

Testimony of Bill John Baker, Principal Chief, Cherokee Nation
House Interior Appropriations Subcommittee
March 25, 2015

I am Bill John Baker, the Principal Chief of the Cherokee Nation. Our tribe is the largest federally recognized Indian tribe in the United States, with more than 315,000 tribal citizens, and spans more than 7,000 square miles in all or part of 14 counties in northeast Oklahoma. Chairman Calvert, Ranking Member McCollum, and members of the Subcommittee, I deeply appreciate and thank you for this opportunity to share a few of our key priorities for the upcoming fiscal year.

Fund IHS Joint Venture Construction Projects

Last year, I testified before this Subcommittee requesting that you urge the Indian Health Service (IHS) to reopen the Joint Venture (JV) Construction Program, which Congress established in 1992 as a cost-effective way for the federal government to address the more than \$2.2 billion backlog of IHS health facilities construction projects. I would like to especially thank Representative McCollum and Representative Cole for spearheading an effort that resulted in several members of Congress, including members of the Subcommittee, sending a bipartisan letter urging the IHS to reopen the Joint Venture program to a new round of solicitations. Due to your efforts, IHS reopened the Joint Venture application process in late FY14, allowing tribes throughout the United States to compete for a JV project. In January, the Cherokee Nation was selected as the number two project from a pool of 37 applicants competing for a JV project. We will fund construction of a new ambulatory care facility in Tahlequah, Oklahoma, our capital city, and IHS will request appropriations from Congress to fund staffing and operations.

When completed, this project will be the third Joint Venture project the Cherokee Nation has been awarded by IHS and funded by Congress. We appreciate the opportunity to partner with the federal government to provide world-class health care to Native Americans across northeast Oklahoma. Cherokee Nation has been focused on ensuring that each of its citizens has access to quality health care in state of the art health care facilities. Cherokee Nation Businesses, the holding company for all of Cherokee Nation's companies, has invested more than \$100 million in profits to build, expand and renovate our eight health care centers and one hospital. These facilities received 1.1 million patient visits in 2014. Ultimately, our goal is to have a health care facility within 30 miles of every Cherokee citizen living within our 14-county jurisdiction. Investing in ourselves is a step in the right direction, but without the support of IHS through the Joint Venture program and Congress, we would be much further away from achieving our goal.

We are deep in the planning stages for our new JV facility, and we are committed to fulfilling our obligation to construct a new facility. ***We request that the Subcommittee work with IHS to***

ensure the federal government meets its obligation by funding the staffing and operations for our Joint Venture facility, including full funding of contract support costs.

Provide Full Funding for Contract Support Costs

Cherokee Nation has long been a leader in the self-governance arena. We were among the first tribes to enter into self-governance compacts: our compact with the Department of the Interior was signed in 1991, and we followed that with a compact with Indian Health Service in 1993. We filed our first claim for contract support costs in 1994. For more than twenty years, Cherokee Nation and other tribes have been litigating contract support cost issues to establish that the federal government's legal obligation to fully fund these costs is necessary to fulfill the policy of tribal self-determination. The U.S. Supreme Court has, on three occasions, confirmed this principle in *Cherokee Nation et al. v. Leavitt* (2005), *Salazar v. Ramah Navajo Chapter* (2012) and *Arctic Slope Native Association v. Sebelius* (2012).

Despite these court rulings, the federal government has not always lived up to its obligations. When the United States does not fully pay contract support costs, we must find ways to make up the shortfall. This means possibly realigning our priorities and reducing funds budgeted for critical health care, education and other tribal services. For every \$1 million that Cherokee Nation must divert from direct patient care to cover contract support costs, we must forego nearly 6,000 patient visits. Failure to fully fund these costs impedes our ability to meet the growing health care needs and other needs of our citizens.

In recent years, both IHS and the Bureau of Indian Affairs (BIA) have reinstated contract support cost workgroups and engaged in meaningful consultations with tribal leaders, and tribal input has informed long-term solutions. These efforts, combined with the bipartisan support of this Subcommittee, have helped to ensure resolution of pending IHS tribal claims. Last year, Cherokee Nation successfully negotiated a \$29.5 million settlement with IHS to recoup nearly a decade of underpaid contract support costs. These funds are being used to improve our health care system.

In January, IHS reported that approximately 94 percent of pending claims were settled. Unlike the IHS claims that deal with individual tribes, BIA's case relates to a class action. Cherokee Nation is a member of this class with claims against BIA. Even though the 2012 *Ramah* case has already established the government's liability to fully fund contract support costs, resolution of this case has been slow. ***We request that the Subcommittee urge the BIA to work with all deliberate speed to reach a settlement with the Ramah class.***

The Cherokee Nation supports the President's FY16 budget proposal to fully fund IHS and BIA contract support costs. For IHS, the budget proposes \$718 million, which is an increase of \$55 million over the FY15 enacted level. The budget proposes \$277 million for BIA, an increase of \$26 million over the FY15 enacted level. In addition, we support the proposal to reclassify contract support costs as a three-year mandatory appropriation and remove these costs from the discretionary budget. Mandatory classification would protect these costs from political

wrangling, especially during sequestration. In FY13, sequester cuts cost the Cherokee Nation more than \$8 million in our health programs alone. We also support implementation of this proposal in FY16, rather than 2017. However, we are concerned about the maximum 2 percent set aside for agency administration. Instead, we believe that BIA and IHS should perform an assessment to determine their exact staffing needs and report these findings to the Subcommittee. Further, we are concerned that the five-year reconciliation initiative proposes to make possible adjustments to contract amounts over the five-year period, which is a departure from current practice of completion at the end of the fiscal year. ***We request that the Subcommittee provide full funding for contract support costs and reclassify these costs as a mandatory appropriation. We also ask the Subcommittee to direct BIA and IHS to assess their exact staffing needs and report back to the Subcommittee instead of authorizing up to 2 percent for agency administration. Finally, we ask the Subcommittee to oppose the five-year reconciliation initiative.***

Clarify that Tribal Enrollment functions are allowable Indirect Costs

For 22 years, under Republican and Democratic administrations, indirect costs associated with administering Cherokee Nation's tribal enrollment activities have been reimbursed to the tribe as a component of the indirect cost reimbursement rates negotiated with the Department of the Interior (DOI). Last year, DOI's Interior Business Center (IBC) unilaterally, and without tribal consultation, determined that these particular activities would be disallowed in FY15. This decision means that Cherokee Nation alone would lose more than \$400,000 in indirect cost reimbursements if this policy is not reversed. IBC based its decision on internally developed guidance that has no foundation in law. Given that most federal programs and services require tribal enrollment verification, it stands to reason that administering enrollment functions would fall within the scope of what's considered allowable reimbursable indirect costs. The National Congress of American Indians adopted resolution #ATL-14-030 in October 2014, urging the Administration to reinstate its original practice and to make no changes to policies and procedures governing indirect costs prior to engaging in tribal consultation. ***We request that the Subcommittee clarify in report language that tribal enrollment activities are allowable as reimbursable indirect costs, and urge DOI-IBC to consult with tribes in accordance with Executive Order 13175 before making a change in policy that has tribal implications.***

Support Proposed IHS Budget Increases

I want to thank the Subcommittee for working across partisan divides with your colleagues to increase overall funding for IHS in this tough fiscal climate. The Cherokee Nation supports the Indian Health Service FY16 budget request of \$5.103 billion, an increase of \$461 million over the FY15 enacted level. Within this amount, we support the request for hospitals and health clinics of \$1.9 billion, an increase of \$99.5 million over the FY15 enacted level that would fully fund medical inflation, pay raises and partially fund population growth. Funding for these fixed costs are necessary to maintain current service levels. Further, we support the proposed increase for the health care facilities construction program of \$185 million, which is an increase of \$100 million over the FY15 enacted level. ***We request that the Subcommittee support the***

proposed increases for IHS, hospitals and health clinics, and the health care facilities construction program.

Additionally, the Purchased and Referred Care (PRC) program, formerly known as “contract health services,” is critical to providing comprehensive health care services to our citizens. Through PRC, we are able to provide essential health care services from outside (non-IHS or non-tribal) providers. These services include inpatient and outpatient care, emergency care, transportation, and such necessary medical support services as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services. Without PRC funds, we cannot adequately treat injuries, cardiovascular and heart disease, diabetes, or cancer, which are among the leading causes of death for Native Americans. The Cherokee Nation supports the budget request for PRC of \$984 million, which is an increase of \$70.3 million over the FY15 enacted level. ***We request that the Subcommittee support an increase of \$70.3 million for PRC to help us better serve our citizens.***

We also support the budget request of \$89 million for the maintenance and improvement program, which is an increase of \$35 million over the FY15 enacted level. We appreciate that maintaining our facilities is vital to delivering adequate health care to our patients. In the Cherokee Nation, we have one hospital that was built 30 years ago and designed to serve about 65,000 patient visits a year. Last year, the hospital received more than 400,000 patient visits. While we are committed to serving our citizens, our hospital’s infrastructure was not designed to handle this influx of patients.. While we are fortunate that our new Joint Venture facility, when completed, will accommodate our growth, it is vitally important that health care facilities receive adequate funds to maintain, repair and improve existing facilities, like our hospital. ***We request that the Subcommittee increase the maintenance and improvement program by \$35 million to keep current facilities in sound condition.***

Conclusion

The Cherokee Nation is taking steps to build a brighter future. We are guided by our traditions and deep desire to make life better for the Cherokee people. We are focused on health care, because the Cherokee people are truly our most valuable resource. We are doing our part to improve the lives of our people, but we can’t do it alone. Through self-governance programs and partnerships with IHS, we have already enjoyed a longstanding relationship with the federal government. We believe that our requests further our shared goal of improving the lives of our people. We look forward to working with the Subcommittee on our requests.