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

HEARING ON THE PRESIDENT'S 2017 BUDGET REQUEST

Testimony of Brandie Miranda Greany, Treasurer Riverside-San Bernardino County Indian Health, Inc.

I am Brandie Miranda Greany and I am a member of the Pechanga Band of Luiseno Indians and the Treasurer of Riverside-San Bernardino County Indian Health, Inc. Thank you for the opportunity to testify about the 2017 appropriations for the Indian Health Service.

Riverside-San Bernardino County Indian Health is a consortium of nine Tribes located in Riverside and San Bernardino counties. Our member Tribes are the Pechanga Band of Luiseno Indians, the Cahuilla Band of Indians, the Santa Rosa Band of Cahuilla Indians, the Ramona Band of Cahuilla Indians, the Soboba Band of Luiseno Indians, the Torres-Martinez Desert Cahuilla Indians, the Agua-Caliente Band of Cahuilla Indians, the Morongo Band of Mission Indians, and the San Manuel Band of Mission Indians. We operate several health centers under a self-governance compact with the Indian Health Service and we are very proud of the vast array of services offered at our clinics, including medical, dental, optical, behavioral health, pharmacy, laboratory, environmental health, community health representative, and nutrition services.

We serve over 15,000 Native Americans and 3,000 related family members, and experience over 100,000 patient visits each year. Our service area includes two of the largest counties in the contiguous United States, so our member Tribes have joined together to develop a way to economically and efficiently provide health care services for our people. We also provide health care for three other local Tribes: the Twenty-Nine Palms Band of Mission Indians, the Cabazon Band of Mission Indians, and the Augustine Band of Cahuilla Indians. Almost two-thirds of our patients come either from these three local Tribes or from members of other non-consortium Tribes who reside in our two-county service area.

Given the number of patients we treat, our IHS dollars can only go so far. But we are thankful for the support of Congress and the funding provided to ensure our people are healthy. We also cannot thank you enough for listening to the tribal representatives that appear at these hearings every year to share their experiences. We were very appreciative that Congress heard our voices last year, and we hope you will continue to pressure IHS to honor the government's trust responsibility to provide culturally-competent and high-quality health care for Native Americans.

Mandatory CSC Appropriations

I want to take this opportunity to express my sincerest gratitude for this Committee's heroic work to achieve full funding for our compact with IHS. We were only able to find a path forward on this contentious issue because of the Committee's unrelenting determination to make

this issue a key priority in its work to uphold the trust responsibility and contractual obligations of the United States to our Native Nations.

The Committee heard our tribal testimonies and included critical language moving CSC to a separate account and providing uncapped appropriations to ensure that our contracts would be fully honored. The committee's action eliminates the threat from IHS—a threat realized in FY 2015—to cut direct care services in order to fully honor our contracts. Fortunately, this Committee took the steps necessary to protect programs and services from this threat, and we agree with the Committee's approach for dealing with this issue.

There is one aspect of the new language which we hope will be changed moving forward. At the agency's insistence, a proviso was included which addresses the tracking of unspent CSC funds. Unintentionally, this proviso will lead to serious problems, and it should be removed. First, it creates an extremely complicated accounting for those funds, with no value to the federal government, the taxpayer, or the tribes. Second, existing law (namely, the Indian Self-Determination Act of 1975) already addresses how to account for unspent funds and commands that such funds must be spent in the next year to carry out the compact or contract. Existing law has worked well for over 40 years, and we therefore strongly urge that the Committee remove this provision in FY 2017 and future years.

Lastly we respectfully request that the Committee direct the Secretary of Health and Human Services to promptly file her annual CSC shortfall reports. Reports have not been filed for FY 2012-2015, and the last data published for FY 2011 is over 5 years old.

RPMS Computer System

For decades, the Indian Health Service has utilized the RPMS computer system as both a practice management software and an electronic health record (EHR). It serves as the patient registration, scheduling, healthcare record, and population management tool, and also as the third party billing system. Although IT technology has rapidly transformed healthcare in the United States, the IHS RPMS system has failed to keep up. The Federal government has invested billions to incentivize hospitals and providers to digitize health records, but IHS's RPMS computer system struggles to develop and make products available that are functional. The roll out to the users and the utility of the RPMS system lags far behind systems found in the private sector.

In short, IHS's RPMS system is falling far behind standard healthcare industry requirements. It has always been cumbersome, but now is so difficult to use that our doctors are unable to document their services accurately, timely, or completely. This is a red flag that the patients and providers who depend on the HIS system of care are in serious jeopardy.

IHS leadership insists that the RPMS shortcomings are caused by a lack of resources. This may be true. After all, the IHS budget for research and development is zero, while only $20 million was requested for IHS IT upgrades in 2017. The VA has 2,000 computer programmers, compared to IHS's 120 computer programmers. Worse yet, IHS has a 3-year backlog for user

requests which grows every year. Simply stated, IHS has not invested adequate resources into the RPMS system and this failure is adversely impacting the ability of the Tribes to provide healthcare services to Native Americans.

The most recent disaster related to this issue was the failed implementation of the new ICD-10 codes that were to be in place last October 1, 2015. IHS was unprepared with the RPMS computer system and its roll out to Tribes. Even more frustrating for the Tribes is that IHS seems to be unable to correct these problems for many years to come. IHS states that it does not have the resources to make these changes within the next few years, yet it doesn't ask Congress for the necessary help to remedy the problem. This leaves the Tribes in an untenable position.

Today, Tribes are left to their own solutions, which includes considering outside vendors to purchase an Electronic Health Record system that includes Patient Records, Dental, Optical, Pharmacy, Behavioral Health Services, Registration, Coding, and Billing. But these EHR software systems are very expensive, and most Tribes simply do not have the financial resources needed to purchase them. Most Tribes have therefore been left with no choice but to keep the IHS RPMS computer system, despite its failure to properly transition to the required ICD-10 conversion.

Overall, the impact to patient care is unacceptable, and the impact to program operations and the distribution of costs is untenable. Rather than invest in software solutions that would allow the programs to operate efficiently, the poorly designed RPMS system distributes and multiplies the cost of delivering healthcare. While America's healthcare industry is massively improving the functionality of EHR systems, IHS lags far behind and patient care is suffering.

We recommend that this Committee direct IHS to purchase an outside Electronic Health Record system that will bring the Tribes into the 21st Century for medical recordkeeping. IHS must stop throwing good money into an old, out-dated RPMS system. IHS could spend millions to try to upgrade the RPMS over the next few years, but that effort is doomed to fail because the RPMS platform is simply ill-suited to today's demands. The far less costly option is to direct IHS to do an open market purchase of a modern-day EHR system. We recommend that the Committee direct that IHS provide an estimate and a spending plan for what it would cost to purchase and install such an EHR system.