



NATIONAL CONGRESS OF AMERICAN INDIANS

May 3, 2011

Testimony of Jacqueline Johnson Pata, NCAI Executive Director

On behalf of the National Congress of American Indians, thank you for the opportunity to testify on tribal programs in the FY 2012 budget under the Interior-Environment Appropriations bill. This testimony will address programs in the Department of Interior, Environmental Protection Agency, and Indian Health Service.

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Despite reductions for many federal agencies and programs, the President's FY 2012 budget proposal largely protects funding for many Indian programs, and even contains some proposed increases for Indian health and public safety. NCAI commends the Administration for these proposed increases, especially given diminished federal resources. But as Congress deliberates over the FY2012 budget, we ask that you remember that funding for Indian programs supports the trust responsibility—and that trust responsibility is not a line item—it is a solemn duty.

Although Congress will begin deliberations on the FY2012 federal budget in a very tight budget atmosphere, it also follows one of the most significant years of bipartisan accomplishments for Indian Country in recent memory. As you know, in 2010, the U.S. government took historic steps to address numerous long-standing challenges faced by tribal nations. Congress made permanent the Indian Health Care Improvement Act (IHCA) and President Obama signed into law the Tribal Law & Order Act (TLOA). But, like other laws, TLOA and IHCA will not mean much if they are not implemented, and effective implementation is contingent upon adequate federal funding for authorized programs. This moment presents the federal government with an extraordinary opportunity to further tribal self-determination and honor the promises of the federal trust responsibility.

A key theme of the last election was that Congress and the federal budget should focus on programs that are undeniably part of the federal government's constitutional role. Federal obligations to tribal citizens—largely funded by the federal budget—are the result of centuries-old treaties negotiated and agreements made between Indian tribes and the U.S. in exchange for land and resources. Together, these obligations make up the trust responsibility. The authority to fund programs that help fulfill this responsibility is founded in the Constitution, specifically the Indian Commerce Clause, the Treaty Clause, and the Property Clause.

Meeting this constitutional responsibility and empowering citizens and communities to meet the challenges that they face is a priority tribal nations share with many new members of Congress. In this context, NCAI commends the Administration for including language for the *Carcieri* fix in the FY 2012 budget request and urges immediate passage of a clean *Caricieri* fix.

NCAI has compiled recommendations on many specific programs and agencies that affect Indian Country, but, in general, NCAI urges Congress to hold Indian programs harmless in the FY 2012 appropriations process and exempt them from across-the-board rescissions. Tribal programs have endured tremendous fluctuations in recent

decades, making it difficult for tribes to achieve community stability. Each year, tribes should receive resources at least equal to those appropriated to state and local governments so that tribes, too, may meet the critical needs of their citizens and so that the federal government may fulfill its sacred trust responsibility. As members of Congress begin considering the nation's federal budgetary priorities, the debate should acknowledge the solemn agreements made with Indian tribes that are backed by the Constitution.

Bureau of Indian Affairs – Public Safety

The recent passage of the Tribal Law & Order Act (TLOA) is proof that the calls of tribal leaders have not fallen on deaf ears. Congress and the Obama Administration have heard the concerns of Indian people and attempted to address them in this new law. The intended ends of the TLOA cannot be achieved unless tribes have the means to implement them. This requires adequate federal funding for TLOA-authorized programs, as well as full funding of other critical tribal justice programs that will support the overarching TLOA vision of comprehensive law enforcement reform.

Under Public Safety and Justice activities in the Bureau of Indian Affairs, the President has proposed a net \$25.8 million increase from the FY 2010 level, which includes \$20 million in programmatic increases and \$10.6 million for fixed costs. *NCAI supports increases for Bureau of Indian Affairs Public Safety and Justice programs.*

Indian Health Service

The FY 2012 Request for the Indian Health Service is \$4.6 billion in discretionary budget authority – a significant increase of \$571 million, or 14.1 percent, over the FY 2010 enacted level. Indian Country won a substantial victory in 2010 with the passage and permanent reauthorization of the Indian Health Care Improvement Act (IHCA) as part of the Patient Protection and Affordable Care Act (PPACA). American Indians and Alaska Natives realized a number of positive provisions in the overall PPACA legislation. As such, Indian Country seeks to ensure that the Indian health care delivery system is strengthened so that Indian people and Indian health programs benefit from reformed systems. In order to achieve these results, fundamental components are necessary to fully implement IHCA and PPACA in Indian Country. *In the current fiscal environment, NCAI and tribal leaders are encouraged to see strong support in the FY 2012 Budget Request for the Indian Health Service and urge Congress to enact the 14.1 percent increase for IHS overall.*

Contract Support Costs (CSC): The FY 2012 request for IHS contract support costs is \$461.8 million, an increase of \$63.3 million and 16 percent. The IHS recently projected that the shortfall in FY 2012 will be \$153 million, which would result in a cut of \$153 million in tribally-contracted programs, not IHS-administered programs. *NCAI recommends the IHS CSC line item be increased to \$615 million.*

Environmental Protection Agency (EPA)

The President's FY 2012 budget request for the Environmental Protection Agency includes proposed funding for a **Multimedia Tribal Implementation Grants** program to support on-the-ground implementation of environmental protection on tribal lands. These grants, for which \$20 million is requested, are tailored to address an individual tribe's most serious environmental needs. This new grant program will advance negotiated environmental plans, measures, and results as agreed upon by tribes and EPA, thus ensuring that tribal environmental priorities are addressed to the fullest extent possible. An additional \$2.9 million is requested for tribal capacity

building and implementation of this new grant program. *NCAI supports this initiative and the proposed FY 2012 levels for grants and implementation.*

The Multimedia Tribal Implementation Grants program will complement the environmental capacity developed under EPA's **Indian Environmental General Assistance Program (GAP)**, for which the Administration requests an \$8.5 million increase, for a proposed FY 2012 level of \$71.4 million. This requested increase will assist tribal environmental programs that have the capacity to take on additional responsibilities. *NCAI supports this requested increase.*

Bureau of Indian Affairs – Natural Resources

After years of natural resources program cuts, several meaningful increases were provided in FY 2010. An increase of \$12 million was provided for **Rights Protection Implementation** and \$4 million for **Fish Hatchery Operations and Maintenance**.

Several modest but helpful increases are requested in the FY 2012 budget request. These include \$1 million for Rights Protection Implementation, \$1 million for **Tribal Management/Development**, \$1 million for **Forestry**, \$1 million for **Water Management Planning and Pre-Development**, \$1 million for **Wildlife and Parks**, \$1 million for Wildlife and Parks fish hatchery maintenance projects, and \$500,000 for **Invasive Species**. Yet, even with these increases, the base TPA programs that fund tribes' day-to-day conservation responsibilities: Tribal Management/Development; Natural Resources TPA; Wildlife and Parks TPA; and Forestry would still remain at funding levels lower than they were a decade ago. *NCAI supports the requested increases, and urges sustained, increased funding in future years, especially given the level funding for BIA natural resources programs over a number of years.*

In FY 2012, there is a provision of \$200,000 for **Cooperative Landscape Conservation** to address climate change adaptation in the Northwest. Compared to the \$131 million provided to Interior in FY 2010 and the \$175 million requested in FY 2012 for climate change adaptation, the \$200,000 is woefully inadequate. This amount of funding must be increased as it is well established that tribes are disproportionately impacted by climate change, and tribal lands make up 4 percent of the entire land area of the United States, and 16 percent of the lands managed by Interior. *NCAI supports a significant increase proportionate to the climate impacts on tribal lands and the size of the Indian Country land base to enable tribes to address the impacts of climate change.*

Support for Tribal Governments

Every tribe in the United States, directly or through intertribal consortia, operates one or more contracts with the IHS or the BIA under the Indian Self-Determination and Education Assistance Act (ISDA, P.L. 93-638). The statute requires that IHS and BIA fully reimburse every tribal contractor for the "contract support costs" that are necessary to carry out the transferred federal activities. Cost-reimbursable government contracts similarly require payment of "general and administrative" costs. Full payment of fixed contract support costs is essential. Without this support, offsetting program reductions must be made, vacancies cannot be filled, and services must be reduced—all to make up for the shortfall.

The BIA reports that its CSC shortfall exceeded \$62 million in FY 2010, meaning full contract support cost requirements that year totaled \$228 million. Yet, the FY 2012 Budget requests only \$195.5 million, which would result in a \$33 million cut to tribally-operated BIA programs next year. *Based on this data, NCAI recommends the BIA CSC line item be increased to \$228 million.*

Tribal Grant Support Costs (TGSC) for Tribally Operated Schools

The operation of schools by tribes or locally elected tribal school boards is a major exercise of tribal self-determination, encouraged by federal Indian policy for the last 35 years. Tribes and tribal organizations that exercise this option are entitled by law to receive Tribal Grant Support Costs or TGSC (formerly known as Administrative Cost Grants) to cover the administrative or indirect costs incurred when they take over a school. In FY2010 the funding available for TGSC met only 60 percent of need, the lowest rate to date. ***For current contract and grant schools, \$70.3 million should be appropriated to fully fund TGSC need, with an additional \$2 million to fund the administrative needs of those schools that convert to contract or grant status in FY2012, to avoid diverting funds from existing tribally operated schools.***

Bureau of Indian Affairs, Overall

The Administration and Congress have listened to the calls from tribes to provide meaningful increases to BIA overall in FY 2010. Efforts have also been made to address tribal priorities in the FY 2012 budget in the face of overall budget constraints. The FY 2012 budget request includes increases for natural resources, law enforcement and courts, and contract support costs. However, from a broader view, BIA and tribes continue to receive less funding in the President's budget requests (and in reality) relative to other bureaus and agencies in the Department of the Interior. For instance, the President's FY 2012 budget requests an increase of \$138 million for the National Park Service (NPS), an increase of \$48 million for the Fish and Wildlife Service (FWS), and a decrease of \$119 million for the BIA. Additionally, over the last nine fiscal years the budget for the FWS has grown by 30 percent; NPS by 28 percent; U. S. Geological Survey by 19 percent; Bureau of Land Management by 13 percent. Meanwhile, the BIA has seen an increase of only 8 percent. ***NCAI and tribal leaders recognize and appreciate that reductions to Indian Affairs funding could have been steeper, but urge this committee and appropriators to reverse this disproportionate funding trend (relative to other agencies) and provide an increase to the overall BIA budget to support tribal self-determination and communities throughout Indian Country.***

Indian Guaranteed Loan Program – The President's budget includes a reduction to this program of \$5.1 million. The Indian Guaranteed Loan Program is a very successful program. It is leveraged money so it makes no sense to cut money that represents a ten to one financing for tribes. Cutting \$1 million is the same as cutting \$10 million. These are guarantees which went unused; however the issue was not with tribes not utilizing the funds but with Interior not getting them out. The individual business program utilizes a 10:1 funding ratio, meaning a \$10 million investment could guarantee \$100 million in business loans. This has worked well for individuals; however, tribes with limited resources willing to develop community-wide businesses and grow their local economies have to turn to the bond market for financing. The market, along with the rating agencies, has not gauged tribal risk effectively, making capital expensive or non-existent. Guaranteed financing is needed for tribal development projects. This applies to loans and surety or performance guarantees, which have a lower 3:1 ratio. The surety guarantees are needed because the surety bond industry excludes tribally-owned construction companies in underwriting. ***NCAI requests that Congress restore funding for the Indian Guaranteed Loan Program for FY 2012.***



**Testimony of D'Shane Barnett, Executive Director
National Council of Urban Indian Health
House Interior Appropriations Subcommittee's Native American Witness Day**

May 3rd, 2011

Introduction: On behalf of the National Council of Urban Indian Health (NCUIH), its 36 member organizations and the 150,000 urban Indian patients that our programs serve annually, I would like to thank the Interior Appropriations Subcommittee for the opportunity to provide testimony addressing the FY2012 Budget. NCUIH strongly urges the full funding of the Urban Indian Health Program (UIHP).

According to the 2000 United States Census, over 60% of AI/AN population currently live in urban centers. However, the division between an urban Indian and a non-urban Indian is a false dichotomy. Originally, Native Americans were forced to urban locations during the Termination and Relocation era due to economic pressures and the federal policy of the time; however, now most Native Americans transition between their tribal homes and the urban centers depending upon their needs and the needs of their families¹. The UIHP is there to provide health care for AI/AN patients when they live in urban settings, thus helping to form a complete circle of care with tribal and IHS health providers. Fulfilling its role in the circle of care for AI/AN patients, UIHPs provide culturally competent, non-duplicative health services to more than 150,000 enrolled members of federally recognized Tribes.

Congress has consistently acknowledged the government's trust responsibility extends to AI/AN patients living in urban settings. From the original Snyder act of 1921 to the Indian Health Care Improvement Act (IHCIA) of 1976, and its Amendments, Congress has consistently found that: "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation*. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and *the responsibility for the provision of health care services follows them there.*"²

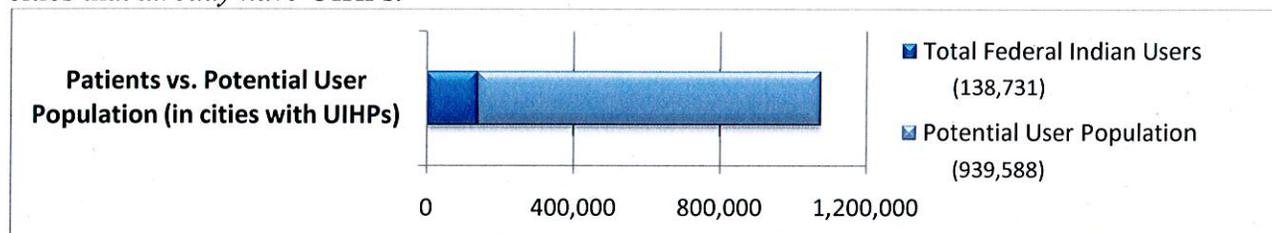
History of Bipartisan Congressional Support: Congress has overwhelmingly rejected attempts by the previous Administration to zero-fund the UIHP. Congress restored the UIHP in the FY07, FY08, and FY09 budgets, and included strong report language in the FY07 and FY08 reports

¹ See *United States v. Raszkwicz*, 196 F.3d 459, 465 7th Cir. 1999, stating: "[the] patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups."

² Senate Report 100-508, Indian Health Care Amendments of 1987, Sept 14, 1988, p25. Emphasis added

supporting the UIHP³. The Obama Administration has already expressed a deep concern on Native American health, as demonstrated by the \$600 million increase to IHS funding in the President's outline of his FY2012 budget. It is the fervent wish of Native Americans everywhere that Congress support President Obama in fully funding IHS. NCUIH hopes that Congress can again come together in a bipartisan fashion to fully fund not only the Indian Health Service, but also fully fund the UIHP at its full level of need.

Unmet Needs of Urban Indians: While the UIHP serves over 150,000 Native Americans annually, there remains a huge unmet need in Urban Indian communities. The last needs assessment for the Urban Indian community was conducted in 1981, nearly 30 years ago. Based on that ancient data, the UIHP is serving approximately 22% of the entire need for the Urban Indian community. Without a doubt the need for the UIHP has grown since 1981. For example, the estimated potential user population of the UIHP is almost 1 million people, and that's just in cities that *already have* UIHPs.

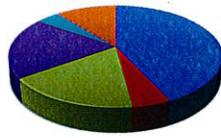


In light of this data, NCUIH urges the Committee to increase funding to UIHP line item by at least \$9 million dollars over FY2010 levels. Minor increases to the UIHP's budget by Congress not kept up with ordinary inflation, much less medical inflation. Thus, the purchasing power of UIHP programs and clinics has steadily decreased for most of the past decade. Cuts to Medicaid and Medicare reimbursement rates and CMS regulations limiting reimbursements to outpatient providers have also negatively impacted the UIHP clinics. With an economy struggling to emerge from the recession and unemployment rates at historically high levels, many clinics are reporting increased patient loads that are straining their already tight budgets. Health care costs are one of the primary reasons for individual bankruptcy filings. If AI/AN patients are unable to receive care at UIHP clinics and programs the likelihood that they will be forced into bankruptcy increases, which then increases the likelihood of their return to their home reservations, thus straining tribal budgets and social services.

Leveraging Funding: UIHP clinics and programs are adept at leveraging their Title V funding to obtain additional dollars from other federal, state, and local sources. The original investment of IHS' monies allocated through Title V of IHCA provides the base funding that allows UIHP clinics and programs to build upon their capacity to reach new patients and provide more services. As a general rule the 36 programs and clinics of the UIHP are able to leverage two new dollars for each dollar of original investment. The ability of the program to effectively seek out additional funding by leveraging the base funding from IHS makes the UIHP a sound investment as a social program. Some of the other sources of funding are shown in the chart below:

³ House Report 109-4665; House Report 110-187; H.R. 1106

Breakdown of Funding Streams



- Title V Funding
- Section 330 (CHC)
- Medicare & Medicaid
- State, County, City, Other
- Third Party/Patient Collections
- Other

Although UIHP clinics and programs have been very adept at leveraging their IHS dollars, they are not able to do so without that core funding. The UIHP line item provides the basis of the program; without it the programs would not be able to compete for other private and federal grants. However, when that base funding is insufficient to maintain core services the competitiveness of UIHP clinics and programs for other private and federal grants is badly damaged. When the competitiveness of the UIHP is damaged it is ultimately the patients who suffer.

Community Health Centers: For more than 40 years, HRSA-supported Community Health Centers have provided comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. CHCs are community-based and patient-directed organizations that serve populations with limited access to health care. Recent moves to slash funding for CHCs by nearly 60% would have a devastating impact on the most vulnerable at a time when they can least afford it. NCUIH strongly opposes cuts that would have a calamitous impact on the provision of care to medically underserved populations living in areas determined to be health provider shortage areas. Already woefully underfunded, further cuts to CHCs would leave countless individuals with no other health options.

Health Promotion/Disease Prevention and Sexual Assault/Domestic Violence Grants: Health Promotion/Disease Prevention grants are an integral part of many UIHP's infrastructure funding. And for many UIHPs, HP/DP and SA/DV grants provide the only source of funding for mental health and substance abuse services for adults. The proposed elimination of these "small grants" will leave a huge hole in the provision of health care for urban Indians, and would impair the development of "patient centered care teams" as required in the Affordable Care Act. These critical grants must be maintained in order to fulfill UIHP's obligations to the communities they serve, and NCUIH strenuously recommends their continued availability to UIHPs. Grants such as these are a wise investment in the long-term health of urban Indians – lowering health care costs in the long-term and addressing medical issues before they require more expensive emergency care.

Top Priorities of the UIHP: As part of comprehensive survey of the UIHP, NCUIH requested its member programs to submit a list of health priorities for the next fiscal year. Those priorities listed below:

Service Priority
Traditional Medicine
Behavioral Health
Dental Services
Maternal & Child Health
Women's Health

Elder Care
Disease/Diabetes Prevention
Nutrition & Dietetics
Telemedicine

In order to provide the services requested and to accommodate the growing demands upon the Urban Indian Health Program, the National Council of Urban Indian Health requests an increase of \$9 million from the FY2010 Congressional budget appropriated amount of \$43 million for a total of \$52 million. This increase will allow the programs to respond to medical inflation, provide additional services, and cope with the increasing demand as the economy continues to deteriorate. An increase to the base funding of the UIHP will also ensure the continued competitiveness of the programs and clinics for other private and federal funds.

Conclusion: In conclusion, I would like to thank the Committee for this opportunity to provide testimony on the appropriations priorities of the UIHP clinics and programs. We are grateful for your commitment and concern for the improvement of the health and well-being of urban Indians. Notwithstanding the difficulties of the past few years, UIHP clinics and programs, working with limited funds, have made a great difference in addressing the unique circumstances and health care needs of the urban Indian population. These small but vital components of the health care system for Native Americans have persevered and developed strong, innovative treatment methods and outreach programs addressing illnesses such as diabetes and chronic disease, substance abuse, and behavioral health disorders. NCUIH hopes that Congress can match President Obama’s commitment and fully fund both the Indian Health Service and the Urban Indian Health Program line item. The time has come to address the serious urban Indian health discrepancies as compared to the general population. It is the position of the NCUIH that the UIHP should receive a \$9 million increase to the UIHP line item, that Community Health Centers should maintain or increase their FY2010 funding levels, and that Domestic Violence/Sexual Assault Grants and Health Promotion/Disease Prevention grants should continue to be available to UIHPs. The time has come to seriously invest in the health of Native Americans.

Budget Request

- 1.) **Full Funding of the Indian Health Service**—If the Native American health delivery system is to truly fulfill the trust responsibility between Native peoples and the federal government, the Indian Health Services, and all of its parts, must be fully funded. Current funding is insufficient to provide quality health care.
- 2.) **\$9 Million Increase for the Urban Indian Health Program**—In order to meet rising need, medical inflation, and remain competitive for other private grants and services the UIHP requests a much needed increase in base funds after several years of flat funding.
- 3.) **Full funding of Community Health Centers** – Community Health Centers were designed to serve patients who live in areas where there is a shortage of available health services. We urge the Committee to maintain funding for these critical components of the health care delivery system. For many individuals, CHCs are the only health care available in their communities.
- 4.) **Maintain funding of Domestic Violence/Sexual Assault Grants and Health Promotion/Disease Prevention grants to UIHPs** – NCUIH opposes the proposed elimination of DV/SA and HP/DP grants to UIHPs. These competitively awarded grants provide our communities with dearly-needed health services that cannot be duplicated through other means.

TESTIMONY BY LESTER SECATERO
ALBUQUERQUE AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD
TO THE HOUSE INTERIOR APPROPRIATIONS SUBCOMMITTEE ON THE
FY 2012 INDIAN HEALTH SERVICE BUDGET
MAY 3, 2011

Mr. Chairman, and Members of the Subcommittee, my name is Lester Secatero. I serve as the Albuquerque Area Representative to the National Indian Health Board (NIHB)¹ and the Chairman of the Albuquerque Area Indian Health Board. The NIHB offers the following comments regarding the President's proposed FY 2012 budget for the Indian Health Service (IHS).

The NIHB was pleased to learn that, for the FY 2012 IHS budget, the Administration recommends a \$571 million increase over the FY 2010 enacted IHS appropriations. This 14.1% increase is quite significant. It acknowledges the critical health needs of our tribal communities and represents the continued commitment to honor the federal government's legal obligation and sacred responsibility to provide health care to American Indians and Alaska Natives (AI/AN).

National Tribal Budget Formulation Workgroup's Recommendations

The trust obligation to provide health care is paramount, and it is upon this foundation that the IHS National Tribal Budget Formulation Workgroup ("Workgroup") built its recommendations for the FY 2012 IHS budget. Each year, this Workgroup consolidates all the IHS Areas' budget formulation recommendations; develops a consensus national tribal budget and health priorities document; and presents the recommendation to the U.S. Department of Health and Human Services (HHS).² The NIHB supports this government-to-government process and the final recommendations developed by the Workgroup.

The Workgroup's recommendations for FY 2012 were formally presented to the HHS on March 4, 2010, eleven months before the President presented his FY 2012 budget proposal to Congress. Since the release of the Workgroup's recommendation, the Patient Protection and Affordable Care Act (ACA), which includes the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), was also passed and enacted. Although not included in the Workgroup's FY 2012 recommendations, we know that funding the new opportunities now available under the reauthorized IHCIA is important to Indian Country.

The Workgroup's recommendations focus on two types of needed increases:

¹ Established in 1972, the NIHB serves all federally recognized tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the federal government's trust responsibility to AI/ANs. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the IHS, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their Area. The NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of the Tribes.

² For copies of previous Workgroup recommendations, please visit the NIHB Budget Formulation page at http://www.nihb.org/legislative/budget_formulation.php.

1. **Current Services Increases: Preserving basic health care programs currently being funded.** Increases in current services are the budget increments needed to enable the Indian health care delivery system to continue operating at its current level. These increases are more importantly than ever. This category contains such items as federal and tribal 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.
2. **Program Increases: Significant program increases are required to address the overwhelming health needs in Indian Country.** The recommended increases are made in key IHS budget accounts to enable programs to improve and expand the services they provide to Indian patients. The IHS has long been plagued by woefully inadequate funding, 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.

Below is a highlight of a few programs targeted by the Tribal Workgroup for vital increases.

Current Services: Federal and Tribal Pay Costs. The Workgroup recommended a \$12 million increase for federal pay costs and a \$13 million increase for tribal pay costs. However, the President's proposal contains a 1.4 percent pay raise for Commissioned Officers that are \$4.1 million and notes that the Federal and Tribal pay costs are subject to the pay freeze enacted by Congress. **The NIHB recommends that Tribal and Federal IHS employees should be exempted from any federal employee pay freeze.**

Current Services: Contract Support Costs - Shortfall. 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 upon the proper appropriation of Contract Support Costs (CSC). Full CSC funding honors the legal duty to pay these costs, and protects health care resources intended for service delivery. A year ago, the projection to fully fund CSC was \$145 and today, IHS projects an FY 2012 shortfall in contract support cost payments of \$153 million. **The NIHB supports the Workgroup's goal of full funding CSC, and urges that the CSC line item be increased by \$153 million for FY2012.**

Program Increases: 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 lacks the capacity to provide directly all the health 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. 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 \$118 million for CHS.**

Program Increase: Sanitation Facilities Construction: Currently 12% of AI/AN homes do not have adequate potable water supply in comparison to 1% of homes for the U.S. general

population.³ The IHS Sanitation Facilities Construction (SFC) program provides potable water and waste disposal facilities and IHS reported that for every dollar IHS spends on sanitation facilities to serve eligible existing homes, at least a twentyfold return in health benefits is achieved.⁴ **Due to the remaining need and success of this investment, the Workgroup recommends \$14 million increase.**

Additional Budget Recommendations

In addition to the Workgroup's recommendations, the NIHB would like to provide additional recommendations regarding the IHS budget.

Projected Savings in the IHS budget

There is a critical need for more funding for basic healthcare services to go directly to all of our facilities and if the President's 14% increase is realized, that will help; however, the proposed cuts to the "small grant" programs hold a small price tag (\$7 million collectively, as articulated in the President's budget request), but, the impact of these programs in Indian Country is enormous. All of these small grants serve and target very vulnerable Native populations, such as children, elders and women, and their purpose is to strengthen and build capacity for the long term health of the Tribes in such areas as public health; wellness; fighting childhood obesity and working to end domestic violence against Native women. In addition, the proposal includes cutting the small grant to the Tribes' primary health care resource for information and coordination of the national Tribal voice: the NIHB. We ask that you do not implement any cuts to this organization, which is vital to improving the health status of all Tribal People.

Protect IHS Budget from rollbacks, freezes and rescissions

As a discretionary budget line, the IHS budget falls target to the across the board cuts to discretionary funding. Indian Country is thankful for the support of Congress and the Administration during the previous two fiscal years for significant increases to the IHS budget. However, the IHS budget has been subject to proposed budget cuts in the past. This was detrimental not only to an agency budget, but on the lives and well being of AI/ANs. Today, the IHS budget is funded approximately at half the level of need. Any budget cuts, in any form, will have harmful affects on the health care delivery to AI/ANs. The NIHB asks the committee to exempt the Indian Health Service from any cuts, freezes, or rescissions.

Create a long-term investment plan to fully fund IHS Total Need

Tribes have long asked for full funding of the IHS. Developing and implementing a plan to achieve funding parity is critical to the future of Indian health and to fulfilling the United States's trust responsibility to AI/AN people. The funding disparities between the IHS and other federal health care expenditures programs still exists and in 2010, IHS spending for medical care was \$2,741 per user in comparison to the average of federal health care expenditure of \$6,909 per person.⁵ Tribes and the NIHB ask the federal government to design and implement a true full funding plan for the IHS budget.

³ IHS Fact Sheets: Safe Water and Waste Disposal Facilities (January 2011) at <http://info.ihs.gov/SafeWater.asp>

⁴ *Id.*

⁵ IHS Fact Sheets: IHS Year 2011 Profile (January 2011) available at <http://info.ihs.gov/Profile2011.asp>.

THE INDIAN HEALTH SERVICE'S FY 2012 BUDGET RECOMMENDATIONS

Current Services Increases

	Tribal Workgroup FY 2012 Proposal¹	President's FY2012 Request
Federal Pay Costs	\$12,000,000	\$4,102,000
Tribal Pay Costs	13,000,000	0
Inflation	63,300,000	155,308,000
Additional Medical Inflation ²	54,800,000	--
Population Growth	42,900,000	96,550,000
Staffing for New/Replacement Facilities	35,000,000	71,533,000
Contract Support Cost – Shortfall	145,000,000	0
Total Current Services	\$366,000,000	\$327,493,000

Program Increases

Hospitals & Clinics	\$90,000,000	\$0
Indian Health Care Improvement Fund	15,000,000	54,000,000
Information Technology	--	4,000,000
Chronic Diseases	--	2,529,000
Dental	5,000,000	0
Mental Health	4,000,000	0
Alcohol and Substance Abuse	10,000,000	4,000,000
Contract Health Services	118,000,000	89,635,000
Urban Indian Health	9,000,000	1,000,000
Direct Operations	--	3,404,000
Business Operations Support	--	6,033,000
Contract Support Costs (New & Expanded)	--	50,000,000
IHCIA Implementation	--	2,000,000
Facilities Maintenance & Improvement	10,000,000	0
Sanitation Facilities Construction	14,000,000	(19,619,000)
Health Care Facilities Construction	84,000,000	53,958,000
Small Ambulatory Program	10,000,000	0
Equipment	5,000,000	0
<i>Proposed Grants Savings</i>	--	(7,000,000)
Total Program Expansion	\$374,000,000	\$243,940,000
Total Increases	\$730,000,000	\$571,433,000

Notes: -- refers to items not considered by the National Tribal Budget Workgroup

¹ The National Tribal Budget Workgroup based their recommendations on the President's proposed budget for FY 2011 and released their recommendations in March 2010. The Tribal figures for current services may need to be adjusted to ensure full funding of current services.

² Funding for IHS programs has not kept pace with inflation, while Medicaid and Medicare have accrued increase of 5 to 10% per year.

American Dental Association
Interior Appropriations Committee
May 3, 2011

Good Morning Chairman Simpson, Ranking Member Moran and Committee Members. I am Dr. Matt Neary, Chairman of the Council on Government Affairs for the American Dental Association (ADA). I am a private practicing dentist in New York City. The ADA, which represents 157,000 dentists, appreciates the opportunity to comment on the oral health issues that affect American Indians and Alaska Natives (AI/ANs), as well as the dentists and oral health care providers who serve in the Indian Health Service (IHS) and tribal dental programs.

I would first like to thank the Committee for the support it has provided the IHS dental program. We believe that the increases in the FY 2010 budget and the funding maintained in the continuing resolutions were instrumental for expanding the dental division's recruitment efforts to dental students, maintaining an adequate level of dentists with advanced training to treat severe oral health care cases and providing an electronic dental record system that should result in savings and more efficient treatment for AI/AN patients. We appreciate your efforts to continue these programs.

We are also pleased that the Administration has recommended an increase for the Division of Oral Health (DOH) to \$170,859,000 for FY 2012. The proposed funding level will allow the Division to maintain its current programs; however, the ADA believes more needs to be done to improve access to dental care and reduce oral disease among AI/ANs.

The level of Early Childhood Caries (ECC), tooth decay, among the AI/AN children has reached epidemic proportions. In fact, ECC prevalence is about 400 percent higher in this population than for all U.S. races. Worse still, the *severity* of decay is substantially higher in AI/AN children compared to the population as a whole. Preschool children average more than 5 decayed teeth compared to 1 decayed tooth among U.S. pre-school children of all races. In many AI/AN communities, between 25–50 percent of preschool children have such extensive ECC that they require full mouth restoration under general anesthesia, compared to less than 1 percent for non-AI/AN children.

A year ago, we reported that the IHS began the Early Childhood Caries Initiative - a new program designed to promote prevention and early intervention of tooth decay in young children through an interdisciplinary approach. During the past year the IHS has been able to conduct oral health assessments of children up to 5 years of age through several partner groups to determine the level of disease as well as the best prevention methods. This is the first national oral health survey conducted by the IHS in over a decade. We believe that the president's request which calls for a \$726,610 increase for the headquarters dental program will allow this initiative to keep moving forward.

Consistent with the IHS initiative to reduce tooth decay, the ADA hosted the second annual Symposium on Early Childhood Caries (ECC) in AI/AN children this year. There continues to be a pressing need to examine ECC in light of the current scientific understanding of the disease and identify new research and strategies that are based on the best available science. The overall

purpose of this symposium was to bring together a group of some of the most experienced caries researchers in the U.S., representing many of the most prestigious caries research centers, to review the state of the science of prevention of caries in the primary dentition, identify gaps in our current understanding of this disease and formulate strategies to close the existing gaps in knowledge. Participants included tribal health officials, pediatric dentists, dental public health staff, dental researchers and consultants with direct experience with this disease.

The ADA and its constituent societies in Indian Country have also been working during the past year to advance oral health outreach and raise awareness in Indian Country. The Arizona and New Mexico Dental Associations established the ADA's Native American Oral Health Care Project to address the imbalance in access to quality oral health care among Native Americans. These organizations have made numerous visits to Indian Nations to meet and collaborate with tribal leaders. Just last month, ADA President Dr. Ray Gist, met with Tribal leaders, health directors, and policy makers to discuss the development of a comprehensive approach for improving oral health care in Indian Country. During these sessions, discussions began on how to recruit American Indians into the dental professions. We anticipate the development of long term partnerships to achieve this goal.

In a meeting with the Pueblos of Jemez and Sandia – both of which operate 638 designated health care and dental facilities – Dr. Gist discussed such goals as improving access to dentures for community elders and supporting oral health care prevention strategies for youth.

Dr. Gist also met with the Inter Tribal Council of Arizona (ITCA) to discuss how the ADA and the ITCA can join forces to pool and leverage resources to enhance prevention efforts to the 21 tribes that the ITCA serves. Further meetings are being planned for next month to identify projects for collaboration.

The ADA has also supported similar efforts between tribes in the Aberdeen area and the North and South Dakota Dental Associations. We are very encouraged by these efforts and wanted to make the committee aware of these talks. As more concrete plans develop we anticipate that there could be a need for additional resources for the Tribal nations for oral health literacy programs, prevention programs, and workforce. We hope that the Committee will support our efforts in building these public-private partnerships.

For several years, the ADA has come before the Committee and shared our concerns regarding the number of dental vacancies in the IHS. Mr. Chairman, we are pleased to report that the IHS dental program is continuing to see improvement in reducing vacancies. Three years ago, we reported that there were over 140 dental positions open. Today, the number is 45. We believe that several factors have contributed to reducing these workforce shortages.

The IHS dental recruiters have conducted an excellent campaign to attract dental students to participate in their summer extern program as a way to introduce them to the Service. Thanks to support from this Committee the IHS was able to place up to 240 applicants during each of the past two summers. Experience has shown that the externs become IHS ambassadors when they return to school and we believe that this results in more dentists applying to the IHS upon graduation. However, in spite of the success of this program it has encountered a new threat.

Recently, a question was raised as to whether the IHS has the legal authority to reimburse the student externs for their travel to the participating sites. This may require bill language to clarify that such payments are legal. We fear if they do not continue it will seriously jeopardize the program's recruitment efforts. We will keep the committee informed of this situation and hope that you will work with us to ensure the summer dental extern program continues.

The average student debt load for dentists is \$200,000 and most begin repaying their debts soon after graduation. The IHS dental loan repayment program offers an attractive incentive for dentists to join the Service. It is also an excellent retention tool for those dentists who want to continue in the IHS beyond their initial agreement. In 2010, the IHS awarded 110 loan repayment contracts for dentists and dental hygienists. Of those, 62 continued their previous contracts beyond their initial commitment which will help to maintain a continuity of care for patients.

In previous years, the Committee has supported the IHS dental program's expansion of its residency program. However, we have recently learned that if a dentist is receiving loan repayment and would like to go on for advanced training in pediatrics or oral surgery, they have to forfeit their loan repayment. This prevents many from applying for the advanced training. We believe that there is a simple solution to this situation – allow them to keep their loan repayment while advancing their specialties, but not count their time in training towards their payback time.

Health Information Technology

The American Recovery and Reinvestment Act (ARRA) provided \$3.5 million for the IHS Electronic Dental Record (EDR). It was estimated a year ago that the Division needed an additional \$12 million to complete the deployment of the EDR to all federal and tribal dental programs. The EDR will provide automated patient dental records and capture dental data from patient encounters and oral examination records to support quality assurance, utilization reviews, resource allocation, clinical measures, and research. The ADA believes that IHS dental patients should have the same quality of care enjoyed by all Americans. Making sure that the DOH can fully implement the EDR in a timely fashion will help to ensure that goal. We appreciate the support the committee has given to this project and we hope you will continue to see it fully implemented.

Continue Congressional Program to Upgrade Dental Facilities

In 1995, the Association testified regarding the urgent need to replace and upgrade dental facilities throughout Indian Country. The Committee recognized that it was impossible to build new dental facilities but acknowledged the need for modern clinics by setting aside at least \$1 million each year to replace modular dental units. This approach has been highly successful, increasing access to care and decreasing the oral health disparity of AI/AN patients. However, it appears that for the last three years, no funding has been allocated for this project in spite of the fact that there are still at least 27 dental programs on the waiting list. We request that the Committee continue this successful program at \$1 million for FY 2012 in the facilities account.

Expand Dental Clinical and Preventive Support Centers

Above I stated the ADA's concerns about early childhood caries – with special emphasis on children up to age 5. However, tooth decay among older children and adults is also a problem. An important additional component for the IHS would be to expand the existing eight dental clinical and preventive support centers. Support Center staff in this program are trained to assist in establishing and maintaining community-based programs to prevent dental disease. Their training includes:

- School-based sealant programs,
- Community water fluoridation,
- School-based fluoride mouth rinse programs,
- Community-based dental education programs, and
- Programs to prevent periodontal disease

In his meetings with the ITCA leadership, Dr. Gist learned that their Support Center was defunded and replaced with a new initiative to evaluate the effectiveness of oral health care service delivery among IHS service units. While the new program is important to them and their member tribes, the Support Center was invaluable to addressing the oral care needs of children. ITCA and their member tribes would like to be able to offer both programs and not have to drop one for the other. In order to restore the ITCA support center and to fully address the needs of all the centers, we recommend that the Committee increase the current funding by \$1 million to \$3 million and designate the funding to be used by the Director of the IHS Headquarters Division of Oral Health. This amount of funding will allow for enough support centers to service each IHS geographic area.

Conclusion

From the Association's experience of working with the IHS dental program for over 35 years, we know that adequately funding dental care can make a difference. The 1991 Oral Health Survey shows that in areas where dental care was accessible there was a:

- 14% increase in the number of children 5-19 years with no decay,
- 12% decrease in the number of children 5-19 years with high decay rates (7 or more cavities), and
- 9% decrease in the number of adults 35-44 years with periodontal disease.

However, as of today, the IHS has not been able to reach its FY 2010 goal of servicing 25 percent of the population who utilize the IHS Health Care system. The successes mentioned above need to be multiplied to really have an impact in preventing oral disease which will result ultimately in cost reductions. We cannot “drill and fill” our way out of dental disease. But we can prevent it – which is a more cost efficient and a better way of reducing oral disease.

Thank you for allowing the ADA to testify and highlight the needs and successes of the IHS dental program. The ADA is committed to working with you, the IHS and the Tribes to aggressively reduce the disparity of oral disease and care that currently exists in Indian Country.

Friends of Indian Health
Interior Appropriations Committee May 3, 2010

Good Morning Chairman Simpson, Ranking Member Moran and Committee Members. I am Dr Pamela B. Deters. I am a member of the Cherokee/Choctaw tribe.), a licensed Clinical Psychologist currently in private practice in Louisiana and Mississippi. I am also the President of the Society of Indian Psychologists whose mission is to provide an organization for Native American people to advocate for their mental well being by increasing the knowledge and awareness of issues impacting them. I am also a proud and active member of the American Psychological Association.

My expertise is in the area of trauma among Native children, families, and communities, with a particular emphasis on cultural revitalization and resilience subsequent to trauma. I have also served as the Statewide Director of Alaska Natives into Psychology, a training program supporting American Indian and Alaska Native graduate and undergraduate students pursuing careers in psychology.

Today, I am representing the Friends of Indian Health – a coalition of over 50 health organizations and individuals dedicated to improving the health care of American Indian/Alaska Natives (AI/ANs) to the highest levels.

The Friends thanks you, Mr. Chairman, and the Committee, for the additional IHS funding secured in the FY 2010 appropriations bill and for maintaining these funding levels in the continuing resolutions that the 112th Congress has addressed. The increased support will help provide needed services without interruption or reductions.

The Friends supports the Administration's proposed FY 2012 funding level for the IHS of \$4,623,808,000, a 14.1% increase. This level is recognition of the great need that still exists to close the gap in disparity of disease and care for AI/AN people. We understand the financial strains that the Committee is under, however, as a representative of health care organizations we want to take this opportunity to identify high priority areas that if not addressed will continue to burden and overwhelm the Indian Health Service.

The most urgent outstanding need of AI/ANs is contract health services. Patients requiring cancer treatments, surgeries, treatment for injuries and additional mental health services need medical care that cannot be provided in IHS or Tribal facilities. In FY 2010, over 168,216 contract health services were denied.

The root cause for this situation lies in the IHS and Tribal delivery system. The IHS and Tribes operate at over 600 locations, which include 45 hospitals, only 19 of which have operating rooms. The majority of facilities mainly provide primary medical care and they must depend on the private sector for secondary and tertiary care. The need to rely on private care is not going to change. In fact, the IHS has plans to convert five hospitals to ambulatory health centers with no inpatient services. Therefore, the request for contract health services funds need to be realistic. The Administration's budget would raise this account to over \$948 million but even that amount doesn't cover all of the need which could be over \$1 billion.

The Friends has for many years advocated for additional funding for prevention and early treatment programs to reduce the need for contract health services. But to implement them, the IHS has to have a sufficient health care provider workforce. Filling vacancies through loan repayment has proven to be the IHS' best recruiting and retention tool. In FY 2009, the IHS had 917 requests and awarded 426 new contracts and 197 one year extensions. We are pleased to see that almost 200 providers wanted to continue their IHS service beyond their original loan repayment obligation because this helps to build a steady workforce and provides continuity of care. In 2008, the IHS reported that the average retention period for loan repayment recipients was over seven years.

The IHS did not report in its FY 2012 budget justification the number of loan repayment requests or the number denied, so it is hard for the Friends to determine the level of need. However, we have concerns about the Administration's request of \$21,159,653 which is \$179,231 less for loan repayment than current funding and will result in 33 fewer contracts.

We remain greatly concerned that instead of increasing this account, the IHS is decreasing it. Because of the nation's fiscal crisis more graduating health professionals are looking to the public health service as alternatives to private practice. We believe, therefore, that this is an ideal time for the IHS to increase this account in order to have a sufficient workforce. Several years ago, we advocated that the Committee commit an additional \$20 million over four years for loan repayment. The Committee included an initial \$5 million in FY 2008 but the account has not kept up with meeting this goal. **The Friends encourages the Committee to resume this funding goal and work toward adding an additional \$15 million for the loan repayments account.**

Before loan repayment can be offered, dedicated, qualified health care professionals have to be recruited. While some of the IHS divisions are very effective at recruitment, others are not. Equally disturbing are reports that interested candidates are not pursued by the Service or, once interviewed and accepted, are not readily processed. Anecdotal accounts claim that delays in hiring can take up to six months and, as a consequence, qualified personnel take positions outside the IHS. A year ago, the IHS Director commissioned a report on recruitment and retention. We were very pleased to see this action because the Friends strongly believe that if the recruitment process were improved it would have a positive effect on filling vacancies. **We urge the Committee to encourage the Service to put into action recommendations made in the report.**

The IHS also needs a strong network of both clinical and support staff. These are staff members who have completed health education training and are capable of providing needed patient care and health education services. These positions are usually filled by Tribal members, providing a crucial cultural link to patients. However, the salaries for some of these positions are below clerical positions; a receptionist earns more than a dental assistant. An experienced nurse midwife will take a 50 percent pay cut and an experienced nurse practitioner or physician assistant will take a 30 percent cut to work in the IHS. Licensed Practical Nurses (LPNs) in Oklahoma are paid more at Wal-Mart than at an IHS facility.

This situation could be improved if the Office of Personnel Management (OPM) would release its recommendation for a new GS 600 Series pay scale, something it has been working on for eight years. **The Friends strongly urges the Committee to seek a report on employee recruitment and retention that determines the effect of the outdated 600 series pay scale and what actions by the IHS and OPM are needed to finalize a new pay scale.**

In conclusion, the Friends is encouraged that the Administration is seeking additional funding that will help eliminate health disparities faced by AI/ANs. We have included below specific health statistics that if addressed would reduce the disparity of disease for AI/ANs and lead to cost savings. We encourage the Committee to do what it can to support and go beyond the Administration's FY 2012 budget proposal to assure that the IHS is fully staffed and will allow it to fulfill its mission to "raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level." The Friends thanks the Committee for the opportunity to testify today. We look forward to working with you to strengthen the IHS health infrastructure and decrease mortality and morbidity rates of American Indians and Alaska Natives.

Appendix A

Women's Health

- Although AI/AN women across Indian country have lower cancer death rates than U.S. citizens of all races, in Alaska and the Northern Plains, the cancer death rates for AI/AN women are 22% and 42% higher, respectively, than for U.S. citizens of all races.
- The 2002 U.S. prevalence of diagnosed diabetes in women 20 and over was 7.1%. For AI/AN women, it was 15.9%, more than double, the rate. This disease increases complications in childbearing, and elevates the risk that their children will also become diabetic.

Children's Health

- More than one-third of the nation's AI/AN population is under the age of 15, and the health of these children consistently lags behind other populations. For example, the SIDS rates among AI/AN infants are nearly twice that of the general population.
- AI/AN children are more than twice as likely to die in the first four years of life than the general population, and remain twice as likely to die through age 24.
- The rate of type 2 diabetes among AI/AN teens aged 15-19 has increased 109% since 1990.

Mental Health

- Inadequate mental health and substance abuse services contribute to a suicide rate for AI/AN that is about 1.7 times the rate for all races in the U.S.; the suicide rate for males 15 to 34 years of age is over two times the national rate.
- The suicide rate for Indian people is 60% higher than the general population.
- Studies have shown that 69.9% of all suicidal acts (completions and attempts) in AI/AN country involved alcohol use.

Kidney Disease

- American Indians have one of the highest rates of irreversible kidney failure (end stage renal disease, or ESRD) of any population, nearly four times the rate of ESRD for white Americans.

- Diabetes is the leading cause of ESRD and its impact on Native Americans is pronounced. It is the primary cause of chronic kidney failure in fewer than 40% of all Americans, but nearly two-thirds of Native American cases of ESRD. Pima Indians in Arizona are thought to have the highest rate of kidney failure in the world, and 90% of cases of ESRD in this tribe are attributable to diabetes.

Diabetes

- Today diabetes has reached epidemic proportions among AI/ANs. According to 2005 data, 14.2% of the AI/ANs aged 20 years or older who received care from the IHS had diagnosed diabetes. After adjusting for population age differences, 16.5% of the total adult population served by IHS had diagnosed diabetes, with rates varying by region from 6.0% among Alaska Native adults to 29.3% among American Indian adults in southern Arizona.
- AI/ANs carry the heaviest burden of diabetes in the United States, suffering from among the highest rates of diabetes in the world. In some American Indian and Alaska Native communities, diabetes prevalence among adults is as high as 60%.

Podiatric Medicine

- Lower extremity amputation (LEA) is one of the most disabling complications of diabetes.
- More than 60% of non-traumatic lower-limb amputations occur in people with diabetes.
- Each year 71,000 people lose their feet or legs to diabetes. Amputation rates among Native Americans are 3-4 times higher than the general populations.
- Comprehensive foot care programs can reduce amputation rates by 45% to 85%. (Source: CDC).

Vision and Eye Health

- A recent three year study of Navajo people (the largest Native population) revealed that within the prior two years only about 33% had an eye exam and that only 20% had visual acuity good enough to qualify for a driver's license, even with their present eyeglasses.
- With the high rate of diabetes, it is imperative that timely detection and treatment be available in Indian country. Diabetic retinopathy occurs in 24.4% of Oklahoma Indians.

Oral Health

- 79% of AI/AN children aged 2-5 years had a history of tooth decay
- 78% of AI/AN adults 35-44 years old and 98% of elders 55 years or older had lost at least one tooth because of dental decay, periodontal (gum) disease or oral trauma.

Pharmacy

- Pharmacists play an important role in disease state management, particularly the monitoring of patients suffering from diabetes and other chronic diseases.
- Native Americans benefit from the role of the IHS pharmacist which emphasizes proper medication management and improving patient adherence.
- Through the pharmacy residency training program, now in 17 sites, the IHS plays a significant role in the education of pharmacists interested in pursuing careers in the IHS.

Cardiovascular Disease (CVD)

- While the general U.S. population has seen a 50% decline in cardiovascular mortality, mortality rates among the AI/AN population are rapidly and dramatically increasing.
- CVD is the leading cause of death among AI/ANs and is double the rate of the general U.S. population.

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

Testimony of Lloyd B. Miller, Counsel, National Tribal Contract Support Cost Coalition

My name is Lloyd Miller and I am a partner in the law firm of Sonosky, Chambers, Sachse, Endreson & Perry, LLP, of Washington, DC. I appear here today as counsel to the National Tribal Contract Support Cost Coalition, comprised of 20 Tribes and tribal organizations situated in 11 States and collectively operating contracts to administer over \$400 million in IHS and BIA facilities and services on behalf of over 250 Native American Tribes.¹ I am here to discuss the legal duty and urgent need to fully fund the “contract support costs” that are owed these and other Tribes performing contracts and compacts in FY 2012 on behalf of the United States pursuant to the Indian Self-Determination Act—specifically \$615 million for IHS contract support cost requirements and \$228 million for BIA contract support cost requirements.

No single enactment has had a more profound effect on more tribal communities than has the Indian Self-Determination Act. In just three decades Tribes and inter-tribal organizations have taken over control of vast portions of the BIA and IHS, including federal governmental functions in the areas of health care, education, law enforcement and land and natural resource protection. Today, not a single Tribe in the United States is without at least one self-determination contract with each agency, and collectively the Tribes administer over **\$2.82 billion** in essential federal governmental functions, employing an estimated 35,000 people.

In the IHS Aberdeen Area, over 20% of the IHS budget is under contract to the Tribes. In Alaska, 100% of the IHS budget and most of the BIA budget has been contracted over to the Tribes. From the Navajo Nation to the Pacific Northwest to California, Tribes in 35 States have demanded their self-determination rights and secured control over IHS and BIA programs.

The ISDA has by any measure been a success unprecedented in the history of America’s relations with its Tribes. It has served not only to shift back to the Tribes the primary role of controlling and administering essential governmental services, but to reinvigorate those Tribal governments so they would be in a position to engage in meaningful economic and resource development to better their communities.

The ISDA employs a contracting mechanism to carry out its goal of transferring essential governmental functions from federal agency administration to tribal government administration. To carry out that goal and meet contract requirements, the Act requires that IHS and the BIA

¹ The NTCSCC is comprised of the: Alaska Native Tribal Health Consortium (AK), Arctic Slope Native Association (AK), Central Council of the Tlingit & Haida Indian Tribes (AK), Cherokee Nation (OK), Chippewa Cree Tribe of the Rocky Boy’s Reservation (MT), Choctaw Nation (OK), Confederated Salish and Kootenai Tribes (MT), Copper River Native Association (AK), Forest County Potawatomi Community (WI), Kodiak Area Native Association (AK), Little River Band of Ottawa Indians (MI), Pueblo of Zuni (NM), Riverside-San Bernardino County Indian Health (CA), Shoshone Bannock Tribes (ID), Shoshone-Paiute Tribes (ID, NV), SouthEast Alaska Regional Health Consortium (AK), Spirit Lake Tribe (ND), Tanana Chiefs Conference (AK), Yukon-Kuskokwim Health Corporation (AK), and the Northwest Portland Area Indian Health Board (43 Tribes in ID, WA, OR).

fully reimburse every tribal contractor for the “contract support costs” that are necessary to carry out the contracted federal activities. (Cost-reimbursable government contracts similarly require reimbursement of “general and administrative” costs.) Full payment of fixed contract support costs is essential: without it, offsetting program reductions must be made, vacancies cannot be filled, and services are reduced, all to make up for the shortfall. In short, a contract support cost shortfall is equivalent to a program cut.²

For years the Administration failed to request full funding for its contract support cost obligations, and the resulting shortfalls grew. The first major effort to address this deficiency in the past 10 years occurred in FY 2010, when Congress and the President supported a \$116 million increase to reduce the IHS contract support cost shortfall by about one-half, and a \$19 million increase to address BIA contract support cost shortfalls. The IHS increase, alone, will eventually restore 2,820 health sector jobs in Indian country. Even still, in FY 2010 these increases left a severe contract support cost shortfall well in excess of \$160 million.

Today IHS projects an FY 2012 shortfall in contract support cost payments of \$153 million. That means a \$153 million cut in tribally-contracted programs next year—not IHS-administered programs, but tribally-administered health programs alone—to cover the shortfall.

The BIA’s most recent projection of full contract support cost requirements is \$228.3 million (set forth in the BIA’s March 2011 shortfall report). Yet, the FY 2012 Budget requests only \$195.5 million, resulting in a required cut in tribally-operated BIA programs of \$33 million next year. Fortunately, the recently enacted FY 2011 Continuing Resolution raises the floor on contract support cost payments to \$220 million. According to the BIA, this should almost close the historic funding gap in paying these contracts.

It is not acceptable for the Administration to seek deficit reduction by singling out tribally-administered health and law enforcement programs for such grave cuts in essential governmental services. Indeed, Congress 23 years ago directed that the agencies “must cease the practice of requiring tribal contractors to take indirect costs from the direct program costs, which results in decreased amounts of funds for services,” S. Rep. No. 100-274, at 9 (1987). Yet, the practice continues.

Funding contract support costs in full will permit the restoration of Indian country jobs that have been cut while the shortfalls continue. The recent FY 2010 reduction in the contract support cost shortfall produced a stunning increase in Indian country jobs. For instance, last year the Cherokee Nation received close to \$8 million of its shortfall and restored 124 positions to the Nation’s health care system; the Forest County Potawatomi Community received about \$400,000 and added 13 positions; the Little River Band of Ottawa Indians received about \$300,000 and

² Contract Support Costs are the necessary costs of operating a federal program under contract. When the BIA and IHS operate these programs, the agencies have the benefit of their own bureaucracies and other agencies to support the programs with personnel and financial management systems, legal resources, procurement systems and the like, both from within their two Departments and from other departments like the General Services Administration and the Office of Personnel Management. Tribal contractors require similar resources to carry out contracted programs, as well as to meet mandatory federal requirements (including annual audits). They cover those resources with contract support costs. Most fixed contract support costs are set by government-issued indirect cost rates, with the rates issued based upon certified independent audits and adjusted based upon post-year audits.

added six clinical positions; the Riverside-San Bernardino County Indian Health consortium received \$2 million and restored 23 positions; and the Southcentral Foundation of Alaska received nearly \$9 million and restored 97 positions. Third-party revenues generated from these new positions will eventually more than double the number of restored positions, and thereby double the amount of health care that tribal organizations will provide in their communities. Similar increases occurred across many of the BIA contractors and compactors in FY 2010, though at far smaller numbers given the BIA's smaller CSC increase that year.

In FY 2012 the National Tribal Contract Support Cost Coalition recommends that: (1) the IHS contract support cost line be increased to \$615 million; and (2) the BIA contract support cost line be increased to \$228 million.

The status quo is not acceptable. First, at the Administration's proposed funding levels the combined projected contract support cost shortfall in FY 2012 for both agencies will exceed \$186 million. That means a \$186 million cut in tribal health, education, law enforcement and other contracted programs, representing over 3,600 jobs.

Second, the *status quo* penalizes Tribes for their self-determination contracting activities. Today, a \$1 million IHS-operated clinic has \$1 million to provide services. But a \$1 million tribally-operated clinic on average has only \$750,000 to serve the same community. That is a cruel and unfair burden to impose on the very Tribes that seek greater tribal self-determination.

Third, the continuing shortfalls have all but brought to a halt forward progress under the ISDA. For years, new IHS and BIA contracting activities have slowed to a trickle, and each agency is stuck at no more than 60% of its budget operated by Tribes. Congress's Policy of Tribal Self-Determination will not move forward until the CSC shortfalls are addressed

Fourth, investing funds here is wise. No part of the IHS or BIA budgets is more highly scrutinized than are the funds awarded under these contracts. There is a transparency and accountability here that is unrivaled in other government contracting work.

Fifth, fully paying CSCs is legally required. The United States Supreme Court so held in the 2005 Cherokee Nation case. It is not a matter of writing a better law, but of honoring the law that Congress has already written.

Finally, it is a stain on America when the Nation honors to the penny all other government contracts, even when honoring those contracts demands supplemental appropriations, but not contracts with Indian Tribes. As much as law, policy, fairness and good sense, the Nation's honor demands that these contracts be paid in full for services duly rendered to the United States.

In addition to these recommended funding levels, the Coalition recommends that the Committee require both agencies to consistently project and budget the additional CSC requirements associated with new contracts and program expansions (on average, 13.5 cents for each new IHS program dollar, and 10.4 cents for each new BIA program dollar). The IHS did

this in its FY 2012 budget, but the BIA did not. Further, the Committee should reconcile the different language used in the IHS and BIA portions of the bill (language attached), eliminate the old "section 314" language (a useless vestige after the Cherokee case), and assure that each agency has an ISD Fund inside the overall CSC appropriation to address new contracting initiatives.

Thank you again for the opportunity to offer these recommendations.

SUGGESTED CHANGES TO IHS AND BIA BILL LANGUAGE
REGARDING CONTRACT SUPPORT COSTS

IHS Language:

Provided further, That, notwithstanding any other provision of law, of the amounts provided herein,

not to exceed [\$461,837,000] \$615,000,000

shall be for payments to tribes and tribal organizations for contract or grant support costs associated with ongoing contracts, grants, self-governance compacts, or annual funding agreements

between the Indian Health Service and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year 2012, as authorized by such Act,

of which not to exceed [\$5,000,000] \$10,000,000 may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements

(proposed new language underscored;
stricken language in brackets or strike-outs)

BIA Language:

and of which, notwithstanding any other provision of law, ~~including but not limited to the Indian Self-Determination Act of 1975, as amended,~~

not to exceed [\$195,490,000] \$228,000,000

shall be ~~available~~ for payments for contract support costs associated with ongoing contracts, grants, compacts, compacts, or annual funding agreements ~~entered into~~

between with the Bureau of Indian Affairs and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year 2012, as authorized by such Act

, of which not to exceed \$5,000,000 may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements