The Confederated Tribes of the Colville Reservation

Prepared Statement of the Honorable Cindy Marchand, Secretary
Confederated Tribes of the Colville Reservation

House Committee on Natural Resources
Subcommittee on Indian and Insular Affairs

Legislative Hearing on the "Restoring Accountability in the Indian Health Service Act of 2023"

July 27, 2023

As a rural, land-based Indian tribe, the Confederated Tribes of the Colville Reservation ("Colville Tribes" or the "CCT") has unique challenges to providing health care for our tribal community. The CCT is a direct service tribe, which means that health care and associated billing and administrative support is provided by Indian Health Service ("IHS") employees. The CCT is in the beginning stages of contracting all IHS functions, but this process will take time. In the meantime, we have to rely on IHS to provide quality health care to our tribal citizens.

The Confederated Tribes of the Colville Reservation is a confederation of twelve aboriginal tribes from across eastern Washington state, northeastern Oregon, Idaho, and British Columbia. The twelve constituent tribes historically occupied a geographic area ranging from the Wallowa Valley in northeast Oregon, west to the crest of the Cascade Mountains in central Washington State, and north to the headwaters of the Okanogan and Columbia Rivers in south-central and southeast British Columbia. Before contact, the traditional territories of the constituent tribes covered approximately 39 million acres.

The present-day Colville Reservation is in north-central Washington state and was established by Executive Order in 1872. The Colville Reservation covers more than 1.4 million acres, and its boundaries include portions of both Okanogan and Ferry counties, two of the lowest median income counties in the state. Geographically, the Colville Reservation is larger than the state of Delaware and is the largest Indian reservation in the pacific Northwest. The Colville Tribes has just under 9,300 enrolled members, about half of whom live on the Colville Reservation.

The CCT appreciates the Committee holding today's hearing on the "Restoring Accountability in the Indian Health Service Act of 2023" (the "Act"). The CCT worked extensively with the committees of jurisdiction when the bill was first being developed in 2015. Much of the bill focuses on IHS issues that are most relevant to direct service tribes. As a direct service tribe that has endured multiple problems with the IHS's delivery of health care to our citizens during the past few years, the Colville Tribes supports the Act and believes that its reforms are long overdue.

A. Recruitment and Retention

Like other rural communities, recruiting and retaining health providers on the Colville Reservation is challenging. There is a 55 percent vacancy rate at the Colville IHS Service Unit, which is nearly *twice* the IHS-wide vacancy rate of 28 percent that IHS Director Roslyn Tso reported during her May 11, 2023, testimony before this Committee. Currently, there is a single, part-time dentist at the Colville Service Unit and many of the vacant positions have been unfilled for years.

Health providers in our area have expressed interest in providing health care services on the Colville Reservation but have indicated they would only do so if they contracted directly with the Colville Tribes and bypass having to work through IHS. Providers have indicated to us that the protracted administrative processes and problems locally with IHS's administration of the Purchased/Referred Care ("PRC") program are the primary reasons for their interest working with the CCT directly. When a doctor or other health provider applies for a vacant position at the Colville Service Unit, they will often accept a position elsewhere because they simply cannot wait for IHS to complete its background and credential review processes, which often takes months.

Every health provider vacancy at an IHS service unit creates a domino effect that negatively impacts tribes and tribal citizens. First, a provider vacancy means longer waits by IHS beneficiaries for health care. Other providers must also absorb the patient load, which often leads to providers burning out and looking for employment elsewhere.

Worse, without enough providers, the user population for a given IHS Service Unit has decreased, which ultimately reduces the Service Unit's allocation of PRC funds under the PRC distribution formula. IHS's Portland Area (which includes tribes in Washington, Oregon, and Idaho) does not have and has never had an IHS or tribally operated hospital. Without hospitals that can internalize costs, tribes in the Portland Area are particularly reliant on PRC funds to refer patients to private providers for specialty care that their facilities cannot accommodate. For a direct service tribe, a single health provider vacancy leads to multiple negative outcomes. The Colville Service Unit currently has 46 vacancies out of a total staff of 84.

The recruitment and retention provisions in Title I of the Act would help address some of these issues. Section 101 would provide parity in the pay schedules for health providers at IHS with those at the Veteran's Health Administration and would also authorize housing assistance. The CCT supports these provisions and recommends that Section 101 also add a provision that allows for incentives for service unit CEOs or other senior management positions at the service unit level. IHS recently advertised the CEO position at the Colville Service Unit and, in the Tribes' view, the pay grade was initially too low to attract the type of applicant to a rural area with the experience and qualifications necessary to implement reforms in our Service Unit.

B. Staffing Demonstration Program

The CCT is particularly supportive of Section 108 of the Act, the "Staffing Demonstration Program." The CCT developed this provision in response to its challenges to update its staffing ratios, which have not changed for nearly one hundred years.

The Colville Tribes has previously testified before this Committee regarding the unique challenges that direct service tribes face in updating their staffing levels. For the CCT and similarly situated direct service tribes, these staffing ratios are determined when their initial IHS health facility opens for operation. There are two ways for direct service tribes to update their staffing levels. One is to construct a new facility with IHS funds under the Facility Construction Priority List ("Priority List"), and the other is to build a facility using tribal funds under the Joint Venture program. The Priority List has been closed since 1992 and remaining projects will cost an estimated $6 billion to complete. Applications for Joint Venture projects are rarely offered, highly competitive, and at the expense of the tribes.

Tribes that have not been able to update their staffing ratios by constructing a new facility under the Priority List or the Joint Venture facility construction programs are frozen in time for staffing ratio purposes. For the CCT, these historic staffing ratios date back to 1927 when the U.S. Public Health Service converted a Department of War building in Nespelem, Washington, for use as the CCT's initial health clinic.

The Colville Tribes was fortunate to have been awarded a Joint Venture facility construction project in 2020 and hopes to update its staffing levels soon. Many other direct service tribes, however, continue to face challenges associated with historically low staffing levels. The Staffing Demonstration Program would allow the IHS to provide federally managed service units with staffing resources on a temporary basis with the expectation that third party revenue generated by the staff would allow them to be permanent. There is currently no other IHS program that allows this.

C. The Act Should Address IHS's Administration of the PRC Program

As noted above, the PRC program is critical for the Colville Tribes and other Indian tribes in the Portland Area because of the lack of inpatient hospital facilities. Based on the Colville Tribes' experiences in recent years, more congressional oversight of IHS's administration of the PRC program is not only warranted, but necessary, as the PRC program for direct service tribes is literally a matter of life and death.

For an approximately three-year period that ended in October 2022, the Portland Area IHS Office administered the PRC program for the Colville Service Unit in Portland using Portland Area Office staff, not local IHS employees located on-reservation. This led to catastrophic results, including deaths. The severity of these issues prompted the House Committee on Appropriations to direct IHS to brief the Committee on its efforts to improve care

at the Colville Service Unit in its report accompanying the FY 2024 Interior spending bill, which the Committee approved last week.

Once the Portland Area Office began administering the PRC program, IHS began imposing onerous documentation requirements not required by the IHS handbook or any other IHS authority on Colville tribal members to prove they were eligible for PRC funds. This meant that tribal elders and other IHS beneficiaries, on an annual basis, had to produce utility bills, certificates of Indian blood and other proof of tribal enrollment, and other information not required by the IHS regulations or the IHS handbook in order to get referrals for specialty care. Those who were unable to produce this information either went without care or obtained care on their own and subsequently faced third party collection agencies when IHS refused to pay for the services.

The Portland IHS Area Director informed the CCT in late 2022 that the additional eligibility requirements should never have been implemented. The damage had already been done, however, and there has never been accountability for those Portland Area IHS personnel that ordered the eligibility requirements implemented at the Colville Service Unit.

In addition to eligibility roadblocks, the communication and beneficiary customer service that IHS provides at the Colville Service Unit has been woeful. Two years ago, a Colville tribal elder tried repeatedly to obtain a referral for ongoing heart issues, complaining to CCT elected officials that he was unable to get calls from IHS returned or otherwise secure a purchase order for the referral by IHS staff responsible for processing them. The tribal elder died of a heart attack before securing the referral. Tragically, there have been many stories like this in the Colville Tribes' tribal community.

For those CCT members who can get referrals and receive specialty care through the PRC program, there is no way to predict if IHS will pay the provider. When IHS does not pay PRC providers in a timely manner, the providers will begin sending the medical bills to IHS beneficiaries directly.

Section 222 of the Indian Health Care Improvement Act (IHCIA) explicitly states that an IHS beneficiary should under no circumstances be liable for payment for authorized PRC services. IHS has never effectively implemented this provision, however, and providers send the bills that IHS does not pay to IHS beneficiaries anyway, which are often later referred to third party collection agencies. This has happened to scores of Colville tribal members in recent years, including CCT elected officials. The CCT is aware of instances where PRC providers have refused to make appointments with IHS beneficiaries—even those with chronic conditions—where the beneficiary has an outstanding balance to the provider that IHS has not paid and the provider has billed to the beneficiary directly.

When faced with notices from collection agencies, the few fortunate IHS beneficiaries who can afford to, will pay the bills out-of-pocket to avoid damage to their credit scores—again, notwithstanding Section 222 of the IHCIA. The IHS has no beneficiary-accessible mechanism for reimbursing IHS beneficiaries in these situations. For the vast majority of IHS beneficiaries

that cannot afford to pay the bills that IHS does not pay themselves, they must live with impaired credit scores, higher interest rates, or the inability to obtain credit altogether.

As the Committee and some in Indian country are aware, in recent years IHS has amassed hundreds of millions in unobligated PRC carryover funds and billions more in carryover funds from other IHS accounts. Despite this carryover, IHS administers the PRC program like rationed healthcare. The fact that IHS has significant PRC carryover funds and Colville tribal members and others in Indian country struggle to obtain referrals for PRC care is unconscionable. Even worse, when PRC providers do not get paid by IHS in a timely manner, the CCT has seen providers to refuse to participate in the PRC program. The Colville Reservation is in a rural, low-income area where there are only a small number of providers to begin with, so the loss of a provider participating in the PRC program because of non-payment by IHS is devastating.

The Colville Tribes has provided the Committee with language that would amend section 222 of the IHCIA to clarify IHS's duties to inform providers that the IHS beneficiaries are not liable for PRC bills and require IHS to implement a reimbursement process for those IHS beneficiaries who pay PRC bills that IHS does not pay. We urge the Committee to consider including this language in Title I of the Act.

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