HEARING BEFORE THE HOUSE SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES ON THE FY 2016 PRESIDENT'S BUDGET REQUEST
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My name is Katherine Gottlieb and I am the President and Chief Executive Officer of Southcentral Foundation (SCF). SCF is a tribal organization that compacts with the Secretary of Health and Human Services under Title V of the Indian Self-Determination Act (ISDA) to provide primary care services to Alaska Native patients within the Anchorage area and throughout the 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 contracting purposes under the ISDA. Thank you for the opportunity to testify on behalf of the Southcentral Foundation and the 150,000 Native American people we serve.

For more than 25 years SCF has carried out Indian Health Service (IHS) programs under ISDA agreements. In accordance with our compact, SCF currently provides medical, dental, optometry, behavioral health and substance abuse treatment services to over 52,000 Alaska Native and American Indian beneficiaries living within the Municipality of Anchorage, the Matanuska-Susitna Borough to the north, 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. Finally, SCF provides statewide tertiary OB/GYN and pediatric services for approximately 150,000 Alaska Native people. To administer and deliver these critical healthcare services, SCF employs 1,900 people.

SCF requests that in FY 2016 Congress (1) focus on general IHS program increases; (2) continue funding the Methamphetamine and Suicide Prevention Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI) and clarify these programs are entitled to contract support costs (CSC) when operated by Tribes; and (3) encourage IHS to implement solutions to streamline CSC calculations and reduce the administrative burden associated with these calculations.

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IHS has split its budget request into two parts, requesting (1) an additional $147.3 million for current services to fully fund medical inflation, pay raises, and partially fund population growth, and (2) $313.3 million to fund specific program increases. We encourage the Committee to refocus attention on the first part—the request to increase the appropriation to maintain current services. As a result of sequestration and two years where the agency has diverted increases to cover CSC shortfalls, the agency has effectively short-changed increases to cover added costs of inflation and population growth. This is extremely serious for an organization like ours where the number of IHS beneficiaries has increased 20% since we last received a population growth increase in FY 2010. This dramatic growth, combined with the ever rising costs of doing

business, make it nearly impossible to meet the needs of our population without funding increases.

In years past, these base increases have been put aside as the agency advocated for specific program increases, such as increases for the purchased/referred care (PRC) line item. In similar fashion, this year less than one third of the requested increases are devoted to maintaining current services. While PRC is important, it is not more important than other portions of the budget, especially for tribal organizations like us that mostly provide direct care services. We ask this Committee to ensure the agency's favored projects are not given priority over the need to maintain and improve our baseline of care.

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We also want to provide our unqualified support of the Methamphetamine and Suicide Prevention Initiative and the Domestic Violence Prevention Initiative. These initiatives provide crucial support in our effort to combat two blights that disproportionately afflict our community. For instance, at SCF we implemented the Family Wellness Warriors Initiative to provide a means for organizations and individuals to effectively address the spiritual, emotional, mental and physical effects of domestic violence, abuse and neglect.

That said, we are deeply concerned about how these funds are being handled.

Congress first appropriated funds for the MSPI in 2008, and first appropriated DVPI funds in 2009. Congress directed that both of these funds should go to the areas that needed them the most. IHS distributed these funds to contracting and compacting Tribes and tribal organizations through amendments to each Tribe's annual funding agreement. These amendments always occurred late in the fiscal year, long after the CSC appropriations had already been spent, so the agency always recognized the Tribe's CSC need associated with these programs but it could never actually pay that need. Now, just when full CSC funding has become a reality, IHS has changed its tune. The agency now says these programs are "special initiatives," they are not covered by the ISDA, and they are not eligible for any CSC support.

Now that full CSC funding is the law, the agency should not be permitted to redesign these programs and try to turn them into discretionary grants. This change affects more than nomenclature: it effectively decreases funding for Tribes that operate these programs, in contravention to the spirit and letter of the ISDA. It is telling this year that the agency requests a $25 million increase for the MSPI, but plans to devote $3 million of that amount for "national management," data reporting and evaluation. In short, the agency is requesting significant amounts to increase its own bureaucracy, while at the same time denying tribal organizations funding for the fixed administrative costs they incur running these vital programs. We ask that in providing amounts for these programs, this Committee make clear that these funds are to be treated like any other IHS program funds subject to the ISDA.

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We would also like to thank this Committee for ensuring that our CSC is fully funded. We completed a historic settlement with the agency last year and we are excited to put these funds to good use. We have some CSC experts on our staff that have been working with the agency on these issues for over 20 years. My staff tells me that the agency and Tribes have made more progress on CSC issues in the past few months than they ever have before. And with all that said, we would like to be done with this issue. Instead of spending hours and hours of staff time each year in negotiations and disputes over calculations, we would like to move on and do what we do best—provide quality health care to our people.

In order to get to that point, we ask this Committee to emphasize its instructions to IHS last year—the agency must simplify and streamline these calculations. For example, we submitted a proposal to negotiate lump sum amounts for CSC that would be in place for five years and that could be renewed by tribal option. This amount would increase only for inflation or for large program expansions. This sort of proposal drastically cuts down on the administrative burden associated with renegotiating and reconciling amounts every year. More importantly, we will have more certainty about the funding we will receive each year and can budget accordingly. We can then focus our efforts on the most effective use of these funds. We ask this Committee to instruct the agencies to embrace these sorts of solutions and to encourage the agencies to reduce bureaucracy.

Similarly, we support a permanent mandatory CSC appropriation. Moving the CSC line item to a mandatory appropriation will protect our core program funds and will ensure the amount appropriated each year for CSC is only the true amount of the need and not merely an estimate. Moreover, it will drastically cut down on the need for agencies to spend countless hours developing these estimates. But this proposal can only work if it is permanent and the funding is not in jeopardy every three years. Only a permanent appropriation would fulfill our need to put the era of CSC disputes behind us and let us simply manage health care.

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Although not germane to this Committee, I must mention one other issue that has grave impacts across Indian Country. We are facing a potential fiscal cliff for our community health center (CHC) funding, which was greatly augmented in 2010. This funding supports ongoing health center operations, creates new health center sites in medically-underserved areas, and expands preventive and primary care services at existing sites. We rely on this funding at SCF to support our health centers in McGrath, Nikolai, Takotna, Iliamna, Sutton, and St. Paul, and we are looking to expand these funds to Port Alsworth and Tyonek. To view the full magnitude of this issue, 27 organizations receive this funding in our State, supporting over 150 sites in Alaska alone. If this appropriation expires in 2016, however, our rural health center funding will be cut by approximately 70%. Since these centers typically provide the only access to health care in these areas, we ask this Committee to work with fellow members of Congress to ensure this funding is reauthorized.

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Thank you again for the opportunity to testify on behalf of the Southcentral Foundation.