DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

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The Honorable Ralph Regula
Chairman, Subcommittee on
Interior and Related Agencies
House of Representatives
Washington, D.C. 20515-6015

Dear Chairman Regula:

I am responding to your January 27 letter concerning the policy I recently adopted that will govern the administration of contract support costs (CSC) in the Indian Health Service (IHS) in fiscal year (FY) 2000. In your letter, you requested that I recall the policy and distribute CSC in a manner different than that stipulated by the policy.

I appreciate your past support for the IHS and for the increases you and the Committee have provided for CSC. I am aware, of course, that funding for Indian health programs is limited. However, a priority of mine has always been to strengthen Indian self-determination and thereby carry out the provisions of the Indian Self-Determination Act (P.L. 93-638, as amended).

I would like to take this opportunity to provide a brief history of CSC in the IHS, including the recent activities that led to my adoption of our new policy, IHS Circular No. 2000-01, "Contract Support Cost Policy."

Since 1992 the IHS has had an established, written CSC policy that was developed and implemented in consultation with tribes and tribal organizations. In fact, the policy that I recently adopted is the third CSC policy that has been implemented by the Agency since 1992. Our new policy was developed as a result of the most extensive tribal consultation to date regarding CSC. As was the case with our two earlier policies, our newly adopted policy instructs Agency personnel on the determination and negotiation of CSC amounts, the allocation of CSC resources, and the reporting of CSC shortfalls to the Congress.

Through FY 1994, CSC appropriations were generally sufficient to fund 100% of the CSC need of tribes and tribal organizations in the IHS. However, beginning in FY 1995, the demand for CSC began to exceed, eventually quite substantially, the amount of appropriations provided by the Congress for that purpose. In my opinion, this was due in large part to two events, both of which

stimulated the accelerated assumption of IHS programs by tribes. These events were the passage of the 1994 amendments to the Indian Self-Determination Act (ISDA) and the authorization of the Self-Governance Demonstration Project in the IHS.

Beginning in FY 1995, the significant growth in self-determination contracting and compacting created a demand for additional CSC that has outpaced the availability of CSC appropriations. At that time, the Agency made a determination that it would not alter its allocation policy to provide for a pro rata funding distribution of CSC. The position of the IHS was that the implementation of a pro rata funding distribution would result in a reduction of funding to a significant number of tribes, which would severely disrupt their delivery of health care services. A fundamental element of the IHS CSC policy that I recently adopted is that CSC funding will not be reduced for those tribes presently receiving less than 100% of their CSC need.

When the Agency began experiencing shortfalls in CSC funding, the IHS did what the Congress directed we do in such circumstances. As required by Section 106(c) of the ISDA, the Agency reported annually on the deficiency of CSC funds necessary to provide full funding for self-determination contracts and compacts. I have also testified each year to Congress on the critical importance of CSC to tribal governments and on the amount needed to fully fund the CSC need. Additionally, I have continually advocated for increased CSC appropriations in the formulation of the President's Budget.

In fiscal year 1999, the Congress provided the Agency an increase of $35 million for CSC and directed that we distribute that increase in a manner that would reduce the inequity in the distribution of CSC in the IHS. This increase was sorely needed, and I am certainly aware that it would not have been made available without your support and advocacy. As a result of consultation with tribal governments, the Agency distributed this increase to those tribes that had the greatest overall CSC need for all programs administered through self-determination contracts and compacts. I believe that this allocation methodology was responsive to concerns expressed by the Committee and Congress that the IHS address the inequity in CSC funding levels of tribes in the IHS system. The allocation of the $35 million increase in this manner enabled the IHS to fund, on average, 86% of the total CSC need associated with IHS contracts and compacts. At the time of the allocation, no tribe was funded at less than 80% of its overall CSC need. The allocation of the increase reduced the gap in CSC funding levels in the IHS considerably.

As part of the 1999 appropriations process, the Congress also requested that the Agency consult with tribes to propose a permanent acceptable solution to the CSC distribution inequity as part of the FY 2000 budget process. The Agency embarked on this consultation with tribes within days after receiving this instruction from the Congress. As I have indicated, the consultation that went into the development of the Agency's solution (i.e., policy) to the CSC distribution inequity was extensive and protracted. My staff provided periodic status reports on the progress of our activities to your staff and other congressional staff on the progress and outcomes of our consultation. Although the policy does not redistribute all CSC on a pro rata basis, it does abandon the historic approach to the Indian Self-Determination (ISD) Fund and the maintenance of a queue system in favor of a pro rata system whereby each eligible tribe with an ISD Fund request receives additional funding proportionate to its overall CSC needs. Those with the greatest unfunded CSC needs will receive the greatest increases in ISD funding under the new policy. The CSC shortfall funding will also be distributed on a similar pro rata basis by providing the greatest CSC increases to those tribes with the greatest unmet CSC needs.

In summary, it is my firm belief that the policy I adopted does address the expectation of Congress as stated in the FY 1999 appropriations committee report. Our analysis of the increase provided for CSC in FY 2000 indicates that there is very little practical variance between the outcomes of the distribution of CSC increases in the manner governed by the policy and other allocation methods. A critically important feature of the new policy is that its allocation provisions were thoroughly discussed with and supported by tribal governments and organizations as required in the instruction the Agency received from the Congress. Over a 9-month period, my staff met with tribal leaders and representatives in a series of special consultation sessions to discuss provisions of the policy. Additionally, the policy was presented and discussed at numerous forums, including meetings of the National Congress of American Indians, the National Indian Health Board, and the Self-Governance tribes and inter-tribal consortiums. In short, the new CSC policy was developed in close adherence to Executive Order 13084, "Consultation and Coordination with Indian Tribal Governments," May 14, 1998, as well as Department of Health and Human Services and Indian Health policies on tribal consultation and participation.

I assure you of my gratitude for your efforts on behalf of Indian people and the IHS and of my sincere interest in continuing to work with you and the Committee on the many difficult issues

concerning CSC. In a recent meeting between Committee staff and IHS officials, the staff of the Committee again expressed its desire that the IHS and the Bureau of Indian Affairs work together with tribal governments to develop a uniform policy to govern the administration and allocation of CSC. I am supportive of such an endeavor and pledge the cooperation of the IHS and its staff in the accomplishment of this worthy goal.

I also want to thank Ms. Loretta Beaumont of your staff for her offer to help coordinate a meeting between you and me to discuss this issue as well as other issues that are of importance to the health of American Indians and Alaska Natives. I look forward to meeting with you in the near future.

Sincerely yours,

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Assistant Surgeon General
Director