Committee on Natural Resources Subcommittee on Indian and Insular Affairs
"Examining the President's FY 2025 Budget Request for the Bureau of Indian Affairs, Indian Health Service, and Office of Insular Affairs."

May 8, 2024

Questions from Rep. Westerman *for the Hon. Roselyn Tso, Director – Indian Health Service, U.S. Department of Health and Human Services:*

Your written statement stated the need for a modernized Electronic Health Record at the Indian Health Service. Can you provide further details on the ongoing modernization effort, and what further steps are needed for full implementation?

The Indian Health Service (IHS) is leading a multi-year endeavor to modernize our mission-critical health information technology infrastructure. The existing IHS electronic health record (EHR) system is over 40 years old, is built on outdated technology, and is unsustainable. The Government Accountability Office identified the IHS EHR as one of ten critical federal legacy systems most in need of modernization. Since 2018, IHS has conducted extensive planning and evaluation to determine the best options for modernizing the system. In 2022, the agency decided to pursue replacement and begin the procurement activities. The agency awarded a ten-year contract to General Dynamics Information Technology in November 2023 to build a new EHR.

The EHR Modernization build-out is in its early stages and will be approached in three tiers which include: (1) Enterprise Design and Build; (2) Pilot Design & Implementation; and (3) iterative Cohort Implementations across Indian Country. The current work status focuses on constructing the cloud infrastructure that will host the new enterprise EHR, as well as configuring and testing 200+ unique applications within the EHR solution to use in the delivery of safe, high-quality care. This first tier is expected to take at least the next 12-18 months. It will include close collaboration with clinical and administrative subject matter experts who will be users of the system.

As more discovery is conducted, IHS will be able to provide more refined timelines reflective of the entire effort. These timelines will be substantially dependent on the availability of requested appropriations. Full implementation of a new EHR requires approximately $4.5 to $6.2 billion to complete the efforts within ten years and within the period of performance of the existing contract. Annual funding delays or budget cuts to this program will increase the implementation time.

Can you provide further information on the 2024 IHS Agency Work Plan, specifically discussing how the 2024 Plan's goals align with the actions IHS needs to take to meet the criteria set forth by GAO to remove the IHS from GAO's High-Risk List?

The IHS found that many of the root causes related to the GAO high risk list included issues with internal communications, management oversight, capability and capacity, and prioritizing the use of funds to address important work. The 2024 Agency Work Plan includes activities to help address these root causes, such as increasing oversight of facility budgets, improving PRC authorization and payment process, creating a care management system to help patients navigate the IHS health care system, and

consistent oversight of the funds received for sanitation facilities construction program projects from the Bipartisan Infrastructure law.

Additionally, the IHS is in the process of updating the agency strategic plan for fiscal years 2024-2028. The new strategic plan uses a High Reliability Organization (HRO) as the framework to address the GAO high risk list and the associated root causes. The continued effort to complete the 2024 Agency Work Plan, the establishment of the new strategic plan, and using the HRO framework creates an agency-wide strategy for success that is all-inclusive and considers risks and demands when making informed decisions and prioritizing action.

The 1993 Priority List for the IHS construction projects has not been completed. Why has it taken over thirty years to finish this priority list? Besides funding, what other considerations have impacted the delay in the completion of the list?

Beyond funding limitations, other setbacks include inflation, which has lessened the buying power of the funding appropriated by Congress to IHS. There is also the impact of new services – the IHS has authority for new health care services which are planned for each new facility. Incorporating the new service capabilities into our facilities raises the cost of each facility and delays other future projects. For example, the Phoenix Indian Medical Center (PIMC) replacement hospital concept had to be revised for the inclusion of new service, Inpatient Behavioral Health and Specialty Services. These new services increase the size of the facility not just for those Health services but all of the support services (facility management, housekeeping, property and supply, administration, laboratory, Pharmacy and others) in the facility. . Finally, another impact involves assimilating new requirements for health care accreditation and the cost of operating facilities, which delay projects further down the priority list.

After the 1993 Priority List is completed, how will the IHS decide on new facility construction priorities?

In language accompanying the Fiscal Year (FY) 2000 Appropriations (P.L.106–291), Congress directed IHS, in consultation with the tribes, to review and revise the existing Healthcare Facility Construction Priority System (HFCPS). The HFCPS uses a variety of factors to estimate the need for a new healthcare facility with facility resources deficiency having the highest weighted value. The data needed to complete this scoring include the existing facility space, the current facility age, the facility condition, the cost to replace the existing facility and the IHS User Population for the facility's service area. The other scoring criterion will utilize available data metrics to determine the need for health care facility creating more of a data driven approach. The HFCPS would limit the number of facilities identified for status on the project priority list and thus minimize the potential for a large backlog of projects sitting for years on the Priority List without funding.

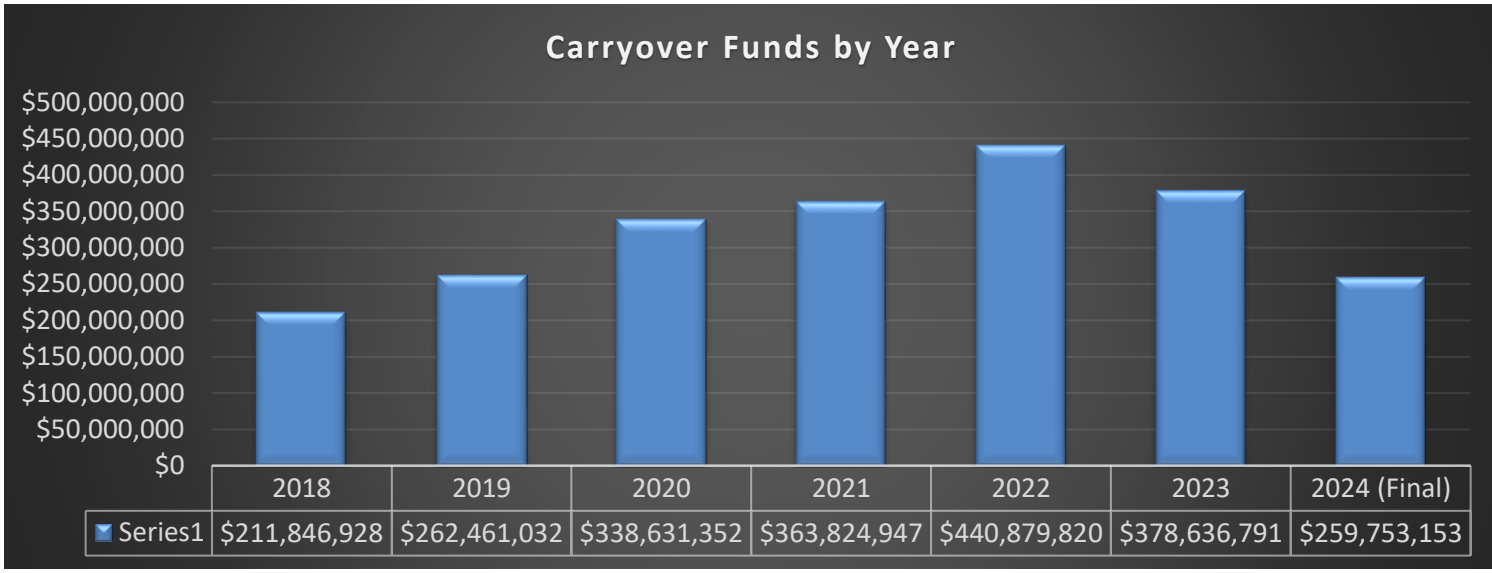
And how will the delays in the finalization of the 1993 Priority List impact the way the IHS moves forward this time?

The IHS is addressing broader health care access needs for American Indian and Alaska Natives (AI/AN) by seeking other funding opportunities and partnering with the tribes to build health care space, but these efforts are limited. The 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress Reports to Congress | Newsroom (ihs.gov) indicates that "Overall health care facility construction need grew from $14.5 billion in 2016 to $23 billion in 2021, a 59 percent

increase".

Your written testimony stated that the IHS is working on to improve the Purchased and Referred Care program and obligate these funds in a timely manner. Can you provide the Committee with the total number of PRC funds carried over from the last fiscal year for all regions? And is the amount carried over been more or less compared to fiscal year 2022?

The IHS carried over approximately $378 million in fiscal year 2023 marking a 14 percent decrease from $440 million in fiscal year 2022. The IHS saw its largest carryover in fiscal year 2022 and we have steadily decreased our carryover thereafter. Furthermore, in fiscal year 2024, the IHS saw a 31 percent decrease with a total carryover amount of $259 million, marking the lowest carryover since fiscal year 2019. Most efforts are ensuring that we properly pay for care and adjust to the newly expanded medical priorities. See chart below for further details.



What additional improvements to the PRC program is the agency working towards this fiscal year, particularly to ensure PRC funds are used in a timely manner?

The IHS continues to work on improving the PRC program. In this fiscal year, IHS aims to prioritize two issues that will improve the PRC Program, first, the PRC Carryover, and second, the PRC Authorization and Payments process.

Agency Priority 1 - PRC Carryover:

IHS in Quarter 2 FY 2024 established funding guidance, strategic spend plans and carryover thresholds. Direct actions are now focused on areas/sites with high carryover. Although we have standardized a majority of these sites, others have unique issues that we are continuing to work on to address individually. Areas and Headquarters now have better visibility and can better identify and manage proper spending for each Federal PRC program. Those efforts have already reduced service unit prior

year funding by **28 percent** since October 1, 2023, with significant progress made in the Albuquerque, Billings, Great Plains, Oklahoma, and Navajo Areas. All these Areas are in line to meet the IHS national target carryover threshold of between 10-25 percent. Overall, IHS can demonstrate through our March 2024 PRC Metric data that we have the funds necessary to provide and advance patient care access with **84 percent** of all sites covering all medical priorities 1-3 referrals.

Agency Priority 2 – PRC Authorization and Payment

Data from IHS PRC metrics indicate a 36 percent staffing vacancy rate. IHS is also in the process of issuing its first set of standardized Position Descriptions to promote and elevate the value of PRC positions to retain and recruit valuable personnel. We have also completed the revised staffing model that places emphasis on additional staffing levels to adequately process referrals and payments. IHS completed revisions to the PRC policy to establish "yes" culture and patient centric mindset such as the reasonable person determination, reducing drive time standards from 90 minutes to 60 minutes, and revising the definition of "elder" from 65 to 55 years of age. It also establishes a revised framework for medical review committees to be conducted on a daily basis to expedite the medical review process allowing for PRC claims to be processed quicker. The Policy also includes the updated Medical Priorities (fully implemented on January 1, 2024) that expanded medical priorities to support a holistic, balanced, outcome oriented, and consistent referral system. Additional information on our Medical Priorities | Purchased/Referred Care (PRC) (ihs.gov).

IHS has taken direct actions to enhance the PRC Fiscal Intermediary reporting tool and ultimately reduced the number of pended claims. We have seen a total decrease of **13.2 percent** in pended claims since our efforts began in January 2024. Furthermore, this marks the lowest number in past two years, demonstrating active reduction in pended claims by **28 percent** from our highest mark in December 2022. Along with these actions, IHS has established PRC Metrics that contain critical PRC data set for area and service unit leadership to monitor including funds management, referral processing metrics, denials, and vacancy data. This provides real-time monthly data to assess current operations within our facilities. All sites are actively reporting data within the PRC metrics power dashboard. We are also working on a PRC Referral Dashboard that builds upon the PRC metrics and establishes a referral processing workflow of tracking referrals from start to finish with insight into the timeliness of referral processing, such as time to approval, time to appointment, average wait time to see provider, etc. Alpha testing is underway. IHS has also strengthened referral language to clearly articulate IHS responsibility and the patient no liability clause within the IHCIA for approved/authorized referrals.

Catastrophic Health Emergency Fund regulations were published on August 30, 2024 and will become effective on October 29, 2024. The updated regulations decreases the threshold from $25,000 to $19,000 which will increase the number of cases that can be authorized for reimbursement.

Lastly, IHS is partnering with OMB's High Impact Service Provider (HISP) program to develop patient engagement assessments. HISPs are selected due to the scale and critical nature of their public-facing services and annually conduct comprehensive assessments of their high-impact services, measure their customer experience maturity, and identify actions to improve service delivery.

The Subcommittee has heard concerns surrounding the recruitment and retention of healthcare workers at IHS facilities, especially in rural America. What is the current vacancy rate, service-wide, for health

care workers in federally managed health units?

The current rates are as follows.

Vacancy Rate Overall	Physicians Vacancy Rate	Nurse Vacancy Rate	Advanced Practice Nurse Vacancy Rate	Dentist Vacancy Rate	Pharmacist Vacancy Rate	Physician Assistant Vacancy Rate	Behavioral Health Vacancy Rate
30%	36%	34%	35%	37%	27%	32%	44%

How does this compare to tribally run health units?

IHS does not have this information, nor an estimate, as tribes are not required to report this information to the IHS.

What is the average timeline from job announcement to onboarding for a new hire?

Current systems have deficits in providing this metric, but the IHS is currently working on a Qliksense application development and launch that will provide IHS-wide information.

And what process barriers should be addressed to ensure timely hiring of healthcare workers?

Some of the process barriers include a) lack of automated human resources systems; b) highly complex laws, regulations, and policies governing the hiring process, including c) those pertaining to Indian Preference, that human resources staff must navigate; and d) a complicated federal recruitment process for applicants to navigate. In addition, the Commissioned Corps process for initial officer call to active duty is lengthy, sometimes causing needed healthcare professional applicants to accept other opportunities.

Questions from Rep. Grijalva for the Honorable Roselyn Tso, Director for the Indian Health Service, U.S. Department of Health and Human Services

One of the principles underlying IHS's budget justification is recruiting and retaining health care professionals.
Could you elaborate on the declining medical employee and trainee recruitment and retention rates within IHS facilities and what factors contribute to poor recruitment and retention rates?

Competition with the public and private sector is a top reason for recruitment and retention issues. This pertains to compensation, student loan repayments, flexibility with scheduling, more desirable locations, etc. Remote and rural locations mean fewer opportunities and amenities for employee families, and housing can be scarce and expensive. In addition, for certain health care professions, the fact that fewer students are graduating from medical programs increases the competition for talent. Complex government hiring regulations and the added complexity of Indian Preference law also create difficulties with recruitment and hiring.

Please expand on how lack of funding for the housing for medical professionals is affecting Indian Country, especially in rural tribal areas?

Many rural/remote locations do not have housing available. In some situations, employees who are not American Indian/Alaska Native are not able to purchase or rent houses on the reservation where the hospital or clinic is located. While the IHS has a program to build employee housing, it is not funded to meet all needs. IHS is piloting a housing subsidy program that may increase recruitment and retention in some locations, but funding of this program remains unsecured on a wider basis, and system issues prevent easy implementation.

What strategies is IHS implementing to address recruitment issues and to promote staff retention?

IHS employs various compensation strategies and flexibilities to attract candidates and retain employees. These include recruitment, relocation, and retention incentives and special salary rates as well as service credit for annual leave, housing subsidies, student loan repayment, grant programs, and scholarships. IHS also applies recruitment and outreach strategies to attract health care professionals at all stages of their careers. Through additional surveys and the strategic use of current employee survey information, the IHS hopes to further understand and address retention issues.

Could you provide the Committee with the number of projects remaining on this list, their status, and the cost needed to complete them?

The costs displayed in this table are current estimates of the current scopes of work with the current schedule. Any change in the scope or schedule will change the funding needed. Currently Gallup Indian Medical Center and Albuquerque are not fully planned and the estimated cost will increase. All projects will increase if schedules change. This chart is in thousands of dollars.

Facility	Appropriated	Total Project cost	Funding required	Phase of the Project
Phoenix Indian Medical Center	84,728	3,220,456	3,135,728	Planning complete
Whiteriver Hospital	199,000	1,049,000	850,000	Design begun
Gallup Indian Medical Center	66,000	1,192,000	1,126,000	Early planning
Alamo Health Center	132,396	161,000	28,604	Design complete
Pueblo Pintado Health Center	231,400	231,400	0	Design complete
Bodaway Gap Health Center	232,200	257,200	25,000	Tribal contract in design
Albuquerque West Health Center	164,143	252,143	88,000	Later planning

Albuquerque Central Health Center	20,734	361,734	341,000	Early planning
Sells Rural Hospital	150,008	673,008	523,000	Early design

How does the status of this list constrained IHS' healthcare facilities?

The facility construction backlog hampers IHS' ability to meet the needs of health care construction for those communities that did meet the criteria to be on the priority list in 1993 but currently have a greater need than those on this list.

How does the limited capacity issue affect IHS' patient population relying upon those facilities?

The facilities of the IHS network are widely dispersed among 37 states in approximately 660 locations. Some 600 of these health care delivery campuses are located on or near American Indian and Alaska Native (AI/AN) communities where travel can be difficult, especially where transportation options are unavailable or limited by long distances and harsh climatic conditions. For most of these rural communities, the IHS and the Tribal health care campuses offer the only feasible source of health care services as alternatives are few or non-existent. Practical access to local health care sites is crucial for the AI/AN population, which is burdened by low health status compared with other Americans.

After the completion of all priority construction projects, what will be the next steps for IHS? Does IHS have a plan of action for other facilities construction?

The IHS will use the Healthcare Facility Construction Priority System (HFCPS) methodology to accomplish next steps including a Comprehensive National Listing of Facility Need by identifying the total need for construction of IHS and Tribal health care facilities, and by prioritizing that need for the authorized facilities construction programs. The prioritized project lists will only contain projects that can be reasonably be funded in a five-year period.

The HFCPS can only evaluate, identify, and prioritize facilities that are part of an Area Health Services and Facilities Master Plan and that are reporting statistical data to the IHS National Patient Information Reporting System (NPIRS). IHS' and Tribal effort is to update and maintain the area master plans so that data for the HFCPS is available when needed. This effort has limited funding, which hampers this process.

The Special Diabetes Program for Indians has been instrumental in addressing the diabetes epidemic in Indian Country. The FY2025 budget request includes $260 million in proposed mandatory funding for the Special Diabetes Program for Indians and two proposals to exempt the program from mandatory sequester and reauthorization for the program.

Could you briefly expand on the impact this program has had on addressing diabetes in tribal communities?

The Special Diabetes Program for Indians (SDPI) funding has enabled staff and programs at the local and national levels to increase access to diabetes treatment and prevention services throughout the

Indian health system. The following table demonstrates substantial increases in access to many activities and services between 1997 and 2019:

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2019	Absolute Percentage increase
Diabetes clinical teams	30%	95%	+65%
Diabetes patient registries	34%	96%	+62%
Nutrition services for adults	39%	94%	+55%
Access to registered dietitians	37%	85%	+48%
Culturally tailored diabetes education materials	36%	96%	+60%
Access to physical activity specialists	8%	84%	+76%
Adult weight management services	19%	76%	+57%

*Data in table above taken from the Annual Progress Reports submitted by SDPI grant recipients

At the same time in which access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained since the inception of SDPI. Examples of positive outcomes include:

- The average blood sugar level (as measured by the A1C test) among AI/ANs with diabetes served by the IHS has decreased from 9.0 percent in 1996 to 7.9 percent in 2023. (Source: IHS Diabetes Care and Outcomes Audit).
- The average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 87 mg/dL in 2023, surpassing the goal of less than 100 mg/dL. (Source: IHS Diabetes Care and Outcomes Audit).
- The rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline than in any other racial group in the U.S. (Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. doi: http://dx.doi.org/10.15585/mmwr.mm6601e1)
- For the first time, diabetes prevalence in AI/AN adults has decreased – and has done so consistently for 4 years, dropping from 15.4 percent in 2013 to 14.6 percent in 2017. (Benoit SR, Hora I, Albright AL, et al. New directions in incidence and prevalence of diagnosed diabetes in the USA. BMJ Open Diab Res Care 2019;7:e000657. doi: http://dx.doi.org/10.1136/bmjdrc-2019-000657)
- Diabetes-related mortality for AI/AN people decreased 37 percent from 54.2 per 100,000 in 1999 to 34.4 per 100,000 in 2017. (National Center for Health Statistics. Health, United States, 2018. Hyattsville, MD. 2019. https://www.cdc.gov/nchs/hus/contents2018.htm#Table_005)
- Hospitalizations for uncontrolled diabetes among AI/AN adults dropped 84 percent from 57.9 per 100,000 in 2000 to 9.4 per 100,000 in 2015. (Agency for Healthcare Research and Quality (AHRQ). Data Spotlight: Hospital admissions for uncontrolled diabetes improving among American Indians and Alaska Natives. AHRQ Publication No. 18(19)-0033-7-EF. December 2018. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/dataspotlight-aian-diabetes.pdf)
- The prevalence of diabetic eye disease (retinopathy) has decreased in AI/AN adults by more than

50 percent compared to reports from the 1980s and 1990s. This represents a substantial reduction in the risk of vision problems and blindness in AI/AN adults with diabetes. (Bursell SE, Fonda SJ, Lewis DG, Horton MB. Prevalence of diabetic retinopathy and diabetic macular edema in a primary care-based teleophthalmology program for American Indians and Alaskan Natives. PLoS One 2018;13(6):e0198551. doi: https://doi.org/10.1371/journal.pone.0198551)

Without SDPI, progress in diabetes prevention and treatment would likely either stall, worsen, or reverse, resulting in poorer health and higher costs.

Why is it so important to exempt the program from mandatory sequesters?

Mandatory sequestration of the SDPI decreases funding by 2 percent ($3 million). This puts the grant recipients at risk for a reduction in their annual grant funding, which is necessary to sustain/maintain their diabetes prevention and treatment programs. Many of the grant recipients are already underfunded, and they rely on SDPI funding to address the lack the infrastructure to meet the diabetes needs of their communities. Staffing is one of the challenges with grant-funded programming. The uncertainty of funding from year-to-year makes it difficult to retain staff and compete with the private sector positions for allied-health workers and other health professionals. An additional decrease in SDPI funding, due to mandatory sequestration, may force many programs to downsize, lay off staff, or limit the services offered to the AI/AN people within their communities.

What are the future ramifications to the health and well-being of tribal communities if the Special Diabetes Program is not reauthorized?

The SDPI currently funds 310 diabetes prevention and treatment grant programs at Tribal, IHS, and Urban sites in 35 states. The SDPI funds may be used to employ AI/AN people as well as professionals possessing cultural competency within Indian country. While some of the clinical services provided using SDPI funds are billable to some degree, most of the services for prevention, diabetes education, nutrition counseling, and case management are either not billable or are reimbursed at low rates that would not sustain the provision of those services. If SDPI is not reauthorized, many of these programs would either disappear or have to be severely scaled back. The result for Tribal communities would be a loss of the services which have contributed to significant reductions in diabetes complications for thousands of AI/AN people (see data in table above that shows substantial increases in access to many activities and services between 1997 and 201--since the inception of SDPI)

The Bipartisan Infrastructure Law (Public Law 117-58) provided $3.5 billion for IHS through FY2022 and FY2026 for the IHS Sanitation Facilities Construction Program and the FY 2025 budget submission for Sanitation Facilities Construction is $200 million. Could you briefly explain the importance of this program and how it contributes to money saved down the line in patient care?

Less than 100 years ago, conditions in Indian Country reflected an environment rife with communicable and contagious diseases that were decimating our populations. The incidence of trachoma and tuberculosis (diseases directly linked to environmental conditions) reached world record levels within Indian Country. In 1955, when the IHS assumed responsibility for AI/AN healthcare, infant and maternal mortality rates within our beneficiary population were skyrocketing beyond national averages.

Over the past 6.5 decades, the Agency's SFC Program played a key role in reducing many health disparities to levels that have nearly equalized with the American population. Public Law 86-121 has been one of the most effective pieces of legislation impacting Indian health in IHS history.

Our Agency's health initiatives cannot be realized without also addressing the environmental health conditions of our people and communities. Efforts aimed at diabetes, obesity prevention, and the treatment of alcoholism are more successful in homes and communities where safe water is available. Infectious diseases are also more readily prevented when sewage is properly disposed and clean water is available.

Improvements to sanitation facilities can reduce inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease. Based on 2023 data, the IHS estimates each dollar invested in water and sewer infrastructure could yield savings of $0.76 in avoided direct health care costs for these diseases. https://www.ihs.gov/newsroom/factsheets/safewater/

The notable achievements of the SFC Program have been substantial, but much remains to be done. Until each American Indian and Alaska Native home has access to safe water and wastewater facilities, we must keep forging ahead by constructing new sanitation facilities and systems where needed, upgrading aging infrastructure, and making the needed investment of resources to support these critical tasks. As the magnitude of the sanitation facility needs increases due to the underlying challenges of construction cost inflation, construction material availability, material supply chain challenges, and failing infrastructure, it is important that the IHS appropriation is timely and adequate to support the Tribes in addressing their sanitation needs.