HOUSE COMMITTEE ON APPROPRIATIONS SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES

FY 2026 BUDGET FOR THE INDIAN HEALTH SERVICE

Testimony of Monique Martin, Vice-President, Intergovernmental Affairs
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My name is Monique Martin, and I serve as Vice-President of Intergovernmental Affairs for the Alaska Native Tribal Health Consortium (ANTHC). ANTHC is a statewide tribal health organization serving all 229 tribes and all Alaska Native and American Indian (AN/AI) people in Alaska. ANTHC provides a wide range of statewide public health, community health, environmental health, and other programs and services for Alaska Native people and their communities.

I am pleased to submit this written testimony on several areas of the fiscal year 2026 in the Indian Health Service (IHS) budget, including contract support cost and section 105(l) issues; the need to provide current services increases for pay costs, inflation, and population growth; medevac and high cost travel challenges in Alaska, and the need for adequate funding for Purchased and Referred Care; and a recommendation to use existing Sanitation Facilities Funding to establish an Operation and Maintenance (O&M) program.

Mandatory Appropriations for Contract Support Costs and 105(*l*) leases

ANTHC applauds the Committee's solution in FY 2015 to create an indefinite discretionary appropriation within a fixed discretionary appropriation to cover the legal obligation of contract support costs (CSC) and 105(*l*) leases costs. While the permanent solution would have been to move the legal requirement for these payments to the mandatory side of the budget, doing so was deemed a potentially insurmountable undertaking as compared to the solution currently in place. That said, the continued presence of an indefinite appropriation within a discretionary agency budget to pay a mandatory obligation of unknown amount, as well as the recent *San Carlos* decision, has produced its own challenges for the Administration and for this Committee.

Given these new realities, **ANTHC continues its longstanding recommendation that mandatory IHS CSC and 105(l) lease payments be moved to the mandatory side of the budget.** Among other means of accomplishing this goal, ANTHC continues to support the enactment of legislation establishing a permanent and indefinite appropriation for CSC and 105(l) lease payments.

ANTHC further urges the Committee to create a similar indefinite appropriation for village-built clinics in Alaska, consistent with the treatment of 105(l) leasing.

Current Services Increases

IHS current services include those costs associated with medical and non-medical inflation, pay act increases, and population growth. Current services estimate the required funding that is necessary to maintain the current levels of health care services. These costs related to inflation, personnel, and a growing Alaska Native population are unavoidable. Unless these costs are funded, they will erode the base budgets of Tribal health care providers resulting in less access and timely health care for AN/AI people. Preserving the health care program by funding current services results in timely access to healthcare and improved health outcomes by allowing for early detection and treatment of diseases, better management of chronic conditions, reduced complications, and ultimately, a lower risk of mortality. Essentially, getting care when needed leads to better overall health and quality of life.

Over the last ten years, Congress has only provided the IHS with funding for inflation, pay costs, or population growth only four times.[1] The Alaska Tribal Health System has been at the forefront of providing high quality health care while at a crossroads of increasing demand for higher acuity care and deepening financial instability. The IHS and Tribal health providers across the United States continue to confront persistent workforce shortages, severe fractures in the supply chain for drugs and supplies, and high levels of inflation, collectively increasing hospital costs to care for patients. At the same time, hospital costs have been met with inadequate increases in reimbursement by public payers, as well as increasing administrative burden due to inappropriate commercial health insurer practices. These issues have created an environment of financial uncertainty for many Tribal hospitals and health care providers operating with little to no margin.

The issues described above are compounded by the fact that Congress has not consistently or adequately funded current services in the IHS appropriation. IHS estimates that current services in FY 2025 will cost at least $345 million. This includes tribal and federal pay costs ($124 million), medical and non-medical inflation ($123 million), and population growth ($98 million). These resources will help the IHS to maintain services at the FY 2023 levels by shoring up base operating budgets of IHS, Tribal, and urban Indian health programs in the face of increasing costs.

ANTHC recommends that the Committee fund at least $345 million for current services in the FY 2026 appropriation. Anything less will continue to erode the buying power of IHS and Tribal health budgets.

Medevac Travel Cost and Purchased and Referred Care

Alaska's remote, large geographic area and very rugged terrain and extreme weather conditions are significant challenges to travel and delivering care in the state. These challenges also serve as an ongoing obstacle to the development of broadband infrastructure that is essential for telehealth capability, which can help alleviate the need to travel for health care in certain circumstances. These travel issues have always been a concern for Alaska, but the more recent increase in costs associated with travel, as well as overall inflationary changes, have exacerbated

[1] In FY 2024 inflation $109.1 million; FY 2018 inflation $93.9 million; FY 2017 inflation $50.3; and FY 2016 pay costs $19.5 million.

these challenges.

Transportation is a necessity in accessing health care and addressing on-going health conditions. Both primary health care and chronic disease care requires clinician visits, medication access, and changes for treatment plans in order to receive the very best quality of care. However, without transportation, delays in clinical interventions can result and patients are more likely to have incomplete preventive cancer screenings, worse chronic disease control, and increased rates of acute care utilization for hospitalization and emergency department visits.

ANTHC and partners of the Alaska Tribal Health System have incurred extremely high costs for air travel, medevac, lodging and other related travel costs when patients seek care at the Alaska Native Medical Center (ANMC). The Purchased and Referred Care (PRC) program budget covers patient travel costs when seeking care at ANMC. Because of the increasing costs for travel, for the first time in decades, many Alaska Tribal health programs are exhausting their PRC budgets before the end of the fiscal year. Tribal health providers feel the strain of inadequate transportation in the administration of health programs too. In the current healthcare environment where physician and nursing shortages are rampant, last-minute scheduling changes may result in unfilled timeslots, underutilization of valuable finite resources, and increased wait times for other patients. A secondary effect is lost third-party resources that help to cover travel expenses or be used to expand care for other patients.

Because of the importance of travel to receive healthcare in Alaska, ANTHC is requesting the Committee provide at least a $75 million increase for the PRC program. We are keenly aware of the unobligated balance issue that affects IHS federally operated programs and that this may be a significant contributing factor in not receiving PRC increases over the last six years. Because of this potential, **we urge the Committee to direct IHS to examine the policies for PRC and work to facilitate timely distribution of PRC funding of authorized travel for acute care services in extremely rural and frontier states.**

<u>Sanitation Facilities Operation and Maintenance</u>

Water and sanitation facilities are an integral component of IHS disease prevention activities that have brought potable water and constructed or rehabilitated waste disposal facilities for Tribal communities since 1960. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally related diseases have been dramatically reduced by about 80 percent since 1973. However, adequate sanitation infrastructure remains critical as Tribes continue to respond to respiratory disease like the COVID-19, influenza, and other infectious disease that can be prevented through basic and essential sanitary living conditions.

The Bipartisan Infrastructure Law (BIL) provided $3.5 billion over five years for the IHS Sanitation Facilities Construction (SFC) Program to address the 2021 estimate for all reported sanitation deficiencies in the Indian health system. Despite the historic level of funding in the BIL for sanitation projects, the need and inflation now exceed the amount of funding that Congress provided. As with other infrastructure issues in Tribal communities, the need to complete sanitation projects remain great. The magnitude of the sanitation facility needs increase

is due to the underlying challenges of construction cost inflation, construction material availability, material supply chain challenges, and failing of existing sanitation infrastructure.

Despite the sizable investment that the BIL will provide to meet sanitation needs, it is clear that additional funding will continue to be needed to support extreme inflation costs associated with these types of projects. Equally important, is the growing need for ongoing operation and maintenance (O&M) funding to support the federal investment that has been made in these projects and maximize their useful life. The Indian Health Care Improvement Act (IHCIA) provides IHS with the authority to fund O&M assistance for—and emergency repairs to—Tribal sanitation facilities, when necessary to avoid a public health hazard or to protect the federal investment in sanitation facilities.

However, IHS has reported to Congress that it is not able to fund O&M because resources have not been appropriated specifically for this purpose. Unfortunately, the lack of O&M resources has historically led to total sanitation system failure, which disrupts access and undermines the public health success of the water and sanitation programs. In the absence of external financial assistance, Tribes are often forced to utilize their limited funds to support O&M activities for sanitation infrastructure. In many instances support may not be available at all because the Tribes may not have the resources or expertise to carry out these functions that require technical support to maintain and repair. Continued dependence on this practice will ensure inadequate O&M of sanitation systems, and will continue to shorten the useful life of existing sanitation systems or expedite the need for total replacement.

In the FY 2024 – 2027 budget recommendations to IHS and the Administration, Tribes have recommended funding to establish an O&M program. In light of the Tribe's national support for this, **ANTHC recommends the Committee provide $10 million to fund a pilot project to develop the criteria, funding methodology, and work requirements for establishing O&M programs.**

Thank you for the opportunity to offer this testimony on behalf of ANTHC and the Alaska Tribal Health System.