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John Lincoln, Board Chair

Testimony on the FY 2017 IHS and BIA Budgets submitted to
the House and the Senate Subcommittees on Interior, Environment and Related Agencies

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Summary. The Maniilaq Association is an Alaska Native tribal organization representing twelve tribes in Northwest Alaska. We provide health services through a self-governance agreement with the Indian Health Service (IHS) and social services through a self-governance agreement with the Bureau of Indian Affairs (BIA). We make the following recommendations regarding FY 2017 IHS and BIA funding:

- Increase funding for the Village Built Clinic leases in Alaska by at least $12.5 million and make it a line item in the IHS budget.
- Make full Contract Support Costs funding for the IHS and BIA mandatory, and ensure there are no provisos on indefinite CSC funding that conflict with the carryover funding authority provided by the Indian Self-Determination and Education Assistance Act.
- Fund the IHS budget on an advanced appropriations basis.
- Support the proposed increases in mental health, suicide prevention and substance abuse spending in the IHS and BIA budgets.

Village Built Clinics

For many years now, Maniilaq has submitted testimony to the Subcommittees regarding the need to address the chronic underfunding of our Village Built Clinic (VBC) facilities. We appreciate the inclusion of language in the FY 2016 Consolidated Appropriations Act, providing that "… $2,000,000 shall be used to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance Act compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service[.]" While the language is not specific to VBCs, we understand that the $2 million was intended for VBCs.

We also appreciate that the Administration has also requested for FY 2017 a $9 million increase for tribal clinic leases, on top of the $2 million provided in FY 2016 funds. Approval of this request would finally help stabilize the desperately needed village-based care that is crucial in Alaska.

The VBCs are essential for us to maintain the Community Health Aide Program (CHAP) in Alaska. As you know, CHAP is mandated by Congress as the instrument for providing basic health services in remote Alaska Native villages and often provides the only local source of health care for Alaska Native people in rural areas. We cannot overstate the critical role of village built clinics in Alaska. 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 and the IHS until this year resisted proposals to increase their funding. 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.

In addition, the President's proposed FY 2017 clinic lease bill language may need some clarification, depending on IHS's interpretation, concerning the references that health care be delivered in a space acquired through a "full service lease". In some cases tribes – including the Maniilaq Association - receive VBC funding as part of their recurring base, and so the IHS no longer has "full service leases" in place for those clinics. We know that the Appropriations Committees do not intend to limit VBC eligibility based on unclear terminology.

In sum, these amounts are a step in the right direction but the 2105 ANHB study that analyzed the funding deficiency statewide for these facilities identified an increased need of $12.5 million increase. We urge that the full amount needed be appropriated. We also support maintaining this funding as a line item in the bill.

Contract Support Costs Mandatory Funding.

Maniilaq appreciates the bipartisan support of the Interior Appropriations Subcommittees for full funding of Contract Support Costs (CSC). We very much appreciate the funding of CSC in FY 2016 at an indefinite ("such sums as necessary") amount, which has helped to ensure that CSC would be fully funded without having to reprogram funding for critical health care services and other programmatic funding to cover the CSC need. Maniilaq continues to believe that the indefinite appropriation of CSC funding must be made mandatory and permanent. We thus support the Administration's proposal to move CSC funding to a mandatory funding basis, although we would like it to begin in FY 2017 rather than waiting until FY 2018. We plan to reach out to and work together with the Senate Committee on Indian Affairs and the House Natural Resources Committee in order to determine the best way to reach our goal for CSC funding to be made indefinite, permanent and mandatory. We ask for this Subcommittee's support for such mandatory CSC funding.

Should CSC funding not be made mandatory in FY 2017, we otherwise are supportive of the President's request for an appropriation of "such sums as may be necessary," with an estimated $800 million for CSC for the IHS, and an estimated $278 million for the BIA, in separate accounts in both the IHS and BIA discretionary budgets. However, we do not agree with the continued insertion of a proviso that could effectively deny the carryover authority granted by the Indian Self-Determination and Education Assistance Act for FY 2017 and thereafter. We thus request the removal of the following proviso: "amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years."

IHS Advance Appropriations

The Maniilaq Association continues to work toward a transition of the IHS budget to an advance appropriations basis. Over the past several fiscal periods, appropriations have been enacted well after the beginning of the federal fiscal year: 2.5 months in both FYs 2016 and 2015, 3.5 months in FY 2014, and 6 months in FY 2013. Following enactment, it takes a few months before funds are cleared through the Office of Management and Budget, allocated to the IHS Area Offices, and then finally provided to the tribes and tribal organizations.

Both the tribal and IHS programs suffer under this situation. We need to be able to do the best job possible in planning, decision-making and administering programs, but we are impeded in our ability to do so because we do not know how much funding will be made available or when we will receive it. This uncertainty requires us to constantly re-work our budget and delay recruiting and hiring decisions, when we should be devoted to providing the best health services possible. These delays also ultimately cost us more money, since we are not able to take full advantage of buying items in bulk for lower cost, such as our heating fuel.

We are asking that Congress appropriate IHS funds on an advance basis, just as it does for the Veterans Administration (VA) medical accounts funding. In the proposed FY 2016 budget (FY 2017 advance appropriations) for the VA, the Administration justifies advance funding for the VA on the basis of providing timely, high-quality health care for the Nation's veterans, and reiterates this justification in the proposed FY 2017 budget. Our need for timely and predictable funding is no less great than it is for the VA.

Alcohol & Substance Abuse Treatment, and Behavioral Health, Suicide Prevention

The Administration's request includes $25 million in program increases for mental health. Of that amount, $21.4 million would be for a behavioral health integration initiative, for which tribes and tribal organizations would be eligible to seek funding for the expansion of their behavioral health services to areas outside of the traditional health care system; training; hiring behavioral health staff; and community-based programs. Another $3.6 million in the proposal would be for funding pilot projects to implement the "Zero Suicide Initiative." The overwhelming majority of the people we lose to suicide

suffer from diagnosable, treatable mental health or substance abuse problems. However, the waiting list for treatment averages nearly 9 months, and due to lack of funding there is often no place to refer people, particularly young people. We therefore request your support for funding the $25 million program increase for these critical programs.

We also appreciate the $10 million appropriated in FY 2016 for the *Generations Indigenous* (*Gen-I*) initiative, which provides increased resources for tribes to address youth behavioral, mental health and substance abuse issues. This funding is critical for the hiring of staff to provide more services and prevention programs for our youth. We ask for your support to fund the expansion of the *Gen-I* program in FY 2017. For the IHS, the Administration is requesting a $16.8 million increase focused on youth: $15 million to expand *Gen-I* for additional staffing and $1.8 million for a pilot program that would provide a continuum of care for youth after discharge from a Youth Regional Treatment Center. For the BIA the proposal includes an increase of $21 million to expand the *Tiwahe Initiative* designed to address the inter-related problems of poverty, violence and substance abuse faced by Native communities, including $12.3 million for social services programs designed to provide culturally appropriate care. We ask for your support for this funding.

The President's proposal also includes two-year mandatory funding of $10 million in FY 2017 to expand the number of behavioral health professionals providing services in Indian communities, and $15 million to provide assistance "to prevent reoccurrences to tribes experiencing behavioral health crises including specialized crisis response staffing, technical assistance, and community engagement." This funding and these programs are desperately needed in our communities. Increased behavioral health staffing is a necessity in order to save lives. We are committed to working together with the Senate Committee on Indian Affairs and the House Natural Resources Committee and any others to develop legislation to support these proposals.

Other.

We wish to join others in Indian Country in supporting the permanent authorization of the Special Diabetes Program for Indians; funding for annual built-in costs for medical and non-medical inflation, pay increases, and population growth; and the establishment of Medicare-like Rates for non-hospital services, thus stretching our otherwise limited Purchased/Referred Care funds.

Thank you for your consideration of our views.