting and compacting Tribes to divert health care dollars to cover these fixed administrative costs. Full CSC funding eliminates that penalty, honors the legal duty to pay these costs, and protects health care resources intended for service delivery. **The NIHB supports the Workgroup's full funding recommendation, and urges that the CSC line item be increased by $150 million (to $550 million) for FY2011.**

Hospitals and Clinics. The Hospital and Clinic budget line item is the core account which funds the Indian health system's medical care programs, including direct medical services, public/community health initiatives and information technology. Increases for this budget item go toward addressing the treatment of chronic diseases, including diabetes, cancer and heart diseases, as well as sustained programs for health promotion and disease prevention initiatives (including obesity reduction) to reduce future demand for chronic care. **Due to its central role, the Workgroup recommends an increase in the overall Hospitals and Clinics account of $500 million.**

A subset within the Hospitals and Clinics line item includes funding for the Indian Health Care Improvement Fund (IHCIF) and for Information Technology (IT). The IHCIF provides separate funding for distribution to selected operating units in order to reduce resource disparities across the IHS system. Without an appropriate level of support in the Hospitals and Clinics account, the United States' trust responsibility for Indian health cannot be met and the Indian health system is unable to fulfill its health care mission. IT is also essential to health service delivery, because the IHS system is in critical need of infrastructure and support systems to implement Electronic Health Records. NIHB appreciates the President's support for an increase of $44 million for IHCIF, $4 million for IT, and $2.5 million to address chronic diseases.

Contract Health Services: The contract health service (CHS) program serves a critical role in addressing the health care needs of Indian people. The CHS program exists because the IHS system is not capable of supplying directly all the care needed by the IHS service population. In theory, CHS should be an effective and efficient way to purchase needed care – especially specialty care – which Indian health facilities are not equipped to provide. In reality, CHS is so grossly underfunded that Indian Country cannot purchase the quantity and types of care needed. At present, less than one-half of the CHS need is being met, leaving too many Indian people with *no* access to necessary medical services. As a consequence, many of our Indian patients are left with untreated and often painful conditions that, if addressed in a timely way, would improve quality of life at lower cost. **The Workgroup proposes an increase of $500 million for CHS.**

Budget Management Issues. Lastly, I would like to call your attention to two additional items which require special attention and instructions.

First, each year the IHS Tribal Budget Formulation Workgroup develops a national tribal consensus on the IHS budget priorities for the upcoming fiscal year and presents its recommendations to the Department during formal tribal consultation. But thereafter, the Workgroup is denied the opportunity to consult with the Office of Management and Budget (OMB) about the Workgroup's recommendations. Tribes are kept entirely in the dark until the President offers his budget proposal nine months later. In this new era of revitalized government-to-government relations between the Federal government and the Tribes, OMB should bring transparency to the budget formulation process by engaging Tribes on an ongoing basis. NIHB recommends that the Committee include an appropriate instruction to OMB on this score.

Second, the passage of health care reform and most importantly, the Indian Health Care Improvement Act (IHCIA), is likely to occur soon. Indian Country needs to be a partner in designing and implementing the new authorities offered in the IHCIA. Implementation will be an enormous task, but designing a blueprint with Tribes as partners in this process is well worth the effort. Here, too, NIHB recommends that the Committee include an appropriate instruction on this score.

On behalf of the National Indian Health Board, thank you for the opportunity to address the Subcommittee on these important matters. I am happy to answer your questions.

Recommendations of the IHS National Tribal Budget Formulation Workgroup

FY 2011 CURRENT SERVICES INCREASES

	President's Proposal	**Tribal Budget Workgroup Proposal**
Federal Pay Costs	$10,935,000	$26,900,000
Tribal Pay Costs	13,417,000	29,200,000
Inflation	59,977,000	63,300,000
Additional Medical Inflation	0	54,800,000
Population Growth	52,466,000	42900000
Staffing for New/Replacement Facilities	38,771,000	25,000,000
Contract Support Cost	0	170,100,000
Health Care Facilities Construction	0	281,324,000
Joint Venture	0	60,000,000
Area Distribution Fund	0	140,000,000
Restore FY 2008 Rescission	0	53,521,000
TOTAL CURRENT SERVICES	**$175,566,000**	**$947,045,000**

FY 2011 PROGRAM INCREASES

Hospitals & Clinics	0	500,000,000
Indian Health Care Improvement Fund	44,000,000	10,000,000*
Information Technology	4,000,000	30,000,000*
Chronic Diseases	2,529,000	--
Dental	0	30,000,000
Mental Health	0	20,600,000
Alcohol and Substance Abuse	4,000,000	19,600,000
Contract Health Services	46,000,000	500,000,000
Public Health Nursing	0	0
Health Education	0	0
Community Health Representatives	0	0
Alaska Immunization	0	0
Urban Indian Health	1,000,000	10,000,000
Indian Health Professions	0	0
Tribal Management	0	0
Direct Operations	0	0
Self-Governance	0	0
Contract Support Costs (New & Expanded)	40,000,000	--
Maintenance & Improvement	0	20,000,000
Sanitation Facilities Construction	36,958,000	35,000,000
Facilities & Environmental Health Support	0	0
Equipment	0	12,000,000
TOTAL PROGAM INCREASES	**$178,487,000**	**$1,147,200,000**

Notes: * Funding is recommended for the IHCIF and IT to be funded as a subset of Hospitals & Clinics Funding.
-- refers to items not considered by the National Tribal Budget Workgroup