TESTIMONY OF ANDY TEUBER
CHAIRMAN AND PRESIDENT, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
PRESIDENT AND CEO, KODIAK AREA NATIVE ASSOCIATION
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES
April 7, 2014

My name is Andy Teuber, I am the Chairman and President of the Alaska Native Tribal Health Consortium (ANTHC) and President and CEO of the Kodiak Area Native Association (KANA). For the fiscal year (FY) 2015 Indian Health Service (IHS) budget we are requesting increased funding for Renovation and Expansion of Existing Health Care Facilities, Medical Equipment, the Village Built Clinic Lease Program, Sanitation Facilities Construction, Contract Support Costs and restoration of sequestration cuts. We are also requesting support for IHS advanced appropriations and a fix for the definitions of Indian in the Affordable Care Act.

ANTHC is a statewide tribal health organization that serves all 229 tribes and over 140,000 American Indians and Alaska Natives (AI/ANs) in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AI/ANs in Alaska.

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

We understand that given the current fiscal constraints that the federal government is under, the FY 2015 IHS appropriations will not meet all of the needs of tribal health programs, but in my testimony I would like to highlight some areas of particular need that have been overlooked in the FY 2015 President's Budget Request.

<u>Renovation and Expansion of Existing Health Care Facilities</u>
According to IHS' 2012 Report to Congress on health care facilities need, the average age of IHS-owned health care facilities is over 30 years and over a third of IHS hospitals and health centers are over 40 years old. This is in contrast to the average age of private-sector hospitals, which is 9 to 10 years.

As existing facilities age, without renovation or expansion, they become increasingly inefficient to operate and costly to maintain. The age of facilities also negatively impacts the ability of IHS and tribal health programs to efficiently and effectively provide health care services to AI/ANs in overcrowded and outdated facilities.

The estimated cost to complete the 17 inpatient and outpatient facilities currently on the IHS planned facilities construction list is $2.5 billion, at the current level of funding for IHS construction facilities it would take 30 years to complete the existing list. As no funds are currently provided to IHS to renovate or expand existing facilities, this leaves many IHS Areas that have very old facilities without a way to improve them.

Fortunately, the reauthorization of the Indian Health Care Improvement Act (IHCIA) in 2010 (S. 1790) amended section 301 of IHCIA to direct the Secretary ensure that the "renovation and expansion needs of Service and non-Service facilities…are fully and equitably integrated into" the IHS health care facility priority system, and to consult and cooperate with tribes to develop innovative approaches to address unmet need for construction of health facilities.

This Committee can spur IHS to innovation by providing funding for an area distribution fund for the renovation and expansion of existing health care facilities. This would provide funding for all IHS Areas and also address the dire unmet need to renovate and expand existing IHS and tribal health facilities to provide more efficient and better care to AI/ANs throughout Indian Country. We request $15 million be provided in FY 2015 to establish an area distribution fund for the renovation and expansion of existing health care facilities.

Medical Equipment

Current IHS funding levels for medical equipment cover only one-third of the level of need and only provide enough funding to replace medical equipment every 18 years. The industry standard for patient safety requires medical equipment to be replaced, on average, every six years.

In order to keep medical equipment up to date to ensure patient safety, meet accreditation standards and provide the best possible care, tribal health programs have to divert scarce resources from other program areas. The Alaska Native Medical Center alone has over $9 million of unmet need to upgrade medical equipment. We request a $5 million increase in FY 2015 for IHS medical equipment to ensure that IHS and tribal health programs can acquire and maintain adequate medical equipment without needing to take-away from other programs.

Village Built Clinic Lease Program

Village Built Clinics (VBCs) are essential to carrying out the Community Health Aide Program (CHAP) in the villages in rural Alaska. Community health aides are often the only health providers available in rural communities and are critical to the Alaska Tribal Health System. CHAP practitioners use VBCs to provide CHAP services in the villages. The majority of VBC lease payments from IHS have not substantially increased since 1989 and current funding is not nearly sufficient to cover inflationary increases and the cost of repair and renovation of the facilities needed to keep them in a safe condition.

Under section 119 of the Indian Health Care Improvement Act, the IHS is responsible for operating the CHAP program. Many VBCs are struggling to meet operating costs to stay open and maintain adequate conditions. Without VBC facilities to provide CHAP services, the CHAP program cannot be properly operated. To ensure the continued operation of the CHAP program, the IHS has a responsibility to provide lease payments that cover the actual cost of operating VBCs.

For FY 2013 an estimated $4.5 million was provided for the VBC lease program by IHS as part of the recurring base budget. This amount likely only covers a little over one-third of the full

cost of operating VBC and we request an additional $8 million for VBCs that is needed to fully fund the operating cost of VBC for FY 2015.

Sanitation Facilities Construction

Sanitation facilities play a critical role in the health of our communities. Babies in communities without adequate sanitation are 11 times more likely to be hospitalized for respiratory infections and 5 times more likely to be hospitalized for skin infections. In villages with very limited water service, one in three infants requires hospitalization each year for lower respiratory tract infection. In Alaska alone we have over $800 million in unmet need for sanitation facilities construction. Despite the enormous, growing unmet need and the significant health benefits derived from sanitation facilities the funding for IHS sanitation facilities construction has actually decreased since FY 2012. We request an increase of at least $5 million for IHS sanitation facility construction in FY 2015.

Contract Support Costs

I would like to thank this Committee for its leadership in addressing the contract support cost (CSC) issue that has hindered tribal health programs for decades. Not only did this Committee reject the CSC "cap" that was proposed for FY 2014, but it saw to it that tribal health programs were finally provided the CSC funding they are contractually due. We are pleased to see that the administration has now followed the guidance provided by this Committee and requested full funding for IHS CSC in FY 2015 in the PBR. We request that this Committee continue its leadership on this issue and fully fund IHS CSC in FY 2015.

Restoration of Sequestration Cuts

The IHS was the only federal health program that was subject to full sequestration in FY 2013, with $220 million cut from its budget. Due to the sequestration, many tribal health programs had to reduce staff, reduce patient visits and delay medical procedures. IHS and tribal health programs still have not fully recovered from the cuts made due to sequestration. There are ten IHS budget line items that under the FY 2015 PBR would receive less funding then they received in FY 2012: Alcohol & Substance Abuse, Community Health Representatives, Immunizations, Urban Heath, Indian Health Professions, Tribal Management, Direct Operations, Self-Governance, Maintenance & Improvement and Sanitation Facilities Construction.

The PBR for FY 2015 requested $63 million for medical inflation for IHS, but left out any request for increased appropriations for non-medical inflation, population growth and the majority of increased pay costs. The Veterans Health Administration, the only other federal program that provides direct health services, was fully exempt from sequestration. The FY 2015 IHS budget should receive an additional $220 million over the PBR to restore the cuts made due to sequestration that can be used to pay for non-medical inflation, population growth and increased pay costs.

IHS Advanced Appropriations

Timely receipt of appropriations is essential for IHS and tribal health programs so that they can properly plan and manage care for AI/ANs. If funding is not timely, it can significantly hamper

IHS and tribal health care providers in budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts.

The sixteen-day government shutdown that began FY 2014 put many tribal health programs in dire financial situations due to the fact that they received no federal funding during the shutdown. If IHS were provided advanced funding this problem would have been avoided, as IHS would have had its funding allocated a year in advance.

The government shutdown merely highlighted an IHS funding problem that already existed—even before the shutdown tribal programs were having difficulties properly planning for the FY due to the lateness of final appropriation bills being passed. There has been only one year since FY 1998 when the Interior, Environment and Related Agencies appropriations bill has been enacted by the beginning of the fiscal year.

The Senate Committee on Indian Affairs held a hearing on April 4, 2014 on S. 1570 which would provide advance appropriations to IHS. Passage of S. 1570 would resolve the funding uncertainty of IHS and tribal health programs, and allow them to more efficiently and effectively manage their budgets to maintain health services and continuity of care for AI/ANs. The Veterans Administration was granted authority to receive advance appropriations in 2010. We hope that this Committee would be supportive of any bill that would provide IHS with advanced appropriations, whether that be S. 1570 or other similar legislation.

Fix for Definition of Indian

The Affordable Care Act (ACA) includes a number of Indian-specific provisions that were intended to give AI/ANs the benefits of ACA while accounting for the unique Indian health care system. These Indian-specific provisions allow "Indians" the benefit of monthly enrollment and cost-sharing exemptions in qualified health plans, as well as an exemption from the individual mandate tax penalty.

Unfortunately, the Department of Health and Human Services (HHS) unnecessarily, and we believe incorrectly, narrowly construed the definition of "Indian" that was included in sections 1311, 1402, and 1501 of ACA, so that it only includes members of federally recognized tribes. Neither the statutory language nor legislative history indicates that Congress intended to limit the definition of "Indian" in such a way. In fact, HHS' interpretation is inconsistent with already existing regulations in place for IHS and the Centers for Medicaid and Medicare Services used to determine who is eligible as an Indian for federal health programs.

HHS' narrow interpretation is particularly troubling in Alaska, where many AI/ANs will not meet this narrow definition. One of the easiest, and likely primary, ways an Alaska Native would validate that they are a member of a federally recognized tribe under the ACA would be by proving shareholder status in a Alaska Native Corporation (ANC), but many Alaska Natives are not ANC shareholders as they were born after the enactment of the Alaska Native Claims Settlement Act and the issuance of original shares in ANCs in 1971. We request this Committee support any method available for clarifying that the definitions of Indian in ACA was meant to include AI/ANs who are eligible for IHS services.