HEARING BEFORE THE HOUSE SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES ON THE FY 2013 BUDGET
March 28, 2012

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Southcentral Foundation (SCF) is a tribal organization that compacts with the Secretary of Health and Human Services under Title V of the Indian Self-Determination Act. Under SCF's compact we carry out various Indian Health Service programs across our region. In doing so, SCF 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, SCF requests that in FY 2013 Congress (1) fully fund our Mat-Su Clinic joint venture staffing requirements, as required by our joint venture contract agreement with IHS, and (2) fully fund SCF's and all other contract support cost requirements at $572 million, as required by over 330 self-determination contracts with IHS.

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 and larger than the State of Oregon. To administer and deliver these critical healthcare services, SCF employs over 1,400 people.

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

1. Joint Venture Funding

The first issue I need to address concerns our joint venture (JV) contract with IHS. Under Section 818(e) of the Indian Health Care Improvement Act, IHS is authorized to enter into JV contracts under which, (a) a Tribe borrows funds to build a facility to IHS specifications, and (b) IHS agrees "to provide the equipment, supplies, and staffing for the operation and maintenance of such health facility." The agreements are contracts and they are enforceable as such.

Two years ago SCF and IHS entered into a binding JV contract. SCF agreed to construct a new 88,451 square-foot Primary Care Clinic in the Mat-Su Valley of Alaska, using borrowed funds from non-IHS sources. In return, IHS agreed that it "shall provide the supplies and staffing for the operation and maintenance of the Facility ... subject to appropriations by the Congress." Art. VIII.A. *See also* Art. VIII.G ("IHS will staff, operate and Maintain the Facility in accordance with Articles XI through XIV of this Agreement."); Art. XI ("As authorized by Section 818(e)(2)

of P.L. 94-437 ("subject to the availability of appropriations for this joint venture project, commencing on the beneficial occupancy date IHS agrees to provide the supplies, and staffing necessary for the operation and maintenance of the Facility. The IHS will request funding from Congress on the same basis as IHS requests funding for any other new Facility.")

Our concern arises out of the fact that, while we will receive our certificate of beneficial occupancy on July 15, 2012, and thus be operational during all of FY 2013 at an IHS-calculated staffing cost of $27 million, *IHS's Budget only requests 50% of the staffing requirement for the Clinic* (or $13.5 million). We are gravely concerned over this gap, all the more because the original $27 million which IHS committed to pay already reflects a 15% reduction of our total staffing costs. (This is because, as a matter of policy, IHS will not staff any new facility at more than 85% of the facility's staffing requirement.) If IHS does not receive additional funds to fully meet its contract commitment to SCF, IHS would be forced to reprogram other funds to make up for the difference.

We are not alone in this situation, and some of the other staffing packages which IHS is committed to provide are similarly underbudgeted. We calculate that to fund the staffing packages will require $95.2 million, not the $49.2 million requested. Before IHS requests, and before Congress funds, discretionary increases in other IHS accounts, contractually-committed staffing packages should be paid in full.

2. Contract Support Cost Funding

The second problem is the Budget's inadequate request for contract support cost funding—another contractually required payment to Indian Self-Determination Act contractors like SCF. The Budget requests a mere $5 million increase for FY 2013, despite the fact that IHS's former contract support cost expert Ron Demaray projects a $99 million shortfall in FY 2013 (calculated at the President's proposed Budget level). Here, we have developed our own projection because, for the first time in some 20 years, the IHS budget justification does not include a shortfall projection.

Contract support cost funding reimburses SCF's fixed costs of running its contract with IHS. If IHS fails to reimburse these costs, SCF has no choice but to cut positions, which in turn cuts services, 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. When in FY 2010 Congress appropriated an historic increase in contract support cost funding, SCF opened **97 positions** to fill multiple healthcare provider teams and support staff.

Our fixed contract support costs are largely "indirect costs" that are set by the HHS Division of Cost Allocation. The remainder of our contract support costs (about 20%) are set directly by IHS. These costs include federally-mandated audits, and such items 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 we have to track property and equipment. All of our costs are independently audited every year by Certified Public Accountants, as required by law.

Last year this Committee reiterated the binding nature of these contracts and directed IHS and the BIA to fully fund all contract support cost requirements. The BIA has done this, but the IHS budget justification defies the Committee's direction and insists that these contracts are not binding at all. So far as we can tell, no other contractors are treated this way. HHS, including IHS, only treats its contracts with Indian Tribes this way—as optional, discretionary agreements that it can choose not to pay. We provide a contracted service for a contracted price, but IHS only pays us what it chooses to pay.

This has to stop. In fiscal year 2013 IHS should finally pay its contract obligations in full. The contract support cost line-item should be fully funded at a minimum $571 million.

As SCF said last year before this Committee, underfunding contact support costs disproportionately balances budgetary constraints on the backs of tribal contractors. Worse yet, it punishes the people being served 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 (like the contract health services line).

Again, SCF respectfully calls upon Congress to provide at least $571 million in contract support cost funding for FY 2013, so that the Department can finally honor these contracts in full. Remember, every Tribe has contracts with IHS to carry out some of the agency's healthcare services, and most of those Tribes are being penalized for taking that initiative. Closing the contract support cost gap will eliminate that penalty and directly benefit the vast majority of Indian and Alaska Native communities served by IHS.

On a related note, SCF requests that Congress direct IHS to resume promptly disclosing to Tribes all IHS data on contract support cost requirements and payments. Up until last year, IHS was doing this regularly. Then suddenly IHS stopped—we think because IHS may have been embarrassed by errors in its data. Now, IHS claims that releasing its data may be opposed by some Tribes—even though the release of data is mandated by section 106 of the ISDA. IHS also claims that because the data is also used in a report to Congress, releasing the data violates OMB clearance procedures, and that there is some kind of embargo on data regarding the expenditure of federal funds (similar to the embargo applicable to the development of the President's Annual Budget). This is simply not so, and in prior years OMB *participated* in the disclosure of IHS data to the Tribes. Contract support cost appropriations belong to the Tribes, and Tribes have a right to know what is happening to these funds on a timely basis. Waiting for a report to Congress that includes other information is not helpful, since most reports never get to Congress. The few that do are interminably delayed. In fact, *the CSC Report Congress just received from IHS regarding 2009 data was two years late*. We ask that the Committee add appropriate language to the appropriations Act directing IHS to disclose its data promptly.

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