H.R. 5406, HELPING ENSURE ACCOUNTABILITY, LEADERSHIP, AND TRUST IN TRIBAL HEALTHCARE ACT, "HEALTTH ACT"

LEGISLATIVE HEARING

BEFORE THE

SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS

OF THE

COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES

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LEGISLATIVE HEARING ON H.R. 5406, TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO IMPROVE ACCESS TO TRIBAL HEALTH CARE BY PROVIDING FOR SYSTEMIC INDIAN HEALTH SERVICE WORKFORCE AND FUNDING ALLOCATION REFORMS, AND FOR OTHER PURPOSES, "HELPING ENSURE ACCOUNTABILITY, LEADERSHIP, AND TRUST IN TRIBAL HEALTHCARE ACT," OR "HEALTTH ACT"

Tuesday, July 12, 2016
U.S. House of Representatives
Subcommittee on Indian, Insular and Alaska Native Affairs
Committee on Natural Resources
Washington, DC

The subcommittee met, pursuant to notice, at 2:04 p.m., in room 1334, Longworth House Office Building, Hon. Don Young [Chairman of the Subcommittee] presiding.

Present: Representatives Young, Benishek, Gosar, LaMalfa; Ruiz, Bordallo, and Sablan.

Also present: Representative Noem.

Mr. YOUNG. The Subcommittee on Indian, Insular and Alaska Native Affairs will come to order.

The subcommittee is meeting today to hear testimony on the following bill: H.R. 5406 from Congressman Kristi Noem to amend the Indian Health Care Improvement Act to improve access to tribal health care by providing for systematic Indian Health Service workforce and funding allocation reforms, and other purposes, or the "Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act."

Under Committee Rules, opening statements will be issued by myself and the Ranking Member. This will allow us time to hear from our witnesses. Therefore, I ask unanimous consent that all other Members who have opening statements be made part of the record if they are submitted to the Subcommittee Clerk by 5:00 p.m. today, or at the close of the hearing, whichever comes first.

And I ask unanimous consent that the gentlewoman from South Dakota, Mrs. Noem, be allowed to join us at the dais to be recognized and participate in today's hearing. Hearing no objection, so ordered.

STATEMENT OF HON. DON YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALASKA

Mr. YOUNG. We are here today to take testimony on a bill intended to address a severe problem in Indian Country. Adequate

health care is one of the most important issues to American Indians and Alaska Natives. However, the Indian Health System (IHS) direct care system is deficient, inadequate, and simply fails in areas of the country that need help the most.

In 2010, a Senate investigation report brought to light some very severe problems plaguing 1 of the 12 regions in the Indian Health Care Service, the Great Plains region. After the report was released, the agency repeatedly assured Congress that issues were being addressed. Then, roughly a year ago, the same IHS region experienced a termination of a provider agreement with Centers for Medicare and Medicaid Services (CMS) at the Winnebago IHS hospital located in Winnebago, Nebraska. CMS found repeated deficiencies at the hospital "had caused actual harm and is likely to cause more harm" to persons seeking examination or treatment.

Since 2015, CMS has found deficiencies in other hospitals in the Great Plains region. Emergency department services have been diverted to hospitals that are 45 miles away. This leaves some tribes asking not 'if,' but 'when' other hospitals may lose CMS provider agreements.

H.R. 5406, the Healthcare Act, is intended to make reforms to the Indian Health Service to help their broken system. This bill does not fix every problem in IHS; however, it is a step in the right direction for Indian County.

And again, I would like to thank the sponsor of the bill for being here today, and she will be one of our witnesses.

Before we turn to our witness, though, I want to acknowledge a group of students that I understand are here in the audience, who are part of the NCAI's Health Fellowship program, which I had the privilege of speaking to in Spokane, all of which are looking to pursue careers in the health field. I am encouraged by your interest, as I think many here in this room are, and I recognize you will play a role in the future of health care in Indian Country.

So, if you are a student, would you raise your hands, please? That is not bad. One, two, three, four, five—five? Where are the rest of you? Six? OK. Anyway, welcome to the healthcare field and this hearing, by the way.

[The prepared statement of Mr. Young follows:]

PREPARED STATEMENT OF THE HON. DON YOUNG, CHAIRMAN, SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS

We are here today to take testimony on a bill intended to address a severe problem in Indian Country. Adequate healthcare is one of the most important issues to American Indians and Alaska Natives; however the IHS direct care system is deficient, inadequate, and is simply failing areas of the country that need help the most.

In 2010, a Senate investigation report brought to light some very severe problems plaguing 1 of the 12 regions of the Indian Health Service, The Great Plains region. After the report was released, the agency repeatedly assured Congress that issues were being addressed. Then, roughly a year ago, the same IHS region experienced the termination of a provider agreement with Centers for Medicare and Medicaid Services at the Winnebago IHS hospital located in Winnebago, Nebraska. CMS found that repeated deficiencies at the hospital "had caused actual harm and is likely to cause harm" to persons seeking examination or treatment.

Since 2015, CMS has found deficiencies in other hospitals in the Great Plains region. Emergency Department services have been diverted to hospitals that are 45 miles away. This leaves some tribes asking not "if" but "when" other hospitals may lose CMS provider agreements.

H.R. 5406, the HEALTTH Act, is intended to make reforms to the Indian Health Service to help a broken system. This bill does not fix every problem in the IHS; however, it is a step in the right direction for Indian Country.

I want to thank the Sponsor of the bill and our witnesses for being here today.

But before we turn to our witnesses, I want to acknowledge a group of students here in the audience who are part of NCAI's Health Fellowship program—all of which are looking to pursue careers in the health field. I am encouraged by your interest and I think many here in this room and elsewhere recognize you will play a role in the future of healthcare in Indian Country.

Mr. YOUNG. With that, I will turn to the Ranking Member for his opening statement.

STATEMENT OF HON. RAUL RUIZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Dr. RUIZ. Thank you, Mr. Chairman. I also want to congratulate the students and encourage you to continue to reach your dreams and your goals, with a passion and compassion that you have, to serve in healthcare capacity. I am an emergency physician, and I have been in your shoes. I can tell you that it is doable, it is absolutely doable, and you can do it.

I also want to thank Congresswoman Noem for being here and discussing your bill, and to thank our other witnesses for taking the time to testify. We are here to talk about one thing, and that is health care in Indian Country. This is a chance to not only hear about the current issues at the Indian Health Services facilities and proposed solutions to address them, but to also take a hard look at the future of health care in Indian Country.

Where do we want to be when it comes to our trust responsibility to ensure the health and well-being of our Native brothers and sisters? We do know where we have been, and the results speak for themselves. American Indian and Alaska Native people have long experienced a desperate health status when compared with other Americans, including a lower life expectancy and a disproportionate disease burden.

American Indians and Alaska Natives born today have a life expectancy that is 4.4 years less than the rest of the U.S. population. American Indians and Alaska Natives continue to die at a higher rate than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes, unintentional injuries, assault, homicide, suicide, and chronic lower respiratory diseases.

There are many reasons for these health disparities, and we know that one of the contributing factors is the adequacy of the Indian health care delivery system. A recent GAO study found that the IHS has never conducted an agency-wide oversight on the timeliness of their care. Even the facilities that do attempt to track wait times are hampered by an outdated electronic health record system.

We all agree on the seriousness of the deficiencies outlined by CMS in their survey of the four Great Plains area hospitals and the effects they have had on the communities they serve. I am saddened and angry to hear about the victims of those deficiencies. And while this is just the Great Plains area, I know that we will probably hear many of the same stories from other service units in other areas; this is not unique to the Great Plains area.

We cannot provide competent, quality health care to Native American and Alaska Natives when we allow this inadequate level of facilities, management, and care. There are long-standing systemic issues at IHS that must be addressed, whether regulatory and legislatively, and the entire system needs to be brought into the 21st century.

This includes an investment in infrastructure and information technology. It includes recruitment and retention of high-quality medical professionals and administrators, starting from grade school all the way to residency and fellowship training. And it includes the ability for tribes to control their own destinies through self-governance, while guaranteeing that the Federal Government lives up to its end of the bargain.

This is the vision I see for the future of Native health care and the IHS, and I think many of my colleagues, both in Congress and the healthcare industry, would agree with me. I appreciate the effort that Acting Director Mary Smith has put forth in an attempt to address the current issues at these Great Plain area hospitals, and to establish a more proactive approach through mock surveys and other measures to prevent these issues from cropping up at other service units.

I want to thank our colleague, Rep. Noem, for shining a light on the concerns at IHS, and bringing this legislation forward. I agree with some of the proposals—in fact, most—in H.R. 5406, and I disagree with others. The fact is that we need to start talking about permanent solutions that comprehensively address long-standing issues at IHS. And I also think we need to seriously talk about finally adequately funding IHS, which includes exempting IHS and its programs from sequestration.

It strikes me as hypocritical to complain about the level of service that is provided, and then turn around and consistently underfund the very agency responsible for providing it. And I know you agree with me, as well.

There are actual lives in the balance, and they deserve better; we can do better as a community and as a country. In the end, I know that we all want the same thing. Everybody on this dais, everybody in the audience, we all want the same thing, the best healthcare system for our Native American communities.

So, I want to yield back my time and thank you, Mr. Chairman, for addressing some of these issues in the past, and bringing this to light now.

[The prepared statement of Dr. Ruiz follows:]

PREPARED STATEMENT OF HON. RAUL RUIZ, RANKING MEMBER, SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS

Thank you, Mr. Chairman. I want to thank our witnesses for taking the time to testify today. We are here today to talk about one thing—Healthcare in Indian Country.

This is a chance to not only hear about current issues at IHS facilities and proposed solutions to address them, but to also take a hard look at the future of healthcare in Indian Country.

Where do we want to be when it comes to our trust responsibility to ensure the health and well-being of our Native brothers and sisters? We do know where we have been, and the results speak for themselves. American Indian and Alaska Native people have long experienced a disparate health status when compared with other Americans, including a lower life expectancy and a disproportionate disease burden.

American Indians and Alaska Natives born today have a life expectancy that is 4.4 years less than the U.S. all races population. American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes, unintentional injuries, assault, homicide, suicide, and chronic lower respiratory diseases.

There are many reasons for these health disparities, and we know that one of the contributing factors is the adequacy of the Indian health care delivery system. A recent GAO study found that the IHS has not ever conducted any agency-wide oversight on the timelines of their care. Even the facilities that do attempt to track wait times are hampered by an outdated electronic health record system.

We all agree on the seriousness of the deficiencies outlined by CMS in their survey of the four Great Plains area hospitals, and the effects they have had on the communities they serve. Like us all, I am saddened and angry to hear about the victims of those deficiencies. And while this is just the Great Plains area, I fear that we could probably hear many of the same stories from other service units in other areas.

We cannot provide competent, quality healthcare to Native American and Alaska Natives when we allow this inadequate level of facilities, management and care. There are long-standing systemic issues at IHS that must be addressed, whether regulatory and legislatively, and the entire system needs to be brought into the 21st century.

This includes an investment in infrastructure and information technology. It includes recruitment and retention of high quality medical professionals and administrators. And it includes the ability for tribes to control their own destinies through self-governance, while guaranteeing that the Federal Government lives up to its end of the bargain.

This is the vision I see for the future of Native healthcare and the IHS, and I think many of my colleagues, both in Congress and the healthcare industry, would agree with me. I appreciate the effort that Acting Director Mary Smith has put forth in an attempt to address the current issues at these Great Plain area hospitals, and to establish a more proactive approach through mock surveys and other measures to prevent these issues from cropping up at other service units.

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It strikes me as hypocritical to complain about the level of service that is provided, and then turn around and consistently underfund the very agency responsible for providing it.

There are actual lives in the balance, and they deserve better. We can do better. In the end, I know that we all want the same thing—the absolute best heath care system for our Native peoples.

Thank you, Mr. Chairman, and I yield back.

Mr. YOUNG. I thank the gentleman, and one thing that I want to make clear—in Alaska, I believe—I may be wrong—the IHS role with contracting is only with the Native organizations, and it works very well, and I think we ought to look at that. We have probably the best Native healthcare system in the United States right now. I am a little proud of that, and I should be.

So, our first witness, Congresswoman Noem, you are up. Thank you for your bill, and thank you for taking the time to be here. We gladly look forward to your testimony.

STATEMENT OF HON. KRISTI L. NOEM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Mrs. NOEM. Thank you, Chairman Young and Ranking Member Ruiz, and the members of the subcommittee. I appreciate you having this hearing today and inviting me to testify in support of my bipartisan bill, H.R. 5406. Maybe by the end of this committee

hearing, I will have you on board, as well, Representative Ruiz, with all parts of the bill.

This bill is called the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare, the HEALTTH Act. And I want to thank today's witnesses who have traveled a long way to be with us. Mr. Bear Shield and Ms. Church, who are here from my home state of South Dakota; we have Mr. Miller and Mrs. Kitcheyan, who are here from Nebraska. And thanks also to Ms. Bohlen and Ms. Smith for being here today to add their perspective.

I don't want to make any mistakes today in telling you clearly we are here because of a crisis. The Indian Health Service is beyond broken. Fixing it is literally a matter of life and death. Nowhere is this truer than in the Great Plains region. The Great Plains service area is home to some of America's most remote and most impoverished tribal communities. Unemployment rates, substance abuse rates, and suicide rates are far above national averages. In fact, many of the unemployment rates in these areas are 80 to 90 percent.

At the center of it all is a healthcare system so deficient that providers are offering care with expired licenses. Their surgical instruments are being washed by hand. Opioids and other drugs are being stolen by the thousands, and premature babies are being born on hospital bathroom floors with no physician present.

Last year, CMS terminated its accreditation of the Winnebago Hospital in Nebraska, which serves the Omaha and the Winnebago Tribes. CMS then cited the Rosebud, Pine Ridge, and Sioux San Hospitals in South Dakota. In Rosebud, the situation is by far the worst. Without warning, IHS closed the facility's emergency room and diverted patients to hospitals located over 50 miles away. In the 7 months that the ER has been closed, five babies have been born in ambulances, and nine people have died in transit to these other hospitals. So, literally, we are talking life and death.

I want everybody to think of this perspective, too, because I think it is important to know—IHS is a subset under HHS, as is CMS. CMS actually refused to reimburse the kind of care that was being delivered at IHS facilities, both under the same umbrella of HHS, which tells you—we have one Federal agency pointing out how terrible of a job another Federal agency is doing—literally, every single day it is important that we recognize how terrible this situation is.

In the years since the 2010 Senate Indian Affairs Committee report that outlined many of the most shocking problems, the IHS has promised again and again to make changes. But it has failed to do so, even at the most basic levels. If you thumb through the past IHS budget requests, you will find the same promises copied and pasted from one year to the next. This is the very definition of status quo.

What has changed is the funding. Congress has delivered funding increases to IHS almost every year since the Senate report, bringing the annual IHS budget almost $1 billion over 2010 levels. Yet the situation is just as bad as it has ever been. So, we know for a fact that money alone is not going to fix the problem.

The HEALTTH Act reforms an agency that is desperately in need of an overhaul. Many tribes are considering self-governance,

which you indicated, Mr. Chairman, works well in Alaska. But for a number of reasons, many of my tribes are not quite ready to administer a hospital when they are so impoverished and lack so many resources. They want to eventually end up there, though, that is the goal.

My bill creates a pilot project in which hospitals can be controlled by tribal-led boards, rather than IHS. This new model will give tribes more control over their hospitals, and equip them with the expertise that they need for self-governance. The IHS's chief obstacle in the Great Plains is staffing. To improve recruitment and retention, my bill extends the agency student loan repayment program to administrators, as well as medical staff, and makes this financial support tax-free, like other government programs that are already out there designed to attract providers to under-served areas. This will make the repayment program a more valuable tool to recruit more competent administrative and medical staff.

We also require cultural competency training to ensure that IHS employees understand the people that they are serving. We ask the agency to report their wait times, and we eliminate barriers that currently prevent medical and dental providers from being able to volunteer at IHS facilities. And finally, the HEALTTH Act reforms the purchased referred care program, which currently operates under an unfair funding allocation formula. My bill would require that IHS update this formula and ensure that the money is getting to those people who need it the most.

As I said before, I believe IHS should get out of the hospital business. I think they are terrible at it. My bill takes us a step in that direction, under this pilot program. We have received widespread support, including from the Rosebud Sioux Tribe, the National Indian Health Board, all the major health systems in South Dakota, and national and state health organizations. But we are not done.

I look forward to a robust discussion today, and I welcome all of the input from the subcommittee, the witnesses, and the tribes across the country.

Chairman Young, Ranking Member Ruiz, and members of the committee, thank you for allowing me to testify today. I truly thank you for your commitment to improving tribal health care. With that, I will yield back.

[The prepared statement of Mrs. Noem follows:]

PREPARED STATEMENT OF THE HON. KRISTI L. NOEM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Chairman Young, Ranking Member Ruiz, and members of the subcommittee, thank you for inviting me to testify in support of my bipartisan bill, H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare—or HEALTTH Act.

I thank today's witnesses, especially Mr. Bear Shield and Ms. Church, who traveled from my home state of South Dakota, and Mr. Miller and Ms. Kitcheyan, who are here from Nebraska. Thanks also to Ms. Bohlen and Ms. Smith for being here today.

We are here today because of a crisis. The Indian Health Service is beyond broken, and fixing it is literally a matter of life and death. Nowhere is this truer than in the Great Plains. The Great Plains service area is home to some of America's most remote and impoverished communities. Unemployment rates, substance abuse rates, and suicide rates are above national averages. At the center of it all is a healthcare system so deficient that providers are offering care with expired licenses,

surgical instruments are being washed by hand, opioids and other drugs are being stolen by the thousands, and premature babies are being born on hospital bathroom floors with no physician present.

Last year, CMS terminated its accreditation of the Winnebago hospital in Nebraska, which serves the Omaha and Winnebago Tribes. CMS then cited the Rosebud, Pine Ridge, and Sioux San hospitals in South Dakota. In Rosebud, the situation is particularly dire. Without warning, the IHS closed the facility's emergency room, diverting patients to hospitals located over 50 miles away. In the 7 months the ER has been diverted, five babies have been born in ambulances while in transit to these other hospitals, and nine people have died.

In the years since a 2010 Senate Indian Affairs Committee report that outlined many of the most shocking problems, the IHS has promised time and again to make changes. But it has failed to do so at even the most basic levels. If you thumb through past IHS budget requests, you will find the same promises copied and pasted from one year to the next. This is the very definition of status quo.

What has changed is funding. Congress has delivered funding increases to the IHS almost every year since the Senate report, bringing the annual IHS budget almost $1 billion over 2010 levels, and yet, the situation is as bad as it has ever been. Money alone will not fix the problems.

The HEALTTH Act reforms an agency in desperate need of change.

Many tribes are considering self-governance, but for a number of reasons, aren't yet ready to administer a hospital. My bill creates a pilot project in which hospitals can be controlled by tribal-led boards, rather than IHS. This new model would give tribes unprecedented control over their hospitals, and equip them with the expertise needed for self-governance.

The IHS's chief obstacle in the Great Plains is staffing. To improve recruitment and retention, my bill extends the agency's student loan repayment program to administrators as well as medical staff and makes that financial support tax-free, like other government programs designed to attract providers to underserved areas. This will make the repayment program a more valuable tool to recruit more competent administrative and medical staff.

We also require cultural competency training to ensure IHS employees understand the people they serve. We ask the agency to report wait times. And we eliminate barriers that currently prevent medical and dental providers from volunteering at IHS facilities.

Finally, the HEALTTH Act reforms the Purchased/Referred Care program, which currently operates under an unfair funding allocation formula. My bill would require the IHS to update this formula and ensure the money is getting to people who need it most.

As I have said before, I believe the IHS should get out of the hospital business, and my bill is a step in that direction.

We have received widespread support, including from the Rosebud Sioux Tribe, the National Indian Health Board, all the major health systems in South Dakota, and national and state health associations. But we're not done. I look forward to a robust discussion today and I welcome input from the subcommittee, the witnesses, and tribes across the country.

Chairman Young and Ranking Member Ruiz, thank you again for inviting me to testify. I thank you for your commitment to improving tribal healthcare. Because this is such a critical issue for my constituents in South Dakota, I respectfully request that the members of the subcommittee allow me to join them on the dais for the remainder of the hearing.

Mr. YOUNG. Thank you, Congresswoman. Ranking Member, do you have any questions?

Just out of curiosity, did you write this bill, or did you have help from the people directly affected?

Mrs. NOEM. We had help from many of the tribes that are impacted directly. We even got technical assistance from IHS originally. The thing that has been the most frustrating for me is that, as you will hear in the testimony today of the IHS's Acting Director, they have some criticisms of our bill, which we have been waiting weeks now for more technical assistance.

So, some of the criticisms that you will hear in testimony today I think are unwarranted, when we did consult with them in drafting the legislation. Our tribes are very happy with the legislation, and recognize that these needed reforms have to be put in place as soon as possible. Every day that emergency department is closed down and services are diverted, their people are dying. IHS doesn't recognize the emergency situation we have on our hands.

Mr. YOUNG. You just led an opening to me, Kristi. We did not get their testimony until last night at 8:00.

Mrs. NOEM. I know.

Mr. YOUNG. I have checked it over, and if I really wanted to be nasty, I would have the Senate testimony and this testimony, and there are just some words that have been transferred.

Mrs. NOEM. Except for the criticisms of this bill.

Mr. YOUNG. That is right.

Mrs. NOEM. That was added on at the end. The rest of it was identical.

Mr. YOUNG. That is right. And I am just saying that is a no-no, so thank you for your legislation.

Mr. Benishek.

Dr. BENISHEK. Well, I want to thank Mrs. Noem for bringing this to my attention. I, frankly, was not aware of the severity of the problem. And looking over the briefing here, it is just remarkable what has been going on. How can there be any defense of this action? I don't know, and I think your legislation is long overdue. I can't wait to hear from the tribal people.

So, this hospital is run by the IHS, is that the story?

Mrs. NOEM. Our hospitals in the Great Plains region, except for one—but all the ones in South Dakota are run by direct service, which means IHS Federal employees deliver the health care in these facilities. Other tribes in other parts of the country operate under a 638, which means that they do not have Federal employees running it, but they receive the funds to run the facilities.

But for us, I think we are in such a tragic situation because we have IHS running these facilities, and you will hear stories from the tribal members today that you would not believe could happen in America. The quality of health care that is being delivered in my tribal communities is third-world health care, and it should not be happening in this country, especially when the Federal Government is responsible for providing health care to them.

Under our treaty obligations—these are treaty tribes that we need to honor by treating them with the respect they deserve and the health care that we have promised them, and we are failing.

And the agency is slow-walking fixes. They will tell you in the testimony today that they have the authority to do some of the things in the bill. Well, the tribal members will tell you if they have had the authority to do this all along, then shame on them because they should have been doing it. Our legislation is making sure that they follow through on delivering the kind of health care that our tribes deserve.

Dr. BENISHEK. Thank you. I yield back.

Mr. YOUNG. Mr. Gosar.

Dr. GOSAR. Sure. One of the things the Office of IHS is supposed to work in consultation with the tribes, and that is foremost and

inadequate in that discovery. We have seen the 638. In fact, in Arizona we have seen the 638 take off. I mean the Navajos were one of the first ones to use the 638. There were some complications, granted, but I am hoping there is a way that what we can do is teach the tribes to take that onus and the transitional factor, so that they have more of the leadership role in that application to health care, but also have the accountability, as well.

So, from that standpoint, I applaud your efforts in that regard. There will be some things that I will have some concerns about, because I want the same type of care from auxiliaries. That has to be mandated differently.

My one question for you is—did you have any input from the Pew Foundation?

Mrs. NOEM. Not that I am aware of, but I will request from my staff and clarify later with you if we did.

Dr. GOSAR. I appreciate it. Thanks.

Dr. BENISHEK. Will you yield for a minute?

Dr. GOSAR. I will yield to the gentleman from Michigan.

Dr. BENISHEK. I thought of another question.

Mrs. NOEM. Sure.

Dr. BENISHEK. Do you know how much the IHS was spending on this hospital?

Mrs. NOEM. One of the problems that we have had with IHS is we cannot get the exact dollar amounts that flow to the Great Plains region and what actually meets the tribes. The tribes will testify to you that they believe a lot of the dollars disappear at the regional center in Aberdeen, that it never quite flows down to the people or actually results in delivered health care to the people.

So, the purchased referred care that I reform within my bill, that money runs out by June every year. In fact, it is common knowledge and there is a saying in Indian Country in South Dakota, "Don't get sick after June," because if you get sick after June, you are just not going to receive care, you will be——

Dr. BENISHEK. This hospital that was closed down, the IHS ran it, but you don't really know how much money they spent there per patient, or the total amount, or any of those numbers. That is all, like——

Mrs. NOEM. Exactly.

Dr. BENISHEK. All right, thank you. I yield back.

Dr. GOSAR. I am going to reclaim my time, because Dr. Benishek actually gave me another question.

One of the things that would—and I mean this is not my first rodeo with problems with IHS and application to the tribes. Part of the reason is credentialing. And dentistry is also a big issue within the tribes. IHS refused to have a core central credentialing protocol in which those that want to volunteer for extended periods of time can do so. I hope that is a real prominent aspect of this bill.

Mrs. NOEM. It is.

Dr. GOSAR. I will spend a little more time with that. Credentialing is a problem. And I would alert the tribes to tell them that, once again, the consultation process—IHS has to function on consultation with a tribe. So, I would beg that the tribes become very affluent and forceful in that regard, to have trans-

parency and have them answer directly to them, because that is the way it is supposed to function; and Congress should back that.

Mrs. NOEM. Representative Gosar, I wholeheartedly agree with you. My tribes will tell you that they feel as though no consultation happens and that virtually they are left out of the decisionmaking process, they are informed when something has already been implemented. When we do have problems with employees, they are shuffled around to other positions, nobody is ever fired.

The consultation piece is one of the biggest complaints that I hear out of my tribes.

Dr. GOSAR. Yes, and I once again would re-acknowledge the point that there are some 638s out there that are becoming very sophisticated in application, not just for tribal members, but off tribal. In Flagstaff, there are some outreach clinics that are associated with the 638s, so there is a lot of possibility that actually works within this.

I appreciate the gentlelady's interest and——

Mrs. NOEM. Well, my tribes would like to get there, they just do not have the resources to get there tomorrow. That is their goal.

Mr. YOUNG. I am going to use my prerogative, Mr. Ruiz.

Dr. RUIZ. Thank you, Mr. Chairman.

Congresswoman Noem, I just want to give a warning that there is no one size that fits all in Indian Country. There are a lot of dynamics and complexities within the different regions, within the different tribes. There is a difference between rural health and urban health. There is a difference within the states, of course. So, sometimes IHS can work within a certain region, within a certain population. Perhaps, in Great Plains, it is not working with the big hospital model, however there have been partnerships with hospitals with IHS and local tribes working together.

So, I think that this is not a one-size-fits-all or this one particular bill is going to fix the entire IHS. We should be flexible in understanding the local unique dynamics within the different regions and the different types of health care and the different types of risk factors that exist in those.

The other thing is that we should really focus on making sure that there are incentives for recruitment. I know this bill has some of those, and also prevent the disincentives for retention, because there are some barriers that are unique in Indian Country in terms of trying to get, as you mentioned, administrators, doctors, and nurses to serve there that we need to address. So, I think it is important that we keep those things in mind and I thank you for your attempt in doing that.

Mrs. NOEM. Thank you. I think that is why you will see that the bill is drafted as a pilot program for the Great Plains region, because we know that we face a different situation than other regions in the country. This is specifically to test this kind of implementation process in our region, where the situation is so terrible.

And also, one of the challenges that we face is the vacancy rates of positions of nurses, doctors, and administration officials. That is why, in the bill, we try to address that through provisions that will help us recruit, but also allow individuals to stay in these communities, become a part of the community, and maybe even train

members of the community, so that they continue to better their lifestyle and livelihood, as well. Thank you.

Mr. YOUNG. Mr. LaMalfa.

Mr. LAMALFA. Thank you, Mr. Chairman. Mrs. Noem, you mentioned a pretty horrific situation there. I wasn't sure if you said that was at Rosebud on the ER closure?

Mrs. NOEM. Yes, for 7 months the emergency department has been closed.

Mr. LAMALFA. And it is still closed?

Mrs. NOEM. Yes.

Mr. LAMALFA. All right. What was the condition of why they chose to close it? Was it the right decision to close it?

Mrs. NOEM. Well, what created the situation was CMS coming in and saying they would no longer reimburse for services provided in that emergency department because of conditions that were occurring there. And what IHS identified and has fixed, some of it was construction, some of it was adding new technology or new medical devices, lack of staff.

But they also put new security measures in on protecting their drugs and——

Mr. LAMALFA. Some of that was done, or was being done——

Mrs. NOEM. That has been done. Then they contracted the emergency department out to a staffing agency that has been hiring and trying to fill positions before they reopen.

I have been told for weeks that it will reopen soon. But every time I have asked IHS, "When will this emergency department open because lives depend on it," I have never gotten an answer.

I understand that CMS is there today conducting a survey; so potentially that is coming soon, and that should be the final step before it reopens. The problem I have had is it has taken them 7 months to get their act together, to get it done, hire staff, and that I never once was given a date on when this emergency department would reopen—and I don't believe my tribes were ever given any kind of an indication. Even if we asked them today, I am not sure they would tell us what day it would open.

But what we need to realize is that we are transporting people across very rural areas of South Dakota, and they are dying in ambulances on the way there——

Mr. LAMALFA. You said five baby deliveries and nine deaths——

Mrs. NOEM. Nine deaths.

Mr. LAMALFA [continuing]. They could attribute to maybe lack of timing?

Mrs. NOEM. Lack of care when they needed it.

Mr. LAMALFA. And was actual closure really necessary, or could they have restaffed a little ongoing? I mean shutting something completely down——

Mrs. NOEM. It was a dangerous situation.

Mr. LAMALFA [continuing]. Versus trying to do something in a couple weeks that would take care of this cleanliness issue, or get one—I mean it would seem like with the cost involved to the community in its convenience or proximity, or whatever you would call it, that is a pretty big cost.

Mrs. NOEM. That is a great question for the Acting Director.

Mr. LAMALFA. The next panel? OK. In the bill, how do you feel about the allocation formula and capping being placed on the PRC. How is that going to play out?

Mrs. NOEM. The PRC funding formula does not currently work, because my tribes run out of money by June. So, for the rest of the year, they cannot get care. Unless they are dying on the table, they might get care. But other than that, those reimbursements or payments are not made to other facilities that are providing care to Natives that IHS should be doing.

Mr. LAMALFA. Because there is a fund somewhere that runs out by June instead of it being properly funded?

Mrs. NOEM. Yes.

Mr. LAMALFA. Or is there a higher cost involved or something that is blowing up the fund, or what?

Mrs. NOEM. Yes. What my legislation does is that it reimburses at Medicare rates, so that it stretches the dollars farther, so that they are not paying astronomical rates to other providers to take care of Native Americans.

And then also what it does is it allocates the formula according to need. Some tribes are getting more dollars than what they can really utilize and have plenty of money to make it through the year. My tribes run out by June because it has never been changed according to population. As population grows in these tribes, I am just asking IHS to redo this formula to make sure that needs are being met.

Mr. LAMALFA. Are you getting any pushback on the Medicare cap?

Mrs. NOEM. I have not.

Mr. LAMALFA. OK. So maybe smooth sailing?

Mrs. NOEM. I am sure there is somebody that is unhappy with it, but it certainly will help my tribes receive care for more months out of the year.

Mr. LAMALFA. And it is probably commensurate with a lot of other medical facilities that maybe are not as tribe-oriented.

Mrs. NOEM. Well, my medical facilities that are providing care to Native Americans today that are not getting paid for that, they are doing it as charity care, sure, they would like to get something.

Mr. LAMALFA. Yes, well, certainly. OK. Very good. Thank you for your testimony.

Mr. YOUNG. I have been informed there are no other questions at this time. We want to hear from the other witnesses, is that correct?

We thank you Congresswoman, very much so, and thanks for bringing this bill forward. We will have Mary Smith, Principal Deputy Director, Indian Health Service; the Honorable William Bear Shield, Chairman of the Rosebud Sioux Tribal Health Board; Ms. Victoria Kitcheyan—I have to say that, Victoria, because it is not Ketchikan; it is very nearly Ketchikan, though, I can tell you that, so you know—a city in Alaska; and the Honorable Vernon Miller, take the witness stand, please.

Which one? Two more? OK. Jerilyn Church and Stacy Bohlen. I think most of you recognize or have testified before. You have 5 minutes. I am pretty lenient if you are making good presentation.

I have to say that because if you start rambling I will enforce the 5-minute rule. So, just keep that in mind.

But I try to give you time. I have never liked the 5-minute rule. But it is because of time. And, unfortunately, you cannot present your real case in 5 minutes, nor can we ask questions in 5 minutes. But because of time we can't.

And Ms. Mary, I have to say that we are not picking on you, we are picking on the system. This is not new. This has been going on for years, and we are just trying to ensure—the congresswoman is trying to arrive at a solution, and we are willing to listen to all sides of this issue and see if we can't get something done for those that have not been served.

So, Ms. Mary, you are up.

STATEMENT OF MARY SMITH, PRINCIPAL DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MARYLAND

Ms. SMITH. Thank you. Good afternoon, Chairman Young, Ranking Member Ruiz, and members of the committee. I want to thank you all for the invitation to join you today to testify on H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act.

And, Mr. Chairman, I do want to apologize personally on the timing of the testimony. I am sorry.

Mr. Chairman, I appreciate and thank you and the committee for your leadership in elevating the importance of delivering quality care at the Indian Health Service. I would also like to thank Representative Noem for her partnership and for focusing attention on the critical needs of health care for Native Americans, and for her participation at the recent field hearing in Rapid City, South Dakota. Finally, I would like to thank my fellow witnesses for all their work and partnership in this important area.

All of us share the goals reflected in this legislation: driving accountability, strengthening the workforce, and improving the quality of care for the Native American communities we serve. I think, while we are sitting on different sides of the table, I think we are all on the same side. We all want to improve the quality of health care for Native Americans.

While the Administration has some concerns with some of the provisions in the bill as drafted, we look forward to working with the committee to improve the bill as it moves through the legislative process.

At the outset, I want to thank the many dedicated staff and providers we have at IHS. They work under difficult conditions to deliver care in some of the poorest and most remote areas of our country. Nonetheless, IHS faces severe operational and staffing challenges, challenges not unlike those shared by other healthcare systems that provide care in rural communities, such as nursing and provider shortages. And, unfortunately, these challenges did not occur overnight. They are long-standing and systemic.

Over the past several years, IHS has encountered challenges with a number of our direct service facilities in the Great Plains area. And more recently, these long-standing challenges have gained attention from Congress, including this committee. We

welcome this attention and momentum that it creates for lasting quality improvements for these facilities because we are on the front lines of medical care in some of the most remote parts of our country.

To underscore, our challenges are daunting. But I am committed, along with the rest of the team at IHS, and with the support of the Department of Health and Human Services, to creating a culture of quality, leadership, and accountability. Since I was asked to lead IHS just a few months ago, I have moved aggressively toward this goal, meeting with tribal leaders to hear their concerns firsthand, visiting facilities, and launching agreements to make improvements in the IHS delivery system that will be sustainable over time.

One area of focus is staffing and the retention of qualified staff. Across the system, IHS is committed to supporting staff with the necessary resources and tools to perform their jobs. For example, IHS is ensuring that living quarters are allocated efficiently to support the retention of health professionals, as a lack of housing is a serious barrier to recruitment. Retaining dedicated IHS staff members is important and essential for the continuity of operations. This year we began executing an aggressive strategy to improve the quality of care at IHS, and we are focusing on a 5-point strategy.

First, we are focusing on assessment. We are taking a close look at the quality of care delivered through our direct-service hospitals. We are beginning a system-wide mock survey initiative for all 27 IHS hospitals to assess compliance with Medicare and readiness for re-accreditation.

Second, we are immediately strengthening service delivery. IHS is working diligently to stem local staff shortages and build a pipeline for staff training and deployment. Already more than 60 clinicians from the U.S. Public Health Service Commissioned Corps have deployed to hospitals in the Great Plains. We are expanding our outpatient hours and we are using telehealth to bring hard-to-find specialty care right to the patient.

Third, we are strengthening IHS management. We are assessing a number of staffing and management office options, including finding innovative ways to compete and retain talent.

Fourth, we are infusing quality expertise. We recently joined a hospital engagement network to reach across all 27 IHS hospitals and share strategies on how to reduce avoidable re-admissions and hospital-acquired infections. We are bringing in experts from different parts of HHS to consult with IHS hospitals to ensure that our improvements are real and measurable.

Fifth, we are engaging local resources. Some of the most helpful expertise and effective leadership are the tribal communities we work with daily. We are committed to strengthening these relationships and engaging further with partners from the community like local and regional healthcare systems, local colleges and universities, and the leadership of our direct-service hospitals.

At IHS, we are committed to making meaningful and measurable progress to improve the health and well-being of all American Indians and Alaska Natives. It is not business as usual. It is not simply pointing out the challenges, but focusing on solutions and

about how we all have been entrusted with providing access to health care for Native people, and how we can work together to tackle these issues to make sustainable improvements so that we can move forward toward solving the long-standing systemic issues and deliver the quality of care that our patients deserve.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Smith follows:]

PREPARED STATEMENT OF MARY SMITH, PRINCIPAL DEPUTY DIRECTOR, INDIAN HEALTH SERVICE

INTRODUCTION

Good afternoon, Chairman Young, Ranking Member Ruiz, and members of the committee. Thank you for the invitation to join you today to testify on H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act (HEALTTH Act). We would like to start by thanking you and the committee for your leadership and for elevating the importance of delivering quality care through the Indian Health Service. I would also like to thank Representative Noem for her leadership and partnership in focusing attention on the critical needs of health care for Native Americans. This committee, IHS, and HHS share common goals of providing consistent, quality health care to the American Indian and Alaska Native communities. The Administration has concerns with some provisions in H.R. 5406 as drafted and looks forward to working with the committee to improve the bill as it moves through the legislative process.

Earlier this year, we strengthened and refocused our resources within the IHS as part of an aggressive strategy to improve the overall quality of care in the Great Plains area, and across the country. IHS is working to instill a culture of quality care, leadership, and accountability across the agency. We are committed to hearing directly from you and the communities we serve to focus sharply on how to best improve access to quality health care and, most importantly, improve the health status of American Indian and Alaska Native families and communities.

To be clear, the acute problems we are seeing right now are largely tied to chronic, long-standing issues, often spanning decades. Recognizing that, the focus of our work this year is to move aggressively to develop both systemic changes even while we're addressing immediate, short-term needs. We have significant efforts underway on both fronts.

It is not business as usual at IHS. Under my leadership, IHS is changing the way it approaches long-standing challenges. We are working to transform the process by which we recruit and retain staff; to create an organizational structure that supports sustained improvement and accountability; and to strengthen our financial management infrastructure.

To ensure that dependable, quality care is delivered consistently across IHS facilities, 3 months ago, Secretary Burwell created the Executive Council on Quality Care and asked Acting Deputy Secretary Wakefield to lead it. This Council includes senior executives from across HHS and draws on expertise from across the Department. We have some of HHS's top managers, clinicians, and program experts taking a fresh look at long-standing obstacles like workforce supply, housing, challenges to delivering quality of care, and addressing key operations issues. The Council provides the framework to ensure that we are leveraging all the resources we can on behalf of tribal communities and the patients we serve.

IHS, in conjunction with the work of this Council, for the past 3 months, has been engaging our work through a five-prong strategy to address these challenges—many of the same obstacles like sufficient workforce, human resources issues, and care quality, that this legislation seeks to address. With this strategy, IHS and the Department are working to (1) surface issues so that we can work to resolve them; (2) improve service delivery; (3) strengthen IHS Area management; (4) infuse quality expertise; and (5) engage with local resources.

Surfacing Issues

First, we are assessing and surfacing issues so that we can work to resolve them. We are taking a very close look at the quality of care delivered through direct-service hospitals at IHS facilities across the Great Plains area as well as throughout Indian Country. We want to affirm and support facilities that are delivering quality care and work closely with facilities that need improvement. It is important that IHS leadership from Headquarters to Area offices to our service units work closely with both tribal leadership and direct service hospitals in a transparent way that

encourages open information exchange about improvement opportunities. We know from decades of experience across the health care continuum, that problems that are not acknowledged and fixed put patients at risk. For the past 20 years, health care systems across the Nation have been embracing new models of improvement, and we are working to embrace those models through the assets of IHS and other HHS operating divisions.

For example, IHS has begun a system-wide mock survey initiative at all 27 of its hospitals to assess compliance with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation and readiness for re-accreditation. These mock surveys will be conducted by survey teams from outside each respective area to reduce potential bias. The new mock survey initiative is being coordinated through the IHS Quality Consortium as a unified effort to reinforce standardization of processes. We are beginning in the Great Plains area with assessments and, when appropriate, interventions through the provision of on-site assistance to hospital staff. Although some direct service hospitals currently conduct self-assessments, IHS is standardizing and improving this process so that direct-service hospitals receive a consistent assessment within the next few months and performance data is centrally tracked, not just at individual facilities but across all facilities.

Through this and other targeted strategies, IHS will move from being reactive to proactive in identifying and addressing performance issues early. Our first efforts were piloted May 10, 2016, at the Rosebud Hospital, and we will continue to do quality surveys at all direct service hospitals, excluding those that have been surveyed in the past year or are scheduled to be formally surveyed through other mechanisms during this time frame. When our survey teams identify problems, we will work swiftly to address these local problems and work to put systems changes in place to resolve the problems. Additionally, best practices that are identified will be shared across IHS facilities.

Another example of surfacing and addressing problems is IHS' enhanced drug testing interim policy. This policy was released on June 6, 2016, and it focuses on drug testing based on reasonable suspicion. The interim policy provides guidance to supervisors and managers on drug testing based on a reasonable suspicion of drug use. This effort was informed by tribal leaders' calls for additional IHS administrative actions in this area.

Improve Service Delivery

Second, we are working to improve service delivery by focusing on workforce and clinical support infrastructure.

Workforce

The IHS continues to face significant workforce challenges with a chronic shortage of health care providers. While we have taken immediate steps to address some local shortages, and are in the process of adding more, such as telemedicine, these long-standing challenges require bolstering and expanding the training and deployment pipelines and full use of innovative approaches to delivering care. In the near-term, with Secretary Burwell, Deputy Secretary Wakefield, and the U.S. Surgeon General's support, over 60 Commissioned Corps clinicians have been deployed for temporary placements into the Great Plains hospitals with CMS findings. In addition, the National Institutes for Health (NIH) and the Health Resources and Services Administration (HRSA) have been helping IHS deploy strategies they have used to recruit applicants. IHS is also revising job announcements and deploying more comprehensive recruitment plans around key positions, in an effort to recruit a greater number of qualified candidates. IHS is utilizing Title 38 pay increases for high-demand Emergency Department clinicians and has established eligibility for payment of relocation expenses for GS–12 and lower graded clinical positions. However, even with these and a number of other strategies that have been utilized during the past few months or that are in development right now, there is still much more work that needs to be done to attract and retain an adequate health care workforce. Some of these changes may require legislative action. In addition, we are working with Office of Personnel Management (OPM), the Office of Management and Budget (OMB), and other affected agencies to explore ways to enhance our current flexibilities. We are also are combining efforts that leverage collaboration between tribal, public, and private academic institutions.

One of the most challenging areas to support is the availability of emergency services, particularly in the Great Plains area. Because of this, on May 17, 2016, IHS initiated a new strategy through a contract award to provide both emergency department staffing and operations support and management services at three hospitals: Rosebud Hospital and Pine Ridge Hospital in South Dakota and Omaha Winnebago Hospital in Nebraska. This contractor will provide health care in these

hospital emergency rooms while IHS reviews the administrative and clinical operations of its facilities across the region to develop long-term solutions. IHS's leadership both in the hospitals and at headquarters have direct oversight of this contractor and is responsible for holding this contractor accountable for providing consistent quality health care. However, because this is a new approach to Emergency Department staffing and management combined, a team of clinicians and attorneys, as well as the CEOs of the facilities, are tracking this initiative weekly to ensure that performance expectations are met.

As part of a longer-term strategy, we are re-examining the scholarship and loan repayments program to make sure that we are maximizing their impact as well as introducing new strategies as well. We are working with the Peace Corps' Global Health Services program that fields clinicians to areas of critical workforce needs and most immediately, we are building communication channels about service to Indian Country to returning volunteers. By the end of last month, for example, 60 returning volunteers learned about opportunities to work in IHS direct service hospitals even as we are engaging other longer-term communication strategies with the broader Global Health Services program. Additionally, the U.S. Public Health Service Commissioned Corps has prioritized assignment of new officers to IHS with a particular focus on the Great Plains area.

On a related front, on June 1, IHS proposed to expand its Community Health Aide Program. Partnership and collaboration are part of our ongoing work to deliver quality health care to patients. Increased access to care is a top priority, which is why IHS is engaging in consultation with tribal leaders on this expanded effort. Community health aides are proven partners, and this important proposed change would bring more health workers directly into American Indian and Alaska Native communities.

Infrastructure

In addition to addressing workforce challenges, the IHS is trying to lessen the loads on our emergency departments by establishing alternative avenues of care, such as urgent care clinics and telehealth services. IHS is working aggressively to reopen the Rosebud Emergency Department as soon as possible. In the meantime, in order to fill the temporary gap, the IHS has re-purposed existing ambulatory care space into an Urgent Care clinic staffed with emergency department and ambulatory providers. Given the types of illnesses that individuals present with to the Rosebud Emergency Department, the Urgent Care clinic can manage the majority of non-emergent care needs.

Specialty services like behavioral health, cardiology, and diabetes care can be difficult to find in rural areas. IHS will also be using telehealth contracts to bring specialty services into the communities where individuals live so they do not need to travel. IHS issued a Telemedicine Request for Proposal on May 5, 2016. Proposals were originally due June 6, 2016; however, at the request of prospective offerors who needed more time to prepare comprehensive proposals, IHS extended the deadline to respond by 30 days.

Strengthening Area Management

Third, we are working to strengthen area management. While we support the workforce at each hospital, we are taking a broader view to strengthen Great Plains area management through the temporary deployment of high-quality managers from within other areas of IHS as well as deploying HHS experts to both IHS headquarters and the field to assist with finance, contracting, and management functions. IHS also established a Human Resources (HR) Steering Committee, which provides oversight and guidance on the implementation of system-wide HR improvements in IHS.

As part of these efforts, Rear Admiral Kevin Meeks spent 3 months leading the Area Office, and he continues to support the Great Plains area in order to provide continuity of leadership. Captain Chris Buchanan joined the Great Plains area leadership team in May and is serving as the Acting Director of the Great Plains Area Office. Captain Buchanan has extensive expertise working with complex health systems which are IHS directly operated facilities as well as tribally managed programs. In the longer term, the IHS is actively looking to find the best possible candidate for the Great Plains Area Director position. We have taken steps to attract as broad a pool of well-qualified candidates as possible. We have also implemented a stronger search committee process for recruiting highly qualified managers and executives. This committee is charged with candidate outreach, assessment, and vetting. IHS is also more widely advertising vacancies through Federal, state, and non-profit partners, and is actively seeking additional venues to help attract a broad and diverse applicant pool. Additionally, going forward, we

have expanded tribal participation in filling vacant Area Director positions and members of a tribe from each area will, for the first time, play a role in these search committees at the outset of the hiring process on these key positions.

Finally, IHS recently announced it is conducting a 90-day consultation with tribal leaders to discuss the organization and operation of the Great Plains Area Office, to, in partnership with the tribes, identify new approaches to better support patients and tribal community health in the area. The first telephonic consultation was held on June 22, and the first in-person consultation will be held in Rapid City later this week on July 15.

Infusing Quality Expertise

Fourth, we are infusing substantial quality expertise into informing and improving care quality in direct service facilities. In partnership with CMS, we have launched a Hospital Engagement Network (HEN) to provide evidence-based efforts in quality improvement. As we announced on May 13, 2016, this HEN is now available to all IHS direct service facilities and focuses on quality improvement methods intended to reduce avoidable readmissions and hospital acquired conditions (e.g. central line blood infections, pressure ulcers, falls, etc.). Hospitals in the network share successful practices and lessons learned to accelerate learning and change.

The HEN will prioritize working with the three Great Plains area hospitals and is currently working with each hospital to schedule on-site meetings.

Additionally, we are bringing in targeted quality improvement assistance through CMS' Quality Improvement Organization (QIO) infrastructure. Among other support and training functions, QIOs assist with root cause analysis of identified problems, assist with the development of improvement plans, establish baseline data, and monitor data to ensure improvement plans are successful and sustained over time. Also through Secretary Burwell's Executive Council on Quality Care, HHS is deploying quality experts, as needed, from throughout the Department to consult with and help our IHS direct-service hospitals that are currently out of compliance with CMS Conditions of Participation and to monitor progress as the facilities come into compliance.

Engaging Local Resources

And fifth, we aim to engage more robustly with local resources. We know that, in addition to our strong partnerships with tribes and their leadership, local academic and health systems organizations can be valuable sources of expertise and partnership. We intend to strengthen our relationships with local and regional health care systems, local colleges and universities and tribal colleges, direct-service hospital leadership and tribal leadership to build stronger academic pipelines and health care connections to ensure we are working collaboratively and effectively to produce health related workers and health care services.

We also recognize that the health of communities is tied to the economic health of communities. Rates of unemployment and poverty matter. Consequently, we are committed to advancing the success of small businesses in tribal communities. The Department's Office of Small and Disadvantaged Business Utilization, in collaboration with the U.S. Small Business Administration, is working to coordinate meetings with tribal leaders and small businesses owned by Native Americans, Indian tribes, and the Native American community at large.

Our team plans to have these meetings in or near the 12 Indian Health Service Area Offices and the events will focus on how to effectively pursue contract opportunities with HHS, IHS, and other Federal agencies.

STRENGTHENING IHS

We have been working to address challenges using new approaches on our end. First, we appreciate the authority we already have to use the pay flexibilities under chapter 74 of title 38. We are working with OPM, OMB, and other affected agencies to explore ways to enhance our current authorities to provide more tools to recruit and retain high-quality staff.

Second, we are seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships. Currently, IHS loan repayment/scholarship awards are taxable, reducing their value. In contrast, participants in the NHSC scholarship program and Armed Forces Health Professions may exclude scholarship amounts used for qualifying expenses from income, and participants in the NHSC loan repayment program may exclude NHSC loan repayment amounts paid on their behalf from income. We recommend adopting the Administration's Fiscal Year 2017 Budget proposal which would conform the tax treatment of IHS repayments/scholarships to

the tax treatment for NHSC and Armed Forces Health Professions repayments/scholarships.

Third, the Indian Health Care Improvement Act requires employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. However, the Affordable Care Act permits certain NHSC loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a 2-year service obligation. We would like similar flexibility in order to attract health care professionals who may not be able to work full-time to fulfill their service obligations.

Being able to access resources is key to amplifying our work. It is critically important that we receive the funding the President requested in his Fiscal Year (FY) 2017 Budget, which includes: an increase of $159 million above FY 2016 to fund medical inflation, pay costs, and accommodate population growth for direct health care services; an increase of $20 million for health information technology to fund the development, modernization, and enhancement of IHS' critical health information technology systems; $2 million to create a new program which will focus on reducing medical errors that adversely affect patients; and $12 million specifically for staff quarters at current facilities, in addition to staff quarters associated with new facilities.

H.R. 5406

H.R. 5406 addresses three broad areas and the paragraphs below include our feedback on various sections of the bill.

Title I—Expanding Authorities and Improving Access to Care

Section 101 of the bill would establish a 7-year pilot project for long-term contracts to fully staff three hospitals. This is a concept IHS is exploring through our sources sought notice for at least two hospitals in the Great Plains that includes the option of contracting out the top senior management of the facility or the option to contract out the entire hospital. This section of the bill presents a third way between the current two methods of providing care through IHS funding, either full direct service or full self-governance.

IHS supports a tribe's decision to receive services directly from IHS or to contract under the Indian Self-Determination and Education Assistance Act (ISDEAA). However, the agency is concerned that this provision while not impacting the right of a tribe to contract under ISDEAA would not absolve IHS from contractual liability to the private sector contractor for up to 7 years. While IHS has the current authority to contract out both the management and staffing of an entire hospital, IHS is concerned with the language in this section that IHS could be expected to fund both a private sector contractor and an ISDEAA tribal contractor, using the same source of funding. We suggest language be added to clarify that, in this situation, a tribe would take over the contract, not be paid in addition. Finally, IHS would be open to further discussing a long-term pilot, and associated funding needs, with the impacted tribes and the committee.

Subsection (d) establishes governance boards for the selected hospitals made up of representatives from IHS, tribes, and experts in health care administration. IHS is concerned that such boards vest authority in individuals (elected tribal officials and other health care experts) who would not be accountable to IHS or the Secretary, who would retain the legal responsibility for running the hospitals. Tribes who want to assume full responsibility for the operation of their hospitals already have this authority under the ISDEAA. Instead, creation of an Advisory Board could ensure that tribes have input into hospital operations and access to information about how the hospital is operated. Advisory boards could also bring in the perspective of outside health experts, benefiting both IHS and tribes.

Section 102 would expand IHS's authorities under chapter 74 of title 38 to help IHS offer more flexible and competitive benefits to recruit employees. IHS appreciates the authority we already have to use the pay flexibilities under chapter 74 of title 38. We are working with OPM, OMB, and other affected agencies to explore ways to enhance our current authorities to provide more tools to recruit and retain high-quality staff.

Section 103 addresses IHS authority to remove or demote employees. The specific provisions on removing or demoting an employee appear unnecessary as IHS already has authorities to implement adverse employment actions as contemplated by this section. While IHS already has these authorities, in an effort to bolster effective leadership and management accountability in addressing employee issues, we have taken the following actions during the past few months: issued a new drug testing policy based on reasonable suspicion; established that a new performance

requirement focused on providing quality health-care be added to all applicable performance plans during the mid-year performance reviews; started providing Employee Relations and Labor Relations training to our managers beginning with the IHS Senior Staff; and issued policy guidance and expectations on reporting of any suspected fraud, waste, and abuse, and Whistleblower protection rights to all IHS employees. In addition, the Department of Justice (DOJ) advised us that it has serious constitutional concerns with the procedures in section 103, which appear to derive from section 707 of the Veterans Access, Choice, and Accountability Act of 2014, codified at 38 U.S.C. § 713. The Attorney General notified Congress in a recent letter that DOJ could not defend section 707 in litigation challenging that provision on Appointments Clause grounds. Section 103 could present similar concerns if enacted in its present form.

Finally, we believe there may be technical issues with some of the bill's language pertaining to applicability to the U.S. Public Health Service (USPHS) Commissioned Corps, and definitions and references to current personnel practices. We would be happy to provide any technical comments.

On expedited appeals, revoking Federal employee protections could lead to the unintended consequence of making IHS a less desirable place to work and thus compound staffing problems.

Section 104 requires IHS to develop and implement standards to measure the timeliness of care at direct-service IHS facilities. IHS believes this provision is unnecessary as IHS already is cascading annual Senior Executive Service performance standards that specifically address improving access to patient care by establishing accountability for all senior managers to implement at least two activities to improve wait times and access to quality health care for patients that are based on enhanced implementation of current quality initiatives or new quality initiatives and that have measurable goals, measures, and outcomes, and requiring improvements to be documented at Headquarters, Area Office and facility levels. In addition, IHS is developing a quality framework that will take action on timeliness of care and provide data analytics.

Title II—Indian Health Service Recruitment and Workforce

Section 201 would provide tax treatment, similar to the treatment provided to recipients of NHSC and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Services Health Professions Scholarships to be excluded from gross income under Section 117(c)(2) of the Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income student loan amounts that are forgiven by the IHS Loan Repayment program under Section 108(f)(4) of the IRC. IHS appreciates the inclusion of this provision as it was requested as part of the President's FY 2017 Budget request.

Section 202 includes health care management or health care executive positions as eligible professions for loan repayment awards, including non-clinical service obligations. Management expertise is very important in a health system as large as IHS.

Section 203 adds specific requirements for implementation of annual mandatory cultural competency training programs for IHS employees, locum tenens providers, and other contracted employees engaged in direct patient care. Cultural competency in the IHS workforce is essential to the provision of quality care.

Section 204 addresses relocation reimbursement. IHS currently has ability to provide payment of relocation expenses. This section appears to combine payment of relocation expenses and relocation incentives. IHS already has the authority to pay Relocation expenses included in 5 CFR part 572 and in accordance with the Federal Travel Regulations, Chapter 302, Relocation Allowances. The authorized allowances are outlined in Chapter 302. We would like the opportunity to better understand why payments of 50–75 percent of an employee's salary would be required under this section of the bill.

IHS also has the authority to pay relocation incentives under 5 CFR part 575—Recruitment, Relocation, and Retention (3Rs) Incentives. To help with difficult-to-fill positions, agencies may authorize an incentive of up to 25 percent of an employee's annual rate of basic pay times the number of years in a service agreement, which could amount to an incentive of as much as 100 percent of an annual salary for 4 years of service. Only OPM can authorize incentive payments above 25 percent based on a critical agency need so that larger incentives may be approved for shorter service obligations. Relocation incentives also can be paid in addition to providing reimbursement of relocation expenses. We would be happy to provide any technical comments in coordination with OPM.

Section 205, which permits a limited waiver of Indian preference, is more restrictive than current law. Impacted Indian tribes and tribal organizations are already permitted to waive Indian preference laws with respect to personnel actions pursuant to 25 U.S.C. § 472a(c)(1). Current waiver authority is unconditional, unlike section 205, which requires the IHS service unit to have a personnel vacancy rate of at least 20 percent.

Section 206 requires a Service-wide centralized credentialing system to credential licensed health professionals who seek to volunteer at a Service facility. IHS shares the goal of this section to streamline and standardize credentialing across the entire IHS system. IHS is exploring options for either installing an enterprise IT system for tracking credentialing and privileging across IHS or for contracting out the credentialing function to a third party. It appears the intent of the bill is for the Secretary to establish a separate and different credentialing system for volunteers. IHS's preference is to pursue the implementation of a single credentialing system for the entire agency, which would include volunteers.

Title III—Purchase/Referred Care Program Reforms

Section 301 is similar to our Final Rule Medicare-like Rate payment for non-IHS, Tribal, or Urban (non-ITU) physician and other health care professional services associated with either outpatient or inpatient care provided at non-ITU facilities. If the intent of the legislation is to codify this regulation, we suggest using the language of the regulation, as there are a number of subtle changes that could drastically impact the meaning and implementation. However, if the intent is reinforcement of the rule then drafters could consider codified enforcement mechanisms, such as civil monetary penalties.

Section 302 requires that the Secretary promulgate regulations to develop and implement a revised distribution formula for the purchase/referred care program (PRC). To the extent that this provision is optional for 638 contractors and not optional for direct service tribes, this proposed legislation will provide incentives for tribes to enter into 638 contracts to run their own PRC programs and essentially cause a race to contract for PRC in order to avoid a revised distribution formula. The Federal Government's legal responsibility is to all AI/ANs, regardless of whether the services are provided directly or through a 638 contractor. The direct service tribes have a right to contract under the ISDEAA, but they also have a right not to do so and there is no basis in the law to penalize them for choosing to stay a direct service tribe.

CONCLUSION

IHS and HHS are committed to making meaningful and measurable progress in the way that IHS delivers care and to ensuring that this progress is sustainable over time. We have already taken significant steps, but there is much more work ahead, including the intense work underway to strengthen and stabilize the hospitals in South Dakota and Nebraska. We look forward to addressing those challenges and making lasting progress in close partnership with you. We look forward to working with the committee on this legislation as it moves through the legislative process. Thank you, and we are happy to take your questions.

QUESTIONS SUBMITTED FOR THE RECORD BY THE HON. DON YOUNG TO MS. MARY SMITH, PRINCIPAL DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. Smith did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Question 1. Section 121 of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, enacted into law as part of P.L. 111–148, required the Secretary of the Department of Health and Human Services to submit to Congress a report on the current health status and resource deficiencies of the Indian Health Service for each service unit, including newly recognized or acknowledged tribes.

Has the Department finalized this report? If not, when can Congress expect to receive the report?

Question 2. 25 U.S.C. §1680h includes the authorization the Indian Health Service to establish joint venture projects under which tribes or tribal organizations would acquire, construct, or renovate a health care facility.

a. For direct service tribes that have not any health facilities constructed under either the health care facility priority system or the Joint Venture Construction Program, does any way exist for those tribes to renegotiate or bring current their facility staffing ratios within the Indian Health Service system?

b. For Joint Venture Construction Program solicitations dating back to 2009, please provide for each the solicitation information that identifies:

- the tribes that submitted applications;
- the applications that progressed beyond the initial round of review and the level of review they progressed to before being denied, and
- the applications that Indian Health Service ultimately selected.

Mr. YOUNG. Thank you, Mary.

The Honorable William Bear Shield, Chairman, Rosebud Sioux Tribal Health Board.

STATEMENT OF HON. WILLIAM BEAR SHIELD, CHAIRMAN, ROSEBUD SIOUX TRIBAL HEALTH BOARD, ROSEBUD, SOUTH DAKOTA

Mr. BEAR SHIELD. Greetings, Chairman Young and Ranking Member Ruiz. I would also like to acknowledge our South Dakota Congresswoman, Kristi Noem, and offer the gratitude and support of the Rosebud Sioux Tribe for her crafting and introducing H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act.

My name is William Bear Shield, and I am a Council Representative for the Rosebud Sioux Tribe, representing the Milks Camp Community, 1 of our 20 communities. I am also the Chairman of our Health Board, the Vice-Chairman of the Great Plains Tribal Chairman's Health Board, and the Chairman of the Unified Tribal Health Board for the Sioux San Hospital in Rapid City, South Dakota, which consists of the Cheyenne River, Oglala and Rosebud Sioux Tribes as members of the governing body.

Sioux San also provides health care to tribal members from all Sioux Tribes and from over 200 federally recognized tribes.

For over the past 2 years, basic health care has declined to an all-time low at the Winnebago, Omaha, Rosebud, Pine Ridge, and Sioux San IHS facilities, as reported by the tribes and confirmed by CMS, that has caused the deaths of tribal members and created other life-threatening issues.

While Director Smith and other IHS officials seem to view the current and ongoing diversion of the emergency room in Rosebud with rose-colored glasses, nine tribal members have died in ambulances and five babies have been born in ambulances while being transported more than 50 miles or, in some instances, up to a 2-hour one-way trip to other off-reservation hospitals, since December 5, 2015 over the past 7 months.

This cries for an investigation by someone other than IHS. Let me repeat: nine tribal members have died while riding in ambulances, and five babies have been born in ambulances while being transported over 50 miles to other hospitals.

Let's highlight another less-than-rosy fact, that Indian Health Service official that suggested that two babies being born on the bathroom floor at the Rosebud IHS hospital in 8 years was "not doing too badly" was the choice of Director Smith to be the Chief Medical Officer of the Great Plains region. No tribal leaders were consulted. Rosebud certainly was not. And, that official clearly has disdain for our people and should work elsewhere.

The Rosebud Sioux Tribe signed a treaty of peace with the United States and promised no more wars between our nations. I bring this to your attention because our treaty is different than others in that it specifically addressed our health care. By 1982 there were 360 federally recognized tribes in Alaska that Natives recognized, and even then funding was not provided fairly by treaty, land base, and population, nor fully.

Since Congress passed the Indian Gaming Regulatory Act, or IGRA, in 1988, the number of federally recognized tribes has increased to 567. As of today, 209 additional tribes have been federally recognized. Of those, none have even a fraction of our land base or population.

We do not object to Congress recognizing other tribes, but we do want a fair formula to address health care needs in accordance with our treaties, land base, and populations. IHS has reported about 67 percent of the IHS budget is administered by 114 tribes, primarily through the authority provided to them under the Indian Self-Determination and Education Assistance Act, leaving approximately 37 percent for the remaining 453 tribes, which, in many cases, are large land-based and large population tribes.

Quite simply, the U.S. Government must live up to its obligations. That means acceptable and quality health care. That means reform, and with reform, additional Federal funding. We recognize this is an authorization bill, but at heart this is an appropriation issue. Congress must not walk away from the obligation to fully fund these treaty and trust responsibilities. A purely private-sector solution is simply not appropriate.

Another challenging issue we wanted to raise before the committee is the tribal employer mandate of the Affordable Care Act, which we oppose along with other large land-based tribes. This law will result in over $2 million in fines from the Internal Revenue Service annually, for just the Rosebud Sioux Tribe alone. We will have to cut elder and youth programs, social assistance for low to no-income tribal members, and let go tribal members who work for the Rosebud Sioux Tribe. Congress needs to fix this law now.

As of this moment, the Rosebud Sioux Tribe, through its economic arm, which is the Rosebud Economic Development Corporation, or REDCo, is working with Avera Hospital in Sioux Falls, South Dakota, to contract the key management positions of the Indian Health Service hospital by utilizing our 8a Native program, and asking IHS to issue a sole-source contract to us. By doing so, this follows the spirit of Section 833, the Service Hospital Long-Term Contract 9 Pilot Program in the proposed legislation. As of this date, IHS has not responded to our request.

These are only some of the examples of why we support this bill, and we ask that IHS justify the funding formula that it is

currently using and why the South Dakota and Great Plains area tribes' budgets are far below that of small land-based and large population-based tribes.

We support direction of the legislation and look forward to working with members of this committee and your staff as you move forward to a legislative markup. We urge that you work to reform and move robust funding.

Last, I would again express appreciation for the leadership of Congresswoman Noem for introducing this legislation and to Chairman Young and Ranking Member Ruiz for holding today's hearing. Thank you.

[The prepared statement of Mr. Bear Shield follows:]

PREPARED STATEMENT OF WILLIAM BEAR SHIELD, CHAIRMAN, ROSEBUD SIOUX TRIBAL HEALTH BOARD

OPENING

Greetings Chairman Young and Ranking Member Ruiz. I would also like to acknowledge our South Dakota Congresswoman Kristi Noem and offer the gratitude and support of the Rosebud Sioux Tribe for her crafting and introducing H.R. 5406 the "Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act."

My name is William (Willie) Bear Shield and I am a Council Representative for the Rosebud Sioux Tribe representing the Milks Camp Community, 1 of our 20 communities. I am also the Chairman of our Health Board, the Vice-Chairman of the Great Plains Tribal Chairman's Health Board, and the Chairman of the Unified Tribal Health Board for the Sioux San Hospital in Rapid City South Dakota which consist the Cheyenne River, Oglala and Rosebud Sioux Tribes as members of the governing body. Sioux San provides health care to tribal members from all Sioux Tribes and from over 200 federally recognized tribes.

PROBLEMS

For over the past 2 years basic health care has declined to an all-time low at the Winnebago-Omaha, Rosebud, Pine Ridge and Sioux San IHS facilities as reported by the tribes and confirmed by CMS that has caused the death of tribal members and created other life threatening issues.

While Director Smith and other IHS officials seem to view the current and ongoing diversion of the Rosebud Emergency Room with rose-colored glasses, nine tribal members have died in ambulances and five babies have been born in ambulances while being transported more than 50 miles (up to a 2-hour one-way trip) to other off reservation hospitals since December 5, 2015—over the last 7 months. This cries out for an investigation—by someone other than IHS. Let me repeat—nine tribal members have died while riding in ambulances and five babies have been born in ambulances while being transported over 50 miles to other hospitals.

And, let us highlight another less than rosy fact. The IHS official that suggested that two babies being born on the bathroom floor at the Rosebud IHS Hospital in 8 years was not doing too badly—was the choice of Director Smith to be the Chief Medical Officer of the Great Plains Region. No tribal leaders were consulted—Rosebud certainly was not. That official clearly has disdain for our people and should work elsewhere.

The Rosebud Sioux Tribe signed a treaty of peace with the United States and promised no more wars between our Nations. I bring this to your attention because our treaty is different than others, in that it specifically addressed our health care. By 1982, there were 360 federally recognized tribes and Alaska Natives recognized and even then funding was not provided fairly by treaty, land base and population, nor fully. Since Congress passed the Indian Gaming Regulatory Act (IGRA) in 1988, the number of federally recognized tribes has increased to 567, so as of today 209 additional tribes have been federally recognized and of those none have even a fraction of our land base or population.

We do not object to Congress recognizing other tribes, but we do want a fair formula to address health care needs in accordance with our treaties, land base and populations.

IHS has reported about 67 percent of the IHS budget is administered by 114 tribes primarily through the authority provided to them under the Indian Self

Determination and Education Assistance Act, leaving approximately 37 percent for the remaining 453 tribes, which in many cases are large land-based and large population tribes. Quite simply, the U.S. Government must live up to its obligations—that means acceptable, quality health care. That means reform, and with reform, additional Federal funding. We recognize this is an authorization bill, but at heart this is an appropriation issue. Congress must not walk away from the obligation to fully fund these Treaty and Trust responsibilities. A purely private sector solution simply is not appropriate.

A SIDELINE ISSUE

Another challenging issue we wanted to raise before the committee is the Tribal Employer Mandate of the Affordable Care Act which we oppose, along with other large land based tribes.

This law will result in over $2 million in fines from the Internal Revenue Service annually for just the Rosebud Sioux Tribe. We will have to cut elder and youth programs, social assistance for low to no income tribal members—and fire (let go) tribal members who work for the Rosebud Sioux Tribe. Congress need to fix this law now.

SOLUTIONS

As of this moment the Rosebud Sioux Tribe through its economic arm (Rosebud Economic Development Corporation, REDCO) is working with the Avera Hospital in Sioux Falls, SD to contract the key management positions of the IHS Hospital by utilizing our 8a Native program and asking IHS to issue a sole source contract to us and by doing so follows the spirit of "SEC. 833. SERVICE HOSPITAL LONG-TERM CONTRACT 9 PILOT PROGRAM in the proposed legislation. As of this date IHS has not responded to our request. These are only some of the examples of why we support this bill and ask that IHS justify its funding formula that it is currently using and why the South Dakota and Great Plains Area Tribes' budget is far below that of small land-based and large population-based tribes.

WORK WITH COMMITTEE AND WRAP UP

We support the direction of the legislation and look forward to working with members of the committee and your staff as you move toward a legislative markup. We urge that you work to pair reform with more robust funding.

Last, I would again express appreciation for the leadership of Congresswoman Noem for introducing this legislation and to Chairman Young and Ranking Member Ruiz for holding today's hearing.

Mr. YOUNG. Thank you, Mr. Bear.

Now we are going to Mr. Miller.

STATEMENT OF HON. VERNON MILLER, CHAIRMAN, OMAHA TRIBE OF NEBRASKA, MACY, NEBRASKA

Mr. MILLER. Thank you, Chairman Young, Ranking Member Ruiz, and members of the subcommittee. I want to thank you for inviting me here to testify regarding Representative Noem's H.R. 5406, HEALTTH Act. Also, I wanted to further discuss with you the immediate need for substantive and effective change on delivery of healthcare services by the IHS.

My name is Vernon Miller, and I am Chairman of the Omaha Tribe of Nebraska. The Omaha Tribe is located in the northeast corner of Nebraska, right along the Nebraska and Iowa border. Our facility is the Omaha Winnebago Hospital, which is a facility that is utilized by both the Winnebago Tribes and the Omaha Tribes within Nebraska. A week from today, it will be a full year since CMS came into our facility and determined that our healthcare services were not adequate for our tribal members, and for tribal members from other tribes, as well.

What this is indicative of is 1 full year of an acknowledgment by an HHS agency that that hospital does not provide adequate care. And it is not an acknowledgment from a year, but it is years of inadequate health care that CMS has finally made that designation a year ago. It was not the only facility within the Great Plains region that does not have that certification, so as a result of that we are going to be seeing some pretty big impacts of that financially from the hospital being able to operate and further even function.

The stories from the Omaha Winnebago Hospital and other IHS facilities in the Pine Ridge and Rosebud Reservations sound like scenes from the third-world countries because they are. Our members routinely seek to avoid the hospital because of its poor services, but often end up there because of an emergency, and we do not have the resources or the means to go elsewhere. I am a prime example. I was born in the late seventies, and even back then my family chose to have me born in Pender, Nebraska, rather than that facility. So that is an indicative example almost four decades of inadequate services that I am a proof of, by not being born in that facility. And that is only 10 miles from where I live.

With the emergency rooms, we have constantly talked about the failures that are within existence within those facilities. Within the Omaha Tribe, we have several committee members who do utilize the ER as a result of not being able to utilize it elsewhere, and we have numerous stories that we could share. I can go on and on, but I will refrain from doing that.

Within our own tribe, we have a dialysis facility as well as a nursing home where we provide long-term healthcare services. As a tribe, we have made it a designation to avoid the hospital and so we use our own tribal resources to divert the facility and go directly to the Sioux City, Iowa facility or even to Ottawa, Iowa, which is over 30 miles away from our community, to have our health care and ER services met.

I want to thank the subcommittee for having this important hearing on this critical issue. I also want to give particular thanks to Representative Noem for introducing this Act, and for spearheading this initiative to really take a hard-hitting look at the health care being provided within the Great Plains area and, more specifically, within the Omaha and Winnebago Hospital, how that really is indicative of the designation it does deserve.

I want to talk about some of the issues within the HEALTTH Act. With long-term contract pilot program, it would create that 7-year program and the Omaha Tribe is definitely interested in pursuing that option. The Omaha Tribe supports the concept of blending tribal and IHS governance within the private operation of direct-service hospitals. Within the hospital itself, the governing board is a group of individuals who sit in Aberdeen, South Dakota, which is about 4 hours away, and through a video monitor, they make decisions based on the health care and the policies that are provided from that facility.

As a result of that, the Chairman from the Winnebago Tribe and I do sit in those meetings, but there is no one there from the community that is able to provide that feedback, provide that narrative that is needed to these individuals, and they are the same

governing board for the rest of the IHS hospitals within the Great Plains region.

So, there definitely needs to be some reform in how the governing process is actually provided, because as a community member and as a tribal leader, we are directly in the field where tribe members come to and bring their complaints and bring their concerns to, and that input is not adequately provided, because we are pretty much just sitting there and listening to their concerns, and we cannot really take action.

I also want to talk about the recycling problem that we have been having with the contractor that has been identified and has been awarded a contract for 4 years, but they are using it for 1 year in our facility. AB Contracting Services has been providing the ER staffing needs, and their whole staff—IHS cannot hire anybody to work there. As a result of that, you see a lot of these issues with our hospital, the Omaha Winnebago Hospital, and the loss of that CMS certification.

And, as a result of that, the bid was announced. Unfortunately, AB Contracting was the contractor that got it again, so we are recycling this problem. I can tell you today of two examples last week, two more examples from the weeks before, of constant inadequate health care that is being provided in that facility. And unfortunately, like I said, the problem has just been recycling, and I would not be surprised if CMS came in and found those same issues today that were existent a year ago when that certification was taken away.

I also want to talk about the need to really monitor that contractor, because now they are expanded to nursing, and that is really a concern within that facility for the inpatient beds, as well as the ER.

I do want to also mention the expanded hiring authority. The Omaha Tribe supports this initiative. We recommend the subcommittee work with Representative Noem to locate authorities that will put IHS's process at the front of the pack, and not just a small step ahead.

In regards to the removal and demotion of employees, the tribe supports provisions enabling the Secretary of HHS to more easily remove or demote employees. We recommend that language be added to this section that any cost for litigation——

Mr. YOUNG. I don't want to cut you off, you are doing well, but we have a vote on.

[The prepared statement of Mr. Miller follows:]

PREPARED STATEMENT OF THE HONORABLE VERNON MILLER, CHAIRMAN, OMAHA TRIBE OF NEBRASKA

Chairman Young, Ranking Member Ruiz, and members of the subcommittee, thank you for inviting me here to testify regarding Representative Noem's H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act (the HEALTTH Act), and to discuss with you the immediate need for substantive and effective change in the delivery of healthcare services by the Indian Health Service, particularly in the Great Plains area. My name is Vernon Miller, and I am the Chairman of the Omaha Tribe of Nebraska. I am part of the Thunder Clan and the former Business Teacher at Umo^{n}ho^{n} (Omaha) Nation Public Schools on the Omaha Tribal Reservation in Macy, Nebraska.

The Omaha Tribe is located in the northeastern corner of Nebraska and, along with our neighbors in the Winnebago Tribe, we receive healthcare services from the Indian Health Service at the Omaha/Winnebago Hospital located in Winnebago,

Nebraska. In just a week from today, it will have been a full year since the Centers for Medicare and Medicaid Services (CMS) ceased payment for services at the hospital because the facility failed to provide for patient safety, failed to combat negligence that resulted in injuries and deaths, and failed to provide adequate care to patients. For us in the Omaha Tribe and our members, the IHS has failed to live up to its treaty and trust obligations to furnish healthcare and failed to treat us with respect and decency.

The stories from the Omaha/Winnebago Hospital and other IHS facilities serving the Pine Ridge and Rosebud Reservations sound like scenes from Third World countries, not the American heartland. Our members routinely seek to avoid the hospital because of its poor services, but often end up there because of an emergency or they do not have the means to go elsewhere. But, the emergency rooms at these hospitals are renowned for their failures. In the Omaha/Winnebago Hospital, the emergency room staff received one of our tribe's members who was complaining of severe back pain. The hospital sent him home, and later left a single voicemail with the man telling him his kidneys were failing. The hospital attempted no further contact, and the man died at a relative's house 2 days later. Another one of our tribal members, a pregnant woman, came to the hospital only to be discharged after the staff could not find a heartbeat for her baby. They told her to drive herself to Sioux City to another hospital to receive care. We've heard stories from our neighbors in South Dakota that their IHS facilities have gone 6 months without sterilization machines so their workers were hand washing medical equipment. We have heard stories of women giving birth on the floor of IHS facilities' bathrooms and people dying of heart attacks with no intervention from staff.

In 2010, Senator Dorgan and the Senate Indian Affairs Committee reported on the Great Plains region's failures. Unfortunately, the problems identified in the Dorgan Report have only gotten worse, and the care our tribal members receive still does not meet minimum standards of quality.

We thank the subcommittee for having this important hearing on this critical issue. We would also like to give particular thanks to Representative Noem for introducing the HEALTTH Act. The HEALTTH Act is a critically important piece of legislation that we hope will empower the Secretary to begin to address the fundamental structural issues that have plagued the IHS in the Great Plains area for far too long. The Omaha Tribe strongly supports it, and urges this committee to consider it favorably.

The issues facing the IHS are not only structural in nature however. The IHS continues to suffer from inadequate funding, and many of the problems it faces stem from the fact that it has always been funded at only a fraction of need. The average spending for an IHS patient is only 25 percent of that for an average Medicare beneficiary. Even if the IHS had no structural issues, the lack of adequate funding would still result in inadequate care. While the HEALTTH Act provides important and needed reforms for the IHS, we are concerned that without additional funding true reform is unlikely to be realized. The problems with the Great Plains area require a two-pronged solution: structural reform and adequate funding. One cannot succeed without the other.

We thus urge you to consider providing additional funding as well. One important change you can make right away is to ensure that the IHS will be held harmless in the event of a sequestration or a government shutdown, just as the Veterans Affairs' health facilities are (through provisions like advanced appropriations and exceptions in shutdown orders). It is unacceptable for our members' health care to get wrapped up in these battles.

THE HEALTTH ACT

The Omaha Tribe generally supports the HEALTTH Act and the reforms at IHS it seeks to achieve. We offer the following comments on specific aspects of the bill, and urge the committee to consider it favorably.

Long-Term Contract Pilot Program

H.R. 5406 would create a 7-year contracting pilot program "to test the viability and advisability of entering into long-term contracts for the operation of eligible Service hospitals with governance structures that include tribal input." For the pilot program, the Secretary of Health and Human Services would be required to select three direct-service IHS hospitals in rural areas, with the permission of the tribes served by those hospitals, and, in consultation with those tribes, to create a governing board for each hospital that includes IHS, hospital, tribal, and expert health care administration and delivery representatives.

The Omaha Tribe supports the concept of blending tribal and IHS governance with private operation of direct service hospitals. The IHS has proven unable to

operate the services it provides, so—as long as private contractors are able to handle the job—we are not opposed to the IHS contracting with another entity to fulfill its treaty and trust obligations so long as IHS and the United States retain ultimate responsibility. We hope the subcommittee agrees that, though this provision calls for a long-term contract, the intent is not to lock the IHS and the tribes into a contract if the contractor fails. Language clarifying that intent in a report may be helpful. We also want to ensure that tribally run programs through self-governance that operate in our hospitals (like some programs at the Omaha/Winnebago facility) that are working are not subject to takeover in these contracts. We also support a strong tribal role in the governance of hospitals under this pilot program, including having say in the selection of the contractor and the hiring and placement of key leadership positions.

We note that the IHS must not be allowed to "recycle" problem contractors. The IHS has hired "AB Staffing" to fill the gap in its services at our hospital and those at Pine Ridge and Rosebud. This company was already providing services when CMS terminated payment at the Omaha/Winnebago Hospital, and now their role has been expanded to include nursing. IHS must look farther afield, including within the Great Plains region, to find providers with expertise in rural health care delivery.

Expanded Hiring Authority

The House bill would permit the Secretary to choose to waive civil service requirements for employees providing healthcare delivery, and to instead exercise statutory and regulatory personnel authorities utilized by the Veterans Health Administration. This option would not apply with respect to senior executive service positions and positions that do not involve health care responsibilities.

The tribe supports the efforts to streamline and speed hiring. Vacancies in health care provisions plague service delivery. However, we believe vacancies in leadership cause similar problems, and believe these provisions should be expanded to include leadership positions even if those are not in service delivery. Further, we would like to see the provisions of S. 2953 requiring consultation with tribes located in the service area included in this legislation.

We do have some concern about using the Veterans Health Administration's personnel provisions for streamlined hiring. Just 2 weeks ago, Representative Wenstrup introduced legislation to reform the hiring process at the VA, calling the process "lengthy and inefficient." Congressman O'Rourke and Congresswoman Stefanik have other legislation aimed at improving the process to increase access to doctors. The Commission on Care's final report of June 30, 2016 recommends many changes to the VA's hiring process. We recommend that this subcommittee work with Representative Noem to locate authority that will put IHS' process at the front of the pack, not just a small step ahead.

Removal and Demotion of Employees

The tribe supports the provisions enabling the Secretary of HHS to more easily remove or demote employees.

Some staff and providers are doing fantastic work with few resources to provide what they can to our people. But, those good workers are cut off at the knees by employees who are unwilling to work or fulfill their duties. The IHS's answer to this is often to transfer the employees or put them on lengthy paid leave. The problem will not be solved by shipping it elsewhere or shutting it out.

We note that some have raised due process concerns about a process that will result in more rapid firing or demotion. We urge the subcommittee and Representative Noem to ensure this authority will not result in lengthy, unwinnable litigation by the IHS, or a practice of the IHS paying settlements to fired employees to avoid such litigation. We recommend that language be added to this section that any costs for litigation arising from these personnel practices and payments resulting to lost cases or settlements be taken from somewhere other than IHS program or services funds, and from either Departmental administrative funds or the Judgment Fund. We cannot afford services money being diverted for legal settlements.

Timeliness of Care

H.R. 5406 includes provisions in response to long wait times for services at IHS facilities. Section 104 of the bill would require the IHS to promulgate regulations establishing standards to measure timeliness of the provision of health care services at IHS facilities and to develop a process for IHS facilities to submit data under those standards to the Secretary. The Omaha Tribe supports these provisions.

Student Loan Provisions

As an employment incentive, the bill would exclude payments made by the IHS student loan repayment program from taxable income, and permit health administration employees to participate in the IHS student loan repayment program by adding health care management and administration degrees to the list of eligible degrees for the program. It would also permit part-time employees to participate in the program, with a longer time commitment. The Omaha Tribe supports these provisions.

Cultural Competency Program

The bill would require the IHS, in consultation with tribal representatives, to develop and implement a mandatory cultural competency training program in each Service area for all employees, locum tenens providers, and contracted employees whose jobs require regular direct patient access. Participation in the cultural competency training program would be mandatory for all employees on an annual basis. The Omaha Tribe supports these provisions.

Relocation Reimbursement

The bill would permit the Secretary to provide between 50 percent and 75 percent of base pay for relocation reimbursement to IHS employees who relocate to serve in a different capacity or position within the IHS, if they relocate to a rural or medically underserved area to fill a position that has not been filled by a full-time noncontractor for at least 6 months, or if the relocation is to fill a hospital management or administration position. The Omaha Tribe supports these provisions provided that relocation costs do not adversely affect the provision of health care services.

Medical Volunteer Credentialing

The bill would require the IHS to implement a uniform credentialing system to credential licensed health professionals who seek to volunteer at an IHS facility. The bill would permit the Secretary to consult with public and private medical provider associations in developing the credentialing system. The bill summary states that the purpose of this provision is to "centralize its licensed health professional volunteer credentialing procedures at the agency level rather than the facility level to reduce the paperwork burden on licensed health professionals who wish to volunteer at IHS direct-service facilities." The Omaha Tribe supports these provisions for the IHS, but is concerned that the provisions apply equally to tribally operated programs, who are already empowered to do their own credentialing of volunteer medical providers. This provision would be strengthened by limiting its applicability to the IHS only.

Waiver of Indian Preference Laws

H.R. 5406 would permit waiver of Indian preference laws. The House bill would permit the Secretary to waive Indian preference laws with respect to a personnel action if it relates to (1) a facility that has a personnel vacancy rate of at least 20 percent, or (2) a former IHS or tribal employee who was removed or demoted from that former employment for misconduct that occurred within the previous 5 years. In order to exercise that authority, the Secretary would be required to first obtain a written request or resolution from an Indian tribe located within the Service unit.

Indian Preference is critically important to the Omaha Tribe, though we support providing the IHS with some flexibility as contemplated here. We recommend that the provision be amended to require that a waiver only be operative if the IHS gets a written request or resolution from all Indian tribes located in the Service unit, not just one. Further, the waiver of preference should be limited in nature, and not provide a blanket lifting of preference. Adding a provision that the IHS present a limited staffing plan or action to which the waiver applies would help avoid the IHS treating requests or resolutions as long-lasting without the tribes' intent that they be.

Financial Stability Reports

The bill would require the Comptroller General, within 1 year, to submit a report to Congress on the financial stability of IHS hospitals and facilities that have experienced sanction or threat of sanction by the Centers for Medicare and Medicaid Services, including any revenues lost as a result and recommendations for legislative action. The Omaha Tribe supports these provisions.

CONCLUSION

On behalf of my tribe, I thank the subcommittee and Representative Noem for their efforts to improve the IHS and the quality of care for Native people in the Great Plains. If there is any way I or my tribe can further assist with these efforts, please do not hesitate to contact me.

Mr. YOUNG. I am going to suggest that you go ahead and testify. It is going to be an hour before we get back here. I guess that is the way we will run it. Eleven votes will be an hour, at least. I hate to do that to the witnesses. This shows you how we run this silly place, I can tell you that right now. It is not good.

Why don't you take over while I am gone—no, no, OK.

Mrs. Noem, would that be OK with you, to just come back?

Mrs. NOEM. If the committee members would come back, I think that the witnesses have really compelling testimony, and I think it would be beneficial, as this legislation moves forward.

Mr. YOUNG. Yes, I——

Mrs. NOEM. So if you will come back, and if they don't mind staying for an hour——

Mr. SABLAN. Mr. Chairman?

Mr. YOUNG. Yes?

Mrs. NOEM. Go get a coffee.

Mr. SABLAN. I have just one question to Ms. Smith, if I may, please.

Mr. YOUNG. Well, go ahead——

Mr. SABLAN. I will make it short.

Mr. YOUNG. You don't vote, so——

Mr. SABLAN. Yes, yes, I know.

Ms. Smith, how prevalent is this problem throughout Native American communities?

Ms. SMITH. Thank you. I think we have challenges throughout the system. Some of them are for any rural healthcare provider and some are unique to IHS in tribal communities.

Mr. YOUNG. OK. We will recess now. And I do apologize to you guys. It is not correct, but that is the way this system works right now.

[Recess.]

Mr. YOUNG. The witnesses can all take the stand, and again I do apologize. Ms. Kitcheyan, you can go ahead and testify.

STATEMENT OF VICTORIA KITCHEYAN, TREASURER, WINNEBAGO TRIBE OF NEBRASKA, WINNEBAGO, NEBRASKA

Ms. KITCHEYAN. Good afternoon, Chairman and members of the committee. My name is Victoria Kitcheyan, and I am a member of the Winnebago Tribe of Nebraska. I serve as the Tribal Treasurer on the Tribal Council, and I want to thank you for holding this hearing on this piece of legislation that is the logical first step in adjusting the systematic changes that need to be made that are present. They have been allowed to go on for far too long. We think that the findings in Winnebago are so profound that only a long-term plan that implements organizational change with the financial resources to match are going to make any concrete changes to the crisis.

The Winnebago Tribe, as background information, is located in northeast Nebraska. We have a 13-bed inpatient IHS facility with a clinic and an ER department. That facility serves the Ponca, Winnebago, and Omaha Tribes, as well as many individual Indians from other tribes living in the area. So, collectively, it has a patient load of about 10,000 patients. Those are 10,000 patients that deserve quality health care.

Since at least 2007, Winnebago Hospital has been operating with demonstrated deficiencies that have been so numerous and so disturbing that in 2015 we actually became the first federally operated facility—and, to our knowledge, the only one—to lose our Medicaid and Medicare reimbursement certification. And to this day we still are without that certification.

Those findings go back to 2007, but have continued through the years. In 2011, there was a re-certification and more findings were uncovered. My Aunt Debbie was a victim of those deficiencies. She was over-medicated, left unsupervised, and died. She died in that hospital, and we questioned the circumstances surrounding that. And before all these CMS findings had come to light, we had no answers. We questioned how long she laid on the floor. We questioned the documentation. We questioned the cold-blooded nurses that covered up the incident.

Debbie's story and countless others need to be told. This example of sub-standard care and numerous documented CMS findings are indicative of the Federal Government's loose commitment to its trust responsibility.

When some of the findings became public, IHS publicly committed to fixing those deficiencies, but just 2 years later in 2014, we had four more unnecessary deaths identified by CMS. In April 2014, a 35-year-old man died of cardiac arrest because the nurses did not know how to call a code blue or operate a crash cart. A female died because they could not load her on the medivac. A 17-year-old female died because they could not administer a dopamine drip. These things are happening at a place of healing, a place that is supposed to be there for the people, yet their health and safety is in jeopardy.

A fourth survey was conducted in 2014, and it had been cited that the facility had caused actual harm and was likely to cause harm to all individuals that come to the hospital for examination and/or treatment of a medical condition. Keep in mind that when CMS comes, they only sample a small portion of the record so we will never know how many people died unnecessarily. We will never know how many people were misdiagnosed.

It is these changes that need to be made, and it is these changes that led up to our certification termination. Throughout this period, IHS assured the tribe that these things were being corrected, yet we were still terminated in July of 2015. We have heard reports for years from tribal members of the notorious reputation, and we go there, as well, so we know how bad it is. But until CMS came in, our complaints fell on deaf ears. CMS was able to provide an independent, verifiable documentation of what was going on. The sister agency put their foot down.

After these five deaths occurred, we asked the central office, "What happens with unusual circumstances? What happens with

questionable death?" And we found that there is no procedure to look into these. When we pressed the issue further, it is the governing body, which is non-existent. Governance was also cited by CMS. So, you have a governing body made up of non-medical professionals overseeing the actions of the physicians, the nurses, and the anesthesiologist.

It is important to note also that Winnebago Hospital has become a short-term stop for a number of IHS contractors. These physicians coming in many times are not Federal employees, they are private contractors who rotate in and out of the facility for 2 to 3 weeks at a time. They are heavily counting on the nursing staff to provide that continuity of care. And with the nursing staff being under-trained and cited in the reports, even if we had the best physician, how are they going to be supported by a poor nursing staff with a poor attitude?

Many of these things have been cited in multiple reports. Finally, in 2015, after the certification had already been lost, IHS commissioned their own consultant, and they came up with 97 deficiencies at that hospital that had not even been identified by CMS.

With that, they came up with a corrective action plan. The tribe has been working hand in hand with IHS to ensure those deficiencies are corrected, but the tribe has no real way of measuring if that mark has been met. That nurse watched a video; does that mean she can operate a crash cart? Things like that, we really have no control over that process.

It is clear that management, recruitment, transparency, and also accountability are major issues. A full year has passed and we are still without a full-time CEO, we are still without a full-time director. We have acting administrators coming in. Without consistent leadership, it is very hard to have consistent health care.

Mr. Chairman, these are the reasons why we support this bill. I must say that we encourage you to pass this legislation, but I implore you do not abandon us after this. It is going to take a team effort, additional resources, and consistent congressional oversight. And, furthermore, we have 10,000 people back at home who need their hope restored. You cannot bring back those lost lives, but we can honor them by passing this legislation and fully supporting it. But until those systematic changes are made within the IHS system, Winnebago Hospital will continue to be the only place where you can legally kill an Indian.

My family has experienced this, countless families in my community have experienced this, and the trauma is so deep that it is beyond repair. It is going to take something outside of the scope of what IHS is accustomed to doing, that culture ingrained in them of self-preservation. We need to restore the patient care, the quality.

[The prepared statement of Ms. Kitcheyan follows:]

PREPARED STATEMENT OF VICTORIA KITCHEYAN, TREASURER, WINNEBAGO TRIBE OF NEBRASKA

Good afternoon Mr. Chairman and members of the subcommittee, my name is Victoria Kitcheyan. I am a member of the Winnebago Tribe of Nebraska and I currently serve as Treasurer of the Winnebago Tribal Council. Thank you for holding this hearing on this very important piece of legislation which presents a logical first step toward addressing systemic problems in the IHS system which have been

allowed to continue for far too long. I say first step because, as my testimony will document, the problems in the current IHS system at Winnebago are so profound that only a long-term plan, which implements organizational changes and comes with additional financial resources, is required to make real concrete changes in our current situation. In order to help you understand my point, allow me to provide you with some background information.

The Winnebago Tribe is located in rural northeast Nebraska. The tribe is served by a thirteen (13) bed Indian Health Service (IHS) operated hospital, clinic and emergency room located on our Reservation. This hospital provides services to members of the Winnebago, Omaha, Ponca and Santee Sioux Tribes. It also provides services to a number of individual Indians from other tribes who reside in the area. Collectively, the hospital has a current service population of approximately 10,000 people.

Since at least 2007, the Winnebago IHS Hospital has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. The CMS deficiencies that have been uncovered are so numerous and so life threatening that in July of 2015, the IHS operated hospital in Winnebago became what is, to the best of our knowledge, the only federally operated hospital ever to lose its Medicare/Medicaid Certification.

Here is a synopsis of the events that led to this decision:

In 2011, CMS conducted a re-certification survey of the hospital and detailed serious deficiencies in nine areas, including Nursing and Emergency Services. My wonderful aunt, Debra Free, was one of the victims of those deficiencies. She died in the Winnebago Hospital in 2011 when she was overmedicated, left unsupervised and fell from her bed in the inpatient area. After her death, a nurse at the hospital told my family that Debra had fallen during the night. She said that nurses from the emergency room had to be called to the inpatient ward to get Debra back into bed because there was inadequate staff and inadequate equipment on the in-patient floor to address that emergency.

While the hospital insisted that they did everything possible to revive her and save her life, we question just how long she remained on the floor and what actually happened. Among those questioning was Debra's sister, Shelly, who was a nurse at the hospital during that period. Unfortunately, my Aunt Shelly was not on duty when this occurred, but she did know enough from her professional training to question the circumstances of the death.

When my Aunt Shelly and the family requested to see the charts to determine what actually happened, we were met with immediate resistance. First, my mother, also Debra's sister, was told she was not authorized to request the chart. Then my grandmother, Aunt Debra's own mother, Lydia Whitebeaver, submitted a request and was denied the information. In fact, the whole family and the attorney that we were forced to hire were all told that the chart was "in the hands of the Aberdeen Area Office's attorneys" and was not available to us.

Because she demanded answers to our very reasonable questions, my Aunt Shelly was retaliated against in the worst way. As an IHS employed nurse at the hospital she was regularly intimidated by her supervisors and colleagues, and generally treated in the most horrific way by the Director of Nursing and her cronies. One of those nurses even reported Shelly to the State Licensing Board. Thank goodness the State Licensing Board's Members saw that report for what it was and dismissed the inquiry almost immediately, but this is a prime example of why we have been unable to get the proof of these incidents before the CMS Reports were released. Fear of retaliation within the IHS system is real. One former IHS employee of the hospital has said that those employees who threaten to speak out are regularly reminded to "remember who you work for."

My aunt, Debra Free, left behind a 9-year-old daughter and a loving family. She should not have been allowed to die like this. Her story and those of countless others need to be told. This example of substandard care and the numerous other examples documented by the CMS Reports are indicative of the Federal Government's loose commitment to upholding its Federal trust responsibility. The Great Plains Service Area is in a state of emergency and the patients who seek care at the Winnebago Service Unit are in jeopardy as we speak!

My ancestors made many sacrifices so that our people's livelihood would continue. As a tribal member and tribal leader, it is my responsibility to carry their efforts forward to protect my people. Neither the Winnebago Tribe, nor I, will stand idle as Indian Health Service kills our people, patient by patient.

In addition to my aunt's case, the 2011 CMS Report also found that during that year: patients who were suicidal were released without adequate protection; that a number of patients who sought care were sent home without being seen, or with

just a nurse's visit, were never documented in any electronic medical records; that out of twenty-two (22) patient files surveyed by CMS, four (4) of those patients were not provided with an examination which was sufficient enough to determine if an emergency existed, and that at least one of those patients suffered an undiagnosed stroke and was sent home from the emergency room without any follow-up care whatsoever.

When some of the findings of the CMS 2011 Report became public, in early 2012, former IHS Director Roubideaux publicly promised improvements. While some minor issues were addressed, many other things got worse. In just the past 2 years, four additional potentially unnecessary patient deaths and numerous additional deficiencies have been cited and documented by CMS. These incidents and reports include:

- April 2014. A 35-year-old male tribal member died of cardiac arrest. CMS found that the Winnebago Hospital's lack of equipment, staff knowledge, staff supervision and training contributed to his death. Specifically, the nursing staff did not know how to call a Code Blue, were unfamiliar with and unable to operate the crash cart equipment, and failed to assure that the cart contained all the necessary equipment. CMS concluded in its report that conditions at the hospital "pose an immediate and serious threat" mandating a termination of the hospital's CMS certification unless they were corrected immediately.
- May 2014. A second CMS survey found that a number of the conditions which pose immediate jeopardy to patients had not been corrected, and that the hospital was out of compliance with CMS Conditions of Participation for Nursing Service.
- June 2014. A female patient died from cardiac arrest while in the care of the hospital. This time the death occurred when the staff was unable to correctly board her on the medivac helicopter. The conditions leading to the unnecessary death are documented in the July 2014 CMS report. This young woman was employed by the Tribe's Health Department and played an active role in the lives of many youth, who often referred to her as "Mother Goose."
- July 2014. A 17-year-old female patient died from cardiac arrest because the nursing staff did not know how to administer the dopamine drip ordered by the doctor. CMS also documented this event in detail in its July 2014 report and found that numerous nursing deficiencies remained uncorrected. This resulted in the issuance of a continuing Immediate Jeopardy citation for the hospital on the Condition of Participation for Nursing Services.
- August 2014. In its fourth survey conducted in 2014, CMS concluded that failure to provide appropriate medical screening or stabilizing treatment "had caused actual harm and is likely to cause harm to all individuals that come to the hospital for examination and/or treatment of a medical condition."
- September 2014. CMS survey jurisdiction over the Winnebago IHS hospital was transferred from the Kansas City regional office to Region VI in Dallas, TX, when IHS attempted to forum shop the next CMS review, but in November 2014, that new CMS office identified more than 25 deficiencies.
- January 2015. Another death occurred when a man was sent home from the Emergency Department with severe back pain. A practitioner later left him a voicemail after discovering, too late, that his lab reports showed critical lab values. The call advised him to return in 2 days. The patient died at home from renal failure before the 2 days were up. This situation is documented in the May 2015 CMS report.
- May 2015. CMS conducted another follow-up survey. In addition to documenting the January 2015 death noted above, the report states that seven CMS Conditions of Participation and EMTALA requirements were found out of compliance at the hospital.
- July 2015. CMS terminated the Winnebago IHS Hospital provider agreement. CMS stated that the hospital "no longer meets the requirements for participation in the Medicare program because of deficiencies that represent an **immediate jeopardy** to patient health and safety."

Keep in mind that the deaths and findings cited by CMS are only the ones that have been documented by CMS. When CMS conducts a survey, only a small sampling of patient records are reviewed. We have no way of knowing how many more unnecessary deaths and misdiagnosis have occurred at the hands of IHS personnel. There is also no way that we can portray the tremendous pain and loss that has been suffered by our families and our community in these few pages. These things

are happening not only in Winnebago, but they are also happening in Rosebud, Pine Ridge and Rapid City. Our people are devastated, angry and demanding change.

The totality of these circumstances finally led CMS to notify the Indian Health Service in April of 2015 that it was pulling its certification of the Winnebago IHS Hospital, unless substantial changes were made. Changes were not made and CMS terminated that certification on July 23, 2015.

Throughout this period the IHS assured the Winnebago Tribal Council that the CMS findings, most of which were never provided to the Winnebago Tribe at least in their totality, were being addressed. In fact, less than 2 weeks before CMS actually pulled the Certification, the IHS Regional Director was still telling the Tribal Council that IHS was talking to its lawyers and planning an appeal. There was in fact no basis for an appeal and, 1 year later, the hospital remains without a permanent qualified CEO and is still not ready to submit an application to CMS for recertification.

When the termination happened and the Winnebago Tribe and its attorneys asked to see a copy of the latest CMS report, they were told by the IHS Regional Office that it needed to be reviewed for privacy concerns before it could be released to us. We finally obtained a copy and also learned that the CMS oversight of Winnebago IHS Hospital was transferred from Kansas City to the Dallas Office. When we asked one CMS employee why this transfer had occurred, he was fairly quick to suggest that, in his opinion, this was forum shopping. Whether there is any truth to this or not, this transfer of CMS oversight certainly raises questions.

While the Winnebago Tribe had heard and reported stories of these atrocities for years, the CMS reports have provided independent verifiable documentation of what was really going on. What we have learned since then is equally disturbing.

When we asked former Acting Director McSwain about the professional medical review that the IHS had engaged in after each of these five deaths occurred, and what role the Central Office played in those reviews, we were shocked to learn that the IHS does not appear to have an established procedure for dealing with questionable deaths or other unusual events that occur in its hospital. In fact, if there was ever a professional peer review of any of those five incidents of questionable death, we can't find it!

When we pushed harder on this issue we were told that this review should have been conducted by the "Governing Body" of the hospital. This basically means that a body, composed largely of other IHS employees who are not doctors or other medical professionals, were supposed to review the actions of the physicians, nurses and anesthesiologists in the emergency room. The end result, however, is that—to the best of our knowledge—no one was fired, no one was reprimanded, no one was suspended pending a medical investigation and no one was reported to the licensing board. This is outrageous!

The Governing Body for the Winnebago IHS Hospital has also basically been nonfunctional. The area of governance was cited numerous times in the CMS reports. The Governing Body is comprised primarily of IHS management officials, many of whom are from the regional office and have no direct personal knowledge of the community, the facility, the staff or the patients served by the hospital. And while there is supposed to be a voting seat on the board from the two primary tribes served by the hospital, we have found that the tribal representatives are not afforded access to all of the same information as other members of the board, or the information is not timely. Furthermore, training has been inadequate and there is no regular meeting schedule for the Governing Body.

It is also important to note that the Winnebago IHS Hospital has become a short-term stop for a number of IHS contractors. Many of the doctors who take care of our needs are not Federal employees, they are private contractors who rotate in and out of our facility. This forces even the best of those physicians to rely heavily on the nursing staff who remain at the facility, many of whom have been found by CMS to be seriously undertrained. Most recently, the IHS advertised to find one contractor to operate the Emergency Departments at three hospitals in the Great Plains region, including Winnebago. The contractor selected by IHS is one of the same problem contractors that has been around for years and that was working at Winnebago during the period of review by CMS. This action was supposedly taken to help improve the quality of services but it was done without consultation with the tribes and not only did we end up with one of the same companies that failed us in the past, the few permanent providers who did work in the Emergency Department were forced to either leave or transfer to other positions.

In the fall of 2015, the IHS hired an outside consultant to perform its own review of the facility. This review was conducted applying standard Federal and state medical standards. During this review, this independent consultant found 97 deficiencies, many of which were never uncovered, or at least never reported, by CMS.

The IHS consultant helped to develop a corrective action plan for the Winnebago facility, and the hospital staff is still continuing to work on implementation of this plan. This is obviously necessary, but the process is slow and it is difficult to trust that checking an item off a list is getting us the real change that we need to see or that those changes will be sustained.

It is clear that management, recruitment, accountability and transparency are all major issues that need to be addressed. One full year has passed since the CMS certification was terminated at Winnebago—and 1 year later, the CEO position at the hospital and the Director of the Regional Office are still being held by individuals detailed from other IHS positions for 30 or 60 days at a time. Real change and the rebuilding of this organization cannot happen without permanent qualified personnel and the funding necessary to carry out the mission.

Mr. Chairman, these are the reasons that the Winnebago Tribe supports the immediate passage of this legislation. But, I must state clearly and bluntly, that while everything in this bill is needed, this legislation alone will not solve our problem. Proper training of hospital staff costs money, new equipment costs money, and recruitment, under these circumstances is also going to cost money. So, while I encourage you to pass this legislation, please do so as an initial first step. I implore you not to abandon us after this bill is passed because correcting this situation is going to require a team effort, additional resources, and consistent congressional oversight of IHS activity.

Thank you again for allowing me to testify, I will be happy to answer any questions you may have.

Mr. YOUNG. Thank you, ma'am. We have another witness, I believe. Is that Ms. Bohlen?

Ms. BOHLEN. Yes, sir.

Mr. YOUNG. Ms. Bohlen, you are welcome. Sorry you got caught in a lock-down. Come on in.

STATEMENT OF STACY BOHLEN, EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD, WASHINGTON, DC

Ms. BOHLEN. Thank you, sir. My name is Stacy Bohlen. I am the Executive Director of the National Indian Health Board in Washington, DC. I am also an enrolled member of the Sault St. Marie Tribe of Chippewa Indians, and on behalf of the National Indian Health Board, thank you for allowing us to be here today.

Our organization was founded in 1972 by the federally recognized tribes, both American Indian and Alaska Native, to ensure that the Federal Government upholds its trust responsibility and honors the treaties of our people for the provision of health care. We also support the sovereignty and self-governance, self-determination of the tribes.

On behalf of the 567 federally recognized tribes, I am honored to be here today. Of course, the hearing today is on the proposed legislation that we have had a quick review of today—the legislation attempting to address long-standing tribal concerns about the Indian Health Service and outlining how to move forward with better staffing practices, improving timeliness of service, increasing cultural competency, and reforming the purchase-referred care system, these are needed changes.

The National Indian Health Board would just like to ensure that in the review of this legislation, and as it moves forward in a bipartisan manner, that it is recognized that the legislation is amending the Indian Health Care Improvement Act that is the foundation of the delivery of health care to all American Indians and Alaska Natives in the United States.

We want to make sure that there is a national voice and presence forming, reviewing, and imparting opinion and knowledge into the system of creating what the final bill will look like.

The solutions that we are looking at, we believe that there are five key areas to improving the Indian Health System. But I want to start with saying that the Number-one thing that the Indian Health System could benefit from is implementing standard business practices.

Medicine is a business. In the United States of America, health systems are a business. There are standard business practices, there are standard accountability practices, and quality improvement measures, patient advocacy, and so forth that are done throughout this country that work very well. And we believe that the Indian Health Service, especially through some of the provisions that are allowed in the Indian Health Care Improvement Act, has the authority to do innovative work. And some of these innovations are the things that I just mentioned.

There needs to be structural and administrative reform, quality assurance, recruitment and retention of qualified medical and administrative personnel, increase in medical literacy and medical health knowledge among American Indians and Alaska Natives, as well, and greater investment in our systems, our recruitment and retention systems that start in kindergarten to grow a cadre of American Indian and Alaska Native health professionals who will serve their own communities or our tribal communities.

We know that there are unique challenges to delivering health care in any rural setting. However, there are unique challenges to the Indian Health System. As the Chairman knows from Alaska, we are talking about incredibly rural and remote areas in some cases. And certainly with the Great Plains, while it is not Kotzebue, it is very remote for Americans, and it is a place where something as simple as a housing shortage for healthcare providers and teachers can keep the tribes from having the kind of healthcare professionals they have.

There is a chronic lack of funding that the IHS has been experiencing for some time. Even now, it is only funded below 50 percent of need. With that is the reality that the tribes fought for years for the Indian Health Care Improvement Act to be reauthorized. Congress was with us. We finally achieved that. And only about 40 to 60 percent of that Act has been implemented because of a lack of funding.

I want to call attention also to a voice in this system that can be very, very beneficial. Today, three American Indian physicians are with us in the hearing room. They are an emergency physician, a primary care physician, and an OB/GYN. They are from the Association of American Indian Physicians. Organizations like that, and the professions and the people they represent, have an additive value to the voice and the consideration of what we are trying to do to improve the Indian Health System.

I could talk more about purchase-referred care and some of the other provisions, but I see that I am just about out of time. So, the National Indian Health Board does support Congresswoman Noem's legislation, and we look forward to working with her,

Congress, and the tribes to forming it into a solution that works for all of Indian Country. Thank you.

[The prepared statement of Ms. Bohlen follows:]

PREPARED STATEMENT OF STACY A. BOHLEN, EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD

Good afternoon, my name is Stacy Bohlen, and I am the Executive Director of the National Indian Health Board (NIHB). Chairman Young, Vice Chairwoman Coleman Radewagen, and members of the subcommittee, thank you for holding this important hearing on the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act.

The National Health Board (NIHB) is a 501(c)3 not for profit, charitable organization providing health care advocacy services, facilitating tribal budget consultation and providing timely information and other services to tribal governments. Whether tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Service (IHS), NIHB is their advocate. Because the NIHB serves all federally recognized tribes, it is important that the work of the NIHB reflect the unity and diversity of tribal values and opinions in an accurate, fair, and culturally sensitive manner. It is our mission to be the **one voice** affirming and empowering American Indian and Alaska Native (AI/AN) peoples to protect and improve health and reduce the health disparities our people face. I appreciate the opportunity to provide this testimony before the Subcommittee on Indian, Insular and Alaska Native Affairs today. I am here today to offer the national perspective of all 567 federally recognized Indian tribes.

This hearing today, and the proposed legislation we are here to discuss, have arisen because of long-standing, systemic issues within the IHS that have led to crisis situations—especially, in the Great Plains Service Area. In the last year, several hospitals in this region have lost, (or received threats of revocation) their ability to bill Centers for Medicare and Medicaid Services (CMS) due to the failure of federally run sites to comply with basic safety and regulatory procedures. However, many of the issues now coming to light are not new to American Indian and Alaska Natives that rely on the Indian Health Service as their primary source of health care and health information. At least 5 years ago, then-Senator Dorgan released a report exposing the chronic mismanagement occurring at both the IHS regional (Area Office) level and the Headquarters level of the Agency. A 2011 report by a separate U.S. Department of Health and Human Services (HHS) task force specifically noted that: ". . . the lack of an agency-wide, systematic approach makes it virtually impossible to hold managers and staff accountable for performance and to correct problems before they reach crisis proportions."

Now that we are in such crises situations, there must be two separate courses of action taken. First and foremost, immediate corrective action must be taken to rectify the closing and cutting of IHS services so there are no more unnecessary deaths of our people, not just in the Great Plains area, but at the national level as well. Once the crisis is stabilized, we must then address the fundamental and systemic issues that have been occurring within the Agency for decades. These reforms may start in the Great Plains area; but they must be implemented nationally in order for all American Indians and Alaska Natives to have access to safe, reliable and quality health care.

The HEALTTH Act (H.R. 5406), proposed by Representative Kristi Noem, is attempting to address long-standing tribal concerns about the IHS, and outlining how to move forward with better staffing practices, improving the timeliness of services, increasing cultural competency and reforming the Purchased/Referred Care program. The spirit and intent of this legislation is clearly aimed at responding to the call of tribal leaders, patients and the families of those who have had adverse experiences within the IHS system. The National Indian Health Board stands ready to work with the committee as the bill is shaped and formed through a tribally engaged and informed process.

Many of the provisions within this bill will provide the IHS with the authorizations they need to improve the quality of health care services delivered at IHS facilities. However, especially because this legislation proposes to amend the Indian Health Care Improvement Act (IHCIA), it is the position of the National Indian Health Board that the bill must be vetted further with a process similar to that utilized during the IHCIA reauthorization. During the years that Indian Country and Congress worked to achieve the reauthorization of IHCIA, the NIHB facilitated a tribal leader led committee. Furthermore, it is the hope of the NIHB that this legislation, and the similar Senate bill (S. 2953), the IHS Accountability Act of 2016, are

the keys that this Congress needs to move into an era where the Indian Health Service can be fully funded at the level of need year after year. While the provisions in these bills that will improve transparency, accountability, and administrative functions are absolutely necessary, increased funding to carry out health care services in parity with the general U.S. population is just as, if not more so, necessary to erase the severe health disparities experienced in tribal communities.

FEDERAL TRUST RESPONSIBILITY

The Federal trust responsibility for health is a sacred promise, grounded in law and honor, which our ancestors made with the United States. In exchange for land and peaceful co-existence, American Indians and Alaska Natives were promised access to certain remunerations, including health care. Since the earliest days of the Republic, all branches of the Federal Government have acknowledged the Nation's obligations to the tribes and the special trust relationship between the United States and American Indians and Alaska Natives. The Snyder Act of 1921 (25 U.S.C. § 13) further affirmed this trust responsibility, as numerous other documents, pieces of legislation, and court cases have. As part of upholding its responsibility, the Federal Government created the Indian Health Service and tasked the Agency with providing health services to AI/ANs. Since its creation in 1955, IHS has worked to provide health care to Native people. As recently as 2010, when Congress renewed the Indian Health Care Improvement Act, it was legislatively affirmed that, "*it is the policy of this Nation, to ensure the highest possible health status for Indians . . . and to* ***provide all resources*** *necessary to effect that policy*."

DISPARITIES

While some statistics have improved for American Indians and Alaska Natives over the years, they are still alarming and not improving fast enough. Across almost all diseases, American Indians and Alaska Native are at greater risk than other Americans. For example, American Indians and Alaska Natives are 520 percent more likely to suffer from alcohol-related deaths; 207 percent greater to die in motor vehicle crashes; and 177 percent more likely to die from complications due to diabetes. Most recently, a report has come out reporting that American Indian and Alaska Natives are disproportionately affected by the hepatitis C virus (HCV). Furthermore, Natives have the highest HCV-related mortality rate of any U.S. racial or ethnic group—resulting in 324 deaths in 2013. And, most devastatingly to our tribal communities, suicide rates are nearly 50 percent higher in American Indian and Alaska Natives compared to non-Hispanic whites.

Although the statistics highlight the severity of the problem, behind each statistic is the story of an individual, a family and a community lacking access to adequate behavioral health and health care services or traditional healing practices, and traditional family models that have been interrupted by historically traumatic events. Devastating risks from historical trauma, poverty, and a lack of adequate treatment resources continue to plague tribal communities. American Indians and Alaska Natives have a life expectancy 4.8 years less than other Americans. But in some areas, it is even lower. For instance, in South Dakota, for white residents the median age is 81, compared to only 58 for American Indians.

STRUCTURAL REFORM

There are unique challenges to delivering health care in any rural area, including provider shortages, isolation, long travel distances, scarcity of specialty care, and under-resourced infrastructure. However, there are successful rural health systems operating all around the country that are able to deliver especially innovative and locally responsive care. A pressing need and opportunity exists within the Indian Health Service, and its many rural, geographically isolated hospitals and clinics, to reform the structure in its administrative oversight of Service Units and Area offices.

The HEALTTH Act would provide one unique approach to rethinking the way current IHS federally run and tribally run facilities are structured. The Act would provide authority to the Agency to conduct a pilot program for a "third way" of health care delivery—in addition to Direct Service and Self-Governance. The NIHB supports piloting this proposed program, as it would create joint hospital boards consisting of IHS, tribal representatives, hospital administration experts and private contractors. The proposed program is written in a way that honors tribal sovereignty by placing decisionmaking authority in tribal leadership and providing resources to prepare tribes to take on self-governance of their clinics and/or hospitals if that is what they choose.

We believe that rather than reinventing a health system out of whole cloth, or reform around the edges of a system desperately in need of dramatic and deep reforms, IHS should aspire to achieve parity with mainstream, successful medical and health systems. The long-term contract pilot program would be a good start to improving administrative oversight and, hopefully, lead to strengthened partnerships between the tribes; the IHS Area and Service Unit employees; and the private healthcare providers within the region. However, other elements absolutely necessary to such an aspiration are dramatic increases in the current funding levels and the adoption of standard and generally accepted business practices. NIHB believes that creating partnerships with mainstream and private entities will help IHS improve operations and systems and perhaps provide a learning laboratory for system-wide reform.

QUALITY ASSURANCE

Many reports attribute the deplorable quality of care at IHS-operated facilities to poor agency management at all levels. We know that hiring decisions are often lengthy, and poor performing employees at both the Service Unit, clinic and hospital administration and Headquarters are not terminated, but rather moved to other positions within IHS—often to a position of equal or higher responsibility level. The cyclical chronic lack of funding and mismanagement of funds also means that managers are often doing more than one job, and managerial oversight of medical conditions is compromised. In addition to the staffing and accountability provisions included in the newly proposed legislation we are discussing here today, attention must be directed at improving the quality of care provided at federally run IHS facilities. This can be done by strengthening agency-wide standards for hiring qualified individuals who are capable of fulfilling the role as expected and improving the timeliness of care.

On April 28, 2016, the Government Accountability Office (GAO) released a report on patient wait times at the Indian Health Service (IHS). As part of this report, GAO found that "IHS has not conducted any systematic, agency-wide oversight of the timeliness of primary care provided in its federally operated facilities." The report further found that the electronic health record system used by IHS does not "provide complete information on patient wait times," making it harder for staff to track the wait times. The GAO recommended that IHS "(1) communicate specific agency-wide standards for patient wait times, and (2) monitor patient wait times in its federally operated facilities, and ensure corrective actions are taken when standards are not met." The NIHB supports these recommendations and applauds the HEALTTH Act for including provisions that would do just that.

Quality would also be increased through implementing and nurturing a culture and practice of continuous quality improvement, management and supervisory training and setting performance benchmarks that are reviewed twice-yearly. If employees are not performing, generally accepted management practices and principals must be in place, respected and consistently upheld. The HEALTTH Act does include provisions that would expand the hiring authority of IHS to that of other Federal medical care services like the U.S. Department of Veterans Affairs, as well as provide expanded authorities to fire or demote underperforming employees. However, before IHS is given greater authority to remove problem employees, the NIHB would like remind Congress that there are procedures already in place to remove problem employees; the real question is whether IHS is using those authorities. We recommend that this committee request a report from IHS documenting the number of times it has exercised its authority to do just that.

RECRUITING AND RETENTION OF PERSONNEL

Title II—the Indian Health Service Recruitment and Workforce of the HEALTTH Act would greatly strengthen the Agency's ability to recruit qualified health professionals by excluding the IHS student loan repayment program from gross income payments, essentially making the scholarship payments tax free. The Agency has asked for years to have similar authorizations as the National Health Service Corps, in order to recruit qualified health professionals to work in Indian Country. Additionally, we are pleased to see the list of degrees that qualify for the loan repayment program would be expanded to include health administrators. One of the inherent flaws in the Indian Health System is the lack of qualified hospital administrators and lack of basic business acumen in the management, leadership and operation of health systems. This provision within the bill will help to recruit, retain and fund students to enter Masters of Business Administration, Hospital Administration and

related professions necessary to achieving and sustaining meaningful reforms in the IHS system.

While we understand that it can be challenging to recruit medical professionals and health administrators to remote areas, it is critical that IHS, and other related agencies within HHS, employ all tools at their disposal to do so. Although there are strong provisions within this bill to improve recruitment practices, there is little that would help with chronic retention issues that we see in all IHS Service Areas—especially in our more remote tribal communities. We have long heard from healthcare professionals on isolated reservations that a lack of housing and quality education are barriers to long-term tenure at Indian health facilities. To rectify this, there will need to be further collaboration among the tribes, government agencies such as HHS and the U.S. Department of Housing and Urban Development (HUD), and Congress to make investments in housing so that people working in IHS facilities have adequate living quarters available. It is also critical to provide support for schools so that the families of medical providers will have access to adequate educational opportunities.

Many policymakers do not realize that the system the United States employs to train medical residents, as well as dentists and some nurses, is through an entitlement program, Graduate Medical Education, within Medicare. The GME program exceeds $15 billion annually. Congress capped the number of residency training positions in the United States as part of the Omnibus Budget Reconciliation Act of 1997. Since 1997, several legislative amendments and changes have occurred to make slight increases and variances on the resident limit; however, the medical specialties remain highly motivated to increase the number of residency training positions within their various colleges and academies. One potential opportunity to increase the number of physicians serving in Indian Country is to set aside a certain number of new residency training positions for those willing to serve in Indian Country. The number of years of service in Indian Country following completion of residency training would be equal to the number of years the resident took to complete the residency. In states like Connecticut, where residency training positions are approximately $155,000 per resident per year, that is an astonishing incentive to complete service to Indian Country. Likewise, since most of the GME funding is in Indirect Medical Education expenses—paid directly to the training institution, perhaps a similar incentive could attach to the training institute if the resident does not fulfill the commitment. Further, there are very limited numbers of residency training programs in IHS facilities—and exceptions to the caps on new residency positions include rural or medically underserved communities or if a residency training program has never before existed in the training center. The Secretary of HHS has the authority to approve such growth: indeed, is this not the very definition of Indian Country?

Tribes and the NIHB also advocate that a long-term solution to addressing American Indian and Alaska Native health disparities lies in investing in our youth. We can improve the future of the Indian health care workforce by developing a culturally and linguistically competent workforce of Native health professionals and administrators. We know that AI/AN providers are more likely to remain in their own communities long-term and to provide culturally appropriate care. Therefore, Congress and the IHS should prioritize resources and relationship building with academic institutions and national health professional organizations to engage Native youth in cultivating interest and capability in pursuing medical and health professions.

PURCHASED/REFERRED CARE REFORM

In addition to the direct healthcare services provided by the Indian Health Service, eligible American Indians and Alaska Natives can also access healthcare services by non-IHS providers through the Purchased/Referred Care Program (PRC). PRC funds are used to supplement and complement other health care resources available to eligible Indian people. The funding for PRC is distributed among the 12 IHS Service Areas through a formula that was created through consultation with the Director's Workgroup on Purchased/Referred Care and Tribal consultation. Regional and national priorities were taken into account when the formula was created and the section of the HEALTTH Act that requires the IHS to develop and implement a new allocation formula within three (3) years, needs to be further consulted on with tribes all across the Nation. The National IHS Tribal Budget Formulation Workgroup, reported to the Secretary of the HHS on June 20, 2016, that "a major concern for tribal leadership is that PRC policies have not been updated in years. The current policies were written during a time when the IHS had to restrict access

to services by creating limits to eligibility and scope of services provided. Tribes have asked the IHS to update these policies and bring them up to today's standard of quality care in order to have a better picture of what the true funding need is for PRC services. The truth is that these needs have been understated for at least 40 years." The HEALTTH Act provides a good opportunity for the Agency to continue working with tribes and the Director's Workgroup to assess and improve the program and allocation formula.

As with the rest of the IHS budget, PRC funds have not kept pace with the health needs of tribal members, the cost of health care and the growth of tribal populations. As a result, PRC funds, which are managed by the IHS, are typically reserved for emergency and specialty services based on a priority schedule developed by the IHS. However, self-governance tribes are able to develop their own priority schedules, so the provision within the HEALTTH Act that would freeze the funding level of facilities who have achieved Priority Level III–V for a 3-year transition period, could disparately impact self-governance tribes and would be a disincentive for high performing facilities. An alternative solution may be to allow IHS facilities or Service Units the same flexibility as tribally operated facilities for developing their own, locally responsive priority schedules.

Furthermore, the provision of the HEALTTH Act that codifies the recent IHS Purchased/Referred Care Final Rule that was published on March 21, 2016, needs to take into account some of the tribal concerns with the final rules. While the rules were created with tribal consultation and input, some concerns remain such as private providers refusing to see AI/AN patients that utilize PRC funds, that implementing PRC rates will increase the volume of services being sought and decrease the quality and length of visits, and that the software systems needed to calculate payment rates are too costly for the already underfunded Federal and tribal run health facilities.

CONCLUSION

In conclusion, the NIHB overall supports the recent efforts made by both the Indian Health Service and Congress to address long-standing issues that our people have faced for far too long. Since issues have come to light in the Great Plains Service Area in the past year, the IHS has sought new leadership and pursued innovative policies and programs. Most recently, the IHS issued a new policy on opioid prescribing that is the first of its kind for a government agency that provides direct medical care. Additionally, law makers have been engaged with tribes across the country and, very much so, with the tribes of the Great Plains region.

Finally, because this legislation seeks to amend the Indian Health Care Improvement Act, the National Indian Health Board would like to take this opportunity to remind the committee that the Indian Health Care Improvement Reauthorization and Extension Act (S. 1790, enacted in H.R. 3590) permanently reauthorized and made several amendments to the Indian Health Care Improvement Act (IHCIA). Numerous provisions of S. 1790 have not yet been fully implemented. Below is a summary of the progress in implementing these provisions. The strides we have already made to achieve quality improvement will remain unfulfilled and continued or future efforts will not be successful without full funding and implementation of these important authorizations for improved Indian health.

I. INDIAN HEALTH MANPOWER	**67% of provisions not yet fully implemented**	
Sec. 119. Community Health Aide Program	Authorizes the Secretary to establish a national Community Health Aide Program (CHAP).	Sufficient funds not yet appropriated.
Sec. 123. Health Professional Chronic Shortage Demonstration Project	Authorizes demonstration programs for Indian health programs to address chronic health professional shortages.	Sufficient funds not yet appropriated.
II. HEALTH SERVICES	**47% of provisions not yet fully implemented**	
Sec. 106. Continuing Education Allowances	Authorizes new education allowances and stipends for professional development.	Sufficient funds not yet appropriated.
Sec. 201. Indian Health Care Improvement Fund	Authorizes expenditure of funds to address health status and resource deficiencies, in consultation with tribes.	After consultation, IHS decided to make no change in use of funds at this time.
Sec. 204. Diabetes Prevention, Treatment, and Control	Authorizes dialysis programs.	Sufficient funds not yet appropriated.
Sec. 205. Other Authority for Provision of Services	Authorizes new programs including hospice care, long-term care, and home- and community-based care.	Sufficient funds not yet appropriated for long term care programs.
Sec. 209. Behavioral Health Training and Community Education Programs	Requires IHS and DOI to identify staff positions whose qualifications should include behavioral health training and to provide such training or funds to complete such training.	Identification of positions has occurred, but IHS and DOI have lacked funds to provide required training.
Sec. 217. American Indians into Psychology Program.	Increases institutions to be awarded grants.	Sufficient funding not yet appropriated for additional grants.
Sec. 218. Prevention, Control, and Elimination of Communicable and Infectious Diseases	Authorizes new grants and demonstration projects.	Sufficient funds not yet appropriated.
Sec. 223. Offices of Indian Men's Health and Indian Women's Health	Authorizes establishment of office on Indian men's health, maintains authorization of office on Indian women's health.	New offices have not yet been created due to lack of funds.

III. HEALTH FACILITIES	**43% of provisions not yet fully implemented**	
Sec. 307. Indian Health Care Delivery Demonstration Projects	Authorizes demonstration projects to test new models/means of health care delivery.	Sufficient funds not yet appropriated.
Sec. 312. Indian Country Modular Component Facilities Demonstration Program	Directs the Secretary to establish a demonstration program with no less than 3 grants for modular facilities.	IHS has not yet established the program due to lack of funds.
Sec. 313. Mobile Health Stations Demonstration Program	Directs the Secretary to establish a demonstration program with at least 3 mobile health station projects.	IHS has not yet established the program due to lack of funds.
IV. ACCESS TO HEALTH SERVICES	**11% of provisions not yet fully implemented**	
Sec. 404. Grants and Contracts to Facilitate Outreach, Enrollment, and Coverage Under Social Security Act and Other Programs	Directs IHS to make grants or enter contracts with tribes and tribal organizations to assist in enrolling Indians in Social Security Act and other health benefit programs	IHS has not yet established the grants due to lack of funds.
V. URBAN INDIANS	**67% of provisions not yet fully implemented**	
Sec. 509. Facilities Renovation	Authorizes funds for construction or expansion.	Sufficient funds not yet appropriated.
Sec. 515. Expand Program Authority for Urban Indian Organizations	Authorizes programs for urban Indian organizations regarding communicable disease and behavioral health.	Sufficient funds not yet appropriated.
Sec. 516. Community Health Representatives	Authorizes Community Health Representative program to train and employ Indians to provide services.	Sufficient funds not yet appropriated.
Sec. 517-18. Use of Federal Government Facilities and Sources of Supply; Health Information Technology	Authorizes access to federal property to meet needs of urban Indian organizations. Authorizes grants to develop, adopt, and implement health information technology.	Protocols developed, but property transfer costs require additional funding. Sufficient funds not yet appropriated.
VI. ORGANIZATIONAL IMPROVEMENTS	**0% of provisions not yet fully implemented**	
VII. BEHAVIORAL HEALTH	**57% of provisions not yet fully implemented**	
Sec. 702. Behavioral Health prevention and Treatment Services	Authorizes programs to create a comprehensive continuum of care.	Sufficient funds not yet appropriated.
Sec. 704. Comprehensive Behavioral Health Prevention and Treatment Program	Authorizes expanded behavioral health prevention and treatment programs, including detoxification, community-based rehabilitation, and other programs.	Sufficient funds not yet appropriated.
Sec. 705. Mental Health Technician Program	Directs IHS to establish a mental health technician program.	IHS has yet not established the program due to lack of funds.
Sec. 707. Indian Women Treatment Programs	Authorizes grants to develop and implement programs specifically addressing the cultural, historical, social, and childcare needs of Indian women.	Sufficient funds not yet appropriated.
Sec. 708. Indian Youth Program	Authorizes expansion of detoxification programs.	Sufficient funds not yet appropriated.
Sec. 709. Inpatient and Community Health Facilities Design, Construction, and Staffing	Authorizes construction and staffing for one inpatient mental health care facility per IHS Area.	Sufficient funds not yet appropriated.
Sec. 710. Training and Community Education	Directs Secretary, in cooperation with Interior, to develop and implement or assist tribes and tribal organizations in developing and implementing community education program for tribal leadership.	Comprehensive community education program has not been implemented due to lack of funds, although IHS and agencies do provide some trainings.
Sec. 711. Behavioral Health Program	Authorizes new competitive grant program for innovative community-based behavioral health programs.	Sufficient funds not yet appropriated.
Sec. 712. Fetal Alcohol Spectrum Disorders	Authorizes new comprehensive training for fetal alcohol spectrum disorders.	Sufficient funds not yet appropriated.
Sec. 713. Child Sexual Abuse and Prevention Treatment Programs	Authorized new regional demonstration projects and treatment programs.	Sufficient funds not yet appropriated.
Sec. 715. Behavioral Health Research	Authorizes grants to research Indian behavioral health issues, including causes of youth suicides	Sufficient funds not yet appropriated.
Sec. 723. Indian Youth Tele-Mental Health Demonstration Project	Authorizes new demonstration projects to develop tele-mental health approaches to youth suicide and other problems.	Sufficient funds not yet appropriated.
VIII. MISCELLANEOUS	**9% of provisions not yet fully implemented**	
Sec. 808A. North Dakota and South Dakota as Contract Health Service Delivery Areas	Provides that North Dakota and South Dakota shall be designated as a contract health service delivery area.	IHS has not yet implemented citing lack of funds.

Mr. YOUNG. If I may, the Indian Health Care Act that was in the Obamacare Act was my bill. It was written by Senator Hirono. It took her 15 years to get that done. It is the only good thing in the whole Obamacare package, by the way. I want you to be aware of that.

And I will say we have not done our job, but we have done pretty good. We are asking for a 5 percent increase, $5.1 billion, this year. May not be enough, but I was interested in what you had to say about management, and we will talk about that later.

Ms. Church, I am glad you made it back. I am sorry if anything happened.

STATEMENT OF JERILYN CHURCH, CHIEF EXECUTIVE OFFICER, GREAT PLAINS TRIBAL CHAIRMEN'S HEALTH BOARD, RAPID CITY, SOUTH DAKOTA

Ms. CHURCH. Good afternoon, Honorable Representative Young, Ranking Member Ruiz, and members of the committee. And thank you, Representative Noem, for your time and your commitment to address the serious quality of care concerns in our region.

My name is Jerilyn Church, and I am a member of the Cheyenne River Sioux Tribe. I was born and raised on the Cheyenne River Reservation. I received my primary care through IHS growing up, and I choose to receive my care from IHS today.

I also serve as the Chief Executive Officer for the Great Plains Tribal Chairman's Health Board. We are a non-profit tribal organization that serves as a vehicle for appointed tribal leaders who are consulted within HHS, including IHS. These representatives represent the 18 tribes in North Dakota, South Dakota, Nebraska, and Iowa. We provide public health messaging and support to our tribal health departments, technical assistance to tribal leaders on topics of health care advocacy, provide training and education opportunities, and provide epidemiologic technical assistance, including disease surveillance, and increasing tribal capacity to develop data products and assist with other emerging health priorities.

In addition to my written testimony, for your consideration I appreciate the opportunity to summarize some of my insights and recommendations, which I hope will serve to strengthen the intent of this Act.

Under Title I, one of the most promising opportunities that I see is the opportunity to create an alternative delivery of care system. The health board's leadership is in early discussions with many tribes and tribal health authorities regarding the opportunities and feasibilities of tribes assuming their programs under the self-determination authority. But resources are needed to explore alternative delivery systems and establish models that ensure healthy financial systems. We do not want our tribes to assume programs that are broken and assume failing programs.

We believe that the pilot project that is recommended under Title I needs to stay under the authority of tribes. But the private sector has a lot to offer. They are experts in delivery of care, and their contractual involvement should be to provide management, mentorship in order for tribes to build their own capacity, rather than providing the direct operational role.

Title I is also designed to provide consistency and parity between the authorities of the VA and IHS, but I would also advocate that that would include protection of IHS funding from sequestration.

Many of the recommendations outlined in Title II serve to address Indian Health Service recruitment and workforce needs in the Great Plains. However, many of the preference laws are imperative to tribal self-determination efforts and developing capacity of tribal health programs. So, I don't know that a statutory change to Indian preference is necessary, however, there needs to be ability for tribes and the IHS to exercise flexibility when it is appropriate, and case by case.

For example, when a position is advertised within IHS, how the Indian preference is currently interpreted is that those that meet the criteria for Indian preference are raised to the top, as they should be, for consideration and for interviews. However, those applicants that do not meet Indian preference criteria are not included in that pool.

So, if it is determined that candidates that meet Indian preference do not have the qualifications or the experience for the position, IHS goes back and then they have to re-advertise, and anybody that is worth their salt who may not make Indian preference criteria probably has moved on to other opportunities. That is an example of where that interpretation could be changed to where we look at all candidates, but still exercise Indian preference.

Expanding scholarship opportunities under Title II is a positive step, but there are many punitive measures for poor performance under Title II, which is important for accountability. I think an even more proactive and effective approach would be to also invest in advanced education and training for the many committed, high-performing staff who are members of our communities and who have dedicated their lives to serving our tribal members. I think they get forgotten and overlooked, especially in a time of crisis.

Title III attempts to address many of the shortfalls of the purchased and referred care program. One of the greatest opportunities that IHS has to improve the PRC program is to implement the authority under the Indian Health Care Improvement Act to recognize North Dakota and South Dakota as one contract support service delivery area.

Currently, IHS continues to operate under the old system that limits care to a limited service delivery area, impeding access and coverage of tribal members who need specialty care that is not available at their local service units.

And while I understand this committee does not have appropriation authority, I would be remiss if I did not stress the importance of funding fundamental change of the IHS. To implement law without adequate funding is paramount to continued failure. There are several other authorities under the Indian Health Care Improvement Act that, if funded, would greatly improve the quality of service and care.

I thank you today for your time.

[The prepared statement of Ms. Church follows:]

PREPARED STATEMENT OF JERILYN CHURCH, CHIEF EXECUTIVE OFFICER, GREAT PLAINS TRIBAL CHAIRMEN'S HEALTH BOARD

Good afternoon Chairman Young, Ranking Member Ruiz, and members of the committee. Thank you, Representative Noem for your time and commitment to address the serious quality of care concerns in the Great Plains Area Indian Health Service.

My name is Jerilyn LeBeau Church; I am a member of the Cheyenne River Sioux Tribe, I was born and raised on Cheyenne River, received my primary care through IHS growing up and I choose to receive my care from IHS today.

I also serve as the Chief Executive Officer for the Great Plains Tribal Chairmen's Health Board. We are a non-profit tribal organization that serves as a vehicle for appointed tribal leaders who consultation with HHS, including the IHS, who represent the 18 tribes in North Dakota, South Dakota, Nebraska and Iowa. We provide public health messaging and support to our tribal health departments, technical assistance to tribal leaders on topics of healthcare advocacy, provide training and educational opportunities and provide epidemiologic technical assistance, including disease surveillance, increasing tribal capacity to develop data products and assist with other emerging health priorities.

In addition to a detailed written testimony for your consideration, I appreciate the opportunity to summarize my insights and recommendations which I hope serve to strengthen the intent of H.R. 5406.

Title I—"Expanding Authorities and Improving Access to Care" provides a promising opportunity to create an alternative delivery of care. GPTCHB leadership is in early discussions with tribal health authorities regarding the opportunities and feasibility of tribes assuming and successfully implementing their health programs through the self-determination authority. Resources are needed to explore alternative delivery systems and to establish models that ensure healthy financial systems. Under any pilot project, the tribe must remain the primary authority to preserve the "IHS" provider status. Private Health Systems are experts in the delivery care, and their contractual involvement should be to provide management mentorship to build capacity rather than providing a direct operational role.

Title I is also designed to provide consistency and parity between the authorities of the VA and IHS, I would also advocate that that would include protection of IHS funding from sequestration.

Many of the recommendations outlined in Title II will serve to address Indian Health Service Recruitment and Workforce needs in the Great Plains. However, Indian Preference Laws are imperative to Tribal Self-Determination efforts and developing the capacity of tribal health programs. Rather than a statutory change to Indian Preference, tribes should have sole authority to exercise regulatory flexibility when appropriate and on a case-by-case basis.

Expanding scholarship opportunities under Title II are a positive step. However, much of the focus on under Title II are punitive measures for poor performance which is important for accountability. A more proactive and effective approach would be to also invest in advanced education and training of the many committed high performing staff who are members of our communities and who dedicated their lives to serving our tribal members.

Title III attempts to address the many shortfalls of the Purchased and Referred Care Program. One of the greatest opportunities that IHS has to improve the PRC program is to implement the authority under the Indian Healthcare Improvement Act to recognize North Dakota and South Dakota as one Contract Support Service Delivery Area. Currently, IHS continues to operate under the old system that limits care to a limited service delivery area, impeding access to and coverage of tribal members who need specialty care that is not available at their local service units.

While I understand this committee does not have allocation authority, I would be remiss if I didn't stress the importance of funding a fundamental change of the IHS. To implement the law without adequate funding is paramount to continued failure. There are several other authorities under the Indian Healthcare Improvement Act if funded would greatly improve the quality of service and care.

Mr. YOUNG. Thank you, Ms. Church. Good testimony, and I will have some questions, but Ms. Kristi, I want to let you go first, it is your bill. If you have questions—they are all in support of it, so be careful. Don't ruin that, you know? No, go ahead.

Mrs. NOEM. Thank you, Mr. Chairman, I appreciate that. I wanted to speak specifically with Chairman Bear Shield because I know you have stayed and actually might be missing a flight to stay here and testify on this bill, because it is so important to your tribe.

The Rosebud Emergency Department has now been diverted for 7 months. I am pleased that we are here today to the point that CMS is now re-surveying the emergency department. But according to the recent article in the *Argus Leader*, in Sioux Falls nine people have died in ambulances on their way to the hospital. Do you confirm these numbers? You have said that in your testimony today.

Mr. BEAR SHIELD. Yes, I just spoke with our ambulance service director this morning, and there were nine deaths.

Mrs. NOEM. Did they believe that those deaths could have been preventable, if the emergency department had been open?

Mr. BEAR SHIELD. I guess they happened during the diversion. We can't say yes, they could have been, but we can't say just the opposite of that. So, our tribe looks at it as being a part of the diversion of the ER.

Mrs. NOEM. Well, I think that if there is going to be an investigation, which you also talked about in your testimony, part of that should be on whether those were preventable. And I believe that it should be done by an unbiased entity like the HHS Inspector General. Is that what you were recommending when you were talking in your testimony?

Mr. BEAR SHIELD. Yes, exactly, somebody from a different agency.

Mrs. NOEM. OK, I appreciate that.

Ms. Smith, will you commit to join me in asking for the HHS Inspector General to investigate those nine deaths?

Ms. SMITH. Yes, Congresswoman, I will.

Mrs. NOEM. OK. I appreciate that very much, because that is really why we have an emergency situation on our hands. I appreciate you being willing to do that.

And the HEALTTH Act also provides authorities for IHS to discipline and fire under-performing employees. One of the things I have heard over the last several years is, oftentimes, when we have a problem with somebody who is providing care or within administration of IHS, they are removed and then they are just rehired somewhere else. They are not necessarily ever punished, there are no consequences for not doing their job properly. I have heard this since I have been in office and have been trying to get to the bottom of it. I have that addressed in my legislation, yet in your testimony you say that that is not needed, you already have those authorities.

So, I would like to know why that has not been done. I have not heard of a single person being fired from IHS because of the poor care that has been delivered in the facilities in the Great Plains region. I have heard of people being moved, and we have had leadership moved, but we have not had anybody pay any consequences.

So, when you say it is not necessary in my bill, obviously, for the last couple of decades that we have had this situation going on, and since I have become aware of it, since I have come into office in the last few years, as we have been able to get all the tribes on the same page and pushing, and then we have had this crisis

situation, now that I have it addressed in my bill you say it is not necessary. Tell me why nothing has been done.

Ms. SMITH. Thank you, Congresswoman Noem. I appreciate the efforts, and I think that at IHS we are committed to providing high-quality care. And to the extent that someone is not meeting that standard, there should be accountability. And you know, in cases that are warranted, people should be disciplined.

Mrs. NOEM. Has anybody been disciplined or fired?

Ms. SMITH. Yes, people have been disciplined.

Mrs. NOEM. Could you get me those names and information?

Ms. SMITH. I am happy to talk to you separately about personnel matters.

Mrs. NOEM. Nobody fired? Do you think anybody has been fired, removed from IHS employment?

Mr. YOUNG. Will the gentlelady yield?

Mrs. NOEM. Yes.

Mr. YOUNG. I think under the personnel laws, you cannot fire anybody. It is like the VA.

Mrs. NOEM. Well, we are asking for the same provisions that the VA has recently received and changes that——

Mr. YOUNG. OK. See, but that——

Mrs. NOEM. That is what we are asking.

Mr. YOUNG [continuing]. Has to be in your legislation.

Mrs. NOEM. Yes. But you indicated in your testimony that it wasn't necessary to have those provisions, so that is why I want to know if that is in place. We can talk about that offline, but I also want it dealt with, too.

You also say that about my requirements for dealing with wait times. Mr. Bear Shield, do people wait a long time in the hospital for appointments and for emergency room treatment when it is open?

Mr. BEAR SHIELD. Oh, yes. They have for many years. Yes.

Mrs. NOEM. And again, Ms. Smith, you say that it is not necessary for us to require you to assess that and fix that problem because you already have those authorities. How come it hasn't been done before? How come it hasn't been fixed before?

Ms. SMITH. I have only been in the job for a few months, but we are working aggressively on that. It is a very important issue. I totally agree with you, Congresswoman.

And two things I can tell you that we are doing—well, actually three things. One, in all the senior executive service performance measures they are supposed to account for two concrete measures on wait times. We are implementing things at different facilities. One thing that has worked is that leaving same-day appointments open so there is flexibility for people to see that, and then third, we are going to be working on coming up with different models to address the wait times. And then, obviously, fourth, one of the issues that ties into that is having full staffing. We are working on a number of recruitment tools. So again, I appreciate your efforts on this important issue.

Mrs. NOEM. I can appreciate the fact that you have only been in your position a few months; but unfortunately, for years we have watched this revolving door happen. And you may not be here long-term in this position, somebody else may come in and they may not

be—that is why we are trying to get certainty in health care here, because we look at the situation we are at today, and people are dying.

So having somebody say, "You don't need to do that, we are going to fix it," we have heard that for years, and that is why we need—I am sorry, Mr. Chairman. I will yield back.

Mr. YOUNG. You can hang around again. I just want to recognize the Ranking Member.

Dr. RUIZ. Thank you.

Ms. Bohlen, I understand that many of the proposals instituted in the permanent reauthorization of the Indian Health Care Improvement Act are still being implemented at the Indian Health Services. In your written testimony, you supplied us with a breakdown of that progress. In your opinion, will the proposals in the HEALTTH Act complement that effort?

Ms. BOHLEN. In the legislation we are talking about today? I think it would complement it, yes. But I also think that there is a level of funding that is not available. If you look at the percentages of the programs that were authorized in the Indian Health Care Improvement Act that have not been implemented, it matches, kind of tracks side by side with, the level of funding that is not there.

Of course, it is true that Congress, led by this House of Representatives, has done an excellent job of increasing funding to the Indian Health Service over the past several years, and that is to be lauded, especially in the budgetary environment we——

Dr. RUIZ. Are the fundings targeted specifically for this problem, or are there fundings for other problems but not this one?

Ms. BOHLEN. I am not the one who can speak to that. The Indian Health Service would know best where those monies are being targeted.

Dr. RUIZ. OK. And you mentioned that an avenue for recruitment for physicians could be through the GME program by setting aside a certain number of residency training positions for those who choose to serve in Indian Country. Can you further explain to us how this could help alleviate the problems with recruitment? And what do you need to make this goal a reality?

Ms. BOHLEN. Thank you for asking that question, because that is an exciting opportunity.

In the Omnibus Budget Reconciliation Act of 1997, Congress put caps on the number of graduate residency training positions that could exist in the United States for the first time since the program was implemented in 1965. And the important thing to understand is that the graduate medical education program of this country is an entitlement program through Medicare, somewhat through Medicaid. There is a direct medical education expense and an indirect medical education expense.

In a residency position that could be reimbursed, like at the University of Michigan, I believe it is about $160,000 per resident per year. Maybe $110,000 of that goes into the institution to pay the indirect expenses to build that residency program, to have the physicians to do the training, and so forth. Yet, in Indian Country, I just learned of a successful program at the Choctaw Nation of

Oklahoma. They are experimenting with this, and they are being very successful.

But where the money goes to build institution and build these residents is where all or substantially all of——

Dr. RUIZ. I think the point here is that a physician is most likely going to practice where they are from originally and they have a family member, and where they last trained. So, if we want more physicians in the recruitment process in under-served communities like in reservations, then we need to take students from the reservation, put them in a program, and then have them trained, their last location of training in the reservation and practicing community health.

I think that is a pipeline program that I have developed with my Future Physician Leaders program in the most under-served area in Southern California, and I think it is important that when we look at a system of recruitment that is comprehensive, that grabs him from the high school, puts him into a pipeline program, and sends him back into the community for training.

Ms. Smith, so we have heard from tribal nations, including the ones before us today, that Indian Health Service regional leadership has not properly informed the DC IHS leadership about problems and deficiencies. What are you doing from the top to proactively manage and monitor the different regions and their facilities?

Ms. SMITH. Thank you, Congressman, for asking that question. We are working aggressively on new reporting methods from all the areas on finances, HR, and other communication methods. And it is important that—I think the one thing that is a priority for me is that there is oversight over all the areas, and that people recognize that we are all one IHS, and we are all working together for the common goal of providing access to health care for Native people. And we will——

Dr. RUIZ. What are your plans on holding the management accountable for consistently implementing these new procedures and using best practices that are shared amongst the different management?

Ms. SMITH. We are working on holding people accountable. One example that has recently been done is there is a new performance standard in all the performance reviews which is holding people accountable for maintaining the conditions of participation with the Centers for Medicare and Medicaid Services.

We are also doing training on practices for managers, so that they know how to document incidents, and that training has already started with senior staff, and it is going to go down to all the staff.

But I will also say, in addition to holding people accountable, it is very important that we are also working on a culture where people feel free that they must report issues. They cannot hide them. They need to present the issue and a solution, and we all need to work together. We are also working on measures in that regard.

Mr. YOUNG. Mr. Benishek.

Dr. BENISHEK. Thank you, Mr. Chairman.

Ms. Smith, how long have you been on the job?

Ms. SMITH. I think it is a little over 3 months.

Dr. BENISHEK. So you are just new to all this, and this huge problem that we have here, the Indian Health Service.

Frankly, Mrs. Noem was right, this sounds very much like the VA, you know, government-run healthcare. Sometimes it does not work.

There are 27 health facilities that the Indian Health Care Service—is that the number that I heard? Is that correct?

Ms. SMITH. That is the number of our hospitals. We have over 160 clinics, as well, that we run.

Dr. BENISHEK. OK. How many of the hospitals have you been to?

Ms. SMITH. How many hospitals have I been to?

Dr. BENISHEK. Yes.

Ms. SMITH. I have been to four of them.

Dr. BENISHEK. Have you been to the one that they are talking about here that had the emergency room closed?

Ms. SMITH. I have been to every hospital that we are talking about today. I have been to Omaha Winnebago, Rosebud, Pine Ridge, and Sioux San.

Dr. BENISHEK. Are these places inspected by JCAHO?

Ms. SMITH. I think that, prior to my arrival, the accrediting body that was being used in the Great Plains and is currently being used is DNV.

Dr. BENISHEK. What is that?

Ms. SMITH. DNV, Doss Veritas——

Dr. BENISHEK. I don't know. The 99 percent of hospitals in the country are certified by JCAHO. It is a foundation—or it is a non-profit founded by the American College of Surgeons, of which I am a member, to inspect hospitals because the types of things that we have seen here I find pretty amazing that have actually occurred in a hospital in America.

I just find it very disconcerting to even hear that this stuff is going on. Mrs. Noem's testimony earlier today was unbelievable. And, I know you have only been on the job for 3 months, but this is a huge issue. And frankly, I am not sure that political appointees is the way this should be done. There should be a long-term management of this with a regular board, just like proposed for the VA. All right? We should not have political appointees coming in every 2 weeks or 2 months and then be responsible for an organization that they don't really understand how it all works.

I mean, you are a manager, but you have a pretty important job here, billions of dollars in funding, health care, people are dying, and we do not have a good answer for it.

So, I think that this is a good step for making things move, but having political appointments, there should be a body, a board of directors that is appointed by the President and Congress. There should be a CEO so that there is continuity and skill involved in this management process. The way this is being done is a disaster.

Mrs. Noem kind of gets to it, but what do you have to say about my idea there, Ms. Smith?

Ms. SMITH. Well, Congressman, I agree that this is a serious situation and a lot of this is just unacceptable. And I certainly agree with you that one of the key things that makes a facility successful is continuity of leadership, strong leadership, and strong governing board organization.

Dr. BENISHEK. All right, good. Well, I have one more question, and that is—you have a balance sheet for every facility so that you know how much you are spending and how much money is coming in so that there is an accountability as to how much money is being spent on administration, on supplies, per facility? Do you do that kind of accounting? They don't do that at the VA very well.

Ms. SMITH. Congressman, thank you so much for asking that. That is actually one of the things we are implementing on the finances. We are wanting to get reports from the areas——

Dr. BENISHEK. So you don't do that now; is that the answer? You are going to start doing that? Is that what you are telling me?

Ms. SMITH. I have been there for a couple months, and we will start doing that. We have already put the process into place.

Dr. BENISHEK. All right. My——

Mr. YOUNG. No, you have 49 seconds.

Dr. BENISHEK. Yes, that is what I thought. I thought I heard you knock——

Mr. YOUNG. No, I am a little nervous. I have to go out and testify in another committee; you are going to take over here in a minute.

Dr. BENISHEK. These are the kind of things that it is pretty amazing for people in the healthcare field to actually listen to, the fact that you are not even taking care of the numbers like that, and yet you are running a multi-billion dollar operation. You see what I am saying? Because a regular hospital could never operate that way. They know exactly how much money is coming in, they know actually where it is going. And you don't.

And we talk about funding levels. Well, the efficient spending of the taxpayer dollar is a pretty important thing. And it doesn't seem to me that this agency is actually doing that. So, I think I will yield back. Thank you.

Mr. YOUNG. Thank you. And you will take over the Chair in a moment here. I have to go down and testify.

One thing I would like to suggest. Chief Bear, you mentioned something about the tribes and the potential fines would be $2 million if you don't participate in the Obamacare bill?

Mr. BEAR SHIELD. It is cheaper for us to pay the fine than it is to pay nearly $400,000 a month in insurance fees for our tribal employees.

Mr. YOUNG. But that is still taking, what you said, about $2 million a year out of your cash-flow that could be used for other purposes?

Mr. BEAR SHIELD. Exactly. And if you understand, in listening to the questions from the committee earlier, there needs to be some education, I feel. And that will be an ongoing process. Just remember the population that we are talking about with these facilities are historically in the top five poorest counties in the Nation; so that is where we are at in the Great Plains area.

Mr. YOUNG. One of my biggest problems personally is that we are doing a pretty good job in Alaska. And the IHS is supporting it financially, but they are not running them. I believe in that self-determination concept, and you do a much better job. And I encourage you—I know what you have said, you do not have the ability right now. And I don't know how we do it, but the sooner we can

get the government out of it and let you run it, I think it would be a lot better off.

Ms. Smith, I want to thank you. I am going to have to let Mr. Benishek take over this deal in a minute. This has not been comfortable for you. And I want to ask you—you have been here 3 months—to use this committee; don't listen to your boss. We are really the boss, because like Mrs. Noem said, this has been going on. It is not just you, or not just this Administration. This has been going on, and it is a very discouraging thing. I have walked through some very interesting places in my life, including some quicksand areas, and you try to get out of it, and the more you struggle, the bigger you get into it, and pretty soon nobody is paying any attention because you are already under the quicksand.

And we need to help. I mean you need help.

Ms. SMITH. Yes.

Mr. YOUNG. We cannot do this by ourselves. I want to move this legislation.

Mrs. NOEM. Mr. Chairman?

Mr. YOUNG. Yes.

Mrs. NOEM. Over here.

Mr. YOUNG. Yes.

Mrs. NOEM. Can I just ask you for a favor? The bill that Mr. Bear Shield was talking about is one that penalizes tribal businesses for not complying with the Obamacare mandate, which our tribal businesses should not be bound to. In Obamacare, it exempted tribal members from the mandate. Our tribal businesses employ tribal members, so they are penalizing our tribal businesses in our tribes for not covering people in insurance that the government is responsible to cover their insurance and health care costs. That is how crazy that thing is. That is another bill that I need your help getting done, too, that is devastating.

Mr. YOUNG. Well, I——

Mrs. NOEM. It has passed through Ways and Means, and we need to get it across the House Floor.

Mr. YOUNG. Well, let's do that. And the second thing I can tell you, respectfully, that if I was the Chief of those tribes, I wouldn't do it and would tell the government to go suck an egg.

I can say that because I probably would not go to jail. But the reality is that is inappropriate, because that was the intent, that you were not to have to pay this. And now they are making you. That is a challenge all over the Nation, as far as the American Indian and Alaska Natives go. And that is something to work on.

Mr. Benishek, would you please take the Chair? I want to thank the witnesses for your input. I like the idea of a business platform, run it right. I don't believe it has been run right. And unfortunately, over the years, it has probably gotten a little rotten. No disrespect, that is probably what has happened. It is a natural phenomenon.

So, with this bill and the help of Ms. Smith, we will be able to try to solve some of these problems, try to get health care to those constituents. We can hear all the sad stories we want, we just do not want it to happen again. What happened yesterday is yesterday. What is going to happen tomorrow is what we have a role in trying to do.

So, Mr. Benishek, would you take the Chair? All right. Behave yourself, too.

Dr. BENISHEK [presiding]. Mr. Ruiz, do you have any questions?

Mrs. Noem, do you have any further questions?

Mrs. NOEM. Just one, if you don't mind.

Ms. Smith, I know we have talked about the fact that it has not been on your watch that a lot of this happened, but this is one instance in which I want to explain to you why there is so much concern and why there is legislation here today, is because last year, in discussion with IHS officials, my staff expressed concern—and Mr. Bear Shield referenced this incident before, as well—but we talked about CMS findings at Rosebud, pointing out a baby was born on the floor, comparing it to the 2010 Senate report, where something like that had happened, as well. And the IHS's Chief Medical Officer had said, "Well, if you have two babies hitting the floor in 8 years, that is pretty good." And I understand that now that individual has been moved and made Acting Chief Medical Officer of the Great Plains.

So, that is the fundamental question that I have—how are we supposed to trust this person to care for people when he makes statements like that? I would have removed the individual for a statement like that. But now they are the Acting Chief Medical Officer of this entire region. How can I trust them with the safety and care of the 122,000 tribal members in the Great Plains?

When was he moved to Acting Chief Medical Officer of the Great Plains? When did that happen?

Ms. SMITH. Thank you, Congresswoman, and I will just say that those comments are unacceptable. And that was made clear that it was unacceptable. I believe that the individual in question has publicly apologized for those comments.

So, I certainly agree that our tribal patients and partners need to have respect and rapport with medical staff at each of our facilities. That is very important to us. And I am happy to talk with you any time and with any of the people here about any issues they have with people, because I think one of the fundamental things is the quality of health care that you have.

Mrs. NOEM. Do you know when that person was moved into that position?

Ms. SMITH. I believe it was probably about a month ago.

Mrs. NOEM. So, that was on your watch.

Ms. SMITH. Yes. And, like I said, the person in question has publicly apologized. I know that she is committed to caring for the patients. And to explain the decision, there was no Chief Medical Officer in the Great Plains, and there was no full-time person. As I have said at this hearing, we have very serious recruitment and retention problems. We have lots of vacancies.

And I can tell you that, personally, I am committed to quality health care in the Great Plains. I spend a lot of time working on that. I know we don't move as fast as people would like. We are not moving as fast as I would like. And I think, from my perspective, that it was important to have a full-time Chief Medical Officer there. So that was the basis of the thinking for that.

And like I said, if there are issues, I am happy to further discuss. But I did feel that it was important to have a Chief Medical Officer full time in the Great Plains to try to assist our patients there.

Mrs. NOEM. One last thing, Ms. Bohlen, your staff was incredibly helpful to us as we drafted this legislation, so I appreciate that.

I know I don't have much time, but can you please tell me a little bit about your alternate idea for the PRC transition provision in the bill? You have an alternate idea?

Ms. BOHLEN. I am trying to think of what our alternate idea is.

Mrs. NOEM. Well, that's all right. If you don't—but I did think that you had another idea for how we could transition the PRC provision in the bill.

I want to just maybe leave this discussion so that everybody knows our hope is to continue to work on this bill. I am not married to this bill exactly the way that it is. I want to pass a bill that fixes problems and that everybody can get behind and recognize is a huge change that was needed in IHS and meets the needs of the tribes in the Great Plains region. And I think it is time to think outside of the box, and it is time for everybody to get on board, because I am not going to quit. So, we need to get on board, and we all need to pull the same direction and fix the problems that we have.

And with that, Mr. Chairman, I yield back.

Dr. BENISHEK. All right. Thank you, Mrs. Noem. I have one more question, because we are talking about this funding issue, and it always comes to funding. We want to be sure that the funding is appropriately spent, and apparently the IHS entered into an $80 million settlement with the employee unions for overtime-related claims at the IHS-operated facilities. Were any of the funds that were used to pay these claims staffing monies? Do you know anything about that?

Ms. SMITH. The settlement was entered into before I took this position, but my understanding is that the settlement was over back pay for people who do provide care at these facilities.

Dr. BENISHEK. Well, the information that I have says that the funding was not paid out of a judgment fund, it came out of the staffing fund, directly from the money that would go to staff these facilities. And there is a separate judgment fund—would you look into that for me, please, and find out what the story is with that?

Ms. SMITH. We are happy to get back to you, Congressman.

Dr. BENISHEK. All right. That was the last question that I had.

So, thank you, Ms. Smith. You know, this is not that easy. And I have a lot of experience in the VA Committee with very similar issues. We have sincere, newly appointed people in the Department who have to explain bad behavior for a long time. And that is, unfortunately, your job here today. And we need sincere people to actually change the way things happen, and not come here to tell us how hard you are working to make a change, and then nothing happens. I am used to that, I am used to the Administration people coming to me and saying, "We really want to fix it," but then, over the course of years, nothing changes.

That is what we are all frustrated about. These people out here have a bad hospital and nobody seems to be responsible. And you

are telling them, "Well, we are doing the best we can," and that does not work any more.

So, anyway, I am sorry about all the comments, but I want to thank the witnesses today for your valuable testimony, and for the Members for their questions.

The members of the committee may have some additional questions for the witnesses, and we will ask you to respond to these in writing.

Under Committee Rule 4(h), the hearing record will be open for 10 business days for these responses.

If there are no further questions, then, without objection, the committee stands adjourned.

[Whereupon, at 5:25 p.m., the subcommittee was adjourned.]

[ADDITIONAL MATERIALS SUBMITTED FOR THE RECORD]

PREPARED STATEMENT OF DEB FISCHER-CLEMENS, SENIOR VICE PRESIDENT, AVERA HEALTH

Good afternoon Chairman Young and members of the Subcommittee on Indian, Insular and Alaska Native Affairs. Avera, the health ministry of the Benedictine and Presentation Sisters, is a regional partnership of health professionals who share support services to maintain excellent care at more than 300 locations in 100 communities throughout eastern South Dakota and surrounding states. On behalf of our health care providers in hospitals, post-acute centers, clinics, Avera Health appreciates the opportunity to submit a statement of record for Congresswoman Kristi Noem's bill, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act of 2016 (H.R. 5406).

Avera greatly appreciates the Congresswoman's work to improve health care for Native Americans and believe the proposed legislation contains many needed steps.

After reviewing the HEALTTH Act, Avera would suggest the following concerns be addressed in an amendment to the legislation:

The Indian Health Service relies on a number of manual processes for Purchased Referred Care (PRC) service authorization, claims processing and payment functions. It would be to the benefit of PRC beneficiaries and health care providers if the IHS would bring its administrative transactions up to the standards specified by the Health Insurance Portability and Accountability Act (HIPAA) and as implemented by Medicare, Medicaid and private sector health care insurers, administrators and providers. Extended processing time frames due to manual processes, and the potential for lost records directly jeopardize an individual's access to needed health care and/or unanticipated medical expenses. Additionally, it means providers are at risk for non-payment or delayed payment for authorized services.

In short, though these technology updates would cost money, they are important to improve the referral and billing process.

Thank you again for considering this input and allowing Avera Health to provide feedback on the HEALTTH Act.

PREPARED STATEMENT OF THE HON. MICHAEL MARCHAND, CHAIRMAN, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

The Confederated Tribes of the Colville Reservation ("Colville Tribes" or the "CCT") appreciates the opportunity to provide this statement on H.R. 5406, the "Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act" ("HEALTTH Act"). The CCT would like to express its thanks to Congresswoman Noem for introducing this important bill that will address long-standing issues with the Indian Health Service ("IHS"), both in the Great Plains and in other IHS regions.

The CCT is one of six direct service tribes in the IHS's Portland Area. The Portland Area oversees 43 Indian tribes in the states of Washington, Oregon, and Idaho. Similar to the tribes in the Great Plains, the CCT has struggled with chronically low staffing levels in its IHS-operated facilities. In the CCT's case, the lack of staff is primarily the result of the absence of a mechanism for tribes that have

not been fortunate enough to construct a new health care facility through the IHS system to bring their staffing levels current. Like the Great Plains, some is also attributable to the challenges of attracting qualified health professionals to work in rural areas.

This statement provides background on these issues and three recommendations on how they can be addressed in the HEALTTH Act. The CCT believes the HEALTTH Act, particularly its provisions relating to staff recruitment and re-examining Purchased-Referred Care funds distribution, is a needed and overdue fresh look at these long-standing issues.

BACKGROUND ON THE COLVILLE TRIBES

Although now considered a single Indian tribe, the Confederated Tribes of the Colville Reservation is, as the name states, a confederation of 12 aboriginal tribes and bands from across the plateau region of the Northwest and extending into Canada. 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 CCT 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. These communities are separated by significant drive times.

FACILITY NEEDS AND HISTORICALLY LOW STAFFING LEVELS

Like other Indian tribes with large service delivery areas, the Colville Tribes face a health care delivery crisis. The CCT's original clinic in Nespelem, was built by the U.S. Department of War in the 1920s and was converted into an IHS facility in the late 1930s. From the information that we have been able to obtain from IHS, the staffing ratios at the Colville IHS Service Unit were established when the Nespelem clinic went into service in the 1930s. While funding levels have increased incrementally with IHS's base budget in the intervening decades, the initial staffing ratios have not changed.

The only way for direct service tribes like the CCT to bring staffing levels current under the IHS system is to construct a new facility under the IHS system. There are currently two ways to accomplish this. The first is the priority list system, which has been in effect since the early 1990s and provides funding for construction of the facilities included on the list as well as 80 percent of the annual staffing costs. The second is the joint venture (JV) program, which requires an Indian tribe to pay the entire up-front cost of construction of a facility in exchange for IHS providing a portion of the annual staffing costs. The priority list has been closed since the early 1990s and the JV program is extraordinarily competitive and has been funded only sporadically during the past decade. Unless a facility is built under either of these two programs, IHS will not update the staffing ratios for a given IHS service unit.

The CCT sought in the 1980s and the early 1990s to replace the Nespelem facility with a new facility through the IHS priority list system. We understand that at one point, the CCT's request for a new clinic in Nespelem was near the top of the priority list but was removed because of concerns that the facility was a historical site. None of the more than 40 tribes in the IHS Portland Area, of which the CCT is a part, have ever had a facility constructed under the priority list system.

Because the CCT's need for a new facility in Nespelem was so great and the priority list had been closed, the CCT was ultimately forced to take matters into its own hands and construct a new Nespelem facility primarily using tribal funds. Since the facility was not on the priority list and the CCT was not selected for the JV program, IHS did not provide any additional staff or otherwise update the antiquated staffing ratios for the Colville Service Unit. This means that, despite paying to construct our own facilities, we continue in a sometimes futile effort to provide modern health delivery to approximately 5,000 tribal citizens using 1930s staffing ratios.

In response to a congressional inquiry, in 2013 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. Later that year, on December 17, 2013, the CCT adopted a resolution declaring a state of emergency in response to the continued lack of healthcare provided by the IHS and vacancies that threatened delivery of healthcare on the Colville Reservation altogether.

The CCT has been doing everything it can to find creative ways to address these issues. For example, we are currently examining the feasibility of deploying Dental

Health Aide Therapists (DHATs) to help bridge the gap in oral health care on the Colville Reservation. The lack of available dentists in Omak (the largest population center on the Reservation) sometimes forces those residents to drive nearly 3 hours to Inchelium for dental services. The CCT is encouraged by the IHS's recent overtures to Indian country to expand the use of DHATs and is fully supportive of this effort.

RECOMMENDATIONS TO ADDRESS STAFFING INEQUITIES IN THE HEALTTH ACT

The CCT has three recommendations on how the HEALTTH Act could address the CCT and other similarly situated tribes' staffing issues. The first would be to provide direction for IHS to provide some pathway for tribes that self-funded and constructed their own health facilities outside the IHS system to obtain staffing packages, whether short term or permanent. Lack of adequate staffing not only means fewer health care providers and longer wait times for our tribal members, it also means that we are unable to maximize third party reimbursements because of lack of administrative support. The limited number of providers are not able to see as many patients, which negatively impacts the CCT's service population and, by domino effect, the Purchased-Referred Care funds allocated to the Colville Service Unit.

Although permanent staffing would be desired, even shorter term staffing would be beneficial. With the 2010 reauthorization of the Indian Health Care Improvement Act, more opportunities exist for tribes to generate additional revenue to pay for staff through third party reimbursements. Providing even a short-term infusion of staff to tribes in this situation would empower those tribes to make these reimbursements and staff self-sustaining.

Another benefit of providing a path forward for tribes to update staffing levels is that it would allow for increased preventative care, which would reduce the need for Purchased-Referred Care by ensuring that minor health conditions do not become severe.

Another recommendation the CCT would like to explore would be to direct IHS to prioritize or provide some enhanced consideration to tribes that are currently operating under historic staffing levels when IHS allocates any increases that Congress may provide to IHS for staffing. If implemented, this would provide some equity to those tribes that have been operating under antiquated historic staffing levels.

Finally, the CCT would also like to see Congress direct IHS to consult with Indian country and provide information to Congress on those IHS service units that are operating under historic staffing levels. Such information could include the volume of third party reimbursements between service units with low staffing levels compared to those with updated staffing ratios, impact on patient care, and other considerations.

The CCT looks forward to working with Congresswoman Noem, this committee, and the other committees of jurisdiction on these issues and assisting in advancing the HEALTTH Act to House approval.

PREPARED STATEMENT OF JOHN YELLOW BIRD STEELE, PRESIDENT, OGLALA SIOUX TRIBE

My name is John Yellow Bird Steele and I serve as the President of the Oglala Sioux Tribal Council. The Oglala Sioux Tribe is pleased to see that Congress and this subcommittee recognizes the urgent need for action to address the current Indian health care crisis in the Great Plains region and throughout the Country. I appreciate the opportunity to submit this testimony on behalf of the Oglala Sioux Tribe to provide the subcommittee with the tribe's views on H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act.

THE URGENT NEED FOR ACTION

The United States owes a trust duty to all tribes and a specific treaty obligation to the Oglala Sioux Tribe to ensure the health and well-being of our Indian people. In the Sioux Treaty of 1868 (known as the Fort Laramie Treaty), the Great Sioux Nation and the United States agreed on a *quid pro quo*: by the terms of the treaty, the United States promised to provide certain benefits and annuities to the Sioux Bands each year, including health care services, in exchange for the right to occupy vast areas of Sioux territory. The IHS is tasked with carrying out this duty by providing quality health care services in our communities, though the responsibility

belongs to the U.S. Federal Government as a whole. The evidence is clear that the IHS—and as a result, the United States—is failing at that task.

Congressional action is sorely needed to address this very serious emergency. As it stands, the Pine Ridge Hospital is not a functioning facility that is capable of meeting even the basic health care needs of our community. On top of the mismanagement problems that have been well highlighted by government reports, witness testimonies, and even news reports, our hospital facility is only utilizing a portion of our inpatient beds, and our intensive care unit is not even operational due to funding, staffing, and equipment shortages and despite the high level of unmet health care needs on our reservation. This situation is unacceptable; falls far short of the Federal Government's treaty obligations to our tribe; and must be addressed.

The Oglala Sioux Tribe appreciates the ongoing efforts of this subcommittee to hold the IHS—and indeed the Federal Government as a whole—accountable to deliver on the promise of quality health care for our people. We believe that H.R. 5406 would take important steps to implement needed reforms, and we would like to comment on the specific provisions of the bill and offer our suggestions to strengthen the bill and its impact even further.

Sec. 101: Service hospital long-term contracting pilot program

H.R. 5406 would create a 7-year contracting pilot program "to test the viability and advisability of entering into long-term contracts for the operation of eligible Service hospitals with governance structures that include tribal input." The pilot program is also designed as "an alternative to full direct-service and full self-governance, with an emphasis on preparing tribes for self-governance."

The Oglala Sioux Tribe is not opposed to the consideration of new and innovative ideas to address deep-rooted and systemic problems, including long-term contracting. Fundamentally, the Oglala Sioux Tribe simply wants a health care system that *works* and that results in the best possible health outcomes for our communities. The tribe also appreciates efforts to provide an alternative to full direct service and full self-governance. However, we emphasize that the trust and treaty responsibility to provide health care to our tribal people belongs to the *U.S. Federal Government* and cannot itself be contracted out or privatized. Accordingly, the Federal Government must always remain ultimately responsible and accountable for Indian health programs. With respect to the pilot program proposal, that means that the contracts and governing board for each hospital must be structured in such a way that the IHS is not relieved of its ultimate responsibility of ensuring quality healthcare for our people. Private involvement should be geared toward capacity-building and systems improvement so that direct service tribes are better served and tribes that eventually choose to contract under the ISDEAA do not inherit a dysfunctional and ineffective system. Further, in addition to leveraging private sector expertise, the Federal Government must commit to providing Federal resources at the full level of need in order to make tribal self-governance a meaningful option for tribes. With these caveats, the tribe supports the proposed pilot project in H.R. 5406.

Sec. 102: Expanded hiring authority for the Indian Health Service

We are also happy to see that H.R. 5406 seeks to address the need to improve and streamline the hiring process within the IHS. H.R. 5406 would allow the Secretary to utilize, in place of the civil service requirements, VA hiring authorities with respect to positions involving direct patient services or services incident to direct patient-care services. The IHS has represented that it already has the ability to exercise at least some of these authorities, and it is not clear to the tribe that these authorities have permitted the VA itself to succeed in resolving the recruitment problems it has faced. Moreover, the bill as currently drafted focuses primarily on recruitment and less on retention, which is equally important. Thus, further consideration should be given to whether the VA authorities are the best substitute for current IHS authorities, and additional measures may be necessary to make a meaningful impact on IHS recruitment and retention.

There are many factors that contribute to the hiring and retention challenges faced by the IHS in the Great Plains area and elsewhere, including mismanagement, uncompetitive salaries, unattractive and underequipped facilities, the rural and isolated location of our facilities combined with the economically depressed character of our communities, and the lack of housing and other infrastructure. As one example, the Oglala Sioux Tribe is in serious need of housing for its health care professionals given the shortage of housing options in the vicinity of our hospital

and clinics—an issue that directly impacts our ability to attract and retain health care professionals and administrators.[1]

The Oglala Sioux Tribe believes that meaningful improvement in recruitment and retention at the IHS depends in large part on resolving these interwoven issues. We agree with other testimony that collaboration between the tribes, the IHS, and other Federal agencies—including the U.S. Department of Housing and Urban Development, the Bureau of Indian Affairs, the Bureau of Indian Education, the U.S. Department of Education, and the U.S. Treasury Department, among others—is needed to ensure that attractive housing, education, and economic opportunities are available to health care professionals considering employment with the IHS in our communities, and to their families. It is exceedingly difficult to attract and retain qualified professionals while asking them to forego quality education for their children or meaningful employment prospects for their spouse. The tribe also supports efforts to recruit and train a Native health care workforce, so that we can staff our health care facilities with tribal members who already have strong ties with and commitments to our communities.

Funding for facilities and equipment also impacts recruitment and retention. Competent, qualified staff do not want to work in a facility where they lack the tools necessary to do their job or where their job is made harder (or even impossible) by a lack of resources. But the Pine Ridge Service Unit has documented a need for, among other things: fetal monitoring systems, telemetry systems, surgery lights, a nurse call system, dental chairs and equipment, and IV pumps, to name a few. Equipment needs are so dire that, as one example, earlier this year we were told that the hospital was waiting for one of its IV Service Unit Pumps to finally stop working so they could take parts from it to fix another one. Some of this equipment is critical and could mean the difference between life or death in a patient emergency, but there is no additional funding for equipment purchases. Additionally, the facility is inadequate to handle the hospital's user population.[2] Even so, not all of the existing space is even being utilized because we lack the necessary staff and equipment. Very few health care or management professionals would want to work in such an environment, even with loan repayment and other incentives, and these realities have a very real impact on IHS recruitment efforts.

Additionally, the tribe feels strongly that key IHS hiring decisions ought to be made with tribal consultation. A bill to reform the IHS currently pending in the Senate, S. 2953, would require the Secretary to consult with Indian tribes located in the service area before hiring or transferring senior executives or top managers, and we believe a similar provision would be appropriate in H.R. 5406.

Sec. 103: Removal or demotion of employees

Poor management practices and the "recycling" or shuffling of problem employees has been a long-standing problem within the Great Plains area, as has the use of administrative leave in lieu of more appropriate action like demotion and firing. H.R. 5406 seeks to address this mismanagement problem by enhancing the Secretary's authority to hire, fire, demote, and reward employees based on performance; by limiting the use of paid administrative leave; and by requiring expedited review of removal and demotion decisions.

The Oglala Sioux Tribe generally supports these reforms, and emphasizes the importance of qualified and accountable leadership within the IHS and the Department of Health and Human Services, as well as strong ongoing congressional oversight, to ensure that these authorities are appropriately used to fulfill the United States' trust responsibility to provide our tribal members with quality health care. Indeed, as the IHS points out in its own testimony, authorities and procedures already exist to remove problem employees, but they have not been used in a consistent or effective manner.

We support the enhanced authorities in H.R. 5406, and recommend that the IHS develop a policy for how it is to use these and existing authorities. Such policy should be developed in consultation with tribes and congressional committees of jurisdiction. This would help to ensure that existing and expanded authorities are utilized as intended by Congress and to the benefit of tribes with meaningful results.

IHS testified that removal of employee protections could impact recruitment by making IHS a less desirable place to work. Our view is that most employees want

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[1] The Pine Ridge Hospital has 450 positions but only 104 housing units. Likewise, the Kyle Health Center has 86 positions but only 20 housing units; the Wanblee Health Center has 35 positions but only 5 housing units; and the LaCreek District Clinic has 6 positions but no housing units. There are few alternative housing options within a reasonable distance of any of these facilities, so staff housing specifically associated with IHS facilities is critical.

[2] The IHS Service Unit profile shows that the Service Unit currently services a user population of 51,227 in a space designed for a user population of 22,000.

a well-thought out policy that is objectively and consistently applied, not an ad hoc, subjective modus operandi.

We also agree with other testimony that any reform measures relating to adverse action against employees should be carefully vetted for constitutional due process concerns to avoid the prospect of copious, lengthy, or costly litigation against the IHS, and that these provisions should specify that the costs of such litigation and any resulting settlements be paid from sources other than IHS program or service funds, such as the United States Judgment Fund.

Finally, the tribe supports the use of mandatory random drug testing for all IHS employees as a key accountability measure. Representative Noem recently introduced H.R. 5437 to implement such a program, and we suggest that the provisions of H.R. 5437 be incorporated into H.R. 5406 to require random drug testing not just for IHS management, but for all IHS employees. We understand that the VA uses pre-employment drug testing as well as random employee drug testing in its facilities, and the same should be true of the IHS. Health professionals should not be reporting for duty while under the influence of illegal substances.

Sec. 104: Improving timeliness of care

Long wait times are a major barrier to care at IHS facilities within the Great Plains area and a serious problem at the Pine Ridge Hospital, where emergency patients wait for hours and sometimes leave without ever being seen. H.R. 5406 would require the IHS to promulgate regulations establishing standards to measure timeliness of the provision of health care services at IHS facilities and to develop a process for IHS facilities to submit data under those standards to the Secretary. However, the draft bill stops short of requiring any particular action in response to those reports. The tribe suggests that the bill be amended to require negotiated rulemaking and to specify that the topics to be addressed in the negotiated rulemakings include follow-up steps to be taken by the IHS, in consultation with affected tribes, to reduce patient wait times in response to the reported data wherever possible.

Sec. 201: Exclusion from gross income for payments made under Indian Health Service Loan Repayment Program

The tribe supports this proposal, which was requested by the IHS in the Administration's Fiscal Year 2017 Budget request and would bring the Indian Health Service loan repayment program into parity with the National Health Service Corps and Armed Forces Health Professions scholarship programs with respect to income tax treatment.

Sec. 202: Clarifying that certain degrees qualify individuals for eligibility in the Indian Health Service Loan Repayment Program

The tribe supports this proposal as a means of improving the IHS's ability to attract health care management and executive professionals. The IHS has long struggled to attract and retain qualified management personnel.

Sec. 203: Cultural competency programs

The tribe supports the bill's provision to require cultural competency training in each service area for all employees.

Sec. 204: Relocation reimbursement

The tribe supports the use of relocation reimbursement and incentives to attract high-quality employees to the IHS, provided funding is not diverted from needed health services. The IHS has testified that it already has authority to provide relocation reimbursement and incentives, again pointing to the need for accountable IHS leadership and strong congressional oversight, as well as adequate funding, to ensure that existing authorities are appropriately utilized.

Sec. 205: Authority to waive Indian preference laws

The tribe appreciates the intent behind this provision to provide greater hiring flexibility while leaving the ultimate decision to waive Indian preference laws to the impacted tribe. Any provision seeking to waive Indian preference should be carefully crafted and fully vetted as Indian preference is an important tool that has been used to strengthen the Indian health care system and build tribal capacity. Furthermore, we note that similar authority already exists under 25 U.S.C. § 472a(c)(1).

Sec. 206: Streamlining medical volunteer credentialing process

The tribe supports the creation of a centralized credentialing system within the IHS to credential volunteer health professionals at direct-service IHS facilities.

Sec. 301: Codification of limitation on charges for health care professional services and non-hospital-based care

The tribe appreciates efforts to improve the Purchased/Referred Care ("PRC") program. The PRC program is designed to ensure access to primary and specialty health care services that the IHS is unable to provide in its own facilities and must purchase from outside providers. Funding for the PRC program is so limited, however, that care is frequently rationed and limited to emergency "life or limb" situations. On Pine Ridge, even these emergency "priority 1" cases are sometimes rejected by the IHS due to funding constraints. Oglala Sioux tribal members routinely forego necessary medical care because the IHS refuses to pay through PRC. In the alternative, if these patients do seek the care, they often find themselves in financial crisis because the IHS will not cover the costs.

The Oglala Sioux Tribe appreciates the fact that H.R. 5406 seeks to extend Medicare-Like Rates to all PRC services. Currently, only payments for hospital-based services are capped at the Medicare-Like Rate by statute, and Medicare-participating hospitals are required to accept those rates as a condition of participation. Extending Medicare-Like Rates to non-hospital PRC services in the same manner would greatly increase the efficiency of the PRC program: in 2013, the GAO released a report finding that extending Medicare-Like Rates to non-hospital PRC services would save the IHS approximately $32 million per year, which could be used to pay for needed services that the IHS must now deny. However, the Tribe believes that the approach taken in the current draft bill could be improved.

Specifically, the bill would limit PRC payments to providers and suppliers by essentially codifying the recently released IHS regulations capping PRC rates for non-hospital services. This approach would cap the IHS or tribal health program's ability to pay (if the tribal health program chooses to opt in), but would not provide any enforcement mechanism or consequences to the provider or supplier if the provider or supplier refuses to accept the capped payment rates. Tribes have argued that, in order for Medicare-Like Rates to be effective, they must be a condition of provider participation in the Medicaid program, as is the case for the existing Medicare-Like Rate caps on payments for hospital services. The IHS regulations do not include this enforcement mechanism because the IHS did not have the authority to impose those requirements, and as a result the regulations have been viewed by tribes as a "next-best" alternative to legislation. Congress, of course, does have the authority to enforce Medicare-Like Rates, and should do so.

A bill was introduced in the last Congress by Senator Betty McCollum (H.R. 4843, 113th Cong.) that would have extended Medicare-Like Rates to non-hospital PRC services by amending the Social Security Act and requiring providers and suppliers to accept the lower rates as a condition of their participation in Medicare. That bill had strong support from Indian Country, and the Oglala Sioux Tribe strongly recommends that H.R. 5406 take the same approach with respect to Medicare-Like Rates.

Sec. 302: Allocation of Purchased/Referred Care program funds

Section 302 would require the Secretary, through negotiated rulemaking with tribes, to develop and implement a revised distribution formula for PRC funding and would prioritize PRC funding increases in service areas where the majority of PRC services currently provided are priority level I or II—in other words, in service areas where only the most serious health care emergencies are funded. First, what is needed and in fact *required* by the Federal Government's treaty and trust responsibilities is *full* PRC funding for all medically necessary care at every level of care. It is incumbent on the United States as our trustee to ensure that preventive, primary, and specialty care is available to our patients *before* their conditions become chronic or life-threatening, not just after. Not only is that the only humane and responsible approach to reduce human suffering, but it is also far more efficient and fiscally responsible: rationing and delaying care until a health condition becomes an emergency means that condition will be significantly more costly and difficult to treat. The tribe cannot emphasize strongly enough the importance of fully funding the PRC program.

An associated problem faced by our tribal members is the cost of transportation to receive PRC services for primary and specialty care that cannot be provided at our hospitals and clinics. Again, due to funding constraints, the IHS does not always pay for these costs and our patients do not have the financial resources. The tribe frequently ends up covering transportation costs associated with medical care, which diverts tribal funding that is badly needed for other purposes. Dedicated, full funding for transportation for health care referrals is necessary to assure access to care. In addition, enhancing the capacity of local IHS facilities like the Pine Ridge

Hospital to provide the full range of primary care services to their full patient population and expanding the scope of specialty care available at those local facilities—especially for specialty care that is in particularly high demand, like psychiatric and respiratory care—would cut down significantly on expensive patient travel. This, of course, would require funding for increased staffing, improved facilities, and necessary medical equipment at the local level. Another strategy for reducing the costs and other burdens associated with patient travel is the development and support of telemedicine. Developing our telemedicine and telehealth capacity has been a priority for the tribe and could be an important feature of a reformed, more responsive, and higher quality health care delivery system in the IHS. The IHS is already exploring telemedicine possibilities, but legislative support—including authorizations for appropriations, pilot projects or programs, and dedicated funding—would help to ensure that these efforts bear fruit.

Improving and fully funding the PRC system, including travel costs associated with PRC referrals, is a top priority for the Oglala Sioux Tribe and must be a part of comprehensive reform efforts. Though fully funding the PRC system would require an up-front investment, the return would be substantial in terms of health outcomes and system efficiency.

Improve the PRC Program through Implementation of 25 U.S.C. § 1678a

The PRC program in the Great Plains area would also be significantly improved through implementation of 25 U.S.C. § 1678a, enacted as part of the permanent reauthorization of the Indian Health Care Improvement Act in 2010, which requires the IHS to designate South Dakota and North Dakota as a single contract health service delivery area (CHSDA). Subsection (b) of that provision further states:

> The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the state of North Dakota or South Dakota if the curtailment is due to the provision of contract services in those states pursuant to the designation of the states as a contract health service delivery area by subsection (a).

However, the IHS is not implementing this provision, and IHS's regulations do not include the states of South Dakota and North Dakota in its list of CHSDAs. *See* 42 CFR § 136.22.

Implementation of 25 U.S.C. § 1678a is not discretionary. Congress mandated that North Dakota and South Dakota be designated a single CHSDA and, as a result, any action by IHS to deny services to any individual based on its pre-existing CHSDAs in those states is unlawful. Yet, IHS continues to deny services to individuals throughout both states based on the geographic limitations in the CHSDAs it established in those states prior to the enactment of 25 U.S.C. § 1678a. This has had multiple negative effects throughout both states: because the IHS continues to deny PRC authorizations for American Indians living outside the pre-existing CHSDAs, those individuals are forced to either forgo needed care or seek care even if they lack the resources to pay for it. When there is no valid PRC authorization, those individuals may be liable for the cost of that care. If they cannot afford the care, both they and their non-IHS provider suffer. The patient's credit may be affected by bill collectors, and the non-IHS provider cannot receive payment for the services they have provided. The issue is compounded for emergency services because hospitals are required under EMTALA to provide such services even when the individual seeking them cannot pay.

The IHS has taken the position that it cannot implement 25 U.S.C. § 1678a without further appropriations. While additional funding is certainly needed for PRC programs, 25 U.S.C. § 1678a is not dependent on additional funding. Rather, it imposes a mandatory statutory duty on the IHS to designate both North Dakota and South Dakota as a single CHSDA and ensure that there is no curtailment of services to individuals living on or near a reservation in North Dakota or South Dakota as result of carrying out Congress's directive that those states should encompass a single CHSDA, 25 U.S.C. § 1678a(b). The tribe, therefore, suggests that H.R. 5406 include a provision that directs the IHS to implement 25 U.S.C. § 1678a. Additionally, as the Pine Ridge Reservation includes a portion of Nebraska, we note that the CHSDA for Nebraska remains the same.

Sec. 304: Report on financial stability of Service hospitals and facilities

The tribe supports the proposal in H.R. 5406 to require the Comptroller General to submit a report to Congress within 1 year on the financial stability of IHS hospitals and facilities that have experienced sanction or threat of sanction by the Centers for Medicare and Medicaid Services, including any revenues lost as a result and recommendations for legislative action.

The tribe also believes that additional measures to ensure transparency in financial management would be helpful. For example, S. 2953 would require the Secretary to provide a report to Congress and tribes each quarter of a fiscal year describing spending and outlays at each level of the IHS, and would require the Secretary to consult with Indian tribes before spending unobligated funds at the end of the fiscal year, except with respect to specific categories of expenditures. In addition, the Oglala Sioux Tribe would like to see tribal consultation on the allocation of funding for the Pine Ridge Service Unit.

Additionally, the IHS should be required to provide a full accounting of the funding received by the Area Office, how it is allocated, its employees, programs, and what functions the Area Office serves. The tribe believes that a fundamental reorganization of the Great Plains area—including quite possibly the elimination of the IHS Area Office altogether—may be needed. We suspect that most of the Area Office functions could be delegated to the service unit level and that the Area Office could operate with only a skeleton crew. Though legislation is not necessary to undergo such reorganization, the tribe has in the past had difficulty obtaining information it needs from the Area Office to fully assess this question. We do note that the IHS has recently initiated consultation on this question and appears open to discussing the possibility of reorganization. We appreciate that step, but a congressionally mandated comprehensive accounting of the Area Office could be a great help.

Finally, to promote fiscal transparency and accountability, H.R. 5406 should include a requirement that IHS report on the amount of third party resources collected by facility and service unit, and how those funds are being used to improve patient care in that service unit. Section 401(c) of the Indian Health Care Improvement Act, 25 U.S.C. § 1641(c), requires the IHS to ensure that each service unit receive 100 percent of any third party resources it collects. Per 25 U.S.C. § 1641(c)(1)(B), third party collections are primarily to be used "to achieve or maintain compliance with the applicable conditions and requirements" of Medicaid and Medicare programs. If there are amounts collected in excess of what is needed for this purpose, such collections shall be used "subject to consultation with the Indian tribes being served by the Service unit . . . for reducing the health resource deficiencies (as determined in section 1621(c) of this title) of such Indian tribes." In addition, Section 207 of the Indian Health Care Improvement Act, 25 U.S.C. § 1621f, requires third party resources collected at the service unit level to be credited to the service unit and used for the provision of health services.

The tribe has reason to doubt that third party collections at the Pine Ridge Service Unit have been left at the Service Unit and used to provide health services at the service unit level and to meet Medicare and Medicaid conditions of participation. First, as has been well documented, the Pine Ridge Hospital is not currently meeting Medicare conditions of participation despite the fact that we understand that it does collect third party resources from the Medicaid and Medicare programs. Second, the IHS recently used $50 million in third party collections to pay an administrative settlement of a union grievance in arbitration.[3] The tribe is gravely concerned by the fact that there was such a large amount of third party collections readily available to the IHS that was not being used for maintaining compliance or for reducing health resource deficiencies at the service unit level as mandated by Congress in Sections 207 and 401 of the IHCIA. Thus, we ask that H.R. 5406 require the IHS to include an accounting of third party resource collections and expenditures at the service unit level.

Adequate Funding is a Necessary Component of Meaningful Reform

One of the most significant impediments to successful reform of the IHS and achieving quality health care for Indian people is the severe funding shortage faced by the system. The National Tribal Budget Formulation Workgroup recently estimated that the full funding need of the IHS is approximately $30.8 billion, but the agency's fiscal year 2016 enacted funding level was only $4.8 billion. Though

[3] The settlement had two categories: $60 million for back pay and back pay-related costs (such as payroll taxes), and $20 million for administrative costs and attorneys' fees. $50 million of the $60 million amount was paid from third party collections and $10 million from expired appropriations. The $20 million was paid from then current fiscal year 2015 appropriations.

reforms to IHS management practices, hiring, transparency and accountability measures are critical, we cannot expect the system to function well with only a fraction of the resources it truly needs. Authorizations and appropriations are needed to fully fund the PRC program; to cover transportation costs when patients must be referred out to far-away facilities; to bring our facilities and equipment up to date and in line with the level of need; to fund recruitment and retention measures including housing, salaries and bonuses so that the IHS is able to attract and maintain qualified professionals; and to increase the scope of services the IHS is able to provide at a local level. All of these are costs, but they are part of the Federal Government's trust and treaty responsibilities to Indian people and they are necessary to achieve anything more than a quick-fix, Band-Aid response to this dire crisis. Moreover, they will reduce suffering and result in significant long-run savings by creating healthier tribal communities and reducing the high-cost chronic and emergency health conditions that are so prevalent among our people today. Our current approach is not sustainable and must be remedied. Though many helpful authorities already exist in law, they cannot be implemented without sufficient funding.

While the Oglala Sioux Tribe recognizes that H.R. 5406 is not an appropriations bill, its drafters must recognize the significance of IHS funding needs in order to carry out the reforms the bill seeks to implement. We ask for continued leadership and support from this subcommittee and individual Members throughout the appropriations process. In the meantime, there are non-appropriations measures that could be included in H.R. 5406 to take small but meaningful steps to ease the IHS funding crisis:

Advance Appropriations. Although advance appropriations alone would not increase IHS resources, it would promote stability and permit better budgetary planning and help to insulate our health care services from the devastating impacts of continuing resolutions and government shutdowns. It would also help with hiring and retention as the IHS would know what funding is available for those purposes ahead of time, and employees would not be impacted by agency funding interruptions to the same degree. For all of these reasons, tribes have been advocating for advance appropriations for IHS for several years. Our treaty rights are not contingent on Congress' ability to enact a timely budget, nor should the health of our people suffer on that basis.

Exempt IHS from Sequestration. Likewise, neither our treaty rights nor the inherent value of our tribal members' lives should be diminished on the basis of mandatory, indiscriminate budget cuts or "sequestration." Other key Federal programs, including health care programs like Medicaid and VA health benefits, are exempt from sequestration, and IHS must also be protected.

Leveraging other Federal funding. Various other measures could also help to ease the funding burden on the IHS system. Directing resources to maximize Affordable Care Act enrollment, for example, would provide a return by boosting third party revenues to the IHS. So would Medicaid expansion under the Affordable Care Act or state waiver or demonstration programs that leverage the newly expanded CMS policy on 100 percent Federal matching for services to American Indians and Alaska Natives. In fact, this subcommittee could investigate whether CMS is doing everything it can to allocate its resources to improve health care for American Indian and Alaska Native beneficiaries and to assist the IHS in doing so. Are there additional Medicare and Medicaid resources that CMS or Congress could direct to the Indian Health System to help it meet CMS standards and Federal treaty responsibilities?

Ensure that the IHS is Maximizing Third Party Revenues. Finally, the Oglala Sioux Tribe is not convinced that IHS staff are sufficiently trained in the collection of third party revenues, and we are concerned that service unit income and budgets suffer because of that. We would propose a study and report to determine whether the IHS is maximizing the recovery of third party resources at all of its facilities, and if not, why not, and what steps can and should be taken to ensure that reimbursement dollars are not left on the table.

Improve Tribal Consultation for Meaningful Reform

Executive Order 13175 mandates that each Federal agency shall have an accountable process to ensure meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications. Every president has reinstated Executive Order 13175 since President Clinton initially issued it in 2000. This Executive Order is regularly cited by tribal governments to keep agencies

accountable and engaging with tribes as agencies develop policies that will affect tribes. However, the consultation process is not always effective or followed to the letter. For instance, Section 3(c) of the Executive Order states:

> When undertaking to formulate and implement policies that have tribal implications, agencies shall: (1) encourage Indian tribes to develop their own policies to achieve program objectives; (2) where possible, defer to Indian tribes to establish standards; . . .

This Section calls for deferring to tribes, where possible, to establish standards. This provision, however, has been routinely overlooked by the IHS, particularly at the Great Plains Area Office. A recent example was the tribe's effort to incorporate language into the Systems Improvement Agreement (SIA) between IHS and CMS to address IHS's deficiencies in operating the Pine Ridge Hospital Emergency Department. We, as the beneficiary of the SIA, submitted several edits for the SIA, but the IHS did not accept them and they did not appear in the final executed SIA.

Furthermore, Section 5(d) of the Executive Order states:

> On issues relating to tribal self-government, tribal trust resources, or Indian tribal treaty and other rights, each agency should explore and, where appropriate, use consensual mechanisms for developing regulations, including negotiated rulemaking.

We highlight the use of consensual mechanisms for developing regulations. As health care is a treaty right, IHS should be implementing the use of consensual mechanisms as we move forward to fix the IHS's provision of health care in the Great Plains.

H.R. 5379, the RESPECT Act, is currently pending in the House. It would essentially codify Executive Order 13175, which would ensure that its provisions have teeth. Provisions of the RESPECT Act could be incorporated within H.R. 5406 to ensure that the IHS carries out effective and meaningful consultation. We highlight Section 401 of the RESPECT Act which provides a remedy for egregious failures of consultation requirements. Per this section a tribe would have the same judicial enforcement remedies as provided in the Administrative Procedures Act. We believe this would work well for holding IHS accountable to its consultation requirements.

CONCLUSION

The Oglala Sioux Tribe thanks Chairman Young, Ranking Member Ruiz, members of the subcommittee and, in particular, Representative Noem for their leadership on this issue and for the opportunity to submit this testimony. We stand ready and willing to offer any assistance we are able to provide as you consider H.R. 5406 and move forward to hold the IHS accountable for ensuring that our people have the meaningful access to quality health care that was promised in our treaties with the U.S. Federal Government.

PREPARED STATEMENT OF SCOTT A. DUKE, CEO, SOUTH DAKOTA ORGANIZATION OF HEALTHCARE ASSOCIATION

Good afternoon Chairman Young and members of the Subcommittee on Indian, Insular and Alaska Native Affairs. On behalf of our hospitals, health systems, post-acute care providers and our 63,000 individual members, the South Dakota Organization of Healthcare Association appreciates the opportunity to submit a statement of record *supporting* Congresswoman Kristi Noem's bill, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act of 2016 (H.R. 5406).

South Dakota tribal members are suffering. Indian Health Services (IHS) has failed—both in its treaty obligation and moral duty—to provide the quality care that Native Americans across the Great Plains deserve. South Dakota tribal members have the second highest infant mortality rate among IHS regions, the highest diabetes death rates, the second highest alcohol related death rates, the highest TB death rates, the lowest life expectancy rates and the highest age adjusted death rates.

For years, Federal reports have documented shocking cases of mismanagement and poorly delivered care. Over time IHS has failed to make improvements on their own even though their funding was increased almost every year. Tragically the recent IHS crisis in South Dakota at several IHS hospitals has resulted in loss of life. For many months the Emergency Department at Rosebud has been shut down because of the unsafe conditions. IHS facilities in Pine Ridge, Rosebud, and Rapid City

have been in jeopardy as well. This is unacceptable. IHS must meet the same quality, safety, and operational standards as all other hospitals.

The effects of the current dire situation have a profound impact on South Dakota and the region. SDAHO member hospitals are actively assisting, but have seen a dramatic increase in Emergency Department (ED) patient volumes and other services. These situations are unpredictable and difficult to manage.

The proposed legislation introduces comprehensive reform by addressing systematic failures in the Great Plains area. To ensure contracts are designed to serve those they are intended to help, the HEALTTH Act requires a partnership between IHS, with tribal input and engagement from independent health care experts. In addition, ensuring the Purchased/Referred Care Program formula is based on factors that impact access to care and match where health care support is needed. Moreover, the bill includes provisions to help drive down prices and stretch every Purchased/Referred Care dollar further. The bill seeks to make the hiring of medical professionals and administrators easier by paying back their student loans. Last, the bill provides critical accountability requirements to ensure ongoing monitoring of what is happening in IHS facilities.

SDAHO's support of the HEALTTH Act, would be *strengthened* by addressing additional concerns to ensure the delivery of quality health care for our tribal communities. These include:

- IHS facilities should be required to have electronic billing and electronic referral as this will expedite patient care when communicating with non-IHS facilities.
- IHS facilities must be required to reimburse care when referring American Indians to non-IHS facilities.
- South Dakota community hospitals should not have to write off more than $10 million annually because IHS refuses to pay.
- Contract negotiation must have meaningful input from the tribal communities to ensure that selected providers are culturally sensitive to their needs.
- Contract awards must contemplate efficiency and integration of care. A step toward achieving this patient-centered objective is implementing contracting terms that allow providers to offer services to individual IHS facilities in a more comprehensive manner.

IHS and its leaders must be held accountable. The passage of the HEALTTH Act will ensure sustainable improvements are achieved. This legislation is urgently needed to ensure sustainable improvements are achieved. We support the innovative and forward thinking of the HEALTTH Act with the additional proposed amendments. We urge your support as well.

PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND AND SELF-GOVERNANCE COMMUNICATION AND EDUCATION TRIBAL CONSORTIUM

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) and the Self-Governance Communication and Education Tribal Consortium, we write to provide the House Committee on Natural Resources Subcommittee on Indian, Insular and Alaska Native Affairs with the following testimony for the record of its July 12, 2016, legislative hearing on H.R. 5406, Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act. Our organizations stand with Tribal Nations across the country in sharing our deep concern regarding the deplorable conditions in the Great Plains area. We appreciate Rep. Noem and the subcommittee's efforts to address the systemic issues which have persisted in the Great Plains region and throughout the Indian Health System for decades, and offer section-by-section recommendations intended to strengthen the provisions of the bill. It is in this spirit that we ask Rep. Noem and the subcommittee to strongly consider the national (rather than regional) implications of H.R. 5406, and to work with Tribal Nations to ensure its impact is positive in all IHS Areas. In particular, we encourage Rep. Noem and the subcommittee to reexamine provisions related to the Purchased/Referred Care (PRC) program. Moreover, we maintain that until Congress fully funds the Indian Health Service (IHS), the Indian Health System will never be able to fully overcome its challenges and fulfill its trust obligations While our organizations support reforms that will improve the quality of service delivered by the IHS, we underscore the obligation of Congress to meet its trust responsibility by providing full funding to IHS and

support additional innovative legislative solutions to improve the Indian Health System.

UPHOLD THE TRUST RESPONSIBILITY TO TRIBAL NATIONS

Through the permanent reauthorization of the Indian Health Care Improvement Act, "Congress declare[d] that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." As long as IHS remains dramatically underfunded, the root causes of the failures in the Great Plains and the Indian Health System will not be addressed, and Congress will not live up to its stated policy and responsibilities. In fiscal year 2015, the IHS medical expenditure per patient was only $3,136 while the Veteran's Administration, the only other Federal provider of direct care services, spent $8,760 per patient. Disparities in health financing lead to disparities in health outcomes. Congress must authorize full funding for the IHS in order to make meaningful progress on the chronic challenges faced by the Indian Health System.

Additionally, we recommend the inclusion of language directing the IHS to request a budget that is reflective of its full demonstrated financial need obligation, as this is the only way to determine the amount of resources required to deliver comprehensive and quality care. We remain hopeful that Congress will take necessary actions to fulfill its Federal trust responsibility and obligation to provide quality health care to Tribal Nations, by providing adequate funding to the IHS.

AUTHORIZE ADVANCED APPROPRIATIONS AND EXEMPT THE IHS BUDGET FROM SEQUESTRATION

Stability in program funding is a critical element in the effective management and delivery of health services. On top of chronic underfunding, IHS and Tribal Nations face the problem of discretionary funding that is almost always delayed. In fact, since Fiscal Year (FY) 1998, there has only been 1 year (FY 2006) in which appropriated funds for the IHS were released prior to the beginning of the new fiscal year. The FY 2016 omnibus bill was not enacted until 79 days into the Fiscal Year, on December 18, 2015. Budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts all depend on annual appropriated funds. Many Tribal Nations reside in areas with high Health Professional Shortage Areas and delays in funding only amplify challenges in providing adequate salaries and hiring of qualified professionals. As Congress seeks to improve IHS' ability to attract and retain quality employees, as well as promote an environment conducive to effective health care administration and management, we urge the inclusion of language that would extend advance appropriations to the IHS.

Additionally, IHS and Tribal Nations continue to face the specter of sequestration. Through the Budget Control Act of 2011 and subsequent failure of the Joint Select Committee on Deficit Reduction, the IHS budget was subjected to Federal spending caps and across-the-board reductions, despite Congress' Federal trust responsibility to finance health care services to Tribal Nations. As a result of the discretionary budget cuts, in FY 2013, IHS lost approximately $220 million from its already underfunded budget. These cuts required the IHS and Tribal Nations to reduce the availability of health services to tribal citizens who already face severe health disparities and are legally entitled to care through IHS. Reductions in funding and the overall instability of the IHS budget sustain conditions which lead to the crises observed in the Great Plains area and throughout the Indian Health System. Restoring these budget cuts and preventing future budgets from harmful reductions will be critical to advancing and improving the care delivered through IHS. We continue to assert that the IHS budget, and all funding for Federal Indian programs, must be exempt from sequestration.

TRIBAL CONSULTATION

We appreciate Rep. Noem's initiative to take action in response to failures in the provision of health care in the Great Plains area. H.R. 5460 seeks to address many of these issues and will have nationwide implications for the Indian Health System. In order to account for the diversity of management structures, including self-governance compacting and self-determination contracting, across the 12 IHS Areas as well as in patient access and experiences among these areas, ongoing tribal consultation must be inclusive of all Tribal Nations impacted. First, we request that Rep. Noem and this subcommittee consider holding an open listening session and soliciting additional comments from Tribal Nations across the country. Second, we request that additional language be inserted into H.R. 5406 requiring tribal con-

sultation on all provisions of the law, as it is implemented, to ensure Tribal Nations have a voice in accordance with the IHS Tribal Consultation Policy. Ongoing, meaningful tribal consultation is essential to mitigating current challenges, preventing future crises, and increasing the health status of American Indians and Alaska Natives (AI/AN).

SECTION-BY-SECTION COMMENTS

In addition to urging the inclusion of the above proposals, we offer the following recommendations to strengthen the existing provisions of H.R. 5406. If implemented together, we believe these policies will provide the necessary framework for IHS and Tribal Nations to improve patient health outcomes the quality of care delivered through the Indian Health System.

Title I—Expanding Authorities and Improving Access to Care

Section 101. Service hospital long-term contract pilot program

As Congress considers reform for the Indian Health System, we support initiatives which empower Tribal Nations to make their own decisions regarding their health care. Through the Indian Self-Determination and Education Assistance Act (ISDEAA) Tribal Nations have made considerable gains in health program administration, patient experience, and community health outcomes. We fully support Tribal Nations that choose to assume health and other programming under this authority. We do, however, want to ensure that Tribal Nations have the adequate infrastructure to assume these functions and that the programs being transferred are not in disrepair. We believe the interim option which would provide Tribal Nations with the authority to pilot self-governance by contracting with the private sector could be a good first step on the path to full self-governance. However, we believe this partnership should be one that fosters mentorship and capacity building in order to ensure these arrangements do not have the adverse effect of diminishing tribal governance.

To that end, we recommend the inclusion of language to clarify that Tribal Nations have the authority to exercise their right to assume programs under the ISDEAA at any time, notwithstanding the duration of any contracts with private entities. This language will ensure Tribal Nations do not unintentionally forfeit their right to assume programs under the ISDEAA while remaining under contract with a private entity. Further, we request additional language which would clarify provider-based status when a tribal hospital is contracted with a private group. This provider-based status is critical to the collection of third party revenue and any disruption could further harm the hospital. Finally, we request ongoing consultation on this specific provision to ensure that this pilot truly provides greater tools and opportunities to enter into self-governance.

Section 102. Expanded hiring authority for the Indian Health Service

Over the course of dialogue regarding this provision and similar language in S. 2953, many have expressed concerns about its constitutionality. Some have suggested that the Department of Justice may be unable to represent the Indian Health Service in cases where the Agency is sued pursuant to action taken under this language. If this is the case, we believe this provision has the potential to destabilize the Indian Health System, rather than strengthen it. Our organizations urge Rep. Noem and the subcommittee to provide Indian Country with more information regarding the potential impact of Section 102. We further ask that this section, including whether to strike the language from the bill, be subject to tribal consultation prior to further legislative action.

Section 103. Removal or demotion of employees

We support expanding the Secretary's authority to remove or demote IHS employees based on performance or misconduct. However, in addition to the Secretary, Tribal Leadership must also be notified when employees within their Service Area become subject to a personnel action. In under Sec. 603(c) "Notice to Secretary," we recommend inserting "Tribal Governments located in the affected service area." Further we recommend inserting similar language included in which S. 2953 establishes "Employment Record Transparency" which ensures that prior to employee personnel actions are adequately notated and considered in future hiring processes. Increasing transparency and access to information for Tribal Nations will be essential to rebuilding the confidence and trust in the IHS.

Section 104. Improving timeliness of care

This provision would establish standards to measure the timeliness of care and develop processes for submitting data to the Secretary on these measures. It is

imperative that these measures and standards are developed in consultation with Tribal Nations. Further, for approximately 170 IHS and tribally operated sites that have chosen to participate in the Improving Patient Care (IPC) initiative, many have already taken steps to improve timeliness of care. We suggest aligning the standards with existing IPC activities and ensuring that standards or reporting are not overly burdensome for tribal health programs. In addition, we request that any data regarding timeliness of care be provided to Tribal Nations, as well as the Secretary.

Title II—Indian Health Service Recruitment and Workforce

Section 201. Exclusion from gross income for payments made under Indian health service loan repayment program

We fully support the provisions which would exempt payments from the Indian Health Service Loan Repayment Program (LRP) from an awardee's taxable income. This will help reduce barriers to recruitment and achieve parity with other Federal health workforce programs, such as loan repayment under National Health Service Corps. Additionally, language should be inserted to ensure that IHS Scholarship Awards receive similar treatment under the Internal Revenue Service Code. Exemptions like this already exist for the Armed Forces and this will assist IHS with creating a pipeline of providers into the Indian Health System.

LRP, and the IHS Scholarship Program, however, are severely underfunded, which has weakened efforts to improve recruitment and retention in the IHS. In FY 2015, LRP was unable to provide loan repayment funding to 613 health professionals who applied, of which only 200 accepted employment at an IHS or tribally operated health facility. IHS estimates that it would need an additional $30.39 million to fund all the health professional applicants from that year. Until Congress moves to adequately fund these accounts, the IHS and Tribal Nations will continue to have challenges attracting qualified providers and there will be gaps in the continuity and quality of care.

Finally, we request that additional funding be made available to assist in the recruitment of AI/AN health professionals from within local tribal communities. We believe that the best way to care for our citizens is to ensure that health professionals are deeply connected to the communities they serve. In order to promote pathways to AI/AN entrance into health professions, we request additional funding, beyond the President's FY 2017 budget request, be made available for the Health Professions Scholarship Program, American Indians into Nursing Program, Indians into Medicine (INMED) program and American Indians into Psychology Program.

Section 202. Clarifying that certain degrees qualify individuals for eligibility in the Indian Health Service Loan Repayment Program

We support the provision of the bill which would recognize degrees in business administration, health administration, hospital administration or public health as eligible for awards under IHS LRP. However, we also recommend inserting similar language to recognize these degrees as eligible under the IHS Scholarship Program. We believe including these degree types into the IHS Scholarship Program will increase the number of AI/AN seeking business and health administration degrees and increase the pool of qualified health professionals.

Section 204. Relocation reimbursement

In order to fight ongoing challenges with recruiting qualified providers into the Indian Health System, we support the provision allowing for reimbursement of reasonable costs associated with relocation. In addition to the criteria listed in the provision, we suggest broadening the language to include positions that are "difficult to fill in the absence of an incentive." This language will allow IHS more flexibility when determining when to offer relocation awards.

In addition to relocation benefits, we recommend the inclusion of language which would authorize IHS to provide other incentives such as housing vouchers, performance based bonuses, and increased pay scales. Especially in the Great Plains and the other medically underserved areas where many of our Tribal Nations exist, access to housing for providers is a major barrier to recruitment. Providing IHS with the authority to offer a variety of benefits will help improve recruitment efforts. We suggest inserting similar language to the provision that exists in the S. 2953 bill under "Sec. 607 Incentives for Recruitment and Retention."

Although we support the proposed incentives, the IHS is not equipped to implement these initiatives without additional appropriations. With IHS funding not meeting demonstrated financial need, we are concerned any initiatives to provide housing vouchers, relocation costs, or increase pay scales must be funded using patient care dollars. While the attraction of qualified staff is critically important, it

must not be done by diverting precious resources from health care services. For this reason, we request that H.R. 5604 include the authorization of additional funding to support these incentives without impacting patient care.

Section 205. Authority to waive Indian preference laws

Although we understand the need to seek ways to recruit qualified candidates, we have concerns regarding the waiver of Indian Preference laws. We firmly believe the providers best suited to care for our communities are ones that come from the communities themselves, and we cannot support efforts that would undermine Indian Preference. As we note above, our vision for a stronger Indian Health System includes a robust pipeline of AI/AN into health professions. In the meantime, we believe that the aims of this provision can be achieved by modifying hiring practices within the current legal framework. We understand the law may be applied in a way that does not provide for timely reviews or hiring of qualified non-Indian candidates where no qualified AI/AN candidate is available. Rather than waiving the laws completely, we think there is room for improvement in hiring practices to ensure that positions are being filled in a timely manner with qualified candidates. We recommend directing the Secretary to update and streamline Indian preference hiring practices to ensure that qualified non-Indian applicants will be considered in cases where no qualified Indian applicants are available, at the sole discretion of the Tribal Nations served.

Title III—Purchased/Referred Care Program Reforms

Section 301. Limitation on charges for certain Purchased/Referred Care Program services

Although we appreciate the language which would codify existing IHS regulation extending Medicare-Like Rates payment methodology to non-hospital based services, in absence of an enforcement mechanism, we believe this could create major access to care issues. Through the 2003 authorization of the Medicare Prescription Drug, Improvement, and Modernization Act, hospital-based Medicare providers and suppliers were required to accept Medicare-Like Rates from IHS and tribally operated facilities as a condition of their participation in the Medicare program. This law has allowed PRC programs to extend their limited resources, while preserving access to care for AI/AN patients by ensuring providers accept the lower rate of payment. Because IHS does not have jurisdiction over Medicare Conditions of Participation, they could not include a similar enforcement mechanism. In cases where physicians or other providers do not wish to accept lower payments from PRC programs, they may refuse to see AI/AN patients and gaps in access will continue to persist. We recommend that language be inserted to this section which would require the acceptance of the MLR for all services authorized by IHS PRC programs as a condition of participation in the Medicare program.

Section 302. Allocation of Purchased/Referred Care Program funds

While we agree that "life and limb" PRC priority levels 1 and 2 provide woefully inadequate levels of care to IHS patients, we assert that rather than redistributing funding, Congress should simply fully fund the PRC account. Consistent underfunding results in the denial and deferral of medically necessary care. In Fiscal Year (FY) 2015, IHS reported 132,200 denied or deferred services, which amounted to $639,177,512 in unmet health care obligations. As a result, medically necessary services are denied by PRC departments and health conditions worsen, quite possibly contributing to many of the issues in the Great Plains. The PRC Medical Priority Level system itself, which forces Tribal Health Programs to ration care based on health condition as a result of underfunding, substantiates the need for Congress to fully fund the account.

We are concerned with the HEALTTH Act's current language, which would impose funding freezes for IHS programs which authorize care at priority level 3 and redistribute funding increases to programs treating only more emergent cases. This will not improve access to care for AI/AN patients, but rather, will spread financial inadequacies across the Indian Health System. Although PRC funding is inadequate, some PRC departments are able to extend their resources through effective financial planning. This provision could penalize PRC programs which have created these types of efficiencies through negotiating competitive rates with providers and have been successful in funding higher levels of care. Further, the care delivered at priorities 3 and below is more likely to be preventive care. A critical element in the fight against the types of emergent and chronic health problems treated at priorities 1 and 2 is preventive care. Treating health problems early avoids more difficult and expensive treatment down the road.

Additionally, we note that the current formula employed by IHS was established in consultation with Tribal Nations. The formula was crafted in recognition of area differences in cost of services, number of patients, access to hospitals, inflation and a number of other factors. In fact, the PRC funding formula is regularly reviewed in consultation with the PRC workgroup and Tribal Nations, so additional work to evaluate the formula is unnecessary at this time. Further, H.R. 5604 lists a number of factors the Secretary must consider in the redevelopment of the formula, which, to our knowledge, were not formulated in consultation with all Tribal Nations.

Section 303. Purchased/Referred Care Program backlog

While we understand that backlogged payments are a major concern in the Great Plains area, this is not true across the Indian Health System. Many Tribal Nations have instituted or agreed to prompt payments. We recommend that the language in this section be amended to exempt tribally operated facilities and limit the review to IHS Areas and direct service sites.

Additionally, we contend that the PRC backlog is not simply the result of delayed payment due to inefficiencies within the IHS. Many PRC providers are unfamiliar with the IHS system and the laws that govern the provision of health care to AI/AN. First, there are the payer of last resort provisions which require private insurance, and other coverage through Medicare and Medicaid, to pay claims prior to IHS PRC programs. In cases where a patient does not have an alternate resource, the determination process may take weeks. Similarly, in cases where a patient fails to attain prior authorization for a service, the PRC department will not pay on the claim and financial liability will go to the patient. Last, some PRC services may meet medical priority but be denied due to lack of funding. In emergent cases, patients will need to receive this care regardless of ability to pay. These scenarios can happen frequently which result in delays or denials of payment of PRC providers. With this in mind, we recommend the inclusion of language call for a Government Accountability Office report on the causes of the PRC backlog, as well as recommendations regarding PRC provider education.

CONCLUSION

Our organizations appreciate congressional efforts to seek solutions to the long-standing challenges within the Indian Health System. However, we note the initiatives proposed in H.R. 5604 do not address the root cause of these issues: the chronic underfunding of the IHS. Only when Congress acts to uphold the Federal trust responsibility by providing full funding and parity for the Agency will the Indian Health System be equipped to provide an adequate level of care to AI/AN people. We thank the subcommittee for the opportunity to provide comments on this bill and look forward to an ongoing dialogue to address the complex challenges of health care delivery in Indian Country.