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Testimony submitted to the House and the Senate Appropriations Subcommittees
on Interior, Environment and Related Agencies

Regarding FY 2014 Indian Health Service Budget

April 24, 2013

The requests of the Norton Sound Health Corporation (NSHC) for the FY 2014 Indian Health Service (IHS) budget are as follows:

- Appropriate an additional $13.58 million to staff and operate the newly opened Norton Sound Regional Hospital, as requested by the Administration.

- Direct the IHS to use existing FY 2014 appropriations to fully fund the Village Built Clinic (VBC) leases in accordance with Section 804 of the Indian Health Care Improvement Act and allocate an additional $8.2 million to VBC leases.

- Fully fund contract support costs at $617 million, an amount $140 million over the President's FY 2014 budget request. We also ask that the Committees direct the IHS to immediately release the outstanding FY 2011 and FY 2012 CSC shortfall reports.

- Reject the Administration's proposal to preclude CSC shortfall recovery by specifying in the appropriations bill amounts for individual Self-Determination contracts.

- Shield the IHS from sequestration.

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The Norton Sound Health Corporation is the only regional health system serving Northwestern Alaska. It is on the edge of the Bering Sea, just miles from the Russian border. We are not connected by road with any part of the State and are 500 air miles from Anchorage - about the distance from Washington, DC to Portland, Maine. Our service area encompasses 44,000 square miles, approximately the size of Indiana. We are proud that our system includes a tribally-owned regional hospital which is operated pursuant to an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement, and 15 village-based clinics.[1] The logistics and costs associated with travel and transportation are a daily challenge, to say the least.

[1] We serve the communities of: Brevig Mission, Council, Diomede, Elim, Gambell, Golovin, King Island, Koyuk, Mary's Igloo, Nome, St. Michael, Savoonga, Shaktoolik, Shishmaref, Solomon, Stebbins, Teller, Unalakleet, Wales, and White Mountain.

Additional Funding Needed To Staff New Hospital Facility. NSHC gained beneficial occupancy of its new replacement hospital and ambulatory care center facility in Nome in June 2012, the construction of which was funded by the Recovery Act. The IHS and NSHC have successfully worked as government-to-government partners to construct and furnish the new facility.

The replacement facility is almost three times the size of the former Norton Sound Regional Hospital and will allow for increased patient visits in the primary and acute care areas, including chronic disease prevention and management, and allow us to provide enhanced trauma and emergency services. NSHC needs to hire additional staff for the new replacement facility including pharmacists, laboratory and x-ray technicians, maintenance, information technology, housekeeping and security personnel.

Now that the new facility is open, IHS has only to fund the expanded staffing needs for operation of the replacement hospital. We need the full amount requested by the President in his FY 2014 Budget – or an additional $13.58 million - in staffing/operating funds to allow optimal use of the facility. These funds, combined with the over $10 million staffing funds provided in the FY 2013 appropriations will ensure that NSHC will be able to safely carry out its mission in the new hospital.

It is important to note that the new hospital is located in a medically underserved area and has one of the highest Health Professions Shortage Area (HPSA) scores in the nation. NSHC has been greatly limited in its ability to recruit and hire medical professionals, instead having to focus primarily on hiring core operational staff. It is very difficult for us to successfully recruit medical staff to Nome, particularly individuals who will need to move to Nome with their families, based solely on our anticipation that Congress might make additional staffing funds available to NSHC sometime in the future. To fully realize the potential of the new replacement hospital, and to ensure that we can safely provide adequate and expanded health care services to the people in our region, we need the full amount of $13.58 million that the President has asked for in his Budget.

Assistance Needed To End Chronic Underfunding Of Village Built Clinics. The NSHC health care system includes 15 Village Built Clinics (VBCs). The VBCs are essential for maintaining the IHS Community Health Aide Program (CHAP) in Alaska, which provides the only local source of health care for many Alaska Native people in rural areas. The CHAP program is mandated by Congress as the instrument for providing basic health services in remote Alaska Native villages. The CHAP program cannot operate without the use of clinic facilities.

The IHS has for many years consistently under-funded the leases of VBCs even though the IHS has had available appropriations to fully fund the leases. Lease rental amounts for the VBCs have failed to keep pace with costs –the majority of the leases for VBCs have not increased since 1989. The IHS has instead shifted its statutory responsibilities onto the villages and NSHC, which does not have adequate financial resources to maintain and upgrade the VBCs for CHAP

staff. As a result, many of the VBCs are unsafe or have had to be closed, leaving some villages in Alaska without a local health care facility.

As we indicated in our joint testimony to the Committees last year, NSHC and many other tribal organizations in Alaska have discussed this issue with the IHS on several occasions, and have proposed solutions that the IHS continues to ignore. IHS continues to assert that it provides for VBC leases all of the funds that Congress has appropriated for the program. In our view, the amounts historically traceable to the VBC leases are not capped by statute and are not the only funds available for that program. The Indian Health Facilities appropriation is a lump-sum appropriation that can be used for construction, repair, maintenance, improvements and equipment, and includes a sub-activity for maintenance and improvement of IHS facilities. The VBCs are IHS facilities acquired by lease in lieu of construction and should thus be eligible for maintenance and improvement funding. The IHS can also access other IHS discretionary funds to fully fund its VBC obligations.

For the FY 2014, we urge that an additional $8.2 million be appropriated to help fully fund VBC leases. We also ask that Congress direct the IHS to use existing FY 2014 appropriations to fully fund the VBC leases in accordance with § 804 of the Indian Health Care Improvement Act.

Contract Support Costs (CSC) Must Be Fully Funded. NSHC appreciates that Congress has in recent years increased funding for IHS contract support costs owed to tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act and federal case law. Even with these additional appropriated funds, the ongoing shortfall of CSC continues to impose significant hardships on NSHC and its patients. We urge the Committees to continue to push for full funding of CSC so that CSC underfunding is finally resolved. While it is difficult to estimate the full CSC need for FY 2014—in part because IHS refuses to release its CSC distribution data for the last two years, as discussed further below—based on projections from FY 2010 we estimate that the total need in FY 2014 to be $617 million.

Given the progress toward full CSC funding in recent years, we are dismayed that the Administration’s budget request proposed only a minimal increase for IHS CSC to $477,205,000. This would force tribes to absorb almost $140 million in uncompensated costs for overhead and administration of federal programs. This continued shortfall compromises NSHC’s ability to serve its patients. We urge the Committees to fully fund IHS CSC at $617 million.

Just as disheartening is the Administration's proposed appropriations act language that attempts to preclude tribes from recovering any of their CSC shortfalls through contract actions, which the Supreme Court said is their right in the *Salazar v. Ramah Navajo Chapter* case from 2012. The proposed bill language would incorporate by reference a table identifying the maximum amount of CSC available for every single ISDEAA agreement. This process is unworkable, and has been proposed with zero input from tribes and other ISDEAA contractors. We urge that the Committee reject this proposed approach and, instead, fully fund CSC for both IHS and BIA.

Direct the IHS to Release CSC Shortfall Data. The IHS has failed to provide CSC shortfall reports to Congress for FYs 2011 and 2012. The IHS must submit these reports no later than

May 15 of each year, per§ 106(c) of the ISDEAA, 25 U.S.C. § 450j-1(c). NSHC and other ISDEAA contractors recently asked the IHS to share the CSC distribution data for those years. Access to the CSC shortfall data is critical to our ability to understand the IHS's view of the scope of CSC underfunding, to evaluate IHS's allocation of its insufficient past CSC appropriations, and to pursue full CSC funding moving forward. The IHS has repeatedly refused to make the reports available, most recently at a March 2013 meeting with the IHS Area Lead Negotiator for the Alaska Area. We thus ask that the Committees direct the IHS to immediately release the FYs 2011 and 2012 CSC shortfall reports—and all future reports—in a timely manner, as required by the ISDEAA.

Protect the IHS from Sequestration. The Office of Management and Budget determined that the IHS's appropriation is fully sequestrable, which resulted in a $220 million cut in funding to the IHS for FY 2013 – roughly 5% of the IHS's overall budget. IHS lost $195 million for programs like hospitals and health clinics services, contract health services, dental services, mental health and alcohol and substance abuse. Programs and projects necessary for maintenance and improvement of health facilities felt these same impacts. These negative effects are then passed down to every ISDEAA contractor, including NSHC. NSHC is already significantly underfunded, resulting in further cuts to the availability of health services we are able to provide to our patients, resulting in real consequences for individuals who have to forego needed care.

We suffer these reductions and experience these new challenges to providing health care for the people of the NSHC region, despite the United States' trust responsibility for the health of Alaska Native and American Indian people. We fail to understand why this responsibility was taken less seriously than the Nation's promises to provide health to our veterans. The Veterans Health Administration (VA) was made fully exempt from the sequester for all programs administered by the VA. *See* § 255 of the Balanced Budget and Emergency Deficit Control Act (BBEDCA), as amended by P.L. 111-139 (2010). Also exempt are state Medicaid grants, and Medicare payments are held harmless except for a 2% reduction for administration of the program. Yet the IHS—which already faces low funding—was subject to full cuts. We thus strongly urge the Committee to support amendment of the BBEDCA to fully exempt the IHS from any future sequestration, just as the VA and other health programs are exempt.

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Thank you for your consideration of our request that adequate FY 2014 IHS staffing funding be made available for the NSHC replacement hospital. We are very excited about the possibilities this facility brings for improved health care for the people of Northwestern Alaska. We also appreciate the Committees' consideration of our requests to address the chronic underfunding of Village Built Clinics and contract support costs. We are happy to provide any additional information you may request.