House Committee on Appropriations
Subcommittee on Interior, Environment and Related Agencies

Hearing on the Fiscal Year 2015 Budget

Testimony of Charles Clement, President and CEO
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My name is Charles Clement and I am the President and CEO of the SouthEast Alaska Regional Health Consortium (SEARHC). Chairman Calvert, Ranking Member Moran, and members of the Committee, it is a pleasure to be here and I thank you for the opportunity to testify before this Committee.

I have been involved in the provision of Alaska Native health care for over 15 years. Prior to my employment at SEARHC I worked for the Southcentral Foundation in Anchorage, Alaska, as the Vice President and Chief Operating Officer; Vice President for Operations; Director of Information Technology and Chief Information Officer; and Special Assistant to the President. I became the President and CEO of SEARHC in 2011, and continue to be amazed and energized at the positive impact our tribal consortium has had on the health of Alaska Natives. Every day I witness first hand tribal self-determination in action, and I can tell you that it works and produces far better services and far better patient results than anything the Indian Health Service is able to do.

SEARHC is an inter-tribal consortium of 18 federally-recognized Tribes situated along the southeast panhandle of Alaska. Our service area encompasses over 35,000 square miles, an area larger than the State of Maine. With no road system connecting our communities, the challenges to deliver robust health services are considerable.

SEARHC meets these challenges through a network of community clinics anchored in the Mt. Edgecumbe Hospital. Our services include medical, dental, mental health, physical therapy, radiology, pharmacy, laboratory, nutritional, audiology, optometry and respiratory therapy services. We also provide supplemental social services, substance abuse treatment, health promotion services, emergency medical services, environmental health services and traditional Native healing.

We administer over $42 million in IHS facilities and related programs and services, and average over 115,000 patient encounters each year. These are federal services which we operate on behalf of the Federal Government, through an Indian Self-Determination Act Title V self-governance compact and funding agreement.

1. **Contract Support Costs.**

This year this Committee led the way in achieving a fundamental policy shift in the funding of the contract support costs that we depend upon to carry out our contract obligations to IHS. That one decision will have far-reaching positive impacts for our people for years to come. For nearly 40 years we have had to divert patient care funding to cover the fixed administrative costs that go along with delivering health care across our remote communities. By insisting on full payment of those costs in 2014, this Committee has paved the way for expanded health care for our members, a population that desperately needs it.

We at SEARHC salute the Committee for this bold and truly historic action. Thank you for your tireless efforts on behalf of Indian Country.

While future contract support cost payments have now been addressed, there remains the issue of back claims. Our claims have been pending for nine years. Yes, I said nine years. The agency would not settle up because it kept hoping the courts would bail it out. But they didn't, and in 2012 the Supreme Court put an end to the litigation. It told the agency to pay up on our claims. But nothing has happened. Last July we gave IHS an offer to settle some of our claims. Today, 9 months later, it has been radio silence.

We at SEARHC cannot understand this. The statute and the IHS Manual are perfectly clear on how contract support costs were to be calculated. They were also clear that IHS had to report to Congress every year on any underpayments. And IHS actually did that: every year IHS sent Congress a certified report on the payments due to SEARHC.

Ideally, Congress would have made a supplemental appropriation to honor our contracts. But, IHS never requested a supplemental and so no such appropriation was made. Still, those certified reports tell us how much IHS owed SEARHC each year for running the agency's programs. And those are the same reports we used to submit our claims. You would think settling up with us would therefore be easy.

Not so. In an effort that will frankly cheat SEARHC, IHS has now disavowed all of its certified reports. Starting from scratch, it has hired an anti-fraud forensic accounting firm—never mind that we have had perfect independent audits every year. It has decided our contracts are cost-reimbursable contracts, so that if the money was never paid to us, and therefore we never spent it, then IHS owes us nothing.

This is nothing short of a shell game. It is designed just to save the government money after losing a Supreme Court case. It is not designed to honor the agency's legal and trust obligations to SEARHC and our member Tribes. It is IHS's obstinate insistence on this process which has stalled our settlement negotiations for so long.

I see that in the Administration's Budget Request, IHS has asked for a provision to protect it from having to repay the Judgment Fund that will be used to pay our claims. We at SEARHC have no problem with this provision—IHS funding is tight enough as it is. But if IHS wants this protection, it needs to start settling claims based upon its certified contract support cost shortfall reports. We at SEARHC respectfully urge the Committee to add to this provision a

requirement that IHS use its certified reports to settle up with SEARHC and the other 200 tribal contractors that have claims pending with the agency.

It is, frankly, ludicrous that we are still waiting to settle up all these old claims when the agency has already certified to Congress how much it owes.

2. Facilities

Second, we at SEARHC encourage the Committee to invest more in IHS facilities. There is a desperate need for facilities funding across Indian Country. As IHS noted in a report to Congress on health facilities needs, the average age of IHS-owned facilities is 31 years, three times the average age of private health facilities. As of 2011, IHS had identified a combined total need of $8.45 billion in facilities needs across Indian Country.

For us, our greatest facilities need is at our hospital, which, at 66 years old, is far older than the national average. In fact, Mt. Edgecumbe is the oldest facility in Alaska and one of the oldest in the United States. Although limited funds prevent us from properly renovating this hospital, there is only so much one can do to repair a 66-year-old hospital that has weathered Alaska's climate. Currently, our hospital has a "conditions index" of 69, a measure of a facility's poor condition. In contrast, in 2011 the average CI of all IHS-owned facilities was 81. Our low score translates into numerous problems that pose significant health risks to our patients and employees. For instance, the hospital ventilation system has an impact on hospital infection rates and cannot be easily or inexpensively upgraded in an older facility like ours. This has a real health cost that dwarfs the cost of building repair or replacement. Likewise, our elevators frequently break down. When they do our patients cannot be moved, which endangers patient lives.

In 2009, IHS conducted a Deep Look Survey to determine what it would take to address our facility needs. The survey identified $10.3 million in current needs and recognized that much of the infrastructure is aging and many departments require remodeling. The deficiencies from the Deep Look Survey are entered into the Facilities Engineering Deficiency System (FEDS), which the IHS uses to track conditions and costs of IHS and Tribal facilities. Today, the FEDS lists the deficiency costs at $18 million. However, the total national appropriation for M&I in FY 2014 is only $53.6 million. In other words, it would take a third of the total national appropriations to update just this one IHS facility. FEDS lists our hospital replacement cost at $62 million. Mt. Edgecumbe must either be remodeled soon or replaced, but there are no funds to do either.

These facilities deficiencies need attention. Despite the overwhelming need for facilities funding in Indian Country, the facilities funding in the IHS budget essentially stayed flat this year, with only a $10 million increase in the Facilities and Environmental Support line and a $1 million increase in the medical equipment line. In fact, M&I funding per square foot is at a ten year low. At this rate, facility needs will continue to far outstrip available funds, desperately needed repairs will not get done, and patients at Mt. Edgecumbe will risk more infections and have no elevator to take them to the OR.

To address these needs, we recommend the Committee do three things: First, the Committee should direct IHS to review and reorder the current facilities priority list to ensure that facilities needs "are fully and equitably integrated into the health care facility priority system." 25 U.S.C. § 1631(c)(1)(B). The current list fails to meet this standard because the current first-come first-served methodology obviously does not reflect actual need. And a system that does not prioritize the greatest needs is not equitable. A new system should be developed—one that does not relegate hospitals that were not historically on the list to the bottom. While we acknowledge the statute also provides for grandfathering the projects historically on the priorities list, we believe this system has led to an inequitable and unworkable system. The wait for funding on the current priorities list is over 30 years long and does not include some projects with the greatest need. Mt. Edgecumbe cannot wait 30 years to be renovated or replaced. At this rate, it cannot even wait five. Second, the Committee should reopen the Joint Venture Project. Third, the Committee should direct IHS to create a priority list to address the personnel and equipment needs of facilities that are tribally renovated. Pursuant to 25 U.S.C. §1634, Tribes can renovate IHS facilities. After such renovations, the statute authorizes IHS to provide staffing and equipment for the newly renovated structure. This is similar to the Joint Venture project. The section 1634 initiative needs to get underway.

3. The Rural Community Hospital Demonstration Program

Third, SEARHC encourages the Committee to support the extension of the Rural Community Hospital Demonstration Program (RCHD). This program allows small rural hospitals that are too large to be Critical Access Hospitals to use cost-based reimbursement rates for billing Medicare and Medicaid. This project is vitally important to rural hospitals like Mt. Edgecumbe, where our costs of providing services are much higher than other areas of the country. Without this program, we would experience negative Medicare margins on inpatient services. In effect, we would be forced to subsidize the treatment of Medicare eligible patients, while other programs do not.

Thanks to the RCHD program, in 2012 we were able to recover $3.1 million more for Medicare patients receiving inpatient services. This translates into care that is closer to home and closer to family that in the long run leads to better outcomes and cost savings.

Without congressional intervention, however, our ability to participate in this program will end in 2015. Rural hospitals already face barriers to providing services because of our remoteness, which include the difficulty in hiring medical professionals, high costs for transporting patients, high costs for shipping goods, and many other costs. The RCHD Program significantly eases some of these burdens. We hope that this Committee can ensure that the RCHD program continues beyond 2014.

Thank you for the opportunity to offer testimony today on the 2015 appropriation for the Indian Health Service.