HEARING BEFORE THE HOUSE SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES ON THE FY 2013 BUDGET
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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. 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. Once again, SCF requests that in FY 2014 Congress (1) fully fund our Mat-Su Clinic joint venture staffing requirements, as required by our joint venture contract agreement with IHS since last year, and (2) fully fund SCF's and all other contract support cost requirements at $617 million, as the Supreme Court and other courts required last year.

For more than 25 years SCF has carried out IHS programs under Self-Determination Act agreements. In accordance with its self-governance compact with the Department of Health and Human Services, 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. Finally, SCF provides statewide tertiary OB/GYN and pediatric services for 110,000 Alaska Native people. 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; they are enforceable as contracts.

Three years ago SCF and IHS entered into a binding joint venture 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." At the same time, IHS only agreed to fund 85% of our staffing requirements,

explaining that, on average, IHS facilities are only funded at 85% of their need. See 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.")

Last July we received our certificate of beneficial occupancy. IHS, in turn, provided $2 million of our $27 million annual staffing requirement. We appreciate IHS's action, since IHS had not anticipated SCF opening our doors in FY 2012. But now we have been operational all of FY 2013, at an IHS-calculated staffing need of $27 million. Yet, in FY 2013, *IHS's Budget only requested 50% of the Clinic's staffing requirement* ($13.5 million). Despite this disappointing request, we are deeply appreciative of the Committee's efforts in the context of sequestration, made in collaboration with IHS and OMB, to secure at least this partial payment within the FY 2013 Continuing Resolution.

But, we must be perfectly frank with the Committee: the amount and timing of this payment have caused severe cutbacks in Clinic operations. Since we remain $12 million short in Clinic funding -- remember, that is at the IHS 85% funding level -- SCF has only been able to provide about **50%** of the medical service capacity, **30%** of wellness and physical therapy services, only minimal behavioral health services, and **nothing** in the way of dental, lab, optometry, audiology, OB-GYN, pediatrics, home health care, or specialty clinics. **Three-quarters of the Clinic has *not* been operated this fiscal year**, though we expect that to improve when this year's funds arrive. Once those funds arrive, we will be able to begin to expand existing services as originally intended. Still, *most of the Clinic will remain unused.*

It appears the President's Budget request is still insufficient to fully fund SCF's Clinic with the remaining $12 million that is due, *even two years late, in 2014.* The Budget request is insufficient and does not honor the joint venture contract under which we built it. It is legally and morally wrong.

Our message is simple: Before IHS requests, and before Congress funds, discretionary increases in other IHS accounts—even an important account like Contract Health Care (which in recent years *has already seen a 40% increase*)—discretionary increases should be suspended until IHS honors its contracts and pays its staffing packages 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 self-governance Tribes like SCF.

The Budget requests an insignificant CSC increase for FY 2014: bringing the total to $477 million. This is the case, despite projections that *the total requirement in FY 2014 is $617 million.* Worse yet, IHS is defying the Supreme Court's Salazar vs. Ramah decision: IHS is imposing a cap on contract payments to each contractor when *no caps have ever existed in those*

payments, reaching back to 1975. This would be a radical change in the law, and one which would go far beyond the work of an appropriations committee. Worse yet, we don't even know what those caps will be for us—everything is being done in secret, and won't be known until long after the appropriation is finalized and we are already performing our contracts.

If IHS is going to underpay us, we should at least have the right to go to Court to vindicate our contract rights. This is how it has always been. To now cap our contract by statute is to essentially kill the principal of tribal self-governance and convert us into grantees—an enormous step backward in the Nation's dealings with Indian Tribes. It is a radical step back, and one we are confident the authorizing committees would never agree to make.

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 on collections from Medicare, Medicaid and private insurers, which in turn cuts off even more staffing and services for our people. The reverse is also true. When in FY 2010 Congress appropriated an historic *increase* in contract support cost funding (thanks to this Committee's leadership), SCF opened 97 positions to fill multiple healthcare provider teams and support staff.

Our fixed contract support costs are largely "indirect costs." Those costs 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. We have to track property and equipment. All of these costs are independently audited every year by Certified Public Accountants, as required by law.

SCF's contract support cost shortfall in FY 2014 will be $8.95 million, including the cost of operating the new Clinic ($5.1 million) on top of our existing contract support cost shortfall ($3.85 million). The loss of almost $9 million in contract support costs, plus the remaining $12 million in new Clinic staff funding, totals $21 million. ***That is well over 150 health care positions***.

In 2012, this Committee reiterated the binding nature of our contracts, and it directed IHS (and the BIA) to fully fund all contract support cost requirements. The Supreme Court agreed with this Committee. Yet, the IHS budget justification defies this Committee's direction and reflects the view that these contracts are not binding at all, and are just another priority to be balanced against something else.

No other government contractors are treated this way. IHS only treats its contracts *with Indian Tribes* this way—as optional, discretionary agreements that it can choose to pay or not to pay. We provide a contracted service for a contracted price, but IHS only pays us what it chooses to pay. That is not the law, and this Committee should reject IHS's effort to rewrite the law.

In fiscal year 2014 IHS should finally pay its contract obligations in full, even if this means forgoing other increases, and even if this means cutting IHS's internal bureaucracy. Either the

contract support cost line-item should be fully funded at $617 million, or the capped contract support cost earmark should be eliminated altogether (as was the case prior to 1998). *The Committee should certainly reject the Administration's shocking new proposal to cap individual contracts*. This way, the Committee will preserve the remedies which existing statutory law provides contractors that suffer contract underpayments.

As SCF has said here before, 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 increases, fairness demands that such actions occur in those portions of the budget that are shouldered equally by IHS and the Tribes (as sadly occurred with the sequester). Tribes should not shoulder the full burden of a cut.

Again, SCF respectfully calls upon Congress in FY 2014 to eliminate all existing caps on contract payments. Alternatively, SCF respectfully calls upon Congress to provide $617 million in contract support cost funding. *Every* Tribe has contracts with IHS to carry out some of the agency's healthcare services, and most are still 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.

3. Data Disclosure

On a related note, SCF requests that Congress direct IHS to resume promptly disclosing to Tribes *and to Congress* all IHS data on contract support cost requirements and payments. Up until 2011, IHS disclosed such information to the Tribes, albeit informally. Then suddenly IHS stopped—because IHS was embarrassed by errors in its data. IHS claims the data is protected from disclosure until it is approved by the Secretary. But, the Secretary then holds the report back from Congress for years. *The fiscal year 2011 data is now one year late, even by IHS's own calculations*. The FY 2009 data was *two years* late. The 2014 Budget keeps secret the agency's projected total CSC requirement.

Contract support cost appropriations belong to the Tribes. Tribes have a right to know what is happening to these funds on a timely basis. So does this Committee. We therefore respectfully urge that the Committee eliminate all privileges against disclosure of IHS data if that data is not timely released to Congress under existing law. This way, the Committee can properly perform its budget oversight function, and Tribes, too, can hold the agency accountable.

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