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

Hearing on the Fiscal Year 2016 Budget

Testimony of Michael Douglas, Vice-President/Chief Legal Officer
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My name is Michael Douglas and I serve as the Vice-President and Chief Legal Officer to the SouthEast Alaska Regional Health Consortium (SEARHC). I am honored to be here to testify before this Committee about SEARHC's priorities and I thank Chairman Calvert, Ranking Member McCollum, and all members of the Committee for the opportunity to do so.

SEARHC is an inter-tribal consortium of 15 federally-recognized Tribes situated along the southeast panhandle of Alaska. Our service area stretches over 35,000 square miles, and with no roads connecting many of the rural communities we serve, we work hard to provide quality health services to our communities. These 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 provide these services through a network of community clinics and the Mt. Edgecumbe Hospital located in Sitka, Alaska.

The urgent health care needs across Indian Country are well known and the challenges in meeting those needs are heightened in areas like Southeast Alaska where communities are isolated and transportation and facilities costs are high. SEARHC applauds the Administration for recognizing these needs by increasing the IHS budget. It is vital that these increases be preserved. But even these increases will not be enough to allow SEARHC and other tribal organizations to meet the health care needs of the people we serve. We will meet these challenges, but to do so we will need your help.

Facilities Funding

Our greatest need is for increased facilities funding. We reported to this Committee last year on this topic and another year of use has only increased those needs. At 67 years old, the Mt. Edgecumbe Hospital is the oldest facility in Alaska and one of the oldest in the Nation. According to IHS's Facilities Engineering Deficiency System, the cost to update SEARHC's facilities is $29,600,000. This results in potential health telecommunications and electric outages, which translates into potential interruptions in critical care services including emergency services. Further, the funding deficiency delays many necessary improvements, impacts physician staffing, and hurts SEARHC's ability to expand and enhance services, such as tele-health. And we are not unique. Estimates place IHS facilities funding needs at $8.13 billion, a number that keeps on rising because IHS lacks sufficient funding to maintain these

facilities. We do our best to patch the problem, but the bottom line is that without adequate facilities, SEARHC cannot provide adequate services.

We request the Committee do four things.

Replace aging IHS facilities. We need a commitment from Congress to start replacing aging IHS facilities. This will require reordering the current facilities priority list, which was created on a first come, first served basis. All rankings should be based on true need.

Increase facilities funding in the current budget proposal. The President's budget contains modest funding increases for facilities needs, totaling $179 million. While we applaud the Administration for taking this first step, it is only a first step, addressing only 2% of the $8.13 billion needed. Similarly, the President's budget proposes for the first time in years, an increase in Maintenance and Improvement funds of $35 million, for a total of $89 million in M&I funding. That said, there is a critical maintenance backlog of $467 million. This means that $378 million of critical maintenance is not going to be addressed. We strongly encourage the Committee to increase the facilities funding in the IHS budget.

Joint Venture Projects. The JV project provides IHS funds to staff facilities built with tribal funds. SEARHC submitted a proposal in the most recent Joint Venture project funding round. Despite receiving a very high score, our proposal to build a facility on Prince of Wales Island was not selected. And in fact, of the 37 applications submitted, only 13 were put on a list to eventually receive funding. The fact that qualified projects were not selected is evidence of the fact that the need for such facilities far outstrips IHS's willingness to enter into these agreements.

Our situation is a good example. Currently, our hospital in Sitka serves people living as far away as Klawock. Travel to Sitka requires a lengthy combination of automobile, ferry, and airplanes and takes at least a day and often is an overnight trip. If weather is bad, as it often is in Southeast Alaska, it can take even longer. The only alternative are costly air ambulance flights. We proposed to construct a Critical Access Hospital in Klawock. This would have strengthened the primary care service in the area, while first the first time also offering complex diagnostic services and acute and emergency care to one of the remotest, most rural area of the Nation. Despite the overwhelming need for these services, our project was rejected.

In order to provide funding for this project, as well as the other JV projects that were not selected this year, we urge this Committee to direct IHS to enter into more Joint Venture Agreements.

The Indian Health Care Improvement Act (IHCIA) renovation program. Finally, we recommend the Committee provide funding for tribally renovated IHS buildings, pursuant to section 1634 of the IHCIA. The IHCIA allows Tribes to renovate IHS facilities and authorizes IHS to provide staffing and equipment for the newly renovated structure, mirroring the JV program. But Congress has never funded this program. We strongly urge the Committee to realize the promise of this program by providing $10 million to fund it. We would be delighted to do an Alaska demonstration project for this new initiative.

Contract Support Costs

In recent years, much progress has been made on the issue of contract support costs, thanks in large part to this Committee. First, Congress's decision to fully fund contract support costs in 2014 recast the issue from one of contention to one of cooperation. And Congress's continued support for full CSC funding has continued to strengthen the relationships between tribal organizations and the Federal Government.

Now we see a new opportunity for your leadership on this issue. The President has requested that, starting in 2017, CSC be funded as a mandatory three-year appropriation. While SEARHC supports the idea of mandatory CSC appropriations, we strongly believe that it should not be limited to three years. As the President's budget request reflects, CSCs are amenable to a mandatory appropriations scheme because they are recurring every year and are required to be added to all new programs that tribal organizations contract from IHS or the BIA. Plus, mandatory appropriations would ensure that neither IHS nor the BIA ever has to redirect funding from direct programs to CSC funding, as the IHS did this year. All these reasons will apply equally five years from now as they do today, and there is no reason to only implement mandatory appropriations for three years. We therefore urge the Committee to work with other relevant committees to support a permanent mandatory appropriation for CSC.

We also hope the Committee will address the Administration's apparent plan to now keep each tribal organization's contract open for five years after the end of the contract year for reconciliation purposes. This approach is simply unworkable. Even now, IHS struggles to get funding out on time, when it is only facing reconciling one year back while also working on the current year funding issues. Trying to reconcile 5 years of contracts plus the current year will frankly be an unnecessary and avoidable disaster. Plus, neither IHS nor our tribal organizations can afford the considerable time such a reconciliation process would demand. It is in al the parties' interest to quickly finalize the amounts needed under the last year's contract so that we can focus on the current year. We therefore request this Committee direct IHS to finalize contract support cost payments to all Tribes within 60 days of the end of each contract period.

We also urge the Committee to include language in the appropriations act making clear that IHS must pay contract support costs on MSPI and DVPI program funds. Despite years of acknowledging that CSC are due on these program funds, IHS recently reversed course and required Tribes to cover CSC costs with program funds. This is contrary to Congress's clear directive in the Indian Self-Determination Act and should be addressed immediately.

Rural Communities Hospital Demonstration Program

SEARHC renews our request from last year that the Committee members support the extension of the Rural Community Hospital Demonstration Program (RCHD). This program supports hospitals like Mt. Edgecumbe that are located in rural areas but do not qualify as critical access hospitals. Because these hospitals do not qualify as critical access hospitals, they would generally be required to bill at the standard Medicare and Medicaid rates. But in rural areas, the costs of providing services are much higher than in other areas of the country and thus the standard rates undercompensate rural providers. The RCHD remedies this problem by allowing qualifying hospitals to use cost-based reimbursement rates for billing Medicare and Medicaid.

Over the past three years, 2012 through 2014, SEARHC recovered $8 million more for inpatient services provided to Medicare-eligible individuals. Without this program, SEARHC would lose money on inpatient Medicare services. As a rural hospital, SEARHC is the least able to absorb such negative margins. We already pay more in every step of the health care delivery chain, from increased cost for providers, to increased transportation costs, to increased food and shipping costs. We simply cannot afford to subsidize treatments to Medicare-eligible individuals.

As important as the RCHD program is, it is due to sunset at the end of this fiscal year. It is vitally important to SEARHC, as well as many other tribal organizations that run rural hospitals, that this program be extended. We hope you will become advocates for this program so that hospitals like Mt. Edgecumbe can continue to provide services in remote areas.

Communities Health Center Funding

SEARHC also urges the Committee members to support adding additional monies to the Community Health Center (CHC) Fund in 42 U.S.C. § 254b–2. This Fund, which provided critical dollars to fund CHCs, is due to run out at the end of this fiscal year.

11 of SEARHC's clinics are Communities Health Centers. This program allows us to provide vital services to remote and underserved communities. Without the CHC Fund, we will have to reduce our services and perhaps even close some of our health centers, leaving individuals without access to primary care in their home communities. A trip to the doctor would mean traveling hundreds of miles by boat or plane. Important care will be foregone, routine care will be deferred, and health outcomes will worsen.

We therefore encourage all Committee members to support appropriating more funds to the CHC Fund.

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Thank you for the opportunity to present to the Committee on SEARHC's priorities.