

Tanana Chiefs Conference

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SUBREGIONS

UPPER KUSKOKWIM

McGrath
Medfra
Nikolai
Takoyna
Telida

LOWER YUKON

Anvik
Grayling
Holy Cross
Shageluk

UPPER TANANA

Dot Lake
Eagle
Healy Lake
Northway
Tanacross
Tettin
Tok

YUKON FLATS

Arctic Village
Beaver
Birch Creek
Canyon Village
Chalkyitsik
Circle
Fort Yukon
Venetie

YUKON KORYUKUK

Galena
Huslia
Kaitag
Koyukuk
Nulato
Ruby

YUKON TANANA

Alatna
Allakaket
Evansville
Fairbanks
Hughes
Lake
Minchumina
Manley Hot
Springs
Minto
Nenana
Rampart
Stevens Village
Tanana

Hearing Before the House Subcommittee on Interior, Environment, and Related Agencies on the FY 2012 Budget May 3, 2011

Testimony of Jerry Isaac President, Tanana Chiefs Conference

My name is Jerry Isaac and I am submitting this testimony as President of the Tanana Chiefs Conference. TCC is an intertribal consortium of 42 Alaska Native Tribes situated in the interior of Alaska and spanning a largely roadless area of 235,000 square miles—almost equal to the State of Texas. I am submitting this testimony to address two specific issues relating to the FY 2012 Budget: (1) staffing for joint venture facilities; and (2) contract support costs. As my testimony explains, TCC believes that: (1) joint venture staffing should be increased by an additional \$25 million over the President's Budget, in anticipation of several JV projects coming on line in FY 2013, and (2) contract support cost funding to IHS should be increased to \$615 million, and to the BIA should be increased to \$228 million, in order to meet the agencies' legal obligations under their contracts and compacts with the Tribes.

Staffing for Joint Venture Facilities

Last year Tanana Chiefs Conference entered into a joint venture agreement with the Indian Health Service. Under the contract, TCC agreed to secure its own financing to build a new desperately needed facility in Fairbanks, Alaska to meet the growing needs of our villages. In return, IHS signed a contract agreeing to provide the funds necessary to staff the facility at 85% of capacity. (IHS says it does not staff any facilities at more than 85% of capacity). Under the joint venture agreement, TCC will continue to administer all IHS-funded health care in our region out of the new facility, operating under our self-governance compact.

The new facility will cost approximately \$72 million. All of this will be borrowed. As you can imagine, the debt service on these funds will be substantial. However, taking on this debt is feasible because once the facility is staffed and operational—as IHS has contractually committed to do—TCC make its debt payments out of program revenues.

In all of these respects, TCC is no different than many other Tribes and tribal organizations around the Nation that have in recent years benefited from the joint venture authority provided under Section 818(e) of the Indian Health Care Improvement Act: the Tribes secure funding to construct facilities which IHS

agrees are necessary and should be built but, which, as a practical matter, IHS cannot build due to severely limited construction appropriations.

I am deeply concerned that, when all of the joint venture facilities come on line in FY 2013, the increased required national appropriation for staffing (\$100 million) and associated contract support (\$25 million) will be too high for Congress to address at one time. For that reason, and because we need to start hiring in FY 2012 to be operational on October 1st, I strongly recommend that Congress consider adding to the FY 2012 Budget \$25 million of the staffing requirements for these joint venture projects. Either by this means or otherwise, it is imperative that the follow-on FY 2013 Budget include sufficient funds for IHS to fully meet its commitment that year to TCC and the other joint venture participants that will operate completed construction projects in FY 2013.

Honoring IHS's contractual commitment to Tribes and tribal organizations like TCC—a commitment upon which TCC has relied in the course of taking on substantial debt—must be IHS's first priority.

Contract Support Costs

The imperative to fully fund IHS's contract support cost requirements comes from the same source: binding government contracts that IHS has entered into with TCC and hundreds of other Tribes and tribal contractors across the country.

At the end of fiscal year 2010 TCC was suffering from a \$3.2 million shortfall in its contract support cost requirements with IHS. Had those funds been paid, TCC would have been able to fill or create over 70 positions. But because IHS failed to meet its contractual obligation to pay TCC's fixed costs incurred to operate IHS's programs, TCC had no choice but to cover those fixed costs by diverting direct service funds. Positions were then left vacant.

The same is true of the BIA contracts that we operate. In FY 2010 the BIA's data reports that TCC was underpaid over \$1 million in contract support costs, forcing vacancies in all of our BIA-funded compact programs.

This has been going on for years, and it is finally time that it stop.

The President's Budget for FY 2012 admits that, at the requested \$462 million funding level, IHS will be unable to cover \$153 million in contract support costs it owes self-governance and self-determination Tribes and tribal organizations. To be clear, that means a *\$153 million cut* in tribally-administered programs in FY 2012, just as TCC was required to *cut* \$3.2 million in FY 2010 from its own compacted programs. The same is true for our BIA compact, where another \$1 million in programs was cut last year, and will be cut again next year absent full funding of our contracts.

It is not only illegal but immoral for IHS and BIA to structure their budgets in such a way that they cut *only* tribally-administered IHS and BIA programs—not IHS-administered or BIA-administered programs, but *only* tribally-administered programs—in order to meet the agencies' overall budget targets. The thousands of Alaska Native patients and clients who we serve should not be punished because those services are administered under self-governance compacts instead of directly by IHS or the BIA.

I am particularly concerned about this issue as we plan for FY 2013. In FY 2013 TCC will have a significantly increased contract support cost requirement associated with operating the new IHS joint venture clinic. We project the requirement will likely exceed \$6 million. As it is, IHS has only committed to staff TCC's clinic at 85% of capacity. If none of TCC's contract support cost requirements to operate the new clinic are covered, the resulting \$6 million cut in staffing will drop the clinic to 65% of staffing capacity. This will severely compromise TCC's ability both to administer the new IHS facility and to meet its debt obligations. Worse yet, services to our people will be gravely compromised.

We understand that the dollars required to finally close the gap in contract support cost requirements are large, but this is only because the problem has been allowed to snowball over so many years. Once a budget correction is made to finally close the contract support cost gap inside both agencies, maintaining full funding of contract support costs on a going-forward basis will be much more manageable.

This is why TCC respectfully requests that the IHS appropriation for CSC be increased by \$153 million above the President's recommended level, to \$615 million, and that the BIA appropriation for CSC for FY 2012 be similarly increased by \$33 million to \$228 million.

Thank you for the opportunity to present this testimony.

Southcentral Foundation



HEARING BEFORE THE HOUSE SUBCOMMITTEE ON INTERIOR, ENVIRONMENT,
AND RELATED AGENCIES ON THE FY 2012 BUDGET
May 3, 2011

Testimony of Ted Mala
Director of Tribal Relations and Traditional Healing Clinic, Southcentral Foundation

My name is Ted Mala. I am the Director of Tribal Relations and Traditional Healing Clinic at Southcentral Foundation in Alaska. Southcentral Foundation is a tribal organization that compacts with the Secretary of Health and Human Services under Title V of the Indian Self-Determination Act to carry out various Indian Health Service programs. In doing so, Southcentral Foundation acts pursuant to tribal authority granted by Cook Inlet Region, Inc., an Alaska Native regional corporation designated by Congress as an Indian Tribe for purposes of Indian Self-Determination Act activities. As my testimony reflects, we request that in FY 2012 Congress fully fund contract support cost requirements by \$615 million, and that it also add \$25 million to forward-fund a small portion FY 2013 joint venture staffing requirements.

Southcentral Foundation (SCF) has carried out IHS programs under Self-Determination Act agreements for more than 25 years. In accordance with its compact with the DHHS, SCF currently provides medical, dental, optometric, behavioral health and substance abuse treatment services to over 45,000 Alaska Native and American Indian beneficiaries living within the Municipality of Anchorage, the Matanuska-Susitna Borough, and nearby villages. SCF also provides services to an additional 13,000 residents of 55 rural Alaska villages covering an area exceeding 100,000 square miles. To administer and deliver these critical healthcare services, SCF employs more than 1,400 people.

Today I will focus my remarks on two issues, contract support cost funding and joint venture funding.

1. Contract Support Cost Funding

The greatest impediment to the full performance of our self-governance compact with IHS has been the historic underfunding of our contract support costs. Since those costs are fixed, when IHS fails to cover our contract support costs—despite a statutory mandate and a contract obligation to do so—SCF has no choice but to cut positions, which in turn cuts services, and which in turn cuts down our billings and collections from Medicare, Medicaid and private insurers (billings which would otherwise go into additional staff and services for our people).

The reverse is also true, and it is proven: when contract support cost shortfalls are finally paid, the results are increased employment, increased services and increased collections leading to more employment and services. In FY 2010 the President requested and Congress approved an historic increase in “contract support cost” appropriations for FY 2010, for which Southcentral

Foundation is deeply appreciative. Nationally, this increase (which totaled \$116 million) cut down the current shortfall in contract support cost payments by about one-half. In a moment I will detail the advances SCF has already made with the partial restoration of its CSC funds in FY 2010.

But before doing that I need to explain the costs that we are talking about. The majority of Southcentral Foundation's contract support costs (about 80%) are comprised of fixed overhead costs that are determined by an indirect cost rate that is approved by the Department's Division of Cost Allocation. The remainder of SCF's contract support costs (about 20%) are set directly by IHS through direct negotiations. Together, these are the fixed contract support costs that Southcentral Foundation actually incurs, year in and year out, whether IHS reimburses us or not. These costs are independently audited each year by Certified Public Accountants, as required by law.

Even though OMB circulars require that every agency must honor our federal indirect cost rate, and despite the fact that the Indian Self-Determination Act mandates that IHS must add "in full" all contract support costs to SCF's self-governance compact, in the past, IHS has never fulfilled those obligations. Nor has IHS ever met its obligation to inform Congress mid-year of the amounts it owes SCF in the current year, and IHS has never requested supplemental appropriations from Congress to address those contract shortfalls. Instead, IHS has adopted a practice of issuing its contract shortfall reports one year late, long after Congress can do anything about it through the supplemental appropriations process.

So far as we have been able to determine, no other contractors are treated this way. The Department of Health and Human Services, including IHS, treats its contracts with Indian Tribes—and only its contracts with Indian Tribes—as if they were just grants. We provide a contracted service for a contracted price, but then IHS only pays us what it thinks it can afford, and it never budgets enough in its annual appropriation to pay all of its contracts with all of the Tribes.

This practice must stop. In fiscal year 2012 IHS should finally pay its contract obligations in full. The contract support cost line-item should be fully funded at \$615 million, as IHS's own calculations disclose is required in the IHS Budget Justification.

It is said that contract support cost shortfalls are the necessary result of fiscal constraints. But as I have noted, neither DHHS nor any other federal agency I know of ever uses that as a reason not to pay a government contractor in full, whether the issue involves other IHS or DHHS procurement contracts, or the Government's contracts to feed our troops overseas. Fiscal constraints are never a reason for a government to renege on its contract obligations, and if they were no one could ever rely on the government as a contracting party.

Existing fiscal constraints should also not fall disproportionately on the tribally-administered portion of the IHS system. On the one hand, when fiscal constraints lead Congress to reduce program funding, the burden of that decision is shared equally between the IHS-operated portion of the healthcare delivery system and the tribally-operated portion of that same system. The Tribe, like IHS, is then awarded a contract to operate a smaller program.

But when budgetary constraints lead to insufficient contract support appropriations. Tribes and tribal organizations like Southcentral Foundation shoulder the full brunt of the reduction, requiring the contracted programs themselves to be cut in order to make up the difference. All the while, parallel programs that remain under IHS operation are entirely protected from those funding decisions.

In effect, and in reality, underfunding contract support costs disproportionately balances budgetary constraints on the backs of tribal contractors, alone. It punishes the people served under those contracts by forcing reductions in contracted programs. If Congress is going to cut budgets or limit budget increases, fairness demands that such actions occur in portions of the budget that are shouldered equally by IHS and the Tribes and tribal organizations.

SCF's contract support cost requirements reflect critical infrastructure, often mandated by Congress. They include federally-mandated costs such as annual independent audits, and they also cover items such as liability and property insurance, workers' compensation insurance, and payroll and procurement systems. We have to buy insurance. We need to make payroll. We have to purchase supplies and services, and track property and equipment. Given these fixed costs, when contract support costs are cut, SCF has no choice but to make up the difference through staffing and service reductions. As a result, the shortfall has had a direct impact on employment—or rather, unemployment—in our area. Indisputably, contract support cost shortfalls mean lost jobs.

At even a high estimate of \$100,000 per average full-time equivalent employee, every \$1 million loss in our contract support cost payments initially costs Southcentral Foundation 10 jobs. In actuality, however, the impact is even worse, since the reduction in services also means a reduction in revenues from Medicare, Medicaid and other third-party insurers and payers. Therefore, the true job loss for Southcentral Foundation is over 20 positions.

SCF is one of the country's larger tribal healthcare contractors. In FY 2008 the Department failed to pay us roughly 40% of our entire contract support cost requirement: **\$10.7 million**. The impact of such a large shortfall on jobs was stunning, and it severely constrained our ability to meet the healthcare needs of the Alaska Native and American Indian population in our service area. The shortfall meant we could not hire doctors, nurse practitioners, home health workers, psychiatrists, mental health clinicians, dentists, dental hygienists, optometrists, pharmacists, and substance abuse counselors—and I could list many more. Things only got worse in FY 2009, when Southcentral Foundation lost another **\$12.8 million**, again nearly 40% of our CSC requirement.

But the reverse is also true, and it is proven: when CSC shortfalls are reduced, more health care is delivered. Thanks to this Administration's unprecedented support in FY 2010, SCF saw its contract support shortfall close last year by about \$8.8 million. As a result, SCF in FY 2010 opened **97 positions** to fill multiple healthcare provider teams and support staff. If the remaining shortfall were closed through appropriate Departmental budget priorities, SCF would be able to add another 50 positions that currently cannot be filled.

SCF applauds the President's proposal in FY 2012 to narrow the nationwide gap by \$66 million over FY 2010 levels. That said, these sums are simply not even close to sufficient to cover either the current shortfall this year or the anticipated shortfall next year. For that reason, SCF respectfully calls upon the Congress to provide \$615 million in contract support cost funding for FY 2012, so that the Department can finally honor these contracts in full.

The Administration has made bold and historic efforts to narrow the gap. Given the continuing recession and a persistent gap in Indian health care, now is the time to finally close it. Every Tribe has contracts with IHS to carry out some of the agency's healthcare services, and nearly every Tribe is currently being penalized for taking that initiative. Closing the CSC gap will directly benefit nearly every Indian and Alaska Native community in the Nation that is served by IHS.

2. Joint Venture Funding

The second issue I need to address concerns the many joint venture projects currently underway across the country in which several Tribes and tribal organizations (including SCF) have secured non-federal financing to construct healthcare facilities to be operated by the Tribes under self-determination or self-governance agreements, in exchange for a contractual commitment by IHS to fund the staffing of those facilities once they are completed.

SCF is gravely concerned that insufficient continuing services appropriations will be available to fully staff the several joint venture projects that will come on line in FY 2013, as well as the associated CSC requirements for running those facilities. As things stand, IHS already commits to only staff these facilities at 85% of full staffing. Without any CSC funding, that percentage will drop to 60%. Such an outcome will severely strain the ability of many Tribes to provide effective care, to meet their debt service obligations, and to properly operate these facilities. Committee instructions to the agency can help insure that such consequences do not befall the joint venture program. Forward-funding a portion of these costs in FY 2012 with \$25 million (one-fifth of what will be required in FY 2013) would be a sound management practice that would permit hiring to begin before we open our doors on October 1, 2012.

Thank you for granting me the opportunity to testify on behalf of Southcentral Foundation and the 58,000 Native American people we serve.

Sincerely,

SOUTHCENTRAL FOUNDATION



Ted Mala, MD, MPH

Director

Tribal Relations and Traditional Healing Clinic

Testimony of Andy Teuber
Chairman and President, Alaska Native Tribal Health Consortium
President and CEO, the Kodiak Area Native Association

House Committee on Appropriations
Subcommittee on Interior, Environment, and Related Agencies
May 3, 2011

My name is Andy Teuber, I am the Chairman and President of the Alaska Native Tribal Health Consortium (ANTHC) and the President and CEO of the Kodiak Area Native Association (KANA). For the FY 2012 Indian Health Service (IHS) budget we are requesting increases over FY 2010 of \$15 million for dental health, \$217 million in contract support costs (CSC), \$7 million for the Village Built Clinic (VBC) Lease program, and \$10 million for implementation of four new provisions of the re-authorized Indian Health Care Improvement Act (IHCIA).

ANTHC is a statewide tribal health organization that serves all 229 tribes and over 135,000 American Indians and Alaska Natives (AI/ANs) in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center (ANMC), the tertiary care hospital for all AI/ANs in Alaska. ANTHC also carries out virtually all non-residual Area Office functions of the IHS that were not already being carried out by Tribal health programs as of 1997.

KANA is a non-profit Tribal organization formed in 1966 to provide health and social services to AI/ANs in the Kodiak Island Area. The KANA service area includes the City of Kodiak and six Alaska Native villages: Akhiok, Karluk, Old Harbor, Ouzinkie, Port Lions, and Larsen Bay. ANTHC and KANA are both self-governance tribal organizations that compact with IHS to provide health services to AI/ANs under the authority of the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

My testimony addresses areas of deficiency in the IHS budget and provisions of IHCIA that are of high priority for implementation. I extend an invitation to members of this Committee to visit Alaska to see first-hand, the many successes we have been able to achieve in providing high quality health services throughout rural Alaska with its challenging environment. Such successes include our advanced, statewide telehealth network, community health aide program, numerous sanitation facilities construction projects, and the Alaska Native Medical Center—Alaska's only Level II Trauma Center.

We were pleased with the significant increase to the IHS budget in FY 2010 and the proposed increase in IHS's FY 2012 Congressional Justification. The passage of the *Indian Health Care Improvement Reauthorization and Extension Act of 2009*, (IHCIA), S. 1790, has granted opportunities for significant improvements in the health status of AI/ANs. However, even with the increase in FY 2010 there are several programs important to Alaska that have been overlooked and IHCIA needs funding to fulfill its promise.

I. Oral Health

Indian Country faces considerable oral health problems. American Indians and Alaska Natives, especially children, continue to be plagued by oral health disparities. Alaska Native children suffer a dental caries rate of 2.5 times the national average. For AI/AN children ages 2 to 4 the rate of tooth decay is 5 times the U.S. average. An astounding 79% of AI/AN children ages 2 to 5 have tooth decay, 60% of which are severe caries. One-third of school-aged children have

missed school because of dental pain. Far too many have needed surgery to remove many or all of their baby teeth.

Due to the high cost of travel in rural Alaska, just one operating room dental case for a child with early childhood dental caries can cost up to \$7,000. An increase in appropriations for IHS dental health aimed at oral health promotion and disease prevention activities is a sound investment for improving the oral health of AI/AN children, but is an even better investment in reducing future oral health care costs.

Increases for dental health in the IHS budget the past few years have barely been sufficient to maintain the current service levels, which are grossly inadequate to meet the needs of Indian Country. A substantial program increase for the dental health subaccount directed for use for community oral health promotion and disease prevention is essential to the long-term improvement of the oral health of AI/ANs.

II. Contract Support Costs

Indian tribes and tribal organizations are the only federal contractors that do not receive full contract support costs (CSC). There is a clear obligation on the part of the federal government to fully fund CSC. But more importantly, lack of full funding for CSC has a very real and detrimental impact on our programs that are already substantially underfunded.

CSC is used to pay for items that we are required to have but are not otherwise covered by the IHS budget either because another governmental department is responsible or because the IHS is not subject to that particular requirement. Examples include federally-required annual audits and telecommunication systems. We cannot operate without these things, so when CSC is underfunded we have to use other program funds to make up the shortfall which means fewer providers that we can hire and fewer types and quantity of health services that we can provide to our patients.

From 2002 to 2009, while there were virtually no increases for IHS CSC appropriations, the level of tribal CSC need increased by over \$130 million. During that period, as our fixed costs increased every year, all major tribal health programs in Alaska were forced to layoff staff due to lack of funds.

With full funding of our CSC needs, ANTHC would be able to fill scores of support positions, such as enrollment technicians, financial analysts, medical billing staff, professional recruiters, maintenance technicians, security officers, information technology support and professional support staff.

We were very pleased with the substantial increase for IHS CSC in FY 2010. And IHS did recommend a \$63 million increase for CSC in its FY 2012 Congressional Justification, but that level does not adequately address the CSC need. Even if IHS CSC were funded at IHS's FY 2012 request level, the projected CSC level of need funded would be 75 percent—a 3.49 percent decrease from FY 2010.

We recommend an increase of \$217 million for CSC in FY 2012 (bringing total IHS CSC funding up to \$615 million) in order meet the full IHS CSC requirement. At a bare minimum we recommend an \$84 million increase for IHS CSC over FY 2010 (brining total IHS CSC funding up to \$482 million) to maintain the level of need funded at the FY 2010 level of 78.49 percent.

III. Village Built Clinic Lease Program

The Village Built Clinic (VBC) Lease program funds rent, utilities, insurance, janitorial, and maintenance costs of healthcare facilities in villages in rural Alaska. Despite an increase in the number and size of clinics throughout Alaska as well as the rapidly increasing fuel costs, funding for the VBC Lease program has barely increased since 1996. Current funding for leases covers less than 60% of the current operating costs and those costs are expected to continue to increase sharply as energy costs continue to skyrocket in rural Alaska.

Without additional funding for the VBC Lease program, Alaska villages will be increasingly forced to reduce clinic operations and defer long term maintenance and improvement projects. This situation reduces the health care available locally to village residents and threatens the nearly \$200 million investment in these facilities by the federal government, Alaska villages, and the regional tribal health organizations in the Alaska Native health care system.

To ensure that the VBC Lease program is adequately funded in the future, we recommend that it be listed as a separate line item in the IHS budget and an increase of \$7 million in funding for the VBC Lease program to the current program base. These funds are required immediately to sustain the program, covering the expected operating costs in FY 2012 as well as establishing funding for long-term maintenance and improvement. Without this funding, many of Alaska's villages will not be able to continue supporting local clinics, eventually leading to serious consequences for the health and safety of Alaska Native people.

IV. Implementation of Indian Health Care Improvement Act

The enactment of IHCA on March 23, 2010, granted the IHS and tribal health programs a host of new authorities in providing care to their beneficiaries. But, IHCA is a bill that only grants authorities, which means little without corresponding appropriations with which to implement those authorities.

We were pleased to see the requested \$1 million for implementation of section 723 of the IHCA in IHS's FY 2012 Congressional Justification and recommend that it be increased to \$2.5 million and further that \$7.5 million more be provided to implement three other new provisions of IHCA.

A major area of concentration of S. 1790 was to greatly expand the behavioral health authorities included in Title VII of IHCA. Four of the provisions grant authority to establish behavioral health facilities or programs in each area of the IHS. These authorities address areas of great need in Indian Country. We recommend that funding be provided for the following sections of IHCA:

Section 709—Inpatient and community-based mental health facilities design, construction and

staffing, allows for the establishment of not less than one inpatient mental health care facility, in each area of the IHS. We recommend that \$2.5 million be made available to work toward the goal of establishing one inpatient mental health facility in each area of the IHS.

Section 713—*Child sexual abuse prevention and treatment programs*, directs IHS to establish a child sexual abuse prevention and treatment program in every Service area. We recommend that \$2.5 million be made available to work toward the goal of establishing at least one child sexual abuse prevention and treatment program in each area of the IHS.

Section 714—*Domestic and Sexual violence prevention and treatment*, authorizes the IHS to establish in each Service area, a domestic and sexual violence prevention and treatment program. We recommend that \$2.5 million be made available to work toward the goal of establishing at least one domestic and sexual violence prevention and treatment program in each area of the IHS.

Section 723—*Indian youth telemental health demonstration project*, authorizes IHS to carry out an Indian youth telemental health demonstration project and to award up to five grants for the provision of telemental health services to Indian youth. We recommend that \$2.5 million be made available to provide funding for all five grants allowed under this provision.

I appreciate your consideration of our recommendations for additional funding to improve the level, quality and accessibility of desperately needed health services for AI/ANs whose health care status continues to lag far behind other populations in Alaska and in this Nation.