Facilities Appropriation Advisory Board

For the

Indian Health Service

July 3, 2024

The Honorable Roselyn Tso
Director
Indian Health Service
5600 Fisher Lane
Rockville, MD 2857

Dear Director Tso:

The mission of the Indian Health Service (IHS) is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level. Current funding provided to joint venture projects makes it very difficult to meet this mission. Inadequate funding places a strain on financial sustainability, which compounds exponentially, year after year. The shortfall in funding leads to budgetary constraints, increasing the risk of financial instability and potentially jeopardizing the long-term viability of healthcare facilities. This not only impacts joint venture projects and federally funded healthcare facilities, but ultimately the health and wellness of First American patients across Indian country. Therefore, the FAAB is recommending the following policy changes:

100% of Staffing Funds instead of the 85%

The FAAB is recommending that instead of using the 85% level of staff for funding new facilities the IHS change their policy/methodology to use 100% level of staff for calculating the RRM budget for new facilities. The assertion is that there is no legislative prohibition in place.

IHCIA Section 818 says:

(e)(1) The Secretary, acting through the Service, shall make arrangements with Indian tribes to establish joint venture demonstration projects under which an Indian tribe shall expend tribal, private, or other available nontribal funds, for the acquisition or construction of a health facility for a minimum of 20 years, under a no-cost lease, in exchange for agreement by the Service to

provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. A tribe may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

While Section 818 specifically states that "the Service will provide the equipment, supplies, and staffing for the operation….", the IHS JVP application process gives additional credit to tribes who agree to be responsible for their own equipment costs. This is a further disadvantage to smaller tribes applying for JV projects. IHS should not penalize or award project applications for the ability to purchase or not purchase medical equipment necessary for the successful operation of the facility.

The FAAB discussed the use of the current methodology for allocating only 85% of the required staffing funds results in several adverse outcomes. Some of these include, lower staff-to-patient ratios, leading to longer wait times, delayed treatments, and reduced patient satisfaction. Consequently, patient outcomes may suffer, undermining our commitment to delivering the highest standard of care. Inadequate staffing funding creates operational challenges in maintaining adequate support staff and administrative personnel. Efficient administrative functions and ancillary services are essential for the smooth operation of our healthcare facility and the overall patient experience. And further, the lack of adequate staffing funding increases the risk of a discontented workforce, higher turnover rates, and a reduced capacity to provide comprehensive care. Competitive salaries, benefits, and professional development opportunities are essential for attracting and retaining top talent.

Sufficient Operational Funds

The FAAB recommends the IHS increase the operational funds percentage from 30% to 40% and monitor these operational costs nationally so they can be increased whenever necessary in the future to allow the system to maintain parity with not-for-profit hospitals. Without an increase in operational funding, facilities will struggle to meet the evolving accreditation requirements and standards of care, jeopardizing patient safety, health outcomes, and overall patient satisfaction.

Presently, the level of operational funding provided by IHS falls far below what is needed to cover the average operating costs across the country. The current IHS policy is to provide 30% of operational costs. The Healthcare Financial Management Association found that from 2008 to 2018, labor's share of total expenses had increased from 50.6% to 54.9% among a sample of not-for-profit hospitals. It can be assumed that the percentage has grown even higher post-COVID. Therefore, it is assumed that personnel expenses for 2025 are approximately 60% of total expenses, with operational expenses accounting for approximately 40% of total expenses.

Insufficient operational funding places strain on financial stability and long-term sustainability. Inadequate resources for operational expenses, such as utilities, maintenance,

insurance coverage, and medical supplies, hinder the ability to maintain a functional and safe healthcare facility. Without an increase in funding, facilities risk accumulating debt, compromising the continuity of services, and facing financial instability that can adversely impact the ability to serve the community.

A lack of operational funding restricts our ability to invest in the latest technologies and innovative solutions that enhance patient care, streamline workflows, and improve operational efficiency. Without an increase in operational funding, tribes are unable to leverage these advancements, inhibiting their ability to meet the evolving healthcare needs of their communities.

Full Projection-based Funding

The FAAB is recommending that the IHS ensure full staffing and operational funds be allocated once a project reaches the 10-year projected user population from the PJD/POR.

At present, IHS anticipates the construction of facilities to accommodate 10-year projected workloads. Staffing and space is also planned for this year 10 workload however, IHS allocates funding for staffing and operations solely based on the opening year of the facility. Therefore, a facility does not receive the full funding based on the facility space and user population that it has been planned to serve.

When determining the budget request, only the *bona fide needs* for the fiscal year in which the facility is inaugurated can be included. Consequently, adjustments to Resource Requirements Models (RRM) and workloads are made to align with the opening year, which reduces the numbers of planned staff and operational funds.

Two methodologies discussed during the FAAB meeting are briefly mentioned in this letter. One methodology example proposes that when the project in question reaches its 10th year from the planning date, IHS requests from Congress the remainder of the funding for the planned staff and operational costs and thus provide the balance of funds that should be allocated to that facility. Another option that could be considered is asking Congress for full funding prior to year 10 when the facility has reached the maximum projected user population that was determined in the PJD/POR. Whatever method is determined most acceptable, IHS should request that Congress provide funding using the most current years funding tables.

In closing, and on behalf of the FAAB, we value our partnership with you and the rest of your leadership at IHS. We also thank you for attending our FAAB meetings and your

commitment to address the FAAB's recommendations. Dates have not been finalized yet, but we invite you to our next FAAB meeting which will be held virtually to discuss these and other issues. Thank you for all you do to advance the mission of the IHS and Tribal health programs.

Sincerely,

Charles Grim

Charles Grim, DDS, MHSA
Chairperson, FAAB