National Indian Health Board
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Testimony of the National Indian Health Board
House Natural Resources Committee Hearing:
Examining Federal Facilities in Indian Country
Thursday, June 17, 2021

Chairwoamn Leger Fernandez, Ranking Member Don Young and Members of the Committee, thank you for holding this critical hearing "*Examining Federal Facilities in Indian Country*." On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, NIHB submits this testimony for the record.

Background – Federal Indian Health Facilities in Indian Country

The Indian Health Service (IHS) system is comprised of 46 hospitals (24 IHS operated, 22 Tribal) and 556 health centers, health stations, village clinics, and school health centers (85 IHS operated, 471 Tribal). At these facilities there were an estimated 40,494 inpatient admissions and 13.752 million outpatient visits in 2018[1].

On average, IHS hospitals are 40 years of age, which is almost four times older than other U.S. hospitals, which have an average age of 10.6 years.[2] A 40-year old facility is about 26 percent more expensive to maintain than a 10-year-old facility. IHS facilities are grossly undersized – by about 52% – for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. To provide additional space for primary healthcare services, in many cases, the management of existing facilities had to relocate to ancillary services outside the main health facility; often times to modular office units. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and creates numerous inefficiencies within the health care system. Furthermore, these aging facilities are largely based on simplistic, outdated design which makes it difficult for the agency to deliver modern services.[3] Improving healthcare facilities is essential for:

- Eliminating health disparities
- Increasing access
- Improving patient outcomes
- Reducing operating and maintenance costs
- Improving staff satisfaction, morale, recruitment and retention
- Reducing medical errors and facility-acquired infection rates
- Improving staff and operational efficiency
- Increasing patient and staff safety

[1] Source: Indian Health Service. Fiscal Year 2021 Congressional Justification. See page CJ-279
[2] Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals (2015 ed., pp. 176-179): https://aharesourcecenter.wordpress. com/2011/10/20/average-age-of-plant-about-10-years/
[3] The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress. Indian Health Service. July 6, 2016. Accessed at https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_ FacilitiesNeedsAssessmentReport.pdf on November 7, 2016. p. 12

At current rates of funding, if a new facility was built today, it would not be replaced for 400 years! The absence of adequate facilities frequently results in the patient delaying treatment or not seeking it at all prompting worsened symptoms; and/or referral of patients to outside communities. This delay in treatment significantly increases the cost of patient care and causes travel hardships for many patients and their families. The amount of aging facilities escalates maintenance and repair costs, risks code noncompliance, lowers productivity, and compromises service delivery. In recent years, AI/AN populations have substantially grown, resulting in severely undersized facility capacity in relation to the current population, particularly the capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services, even if staffing levels are adequate.

Over the last several years, investigators at the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) have cited that outdated facilities directly threaten a patient's care. For example, in more than half of the hospitals surveyed by the OIG in 2016, administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance" with the Medicare Hospital Conditions of Participation (CoPs).[4] "Further, according to administrators at most IHS hospitals (22 of 28), maintaining aging buildings and equipment is a major challenge because of limited resources. In FY 2013, funding limitations for essential maintenance, alterations, and repairs resulted in backlowegs totaling approximately $166 million."[5] Other facilities are just not designed to be hospitals, and IHS has had to work around historical buildings which are not equipped for a modern medical environment.[6]

For many AI/AN communities, these failing facilities are the only option of healthcare that patients have. Tribal communities are often located in remote, rural locations and many patients do not have access to other forms of health insurance to get treated elsewhere. AI/AN patients, who are often elders and youth, deserve healthcare facilities that are safe and provide the best care possible. However, those goals are difficult to achieve when facilities are in disrepair, overcrowded, and medical equipment has outlived its useful life.

Policy Recommendations

To ensure that Federal Indian healthcare facilities are funded and equipped to handle the health needs of AI/AN benificiaires, NIHB urges the Committee to pass the following policy priorities.

1. **Create a mandatory appropriation account for the status and legal obligation to pay Contract Support Costs (CSC) and 105(l) lease agreements, to avoid competition with discretionary funding that could be directed to other program increases.**

The Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5324(l) authorizes IHS to enter into a lease for a facility upon the request of a Tribal Nation or Tribal organization for the administration or delivery of programs, services, and other activities under the Act. Lease requests have

[4] Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI-06-14-00011.
[5] Ibid, p. 14.
[6] Ibid, 15.

grown exponentially in the past four years, with many Tribal Nations increasingly turning to 105(l) leases in response to the chronic underfunding of facility maintenance, repair, and replacement costs.

As held by the U.S. District Court for the District of Columbia under Maniilaq Association v. Burwell in 2016, Section 105(l) leases must be paid in full by IHS. However, in response to growing lease proposals and after failing to adequately project costs in both FY 2018 and FY 2019, IHS chose to disregard Tribal recommendations, obtained through government-to-government consultation, by unilaterally reprogramming critical funding twice from other line items to fund these obligations. This included $25 million in FY 2018 from inflationary increases, as well as $72 million in FY 2019 from inflationary increases and staffing packages due to delays in construction. For FY 2020, Congress provided $125 million for 105(l) lease funding, an $89 million increase from the FY 2019 enacted level. While this increase helped to prevent another large reprogram within the IHS budget, it impacted overall funding for IHS by consuming approximately 50% of the agency's total appropriations increase in FY 2020.

For FY 2021, IHS supported a separate, indefinite appropriation for 105(l) leases, in accordance with long-standing recommendations from Tribal Nations. While Tribal Nations are pleased that Congress honored NIHB's guidance and provided a separate, indefinite appropriation for this binding obligation, it is only a short-term solution to address the impacts of rising 105(l) costs. Although this mechanism insulates other IHS budget lines from future reprogramming, IHS' estimate of total funding for 105(l) obligations is funded as a part of its total allocation from Congress.

With every likelihood that this obligation, and therefore, IHS' estimate, will grow, Tribal Nations are concerned that 105(l) costs could have detrimental impact on overall increases for IHS, including funds for patient care. It is with this in mind that the NIHB continues to urge that funding for 105(l) leasing be moved to the mandatory side of the federal budget. NIHB urges IHS to support this move as a way to ensure that its other lines are truly insulated from its binding obligations.

NIHB asks that IHS convene a joint Tribal-federal workgroup to assist with policy development around 105(l) lease negotiations and calculations. The Workgroup further expects that any 105(l) leasing policy be developed in consultation with Tribal Nations.

2. Fully fund critical infrastructure investments for Tribal facilities, healthcare facilities construction, and demonstration projects.

The Indian health system is beset by antiquated and largely deficient health care facilities that are largely unequipped to respond to the COVID-19 pandemic. The average age of an IHS hospital is 40 years, compared to 10 years for mainstream hospitals. IHS facilities are only able to accommodate about 52% of need based on AI/AN population sizes. Especially in small villages and remote Tribal locations, there is no ability to place a patient in isolation especially while waiting for a care referral. While most medical equipment has an average useful lifespan of six years, medical and laboratory equipment in most IHS facilities are more than twice as old as that. This poses a serious public health risk for entire Tribal communities. IHS and Tribal hospitals have a severe shortage of beds in intensive care units (ICUs), and/or lack of inpatient facilities altogether. Going further, many of the hospital and clinic facilities lack the space to provide mandatory reoccurring services such as dialysis treatment. There is an urgent need to not only fund those facilities on the Health Care Facilities Construction Priority List (Priority List), but to

help fund the construction costs for the Joint Venture Construction Program (JVCP) and for the Small Ambulatory Program (SAP).

There is significant concern that without an influx of funding many JVCP projects will be delayed or lose resources for construction projects. There is a need to fund the construction costs of all the JVCP projects for all Tribes and Tribal organizations that satisfied eligibility for the past and current JVCP competition. SAP funds are particularly important for Tribes that are not on the Priority List or participating in JVCP to address COVID-19 health care facility construction needs. The SAP is especially critical for those Areas that have no IHS or Tribally operated hospitals. There is significant concern that without immediate funding relief for health facilities in Indian Country, the Indian health system will buckle under this emergency. IHS and Tribes need equitable and flexible funding not only to increase hospital and clinic capacity and the shortage of hospital beds, but also to acquire and construct shelters of opportunity – such as by renovating Tribal gymnasiums or other suitable facilities to serve as triage units, along with other priorities.

Maintenance and Improvement (M&I) funds are the primary source for maintenance, repair, and improvements for facilities that house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. The M&I program funding is distributed through a formula allocation methodology based on health facility industry standards. Current funding levels for M&I are below about 78% of the total needed for all eligible facilities. The backlog of essential maintenance and repair is estimated to be $767 million to fully fund all M&I needs. Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy health accreditation standards.

Tribes have waited for years for the funding to alleviate lack of space and old infrastructure in order to increase the quality of patient health care. Navajo Area has three facilities on the Priority List which are the Pueblo Pintado Health Center, the Bodaway-Gap Health Center and the Gallup Indian Medical Center). Phoenix Area's two major inpatient replacement projects include two hospitals - the Phoenix Indian Medical Center (PIMC) and the White River Indian Hospital and in the Tucson Area, the Sells Indian Hospital. Tribes in Nevada (Phoenix Area) began discussions in their Master Plan in 2015 to increase specialty care services in that state as there are no IHS hospitals in that region since the closure of the facility in Schurz, Nevada. They sought alternatives other than traveling to PIMC in Phoenix for these services which is not optimal and puts patients at risk or exponential use of Purchased Referred Care (PRC) resources. They worked on the concept of a specialty care facility through the PIMC project, but were apprised that it may require Congressional authorization.

The Indian Health Care Improvement Act (IHCIA) encourages the establishment of projects that use alternative or innovative methods of delivery of health care services. Essential specialty health care services are difficult to access for many AI/AN people in Contract Health Service dependent areas. One solution is to fund demonstration projects that include planning, design, construction, and staffing of a regional specialty referral centers to improve access to specialty care.

An important provision of the law under the new priority system, is the establishment of an Area Distribution Fund in which a portion of health facility construction funding could be devoted to all Service Areas. It requires that the Department of Health and Human Services (HHS) Secretary shall consult and

cooperate with Indian Tribes and Tribal organizations, and confer with urban Indian organizations (UIOs), in developing innovative approaches to address all or part of the total unmet need for construction of health facilities. It also requires each IHS Area to generate an updated priority list every three years for a combined submission of top Area priorities to the U.S. Congress. A robust Tribal consultation and conferring process will help to identify the most pressing facility and infrastructure needs in each Area and ensure that these needs are addressed more expeditiously.

Lastly, Tribal Leaders commend the IHS policy that all new Health Care Facilities Construction funded projects include an additional 4% of the necessary resources dedicated to the incorporation of sustainability features into construction projects. Tribal values align with promoting human health and energy efficiency which lessen any negative environmental impacts on Tribal lands in the construction process:

- At least $21 billion for Healthcare Facilities Construction, including but not be limited to, support for new and current planned projects, the Small Ambulatory Health Center Program, UIOs, the Joint Venture Construction Program, and innovative approaches to addressing unmet construction needs for health facilities as described in 25 U.S.C. §1631(f).
- At least $10 billion in facilities construction funding that is available outside of the current Healthcare Facilities Construction Priority System (HFCPS) as a new, equitable source of funding that will provide access to construction funds and demonstration project funds for Tribes that do not qualify under HFCPS criteria.
- At least $2.9 billion for Sanitation Facilities Construction.
- At least $2 billion for behavioral health facilities.
- At least $1.8 billion for equipment.
- At least $750 million for maintenance and improvement of IHS and Tribal facilities.
- At least $580 million devoted to incorporating sustainability features into construction projects (new and existing facilities)

3. Provide Greater Health Care Access and Financial Support for I/T/U Facilities

Medicare and Medicaid play an integral role in ensuring access to health services for AI/AN people and provide critically important funding support for the Indian health system overall. In fact, in many places across Indian Country, the Centers for Medicare and Medicaid Services (CMS) programs allow for Indian health system sites to address medical needs that previously went unmet as a result of chronic underfunding of the Indian health system. The role of the CMS programs in Indian Country goes beyond advancing general program goals and meeting the needs of individual healthcare consumers. As an operating division of HHS, CMS owes a Trust Responsibility to the Tribes, as that solemn duty runs from the entire federal government to all federally recognized Tribes.

In addition to the benefits these programs provide to enrollees, Medicare and Medicaid also support the Indian/Tribal/Urban (I/T/U) system by enabling facilities to collect third-party revenue. Third-party revenue significantly contributes to the financial stability of Indian health system clinics and hospitals.

According to a 2019 report by the Government Accountability Office[7], between Fiscal Year 2013 and Fiscal Year 2018, third-party collections at IHS and Tribal facilities increased by $360 million, with 65% coming from Medicaid, a substantial portion by any measure. Moreover, data show that the number of AI/ANs with Medicaid increased from 1,458,746 in 2012 to 1,793,339 in 2018. The 334,593 increase in Medicaid coverage is a 22.94% increase over 2012. In 2018, 33.55% of all AI/ANs had Medicaid compared to 29.55% in 2012. During that same period, Medicare collections grew 47% from $496 million in FY 2013 to $729 million in FY 2018. To ensure financial health, Indian Country must protect and strengthen access to third party revenue within the Indian health system and ask that Congress:

- Authorize Medicaid reimbursements across all states to allow Indian health system providers to receive Medicaid reimbursement for all mandatory and optional services described as "medical assistance" under Medicaid and specified services authorized under the Indian Health Care Improvement Act (IHCIA)—referred to as Qualified Indian Provider Services—when delivered to Medicaid-eligible AI/ANs.
- Create an optional eligibility category under federal Medicaid law providing authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level (FPL).
- Extend full federal funding through a 100% Federal Medical Assistance Percentage (FMAP) rate for Medicaid services furnished by Urban Indian Organizations (UIOs) to AI/ANs.
- Clarify that AI/AN exemptions from mandatory managed care applying to plans enacted through state plan amendments (SPA) also apply to all waiver authorities.
- Amend Section 105(a)(9) of the Social Security Act in order to clarify the definition of "Clinic Services" and ensure that services provided through an Indian health care program are eligible for reimbursement at the OMB/IHS all-inclusive rate, no matter where service is provided.
- Exempt AI/ANs from any additional restrictions, such as work requirements, that may be placed on Medicaid access.
  Exempt IHCPs from any measures, such as limiting retroactive eligibility, that are designed as a cost-saving measure for the state

4. Establish a 21st Century Health Information Technology (HIT) System at IHS

HHS provides the technology infrastructure for a nationwide healthcare system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS Health Information Technology (HIT) also supports the mission-critical healthcare operations of the I/T/U with comprehensive health information solutions, including an Electronic Health Record (EHR) and more than 100 applications.

A properly resourced IHS HIT program directly supports better ways to: 1) care for patients; 2) pay providers; 3) coordinate referral services; 4) recover costs; and 5) support clinical decision-making and reporting, all of which results in better care, efficient spending, and healthier communities. The Resource and Patient Management System (RPMS) – used by IHS and many Tribal health programs—depends on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture

[7] See https://www.gao.gov/assets/710/701133.pdf

(VistA). The RPMS manages clinical, financial, and administrative information throughout the I/T/U, although it is deployed at various levels across the service delivery types.

In recent years, many Tribes and several UIOs have elected to purchase their own commercial off-the-shelf (COTS) systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and allow for smoother navigation and use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system. When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), Tribes ramped up their efforts to re-evaluate the IHS HIT system and explore how Veterans Health Administration (VHA) and I/T/U EHR interoperability could continue. Tribes have significant concerns about Tribal COTS interoperability with RPMS, and the overall viability of continuing to use RPMS.

- Provide funding needed to establish a fully functional and comprehensive health IT system for the Indian health system that is fully interoperable with Tribal, urban, private sector, and Department of Veterans Affairs (VA) HIT systems.
- Offset costs for Tribes that have already expended to modernize their system in the absence of federal action.
- Provide additional time for Indian health system providers to comply with CERT 2015.
    - Current legislative language only allows for five years of exemptions. It will take more time for IHS get the RPMS system CERT 2015.

Conclusion

Tribal treaties stand the test of time. The treaties are the Supreme Law of this land. If a Nation's honor and exceptionalism is a measure of its integrity to its own laws and creed, then one must look no further than the United States' continued abrogation of its own treaties to recognize that its honor is in short supply. Every square inch of this nation is Tribal People's land. As the sole national organization committed to advocating for the fulfilment of the federal government's trust and treaty obligations for health, NIHB will always be dedicated to bringing into fruition the day where all Tribal People can state with dignity that the United States held true to its solemn word. Ideally, fulfillment of trust and treaty obligations should be without debate and the U.S. should honor its promises. This includes ensuring that Tribes have up to date facilities and adequate infrastrucutre to care for their populations.

In closing, NIHB thanks the Committee for the continued commitment to Indian Country and urge you to further prioritize Indian healthcare facilities in upcoming legislation. Tribes patiently remind you that federal treaty obligations to the Tribes and AI/AN People exist in perpetuity and must not be forgotten during this pandemic. As always, NIHB stands ready to work with you in a bipartisan fashion to advance health in Indian Country.