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S. HRG. 113–416

THE INDIAN HEALTH SERVICE: ENSURING THE IHS IS LIVING UP TO ITS TRUST RESPONSIBILITY

FIELD HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

MAY 27, 2014

Printed for the use of the Committee on Indian Affairs

U.S. GOVERNMENT PRINTING OFFICE

90–731 PDF WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
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CONTENTS

	Page
Field Hearing held on May 27, 2014	1
Statement of Senator Tester	1

WITNESSES

Azure, Hon. Mark L., President, Fort Belknap Indian Community Council	29
Prepared statement	31
Fisher, Hon. Llevando, President, Northern Cheyenne Tribe	20
Prepared statement	22
Lankford, Hon. Carole, Vice-Chair, Confederated Salish and Kootenai Tribes of the Flathead Reservation	34
Prepared statement	37
Old Coyote, Hon. Darrin, Chairman, Crow Tribe	41
Prepared statement	44
O'neal, Sr., Hon. Darrell, Chairman, Northern Arapaho Tribe	47
Prepared statement	49
Rosette, Tim, Interim CEO, Rocky Boy Tribal Health Board, Chippewa-Cree Indians, Rocky Boy's Reservation	51
Prepared statement	54
Roubideaux, Hon. Yvette, M.D., M.P.H., Acting Director, Indian Health Service, U.S. Department of Health and Human Services; accompanied by Randy Grinnell, Deputy Director for Field Operations	3
Prepared statement	5
Stafne, Hon. A.T. "Rusty", Chairman, Assiniboine and Sioux Tribes of the Fort Peck Reservation	24
Prepared statement	26

APPENDIX

Aune, Dan M., Owner/Consultant, Aune Associates Consulting, prepared statement	64
Barnard, Laurie, Audiologist, Browning Public Schools, prepared statement	72
Brady, Sr., Steven, Northern Cheyenne Tribe Member, prepared statement	69
Henan, Joseph, Eastern Shoshone Tribe Member, prepared statement	61
Hunter, Diana, RN BSN, Standing Rock Sioux Tribe Member; Former Director of Nursing, Fort Belknap Health Services, prepared statement	64
James-Hawley, Jessie, prepared statement	66
Plume, David "Tally", Oglala Lakota Nation Member, prepared statement	67
Response to written questions submitted by Hon. Tom Udall to Hon. Yvette Roubideaux	80
Wolter, Nicholas, M.D., CEO, Billings Clinic, prepared statement	77
Walsh, Hon. John E., U.S. Senator from Montana, prepared statement	71

THE INDIAN HEALTH SERVICE: ENSURING THE IHS IS LIVING UP TO ITS TRUST RESPONSIBILITY

TUESDAY, MAY 27, 2014

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Billings, Montana

The Committee met, pursuant to notice, at 10:30 a.m. at the Billings Public Library, Billings, Montana, Hon. Jon Tester, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

The CHAIRMAN. I would like to call this Senate hearing of the Indian Affairs Committee to order.

I want to begin by thanking each of our tribal leaders who are here today to talk about the Indian Health Service, people that are here to help Indian people; I want to thank Dr. Roubideaux, the head of the Indian Health Service for being with us today, along with Randy Grinnell. I know that tribal leaders have come a long way to be here today, I very much appreciate that. I also appreciate Dr. Roubideaux for being here today.

Before I get into my prepared remarks, I just want to say something that was pointed out to me by one of the tribal members in the hall, and that is that we are not having this hearing for the sake of having a hearing, we are having a hearing to find out what the problems are, how pervasive they are and look for ideas on how to fix them. We want to make tribal leaders stronger and Indian Country stronger, and we want to make the Indian Health Service stronger in providing the services that are so critically important for the folks in this room today and a whole lot of other folks who couldn't make it.

Now, it doesn't matter if you are talking about a Fortune 500 corporation or a 15,000-person federal agency, there is nothing that replaces being on the ground and hearing from the clients and the customers that you are serving, a firsthand account of experiences of American Indians and Alaska Natives that have an Indian Health Service are beneficial to all of us if we are going to improve the delivery of care.

The Indian Health Service provides healthcare to roughly 2.1 million American Indians and Alaska Natives from 566 federally-recognized Tribes in 35 states.

Here in the Billings region, IHS is responsible for providing care to over 67,000 American Indians in Montana and in Wyoming. As the population of Tribes grows, the number of those needing and receiving care will also increase over the coming years, and one thing has remained constant throughout our long history of Indian healthcare, the Federal Government acknowledges the unique legal duties and moral obligations it has to provide for the health and welfare of Indian people. These duties and obligations are grounded in the United States Constitution, as well as various treaties, federal statutes and Supreme Court decisions. We have come a long way in ensuring adequate healthcare for American Indians and Alaska Natives, but make no mistake about it, there are many challenges out there that still remain.

American Indian and Alaska Native populations have long experienced lower health status compared with other Americans. We all know the statistics, I won't go through all of them, but there is one I want to highlight, in the 2013 report from the Montana Department of Health and Human Services, it is entitled State of the States, it was reported that non-Indian men in Montana live an average of 19 years longer than Indian men; and non-Indian women live an average of 20 years longer than Indian women. This puts the life expectancy of Native men in Montana at 56; and Native women, 62. These statistics are staggering and unacceptable.

In many cases when we are discussing this, we are discussing issues literally of life and death. Tribes know better than anyone else the reality of receiving care based on life or limb and just how real these conversations can be. The bottom line is that we can do better, and we must do better.

The dialogue we are going to have today will highlight the issues that are facing Tribes and Indian people, regarding delivery health services in this Billings region. While this is a forum to receive testimony from tribal leaders regarding their experiences with IHS, I also hope to hear strategies to address the critical needs and seek a path forward to improve the lives of Indian people in the Billings region and throughout Indian Country.

We need to look at the whole spectrum of needs that are hindering the delivery of quality entitled care, including infrastructure and staffing needs. It seems so often that in all of our discussions, policy and politics, the idea of care gets lost. Indian Country has lost a lot of confidence in the Indian Health Service, so let's see what we can do about getting it back.

I would also point out that my partner in the Senate, Senator John Walsh, is not here today, wasn't able to join us, but he has worked hard for Indian Country, and after meeting several times this winter—he and I—had asked the Government Accountability Office to launch a full investigation of the Indian Health Service. Now, we look forward to getting some recommendations from them about how to improve IHS and how to revitalize this agency, he has provided some testimony in writing, and that testimony will be entered into the official record.

I know we've got limited time today so I'm going to wrap it up so we can get to Dr. Roubideaux, but I would like to remind the witnesses to limit testimony to five minutes so that we can hear from all of you. Know that your full written testimony will be a

part of the record, and the record will be open for another two weeks.

So thank you all for being here, the tribal leaders, Dr. Roubideaux, thank you all the members who have taken time out of your busy schedule to be here.

We are going to start with Dr. Roubideaux who is the head of Indian Health Service, and it is my understanding that Dr. Roubideaux will remain here and listen to the testimony from the tribal leaders and maybe visit with folks, hopefully.

And so we welcome you to the great State of Montana and the great city of Billings and the great county of Yellowstone.

You may proceed, Doctor.

STATEMENT OF HON. YVETTE ROUBIDEAUX, M.D., M.P.H., ACTING DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY RANDY GRINNELL, DEPUTY DIRECTOR FOR FIELD OPERATIONS

Dr. ROUBIDEAUX. Thank you, and good morning, Senator Tester. I'm Dr. Yvette Roubideaux, Acting Director of the Indian Health Service, and accompanying me today is Mr. Randy Grinnell, the Deputy Director for Field Operations, or, as I like to call him, the boss of the area directors.

There's been a lot of discussion in Montana recently about the challenges facing the Indian Health Service, and I'm really glad to have the opportunity today to update you on some progress we've made, but to discuss the work that clearly remains to be done, and I'm really looking forward to hearing recommendations.

IHS is striving to fulfill its role as a health system and represents the only source of healthcare for many of our American Indians and Alaska Native patients, and while we are operating in a constrained fiscal environment, funding is critical, and while the IHS budget has increased by 33 percent since 2008, and thank you for your advocacy on that, the need continues to be significant and challenges remain.

Despite the challenges, our patients are counting on us to make improvements. Over the past few years, we have been working to change and improve the IHS nationally and in the Billings area so we have made progress, but as you know, much work remains to be done. At IHS, we remain strongly committed to continuing to make improvements.

We have improved and strengthened our tribal consultation process, and I recently held a listening session with Tribes in the Billings area. Their input and recommendations are helping guide priorities for actions and improvements. For example, the Billings area Tribes have strongly advocated for increased funding for referrals made for our Purchase and Referred Care Program—PRC—formerly known as Contract Health Service, and there has been a 60 percent increase in PRC funding since 2008, and it has made a difference by resulting in approvals beyond Medical Priority 1, however, the 2013 recision and sequestration reduced PRC budget in the Billings area by $3 million, resulting in having to go back to only Medical 1 priority approval. We are hopeful that the increases in funding in the fiscal year 2014 budget and the proposed FY 2015

President's budget will again help increase the number of referrals for payment beyond Medical Priority 1.

The number of referrals we can authorize for payment is heavily dependent on funding levels, and we will continue to fight for PRC funding increases to help patients get the referrals they need.

Our priority to reform the IHS includes instilling accountability into IHS management and staff and improving our business practices, especially at the local level which is a priority that the Billings area Tribes emphasized at the recent listening session.

We are working to maximize collections from third-party payors to bring in more resources for services. We are making improvements in hiring, recruitment, and retention efforts; and for our third priority, we are working on a number of initiatives to improve the quality of and access to care.

We are encouraging our local CEOs to work more in partnership with Tribes to develop priorities for improvement together, and I think that's going to be fundamental for us making changes. Rather than fighting each other, I think we need to be working more together.

These reforms are now being implemented throughout the IHS at the national level systemwide, however, I know what matters most to the members of the tribe in the Billings area is the day-to-day care they receive from our facilities. In an attachment that I will share in follow-up, I will provide a detailed listing of recent reforms in the Billings area. Today I would like to emphasize a few key actions we've taken to make improvements.

First, IHS is implementing the corrective actions for findings from the 2011 area oversight review, and several improvements have been made in the area of hiring and human resources, funds management, Purchase/Referred Care, pharmacy controls, health professional licensure, and facility accreditation.

Second, IHS is focused on making local improvements in response to tribal concerns. For example, IHS is implementing recommendations for the Crow-Northern Cheyenne Hospital from the recent commission corps deployments that were brought in to make recommendations on how to improve quality of care.

Third, we are implementing the 2010 MOU with the VA to improve coordination of care for veterans and have implemented the 2012 VA reimbursement agreement in all federal sites in the Billings area.

And fourth, we have now instituted a practice in the Billings area of providing each service unit a daily report of each clinical provider's productivity which has resulted in improved monitoring of schedules, numbers of patient visits, and that is helping us improve care and access to care.

So in conclusion, while we are making progress in and are committed to making progress and changing and improving the IHS, we know that much more needs to be done. We are committed to working hard with you and in partnership with Tribes to improve the Billings area IHS through our reform efforts, and we thank you for your support and partnership.

In closing, I just want to say that I really truly believe that the only way we are going to improve the health of our community is to work in partnership and have both of us working on action steps

together that will make lasting improvements, and we are committed to do that. Thank you.

[The prepared statement of Dr. Roubideaux follows:]

PREPARED STATEMENT OF HON. YVETTE ROUBIDEAUX, M.D., M.P.H., ACTING DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good Morning Chairman Tester and Members of the Committee. I am Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS), and accompanying me is Mr. Randy Grinnell, Deputy Director for Field Operations. I am pleased to have the opportunity to testify before the Senate Committee on Indian Affairs at this Field Hearing in Billings, Montana.

As you know, IHS plays a unique role in the Department of Health and Human Services (HHS) because it is a health care system that was established to meet the Federal trust responsibility by providing health care to American Indians and Alaska Natives (AI/ANs). The mission of IHS, in partnership with AI/AN people, is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. IHS provides comprehensive health service delivery to approximately 2.1 million AI/ANs from 566 Federally-recognized Tribes in 35 states. The IHS system is organized and administered through its Headquarters in Rockville, MD, 12 Area Offices, and 168 Service Units that provide care at the local level. In support of the IHS mission, health services are provided directly by IHS Federally-operated facilities, through Tribally-contracted and -operated health programs, through services purchased from private providers, and through urban Indian health programs.

There has been a lot of discussion in Montana recently about the challenges faced by IHS. I am glad to have the opportunity to update you on the progress we have made and the work that remains.

IHS as a whole has an important mission. The population has grown in the communities we serve, and we see a greater incidence of chronic conditions and their underlying risk factors, such as diabetes and childhood obesity. Moreover, the circumstances in many of our communities—poverty, unemployment, and crime—often exacerbate the challenges we face. In a constrained fiscal environment, IHS strives to meet these challenges and fulfill its role as the health system that often represents the only source of health care for many AI/AN individuals, especially for those who live in the most remote and poverty-stricken areas of the United States.

We have been working to change and improve the IHS for the last five years, all around Indian Country and in the Billings Area of IHS. We have made significant progress but as we know much work remains to be done.

IHS has substantially more resources than we did five years ago, thanks to the support of President Obama and congressional champions like Chairman Tester and other members of the Senate Committee on Indian Affairs. Since FY 2008, the overall IHS budget has increased by 33 percent through FY 2014. The FY 2015 President's Budget proposes an additional $199.7 million, a sign that IHS continues to be a priority in a tight fiscal environment.

At IHS, consultation with Tribes is an Agency priority. We have made improvements in our Tribal consultation process, which helps set Agency priorities for improvements and measure progress. In order to continue our commitment to Tribal consultation, I am in the process of personally conducting listening sessions in all IHS Areas this year to hear views from Tribes on how we can continue to make progress on our Agency reforms. I held a listening session on March 31 in the Billings Area, and appreciate the input and recommendations of the Tribes which will help guide further improvements.

In fact, the Billings Area Tribes have strongly advocated for increased funding for referrals made through our Purchased/Referred Care Program (PRC), formerly known as Contract Health Service, and IHS funding for PRC has increased Agency-wide 60 percent since 2008. This increased funding has made a significant difference in the Billings Area. Four years ago, all PRC programs in the Billings Area were only paying for Medical Priority 1, or "life or limb" referrals. In FY 2010, all of the six Federally-operated PRC programs in the Billings Area were able to approve a number of referrals for payment beyond Medical Priority 1. Between FY 2010 and FY 2012, the total number of purchase orders issued for referrals approved for payment increased from approximately 107,000 to approximately 120,000; and, during the same time period, the number of denials decreased from approximately 28,000 to 23,000. However, the 2013 rescission and sequestration cuts reduced the Billings Area PRC budget by approximately three million dollars, and, by the end of FY 2013, three Service Units were only able to approve referrals for payments for Med-

ical Priority 1. We are hopeful the increase in PRC in the FY 2015 President's Budget will help again increase the number of referrals approved for payment under the PRC program. The Billings Area Tribes have identified Purchased/Referred Care, Mental Health, Hospitals and Clinics, Alcohol and Substance Abuse, and Health Education as the top priorities for funding.

My second priority to reform the IHS includes instilling accountability into the IHS management structure, setting goals for managers and then holding them accountable when targets are not achieved. An important element of this is improving our business practices, which is something the Billings Area tribes emphasized at the recent listening session. I have been working with our Area Directors to improve our financial management and how we plan and execute our budgets each year to maximize the care our patients receive. We are working to maximize collections from third party payers to bring more resources into our service units. We are making improvements in the hiring process, recruitment and retention efforts, and, for our third priority, are working on a number of initiatives to improve the quality of and access to care and promote healthy Tribal communities. One important new initiative is our hospital consortium which is working to improve quality and maintain accreditation requirements in all our hospitals by establishing a system-wide business approach to accreditation.

These reforms are being implemented throughout IHS at a national, system-wide level. However, I know that what matters to members of the tribes in the Billings Area is the day-to-day care they receive from our service units and hospitals. Within the Billings Area, IHS delivers health care to approximately 80,000 Indians living in both rural and urban areas. The Area Office located in Billings, Montana is the administrative headquarters for eight service units consisting of three hospitals, eleven ambulatory health centers, and four health stations. In addition, the Billings Area has an active research effort through the Epidemiology Program operated by the Montana-Wyoming Tribal Leaders Council. Research projects focus on diabetes, cardiovascular disease, cancer, and the application of health risk appraisals in all communities. Tribally managed healthcare facilities include health clinics operated by the Chippewa-Cree Tribe of Rocky Boy Montana and the Confederated Salish and Kootenai Tribe. The remaining facilities are administered by the IHS, but Tribes operate some of the programs associated with those facilities.

In an attachment that I will share in follow up, I will provide a detailed listing of recent reforms and changes in the Billings Area, and, in particular, the steps being taken to improve IHS service to tribes in this Area as a result of the 2011 IHS Area Oversight Reviews. I would like to emphasize a few key points before concluding my testimony and answering your questions.

First, IHS is implementing corrective actions for findings from the 2011 Area Oversight Reviews conducted as a result of the Senate Committee on Indian Affairs investigation of the Aberdeen Area. Several improvements have been made in the Billings Area in the areas of policies and practices relating to hiring and human resources, funds management, purchased referred care, pharmacy controls, health professional licensure, and facility accreditation.

Second, IHS is focused on making local improvements in response to Tribal concerns. For example, IHS is directly engaged in improving the quality of care at Crow Hospital. When it became clear last year that the facility had significant challenges, we requested an outside team of experts from the Commissioned Corps conduct a review of the quality of care and provide us with a set of recommendations which we are now being implemented.

Third, we are implementing the 2010 MOU with the VA to improve coordination of care for Veterans eligible for both IHS and VA benefits, and we have implemented the 2012 VA IHS reimbursement agreement in all Federal sites in the Billings Area which are now billing for and receiving VA reimbursements. So far in FY 2014, this has brought in nearly $700,000 in additional funding from reimbursements.

Fourth, we have now instituted a practice of providing to each Service Unit in the Billings Area a daily report of each clinical provider's productivity which has resulted in improved monitoring of clinic schedules and the number of patient visits. We can now use this information to increase provider appointments and improve scheduling processes to increase access for patients.

In conclusion, as I said at the beginning, while we are making progress in changing and improving the IHS, we know that more needs to be done. We are committed to working hard, and in partnership with Tribes, to improve the Billings Area IHS through our reform efforts, and we thank you for your support and partnership. By working together our efforts can change and improve the IHS to ensure our AI/AN patients and communities receive the quality health care they need and deserve.

Thank you and I am happy to answer questions.

Attachment

BILLINGS AREA IMPROVEMENTS—INDIAN HEALTH SERVICE

The Billings Area faces several challenges, including difficulties associated with providing care in rural communities, an increasing user population, finite resources for healthcare facility expansion, and staffing limitations. The Billings Area Master Plan completed in 2004 estimated the need for healthcare facility expansion and staff at the Service Unit level would have to double by 2015 to serve the projected growth of the population served. In 1993, the Billings Area annual budget was $83 million with approximately 730 Service Unit employees and 140 Area Office employees. In 2013, the annual budget has grown to $228 million and Service Unit employees have increased by 50 percent to approximately 1,100 Service Unit employees; however, the number of Area Office employees has decreased to 83, impacting support of health care delivery in the area. During this same period, ambulatory patient care visits increased by 68 percent from over 363,000 visits to over 611,000 visits. Despite these challenges, IHS has made progress in addressing some of the many issues facing the Billings Area IHS.

Billings Area Oversight Review

The 2010 Senate Committee on Indian Affairs investigation of the Aberdeen Area prompted IHS to conduct oversight reviews in all other IHS Areas to determine if the same issues were present and, if so, to implement corrective actions. In March 2011, IHS Headquarters conducted an Oversight Review of the Billings Area focusing on policies and practices relating to hiring and human resources, funds management, purchased referred care, pharmacy controls, health professional licensure, and facility accreditation. Corrective actions and improvements since the oversight review include the following:

- The Billings Area has implemented the Agency's pre-employment suitability requirements and procedures for background checks on new hires and has improved processes to ensure that the documentation of all fingerprints and Office of Inspector General checks are completed prior to the employees' entrance on duty. The Area has also reduced the number of backlog investigations.
- The Billings Area has addressed the administrative leave-approval process to limit its use only when absolutely necessary. All requests are approved by the Area Director with justification and written approval records maintained in the Employee Relations case file.
- In addressing the financial management improvements, the FY 2011 total Accounts Receivable balance of seven million dollars found during the oversight review has been reduced to $2.3 million. The total Accounts Payable amount of $19.4 million in FY 2011 has been reduced to $1.4 million.
- The Purchased/Referred Care issues regarding backlogs of referrals and unpaid balances found during the oversight review have been addressed through on-site Service Units program reviews and the development of Corrective Action Plans with increased monitoring and reporting to Billings Area Executive Management.
- Pharmacy control and security has been improved within the Billings Area with the ongoing installation of security measures (*e.g.,* cameras) and filling of pharmacy department vacancies. All pharmacies have their controlled substances locked in a safe and the departments have an alarm system for additional security. In FY 2013, on-site Service Unit Pharmacy Reviews were conducted with a controlled substance audit performed. The Billings Area will schedule and conduct Audits for all Service Units in FY 2014.
- Regarding health professional licensure, the Billings Area coordinated efforts with each Service Unit to achieve compliance with all credentialing files. The Credentialing Status Report is submitted monthly by the Service Units to the Billings Area Office for review and brought forth to the Area Governing Body, which consists of the Area Director; Area Executive staff and Service Unit CEO on a quarterly basis.
- The Billings Area facilities continue to maintain their accreditation and/or Centers for Medicare & Medicaid Services (CMS) certification. Three ambulatory care facilities are accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). The Northern Cheyenne and Wind River Service Units are also accredited as Medical Homes by AAAHC. The Billings Area inpatient facilities (Blackfeet, Crow, and Fort Belknap) are CMS certified.

- The Billings Area continues to monitor and update each subject identified in the initial oversight report.

Additional Improvements

The Billings Area has undertaken additional activities to improve service, ensure appropriate care is provided to all eligible AI/ANs, and ensure success in achieving the IHS mission. Some of these efforts are detailed below.

Restructuring of Area Governing Body Oversight of Service Units

Over the last year, the Billings Area IHS has undergone a total restructuring of the individual Service Unit's Governing Body bylaws, membership, agenda, and record-keeping. This initiative was undertaken with the intent of addressing all four of the Agency priorities and improving the overall administration of health care services in the Billings Area IHS. The first objective of this restructuring of the Governing Body oversight was to strengthen our partnership with Tribes while making all work transparent, accountable, fair, and inclusive. The restructuring of the quarterly Governing Body meetings improved the sharing of both administrative and clinical data. The change also resulted in the strengthening of the relationship between the Area office and the Service Units.

The second objective of this effort was to improve the quality of care while reforming services. The Governing Body bylaws were carefully structured to meet all applicable standards for CMS or accrediting bodies. Regular reporting of information on agency reforms facilitates Service Unit and Area staff collaboration to improve the efficiency and accuracy of data presented. The Governing Body agenda was restructured to focus on administrative/budget issues while increasing attention to quality and access to care. This transformation continues with plans to improve quality and access to reporting and monitoring. Also, a major focus of the next phase will explore standardization of medical staff bylaws and structure. These improvements in Area Governing Body oversight will help ensure regular review of improvements and progress on Agency reforms.

Access to Care and Provider Productivity

The Billings Area has instituted a practice of providing to each Service Unit a daily report of each clinical provider's productivity which has resulted in improved monitoring of clinic schedules and the number of patient visits. In addition, this information is used to implement changes that increase the number of provider appointments, improve scheduling processes, expand access, and increase patient satisfaction across a variety of patient care delivery areas. This data is reviewed by each Service Unit daily, discussed at weekly Executive Team meetings, and shared during weekly conference calls with Area Office staff. On a quarterly basis, cumulative data is reviewed at the Governing Body meeting. Since implementing these changes, IHS facilities in the Billings Area have stressed to the Service Units the key relationship between quality and access. Over the last year, the Fort Belknap Service Unit has noted significant improvements in access to care. For example, since implementing Improving Patient Care concepts, the Fort Belknap Service Unit has doubled the number of patients with access to outpatient services.

Improvements in Third Party Reimbursements

The Billings Area Tribes have indicated that they want IHS to improve its ability to collect third-party reimbursements because additional resources will help make improvements at the local level. The Billings Area Business Offices are focusing on making improvements in this area. In FY 2010, the Billings Area collected approximately $48 million in third party reimbursements. By the end of FY 2013 these collections had increased to approximately $54 million. Monitoring takes place daily and or weekly by the Service Units and the Area Office staff monitor third party reimbursements weekly and create Third Party Generation Reports that track collection targets, coding and billing backlogs, total claims billed weekly, and accounts receivable. Examples of improvements supported by third party reimbursements include the following:

- The Crow/Northern Cheyenne Hospital has used increased reimbursements to renovate the labor and delivery area and to hire additional provider staff.
- The Wind River Service Unit has used increased reimbursements to purchase new x-ray equipment and to renovate the outpatient department to increase the number of exam rooms.
- Other Service Units have used increased reimbursements to purchase more health care services through the Purchased/Referred Care program.

Affordable Care Act Implementation and Outreach

For the past year, the Billings Area focused on implementation and outreach activities to ensure that our patients receive Affordable Care Act benefits. Patients who visit our healthcare facilities get education and assistance primarily from the benefit coordinator staff in the Business office.

- The Billings Area has appointed an Area Affordable Care Act Point of Contact who is working with all sites to educate our patients on the Affordable Care Act.
- Six Federal Facilities have at least one certified application counselor (CAC). Each IHS facility has at least two CACs, each Tribal facility and urban program has at least one CAC in their facility.
- The Billings Area Tribes and IHS have worked in partnership to plan, conduct, and coordinate meetings to provide Affordable Care Act training in all Tribal communities in the Area. Currently, in the Billings Area there are 35 IHS/Tribal/Urban (I/T/U) employees who are CACs and have completed the required Federal Training.
- The Billings Area has held twenty eight Outreach and Education events since January 2014 in all I/T/U communities. These events consisted of education and enrollment opportunities with more than five hundred consumers being educated on the Affordable Care Act.

VA/IHS Reimbursement Agreement

All Federal sites in the Billings Area are fully implementing procedures for billing and receiving reimbursements from the Department of Veteran Affairs (VA) under the 2012 VA–IHS reimbursement agreement. The Federal sites in the Billings Area began billing in August 2013 and collected approximately $64,000 by the end of the fiscal year and have collected $685,000 in FY 2014 to date. For example, the Northern Cheyenne Service Unit currently has 56 Veterans registered in the Resource and Patient Management System and is billing and collecting reimbursements from VA for direct care services provided to eligible Veterans. From the beginning of the fiscal year to January 2014, the service unit collected $30,600 for 163 Outpatient visits and 106 Pharmacy visits.

VA–IHS Memorandum of Understanding (MOU)

The Service Units continue to coordinate care with VA to enhance the health care provided to eligible Veterans. Examples of improvements in care for veterans in the Billings Area include the following:

- The Blackfeet Service Unit has worked diligently with VA to establish a better network between the agencies. They have collaborated with VA at the regional and local levels to establish an area within the Blackfeet Service Unit for VA to provide clinic and Tele-health services for eligible Veterans.
- The Crow Service Unit provides assistance with enrolling eligible Veterans into VA and collaborates with the Crow Tribe in identifying Tribal Veterans who need specific assistance with enrollment and other services.
- The Fort Belknap Service Unit provides Tele-psychiatry services from VA to eligible Veterans in a secure office provided by the IHS Service Unit.
- The Fort Peck Service Unit is working with VA to have a Tele-psych unit in the local IHS facility. The VA psychiatrist will provide services to eligible veterans with equipment installed in the IHS Poplar Clinic. The Tribe is recruiting a Tribal Outreach Worker who would assist in the scheduling of eligible veterans.
- The Wind River Service Unit coordinates outreach and health care services (primary care and mental health services) for eligible Veterans on the reservation through visits by the VA Mobile Van to IHS facilities.

Staffing

The Billings Area has focused on improvements in hiring, recruitment and retention of staff. The Northern Plains Region Human Resources (NPRHR) Staffing Department continues to maintain an average hiring time of less than the 80-day Agency requirement. Monthly calls with each Service Unit are conducted to review the status of recruitment actions initiated by the Service Units. The NPRHR implemented an electronic help desk to assist managers in the recruitment process. The current vacancy rate in the Billings Area is 10.58 percent, with 121 positions vacant and in various stages of recruitment.

Currently, there are only two physician and five mid-level vacancies as compared to 22 physician and 11 mid-level vacancies in 2012.

Government Performance and Results Act

The goal of IHS' reform efforts is to improve care and patient outcomes. In 2013, the Billings Area met 19 of 21 Government Performance and Results Act (GPRA) measures demonstrating a dramatic improvement over the 2012 result when it met 13 of the 21 measures. GPRA improvement activities have varied depending on clinical site needs, improving provider specific education on GPRA measures, providing bi-monthly GPRA data reports to executive and clinical staff, and monitoring outcomes through the Clinical Reporting System Dashboard report. One on one GPRA improvement calls with Service Units also have provided technical assistance on the IHS' Electronic Health Record that enables them to create panels, improve management of patient populations, and more closely monitor GPRA-related services. Problem solving for outpatient clinical care to evaluate access, length of appointment, patient wait times, and follow-up for missed and cancelled appointments are also integral to the Area GPRA improvement strategies.

Behavioral Health

Billings Area Tribes have indicated that addressing Behavioral Health issues is a priority. IHS is in the fifth year of funding for the Methamphetamine Suicide Prevention Initiative (MSPI) which provides funding to Tribal organizations and urban Indian health programs to provide methamphetamine and/or suicide prevention and treatment services. All Tribes in Montana and Wyoming have an MSPI program. IHS partners with Tribes to deliver services by and for the communities themselves. All programs use evidence based or practice based suicide prevention or intervention projects.

IHS is in the fourth year of funding of the Domestic Violence Prevention Initiative (DVPI). Most of the Tribal communities in the Billings Area have a DVPI program that can focus on data collection, emergency domestic violence assistance and community outreach/prevention education. The Billings Area, in cooperation with the Crow Service Unit, is providing Billings Area Federal, Tribal and Urban sites training on child maltreatment and adult sexual assault. Such trainings enable sites to develop and/or improve services for child and adult victims of abuse, neglect, assault and rape. Upcoming trainings in the Billings Area include: Adult Sexual Assault Examiner; Pediatric Sexual Abuse Examiner; and Domestic Violence Examiner.

The CHAIRMAN. Thank you, Dr. Roubideaux. I will just add to that, not only partnerships between the IHS and Congress, but partnerships between Congress, IHS, and the Tribes.

We will start out with some pretty basic stuff. In your opinion, could you give me your biggest concern with IHS? What keeps you up at night right now?

Dr. ROUBIDEAUX. What really keeps me up at night is the growing need and the lack of resources, because we have the steps and the tools to make improvements and spend our money more efficiently and we are doing that, but what keeps me up at night is the funding situation. Medical inflation is rising, population is growing, and the budget, even though it is increasing, the demand is enormous. If you look at comparing our funding to the Federal Employees Health Benefits Program, we are only funded at 57 percent of the per capita amount that they are funded at, and funded much less than other federal healthcare programs, and so my top priority is fighting as hard as I can to get more resources, because in the end, that will make the biggest difference. We saw that with Contract Health, then sequestration made us fall back again, and I just worry about the constrained fiscal environment, and I understand how there needs to be more fiscal restraint overall in the country, but there is also the responsibility to American Indians and Alaska Natives, and we are doing everything we can to make the improvements we need to make.

The CHAIRMAN. Can you tell me briefly what role third-party collections are, what role they play in your ability to get proper resources?

Dr. ROUBIDEAUX. Third-party collections are critical. Since the appropriations have not kept up with medical inflation and population growth, we look to the third-party-collections to help expand and maintain services. It used to be that third-party collections were only 10 or 15 percent of the budget, now it's grown to 30 or 40 percent of the budget in some places, and so it's very critical that we are able to help our patients know what their options are to get covered; and as they come to us, we can have revenues.

The CHAIRMAN. And whose responsibility are those third-party collections? Is that the responsibility of your office, the regional office, the Tribes, who; the individual?

Dr. ROUBIDEAUX. The third-party collections in terms of collecting them or of obtaining them?

The CHAIRMAN. As far as finding out about them, collecting them, what's the process?

Dr. ROUBIDEAUX. It's everybody's responsibility. It starts at the local level with the local business office having a conversation with patients about what resources they have and assisting them to enroll; it's the area office's responsibility to do training and education and to also do monitoring and oversight of the local facilities and outreach efforts; and then of course at the national level, it's our responsibility as well to make sure we are doing everything we can to maximize——

The CHAIRMAN. I don't want to stick on this third-party stuff for a long time because I've got questions in other areas, but is that process working right now? Does everyone know within the chain of command what their job is to be able to make those collections?

Dr. ROUBIDEAUX. Everybody knows it is a priority. It's in our performance management plans, I think we could do a better job of holding people accountable.

The CHAIRMAN. In your confirmation hearing last year, you listed four top priorities for Indian Health Service, those being—correct me if I'm wrong—strengthening partnerships with Tribes by improving tribal consultations; the second one was reforming IHS which we will probably dig into a little more; the third one is organizational and administrative reforms, and the fourth is one is access to customer service. Can you give me the progress that IHS has made in these four areas that you've pointed out?

Dr. ROUBIDEAUX. So briefly for the strengthening the partnership with Tribes, we've made a lot of improvements at the national and area levels. I think that our new focus is to make more push at the local levels where on the direct service, the CEOs are regularly communicating with the Tribes, sending them reports, meeting with the tribal councils; we want to do more of that, and that's really going to be our big push moving forward.

In terms of reforming the IHS, we have made a number of improvement nationally in terms of financial management improvements, making business practices more consistent. We are now in the point of that progress where we are really going to be more again focusing at the local levels, making sure people are implementing those reforms.

Mr. Grinnell is involved in the oversight of that as well, reviewing monthly dashboards and targets and measures with our area directors to make sure that they are implementing reforms, and then the area directors should also be reviewing those with the local CEOs, but now we need to double down our focus at the local level.

And then the last area, improving the quality of and access to care; we've been implementing the improving patient care program, it's now in 171 sites, that's the patient centered medical home, basing care on the patients' need, increasing, but better flow of the clinics, getting more patients in, improving appointments and those sorts of things, so we are implementing that, and that's our goal, to increase access to care, and many of these improvements have been initiated, and there is progress in some areas, but some areas need an extra push.

The CHAIRMAN. One of the biggest areas of concern that I've been hearing from Indian Country towards IHS is we are hearing about a lack of communication between IHS headquarters in DC and the area offices, and you can disagree with me if you don't think this is the case, this is what I've been told, and I think I spoke to you about this issue last February, as far as communication between headquarters in DC and the area offices, has anything changed since I visited with you about this in February? Do you think this is a problem?

Dr. ROUBIDEAUX. So in February, we had discussed the communications at the local levels and with the Tribes, and the improvement we've made are I've scheduled listening sessions in all 12 areas to make sure that I hear the input directly from the Tribes myself.

In terms of communicating the priorities and the accountability and what we need to accomplish, we do meet weekly with our leadership in the area by phone, we do have weekly calls with area directors that help us know what's going on at the ground and help us communicate progress.

We have an enhanced and improved performance management plan that has all the measurable targets that they are supposed to be meeting, and what I have been doing is we are reorganizing a bit of our staff at headquarters to free me up to be able to interact more with Tribes, and, for example, just recently I jumped on the phone with the local Tribes after the previous area director resigned to come up with an action plan with the Tribes together on how we can immediately advertise the position and for how long and how they will be involved in that, so we've done a lot since we last talked to you to try to increase responsiveness in communication with both area offices.

I think that what I learned in the local listening session here in Billings a month ago was that the Tribes were saying that they felt like the communication problem was at the local level and they didn't think that the local CEOs were implementing the reforms that they hear us talking about at the national level, so we will be working hard to emphasize communication and accountability at that level.

The CHAIRMAN. The director position, has it been advertised?

Dr. ROUBIDEAUX. Yes. It was advertised within a couple of days of the call with the Tribes, and it has been advertised now for almost four weeks, and it is closing on June 6.

The CHAIRMAN. How many applicants do you have?

Dr. ROUBIDEAUX. I won't see that until it closes. I'm hoping that we will have——

The CHAIRMAN. If it closes and you don't have any applicants, you've got a problem.

Dr. ROUBIDEAUX. That's right. And so basically it's monitored through an electronic system through IHS HR and the department, and what happens is once the listing closes, they give us a list of all the people who have applied, and we look at them for their suitability. I want to make sure we get a qualified person for the job.

The CHAIRMAN. I agree. I think it is a very important position.

Let's get down to what I think we may hear from some of the Tribal Chairmen and Tribal representatives, and that is that we've got folks out there that aren't getting healthcare. I addressed it—it's not just life and limb now, they are not getting healthcare. We've had listening sessions here a month ago, there's audit going on now, I assume you are part of that, giving them information; where is the breakdown at? I mean, look, I think I've read articles where there was one provider that saw one patient a day; now, I know that's not the rule, but even that happening once is not acceptable.

Where is the breakdown? Why did the Crow—their version of the Senate and the House—put forth a recommendation to the congressional delegation to do something about this huge problem? They wouldn't have done that if there weren't a problem out here, and I've got a notion we'll hear about some other problems, too, so where is the breakdown? Where do we need focus?

Dr. ROUBIDEAUX. Well, I've given that a lot of thought because I figured you would ask me that question, you know, for a long time I think the model of IHS has been to make sure that we are meeting the standards that are set nationally for the healthcare system, and if you think about it, we do because our facilities are accredited, sort of objectively we meet the standards, but that's not the problem, the problem is in the eyes of the patients, we are not meeting expectations and we are not meeting their needs, and so what I think is we need a completely different mindset in the Indian Health Service, and that's what we've been trying to promote, is the partnership with Tribes and customer service with our patients and focusing on a more patient centered model of care. We can't do that overnight, but we are working towards that, and we are giving the local service units the tools we need, I think we just need to have more accountability and more focus on it.

And the good thing was at the listening session, we required all the local CEOs to come and attend it and to listen, and for me to be able to say to them this is what we are going do and what we are going to work on, and that helps close the loop so that we can start making real reforms.

But the only way we are going to make this healthcare better in the Indian Health Service is to base it on the perspective from the patient and from the Tribes, and that's a very different perspective

that it's going to take us a little time to achieve, but we are committed to do it.

The CHAIRMAN. So help me out, what are we focused on now, if we are not focused on the patient?

Dr. ROUBIDEAUX. Well, I think I've heard a lot of Tribes tell me that they don't think that our staff are focused on the patient, and I think that in medical care in general, people tend to measure their—how they are focused on whether they meet national quality indicators, whether they meet accreditation, and whether they get through the patients through the day, but that's clearly not enough, and we need to do more to focus on what quality is defined by our patients, not defined by us, what quality as defined by the Tribes and patients that we have.

The CHAIRMAN. We will come back and probably talk about this issue some more today, in fact I'm sure we will today, but I'm not a doc, I'm not a nurse, but it would seem to me the only way you can meet the criteria that are set up is if the patients are dealt with first, and I don't care if we are talking about Indian health or veterans or whatever you're talking about, but it's got to be focused on the patient.

But let's talk about consultation for a second. When you are dealing with consultation with Tribes, are you dealing with more than just elected officials? Let's say that—Tim Rosette is a good example, Tim Rosette is appointed to take care of the Indian Health in Rocky Boy; as an appointed person, is Tim allowed in those consultations?

Dr. ROUBIDEAUX. There's different levels of consultation in the agency. When I'm consulting with Tribes, it's usually with the elected officials at the government-to-government level.

At the area office level, it's with Tribal officials and health directors——

The CHAIRMAN. Do you think that should be changed? I mean there's a Federal Advisory Committee Act that probably is open for interpretation, it would appear to me—nothing against the Tribal men and chairmen, they are all smart people and they are all really good, but it seems to me the folks dealing with the patients probably have the greatest perspective on what's wrong or what's right?

Dr. ROUBIDEAUX. Well, it turns out that the complaints I'm hearing is that the local CEOs are talking with the health directors and that the councils don't know what's going on, so what I hear from the Tribal leaders is they are not hearing what's happening.

The CHAIRMAN. So how can you have consultation if you are dealing with Tribal-elected leaders and they don't know what's going on?

Dr. ROUBIDEAUX. We do deal with health directors as well. If the Tribal leader doesn't want to serve on the committees, they will designate their health director to be on the work group and committee with us so we do get input from health directors all the time.

The CHAIRMAN. Can they designate folks who they want to help with the questions and answers of consultation to the nonelected folks?

Dr. ROUBIDEAUX. Yes. The Federal Advisory Committee Act, we've come up with an easy solution, is that in order to meet those

requirements, the Tribal leader has to write a short letter that says they are designating the health director to be on the committee.

The CHAIRMAN. The previous director was a lady by the name of Anna Whiting Sorrell, somebody who I've worked with for the last 15 years, and in describing why she was resigning as director of the Billings Area Office after barely a year in that position, Anna is quoted as saying there needs to be a much broader conversation as to what the federal healthcare system looks like for Indians; does the federal healthcare system for Indians need to be improved; and more importantly, what should that healthcare system look like?

Dr. ROUBIDEAUX. Absolutely. The Indian Health Service needs to be improved, and that's what we are committed to doing; and I think it needs to look like how our patients want it to look like, and in order for us to be able to do that, we have to work in partnership with the Tribes that we serve and the communities we serve, and that's what we've been trying to work on.

It's a big change from the way the organization had worked in the past, and so we are continuing to encourage more dialogue, more discussions with Tribes, and that's why I appreciate the hearing today as an opportunity to hear that input.

The CHAIRMAN. So today we will probably hear problems and probably some potential solutions; what do you intend to do with either?

Dr. ROUBIDEAUX. Well, I realized about a year ago that the problem we've had is that we've had a lot of consultations, but we were seeing some places, actions were being taken; and in some places, they weren't. Now we are starting to be more rigorous about working with the Tribe to develop an action plan based on the recommendations and the complaints and to develop that action plan together with the Tribe so that we can hold each other accountable for those improvements, and it started to work in other areas, and we've started to do it in this area, and I think it's going to be a way that we can be held accountable for improvements and the Tribes can help us in designing what those improvements should be.

The CHAIRMAN. Just as a sidebar comment, Dr. Roubideaux, here is what I hope happens at today's hearing: I hope that you take good notes, as Randy is, and you take a look at the records when it's all said and done, and we are going to have staff waiting around here to take input from rank and file Tribal members, and I would hope you would look at those problems and ask yourself is there a pattern and what can we do to solve that problem.

And then I would also ask, because I think we've got some smart people in this room, that are going to come up with some potential solutions, that you would take a look at those solutions and see if you can apply them. This should really be focused on hearing what the concerns are and dealing with solutions to those in a way—we are all under budgetary pressures, there's no doubt about it, I feel your pain, but the bottom line is we have to do better with what we have.

On reimbursements, we've heard from several counties that they are not able to receive reimbursements for ambulatory services in a timely manner, this delay in reimbursement puts a strain on al-

ready tight budgets in rural counties, not only in Montana, but across the country; are you aware of the issue?

Dr. ROUBIDEAUX. Yes, the issue of whether IHS is paying the providers that provide service for us, and we have been making improvements to reduce the delays and to increase education on what we do and do not pay for.

The CHAIRMAN. How are you ensuring timely payments?

Dr. ROUBIDEAUX. We have worked on implementing some better practices, we have reduced backlogs, and we are doing more to actually go out and meet with the local facilities to make sure they understand the circumstances where we will and what we don't pay. We don't pay for every single episode of care because of the limited funding and regulations. We have the medical priority and the eligibility rules we have to follow, and by educating the local facilities and emergency rooms and hospitals and clinics on those different eligibility rules is like any—like any insurance company would work, we have rules on whether we will pay or not, but we've been able to do better in other areas by educating, working with the local providers, and I will make sure we do more of that.

The CHAIRMAN. The MOU with the Veterans Affairs, how is it working?

Dr. ROUBIDEAUX. It's actually resulting in a lot of great improvements, and there's actually been a lot of good things happening here in the Billings area.

The CHAIRMAN. All right. Are there any adjustments you think need to be made to that MOU?

Dr. ROUBIDEAUX. The MOU is currently being evaluated by a group that is looking at—and we did have a—I can't remember if it's OIG or GAO gave some recommendations about how to make sure that we have better evaluation of the different areas of the MOU so we are implementing that now.

The CHAIRMAN. I'm going to get into the vacancy rate in a second. Before I do that, though, I want to talk about IHS and the VA; do they share staff?

Dr. ROUBIDEAUX. Yes, there are some places where staff from the VA will come and work in an IHS facility, and our staff will go and work there; and the sharing of actual facilities, telemedicine will help, it's something that's implemented here in this area that's working well to share some services.

The CHAIRMAN. How about reimbursements from the VA to IHS—I think it's 50 million bucks, I believe—how is that going? Is reimbursement happening——

Dr. ROUBIDEAUX. The reimbursement is happening——

The CHAIRMAN.—in a timely manner?

Dr. ROUBIDEAUX. It's implemented at all of our federal sites. We've collected at least 5 million overall for the agency, and about 700,000 here in the Billings area; and the processing and placement in the Billings area was the first to adopt the billing process that everybody else is using, that is making progress.

The CHAIRMAN. And happening timely—the reimbursement?

Dr. ROUBIDEAUX. I will have to go back and look. I think that there are some challenges with determining—the VA will only pay for the services that the veteran is eligible for at the VA, and that takes a little time to do.

The CHAIRMAN. Okay. Electronic medical records, the VA has an MOU with IHS or vice versa; how is that working?

Dr. ROUBIDEAUX. Well, we've worked closely with the VA for many years on our administrative and electronic health records, and we continue to be in constant communication with them to make improvements together and share information.

The CHAIRMAN. Currently the hottest issue in the press right now is VA wait times; is there a comparable situation in IHS?

Dr. ROUBIDEAUX. In some facilities, there are; and in some facilities, there's an improvement in patient waiting times, so it's not related to—it's not the same thing because it is slightly different in Indian Health Service, there's two areas—wait to get direct service in a clinic, and our improving patient care program is improving that, and then it's really—in terms of the referral process, we have reduced the backlogs and waits, it's just the amount of resources, we don't have enough funding to pay for all the referrals that we want to make, and that's the challenge that we have.

The CHAIRMAN. I want to talk about vacancy rates for a second, it's an issue that's been brought to me multiple times, we will try to put this as succinctly as possible, the IHS shows vacancy rates that are getting better; is that correct?

Dr. ROUBIDEAUX. For some professions, yes.

The CHAIRMAN. Overall—and I think we've got these numbers out of the budget—it shows just the opposite; that there are getting to be more vacancies, less people, so less people would indicate to me that there's more vacancies; am I losing something in translation here?

Dr. ROUBIDEAUX. Well, there's two issues related to that. If you look at healthcare professional provider vacancies, we are doing better in some areas. IHS overall has less staff, especially in the headquarters and area offices due to Tribal shares and resources going to the Tribes, and the staff is then—the resources for staff is transferred to them.

The CHAIRMAN. So what you're saying is we are hiring more medical professionals on the ground than we were——

Dr. ROUBIDEAUX. Yes——

The CHAIRMAN.—that the vacancies that we are seeing are reductions in administrative—the slots we are seeing reduced are in administrative areas?

Dr. ROUBIDEAUX. It's a little bit of both, but, for example, dentists used to be a 30 percent vacancy, now it's less than a 10 percent vacancy.

The CHAIRMAN. What kind of overall vacancy rate do we have for healthcare providers?

Dr. ROUBIDEAUX. Overall vacancies range from 5 to 20 percent.

The CHAIRMAN. What's the average?

Dr. ROUBIDEAUX. Depending on the particular——

The CHAIRMAN. What is the vacancy rate in the Billings region?

Dr. ROUBIDEAUX. The Billings region is at about 10 percent, and it's actually gotten better. There used to be 22 provider vacancies, now there's only 2.

The CHAIRMAN. And those provider vacancies, are we talking docs or nurses?

Dr. ROUBIDEAUX. Doctors.

The CHAIRMAN. How many nurses are we short?

Dr. ROUBIDEAUX. I will have to look that up and get that information to you.

The CHAIRMAN. And the percent, if you could get me the numbers that would go with the percentages, that would be great, too.

Dr. ROUBIDEAUX. We are doing things to try to improve the salaries that we have in the improvement efforts. It is a constant challenge, though, just in general in rural areas recruiting individuals, but I do think if we improve the Indian Health Service, it's a better place to work and people will stay longer.

The CHAIRMAN. All right. This Committee, the Senate Indian Affairs Committee, conducted an investigation of the Aberdeen area office of IHS in 2010; are you familiar with that? And it released some results that, quite frankly, were pretty damning.

You testified before the Senate last year that the internal investigations had been completed for all area offices and each one was operating prepared to fulfill its mission. We are here today not because we want to be, but because there's something wrong with the system, something wrong with the system in the Billings area, so the question is who in the administration is making sure that this Billings area is being—that the problem is being solved.

Dr. ROUBIDEAUX. Well, that's our responsibility. In the Indian Health Service, both I and the deputy director of field operations and the area director are responsible for making those reforms.

The CHAIRMAN. And the reforms you are making at this point in time, are they mainly organizational or if you could give me some insight into what you are looking at or what are we not looking at?

Dr. ROUBIDEAUX. There's pages and pages of reforms that we are making to the organization that are both administrative and clinical. If you look at those oversight reviews, they were primarily administrative things from the Aberdeen area that we are fixing in the Billings area—control of funds, contract health backlogs, pharmacy control, licensure, accreditation, background investigations for employees, but we also are making a number of improvements in the quality of care that we are delivering,—increasing number of mammograms, colonoscopies, screening for depression and so on—and we are certainly—we have a long list of targets and goals that all of our senior leaders are responsible for meeting. We've improved in our GPRA measures—we've made a number of improvements, but it's really clear that there's much more to go, and it's a lot of complicated things that we are working on, but I am confident that we've had some progress, but we have much more to do. We are absolutely committed to working on making further improvements in Indian Health Service, it is the whole reason we are here. We are not here to sit around and collect a salary, we are here to make improvements, and I and my senior leaders are all committed to making those improvements to Indian Health Service.

The CHAIRMAN. I appreciate that. I will just make a final comment, and then we'll bring up our second panel. I would just say this: I think it is important that we listen, but that we do more than just listen, that we actually hear the concerns and figure out solutions.

We've got problems in this region, there's no if's, and's or but's about it. Since I took over chair of this Committee, I have become enlightened with comments from folks that I trust and respect about the issues of inadequate healthcare in this region.

We have good people, and those good people in this region, those good people have a track record of success. I think that track record could be implemented throughout this region and throughout the country and we could get more bang for the buck and get more service to the folks on the ground, but it's not going to happen from Washington, DC, as we said, it is going to happen by folks working together, and we only work together if we really work together.

I appreciate your coming in, Dr. Roubideaux. I actually appreciate the fact that you are going to stay and listen to the second and third panel that we are going to have here today, because I think what they have to say can be helpful and can create an opportunity for solutions.

So with that, I want to thank you and Randy for being here today. I appreciate you making the trek out, and hopefully you had the time to get around to see some folks while you were here, and you will absolutely have the opportunity to hear from them here in a moment. Thank you very much. You are dismissed, and we will bring up the second panel. Thank you very much.

The second panel is going to consist of Llevando Fisher who is the President of the Northern Cheyenne Tribe, and we are going to replace the name tags to protect the innocent, so you guys can come up, we will introduce you.

And after Llevando, we are going to hear from Rusty Stafne, Chairman of the Assiniboine and Sioux Tribes of the Fort Peck Reservation.

Following that, we will turn to the Honorable Mark Azure who is President of the Fort Belknap Indian Community.

And finally, this panel will hear from Carole Lankford who is the Vice-Chair of the Confederated Salish and Kootenai Tribes of the Flathead Reservation.

I want to thank you folks.

So here is the deal, okay, because what I would like to have you do is keep this as close to five minutes as you can. I know one of you may run over five minutes a little bit, but keep it as close to five minutes as you can.

I think the point here is to make sure that you get the points across that you think are important and impact your people, and I think it could come—you know, like I say, you can tighten it up as much as you can because that way I've got time to ask you guys a whole bunch of question which is always fun.

So the five-minute rule will apply, and know that your entire written testimony will be part of the public record. I want to thank you for being here today, I appreciate you making the trek to Billings.

And with that, we are going to start with you, President Fisher.

STATEMENT OF HON. LLEVANDO FISHER, PRESIDENT, NORTHERN CHEYENNE TRIBE

Mr. FISHER. Good morning. My name is Llevando Fisher, I'm the President of the Northern Cheyenne Tribe, and I have three concerns.

One of the main issues is the budget shortfall. The contract care cost exceeds over $2 million, and mismanagement of staff in the system. The shortfalls and standards at prior levels for referral of money on a yearly basis only lasts a few months. The few months are from June to September, we only get care from facilities for life-threatening situations. Those do not include minor situations, such as kidney stones, blockage, gallbladder attacks. It's limited to individuals with head injuries or broken bones.

The bills are not getting paid in a timely fashion. The committee members have prior approval to see doctors, and the bills are sent to collection agencies. They have ruined the credit ability of the Northern Cheyenne Tribe, and some of these are referred to bill collections, and it is causing some of our membership to declare bankruptcy due to the bills not being paid in a timely fashion.

We have high maintenance disease that are delayed in treatment and impact budget, such as cancer, heart disease, liver disease.

The transportation of the patients are stressed in the community. Transportation currently is only transporting dialysis patients to the department and does not have enough money to serve the whole community's needs. The Indian Health Service has not made available to the community members information about why the payments are denied after referrals to outside facilities are made and attending emergency room physicians.

Further denying of payments over the years are an ongoing problem in the case of a family of four or more children trying to apply for bankruptcy and creates hardships financially for the individuals who have a fixed income, a limited income or no income. The impact of the budget leaves the entire community without that ability to get referred to doctors in the field of need. This would include doctors who give information to the patient on how to manage the disease, such as heart attack, kidney failure, liver care, cancer care. Currently, the Indian Health Service only allows community members to have one follow-up visit with surgeons, such as heart bypasses.

And the lack of screening for heart disease and strokes, the lack of communication of providers decreases is—some of our great needs for the Northern Cheyenne Tribe is we would like to have you come down there and do a thorough investigation on our clinic itself, and I would like to invite you to come down and have a town meeting with the community people and hear the horror stories that our Tribal membership is receiving by not getting care from our Indian Health Service.

A lot of times they misdiagnose our patients. They say we have a virus and we don't need medical attention, and it ends up being a life-threatening problem as time goes on.

Waiting for referrals for our emergency transfer to the community, we need to get approval and end up—I'm getting messed up here, but anyway, I would like to have you come down and visit our facility, and our CEO is not informing the Tribal administra-

tion of what's going on, and we need follow-up from your office to come down and assist us, and a lot of times the majority of our problems, we end up only with life-threatening situations and a loss of limb and life.

I would like to have you come down and check on these situations. We don't have adequate funding, we don't get the quality healthcare that we need, and our people suffer from misdiagnosis, getting loss of limbs and life-threatening situations, and they only refer on life-threatening situations, not everybody is being seen there by medical physicians.

So in closing, I would like to really invite you to come down to investigate our clinic. We don't have all the information we need from—or there's lack of communication between Indian Health Service and the Tribal administration, so we need to be in contact more with our healthcare issues.

But one of the things I like to talk about our Veterans, we have a lot of Veterans on the Northern Cheyenne Reservation, and they want to go to Fort Mead, South Dakota, and they won't provide the transportation for our Veterans to go to Ford Mead and they want to hold them within the State of Montana, but that's a request of these Veterans that do want to go to Fort Mead and get better services at the VA system down in Fort Meade.

And the Northern Cheyenne-Crow Hospital, we seem to be left out of the loop when it gets to the Northern Cheyenne-Crow Hospital. The Northern Cheyenne are never—seems like they are never involved in these discussions what happens at Northern Cheyenne-Crow hospital. We lose—I mean we are losing a lot of contract moneys by transporting all of our patients to Billings rather than to the Northern Cheyenne-Crow Hospital.

And we did give OB's to Crow, but now we refer them all to Billings and it's costing a lot more for our contract care. And with that, I would like to close, and I would like to thank you for hearing me out. We have a lots of other concerns, you know, I would sure like to have you come to Lame Deer and visit with us.

The CHAIRMAN. Thank you, President Fisher. Are you talking about the clinic in Lame Deer?

Mr. FISHER. Right. The Lame Deer Clinic and Northern Cheyenne-Crow Hospital.

The CHAIRMAN. I was there four months ago, and I didn't do an investigation—and by the way, I don't have the capacity to do the investigation, but we are more than happy to visit with you and other folks about this issue.

And by the way, the folks from Northern Cheyenne that are here today, I've got staff here and I want you to make a point—I will introduce them at the end, they will stand up, I want to make sure you make it a point to visit with these folks because it's great talking to me, but it's even better talking to them because they make sure I get the work done.

Thank you, President Fisher.

[The prepared statement of Mr. Fisher follows:]

PREPARED STATEMENT OF HON. LLEVANDO FISHER, PRESIDENT, NORTHERN CHEYENNE TRIBE

Good morning, Mr. Chairman, thank you for giving me the opportunity to address the Subcommittee on the very timely and important issue of health care delivery and quality. As you know, this issue has been of great concern in the health care delivery system provided to the Northern Cheyenne Tribe by the Indian Health Service. As we continue to witness the dramatic changes in the structure and delivery of care and steady decline in our quality of patient care. Today, I would like to provide you with my perspective on the impacts of the budget shortfalls, access to care, and the quality of care administered to our Northern Cheyenne Tribal members.

The impact of the budget shortfalls are evident year to year. The only variation and question to this situation is the money and services ending in June or May of each year. The amount that is allowed in the budget does not allot enough money to provide care for the entire year. The impact of this budget shortfall places a limitation to our services to health care with the inability meet the minimal need of survival for our people. The limitation of services during this time period has increased the morbidity and mortality of our Northern Cheyenne Tribal members. They do not get the services provided to the general population in regards to minor surgery and emergent situations such as gall bladder attacks, kidney stone blockage, broken bones, and head injury get minimized to prevent getting an outside opinion.

The mismanagement of the Indian Health Service to properly supervise the position of the Contract Health Representative at the local level has placed Northern Cheyenne Tribal members being reported to the collections department because of the inability to pay the bills in a timely manner. These are bills that have been preauthorized by the Indian Health Service and have not been made accordingly. The Indian Health Service has not made any comments in regards to this issue. At an estimate this costs exceeds more than 2 million dollars. This is a direct violation of the trust responsibility and the inability to perform these functions required by this office has left another impact to our community members. The outside providers that are waiting for payment now have lost the trust and respect of these providers. Not only did this impact our population but also with the limited socioeconomic status of our community members they have now gotten their credit ruined and the ability for enrolled tribal members to have opportunities such as purchasing reliable transportation and affordable appliances and improvement loans.

The continued mismanagement of the Indian Health Service in regards to the Contract care process has had them deny payment for services that were referred out by the Emergency Room Physician. This process needs further clarification to not only our community members but also to the Northern Cheyenne Tribal Administration, in regards to the status of a referral by the Attending Physician and not addressing this prior to the transfer for care outside of the local facility. The denial of services goes back three to four years and only states that the denial is based on the inability to apply for Medicaid. These individuals will not be able to go back three to four years to complete these processes, therefore, setting them up again for failure and bankruptcy at the cost of a service that was thought to be provided and referred by the Indian Health Service.

Additional impacts of the budget shortfall is a direct result to our community members ability to get specialized services, These services include the rehabilitation of Coronary bypass surgery, cancer treatment and transportation, heart disease, and liver failure.

These shortfalls also dictate the ability for community members to get care that is not provided at the local service unit. The priority levels follow the budget shortfalls with further limitations to the user population. During the second half of the year, community members are only sent out when they are in a life or death situation. This has compromised our community in other areas and we have lost individuals who did not meet the screening criteria waiting to get care during this time. The budget does not account for our geographic area, lack of reliable transportation, and the limited socio-economic status or our population in regards to transportation. The Service Unit is not able to provide the entire service of transportation to our community members. They have made an internal decision to provide only to the dialysis patients which are transported six days out of the week. As this department had been retroceded to the Indian Health Service from the Northern Cheyenne Tribe we have had no input into the priority of transports. In addition to the budget shortfalls we will now start to address the issues of accessibility of care for our community members.

The access to care for our community members is limited and based on timing. The inability of the local service unit to have any specialty services available onsite decreases the access and ability of our community members to get patient education and guidance for newly diagnosed chronic disease's such as Heart Disease and failure, Diabetes, Cancer, amputation, Renal failure, stroke, and liver failure. Currently the Indian Health Service only allows for one follow up visit after a major surgeries such as Heart Bypass, intensive care hospitalizations, amputations, and stroke awareness. The lack of screening for preventable diseases which increases our risks for Cancer, Heart Disease, and Strokes. The inability to provide a continuum of care for our population decreases and inhibits the community the opportunity the chance for full recovery and preventing any further complications when they come back home. The community members have frequent re-admission to either the emergency room or hospital because of the fragmentation of care. The delay of treatment options provided for the community have increased the morbidity and mortality with such disease process as Heart Disease and Cancer. The response to patient and family needs has been dramatic and the inability to have created a structure that can accommodate the growth of our community in response to the need for more complex patient care services. Healthcare isn't just improvement and measurement. It is about our core values. our culture, and ultimately our vision for the future. With this, I would like to address the quality and patient care issues.

Quality at its most basic is doing the right thing, in the right way, for the right person. The challenge is knowing as a community member and administrator what the right thing is. The Indian Health Service has made several mistakes in regards to the misdiagnosis of conditions within our population. These mistakes have caused the community members to lose limbs, shorten the life span, and in some cases death. They are now faced with living with a chronic condition that they thought was non-emergent and only a virus by the local provider. The shock and anger associated with this affects the t rust with the providers at the local service unit. As a licensed professional they are required to advocate for the patient rights and conditions knowing when the time is right and what treatment options are available and needed. The approach with medication Is generic across the board with the entire population. Medication is stocked and ordered to a limited availability. If a patient was to come out of the hospital with a new medication and the local service unit did not have this medication, the patient would have it changed or go without. The gap between what is known and what is delivered is evidenced by this continued practice at the mercy of the community member.

Quality is measured thru three dimensions: structure, process, and outcome. Structure and the foundation represents the basic characteristics of physicians and the ability to communicate with other hospitals, other professionals and other facilities such as skilled nursing homes. The Northern Cheyenne Tribal administration is unaware of the communication between facilities. The current structure and framework is limited and based on the availability of the budget.

If we truly wanted to be a model or a candidate for this nation's health care organizations, we need to be offered a systematic process to evaluate and address the patient care issues and concerns in a confidential manner. The inability to have a complaint management process in place limits the ability to identify and measure the goals and objectives of the current healthcare system. Have a strategic planning session that will bring forth priorities that the administration feels is important and needs to be addressed. This allows the opportunity to deliver a better care to our patients, and having a greater and more positive impact on the lives of all of our community members with a criteria and a commitment to quality, satisfaction, and continuous improvement.

In closing, for years we have voiced our concerns at the Tribal Consultation meetings with the Indian Health Service when doing the budget formulation and prioritized Contract Health Services each year and each year we continue to run out of funding. We have lost tribal members, disabled many, and harmed the welfare of others due to the inability of being provided quality and consistent health care to our people. I am asking you at t his time to ensure the survival and welfare of the Northern Cheyenne Tribe we are requesting that you hear us and guarantee that the Indian Health Service fulfill the general trust responsibility.

STATEMENT OF HON. A.T. "RUSTY" STAFNE, CHAIRMAN, ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK RESERVATION

Mr. STAFNE. First of all, I want to thank you for being here for members of Montana, and nationally, I guess, Indian members, I know you've been a champion for my Tribe, I certainly want to thank you. Without you, there's a lot of things that we would not have. With that, I thank you for conducting this hearing.

It is an honor for me to be here. My name is A.T. Stafne, and I am Chairman of the Assiniboine Sioux Tribes of the Fort Peck Reservation.

Our reservation is large and remote, our residents and members are poor and have poor health. Poverty levels present the greatest obstacles to addressing our healthcare needs. Nearly half of the people living on the Reservation are below the federal poverty level. Roosevelt County where most of our Tribal members live has the poorest health in the State of Montana. Our numbers suggest that our average Fort Peck Tribal member dies at the age of 51. We were encouraged by the permanent reauthorization of the Indian Healthcare Improvement Act, as well as benefits to individual Indians under the Affordable Care Act, we hope it will increase insurance coverage of American Indians, yet we are concerned that the Secretary has not conducted meaningful consultation with our Tribes on the Affordable Care Act and are uncertain about implementation in Indian Country, especially in states like Montana that rejected the Medicaid expansion, and we are confused by the way the Act defines Indian differently from long established policy. Clearly there is more work to be done if the government is to fulfill its trust responsibility to provide quality healthcare to Indian people, a mandatory obligation under treaties and agreements entered into with Tribal governments.

We've upheld our end; the United States must do the same. Working together, we must develop a plan to develop quality healthcare systems, allowing this nation to fulfill its promises. Our members are not getting the care they need in many cases because the care is not deemed a life or limb necessity. All too often Tribal members complain of an ailment, but get sent home from the Indian Health Service with cough medicine or pain killers. Later we learn the condition was much more serious, like cancer.

The board believes that with a better continuum of care, better detection, better prevention efforts, and improved efforts to address the ability to pay, the health status of the people at Fort Peck could improve significantly. Rather than continuing to provide substandard healthcare, the Indian Health Service should develop a strategy to better address all of the healthcare needs of the people living at the Fort Peck Reservation. This strategic plan would identify the reasons why the system is not meeting the needs of our people and establish measurable goals and a targeted implementation plan.

The strategic plan should address at least 5 areas. First, the plan must include an assessment of our critical health and psychiatric needs, the barriers to positive health status, and the opportunity for greatest improvement. For example, this type of study should help us understand if the IHS life or limb policy that results in the

denial of orthopedic and other repair surgery is effective in saving resources for more serious conditions. We must suspect that the risks and costs associated with treating surgical needs with pain killers in the long run has a greater cost than the surgery itself. We have lost fathers, mothers, sons, daughters, brothers, and future leaders because they were unable to get the healthcare they needed and fell victim to the downward spiral of addiction, depression and suicide.

A study like this may suggest our efforts are best focused on education campaigns targeted at children. Recently we have engaged in several prevention initiatives with little support from IHS. We believe these efforts are working to improve health and save IHS resources. A health assessment could tell us where we should target our resources to achieve the greatest benefits.

Second, the plan must address the Reservation's facility needs. Although IHS offers two health clinics on our Reservation, it reports 85,000 patient encounters annually, 3 times the capacity. Turning people away because of a lack of facilities or personnel results in loss of third party billing. The overspending of contract health funding and the overall poor health of our community and our needs are increasing due to our proximity to the Bakken oil fields. We are seeing the negative impacts of oil and gas development without the financial benefits. Methamphetamine and prescription drug abuse is on the rise at Fort Peck.

Third, the strategy to improve the health delivery system at Fort Peck must recognize and address the issues related to our remote location. We are the most remote location in the lower 48. The nearest regional medical facility for Fort Peck is over 300 miles away here in Billings, and the emergencies that cost the association with air ambulance services from Fort Peck to Billings are staggering and a major cost to the service unit. The distance involved results in higher costs, greater time away from home, and high levels of stress. Our remote location requires a plan to improve telemedicine opportunities, access to mobile health facilities and ways to bring specialists to our Reservation.

Fourth, the strategy must also address recruitment and retention of qualified professionals to address high turnover and vacancy rates which we know are related to our remote location. The service unit needs the flexibility to deal with this area through higher compensation and greater benefits. Since the continuum of care by the same medical professionals greatly improves a person's health, a stable healthcare workforce is key to improving health status.

Finally, the strategy must examine the business practices of the Fort Peck service unit and the Indian Health Service. IHS and the Tribes need to know if the service unit is achieving the best possible outcome in terms of third-party receipts for both the service unit and the patients. There should be no waste or lost revenue to the service unit, and patients should not be faced with collection actions and bankruptcy when IHS fails to pay bills. If IHS fails to pay for emergency air transportation to Billings, a patient is sent a bill for several times the amount of a family's annual income. IHS must be consistent in both the collection of third-party receipts and cost share payments.

In addition, there's certainly room for improvement with the finance and procurement system of Indian Health Services. Indian Health Service leadership must step up and bring about these types of long overdue changes. We also believe that IHS should be given better tools by Congress to effectively do its job. We encourage Congress to take immediate action on proposals now before you to authorize Indian Health Service to pay Medicare like rates for non-hospital care costs.

Thank you for this opportunity to provide our recommendations on this important subject. We encourage you to join us in developing this strategic plan to build a better healthcare system on the Fort Peck Reservation to fulfill the government's mandatory trust obligations to our Tribe.

[The prepared statement of Mr. Stafne follows:]

PREPARED STATEMENT OF HON. A.T. "RUSTY" STAFNE, CHAIRMAN, ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK RESERVATION

Good morning and thank you for recognizing the importance of fulfilling the government's trust responsibility to provide quality health care to American Indians. We are all too aware that the unmet needs and underfunding of health care in Indian Country further perpetuates the poor health of American Indians. That is why I am here today, to ask you to join us in making commitment to building a better healthcare system, both on our Reservation and throughout Indian Country.

To be sure, the government's trust responsibility to provide quality health care to Indian people is not discretionary; but is the fulfillment of the federal government's mandatory obligation under the treaties and agreements entered into with Tribal governments. We've upheld our end. The United States must do the same. Working together we can build quality healthcare systems, allowing this nation to fulfill its promises.

Chairman Tester and Members of the Committee, I am honored by this opportunity and thank you for your time today. My name is A.T. Stafne and I am the Chairman of the Assiniboine and Sioux Tribes of the Fort Peck Reservation. We are a large, land-based tribe. Our Reservation spans 2.1 million acres of Montana's northeastern plains and our boundaries encompass parts of four Montana counties: Roosevelt, Valley, Sheridan, and Daniels. The Reservation's Indian population is approaching 8,000 while our overall Tribal enrollment is approximately 13,000 members.

To date, the Fort Peck Reservation remains one of the most impoverished communities in the country. Nearly half of the people living on the Reservation are below the federal poverty level. Roosevelt County residents have the poorest health in the state of Montana, followed closely by Bighorn and Glacier Counties, both of which are also located primarily on Indian Reservations. Our review of recent data suggests that the average age of death of Fort Peck Tribal members in the past two years is 51 years of age. It is not surprising, then, that almost half the population living on the Reservation is under the age of twenty-four. Thus, we are a poor, unhealthy, and young community. Because of our youth we must do better and make the changes in our community to implement positive health strategies that will prevent the chronic and debilitating diseases that plague our Community.

Poverty levels present the greatest obstacles to addressing our health care needs. People living on Reservations and living in poverty are the least likely to have health insurance. Recent studies are beginning to conclude that death rates decrease among people with health insurance. In order for IHS to fulfill its trust responsibility, it should be working to secure health insurance to all American Indians.

We were encouraged by the permanent reauthorization of the Indian Health Care Improvement Act, as well as the benefits to individual Indians under the Affordable Care Act. We are hopeful that exemptions from open-enrollment periods and zero cost sharing may increase the number of American Indians covered by health insurance. However, we are concerned about the Act's implementation in Indian Country. Despite our written request for consultation, the Secretary of Health and Human Services has not yet conducted meaningful consultation with our Tribes, as required under the Act. This is particularly concerning to us because the State of Montana has decided not to expand Medicaid. As a result thousands of Montana Indians may

not be able to obtain health coverage as intended by the Affordable Care Act. Moreover, the Act has created uncertainty regarding who is considered an Indian and represents a departure from longestablished Federal Indian health policy.

From recent studies, we know that heart disease, cancer, and accidents are the three leading causes of death in our community. More than 3 percent of our children will try committing suicide in their lifetime and more than 65 percent of our children have already consumed alcohol. Anecdotally, the Board hears from members who are not getting the care they need our local IHS facilities, because the care is not deemed "life or limb" necessary. This care can range from gall bladder surgery, hernia surgery, dental surgery, or orthopedic surgery. We know that the ability to pay, continuum care, and early detection contribute to the health status of individuals. The Board hears all too often about their members who complained of an ailment for months at IHS clinics, but who were repeatedly sent home with cough medicine or pain killers, only to learn later that the Tribal member was suffering from a much more serious condition, like cancer. The Board believes that with a better continuum of care, better detection, better prevention efforts, and improved efforts to address the ability to pay, the health status of the people at Fort Peck could improve significantly.

The continuing failure to provide this necessary health care at the Fort Peck Service Unit is unacceptable to the Tribes. The Tribes recognize that Fort Peck Service Unit is trying to improve the delivery system by implementing the Improvement Patient Care process, which includes empanelment of patients so that the patient is treated by the entire team of medical professionals and not treated in isolation. However, the Indian Health Service should take this initiative a step further to develop a strategy to better address all of the health care needs of the people living on the Fort Peck Reservation. Such a "Strategic Plan" would identify and target the reasons why the healthcare system on the Fort Peck Reservation is not meeting the needs of our people. This Plan would include measurable goals and an implementation plan to achieve these goals.

This Strategic Plan could be similar to the BIA's "High Priority Performance Goal Initiative" which targeted four reservations where public safety needs had reached critical stages. We believe the health care needs of the Fort Peck Reservation are just as critical. We can no longer tolerate our people dying, living in chronic pain, or suffering permanent disability because they lack access to health care.

In the Tribes' view, the Service Unit is operating in triage "life or limb" mode; treating people as they come into the two clinics in Poplar and Wolf Point. The Service Unit is failing to treat the whole person. This "life or limb" mode, results in people with health insurance, including Medicaid and VA coverage, not being referred out for medically necessary treatments and surgeries because the Indian Health Service has not refined its own third-party billing activities that would allow it to pay the co-pays and deductibles for these treatments. This often results in the IHS paying much higher costs when the injury progresses to the emergency stage. Without a Strategic Plan, the Board believes that the Indian Health Service will remain stuck in the "life or limb" paradigm and the substandard health conditions at Fort Peck will continue.

It is important to mention, however, that the Board does not attribute these problems to individual employees or providers at the Fort Peck Service Unit. Indeed, there are many fine individuals working hard with limited resources to serve our health care needs. Our hope is that together we can give those providers the systems and resources needed to better serve our community by developing a strategic plan with that goal in mind. One that is tailored to the unique situation experienced at Fort Peck.

There are at least five areas that such a Strategic Plan could address and I would like to take this opportunity to explain each of them.

First, the Plan must include an epidemiological assessment of the Fort Peck Reservation. This study would identify the critical health and psychiatric needs of our people living on the Reservation and pinpoint the existing barriers to achieving a positive health status. Our Tribal Board often hears about the health-related challenges faced by our Tribal members and each Board member has their own personal experiences. However, it is not clear from these snapshots what areas should be targeted, and where the opportunities for greatest improvement are.

For instance, the Board is aware of a number people in need of orthopedic surgery (ACL, meniscus injuries), but because this kind of surgery is not considered "life or limb care" they are not able to get the surgery. While this may not seem like a critical health care need in a community battling high cancer rates, high diabetes rates, and high cardiovascular disease rates, in fact this lack of care has serious consequences for our community.

In many instances because people cannot get the repair surgery, they are prescribed painkillers, which they may become addicted to and may have negative side effects. This increases the Service Unit's costs in two ways. First, the cost of providing these painkillers contributes to the Service Unit's high pharmaceutical cost. Secondly, the Service Unit and the community have to deal with the high cost of opiate and other painkiller addictions. Furthermore, in cases where people are deemed "high risk" and are not prescribed a painkiller, they sometimes self-medicate with alcohol or other substances. This too has a high cost to our community.

More seriously, the Board is aware of instances where individuals who were not provided the necessary repair surgery have fallen into a depression because of the pain and inability to live the life they had lived before the injury. In some cases, this has resulted in our Tribal members taking their own lives. While this particular example may not be statistically significant in the broader context of the Indian healthcare system, at Fort Peck it is very significant. We have lost fathers, mothers, sons, daughters, brothers, and future leaders because they were unable to get the health care they needed.

We know that the IHS budget for substance abuse, alcohol, and family counseling is insufficient for our well-documented needs. Just this past month, two babies were born on the Reservation addicted to meth. We had no choice but to place those babies with foster families off-reservation, who were qualified to care for their special-needs. We need to better understand the resources needed to prevent meth use among our members. We must also care for those addicted to meth and other drugs, and understand how to best provide that care. It may be that our efforts are best focused on education campaigns targeted to school age children.

Over the past few years our Tribes have engaged in several preventative health initiatives with little or no support from the Service Unit or Indian Health Service. We believe these efforts will have a positive effect on the long-term health of our members and will help to protect the resources of the Indian Health Service.

An epidemiological study could substantiate and focus our concerns, as well as reinforce the need for more preventative initiatives in addition to the ones the Tribes are operating now. Once this information is gathered, the Tribes could work with the Service Unit to create a pathway to have the medically necessary surgeries and services provided so that these Tribal members can live more productive, pain-free lives. Moreover, a study could help identify where the Board and the Service Unit should focus our prevention efforts, whether on smoking cessation, radon testing, diabetes screening, sanitation improvements, or mammography. This data could tell us where we should target our resources to achieve the greatest benefit.

Second, the Plan must address the Reservation's facility needs. As I've mentioned already, IHS operates two health clinics on our Reservation—one in Poplar and one in Wolf Point. The Tribes operate nine Tribal Health Programs, including a dialysis clinic, outpatient substance abuse counseling, community health representative services, health promotion and key prevention programs. The services provided at the IHS clinics now include primary care, pharmacy, laboratory, dental, behavioral health and women's health. The Service Unit currently reports 85,000 patient encounters annually—more than triple our facilities' capacity.

In key areas like dental, the Service Unit turns people away because it lacks the facilities or personnel to meet the demand. This results in a loss of third-party billings and contributes to the over subscription of Contract Health Care funding. In addition, the Tribes' Dialysis Unit must turn patients away because it is at capacity, operating six days a week with three shifts.

Similarly, there is a clear need for substance abuse detoxification and treatment. Current outpatient services cannot fully address the substance abuse issues on the Reservation, particularly in light of our proximity to the Bakken oil fields of eastern Montana and western North Dakota. We are already seeing the negative impacts of oil and gas development without any financial benefits. While we welcome opportunities for economic development, we are also unprepared for the downside of rapid growth; rising costs for food, clothing and services, increased truck traffic, motor vehicle crashes and injuries, and increased crime, especially drug related. Undoubtedly, methamphetamine and prescription drug abuse is on the rise at Fort Peck.

Third, the strategy to improve the health delivery system at Fort Peck must recognize and address the issues related to the remoteness of the Fort Peck Reservation. There are very few Reservations in the lower 48 that are as far from a regional health facility as Fort Peck is. Our remote location requires developing a plan to improve telemedicine opportunities and access to mobile health facilities.

Over the past several years, there has been much discussion nationally on health care generally, but very little about access to health care. This has been disconcerting to us since the nearest comprehensive regional medical facility to the Fort Peck Reservation is located over 300 miles away in Billings, Montana. We have

little choice over where we receive our health care. We have higher transportation costs. We are forced to spend more time away from home, work, and school. These realities are made worse when a Community member must be transported off the Reservation in an emergency. Costs associated with air ambulance services from Fort Peck to Billings are staggering and a major cost to the Service Unit. For family members unexpected travel is more expensive and more stressful. We must work together to bring specialists to the Reservation whenever possible and invest in facilities where those visiting specialists serve their patient's needs. Follow-up visits should not require three days away from home.

Fourth, the strategy must also address recruitment and retention of qualified professionals to address high turnover and vacancy rates. We know that the remoteness of our Reservation is a barrier to recruitment and retention of qualified health professionals. Thus, as the Service Unit recruits new health professionals, it has to be given the flexibility to respond to this barrier through higher compensation and greater benefits. It is proven that the continuum of care by the same medical professional greatly improves a person's health care. Thus, we believe a stable healthcare workforce is a key to improving the health status at Fort Peck.

Finally, the strategy must examine the business practices of the Fort Peck Service Unit and the Indian Health Service. IHS and the Tribes need to know if the Service Unit is achieving the best possible outcome in terms of third party receipts. These receipts are critical to the Service Unit's ability to meet the health care needs of the Reservation and must be optimized.

In addition, the Service must refine its own third-party billing activities to allow it to pay the co-pays and deductibles for surgeries and other treatments that are not available at the Service Unit. As Tribal leaders we have heard countless stories from our members, and many of us have personal experience, with IHS collecting third-party reimbursement from the Veteran's Administration or Medicaid, but failing to pay deductibles, co-pays, or other shared costs. As a result individual patients or their families are billed for these costs even though IHS has a responsibility to cover these costs. If these bills go unpaid, the patient or the patient's family are subjected to collection agents and collection lawsuits. These bills often involve emergency air transportation to Billings, Montana, or other distant locations. As you might imagine the amounts involved are staggering often several times the amount of a family's annual income.

Given this reality, we are very concerned that IHS and the Service Unit are not equipped to comply with the zero cost share requirements of the Affordable Care Act. In order to run an efficient and effective healthcare system and comply with the law, IHS must be consistent in both the collection third party receipts and cost share payments.

In addition, there is undoubtedly room for improvement with the finance and procurement systems of Indian Health Service. These systems could be modernized and reviewed for efficiency and relevancy. For example, we suspect that the Service's procurement system is designed to accommodate large contracts for nationwide goods or services, but is not equipped for smaller purchases like medication and supplies. In our view the Indian Health Service has lacked the leadership necessary to bring about these types of long overdue changes.

We also believe that IHS could be given better tools by Congress to effectively do its job. We encourage Congress to take immediate action on proposals now before you to authorize Indian Health Service to pay Medicare-like rates for non-hospital care costs.

We encourage you to join us in developing this strategic plan to build a better healthcare system on the Fort Peck Reservation to fulfill the government's mandatory trust obligations to our Tribes. Thank you for the opportunity to share our thoughts on this very important subject. I would be happy to answer any of your questions.

The CHAIRMAN. Thank you.

Chairman Azure?

STATEMENT OF HON. MARK L. AZURE, PRESIDENT, FORT BELKNAP INDIAN COMMUNITY COUNCIL

Mr. AZURE. Good morning, Mr. Chairman, Committee members, guests, thank you for providing and assembling the Tribes of Fort Belknap an opportunity to express our concerns today. My name is Mark Azure, I'm the President of the Fort Belknap Community

Council, and I'm here to represent those 7,000 plus enrolled members that reside on Fort Belknap, and today my testimony is directed towards our healthcare facility at Fort Belknap, and also towards the regional office here in Billings of the Indian Health Service.

I feel compelled today to be here as the top elected official at Fort Belknap. This is a serious, serious issue. It's something that I think has been ongoing for a lot of years, and the fact that we had to take this on as a Tribal council when we were brought into office here about six months ago. One of the things that we did at the Tribal council was sit down with the providers—myself and the Vice-Chair and heard their concerns, and it somewhat echoes what we've heard this morning so far, and at Fort Belknap, we look at those providers as being just as important as our teachers and our law enforcement personnel, that they are part of our community and we need to look out and try to help.

So part of the information that I have today was put together in collaboration by the council, our Tribal health program, and our Indian Health Service there at Fort Belknap.

First off, the thing I would like to touch on is the projected shortfall at Fort Belknap for the 2014 fiscal year is at over $1.2 million. That's just unacceptable, it's putting constraints on the services and personnel at the Indian Health Service there at Fort Belknap.

Some of the other topics, they are all health related, but before I get to those, I want to mention that we've had problems with our ambulance service and actually putting one in place on the south end of the reservation where approximately 50 percent of our residents reside and that we've tried to take it upon ourselves to get that rolling. We had 12 community members get out there and take that EMT course, and they were certified—and they did this on their own, basically they kind of got together grassroots, got a physician to come in and certify them, and now they are certified throughout the nation to do this. We asked for an ambulance which we were told we would have. In the end, our ambulance service hired one individual, and he is on the north end of the reservation which defeats the whole purpose of why we got involved, so there's still that lack of care on the south end of the reservation. We recently here about two or three weeks ago lost a young Tribal member in a vehicle accident, and we don't know if that ambulance service on the south end would have helped save her life, but now we will never know because it wasn't there, it had to come from the north end of the reservation which was a somewhat lengthier distance to get there.

The healthcare concerns we have, diabetes, of course, you know, in 2012, the Center For Disease Control indicated that 14.2 percent of Native Americans age 20 and older were diagnosed with diabetes, this is higher than any other ethnic group across the country so it's definitely a concern of ours.

Cancer, that's, I believe, 220 Indians across Montana get cancer every year, there's roughly 14 on Fort Belknap, and it's just—the limited care that we get just isn't working. Our mental health is—our mental providers are just very overworked. We have two at Fort Belknap, but it's almost a 45-day wait if you make an appoint-

ment, and that also—our folks who end up in our detention facility are also part of that.

You mentioned the life expectancy, so I won't go over that, it's something that concerns us.

The third-party billing also, you know, where are we at with that, and why is it not what it should be. Is our staff not trained, is it just too much work; we don't know, we are asking those questions and not receiving a lot of answers.

Unemployment, of course, that's in the upper 70s at Fort Belknap, so that, you know, plays a huge role in our people being able to help themselves, and so I will close here, but in closing, that 1.2 million shortfall that my IHS facility is going to feel in 2014, our Tribal government is going to have to step in and try to help our Tribal members with assistance in getting to appointments and things like that, and that takes a hit right back on the Tribal government, so with that, I will close, and thank you.

[The prepared statement of Mr. Azure follows:]

PREPARED STATEMENT OF HON. MARK L. AZURE, PRESIDENT, FORT BELKNAP INDIAN COMMUNITY COUNCIL

Good Afternoon Mr. Chairman, Committee Members and guests, and thank you for providing the Gros Ventre and Assiniboine Tribes of Fort Belknap an opportunity to express our concerns and for including us in the hearing, "Ensuring the Indian Health Service is Living Up to Its Trust Responsibility". My name is Mark Azure and I am the President of the Fort Belknap Indian Community Council, the governing body of the Gros Ventre and Assiniboine Tribes of the Fort Belknap Indian Reservation in Montana. The Fort Belknap Indian Community consists of a total of over 7000 enrolled members between the two Tribes, and I am pleased to offer these comments on their behalf.

My testimony today is directed toward our healthcare facility at Fort Belknap and also, toward the Billings Area Office for Indian Health Services. Tribal governments, just like state and municipal governments, provide critical services, shape values, and promote healthy environments. I feel compelled to be here today as tribal council members are the elected officials responsible for our community members and ultimately the ones most accountable for the economic conditions as well as the health conditions of our tribal members who reside on our reservation communities. The following information is provided to you through the Fort Belknap Indian Community Council in collaboration with the Tribal Health programs and the Fort Belknap Indian Health Service.

The United States Code: title 25, section 1602 lists the special trust responsibilities and legal obligations that are the policy of the nation to fulfill.

Among those responsibilities are, "to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[1] Due to inadequate funding, the IHS and the tribal programs are unable to provide sufficient health service to our enrolled members. The Fort Belknap IHS is projected to have a shortfall of $1,287,116.37 for fiscal year 2014. This places constraints on services and personnel at Fort Belknap Service Center, and consequently, the delivery of health care. Delivery of health care at Fort Belknap needs to be redirected toward a greater emphasis on wellness services and behavior health, so that it will contribute to a healthier future for people. The following is a list of some of the glaring health disparities and statistics that we are faced with.

Diabetes - Type 1-13, type 2-500. The federally funded program Special Diabetes Program for Indians (SDPI) Healthy Heart initiatives targets American Indians who have been diagnosed with diabetes. These services work toward preventing and treating diabetes, but data from a National Health and Nutrition Survey conducted by the Center for Disease control in 2011 indicated that 14.2% of Native Americans age twenty and over were diagnosed with diabetes. This is a higher percentage than for any other racial or ethnic group.[2] However, one of the other trust responsibilities that IHS has to Native Americans is, "to raise the health status of Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objective."[3] The goal listed under the Healthy People 2020 Initiative for diabetes was to "reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for DM."[4] However, I have received complaints from several individuals that they have trouble getting to dialysis appointments because they are required to travel long distances and the means of transporting individuals is lacking. Many people are put on the "deferred" list because their situation is not

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[1] 25 USC § 1602 (1)

[2] Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011

[3] 25 USC § 1602 (2)

[4] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=8#three (Updated 5/8/2014)

considered an emergency. However, without obtaining proper medical attention their situation will not be improved, as is the goal.

Cancer – Approximately two hundred twenty (220) Native Americans diagnosed with cancer every year in Montana[5]; and roughly fourteen people in Fort Belknap are diagnosed with cancer each year. This number is high given our small population and funds to assist with care for these patients are extremely limited. Cancer occurs at a much greater rate among Indians in Montana than any other Natives and Alaskans in the US population and Lung cancer and colorectal cancer occurred at a significantly greater rate among Indians compared to the white population in Montana.[6] This means we have to be able to care for these patients, but with the quality of service currently provided, we cannot. In fact, many cancer patients come to the council to ask for help because the IHS just does not have enough funding to transport the number of patients we have, or to cover the costs of overnight stays for patients undergoing chemotherapy (which is administered hundreds of miles away). After treatment, they are much too sick to travel home.

Mental Health – Fort Belknap is chronically understaffed. We have two clinical physiologists, we have two vacant positions due to lack of funding a Social Worker and a psychiatrist. The funding has to be increased to recruit and retain qualified professionals, and we have a significant need for a youth specialist in this field as well.

Life expectancy – The life expectancy for Native American men is 56 years of age and Native women is 62 in the State of Montana. In comparison, the life expectancy for white men is 75 years of age and White women is 82 in Montana. That is more than a ten year difference for each group. That is an astounding difference to me and translates to me as being deprived of ten years with my family members and friends.

Purchased Referred Care (PRC) (currently contract health services), which is set up to help members obtain health care and dental services from a non-Indian

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[5] Augare, Victoria. http://www.dphhs.mt.gov/publichealth/cancer/malwhc/documents/CancerFactSheetAmericanIndian.pdf (updated 5/1/2013

[6] Augare, Victoria. http://www.dphhs.mt.gov/publichealth/cancer/malwhc/documents/CancerFactSheetAmericanIndian.pdf (updated 5/1/2013

Health Service or tribal health care facility, will only refer priority one patients to specialists, meaning a condition has to qualify as an emergency before this can happen. Some of the community members have to wait months and even years before they are referred out to a specialist. I am well aware of this situation from my own experience and it is extremely frustrating. IHS simply does not have adequate funding to transport Indian patients to specialists or specialty clinics and this is causing harm to our people as a whole.

We have a 73 % unemployment rate at Fort Belknap and with no steady income; dealing with these health problems puts a tremendous burden on the tribe as we struggle to assist our members with financial assistance to go to appointments for chemotherapy treatments, dialysis, and other referrals to specialists outside of our service area. For the tribe alone, this creates an average cost of approximately $120,000.00 in medical assistance.

The health problems facing Indian country and more specifically the Gros Ventre and Assiniboine tribes are far from ensuring the highest possible health status with the inadequate funding provided to the tribe and to the IHS.

The reality of the delivery of health care at Fort Belknap is dismal and in all honesty, I do not feel the government is living up to its trust responsibilities 'to ensure the highest possible health care for Native American people' and more specifically to my people at Fort Belknap.

Thank you again for the opportunity to provide our perspective.

The CHAIRMAN. Thank you.
Vice-Chairman Lankford?

STATEMENT OF HON. CAROLE LANKFORD, VICE-CHAIR, CONFEDERATED SALISH AND KOOTENAI TRIBES OF THE FLATHEAD RESERVATION

Ms. LANKFORD. Senator Tester, Committee members, and staff, thank you for conducting this field hearing on Indian Health Service and health of our Indian people. My name is Carole Lankford, I serve as the Vice-Chair of the Tribal Council of the Confederated Salish and Kootenai Tribes.

This hearing is timely and necessary, as there is nothing more important than protecting the health of our people. It is also important to note the current allegations of poor access and quality of health being leveled against the Veterans Administration. While we await the results of the federal investigation, we join with the country to demand the best care for our Veterans as they have given us so much for our freedom that we all enjoy.

The complaints lodged against the VA are not so different from the ones I hear from our Tribal members. When one examines the

health disparity between Indians in Montana and their non-Indian counterparts, it is hard to ignore the concerns. I don't want to repeat what you said about the Montana Department of Health and Human Services and the quote that was made about a comparison to Tribal members so I will pass that up, but I just want to say how can those discrepancies still exist? It is unacceptable.

Over 20 years ago, CSKT realized it must take responsibility for the healthcare of our people when we became one of the first Tribes in the county to assume the management and operation of services provided by IHS, the plan that's servicing it. The CSKT care system was and continues to depend on contract health service, now called Purchase and Referred Care.

Over the past 20 years, CSKT has focused on building quality healthcare. It includes increasing healthcare services and tribally-operated clinics, like community health services in clinics located from Hot Springs to Arlee. We have built a state of the art health clinic in Polson, and we extend an invitation for you to join us at the grand opening of our newly renovated health clinic in St. Ignatius. It will have eight exam rooms, eight dental chairs, increased space for our pharmacy and community health nurses. It will allow for improved patient registration and the activities needed to increase the revenue from alternative resources, such as the VA, Medicaid, Medicare, Healthy Montana Kids and private insurance.

In 2005, the CSKT Tribal Council was forced to make the decision to retrocede the management of CHS back to IHS, and it remains in their management since that time.

Sometime last year, the CHS program moved to a Level 1 rating. This means only those whose life, limb or senses are at risk will be approved for referral and payment, all others will be denied. Let me give you a common example, let's say a provider conducts a series of tests and determines a patient's gallbladder needs to be removed, but it has not yet burst, the procedure would be denied, and most likely the patient would be sent home with pain medication. This scenario has been repeatedly played out, and it results in poor care and increased prescription drug addiction. Doctors who are working in IHS facilities or those who serve IHS beneficiaries struggle with the dilemma of knowing that the patients need immediate medical care and the long-term impact of those patients not getting that care, the patient and medical care providers to meet the Level 1 criteria that is set by CHS is too dangerous, too many patients die.

Payments for service is a major problem. Tribal health recently received a complaint from a Tribal widow whose husband died in December 2012. The payment for service that was authorized for his end of life care still has not been paid and her wages have been garnished. This is not an isolated event, but is common. In the end, your credit is ruined when services are authorized, but not paid in a timely manner and those bills are sent to collection agencies.

Patients can't protect themselves as the rules of payment change. Expectations of payments by the patient, when those expectations have not been communicated, have hurt the Tribal membership. It is nearly impossible to navigate a complicated healthcare system without assistance.

With the risk of life or limb criteria, IHS, CHS beneficiaries will never receive a complete array of benefits others are entitled to under the Affordable Care Act and the beneficial benefits required in the qualified healthcare plan offered by insurance companies through the federally facilitated insurance marketplace.

The Tribal Council came to a conclusion a few days ago that we could no longer tolerate this type of management and voted to notify IHS of our intent to reassume the management of CHS programs effective October 1, 2014. This decision is possible because—only because of the opportunity for additional third-party questions which are made through Indian specific program provisions in ACA which include a permanent authorized agent of the Indian Healthcare Improvement Act.

For CSKT to be successful, we must build a health delivery system that brings together all federal resources, including Tribal and IHS, Medicaid and medical care, Healthy Montana Kids, and the VA, and the private insurance companies, such as Blue Cross Blue Shield, Pacific Source and the Montana Health co-op. Collectively, if we enroll our beneficiaries and educate them about those resources and how they can use those resources, it will work. The Tribal health role is to establish quality medical care and maximize the delivery and use of it. We must focus on 10 essential benefits and services governed by alternate resources.

Finally, patient satisfaction and good customer service is mandatory for us to become a desired place to get quality healthcare. Senator Tester, we are asking you for the following assistance: Number one, join us this summer as we host a healthcare summit to bring together policymakers and decision makers involved in providing and paying for healthcare for our beneficiaries. We must have a conversation with solid recommendations that all federal and private partners agree to in order for us to be successful. It could be a pilot project that other Montana-Wyoming Tribes could use as they build their healthcare system.

Number two, support multi-year funding for IHS and allow Tribes' stability in administering healthcare programs. In the past when there's been multi-continuing resolutions, and even a Federal Government shutdown, it caused uncertainty into the program and the patients they serve.

Number three, investigate complaints by IHS beneficiaries. Please listen to the people who are receiving services, or in some cases, not receiving services. There must be access to healthcare.

While CSKT is committed to building quality healthcare based on a business model, healthcare is very personal to all of us. A couple of months ago, a relative of mine was diagnosed with a major illness. He is a young man with young children and a bright future ahead of him. He has very good healthcare insurance from his employer. He was referred by a primary care provider to a specialist, it is truly a life or death situation. After getting the bureaucratic runaround, he asked if I could help. He was scared, and so was I. If it hadn't been for the intervention at the highest level in the healthcare system, I don't know what would have gotten the care—if he would have gotten the care he needed today. He is on the road to recovery.

It shouldn't be like that, we deserve better. In our treaty, we ceded most of western Montana in exchange for healthcare and other important rights. Please, Senator Tester, make the Indian Health Service live up to its trust responsibilities.

Thank you for your time.

[The prepared statement of Ms. Lankford follows:]

PREPARED STATEMENT OF HON. CAROLE LANKFORD, VICE-CHAIR, CONFEDERATED SALISH AND KOOTENAI TRIBES OF THE FLATHEAD RESERVATION

Senator Tester, Committee members and staff, thank you for conducting this field hearing on Indian Health Service and the health care for Indian people. My name is Carole Depoe Lankford. I serve as the Tribal Council Vice Chairman for the Confederated Salish and Kootenai Tribes and accompanying me is our Tribal Health Director Kevin Howlett.

This hearing is timely and necessary as there is nothing more important than protecting the health of our people. It is also important with the current allegations regarding the access and quality of health care provided by the Veteran's Health Administration. While we await the results of the federal investigation, we join with the Country to demand the best care for our Veteran's as they have given so much for freedom we all enjoy.

The complaints lodged against the VA are not so different from the ones I hear from our tribal members. When one examines the health disparity between Indians in Montana when compared to their non-Indian counterparts, it is hard to discount their concern. In 2013, the Montana Department of Public Health and Human Services published a report: The State of the State's Health. The purpose of the Report was to identify ways to improve the health of Montanans.

Comparisons are made throughout the Report between Indian health status to non-Indian. The most telling comparison is on page 11. I want to directly quote from the Report one finding:

> "White men in Montana lived 19 years longer than American Indian men and white women lived 20 years longer than American Indian women".

How can this discrepancy still exist? It is shocking and unacceptable.

CSKT realized it must take responsibility for the health care provided over twenty years ago when we become one of the first tribes in the Country to assume the management and operation of the services provided at the IHS—Flathead Service Unit. CSKT health care system was and continues to dependent on Contract Health Services, now being called Purchased and Referred Care (PRC) resulting from an abundance of private medical providers and facilities located on the Reservation or within a reasonable driving distance in Missoula or Kalispell.

Over the past 20 years, CSKT has focused on building quality health care. It includes increasing the provision of healthcare services in tribally operated clinics and through a wide range of community health services in clinics located from Hot Springs to Arlee. We have built a state-of-the art health clinic in Polson and extend an invitation for you to join us at the Grand Opening of a newly renovated health clinic in St. Ignatius on August 5, 2014. It will have 8 medical exam rooms, 8 dental chairs, increased space for our pharmacy and community health nursing. It will allow for improved patient registration and activities required to increased revenue from alternate resources such as the VA, Medicaid/Medicare, Health Montana Kids and private insurance.

In 2005, the CSKT Tribal Council was forced to make the decision to retrocede the management of CHS back to IHS and it has remained in their management since that time. The complaints I have heard over the past nine years regarding federal management of CHS should never be allowed to continue.

Sometime last year, the CHS program moved to level 1 rating. This means that only those services that put someone's life, limb or senses at risk will be approved for referral and payment. All others will be denied. Let me give you a common example. Let's say a provider conducts a series of tests and determines a patient's gall bladder needs to be removed but it has not burst. The procedure would be denied and most likely the patient would be sent home with pain medication. This scenario has been repeatedly played out and results in poor care and increased prescription drug addiction. Doctors working at IHS facilities or those who serve IHS beneficiaries struggle as they know the long term impact on the patient's health.

For patients and medical providers, waiting to meet the criteria is a gamble. When is a life in danger? When too much time passes or the expectant happens, patients die.

While the care is limited or not provided even when services are authorized by CHS, payment becomes a major problem. THHS recently received a complaint by a tribal member's widow whose husband died in December 2012. The payments for services authorized for his end of life care still have not been paid and her wages have been garnished. This is not a singular event but a common practice. There are long waits for needed medical care or no service and if it occurs, your credit is ruined when services are authorized but not paid in a timely manner and sent to collection agencies.

Patients can't protect themselves as the rules for payment change, expectations for the patient aren't published or communicated and the patient is forced to navigate the complicated system without assistance.

With the risk to life or limb limitation, IHS CHS beneficiaries will never receive the complete array of benefits everyone else are required to receive under the Affordable Care Act (ACA) and the 10 essential benefits required in the qualified health care plans offered by insurance companies through the federally facilitated insurance marketplace.

The Tribal Council came to the conclusion a few days ago that we could no longer tolerate this type of management and voted to notify IHS of our intent to re-assume management of the CHS program effective October 1, 2014. This decision is possible only because of opportunities for additional third party collections made available through Indian-specific provisions in the ACA, which included the permanent authorization of the Indian Health Care Improvement Act.

For CSKT to be successful, we must build a healthcare delivery system that brings together all the federal resources, including Tribal and IHS, Medicaid and Medicare, Healthy Montana Kids, VA and the private insurance companies Blue Cross Blue Shield of Montana, Pacific Source and the Montana Health Co-op. Collectively, if we enroll our beneficiaries and provide education to teach them to use it, it can work. THHS' role is to establish quality medical care and maximize the delivery and utilization of it. We must focus on the 10 essential benefits and services covered by alternate resources. Finally, patient satisfaction and good customer service is mandatory as we become the desired place to get health care.

Senator Tester, we are asking for the following assistance.

1.) Join with us this summer as we host a healthcare summit to bring together policy makers and decision makers involved in providing and paying for health care for our beneficiaries. We must have a conversation with solid recommendations that all the federal and private partners agree to if our efforts will be successful. It could be a pilot project that others in Montana and Wyoming could use as they build their systems.

2.) Support multi—year funding for IHS to allow tribes stability in administering health care programs. In past years when there have been multiple continuing resolutions and even a federal government shut-down, it causes uncertainty for the programs and the patients we serve.

3.) Investigate complaints by IHS beneficiaries. Please listen to people who are receiving the services or in some cases not receiving the. There must be access to care, providers willing to see Indian patients and it must be quality care.

While CSKT is committed to building quality health care based on business model, healthcare is very personal to all of us. A couple of months ago a relative of mine was diagnosed with a major illness. He is a young man, with young children and a bright future ahead of him. He has good health insurance from his employer. He was referred by his primary care provider to a specialist. It was truly a life or death situation. After getting the bureaucratic run around, he asked if I could help. He was scared and so was I. Time was of the essence. If it wasn't for intervention at the highest level of the health care system, I don't know if he would have gotten the care he needed. Today, he is on the road to recovery. It shouldn't be like that. We deserve better. In our treaty, we ceded most of western Montana in exchange for healthcare and other important rights. Please Senator Tester, make IHS live up to the trust responsibility.

The CHAIRMAN. Thank you, Carole. I want to thank everybody for their testimony. When is the summit?

Ms. LANKFORD. We will let you know.

The CHAIRMAN. We've got an opportunity today to voice the concerns, as you have, and explain the problems, and so we will just go down the list—go down the panel, I mean, what is the greatest difficulty that you have right now in attaining services from Indian Health Service—I know, Cowboy, you talked about budget shortfalls, bills not being paid, and transportation issues—there's a lot; what's the biggest?

Dr. ROUBIDEAUX. Our biggest problem is that Indian Health Service has a shortfall by about $2 million, and a lot of times we don't have a proper diagnosis of our patients, and a lot of them are—they say it's just a virus, and as it goes on, it ends up to be a life-threatening situation, and the loss of limb. I think we need to have a better communication between the patients and their doctor so they know what the problems are. There's a lack of communication between the patients and the doctors.

Mr. STAFNE. It's hard to pick out just one, but I think it's funding, and life or limb, both do really bad for the Tribes, especially for us, I guess, being so far away.

The CHAIRMAN. President Azure?

Mr. AZURE. Mr. Chairman, I think it is the same as the previous two. Number one is the funding; number two is that I think—and this is something that I heard from the providers when myself and the Vice-Chair sat down with them is that they are being asked to see more patients within the same eight-hour timeframe so that's going to limit the amount of time that when I actually do get into that room with the doctor, instead of 8, 9, 10 minutes, now it's going to be 5 or 6 minutes, and I don't know that we can be properly diagnosed.

The CHAIRMAN. Carole?

Ms. LANKFORD. It's the uncertainty of preferred care being taken care of in a timely manner, and it's also bills being paid for by the IHS program in a timely manner.

The CHAIRMAN. Okay. Let me ask each one of you, and you may not be able to answer this question, but you each have healthcare facilities, multiple healthcare facilities in some cases; where are you at staffing wise, and if you cannot answer, you can get back to me on it?

Cowboy, we will start with you.

Mr. FISHER. Short-staffed, and we need to have better quality staff that come in, and there are some people that are transferred in from foreign countries that some of our Cheyenne people have a hard time understanding and we damn near need an interpreter to translate.

The CHAIRMAN. Chairman Stafne?

Mr. STAFNE. Well, yes, I think we have a problem with filling vacancies.

I would like to inform you that Fort Peck does operate a dialysis center. We are—people are working an enormous amount of hours—three shifts a day, six days a week, and there's still not enough time to meet the needs of it.

Mr. Chairman, I don't know the exact number, but I do know we have two facilities—one on the north end, and one on the south end—and the one on the south end just seems to lose service after service every year, and now it's limited that we can't get a provider

out there, and if something should happen fast, that means they are going to have to drive that extra 40, 45 miles to get to that clinic on the north end.

The CHAIRMAN. So the lack of services is a direct correlation to the lack of professionals?

Mr. STAFNE. Absolutely.

Ms. LANKFORD. As we built facilities, we were able to bring on staff as needed, and we pay for those additional staff with the third-party revenues we collect.

The CHAIRMAN. Okay. Good. So let's talk about third-party collection. I talked to Dr. Roubideaux about this with some degree of concern. To your knowledge, how is it supposed to work the—third-party billing?

Mr. FISHER. To my knowledge——

The CHAIRMAN. You guys have your chairmen and Tribal councils, I don't expect you to be experts in healthcare. If in fact you can't answer the question, we can get it from somebody else in your Tribe.

Mr. FISHER. Right now we are just starting to build our third-party billing, and it seems to be working, but we need a lot of training in getting our Tribal people trained so they can do the third-party billing.

The CHAIRMAN. And who do you look to to do that training? Is it something you look at Indian Health Service for or to area office——

Ms. LANKFORD. Well, we look for Indian Health Service to provide that information for us.

Mr. STAFNE. The Tribes have created a lot of programs, and we are doing a lot of third-party billing, we're really doing good on it, but I don't really know how IHS——

Mr. AZURE. Mr. Chairman, I believe that third-party billings is if you have insurance, you're seen at IHS, and then they bill your insurance; I think at Fort Belknap, anyway, there might be a lack of that happening. Personal experience, I'm an Army veteran, I have the Tribe care for myself and my family, and we've been home now for about three years, and the first bill that I saw was about three weeks ago from my insurance, and so I don't know if it's a lack of education for the folks in that office or, again, if they are just so overworked that it takes an insurmountable amount of time.

The CHAIRMAN. The question was how does third-party billing work in your neck of the woods?

Ms. LANKFORD. It works very well. Kevin does a very good job, and we try to maximize every opportunity we can to collect third-party revenues. As a state, we are working on trying to utilize that program and get more revenue that way, and also the BIA just got a proposal and we are trying to maximize that, so we are trying to do everything we can.

The CHAIRMAN. Medicaid expansion was talked about a little bit, and you guys, for the most part, have seen some of the negative impacts for lack of Medicaid expansion; that aside, can you tell me if members have been signing up for the federal exchange or if they have not?

Mr. FISHER. We recently started signing up, and I don't know how many we've got signed up right now.

The CHAIRMAN. Chairman Stafne?

Mr. STAFNE. Likewise here.

The CHAIRMAN. President Azure?

Mr. AZURE. Same.

Ms. LANKFORD. We are working hard to get people signed up right now, but we are working on it and also hiring staff to work with getting people knowledgeable.

The CHAIRMAN. All right. CSKT and, I think, Rocky Boy is the other one that has self-governance compacts with the Indian Healthcare Service; this is for you, Carole, could you describe how these contracts are working or not working for CSKT?

Ms. LANKFORD. I think they are working fairly well because we are able to develop and design our programs in the way that we feel will best serve our public, the only thing is it's the funding issues, and there are some of the guidelines within the compact that probably hurt us a little bit. I'm sure Kevin could probably expound on that a little more. I would like to have an opportunity to get a better answer to you, but it seems to work fairly well, it's just that we are like everyone else up here.

The CHAIRMAN. I will ask Tim that question in the next panel.

I appreciate your guys' testimony today. I think it's—by the way, I appreciate your recommendations—all of you—I think there's some opportunity here for some good dialogue and some good consultations that we can address some of these issues, maybe not perfectly, but a heck of a lot better than they are being addressed right now. I thank you for your service to your Tribes and the State. Thank you for being here.

I will now call up the third panel and final panel today. First we are going to hear from Darrin Old Coyote who is the Chairman of the Crow Tribe; next we will turn to Honorable Darrell O'Neal, Senior, who is the Chairman of the Arapaho Tribe of the Wind River Reservation of Wyoming. We welcome you to Montana, Darrell.

And finally, we are going to hear from Tim Rosette, Interim Chief Executive Officer of the Rocky Boy Tribal Health Board.

Gentlemen, I welcome you all, thank you for being here. I've had the opportunity to work with the previous panel, and two of the three members of this panel directly, I look forward to working with you, too, Darrell. You guys know the rules, we try to keep it to five, if you can; if you go over a little bit, as you saw with the last panel, I don't get too wicked with you, but I appreciate your comments, your suggestions and concerns.

So we will start—and know that your full testimony will be a part of the record, the full written testimony part of the record.

Darrin, I will start with you.

STATEMENT OF HON. DARRIN OLD COYOTE, CHAIRMAN, CROW TRIBE

Mr. OLD COYOTE. Good morning—I think like it's two minutes until noon, so good morning. Welcome, Senator Tester, Committee members and staff and honored guests, thank you for the opportunity to speak today regarding the ongoing issues surrounding the

provision of healthcare to the people of the Apsaalooke Nation. It has been what seems to be a never-ending struggle for our community to access quality healthcare at the Crow Service Unit.

In the spirit of today's hearing, I want to remind everyone that the Crow people not only deserve better access and quality of care, but also that it is owed to them. The Tribe's ancestors signed treaties with the Federal Government, ceding many millions of prime acres rich in resources in exchange for goods and services. One of those services was healthcare not only for themselves, but for generations to come. The Tribe held up its end of the exchange, but the Federal Government has failed, and the Tribes should not be in a position where it has to continue to fight for something that its owed.

I also want to talk about a few different ways that the IHS has failed in living up to it obligations to Crow. I will focus on three areas: Financial, patient care or lack thereof, and personnel issues.

The Crow Service Unit's budget consists of 40 to 50 percent from Indian Health Service headquarters, and the remainder from third-party reimbursement from Medicaid, Medicare and private insurance. One thing that's a problem with the Crow Service Unit level that has become a problem in recent years is that it's based on old enrollment numbers. When the budget at the Crow Service Unit was developed, the Crow population was around 10,000; the Crow population has since grown by 4,000 members, an increase of 40 percent, but the budget has remained unchanged.

The budget remains extremely top heavy at the Billings Area Office. For example, in fiscal year 2013, 66 percent of 10 million plus budget went to administration, and only 15 percent went to healthcare services. It seems that funds are literally tied up at the Billings Area Office, causing an additional backlog of bills and vendors to stop services.

Sources close to the Billings Area Office have also stated funds are not made available in a timely manner. Crow is usually the last Tribe to receive funding, and that any backlog of funds are kept by the Billings Area Office rather than disbursed to the Crow Service Unit that come directly from people within the area.

The Tribe asks for the Committee's support in requesting a forensic audit of the financial management practices endorsed by the Billings Area Office for the Crow Service Unit.

After the catastrophic flood of 2011—this is for patient care—the Crow-Northern Cheyenne Hospital was inaccessible and closed for several weeks. To this day, Crow women still cannot deliver their babies on the Crow Indian Reservation due to the continued closure of the OB. This is problematic for many reasons.

First, it is disruptive to the community as future generations are not able to be born in the community in which they will be raised.

Second, it presents a burden on contract healthcare funds which are already limited.

Third, requiring Tribal members to travel long distances to be admitted for inpatient OB and delivery purposes which is expensive and burdensome, especially for those relatives traveling off reservation to support family and relatives who are hospitalized or greet new relatives when they are born.

The Tribe has recently learned that the Billings Area Office plans to bring in a midwife. This creates concern regarding an expectant mother's safety because usually a nurse, anesthesiologist should be available for all deliveries.

It should also be noted that even when faced with the additional burden of traveling off reservation to receive basic services that are in high demand by our communities, many of these patients choose to continue to receive service off reservation.

Also, patients are often forced to go to the emergency room to ensure access to a provider even when it is for nonemergency care. An example is this last year, there were 15,000 visits to the emergency room, 85 percent of which were nonemergency, and only 6,200 outpatient visits.

The failure to provide these services is driving many revenue-generating patients away permanently, as patients are choosing to go elsewhere for healthcare services.

Personnel. Staffing issues continue to present a challenge to patients who need access to healthcare providers. There are some dedicated providers at the Crow Service Unit, but there are not enough of them. In order to address understaffing, the Crow Service Unit started the practice of traveling doctors or locums, but the locums are costly and place a burden on an already stressed budget. There is no question that they are necessary, but it is a short term solution to a long-term problem.

Staffing problems also result in compromised emergency room services because many individuals put off medical care or are unable to dedicate the time it takes to be seen by outpatient providers until their condition becomes acute or they are forced to go to the emergency room in order to be seen by a provider.

With the upcoming vacancy for the Acting Director with the retirement of Pete Conway, I want to remind everyone that those individuals that are currently within the Billings office have been there when all of these issues have been going on, therefore it is important to bring in someone from the outside to fill that position. Currently, Dorothy Dupree from the Phoenix Area Office is a candidate for the position as Acting Director.

As I mentioned earlier, the Billings Area Office is the starting point for many of these issues and challenges faced by the Crow Service Unit, but Indian Health Service headquarters is not blameless. On March 10, 2014, after making several requests to the Billings Area Office with little or no progress, the Tribe requested a meeting with Dr. Roubideaux. A meeting was called at headquarters in Rockville, Maryland.

Dr. Roubideaux was receptive to the Tribe's concerns, but those concerns have ultimately gone unattended. In fact, she suggested the Tribe work with the Billings Area Office in addressing its complaints, even though the Tribe's objective for the meeting was to bypass the area office and get assistance from a higher authority since the Billings Area Office was unresponsive to the Tribe's needs; and telling our community members and private members to stop bringing the same complaints to us at the same volume, we will not stop advocating for reform and accountability at every level.

The proper people need to be accountable, and not just at the Billings Area Office, but all levels, including holding medical staff accountable and requiring them to treat staff and patients in a professional, courteous and respectful manner.

As mentioned earlier, it is imperative to acknowledge the fact that what the Tribe is demanding has already been paid for. Indian Health Service must know that the Crow people deserve better access and quality of care because it is owed to them. We implore this Committee to assist the Tribe in demanding that the correct people within the Indian Health Service are being held accountable for the poor access of quality of care provided to the Crow people. It is imperative that the Indian Health Service live up to its obligation to provide quality healthcare to our community because our Tribal members have the right to be treated with dignity and respect by Indian Health Service employees and to have their medical issues addressed and treated.

Thank you.

[The prepared statement of Mr. Old Coyote follows:]

PREPARED STATEMENT OF HON. DARRIN OLD COYOTE, CHAIRMAN, CROW TRIBE

Introduction

Good morning and welcome Senator Testor, Committee members and staff, and honored guests. Thank you for the opportunity to speak today regarding the ongoing issues surrounding the provision of health care to the people of the Apsaalooke Nation. It has been an on-going struggle for our community to access quality health care at the Crow Service Unit, and specifically the Crow/Northern Cheyenne Hospital.

Background

The Crow Tribe is comprised of approximately 14,000 members, with over 75 percent living on or near the reservation. The Crow/Northern Cheyenne Hospital serves a user population well in excess of the Tribe's almost 11,000 tribal members living on or near the reservation. In addition to Crow tribal members, the Crow/Northern Cheyenne Hospital also serves members of the Northern Cheyenne Tribe, a tribe whose reservation is to the east and whose boundaries are contiguous to that of the Crow, as well as other Native Americans in the area. For example, there are a significant number of individuals from various other tribes who reside either on the Crow Reservation, or in the nearby city of Billings, Montana, which is approximately 60 miles away from the hospital.

It is important to remember that the Crow people not only deserve better access and quality of care, but also that it is owed to them. The Tribe's ancestors signed treaties with the federal government ceding many millions of prime acres rich in resources in exchange for goods and services. One of those services was healthcare, not only for themselves but for generations to come. The Tribe held up its end of the exchange, but the federal government has failed and the Tribe should not be in a position where it is having to continually fight for something that it is owed.

Members of the Tribe, particularly those living on or near the Crow Reservation, face many challenges in accessing quality health care. There are factors beyond the Tribe's control that Crow tribal members suffer from at a disproportionate rate than the rest of the country—notably diabetes, heart disease, alcoholism, and mental illness. However, other factors, like the Crow people's ability to have access to quality healthcare, are not beyond the Tribe's control. That is why we are here today: to address issues within the Billings Area Office and Crow Service Unit, including the Crow/Northern Cheyenne Hospital, and ask for the Committee's support.

We implore this Committee to assist the Tribe in demanding that the correct people within the Indian Health Service are being held accountable for the poor access and quality of care provided to the Crow people. It is imperative that the Indian Health Service live up to its obligation to provide quality health care to our community because our tribal members have the right to be treated with dignity and respect by Indian Health Service employees, and to have their medical issues addressed and treated.

1. Billings Area Office

Many of the issues seen at the Crow Service Unit are attributable to the Billings Area Office. The Billings Area Office, as the direct administrative support to the Crow Service Unit, is responsible for overseeing the successful operation and management of the Crow/Northern Cheyenne Hospital, the Lodge Grass Health Clinic and Pryor Health Station. In recent months, there has been extensive communication between the Tribe and Billings Area Office regarding the status of the Crow Service Unit, yet, as explained in the following paragraphs, the quality of care and access to services remains poor. The Tribe's concerns have developed not only from information provided by the Billings Area Office itself, but have also developed from anecdotal accounts by patients, community members and employees at the Crow Service Unit and Billings Area Office.

The Tribe has made an effort to organize and catalog these accounts to pin point the cause for the deficient healthcare services, or at least provide a fuller picture of the issues involved. One of the primary mechanisms for the collection of information has been the Apsaalooke Nation Health Board. In January 2010, the Crow Tribe Legislative Branch passed the Apsaalooke Nation Health Board Ordinance. This ordinance established a seven member tribal administrative board with the authority and responsibility to represent the Tribe with the federal government on healthcare matters. The Apsaalooke Nation Health Board advises the Crow tribal government on healthcare budgets, policies, and programs, and provides oversight of the Tribe with regard to federal government healthcare programs and services. In May 2010, the legislature confirmed the first board of duly appointed memebers with authority to represent the Tribe on healthcare matters.

The accounts by individuals of problems occurring at the Crow Service Unit and Billings Area Office are not only disturbing but also inexcusable and unacceptable. The issues can be broken down into three categories: financial, patient care (or lack thereof) and personnel matters. The issues within each of these categories is described further below.

a. Financial

The Billings Area Office is in charge of disbursement of funds to the various tribal service units, including the Crow Service Unit. The Crow Service Unit's budget consists of 40–50 percent from Indian Health Service Headquarters, and the remainder from third-party reimbursements from Medicare, Medicaid and private insurance. One major problem with the budget at the Crow Service Unit level that has become a problem in recent years is that it is based on old enrollment numbers. When the budget at the Crow Service Unit was developed, the Crow population was around 10,000. The Crow population has since grown by 4,000 members (an increase of 40 percent) but the budget has remained unchanged.

Any financial problems within the Billings Area Office or Crow Service Unit has a direct impact on patients' access to quality healthcare because without the appropriate funding, vendors and bills cannot be paid, and services are shut off. For example, the Tribe learned that recently the Emergency Room could not provide emergency services and could not accept patients due to lack of payment to contracted providers. As a result, doctors and nurses were unavailable to provide emergency care—requiring patients to be transferred to Hardin and Billings hospitals as instructed.

According to several past employees, it seems that funds are deliberately tied up at the Billings Area Office, causing an additional backlog of bills and forcing vendors to stop services. Sources close to the Billings Area Office have also stated funds are not made available in a timely manner, Crow is usually the last tribe to receive funding and that any backlog of funds are kept by the Billings Area Office rather than dispersed to the Crow Service Unit. In addition, the Tribe has learned of problems within the Business Office Department at the Crow/Northern Cheyenne Hospital. Apparently, there is a practice within that Department that has the effect of bottle necking revenue that could be recouped by the hospital. For example, explanations of benefits, or an "EOB" as they are commonly referred to, are held on to for over a year so that by the time the billers receive them they are too out of date to follow up on, ultimately preventing the hospital from receiving revenue before the end of the year. In addition, there is only one billing coder for third-party billing at the Crow/Northern Cheyenne Hospital when other tribes have 2, 3 and even 4 coders. The Tribe asks for the Committee's support in requesting a forensic audit of the financial management practices endorsed by the Billings Area Office.

Another area of concern for the Tribe is the status of ambulance services for the Crow Service Unit. Originally, there was a contract with Big Horn County to provide ambulance services. The contract was negotiated without tribal involvement or input, and was in place for a number of years. In recent months, the Tribe ex-

pressed concern that the Crow/Northern Cheyenne Hospital again contracted for ambulance services with Big Horn County without tribal consultation. After inquiring, the Billings Area Office provided a four sentence memo explaining that there has not been a contract for ambulance services with any provider since September 2011, and that the hospital has since been reimbursing ambulance providers on a fee basis for each service run provided.

The response to the Tribe's concern regarding the status of ambulance services is just one example among many of how the Billings Area Office is dismissive of the Tribe's concerns. The Tribe is entitled to know how monies designated for providing services to the Crow people are being allocated. The Tribe will continue our investigation into this area, and would ask for support and cooperation from Indian Health Service in determining how the funding that currently is going out to ambulance providers will benefit Crow people members more directly in the future.

The budget remains extremely top heavy at the Billings Area Office. For example, in fiscal year 2013, 66 percent of the $10,000,000.00 plus budget went to administration, and only 15 percent went to health care services. With such a large amount of money going into administrative oversight of the Crow Service Unit, with little to no improvement in the quality of healthcare received, it is no wonder there has been discussion among the Tribe to eliminate the Area Office all together and administer the funds itself, or transfer the Crow Service Unit to another area office.

b. Patient care

After the catastrophic flood of 2011, the hospital was inaccessible and closed for several weeks. In addition, continuing water and sewer infrastructure left in-patient services closed for months. Even after the hospital reopened, OB/GYN unit delivery services remained unavailable, and to this day, Crow woman still cannot deliver their babies on the Crow Indian Reservation. Expectant mothers are sent to Billings, Hardin, or Sheridan, depending on their residence and any potential complications in their delivery. This is problematic for many reasons. First, it is disruptive to the community as future generations are not able to be born in the community in which they will be raised. Second, it also presents a burden on contract health care funds, which are already limited. Third, requiring tribal members to travel long distances to be admitted for in-patient and OB delivery services is expensive and burdensome, especially for those relatives travelling off-reservation to support their relatives who are hospitalized, or to greet new relatives when they are born. The Tribe has recently learned of the Billings Area Office's plans to bring in a mid-wife. This creates concern regarding expectant mother's safety, because usually a nurse anesthesiologist should be available for all deliveries.

It should also be noted that, even when faced with the additional burdens of traveling off-reservation to receive basic services that are in high demand by our community, many of these patients choose to continue to receive services off-reservation—especially those who are eligible for third-party payment, such as Medicare/Medicaid, and those with private insurance. Two of the most common complaints in the community is the wait times and level of patient interaction. Patients are often forced to go to the Emergency Room to ensure access to a provider, even when it is for non-emergency care. An example of this is there were 15,000 visits to the Emergency Room, 85 percent of which were non-emergency, and only 6,200 in-patient visits. But when patients go off-reservation to receive services, they encounter dramatically shorter wait times and a more respectful level of provider interaction and customer service. The Tribe has continued to inquire into how the Billings Area Office plans to change from provider-centered care to patient-centered care, but has received little to no guidance.

In short, the failure to provide these services is driving many revenue-generating patients away permanently. The continuing reduction in third-party revenue is deteriorating the budget. The Billings Area Office is again responsible in this regard as they should be providing the necessary training and administrative oversight to correct any deficiencies. We should be able to rely on third-party billing revenue to supplement the budget, but this will not be a viable option if the current situation continues.

Tragedy is unfortunately an all too familiar aspect of life for the Crow people. As mentioned earlier, the Crow people suffer disproportionately from a number of diseases including diabetes, heart disease, alcoholism, and mental illness. I bring this to your attention to highlight and underscore the severe need we have for substance abuse treatment services, and for mental health services. As you are aware, the issues of mental health and substance abuse are fundamentally intertwined in nearly every case. There is a high demand from Crow tribal members for mental health services and for grief counseling. For the vast majority of tribal members who suffer

from mental illness, they are only able to access these services when it is ordered by a court.

c. Personnel

Staffing issues continue to present a challenge to patients who need access to health care providers. There are some dedicated providers at the Crow Service Unit, but there are not enough of them. It also results in compromising Emergency Room services because many individuals put off medical care, or are unable to dedicate the time it takes to be seen by out-patient providers until their condition becomes acute and they are forced to go the Emergency Room in order to be seen by a provider. In order to address understaffing, Crow Service Unit started the practice of using traveling doctors, or "locums." But the locums are costly, and place a burden on an already stressed budget. There is no question that they are necessary, but it is a short-term solution to a long-term problem.

Another issue that has raised tribal concern is the inability to hire qualified Crow tribal members. Clayton Old Elk—a Crow tribal member—was successfully hired into the position of Chief Executive Officer for the Crow/Northern Cheyenne Hospital, but was there for less than a year and a half before returning to Indian Health Service Headquarters. The Tribe learned that Mr. Old Elk's decisionmaking authority was micro-managed by the Billings Area Office administration and health care programs, which is why he ultimately left the hospital. We want to see those Crow tribal members who have worked hard to achieve their credentials supported in their goals to fill positions such as these, where they can work to improve the quality of patient care provided to their fellow tribal members.

2. Indian Health Service Headquarters

As mentioned earlier, the Billings Area Office is the starting point for many of the issues and challenges faced by the Crow Service Unit. But Indian Health Services' Headquarters is not completely faultless either. For example, on March 10, 2014, after making several requests to the Billings Area Office with little to no progress, the Tribe requested a meeting with Dr. Roubideaux. A meeting was called at Headquarters in Rockville, Maryland. Dr. Roubideaux was receptive to the Tribe's concerns, but those concerns have ultimately gone unattended. In fact, she suggested the Tribe work with the Billings Area Office in addressing its complaints even though the Tribe's objective for the meeting was to by-pass the area office and get assistance from a higher authority since the Billings Area Office was being unresponsive to the Tribe's needs.

Conclusion

Until our community members stop bringing the same complaints to us at the same volume, we will not stop advocating for reform and accountability at every level. The proper people need to be held accountable, and not just at the Billings Area Office but at all levels, including holding medical staff accountable and requiring them to treat staff and patients in a professional, courteous, and respectful manner. As mentioned earlier, it is imperative to acknowledge the fact that what the Tribe is demanding has already been paid for; Indian Health Service must know that the Crow people deserve better access and quality of care because it is owed to them.

The CHAIRMAN. Thank you, Chairman Old Coyote.

STATEMENT OF HON. DARRELL O'NEAL, SR., CHAIRMAN, NORTHERN ARAPAHO TRIBE

Mr. O'NEAL. Chairman Tester, we are here today to reenter our concerns about health disparities in Wyoming. I would like to thank you for holding this important oversight hearing on Indian health and for the Committee efforts to reauthorize the Indian Health Care Improvements Act.

We understand the recent resignation of Anna Whiting Sorrell, Area Director of the Billings Area Office, her parting recitation of problems associated with Indian healthcare, more specifically her parting comments about the long-standing recognition that Native Americans are diagnosed with diabetes and alcoholism, suicide and

other health conditions at a shocking rate compared to non-Natives.

One of the things we face is a financial barrier. The United States has a trust responsibility and treaty obligation to provide quality healthcare to American Indians; unfortunately, the Indian Health Service continues to be woefully underfunded. The Indian Health Service is funded at $1900 per capita which is one half the amount federal prisoners are funded on a per capita basis. Local resources cannot make up the difference. Annual per capita healthcare expenditures for Native Americans are only 60 percent of the amount spent on other Americans under mainstream health plans. Annual per capita expenditures fall below the level for every other federal medical program and standard. Annual increases in Indian Health Service fundings have failed to account for medical inflation rates and increases in population.

One other item that, you know, for our Reservation is our facilities construction, you know, where in Wind River, Wyoming, our Reservation is—I think it's 2.2 million acres, and we have two Tribes that are not federally—they are—not federation, they are joint Tribes with federally-recognized sovereignty, both different sovereigns, but we have a 100-year-old Wyoming health facility on the Wind River Reservation. The health service has failed to assist the Tribe in replacing the facility. The average age of a current Indian health facility is 32 years, compared with 9 years in private sector facilities. New and properly designed facilities are needed to provide efficient space in which to provide services. Older facilities tend to be inefficient, haphazard, and may not be in compliance with OSHA or Americans with Disabilities Act standards, and the Indian Health Service is unresponsive.

Availability and accessibility of healthcare for Native Americans in Wyoming are influenced by the Indian Health Service organization, and that service delivery system—IHS services are structured, and when those services are provided, it significantly influences the degree in which Native Americans have access to healthcare.

Indian Health Service is not responsive to implementing the IHCIA which means addressing the following: Management or oversight issues related to different Indian Health Service programs; Tribal input to provider scheduling and productivity need attention; geographic location of facilities is a burden to Tribal members, transportation continues to be a problem; outdated and aging facilities; misdiagnosis or late diagnosis of diseases; contract health services priority level is administered at area level and discounts local level need.

Recommended Tribal corrective plans. Financial barriers and limited Native American access to healthcare contributes to health disparities. I've got kind of like a printout on these if you guys would like to look at it.

I think one of the things I wanted to point out, too, is, you know, where our population of our Tribe—the Arapaho Tribe is near 10,000—well, it will become 20,000 in 2015; half of our population is 18 and under so, you know, we have the same problems, you know, as the other Tribes here. Thank you.

[The prepared statement of Mr. O'neal follows:]

PREPARED STATEMENT OF HON. DARRELL O'NEAL, SR., CHAIRMAN, NORTHERN ARAPAHO TRIBE

Chairman Tester, and members of the Committee, I am Darrell O'Neal, Chairman of the Northern Arapaho Tribe. We are here today to reiterate our concern about health disparities in Wyoming.

I would like to thank the Committee for holding this important oversight hearing on Indian Health, and for the Committee's efforts to reauthorize the Indian Health Care Improvement Act (P.L. 94-437) this Congress.

We understand the recent resignation of Anna Whiting Surrell ; Area Director, Billings Area Office, and her parting recitation of problems associated with the Indian Health Service. More specifically, her parting comments about the long standing recognition that Native Americans are dying of diabetes, alcoholism, suicide, and other health conditions at shocking rates compared to non-natives.

I. Financial Barriers

The United States has a trust responsibility and treaty obligation to provide quality health care to American Indians. Unfortunately, the Indian Health Service continues to be woefully under-funded. The Indian Health Service (IHS) is funded at $1900 per capita, which is one-half the amount federal prisoners are funded on a per-capita basis. Local resources cannot make up the difference.

- ✓ Annual per capita health expenditures for Native Americans are only 60 percent of the amount spent on other Americans under mainstream health plans
- ✓ Annual per capita expenditures fall below the level for every other federal medical program and standard
- ✓ Annual increases in Indian Health Service funding have failed to account for medical inflation rates and increases in population

II. Facilities Construction

A 100 year old Wyoming health facility on the Wind River Reservation. The Indian Health Service has failed to assist the tribe in replacing this facility.

- ✓ The average age of current Indian Health facilities is 32 years, compared with nine years for private sector facilities.
- ✓ New and properly designed facilities are needed to provide efficient space in which to provide services
- ✓ Older facilities tend to be inefficient and haphazard in their arrangement of space, and may not be in compliance with OSHA and/or Americans with Disabilities Act standards

III. Indian Health Service is Unresponsive

The availability and accessibility of health care for Native Americans in Wyoming are influenced by the Indian Health Service organization and its service delivery system. How I H S services are structured and where those services are provided significantly influence the degree to which Native Americans have access to health care. Indian Health Service lacks responsive in implementing the IHCIA, which would address the following:

- ✓ Management or oversight issues relating to different Indian Health Service Programs. Tribal input to provider scheduling and productivity need attention.
- ✓ Geographic location of facilities is burdensome to tribal members. Transportation continues to be a problem.
- ✓ Outdated and aging facilities
- ✓ Misdiagnosis or late diagnosis of diseases
- ✓ Contract Health Service priority level is administered at Area level and discount local level need

Recommended Tribal Corrective Plans

Financial barriers and limiting Native American Access to Health Care Contribute to Health Disparities. Please see attached Health Disparities in Wyoming

- ✓ ***Establish a task force to develop a strategy to replace the aging Indian Health Service Clinic***
- ✓ ***Provide Technical Assistance:*** The Tribal health care systems are fragmented and understaffed. The tribes will require technical support to work with Indian Health Service in implementing the IHCIA. More specifically:
  - o Expanding programs for mental and behavioral health treatment and prevention.
  - o Expanding the authorities for funding of patient travel costs.
  - o Establishment of a health program offering care outside of regular clinic operational hours in alternate settings
  - o Assist tribal substance abuse program by Eradicating Alcoholism on the Reservation by 10%
  - o Purchase of Health Care Coverage by utilizing Contract Health Service resources
  - o Meet tribal shortage of staff by sharing Indian Health Service facilities and staff

- ✓ ***Provide a Broad Range of Healthcare strategies that reflect the needs of WRIR tribal members:***
- ✓ ***Create an interagency task force comprised of an official from each of the federal agencies involved to address the healthcare disparities in Wyoming***
- ✓ ***Behavioral Health.*** Tribal communities are taking a leadership role in addressing the myriad of needs associated with behavioral health problems. Building upon that local leadership and initiative offers a strategic opportunity to improve coordination of local and federal services, to bring services up to critical level of capacity, and to get going a renaissance in Wyoming.

HEALTH DISPARITIES IN WYOMING

Life Expectancy-Average Age of Death	Years
General Population	78.7
Native Americans in United States	71.1
Native Americans in Wyoming	53.1

Source: Wyoming Vital Statistics for 2001-10/11

In Wyoming

Mortality Rates/100,000 Population	Native Americans	Non-Natives
Cancer	185.70	173.10
Heart Disease	170.28	164.07
Accidents and Adverse Effects	121.01	61.75
Diabetes	90.01	23.20
Chronic Liver Disease	87.00	9.85
Infant Mortality/1000	14.00	6.00

Causes of Deaths for Wyoming's Tribal Population

#1 Accidents and Other Adverse Effects

#2 Cancer

#3 Heart Disease

#4 Chronic Liver Disease (Cirrhosis)

#5 Diabetes

#6 Chronic Obstuctive Pulmonary Disease

The CHAIRMAN. Thank you for making the trek up.

STATEMENT OF TIM ROSETTE, INTERIM CEO, ROCKY BOY TRIBAL HEALTH BOARD, CHIPPEWA-CREE INDIANS, ROCKY BOY'S RESERVATION

Mr. ROSETTE. Thank you, Mr. Chairman. Thank you for holding this meeting today, my name is Tim Rosette, and I've had the great honor of being asked by the leadership of my Tribe, the Chippewa-Cree, and members of our health board to be the Director of Health Services on the Rocky Boy Reservation. It's an honor to be entrusted to operate the healthcare programs for our people, but I have to tell you, it's probably the hardest job I've ever dealt with in my life. I've dealt with a lot of difficult situations my entire life.

Turning down health requests for Tribal member, children, you know, it's heartbreaking on a daily basis. Today's meeting was entitled ensuring the Indian Health Service is living up to its respon-

sibility; I think it's safe to say, after everybody's talked, that, no, no, they are not. To be honest, let's just throw it all out on the table, everybody has hit the points I've already hit, Mr. Chairman, so basically I'm going to go off the cuff here a little bit, so look out.

The issues that sit in front of us, you know, today have to do with—basically have to do with money. Everybody talks about life or limb, you know, one solution to that is fund—have a funding mechanism for all Priority 1 and Priority 2 needs out there in Indian Country; yes, it costs money, but we don't want to be the leaders anymore. We don't want to be the leaders in heart problems and diabetes, we don't want to be the leaders in suicide, we don't want to be the leader in alcohol rates, we don't want to be the leaders in drug addiction, we do not want to be the leaders in those types of situations, Mr. Chairman, so today I ask you, the Indian Health Service, and everybody here, you know, fund those priorities and let's get those people the help that they need all across the country.

You know, we talk about—everybody talks about the disparities, life and limb, you talked about it yourself, 19 to 20 years fewer from the state, but, you know, the U.S. spends on average about $7,000 per Veteran, and they deserve it wholeheartedly, they probably deserve it more than that; whereas, the US spends less than $3,000 per year for Indians and their healthcare, and you can see why we are the leaders in everything, unfortunately. We don't want to be the leaders in those types of things.

Medicare pays for 12,000 per year per capita. The stats, as you know, are widely available so what I can't understand is that if the Indian Health Service Office, OMB know that we are getting one-quarter to one-half of the funding of other federal beneficiaries, and they know how that lack of funding is resulting in our people suffering from the lack of healthcare, then how is it that they don't ask for sufficient funds to eliminate the disparity? Are they racist or do people just not care? They look at it, they see it, and they don't care. I care. I think everybody in here cares, you know, and we have to do something about it.

Again, I don't mean to sound cynical, but we need to get answers to these questions. We are told the Federal Government just doesn't have the money, but we are going to spend over $820 billion in fiscal year '15 on the Department of Defense budget, so there is money for priorities; when are we going to be a priority? What we are asking—you know, the DOD, they prioritize things, what I'm asking is that you just—all of us prioritize basic human life.

I've cited a few examples in my testimony, Mr. Chairman, they are of actual cases—60-year-old female who had some bleeding—rectal bleeding problems in January of 2013, she was referred to a general surgeon, not having an alternate resource, she went to one of the service units where the general surgeon performs colonoscopies, that appointment was scheduled for June of 2013, the surgeon told her she did not need it, she presented back in September to our clinic with increased pain and weight loss, and was emergently referred to a gastroenterologist where she was diagnosed with colorectal cancer that had spread to her lymph nodes, requiring extensive surgery, chemo and radiation treatment that

she's still struggling with today. This person's life could have been—I don't know, I can't say that, you know what I mean.

On a more general basis, colonoscopy is the preferred screening test for colon cancer in patients over the age of 50, and it's covered by Medicare for patients between 50 and 65, however, as our contract health service has always been in deficit, the only way we could refer people was to refer them to Crow or Blackfeet Service Unit where a general surgeon could perform the procedure. Both sites are very distant, three hours or greater. More importantly, appointments there are either not scheduled or scheduled a long time out so most referred—we are not able to get the tests. If people can be screened through the colonoscopy, then they can remove the polyps, thereby preventing cancer, or if there's already cancer present, find it and treat it at the early stages where it is treatable and you could live through it.

Another general issue, Mr. Chairman, when we were trying to improve access issues, to the best of our abilities here recruiting and retaining medical providers is extremely difficult. This is a question to ask. For us, it has been extremely difficult. We pay some of the best wages that I could possibly do within my budget, and it leads to basic lack of the continuity of care and overall decreased access for chronic and preventive care that our people deserve.

Tribes are entitled to obtain reimbursement for reasonable administrative overhead costs pursuant to the ISDEAA. Contract support cost funding reimbursement was settled by law and has been reaffirmed by US Supreme Court, most recently Salazar versus Ramah Navajo. The Federal Government's obligation to pay contract support costs under the Indian Self-Determination and Education Assistance Act are legally binding, and the right to full payment of contract support costs should be funded on a mandatory basis, however, CSC is law, and now a recurring expense for the Federal Government through the IHS with no additional funding attached to cover CSC expenses. If additional CSC dollars are not appropriated and permanently allocated by the Federal Government to the Indian Health Service, then IHS will be forced to further reduce direct services to Indian people in order to comply with the CSC law which they are now bound to.

Mr. Chairman, it is now May, the eighth month of the fiscal year. I got my budget about two weeks ago—I got my final budget about two weeks ago. How can I possibly do any planning, how do I hire staff, determine allocation of funds, how do I know where I'm going over or under—we had some fluctuations in contract health services, how do I know what's going on when we wait until the eighth month to get this out.

I must strongly support what's been offered up; that Indian Health Service be given a minimum, a minimum of a two-year allocation appropriation in order to adequately plan and administer their trust responsibilities to the Tribes. Without it means continued chaos and a further erosion of our already diminishing trust with IHS due to the inability to plan appropriately. Without a plan, we cannot move forward.

Beyond the need for sufficient funding, simple parity funding with other federal beneficiaries, we need to approach things in

some innovative ways. There are opportunities under the Affordable Care Act for Indian Country that at the current pace will take several years to fully understand the true benefits for our people to be realized. This will happen, and it will take some time, Mr. Chairman, it's a good law and our people will come around to it, but it is going to take education and time.

The final point I would like to bring to light is the lack of mental addictive counseling and inpatient services for our children 17 years and younger. This is one that no Tribes have brought forward, but I'm sure most of them suffer from. The Tribes in our region and our nontribal counterparts in the State of Montana and surrounding rural areas lack for qualified, competent inpatient facilities that deal with the nature of our Indian adolescent problems facing our children today. For example, recently, two adolescent suicide attempts—one was 9 years old, one was 14 years old—the only resource I had available, Mr. Chairman, was the hospital. Two days later, they said they were fine, they could go home. That's after grandpa cut one down off of a cord, and the other one tried to cut his wrist—they are fine, they can go home now after two days—I think the mental and the other issues dealing with that probably take more than two days to address. And finding a facility—inpatient facility to take them, we've got to be lucky there's a bed open. We do, all of us have to be lucky there's a bed open in Montana or the surrounding region. I recently sent a young person to San Marcos, Texas, because I couldn't provide the services, we couldn't provide the services anywhere near here for that long of a period of time.

The State of Montana has the highest rate of suicide in the country, and you add the fact that Indian Country doubles Montana's rate of suicide rate per capita, I believe the system is a total failure not just for Indian children, but for all children in the great state of Montana as well, which I advocate for all the children. A regional center for adolescent mental health and addictive disorders has to be established within the boundaries of Montana in order to save the lives of our children. Something has to be done, Mr. Chairman.

In summary, to answer the question, does IHS live up to its trust responsibilities, the answer is, quite frankly, no; however, through bridging the disparity gap in funding, improving access and providing incentives for medical providers, providing additional permanent funding to CSC, multi-year funding allocations, while collaborating on establishing a regional youth mental and addiction inpatient facility dedicated to the betterment of our youth, we can all strive to provide quality physical and mental health options available for Indian people from birth to our oldest.

Thank you, sir.

[The prepared statement of Mr. Rosette follows:]

PREPARED STATEMENT OF TIM ROSETTE, INTERIM CEO, ROCKY BOY TRIBAL HEALTH BOARD, CHIPPEWA-CREE INDIANS, ROCKY BOY'S RESERVATION

Chairman Tester and Members of the Indians Affairs Committee, my name is Tim Rosette and I have the great honor of having been asked by the leadership of my Tribe, the Chippewa Cree and by the members of our Health Board, to be the Director of Health Services on the Rocky Boy's Reservation. It is an honor to be entrusted to operate the health care programs for our people but I must tell you that there

are times when I wouldn't wish this job on my worst enemy. I will challenge any person in this country to try and undertake a job when the funding to succeed is so totally lacking that failure is almost assured. It breaks my heart to have to turn down health care requests by tribal members, including children, who so desperately need it.

You have entitled today's meeting as a hearing on "Ensuring the Indian Health Service is living up to its Trust Responsibility." I think it is safe to say that the IHS is not even close to living up to its trust responsibility relative to the health of the Indian people. One problem on this matter is that it would be nearly impossible to quantify when the trust responsibility has been met and when it has not, but I can tell you that when contract health care is limited to Priority 1, meaning an Indian person can only be referred to a private doctor if the person's life or limb are at stake, we are not close to meeting a trust responsibility. When according to data supplied by the State of Montana, Indian men and women live 19 to 20 fewer years on average than their non-Indian counterparts; we have not come close to meeting the trust responsibility. Montana is abuzz with stories about how Veterans are not being properly treated in their health care and we strongly support those Veterans. But please know the following: the U.S. spends, on average, almost $7,000 per Veteran per year through the VA whereas the U.S. spends less that $3,000 per year for Indians for health care. The U.S. also spends over $12,000 per year for each recipient of Medicare. What is the Federal government saying with these spending patterns? Are Indian people really worth less than half what Veterans are worth? Are we worth only one-quarter of the value to the U.S. of a Medicare recipient? It is difficult to look at this data and not reach what probably sound like cynical conclusions. I am sure you have seen the results of this disparity. Not only do Indian people live fewer years but we have worse indicators in almost all known ways of measuring health. So is the IHS living up to its trust responsibility? Not even remotely.

The statistics I cited previously are widely available. So what I can't understand is that if the Indian Health Service and the Office of Management and Budget know that we are getting one quarter to one half the funding of other federal beneficiaries and they know how that lack of funding is resulting in our people suffering from lack of health care, then how is that they do not ask for sufficient funds to eliminate the disparity? Are these agencies racist, or do they just not care? Again, I don't mean to sound so cynical but we need to get answers to these questions. We are told that the Federal Government just doesn't have the money, but we are going to spend over $820 billion in FY15 on the DOD budget, so we apparently do have money for things that are a priority. How can the Federal Government prioritize and budget that much money for the DOD, and not prioritize basic human life?

I want to give you a few examples of how the disparity has affected just a few of my people recently:

1. JT: a 44 year old male with severe arthritis of his R hip, related to a condition he had as a teenager. Surgery for repair/replacement has been deferred/denied over more than 4 years due to lack of funding. This has led to increasing need for narcotics, to control his pain enough that he is able to try to work. He cannot stand for long periods due to his pain although he is working.

2. AV: a 28 year old male with worsening depression and some psychotic features would have benefited from psychiatric help, but referral was deferred multiple times until he eventually required hospitalization and inpatient care, and now faces legal issues as well.

3. EA: a 61 year old female with severe arthritis of bilateral hips, who has been recommended to have surgery for over 5 years, with orthopedic referrals deferred/denied due to lack of funding. She is caring for multiple grandchildren in her home and is in severe pain.

4. DH: a 60 year old female who was known to have hemorrhoids but had increased rectal bleeding; in January 2013 she was referred to General Surgery, and not having an alternate resource she was sent to Blackfeet Service Unit, where a General Surgeon performs colonoscopies; that appointment was scheduled for June 2013. The surgeon there told her she did not need a colonoscopy. She presented back at our clinic in September with increased pain and weight loss, and was emergently referred to Gastroenterology, where she was diagnosed with colorectal cancer that had spread to lymph nodes, requiring extensive surgery, chemo and radiation treatment.

On a more general basis: colonoscopy is the preferred screening test for colon cancer in patients over the age of 50. It is covered by Medicare for patients between the ages of 50 and 65; however, as our Contract Health Service is always in a def-

icit, the only way we could refer people was to refer them to the Crow or Blackfeet service units, where a General Surgeon could perform the procedure. Both sites are very distant (>3 hours). More importantly, appointments there were either not scheduled or scheduled a long time out, so most people referred were not able to get the test. If people can be screened, colonoscopy can remove the polyps, thereby preventing cancer, or if there is already cancer present, find and treat it at an earlier stage.

Another general issue: while we are trying to improve access issues to the best of our abilities here, recruiting and retaining medical providers is extremely difficult. Multiple providers have left for higher paying jobs in less remote areas. This leads to a lack of basic continuity of care, and overall decreased access for chronic and preventative care (fewer breast exams done, harder for patients to get in for better control of their diabetes, etc.).

Tribes are entitled to obtain reimbursements for reasonable administrative and overhead costs pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). Contract support costs funding reimbursement is settled law and has been reaffirmed by the U.S. Supreme Court, most recently in *Salazar v. Ramah Navajo Chapter*. The Federal Government's obligation to pay contract support costs (CSC) under ISDEAA contracts is legally binding and the right to full payment of CSC should be funded on a mandatory basis. However, CSC is law and now a recurring expense for the Federal Government through the IHS with no additional funding attached to cover these CSC expenses. If additional CSC dollars are not appropriated and permanently allocated by the Federal Government to the IHS, then IHS will be forced to reduce direct health services to Indian people in order to comply with the CSC law, which in turn means less dollars going to an already grossly underfunded Indian population.

Mr. Chairman, it is now May, the eighth month of the fiscal year. Do you know when I got my final FY14 budget from the IHS? Two weeks ago! How can I possibly do any planning, how do I hire staff and determine how to allocate funding for patient care when I don't know how much money I have to work with two-thirds of the way through the fiscal year? In order for the IHS to function through these troubling budgetary times, IHS must be given a minimum of a two year allocation/appropriation in order to adequately plan and administer their trust responsibilities to the tribes. Without it means continued chaos and a further erosion of our already diminishing trust with IHS due to the inability to plan appropriately.

Beyond the need for sufficient funding—simple parity funding with other federal beneficiaries—we need to approach things in some innovative ways. There are opportunities under the Affordable Care Act for Indian country that at current pace will take several years to fully understand the true benefits for our people.

The final point I would like to bring to light is the lack of Mental/Addictive Counseling and Impatient services to our children 17 years and younger. The tribes in our region and our non-tribal counterparts in the state of Montana and surrounding rural areas lack for qualified, competent inpatient facilities that deals with the nature of our Indian adolescent problems facing our children today. For example, we recently had two adolescent suicide attempts, one was 9 years old and one 14 years old, where the only resource available was our local hospital who kept them for two days under observation, then notified our providers that the children were fine and were referred back to their homes. Our local hospital is not equipped and does not have the qualified staff, like many rural hospitals, to serve these children. The state of Montana has the highest rate of suicide in the country, and you add the fact that Indian country doubles Montana's rate of suicide per capita. I believe the system is a total failure, not just for Indian children, but for all children of our great state of Montana as well. A regional center for adolescent mental and addictive disorders has to be established within the boundaries of Montana in order to save the lives of OUR children.

In summary, to answer the question, does the IHS live up to its trust responsibility, the answer is quite simply. . .NO! However, through bridging the disparity gap in funding, improving access and providing incentives for medical providers, providing additional permanent funding to CSC, multi-year funding allocations, while collaborating on establishing a regional youth mental and addiction inpatient facility dedicated to the betterment of our youth. We all can strive to provide quality physical and mental health options available for Indian people from birth to our eldest elder.

The CHAIRMAN. Thank you, sir. Thank you everybody for testifying today. Sobering statistics, sobering facts. As a sidebar, before we begin to our questions, I will tell you that, Tim, the biggest

problem facing this country as a whole is mental health. Going forward, it is very challenging, very expensive, and we are seeing it whether you are a veteran returning home from war or Native American or anybody else, it is a huge issue.

I'm going to run this panel a little bit different, Darrin, I'm going to ask you a question, if you guys want to chime in, feel free to. The reason I want to start with Darrin is because he brought up some statistics I wanted to dig down into a little bit more.

Darrin, you talked about the funds being top heavy; my interpretation of that is more money is spent on administration than what needs to be spent on administration. You said that about 15 percent of the healthcare dollars get to the ground, the UC; could you elaborate on that a little more?

Mr. OLD COYOTE. Well, I think everything that the area office—we go to the area office, and they are put there to make decisions, and they pass the buck to the central office, then we go to central office—it kind of goes back and forth, and I think we—to tell the truth, I don't think we need area offices, because we are duplicating—it would be like having you, Senator, in DC, and having a Senator here in Montana, people aren't—we've got to have a direct channel to decision makers, because we go to the area office and it's just kind of the people there tell us, oh, it's the central office's fault, we go to the central office and they say go speak with the area office, so if we got rid of that, we could have better healthcare for all the people.

The CHAIRMAN. More accountability, less ping-pong, so to speak.

The issue that you talked about—does anybody want to add to that?

[No affirmative response.]

The CHAIRMAN. The issue you also talked about was the personnel challenge, an issue I brought up with Dr. Roubideaux and we talked a little bit in the previous panel about staffing.

Mr. OLD COYOTE. Well, the staff—I'm not—I can't speak for other service units, but a lot of people that we ask to be removed are removed from other places, they end up at the area office, they are the ones that make the decisions—when we ask to remove them from our service units, they are sent to the area office and then the problem gets worse, because a lot of these people, instead of being reprimanded and demoted, they are promoted to the area office, they are the ones that are deciding the fate of our Tribes.

The CHAIRMAN. Just nod your heads, if you would, I appreciate that. This is not unique to Indian healthcare, we've heard the same thing with Veterans healthcare about people who aren't doing the job don't get fired, but get moved, and we do have to figure out a solution for both of these to—because we don't want people being fired because of political reasons, if they are going to get fired, that there's a clear reason in job performance.

The issue of holding everybody accountable, medical staff included, is solid. The question for me becomes you also talked about how you are short on medical staff, medical providers, and correct me if I'm wrong, but that's what my notes say; if you—do you think they are diametrically opposed, is what I'm saying? You've got to hold medical staff accountable, if they are not doing the job, I agree with you, you've got to get them replaced; how do you get the mes-

sage out to other folks that Indian Country is a good place to work, and if you do a good job, we will reward you for that?

Mr. OLD COYOTE. There's quite a few contract doctors coming in that kind of strains our budget in providing good quality healthcare to the patients—the actual money going to the patient, but a lot of it is going to the contracts, and these contracts, you know, you could have people coming in from other countries that may have a malpractice in another country, but they come here, and basically what we are getting from a lot of these doctors is we want to be respected as human beings, and we want to have quality healthcare providers, and there are some out there, but kind of the area office, as being the way it is, a lot of people don't want to come here because the way they are treated by the area office.

The CHAIRMAN. What's your staffing shortfall—I'm talking doctors and nurses, where are you at with that?

Mr. OLD COYOTE. Well, in 2011 when we had the flood, surgery was closed down, OB, and then the clinic, and so my question is where did this funding go; and then there was a CAT scan machine that was supposed to be brought in to Crow as well, and we don't know where that went as well, and the person that requested that with the biggest need—because right now we are taking our patients—both Northern Cheyenne and Crow—for CAT scan, we take them over to Hardin off the reservation, and, you know, the machine that was there, we would save a lot of money on that, but where was that taken, we don't know. The lab tech that questioned was reprimanded and removed, so when we start asking questions, people are—right now we will probably be—our service unit will probably be—adequate healthcare won't be provided to the Crow Service Unit because of what I'm saying today by the area office.

The CHAIRMAN. We will make sure that doesn't happen, by the way, and I will get into that with the close. By the way, if you've got problems, you ought to be able to speak out, and hopefully the issues that are being brought up here today, when you speak out, it will start a dialogue to solve the problem, not make it worse.

But when it comes to doctors and nurses, could you get me how many you guys are short, because I think that's important going forward. You don't have to do it right now, Darrin, unless it's at the tip of your tongue.

Same thing with you guys, are you short medical providers in Wind River; and if so, at what rate? If you don't have it, you can get back to me.

Mr. O'NEAL. I can't really answer that question right now, but I can answer the question before that.

The CHAIRMAN. Go ahead.

Mr. O'NEAL. I would just reiterate some of Darrin's concerns with some of the people employed by the Indian Health Service. We've issued our concerns on certain employees, but nothing has ever been done so it's a similar kind of pattern.

The CHAIRMAN. Thank you. Tim?

Mr. ROSETTE. We were very emergent, we had two docs go down due to illness last week, that left me with one provider for the whole clinic.

The CHAIRMAN. Nursing?

Mr. ROSETTE. We are fine in the nursing area, but we are down three FTEs on the docs.

The CHAIRMAN. Let me talk to you about self-governance because I told you I was going to ask you about it. How does it work? Do you think it works better than the other method? It's been around for a while.

Mr. ROSETTE. I think so, sir, I do, I think it does. It gives Tribes more flexibility to move—you know, set their priorities, let me put it that way.

The CHAIRMAN. Do you think it helps you with medical recruitment?

Mr. ROSETTE. Yes, I do. I think it would if there's availability. There's a big problem with availability in the country right now.

The CHAIRMAN. Sign up—and this is always prefaced with the fact that Medicaid expansion never happened yet—hopefully it will—but the signup for the Affordable Care Act, how has it worked in each one of your communities—and I don't know, did Wyoming do Medicaid expansion? I don't know that.

Mr. O'NEAL. We are working on it.

The CHAIRMAN. That was my knowledge, too, but it never got to the point where they actually did it.

How is the signup going, Mr. Chairman?

Mr. FISHER. For Affordable Care Act, we've been working with the White House, doing some signups on the reservation, along with the State, and we did get some people that came in and signed up, but we need to do more outreach for Tribal members.

The CHAIRMAN. How about Wind River, how is the signup for the Affordable Care Act?

Mr. O'NEAL. Like I said, we are still working on it. I don't know the numbers right now.

The CHAIRMAN. Tim?

Mr. ROSETTE. Honestly, not very well, Mr. Chairman. I think there needs to be a better education system, radio—somehow we've got to get our community educated.

The CHAIRMAN. Hopefully the Medicare expansion will come down the pike because I think it's the right thing to do for everybody in the state, but that will help you with third-party billing across the board in an incredible way, in incredible measures.

I want to thank the three of you, as well as the previous panels, Dr. Roubideaux, and the Tribal chairmen and representatives, thank you all for being here today.

There is a reporter for the Gazette—I don't believe she's here today because she's on vacation—named Cindy Uken who called me last week because she was doing a story, and I think it was written in the Gazette last Sunday. One of the things that Cindy said is she had a hard time getting people—not getting people to talk to her, but she had a hard time getting their names at the end because they are afraid of retribution from somebody. I can tell you that that cannot happen and must not happen. That is a good reason for termination, from my perspective, and I think your Tribal members would do the same thing to you. People come to you with concerns, and if it results in retribution, I don't think you would have a job very long.

So I will just say my staff is going to be here until 2:30—we are going to gavel out here pretty quick, but they are going to be here until 2:30, anybody who wants to tell their story, talk about their issues with Indian Health Service, I would love to have you come talk about your story, because I think it's important we talk about real life experiences as we move forward.

Now, here are the folks that are going to be here, and you will have to help me if I don't get you all, please raise your hands: Mary Pavel, Carla Lott, Brandon, Sarah—these are the folks that are going to be here to take input, and I don't know, Brandon, if you would like to, too, but this is—these folks are with my staff; Brandon is with Senator Walsh's staff, but feel free to talk to them.

We will also have a few other folks—Rachel who is sitting in the crowd who is my regional director here in Billings, she will be here; and Katie Russell, feel free—run these folks down, tell them your story, let us know what the experiences are, because I think it is going to be really, really important as we are moving forward.

I will end where we started. This hearing was for several reasons—one, to give information to me, to Dr. Roubideaux, to our staffs; two, to come up with solutions—to understand if there's a problem, number one, and start getting solutions. I think that there's been some very good information delivered here today that we can start working to live up to those trust responsibilities that we are not living up to, Tim, and I think that there's been some good thinking and some good concerns and some pretty sobering testimony, quite frankly when we go back over it.

I would be remiss if I didn't thank everybody else who is sitting in the audience for coming. I think the showing of you being here shows that there is a big concern out there over this issue and a big issue that we need to deal with. I'm the Chairman of the Committee, but I guarantee the proceedings of this meeting will go to our Committee members, and hopefully we can get a consensus to act, and we will be encouraging a consensus to do that.

Thank you for being here.

This Committee hearing is adjourned.

A P P E N D I X

PREPARED STATEMENT OF JOSEPH HENAN, EASTERN SHOSHONE TRIBE MEMBER

My name is Joseph Henan, and I am an enrolled member of the Eastern Shoshone Tribe on the Wind River Reservation. I recently retired from the Billings Area Indian Health Service. I am writing in regards to your upcoming investigation into the Billings Area Indian Health Service. In my thirty-two years working in government service, I served twenty-two years in the Billings Area Office and can honestly say "lack of funding" is only one of many problems plaguing this valuable resource for Native American families. More than simple funding problems, *management* within the Billings Area office is the true root the issues. I am hopeful that the following information will create questions and inspire you and your investigators to look for deeper problems within the Billings Area IHS office.

Under Pete Conway's tenure as Area Director, the following oversights and mismanagement occurred:

1. The Crow Hospital incurred record debt.
2. Telecommunications funds were misappropriated for construction of new offices which prohibited any upgrades of telecommunications equipment or telephony.
3. Additionally, other IHS funding was used to hire *Creattve Leadership Group*. Despite numerous meetings and information gathering meant to improve leadership and group relationships, no significant improvements were made in the workplace and in fact seemed to only exacerbate an already unhealthy environment. The only accomplishment which occurred during the five year contract was a significant drain of funds away from Native American health care.

Under Dina Hansen's time as Office of Information Management director, the work place conditions and treatment of employees fell drastically. These issues persist in not only the Office of Information Management but also other offices within Indian Health Service.

1. Within the last five years the OIM Director has promoted Ryan MacDonald from a GS7 to a GS13? MacDonald has no college degree, and the Position Descriptions required rewriting and the position advertised. How was this done?

2. OIM Director provides unlimited overtime to certain employees but denied to others. How is this an appropriate use of department payroll and worked hours? And why is this consistently approved over the course of many years?
3. Specialist Ryan MacDonald, as a volunteer, built in a "backdoor" to IHS computer systems to allow unauthorized access after hours. Ryan's father was temp HR director at the time and convinced the current OIM director Mike Danielson to not report the hack and threatened his employees to not report it. Ryan MacDonald lost an IHS laptop during a tech conference in New Orleans. MacDonald refused to fill out proper report of the incident, and the OIM director Dina Hansen and Information Security Officer Leann Christianson also did not report the loss of the computer and aided in the cover up.

The February, 2014 issue of *Magic* Magazine has an article titled "Bullies at Large" specifically itemizes and describes the abuses and dysfunction which contribute to and create a toxic working environment. From my experiences and observations, the Indian Health Service Billings Area office epitomizes such an environment, and that is, I believe, the larger cause of any fiscal or financial difficulties afflicting this otherwise productive and beneficial Montana public service.

"Bullies at Large" - Personal experiences

I would like to focus now on personal experiences that I both witnessed and experienced during my final five years at IHS. Former Information Security Officer, Hunter Schildt, an Iraq war veteran and a very friendly and outgoing employee who always offered his help, was denied access to computer logs and other necessary information effectively preventing him from performing his security duties. Furthermore, while Mr. Schildt was currently employed at IHS, OIM director Dina Hansen coordinated with Billings Area Contracting Officer, Jerry Black, to create a new contractor position meant to be filled by Leann Christiansen. After such poor, disrespectful, and unprofessional treatment, Mr. Schildt took a position in the Portland Area Indian Health and left the Billings Area. The loss of Mr. Schildt as both an employee and Billings citizen was a terrible loss to an already suffering work environment.

Finally, my own time spent at IHS demonstrates the downward trajectory of this valuable community service. After 29 years of receiving good performance evaluations and awards for my work with the Native American health community, the new OIM director, Dina Hansen, gave me a bad evaluation, after which I filed a grievance against and won. Over the course of the next five years, I filed 5 grievances and won each decision. Each grievance stated favoritism, withholding of vital information, and misplaced blame for others' mistakes. All of these actions prevented me from optimally performing my duties. After each of these grievances, the OIM director responded by isolating me from the larger working environment. The only person to speak to me in the OIM office was the director and that was only once or twice a week. Other employees who were not a personal "friend" of the director seldom spoke to me perhaps for fear of reprisal from

above. Any questions I would ask were met with vague, elusive, and dismissive response. Also, duties were taken from my position stating I was not doing them properly. Yet, when the duties were reassigned to someone in the "inner circle," they were give access to all the tools and resources needed, access which I was denied.

As you can plainly see, the problems with the Billings Area Indian Health are not simply a matter of more funding. Like many other federally and state supported services, IHS is not properly funded, but until something is done to correct the mismanagement of the Billings Area IHS, no amount of additional funding will correct the health care issues. Unless certain staffing and personnel issues are addressed, the mismanagement, favoritism, waste, and abuse will continue to eat away at the morale and efficacy of this organization. Both the Native American people who rely on the health care services and the employees who serve them will continue to suffer if the immature behavior and greed are not stopped. Without a doubt, this chain of waste and abuse must end, and I hope that your investigation and inquiry will help restore trust and honor to this valued and integral part of Montana Native American health care.

PREPARED STATEMENT OF DAN M. AUNE, OWNER/CONSULTANT, AUNE ASSOCIATES CONSULTING

Dear Senator Tester:

Thank you for your work in representing and supporting Montana citizens in Washington D.C. and for holding this important hearing in regards to the health care of American Indians who may receive their care from Indian Health Services. Thank you for the opportunity to offer testimony.

Background Information

For the last five years I have been involved with approximately 20 Tribal communities working to develop capacity for the community to develop and run their own community-based and outreach model wellness center. The initiative has typically started as a result of the Tribe being awarded either a Circles of Care or System of Care project grant through the Substance Abuse Mental Health Services Administration (SAMHSA). A key element in these projects is sustainability beyond the grant award period which involves building operational and service delivery capacity to bill Medicaid and a state's Children's Health Insurance Program (S-CHIP). This work has two primary goals: 1) Mental health/wellness services for children and families and 2) Drive healthcare revenue into Tribal communities.

In this effort I and the Tribal community programs have attempted to establish a relationship with the Indian Health Services facility to enlist the facility to extend the health care continuum of care from clinic and crisis based services to a full continuum to include the community-based and outreach model. The success of connecting with IHS on a National and/or Area Office level has been minimal. I have had a great deal of support from the Region VIII Federal partners in Denver (SAMHSA, HHS, & CMS) and for this I and the Tribal communities are thankful. My interpretation of IHS response to the inquiries is two-fold: 1) IHS sees the initiative as competition and 2) IHS has stated there is no precedence for "sub-contracting" community-based and outreach model services with a Tribal entity.

In representing the approximately 20 Tribal communities I would ask that you and the Senate Indian Affairs Commission assist with the following:

1. Engage the Federal IHS agency to develop a "sub-contracting" model with Tribal organizations wishing to extend the Tribal community health care continuum.
2. Engage the Federal partners to include IHS in a conversation regarding mutual working relationships to encourage states to work with Tribes and to possibly have the state Medicaid division sponsor a health care capacity building initiative. The benefit to states is that Tribes can access 100% Federal Medicaid funding and eliminate the state match.
3. Build the ability of IHS facilities to enroll Tribal members in a health care insurance product both bringing an additional payer to the IHS facility and insuring Tribal members have access to health care whether in the IHS facility or with a community partner.

Thank you again for the opportunity to offer testimony and for your continued support of all Montanans and the American Indian community.

PREPARED STATEMENT OF DIANA HUNTER, RN BSN, STANDING ROCK SIOUX TRIBE MEMBER; FORMER DIRECTOR OF NURSING, FORT BELKNAP HEALTH SERVICES

My resignation I'm sure is not a surprise as this information is nothing new on FBSU situation with our lack of leadership, lack of leadership oversight, lack of holding employees responsible and accountable for their actions or lack of actions, lack of knowledge/experience or even education, finances/budgeting no one ever seems to know if we have money to order patient supplies, orders getting denied from vendors because we haven't paid our bills thus our patients have to suffer and no one seems to care or know where the money went, IHS housing rent is for improvement and maintaining these IHS homes yet most are falling apart, need repairs but the money for this has been used elsewhere so we live in mold growing, stale sitting water in crawl spaces that they expect tenants to pay high electric bills to keep a pump running or live with the unbearable smell of sitting water, shingles falling off, homes leaking etc.Constant secrets, going behind everyone's back for personal or departmental gain, covering up errors/mistakes instead of owning up to them and learning from them and lack of transparency especially when it comes to reporting to the Tribal Council as I have been asked to "change your reports the

tribe doesn't need to have more ammo against us they're already all fired up about(fill in the blank)". The poor quality of care that has been acceptable practice over the year I have been here (however I'm told this is better than it used to be as providers would only see a set limited amount based on their personal schedule at least we can screen everyone to make sure it's not an emergency, I'm not sure how that could be possible that it's better as it's still awful), inexcusable allowed absences by providers who are scheduled with patients at 0800 but don't call into their supervisor until after 0830 IF they even wake up to make the call in the meantime patients are left sitting and waiting on a provider who didn't care enough to come to work on time to see patients which makes the clinic flow suffer along with every other appointment not to mention the walk ins who have to wait for an opening, unacceptable delays in providing quality care not only within facility but with CHS process with constant disagreements between CHS staff and providers, patients not being informed of appointments or scheduled rides having to miss appointments, not having the CHS meeting to review referrals if CMO not in for the day, unethical comments as to why certain patients don't deserve their rating for a referral such as "well she wasted enough of our money, their just a drunk, druggie, seeking, or it's not our fault she's stupid enough to keep going back to the same worthless man who beats her she obvious doesn't care about herself why waste money on her she just has to wait, their well enough to get a job they need to get off their lazy ass and find a job instead of wasting IHS money denied or who's she related too" are just a few comments that have been stated on multiple CHS meetings by the provider to the point of making me very uncomfortable but reporting this behavior gets a laugh from CEO stating "that's Ethel she can get away with anything, that's just how she has been for years it's not gonna change, can't teach an old dog like her new tricks", unethical documentation practice allowed by providers by copying/pasting nursing notes to complete their medical notes from 2011, 2012, 2013 on incomplete medical records, hostile work environment among departments with no backing or support from leadership within facility as excuses are made instead as to why certain departments get office supplies when patients can't get healthcare supplies, lack of teamwork between departments road blocks put up instead of helping to find the solutions for our patients, no follow through with anything from executive staff or executive decisions that were made over a year ago as we are still discussing the same topics that were decided on as an executive group over a year ago, no follow through with anything from medical staff as they allow unsafe practice from ER providers without intervening and allowing her to still practice on our people in the ER without a care as long as they don't have to cover a shift , unethical and unlawful practices of providers not following medical bylaws, allowed unprofessional slandering from providers to coworkers and patients in regards to our ineffective leaders not only within facility but within our BA, hindering of access to care, constantly having to close down the Hays Eagle Child Clinic to suit the providers schedule with total disregard for patients access to care. Providers allowed 10hr shifts instead of 8hrs shifts which gives maximum coverage as we currently only have one provider working on Monday's and having to close down Hays clinic to suit the providers 10 hr shifts. These issues are not new to BA either as I have witnessed these issues reported over and over with the only excuse they have used is "we know (CEO) not competent, he's only there to make the tribe happy since he's from Fort Belknap, same with (AO) but we are hoping Jim Sabatinos can help them" this type of statement has come from multiple BA leaders said to multiple people at the facility level and shared among the staff. This was when we were told "Jim Sabatinos who retired from BA, hired back by BA as nurse consultant and coming to FBSU as a contract to help (CEO) & (AO) do their jobs" to which many comments were "why are we wasting money on a nurse consultant when we could use it towards another provider in the clinic to help with access to care or on patient healthcare supplies" we were told "because we don't have anyone to replace them yet and there has been too much change at FBSU", this was shocking information as why would Billings Area leaders could allowed incompetent leaders to continue to receive high paying incomes when BA has to bring another person to help them do their jobs so we are now paying three people and our patients are left without the supplies/care they not only need but deserve. We can't afford providers at the Hays Clinic but we can pay for a nurse consultant that the facility didn't have a choice or say in paying for according to CEO.BA Human Resources interest is on how to stop a supervisor in holding employees responsible and accountable, multiple HR help desk tickets submitted on multiple complaints from patients on rude, unprofessional, unethical behavior from nursing staff that go unanswered and IF they do finally get around to answering you there's nothing you can do which only allows for this continued behavior by staff when they know they can violate policies and procedures, treat people poorly and get away with it, continue

to put "acting" positions on these same rude, unprofessional and uneducated individuals. The nursing department: why put an non-native Acting Director of Nursing in place that failed the last couple of times she was "acting" and expecting different results when we have strong Native American nurses within the facility who would love the opportunity to lead? Patients coming to ER for help only to be turned away, clear violations of EMTALA by patients statements yet BA HR states "it's he said she said" so now we don't believe the patients and in this case two other employees came forward with statements verifying this violation yet BA did not report this violation to CMS which violates so many other state and federal laws, patients being treated rudely or labeled a "drug seeker" yet have serious illnesses and when a supervisor tries to make those accountable you're the bad guy with no support internally from your leaders or BA. I could go on and on but it's just so depressing to see the dysfunction of the Billings Area leadership, how that dysfunction is placed at the facility level and who suffers is the communities. I'm disgusted with this type of allowed treatment to Native Americans and yet those contributing and allowing such dysfunction are from this tribal area. They are not acting in your people's best interest and it's sickening to see us Native's treat each other this way. Unless BA goes through a complete "clean out" of individuals who have played a key role in allowing such unacceptable dysfunction at the area level and at the facility level I do not see BA IHS improving in its care to our people. "Clean out" does not mean transfer or detail those dysfunctional BA employees to another facility that they didn't succeed at in the first place and those having an educational background in the area they are placed not just because they need to create a place for them only allows for continued dysfunction. I have only been with FBSU for over a year but can clearly see the dysfunction, meaningless waste of money/resources etc. that's enforced by BA.

I have felt hindered for quite some time by not only our facilities HR but by BA HR to be an effective leader here at FBSU as it is difficult to be a supervisor here when you attempt to hold your staff accountable and responsible for their actions (especially those who have been known as "troubled employees" who receive multiple complaints on their mistreatment of patients) only to submit multiple help desk tickets without receiving any guidance until months later after the incidents or have nursing decisions made by others who do not have medical backgrounds or any knowledge of nursing. As a supervisor you cannot lead with your hands tied behind your back, blind folded in a pitch black room and expect results.

PREPARED STATEMENT OF JESSIE JAMES-HAWLEY

Senator Tester,

When Anna Whiting-Sorrell resigned as Billings Area Indian Health Service Director she said, "The system is broken." Fort Belknap Reservation is suffering the worst at this broken system. I am 75 years old. I have had a lifetime interest in the health care/and or lack of it, concerning our people. We have a completely broken system here at the administrative level of Indian Health Service. Billing is not being done, which results in lack of funding to provide contract health care for patients as well as other needed services. We have some very good doctors who are leaving because they cannot provide the services needed for their patients. If you want to know the problems in Indian Health Service I would strongly recommend that you have a special hearing with the medical staff rather than tribal councils and or IHS administrators.

PREPARED STATEMENT OF DAVID "TALLY" PLUME, OGLALA LAKOTA NATION MEMBER

My name is David "Tally" Plume, and I am an enrolled member of the Oglala Lakota Nation and a resident of the Pine Ridge Indian reservation where I have business interests, one of which provides services to the Indian Health Service.

If I may, I would like to personally thank you for taking the time to hear the voices of your tribal constituency and for allowing me to voice my concerns which in no way represent or should be viewed as the official position of my tribe. I traveled to Billings on my own to present this testimony and to echo the sentiments of many of my fellow tribal members. In my testimony I may echo some of the sentiments shared by our esteemed leaders in previous testimony. If I do then we know it's happening in the Aberdeen Area also.

I would like to shine a light on__ areas that I see that are problematic yet not insurmountable.

1. **Divide and Conquer**

   A large number of the employees at our Service Unit and clinics are tribal members and work diligently in their jobs. Jobs which are hard to come by in our communities, so in order to sustain their employment they follow the rules and regulations to the letter, or risk some sort of disciplinary action. With families to support I can't blame them for following IHS regulations. In doing so they become the face of the IHS, and subsequently receive the criticism and ill will directed at the agency. This only serves to divide our people even more as they take the brunt of the hostility directed at an underfunded agency despite the trust obligation the US Government has for our tribes. Intended or unintended, the by product is the age old divide and conquer tactic that congress has contributed to by the continued underfunding of its trust responsibilities.

2. **Hope Is Distant and Unattainable**

   According to figures presented by our Service Unit Director, Contract Health Services (CHS) spends approximately $200,000.00 per week in referrals. And yet many priority one referrals will go unpaid, leaving the patient with tens of thousands of dollars in medical bills that were denied because of lack of funds. This leaves the patient with a

lengthy and time consuming appeals process that contributes to the patient's apathetic feeling. With a low FICO score patients are left with little or no hope of finding a private sector job, reliable transportation and decent housing outside the reservation. This is a direct contributor to the dependency that is prevalent on our reservation.

3. **Rate Quote Methodology (RQM)**

In one instance the Area Office negotiated a RQM with a service provider that gave the IHS a very low rate for patients whose bill was the responsibility of CHS. What the provider failed to disclose to the Area Office was that for any patient whom the CHS denied payment, then that patient would be liable for the bill at the provider's customary and usual rate. So what should have been a $3,500.00 service, priority one patients were hit with an invoice ranging between $35,000.00 and $45,000.00. (See attached invoice). When payment doesn't arrive within 90 days then the bill goes to collection and this particular company will begin a records search for unencumbered assets to lien on and liquidate to satisfy judgments obtained in state courts. Don't be surprised if this provider will try to file liens on court ordered settlement payments such as Cobell, Keeps Eagle, and others.

4. **Prompt Payment Act**

The Prompt Payment final rule (5 CFR Part 1315) requires Executive departments (including IHS) and agencies to pay commercial obligations within certain time periods and to pay interest penalties when payments are late.
For patients who are referred to a higher level of care from an IHS facility, and then the IHS IS responsible for the prompt payment for any and all healthcare costs associated with that particular referral. It is incumbent on the provider to pursue this action against the agency. And not the patient!

5. **All Men are Created Equal**

The second paragraph in the Declaration of Independence states, "We hold these truths to be self-evident, that <u>all Men are created equal</u>, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the Pursuit of Happiness."
Yet disparities are evident by numerous comparisons of per capita health care costs depending on whose study you review. Regardless, the IHS per capita expenditure is less than $2800.00 per enrollee, whereas the Bureau of Prisons spends in excess of $7,000.00 per inmate. There is something wrong with that picture. The message being, if you want the US Government to uphold its trust healthcare obligations to American Indians then go to a federal prison.

6. **My own Experience**

In the early morning hours of May 21, 2013 while I was in Shakopee MN on business, I began experiencing chest pain and so I drove myself to a nearby Emergency room where I was promptly admitted and then transferred later in the morning to Abbott Northwestern Hospital in Minneapolis. I was hospitalized for 4 days while numerous tests were performed and was diagnosed with a blood clot that had temporarily lodged in my heart. I did all the IHS protocols as far as reporting the event to the Pine Ridge Service Unit so that CHS would be aware and liable for the hospitalization costs; I figured I was okay since it wasn't June 1st yet. Remember don't get sick after June 1st, is a phrase commonly used in Indian Country. I was assured by CHS that everything was in order and to just worry about getting well. A couple weeks later I get a letter from the Quentin N. Burdick health Center in Belcourt North Dakota, telling me that my hospitalization costs were not going to be covered because I did not reside or could not prove residency on the Turtle Mountain Chippewa Indian reservation, nor was I an enrolled member of their tribe. When I finally get all this squared away with the proper Service Unit, I was once again denied payment by my own Service Unit. Reason? No funds!!

Later that summer on August 4th, while visiting my girlfriend on the Rosebud Indian Reservation, I began experiencing numbness on the left side of my face and slurred speech. I was rushed to the Rosebud Service Unit emergency room, where I was diagnosed with a stroke and was told that it would be nearly 2 ½ hours before I would arrive at a higher level of care in Sioux Falls due to having to wait for an air craft to fly out from Sioux Falls. My girlfriend was angry and adamant that my partners had an ALS equipped aircraft less than 10 minutes away and that I would not fly on the Sanford Aircraft. The ER doctor finally agreed to call the Valentine NE based Air Ambulance despite being told by then Aberdeen Area not to use the local life flight company. Needless to say this hospitalization was denied payment by CHS.

I am not the only one who has had to wait for Sioux Falls aircraft. In January 2010, a close friend of mine had to wait nearly 6 hours for a flight out of the Rosebud Service Unit, despite my partners having a plane 40 minutes away that was ready to go.

Last November a patient in Rosebud had to wait for a plane to come back from Denver via Rapid City to pick the patient up. Instead of flying directly to Rosebud, that crew flew to Rapid City. Meanwhile my partners and I had a plane less than ten minutes away in Valentine Ne, yet we were not called.

If you were to take a Rosebud Service Unit, close look you will find multiple issues similar to what I experienced.

Once again thank you and I for one appreciate the concern and compassion shown for our plight.

PREPARED STATEMENT OF STEVEN BRADY, SR., NORTHERN CHEYENNE TRIBE MEMBER

First of all, I want thank Senator Tester for holding a hearing in Billings regarding the concerns of the Indian Health Service for the Montana/Wyoming tribes. It has been very much long over-due.

Secondly, I would like to preface my statement that U.S. Congress ultimately holds a special fiduciary trust responsibility for the Northern Cheyenne Tribe and its members as direct result of treaties and agreements entered into by our ancestors. This special fiduciary trust responsibility is carried out and enforced by the Executive Branch and extends to all federal agencies and departments, including the Indian Health Service. Only U.S. Congress in consultation with tribes can change, modify or otherwise abrogate this special fiduciary trust responsibility.

Dialysis

I have been on Hemo-Dialysis for over seven (7) years at the Billings Clinic (now DCI/Billings Clinic) as result of Diabetes. I am insulin dependent. I was referred by Dr. Robert Wilson from the Crow/Northern Cheyenne Clinic for Dialysis.

Transportation

I generally drive myself and provide my own transportation at a 200 mile round trip per day at 3 times a week, regardless of weather conditions. Additionally, I have numerous other appointments such as podiatry, out-patient and in-patient procedures and tests as required by Nephrology. I am also engaged in transplant processes and tests for Porter Kidney Transplant from Denver, CO and Kidney Transplant from Mayo Clinic from Rochester, MN requiring numerous and periodic appointments and tests. While the Northern Cheyenne Clinic provides transportation for regular dialysis scheduled appointments, it would be next impossible for me to depend on the Northern Cheyenne Clinic for transportation for the many other appointments relevant to End Stage Renal Disease or transplant procedures. Initially, the Northern Cheyenne Tribal Health provided the transportation and due to insufficient funds transportation reverted back to the Northern Cheyenne Clinic, even then the Northern Cheyenne occasionally requests fund support from the Tribal Health program.

Appointments

Frequent podiatrist appointments are of absolute necessity especially for diabetic for infection and amputation prevention. I used to go to the Crow/Northern Clinic for podiatry, several years ago I noticed that there was only one Podiatrist for both the Northern Cheyenne Clinic and the Crow/Northern Cheyenne Clinic (both reservations). It was taken a long time between scheduled appointments and most of the time no appointments at all, due to the lack of availability of the podiatrist. Consequently, I went to Billings Clinic without a referral from IHS for the purpose of regular scheduled appointments for podiatry.

Moreover, the same principle applies to necessary frequent eye-exams to prevent blindness from the effects of Diabetes, as well as dental exams. It is extremely difficult to schedule an appointments and next to impossible to schedule an appointment for either, podiatry, eye-exam or dental. Generally, things are too far gone before you are seen and by then it is too little too late.

Medical Bills

First of all, the Indian Health Service Contract Health Care Medical Billing system lacks transparency and is inefficient. Often times, medical bills have been referred to collections or credit agencies negatively affecting personal credit rating. I personally have had discussions with Billings Clinic, they are equally frustrated due to lack of response from Contract Health Care. Other times, Contract Health Care will send out form letters denying payment without no reason or justification. Regarding referrals, there are several Indian Health Service staff in Contract Health Care authorized to make life and death decisions with absolutely no medical background and again, it is often too little too late.

Outreach

There is an absolute failure and a lack of outreach regarding dialysis patients. It seems that once a dialysis patient is referred out then they're on their own to fend for themselves. In the more than seven (7) years that I have been on dialysis, never once have I seen an Indian Health Service official do a visit to the dialysis clinic. The concerns of a dialysis patient are numerous and become complicated. As an example, there special dietary needs or in home handicap accessibility concerns. Not kidney transplant preparations or procedures. Diabetes and Dialysis are increasing exponentially and are not going to go away anytime soon.

Conflict of Interest

Debby Bends, the CEO of the IHS Northern Cheyenne Service Unit is the principle manager, while at the same time running a cattle operation on the Northern Cheyenne Reservation. Regardless of federal regulations or tribal law governing grazing allotments, I have maintained that Ms. Bends is engaged in "Conflict of Interest," Ms. Bends has the potential to make serious medical decisions on my part, while grazing cattle on my allotment. This has been addressed in writing to both Debby Bends as the CEO of IHS Northern Cheyenne Service Unit and Mike Addy the Superintendent of Bureau of Indian Affairs, both have maintained that there is "no conflict of interest." I should also add that the BIA Superintendent's wife works for Debby Bends at the Lame Deer Clinic. At times, Ms. Bends has been observed being involved and engaged in tribal politics during working hours when it

pertains to cattle operations on the Northern Cheyenne Reservation. It is obvious these two (2) agency heads have monopolized and provide protection to each other's interests.

Physician

Several years ago, a Medical Doctor by the name of Dr. Steven Sonntagg was engaged in pseudo-Indian shamanism by performing certain rituals rites on tribal land on the Northern Cheyenne Reservation. The use of tribal land by Dr. Sonntagg for this purpose was not authorized by the Northern Cheyenne Tribe. Because I had confronted Dr. Sonntagg on this, I am refrained from going to the Northern Cheyenne Clinic. Dr. Sonntagg was never investigated for his inappropriate conduct. Debby Bends was very protective of Dr. Sontagg.

Service Area

The Northern Cheyenne Tribe and the Reservation is extremely limited in opportunities with respect to employment and housing availability. I sincerely believe that time has come to extend the service area to in include the Billings area (Yellowstone County) for Indian Health Service, to especially include Contract Health Care. Many tribal members out necessity have moved to Billings and are outside of service area and yet, the Northern Cheyenne Contract Health Care will provide services to a tribal member considered transient.

In conclusion, it is very difficult to my full faith and trust, not to mention literally my life to an incompetent and grossly inept healthcare agency that is obligated and is supposed to provide quality health care to the members of the Northern Cheyenne Tribe.

PREPARED STATEMENT OF HON. JOHN E. WALSH, U.S. SENATOR FROM MONTANA

Thank you, Chairman Tester for holding this important hearing today. Along with you, I share the great honor of representing Montana's tribal nations in the U.S. Senate.

We have both heard from Montana tribes about the troubling situation regarding the Indian Health Service and the level of care being provided by Billings Area Office. In light of these concerns, I am pleased that the GAO has accepted our request to review the IHS with emphasis on the Billings Area Office.

As a Nation, we have a trust obligation to provide for the health and well-being of our tribal members. The IHS is the most visible and direct provider of these services. Unfortunately they are failing to meet their trust responsibilities and Montana tribes are suffering as a result.

Of particular concern to me is the failure to provide quality and timely care to patients through IHS facilities. Many tribal members are completely reliant on the IHS to receive medical care, but are forced to endure inadequate services or in some cases, none at all, and face extremely long delays in receiving basic services such as filling a prescription or seeing a physician. For children and the elderly, delays in what seem like simple health care services can have dramatic effects.

I have also heard directly from tribal leaders that feel IHS is only meeting half of the health needs in Indian Country. It is no secret that the IHS struggles with chronic underfunding. While acknowledging these resource challenges, it is even more galling to hear concerns that IHS facilities are not seeking reimbursements from third-party insurers, thereby denying desperately needed capital for these programs.

Lastly, I want to convey my grave concern regarding the long standing vacancies in critical health care positions. While these positions remain vacant, tribal members are effectively prevented from receiving the health care they desperately need and that we promised them.

I am anxious to read Dr. Roubideaux's testimony and plan to submit questions for the record as necessary. Thank you again Chairmen Tester for your leadership in Indian Country. I look forward to working with you to hold IHS accountable in their trust responsibility to our tribes.

Prepared Statement of Laurie Barnard, Audiologist, Browning Public Schools

I am an audiologist contracted through the Browning Public Schools and am submitting testimony concerning the status of IHS medical services at the Browning Community Hospital (BCH).

I am writing as an advocate for the children of the Blackfeet Reservation and as a tax payer. The audiology, ear nose and throat (ENT), and surgical contracted positions were cut during the sequester and still have not been reinstated.

Please see the attached letters which detail the current inefficient use of funds and effects of the loss of Audiology, ENT, and ENT surgical services.

It is my understanding that a Blackfeet patient who needs a hearing aid now is referred to a private audiologist in Great Falls and the funding comes out of IHS Contract Health Services. The expense to IHS is an average of $5,250 for the retail cost and fitting of ONE hearing aid, plus travel and time for the patient. When services are provided onsite at BCH, the wholesale cost of an aid is $500. That is an extra expense of $4,750 for 1 hearing aid for 1 person. Consider how much that is over a year. The onsite services also include a 2 year warranty for replacement of lost aids and repair of broken aids during the first 2 years of wear, which is not offered in the retail market.

With this current practice, it only takes the referral of ONE patient being fit with 2 hearing aids per month for ONE year to create enough savings to exceed the cost of the past TWELVE months of audiology services at BCH serving hundreds of patients per year by an onsite audiologist, rather than only 12 patients per year in Great Falls.

This is only one of the many adverse effects of cutting Audiology services. As an audiologist working through the schools, when a child needs replacement or repair of a hearing aid, they need to be taken out of school for a day to travel to Great Falls plus the cost of fitting the repaired/replaced aid, which is $250. Before the budget reductions this would have been done with minimal cost and time onsite. There are also children now who need hearing evaluations that have to be referred to outside audiologists.

I have not even discussed the detrimental effects for the Blackfeet people of the budget cuts on the ENT and surgical services. For further details I am attaching several comprehensive letters that have been written by the former audiologist, ENT nurse practitioner, and me to IHS Administration and Congressmen. The ENT/Audiology staff have been contracted for over 28 years, which I believe indicates dedication and quality services on the Blackfeet Reservation.

Attachments

Dear Ms. Sorrell, Mr. Gilham and Dr. Gray,

I continue to be concerned about the lack of Audiology Services at the Blackfeet Community Hospital (BCH). Please consider this a continuation of the attached letter that I sent to you on November 21st. Please refer to this letter for additional details.

I know that BCH is under considerable pressure to make good choices about what kind of health care to provide to the Blackfeet Nation. I thought if I explained my understanding of the funding of BCH's Audiology Department from the perspective of my 30 plus years contracting to provide this service, it would help you decide if you can support reinstating Audiology Services.

Keep in mind that the dollar value of a contract is not comparable to the 'salary' of a government employee. A contract's dollar value includes the contractor's salary plus benefits; such as Social Security, Retirement, Liability Insurance, Disability Insurance, Health Insurance, Workman's Compensation, Unemployment Insurance, etc. Expenses to service the contract, such as commuting costs, are also included. Most IHS contractors do not live in the neighborhood where they are providing their service. And, contractors are typically not compensated like an employee for sick leave, education, vacation, etc.

Now, consider the following based on my personal experience at servicing past Audiology Contracts at BCH:

1) Because of my experience and my nature, I am quicker than the average audiologist. That means I am able to see more patients per day, thus reducing the per patient cost. I was once told by Billings Area that I was seeing more patients at the BCH than all the other audiologists working in the Billings Area combined. I do not know if this was still true during my last contract, but suspect it might have been?
2) My skill and willingness to fit in walk-in patients with their varied needs/demands in an already scheduled and busy clinic is very good. Meaning that those with urgent needs usually are fit in to my day.
3) Providing services at BCH saves your patients time and travel expense and better serves the needs of your entire community. Your current policy of referring those with the greatest need to Great Falls and paying **retail** prices for services/hearing aids is very expensive and serves only a few of the many with hearing related needs.
4) An on site contractor, also has access through Indian Health Service's **wholesale** pricing for the purchase of hearing aids/batteries that either you or the patient pays for. This further reduces your expenses for providing Audiology services. For example:

1 fitted hearing aid / on site BCH wholesale pricing - $500.00 / Great Falls retail pricing - $5,250.00 / Savings to BCH or to patient of $4,750.00 per hearing aid fit at BCH.
10 fitted hearing aids per month for 1 year or 120 hearing aids / on site BCH

wholesale pricing - $60,000.00 / Great Falls retail pricing - $630,000.00 /
Savings to BCH and/or patients of $570,000.00 per year for 120 hearing aids.

This example does not reflect the time and expense of traveling for the patient to keep their initial evaluation and follow-up fitting appointments in Great Falls.

5) When services are provided at BCH, BCH is able to bill for third party reimbursement for Audiology services and for some hearing aids. I do not know the amount of reimbursement for past years, however, whatever is collected reduces the expense to you for providing Audiology services and hearing aids at BCH.
6) Hearing aids purchased through IHS also come with a 2 year warranty for replacement of lost aids and repair of broken aids during the first 2 years of wear. This warranty is not offered with the purchase of any aid in the retail market. This very good warranty reduces BCH's and/or patient's cost to replace lost aids or repair broken aids.
7) BCH currently has no other Health Care Provider who can do hearing exams, fit hearing aids, service hearing aids, etc. Keith McDivitt is a Nurse Practitioner and is sometimes confused by patients and Health Care Providers as being able to provide Audiology services. He has been trained to provide very basic hearing screening, but cannot do diagnostic Audiology or fit or repair hearing aids.
8) The median salary of an Audiologist in Montana is $77,000 plus benefits and expenses.
9) Etc.

With no Audiologist at BCH and continuing to use your current Contract Health Services (CHS) referral policy to Great Falls, it only takes the referral of one patient being fit with 2 hearing aids per month for 1 year to create enough savings to exceed the cost of the last 12 month Audiology contract at BCH. Savings of $9500.00 per month for 2 hearing aids fit at BCH X 12 months = $114,000.00. And, with an audiologist at BCH, you have the added benefit of serving hundreds of patients per year rather than just 12 patients per year in Great Falls. (If you evaluate past records for the past several years, the numbers for the purchase and fitting of hearing aids will only reflect 5-7 months out of the 12 months in any fiscal year due to budget freezes. If BCH were able to provide this service every month of every year, your financial savings for providing Audiology at BCH would be even greater than currently indicated.)

Audiologists are also in short supply in our current economy. And, most Audiologists prefer working in the private sector rather than Public Health Service because they receive better compensation. I suspect attracting and keeping a new audiologist in a cold and rural Montana community may be difficult. However, if you are interested in continuing to contract with me, you would already have a proven audiologist who loves and appreciates your community, neighborhood and the work.

Thank you for continuing to consider both the need for an Audiology Program and contracting with me to provide that service.

Sincerely,
Debra Sykes, Audiologist

Honorable Steve Daines (House of Representative)
206 Cannon House Office Building
Washington, DC 20510

April 2, 2014

Keith McDivitt
114 4th Street SW
Cut Bank, MT 59427

Dear Honorable Steve Daines:

I would like to bring to your attention some concerns regarding the Indian Health Service (IHS) Blackfeet Community Hospital (BCH) on the Blackfeet Indian Reservation in Browning, Montana. In particular, I would like to address the current lack of adequate health care services that were previously provided in the ear-nose-throat (ENT) Clinic and audiology (AUD) Clinic consistently for over 28 years. I do this with some reluctance and hesitancy; however I am no longer a federal employee (that respected and abided by the chain of command). I am a concerned private citizen, choosing to speak out while being a volunteer serving Native American people on the Blackfeet Indian Reservation.

For many years the ENT/AUD Clinic was staffed by a full-time nurse practitioner (me for 28 years), part-time contract audiologist (over 30 years), and part-time contract otolaryngologist/plastic surgeon (over 30 years). The IHS ENT/AUD Clinic in Browning has provided quality, consistent, and specialized ENT and Audiology services that were likely some of the best offered in all of the IHS, especially in a rural and remote setting. The ENT/AUD Clinic staff was dedicated and chose to work serving the Native American population in a rural and remote setting.

Now, the entire program has been decimated due to budget reductions. Here is what happened. In January of 2013, after being a Commissioned Officer in the Public Health Service for 31 years of active duty, I faced a mandatory retirement as the nurse practitioner that had worked in the ENT Clinic for 28 years. I then worked as an emergency hire (60 days) part-time civil service employee in the same position until March 31. Near the end of March, I was notified (after applying for the vacant position) by the Billings Area Office (BAO) that I was hired to work in the same position as a full-time civil service employee. Then several days later, I was informed by the BAO that due to "sequestration" the position could not be filled. Now 12 months later, the position has yet to be advertised or filled. However, since April 1, 2013, I continue to work as a nurse practitioner one day a week as a volunteer attempting to keep the ENT Clinic afloat and seeing many patients.

The audiologist in the AUD Clinic had worked as a part-time contractor for over 30 years in Browning. In May of 2013, she was given a 2 week notice (by BAO) and notified that her position was being terminated to save money. May 31, 2013 was her last day of work. Now children, adults, and the elderly who need a hearing exam, hearing aid, or hearing aid repairs have to travel over 2 hours one way for service in the private sector when the patient may have to cover their costs. A hearing aid that was previously purchased through the IHS and the VA contract in Browning for about $375, now costs the patient or the IHS about $3,000 to $5,000. Keep in mind that there is a national shortage of experienced audiologists and few that would choose to work in a rural and remote setting.

The otolaryngologist/plastic surgeon had worked as a part-time contractor for over 12 years in Browning. In May of 2013, he was given a 2 week notice (by BAO) and notified that his position was being terminated to save money. Keep in mind this was a double boarded certified surgeon in Otolaryngology and Plastic Surgery that chose to work in a rural and remote setting. He saw many patients in the ENT Clinic and did many outpatient and overnight stay surgeries at the local hospital. He is one of the best surgeons in not only the state of Montana but probably the entire northwest. He was loved and respected by so many of his Native American patients. Keep in mind how difficult is to recruit and maintain such quality surgeons who are willing to serve in rural and remote settings.

It is my understanding that my supervisor (clinical director) and hospital CEO and AD have supported and have lobbied for nearly a year for funding and the ability to fill vacant positions in the ENT/AUD Clinic. However, to this date the ENT/AUD Clinic has no audiologist, no otolaryngologist/plastic surgeon, and just a nurse practitioner (me) that volunteer one day each week. It is my understanding that providers in the ENT/AUD Clinic while provided necessary specialized services, they generated revenue for the hospital. Patients that are now being seen in the emergency room (ER) could be seen in a much more cost effective manner if seen in the ENT Clinic. Patients that have been totally satisfied with their services and providers at the ENT/AUD Clinic for so many years, now have little if any choice to receive these specialized and important services in their community. Could you please look into these concerns? If you would like additional information, please feel free to contact me (406-873-9157). Thank you for your assistance.

Respectfully,

Keith McDivitt, ENT Nurse Practitioner

To: Hana Waring Sorrell, Area Director
Billings Area Indian Health Services
2900 4th Avenue North
Billings, MT 59101

November 11, 2014

From: Laurie Bauman, MA
Audiologist/Speech-Language Pathologist
PO Box 1658
Red Lodge MT 59068

Dear Ms. Waring Sorrell,

I am an audiologist contracted through the Browning Public Schools and have worked closely with the ENT and audiology staff at the Blackfeet Community Hospital since 1980. I am writing to you with concerns regarding the loss of ENT and audiological services at the Blackfeet Hospital four months ago. There are currently no ear, nose or throat evaluations, medical or surgical treatments for ear, nose or throat problems through the ENT clinic, hearing evaluations, hearing aid evaluations, hearing aid fittings or repair of hearing aids.

The Blackfeet Hospital ENT/Audiology program has been available to the Blackfeet people for at least 33 years. There are currently over 2000 people in the Browning area with hearing loss not being served at this time due to the loss of the ENT/Audiology services.

The ENT nurse practitioner, Kerry McDivitt, has provided consistent, quality services to the Browning area patients for at least the past 27 years. The audiologist, Debra Sykes, has developed a rapport with the patients over the past 33 years, providing excellent service. These two professionals have developed trusting relationships with the patients at the Blackfeet Hospital. Because of the budget cuts to this program, Dr. Simone Sahim's services none also eliminated. He is an outstanding surgeon who has provided surgery to patients with cleft palate, cleft lip and facial anomalies, as well as other types of surgeries to restore hearing and function of the nose and throat to these patients.

All of these professionals want to be working at the Blackfeet Community Hospital, serving the Blackfeet people. The high quality, specialized equipment such as the ear otoscope, and audiological measurement equipment are only sitting in the ENT clinic. Kerry McDivitt is volunteering her time and expertise about once a week to serve the most at-risk patients. The school nurses and I met with Kerry last week to try to work in a few of the children with the most severe issues into his schedule. There are children who have otitis media, children who are in need of tympanoplasties to repair perforations of their eardrums, and children who need pressure equalization tubes. These issues are causing them to suffer from hearing loss and there are no audiological services available in Browning to treat their hearing loss.

I have one child who is in need of hearing aids in a 1st grade classroom. She has had to travel to Great Falls, which incurs the cost and time of travel for several visits. She is not eligible for Medicaid and her mother is unable to pay for the aids herself. The expense of hearing aids purchased privately is much higher than the price for which IHS is able to purchase the aids. The child is currently without hearing aids in the school while her mother is jumping through hoops to try to get funding for the aids.

I am working with other children in the Browning schools who have audiological needs. It is at least a two hour drive in good weather to the nearest clinic for a hearing aid evaluation. How are these appointments funded?
A kindergarten student is in need of a hearing evaluation. Two students have needs regarding their hearing aids that were provided by IHS. One hearing aid was in need of repair, one was lost, and Debra Sykes was been kind enough to volunteer time with me helping to get these aids repaired and replaced. When a new hearing aid is needed, I do not know how IHS is handling the purchase. If they are paying for private purchase of aids, it will cost significantly more than if it was done through IHS.

I am not clear on what the current Blackfeet Community Hospital protocol is for adult patients with hearing aids or in need of hearing aids, but I am sure that there are many patients out there right now without hearing aids or hearing aids in need of repair that are unable to get these services due to travel issues and funding for the services.

I hope that you can find a way to provide at least some ENT and audiology services to the patients of the Blackfeet Community Hospital. Even if it is part-time, the people will benefit from the essential services for hearing, ear, nose and throat problems.

Sincerely,

Laurie Bauman

Anna Whiting Sorrell, Billings Area Director
Indian Health Service
2900 4th Avenue North
Billings, MT 59101

21 November 2013

Dear Ms. Sorrell,

I am concerned about the lack of services for people with hearing loss on the Blackfeet Reservation. Over the past several months, I have been contacted by a number of patients and professionals about the elimination of my contract to provide hearing related services at the Audiology Clinic since June 1, 2013.

I have been told that there are still no services at the Blackfeet Community Hospital (BCH) to evaluate pediatric or adult hearing either routinely or for follow-up of those previously identified as hearing-impaired. Thus, leaving Blackfeet children and adults with significant hearing loss to either go without hearing aids or have inadequate amplification for their hearing loss. And, Headstart screenings and required physical exams for fire fighters and state and federal employees are no longer being provided by BCH.

There are over 2500 Blackfeet people with hearing loss that live, work and/or go to school on the Blackfeet Reservation. Most children and adults with hearing loss tend to withdraw from family, friends and community when they are unable to hear. It is no wonder that people are contacting me more now, as we go into the holidays. Most people with hearing loss suffer great anxiety from being unable to hear and communicate comfortably at family gatherings.

Keith McDivitt, ENT NP, tells me that some local providers are referring those with the greatest need through Contract Health Services (CHS) at retail prices to Great Falls and Kalispell, This requires significant time, travel and expense for the patient and substantial expense to the Blackfeet Service Unit and provides only limited service to a few.

When I was providing these services through a contract, I was not only able to provide more service to greater numbers of patients at less cost per patient than CHS, but I was also able to purchase hearing aids and batteries at wholesale prices through the Indian Health Service. As a result, the Blackfeet Service Unit was able to purchase more service/hearing aids for every dollar spent and subsidize the expense of my contract through third party reimbursement for eligible services and hearing aids.

Reinstating the Audiology Department and providing services on site at the Blackfeet Service Unit will not only be more cost effective but will also serve more members of the Blackfeet Nation than is possible through the current process of CHS referrals. I hope you will reconsider the option of providing audiology services at the Blackfeet Service Unit.

Sincerely,

Debra Sykes
Audiologist

PREPARED STATEMENT OF NICHOLAS WOLTER, M.D., CEO, BILLINGS CLINIC

Dear Senator Tester:

Thank you for your interest in and commitment to health care for the American Indian/Alaska Native (AI/AN) population, and your support of the permanent authorization of the Indian Health Care Improvement Act (IHCIA) within the Patient Protection and Affordable Care Act (ACA). Billings Clinic was in attendance at the May 27, 2014 Senate Indian Affairs Committee Field Hearing on "Indian Health Service: Ensuring the IHS is Living Up to Its Trust Responsibility" in Billings, and wanted to add the perspective of a private, not for profit health care organization that is also impacted by the issues related to the Indian Health Service (IHS).

Billings Clinic is an integrated health care organization, consisting of a multi-specialty physician group practice and hospital providing medical services to the AI/AN population. Until recently we operated under a now expired contract with IHS Contract Health Services ("CHS") (recently renamed "Purchased/Referred Care"). We have been unable to come to a new agreement with Billings Area IHS because IHS

is unable to commit to obligations in the agreement such as prospective approval and funding of services, timely issuance of purchase orders to pay for services, and specific business processes to create efficiencies and reduce administrative burdens, and other performance timelines.

Billings Clinic agrees with and is also impacted by many of the issues reported by the speakers at the Hearing; including poor access to quality medical care (especially preventive care and screenings) for the AI/AN population, chronic under-funding of IHS, poor business processes within IHS, and non-payment for services by IHS.

From the clinical perspective, we are aware of the health disparities of the AI/AN population compared to non-AI/AN populations. The medical services available at tribal clinics, hospitals and urban clinics through IHS are limited in scope for a variety of reasons, necessitating referrals for care to specialists outside the IHS care system via CHS. However, the Billings Area IHS has been generally operating under a Medical Priority Level 1 (also known as "Life or Limb"), meaning that only life threatening, acute injury or obstetrical/neonatal care is able to be funded by IHS. Preventive care and screenings, treatment of chronic diseases such as diabetes and hypertension, and behavioral health care are not able to be routinely provided to the population due to the restricted funding level. Lack of access to timely and appropriate health care services results in poorer health status and greater health risk, causing more serious and costly care once the condition becomes life threatening. We encourage IHS to pursue new models of care, such as Patient Centered Medical Homes or Accountable Care Organizations, to focus on primary, preventive, chronic, and behavioral health care services, as opposed to the current model that generally provides funding only for catastrophic care. Partnerships between IHS providers and private providers should be forged, to reduce duplication of available specialty services and coordinate the delivery of optimal care to the AI/AN population.

From a financial perspective, we are aware of the chronic under-funding within the IHS system. The funding challenges not only create issues with the medical priorities mentioned above, but also result in non-payment for health care services that have been delivered by non-IHS providers like Billings Clinic. Currently Billings Clinic has over $7.4 million in unpaid claims for IHS patients. Of that, approximately $2.8 million is now the responsibility of the patients due to denial of payment or no payment from IHS. For calendar year 2013 dates of service, we had an additional $4.5 million that was the responsibility of the patients that went to collections due to non-payment by IHS. We recommend IHS funding be increased to a higher percentage of the known need, and move to multi-year funding to allow stability for operation of health care programs and payments for delivered services. Also, funding should be utilized primarily for the funding and payment for the provision of health care services, rather than for overhead and administrative expenses. IHS should be held to the same Medical Loss Ratio standards as other organizations funding the cost of health care.

The CHS program is a medical priority system, necessitating that services be reviewed, approved and funded prior to services being rendered. Separate from the clinical and medical priority concerns related to CHS already mentioned, the business processes necessary to administer the approval and payment of CHS services is unusual and complex, resulting in inconsistent and inefficient manual processes among Service Units and providers, and duplication of processes with the out-of-state Fiscal Intermediary that administers funded claims. In our experience, the Billings Area IHS does not operate CHS prospectively as it was designed; resulting instead in a lengthy retrospective process of untimely payment or non-payment for delivered services, due to poor business processes. Because referred services are not able to be pre-approved and pre-funded as the CHS process is designed, payment denials and payment delays are common. Payment delays are not financially sustainable for private providers to absorb, which may result in more providers refusing to provide care under CHS, if there is no reasonable guarantee of payment. Ultimately, denied and unpaid amounts become the financial responsibility of the AI/AN patient, further burdening the population with millions of dollars in unpaid medical expense debt. We propose that business processes for CHS be standardized across IHS, and business administration systems and personnel be consolidated where possible. Also technology should be used to allow providers to proactively identify eligibility for AI/AN members, and to receive pre-approval and pre-funding for necessary services. Funding decisions must be made by IHS prospectively (except in the case of emergencies), to allow informed decisions by AI/AN patients related to the expected cost of their care, to expedite needed care and payment for that care under the CHS program. Please refer to the attached copy of the CHS Authorization

Process.* This process is not followed by Billings Area IHS, and instead services are routinely delivered before authorization and purchase orders are issued. The designed process must be followed by IHS, and agreed to by IHS in the CHS contract.

There are several provisions in the ACA, IHCIA and previous Federal legislation of benefit to AI/AN health care that should be optimized by IHS, Tribes and members. These provisions include 100 percent coverage of preventive services and certain screenings for adults with certain conditions, coverage of ten essential health benefits, elimination of pre-existing conditions, and elimination of annual and lifetime limits via coverage through plans offered on Health Insurance Marketplace ("HIM"). For the qualifying AI/AN, the HIM provides Federal subsidies up to 400 percent of the Federal Poverty Level, elimination of cost-sharing (deductibles and coinsurance) up to 300 percent of the Federal Poverty Level, and the ability to enroll or disenroll once per month. Tribes are allowed to fund premium payments for members to obtain insurance coverage. The IHCIA allows for third party billing and collections, reimbursement from Medicare, Medicaid and the Children's Health Insurance Program (CHIP), as well as reimbursement from other Federal Programs including Veterans Administration (VA) and the Department of Defense. We encourage IHS and the Tribes to increase efforts to educate members about the ACA, and maximize enrollment in alternate coverage including the HIM. This would allow for essential health benefits, preventive and screening services, treatment of chronic diseases and behavioral health care needs to be paid through alternate resources; improving health and preserving IHS funds. Tribes should consider funding premium payments for members to obtain such coverage. Tribes should also maximize all third party billing and collections for those alternatively covered members, to optimize revenue and preserve IHS funds.

The expansion of Medicaid, under ACA, is another opportunity to optimize coverage for the Indian population, as well as maximize reimbursements to IHS via third party billing and collections. Unfortunately, Montana and Wyoming have not yet chosen to expand Medicaid. Billings Clinic strongly supports the expansion of Medicaid, and specifically I–170—The Healthy Montana Initiative. We recommend Tribes and members support and be strong advocates for the expansion of Medicaid in the states of Montana and Wyoming.

We were struck and duly impressed by the testimony of the Honorable Carole Lankford, Vice Chair Tribal Council, Confederated Salish and Kootenai Tribes of the Flathead Nation (CSKT). Our understanding is that CSKT is operating under a "self governance compact" with IHS (through the Tribal Self-Governance Program "TSGP"), meaning they are able to assume funding and responsibility over their own programs that IHS would otherwise provide. This allows CSKT to control and manage funds to best serve the needs of their own Tribal community. Although Ms. Lankford acknowledged that IHS is underfunded, the flexibility gained through the TSGP has allowed CSKT to build quality health care through tribally operated clinics, increased revenue through third party billing and collections, and to leverage all resources available to provide education and enroll the Tribal members in coverage programs including Medicare, Medicaid, CHIP, VA and private insurance coverage through the HIM. This alternate resource coverage not only leverages Federal dollars, but also allows for coverage of preventive and screening services, along with other essential health benefits, not currently routinely available to the AI/AN population through IHS. We understand that the TSGP also provides the opportunity for Tribes to have carry over funding, be eligible for Grant funding, and receive a Medicaid administrative match. CSKT will be hosting a summit this summer to bring together all AI/AN health stakeholders, and is willing to be a pilot program for other Montana and Wyoming Tribes to model.

In summary, Billings Clinic proposes that the following recommendations be considered.

- Pursue new models of care, with a focus on prevention and chronic disease and behavioral health management
- Partner with non-IHS specialty providers to reduce duplication of services and improve coordination of care
- Increase funding to the IHS to a higher percentage of the known need, and move to multi-year funding. Implement appropriate ratios of total funding for administrative costs vs. medical costs
- Standardize and modernize business processes—reduce duplication and inefficiency
- Operate CHS prospectively as designed

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*The information referred to has been retained in the Committee files.

- Increase education about ACA, maximize enrollment in alternate resources, fund premium payments for purchasing coverage on the HIM, and maximize third party billing and collections
- Support and advocate for the expansion of Medicaid in Montana and Wyoming
- Consider participation in the Tribal Self-Governance Program to enable maximum flexibility for Tribes, allowing the above recommendations to be implemented more quickly

Billings Clinic is pleased that there is increased attention to the issues related to IHS and health care for the American Indian/Alaska Native (AI/AN) population. Through partnership with Federal, State and Tribal governments, private insurance carriers, IHS, and the Billings Area IHS, we hope that meaningful solutions can be developed to create health improvements for the AI/AN population at a reasonable cost.

Several Indian Health Service complaint letters have been retained in the Committee files.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO HON. YVETTE ROUBIDEAUX

Question 1. How will fully funding Contract Support Services costs affect your efforts to fully recruit and retain healthcare providers in IHS, especially in the underserved areas and professions?

Answer. Within a limited discretionary appropriation, fully funding contract support costs (CSC) requires a delicate balance among competing Agency priorities, such as recruitment and retention of health care providers. If the appropriation does not include sufficient additional funds for CSC need, there could be a negative impact on recruitment and retention as well as other health care programs, because the IHS would be required to reallocate funds from other Services budget line items in order to fully fund CSC.

Question 2. How does working with USAJOBS.gov affect the process of recruitment and retention?

Answer. The use of USAJOBS.gov is one important component in the federal hiring process. Indian Health Service (IHS) also uses other valuable tools such as national and local advertising, marketing, recruitment materials, booths at national and local conferences, school visits, virtual career fairs, and personal contacts with potential health professionals and support staff to direct potential recruits to the IHSjobs.gov website and then onto USAJOBS.gov.

The impact of USAJOBS.gov on the process of recruitment and retention can be dependent on the type of job announcement, the experience of the user submitting an application using USAJOBS.gov, and the support provided to the applicant. IHS has recognized some common issues that may impact an applicant's experience with USAJOBS and is working to ensure that human resource professionals and health professions recruiters are available to assist applicants. IHS will be requesting assistance from the USAJOBS Program office touse the USAJOBS.gov "spotlight" feature to highlight IHS mission critical job(s) to all job seekers.

In 2013, IHS updated all the vacancy announcement templates to ensure essential job information and applicant procedures were clear and easy to understand when viewing in USAJOBS. IHS also partnered with the Office of Personnel Management and used their assessment review services to help strengthen IHS' library of high-quality assessment questionnaires for select mission critical positions. In addition, the IHS recruitment team and HR Office review surveys from our applicants and determine what other process improvements can be made.

The USAJOBS.gov does have several highly helpful features including the Resume Builder and notification when similar jobs are advertised. IHS will continue to work to assist applicants as they use USAJOBS. IHS works closely with HHS and will continue to report any problems or applicant issues with USAJOBS to them.

Question 3. We have heard stories about delays of several months—discouraging experienced applicants from waiting for a reply and choosing to go elsewhere. What has your experience been?

Answer. Delays in the hiring process can have a great impact on recruitment, especially for health professionals that are in great demand. IHS is competing with the private sector which can offer a position within a few days of receiving an application. IHS hires individuals through the federal hiring process and has been working to reduce hiring times through a variety of improvements.

The hiring process has feedback to the applicant built into the process. When an applicant submits their resume and supporting documentation (if required) into USAJOBS via the USA Staffing Applicant Manager System, applicants receive an automatic notification that their application has been received. Once the vacancy announcement closes, applicants are screened by Human Resources for eligibility, minimum qualifications, preference (if applicable), and verification of assessment questionnaire. Once the screening process is complete, applicants receive an automatic notification of results on their eligibility and qualification status, and if their application is amongst the highest qualified for referral to the hiring official(s) for further consideration. Upon selection by the hiring official, all applicants will receive an automatic notification on the disposition of their application (e.g., selection, non-selection, etc.). While delays can also occur during the interview and decision-making process, IHS hiring officials are encouraged to make selections as soon as possible.

In some cases, key leadership positions involve tribal participation in the interview process, which may result in additional time to schedule interviews among participants. Including local Tribal representatives in the interview process is very helpful for recruitment efforts since it gives them a chance to meet applicants during interviews and to showcase positive aspects of living in the local community.

While some applicants experience problems with USAJOBS, OPM has developed YouTube videos to assist applicants in understanding the application process. USAJOBS is one part of the hiring process, and as mentioned above, IHS will continue to work with OPM to maximize its effective use in the recruitment and hiring process.

IHS will continue to develop strategies to reduce hiring times and to assist candidates throughout the hiring process.

Question 4. What obligation does IHS have to monitor compliance with a Buy-Indian contractor to assure compliance with regulations that prohibit a Buy-Indian contractor from subcontracting more than 50 percent of the work on a Buy-Indian contract to a non-Indian firm?

Answer. IHS has the same obligation as we do with other small business related requirements. For example, in regard to small business set-asides, FAR Clause 52.219–14 (Limitations on Subcontracting) states that by submission of an offer and execution of a contract, the Offeror/Contractor agrees that in performance of the contract in the case of a contract for—

(1) Services (except construction). At least 50 percent of the cost of contract performance incurred for personnel shall be expended for employees of the concern.

(2) Supplies (other than procurement from a non-manufacturer of such supplies). The concern shall perform work for at least 50 percent of the cost of manufacturing the supplies, not including the cost of materials.

(3) General construction. The concern will perform at least 15 percent of the cost of the contract, not including the cost of materials, with its own employees.

(4) Construction by special trade contractors. The concern will perform at least 25 percent of the cost of the contract, not including the cost of materials, with its own employees.

Question 5. What systems and processes does IHS have in place for oversight throughout the contract?

Answer. One of our primary contract administration responsibilities is to ensure both contracting parties comply with all terms and conditions of the contract and daily oversight is provided by a certified Contracting Officer's Representative (COR). For construction projects specifically, monthly progress meetings, daily reports, certified payrolls and labor standard interviews are conducted, all which allow the Contracting Officer (CO) and Program Manager (PM) to ensure who is performing work. The contractor may submit periodic reports which illustrate compliance with the subcontracting plan, submission of Individual Subcontracting Report (ISR), and Summary Subcontract Report (SSR) and subcontractors' electronic submission of ISRs and SSRs.

Question 6. What have you concluded about contractor compliance with this regulation regarding the Buy-Indian contract for air ambulance services in the Phoenix Area?

Answer. The contractor is in compliance with the Buy Indian Act regulations regarding subcontracting. When the prime contractor utilizes subcontractors, they include responsible Indian economic enterprises capable of performing. Prior to award, the Small Business Subcontracting Plan was reviewed and approved. The plan reflects a goal of 5 percent for Small Disadvantage Business (including 8(a) program participants, Alaska Native Corporation (ANC) and Indian Tribes (hereafter re-

ferred to as SDB)). The contractor will subcontract at least 2 percent of the 5 percent total to Indian owned Businesses. The contractor subcontracts with other Indian owned businesses that are able to provide air ambulance transport, when needed and based upon geographical area and availability of fixed wing and/or helicopter. The contractor utilizes resources such as Dynamic Small Business Search and services provided by PRO-net to gather information on current and active small disadvantaged businesses, including Indian owned businesses.

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