The Confederated Tribes of the Colville Reservation

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Subcommittee on Indian, Insular and Alaska Native Affairs

Legislative Hearing on H.R. 2662, the "Restoring Accountability in the Indian Health Service Act of 2017"

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On behalf of the Confederated Tribes of the Colville Reservation ("Colville Tribes" or the "CCT"), I thank you for this opportunity to provide testimony on the "Restoring Accountability in the Indian Service Act of 2017," H.R. 2662.

My name is Andy Joseph, Jr., and I am a member of the Colville Business Council, the governing body of the Colville Tribes, and serve as the Chair of the Council's Human Services Committee. I also serve as the President of the Portland Northwest Area Indian Health Board, which has 43 federally recognized member tribes in Oregon, Washington and Idaho and serves as the health advocacy organization for the Northwest region. I provide this testimony in my capacity as a representative of the Colville Tribes.

As an initial matter, I would like to express the Colville Tribes' thanks to Congresswoman Kristi Noem and her staff for their work over the past year in developing this legislation. I would also like to thank the staff for this Committee, who toured the health facilities on the Colville Reservation last year and heard directly from our staff about the challenges they face in providing care to our members.

H.R. 2662 addresses several long-standing issues with the Indian Health Service ("IHS") and would benefit the Colville Tribes and other tribes in many ways. The Colville Tribes supports H.R. 2662 and urges the Committee to move the legislation forward through the legislative process. We offer some specific recommendations on how the bill can be clarified to garner even broader Indian country support.

BACKGROUND ON THE COLVILLE TRIBES

The present-day Colville Reservation is approximately 1.4 million acres and occupies a geographic area in north central Washington State that is slightly larger than the state of Delaware. The Colville Tribes has more than 9,500 enrolled members, about half of whom live on the Colville

Reservation. In terms of both land base and tribal membership, the Colville Tribes is one of the largest Indian tribes in the Pacific Northwest.

Most of the Colville Reservation is rural timberland and rangeland and most residents live in one of four communities on the Reservation: Nespelem, Omak, Keller, and Inchelium. The Colville Tribes has a large IHS service area and these communities are separated by significant drive times. The CCT's primary IHS facility is in Nespelem, WA, and residents from Inchelium that require care must drive, in many cases, more than 90 minutes through two mountain passes. Although the CCT has contracted some discrete IHS activities under Pub. L. 93-638, the IHS directly provides most of the healthcare services on the Colville Reservation.

STAFFING INEQUITIES IN THE IHS SYSTEM

The Colville Tribes has, for decades, endured chronically low staffing levels. On December 17, 2013, the Colville Business Council adopted a resolution declaring a state of emergency on the Colville Reservation in response to immediate IHS staffing shortages and a large number of current and forecasted vacancies. In response to a congressional inquiry resulting from that declaration, the IHS calculated that the Colville Service Unit had less than one third of the required number of clinical staff and only one quarter of the required number of dental staff.

For the Colville Tribes and similarly situated direct service tribes, facility staffing ratios are essentially set when the initial IHS health facility opens for operation. These levels may increase incrementally as the IHS base budget increases, but they can never be brought anywhere close to what is needed in modern times.

The only way for a tribe to update its staffing levels to reflect growth and modern health delivery needs is to either construct a new facility with IHS funds under the Health Care Facility Construction Priority List ("Priority List") or construct a facility using tribal funds under the Joint Venture construction program. The Priority List has been closed since 1992 and solicitations for the Joint Venture program are offered very infrequently and are extraordinarily competitive.

Direct service tribes that have not been able to update their staffing ratios through these two IHS programs <u>are essentially frozen in time</u> for staffing ratio purposes. For the Colville Tribes, these historic staffing ratios date back to the late 1930s when the U.S. Public Health Service converted a Department of War building for use as the Colville Service Unit's health clinic. This historic facility—which the CCT understands from former IHS officials was removed from the Priority List in the 1980s because of its historical significance—was used as the CCT's primary health clinic until the CCT used its own tribal funds to construct a new facility. That facility opened in June 2007.

Staffing shortages not only increase the wait times for patients, but in the CCT's case, they have also had other consequences. Lack of health providers has resulted in fewer patient encounters, which has had a negative domino effect on the CCT's Purchased/Referred Care funding and user population. The staffing shortages have also prompted other health care providers to seek other employment because many of the patients in their respective panels have chronic illnesses that multiply the number of visits in their annual workloads.

Despite increases to the IHS's base budget in recent years, the Colville Tribes' staffing ratios have not improved. This is because increases for IHS staffing in the President's Budget request have been earmarked to staff new facilities that come online that were constructed under either the Priority List or the Joint Venture programs. Again, for direct service tribes like the CCT that have been unable to build anything under those IHS construction programs, our staffing ratios are frozen in time. In our case, the 1930s.

THE SECTION 109 STAFFING DEMONSTRATION PROJECT PROVIDES AN INNOVATIVE APPROACH TO ADDRESSING STAFFING INEQUITIES

The Staffing Demonstration Project in Section 109 would provide a mechanism to address these inequities by authorizing the IHS to deploy an infusion of staffing resources to federally managed IHS Service Units. While temporary, the deployment of staff is intended to enable Service Units to incorporate the additional staff into their billing and collection processes to enable the staff to be self-sustaining and permanent. The Staffing Demonstration Project could be funded separately but, as drafted, it is intended to allow the IHS to utilize carryover or other available funds.

Section 109 would address a much-needed void in the IHS system by providing a path for tribes with historically low staffing ratios to update those ratios. With the advances in opportunities for third party billing in the last reauthorization of the Indian Health Care Improvement Act, if successful, the Staffing Demonstration Project could be a model to address staffing inequities throughout the IHS system. We greatly appreciate that this language was included in the bill and strongly support it.

OTHER COMMENTS AND RECOMMENDATIONS

Although the CCT is primarily a direct service tribe and most of H.R. 2662 is intended to address issues applicable to direct service tribes, we recommend that language be added that clarifies the applicability of H.R. 2662 to tribally-operated facilities. We believe that tribally-operated facilities would likely want the opportunity to opt-in to certain provisions of the Act, such as the parity in pay requirements in Section 101, but might also want to opt out of certain provisions as well. We encourage further discussion with tribes and tribal organizations to clarify application of H.R. 2662 to tribally operated facilities.

Sec. 101. Incentives for Recruitment and Retention: The Colville Tribes strongly supports Section 101, which would direct the Secretary to establish a pay system for physicians, dentists, nurses, and other health care professionals employed by the IHS comparable to the pay provided by the Department of Veterans Affairs. We also support authorizing the IHS to reimburse relocation costs. Despite whatever recruiting challenges might exist, the IHS has an obligation to provide adequate care to federally managed service units. The Colville Service Unit is in a rural area and these tools are necessary to attract and incentivize health providers to take jobs there.

Sec. 102. Medical Credentialing System: This section would direct the Secretary to consult with Indian tribes and any public or private association of medical providers, government agencies, or relevant experts in developing an IHS-wide credentialing system. While the CCT appreciates the

need to standardize credentialing, we are concerned that directing the Secretary to consult with private associations may provide an opportunity for those associations that do not share tribal goals to cause mischief or erect barriers in developing credentialing standards.

Sec. 105. Improvements in Hiring Practices: Section 105 would amend the IHCIA to authorize the Secretary to directly hire candidates to vacant positions within the IHS. The section also directs the Secretary to notify each Indian tribe located within a geographic Service Area and, in some instances, obtain a waiver of Indian preference laws from each Indian tribe concerned. The CCT is concerned about the directive for the Secretary to obtain a waiver of Indian preference from tribes. We recommend additional discussion on this provision with Indian tribes and tribal organizations.

Sec. 106. Removal or Demotion of IHS Employees Based on Performance or Misconduct: The Colville Tribes strongly supports this section. While the Colville Service Unit has not experienced the personnel issues that other IHS areas have reported regarding problem personnel, these tools should be available for all IHS areas.

Sec. 202. Fiscal Accountability: The Colville Tribes strongly supports Section 202, which would direct the Secretary to use unobligated or unexpended funding to support essential medical equipment, purchased or referred care, or staffing. The Colville Tribes is troubled by reports that the IHS has carried over significant funds from year to year. The CCT was also disturbed that in 2015, the IHS paid $80 million from funds that could have otherwise been used for staffing to the Laborers' International Union of North America to settle overtime claims.

There has long been a lack of transparency in how the IHS spends its appropriated funds. Had Indian country known that this $80 million was available, it could have used it for needed programs and services. The IHS needs congressional direction on how it should use unobligated or unexpended funds and Section 202 is a good start.

Sec. 303. Reports by the Comptroller General: The Colville Tribes strongly supports Section 303, which would direct the U.S. Comptroller General to develop and submit to Congress three reports. With regard to the staffing report in Section 303(b)(2), the CCT recommends additional specificity be added to ensure that the formulas or methodologies that the IHS has previously used and currently uses to assess staffing needs are identified in the report. The Colville Tribes has received conflicting information from the IHS about these issues in past years when it was attempting to ascertain what its needed staffing levels should be.

This concludes my testimony. Thank you for allowing the Colville Tribes to testify today. I would be happy to answer any questions that the members of the Committee may have.