

**H.R. 2662, “RESTORING ACCOUNT-  
ABILITY IN THE INDIAN HEALTH  
SERVICE ACT OF 2017”**

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**LEGISLATIVE HEARING**

BEFORE THE

SUBCOMMITTEE ON INDIAN, INSULAR AND  
ALASKA NATIVE AFFAIRS

OF THE

COMMITTEE ON NATURAL RESOURCES  
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

Wednesday, June 21, 2017

**Serial No. 115-10**

Printed for the use of the Committee on Natural Resources



Available via the World Wide Web: <http://www.fdsys.gov>

or

Committee address: <http://naturalresources.house.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

25-969 PDF

WASHINGTON : 2017

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**LEGISLATIVE HEARING ON H.R. 2662, TO  
AMEND THE INDIAN HEALTH CARE IM-  
PROVEMENT ACT TO IMPROVE THE  
RECRUITMENT AND RETENTION OF EM-  
PLOYEES IN THE INDIAN HEALTH SERVICE,  
RESTORE ACCOUNTABILITY IN THE INDIAN  
HEALTH SERVICE, IMPROVE HEALTH  
SERVICES, AND FOR OTHER PURPOSES,  
“RESTORING ACCOUNTABILITY IN THE  
INDIAN HEALTH SERVICE ACT OF 2017”**

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**Wednesday, June 21, 2017  
U.S. House of Representatives  
Subcommittee on Indian, Insular and Alaska Native Affairs  
Committee on Natural Resources  
Washington, DC**

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The Subcommittee met, pursuant to notice, at 2:48 p.m., in room 1324, Longworth House Office Building, Hon. Doug LaMalfa [Chairman of the Subcommittee] presiding.

Present: Representatives LaMalfa, Radewagen, González-Colón; and Torres.

Mr. LAMALFA. Good afternoon. The Subcommittee on Indian, Insular and Alaska Native Affairs will come to order. The Subcommittee is meeting today to hear testimony on H.R. 2662, by Representative Kristi Noem, to amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes; or known as the “Restoring Accountability in the Indian Health Service Act of 2017.”

Under Committee Rule 4(f), any oral opening statements at hearings are limited to the Chairman, the Ranking Minority Member, and the Vice Chair. This will allow us to hear from our witnesses sooner, and help Members keep to their schedules. Therefore, I ask unanimous consent that all other Members’ opening statements be made part of the hearing record if they are submitted to the Subcommittee Clerk by 5:00 p.m. today.

Without objection, so ordered.

**STATEMENT OF THE HON. DOUG LAMALFA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. LAMALFA. Today, we are here to take testimony on the bill intended to address a severe problem in Indian Country. Adequate health care is one of the most important issues to American Indian and Alaska Natives; however, the IHS direct care system is

deficient, inadequate, and is simply failing areas of the country that need help the most.

In 2010, a Senate investigation report brought to light some very severe problems plaguing 1 of the 12 regions of the IHS: the Great Plains area. After the report was released, the agency repeatedly assured Congress that issues were being addressed.

Then, in 2015, the same IHS region experienced the termination of a provider agreement with Centers for Medicare and Medicaid Services at the Winnebago IHS Hospital in Nebraska. CMS found that repeated deficiencies at the hospital “had caused actual harm and is likely to cause harm” to persons seeking examination or treatment.

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

Congress has continued to increase IHS funding almost each year since 2010, and it continues to increase it. In Fiscal Year 2014 and Fiscal Year 2015, Congress exceeded President Obama’s budget.

Since 2008, funding for the IHS has increased by more than 50 percent. The House’s Fiscal Year 2017 proposal appropriation is at approximately \$1 billion over Fiscal Year 2010 levels, yet the dangerous situation in the Great Plains area and the staffing shortage problem throughout the 12 IHS areas continues to exist, if not to grow.

In March of 2017, and despite funding increases, the Government Accountability Office added Indian health care to its biennial high-risk report for programs that are most susceptible to waste, fraud, and abuse.

H.R. 2662, the Restoring Accountability in the Indian Health Service Act, is intended to make reforms to the Indian Health Service to help a broken system. This bill would amend the Indian Health Care Improvement Act to improve the IHS by reforming the agency’s personnel processes, timeliness standards, and other operations.

The bill also includes accountability language similar to what Congress has enacted to help the Veterans Affairs Administration make it easier to discipline and fire underperforming employees.

The bill is a continuation of the work in the 114th Congress found in H.R. 5406, Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act, commonly known as the “HEALTTH Act.” This bill does not fix every problem in the IHS, however, it is a step in the right direction for Indian Country.

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

[The prepared statement of Mr. LaMalfa follows:]

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

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

In 2010, a Senate investigation report brought to light some very severe problems plaguing 1 of the 12 regions of the Indian Health Service, the Great Plains area. After the report was released the agency repeatedly assured Congress that issues were being addressed.

Then in 2015, the same IHS region experienced the termination of a provider agreement with Centers for Medicare and Medicaid Services at the Winnebago IHS Hospital Nebraska. CMS found that repeated deficiencies at the hospital “had caused actual harm and is likely to cause harm” to persons seeking examination or treatment.

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

Congress has continued increase IHS funding almost each year since the 2010, and it continues to increase. In FY14 and FY15, Congress exceeded President Obama’s budget.

Since 2008, funding for the Indian Health Service has increased by more than 50 percent. The House’s FY17 proposed appropriation is at approximately \$1 billion over FY10 levels, yet the dangerous situation in the Great Plains area and the staffing shortage problem throughout the 12 IHS areas continues to exist if not grow.

In March of 2017, and despite funding increases, the Government Accountability office added Indian health care to its biennial high risk report, for programs that are most susceptible to waste, fraud and abuse.

H.R. 2662, the Restoring Accountability in the Indian Health Service Act is intended to make reforms to the Indian Health Service to help a broken system.

This bill would amend the Indian Health Care Improvement Act to improve the Indian Health Service by reforming the agency’s personnel processes, timeliness standards, and other operations.

The bill also includes accountability language similar to what Congress has enacted to help the Veterans Affairs Administration making it easier to discipline and fire underperforming employees.

This bill is a continuation of the work in the 114th Congress found in H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act, commonly known as the “HEALTH Act.”

This bill does not fix every problem in the IHS; however it is a step in the right direction for Indian Country. I want to thank the Sponsor of the bill and our witnesses for being here today.

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Mr. LAMALFA. I would now like to recognize our Ranking Member for any opening statement.

**STATEMENT OF THE HON. NORMA J. TORRES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mrs. TORRES. Thank you so much, Mr. Chairman, and good afternoon to everyone here, and our witnesses.

Today is our opportunity to take a hard look at the current state and possible future of health care in Indian Country.

American Indian and Alaska Native people have long experienced health disparities when compared with other Americans, including a lower life expectancy and higher rates of disease. There are many reasons for this, but we know that one of the factors has been the chronic underfunding of the Indian Health Service. These issues have been brought back to the forefront after what occurred with the Great Plains area hospitals, but I worry that we will hear many of the same stories from IHS facilities throughout the country.

The fact is that we cannot provide competent, quality health care to Native American and Alaska Natives when we allow inadequate facilities and substandard levels of care to continue to exist. I am glad to have this discussion today, because we need to start talking

about permanent solutions that will address the long-standing issues at IHS.

We have to acknowledge that to bring about true transformation at IHS facilities, we need to start funding IHS appropriately. IHS has been shamefully underfunded for years, and the President's proposed Fiscal Year 2018 budget looks to cut another \$59 million.

Mr. Chairman, the hospitals are old, their technology is outdated, and they face major hurdles when hiring and keeping quality healthcare professionals.

So, yes, we do need reforms at IHS, but even with the best-intentioned reforms, we will just be giving lip service if we do not supply the funding to implement real change.

I want to thank our colleague, Representative Noem, for bringing this legislation forward; and I thank all of our witnesses for taking time today to share your thoughts on this legislation.

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

[The prepared statement of Mrs. Torres follows:]

PREPARED STATEMENT OF THE HON. NORMA J. TORRES, RANKING MEMBER,  
SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS

Thank you, Mr. Chairman.

Today is our chance to take a hard look at the current state and possible future of health care in Indian Country. American Indian and Alaska Native people have long experienced health disparities when compared with other Americans, including a lower life expectancy and higher rates of diseases.

There are many reasons for this, but we know that one of the factors has been the chronic underfunding of the Indian Health Service. These issues have been brought back to the forefront after what occurred with the Great Plains area hospitals, but I worry we'll hear many of the same stories from IHS facilities throughout the country.

The fact is that we cannot provide competent, quality health care to Native American and Alaska Natives when we allow inadequate facilities and sub-standard levels of care to exist.

I'm glad to have this discussion today, because we need to start talking about permanent solutions that will address the long-standing issues at IHS. We have to acknowledge that to bring about a true transformation at IHS facilities, we need to start funding IHS at an appropriate level.

IHS has been shamefully underfunded for years, and the President's proposed FY2018 budget looks to cut another \$59 million.

Mr. Chairman, the hospitals are old, their technology is outdated, and they face major hurdles when hiring and keeping quality healthcare professionals. So, yes, we do need reforms at IHS, but even the best intentioned reforms will just be lip service if we don't supply the funding to implement real change. There are actual lives in the balance, and they deserve better.

I want to thank our colleague Rep. Noem for bringing this legislation forward, and I thank all our witnesses for taking the time today to share your thoughts on this legislation.

Thank you Mr. Chairman, and I yield back.

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Mr. LAMALFA. Thank you. It is now up to me to introduce our witness for our first panel, the Honorable Kristi Noem, U.S. Congresswoman for the state of South Dakota.

We remind the witness that under Committee Rules, there is a 5-minute limit to the statement, but the entire statement will appear in the record.

So, allow me to recognize you, Congresswoman Noem, for your testimony. Thank you for appearing here.



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

Mrs. NOEM. Thank you, Chairman. And thank you also, Ranking Member Torres, as well, and the rest of the members of the Subcommittee, for allowing me to be here today to talk about the Indian Health Service. Many of the items that you discussed in your opening statements are very true. I couldn't find anything in there that I would disagree with.

I do want to point out that we have increased funding for Indian health services over many, many years. And since I have been in Congress we have done that, but we still have not seen improvements. In fact, the situation has only gotten worse. And that is one of the reasons you have this bill before you today.

I appreciate the opportunity to talk about H.R. 2662. It is the Restoring Accountability in the Indian Health Service Act. And before I begin, I wanted to also inform you that yesterday I was told the HHS senior staff are traveling to South Dakota this week. They are going to visit the IHS hospital at the Pine Ridge Indian Reservation, which is the home to the Oglala Sioux Tribe.

That is one of the areas that has been the worst in the Nation. The Great Plains District has been a disaster. We have had third-world care being delivered there, and just a few weeks ago I had asked Secretary Price for his leadership and his help in addressing the situations that we are currently facing. So, I want to thank him and his team for his quick action in going there this week to look at the situation on the ground. I look forward to working with them to find solutions to the many issues that we face in Indian Country.

Now, turning to our hearing today, I personally thank the witnesses who traveled here to Washington, DC to be at this hearing, especially Mr. William Bear Shield from the Rosebud Sioux Tribe. Mr. Bear Shield has testified before you before. In fact, he was here to testify on the legislation that I had last Congress. He is here to offer his critical insights into what the situation is on the ground.

Last year, I, too, sat before this Subcommittee, testifying on the same issue. I told you that the state of Indian health care in South Dakota had fallen to emergency levels. Today, I could report to you that in some areas we have seen a little bit of progress, but it is not enough. We need to get help to these people that are relying on this agency for health care, and they are failing them dramatically.

Since this most recent crisis has begun, the Centers for Medicare and Medicaid Services has found three IHS hospitals in South Dakota to be deficient, which resulted in the closure of two emergency rooms. One has since reopened, but nonetheless, these closures have put a serious strain on local community hospitals and has drastically curtailed access to care for my constituents. Many of them are traveling much farther in situations. In fact, I believe Mr. Bear Shield will talk today about how they believe they have lost lives because of the situation of IHS not delivering care that is needed.

And it is not just South Dakota that has been affected; it is a nationwide issue. The hospital serving the Winnebago and Omaha Tribes had its relationship with CMS almost completely severed.

And most recently, a hospital in Minnesota was cited by CMS, as well. In fact, my constituents tell me that the only reason that some IHS facilities are open today is because CMS just hasn't visited them yet.

I am working hard to produce legislative solutions to this problem. Last year, I introduced the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act, and this Subcommittee held a hearing. Today the bill looks a little bit different, and I will tell you why. It is because I have worked together with my colleagues in the Senate to craft a bill that includes elements of that bill that I had last Congress, but also a bill that Senator Barrasso introduced last year. His bill was called the IHS Accountability Act. The result of our cooperation is identical bills in the House and the Senate, and I am pleased that we are working together to address the serious deficiencies in the agency.

The Restoring Accountability in the Indian Health Service Act contains several meaningful provisions and ensures that the agency's employees are held accountable.

For example, the bill requires regular reporting from IHS, as well as GAO and the HHS Inspector General. New reporting is going to be critical. In our discussions with IHS over the last several years, the agency has been unable to even provide us with basic data related to its regular operations, which seemed pretty basic to us, but we realized they had not done any kind of data collection or reporting. The reporting will ensure that Congress has the information it needs to conduct oversight and make good decisions in the future.

The bill also improves recruitment and retention by allowing the agency to look at employees and how they get them to come and serve at these facilities.

The bill also will help IHS attract new management talent by allowing those managers to participate in the student loan repayment program. This is just an overview, but the bill contains several other provisions to improve patient care and streamline IHS processes.

This bill, while important, I want to be clear is just a first step. There is so much to do in Indian Country to address substance abuse, domestic abuse, violent crime, child abuse, and, most tragically, the youth suicide situation that we are seeing in our tribes in South Dakota. Tribes in South Dakota are affected by all of these issues, and I look forward to working with you on them in the future.

Again, these are situations that, if they can't get basic health care, you can see why none of the other needs are being met. I want to get this right. I have already reached out to HHS and IHS for technical assistance on this bill. So, that has been done, and I have worked with stakeholders across Indian Country—patients, tribal leaders, IHS employees, healthcare providers, private hospitals—to submit testimony for the record and give us feedback on the bill.

I am excited to work with you and our tribes and thank you for the opportunity to discuss this bill with you today.

[The prepared statement of Mrs. Noem follows:]

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

Chairman LaMalfa, Ranking Member Torres, and members of the Subcommittee, thank you for inviting me to testify at today's hearing about my bill, H.R. 2662, the Restoring Accountability in the Indian Health Service Act.

Before I begin, I want to inform you that I was notified yesterday that HHS senior staff are traveling to South Dakota this week to visit the IHS hospital at Pine Ridge, which is home to the Oglala Sioux Tribe.

Just a few weeks ago, I asked Secretary Price for his leadership and help in addressing this situation, and I thank him and his team for their quick action. I look forward to working with Secretary Price and the Administration on this and the many issues facing Indian Country.

Now, turning to our hearing today: I personally thank the witnesses who traveled here to Washington, DC to testify today, especially Mr. William Bear Shield of the Rosebud Sioux Tribe. Mr. Bear Shield testified before you last year, and I am pleased he is here to offer his critical insights.

Last year, I too, sat before this Subcommittee testifying on this same issue. I told you that the state of Indian health care in South Dakota had fallen to emergency levels. Today I can report to you that some progress has been made, but it's not enough, and it's not happening fast enough.

Since this most recent crisis began, the Centers for Medicare and Medicaid Services has found three IHS hospitals in South Dakota to be deficient, which resulted in the closure of two emergency rooms. One has since reopened, but nevertheless, these closures have put serious strain on local community hospitals and drastically curtailed access to care for my constituents.

And it's not just South Dakota that is affected. This is a nationwide issue.

The hospital serving the Winnebago and Omaha Tribes had its relationship with CMS almost completely severed, and most recently, a hospital in Minnesota was cited by CMS as well. In fact, my constituents tell me that the only reason some IHS facilities remain open today is because CMS just hasn't visited them yet.

I am working hard to produce legislative solutions to this problem. Last year, I introduced the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act, and this Subcommittee held a hearing on the bill. Today's bill looks slightly different.

That's because I have worked together with my colleagues in the Senate to craft a bill that includes elements from my HEALTH Act and a bill Senator Barrasso introduced last year, the IHS Accountability Act. The result of our cooperation is identical bills in both the House and the Senate, and I am pleased that we are working together to address the serious deficiencies in the agency.

The Restoring Accountability in the IHS Act contains several meaningful provisions that would streamline the agency's bureaucracy and ensure that the agency's employees are held accountable. For example, the bill would require regular reporting from the IHS, as well as GAO and the HHS Inspector General.

New reporting is critical. In our discussions with the IHS over the past couple of years, the agency has been unable to provide us basic data related to its regular operations. This reporting will ensure Congress has all the information it needs to conduct thorough oversight of the agency.

The bill would also improve recruitment and retention by allowing the agency to offer more robust benefits for employees. The bill would help the IHS attract new management talent by allowing managers to participate in the student loan repayment program.

That's just an overview—the bill contains several other provisions to improve patient care and streamline IHS processes.

This bill, while important, is only a first step. There's so much more to do to in Indian Country to address substance abuse, domestic abuse, violent crime, child abuse, and most tragically, youth suicide. Tribes in South Dakota are affected by all of these issues and I look forward to working with all of you on them in the future.

In closing, let me be clear: I want to get this right. I have already reached out to HHS and IHS to obtain technical assistance for this bill, and I hope to get it this week.

I encourage stakeholders across Indian Country—patients, tribal leaders, IHS employees, healthcare providers, private hospitals—to submit testimony for the record and give us feedback on the bill.

I am excited to work closely with the Committee, tribes, and other stakeholders to pass this critical legislation. Thank you again for the opportunity to discuss the Restoring Accountability in the IHS Act.

Mr. LAMALFA. Thank you, Mrs. Noem, for that. I appreciate your testimony.

Would there be any questions of our panel up here? OK.

You do? OK. Recognizing our Vice Chair.

Miss GONZÁLEZ-COLÓN. Thank you, Mr. Chairman. I want to commend my colleague for her noteworthy efforts to deliver improved health care to her constituents. Much of the IHS user population struggles in accessing timely quality care.

While those facilities suffer from serious deficiencies memorialized in the 2010 Dorgan Report, they are still having those problems, and unfortunately, many of these challenges continue. I look forward to addressing those issues in the next panel.

I have just two questions for you. One is the interest of H.R. 2662 to apply tribally operated facilities and recommend that these facilities shall have the ability to opt in and opt out of certain provisions of the bill. Do you think this bill will make it available to opt in, opt out for certain services, or not?

Mrs. NOEM. It will be, and it allows us to really meet the needs of those local communities that it is going to serve, and give us the opportunity—some of the reforms that we put into the legislation are ones that we have considered and debated when it comes to reforms in the VA.

We looked at what was working there, as far as reforms. And some of the same problems that we have had in the VA, we are seeing in IHS as well. Some of them have to do with being able to fire employees that were not doing their job. Some of them had to do with recruitment issues that we are having. So, some of those abilities, to bring reforms to that federally run healthcare system of the VA, we put in this legislation as well, to meet some of the reforms that we believe are necessary within IHS.

Miss GONZÁLEZ-COLÓN. I made that question because some of the witnesses that are going to be here in the next panel just expressed that option of having opt in or opt out. And as a sponsor of the bill, I want to have your input about having that option or not.

Mrs. NOEM. Yes.

Miss GONZÁLEZ-COLÓN. The other question is, the deputy director of the Indian Health Service, Mr. Buchanan, mentions in his testimony that Section 110 of the bill requires to establish a tribal consultation policy. And he thinks that it is unnecessary, because the IHS already has a tribal consultation policy. What is your consideration?

Mrs. NOEM. I would encourage you to ask the others who are going to testify today about what consultation has been in the past. They will tell you that there has been no consultation. What IHS deems is called consultation with the tribe is non-existent, so that is why it is required within the legislation, so that we now, as Members of Congress—and it is in statute—that oversight has to happen on how that consultation piece is put into place, so that they have some input into what kind of health care is delivered to their communities.

This is something that I have heard over and over, dozens and dozens of times through the years, that IHS has ignored many of the protocols that they have been encouraged to do, and consultation is one of the biggest things that they have failed at.

Miss GONZÁLEZ-COLÓN. Thank you. I yield back the rest of my time, Chairman.

Mr. LAMALFA. Thank you. Anybody else on the panel wish to question?

OK. Well, Mrs. Noem, you have answered it very well. I see a lot of parallels with the Veterans Administration and IHS here, and so the reforms you are pushing for I hope can be a template—one for the other—whichever one can get it done sooner.

Is there anything else you would wish to elaborate on, on that parallel there?

Mrs. NOEM. Just the dire situation that we face. I would encourage all of you, if you have the opportunity, to come to the Great Plains region and see some of these facilities that have been affected. It really is like delivering health care in a third-world country. We have had babies born on the floor, we have had providers delivering care while they are on alcohol or drugs. We have had non-compliance on even just basic safety issues.

And then we have no consistency in leadership or in providers. And many employees are left—they are understaffed, under-supported. And in the past, when we have given more money to IHS, the problems still have not been fixed. I believe that is why you see HHS on the ground today in South Dakota, because even in light of what has happened in the last couple of years, of shining some more light on this situation, IHS still has not made the changes that they promised to us that they would make.

We held a hearing in South Dakota. We have had hearings here. We have been extremely vocal about this. This is why you see legislation today. We have tried to work with IHS in the past, and that has failed, and that is why we are pushing to have these reforms put in place. And listening to those who will testify on the next panel is critically important for you to get a clear picture as to the situation and the emergency situation that we have on the ground. Thank you.

Mr. LAMALFA. All right. Congresswoman Noem, thank you for again bringing this bill forward, and for your strong efforts this year and last year in shining the light on this, and working toward an important solution for, in some cases, a pretty shameful situation.

Thank you, and we will go ahead and seat the next panel. If you wish to stay along or do other duties—again, thank you for being here.

[Pause.]

Mr. LAMALFA. OK, I will introduce our second panel of witnesses as they come up to the dais.

We have Rear Admiral Chris Buchanan, who is Assistant Surgeon General, U.S. Public Health Service, and the Deputy Director of Indian Health Service; we have the Honorable William Bear Shield, Chairman, Rosebud Sioux Tribal Health Board; we have the Honorable Andy Joseph, Business Council Member of the Confederated Tribes of the Colville Reservation; Mr. Robert TwoBears, District V Representative, Ho-Chunk Nation Legislature; and we have Ms. Victoria Kitcheyan, Great Plains Area Representative, National Indian Health Board.

So, as you are seated, I will remind the witnesses again that under our Committee Rules, oral statements are limited to 5 minutes. Their entire statement will appear in the hearing record.

I think you all know the drill on the microphones, but they are not automatic. You need to press the button when you begin your testimony as we go down the line. A green light will turn on, which will allow you 4 minutes. The yellow light will allow you 1 additional minute, and your time will expire when the red light comes on, which we ask you to sum up and complete.

We will have the entire panel give their testimony before the questioning will happen for the panel, as well. So, the Chair now recognizes Rear Admiral Buchanan to testify.

**STATEMENT OF CHRIS BUCHANAN, REHS, MPH, REAR ADMIRAL, ASSISTANT SURGEON GENERAL, USPHS; DEPUTY DIRECTOR, INDIAN HEALTH SERVICE**

Admiral BUCHANAN. Good afternoon, Chairman LaMalfa, Ranking Member Torres, and members of the Subcommittee, I am Chris Buchanan, I am an enrolled member of the Seminole Nation of Oklahoma, and Deputy Director of the Indian Health Service. I am pleased to have the opportunity to testify before the Subcommittee on H.R. 2662, the Restoring Accountability in the Indian Health Service Act of 2017.

The mission of Indian Health Service, in partnership with American Indians and Alaska Natives, is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Providing quality health care is our highest priority. We share the urgency of addressing the long-standing systemic problems that hamper our ability to fully carry out the IHS mission.

In November of 2016, we launched our Quality Framework and Implementation Plan to strengthen the quality of care that IHS delivers to the patients we serve. Since November of 2016, IHS has made substantial progress in implementing the Quality Framework and addressing many of the challenges you have identified in your proposed legislation.

The Quality Framework guides how we develop, implement, and sustain an effective quality program that improves patient experience and outcomes. We are doing this by strengthening our organizational capacity, and ensuring the delivery of reliable, high-quality health care at IHS direct-service facilities.

The new IHS credentialing system will streamline credentialing and facilitate the hiring of qualified practitioners, as well as privileging and performance evaluations of IHS practitioners. It will allow the local and area offices to perform these functions in alignment with the Centers for Medicare and Medicaid Services' conditions of participation, and accreditation standards for governance of hospitals and ambulatory care facilities. We will pilot it in four IHS areas in July, and implement it across the remaining IHS areas by the end of 2017.

Ensuring timely access to care requires that we develop standards for waiting times for appointments, as well as for the time spent in providers' offices, and that we benchmark against clear

standards. Agency-wide standards for wait times are also in development. To ensure accountability at the highest level, and to improve transparency about access to and quality of care, IHS is implementing a performance accountability dashboard. This includes reporting on patient wait times. Pilot testing of the dashboard and associated data collection is targeted for this summer.

Strengthening governance and leadership at all levels of IHS is essential for assuring quality health care. IHS now requires a standardized governance process and use of a standard governing board agenda across all IHS areas with federally operated facilities.

The first leadership training class to prepare selected individuals to serve in leadership positions at the service unit, area, and headquarters levels was launched June 6, with 34 participants. IHS faces significant recruitment challenges due to the remote, rural locations of our healthcare facilities and area offices.

IHS is implementing various strategies to increase recruitment and retention. Global recruitment is one strategy that we have implemented for a streamlined approach to filling critical provider vacancies at multiple locations. Applicants only need to apply to a single vacancy announcement, and can be considered for multiple positions throughout the country. Recruiting for critical positions by using a single announcement to recruit for multiple positions is showing promise.

Now, IHS has priority access to new commissioned corps applicants. This allows IHS to make first contact with these applicants in efforts to recruit them to fill health professional vacancies throughout IHS.

Also, IHS facilities can use the National Health Service Corps scholarship and loan repayment incentives to recruit and retain primary care providers. As of April 2017, 472 National Health Service Corps recipients are currently part of our workforce serving in IHS tribal and urban facilities. These actions demonstrate that IHS is taking challenges seriously, and is continuing to take assertive and proactive steps to address them.

IHS is prepared to provide the Subcommittee technical assistance on specific authorities proposed by H.R. 2662. Despite all of the challenges, I am firmly committed to improving quality, safety, and access to health care for American Indians and Alaska Natives.

In collaboration with HHS, our partners across Indian Country, and Congress, we look forward to working with the Subcommittee on this legislation as it moves through the legislative process, and I am happy to answer any questions the Subcommittee may have. Thank you.

[The prepared statement of Admiral Buchanan follows:]

PREPARED STATEMENT OF CHRIS BUCHANAN, R.E.H.S., M.P.H., ASSISTANT SURGEON GENERAL, USPHS; DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good afternoon, Chairman LaMalfa, Ranking Member Torres, and members of the Subcommittee. I am Chris Buchanan, an enrolled member of the Seminole Nation of Oklahoma and Deputy Director of the Indian Health Service (IHS). I am pleased to have the opportunity to testify before the House Natural Resources Committee's Subcommittee on Indian, Insular and Alaska Native Affairs on H.R. 2662, the "Restoring Accountability in the Indian Health Service Act of 2017." I would like

to thank you, Chairman LaMalfa and members of the Subcommittee for elevating the importance of delivering quality care through the IHS.

IHS plays a unique role in the Department of Health and Human Services (HHS) because it was established to carry out the responsibilities, authorities, and functions of the United States to provide healthcare services to American Indians and Alaska Natives. The mission of IHS, in partnership with American Indian and Alaska Native people, is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS provides comprehensive health care delivery to approximately 2.2 million American Indians and Alaska Natives through 26 hospitals, 59 health centers, 32 health stations, and 9 school health centers. Tribes also provide health care access through an additional 19 hospitals, 284 health centers, 163 Alaska Village Clinics, 79 health stations, and 8 school health centers.

Providing quality health care is our highest priority. We share the urgency of addressing long-standing systemic problems that hamper our ability to fully carry out the IHS mission. In November 2016, we launched our 2016–2017 Quality Framework and Implementation Plan to strengthen the quality of care that IHS delivers to the patients we serve. Implementation of the Quality Framework is intended to strengthen organizational capacity to improve quality of care, improve our ability to meet and maintain accreditation for IHS direct-service facilities, align service delivery processes to improve the patient experience, ensure patient safety, and improve processes and strengthen communications for early identification of risks. The Quality Framework will be reviewed and updated at least annually in partnership with tribes.

The HHS Executive Council on Quality Care (the Council), which was stood up in November 2016, provides support to IHS by identifying and facilitating collaborative, action-oriented approaches from across the Department to address issues that affect the quality of health care provided to American Indians and Alaska Natives we serve. The Council includes leadership from 12 HHS Staff and Operating Divisions. The Council's mission is to support IHS' efforts to develop, enact, and sustain an effective quality program—to improve quality and patient safety in the hospitals and clinics that IHS administers. This may include providing technical assistance to bolster quality and safety, identifying solutions to address workforce recruitment and retention challenges, seeking creative solutions to infrastructure needs, and enhancing stakeholder engagement. The Council partners with HHS leadership and staff in policy implementation.

Since November 2016, IHS has made substantial progress in implementing the Quality Framework and in addressing many of the challenges you have identified in your proposed legislation.

#### STRENGTHENING ORGANIZATIONAL CAPACITY

The Quality Framework guides how we develop, implement, and sustain an effective quality program that improves patient experience and outcomes. We are doing this by strengthening our organizational capacity, and ensuring the delivery of reliable, high quality health care at IHS direct-service facilities.

We recently awarded a contract for credentialing software that will provide enhanced capabilities and standardize the credentialing process across IHS. The new system will streamline credentialing and facilitate the hiring of qualified practitioners as well as, privileging and performance evaluations of IHS practitioners. This will help ensure the quality and safety of care delivered in IHS Federal Government hospitals and health centers. We are on course with the implementation of this medical credentialing system. We expect to test it in four IHS Areas in July 2017, and plan to implement it across the remaining IHS Areas by the end of 2017. Our agency credentialing policy is in the process of being updated.

Ensuring timely access to care requires that we develop standards for waiting times for appointments, as well as for the time spent in the provider's office, and that we benchmark against clear standards. IHS Service Units currently collect patient wait time data to track the patient care experience as part of the Improving Patient Care program. Agency-wide standards for wait times are also in development. To ensure accountability at the highest level, and to improve transparency about access to and quality of care, IHS is implementing a performance accountability dashboard. This includes reporting on patient wait times. Pilot testing of the dashboard and associated data collection is targeted for this summer.

Strengthening governance and leadership at all levels of the IHS system is essential to assuring quality health care. IHS now requires a standardized governance process and use of a standard governing board agenda across all IHS Areas with federally operated facilities. The first leadership training class to prepare selected



individuals to serve in leadership positions at the Service unit, Area, and Headquarters levels was launched June 6 with 34 participants. In addition, IHS has begun implementing a leadership coaching and mentoring program in the Great Plains area as new leaders are recruited.

#### WORKFORCE STRATEGIES

IHS faces significant recruitment challenges due to the remote, rural location of our healthcare facilities and Area offices. To make a career in IHS more attractive to modern healthcare practitioners, IHS is implementing various strategies to increase recruitment and retention. Global recruitment is one strategy we have implemented that allows for a streamlined approach to filling critical provider vacancies at multiple locations. Applicants only need to apply to a single vacancy announcement and can be considered for multiple positions throughout the country. Recruiting for critical positions by using a single announcement to recruit for multiple positions is showing promise.

IHS continues the successful partnership with the Office of the Surgeon General to increase the recruitment and retention of Commissioned Corps officers, and most recently the IHS has been given priority access to new Commissioned Corps applicants. This allows IHS to make the first contact with these applicants in an effort to recruit them to fill health professional vacancies throughout IHS. This new effort began in May, and we can provide periodic updates on this effort. IHS also continues to partner with the National Health Service Corps (NHSC). Use of NHSC allows IHS facilities to recruit and retain primary care providers by using NHSC scholarship and loan repayment incentives. As of April 2017, 472 NHSC recipients are currently part of our workforce serving in IHS, tribal and urban facilities.

These actions demonstrate that IHS is taking its challenges seriously, and is continuing to take assertive and proactive steps to address them.

#### H.R. 2662

H.R. 2662 proposes specific authorities to aid us in elevating the health of American Indians and Alaska Natives to the highest level. IHS is prepared to provide the Subcommittee technical assistance on the legislation and I would like to provide additional technical comments on various sections of the bill.

Section 101 would address the need for IHS to offer more flexible and competitive benefits to recruit employees by establishing a comparable pay system as allowed under Chapter 74 of Title 38. IHS appreciates the authority we already have to use the pay flexibilities under Chapter 74 of Title 38. We are working with OPM, OMB, and other affected agencies to explore ways to enhance utilization of our current pay authorities to enhance our ability to recruit and retain high quality staff.

Section 102 requires a Service-wide centralized credentialing system to credential licensed health professionals who seek to provide healthcare services at any Service facility. IHS supports the use of a standard system for credentialing. We are implementing a national system for credentialing as well as privileging and evaluating performance of IHS practitioners. Our new system will allow the local and/or Area offices to perform these functions in alignment with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation and external accreditation standards for governance of hospitals and ambulatory care facilities.

Section 104 would make certain healthcare management or healthcare executive positions eligible professions for loan repayment awards, in exchange for non-clinical service obligations. Management expertise is very important in a health system as large as IHS.

Section 106 addresses IHS authority to remove or demote employees. IHS has existing authorities to implement adverse employment actions.

Section 107 requires IHS to develop and implement standards to measure the timeliness of care at direct-service IHS facilities. As described above, IHS is in the process of establishing agency-wide standards for wait times to each federally operated service unit. A process for uniform data collection and reporting is also being established.

Section 108 adds specific requirements for implementation of annual mandatory cultural competency training programs for IHS employees, and other contracted employees engaged in direct patient care. Cultural competency in the IHS workforce is essential to the provision of quality care and is a requirement under the accreditation standards for hospitals. I have recently issued direction for all IHS employees to complete training, which will become an annual requirement.

Section 110 requires IHS to establish a tribal consultation policy. The specific provision is unnecessary as IHS already has a tribal consultation policy in place. The requirements for consultation are contained in statutes and various Presidential

Executive Orders including: the Indian Self-Determination and Education Assistance Act, Indian Health Care Improvement Act, Presidential Memoranda in 1994 and 2004, and Executive Orders in 1998 and 2000. It is the policy of HHS and IHS that consultation with American Indian and Alaska Native tribes will occur to the extent practicable and permitted by law before any action is taken that will significantly affect Indian tribes. IHS is committed to regular and meaningful tribal consultation and collaboration as an essential element for a sound and productive relationship with tribes.

Despite all of the challenges, I am firmly committed to improving quality, safety, and access to health care for American Indians and Alaska Natives, in collaboration with HHS, our partners across Indian Country, and Congress. I appreciate all your efforts in helping us provide the best possible healthcare services to the people we serve to ensure a healthier future for all American Indians and Alaska Natives.

We look forward to working with the Subcommittee on this legislation as it moves through the legislative process. Thank you for your commitment to improving quality, safety, and access to health care for American Indians and Alaska Natives. I am happy to answer any questions the Subcommittee may have.

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QUESTIONS SUBMITTED FOR THE RECORD BY REP. LAMALFA TO RADM CHRIS  
BUCHANAN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE

*Question 1.* The Indian Health Service (IHS) operates the Joint Venture Construction Program, allowing tribes to expend tribal, private, or other available non-IHS funds to acquire or construct a healthcare facility, usually clinics.

In exchange, IHS agrees to request congressional appropriations for additional staff and operation costs to maintain the facility under a no-cost lease for a minimum of 20 years.

While this program is yielding some success, funding for the construction of healthcare facilities has been limited to clinics and fails to address the challenge of providing physician care to those areas of Indian Country which are most in need.

How would the IHS respond to the idea of modifying the Joint Venture model by tasking the Federal Government to build, perhaps with the involvement of private investment, 20–30 bed micro hospitals and then allowing willing tribes take on the task of equipping and staffing the facility?

Answer. The current Joint Venture Construction Program (JVCP) is a way for the IHS to bring new healthcare facilities into the IHS system. Tribes strongly support the JVCP because it provides them the opportunity to use their own capital on a one-time basis to acquire or construct a facility. In exchange, IHS agrees to submit requests to Congress for initial and recurring staffing and operation funding for that facility. The last solicitation for the JVCP yielded 37 applications. Seven of those applicants were approved to proceed with planning on variously sized ambulatory and inpatient facilities.

The IHS currently does not have the authority to fund construction of Joint Venture Construction projects. If Congress provided IHS with construction authority for such projects, it would likely impact IHS's ability to fund the construction of other new and replacement healthcare facilities that have been identified by the Secretary as priorities under the Health Care Facility Priority System (HCFPS). Generally, IHS appropriations for construction are limited to the amounts required to construct new and replacement healthcare facilities identified as HCFPS priorities.

The HCFPS list was last updated in 1992, identifying 27 facilities that need to be completed before new facilities are added. Today, there are 11 healthcare facilities that remain on the list that have either received funds for design and construction or are waiting to be funded. The rate of funding to date has been approximately one facility per year. IHS funding the construction of other facilities would delay continued progress on addressing the HCFPS list.

In summary, the IHS is open to working with tribal leaders to explore how we can utilize existing authorities within the IHS and other resources to maximize resources for Indian Country.

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Miss. GONZÁLEZ-COLÓN [presiding]. Thank you. Now the Chair recognizes Chairman Bear Shield to testify.

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

Mr. SHIELD. Good afternoon. Thank you, Committee, for once again allowing me to be here to testify about H.R. 2662. I want to acknowledge our South Dakota Congresswoman, Mrs. Kristi Noem, and our gratitude for her reaching out to us on working together on creating this legislation.

I am William Bear Shield, a member of the Rosebud Sioux Tribal Council. I am also the Chairman of our Rosebud Sioux Health Board and the Unified Health Board that serves the Sioux San IHS Hospital in Rapid City, South Dakota, as well as the Vice Chairman of our Great Plains Tribal Chairman's Health Board, and I sit on the Health and Human Service's Secretary's Tribal Advisory Committee.

The problems within IHS did not happen overnight. In fact, in 2010, former U.S. Senator Dorgan from North Dakota released the Dorgan Report that identified most of the same issues. The difference is something is now being done to correct those issues.

The fundamental problem found in the Dorgan Report in 2010 and the findings now before the House is IHS leadership was failing then, as it is failing now. So, before I talk about this bill, I first feel the need to stress the appointment of a new principal director of IHS. The Rosebud Sioux Tribe has endorsed a candidate that we believe will bring a new perspective, and is not a member of PHS. We believe this is necessary if the rebuilding of IHS is to have any change at all.

We strongly urge the Members to press for the nomination of a permanent director of IHS as soon as possible. Along with the naming of a permanent director, the position must be given authority to deal with rebuilding IHS, which H.R. 2662 does.

We feel that IHS needs a deputy secretary-level position at the Health and Human Services level. It is appropriate and necessary that tribal health care be given the priority and status it deserves, and this helps in creating positive change.

As a starting point for commenting on any legislation, it must be acknowledged that the current structure, systems, and management of IHS are outdated, broken, and cannot be fixed. It has reached a point where only adding tools and responsibilities will not help. The IHS must be set aside and be completely rebuilt from the ground up. If this is not the view, we will be back here next year and in the following years talking about the same issues and more tribal members will have needlessly perished.

Specifically, it is our view that this legislation accomplishes the following: This legislation respects our treaty rights—this means always recognizing and affirming the obligations of the U.S. Government to provide the highest quality of health care to every tribal member.

This legislation allows the delivery of patient-focused health care, and this should be the first and truly only priority of IHS. Regardless of what may be said or reported, this is not the case now and it has not been for a very long time.

This legislation mandates the required meaningful communication at all levels between the IHS and tribes. You may hear that

there is a consultation policy in place and that it is working. It is not working, and I am here to tell you that. Consultation only works when there is a direct and substantial dialogue. It only works when the dialogue leads to better care, solves real problems, and is accountable. Because of this, we ask Congress to direct IHS to work with tribes, and we are included in developing the consultation policies as directed in the proposed legislation.

We applaud the task force set up by the House. It is our hope that this signals the rebuilding efforts we advocate are supported by the Members. We will work with the task force in continuing to advocate for real, meaningful recommendations that rebuild and strengthen IHS.

As we move forward, there are other areas we need to focus on: Drug pricing—allow the IHS to use existing Federal authority to negotiate prices to better deploy IHS budgeted funds.

PRC—focus on better systems and processes, so that tribes can access Medicaid and third-party dollars. We ask that Congress work with us and the Centers for Medicare and Medicaid Services to update a policy on funding 100 percent of funds for Medicaid-eligible American Indians through the Indian Health Service and/or tribes.

HIPAA changes—explore amendments to HIPAA that would give access to records and accountability for all Indian healthcare facilities and operations.

We would also favor the President using an Executive Order, very like the one he issued for the VA. It could be possibly titled, “Improving Accountability and Whistleblower Protection at IHS.”

Create a modern, state-of-the-art healthcare delivery and administrative system for tribal health care. There are many examples in the private sector and the direction the VA is moving may be worth examining. At a minimum, modern systems address credentialing, waiting times, and quality of service.

Miss GONZALEZ-COLÓN. Chairman, could you summarize?

Mr. SHIELD. Yes. Last, again, it may be said that there are plans being implemented to address this issue. How long has IHS been in this planning mode? We still need to see that implemented. When there are no leadership and no systems, plans are all that can be talked about. We look forward to this bill in changing those systems within IHS. Thank you.

[The prepared statement of Mr. Shield follows:]

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

Thank you for inviting me to testify about H.R. 2662. I want to acknowledge our South Dakota Congresswoman Kristi Noem, and give our gratitude to her for reaching out to us on working together in creating this legislation.

I am Willie Bear Shield. I am a member of the Rosebud Sioux Tribal Council, I am also the Chairman of the Rosebud Sioux Health Board and Unified Health Board that serves the Sioux San IHS Hospital in Rapid City, South Dakota, as well as the Vice-Chairman of the Great Plains Tribal Chairman’s Health Board and I sit on the HHS Secretary’s Tribal Advisory Committee.

The problems within IHS did not happen overnight, in fact in 2010 former U.S. Senator Dorgan from North Dakota released the Dorgan report that identified most of these same issues, the difference is something is now being done to correct the problems.

The fundamental problem found in the Dorgan report in 2010 and the findings now before the House is IHS, LEADERSHIP was failing then as it is failing now.

So, before I talk more about the bill, I feel the first thing we must do is appoint a new Principle Director of IHS. The Rosebud Sioux Tribe has endorsed a candidate that we believe will bring a new perspective and is not a member of PHS. We believe this is necessary if the rebuilding of IHS is to have any change at all.

We strongly urge the members to press for the nomination of a permanent Director of IHS as soon as possible. Along with the naming of a permanent Director, the position must be given authority to deal with rebuilding IHS, which H.R. 2662 does. We feel that IHS needs a Deputy Secretary level position at HHS. It is appropriate and necessary that tribal health care be given the priority and status it deserves and this helps in creating positive change.

As a starting point for commenting on any legislation it must be acknowledged that the current structure, systems and management of IHS are outdated, broken and cannot be fixed. It has reached a point where only adding tools and responsibilities will not help. The IHS must be set aside and be completely rebuilt from the ground up. If this is not the view, we will be back here next year and the years following talking about the same issues and more tribal members will have needlessly died.

Specifically, it is our view that this legislation accomplishes the following:

- This legislation, Respects Treaty Rights—this means always recognizing and affirming the obligations of the U.S. Government to provide the highest quality health care to every tribal member.
- This legislation allows the delivery of patient focused health care and this should be the first and truly only priority of IHS. Regardless of what may be said or reported this is not the case now and has not been for a very long time.
- This legislation mandates the required meaningful communication at all levels between the IHS and tribes. You may hear that there is a Consultation Policy in place and that it is working. It is not working. Consultation only works when there is a direct and substantial dialogue. It only works when the dialogue leads to better care, solves real problems and is accountable. Because of this we ask Congress to direct IHS to work with tribes and we are included in developing the consultation policies as directed in the proposed legislation.

We applaud the task force set up by the House. It is our hope that this signals the rebuilding efforts we advocate are supported by the Members. We will work with the task force and continue to advocate for real meaningful recommendations that rebuild and strengthen IHS.

As we move forward there are other areas we need to focus on:

Drug pricing—Allow the IHS to use existing Federal authority to negotiate prices to better deploy IHS budgeted funds.

PRC—Focus on better systems and processes so that tribes can access Medicaid and third-party money. We ask that Congress work with us and the Centers for Medicare and Medicaid Services (CMS) to update a policy on funding 100 percent of funds for Medicaid-eligible American Indians through the Indian Health Service or tribes.

HIPPA changes—Explore amendments to HIPPA that would give access to records and accountability for all Indian healthcare facilities and operations.

We would also favor the President issuing an Executive Order very like the one issued for the VA. It could be possibly titled, Improving Accountability and Whistleblower Protection at IHS.

Create a modern state-of-the-art healthcare delivery and administrative system for tribal health care. There are many examples in the private sector and the direction the VA is moving may be worth examining. At a minimum, modern systems address credentialing, wait times and quality of service.

For example:

- We all hear how terrible the credentialing systems are at IHS. The reason is because of the lack of leadership practically every service unit within IHS uses its own method of credentialing. This means that a doctor at IHS Pine Ridge cannot easily come to IHS Rosebud and provide service. It may take 30, 60, 90 days or longer. Also, if a bad doctor is moved out of any given IHS facility they can be credentialed at another because of the lack of systems that track and are accessible system wide in the IHS. An \$85 million contract does not solve this, because it requires leadership to make it work.

- At the Rosebud ER, and others, the lack of standing orders and other processes that are standard in most every other healthcare system in the United States has killed our people. Let me explain—It is common and best practice for an ER to have standing orders issued by a doctor. This enable the staff to quickly treat and otherwise deal with incidents. The orders follow well established medical practice and allow staff to administer drugs and other treatments if an attending or on call doctor is not immediately available. This then allows for effective service, evaluations, and assessments as well as saving lives. Why is it that IHS leadership does not require that this fundamental medical practice be implemented everywhere? It is beyond me.

Again, it may be said that there are plans being implemented to address this issue. How long has IHS been in the planning mode. When there is no leadership and no systems—plans are all that can be talked about!

Once again, I want to thank you for the opportunity to testify before you and want to advise you that we strongly support this legislation and ask that all Members of Congress do the same to start the rebuilding of a broken system into one that provides quality health care.

We strongly urge the Members to press for the nomination of a permanent Director of IHS as soon as possible. Along with the naming of a permanent Director, the position must be given authority to deal with the rebuild. H.R. 2662 does some of that. Let me suggest that the IHS needs a Deputy Secretary level position at HHS. It is appropriate and necessary that tribal health care be given the priority and status it deserves this change within HHS would bring.

As to the rebuild, we applaud the task force set up by the House of Representatives. It is our hope that this signals the rebuilding efforts we advocate are supported by the Members. We will work with the task force and continue to advocate for real meaningful recommendations that rebuild and strengthen IHS.

There are other areas for the Members to focus on:

- Drug pricing—Allow the IHS to use existing Federal authority to negotiate prices to better deploy IHS budgeted funds.
- PRC—Focus on better systems and processes so that tribes can access Medicaid and third-party money.
- HIPPA changes—Explore amendments to HIPPA that would give access to records and accountability for all Indian healthcare facilities and operations.

We recognize the provision of health care is complicated. We see the national demand for change in delivery, service and financing of the healthcare system. We ask that Members focus on the rebuilding of the IHS as both a way to meet the obligations of the U.S. Government to tribes and to make sure that tribes have a place at the table as the overall national debate on health care moves forward.

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Miss. GONZÁLEZ-COLÓN. Thank you, Chairman. The Chair now recognizes the Honorable Andy Joseph, Business Council Member of the Confederated Tribes of the Colville Reservation.

**STATEMENT OF THE HON. ANDY JOSEPH, BUSINESS COUNCIL MEMBER, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION, NESPELEM, WASHINGTON**

Mr. JOSEPH. Good afternoon, members of the Subcommittee. [Speaking native language.] My name is Andy Joseph, Jr. I am a member of the Colville Business Council, the governing body of the Confederated Tribes of the Colville Reservation. I serve as the Chair of the Council's Health and Human Services Committee.

H.R. 2662 addresses several long-standing problems with IHS service. The Colville is a direct-service tribe, and the bill would benefit us and other direct-service tribes in several ways. We strongly support H.R. 2662 and urge the Committee to move the legislation forward.

I would like to express the Colville Tribes' thanks to Congresswoman Kristi Noem and her staff for their work in developing this

legislation. I would also like to thank this Committee for its work in outreach on the bill.

Last year, your staff toured the health facilities on the Colville Reservation and heard firsthand about the challenges we face in providing care for our members. I would also like to thank Rear Admiral Chris Buchanan for him and his staff who came to our reservation and toured our clinics.

For decades, the Colville Tribes have endured chronically low staffing levels. On December 17, 2013, the Colville Business Council adopted a resolution declaring a state of emergency because of IHS staffing shortages. After that declaration, IHS calculated that the Colville Tribe service unit had less than one-third of the required number of clinical staff and only one-quarter of the required number of dental staff.

For direct-service tribes, facility staffing ratios are established when the initial IHS health facility opens for operations. Those levels may increase slightly as the IHS base budget increases, but they can never be brought anywhere close to what is needed in modern times.

There are two ways for direct-service tribes to update their staffing levels. One is to construct a new facility with IHS funds under the Facility Construction Priority System. The other is to build the facility using tribal funds under a joint venture program. The priority list has been closed since 1992, and applicants for joint venture programs are offered rarely and are highly competitive.

Direct-service tribes that have not been able to update their staffing ratios through these two IHS programs are frozen in time for staffing purposes. For the Colville Tribes, this historic staffing ratio dates back to 1938. That is when the U.S. Public Health Service converted a Department of War building for use as the Colville service unit's health clinic. Former IHS officials have told us that this facility was removed from the priority list in the 1980s because of its historical significance. This building was used as a tribe's primary health clinic until the tribe used its own tribal funds to construct a new facility.

Staffing shortages increase the waiting times for patients and have other consequences. Lack of staffing has also resulted in fewer patient encounters. Fewer encounters means our user population decreases, which means our allocation of purchased and referred care funding decreases.

The staffing shortages have also driven our healthcare providers to seek other employment. Many of their patients have chronic illnesses that multiply the number of visits in their annual workload. Despite increases in the IHS base budget in recent years, the Colville Tribes' staffing ratios have not improved. This is because the increases for IHS staffing in the President's budget request are almost always earmarked to staff new facilities that come on-line under the priority list or the joint venture program.

For direct-service tribes like the Colville that have been unable to build anything under these programs, our staffing ratios are frozen in time. In our case, time was 70 years ago.

The staffing demonstration project in Section 109 would provide a way to address these inequities. It would authorize IHS to

provide additional staffing resources to the Indian Health Service units on a temporary basis. A deployment—

Miss GONZÁLEZ-COLÓN. Mr. Joseph, can you summarize?

Mr. JOSEPH. Yes. I just have a couple more—this would enable staffing to be self-sustaining and permanent.

Section 109 would address a much-needed void in the Indian Health System. It would provide a path to direct-service tribes with historically low staffing ratios to update their ratios. This could be a model to address staffing inequities throughout the IHS system for well-managed IHS service units.

My written testimony is in for the record. Thank you for this time.

[The prepared statement of Mr. Joseph follows:]

PREPARED STATEMENT OF THE HONORABLE ANDREW JOSEPH, JR., COUNCIL MEMBER, COLVILLE BUSINESS COUNCIL, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

On behalf of the Confederated Tribes of the Colville Reservation (“Colville Tribes” or the “CCT”), I thank you for this opportunity to provide testimony on the “Restoring Accountability in the Indian Service Act of 2017,” H.R. 2662.

My name is Andy Joseph, Jr., and I am a member of the Colville Business Council, the governing body of the Colville Tribes, and serve as the Chair of the Council’s Human Services Committee. I also serve as the President of the Portland Northwest Area Indian Health Board, which has 43 federally recognized member tribes in Oregon, Washington and Idaho and serves as the health advocacy organization for the Northwest region. I provide this testimony in my capacity as a representative of the Colville Tribes.

As an initial matter, I would like to express the Colville Tribes’ thanks to Congresswoman Kristi Noem and her staff for their work over the past year in developing this legislation. I would also like to thank the staff for this Committee, who toured the health facilities on the Colville Reservation last year and heard directly from our staff about the challenges they face in providing care to our members.

H.R. 2662 addresses several long-standing issues with the Indian Health Service (“IHS”) and would benefit the Colville Tribes and other tribes in many ways. The Colville Tribes supports H.R. 2662 and urges the Committee to move the legislation forward through the legislative process. We offer some specific recommendations on how the bill can be clarified to garner even broader Indian Country support.

#### BACKGROUND ON THE COLVILLE TRIBES

The present-day Colville Reservation is approximately 1.4 million acres and occupies a geographic area in north central Washington State that is slightly larger than the state of Delaware. The Colville Tribes has more than 9,500 enrolled members, about half of whom live on the Colville Reservation. In terms of both land base and tribal membership, the Colville Tribes is one of the largest Indian tribes in the Pacific Northwest.

Most of the Colville Reservation is rural timberland and rangeland and most residents live in one of four communities on the Reservation: Nespelem, Omak, Keller, and Inchelium. The Colville Tribes has a large IHS service area and these communities are separated by significant drive times. The CCT’s primary IHS facility is in Nespelem, WA, and residents from Inchelium that require care must drive, in many cases, more than 90 minutes through two mountain passes. Although the CCT has contracted some discrete IHS activities under Pub. L. 93–638, the IHS directly provides most of the healthcare services on the Colville Reservation.

#### STAFFING INEQUITIES IN THE IHS SYSTEM

The Colville Tribes has, for decades, endured chronically low staffing levels. On December 17, 2013, the Colville Business Council adopted a resolution declaring a state of emergency on the Colville Reservation in response to immediate IHS staffing shortages and a large number of current and forecasted vacancies. In response to a congressional inquiry resulting from that declaration, the IHS calculated that the Colville Service Unit had less than one-third of the required number of clinical staff and only one-quarter of the required number of dental staff.



For the Colville Tribes and similarly situated direct-service tribes, facility staffing ratios are essentially set when the initial IHS health facility opens for operation. These levels may increase incrementally as the IHS base budget increases, but they can never be brought anywhere close to what is needed in modern times.

The only way for a tribe to update its staffing levels to reflect growth and modern health delivery needs is to either construct a new facility with IHS funds under the Health Care Facility Construction Priority List ("Priority List") or construct a facility using tribal funds under the Joint Venture construction program. The Priority List has been closed since 1992 and solicitations for the Joint Venture program are offered very infrequently and are extraordinarily competitive.

Direct service tribes that have not been able to update their staffing ratios through these two IHS programs *are essentially frozen in time* for staffing ratio purposes. For the Colville Tribes, these historic staffing ratios date back to the late 1930s when the U.S. Public Health Service converted a Department of War building for use as the Colville Service Unit's health clinic. This historic facility—which the CCT understands from former IHS officials was removed from the Priority List in the 1980s because of its historical significance—was used as the CCT's primary health clinic until the CCT used its own tribal funds to construct a new facility. That facility opened in June 2007.

Staffing shortages not only increase the wait times for patients, but in the CCT's case, they have also had other consequences. Lack of health providers has resulted in fewer patient encounters, which has had a negative domino effect on the CCT's Purchased/Referred Care funding and user population. The staffing shortages have also prompted other healthcare providers to seek other employment because many of the patients in their respective panels have chronic illnesses that multiply the number of visits in their annual workloads.

Despite increases to the IHS's base budget in recent years, the Colville Tribes' staffing ratios have not improved. This is because increases for IHS staffing in the President's Budget request have been *earmarked to staff new facilities* that come on-line that were constructed under either the Priority List or the Joint Venture programs. Again, for direct-service tribes like the CCT that have been unable to build anything under those IHS construction programs, our staffing ratios are frozen in time. In our case, the 1930s.

#### THE SECTION 109 STAFFING DEMONSTRATION PROJECT PROVIDES AN INNOVATIVE APPROACH TO ADDRESSING STAFFING INEQUITIES

The Staffing Demonstration Project in Section 109 would provide a mechanism to address these inequities by authorizing the IHS to deploy an infusion of staffing resources to federally managed IHS Service Units. While temporary, the deployment of staff is intended to enable Service Units to incorporate the additional staff into their billing and collection processes to enable the staff to be self-sustaining and permanent. The Staffing Demonstration Project could be funded separately but, as drafted, it is intended to allow the IHS to utilize carryover or other available funds.

Section 109 would address a much-needed void in the IHS system by providing a path for tribes with historically low staffing ratios to update those ratios. With the advances in opportunities for third party billing in the last reauthorization of the Indian Health Care Improvement Act, if successful, the Staffing Demonstration Project could be a model to address staffing inequities throughout the IHS system. We greatly appreciate that this language was included in the bill and strongly support it.

#### OTHER COMMENTS AND RECOMMENDATIONS

Although the CCT is primarily a direct-service tribe and most of H.R. 2662 is intended to address issues applicable to direct-service tribes, we recommend that language be added that clarifies the applicability of H.R. 2662 to tribally operated facilities. We believe that tribally operated facilities would likely want the opportunity to opt-in to certain provisions of the Act, such as the parity in pay requirements in Section 101, but might also want to opt out of certain provisions as well. We encourage further discussion with tribes and tribal organizations to clarify application of H.R. 2662 to tribally operated facilities.

#### *Sec. 101. Incentives for Recruitment and Retention*

The Colville Tribes strongly supports Section 101, which would direct the Secretary to establish a pay system for physicians, dentists, nurses, and other healthcare professionals employed by the IHS comparable to the pay provided by the Department of Veterans Affairs. We also support authorizing the IHS to reimburse relocation costs. Despite whatever recruiting challenges might exist, the IHS

has an obligation to provide adequate care to federally managed service units. The Colville Service Unit is in a rural area and these tools are necessary to attract and incentivize health providers to take jobs there.

*Sec. 102. Medical Credentialing System*

This section would direct the Secretary to consult with Indian tribes and any public or private association of medical providers, government agencies, or relevant experts in developing an IHS-wide credentialing system. While the CCT appreciates the need to standardize credentialing, we are concerned that directing the Secretary to consult with private associations may provide an opportunity for those associations that do not share tribal goals to cause mischief or erect barriers in developing credentialing standards.

*Sec. 105. Improvements in Hiring Practices*

Section 105 would amend the IHClA to authorize the Secretary to directly hire candidates to vacant positions within the IHS. The section also directs the Secretary to notify each Indian tribe located within a geographic Service Area and, in some instances, obtain a waiver of Indian preference laws from each Indian tribe concerned. The CCT is concerned about the directive for the Secretary to obtain a waiver of Indian preference from tribes. We recommend additional discussion on this provision with Indian tribes and tribal organizations.

*Sec. 106. Removal or Demotion of IHS Employees Based on Performance or Misconduct*

The Colville Tribes strongly supports this section. While the Colville Service Unit has not experienced the personnel issues that other IHS areas have reported regarding problem personnel, these tools should be available for all IHS areas.

*Sec. 202. Fiscal Accountability*

The Colville Tribes strongly supports Section 202, which would direct the Secretary to use unobligated or unexpended funding to support essential medical equipment, purchased or referred care, or staffing. The Colville Tribes is troubled by reports that the IHS has carried over significant funds from year to year. The CCT was also disturbed that in 2015, the IHS paid \$80 million from funds that could have otherwise been used for staffing to the Laborers' International Union of North America to settle overtime claims.

There has long been a lack of transparency in how the IHS spends its appropriated funds. Had Indian Country known that this \$80 million was available, it could have used it for needed programs and services. The IHS needs congressional direction on how it should use unobligated or unexpended funds and Section 202 is a good start.

*Sec. 303. Reports by the Comptroller General*

The Colville Tribes strongly supports Section 303, which would direct the U.S. Comptroller General to develop and submit to Congress three reports. With regard to the staffing report in Section 303(b)(2), the CCT recommends additional specificity be added to ensure that the formulas or methodologies that the IHS has previously used and currently uses to assess staffing needs are identified in the report. The Colville Tribes has received conflicting information from the IHS about these issues in past years when it was attempting to ascertain what its needed staffing levels should be.

This concludes my testimony. Thank you for allowing the Colville Tribes to testify today. I would be happy to answer any questions that the members of the Committee may have.

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Miss GONZÁLEZ-COLÓN. Thank you, Mr. Joseph. Now the Chair recognized the Honorable Robert TwoBears.

**STATEMENT OF TWOBears, ROBERT, DISTRICT V  
REPRESENTATIVE, HO-CHUNK NATION LEGISLATURE,  
BLACK RIVER FALLS, WISCONSIN**

Mr. TWOBears. I would like to thank you for the invitation to appear before you today to discuss H.R. 2662, the Restoring Accountability in the Indian Health Service Act of 2017.

My name is Robert TwoBears. I am a District V Representative of the Ho-Chunk Nation Legislature. The Ho-Chunk Nation has over 7,000 tribal members spread across 18 counties in the state of Wisconsin. We have a diverse and strong tribal economy that employs thousands of tribal members in the surrounding communities.

The Nation operates two health facilities, one in Black River Falls and one in Wisconsin Dells. The Black River Falls facility has 23 exam rooms and 6 operatories. The Wisconsin Dells facility has 11 exam rooms and 3 dental operatories.

The facilities in itself are very similar to community health centers. They handle a pharmacy, optometry, and also community health departments.

You have read our written statement, so I would just like to highlight a few provisions the Nation believes are most important.

Section 100 requires Indian Health Service doctors, dentists, and other professionals have a pay parity and relocation cost with their counterparts, similar to the Department of Veterans Affairs.

Section 104 expands a loan repayment program for administrators, health managers, and the like. These sections will help attract and retain high-quality professionals to Indian lands.

Section 109 would allow staffing demonstration pilot to increase staffing resources for federally run health units with an emphasis on those tribes that have contributed substantially to the constrictions of the facility.

Last, a word about consultation. I know that there are two different types of tribal consultations being considered under this bill. Section 110—the first being the previous tribal consultation, as mandated by the Indian Health Service, in which Indian Health Service is utilized in dealing with the Indian tribes. This policy was endorsed by Executive Orders and formalized by CMS. The policy that Indian Health Service utilizes requires tribes to be contacted, consulted at any point during a rulemaking or Federal planning decision where a tribe could be affected.

In his extended remarks on the final negotiated rulemaking process on October 23, 1990, he indicated that this Act was not intended to apply to policy decisions. I think early in the earlier testimonies they were talking about consultations, and I actually attended the consultation for the Midwest region. We met with the Health and Human Services region, and we actually have a work plan that we reviewed with the appropriate staff from the region, CMS, Indian Health Service, HRSA, SAMHSA.

And just to really kind of clarify from a tribal perspective is we talk about issues that are affecting the tribes. When we were having these consultations, we sit in a room similar to this. The tribes are on this side, similar to this, and the Feds are on one side. And then we actually just ask questions and look for guidance and assistance to help us with some of our health disparities, whether it is substance abuse, diabetes, and so forth.

But really, what doesn't happen is that when the tribes are requesting this assistance, we just get the looks back from the Feds, looking for us. So, in a sense they give us, the tribes, an opportunity to talk about their issues. But on the back end is we never get the answers that we are looking for.

So, in a sense, that consultation does work. We are at the table with the appropriate people. As far as any actionable items that we request back from the Feds, the tribes still have that work plan in place, and it is never addressed.

This concludes my testimony. I will be happy to answer any questions. Thank you.

[The prepared statement of Mr. TwoBears follows:]

PREPARED STATEMENT OF THE HONORABLE ROBERT TWOBears, HO-CHUNK NATION,  
LEGISLATIVE REPRESENTATIVE, DISTRICT V, BLACK RIVER FALLS, WISCONSIN

Greetings Chairman LaMalfa, Ranking Member Torres, and esteemed members of the Subcommittee. My name is Robert TwoBears, and once again, I am one of the acting Legislative Representatives for District V of the Ho-Chunk Nation (the "Nation").

Please allow me to extend some previous-stated background on the Ho-Chunk Nation. The Nation has nearly 7,000 tribal members, and while it does not have a reservation, its land base consists of trust lands and fee simple lands spread across eighteen (18) counties in the state of Wisconsin. The Nation also maintains fee simple lands in the states of Minnesota and Illinois. Further, the Nation has a diverse economy that includes forestry, gaming, agriculture services, and a number of retail outlets. The Nation employs approximately 4,000 individuals, and is the largest employer in Sauk and Jackson counties in Wisconsin. As a Legislative Representative for District V of the Nation, I represent the at-large tribal population residing outside of Wisconsin.

For years the Nation has received direct healthcare services from the Indian Health Service ("IHS") but recently, the Nation has finalized negotiations with IHS under its annual funding agreement, and now proudly operates its health facilities through the Self-Governance Compact and Funding Agreement under Title V of the Indian Self-Determination and Education Assistance Act ("ISDEAA") 25 U.S.C. § 5381.

Again, we applaud H.R. 2662, "Restoring Accountability in the Indian Health Service Act of 2017", as it provides workable measures for the success and betterment of employee recruitment, employee hiring, and employee retention in the Indian Health Service ("IHS") workforce. We again note that H.R. 2662 takes affirmative steps to restore accountability in the standards and timeliness of care that IHS provides to its Native People. A significant obstacle H.R. 2662 undertakes, which is essential to providing adequate health to Native Americans, is imposing firmer reporting requirements for the Federal Government to utilize, that if followed, would report with better clarity and accuracy, on the true state of all Indian Health Service Units.

Although not applicable to all service units, Section 833 of H.R. 2662, proposes the creation of a staffing demonstration project. This project would provide federally managed service units with additional staffing resources. The hope is, that in providing these additional resources to a tribe, the additionally staffed service area will become a self-sustaining source of revenue for the unit at the end of a 3-5 year period. The staffing demonstration project is ambitious, to say the least, as it would indicate upon completion, whether giving tribes additional staffing resources could generate sufficient service revenue for the unit to retain the staffed service area on a permanent basis.

In essence, this is the start of a self-help formula for federally managed tribal service units to identify their unmet needs, and then seek to relieve those needs by placing government provided additional staffing resources toward identified areas of concern, with the hoped-for-wish that the provision of additional resources creates self-sustaining sources of internal revenue. However, such a project cannot be initiated and completed without appropriate tribal consultation.

In submitting testimony on H.R. 2662, the Nation is not in support of H.R. 2662's amendment, as proposed under Section 834, to replace the tribal consultation policy under Circular No. 2006-01 of IHS, with the Negotiated Rulemaking Act of 1990. In providing health care to its People, the Nation has consistently relied on the deictic channels of communication as provided by the tribal consultation policy under Circular No. 2006-01.

On September 1, 2016, the Nation submitted a Comment on the Proposed Rule for "Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Proposed Expansion of Medicare Diabetes Prevention. The Nation urged the Centers for Medicare and Medicaid Services

("CMS") to take into account the unique position of tribes, and requested that consultation occur at all stages where there could be a substantial effect on a tribe, which mirrors the standards as set forth under Circular No. 2006-01.

Whether any relief the Nation requested was provided, remains undetermined, however the tribal consultation policy, as utilized by the Service, provides the only viable notice to the Nation, and to all tribes, to assert standing and express all and any concerns regarding their health care as serviced by IHS and the Federal Government at large.

Additionally, the Nation would like to remind the Committee that, in his extended remarks on the Final Passage of the Negotiated Rulemaking Act of 1990, Speaker Donald J. Pease, then stated that he does not ". . . intend that negotiated rulemaking be employed to establish fundamental policy directives or to permit Federal agencies to frustrate the will of the Congress." (See attached Exhibit A. Final Passage of The Negotiated Rulemaking Act of 1990, 136 Cong Rec E 3414). Speaker Donald J. Pease was the first to introduce the Negotiated Rulemaking Act, and was a strong supporter of this legislation from its creation to its enactment.

Given the special relationship that exists between tribes and the Federal Government, as well as the promulgations long-established in the then-titled Indian Health Care Improvement Act of 1976, as since amended, Congress spoke quite clearly when it found that ". . . a goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."(See attached Exhibit B. 94 P.L. 437, 90 Stat. 1400).

Although the Indian Health Care Improvement Act has undergone many transformations since its inception, congressional intent for tribes to be meaningfully engaged and consulted regarding their health services as provided by the Federal Government, remains intact. Adopting the Negotiated Rulemaking Act of 1990 to determine or guide tribal consultation for services through IHS, under H.R. 2662, frustrates this congressional intent, and is a misapplication of the legislative intent of the Negotiated Rulemaking Act.

The Ho-Chunk Nation wishes for the tribal consultation policy under Circular No. 2006-01 to remain and continue under H.R. 2662. Although by no means perfect, this policy at the very least, recognizes and meets the unique consultation needs of Indian tribes, as recognized by Congress.

In considering the unique position of tribes, and the consequent need for tribal consultation, the Nation wishes to expand its commentary regarding the legislation's intent to increase physician retention rate under the service by offering the following insight. Upon reading H.R. 2662, and reviewing the testimony that was offered, Executive Director of the Ho-Chunk Nation Department of Health, Ona M. Garvin, found that physician retention rate in Indian Country would be better served by IHS receiving and funding tribes with more monies to hire physicians with a pay-rate that is commensurate with physicians in private practice, specifically in the 330k-range.

Once again, I appreciate your kind invitation to testify and appear before you to discuss the Ho-Chunk Nation's commentary regarding H.R. 2662, "Restoring Accountability in the Indian Health Service Act of 2017." I would like to thank Congresswoman Kristi Noem for introducing this important bill, as well as Chairman LaMalfa, the Full Committee, Chairman Rob Bishop, and others, for co-sponsoring this proposed legislation.

I look forward to working together with all concerned parties to further "Restoring Accountability in the Indian Health Service Act of 2017." Thank you again for this kind invitation to the Ho-Chunk Nation to offer testimony on H.R. 2662.

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The following documents were submitted as supplements to Mr. TwoBears' testimony. These documents are part of the hearing record and are being retained in the Committee's official files:

- Exhibit A: Final Passage of The Negotiated Rulemaking Act of 1990, 136 Cong Rec E 3414
- Exhibit B. 94 P.L. 437, 90 Stat. 1400

Miss GONZÁLEZ-COLÓN. I want to thank you, Representative TwoBears, for your statement. Now the Chair recognizes Ms. Victoria Kitcheyan, representative of the Great Plains Area National Indian Health Board.

**STATEMENT OF VICTORIA KITCHEYAN, GREAT PLAINS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD, WASHINGTON, DC**

Ms. KITCHEYAN. Good afternoon, Committee members and Ranking Member Torres. Thank you for the opportunity to offer testimony on this important bill. My name is Victoria Kitcheyan, and I serve as the Great Plains area rep for the National Indian Health Board. I am also a Winnebago tribal member and I serve on the Tribal Council as Treasurer.

We appreciate the commitment of this Committee to find lasting solutions to the long-faced challenges in the health care delivery in Indian Country. Legislative efforts to address these issues should be conducted in conjunction with increased oversight and scrutiny of the agency. We need to get this right. I have heard from my colleagues today, and some of our supportive representatives, that our people need help. And some of the quality care issues found in my tribe and elsewhere within the Great Plains have been going on for far too long.

But I want to, I guess, kindly remind the Committee that we need to do this in tandem with all of Indian Country, because this is going to affect us all. And we need to work together so we have the best possible outcome and product for the whole IHS agency and Indian Country. This includes making the legislation work for direct-service tribes as well as self-governance tribes, and we look forward to working with this Committee and Indian Country in the coming weeks to further engage in this consultation on the bill.

As I have shared in previous testimonies with this Committee, as documented since 2007, that we have had these demonstrated deficiencies in Winnebago. And it is our feeling that these should not exist at any facility run by the Federal Government. And Winnebago still remains the only Federal facility to lose its CMS certification. We lost that in July of 2015. Two years later we are still without that certification. Other tribes in our region continue to experience similar circumstances, although they have not lost their certification.

So, we are looking for both long-term and short-term solutions that would improve the quality of services delivered at these IHS hospitals that would improve staffing and management.

Though this bill addresses crucial care issues, it is important that we consider that it will affect the whole Indian healthcare system. For instance, savings clauses in the bill should be more clear in how they intend to exempt self-governance tribes.

There are a few other items in the legislation I would like to address so that it works for all of us.

First and foremost, I again want to emphasize that legislation should not be enacted without thorough input and agreement of Indian Country. The legislation will affect everyone, and we want to ensure that all voices are heard. This remains a high priority for the National Indian Health Board.

There are many provisions that address new programs and functions for IHS, which will be beneficial if they receive adequate resources and oversight. We want to make sure that this legislation put forward is something that is not going to become an unfunded mandate. Many of the provisions within the Indian Health Care Improvement Act passed 7 years ago remain to be unfunded. So, I just ask that this bill be funded so that it is not another broken promise to Indian Country.

NIHB also appreciates the intent to streamline the system for licensed healthcare professionals' credentialing procedures. However, we do not want that to be mistaken as the replacement to providing permanent healthcare providers to the tribes and the IHS. We are striving for permanent providers here, and we just want to make sure that there is a commitment.

Tribes in some of the areas have already come up with some creative solutions to gain that commitment at the local level, and I think that there is value there, and we can mimic those throughout Indian Country and replicate those models. We look forward to further developing some of those concepts and creative solutions to address the change that is much needed.

When it comes to hiring authorities outlined in the legislation, NIHB appreciates the streamlining of Federal hiring authority. However, we believe that changes to the legislative language are needed to include more tribal input, again, and most notably when it comes to waiving the Indian hiring preference. And we want to make sure that that is not an erosion of that as a distinct political people—it is important that that stays intact.

Section 110 establishes rules regarding a tribal consultation policy. We are in complete agreement that this consultation policy needs to be strengthened so it is meaningful for the tribes. And had this been done from the beginning, many of the Great Plains issues and deficiencies may have been identified sooner and not have risen to this crisis level.

We believe increasing fiscal accountability for IHS outlined in the bill makes sense. However, we want to make sure that in Section 202, that the tribes are involved so that those third-party revenue dollars are spent at the local level, so the tribes can identify where those services are needed the most.

Finally, we are glad to see some of the reporting requirements outlined on the quality of care, but we also want to include purchase-referred care. In addition, tribes should have input on how those reports are released.

Again, we thank the Committee for its genuine interest to elevate our problems—alleviate, not elevate—I think they have been elevated. It is clear that management, recruitment, accountability, and transparency are still issues within the agency. I thank you for the increased efforts that this Committee has made, so that the tribes can be consulted with and we can make effective change for long-term care for Indian tribes and Alaska Natives.

[The prepared statement of Ms. Kitcheyan follows:]

PREPARED STATEMENT OF VICTORIA KITCHEYAN, GREAT PLAINS AREA  
REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Chairman LaMalfa, Ranking Member Torres and members of the Committee, thank you for holding this hearing on this very important piece of legislation. My name is Victoria Kitcheyan. I am a member of the Winnebago Tribe of Nebraska and I currently serve as Treasurer of the Winnebago Tribal Council. I also serve as the Great Plains Area Representative of the National Indian Health Board. The National Indian Health Board serves all 567 federally recognized tribal nations when it comes to health. This means we serve both tribes who receive care directly from the Indian Health Service (IHS) and those who operate their health systems through self-governance compacts and contracts.

The Federal Government has a duty, agreed to long ago and reaffirmed many times by all three branches of government, to provide health care to tribes and their members throughout the country. Yet, the Federal Government has never lived up to that trust responsibility to provide adequate health services to our Nation's indigenous peoples. Historical trauma, poverty, lack of access to healthy foods, loss of culture and many other social, economic and environmental determinants of health as well as lack of a developed public health infrastructure in Indian Country all contribute to the poor state of American Indian and Alaska Native (AI/AN) health. AI/ANs suffer some of the worst health disparities of all Americans. We live 4.5 years less than other Americans. In some states, life expectancy is 20 years less, and in some counties, the disparity is even more severe. With these statistics, it is unconscionable that some IHS-operated facilities continue to deliver a poor quality of care to our people.

We appreciate the commitment of this Committee to find lasting change at IHS which has long-faced challenges in the delivery of health care. Legislative efforts to address these issues should be conducted in tandem with increased oversight and scrutiny over the administration of the delivery of care at service units operated by the Indian Health Service. The current legal framework for IHS provides much of the necessary guidelines for the operation of the agency.

While we appreciate the speed at which the House is considering the legislation given the critical situation going on in the Great Plains region, we need to make sure we get this right. It is true, our people need help. These issues surrounding quality of care cannot go on any longer. However, it is also important that these changes are accompanied by input from all tribal nations to ensure the best possible outcome and product. Tribes across the country would have appreciated the time to review any draft legislative language before H.R. 2662 was introduced. NIHB is ready and willing to lead a legislative consultation on this bill and we intend to do so in the coming weeks and months. This step must happen first before anything can be enacted.

IHS HOSPITAL OPERATIONS

Quality of care issues at IHS-operated hospitals and facilities are well documented. Since at least 2007, the Winnebago IHS Hospital has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. The Centers for Medicare and Medicaid Services (CMS) deficiencies were so numerous and so life-threatening that in July 2015 the IHS Hospital in Winnebago became what still is, to the best of our knowledge, the only federally operated hospital ever to lose its CMS certification. Other IHS facilities in the Great Plains region such as Rosebud Indian Hospital and Pine Ridge Hospital have been experiencing similar quality of care issues throughout this time and are also under threat of decertification by CMS. These facilities continue to have quality of care issues, and it is unclear if the actions the agency has taken are substantially improving the situation. This situation is especially troubling considering the challenges that have been identified are not new. In 2010, for example, then-Chairman of the Senate Committee on Indian Affairs, Byron Dorgan (D-ND) issued a report detailing issues in the Great Plains area that sound similar to those still experienced today. As recently as October 2016, the Department of Health and Human Services' Office of the Inspector General published a report that highlighted the long-standing challenges IHS-operated hospitals experience across the system.<sup>1</sup>

<sup>1</sup>Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI-06-14-00011, p. 14-15.



Though we continue to express the need for more review and comment by the tribes, we have some general areas of concern regarding the proposed legislation. There are provisions in the bill that create new programs and functions for the IHS, which will be beneficial if they are actually funded. We want to make sure the legislation does not put forward programs that become in essence unfunded mandates. We urge this Committee to work with the Appropriations Committee to ensure that these provisions are funded so they do not end up just being lip service to tribal communities. The Indian Health Care Improvement Act was permanently enacted in 2010 and contained many provisions designed to modernize the provision of care, such as the development of new health care delivery demonstration projects and expansion of the types of health professionals available within the Indian health system. Yet many of those provisions remain unimplemented due to lack of adequate funding. We do not want to see the same type of thing happen with this legislation. Congress cannot continue to starve the Indian health system and expect major change.

About 60 percent of the IHS budget is delivered directly to the tribes through contracts and compacts. We are concerned that the proposed legislation does not do an adequate job of stating which provisions of the legislation pertain to self-governance tribes and which do not. The legislation provides a "Savings Clause" that appears to ensure the legislation does not interfere with tribal contracting or compacting. Yet the provision at 607(e) of the proposed legislation is not clear on what provision or provisions that Savings Clause language pertains. This language does not clearly state that the provision it is contained in does not apply to tribal health programs. Instead, it just states that it cannot be construed to interfere with tribes' rights under the Indian Self-Determination and Education Assistance Act (ISDEAA). If enacted, it is entirely possible that IHS or others could interpret the operative position to apply to self-governance tribes because, in their view, compliance with that provision would not inhibit the authority of a tribe to exercise its ISDEAA rights. As a result, we think it important that the rule of construction be clarified throughout the bill so as to clearly state that the provision does not apply to tribal health programs. Similarly, we believe that language should be constructed in such a way that self-governance tribes *could* opt into some of the provisions if they so choose or would be eligible for new programs in the bill such as liability protections for health professional volunteers as described in Section 103.

NIHB understands the intent to make a streamlined system for licensed healthcare professional credentialing procedures, including volunteers, as outlined in Section 102 and provisions in Section 103 that support liability protections for health professional volunteers at IHS that would allow for healthcare professionals who volunteer at an IHS service unit to be considered an employee of the IHS in order to receive liability protections.

However, we note that these provisions should not be considered a substitute or final step for increasing available providers to the IHS and tribes throughout the country. For example, NIHB and a large majority of tribes support the expansion of the dental therapy model, which was first brought to the United States by tribes in Alaska in 2004. It is a highly effective way to provide reliable, safe, and quality dental care providers to underserved areas. We urge the Committee to consider models such as these to address the chronic staffing shortages in the Indian health system, rather than exclusively relying on a patchwork of volunteers. Additionally, NIHB supports provisions included in similar legislation introduced in the 114th Congress (H.R. 5406) that would provide tax-exempt status for IHS student loan repayment. Because IHS is paying the necessary taxes on the loan payments to the medical professionals, this provision would allow IHS to fund more medical professionals for loan repayment, thereby increase the amount of practitioners in the IHS system.

Section 105 addresses improvement in hiring practices. While we certainly agree that hiring practices need drastic improvement, we are concerned that some of the proposals in the bill do not adequately involve the tribes, which has been a central concern with some of the issues in the Great Plains region. Furthermore, this provision indicates that the Secretary has direct hire authority, but Tribal Preference should not be ignored in this process. This provision of the proposed legislation goes on to note that the Secretary shall notify each tribe in the service area prior to the direct hire taking place without further guidance on how or why. While notice is appreciated, tribes should be able to file objections to any hire, especially if the new hire is somebody who has been recycled through the system previously and has not performed well with other tribes in the Region, which has been a common practice at IHS. Last, this provision provides that the Secretary may seek waivers to Indian

preference from each Indian tribe concerned if certain criteria are met. Tribes are concerned about diminishing Indian preference in the hiring process. Further, consultation on this provision is needed to ensure that IHS receives a more streamlined hiring system, but also that Indian hiring preference is respected across the agency, as is current practice.

We are pleased to see a provision addressing the Timeliness of Care in Section 107. We believe that timeliness of care has been an issue for many years and that additional standards to improve the reporting and tracking of timeliness are necessary. It should be noted that underfunding also contributes to the inadequate and untimely care. There is currently a system in place that, if implemented, correctly tracks these important care initiatives. However, if a region does nothing to implement the current system or inadequate staffing impedes the ability to track these initiatives, then it becomes a major problem. We feel that additional congressional oversight over this particular area may be necessary. Section 107 also states that regulations and standards to measure the timeliness of the provisions of healthcare services must be done within 180 days of the enactment of this legislation. We are concerned that 180 days may not be enough time to develop the regulations and standards if proper consultation with the tribes is used to develop said regulations and standards. Last, we request that any data gathered regarding the timeliness of care be provided to the tribes as well as the Secretary.

NIHB believes that Section 108 regarding training programs in tribal culture and history is of utmost importance. Meaningful cultural training will help IHS employees as they learn the history and culture of the people they are serving on a daily basis. We think this training should be mandatory and it should not only include medical professionals but also include all IHS employees from headquarters to all staff at the service unit facilities, who have daily interaction with Native American people. It would be even more useful if the training was specifically developed by the tribes and was tailored specifically for the tribes in the service area.

Section 110 establishes rules regarding a tribal consultation policy. We are in complete agreement that a consultation policy should exist and that tribes should have input into the way services are provided to tribal communities. However, it is imperative that the consultation policy developed under this section mandate to IHS staff that consultation shall be more than simple lip service or a listening session with the tribes. It should be viewed as a true partnership and collaborative effort. Tribal input is key to IHS in providing high quality services and must be taken seriously. The problems in the Great Plains area would have never have risen to the current critical level if there was true consultation and collaboration at every step in this process; and these issues never would have received the attention they have if not for tribal oversight and actions.

Fiscal accountability is never a bad thing, but the provision in Section 202, subsection (b) that addresses the prioritization of patient care is concerning due to the specific guidelines provided. This section explains that IHS should only use certain dollars for patient care directly and limits their use to essential medical equipment; purchased/referred care; and staffing. While it is understandable the agency should have more scrutiny over these funds, we worry that the criteria may end up being too constraining. IHS should consult with the tribes in their service area before making decisions on what can be done with the funds pertaining to this section. With consultation, the money can go to the most needed programs in a particular service area.

Most of Title III of the proposed legislation outlines a series of reports. One report that drew our attention was the Inspector General reports on patient care in Section 304. We agree that reports on the quality of care and patient harm at IHS are necessary. However, we want to draw attention to the fact that many tribal members end up receiving their care outside of the IHS system through the Purchased/Referred Care program. For example, in South Dakota, approximately 70 percent of care is referred outside of IHS facilities. It would be useful to also have information on quality of care once a patient has left the IHS facility as part of reporting. Additionally, we believe that any and all reports that come as a result of this legislation be first shared with the tribes for review and comment before they are made public.

Again, we thank the Committee for its genuine interest in trying to alleviate problems within IHS. It is clear that management, recruitment, accountability and transparency are all still issues that need to be addressed at IHS-operated facilities. Real change and the rebuilding of many of the areas in the Great Plains region cannot happen without permanent qualified personnel and the funding necessary to carry out the mission. However, we reiterate our request that additional time be taken to review the legislation with Indian Country before the legislation moves

forward in the legislative process. It is critical that we are able to more fully understand the implications of the bill.

Legislation alone will not solve issues in the IHS. Proper training of hospital staff costs money, new equipment costs money, and recruitment under these circumstances is also going to cost money. Correcting this situation is going to require a continuous team effort, additional resources, and consistent congressional oversight of IHS activity.

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

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Miss GONZÁLEZ-COLÓN. Thank you, Ms. Kitcheyan. I want to thank the panel for their testimony.

And I remind the Members that Committee Rule 3(d) imposes a 5-minute limit on questions. Right now the Chair will recognize Members for questions, and I will recognize myself for 5 minutes.

First of all, I want to begin with you, our last witness. You said about Section 110, regarding the consultation policy with the IHS, you said that the fear that mandate will result in lip service or listening sessions with the tribes, could you provide more examples of, or specifics about what kind of recommendation we can include in the bill to make that policy be a true help to the Indian tribes?

Ms. KITCHEYAN. Thank you for that question. We certainly view consultation as our voice in the process, and we want to be taken seriously. So, when the tribes, at a very sophisticated level, engage with IHS and have the technical assistance to ask the right questions, we expect an answer. And there are many resources brought together from the tribes, from the regional health boards, that bring that technical assistance.

When we come to the meeting, we come prepared and ready to engage. And when IHS comes, we just don't feel like they are ready to truly engage with us, or we are not given the information that we have asked for time and time again.

So, I would just cite that as an example that I have experienced in the Great Plains. And some of it may come down to some miscommunications. But all in all, I feel like the tribes have put their best foot forward in gathering our issues and our concerns that we need addressed and need answered through data-driven information, not just, like, hey, we are here, and to have some face-to-face—

Miss GONZÁLEZ-COLÓN. Can you make specific recommendations about exercise or initiatives that can truly make this a true partnership? To enhance the bill we would need to have what kind of experience or exercise, do you think, that will improve that kind of relation?

You can provide that in writing after this hearing. You don't have to write it right now. You may have some days to provide that.

Ms. KITCHEYAN. I just had a note from my colleague, and it may sound crazy, but increased consultation on the consultation, because we are not getting the answers, and it feels like a press release when we engage in this consultation. So, anything that is brought forward is not really factored into the decision or the next roll-out. It is just they had to do it, they checked that they engaged with the tribe.

I would just say this word “meaningful” is so overused, but it needs to be meaningful to tribes so that they felt like they were heard, and that whatever recommendations or input was actually incorporated, not just dismissed.

Miss GONZÁLEZ-COLÓN. Thank you. Question to Mr. Buchanan.

Section 202 of the bill will direct the Secretary of HHS to use unobligated or unexpected funding to support essential medical equipment, or refer care for staffing. This raises the long-term issue of transparency on how IHS spends its appropriated funds. Do you believe that IHS suffers from lack of transparency?

Admiral BUCHANAN. With the budget, we are—with the resources that we get, we are extremely prudent with those. We try to manage those as best as we can, going forward. Is there a specific question that I can—

Miss GONZÁLEZ-COLÓN. I am just referring to Section 202, in terms of the transparency of the use of those funds. I was referring you about how you use the funds of the long-term issue of the funding for the equipment. Do you have any specific feedback of how this Committee can use or address the transparency issue in IHS?

Admiral BUCHANAN. All right. As far as funding and transparency, we look at all opportunities to provide transparency related to funding and budget activities. A lot of our funds and—are located on our IHS website. And we also have other websites that they are located at.

We have been providing training across the agency by doing some all-tribes calls so that we can explain where those funds are located. We just recently held an all-tribes call—I believe it was back in May—related to where you can find those.

One of the things, kind of getting back to the tribal consultation issues, is providing that information. For me it is really technical; I have to rely on my experts to explain that to me. So, providing information that is meaningful is one of the goals that we have been trying to implement. And also providing information at the local level that is meaningful and useful. We are rolling out templates to provide information at the local level so that we can have those communications with the tribes on an ongoing basis.

Miss GONZÁLEZ-COLÓN. Thank you. The Chair now recognizes Ranking Member Torres.

Mrs. TORRES. Thank you.

Mr. Buchanan, I would like to go back to what Ms. Victoria Kitcheyan was talking about regarding what sounds like wonderful meet-and-greet meetings, but with absolutely no follow-up. Can you respond to that? What do you do? What is the purpose of wasting time and money traveling and pretend that you actually care about what they are saying to you, and there is no followup from IHS?

Admiral BUCHANAN. Thank you for the question. Our tribal consultation—we are committed to regular consultation—

Mrs. TORRES. Well, that commitment hasn’t shown, sir. It is obvious to me by all of the witnesses that they have tried time and time again to provide to you, to your department, feedback. And yet that feedback has fallen to deaf ears.

Admiral BUCHANAN. I hear the concerns that you are expressing. I hear the concerns that the tribes have expressed.

Meaningful consultation, I get that. The agency gets that. We are open to improving. When we think we have consulted enough, we know that we have not. We can always do better. We can always continue to improve. We are open to revising our consultation policy, going forward, hearing those concerns—

Mrs. TORRES. How is this bill going to help you improve what you haven't been able to improve to date?

Admiral BUCHANAN. Well, some of the things that we have done to improve the consultation process is having all-tribes calls, providing information and being more transparent.

With the Quality Framework and Implementation Plan, we have identified five priority areas, specifically organizational capacity, accreditation, patient experience, patient safety, and last but not least is transparency and communication. So, that is one of the priorities, going forward with IHS.

Mrs. TORRES. Let's talk about Section 106. It is my understanding that Section 106 of this bill is based on language found in the Veterans Access Choice, an accountability act of 2014. In May of this year, the U.S. Court of Appeals for the Federal Circuit held that some provision from the 2014 statute to be unconstitutional.

In light of this ruling, how do you think enactment of Section 106 would impact IHS?

Admiral BUCHANAN. I don't have the bill in front of me—106 specifically relates to?

Mrs. TORRES. The authority for hiring and firing, or dismissing personnel.

Admiral BUCHANAN. Right. We have lots of hiring authorities, and we also have authorities in place that allow us to discipline problem employees. But specifically, we have 15,000 employees across the agency that are hard-working employees that are mission-focused related to Indian Health Service. We have those authorities in place to address that—

Mrs. TORRES. I understand that. In your statement you say IHS has existing authorities to implement adverse employment actions. I am reading that from your statement. Yet, what I am telling you is that DoJ has already weighed in on this, stating that they will not defend that position.

Could enactment of Section 106 open IHS up to potential costly litigation that would further take away funding from the program to defend?

Admiral BUCHANAN. Great question, a question for DoJ. DoJ represents us in litigation issues, so I would have to defer to DoJ.

Mrs. TORRES. OK, because it could also lead to the possibility of having the ongoing bad employees continue to stay on the payroll. We don't want the bad employees, we want to help recruit more people.

Walk me through that process. What are some of the incentives to recruit new candidates? Have you met with HUD?

And I understand that housing is part of the problem. How are you incorporating other agencies, and ensuring that you are able to have proper housing for good candidates? I mean I don't want to move to an area and bring children and a spouse if they don't

have proper housing for them. So, what incentives have you provided?

Admiral BUCHANAN. Great question. Again, recruitment and retention is a challenge, not only in Indian Health Service, but rural America, rural healthcare systems across the country.

Some of the things that we have done specifically related to housing, we have used models in other areas, and we are incorporating those in places like the Great Plains, specifically Rosebud—

Mrs. TORRES. My time has expired. I hope that you would follow up with a written statement on that.

Admiral BUCHANAN. Yes, ma'am. Sure will.

Mrs. TORRES. I yield back.

Mr. LAMALFA [presiding]. Thank you. I will recognize myself for up to 5 minutes here. Let me start with Admiral Buchanan.

I understand that when the South Dakota delegation met with your predecessor and asked questions about staffing needs, the agency was not able to produce reliable data on that. How do you determine what staffing levels will be needed at the facilities?

Admiral BUCHANAN. So, specifically related to staffing levels at the facilities? Having been a former CEO, I would know the staffing levels associated within my facility, within Indian Health Service. We have a vacancy rate of 20 percent. Some of the facilities that we are talking about today, including Rosebud, we have vacancy levels at 22 percent. Pine Ridge, we have vacancy levels at 22 percent. Rapid City, we have 11 percent vacancy levels. Omaha Winnebago we have 29 percent vacancy levels—lots of those physicians, chief executive officers, chief of nursing officers, operation officers.

So, definitely a challenge. Recruitment and retention, as Mrs. Torres had mentioned earlier, is a challenge across IHS in our rural, remote locations.

Mr. LAMALFA. OK, thank you. Let me shift over to Andy Joseph for a moment here.

Your testimony indicated that in 2013, IHS determined that the Colville service unit had fewer than one-third of the required number of clinical staff. Not just short 20 percent, but that would be over 60 percent required number of clinical staff, and one-quarter of the required number of dental staff.

Is that consistent with what we are understanding here? And then, what is the effect on the Colville Reservation with that kind of staffing?

Mr. JOSEPH. The effect is a lot of our patients that go there, they have to wait for a chance to actually get in to see one of the providers that we have. So, by not having the providers there, they are not really getting the basic health care needs taken care of.

And a lot of times what happens is our patients end up really hurting, and they will go into emergency and find out they might have Stage 3 or Stage 4 cancer, or they might be a diabetic, or they might need some kind of surgery procedure done, and then that ends up costing the government a whole lot more money.

If we had the adequate amount of basic healthcare providers, we would be able probably to keep our patients out of the hospital.

So, what we are really looking at is staffing for basic health care needs to keep us from burying our people. We have lost so many of our people due to not having those needs and going into emergency. Thank you.

Mr. LAMALFA. Thank you. So, you feel, according to your testimony, that you really have about one-third of the required staff. But Admiral Buchanan, do you know what that is, specifically to Colville? Or is that kind of an average across the region, when you said numbers between 20 to 29 percent short of a full staff?

Admiral BUCHANAN. I do not have Colville-specific numbers in front of me, but I am happy to provide those for the record.

Mr. LAMALFA. You believe that is probably likely, too, as what Mr. Joseph is saying? It could be as low as one-third?

Admiral BUCHANAN. Not knowing specifically what Colville is like, I—

Mr. LAMALFA. That is a problem at that kind of level.

Mr. JOSEPH. I could give you an example. One of our districts, Omak District, was going to get a joint venture. If we would have did a joint venture, that community, that district, would have got 115 new staff that would have come with that project. Right now, they are borrowing from our main clinic, I believe, 12 or 13 staff. There are two doctors that are there.

So, that is where the inequity is, I guess, for staffing. We built three of our four clinics with our dollars, but have never been given a staffing increase from clear back in the 1930s. So, it is based on our population back then, which was probably about 3,000; now we are almost 10,000 members. So, the user population goes backwards. It has been going that way with Colville for quite a few years now.

Mr. LAMALFA. OK, thank you. My time has expired. If the Committee cares to have a second round—oh, I am sorry, I need to recognize Mrs. Radewagen on the first round. I was away for a little bit. So, thank you, please, 5 minutes.

Mrs. RADEWAGEN. I want to thank you, Chairman LaMalfa and Ranking Member Torres, for holding this hearing. I especially want to thank the panel for taking the time to be here today.

And I particularly want to acknowledge my colleague, Representative Noem, for her bill, H.R. 2662. This much-needed legislation will make important changes to the Indian Health Service, and I look forward to seeing the bill added to the markup schedule in the near future.

I have a couple of questions for you, Admiral Buchanan. Your predecessor, Mary Smith, testified before this Subcommittee last year about a previous version of the bill we are considering today. In her testimony, she agreed to sign on to a request to the HHS Inspector General to investigate the deaths at Rosebud Hospital that occurred during the diversion. Unfortunately, that never occurred.

Here is my question. Will you commit to helping Mrs. Noem in co-signing a request to the HHS Inspector General to investigate the deaths?

Admiral BUCHANAN. That is a great question. Actually, Indian Health Service is already engaged with the Office of the Inspector

General. I am not able to comment much more because of the investigation that is currently going on.

Mrs. RADEWAGEN. Thank you. Admiral Buchanan, one of the chief concerns about the situation at Pine Ridge Hospital is that a revolving door of leadership staff has resulted in inconsistent leadership, and led ultimately to the most recent immediate jeopardy findings by CMS.

My question is how many CEOs has Pine Ridge had in the last 2 years? And does the facility now have permanent leadership?

Admiral BUCHANAN. Great question. I don't know the specific number of CEOs we have had in the last 2 years. I was the acting area director in the Great Plains. I can recall two in hiring the permanent one, Mr. Mark Meersman, who is currently the CEO at Pine Ridge.

Mrs. RADEWAGEN. I would appreciate you following up and getting that information to us.

And last, Admiral Buchanan, clearly our most immediate goal in the Great Plains is to get these Federal facilities in a state in which they are fully functional and safe. What is the long-term goal in the Great Plains? What is our ultimate aspiration beyond simply ensuring these facilities are safe?

Admiral BUCHANAN. Our ultimate goal is to provide good, quality health care for the Great Plains area. Not only the Great Plains area, but all of IHS areas. All of our patients deserve that.

To meet the mission of Indian Health Service, to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level is something that all of our 15,000 employees are striving to do.

We are implementing the Quality Framework. That is our long-range goal. In that framework, we have several things that we are implementing that are related to this bill. Talking about the credentialing aspect, we are going to be rolling that out for pilot sites in July. A policy that is going to be rolling out with that, also in July. So, we are excited about that.

We will be establishing wait times. That was something that was identified in some of the GAO reports and also in this bill. So, we will be rolling those out, will definitely have that in July, and we are excited about the progress that we are making there.

That is not enough. I mean when we continue to, like I mentioned earlier, think we are providing good-quality care, we can always do better. So, that is the long-term goal, the Quality Framework, providing performance metrics so that we can measure if we are making true progress when we come to hearings like this, when we meet with tribal leaders, to show them that here are the areas that we are having challenges with, here are the areas that we are improving with, get input at those local levels.

Part of that framework is a governance process, where we can meet on a regular basis to make sure that our health centers and our hospitals are providing good, quality care to our patients.

Mrs. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

Mr. LAMALFA. OK, thank you. You can hear the buzz. We are going to have to go back for votes here any minute, but we can go for a brief second round of questions or comments.



Let me go ahead and recognize our Ranking Member for the second round, for a statement, and then—

Mrs. TORRES. Thank you, Mr. Chairman. I simply want to say that we have heard over and over in this meeting that there was very little tribal consultation before introducing this legislation. While there might have been some meet-and-greet opportunities thereafter, the tribes still feel that they have not been heard and their concerns have not been addressed or even replied to, which means that you have not acknowledged that they have real issues. And that is tragic.

Additionally, many of these new provisions in this bill would require funding for implementation. Yet, there is no authorized funding found anywhere in the bill; and, as I stated in my opening statement, IHS is already chronically underfunded, and we must not impose new unfunded mandates on IHS or Indian Country.

As we know, many of the Indian Health Care Improvement Act provisions from 2010 still remain unimplemented, due to lack of adequate funding. Unless we want the same outcome for this bill, we need to finally fund IHS at an appropriate level.

I would suggest that you sit down with rural communities, counties, because they have a lot of the same issues, and try to maximize funding so that you can address some of these issues, if funding continues to be an issue for you.

Finally, let me say that I think that this bill is a good starting point with some good provisions. And I want to again thank Mrs. Noem for putting pressure on this issue. But we have one chance at this, and we need to make sure that we get it right this time.

So, before we move forward, I recommend that tribes be consulted—and not just sitting down and meeting with them, but actually listening to them. And not just the tribes that are here today, but tribes across the country. Their ideas, they have a lot of great ideas, and we need to hear them.

Then we can come back together, in a bipartisan fashion, and amend this bill so that we have a workable solution. And I look to you for this leadership. I yield back, Mr. Chairman, thank you.

Mr. LAMALFA. Thank you. All right. I will wrap up with just a couple more questions here. I want to come back to Admiral Buchanan, please.

Do you have in place a reliable way to measure the number of full-time equivalents needed at a given facility to meet the need of that facility at this point? And please be brief, because we have—

Admiral BUCHANAN. For sure. As Chair Joseph was talking about, we use a process called, I believe, RRM. The acronym escapes me right now, but it is a process that we typically use to staff facilities, as he was referencing earlier.

Mr. LAMALFA. So, you believe that that method will be accurate for the number of full-time equivalents that will be needed as you work toward that?

Admiral BUCHANAN. We typically use that process when we staff and build a new facility.

Mr. LAMALFA. OK. Let me jump to a couple more questions here.

Chairman William Bear Shield—again, I have to go faster, so maybe a little more yes or no, if you don't mind—would you say

that the Federal employees at the Rosebud Hospital are accountable to you?

Mr. SHIELD. Excuse me?

Mr. LAMALFA. Are the Federal employees at the Rosebud Hospital accountable?

Mr. SHIELD. There are several good employees, as was pointed out, of Indian Health Service. As far as accountable, there are still issues that were mentioned today with credentialing. And the ones that need to be held accountable, seemingly, are moved throughout the system.

Mr. LAMALFA. How would you feel about that at the Aberdeen office? Are they accountable, on the ball for you?

Mr. SHIELD. Well, we have different issues with the Aberdeen area office and, really, the need for it there. A lot of decisions are not made there, they are made up at the headquarters level. And—

Mr. LAMALFA. What is the relationship like with that area office?

Mr. SHIELD. It all falls back on meaningful consultation.

Mr. LAMALFA. Yes.

Mr. SHIELD. And the non-existence of it. And it is hard to win trust back when we are not afforded meaningful consultation or our questions are not answered, especially when it comes to the budget.

Mr. LAMALFA. OK, all right. Do you believe that the Federal Government and its employees can effectively spend the dollars that would improve patient care at this point? Do you see the seeds of improvement?

Mr. SHIELD. Yes, I do, in a revamping of the whole system. But it is going to take strong leadership, starting at the Health and Human Services Secretary level and the incoming Indian Health Director.

Mr. LAMALFA. OK, thank you. As was mentioned earlier, I believe, in our Ranking Member's line of questioning, some tribal leaders—this is for Ms. Kitcheyan—that the only reason some IHS facilities in the Great Plains remain open—maybe that was in Mrs. Noem's testimony, as well—is because CMS simply has not visited them recently. Do you believe that is an accurate statement?

Ms. KITCHeyAN. I believe that is very accurate. I believe across the whole country there are probably facilities that are in jeopardy, and they just have not been identified yet. So, our problem is not just in the Great Plains, it is agency-wide, and that is why it is so important that the solutions that come out of this bill are going to affect positive change across Indian Country.

Mr. LAMALFA. OK. And the problems outlined earlier on a more individual basis—Winnebago, Rosebud, et cetera—do you think it is widespread across the entire Great Plains area?

Ms. KITCHeyAN. Yes, I do. And we are finding that, as we think we can look toward our area office for some of these answers and solutions, we are finding, unfortunately, that that capacity is not there. And I don't mean to be disrespectful to our area office, but the tribes are very frustrated with the services that are coming out of that to the extent that we want to dismantle it. It is just not serving our needs.

Mr. LAMALFA. Yes, OK. That is unfortunate, but this Committee is committed toward vastly improving the situation, as Mrs. Noem is, and carrying the legislation, so I expect positive results coming from our efforts here in the Committee, and the Committee as a whole.

With that, again, the clock is running fast here, so I do want to thank the panel for your travel, for your effort to be here, and to share your important testimony with us today, informing this Committee.

I would remind that the members of the Committee may have additional questions for the witnesses, and we will ask you to respond to those in writing later on. Under Committee Rule 3(o), members of the Committee must submit witness questions within 3 business days following the hearing, and the hearing record will be held open for 10 business days for these responses.

If there is no further business, without objection, the Subcommittee stands adjourned.

[Whereupon, at 4:06 p.m., the Subcommittee was adjourned.]

[LIST OF DOCUMENTS SUBMITTED FOR THE RECORD RETAINED IN THE COMMITTEE'S OFFICIAL FILES]

— Letter from Chairman William Bear Shield, Rosebud Sioux Tribe to the Hon. Kristi Noem dated June 20, 2017.

**Rep. Gosar Submission**

— Statement of the American Dental Association to the Subcommittee on Indian, Insular and Alaska Native Affairs on “Restoring Accountability in the Indian Health Service Act of 2017, H.R. 2662” dated June 21, 2017.

**Rep. Grijalva Submissions**

— Written Testimony of the Hon. W. Ron Allen, Chairman, Self-Governance Communication & Education Tribal Consortium and Tribal Chairman/CEO, Jamestown S’Klallam Tribe to the House Committee on Natural Resources, Subcommittee on Indian Insular and Alaska Native Affairs. H.R. 2662, “Restoring Accountability in the Indian Health Service Act of 2017” dated June 21, 2017.

— Written Testimony of United South and Eastern Tribes Sovereignty Protection Fund to the House Committee on Natural Resources, Subcommittee on Indian, Insular and Alaska Native Affairs on “Restoring Accountability in the Indian Health Service Act of 2017,” dated July 5, 2017.