

DEPARTMENT OF THE INTERIOR, ENVIRONMENT, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2016

WEDNESDAY, MARCH 11, 2015

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:07 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Lisa Murkowski (chairwoman) presiding.

Present: Senators Murkowski, Cochran, Daines, Cassidy, Udall, and Tester.

DEPARTMENT OF THE INTERIOR

INDIAN HEALTH SERVICE

STATEMENT OF DR. YVETTE ROUBIDEAUX, SENIOR ADVISOR TO THE SECRETARY FOR AMERICAN INDIANS AND ALASKA NATIVES

OPENING STATEMENT OF SENATOR LISA MURKOWSKI

Senator MURKOWSKI. I will call to order the meeting of the Interior Appropriations Subcommittee. Welcome to Dr. Roubideaux. We understand that Mr. McSwain will be joining us shortly, but he along with apparently many in Washington, DC, this morning have been delayed due to traffic issues. So when he comes in, we are not going to count this as a tardy. We know he is making good efforts to be here. Appreciate members of the subcommittee joining us for our second hearing of the Interior Appropriations Subcommittee for fiscal year 2016.

Today we are going to examine the budget request for the Indian Health Service (IHS). I want to thank Dr. Roubideaux, our senior advisor to the Secretary for American Indians and Alaska Natives, and then Mr. McSwain, the acting director of IHS, for appearing before us today.

Briefly, just a reminder in terms of how we proceed here in the subcommittee, it is early bird rule for recognizing members for questions. I am going to call on members in the order in which they have arrived, and we will do 6-minute rounds. I see that Mr. McSwain has arrived. We are glad that you are here safely. And as I mentioned, there is no—you do not have to get a tardy excuse to show up here. We appreciate the efforts that you made, and hopefully you will have a minute here to just settle before we move to statements and questions.

As I noted in my opening statement last week in this subcommittee, we have not marked up an interior bill in 5 years. And likewise, it has been over 5 years since we have done a hearing on the IHS budget, so this hearing is long overdue. With over half of the federally-recognized tribes in Alaska and all healthcare delivered by tribal organizations through compacting agreements, it is impossible for me to overstate the significance of the Indian Health Service to the people of my State. And I know that Senator Udall also shares my view of the importance of this Agency, so I look forward to us exercising more oversight over IHS while we serve as chairman and ranking member of this subcommittee.

Now, turning to the budget request for the Service, it is \$5.1 billion for the programs within this subcommittee's jurisdiction. This is an increase of \$461 million, which is 10 percent over last year's enacted level. There are some very worthy increases in this budget that I certainly support. I support the increase of \$55 million more to fully pay contract support costs, and \$100 million more to address the \$2 billion backlog on the current Healthcare Facilities Construction List. I also support the additional \$25 million request to provide for suicide prevention and combatting substance abuse among our native youth.

But as I have said at all the budget hearings that I have chaired, whether in this subcommittee or on the Energy Committee, the administration developed these budgets assuming that sequester would go away in fiscal year 2016. I do not think that this is an assumption that we can make. Even if there is some agreement related to the sequester, we cannot assume the agreement will provide the amount of resources that the President has requested governmentwide.

Regardless of whether there is an overall agreement related to the sequester, I am committed to working with the Budget Committee to provide sequester relief for the IHS in the same fashion as the relief that is provided to the Veterans Administration (VA). I believe that all Federal healthcare providers should be placed on equal footing, particularly when the VA and the IHS work cooperatively to provide services to both veterans and Native Americans at their respective facilities.

So while I appreciate the desire to increase funding to meet our obligations to native people, the reality is that in this difficult budget climate, we are likely to have roughly the same amount to spend as we did last year. And because that is the case, it is vital that we work closely with the Service in establishing priorities within this tight environment.

I do want to raise a proposal in your budget that concerns contract support costs. You are aware how critical funding of these costs is to Alaska healthcare providers as they have compacted to provide all healthcare services for Alaska Natives. In fiscal year 2014, the administration proposed capping the amounts available for tribes for contract support costs. I believe that proposal was an effort to circumvent the tribes' victory in the *Ramah* case decided by the Supreme Court. And thankfully my colleagues on both sides of the aisle and in the House and Senate determined that this was not the right approach. We rejected that proposal.

In the Service's current budget proposal, the administration has announced it will not only pay full contract support costs for the current fiscal year at a cost of \$718 million, but also that beginning in fiscal year 2017, contract support costs would become mandatory spending for 3 years. Now, frequently this administration has made general statements about providing mandatory funding for certain programs, but after making the statements, it fails to send up a legislative proposal. When it comes to this particular issue, your budget request does not have any specific legislative language. When we get to the questions that is something I want to explore in greater detail.

As an appropriator, I am generally not a supporter of moving programs to the mandatory side of the ledger where they do not have to compete with other priorities each year. However, the Supreme Court in the *Ramah* case essentially made contract support costs an entitlement. And as appropriators, we have no discretion over what amounts to include in this bill because the Congressional Budget Office (CBO) scores are billed based on whatever Agency says are full support costs. So given the circumstances, I think that exploring mandatory funding and figuring out a way to responsibly pay for it is entirely appropriate.

So, again, I thank our witnesses for being here. I turn to Ranking Member Udall for any comments that he may make.

STATEMENT OF SENATOR TOM UDALL

Senator UDALL. Good morning, and let me—I first want to welcome Dr. Roubideaux and Acting Director McSwain, and thank you for joining us today. And we really appreciate you coming to discuss the fiscal year 2016 budget request for the Indian Health Service.

And I would also like to thank Chairman Murkowski for convening this important hearing. It has been many years since this subcommittee has held a hearing on the Indian Health Service budget, and I want to acknowledge her leadership in elevating this conversation. Healthcare for American Indians and Alaska Natives is an important issue, and I thank you for giving it the attention it deserves. And just like she said, it is a burning issue in New Mexico, and it is also one, as she has expressed, in Alaska, and it certainly deserves our attention.

Access to quality healthcare is incredibly important for the 22 tribes and pueblos in my State, but there is more to it than that. Throughout the Nation's history, the United States has made a solemn commitment to provide healthcare through the treaties and agreements negotiated with the tribes. We have to honor that commitment. Support for the budget of the Indian Health Service helps ensure that we do that.

Congress has stepped up and provided significant increases for tribal health programs over the past several years, but we clearly have a lot of work to do, and we will do more. The President's budget for the Indian Health Service includes a 10 percent increase for health services and facilities needs, and I am pleased to see that. Dr. Roubideaux, I want to commend the administration for fully funding contract support costs, which I know Chairman Murkowski also mentioned, and I look forward to discussing your pro-

posal to authorize mandatory funding for the program starting in 2017.

The budget request also proposes an increase of \$70 million for purchased and referred care. These funds ensure that tribes can access healthcare outside of the Indian Health Service, including preventive and specialty care. The request also includes new substance abuse and behavioral health investments for Native youth, which I look forward to discussing. And finally, it includes large increases for healthcare construction and maintenance programs. These funds are critically needed to repair aging hospitals and health clinics like those we have in my home State of New Mexico.

This is a good budget request, but it is worth noting that it is only a downpayment on the needs in Indian country. Tribal health spending per patient continues to lag behind the national average for health spending. The average medical spending per IHS patient, according to the Indian Health Service, was just \$3,100 in 2014. That is less than half the average amount spent per patient for health services on a national basis, according to the Centers for Medicare and Medicaid Services. These funding limitations are a major factor in health disparities faced by our Native population, including higher rates of diabetes, suicide, and preventable illnesses.

We need to close this gap, and we need to close it now. That is why I look forward to hearing more about the details of how your budget can improve health outcomes. And health outcomes, I think we really need to be discussing more and more because that is what we want to see, Dr. Roubideaux. I appreciate you and Mr. McSwain appearing before us today, and thank Chairman Murkowski for working so hard on this issue.

Senator MURKOWSKI. Thank you, Senator Udall. I would now like to turn to Chairman Cochran. I understand that you have other committee obligations this morning, and you might like to make a quick opening statement before you depart the subcommittee.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Madam Chair, thank you very much. I am glad to be able to join you in welcoming our distinguished panel of witnesses this morning. Our friend who is the ranking member of the subcommittee, I think you have done an excellent job in outlining the issues that we need to be aware of and making a commitment that we do what is necessary to ensure that we continue to make available healthcare, and healthcare services, and related assets to be sure that the Indian Health Service is able to carry out its responsibilities.

Our State, as some may know, is home to the Mississippi Band of Choctaw Indians. This week coincidentally marked an important milestone in our State as the Indian Health Service moved into their new health center in Mississippi. I am happy to join you in commending all of those responsible for the good work, and to thank the subcommittee for its support in this effort.

I am hopeful we can continue to work together to ensure that the healthcare needs of Choctaws and others are enjoyed and benefited as we intend. Thank you very much.

Senator MURKOWSKI. Thank you, Senator Cochran. And with that, I would like to turn to Dr. Roubideaux this morning for your opening comments, and welcome.

SUMMARY STATEMENT OF DR. YVETTE ROUBIDEAUX

Dr. ROUBIDEAUX. Thank you, Chairman Murkowski and members of the subcommittee. I am Dr. Yvette Roubideaux, the senior advisor to the Secretary for American Indians and Alaska Natives, and with me today is Mr. Robert McSwain, who is the acting director of the Indian Health Service. I am pleased to provide testimony on the President's fiscal year 2016 budget for the Indian Health Service.

Well, since 2008, Indian Health Service appropriations have increased 39 percent, and thanks in part to your subcommittee for that hard work in helping us achieve those investments because they are making a substantial difference and impact in the quality and quantity of healthcare provided to American Indians and Alaska Natives. The fiscal year 2016 President's budget proposes to continue that progress by increasing the IHS budget by \$460 million to a level of \$5.1 billion, which, if appropriated, would increase the IHS budget by 53 percent since 2008. So this budget continues the administration's commitment to improving healthcare for American Indians and Alaska Natives.

So the budget proposes increases totaling \$147 million to help address medical inflation, population growth, and pay costs to help maintain current services. The budget also addresses a top tribal priority by proposing an overall \$70 million increase in the Purchase and Referred Care Program, formerly known as Contract Health Service, which will help us fund more referrals for patients and result in more programs funding more than priority one life or limb services. And the recent increases in PRC have also enabled the Catastrophic Health Emergency Fund, or CHEF Fund, to reimburse high cost cases submitted through mid-September rather than only through June as in the past.

The budget proposes an additional \$25 million for the IHS to expand its successful methamphetamine and suicide prevention initiative to increase the number of child and adolescent behavioral health professionals, who will provide direct services and implement youth-based programming as a part of the President's Generation Indigenous Initiative.

The budget also includes other increases focused on improving access to affordable healthcare, including improving third party collections, and helping IHS continue to achieve meaningful use of its electronic health record. The budget proposes to reauthorize the successful Special Diabetes Program for Indians, or SDPI, for another 3 years at the current \$150 million funding level to continue progress on preventing and treating diabetes in American Indians and Alaska Natives.

The budget includes significant investments in IHS facilities, including increases for maintenance and improvement, sanitation facilities construction, and healthcare facilities construction, which will help us make significant progress on the IHS healthcare facilities construction priority list. The budget proposes \$18 million to

fund additional staffing for three newly constructed facilities that are opening just prior to or in fiscal year 2016.

A top priority of IHS is to strengthen the partnership with tribes, and I truly believe that the only way we are going to improve the health of these communities is to work in partnership with them. This includes honoring and supporting tribal self-determination and self-governance. That is why I am so pleased to inform you that the fiscal year 2016 President's budget includes a two-part long-term approach to funding contract support costs, which is the result of our tribal consultation that was requested last year on a long-term solution for contract support costs appropriations.

The first part of the approach is full funding of contract support costs that estimate a need in fiscal year 2016 for which the budget requests an increase of \$55 million. The second part of this approach is a proposal to reclassify contract support costs as mandatory rather than discretionary, starting in fiscal year 2017 after tribal consultation and to allow time for Congress to work on this issue with us. The proposal is consistent with the top recommendation from tribes to fully fund contract support costs (CSC), but to do it separately from the Service budget.

IHS also worked in partnership with tribes to improve estimates of CSC need and the Agency's business practices related to contract support cost funding. The proposal to reclassify contract support costs as a mandatory appropriation helps us continue progress on this issue, and we look forward to working with you on the proposed approach. IHS has also made progress on past contract support cost claims with offers extended on 1,232 claims and settlements on 889 claims for a total value of \$699 million.

So in summary, the fiscal year 2016 President's budget helps IHS continue progress in improving access to quality healthcare, changing and improving the Indian Health Service, and strengthens our partnership with tribes. I appreciate all of your efforts to help us ensure a healthier future for American Indians and Alaska Natives. So thank you, and we are happy to answer questions.

[The statement follows:]

PREPARED STATEMENT OF DR. YVETTE ROUBIDEAUX

Chairman Murkowski and members of the subcommittee:

Good morning, I am Dr. Yvette Roubideaux, Senior Advisor to the Secretary for American Indians and Alaska Natives. Accompanying me is Mr. Robert G. McSwain, Acting Director of the Indian Health Service (IHS). I am pleased to provide testimony on the President's proposed fiscal year 2016 budget for the IHS and to describe our accomplishments that show the budgets enacted in recent years have made a difference in helping us address our agency mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level.

The IHS is an agency within the Department of Health and Human Services (HHS) that provides a comprehensive health service delivery system for approximately 2.2 million AI/ANs from 566 federally recognized tribes in 35 States. The IHS system consists of 12 area offices, which are further divided into 170 Service Units that provide care at the local level. Health services are provided directly by the IHS, through tribally contracted and operated health programs, through services purchased from private providers, and through urban Indian health programs.

As an agency we are committed to ensuring a healthier future for all AI/AN people, and the IHS budget is critical to our progress in accomplishing this. Since 2008, IHS appropriations have increased by 39 percent, thanks in part to your subcommittee, and these investments are making a substantial impact in the quantity and quality of healthcare we are able to provide to AI/ANs. The fiscal year 2016

President's budget proposes to increase the IHS budget to \$5.1 billion, which will add \$460 million to the fiscal year 2015 enacted funding level, and if appropriated, will increase the IHS budget by 53 percent since fiscal year 2008.

The funding increases proposed in the President's budget are part of an "all of government" approach to addressing tribal needs, with a particular focus on AI/AN youth. For the IHS, the increases will help us improve the quality of and access to care for the patients we serve by expanding access to priority healthcare services that our patients need, which will result in better quality and health outcomes.

The fiscal year 2016 President's budget proposes current services increases totaling \$147 million, which are critical to maintain the base budgets of our IHS and tribal hospitals and clinics, help address medical inflation, population growth and pay costs, and ensure continued support of services that are vital to improving health outcomes.

The fiscal year 2016 President's budget also addresses a top tribal priority by proposing an overall \$70 million increase to the Purchased/Referred Care (PRC) budget, formerly known as Contract Health Services. This increase includes \$43.6 million in medical inflation, \$1.2 million in additional staffing for new facilities and a \$25 million program increase. PRC funding has increased almost every year since 2008 (58 percent overall), which has allowed some of the IHS and tribally managed PRC programs to approve referrals in priority categories other than Medical Priority I—Emergent or Acutely Urgent Care Services (life or limb), including some preventive care services, thus increasing access to patient care services. In 2009, only four IHS-operated PRC programs were able to fund referrals that met PRC Medical Priority I. In fiscal year 2013, 23 IHS-operated PRC programs were able to purchase services beyond Medical Priority I. This number increased to 41 of 69 IHS-operated PRC programs with the PRC increase in fiscal year 2014. The recent increases in PRC have also enabled the Catastrophic Health Emergency Fund (CHEF) to reimburse high cost cases submitted through mid-September, rather than only through June as in the past.

The fiscal year 2016 President's budget proposes an additional \$25 million for the IHS to expand its successful Methamphetamine and Suicide Prevention Initiative (MSPI) to increase the number of child and adolescent behavioral health professionals who will provide direct services and implement youth based programming at IHS, tribal, and urban Indian health programs, school based health centers, or youth based programs. This funding will enable the hiring of more behavioral health providers specializing in child, adolescent, and family services, which will improve access to behavioral health prevention treatment services for AI/AN youth. This expansion of the MSPI is the central focus of the Tribal Behavioral Health Initiative for Native Youth, which is part of the President's comprehensive Generation Indigenous Initiative to remove barriers to success and to create opportunities for Native youth and reflects a collaborative effort between the IHS and the Substance Abuse and Mental Health Services Administration.

The IHS and tribes have made progress in improving behavioral health over the past few years with both the MSPI and the Domestic Violence Prevention Initiative (DVPI). The MSPI has funded 130 IHS, tribal, and urban community developed programs since 2009 that have provided over 500,000 evidence-based and practice-based youth encounters in the first 5 years of MSPI implementation. The successes of the MSPI highlight the effective use of strength-based interventions and protective factors, such as identification with Native culture, increased social connectedness, and discussing problems with friends or family, emotional health, and connectedness to family, consistent with the scientific literature on prevention of suicide and substance abuse among AI/AN youth. The increase in services is significant; the percent of individuals receiving depression screening in IHS and tribal facilities increased from 35 percent in fiscal year 2008 to 66 percent in fiscal year 2014.

The DVPI currently funds 57 projects focusing on prevention, intervention, and treatment of domestic and sexual violence. Together these services have resulted in 50,500 direct service encounters, more than 38,000 referrals, and the delivery of over 600 forensic evidence collection kits submitted to Federal, State, and tribal law enforcement. These are vital services. According to a 2014 Centers for Disease Control and Prevention report, American Indian women residing on Indian reservations suffer domestic and sexual violence at rates far exceeding women of other ethnicities and locations. Native women are over 2.5 times more likely to be raped or sexually assaulted compared to other women in the United States.

The fiscal year 2016 President's budget also includes other increase focused on improving access to affordable healthcare. With the Affordable Care Act's Health Insurance Marketplaces and the Medicaid expansion, IHS has the potential to increase revenues to support more services through third party reimbursements when it provides services to eligible American Indians and Alaska Natives with other

health insurance coverage. The fiscal year 2016 President's budget includes a \$10 million funding increase to improve third party billing and collections at IHS and tribally operated facilities. Having more patients who are Medicaid beneficiaries or have private insurance is one part of increasing revenues for our hospitals and clinics. Improving our business practices to ensure timely and accurate billing, monitoring of open receivables, and follow up on unpaid bills is another critical component on which IHS has made progress. In fiscal year 2014, IHS third party collections increased by \$49 million, mainly due to improvements in business practices and from increased third party reimbursements from patients with health coverage.

Another important component necessary to improving quality and ensuring better outcomes for our patients is an effective, state-of-the-art health information technology system that helps us measure outcomes and provide better patient care. That is why we continue to upgrade the capabilities of our IHS Resource and Patient Management System (RPMS), which includes IHS' Electronic Health Record (EHR). The fiscal year 2016 President's budget will help IHS to comply with the requirements for the 2015 EHR Certification and Stage 3 Meaningful Use (MU). Participation in MU is critical for the agency since it promotes activities to improve quality and penalties in Medicare payments will occur if IHS does not participate.

IHS has implemented several major upgrades related to the Meaningful Use (MU) initiative. The IHS was an early adopter of EHR technology and achieved certification for Stage 1 Meaningful Use, resulting in the IHS and tribal health systems receiving over \$120 million to date from the MU incentives. IHS recently received certification for the 2014 Certified EHR and is developing upgrades that will include the ability to achieve Meaningful Use Stage 2, which includes the ability to share records between facilities, have patients view their health records online, and even have patients send direct secure email to providers. IHS is also preparing to implement ICD-10 which can now proceed since IHS met the 2014 EHR Certification requirements. The IHS RPMS team is currently conducting testing of ICD-10 software upgrades with four sites and with external payers. We are on track to meet the ICD-10 implementation date of October 1, 2015 and plan to begin upgrading local RPMS systems in June.

Another successful program that is helping us improve the provision of quality healthcare is our Special Diabetes Program for Indians (SDPI). The fiscal year 2016 President's budget proposes to reauthorize the SDPI for another 3 years at the current \$150 million funding level to continue progress in preventing and treating diabetes in the AI/AN population. This program has shown that, in partnership with our communities, we can prevent and treat diabetes in Indian Country with innovative and culturally appropriate activities. The most recent SDPI data reflect improvements in diabetes care throughout our system. For example, the rate of increase in diabetes prevalence in adults is slowing and there is almost no increase in diabetes prevalence in youth. In addition, the most recent outcomes paper for the SDPI Diabetes Prevention Program (DPP) suggests that the DPP may reduce new cases of diabetes through lifestyle changes. Preventing diabetes, especially among Native youth, is important since it will help them avoid a lifetime of diabetes and related health problems.

Ensuring access to healthcare requires efficient and effective facilities and infrastructure, which contribute to improving public health and health outcomes. The fiscal year 2016 President's budget includes significant investments in IHS facilities, including increases for maintenance and improvement, sanitation facility construction, and healthcare facility construction. Since 2008 the IHS has maintained the facility condition of its healthcare facilities, provided sanitation facilities service to 159,990 Indian homes, funded 2 hospitals, 6 health centers, and 2 youth regional treatment centers, and participated with tribes in 12 joint venture projects. However, the backlog of essential maintenance, alteration, and repair is \$467 million as of the end of fiscal year 2014, over 34,500 AI/AN homes are without access to safe water or adequate wastewater disposal facility infrastructure and over 182,500 AI/AN homes that require upgrades and/or capital improvements to the existing sanitation facilities, and there remains \$2 billion of construction projects still to construct on the IHS Health Care Facilities Construction Priority List.

The fiscal year 2016 President's budget proposes an additional \$171 million for the Facilities appropriation to address these needs. Included is \$35 million to address the maintenance backlog and \$36 million to provide sanitation facilities to 7,700 more homes than estimated to be served in fiscal year 2015. In addition, the healthcare facilities construction budget is proposed to be increased by \$100 million for a total funding level of \$185 million, which will enable the IHS to complete construction of the Gila River Southeast Health Center, and begin construction on three other projects on the IHS Health Care Facility Construction Priority List including the Salt River Northeast Health Center in Arizona, the Rapid City Health

Center in South Dakota, and the Dilkon Alternative Rural Health Center in Arizona.

Additional staffing for newly constructed facilities is critical to achieving the planned increased access to healthcare. The fiscal year 2016 President's budget proposes to fund all three of the projects that are opening just prior to or in fiscal year 2016. The requested amount is \$18 million to complete the staffing packages for the Southern California Youth Regional Treatment Center and the Mississippi Band of Choctaw Indians' joint venture health center, and to begin funding of the staffing package for the Fort Yuma Health Center.

A top priority of the IHS is to strengthen our partnership with tribes. I truly believe that the only way that we are going to improve the health of our communities is to work in partnership with them. This includes honoring and supporting tribal self-determination and self-governance. That is why I am pleased to inform you that the fiscal year 2016 President's budget includes a two-part, long-term approach to funding Contract Support Costs (CSC), which is the result of our tribal consultation that you requested last year on a long-term solution for CSC appropriations. The first part of the approach is full funding of the estimated CSC need in fiscal year 2016, for which the budget requests an increase of \$55 million.

The second part of the approach is a proposal to reclassify CSC as mandatory, rather than discretionary, starting in fiscal year 2017, after tribal consultation in fiscal year 2016. The reclassification of CSC as mandatory would be authorized for a 3-year period that specifies annual amounts that fully fund the estimated CSC need for each year for fiscal years 2017–2019. This proposal is consistent with the top recommendation in fiscal year 2014 from tribes to shift CSC to a mandatory account as the long-term approach to fully funding CSC, and will accomplish the top tribal recommendation to fully fund CSC separately from the services budgets.

In the past year, IHS has worked in partnership with tribes to improve estimates of CSC need and the agency's business practices related to CSC appropriations. IHS has also made progress on past CSC claims, with offers extended on 1,232 past CSC claims and settlements on 889 claims for a total value of \$699 million. The fiscal year 2016 President's budget proposal to move CSC to a mandatory appropriation helps us continue progress on this issue which is a top priority of tribes and we look forward to working with you on this proposed approach.

I want to close by emphasizing that even with all the challenges we face, I know that, working together with our partners in Indian Country and Congress, we can continue changing and improving the IHS to better serve tribal communities. The fiscal year 2016 President's budget helps IHS continue progress on improving access to quality healthcare and strengthens our partnership with tribes. I appreciate all your efforts in helping us provide the best possible healthcare services to the people we serve, and in helping to ensure a healthier future for American Indians and Alaska Natives.

Thank you and I am happy to answer any questions you may have.

Senator MURKOWSKI. Thank you, Dr. Roubideaux. I understand that, Mr. McSwain, you are not going to be providing a statement. You are just here to answer questions as we hand them your way.

Mr. MCSWAIN. That is very correct. As they come to me.

Senator MURKOWSKI. Great.

Mr. MCSWAIN. We have got it worked out as to which questions I may ask or answer and which ones that she will answer.

CONTRACT SUPPORT COST

Senator MURKOWSKI. We will see where they go from here. I am going to start where you left off, Dr. Roubideaux, and this relates to the contract support costs. You have outlined what the administration is prepared to do with full funding and mandatory beginning in 2017. And I appreciate you putting that statement before the subcommittee here this morning.

As I mentioned in my opening statement, oftentimes what we will get is we will get the statement of general support, but then we do not see an actual legislative proposal. Do you plan to send the Congress a proposal for contract support costs, and if so, when?

Dr. ROUBIDEAUX. Well, the Congressional Budget justification includes the details for the main components of the proposal. And we did not want to give a detailed proposal because we wanted to take the time to work with Congress and the tribes on it and give time for consultation.

But basically, the proposal to reclassify in 2017 is to make contract support costs a mandatory authorization for 3 years with amounts for each of those 3 years that would aim to fully fund contract support costs, and they are set at levels high enough to make sure we have enough funding to do that. And then it would allow for revisiting the estimates and reauthorizing every 3 years.

Senator MURKOWSKI. I understand that, but I also recognize that given the timeline, this all happens after this administration is no longer in place, and so that is why I am curious as to whether or not we are actually going to see that proposal. As you have outlined, the cost for contract support in 2017, 2018, then in 2019—have PAYGO offsets been identified for the new mandatory spending?

Dr. ROUBIDEAUX. While there is no specific PAYGO identified, all the proposals in the fiscal year 2016 President's budget are paid for in the context of the budget in savings and investments for both fiscal year 2016 and proposals in the out years as well.

Senator MURKOWSKI. So for the proposals in 2017, 2018, 2019, you do have that addressed in our proposal.

Dr. ROUBIDEAUX. The overall President's budget addresses that through savings and other investments.

Senator MURKOWSKI. Just a question as to why a 3-year period. Why is the proposal not to make the program mandatory permanently? What is the magic there?

Dr. ROUBIDEAUX. Well, we are eager to discuss this proposal with you, and did consider all options. This is the proposal that the administration is putting forward, but we do want to discuss it with you. And we are eager to fix this. We want to get full funding and contract support costs, that policy to continue, and we wanted to take time. As you mentioned before, people were mad about that proposal in 2014. Now we are providing time for people to actually come up with a proposal that can work for all of us.

VILLAGE BUILT CLINICS

Senator MURKOWSKI. Well, and it is something that if we are kind of revisiting this every 3 years, that can be complicated, too. So I will look forward to discussing it more with you.

I am going to bring up an issue that is pretty consistent every time you and I visit through these hearings, and that is as it relates to village built clinics. I think you know how strongly I feel about this issue. There are about 150 village built clinics in the State of Alaska. Most of them are effectively the only local option for healthcare, have serious maintenance needs. And yet the Agency's view is that the tribes are responsible for paying the costs out of other funds that they get from IHS. I probably hear more about this issue than almost anything else when I am out in the villages. Can you tell me today or perhaps provide for the record what the projected backlog of maintenance is for the VBCs in the State?

Dr. ROUBIDEAUX. I do not have that number with me, but we can go back—

Senator MURKOWSKI. Can you get that for me?

Dr. ROUBIDEAUX [continuing]. And take a look at that. I know the tribes are looking at that as well in Alaska.

Senator MURKOWSKI. Well, if you can help us out with that information, I would appreciate it.

[The information follows:]

IHS routinely collects maintenance needs from IHS and tribal facilities and updates this list annually as the Backlog of Essential Maintenance and Repair (BEMAR). This priority list was developed in consultation with tribes from all IHS areas.

The Village Built Clinics (VBC) are owned by the local city, village councils, and/or Indian Reorganization Act councils and likely have a backlog of maintenance, but that information has not been provided to the Indian Health Service, nor is it provided by any other vendor from whom the agency has a full service lease.

The Alaska tribes and tribal health organizations have requested that funding for VBCs be increased by \$8.84 million to cover operating and utility costs and deferred maintenance. IHS has not seen actual data related to this request but would be willing to review any information provided.

DEFINITION OF INDIAN

Senator MURKOWSKI. But I am going to ask you for what I have asked before, which is a commitment to work with me, to work with my staff, to come up with a solution to this issue. This is purely a budget issue, and it seems to me that there is no reason that we should not be able to get this resolved.

And I am not quite sure how much more forceful and direct I need to be with this. We had this same conversation in discussion in the Indian Affairs Committee and in the Appropriations Subcommittee. Obviously this is the subcommittee that has the gavel now, so we do need to work through these issues. So I ask for that commitment.

Last question for you before we move on to others, and this is the definition of “Indian” under the Affordable Health Care Act. This is something that I think we all know that when the ACA was implemented, there was not uniformity within that legislation that defined the term “Indian.” It has potential for, I think, significant confusion in the implementation. It can hurt American Indians, Native Alaskans in receiving the benefits to which they are entitled.

And I have asked you to fix the issue administratively. For some reason it is still hanging out there. We included report language in the fiscal year 2015 omnibus appropriations bill that was pretty specific. It said, “The committee, therefore, directs the Department of Health and Human Services, the IHS, and the Department of Treasury to work together to establish a consistent definition of an Indian for purposes of providing health benefits.” So where are we? Have we resolved this? What has IHS done in response to this directive in the omnibus?

Dr. ROUBIDEAUX. Well, we are as concerned about it as you are, and we actually have been working as hard as we can on it. We have done as much as we can do administratively, and the determination was that a legislative fix was needed. We actually worked with tribes on language, and we gave technical assistance to the Finance Committee.

We do want to work with you on this. We do want to find a solution. We know so many people will benefit. And just like village built clinics as well, and I was glad to meet with your staff to start conversations about what some solutions might be there as well. So we really are willing to work with you on these issues. We understand they are very significant.

Senator MURKOWSKI. Well, and you need to understand my frustration here because the ACA was passed years ago. We identified this as an issue and a problem, and we were told do not worry about it because this part of the ACA does not go into play until 2015. Well, we are now in 2015. We are now in a situation where I am having Alaska Natives coming and saying, well, have you guys cleared this up? What is the status? What is going on? And now you are sitting in front of me telling me it is going to require a legislative fix when you have said all along we should be able to resolve this administratively.

In the meantime, you have got Alaska Natives and American Indians that are caught up in this great washing machine of the ACA. This is not fair to them. This is not right. I think that we can do an administrative fix. And, you know, you look at the other areas that this executive has chosen to wave the magic wand, and rectify, or push back or do something to help. Well, if we cannot figure out how we are going to help our native people with this kind of self-inflicted confusion here, that is a shame to them. So we have got to address this.

Dr. ROUBIDEAUX. Well, we definitely want to keep looking for solutions. We agree with you that this is a really challenging problem for the American Indians and Alaska Natives who do not fit the current definitions in law. So we would definitely like to find some solutions and continue working on it with you.

Senator MURKOWSKI. Well, know that I am going to be conferring directly with the Secretary of Health and Human Services and at Treasury to determine—there has got to be a way to fix this short of legislation. I have gone well over my time, and I apologize.

Senator UDALL. Chairman Murkowski, I am going to defer and allow Senator Tester to go on this round.

VA MEMORANDUM OF UNDERSTANDING

Senator TESTER. Thank you, Ranking Member Udall, and thank you, Chairman Murkowski. I would just say from the opening comments I look forward to working with everybody on this subcommittee, especially, Madam Chairwoman, to get sequester relief for Indian tribes. I do not know how we are going to do that and stay under the caps, but we will do what we can do because I think it is important with our trust responsibilities we have to Indian country.

I want to talk about the VA for a second to Indian Health Service. You have, I believe, 65 memorandums of understanding out there with—the VA has 65—you do not have—they have 65 memorandums of understanding with the Indian Health Service. Do you anticipate more coming up this year, and if so, how many?

Dr. ROUBIDEAUX. Well, with regards to the reimbursement agreement, all the Federal facilities have agreements in place, and it is the tribal facilities where there are 65 agreements. And we are

definitely hopeful that the VA will continue to enter into agreements with tribes directly on that.

Senator TESTER. Okay. And in that regard, who is the point of contact for Indian Health Service for the VA to set up these agreements?

Dr. ROUBIDEAUX. On the VA to set up the—

Senator TESTER. Agreements with Indian Health Service.

Dr. ROUBIDEAUX. The agreements are all set up with the Indian Health Service on the reimbursement part.

Senator TESTER. Yes, but who?

Dr. ROUBIDEAUX. Dr. Susan Karol is our lead for the VA work that we do. And we also have the overall memorandum of understanding, or MOU, on the coordination of care for veterans as well.

Senator TESTER. Okay. And so far, how has this worked?

Dr. ROUBIDEAUX. Well, the best thing about the MOU over the past couple of years is that it has brought the VA and IHS together in regular meetings, and we are starting to talk about sharing services. We actually are sharing services, training, providers, telemedicine.

Senator TESTER. Do you have any figures on how much it has saved in reduction of duplication?

Dr. ROUBIDEAUX. That is a good question. I can refer that back to IHS to maybe figure that out.

[The Information follows:]

The Veteran Affairs (VA) and Indian Health Service (IHS) partnership under the 2010 Memorandum of Understanding and the 2012 Reimbursement Agreement has saved on reduction of duplication in many areas. The VA-IHS partnership utilizes doctors that are already on staff at either IHS or tribal health programs (THP) facilities instead of increasing staff at VA Community Based Outpatient Clinics (CBOC). Facility costs are reduced by utilizing existing facilities that currently receive Federal dollars instead of building or contracting for new facilities. The IHS has also collaborated with VA to implement its Central Mail Order Pharmacy (CMOP). Mailing prescriptions when they receive care from either the VA or IHS saves veterans on travel costs they otherwise would have had to incur if they had to physically travel to the IHS or VA facility to receive their refills. In the first quarter of fiscal year 2015, there was no duplication of pharmacy services while filling 114,377 prescriptions (all at IHS sites) which were transmitted to CMOP. This is equivalent to 26 percent of the 440,575 Rx's (all at IHS sites) that were transmitted to CMOP in fiscal year 2014, and is equivalent to 86 percent of all of the Rx's that were transmitted in the first 3 years of the program in fiscal year 2010-fiscal year 2012. The VA-IHS partnership has clearly demonstrated that American Indian (AI) and Alaskan Native (AN) Veterans are utilizing IHS/THP facilities in increasing numbers. This partnership will lead to increased positive effects beyond the Memorandum of Understanding (MOU) for the IHS/THP facilities and their non-Veteran patients due to increased customer utilization and funding. The VA has also paid the IHS and tribal programs with reimbursement agreements approximately \$15 million to date for veterans receiving direct services at IHS and tribal facilities. Again, veterans are saving on transportation costs to the VA if they can be seen more locally in the IHS or tribal facility. All of these areas where duplication has been reduced clearly benefit the veteran by improving access to and coordination of care.

Senator TESTER. I would love to have that because that is the goal. The goal is you are serving the same population, Native Americans serve at a higher rate than any other minority in the Services, and so you are serving the same population, and the goal is to make the money run further for other folks.

Dr. ROUBIDEAUX. Well, the one data that we do have is on the reimbursement agreement.

Senator TESTER. Yes.

Dr. ROUBIDEAUX. Since it has been put in place in all the Federal facilities and with the tribal facilities to date, we have received a total of \$17.8 million of payments from the VA, which help us expand services.

THIRD PARTY BILLING

Senator TESTER. Okay, that is good. I want to talk about third party billing. I had a hearing in Billings, Montana, I do not know, eight or 9 months ago, 10 months ago. And it was apparent that a lot of the local providers were not utilizing third party billing, and there was a lot—I mean a lot—of dollars being left on the table that could be brought into Indian Health Service, could be utilized to help expand your purview in Indian country. Are you doing anything about educating the local providers on how to third party bill?

Dr. ROUBIDEAUX. Absolutely. So related to third party collections, when we—well, it goes both ways. When we provide the services, we are billing Medicare and Medicaid and private insurance to pay for us. When we refer out to other providers, then we work on the payments to them. We have done a lot to improve both of those business processes over the last few years, and in terms of third party collections, in the last year we were able to increase them by \$49 million through a lot of improvements in the process.

Senator TESTER. So the question is, what are you doing to help those local providers, the one in Fort Peck, for example, that provides a service? There is insurance money out there. They are not getting it.

Dr. ROUBIDEAUX. Oh, local, the local Indian health providers, yes.

Senator TESTER. Yes. Are you able to do anything?

Dr. ROUBIDEAUX. Yes, absolutely. We have been providing technical assistance. We have developed a third party collections tool that monitors collections every month, and so if there are any problems, we can help them.

Senator TESTER. And how is that being received? Is it being received well?

Dr. ROUBIDEAUX. I have heard it is being received well because what it means is people are getting more dollars to provide services locally.

Senator TESTER. That is right. So how much do you think is still being left on the table? You said it has been increased by 40-some—

Dr. ROUBIDEAUX. Forty-nine million dollars last year.

Senator TESTER. How much do you think is still out there to be gotten?

Dr. ROUBIDEAUX. It is hard to estimate, but it could be a lot more with Medicaid expansion in those States that expanded, with private insurance now with the Affordable Health Care Act, and with just the overall making sure that we are following up on the bills, making sure that we are addressing open receivables, making sure that we are getting the bills paid so that we have the revenues.

IHS STRATEGIC PLAN

Senator TESTER. Okay. When I talk to Indian country, I can tell you that, and it really has not changed much in the last 8 years. The big concern is healthcare, and it is still the big concern. Sometimes you guys are a scapegoat, and sometimes it is warranted when it comes to finger pointing. Is there a strategic plan in place to move forward and change the perception of IHS in Indian country, and if so, when is going to be implemented, or has it already been implemented?

Dr. ROUBIDEAUX. Well, the overall plan to change and improve the IHS over the past several years has been to try to work closer with the tribes that we serve. I mean, the first step is to work with our customers, and the first step is to try to meet their needs. You know, we are in the business of healthcare, to try to improve those communications. And we have been able to improve that at the national area levels, and now the focus is improving that at the local level. That is the first step really in improving the overall—

Senator TESTER. Communication is critical. I want to talk about something else that is critical, and that is mental health.

Dr. ROUBIDEAUX. Yes.

MENTAL ILLNESS

Senator TESTER. Mental illness in Indian country. We have heard that local service centers are trying to incorporate, from your testimony, mental health screenings and for medical visits, checkups, wellness care. I applaud that. Can you tell me how successful that has been very briefly because my time is out, how successful that mental health incorporation has been?

Dr. ROUBIDEAUX. Well, it is successful for the patients so they do not have to go other places.

Senator TESTER. Right.

Dr. ROUBIDEAUX. In the testimony we have statistics about the increase in the number of people being screened for depression that has increased quite a bit from like the low 20s up into 60s.

Senator TESTER. Thank you, and thank you.

Senator MURKOWSKI. Thank you, Senator Tester. Senator Daines.

REIMBURSEMENTS

Senator DAINES. Thank you, Madam Chairman. Director McSwain, according to Northern Cheyenne tribal leaders we spent some time with, IHS owes over \$2 million to the Northern Cheyenne members for healthcare received from non-IHS providers. Some of these tribal members get in trouble with bill collectors. They have got to put off paying other bills in order to pay healthcare costs that should be reimbursed by IHS. My question is, what is IHS doing to make reimbursements clear and understandable for the average patient who is juggling work, kids, and other responsibilities?

Mr. MCSWAIN. Thank you, Senator Daines. What we are doing on several fronts, and it is something that Dr. Roubideaux just mentioned, which is the education program that we have put in place. I know that we have a new acting director up in Billings who

has really been doing some great things about orientation of the hospitals—she is a hospitals expert—and to really get out and talk to the providers.

What we are finding out is people self-refer, and so we need to connect with the facilities that they are self-referring to, and ensure that they are being referred to them for payments so we can ensure that they do not get caught outside of an authorization, because if they are going into a facility, our contracts are actually—it is now referred to as purchase referred care—has a set of requirements on referral, and a lot of it is just for maintaining continuity of care.

Senator DAINES. Do they track that number? Is that something—is a metric that people look at, and have you focused on it?

Mr. MCSWAIN. This is one that we monitored closely through the businesses and the like.

Senator DAINES. Yes, for example, like the Northern Cheyenne situation, if there is \$2 million outstanding, who looks at that number, and who reports it, and who is held accountable for it?

Mr. MCSWAIN. Each of the area offices across the country that begin to face these larger amounts sit down with the hospitals and actually go down through the actual claims that are being levied against the patients, because obviously we want to get in front of those and resolve them.

Senator DAINES. Yes, it would be helpful, I think, for us, too, because we have got a Billings office there I think inside your Billings regional office. We could look at those numbers and track those with you to see is that declining. Is the number going down every month?

Mr. MCSWAIN. Yes, I made a note of it, and we follow up on it.

Senator DAINES. All right. I would love to see that number.

Mr. MCSWAIN. Yes.

ADMINISTRATIVE COSTS

Senator DAINES. All right. Great, thank you. Dr. Roubideaux, two weeks ago when you testified before the Senate Committee on Indian Affairs, we talked about the administrative costs at IHS. I know that in fiscal year 2013, \$6 and half a million was spent on admin costs at our Billings area office out of \$18 and a half million spent overall in the Billings area IHS. While I understand that it is necessary to have some admin costs in any organization, is this money being effectively spent, because that is about 35 percent of the total spend there out of Billings. And how exactly does this money help get our services to our tribal members who need it?

Dr. ROUBIDEAUX. Well, there are statistics out there. There are two sets of statistics, and what I am finding is that there is confusion about the statistics that people are looking at, so we will provide you with two pictures. One is the overall administrative costs for the Billings area, and that is about 11 percent. But if you look just at the area office, the area office is—the purpose of it is for administration, to help the local service units.

So I think that there have been some charts and graphs out there that I think there has been some overall misunderstanding. But when you are running a healthcare program, I know that everybody sees the doctor and thinks that is all that needs to happen.

But you definitely need to have some administration overall for the Indian Health Service that is about 10 to 11 percent. And in the Billings area, overall when you look at the whole area, it is only 11 percent. But the area office itself would have that higher proportion just because it is providing administrative functions to support the local—

Senator DAINES. Do you all have a goal to try to continue to reduce your admin costs as a percent of overall spend? Is that something you have set targets for to see reductions in that number?

Dr. ROUBIDEAUX. We have worked on ways to reduce that number. The number will also reduce over time as more tribes contract and compact. But we have done things like reduce travel by half, we have reduced conference expenditures by a third, and we are always looking for ways to be more efficient and to save dollars.

PERFORMANCE OUTCOMES

Senator DAINES. And speaking of measurements, and I was struck by the testimony, Dr. Roubideaux, a 39 percent increase, I believe, in IHS funding since 2008, 53 percent with the President's budget versus 2008. I see we are touting increases in spending. I want to talk a little about what are we doing in terms of measuring outcomes, in terms of what are we getting for the investments made, in terms of improving health in Indian country.

I was recently—our staff was engaged with the chairman's staff in Assiniboine and Sioux Tribes of the Fort Peck Reservation. The average age of death for tribal members over the last few years has been 51. As I get older, 51 sounds like a lot younger. The Fort Peck Reservation is larger than the State of Delaware, yet has only two IHS clinics. And as Senator Tester mentioned, I hear the same thing. I probably hear more complaints about IHS than anything else I hear out in Indian country. The challenges are enormous, and the problem is made worse by these huge distances to get to both IHS and non-IHS facilities.

Question: what are we doing to measure outcomes from IHS? I mean, I heard all about increased spending—more money, more money. But what are we doing right now, and how are we measuring outcomes in terms of improving health in Indian country?

Dr. ROUBIDEAUX. Well, we have actually done a lot over the past few years to improve and measure outcomes. We measure outcomes on the quality of care as how we are working, and we have so many examples of that when we do the Government and Performance Results Act or GPRA indicators.

We also have some data that should be available soon on how we measure the ultimate long-term outcomes, like mortality and life expectancy. And, you know, the numbers are getting better overall. If you look at the life expectancy at birth in 1972 to 1974, it was 63.6 years overall. Now, for 2007–2009, it is 73.7 years, so we have gained like 10 years overall. But it is clear that there are some areas where when you look at the specific tribal data, you can see that there are disparities even among tribes in terms of their life expectancy, and we absolutely want to continue to try to get that trend of improving life expectancy and reducing mortality in a number of areas.

The Special Diabetes Program for Indians is the best example. It is funded to be evaluated. We have not only been able to show improved care, we have been able to show that the diabetes prevalence is slowing. It is not going up as fast as it was. And we are able to prevent diabetes—

Senator DAINES. Yes, I am out of time, but one last follow-up and then I yield my time. But I would love to align our tribal leaders, and chat with the IHS, and get on the same page in terms of outcomes and measurements of quality of care, so that these are measures that the tribal leaders will say, yes, that is the right way to measure the quality of care versus what is coming out of our centralized command and control here in Washington, DC bureaucracies. So thank you.

Dr. ROUBIDEAUX. I completely agree with you on that, and that is what we are trying to do with the—we are encouraging the CEOs at the local facilities to meet regularly with the tribes and understand tribal priorities and develop those measures together—

Senator DAINES. Because ultimately that is the customer. That is who we are trying to help.

Dr. ROUBIDEAUX. Love to work with you on that.

Senator DAINES. Okay, thank you.

Senator MURKOWSKI. Thank you, Senator Daines. Senator Udall.

PURCHASED AND REFERRED CARE

Senator UDALL. Thank you, Madam Chair. Dr. Roubideaux, your budget increases funding for purchased and referred care, which is known, I think, as the PRC, by \$70 million above the fiscal year 2015 level, which is an 8 percent increase. Patients depend on the PRC program to cover the cost of services not provided directly by the Indian Health Service, including emergency and specialty care.

Your proposed increase is only a down payment toward the actual need for the PRC program. In 2014, you reported that 69 percent of PRC programs across the country were able to cover services beyond priority one, life and limb emergencies, and that means nearly one-third of the programs were unable to cover referrals for preventive care. That is clearly a huge demand for the PRC Program funds, which means that even if Congress is able to support your request for additional funding, we may also ensure that every—

How may we also ensure that every dollar in this program stretches as far as it can? What progress would you expect to make towards expanding PRC services if Congress approves your budget request? Can you talk about how the funds will be allocated and whether they will be distributed to reflect the greatest needs on the ground?

Dr. ROUBIDEAUX. Well, thank you. The need in the Purchase and Referred Care Program is enormous. If you look at the denied and deferred statistics from our Federal and our tribal facilities, in 2013 \$761 million was denied and deferred because of our funding levels not being enough to pay for all of those. So every dollar that we can get in an increase in purchase and referred care will mean more referrals. Related to this particular proposal, the increase could fund 980 more hospital admissions, 19,000 outpatient visits,

1,200 patient travel trips over the base funding if we get that increase.

We are doing everything we can to spend that money efficiently. That is why we hire a fiscal intermediary to review all of our referrals and payments, and make sure we are maximizing third party collections so that we can save resources for those that do not have other resources. Our fiscal intermediary in 2013 was able to save us \$1.1 billion in contracts, Medicare-like rates, and alternate resource savings that were negotiated as well. So we know these dollars are precious because every bit of them can pay for referrals for care that patients need. So that is why it is a top priority of tribes, and it has always been a top priority in our budgets over the last few years.

Senator UDALL. Now, you mentioned Medicare-like rates, and I have a question there. Your budget request includes a legislative proposal to charge providers Medicare-like rates for services. And the service has also proposed a rule relating to this new rate structure. Can you share with us what you expect the impact of this proposal would be in terms of dollars reinvested in care and additional patients treated?

Dr. ROUBIDEAUX. There was a Government Accountability Office (GAO) report that said on the Federal side the Indian Health Service could save around \$32 million in purchased and referred care funds if we were able to negotiate the lower rates with the outside providers that we pay for services. And so, that is why we are trying to do everything we can on all levels to implement Medicare-like rates for non-hospital and physician services. And the notice of proposed rulemaking that went out in December, the comment period has closed. The Indian Health Service is reviewing those comments trying to find a way to make that work administratively as well.

We know there is legislation pending that is actually better on the enforcement piece, but this is one where we are trying to push all the levers on this because the amount that we could save is millions of dollars, and that is just on the Federal side. I have seen tribes estimate they could save like \$60 or more million if we were able to get these lower Medicare-like rates that we pay the outside providers.

Senator UDALL. Now, if you are proposing your own rule, could you address the need to have Congress—why you are requesting Congress to act on this issue, and why is the legislative proposal still necessary?

Dr. ROUBIDEAUX. Well, the legislative proposal that we have seen does tie the Medicare-like rates to Medicare participation by those outside providers, so it has a much stronger lever than we are able to do administratively. And I know the tribes really prefer that legislation, but that is still working its way through Congress. And tribes have also asked us to try any and all options. So that is why the administrative solution is another option to be considered here.

Senator UDALL. Thank you. Thank you, Madam Chair.

Senator MURKOWSKI. Thank you. Senator Cassidy.

TRIBAL PATIENT COVERAGE

Senator CASSIDY. Thank you. Dr. Roubideaux, how many patients is the Indian Health Service responsible for?

Dr. ROUBIDEAUX. The Service population is 2.2 million.

Senator CASSIDY. 2.2 million. What is the mean age of those served?

Dr. ROUBIDEAUX. It is younger than the general population. I do not have the statistic in front of me.

Senator CASSIDY. Do you have a ballpark, a mean and a median? Do you have a ballpark of that?

Dr. ROUBIDEAUX. We would have to get that for you.

Senator CASSIDY. Senator Udall mentioned that the spending per recipient is less than the elsewhere per Centers for Medicare and Medicaid Services (CMS), but obviously the younger your population, the less expensive. A 28-year-old man would be typically on average \$500 a year. Ballpark it looks as if you do have a much younger population with relatively few people over age 65. I say that because if we look at funding levels, we have to look at obviously apples and apples, right?

Dr. ROUBIDEAUX. Well, that is true. However, our younger population has a higher burden of disease, accidents, injury, diabetes occurring at—

Senator CASSIDY. Totally accept that you would have to control for disease, but nonetheless if you look at the average health of me, 57, versus my assistant back there, who is 25?

VOICE. Yes, sir.

Senator CASSIDY. Let us just say he is lower than me. Now, in your budget you mentioned a 39 percent increase. Does that include the increased amounts you receive from Medicaid and other third party recipients?

Dr. ROUBIDEAUX. No, that is with regard to increases in appropriations.

Senator CASSIDY. So if you just look at—if you include your increase, because obviously you received a large amount from the stimulus package, and then there have been provisions in the ACA that have increased reimbursement. How much is your budget increased if you do all third party, the stimulus, et cetera? How much is your budget increase? Do you know that?

Dr. ROUBIDEAUX. Well, we know from the statistics from 2013 to 2014, we increased our third party collections by \$49 million. Third party collections are about \$1 billion of our total budget. In this proposal, we are proposing—

Senator CASSIDY. So just because I have limited time, so really your increased funding is more like 45 percent if you bring in the increased amount you have brought in from Medicaid and perhaps even a little bit more. I am saying that off the top of my head, so I am trying to get a sense of the growth of your budget.

Now, we just divided your total budget number by the per person, knowing that you have a younger population, by the 2.2 million people whom you serve, and it looks like you are receiving about \$2,900 per person. For a family of five that would be roughly \$15,000, which could buy you a pretty good group policy, you know. It would be a very good policy actually. So I am not sure if we have

a problem with funding frankly because if you control for age and you take in the third party, then you actually have, and knowing that children cost far less than adults, you have less. So I just say that because obviously with budgets being tight, we have to have a good sense of that being done.

There have been problems in the past in 2008 and 2009 with your inventory control, with the GAO report very concerned. I know that you did not begin then, but it seemed as if in 2008, the report was of millions, and then in 2009 again there was \$3.5 million reported lost in fiscal year 2009. What is the state of your inventory control now?

Dr. ROUBIDEAUX. With regard to property and inventories, a number of improvements have been implemented since that GAO report. There has been a greater accountability for the individuals who have personal property within the Agency. There has been improvements in the policies. There have been improvements in the tracking.

Senator CASSIDY. So do you have a sense of what your loss ratio is or the absolute amount ratio is now relative to before? Is there kind of ongoing audits as to inventory?

Dr. ROUBIDEAUX. I will ask Mr. McSwain if he knows that.

Mr. MCSWAIN. Yes, having lived through that period of time that some of you know about, the property issue. We have reduced it. The last count is of lost—missing property is just around \$600,000 from \$13 million.

INFORMATION SECURITY

Senator CASSIDY. And there was a problem with some of those being computers with personal information, medical information. And how is the control going for that?

Mr. MCSWAIN. Those are being controlled completely now. We secure them before we—

Senator CASSIDY. Great. I have just limited time, so I do not mean to be rude.

Mr. MCSWAIN. Right.

PROVIDER—PATIENT RATIO

Senator CASSIDY. I see that you are asking for increased staffing in multiple clinics. Do you have an average that you can make available to us, your average nurse-patient ratio at these clinics or all clinics and your average physician-patient ratio, as well as the number of visits each physician sees, subtracted by the no-show rate? Do you follow what I am saying?

Dr. ROUBIDEAUX. Yes, I do. We will need to get back with you on that.

[The information follows:]

A nurse-patient ratio of 1:5 is the base staffing plan for an inpatient IHS Medical-Surgical Unit. Actual provider-patient staffing levels may vary due to staff turnover and the difficulty of recruiting nurses in what are often remote facilities.

All patients are assessed an acuity level of I-IV and based upon the acuity level staffing requirements are adjusted to meet patient care demands and to provide safe and quality patient care services. IHS Emergency Departments, Obstetrical and Intensive Care Units adhere to a 1:1 or 1:2, nurse-patient ratio as established by national standards. Primary Care Provider (PCP) workloads or panel size, no-show reports and provider performance are aggregated and analyzed locally to improve continuity of care, access to care and to identify appropriate physician-patient ratios to

meet patient demands. IHS has been implementing the Improving Patient Care (IPC) initiative since 2006 which is its patient centered medical home model to improve care. As a part of the IPC, facilities have been encouraged to work on improvement projects that are priorities at the local level. Many, but not all, facilities have worked on patient flow statistics and staffing pattern improvements, and the specific flow processes analyzed are based on customer input and are in general not consistent enough to nationally aggregate or report. IHS can provide examples about how some facilities have measured and improvement patient flow and staffing patterns upon request.

QUESTIONS FOR THE RECORD

Senator CASSIDY. Now, I will say in 2008, you all testified before Energy and Commerce, and I do not mean to be accusatory, but I will point out that I asked several questions for the record and frankly never got a response. It was frustrating, and you had just started, so maybe there was disorganization. But I will say then when you testified I asked specific questions for the record, did not receive answers. And, again, I say that only to point that out and look forward to receiving these.

Dr. ROUBIDEAUX. You mean on Energy and Commerce?

Senator CASSIDY. No, I was on Natural Resources then in 2008.

Dr. ROUBIDEAUX. Oh, Natural Resources in 2008.

Senator CASSIDY. So I am out of time. I yield back. Thank you.

Senator MURKOWSKI. Thank you, Senator Cassidy. And I think your point about expecting replies to the questions for the record is a good reminder. And I would certainly remind not only you, Dr. Roubideaux and Mr. McSwain, but everyone who comes before the subcommittee, when we ask the questions, it is not just for busy work. It is because typically we run out of time.

Senator CASSIDY. Can I make another—

Senator MURKOWSKI. Senator.

STAFFING RATIO

Senator CASSIDY. Thank you, Madam Chair. I also say the VA has done something which I admire. They have given a spreadsheet which we can all look at that has these statistics per clinic. So if Senator Udall wants to look in his State at the particular clinic with their staffing ratios, with their number of visits, with the percent of those which are no-show, which is a failure of a system, or if Senator Murkowski wishes to do so in Alaska, they can do so. And that allows us and our staff to on a longitudinal basis see your progress. Frankly, that will make us your best friend if we see those numbers improving, but nonetheless it allows us to fulfill our constitutional responsibility of defending the taxpayer. I yield back. Thank you.

JOINT VENTURE PROGRAM

Senator MURKOWSKI. Thank you. Excellent point, and I think many of us were on the Approps Subcommittee yesterday when we were talking about these issues with the VA.

Dr. Roubideaux, I wanted to ask about probably one of the more successful programs that we have within the IHS right now, and this is the Joint Venture Program. With the substantial backlog that we have with Healthcare Facilities Construction List, what we have seen is the ability for tribes to come forward, pay for the con-

struction of a facility with the promise that IHS is later going to come in and provide the staffing packages to operate the facility.

And we have had some enormous success in Alaska in recent years. We have got the facility for TCC in Fairbanks, which is beautiful, the South Central Foundation in Wasilla, Dena'ina, and Kenai, and now Alaska is on the list for a Joint Venture (JV) project. But one of the problems that we have run into that is that our tribes have been so efficient in that they built the facilities faster than IHS predicted, and so there was a gap or a lag between when the facility was ready and when the funds were available for staffing packages.

So two questions for you on joint venture. First, if you can give me an update or current status on the Alaska project. And then second, and probably more importantly from a structure perspective, have you come up with a better model to predict timing when facilities are finished so that, again, we do not face this lag between having a great facility and not having the folks to go in them?

Dr. ROUBIDEAUX. Well, thank you. And, you know, Alaska has really taken a lead in the Joint Venture Program and done a great job. And I want to thank you for your advocacy over the last few years to help get those staffing packages during difficult budget climates, and so I am really grateful for that. It has been great to go to Alaska and visit those facilities, and see how beautiful they are.

It is a very popular program. It is extremely competitive because of the need. The update is that we had a more recent round of the Joint Venture Construction Program. We had 37 applicants—pre-applicants. And based on exactly what you are saying, we do not want to get ahead of ourselves. And that is where we want to work together with you is making sure that the appropriations can be timed at the same time that they are opening. We anticipate that in this current round the plan was to notify two to three facilities to proceed each year, and then work closely with those tribes to determine the estimated date of beneficial occupancy or opening, and then we would be giving you the updates as quickly—

Senator MURKOWSKI. Is that any different than what we have done in the past because it has been a smaller block, and I thought we were in sync. But then, again, we were efficient, we got it done, staffing package not there.

Dr. ROUBIDEAUX. Well, two things happened. The first was, yes, the tribes were great at getting them done early, and there was a lull in appropriations in 2011, which sort of caused us to be a little bit more behind, and it is what it is. I think we learned some good lessons from that to make sure that we are timing and communicating well on what the timing is.

Senator MURKOWSKI. So where are we with Unalaska then?

Dr. ROUBIDEAUX. Unalaska is one of the facilities from the last round that is working on that. I am going to refer to Mr. McSwain on that.

Mr. MCSWAIN. Yes. I think your overall question is one that is always a challenge for us because the tribes build them, and so we try to keep really track of them as to when they are going to open. Fortunately with Alaska, I know that we had the occasion where

we had one that was opening really early, and we had one that was in the lower 48 that was opening really late.

Senator MURKOWSKI. We got lucky.

Mr. MCSWAIN. And so, we shifted money to make sure that we could have them open on time and not leave it vacant because that is the one thing we do not want to do. Unalaska is on schedule, and we have not signed the agreement. There is an agreement that goes in place where we actually say, you know, you will tell us when you are going to complete, and we commit to providing the staffing in accordance with a staffing package that we agree on.

So Unalaska is technically on schedule right now because it is the last of the last—actually three of the first round that are still working. So there is one in Oklahoma, one in Alaska, and then we had one in Wyoming that is having problems because the tribes elected not to join in on the project. But anyway, that is where we are, but it is a good question. We just would like a little more engaging of time because when the tribe is going to build it, it is their construction that is beyond our control.

Senator MURKOWSKI. It really just comes back to very constant communication on this.

Mr. MCSWAIN. Right. Correct.

STAFF RECRUITMENT AND RETENTION

Senator MURKOWSKI. One last question for you, and this relates to physician recruitment and retention, because, again, you can build facilities that are state-of-the-art, but if you do not have the men and women, the professionals, and their teams to open the doors, it does not do any good. And there is nothing that is a more glaring example of, you know, Government not working than when you have this great facility, but you do not have the providers.

I am told that the vacancy rate for physicians right now within IHS is 20 percent, so that means effectively that one in five physician positions is vacant. And furthermore, you look at that and you say, well, that is not acceptable, and then you go beyond that. The turnover rate is 18 percent. And I am told that these numbers are actually coming down, but that is still too high. I think we would agree that is still too high. So what are we doing within the President's budget to improve the recruitment and the retention, and how do we do better within this system?

Dr. ROUBIDEAUX. Well, if I may, this is a significant problem for both Federal facilities and tribal facilities, and the statistics you are quoting are Federal facility statistics. We do not have the statistics for tribes, but we have heard from them. They are facing the same challenges.

The Indian Health Service over the past few years, number one, has addressed more competitive salaries by using the VA Title 38 pay scale because of the primary care shortage—

Senator MURKOWSKI. That does not help us in Alaska, though, because we cannot get our physicians in the VA. So if we are going by the VA pay scale, and we heard yesterday from the Undersecretary that they have got to reevaluate their VA pay scale because they are not able to attract physicians there. So I do not know that I would use them as a model.

Dr. ROUBIDEAUX. Well, it is higher than our old pay scale, so it is an improvement for us, but you are right. With the physician shortage that is looming now, right now even to get a physician to look at your facility, you have to pay them over \$200,000, and if they are a specialist you are talking closer to \$300,000. And that is hard for our facilities to pay for.

The other thing is the Loan Repayment Program, the Scholarship Program. We are grateful for the introduction of the amendment to make them tax exempt because that would allow us to be able to fund more of them. The National Health Service Corps is so critical for us. It has helped to fund over 300 providers, not just physicians, but like dentists and behavioral health providers.

Senator MURKOWSKI. So you are seeing more and more coming from the Corps?

Dr. ROUBIDEAUX. Yes. And we are concerned because we have heard that they need their funding renewed either on the mandatory or discretionary side, and it is really critical for us. We would lose these—all these great new providers that our facilities have, so we hope you can work with us on that.

Senator MURKOWSKI. It is a big issue. Senator Udall.

PATIENT COVERAGE

Senator UDALL. Thank you, Chairman Murkowski. I really appreciate Senator Cassidy's comments and questions, and I hope that we can get the answers to those. I think it is important when we make comparisons, and I made the comparison about \$3,100 a year I think approximately per patient, and how it is double in other circumstances around the country. And let us be fair with the comparison there, and try to answer the question thoroughly.

But my—and clearly IHS needs to be held accountable for what they spend, what you all spend, but I do not think these are the average patients. I think they have a higher disease burden. They live in remote areas where the provision of health services is more expensive. Their referrals for basic services, Dr. Roubideaux, as I think you have said, are still being denied. So the idea that the Indian Health Service has enough funding at this point I think is incorrect. But I hope that you will help us with that, and I will probably submit a couple of questions, too, so that you can answer that very thoroughly, and give us an idea of what the comparison is.

Senator UDALL. You know, it was mentioned that if you had a private policy, it would be a good private policy. Well, a lot of these people live hundreds of miles from physicians. And so, if you had a private policy, then you would end up exercising that option, which I do not think is a very good option for many Native Americans.

And, Chairman Murkowski, I am glad you talked about retention. I am really proud to have co-sponsored legislation with you on the Scholarships and Loan Repayment Programs funded through IHS, which I think this makes them tax exempt, and to try to attract and keep people there. And so, that is, I think, an important one, and we clearly need to do more there.

HEALTH FACILITIES

Dr. Roubideaux, I would like to talk about your request for health facilities in Indian country. While I am pleased that you have requested an increase of \$100 million in your budget for healthcare construction, I know that the request only scratches the surface. I believe that the Chairman said earlier \$2 billion, \$100 million of funds that the IHS needs to fully fund its current construction priority list.

In New Mexico, we have been waiting for years to receive funding to address the four aging facilities we have on the priority, including the Gallup Indian Medical Center. You and I have both visited Gallup together, Dr. Roubideaux, and we both have seen firsthand how outdated the facility is. Tribes tell me that already it serves less than half the local needs, and yet we are still waiting. I know you share my frustration, and we are simply not making enough progress in replacing these facilities. So let us talk about the backlog. At your current rate of funding, how many years would it take to complete your current construction priority list?

Dr. ROUBIDEAUX. I think I will have to get you that specific number. It is dependent on appropriations. It is a \$2.2 billion remaining need on the list that the Indian Health Care Improvement Act says we have to complete before we get to the other \$5 billion estimated need for facilities for everyone else.

And so, I have been to Gallup Indian Medical Center. I have seen the condition of it. The providers working there are heroes to be able to do what they do with the facility there. This President's budget helps us make significant progress moving down the list, so it would get us to Gallup Indian Medical Center sooner.

And just on the—I am grateful for your comments about the data issue, and we want to work with you all on providing more data and more information to help you in your decisionmaking on the budget. There is data and there is what we hear from the tribes, and the tribes tell us that there still is significant need, and we hear that from our providers as well. And just appreciate your comments on if we are looking at the data, let us also remember the voices of the tribes who say there is a huge disparity in need as well, and we will be happy to work on some of the data issues also.

Senator UDALL. Well, it seems to me with the number you mentioned, the \$2.2 billion and then the \$100 extra million, still the Gallup facility, I think, is \$500 million, so I think that is going to be a very, very difficult lift. And so, that is why I think we need to see from you some kind of outside the box thinking of how we are going to address these kinds of construction needs. And, you know, previous administrations have come up with a 5-year plan or whatever it is. I mean, I hope you give some thought to that, and then interact with us in terms of improvements there.

Under the Indian Health Care Improvement Act, IHS is due to make annual progress reports on its construction program. When can we expect to see your next report, and will it include estimates for the funds that IHS needs to construct all remaining facilities on the list, including the Gallup Indian Medical Center I have talked about?

Mr. MCSWAIN. Mr. Vice Chairman, Dr. Roubideaux actually started an authorized Federal Appropriations Advisory Board made up of tribal leaders and a couple of staff people. And they have actually been charged with coming up with the report that is due next year, and they will be doing a wide search. We will be talking about consulting with tribes, particularly on the new authorities that are in the Indian Health Care Improvement Act. But we will have the report prepared on time for submission the early part of next year.

Senator UDALL. Thank you.

CONTRACT SUPPORT COSTS

Senator MURKOWSKI. I have just hopefully two quick questions, and we will be able to wrap up soon. I know both of us have many different hearings this morning, but I appreciate the time that our witnesses have given us.

Dr. Roubideaux, back in 2010, I understand that you sent a letter to Jefferson Keel, who was then the chairman of the Tribal Self-Governance Advisory Committee. And effectively, the letter said that contract support costs would be computed on top of all the methamphetamine prevention and domestic violence funds. And then last summer IHS announced that tribes would have to waive all rights to additional contract support cost funding if they wanted to receive these same funds again. And in Alaska, South Central Foundation operates what I think is one of the country's best domestic violence programs. And the Agency's approach is requiring South Central to divert hundreds of thousands of dollars to cover overhead.

So the question to you this morning is what authority do you have from Congress to change what you, I think, accurately said in 2010, which was a legal obligation to add contract support costs to those funds?

Dr. ROUBIDEAUX. Well, while I am not able to comment on litigation that is in progress, I do want you to know that we are consulting with tribes on the issue related to the MSPI and how it is funded currently, and we will see what comments we get on that. But I cannot comment on active litigation. But I do want to—

DOMESTIC VIOLENCE PREVENTION

Senator MURKOWSKI. What about with the Domestic Violence Prevention funds?

Dr. ROUBIDEAUX. Also we are consulting with tribes on that at this point, and we would like to talk about—we want to make sure that tribes do get the administrative costs that they need to run the program. It is just that we have limited funds available for those initiatives, and so we have to figure out a way to do that. And Mr. McSwain will probably make the decision after the consultation since he is the acting director, and, you know, we are hopeful to try to find a solution. But it also is related to litigation, which makes it difficult for us to talk about it at a hearing, but we would love to talk with you—

Senator MURKOWSKI. Well, and perhaps we should have further discussion because I think we would all agree, those of us here within the Interior Appropriations Committee—Senator Udall and

I both sit on the Indian Affairs Committee. And we all know that our statistics as they relate to domestic violence when it comes to Alaska Natives and American Indians are among the worst in the country. And the statistics that we have are not only troubling, they are just unacceptable. And so, if what we are doing is we are limiting the ability of our providers out in Indian country to address some of these issues, we have got to look at it.

One last point on domestic violence. As we look at the Agency's website, between 2010 and 2014, the Domestic Violence Prevention Initiative resulted in over 50,000 direct encounters, including crisis intervention and case management consulting. More than 38,000 of those referrals were made for domestic violence services, and then there was a total of 600 forensic evidence collection kits that were submitted to either Federal, State, or tribal law enforcement.

I find those numbers somewhat surprising. The sheer numbers that we are talking about are in the tens of thousands, and yet we are only seeing 600 rape kits submitted to various law enforcement agencies. I know that when we were moving the Violence Against Women bill through the Congress, part of the discussion at that time was we simply did not have sufficient rape kits that were distributed, certainly in my State. Is that still our situation? Do we have enough kits that are available across the agencies, various service units? Is that part of the problem, because if it is that basic, that is something that we need to be talking about, too, because you cannot get to prosecution if you have not collected the evidence. So have we addressed that aspect of the problem?

Dr. ROUBIDEAUX. Well, I am glad you brought this up. We have \$8.9 million total for the Domestic Violence Prevention Initiative, and with that we have funded more availability of those kits. There are other factors. Sometimes the—

Senator MURKOWSKI. Have we funded it to the level of need?

Dr. ROUBIDEAUX. Well, the problem is it is difficult to know the level of need because some patients do not come into the clinic. Some patients might come in for an exam, but not consent to having it go to law enforcement. Some may be outside the timeframe where a kit would be relevant. And so, there are some issues for why not every encounter is associated with a kit.

Senator MURKOWSKI. Understood, and I also understand that one of the problems that we have, and at least in many of the rural places in Alaska, is we do not have the individuals that are trained in collecting that evidence. And so, sometimes it is the lack of availability of a kit. Other times it is not having a trained individual. I mean, there are many reasons.

Dr. ROUBIDEAUX. This funding—

Senator MURKOWSKI. But we can do better.

Dr. ROUBIDEAUX. Well, this funding has helped us increase our activities to provide the training necessary and forensic equipment to do the exams. There are SANE, SAFE, and SART training and activities. Unfortunately, this funding is not enough to fund everybody, and that is why we are trying to address it as best we can with the funding that we have. And we would love to work with you on this on such a need.

Senator MURKOWSKI. Well, it would be helpful, Dr. Roubideaux, for us to have a little bit more definition in terms of what you are

doing with the money from this initiative, how it is being allocated, what it is being used for, where the gaps are, because, again, if this is a situation where the number of assaults continues at an elevated level. But if you have a situation where an individual knows that there is nobody in my village that even knows how to collect the evidence, or there is no kit, there is not going to be—the individual is going to say, why even bother going on.

Dr. ROUBIDEAUX. I agree with you.

Senator MURKOWSKI. So the perpetrator goes out. It is a horrible cycle.

Dr. ROUBIDEAUX. Well, I would love to have us work more with you on this issue and help you get you the data and information you need to—

Senator MURKOWSKI. If you can get us that data, it would be appreciated.

[The information follows:]

The Domestic Violence Prevention Initiative (DVPI) is currently funded at \$8.9 million program and funds 65 IHS, tribal, and urban Indian health projects. The funding is allocated to projects in three categories: domestic violence (DV) community developed prevention models, sexual assault (SA) prevention expansion projects, and sexual assault examiner (SAE) programs. There are 38 DV focused projects, 19 SA focused projects, and 8 SAE projects. The 8 SAE projects focus on training their providers to conduct medical forensic projects and establishing a coordinated response to sexual violence. The 600 evidence collection kits have been submitted to law enforcement by those 8 funded projects. The number does not represent the total number of evidence collection kits collected or the total number of patients who received a medical forensic examination. The number is also not representative of the entire Indian health system, the number is only from the progress reports collected from the 8 funded SAE projects. Evidence collection kits are made available to IHS and tribal healthcare facilities at no charge from either law enforcement entities or State crime labs. IHS has not received recent reports of facilities having difficulty obtaining evidence collection kits.

There are no current ICD-9 codes to collect data from the electronic health record to determine the number of evidence collection kits that are collected from patients system-wide. There will be more specificity with ICD-10, which will enable IHS to make better determinations in relation to the gaps in services for domestic and sexual violence. ICD-10 is on track to be implemented starting October 1, 2015 and more data should be available next year.

The funds are also used to provide medical forensic examiner training to IHS, tribal, urban Indian, and referral healthcare providers and purchase forensic equipment for IHS and tribal healthcare facilities. Over 290 healthcare providers have been trained to conduct medical forensic examinations through IHS' Tribal Forensic Healthcare Training Program and 90 facilities have state-of-the-art forensic equipment to aid in the photo-documentation of domestic and sexual violence cases. The training is provided through in-person and online courses, including Alaska specific courses for Sexual Assault Examiner, Pediatric Sexual Assault Examiner, and Domestic Violence Examiner.

The allocation of funding for DVPI was determined after tribal consultation and the funding is distributed to the sites with highest need. Not all applicants are able to receive funding. The DVPI evaluation includes various measures to help illustrate how the appropriated amount of funding is used to implement the programs described above to selected sites.

Senator MURKOWSKI. Senator Udall, do you have any final questions here for us this morning?

SANITATION

Senator UDALL. Yes, thank you very much. Just a couple of quick ones here. Dr. Roubideaux, your budget includes \$35 million in new funds to address sanitation needs in Indian country, which is a 44 percent increase in the program. These funds are badly needed to make sure that homes in Indian country have proper access to

clean drinking water and wastewater disposal, especially since your budget estimates that 13 percent of these homes have no connection to sanitation facilities at all.

Can you share with us how you expect to use these funds to improve public health? How do you propose to allocate the funds, and how many homes do you expect you will be able to serve? What kind of progress will this proposed increase allow you to make?

Dr. ROUBIDEAUX. Well, the need is significant. There is about \$2 billion worth of need in projects that would be feasible to do. This particular increase would help us provide sanitation facilities to 7,700 Indian homes above the base funding. The Indian Health Service proposes in its justification to distribute this to both priority projects for existing homes and for new homes as well.

And there is no doubt that any funding we can have in this area is going to help. You know, I had the opportunity to visit very rural areas in Alaska and other places, and it is just—it is heartbreaking to see that here we are in, you know, 2015, and there are people that do not have sanitation facilities, do not have potable water. It is heartbreaking. And so, that is why we are wanting to make some progress with this budget to propose the \$35 million investment. It is not the entire need, but it certainly helps us get started on addressing that need.

DENTAL CARE

Senator UDALL. Thank you. And shifting over to a quick question on dental care, there was language in last year's omnibus that encouraged IHS to work with the Bureau of Indian Education to provide Native youth with preventive dental care. As you know, Native American youth face far higher rates of childhood tooth decay and dental disease compared to the overall U.S. population. So providing these children with access to good dental services is critical, and will help, I think, reverse these health disparities. Could you please update on your efforts to improve dental care in the school setting, and will you work with me to make this a priority?

Dr. ROUBIDEAUX. Absolutely, it is a priority. It is so important, good dental care. We surveyed our dentists recently in light of this request, and found that in nine of 12 areas, we already have prevention and treatment activities with 93 Bureau of Indian Education schools. So we have reached out to the BIE, and would love to work with you on making sure we can increase access.

Senator UDALL. Thank you. I am finished.

Senator MURKOWSKI. Thank you, Senator Udall, and know that I am happy to work with you on the oral health needs of our Native people. We have implemented in Alaska, I think, a great model with regards to our dental health therapists, kind of that mid-level provider. And we have encountered a little bit of resistance at times from the American Dental Association, but I think we have reached an accord with them, and the track record that we have seen has made a difference. When you have somebody in a village who is working with kids on just basic care—brushing your teeth, and passing out toothbrushes at the grocery, and being there to address cavities so that you do not have to pull them—it does make a difference. And I think we have got a very strong model going in Alaska that I would love to talk with you about.

ADDITIONAL COMMITTEE QUESTIONS

Thank you, Dr. Roubideaux. Thank you, Mr. McSwain. I have some additional questions that I am going to be submitting for the record. One relates to the 477 Program, as well as the Native Youth Suicide Program that you have incorporated, the healthcare initiative for Native youth. Know that many of us are very focused on making some headway there as we deal with our Native youth. But I know that other members will also have questions that they would ask to have submitted for the record, and we would appreciate your timely responses to each of them.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO DR. YVETTE ROUBIDEAUX

QUESTIONS SUBMITTED BY SENATOR LISA MURKOWSKI

Question. For fiscal year 2016, the administration has announced it will pay full contract support costs within the Indian Health Service (IHS) budget (\$718 million). The administration has also proposed that beginning in fiscal year 2017 Contract Support Costs (CSC) become mandatory spending.

At a recent National Congress of American Indians (NCAI) Listening Session, the indication was made that the administration's proposal would authorize up to 2 percent of the contract support cost appropriation to be used for overhead. How much is IHS currently spending to administer its annual appropriation for contract support costs? Please exclude funding for legal claims and include funding used with allocating and paying the annual contract support cost appropriation.

Answer. IHS estimates spending approximately \$12 million dollars in fiscal year 2014 to administer CSC-related activities. This includes costs for CSC need negotiations with each tribe, payment reconciliations, CSC meetings at the Area and Headquarters level, and contractor support to assist with ensuring consistency in process/negotiation issues identified during claims analysis.

Question. What is the administration's position on the lawsuit that Manililaq brought against the Indian Health Service in the U.S. District Court? The lawsuit concerns the tribe's Village Built Clinic (VBC) in Ambler which had been chronically underfunded for years under its Indian Self Determination Act agreement. The court ruled that the Self-Determination Act must be interpreted in the light that is most favorable to tribes and that "Congress intended the Indian Self-Determination and Education Assistance Act (ISDEAA) must be interpreted in a manner favoring flexibility in funding agreements like the one at issue in this case."

Does the administration believe the court's rationale is at odds with the IHS's approach to the VBC issue? Why or why not?

Answer. Although the case referenced has been decided, the Department of Health and Human Services (HHS) is involved in ongoing litigation related to the VBC issue. As a result of ongoing litigation the IHS is not able to comment at this time.

Question. What could be the impact of this case on other VBC's in Alaska if the tribe prevails on appeal?

Answer. As a result of ongoing litigation the IHS is not able to comment at this time.

Question. Public Law 102-477 is a self-determination statute that allows tribes greater control over delivery of social-welfare and workforce-development services from funds received through the Department of the Interior, Department of Labor, and the Department of Health and Human Services. I know that DOI is the lead agency for the "477" program but obviously funds come from the Department and it seems that some of the flexibility that tribes have enjoyed with this program in the past were restricted based on new interpretations of the law by HHS. In fact, we addressed this issue in the fiscal year 2012 Interior bill and asked for the administration to work with the "477" Tribal Working Group to resolve auditing requirements for tribes.

Does the administration agree or disagree that additional flexibility is helpful to tribes in best managing their limited resources?

Answer. The administration sees the benefit of providing the flexibility to adjust priorities due to local circumstances and changing priorities over time. However, the

administration is also respectful of the statutory purposes for which funds are appropriated and the regulations associated with those programs. It is essential that we work collaboratively with tribes to identify opportunities to maximize flexibility and reduce administrative burdens wherever possible.

Question. Also, my understanding is that there has never been an issue with the misuse of funds concerning the co-mingling of 477 funds to maximize results on the ground for tribes. Is that your understanding as well?

Answer. The Indian Health Service is not aware of any information regarding co-mingling of funds. IHS programs are not included in 477 employment and training programs.

Question. One of the proposed increases in the budget that I'd like to understand more about is the \$25 million aimed at suicide prevention and substance abuse within our Native youth. Information from the Alaska Department of Health and Social Services indicates that Alaska Native men between the ages of 15–24 have the highest rate of suicide of any demographic in the country. We also know the devastating impacts of alcohol and other drugs in our Native communities. These statistics are heartbreaking.

Can the IHS outline how the additional funds would be used?

Answer. The funds would be used to award additional Methamphetamine and Suicide Prevention Initiative (MSPI) projects for a 5-year funding cycle to hire behavioral health staff for prevention and early intervention of youth suicide and substance abuse, as well as other mental health services. Funding would be awarded through a competitive application process based on greatest need to those projects with plans to use the funding to provide services for youth in local IHS, tribal, and urban Indian healthcare facilities, school-based settings, or in other youth based programs, such as the Boys & Girls Club of America.

Question. Increased funding for programs is one way to help address this issue, but is the IHS developing better strategies and identifying other things to do in order to help our Native youth?

Answer. The IHS continues to support and monitor youth behavioral health programming provided by IHS, tribal and urban Indian health programs, including the Youth Regional Treatment Centers (YRTCs), the Methamphetamine and Suicide Prevention Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI). IHS develops, utilizes and disseminates best and promising practices, as well as culturally appropriate services from the current MSPI and DVPI programs to inform future youth specific services and programming.

IHS also provides on-going training for its healthcare providers to build a competent workforce prepared to promote the health and wellbeing of AI/AN youth through the IHS Tele-Behavioral Health Center of Excellence (TBHCE). In fiscal year 2014, over 8,000 healthcare providers received no cost continuing education through the TBHCE. In the same time period, IHS hosted 59 youth-related training events with more than 2300 attendees.

Question. The reauthorization of the Indian Health Care Improvement Act authorized the Indian Health Service to expand services to include dialysis services.

How many IHS funded facilities offer dialysis?

Answer. No IHS facilities directly provide dialysis services. According to the OIG report from September 2011 entitled "Access to Kidney Dialysis Services at Indian Health Service and Tribal Health Facilities", there are 20 tribal facilities that provide dialysis at their facilities: 3 have tribally operated dialysis facilities and 17 provide dialysis services through an independent for-profit or nonprofit company. As the majority of IHS beneficiaries on dialysis are eligible for Medicare, funding for dialysis programs comes primarily by billing Medicare and other third party payers for services. Purchased/Referred Care is used infrequently for dialysis services, only when other third party payment is not available.

Question. What is the average distance a dialysis patient has to travel in Indian Country if there is not a Service facility nearby?

Answer. IHS does not have data available on the average distance a dialysis patient has to travel to receive dialysis services. The distance can range from a few blocks to a tribally managed dialysis center in the community to a drive to the next city or town with a dialysis center. Since dialysis services are often covered by Medicare and many patients do not go through IHS to obtain their dialysis services, IHS does not have access to information to be able to calculate the average distance.

Question. Does the Purchased/Referred Care money have to be used to pay for both this travel and this care? If so, how much of PRC funding goes to dialysis care?

Answer. The Purchased/Referred Care (PRC) funding is not required to be used to pay for both travel and dialysis services. PRC may be used for transportation and dialysis services depending on eligibility, notification, ranking within medical priority, alternate resource use and funds availability. Otherwise alternate resources

such as private insurance, Medicaid, or tribal transportation services may pay for travel. In general, Medicare covers the cost of dialysis services for most patients which saves PRC funding for other types of referrals.

In fiscal year 2013, approximately \$12,770,215 of funding for Federal PRC programs was spent on dialysis care. This is approximately 3.3 percent of the total IHS Federal PRC budget and does not include transportation costs.

Question. The Indian Health Service system is heavily reliant on the funds it gets from third party receivables whether private insurance or medicare/medicaid. As CEO of the Indian Health Service, you must hold the Service unit's accountable.

How often do you monitor reports of 3rd party collection from the various Service units? Reports are that in some Service units (Billings Service Unit, Crow Hospital) there are providers who only see one patient a day. Is that accurate?

Answer. IHS Headquarters, through the Office of Resource Access and Partnerships and the Unified Financial Management System, monitors collections by Facility (Tax ID) on a monthly basis, with any discrepancies or downward trends shared with the Facility/Area in question. Facilities and Areas are responsible for tracking collections specifically at the local level on a more frequent basis (weekly). Since this tracking is by facility, it does not track collections by individual provider. Neither of the facilities mentioned has providers that see only one patient a day. IHS facility management monitors monthly workload reports in addition to overall facility collections so that if there are providers that need to increase their workload IHS facility management can address those providers directly.

Question. Is there someone assigned to diligently monitor collections to determine if a provider is doing his/her job in that facility?

Answer. Service Unit staff and Area Office staff are responsible for tracking collections at the local facility level. However, IHS headquarters has not recommended tracking collections by individual provider and judging productivity for providers based on collections amounts because it is complex, impacted by other factors outside of the control of the provider and can be misleading. For example, some patients may not have an alternate resource that IHS may be able to bill for covered services. Also, providers do not manage or control their payer mix in IHS. Providers are required to see all IHS patients regardless of any additional third party coverage. For example, Provider A may coincidentally see more Medicaid patients (at a higher rate of reimbursement) than Provider B, even though they see the same total number of patients.

However, IHS has implemented business planning at local Federal facilities to ensure that CEOs are responsible to regularly update their strategic planning to maximize third party collections, and that includes reviewing staffing patterns. In addition, implementation of the IHS Improving Patient Care (IPC) Program allows physicians to spend less of their time on administrative and other tasks that can be done by other members of the team which will allow them to improve their efficiency and have time to see more patients. This will potentially result in increased opportunities for third party collections for services provided to patients that have coverage.

In the Billings Area, tracking of provider productivity regarding number of patients seen per day is extracted from the Resource Patient Management System (RPMS). CEOs are able to review this data over time.

The Billings Area and Crow Hospital monitor provider productivity on daily/weekly basis and specifically address any issues with providers when needed. The Billings Area also addresses issues of documentation, billing, posting, and accounts receivable backlog with individual providers when pertaining specifically to providers.

In order to respond to tribal input and increase access to care, an Express Clinic was opened at the Crow Service Unit in the past year that provided care after regular clinic hours. The increased volume of patients seen could help increase third party collections if those patients have coverage.

QUESTIONS SUBMITTED BY SENATOR TOM UDALL

CONTRACT SUPPORT COSTS

Question. Are you confident that the budget request you have proposed for fiscal year 2016 will fully cover your estimated contract support cost needs?

Answer. IHS is confident that the amount proposed for fiscal year 2016 will fully cover the estimated contract support costs needs, based on the information available at the time of the budget submission. Since CSC estimates can change over time due to a number of factors, IHS will provide updates to the subcommittee.

Question. Can you tell us more about the Service's efforts to work with tribes to improve contract support cost budget estimates in 2016 and going forward?

Answer. The consultation on the long term solution after the Supreme Court's decision in *Salazar v. Ramah Navajo Chapter* was helpful in generating discussion and collaboration between the agencies and tribes on how to improve CSC estimates, and the IHS has implemented improved business practices and a calculation tool to use with tribes to provide more consistent and verifiable CSC amounts for negotiations, reconciliation and payments. In addition, IHS performs monthly data reconciliation of CSC estimates and payments. The data reconciliation assures that IHS is updating the CSC estimates of need for each tribe throughout the year as new information becomes available. This process of monitoring CSC activity on a regular basis, identifying additional amounts owed to tribes by IHS or amounts owed to IHS from tribes, and adjusting payments on a regular basis to assure full CSC funding, provides the ability to better estimate the full amount of CSC need during the fiscal year and ensure there is no shortfall for the estimate identified by the end of the fiscal year.

RECRUITMENT AND RETENTION OF HEALTH CARE PROVIDERS

Question. I am concerned about turnover and low morale at the Indian Health Service—and the agency's reported vacancy rate of 23 percent for doctors particularly troubles me. That means you are operating without almost one-quarter of the doctors you need. Congress and IHS need to work together so that we can be sure you are hiring enough qualified healthcare providers to properly staff every facility—and to make sure that providers stay with IHS to develop relationships with patients and improve health outcomes. I also understand that every vacancy left open also costs the Service potential revenue from third-party billing, so there's also a case that filling these vacancies makes good business sense.

What are you doing to make recruitment and retention of healthcare providers a priority, and how are you engaging tribes to participate in retention efforts—especially since they have a personal stake in the outcome?

Answer. The vacancy rate represents positions that are not permanently filled at the time of that specific report. However, many facilities will hire temporary or contract providers to ensure that patients can get the care they need while the facility is recruiting to permanently fill the position. Third party billing can continue even with a temporary or contract provider.

Recruitment and retention of healthcare professionals is an ongoing issue for the IHS and other healthcare organizations that serve rural and remote locations. The IHS has made it a priority and uses a number of incentives to assist in the recruitment and retention of health professionals including loan repayment, scholarships and extern programs, maximizing use of pay authorities, the National Health Service Corps, and involvement of local tribal leadership.

Many health professionals leave school or post graduate training with substantial educational loan debt. The IHS Loan Repayment Program (LRP) allows IHS to attract individuals interested in working in Indian communities, but who would be unable to do so if there were not a way to pay their educational loans. In fiscal year 2014, the IHS LRP was able to award 710 healthcare professionals. In fiscal year 2014, the IHS Scholarship Program was able to fund 260 health professions students that will provide clinical services for 2 to 4 years at Indian health sites once they complete their training. The IHS Extern Program is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and tribal health professionals in their chosen discipline. The program also allows students the opportunity to work at sites they may want to apply to for employment after they complete their health professions training. This program is open to IHS scholars and non-IHS scholars. Students are employed up to 120 days annually, with most students working during the summer months. In fiscal year 2014, the Extern Program funded a total of 111 extern students. Hundreds of additional students rotate through Indian health facilities on academic rotations throughout the school year.

IHS facilities have existing authorities for other incentives to assist in the recruitment and retention of health professionals. These include Title 5 and Title 38 Special Salary Rates, Title 38 Physician and Dentists Market Pay, the 3Rs (recruitment, retention and relocation incentive pays), and use of service credit for annual leave accrual rate purposes based on prior non-Federal work experience or a period of active duty in a uniformed service. Title 5 and 38 Special Salary Rates have allowed IHS facilities to recently offer more competitive pay that is closer to what healthcare providers would receive in the private sector. Title 38 Physician and Dentists Market Pay enables IHS to pay physicians at salary levels comparable to

the VA and to hire specialists, such as orthopedic surgeons, that would otherwise not consider IHS employment for the pay and incentives offered under Title 5.

The IHS and Health Resources and Services Administration (HRSA) continue to work together to make the National Health Service Corps (NHSC) more accessible to fill health professional vacancies. Starting in 2010, the IHS and HRSA collaborated to expand the number of IHS and tribal facilities designated as NHSC-approved sites. This allows these facilities to recruit and retain primary care providers by using NHSC scholarship and loan repayment incentives. As of January 2015, a total of 648 IHS, Tribal Clinics, and Urban Indian Health Clinics are approved as eligible sites for NHSC scholars and LRP applicants, compared to 60 at the end of 2010. There are currently 197 positions at IHS and tribal sites listed on the NHSC Job Center Web site that serves as the central source for scholars and loan repayment recipients to find placements. As of January 2015, a total of 33 NHSC scholars and 351 NHSC loan repayment recipients were providing healthcare services to Indian communities.

Many tribes have their own health professions recruitment programs. The IHS works to encourage tribal leaders and the local community to participate in recruitment efforts. The IHS provides assistance to local chief executive officers, clinical directors, tribal leaders and prospective new hires through the development of recruitment and retention materials. The Applicant Support Program Guide provides guidance to IHS and tribal hiring officials on building relationships with prospective hires as they go through the hiring process. The *Planning Your Successful Transition* brochure and workbook help new hires and their family's transition to a new culture and rural community. The Community Liaisons brochure focuses on preparing a community liaison to work with prospective employees and new hires and the Organizational Onboarding guide sets the stage for continued employee satisfaction, thereby promoting retention of these healthcare professionals.

Question. How does IHS measure its success for its recruitment and retention efforts—and how will you show that improvements have a beneficial effect on patient care?

Answer. The goal of the IHS health professions recruitment and retention effort is to provide highly skilled health professionals to Indian health facilities to deliver high quality care to Indian people. At the national level, IHS conducts a comprehensive set of activities in support of healthcare provider recruitment and retention, including national advertising campaigns, marketing of the Loan Repayment and Scholarship Programs and development of collateral materials that are distributed and used by national, Area and local recruiters. The effectiveness of these activities is evaluated in terms of the number and types of activities as well as the number of individuals viewing advertisements, contacting recruiters and recruited to key health professions positions. IHS has been able to measure improvements in specific health professional disciplines. For example, the vacancy rate for dentists improved from over 30 percent prior to 2009 to less than 10 percent recently after a coordinated push to increase a variety of recruitment activities, including the use of Title 38 Physician and Dentist Market Pay for that profession. IHS measures and routinely monitors vacancy rates and turnover rates at IHS Federal facilities for high priority health professions. IHS does not have complete information on tribal vacancy rates since they are not required to submit data on this under their Indian Self-Determination and Education Assistance Act (ISDEAA) contracts and compacts.

The IHS Improving Patient Care (IPC) Program encourages greater continuity of care for patients through teamwork and improvements in processes of care. IPC has measured greater patient satisfaction with improved processes among participating programs. Filling vacancies helps improve continuity of care for patients, which can result in improved quality of care.

Question. I'm proud to have sponsored legislation with Chairwoman Murkowski that would make scholarships and loan repayment programs funded through IHS tax-exempt to help you attract and I am happy to see your budget request proposes something similar. Can you please tell us what you expect the impact of making scholarships and loan repayment tax exempt will be on your vacancy rates?

Answer. The IHS Scholarship Program (SP) and Loan Repayment Program (LRP) are invaluable tools for recruiting and retaining healthcare professionals. The SP assists American Indian and Alaska Native (AI/AN) health professions students with tuition and monthly stipend support while they are in school. Students must agree to a year of service for each year of financial support with a minimum 2 year commitment. IHS is not authorized to provide funding to offset tax liability for SP recipients, who must fund this cost from their stipend or through other means. The LRP offers healthcare professionals the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve 2 years at an Indian health program in exchange for up to

\$20,000 per year in loan repayment funding. Currently, for every LRP award of \$20,000, the LRP sets aside \$5,836 of its appropriated funding to account for taxes; \$4,000 for Federal tax and \$1,836 for Federal Insurance Contributions Act (FICA) costs. If the IHS SP had a tax exemption similar to that of the National Health Service Corps (NHSC) Scholarship Program as proposed in the President's budget, AI/AN students receiving scholarship support could use their entire \$1,500 monthly stipend to assist with their living expenses rather than using it to pay taxes on their scholarship award. If the IHS LRP were to receive tax exemption equivalent to the NHSC LRP, the IHS LRP could use the \$5,711,893 of loan repayment funding currently paying taxes associated with LRP awards to make an additional 132 LRP awards.

INNOVATION IN HEALTH CARE CONSTRUCTION

Question. I believe that it's very important that you also make sure that the buildings you construct are flexible enough to meet future needs, given the construction backlog and the limited resources we face.

How are you using innovation such as flexible floor plans and green building technologies to address your facilities' current and future needs?

Answer. IHS agrees that innovation in construction techniques are needed to address the changing health delivery methods and green building technologies. Our healthcare facilities construction program attempts to incorporate flexibility during the design stages working hand in hand with our tribal partners, healthcare professionals, and engineers/architects with specific experience in healthcare facility design. IHS healthcare facilities are being constructed to incorporate many sustainability/"green" features and IHS continues to investigate cost-effective options in the future design of planned facilities. Also, IHS is complying with Public Laws and Executive Orders that direct Federal agencies to increase energy efficiency and reduce water consumption in their facilities. The IHS meets sustainability requirements and Leadership in Energy & Environmental Design (LEED) Silver when constructing new healthcare facilities. Also, IHS completed a report on modular construction where the results revealed that modular facilities can be constructed to last 50 or more years. Modular facilities are constructed using typical construction grade materials such as concrete, structural steel, masonry units, found in permanent buildings.

YOUTH BEHAVIORAL HEALTH INITIATIVE

Question. Your budget request includes \$25 million in new funds to address suicide risk and substance abuse as part of the President's cross cutting initiative on Native youth, "Generation Indigenous". I understand that that funds requested through the Indian Health Service would be used to expand access to behavioral health professionals, and that these funds are complemented by increases proposed in the budgets of the Substance Abuse and Mental Health Administration and other Federal agencies.

Your budget states that the new funds within the IHS budget would be used expand service for Native youth through the existing Methamphetamine and Suicide Prevention Initiative grants program ("MSPI"). The MSPI pilot program started in 2009, so I'm interested to learn more about its track record, as well as the expected outcomes in your budget proposal.

Can you share some of the accomplishments of the current MSPI program and elaborate on why you believe that it's the best model to address mental health and substance abuse issues for Native youth? How do you measure success?

Answer. The primary goals and accomplishments of the MSPI projects include the expansion of behavioral healthcare and services—providing more services and wider access—to tribal communities. The MSPI focuses on implementing evidence-based and practice-based strategies that are culturally appropriate and community based. Statistics that document users, or the number of individuals impacted by these services, are one clear indicator of accomplishment. In the course of the initiatives, many tribal youth and families increased their knowledge about and/or participated in services and treatment related to methamphetamine, drug use, suicidality, and depression. Over 528,000 encounters with youth have been provided as part of evidence-based and practice-based prevention activities.

As a result of the MSPI, over 9,400 individuals entered treatment for methamphetamine abuse. MSPI projects also offer treatment options for marijuana, alcohol, and prescription drugs as the most common substances other than methamphetamine for which treatment was provided. Fifty-nine percent of MSPI projects focus on depression screening with a 12 percent positive rate. To help improve access to quality care for patients, more than 12,000 substance abuse and mental

health encounters were delivered via tele-behavioral health. MSPI projects also deliver treatment options with motivational interviewing and cognitive behavioral health therapy as the most commonly utilized evidence-based practice types. MSPI projects have also trained over 13,000 professionals and community members to respond to suicide crises.

The model in use for MSPI demonstration projects is community driven and solution focused from a community needs context making its success the best model to address mental health and substance use and abuse.

Question. How will you allocate the funds proposed in your request to ensure that they actually reach the youth who are at the greatest risk—and that they also reach the greatest number of tribes? What role do you see for schools and education professionals to play? What about tribal leaders?

Answer. The funding formula for MSPI considers the greatest need based on data on population served, poverty, and disease burden. Determining greatest need has been based on consultation with tribes and includes recommendations for funding applicants to submit related findings from relevant community data, needs assessments, or evaluation to support their application and request for funding.

Educational professionals and schools serving AI/AN youth, including organizations such as Boys & Girls Club of America, are vital participants in the success of youth directed prevention, early identification and intervention, treatment, and recovery services. Selecting projects that will provide these types of services in school settings are ideal since this is where youth spend much of the day and can more easily access services. Early identification and intervention is essential in the school environment. If schools do not have the capacity to intervene themselves, it is essential that they are able to engage the youth and assist in a seamless introduction and/or referral to a behavioral health professional. Finally, when youth are receiving or have received behavioral health services, it is essential for school professionals to encourage and support the youth as they return to the school in their reintegration and recovery process.

Tribal leaders are necessary participants in the planning, development, implementation, and monitoring of any behavioral health services directed for AI/AN youth in their communities. Buy-in and active participation from tribal leaders is vital to the success of youth behavioral health programs. One element identified in the lessons learned from the MSPI and DVPI demonstration programs was the ability to garner support and participation of community members and tribal leaders.

Question. Can you talk more about the overarching goals of the “Generation Indigenous” proposal, and share specific details about how IHS plans to coordinate with other Federal agencies to implement these goals? If they are funded, what are the metrics that this administration plans to use to show that these investments are working to change the lives of Native youth?

Answer. The Generation Indigenous initiative was developed after the President and First Lady took a historic trip to the Standing Rock Sioux Reservation in North Dakota in 2014 where they heard directly from Native youth who described significant challenges. President Obama launched the Generation Indigenous (Gen I) initiative at the 2014 White House Tribal Nations Conference which takes a comprehensive, culturally appropriate approach to remove barriers and help improve the lives and opportunities for Native youth by using new investments and strengthening the administration’s engagement with public and private partners. The IHS participates in the Gen I initiative along with other Federal agencies.

The major components of the overall Gen I initiative include: (1) White House Native Youth Report (released earlier this year); (2) fiscal year 2016 President’s budget proposals for several agencies, including the Department of Education proposal for Native Youth Community Projects and Bureau of Indian Education reform proposals; (3) National Tribal Youth Network; (4) Cabinet Secretary Listening Tour; (5) White House Tribal Youth Gathering; and (6) Generation Indigenous Youth and Tribal Leader Challenges.

IHS sees itself as a critical partner in this important work. IHS’ initial contribution to this work is the fiscal year 2016 budget proposal in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA). The \$50 million proposal from the Department of Health and Human Services to address behavioral health issues in youth includes \$25 million for SAMHSA’s Tribal Behavioral Health Grants and \$25 million for IHS to expand the Methamphetamine and Suicide Prevention Initiative (MSPI) to hire additional behavioral health providers to focus on youth services and programming. This collaboration represents a proposal for the agency efforts to compliment and not duplicate other efforts. While SAMHSA focuses in expanding community based services, IHS’ proposal focuses on adding providers on the clinical side. Both proposals are needed to support and address behavioral health issues in youth. Improvements by other agencies in schools

and other services are complimented by addressing behavioral health issues, which are often a significant challenge and barrier to success for Native youth.

Evaluation of the IHS proposal will be included in the ongoing MSPI evaluation of the provision of services and their impact on patients served. This proposal meets the first goal of MSPI to increase access to behavioral health services. Specifically, IHS will include measures such as the number of new projects funded, numbers of new behavioral health providers hired by projects, and the numbers of and effectiveness of services and activities implemented for youth with these additional funds.

THIRD PARTY COLLECTIONS

Question. Dr. Roubideaux, IHS currently collects about \$1.1 billion in these funds each year from third-party payers such as Medicare, Medicaid, the Department of Veterans Affairs and private insurers. I understand that IHS is trying to better leverage third-party collections, especially with the passage of the Affordable Care Act, and I see that your budget request includes \$10 million in new funds to expand collections efforts at your health facilities. The Affordable Care Act greatly increases the potential for expanded participation in Medicaid and private insurance through the health insurance marketplaces, allowing the Service to bill these third party payers for medical care.

Can you share with us what specific impacts these changes are having on the IHS budget?

Answer. The Affordable Care Act increases the potential for increased third party coverage for IHS patients and if they receive services through IHS, increases the potential for third party collections. IHS facilities are required to conduct regular business planning to assess the potential impact of the Affordable Care Act on their facilities and to develop strategies to maximize third party collections. While it is still early to determine the full impact of coverage expansions that began in 2014, in fiscal year 2014, IHS was able to increase third party collections by \$49 million compared to fiscal year 2013, in part due to increased third party coverage of its patients and through improvements in business practices. In order to maximize outreach, education, enrollment, case management, and third party billing moving forward, IHS proposed the increase of \$10 million to help provide additional support to IHS business offices, including additional training, technical assistance, improvements in business office processes and compliance. This additional funding is needed since the volume of business related to third party coverage and collections is anticipated to continue to increase as a result of the Affordable Care Act.

Question. Can you tell us how exactly you plan to spend the additional \$10 million proposed in your budget, and share with us why you think IHS needs additional funding to implement better collections?

Answer. IHS and tribal business offices are the backbone of the Indian healthcare system. In order to maintain and increase collections for the services provided, the \$10 million increase in the Hospital & Health Clinics (H&HC) budget will be used to provide support in the areas of training, technical assistance (TA), and business process and compliance issues. The training will be instrumental in increasing the skill sets of the employees that work directly on third party billing and collections. Better trained staff will make the business process more efficient and effective thereby making better use of resources available for patient care. Billing practices will improve, third party collections will increase and there will be better accountability of collections. This will be accomplished through the development of appropriate training materials and the establishment of TA programs that are tailored to IHS and tribal business office needs. This TA will provide needed information on regular and recent changes to the business process such as billing code changes, rate increases for Medicare and Medicaid, regulatory policy and technical changes, and new technology, including information technology. The additional funding is needed to develop and deliver this training and technical assistance and to increase staff ability to adapt to the anticipated increased workload due to the Affordable Care Act.

Question. Are there steps that you could take to improve collections right now by simply improving your existing business practices?

Answer. Yes, we can and we have been taking as many steps as possible with existing resources to improve business practices related to third party collections. We have just completed an update of the Third Party Internal Controls/Accounts Receivable Policy and are now taking steps to ensure its implementation in every Area and local hospital and clinic. This spring, we are also finishing an update of the IHS Revenue Operations manual, our system-wide reference resource for all IHS and tribal facilities across the United States, to assist any and all staff with any function related to business operation procedures and processes, including administra-

tive Roles and responsibilities, patient registration, Coding, Billing, and Accounts management. Finally, as we prepare for ICD-10 implementation, we are making sure that every Area, hospital, and clinic, has received and reviewed our checklist for local implementation.

Question. How much additional revenue will IHS recover through this proposal? What's the expected return on investment?

Answer. IHS estimates that we will increase our collections by 2 percent by the end of the first year of implementation if this investment is enacted and that this will increase in outlying years as implementation progresses. However, without knowing the final enacted funding level, it is premature to estimate an expected return on investment.

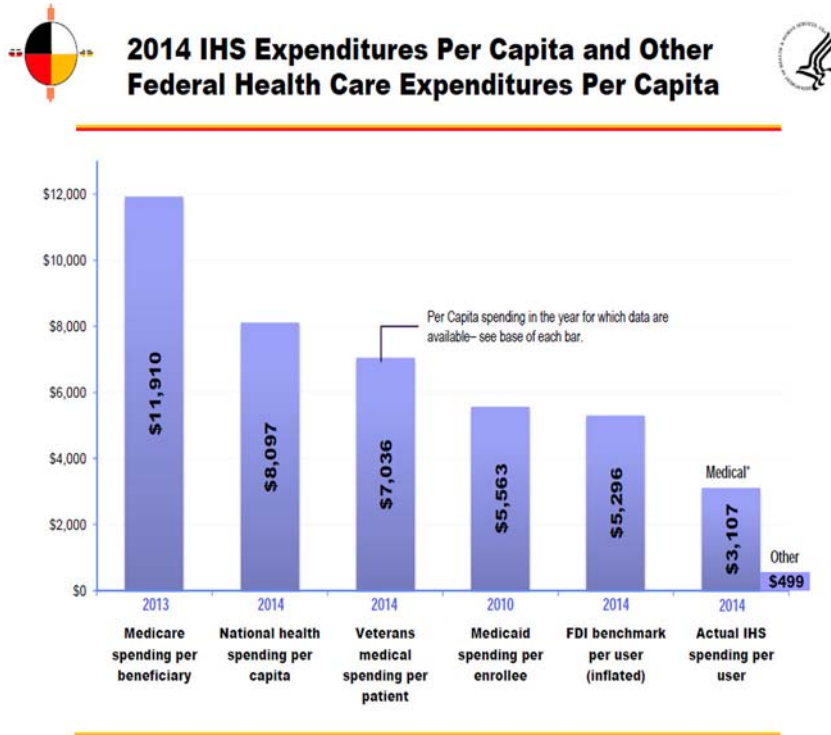
DATA COLLECTION

Question. As we discussed during the hearing, I remain concerned that per-patient health expenditures by the Indian Health Service continue to lag behind spending for other Federal programs.

Please provide updated data that compares per-patient spending by the Indian Health Service with the following Federal programs: (1) Medicare spending per beneficiary; (2) national health spending per capita; (3) medical spending per patient by the Department of Veterans' Affairs; (4) Medicaid spending per enrollee; and (5) per-patient spending for enrollees of the Federal Health Benefits Program.

Answer. The 2014 IHS expenditures per capita data indicates that \$11,910 is spent per Medicare beneficiary; \$8,097 is the national healthcare spending per capita; \$7,036 is the amount of medical spending per patient by the Department of Veterans' Affairs; and \$5,563 is the amount spent per Medicaid enrollee. IHS does not have data available for the per-patient spending for enrollees of the Federal Health Benefits Program (FEHB).

However, a comparative cost benchmark linked to premiums, deductibles, and co-pays from the FEHB is included in annual comparison charts.



See notes on next page for data. *The extent of payments by other sources for medical services provided to AIANs outside IHS is unknown.

2/13/2015



Data Sources and Calculations -- Health Care Expenditures Per Capita



1. \$11,910—2013 AVERAGE MEDICARE BENEFIT PER ENROLLEE: Source—2014 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS; available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf> in Table II.B1 Medicare Data for 2013, page 10.
2. \$8,097—PROJECTED 2014 NATIONAL HEALTH CARE EXPENDITURES PER CAPITA: Source—Table 5 Personal Health Care Expenditures; Aggregate and per Capital Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2013-2023; available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>.
3. \$7,036—2014 MEDICAL CARE PER VETERANS ADMINISTRATION PATIENT: Source—Volume II—Medical Programs and Information Technology Programs—Congressional Submission, available at <http://www.va.gov/budget/docs/summary/FY2015-Volumell-MedicalProgramsAndInformationTechnology.pdf>. Per capita spending estimate is calculated by dividing 6,616,963 unique VA patients (page VHA-7 “Unique Patients” table) into \$46,554,000,000 total health care services (page VHA-8, Executive Summary of Medical Care table).
4. \$5,563—2010 MEDICAID PAYMENTS PER BENEFICIARY. The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS). 2010. Available at <http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/#>.
5. \$5,296—FDI BENCHMARK PER IHS USER (Interim Inflated): The ACA expands health care resources potentially available to AI/ANs. IHS’ long standing methodology projecting per-capita resource needs has not yet incorporated these factors due to unavailable data. In the interim, the last benchmark was inflated to 2014 pending future methodological adjustments for ACA effects.
6. \$3,107—2014 IHS MEDICAL CARE EXPENDITURES PER USER: Source—IHS appropriations for 2014. Appropriations spent for personal health care services plus IHS collections from third parties are totaled and divided by 2014 user counts (1,597,500). IHS spends an additional \$499 per person for public health, community programs, sanitation and environmental projects, education, and other purposes unrelated to personal medical care. An unknown additional amount of spending occurs outside the IHS system when patients obtain a portion of their medical services elsewhere, e.g. payments by private insurance, Medicare and Medicaid to non-IHS providers for services to Indians who also use the IHS.

Question. We also discussed how unique challenges in Indian Country such as disease burden and geography further compound the challenges that the Service faces in providing healthcare to American Indians and Alaska Natives. Could you also discuss why measuring IHS spending against these benchmarks may not fully capture some of the additional challenge you face? In other words, why is an IHS patient not a “typical” patient that is enrolled in Medicaid or the Federal Health Benefits program?

Answer. The American Indian and Alaska Native (AI/AN) people continue to experience health disparities and multiple chronic conditions that are greater on average than those that a typical patient enrolled in Medicaid or the Federal Health Benefits Program may face. For instance, while the rate of increase in diabetes prevalence appears to be slowing in AI/AN adults, the current prevalence of 15.9 percent it was still more than twice that of U.S. white adults (7.6 percent) and more than 4 percent higher than the general U.S. adult population in 2012. Diabetes at least doubles the risk of cardiovascular disease and other complications are also common in patients with longstanding diabetes, including kidney, eye, and nerve problems. Management of patients with diabetes, diabetes complications and other associated chronic conditions is extremely challenging and requires more time and resources.

Additionally, AI/AN people have experienced high rates of adverse childhood experiences (ACE), which are strongly related to many adult health and mental health outcomes. One study of ACE exposures in 1,660 AI people from seven southwest tribes (Am J Prev Med 2003;25:238–244) found that the prevalence of adverse childhood experiences was very high in all 7 tribes studied. Two-thirds of participants reported having at least one parent with alcohol problems. The most common types of maltreatment were physical neglect (men: 45 percent; women: 42 percent) and physical abuse (men: 40 percent; women: 42 percent), sexual abuse (men: 24 percent; women: 31 percent), emotional abuse (men: 23 percent; women: 36 percent), and emotional neglect (men: 20 percent; women: 23 percent). One-third of partici-

pants had experienced at least 4 types of ACE exposures. In the original ACE study conducted with over 9,500 adult HMO enrollees in California, having experienced at least 4 types of childhood adversities increased the risk of alcoholism, drug abuse, depression, and suicide attempt by 4–12 times; the risk of smoking, poor self-rated health, and sexually transmitted disease by 2–4 times; and the risk of physical inactivity and severe obesity by 1.4–1.6 times (Am J Prev Med 1998;14:245–258). Further, the experience of chronic poverty, food insecurity, and discrimination compounds the effects of childhood adversities to create significant risks for the health and mental health of AI/AN people.

The AI/AN population is younger, but it experiences mortality at a much higher rate than the overall U.S. population (U.S. All Races). Children aged 5–14 years comprises 21.6 percent of the AI/AN service population, whereas in the overall U.S. population this group accounts for 14.6 percent. The median age of the IHS Service Area AI/AN population is 25.0 years. In comparison to the overall U.S. population, the median age is 34.9 years.

AI/AN persons aged 15–24 years are 17.8 percent of the population in the IHS Service Area, compared to 14.0 percent of the overall U.S. population. In four key areas, this age group experiences significantly higher mortality as summarized in the table below.

ADJUSTED MORTALITY PER 100,000 POPULATION
15–24 YEARS OF AGE
IHS SERVICE AREA (2007–2009)

Cause of Death	AI/AN	All Races	Ratio
Alcohol Related	5.4	0.4	13.5
Suicide	39.7	9.9	4.0
Heart Disease	3.8	2.5	1.5
Homicide	16.9	12.2	1.4

Mortality rates for alcohol-related deaths, suicide, heart disease and homicide among AI/AN persons aged 15–24 years are in excess of U.S. All races, ranging from 1.4 times (homicide) to 13.5 times (alcohol related) higher.

SUBCOMMITTEE RECESS

Senator MURKOWSKI. We look forward to working with you on many of these issues. And with that, the subcommittee stands adjourned.

[Whereupon, at 11:26 a.m., Wednesday, March 11, the subcommittee was recessed, to reconvene subject to the call of the Chair.]