

DEPARTMENT OF THE INTERIOR, ENVIRONMENT, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2018

WEDNESDAY, JULY 12, 2017

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

The subcommittee met at 9:36 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Lisa Murkowski (Chairman) presiding.

Present: Senators Murkowski, Hoeven, Daines, Udall, Tester, and Van Hollen.

INDIAN HEALTH SERVICE

STATEMENT OF REAR ADMIRAL MICHAEL WEAHKEE, ACTING DIRECTOR

ACCOMPANIED BY:

**REAR ADMIRAL CHRIS BUCHANAN, DEPUTY DIRECTOR
GARY HARTZ, DIRECTOR OF THE OFFICE OF ENVIRONMENTAL
HEALTH AND ENGINEERING
ELIZABETH FOWLER, DEPUTY DIRECTOR FOR MANAGEMENT OPERATIONS**

OPENING STATEMENT OF SENATOR LISA MURKOWSKI

Senator MURKOWSKI. Good morning. The subcommittee will come to order.

I would like to welcome everyone this morning to the final budget hearing. I cannot believe it is already the final.

Senator UDALL. Yes.

Senator MURKOWSKI. It seems like we just got started.

Senator UDALL. We are roaring through them.

Senator MURKOWSKI. Yes. Anyway, this is an important one this morning for the Interior Appropriations Subcommittee.

Today, we will examine the budget request for the Indian Health Service, IHS. I would like to thank and welcome Rear Admiral Michael Weahkee, the new Acting Director for the Indian Health Service, appearing before us today.

I think we all recognize that the head of IHS is a tough job and it is also a critical one. It is certainly critical for us in Alaska. I know for Senator Udall, it is equally important and critical in his State, but recognizing that, again, we appreciate the role that you play here today.

Director Weahkee is accompanied by Rear Admiral Chris Buchanan, the Deputy Director for IHS; Gary Hartz, the Director of the Office of Environmental Health and Engineering; and Elizabeth Fowler, the Deputy Director for Management Operations. So we welcome all of you.

The IHS budget request for fiscal year 2018 is \$4.7 billion for programs within this subcommittee's jurisdiction. This is a decrease of \$300 million, 6 percent below last year's enacted. By comparison, other agencies within the Department of Health and Human Services were reduced by an average of 18 percent. So I think when you compare it on balance, it is important to recognize that I think there was some effort to mitigate the impacts on the IHS budget relative to other agencies.

I am pleased to recognize that the budget does provide full funding for Contract Support Costs by maintaining the indefinite appropriations language that I first included in the fiscal year 2016 appropriations bills. I think that this has helped provide a level of certainty for Tribes as well as protecting other IHS programs. What we were seeing was effectively robbing Peter to pay Paul, borrowing from other accounts. And while it may have helped one, it was at the expense of others, which I think we recognized was not a good direction in how we meet the Government's legal obligations.

Now having said that, I support where we are with contract support, and appreciating the fact that the cuts that we are seeing within the IHS budget are not as severe as they are in other areas, I am very, very concerned that the budget request does not adequately meet the needs for healthcare in Indian country. I think we recognize the disparities between health outcomes for American Indian and Alaska Native people compared to the population at large are staggering, just staggering.

For example, American Indians and Alaska Natives are three times more likely to die from diabetes. The drug-related death rate for Native Americans has increased 454 percent since 1979 to almost twice the rate for all other ethnicities. Of course, we unfortunately talk far too often about the incidence of suicide. The suicide rate amongst our First Peoples is roughly twice that for the rest of the population.

So in order to improve healthcare delivery, the IHS must do a better job at hiring, as well as retaining, an adequate number of qualified doctors and nurses. The IHS must also do a better job of maintaining a large facilities infrastructure that serves 2.2 million American Indians and Alaska Natives, and this requires significant resources. We all recognize and appreciate that.

Currently, the vacancy rate for IHS doctors, dentists, and physician assistants is roughly 30 percent. The backlog of facilities maintenance at IHS hospitals is over half a billion dollars and this according to the agency's own budget documents. The average age of its facilities is roughly four times that of its private sector counterparts.

And I think we recognize that additional resources are not the only answer. So much of this comes down to the quality of the existing workforce.

I read, and I am sure that my colleagues also read, several of the articles that appeared in the “Wall Street Journal” just last week on July 7. And I have to tell you, I was horrified. I was sickened. I was mad. There was a whole range of emotions as I read that because this is our IHS. These are our facilities that are supposed to care for our First People.

The stories that were detailed were shocking. There are deplorable conditions that we see, unfortunately, at several of our IHS facilities at the Great Plains.

In one case, a 35-year-old man stopped breathing in his hospital room. You have nurses that are responding to the emergency and they cannot find a crucial medical device that is needed to prop open airways to his lungs. It is a device that should have been stored in an emergency supply cart. It cost them a crucial 20 minutes.

Later in the internal report, they found that that 20-minute delay cost the patient his life. The investigation also revealed that the responding nurses were unfamiliar with how to use the hospital’s intercom system or defibrillator.

In another case, a 45-year-old woman died 10 hours after IHS nurses ignored a doctor’s orders to stop giving the patient a powerful cocktail of narcotics. A Federal inspection report found that two different doctors told staff that they were concerned that the patient was being over sedated.

One of the doctors ordered nurses to stop giving the patient morphine and to remove a patch that dispensed fentanyl. The patch was never removed and when the patient fell off her bed that night, nurses gave her even more pain medicine including a sleeping pill and oxycodone. As she fell into a catatonic state, coughing and frothing at the mouth, nurses failed to alert doctors. She was later found dead.

I will have both of these articles from the “Wall Street Journal” from July 7, 2017 included as part of the record.

[The information follows:]

[Articles from the Wall Street Journal, Friday, July 7, 2017]

FAMILIES SPEAK OUT: STORIES OF INDIAN HEALTH SERVICE PATIENTS

Regulators cite facilities of Federal health agency for Native Americans for dangerous care, unnecessary deaths

The Indian Health Service is responsible for providing medical care to about 2.2 million Tribal members across the U.S., but the system is in crisis after IHS hospitals repeatedly failed inspections, shut down services or lost access to crucial Federal funds.

The facilities, which operate in some of the poorest areas of the country, have rendered dangerous care and caused unnecessary deaths, according to Federal regulators, agency documents and interviews.

The families of some IHS patients who died say the agency is responsible for their deaths. An IHS spokeswoman, Jennifer Buschick, provided a written statement saying the agency, a unit of the Department of Health and Human Services, declined to comment on specific medical cases, lawsuits or regulatory findings.

Debra Free

Ten hours after nurses ignored a doctor’s orders to stop giving Debra Free a powerful cocktail of narcotics, she died of an apparent opioid overdose at the Indian Health Service hospital in Winnebago, Neb.

Federal hospital regulators laid the blame for her death at the feet of the hospital's medical staff, who they said disregarded concerns that the 45-year-old food-services worker was being over-sedated, documents from the Centers for Medicare and Medicaid Services show.

Ms. Free was initially admitted to the Winnebago IHS facility on April 5, 2011, for complications from toe amputations due to her chronic diabetes, a common condition among Native Americans that the agency often treats.

A Federal inspection report found that on April 8, two different doctors told staff they were concerned that Ms. Free was being oversedated. At one point, one of the doctors ordered nurses to stop giving Ms. Free morphine and to remove a patch that dispensed Fentanyl, a highly potent synthetic narcotic. But that never happened, regulators found. Instead, a nurse who was told to remove the Fentanyl patch mistakenly thought she was meant to leave it on until it expired in 72 hours.

When Ms. Free fell off her bed that night, medical staff responded by plying her with more pain medicine—a sleeping pill and oxycodone—regulators said.

Ms. Free soon drifted into a catatonic state, sometimes coughing and frothing at the mouth, the report said. But even as her condition deteriorated, nurses never alerted doctors. Ms. Free was found dead in her bed by hospital staff in the early morning hours of April 9.

According to Ms. Free's death certificate, the cause was cardiac arrest.

CMS declined to comment on its report.

Ms. Free's niece, Tori Kitcheyan, a Winnebago Tribal councilor, helps take care of Ms. Free's only daughter, Angelina, now 15. Last year, Ms. Kitcheyan told her aunt's story before a congressional committee. She blames the IHS for Ms. Free's death and is leading a push for the Tribe to take over operations of the hospital from the IHS.

Ms. Kitcheyan recalled her aunt as a passionate cook, who devoted hours to preparing meals for family events.

"She was a constant presence in our lives. Our family has never been the same since she died. It has been devastating," she said.

Charles White Pipe

Charles White Pipe, 68, a former Tribal treasurer and council member for the Rosebud Sioux, was first diagnosed with lymph-node cancer on April 2, 2016. But it took the Indian Health Service until early May to approve specialized treatment at a private hospital, his daughter said. By then, Mr. White Pipe was near death and had complained of untreated pain for weeks.

The IHS's program for referrals is often short on funding, leaving patients waiting, IHS records show. An agency budget document said it rejected around 40 percent of such claims for needed treatment in 2015 because of a lack of funding.

Lisa White Pipe, Charles's daughter and a Rosebud Tribal councilor, said that after her father was diagnosed, he attempted several times to seek relief and treatment at the reservation's Indian hospital.

On April 21, Mr. White Pipe, unable to hold down any food, called the Rosebud hospital to say his pain was increasing, but he was told to wait at home for a referral to a cancer specialist, she said. A few days later, when he called again, a medical staffer said the facility was too crowded, his daughter said, noting that he wasn't prescribed additional medication for his pain.

On the night of April 27, her father now barely able to walk, his legs and feet swollen, Ms. White Pipe drove him to the Rosebud hospital. Medical providers there informed Mr. White Pipe that his condition was terminal, gave him more pain medication and told him to keep waiting for his referral, his daughter said.

When Mr. White Pipe finally received a referral to a Sioux Falls, South Dakota, cancer center, doctors there said it was too late to determine where the cancer originated and that there was little they could do, she recounted.

He died on May 28.

"It felt undignified how he was treated," Ms. White Pipe said. "He was in pain and just pushed to the side."

Shiree Wilson

Hours after she was discharged from the Indian Health Service hospital in Belcourt, North Dakota, with a diagnosis of pneumonia, Shiree Wilson, a 24-year-old new mother, collapsed on the floor of her home and later died.

Eight days earlier, on Jan. 14, 2014, Ms. Wilson's son had been delivered by caesarean section at the IHS hospital.

Ms. Wilson, who was diagnosed with a mild cough and high white blood cell count in the days before she gave birth, returned to the facility on Jan. 22, complaining that her cough had worsened.

According to a wrongful-death lawsuit filed by Ms. Wilson's mother, Christine Fluhner, tests conducted during that visit revealed fluid was possibly seeping into her lungs, her white blood cell count had risen and her heart was "mildly enlarged." After diagnosing Ms. Wilson with pneumonia, doctors sent her home with decongestants and antibiotics.

After she died, the Grand Forks County coroner found Ms. Wilson's heart weighed 580 grams, twice the normal heart weight for someone her age, and that she suffered from severe pulmonary congestion and edema, according to the court filings.

The lawsuit alleges IHS medical staff failed to follow up, despite warning signs. A doctor also noted in Ms. Wilson's chart that he was concerned about a pulmonary embolism, the suit said. The IHS acknowledged the basic facts of Ms. Wilson's treatment and medical ailments, court filings show, though the agency denied any wrongdoing in her death.

In November, the IHS settled the lawsuit for an undisclosed sum, Ms. Fluhner's lawyer, Reed Soderstrom, said. He declined to comment further. Ms. Fluhner said she didn't wish to discuss her daughter's death.

According to an obituary, Ms. Wilson had worked at a local cafe for many years and wanted to learn how to cook. She loved swimming at the local pool and going to horse races. Her newborn son, Paxton, was her only child.

Paul West

When Paul West stopped breathing in his hospital room, nurses responding to the "code blue" couldn't find a crucial medical device used to prop open airways that was supposed to be stored in their emergency supply cart.

That problem cost the team of nurses and doctors responding to the incident a critical 20 minutes—and Mr. West, his life—according to an internal report by an Indian Health Service nurse and a lawsuit brought by his family.

Mr. West, a 35-year-old porter at the local casino, was declared dead at the Winnebago hospital on April 17, 2014.

"Delay in care for patient, and ultimately death of patient," said the internal report, called a Code Blue Critique, examining the case. The report, which was reviewed by The Wall Street Journal, concluded the hospital should "stock the Crash Cart" and practice code blues—emergency situations typically demanding patient resuscitations—at least monthly.

Regulators separately said nurses responding to the incident were unfamiliar with how to operate equipment ranging from the hospital's intercom system to the defibrillator.

The IHS said in a statement after this article was published online that the Winnebago hospital "holds monthly practice 'code blues,'" reviews logs of those practice sessions quarterly and checks crash cart inventory daily.

Some of the medical staff who participated in his care said in emails at the time and in interviews with the Journal that the Winnebago staff missed other chances to save Mr. West, too. Mr. West, who was obese and had a variety of chronic illnesses, had been getting sicker throughout the morning before he died. He had begun falling asleep while talking, and could no longer breathe without leaning forward, his family said in the lawsuit. U.S. lawyers denied many of the family's allegations in a court filing, saying alleged injuries weren't caused by negligent acts by government employees.

The death of Mr. West, who was described by Tribal members as a gregarious personality who made lighthearted jokes, shocked the Winnebago reservation, because of his young age and popularity. His family declined to comment through their lawyer.

"PEOPLE ARE DYING HERE": FEDERAL HOSPITALS FAIL TRIBES

Indian Health Service facilities sanctioned for dangerous, faulty care, leaving often-impoorished patients on remote reservations without services required by law

(By Dan Frosch and Christopher Weaver)

Service hospital in Pine Ridge, South Dakota, a 57-year-old man was sent home with a bronchitis diagnosis—only to die five hours later of heart failure. When a patient at the Federal agency's Winnebago, Nebraska, facility stopped breathing, nurses responding to the "code blue" found the emergency supply cart was empty, and the man died. In Sisseton, South Dakota, a high school prom queen was

coughing up blood. An IHS doctor gave her cough syrup and antianxiety medication; within days she died of a blood clot in her lung.

In some of the Nation's poorest places, the government health service charged with treating Native Americans failed to meet minimum U.S. standards for medical facilities, turned away gravely ill patients and caused unnecessary deaths, according to Federal regulators, agency documents and interviews.

But that system has collapsed in the often-remote corners of Indian Country, where patients live hours from other medical providers, often have no insurance and depend on the Federal service. "We've lost faith in the IHS, but we have no alternatives to go anywhere else," said Lisa White Pipe, a Tribal Council member for the Rosebud Sioux, whose father died last year after a delay in cancer treatment that she blames on the agency. Read more about his and other cases, and see the regulator's reports.

The problems have come to a head in recent months after IHS hospitals repeatedly failed inspections, shut down services or lost access to crucial Federal funds. Such failures have prompted new calls for broader oversight of the IHS by Congress. The Rosebud Tribe, whose reservation stretches across a rural swath of South Dakota, is also now suing the agency in Federal court, alleging that the IHS has failed to fulfill its treaty responsibility to care for Tribal members.

"People are dying here as a result of the care they are not receiving, or the care they are receiving," said U.S. Senator John Barrasso, (Republican, Wyoming), who until January chaired Congress's Indian Affairs Committee, in an interview.

The IHS, a unit of the Department of Health and Human Services, operates a network of hospitals and clinics, much like the Veterans Health Administration. Under U.S. treaties that date back generations, the service is legally responsible for providing medical care to about 2.2 million Tribal members.

The latest crisis has arisen after the IHS and the Health Department failed to address a chorus of warnings over many years about neglect at the agency's facilities. The warnings came from lawmakers in both parties, internal whistleblowers and the families of patients who died. Over and over, they reported that IHS hospitals were plagued by inadequate supplies, poor training, overwhelmed staff and critical positions left unfilled.

The agency has lacked a permanent director since 2015. People familiar with the matter said they expect a nominee for that post to be announced soon.

Rear Adm. Michael D. Weahkee, the agency's current acting director, said in a statement after this article was published online, "IHS is committed to improving patient safety and the quality of healthcare across the agency. We are faced with many challenges, but that is no excuse for substandard care." He said the agency is "holding all employees fully accountable and working to improve the systems that recruit, retain, and support those employees to meet standards."

Adm. Weahkee, a member of the U.S. Public Health Service Commissioned Corps, which provides medical staff to Federal agencies, was appointed to temporarily lead IHS in June. Back in 2010, a commission chaired by then-Senator Byron Dorgan, (Democrat, North Dakota), found improperly credentialed medical staff were treating patients at some remote hospitals and employees accused of misconduct—even crimes, including stealing drugs from hospital pharmacies—weren't disciplined.

The agency promised changes, but the situation has only disintegrated since, according to interviews with Tribal officials, civil and criminal court records, and a raft of Federal inspection reports.

Wilmer Spotted Wood hobbled into the IHS hospital in Winnebago but was sent home without treatment despite medical staff documenting his severe back pain—10 on a scale of 10—and ashen skin color, according to one of those reports.

Hours later, a nurse read a test result that showed his kidneys were shutting down. The finding would normally lead to hospitalization, doctors say. Instead, the nurse left a phone message telling Mr. Spotted Wood to avoid calcium products like the antacid Tums and come back in two days, a Federal inspection report said.

One of his sisters, Betsy Spotted Wood, herself an IHS nurse who was at the hospital that day, said "his skin coloring was way off. You could tell something was seriously wrong." Mr. Spotted Wood didn't make it to his follow-up appointment. He died in his bed of kidney failure on Jan. 1, 2015, the day he had planned to return to the hospital.

An IHS spokeswoman, Jennifer Buschick, provided a statement saying the agency wouldn't comment on specific medical cases, lawsuits or regulatory findings. Officials at the IHS's Maryland headquarters fielded queries from The Wall Street Journal related to the agency's individual hospitals and clinics.

Following Mr. Spotted Wood's death, U.S. hospital regulators found the Winnebago facility failed to meet basic standards in 11 of 30 random cases they reviewed, including his case, during a routine inspection.

Winnebago is one of seven IHS hospitals that the regulator, the Centers for Medicare and Medicaid Services, said had put patients in danger since 2010—more than a quarter of the 26 hospitals the IHS manages around the country.

The IHS and Tribal health advocates say Congress underfunds the agency, and the Trump administration's 2018 budget proposes cutting about \$300 million, a roughly 6 percent decrease from its 2017 level.

The IHS spent \$3,688 on care for the average patient in 2015, according to an agency document. The Veterans Health Administration, for comparison, spent an average of \$11,056 on medical services for each veteran receiving VA healthcare in 2015, that agency's records show. The two agencies count the users of their services differently, and their populations vary.

Obesity and diabetes on the Rosebud and Pine Ridge reservations are more than 40 percent higher than nationwide, according to a Journal analysis of data from the University of Wisconsin. At least 50 percent of residents of those two reservations, as well as a third of those served by the Winnebago hospital, earned less than the Federal poverty line, 2015 data show.

Such factors, coupled with remoteness—Rosebud is more than 100 miles from the nearest Wal-Mart—make recruitment difficult. The IHS said vacancy rates for medical staff at its Great Plains facilities run as high as 37 percent. By contrast, the Massachusetts Health and Hospital Association reported only about 6 percent of nursing jobs vacant in 2015.

Earlier this year, a longtime Pine Ridge pediatrician was indicted for allegedly sexually assaulting his patients. The doctor, Stanley Patrick Weber, who resigned last spring from the agency, pleaded not guilty. His lawyers didn't respond to a request for comment.

The top medical officer at Winnebago was indicted late last year on allegations he defrauded Tennessee's Medicaid program before joining the IHS, court records show. The doctor, Scott McLain, had been brought on in a shake-up the IHS said showed commitment to high-quality care.

Dr. McLain entered a plea of not guilty and has asked a judge to dismiss the case, his lawyer said. He said Dr. McLain had resigned from the IHS.

In its written statement, the IHS declined to comment on the indictments. It said the agency has revamped staff credentialing procedures, overhauled management of many hospitals and brought in outside contractors to fill vacancies.

The agency's seven sanctioned hospitals—in Pine Ridge, Rosebud and Rapid City, South Dakota; Cass Lake, Minnesota; Crow Agency, Montana; Acoma, New Mexico; and the Winnebago facility that treated Mr. Spotted Wood—all put patients in "immediate jeopardy" of harm and failed to meet hospital requirements, according to Federal regulators.

The South Dakota and Nebraska facilities have each been cited for putting patients in danger multiple times. Since 2011, regulators reviewing cases at those four IHS hospitals said inadequate care contributed to at least 11 deaths, documents show.

In a second statement after this article was published online, the IHS said it complies with widely accepted "death review processes" and reviews adverse events at the regional level, but doesn't report nationwide tallies of such incidents.

The agency said, "Any deficiency in service to patients receiving care at any IHS facility is unacceptable and does not reflect the organization's commitment to delivering a high quality of care to its patients. Upon learning of these survey results IHS immediately began instituting improvements at each hospital."

In many cases, the hospitals haven't fixed their problems, according to regulatory documents. In April, inspectors cited ongoing failures at the Rosebud hospital for at least the third time in a row; in 2015 and 2016, its emergency room was closed for 7 months. In May, inspectors found the Pine Ridge facility had failed U.S. hospital requirements for the second time in 5 months. The Winnebago hospital has been barred since 2015 from billing Medicare because it failed to meet requirements for hospitals participating in Federal programs, a punishment given to just five general hospitals in the U.S. that year, Federal data show.

In its initial written statement, the agency cited data showing many non-IHS hospitals in North and South Dakota and Nebraska also failed to meet requirements. It is less common though for regulators to cite hospitals for putting patients in danger in connection with such failures. Regulatory data show half of the eight facilities run by the IHS in the three States were found to have put patients in danger from 2011 to 2015. The data show the proportion for all non-IHS general hospitals with a patient-harm finding in those States was 7 percent.

Some of the families of patients who died unexpectedly under the IHS's care said the toll extends beyond the hospitals that have been sanctioned. Among them, is Wakanda Gonsalves, a high school senior and prom queen, who went to an IHS clin-

ic in Sisseton, South Dakota, on May 4, 2012, because she was coughing up blood. She was sent home that same day, with cough syrup, an inhaler and antianxiety medication. Two nights later, her parents woke to Ms. Gonsalves's screams, her mother, Lisa, recalled. They found her convulsing in bed before she went limp. "My husband kept doing CPR and chest compressions. Over and over," Lisa Gonsalves said. "But she had no pulse."

An autopsy showed Ms. Gonsalves suffered a blood clot in her lung. The IHS-contracted doctor who treated her said in a court deposition he didn't review an X-ray showing a lung abnormality, or follow up after an irregular blood test. The staffing agency that employed the doctor settled a lawsuit with Ms. Gonsalves's family for an undisclosed sum in 2015.

In court filings, both the doctor and the contractor denied any wrongdoing. Lawyers for both didn't respond to requests for comment.

When confronted with regulatory failures, top IHS officials prioritized other matters, and Health Department leadership brushed aside warnings, records and interviews show.

After a 2010 Senate hearing on Senator Dorgan's probe outlining serious deficiencies in care and training, then-IHS director Yvette Roubideaux emailed agency employees, acknowledging problems and saying fixes "cannot happen overnight." She asked staff to, among other things, "put a story in the local newspaper about all the good things you are doing," according to a 2010 email reviewed by the Journal.

In 2014, despite complaints of understaffing, Dr. Roubideaux dispatched 21 IHS medical staffers to West Africa to aid the U.S. response to the Ebola outbreak, over protests of Tribal health officials.

"If the Federal Government is going to send public health officials anywhere it should be sending them to Indian Country," a Tribal health committee wrote to Dr. Roubideaux.

Dr. Roubideaux argued the outbreak was an unprecedented epidemic. The agency statement to the Journal said the staff was needed to help prevent a potential U.S. outbreak.

Dr. Roubideaux, a Rosebud Tribal member and Harvard-trained doctor who left the agency in 2015, referred inquiries from the Journal to the IHS about what she called "longstanding" problems.

At a meeting of regional IHS heads in 2013 called by agency leadership, "we were basically told, 'these are your problems, you deal with it,'" said Anna Whiting Sorrell, who formerly ran the IHS's Billings, Montana-based region, where a hospital was sanctioned for dangerous care in 2014. The agency told the Journal that the IHS's regional chief medical officers have "primary responsibility for clinical issues."

One doctor, Alida Asencio, said she was ridiculed at staff meetings after telling the Winnebago medical director about problems in 2014. Dr. Asencio later raised a concern about a death at the hospital with regulators, who, documents show, concluded it was avoidable. She later complained to top agency officials that her supervisor pressured her to take paid leave ahead of an inspection to keep her from raising further concerns, an email viewed by the Journal shows.

The agency said its "leadership maintains a culture where employees are encouraged and expected to report any reasonable suspicion of wrongdoing, misconduct, waste, or abuse, particularly when it involves the safety and wellbeing of patients or employees." It said such disclosures can "save lives."

Then-U.S. Senator Mark Begich, an Alaska Democrat, said he met with former Health and Human Services Secretary Kathleen Sebelius in 2012 to discuss IHS concerns. He said it was clear from the conversation that implementing the Affordable Care Act "eclipsed things."

Ms. Sebelius said in an interview "it's totally appropriate for him to say, 'they just didn't do enough,'" referring to her own department. She said she took the IHS's failures seriously and tried to address them by seeking more funds and improving communication with tribes. The current Health Department secretary, Tom Price, said during his confirmation hearing in January he was committed to turning the IHS around.

Some people who rely on the troubled hospitals said they are afraid to seek treatment there. Among them is the family of Tonya Drapeau, a 39-year-old mother of five from the Omaha reservation, who died suddenly in March 2016 after a visit to the Winnebago hospital. Days later, a government doctor wrote in a letter to an IHS official that Ms. Drapeau's treatment "was below the standard of care."

Her family filed a legal claim alleging negligence in February with the Health Department, their lawyer said, the first step in filing a lawsuit against the U.S. Gov-

ernment. Medical records show Ms. Drapeau went to Winnebago because she was having trouble breathing.

The agency's records of her past care, which medical staff reviewed that morning, showed she had diabetes and a history of respiratory complications. A doctor didn't check her blood sugar and sent her home later that day with antianxiety pills.

Hours later, Ms. Drapeau's teenage son found her unconscious. The records show she died, after being airlifted to a private hospital, of diabetic shock.

Senator MURKOWSKI. But again, I think when we read these as lawmakers—and certainly as one who has oversight of IHS through this appropriations subcommittee, but as one who serves on the Indian Affairs Committee—this is not acceptable.

I know that oftentimes they say when it is not about the funding, it really is about the funding. But it is about the funding. It is about the quality of the individuals. It is about the ability to get good people in. It is about making sure that the infrastructure is maintained. We are not doing right by our Native peoples and this must be remedied.

Last year, we had the Acting Director of IHS, Mary Smith, before the subcommittee and I asked what the agency was doing to fix the serious problems in the Great Plains region at the Pine Ridge, Rosebud, and Winnebago hospitals, all of which were mentioned in these "Wall Street Journal" articles. She indicated at the time that the agency was committed to doing, quote, "whatever it takes," to deliver quality care.

Well, here we are. I do believe that the agency is aware, does understand, is sincere in its desire to fix these problems, but we cannot move from year to year and continue to see a degradation in the services.

The Winnebago hospital has not received certification from CMS. The Rosebud Hospital and the Pine Ridge Hospital are still operating under System Improvement Agreements with CMS. So it is one thing to come before the subcommittee and say, "We are going to try to do better." But we have to have better results, and I think you know that.

In the fiscal year 2017 Omnibus Appropriations, the subcommittee provided an additional \$29 million to address problems at these facilities.

So I would hope that today we will hear how the agency is allocating these funds, and if there was a shortage, why you did not request further funding for the problems that we have seen in the Great Plains region for fiscal year 2018.

I think, again, the situation is absolutely unacceptable, intolerable, and we need to have a clear and specific plan as to how to address it.

So I now turn to my Ranking Member for his comments, and then we look forward to responses from the panel and questions from us.

STATEMENT OF SENATOR TOM UDALL

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

And I join you on your outrage on the situation in the Great Plains region. It is a really deplorable situation, which we hope you can assure us that we are going to get on a path, so we can remedy this.

I want to offer a warm welcome to the new IHS Acting Director, Rear Admiral Michael Weahkee, who hails from New Mexico. I believe the Zuni Pueblo. I am told that you have a lifetime experience with the IHS system starting from the very beginning when you were born in an IHS hospital in Shiprock, New Mexico.

I also want to welcome Rear Admiral Chris Buchanan, IHS Deputy Director; Mr. Gary Hartz, Director, IHS Office of Environmental Health and Engineering; and Ms. Elizabeth Fowler, IHS Deputy Director for Management Operations. We really look forward to hearing from you here today.

Before we get to the budget, I want to recognize the leadership of Senator Murkowski, who has done a tremendous job as Chair of this subcommittee, and is someone I am really proud to work with. Senator Murkowski, and all the Members of this subcommittee, understands the value and importance of IHS for all Native communities. We have made real progress to secure funding to improve healthcare in Indian country.

I am proud of the subcommittee's work that included an increase for IHS in the most recent Omnibus. Securing a 5 percent increase for IHS for fiscal year 2017—one of the largest increases in the entire appropriations bill—was no small feat. But the Members of this subcommittee believe that these investments are critical for healthy Native communities and families.

I look forward to continuing our work together as a subcommittee and to continued cooperation on a bipartisan basis.

The budget proposed by the administration for fiscal year 2018 is a complete departure from the progress we have made to rebuild the IHS budget. This proposal would not provide the resources needed for the health and wellbeing of American Indians and Alaska Natives. It is wholly insufficient to effectively serve communities in dire need of healthcare services.

Passing the President's budget would mean less money for inpatient services, preventive healthcare programs, drug addiction treatment, mental health programs, and specialty care. It would mean fewer resources to recruit and retain a qualified workforce and to address already underfunded facility infrastructure needs.

With a proposed overall cut to the service of \$300.5 million, this budget would eviscerate the gains we made in fiscal year 2017 by instituting a 6 percent reduction, and undo the progress we have made to restore IHS funding levels to the pre-2013 sequestration levels.

My experiences have taught me that healthcare in Indian country suffers from generations of underfunding. It is disheartening to see this administration put forward a budget that would force entire Tribal communities to fully return to a cruel system of healthcare rationing. Life or limb is no way to run a hospital and no way to promote healthy Native communities and families.

The President's proposed fiscal year 2018 budget systematically cuts the legs out from that progress. I am concerned and I know that Tribes are as well.

I am concerned that this budget cuts \$99 million from IHS facilities despite the Service's estimated \$10 billion construction backlog.

I am concerned that it cuts funding for hospitals and health clinic services by \$64 million.

I am concerned it cuts \$22 million from mental health and substance abuse programs.

And I am concerned it cuts \$6 million from loan repayment and scholarship programs needed to fill critical vacancies at IHS facilities.

MEDICAID

Finally, I would quickly like to address the issue of the larger 2018 budget and the cuts it assumes to Medicaid. For decades, Medicaid has been a crucial program for fulfillment of the Federal Government's trust responsibilities.

It is clear to me that any potential changes to national policy regarding Medicaid and health insurance programs—like those contained in the Senate Republicans' Better Care Reconciliation Act—will directly impact Tribal communities and Native lives.

So for the record, I would like to urge the majority on all committees to follow regular order, hold hearings, and seek Tribal consultation on any proposal that would cut access to critical healthcare programs.

Now is not the time to lose ground on the progress we have made. We know that Tribal communities can thrive when they have adequate access to healthcare. We know that Tribal health outcomes improve when access to quality, preventative care is expanded, like what we have seen over the past 20 years with the Special Diabetes Program for Indians, SDPI, and like we have seen over the past few years with Medicaid expansion and third party billing revenue increases.

I look forward to speaking with all of you today about how we can do more for Indian country. And I look forward to the work of this subcommittee to secure the resources necessary to make this happen.

Thank you, Madam Chair.

Senator MURKOWSKI. Thank you, Senator Udall.

At this time, we will hear from Rear Admiral Michael Weahkee, who is, again, the Acting Director for IHS.

So do I understand correctly that the others will just be there as back up, or will you, Rear Admiral Buchanan, or Mr. Hartz, or Ms. Fowler be addressing the subcommittee as well?

Admiral WEAHKEE. Yes, ma'am. I will make the primary comments and call on my colleagues as needed.

Senator MURKOWSKI. Great. Thank you.

Admiral WEAHKEE. Thank you.

Senator MURKOWSKI. If you will proceed, thank you.

SUMMARY STATEMENT OF REAR ADMIRAL MICHAEL WEAHKEE

Admiral WEAHKEE. Good morning, Madam Chairman, and Members of the subcommittee.

As mentioned, my name is Michael Weahkee, Rear Admiral in the U.S. Public Health Service and Acting Director of the Indian Health Service.

I am here today with three of my colleagues, Rear Admiral Chris Buchanan, the Permanent Deputy Director with the Indian Health

Service; Elizabeth Fowler, the Deputy Director for Management Operations; and Gary Hartz, Director of Office of Environmental Health and Engineering.

Today, I am providing testimony on the President's fiscal year 2018 budget request for the Indian Health Service, which will allow us to maintain and address our agency mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Our four agency priorities of people, partnerships, quality, and resources put our patients at the center of everything we do. In addition, IHS is proud of the work we are doing in aligning with our Secretary's three health priorities on childhood obesity, mental health, and opioids.

The IHS is responsible for providing Federal healthcare services to approximately 2.2 million American Indians and Alaska Natives from 567 federally recognized Tribes located in 36 States across our Nation.

Health services are provided through facilities managed directly by the Indian Health Service, by Tribes and Tribal organizations, and through urban Indian health programs.

Our budget plays a critical role in providing a path to fulfill our commitment to ensure a healthier future for all American Indians and Alaska Natives.

The fiscal year 2018 President's budget proposes a total discretionary budget authority for IHS of \$4.7 billion, which was \$59 million below the fiscal year 2017 annualized continuing resolution. The fiscal year 2017 annualized continuing resolution was the planning base level for this budget.

This budget reflects the administration's high priority commitment to protecting direct Indian healthcare investments, and reducing IHS's overall program level by only 0.9 percent in the context of an 18 percent reduction within the overall HHS discretionary budget.

The budget also supports self-determination by continuing the separate, indefinite appropriation account for Contract Support Costs.

In order to prioritize funding for direct healthcare services for our people, the budget includes a reduction to the funding level for facilities infrastructure projects and management activities of \$75 million below the fiscal year 2017 annualized continuing resolution.

The IHS remains committed to addressing behavioral health challenges including high rates of alcohol and substance abuse, mental health disorders, and suicide in our American Indian and Alaska Native communities. The budget for these services is maintained at the fiscal year 2016 level for a total of \$288 million.

The IHS, in partnership with Tribes, uses evidence-based practices to reduce the incidence of preventable disease and improve the health of individuals, families, and communities across Indian country.

Programs such as public health nursing, health education, and community health representatives play integral roles in delivering culturally appropriate services to American Indians and Alaska Natives who live in rural and isolated communities.

DIABETES

The Special Diabetes Program for Indians, or SDPI, provides grants for evidence-based diabetes treatment and prevention services across Indian country. Diabetes health outcomes have improved significantly in American Indian and Alaska Native communities since the inception of the SDPI.

Within our communities, the longtime trend of increasing rates of diabetes ended in 2011. One of the most important improvements has been an 8 percent reduction in the average blood sugar level of American Indian and Alaska Natives with diagnosed diabetes between the years 1997 and 2015.

Improved blood sugar control reduces complications from diabetes. In addition, new cases of kidney failure due to diabetes have declined by 54 percent among American Indians and Alaska Native adults from 1996 to 2013.

The budget request includes \$20 million to support staffing and operating costs for two joint venture construction program projects that include the Choctaw Nation Regional Medical Clinic in Oklahoma and the Flandreau Health Center in South Dakota.

The IHS, through these joint venture agreements, and partners with Tribes to provide funds for staffing, equipment, and operating the facilities while the Tribes invest in the design and construction costs associated with the new facilities.

The healthcare facilities construction budget includes funding for three facility projects including the Alamo Health Center in New Mexico, the Rapid City Health Center in South Dakota, and the Dilkon Alternative Rural Health Center in Arizona.

IHS has a lot of positive information to share about the care we are providing throughout the system. Some examples include launching a new pilot project to integrate trauma informed care at IHS and Tribal facilities in conjunction with the Pediatric Integrated Care Collaborative, which is part of the Johns Hopkins Center for Mental Health Services.

Advancing innovation and new technologies bring emergency medicine expertise to our emergency departments in both the Great Plains and the Billings areas, and initiating telehealth services in the Portland and Albuquerque areas with direct support from the University of New Mexico's Project ECHO.

Continued implementation of our improving patient care initiative, such as the Lawton Indian Hospital in the Oklahoma City area, has been able to reduce their emergency room's medium length of stay from 138 minutes down to 86 minutes.

All of our IHS areas are continually engaging in training and accreditation readiness survey activities. For example, in our Portland area, an area survey readiness team has been established which includes inter-facility participation by both chief executive officers and clinic directors to learn and share best practices.

QUALITY FRAMEWORK

Finally, we are continuing to focus our efforts to improve quality. In November of 2016, we launched our quality framework to strengthen the quality of care that the IHS delivers to the patients that we serve.

Implementation of the quality framework will strengthen organizational capacity to improve quality of care, improve our ability to meet and maintain accreditation for our 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. This framework will be reviewed and updated as necessary in partnership with our Tribes and other stakeholders.

Despite all the challenges, I am firmly committed to improving quality, safety, and access to healthcare for American Indians and Alaska Natives in collaboration with HHS, our partners across Indian country, and in collaboration with 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.

Thank you.

And I am happy to answer any questions that you may have.

[The statement follows:]

PREPARED STATEMENT OF REAR ADMIRAL MICHAEL WEAHKEE

Mr. Chairman and Members of the subcommittee:

Good morning. I am RADM Michael Weahkee, Acting Director of the Indian Health Service (IHS). I am pleased to provide testimony on the President's fiscal year 2018 budget request for the IHS, which will allow us to maintain and address our agency mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level. Our four agency priorities put our patients at the center of everything we do, and these include recruiting, developing, and retaining a dedicated, competent, caring workforce; building, strengthening and sustaining collaborative relationships; excellence in everything we do to assure a high-performing Indian health system; and securing and effectively managing the assets needed to promote the IHS mission.

The IHS, an agency within the Department of Health and Human Services (HHS), is responsible for providing Federal health services to approximately 2.2 million AI/ANs from 567 federally recognized Tribes in 36 States. The IHS system consists of 12 Area offices, which oversee 170 Service Units that provide care at the local level. Health services are provided through facilities managed directly by the IHS, by Tribes and Tribal organizations under authorities of the Indian Self-Determination and Education Assistance Act (ISDEAA), through services purchased from private providers, and through contracts and grants awarded to urban Indian organizations authorized by the Indian Health Care Improvement Act.

Our budget plays a critical role in providing a path to fulfill our commitment to ensure a healthier future for all AI/AN people and to maintain progress made to date. The fiscal year 2018 President's budget proposed a total discretionary budget authority for IHS of \$4.7 billion, which was \$59 million below the fiscal year 2017 Annualized Continuing Resolution and proposes Program Level funding of \$6.1 billion, which was \$56 million below the fiscal year 2017 Annualized Continuing Resolution. The fiscal year 2017 Annualized Continuing Resolution was the planning base level for this budget.

PRIORITIZING HEALTH CARE SERVICES

The IHS provides comprehensive healthcare, including but not limited to primary medical services, dental care, behavioral health services, community health services, and public health services such as environmental health and sanitation facilities, through a network of 662 hospitals, clinics, and health stations in and near Indian reservations. The budget reflects the administration's high priority commitment to Indian Country, protecting direct healthcare investments and reducing IHS's overall program level by only 0.9 percent when compared to the Annualized Continuing Resolution, in the context of an 18 percent reduction within the overall HHS discretionary budget. In order to prioritize funding for direct healthcare services to AI/ANs and the staffing and operating costs for newly-constructed Joint Venture healthcare facilities scheduled to open in fiscal year 2017, the budget includes a reduction to the funding level for facilities infrastructure projects and management ac-

tivities of \$75 million below the fiscal year 2017 Annualized Continuing Resolution. Direct healthcare services include outpatient and inpatient care in hospitals and clinics, behavioral health services, and dental health services.

The budget maintains the Purchased/Referred Care program funding that is essential for ensuring access to care by our AI/AN patients at \$914 million, which is \$2 million above the fiscal year 2017 Annualized Continuing Resolution. This program provides critical healthcare services that IHS and tribally-managed facilities are otherwise unable to provide through contracts with hospitals and other healthcare providers to purchase such specialized or critical care. In addition, it supports high cost medical care for catastrophic injuries and specialized care.

The IHS remains committed to addressing behavioral health challenges, including high rates of alcohol and substance abuse, mental health disorders, and suicide in AI/AN communities. The budget for these services is maintained at the fiscal year 2016 level for a total of \$288 million, which is \$1 million above the fiscal year 2017 Annualized Continuing Resolution.

Funding for preventive health services is preserved at the fiscal year 2016 level as well for a total of \$157 million, which is \$1 million above the fiscal year 2017 Annualized Continuing Resolution. The IHS, in partnership with Tribes, uses evidence-based practices at the local level to reduce the incidence of preventable disease, and improve the health of individuals, families, and communities across Indian Country. Programs such as public health nursing, health education, and community health representatives play integral roles in delivering culturally appropriate services to AI/ANs and ensuring access to care for homebound patients and others who live in rural and isolated communities.

SPECIAL DIABETES PROGRAM FOR INDIANS

The Special Diabetes Program for Indians (SDPI) provides grants for evidence-based diabetes treatment and prevention services across Indian Country. Diabetes health outcomes have improved significantly in AI/AN communities since the inception of the SDPI. Within our communities, the longtime trend of increasing rates of diabetes ended in 2011. One of the most important improvements has been an 8 percent reduction in the average blood sugar level of AI/ANs with diagnosed diabetes between 1997 and 2015. Improved blood sugar control reduces complications from diabetes. In addition, new cases of kidney failure due to diabetes declined by 54 percent among AI/AN adults from 1996 to 2013.

The SDPI grant program provides funding for diabetes treatment and prevention to 301 Indian health, Tribal, and Urban health programs. Most recently, the SDPI was reauthorized through September 2017.

HEALTH INSURANCE REIMBURSEMENTS

The budget assumes \$1.2 billion in estimated health insurance reimbursements from third party collections. The collection of health insurance reimbursements for the provision of care to patients covered by Medicare, Medicaid, the Veterans Health Administration, and private insurance allows IHS and tribally-managed programs to meet accreditation and compliance standards and expand the provision of healthcare services by funding staff positions, purchasing new medical equipment, and maintaining and improving buildings.

ACCESS TO QUALITY HEALTH CARE SERVICES THROUGH IMPROVED INFRASTRUCTURE

The budget proposes \$20 million for staffing of newly-constructed healthcare facilities. This funding will support staffing and operating costs for two Joint Venture Construction Program (JVCP) projects: the Choctaw Nation Regional Medical Clinic in Oklahoma and the Flandreau Health Center in South Dakota. Through JVCP agreements, the IHS partnered with the Tribes to provide funds for staffing, equipping, and operating the facilities while the Tribes invested in the design and construction costs associated with the new facilities. These funds will allow the new facilities to expand the provision of healthcare in areas where the existing capacity is overextended.

The Health Care Facilities Construction budget includes funding for the following three facilities projects: (1) to design the Alamo Health Center in New Mexico, (2) to complete replacement of the Rapid City Health Center in South Dakota, and (3) to continue construction of the Dilkon Alternative Rural Health Center in Arizona.

SUPPORTING INDIAN SELF-DETERMINATION

The budget supports self-determination by continuing the separate indefinite appropriation account for contract support costs (CSC) through fiscal year 2018. Au-

thorized and required by the ISDEAA, CSC funding supports certain operational costs of Tribes and Tribal organizations administering healthcare service programs under self-determination contracts and self-governance compacts. The budget includes an estimate of \$718 million to fully fund CSC, which is \$1 million above the fiscal year 2017 Annualized Continuing Resolution. Maintaining the flexible funding authority of an indefinite appropriation allows the IHS to guarantee full funding of CSC, as required by the law, while protecting services funding for direct services Tribes.

IHS HEALTH CARE

IHS has a lot of positive information to share about the care we're providing throughout the IHS system. Some examples include: launching a new year-long pilot project at 10 locations to integrate trauma-informed care at IHS and tribal facilities, in conjunction with the Pediatric Integrated Care Collaborative, part of the Johns Hopkins Center for Mental Health Services in Pediatric Primary Care; advancing innovation and new technologies to bring emergency medicine expertise to emergency departments in the Great Plains and Billings Areas through a telehealth contract and initiating telehealth services in the Portland and Albuquerque Areas to screen, diagnose, and treat chronic hepatitis C with direct support from the University of New Mexico's Extension for Community Healthcare Outcomes (Project ECHO) hepatitis C program, which has resulted in screening rates of 92 percent in the Portland target population, up from 67 percent in 2015; and continued implementation of the Improving Patient Care initiative, such as at the Lawton Indian Hospital in the Oklahoma City Area which has reduced their Emergency Room's Median Length of Stay from 138 minutes in April of 2016 to 86 minutes in June of 2017. All Areas also continually engage in training and accreditation survey readiness activities, with a few notable examples. The Claremore Indian Hospital embarked on an initiative to design a better clinical skills and competency nurse training program in fiscal year 2016. Claremore implemented the use of the METIMan® Patient Simulator, which allows local nursing staff to have available the most advanced physiological modeling system incorporated into their training and competency program. Claremore hired nurse educators with experience in clinical simulations and integrated simulation in their curriculum in multiple locations in the hospital. Nursing staff has reporting increased satisfaction with clinical training since the integration of clinical simulations. The Albuquerque Area utilizes a laboratory team made up of the Area Lab Consultant and Service Unit Lab Supervisors to stay in continuous readiness for laboratory accreditation. As a result, the Mesquero Indian Hospital received national recognition and received their National Excellence Award in 2016. In the Portland Area, an Area Survey Readiness Team has been established which includes interfacility participation by Chief Executive Officers and Clinical Directors to learn and share best practices. In addition, in the Bemidji Area, the White Earth clinic achieved the highest scores possible when it received accreditation from the Accreditation Association for Ambulatory Health Care.

Finally, we are continuing to focus our efforts to improve quality. The position of Deputy Director for Quality Health Care was established as part of the senior leadership team at Headquarters to provide specific expertise in advising me as acting IHS Director and providing leadership and guidance to the field on all aspects of assuring quality healthcare. In November 2016, we launched our 2016–2017 Quality Framework and Implementation Plan to strengthen the quality of care that the IHS delivers to the patients we serve. Implementation of the Quality Framework will 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. This framework will be reviewed and updated as needed in partnership with Tribes.

IHS also has worked collaboratively with HHS staff and operating divisions to identify Department-wide strategies and resources that can be used to address issues affecting the quality of healthcare provided to AI/ANs served by IHS facilities. Through this work IHS was able to leverage additional staff support for patient care and technical assistance and accomplish policy changes that helped IHS complete salary negotiations and relocation allowances more efficiently to improve the recruitment process. IHS continues to actively engage with HHS in its work to update its Strategic Plan and was an eager participant in the Reimagine HHS work which was focused on making HHS more effective at fulfilling its mission, more focused on serving the American people, and a better place to work. In concert with these activities, IHS is seeking to implement innovative approaches to delivering

and improving healthcare, identifying areas where regulatory reform can facilitate IHS' processes, and strengthening our structure to carry out our mission more effectively and efficiently.

Despite all of the challenges, I am firmly committed to improving quality, safety, and access to healthcare 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.

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

Senator MURKOWSKI. Thank you, Rear Admiral.

I know that your job is to defend this budget, but I just have to say wow. After listening to that, I would think that we do not have a problem within the IHS system. That we do not have a scenario as was described in these two recent articles from just last week with regards to the facilities, particularly in the Great Plains.

You say that the goal here is to improve the patient experience. Well, the experience is people are dying in these facilities. So to suggest that all is good and that you can have a budget that is sufficient from a facilities' perspective or otherwise, if we take it back to the fiscal year 2016 levels, I just find quite stunning.

We need you to be the advocate for those within the IHS system. I know that everyone within the administration has to walk that fine line where you have a budget proposal that is presented to you.

But I guess I would ask the question, have you read these two articles that I referenced from the "Wall Street Journal" from last week?

Admiral WEAHKEE. Yes, ma'am. I have.

Senator MURKOWSKI. Do you think that those reflect accurately some of what we have seen at these facilities in the Great Plains regions?

Admiral WEAHKEE. Ma'am, I had the opportunity on my second day on the job at the request of Secretary Price, to travel to Pine Ridge, and do a firsthand assessment of the situation, and what the progress has been like.

Senator MURKOWSKI. And what did you see there at Pine Ridge?

Admiral WEAHKEE. I definitely saw a committed, caring workforce who has been working hard to address the issues that have been identified by CMS. They are making significant improvements in their quality assurance and performance improvements, and their oversight of the emergency departments. They work with the area office to ensure governance is monitoring the right things.

I took that trip also with some objective reviewers, the Acting Surgeon General, Rear Admiral Sylvia Trent-Adams, also accompanied me on that visit. And we provided a firsthand account of our findings back to the Secretary, who asked that I convey to the subcommittee his commitment to improving the Indian Health Service.

Senator MURKOWSKI. Do you think that you can keep that commitment and he can keep that commitment to improving the Indian Health Service with the funding levels that are proposed within this budget here?

Admiral WEAHKEE. Well, ma'am, we see the budget as an initial proposal, but we are open to working with you and others to iden-

tify and help meet the needs of our American Indian and Alaska Native people.

Senator MURKOWSKI. Well, I want to work with you. Know that that is sincere and I think that is so with every other Member of this subcommittee.

But I guess I am a little bit—no, I am not a little bit—I am really concerned with the situation that has been clearly articulated in the fiscal year 2017 budget. We said, “Look. We have issues in the Great Plains with Winnebago, with Pine Ridge, with Rosebud.” There was specific funding that was directed for these accreditation emergencies.

Again, it is my understanding that we still have not seen the recertification from CMS. The Winnebago, the Rosebud, and the Pine Ridge hospitals are still operating under this system improvement agreement. And so, I am wondering, has that \$29 million—

You have indicated that you are seeing some progress there at Pine Ridge. But you have not come to us with a request for additional funding to address any of these discrepancies with fiscal year 2018.

Do you think that you can address what you need to address, and again, given the reductions that we are seeing in this budget for these accounts?

Admiral WEAHKEE. The IHS really appreciates the funding that was provided in the 2017 budget for accreditation emergencies. We are using those funds to support contracts, national contracts to address credentialing, national contracts for accreditation. We know that the challenges will persist.

Senator MURKOWSKI. Is the \$29 million that you received last year sufficient to do what it is that we asked you to do within that Omnibus bill?

Admiral WEAHKEE. IHS is committed to patient safety and the quality of healthcare.

Senator MURKOWSKI. Right. But is the \$29 million sufficient for you to do the job that we need you to do, and that those who receive services there at these facilities expect and deserve?

Admiral WEAHKEE. We are focusing a lot of efforts in the three locations that you have identified: Rapid City, or I am sorry, Pine Ridge, Rosebud, and Omaha Winnebago.

A lot of the changes that we are making to the system overall are a result of what we have found in the improvement work that we have really focused in those areas.

We have experts from the Oklahoma City area, from Phoenix, from the Portland area repositioned and really working directly with those programs to implement best practices. Not only from other parts of the IHS, but from our Tribal programs like the South Central Foundation, the Nuka Institute, implementing patient-centered medical homes and care teams.

So we appreciate the resources that are dedicated to helping us address these issues.

Senator MURKOWSKI. Well, sir, you have not directly answered the question whether or not we have provided you with sufficient resources. That is what this subcommittee does as the appropriation subcommittee for the Interior for oversight of IHS.

We want to help you. We want to know that you have the resources that you need because it is my assumption that the three that I am highlighting here—Rosebud, Pine Ridge, and Winnebago—are just the ones that make the “Wall Street Journal”. That there are other facilities; I know that there are other facilities.

In Alaska, we are a different model, a different system. And I think you know, certainly my colleagues here know that usually I am laser focused on the situation in Alaska. But I cannot stand down knowing that our system is failing so many of our Native people around the country.

So we want to help you, but we need to know how we can best facilitate that. So this conversation will continue.

I will turn to my colleague, Senator Udall.

Senator UDALL. Thank you, Madam Chair.

Admiral, I want to quickly raise a process concern. It is a long-standing practice for Members of this subcommittee of both parties to request information from your department.

PURCHASED REFERRED CARE

Can you confirm that you will continue the longstanding practice of responding to all questions, including written correspondence, from both majority and minority Members of this subcommittee as quickly as possible?

Admiral WEAHKEE. Yes, sir. Absolutely, we will work with you very closely in helping fulfill it.

Senator UDALL. Thank you very much.

This budget reduces funding for purchased and referred care by over \$14 million. I have heard from many Tribes, who are rightfully very concerned, about the ability of IHS to continue serving patients above Medical Priority Level One. They are concerned about returning to an era of IHS healthcare rationing.

This question is for Ms. Fowler. Do you have an estimate of the total amount of reimbursement IHS facilities have received due to the Medicaid expansion?

Ms. FOWLER. Thank you for the question.

I do not have the specific amount that is due specifically to Medicaid expansion, but we can provide some additional follow up for you on that.

Senator UDALL. Will you give me those numbers, please?

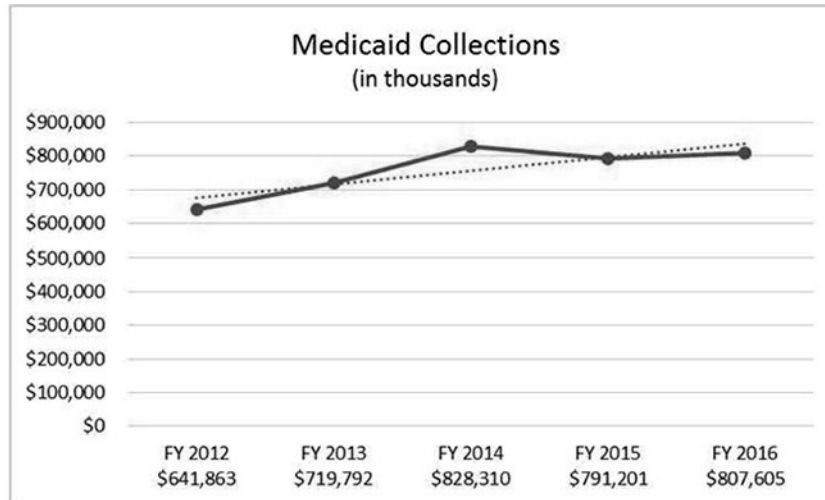
Ms. FOWLER. To the extent that we have it available.

Senator UDALL. Yes. Well, I know in previous testimony with Admiral Buchanan, the discussion was about a significant amount of resources coming in as a result of Medicaid expansion. And so, I really want to have those numbers.

[The information follows:]

TOTAL AMOUNT OF REIMBURSEMENTS IHS FACILITIES HAVE RECEIVED DUE TO MEDICAID EXPANSION

The Indian Health Service (IHS) reported a total of \$807.6 million in Medicaid reimbursements during fiscal year 2016. The table provided below shows an upward trend in Medicaid collections from fiscal year 2012 to fiscal year 2016.



Note: Medicaid Collections in this chart include Tribal collection estimates from the Centers for Medicare & Medicaid Services (CMS) and Tribal collection estimates due to direct billing between fiscal year 2002–fiscal year 2015.

The IHS is unable to identify which patients became eligible as a result of Medicaid expansion on or after January 1, 2014. Therefore, the IHS cannot determine how much of the increase in Medicaid reimbursements is directly attributable to services provided to:

- Patients in the new “expansion” categories;
- Patients in “restoration” categories (in States where enrollment in certain eligibility categories was frozen prior to Medicaid expansion);
- Patients who may have previously been eligible but not enrolled prior to January 1, 2014, and,
- Previously enrolled patients.

For additional details regarding Medicaid, expenditure reports from the CMS known as the “CMS 64 Reports” for fiscal year 2013–fiscal year 2016 are enclosed. The reports include Federal reimbursement to State Medicaid programs for services eligible for 100 percent Federal Medical Assistance Percentages which are provided by IHS and Tribal Health Programs operated under Public Law 93–638, the Indian Self-Determination and Education Assistance Act. States may request adjustments in expenditures up to 2 years after the respective quarter of expenditures. These reports were updated as of August 7, 2017.

Senator UDALL. Admiral Weahkee, do you have anything to add there in terms of specifically the amount of money because of the Medicaid expansion?

Admiral WEAHKEE. Sir, not with specificity, but my job prior to coming into this role was as a CEO at the hospital level.

I know that we rely very heavily on our third party collections not only Medicaid, but Medicare, private insurance, and V.A. reimbursements as well to help meet the needs of our patients.

Senator UDALL. Yes.

Ms. Fowler, how many IHS service units used Medicaid expansion to provide services at Medical Priority Level 2 or higher in fiscal year 2016?

Ms. FOWLER. In 2016, 47 out of 67 Federal PRC programs were able to fund care at Priority 2 and lower.

Senator UDALL. Thank you.

If Medicaid expansion funding were eliminated, how much additional purchased and referred care appropriations funding would IHS need to maintain care above Medical Priority Level 1?

Ms. FOWLER. That is a difficult question to answer. Again, attributing the amount to patients who were eligible for Medicaid as a result of Medicaid expansion is the key there. And I do not believe that we have information data that goes to that level of specificity, but we can certainly see what information we do have and provide that to you and follow up.

Senator UDALL. Thank you very much. Please do that for the record.

[The information follows:]

AMOUNT OF ADDITIONAL PURCHASED AND REFERRED CARE APPROPRIATIONS FUNDING NEEDED TO MAINTAIN CARE ABOVE MEDICAL PRIORITY LEVEL 1 IF MEDICAID EXPANSION FUNDING WERE ELIMINATED

The Indian Health Service (IHS) cannot reasonably determine the additional amount of appropriated Purchased/Referred Care (PRC) funding that might be needed to maintain or provide healthcare services beyond Medical Priority Level I (life or limb threatening) if Medicaid expansion were eliminated. This is because American Indian and Alaska Native patients eligible for Medicaid do not need a PRC referral to access care. In the case of Medicaid eligible patients, Medicaid reimburses the private provider in full and there is no cost sharing for the beneficiary or the PRC program. Since a referral or request for service is not required and patients often go on their own to Medicaid providers, the IHS is unable to track these instances when Medicaid is the payer instead of the PRC program.

Senator UDALL. As all of you know, there used to be a saying in the Indian Health Service, "Do not get sick after June," and that is because we ran out of money in this purchased and referred care item. And so my belief is that is no way to run a hospital and a healthcare system.

So we need to make sure that we try to do the very best and I think that is the same theme that Senator Murkowski has pushed here today.

Republican proposals to repeal Medicaid expansion, along with the ACA, would clearly have direct and dramatic impacts on the Indian Health Service.

Admiral Weahkee, can you please answer me with a simple yes or no to the following question? Have you, or any of your staff, at IHS been contacted by House or Senate Republican Leadership or the White House, requesting consultation or technical assistance for various drafts of Trumpcare?

Admiral WEAHKEE. Not to my knowledge, sir. Again, this is my third week on the job and I am not aware of any requests for information at this point.

Senator UDALL. Admiral Buchanan, would you answer that question?

Admiral BUCHANAN. Not to my knowledge either.

Senator UDALL. Thank you.

As mentioned in my opening, I am concerned this budget proposal would cut more than \$12 million from these line items, that is, mental health and substance abuse. This steep cut to an already underfunded line item would be particularly devastating if combined with the repeal of Federal essential health benefit requirements, like the BCRA that requires Medicaid and insurance coverage of these critical services.

Can you tell me what mental health and substance abuse services would be cut if this \$12 million decrease were enacted?

BEHAVIORAL HEALTH

Admiral WEAHKEE. I have information in terms of some of the work that we are doing in behavioral health. We are funding substance abuse and suicide prevention grants. We are funding domestic violence prevention programs.

We are very close to announcing the next round of substance abuse grantees. I believe we have it in the range of 30 of them. Many of those successful grantees are from the State of Alaska. We will soon be putting another solicitation out for domestic violence. I think we have funding for an additional 20 in terms of the specifics about impacts with the changes.

I may have to defer here on this one to Ms. Fowler, if she has any thoughts on that.

Ms. FOWLER. I would just say that as Admiral Weahkee has already indicated that we view this budget as an initial proposal. So we would hope to work with you on adjusting the needs particularly for our behavioral health services.

Senator UDALL. Yes. Well, I do not have any doubt that if you are cutting \$12 million out of mental health and substance abuse treatment that people are going to lose services, and we are going to be in a worse situation.

Thank you, Madam Chair.

Senator MURKOWSKI. Senator Van Hollen.

Senator VAN HOLLEN. Thank you, Madam Chair.

Thank you and the Ranking Member for your leadership on this issue as I welcome everybody.

The Indian Health Service has major facilities in the State of Maryland, in Rockville, in the State of Maryland and I look forward to working with all of you going forward.

I have to say I have been appalled in preparing for this hearing and reading the articles that Senator Murkowski referenced. What is even more appalling is that if you do a little work, you realize that this has been a chronic issue. Right? I mean, there have been hearings in the Congress dating back many, many years that focused a spotlight on this issue and yet, it does not seem to be getting any better.

With all respect, Admiral, I understand you are recently appointed here in terms of your current capacity, but I think you were obviously given a particular budget.

I think what this committee needs is information from all of you, facts, so we can evaluate the impact. And so, I would appreciate it if you would get us some information, first of all, regarding the impact of the proposed Medicaid cuts.

As I looked at the sources of revenue for a lot of the healthcare services provided by the Indian Health Service, you have a number of third party payers. The largest, by far, is Medicaid. Over 60 percent, I believe, of the payments for services rendered.

Is that correct?

Admiral WEAHKEE. Yes, sir.

Senator VAN HOLLEN. All right. So if you could please give us an analysis of what the impact of the current proposal here in the

Senate with respect to this so-called healthcare bill, which would cut over \$770 billion from Medicaid would be, plus the \$600 billion additional cut proposed in the budget that has been submitted by the Trump administration. That is \$1.4 trillion overall. And the Indian Health Service more than most other agencies is highly dependent on those Medicaid funds.

So can you commit to providing us with an analysis of your assessment of what the impact of those cuts would be on your ability to provide healthcare both in the physical health area, but also importantly in the behavioral health area? Could you give us that information and that analysis?

Admiral WEAHKEE. We will undertake that assessment and provide you with the information. Look forward to partnering with you.

[The information follows:]

ANALYSIS OF WHAT THE IMPACT OF CUTS TO THE BUDGET WOULD HAVE ON THE
PHYSICAL HEALTH AREA AND THE BEHAVIORAL HEALTH AREA

The fiscal year 2018 President's budget reflects the administration's high priority commitment to Indian Country, protecting direct healthcare investments and reducing IHS's overall program level by only 0.9 percent when compared to the Annualized Continuing Resolution, in the context of an 18 percent reduction within the overall HHS discretionary budget. Therefore, difficult decisions at the Department and across the Federal Government were required to ensure fiscal responsibility and long-term sustainability. The IHS remains dedicated to the mission and will continue to prioritize funding for direct healthcare services.

Please refer to the enclosed table that provides a comparison of the fiscal year 2017 enacted funding level and the proposed fiscal year 2018 budget. Reductions to IHS funding levels may result in the reduction or elimination of programs.

In addition, some aging healthcare equipment may need to be used well beyond recommended replacement cycles in order to prioritize funding for repair or replacement of only the most critical equipment necessary for safe patient care. Most IHS healthcare sites supplement their annual medical equipment funds with collections to replace medical equipment. IHS healthcare sites with more robust collections have the resources available to purchase medical equipment at a greater rate. Other sites may need to pool resources over a few years.

Senator VAN HOLLEN. I would appreciate that.

I also think it is important that in addition to those cuts, we get an assessment, a factual assessment, of the impact of the proposed cuts to your specific budget, the \$300 million cut. Because I know on a bipartisan basis, Members of the Senate and the House have worked to try to address some of those issues and provide additional resources to avoid the kind of problems that we are seeing.

I agree with Senator Murkowski, I think the "Wall Street Journal" decided to look at three particular facilities, but my guess is if you are seeing such chronic problems at these three, if they were to do an investigation of some of the other sites, we would uncover some more issues.

So I know you believe in your mission. I think our mission is to try to make sure we get the information necessary so we can make reasonable judgments about resources. And so your analysis, you have the information with respect to how much received from Medicaid, and so I would very much appreciate it if you could give us that analysis. Just the facts.

Can you do that?

Admiral WEAHKEE. Thank you, sir. Yes, sir.

[The information follows:]

FACTUAL ASSESSMENT OF THE IMPACT OF CUTS TO THE SPECIFIC IHS BUDGET

[Dollars in thousands]

Program	Fiscal Year 2017 Enacted	Fiscal Year 2018 President's Budget	Fiscal Year 2017 + / - Fiscal Year 2018	Notes
SERVICES				
Hospitals & Health Clinics	\$1,935,178	\$1,870,405	(\$64,773)	Loss of \$1 million Prescription Drug Monitoring, \$4 million Domestic Violence Prevention Program, \$27 million Accreditation Emergency Fund, \$9 million Tribal Clinic Leases, \$21 million Current Services; and a reduction of \$1.6 million to offset the funding request for Staffing New Facilities
Dental Services	\$182,597	\$179,751	(\$2,846)	Loss of Current Services
Mental Health	\$94,080	\$82,654	(\$11,426)	Loss of \$6.9 million Behavioral Health Integration, \$3.6 million Zero Suicide, and \$942,000 Current Services
Alcohol & Substance Abuse	\$218,353	\$205,593	(\$12,760)	Loss of \$6.5 million Generation Indigenous (Substance Abuse and Suicide Prevention Program), \$1.8 million Youth Aftercare Pilots, \$2 million Detoxification Services, and \$2.5 million Current Services
Purchased/Referred Care	\$928,830	\$914,139	(\$14,691)	Loss of Current Services
Total, Clinical Services	\$3,359,038	\$3,252,542	(\$106,496)	
Public Health Nursing	\$78,701	\$77,498	(\$1,203)	Loss of Current Services
Health Education	\$18,663	\$18,313	(\$350)	Loss of Current Services
Community Health Representatives	\$60,325	\$58,906	(\$1,419)	Loss of Current Services
Immunization AK	\$2,041	\$1,950	(\$91)	Loss of Current Services
Total, Preventive Health	\$159,730	\$156,667	(\$3,063)	
Urban Health	\$47,678	\$44,741	(\$2,937)	Loss of \$1.1 million Program Increase and \$1.8 million Current Services
Indian Health Professions	\$49,345	\$43,342	(\$6,003)	Loss of \$500,000 Program Increase and \$503,000 Current Services; and a reduction of \$5 million to offset the funding request for Staffing New Facilities
Tribal Management Grants	\$2,465	\$0	(\$2,465)	Loss of \$23,000 Current Services and a reduction of \$2.4 million to offset the funding request for Staffing New Facilities
Direct Operations	\$70,420	\$72,338	\$1,918	
Self-Governance	\$5,786	\$4,735	(\$1,051)	Loss of \$51,000 Current Services and a reduction of \$1 million to offset the funding request for Staffing New Facilities
Total, Other Services	\$175,694	\$165,156	(\$10,538)	
TOTAL, SERVICES	\$3,694,462	\$3,574,365	(\$120,097)	
CONTRACT SUPPORT COSTS				
TOTAL, CONTRACT SUPPORT COSTS	\$800,000	\$717,970	(\$82,030)	Reflects estimated CSC need at the time the President's budget was submitted
FACILITIES				
Maintenance & Improvement	\$75,745	\$60,000	(\$15,745)	Program reduction, results in only 85 percent sustainment of M&I needs
Sanitation Facilities Construction	\$101,772	\$75,423	(\$26,349)	Program reduction, decreases the number of sanitation programs that can be funded
Health Care Facilities Construction	\$117,991	\$100,000	(\$17,991)	Program reduction. Annual funding at this level increases the length of time needed to complete the "grandfathered" priority list of facilities
Facilities & Environmental Health Support	\$226,950	\$192,022	(\$34,928)	Program reduction, results in the need to redirect funding from other sources (e.g., third party collections) to fund FTEs
Equipment	\$22,966	\$19,511	(\$3,455)	Program reduction, results in decreased equipment distributions and increased usage of equipment beyond recommended lifecycle refresh periods
TOTAL, FACILITIES	\$545,424	\$446,956	(\$98,468)	
TOTAL, BUDGET AUTHORITY	\$5,039,886	\$4,739,291	(\$300,595)	

Senator VAN HOLLEN. Thank you.

Senator MURKOWSKI. Senator Van Hollen, thank you for raising that.

Admiral, I would add to Senator Van Hollen's request that you provide us with this level of detail, but that you do it on a very expedited basis.

As we all know, the current subject of discussion right now, we are going to have a new discussion draft that will be laid down supposedly on Thursday. I am not certain what it will entail, but I have been unable to get from Health and Social Services this break down as to how IHS is impacted by the various proposals to cut Medicaid. Medicaid expansion is one aspect of it.

But I am told that they cannot separate out the numbers insofar as the various categories within Medicaid, whether it is children, those with disabilities, or seniors. I am asking, I think, a very fair and legitimate question.

If you do not have the numbers and the data between IHS and Health and Social Services, how can I do a fair assessment as to the impact of these proposals on our Alaska Native people or our American Indians, our Native people in the country?

So I have asked for these numbers from Health and Social Services. You now have a formal request from the subcommittee. But we would ask that you do it on a very expedited basis because it is imperative that we have this understanding.

Senator TESTER.

Senator TESTER. Thank you, Madam Chair. Could I get my time set back?

Senator MURKOWSKI. You have it.

Senator TESTER. I just want to make sure.

Senator MURKOWSKI. That is your introduction.

Senator TESTER. Thank you very much.

Well, first of all, thank you for coming.

Rear Admiral, when I was looking at your bio, you worked at IHS facility in Phoenix.

Is that correct?

Admiral WEAHKEE. Yes, sir.

Senator TESTER. And then you worked in the IHS, I assume, here in DC Clinical and Prevention Services, manager of Policy and Internal Control Staff.

Is that correct? Anything else you would like to add to that resume that is particularly pertinent here?

Admiral WEAHKEE. I think important to my upbringing, if you will, is 6 years spent with the California Tribes getting a perspective on the other side.

Senator TESTER. So I do not think any of the things that have been brought up here today by the Chairman, or Ranking Member, or Senator Van Hollen should be a surprise to you. You probably have lived it. We have not.

And so when we talk about inadequate facilities, or not having enough staff, or dealing with behavioral health, this is not new to you. Right?

Admiral WEAHKEE. Our agency has many challenges.

Senator TESTER. I am talking about you personally. It is not new to you.

Admiral WEAHKEE. I have made a career serving my people. Yes, sir.

Senator TESTER. Were you told not to answer any questions here, by the way?

Admiral WEAHKEE. No, no.

Senator TESTER. Okay. Because I think it is absolutely unbelievable that you cannot separate how much money that Medicaid has helped you with third party billing.

I mean, to the point where I think we should almost demand an audit because that is not how things work and you should have those numbers at the tip of your tongue, to be honest with you. If we are going to make policy here, we have to figure out what the impacts of that policy are going to be. And, by the way, it is your agency that deals with Indian health, nothing else. And so, we have to have it.

I do not mean to lecture to you, but have you had a chance to do an assessment on what the needs are during your 3 weeks at IHS?

Admiral WEAHKEE. I have been able to leverage a lot of work that has been done prior.

Senator TESTER. What would you say is the number one need is in IHS right now?

Admiral WEAHKEE. Absolutely, it is shoring up our longstanding vacancies in some key leadership positions.

Senator TESTER. So it is people.

Admiral WEAHKEE. People. Yes, sir.

Senator TESTER. What does this budget do to your ability to hire staff?

Admiral WEAHKEE. We have a lot of efforts underway.

Senator TESTER. Is there an increase in dollars for hiring staff or a decrease?

Admiral WEAHKEE. We prioritized maintaining direct care services.

Senator TESTER. As far as total dollars go, is there an increase in dollars for hiring staff or a decrease?

Admiral WEAHKEE. Our priority has been on ensuring that we can continue direct care services.

Senator TESTER. That is not my question. You said it is the number one issue facing. I agree with you, by the way.

So does the budget, does it increase the number of dollars for hiring people or is it a decrease? I would assume you would know that.

Admiral WEAHKEE. Well, sir, we had to make a lot of tough decisions.

Senator TESTER. Okay. So it is a decrease. Is that what you are saying?

Admiral WEAHKEE. No, sir. I did not say that.

Senator TESTER. So is it? Come on, man. I mean, just answer the question. I will back you if the administration comes after you, but is it an increase or a decrease?

Admiral WEAHKEE. We really prioritize—

Senator TESTER. No, no, no, no. Come on.

Admiral WEAHKEE [continuing]. Our direct services.

Senator TESTER. Really? I mean, I am on your side. Okay? I am a former Chairman of Indian Affairs Committee, former Ranking

Member. I have been on this subcommittee now for 8 years. Just tell me if it is an increase or a decrease. It is that simple.

Admiral WEAHKEE. Well, sir, looking at our line items, our priority has been to ensure that we can continue to provide direct healthcare services, and those funds had been prioritized and maintained at the levels that we can ensure that we do not have to decrease the level of service.

Senator TESTER. And that is your answer.

Admiral WEAHKEE. That is my answer. Yes, sir.

Senator TESTER. Wow. I am not even going to go into facilities. I am not going to go into what is going on with mental health. I am not going to go into what is going on with the problem with drugs.

I will tell you that with the previous IHS staff, I remember giving a speech similar to what the Chairman did, and that is if you guys do not advocate for a budget, how are we supposed to fix it?

I have never had in 10 years on this subcommittee, I have never had somebody come up here and when I asked them a direct question, they do not answer it.

I asked you a direct question on whether this budget was up or down, and you would not answer. You refused to answer it. That is totally unacceptable. I did not come in here with my hair on fire, but I am leaving here with it.

I am going to tell you something. Indian Health Service is in a crisis and if you have served in Indian Health Service for 10 years, and you have answered the questions in Indian Health Service like you have here today, it is no wonder that it is in crisis.

I cannot believe what has transpired in this hearing today. All I want is some answers. That is it. And if we cannot get answers from Indian Health, where do we go to get those answers? I do not expect you to answer that either.

This is an unbelievable hearing. I just have to tell you. I have not had one like this in my tenure in here. When I ask a question, I want an answer. It is unbelievable.

Senator MURKOWSKI. Thank you, Senator. I think all of us share the frustration.

Senator Hoeven.

Senator HOEVEN. Thank you, Madam Chairman.

Admiral, pronounce your last name for me, please.

Admiral WEAHKEE. It is Weahkee.

Senator HOEVEN. Weahkee.

GAO

Earlier this year, the GAO released a report on Government agencies that were at high risk for financial waste, fraud, and abuse. IHS was listed as one of them. As part of the report, GAO made recommendations for IHS to address these shortcomings.

On June 13, the Deputy Acting Director, Admiral Chris Buchanan, who is also here today, came before the Indian Affairs Committee and committed IHS to implementing the recommendations in a timely manner from that GAO report.

Can you share with the subcommittee what recommendations from GAO have been implemented and do you have a timeline

when outstanding recommendations will be put in place? And that is both for you and for Admiral Buchanan.

Admiral WEAHKEE. Thank you, Senator Hoeven.

I will take the good news first, which is we are happy to identify that just last week, we have submitted recommendations to close four of those outstanding GAO reports.

And I would like to ask Admiral Buchanan to talk a little bit more with some specificity about those GAO reports.

Admiral BUCHANAN. Thank you and appreciate the opportunity to respond.

As Admiral Weahkee had mentioned, four of the nine reports have been submitted for closure. Of those, there are about roughly 14 specific recommendations. Of those, seven we are recommending closure. Where we have implemented one, we did not agree with the recommendation and the other eight, I believe, are in the process of closure.

So with the anticipated timeline, by the end of this year, I believe, there is opportunity to close out those other opened recommendations.

Senator HOEVEN. So one more time, take me through how many have been closed out and how many are still in process?

Admiral BUCHANAN. Okay. Seven have been recommended for closure to GAO. One is not, we did not agree with GAO recommendations. And the other eight, I believe, are still in process.

Senator HOEVEN. Okay. And your timeline on those is by the end of this year?

Admiral BUCHANAN. Anticipated by the end of this year. Right.

Senator HOEVEN. And as we discussed at our last Indian Affairs Committee hearing where you were present, I am going to ask you to appear for the committee again.

We had looked at possibly doing it in July. Based on the schedule now, we may do it in early August or the first part of September. And then we are going to want a detailed report on the closed items and then also on the pending items.

Admiral BUCHANAN. Definitely.

Senator HOEVEN. Okay. And we will ask you to appear.

IHS CREDENTIALING SYSTEM

One of the challenges I have learned, regarding IHS personnel, is the credentialing system the agency employs. While it is necessary to ensure that IHS healthcare providers have the proper qualifications, the credentialing process has been reported as cumbersome and deters qualified healthcare professionals, who are in good standing with their States' medical boards, from offering their services in Indian country. We want to get more health services out in Indian country, so this is a problem.

Has IHS taken actions to streamline the credentialing process? And if not, what are you doing and what can you do to get more healthcare providers, as well as volunteers, to come out in some of these underserved areas in Indian country?

Again, Admiral Weahkee, I will start with you, and then ask for Admiral Buchanan to respond as well.

Admiral WEAHKEE. Thank you, sir. I appreciate the question.

The credentialing issue has been undertaken as part of our quality framework and we have launched a national system to credential healthcare providers across all of IHS, standardizing and increasing process efficiency to shorten the time that it takes to get providers in, and to help ensure that problem providers are not credentialed anywhere else in the IHS.

We have recently contracted with a software company to purchase a system for the entire agency. We have taken a phased implementation. We have started with four pilot sites to work out the bugs, and we anticipate to have that new credentialing system completely implemented agency-wide by the end of the year.

I will turn to Admiral Buchanan, if he has anything else to add.

Admiral BUCHANAN. Yes, just the quality framework is at the forefront of everything that we have been doing related to organizational capacity, recruitment and retention activities.

We have been actively involved in several of those, including global recruitment activities. We have some programs that we are working on. We are working with some postgraduate training activities to increase our access. We are showing, as I mentioned, the global recruitment, a lot of promise in being able to put out one announcement and have multiple applications from across the country.

Another activity that we have been doing is with the Commissioned Corps related to what I have been calling, or what the agency has been calling, we have been talking about is first dibs. Meaning that people interested in applying to the Commissioned Corps are given priority to Great Plains, Billings, and Navajo.

So those are just a couple of additional items that I would like to add.

Senator HOEVEN. Well, again, I want to emphasize the importance because of our need to get qualified healthcare professionals out in Indian country. As well as to take advantage of volunteers, for example, in dentistry and other areas; to get healthcare professionals out there doing healthcare on a voluntary basis as well. So this is very important and it needs to be completed so that we can get more people out providing those services.

I have your commitment that you are going to make this an absolute priority?

Admiral WEAHKEE. Yes, sir.

Senator HOEVEN. Thank you.

Senator MURKOWSKI. Thank you, Senator Hoeven.

Just to continue on with the recruitment and retention issues. What is the current turnover rate with physicians within IHS right now?

Admiral WEAHKEE. We are looking at between an 11 and 13 percent turnover rate currently, agency wide.

Senator MURKOWSKI. Agency wide. And so, it was a difficult exchange with you and Senator Tester there in terms of the impact that this budget will have on your ability to recruit and retain.

I think we all recognize that this has got to be a priority. You have just given Senator Hoeven a commitment that you will retain this as a priority.

Do you have the flexibility within IHS to offer competitive salaries? Is that part of our issue?

Admiral WEAHKEE. We have a lot of tools in our tool belt, our abilities to provide recruitment retention incentives. We use the Federal system.

Senator MURKOWSKI. Is salary a primary barrier?

Admiral WEAHKEE. We have been able to attract some of the very best of the best. Some of my colleagues in the IHS are at the top of their profession, top of their game.

I think it is not so much an inability to recruit the best of the best. It is recruiting enough of the best of the best.

Senator MURKOWSKI. Well, and it is also retention because when you have turn over like this, it is one thing to get folks out there. It is another thing to keep them.

I know in Alaska, housing is a big consideration. You go out to many of our areas and there is no housing available. You have your physicians that are effectively living in the hospitals, living in the clinics.

How big of an issue is housing, for instance, in the Great Plains areas that I was speaking about earlier in an effort to recruit and retain your professionals?

HOUSING

Admiral WEAHKEE. Yes, ma'am.

I had the opportunity last year to live in Rosebud myself for 5 months and to really assess the situation. Housing is definitely a concern in Rosebud, Pine Ridge, and other rural, remote locations.

Senator MURKOWSKI. What are you doing to address that?

Admiral WEAHKEE. I know that we have been able to, with resources provided, start to look at some innovative designs and building some hotel-type facilities. Specifically, in Pine Ridge and Rosebud, we have some 19-unit construction projects that are underway.

I would like to ask if Mr. Hartz, who is our facility construction expert, can weigh in more.

Senator MURKOWSKI. Please.

Mr. HARTZ. Thank you, Admiral Weahkee and thank you, Senator Murkowski. Good to see you again.

What you have identified is definitely a need across all of Indian country. In this past year, we have provided resources to construct the apartment type complexes for permanent single family, two bedroom units, as well as for itinerant people coming into Pine Ridge, Rosebud, Chinle, and Crown Point on the Navajo Reservation, also addressing some issues in the Hopi Reservation.

With the resources that you folks provided to us in fiscal year 2017, we are going to distribute money—I was going to say we might have already even distributed it but—money will be distributed to the three primary areas that have the greatest need for housing and that is Alaska, Great Plains, and Navajo. So we will be providing those resources from 2017 for that purpose.

It relates back to “build it and they will come,” whether it is in healthcare facility construction, whether it is having the ability to house people in quarters that are not 60 years old. It makes a difference.

Even the Senator who has left may acknowledge, but the best program in the country is at the University of North Dakota that

has the INMED program. That school has graduated more physicians, Indian physicians, than any other institution in this country. And we have many, many of them across the infrastructure of Indian healthcare delivery, Tribal and Federal.

Housing need is something that we are addressing. We thank you for the partnership of assisting us in getting those quarters out there, and we will continue to do that in any way we can.

We are even looking at the HUD program under Section 184 and whether there are ways we can develop private, Tribal, and Federal partnerships to come up with a way to further supplement this need that exists across Indian country.

Senator MURKOWSKI. Well, and I think that is an important part of what we need to look to when we try to understand what is going on with recruitment and retention.

If you are out in the area where there is no housing or where the housing is so substandard, there is a lot of competition for doctors all over the country.

Mr. HARTZ. Right.

Senator MURKOWSKI. And it is not just within IHS. We are still trying to get doctors within the V.A. system. We are trying to get doctors throughout and so things like housing are important.

But it takes me back to the budget that we are looking at. This budget request proposes an 18 percent cut to the facilities program. So whether we are talking about housing initiatives, or recognizing that the facilities that are aiming to meet the needs of our Native peoples are roughly four times the age of their private sector counterparts, you have a maintenance backlog that is also over half a billion dollars.

So I understand. I am on the appropriations committee. I understand that we have an administration that is trying to rein in our spending. We need to do that. We need to be responsible to it, but we also have a trust responsibility to our Native people. In order to meet that, we need to make appropriate investments and those appropriate investments are being overlooked, I think, in this budget.

I do not see that with this large backlog of construction and maintenance projects we have that we can continue to do the good work that I think you have outlined, Mr. Hartz. We are making some progress.

How do we continue that progress when you have an 18 percent cut in your facilities budget here? Does anybody have an answer? Mr. Hartz.

Mr. HARTZ. Some people may say I have been around too long, but I have seen a lot. As the budgets have gone up and the budgets have gone down, we have had to come up with ways to manage that within the confines of the resources we are provided, ever mindful of the priority to serve the American Indian and Alaska Native to the highest level that we can.

Regarding the M&I account, you mentioned that. The need is in excess of half a billion dollars. No question about it. We have taken the appropriations that we have received and coupled that with Medicare, Medicaid, and private insurance collections.

We have examples of areas taking 75 percent of project funds going into some M&I work in the Portland area where resources came from other than the M&I appropriation.

So we continue to work to see how we can best partner with others, whether it is in sanitation facilities. We have done the same thing in delivering sanitation facilities.

On the healthcare arena, it is pretty clear that construction is tied to appropriations. Unless, of course, we can get involved in the joint venture program, the small ambulatory program that you helped us out with, again, this past year. We appreciate that coming from the subcommittee.

Approximately a year ago, we submitted the second facilities assessment report to the Congress and that report indicates the needs that were determined; not only existing authorities, but the new authorities that came with the reauthorized Indian Healthcare law were incorporated in.

It already has been stated, I think, here at the hearing that that existing authorities was over \$10 billion of a need for healthcare facilities. The new piece, new authorities is another \$4 billion plus.

So yes, we have these needs. We have managed exceedingly well. We do not come back to the Congress for money for any of our projects. We take a look at cost, scope, and schedule. We work within that to make sure we deliver quality healthcare.

I can go to places in New Mexico. I can go to places in Alaska where you and I have been for dedications. I can go to Arizona. I can go to the places that we have tried to keep up with the resources to deliver healthcare.

We have done a fantastic job and it helps recruitment. It provides staffing at an 85 percent level and the balance is covered by third party collections.

Senator MURKOWSKI. Well, and Mr. Hartz, I am going to interrupt because my time has expired. But your comment just there, that it has been helped by the third party payers is exactly why we need to get this information from you about the impact, the benefit then that accrues to IHS through Medicaid and Medicaid expansion.

If decisions are going to be made to make reductions in this particular program, again, we need to understand what that is going to be doing to the delivery of the services that are expected.

Let me turn to Senator Udall.

Senator UDALL. Thank you, Madam Chair.

I was pleased this subcommittee was able to secure additional funding for alcohol and substance abuse programs in the Omnibus, Miss Fowler. And I know that this funding is critical to patch gaps in service like those we see in the community of Gallup, New Mexico.

Miss Fowler, can you tell me how soon you expect an announcement to be made about this funding?

Ms. FOWLER. Yes, sir. We are working on a cooperative agreement and we expect that to be awarded by the end of this fiscal year.

Senator UDALL. And how long after the announcement is made will it take to get this funding on the ground to these areas of greatest need?

Ms. FOWLER. It would be immediately.

Senator UDALL. Okay. Thank you.

Now, back to this issue of the CMS funds and the information on Medicaid, as I understand, CMS keeps records of what it pays for every Medicaid service in the country. I believe it is called the CMS-64 and it has an entire column of payments for IHS services.

Why does no one at the HHS, CMS, or IHS have that data file to share with the subcommittee? And will you get that data file and share it with the subcommittee?

Admiral WEAHKEE. Sir, we are happy to partner with CMS, and assess what data they have available, and bring that back to you.

Senator UDALL. Am I correct about the CMS-64, that that exists?

Admiral WEAHKEE. It is a little bit outside of my area of expertise.

Senator UDALL. Admiral Buchanan.

Admiral BUCHANAN. It is also out of my area of expertise.

Senator UDALL. Okay. Well, find it and get it for us. Thank you.
[The information follows:]

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Inpatient Hospital— Reg. Payments Total Computable	Inpatient Hospital— DSH Total Computable	Inpatient Hospital— Sup. Payments Total Computable	Inpatient Hospital— GME Payments Total Computable	Mental Health Facility Services— Reg. Payments Total Computable
Alabama	\$1,784,832	\$0	\$0	\$0	\$340,412
Alaska	\$70,886,116	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0
Arizona	\$62,350,100	\$0	\$0	\$0	\$2,895,520
Arkansas	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$0	\$0
Minnesota	\$573,906	\$0	\$0	\$0	\$15,446,913
Mississippi	\$256,848	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0
Montana	\$1,662,959	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0
New Mexico	\$19,188,586	\$0	\$0	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$0
North Carolina	\$332,541	\$0	\$0	\$0	\$0
North Dakota	\$1,080,340	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$20,732,444	\$0	\$0	\$0	\$0
Oregon	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0
South Dakota	\$6,378,343	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0
Utah	\$124,881	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$736
Totals:	\$185,351,896	\$0	\$0	\$0	\$18,683,581

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Mental Health Facility—DSH Total Computable	Nursing Facility Services—Reg. Payments Total Computable	Nursing Facility Services—Sup. Payments Total Computable	Intermediate Care Facility Services—Ind. with Intellectual Disabilities: Pub- lic Providers Total Computable	Intermediate Care Facility Services—Ind. with Intellectual Disabilities: Pri- vate Providers Total Computable	Intermediate Care Facility Services—Ind. with Intellectual Disabilities: Sup- plemental Pay- ments Total Computable
Alabama	\$0	\$732,408	\$0	\$0	\$0	\$0
Alaska	\$0	\$15,191,302	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$13,734	\$0	\$0	\$0	\$0
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$0	\$0	\$0
Minnesota	\$0	\$3,394,289	\$0	\$0	\$0	\$0
Mississippi	\$0	\$4,934,508	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$4,680,194	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$0	\$89,419	\$76,935	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$0	\$3,009,471	\$0	\$0	\$0	\$0
North Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$423	\$0	\$0	\$0	\$0
Oregon	\$0	(\$158)	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$639,665	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$1,915,211	\$0	\$0	\$0	\$0
Wyoming	\$0	\$1,507,584	\$0	\$0	\$0	\$0
Totals:	\$0	\$36,018,631	\$0	\$89,419	\$76,935	\$0

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Physician & Surgical Services— Reg. Payments Total Computable	Physician & Surgical Services— Sup. Payments Total Computable	Physician & Surgical Services— Evaluation and Management Total Computable	Physician & Surgical Services— Vaccine Codes Total Computable	Outpatient Hospital Services— Reg. Payments Total Computable	Outpatient Hospital Services— Sup. Payments Total Computable
Alabama	\$1,103,338	\$0	\$0	\$0	\$354,884	\$0
Alaska	\$0	\$0	\$0	\$0	\$86,616,510	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$4,951,687	\$0	\$0	\$0	\$472,683,520	\$7,711,397
Arkansas	\$0	\$0	\$0	\$0	\$321,152	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$720,763	\$0	\$18,010	\$656	\$3,126	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$866,104	\$488	\$0	\$0
Minnesota	\$10,068,170	\$0	\$0	\$0	\$3,856	\$0
Mississippi	\$194,473	\$0	\$0	\$0	\$5,963,910	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$61,946,583	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$3,850	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$1,543,257	\$56,011	\$399	\$0	\$94,589,729	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$1,034,202	\$0	\$0	\$0	\$8,388,862	\$0
North Dakota	\$16,046	\$0	\$0	\$0	\$5,527,363	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$2,877,356	\$0	\$0	\$0	\$41,906,818	\$0
Oregon	\$0	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$9,306	\$0	\$0	\$0	\$0	\$0
South Carolina	\$10,142	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$1,116,994	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$55,036	\$0
Utah	\$3,115,412	\$0	\$0	\$0	\$87,084	\$0
Vermont	\$27	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$5,709,652	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$0	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$31,459	\$0
Totals:	\$31,353,831	\$56,011	\$884,513	\$1,144	\$779,600,736	\$7,711,397

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Prescribed Drugs Total Computable	Drug Rebate Off- set—National Total Computable	Drug Rebate Off- set—State Side- bar Agreement Total Computable	MCO—National Agreement Total Computable	MCO—State Sidebar Agree- ment Total Computable	Increased ACA OFFSET—Fee for Service—100% Total Computable
Alabama	\$1,856,101	(\$398,330)	(\$20,776)	\$0	\$0	\$0
Alaska	\$19,149,671	(\$9,938,455)	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$0	\$0	\$0	\$0
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$1,221,828	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$166,011	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$410,211	(\$134,987)	(\$7,456)	(\$18)	\$0	\$0
Kansas	\$1,575	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$182,802	(\$115,629)	(\$6,233)	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$4	\$0	\$0	\$0	\$0	\$0
Minnesota	\$27,218,864	(\$798,557)	(\$52,694)	\$0	\$0	\$0
Mississippi	\$0	\$0	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$3,916,880	(\$3,799,067)	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$337,192	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$1,210,450	(\$145,991)	\$0	\$2,179,492	\$0	\$0
New York	\$28,896	\$0	\$0	\$0	\$0	\$0
North Carolina	\$20,989	(\$452,459)	\$0	\$0	\$0	\$0
North Dakota	\$4,975,951	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$17,784,129	\$0	\$0	\$0	\$0	\$0
Oregon	\$1,063,358	\$174,970	(\$42,490)	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$19,287	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$4,877,447	(\$3,328,605)	(\$38,718)	(\$2,730,460)	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$139,773	(\$30,828)	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$1,217,888	(\$1,895,482)	(\$77,906)	\$0	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$85,799,307	(\$20,863,420)	(\$246,273)	(\$550,986)	\$0	\$0

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Increased ACA OFFSET—MCO— 100% Total Computable	Dental Services Total Computable	Other Practi- tioners Serv- ices—Reg. Pay- ments Total Computable	Other Practi- tioners Serv- ices—Sup. Pay- ments Total Computable	Clinic Services Total Computable	Laboratory/Radio- logical Total Computable
Alabama	\$0	\$305,949	\$69,467	\$0	\$49,371	\$297,671
Alaska	\$0	\$28,923,459	\$0	\$0	\$143,206,019	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$217,723	\$1,049,342	\$0	\$5,612,860	\$635,587
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$13,522,319	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$82,936	\$25,778	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$32,982	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$2,060,924	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$223,289	\$0
Michigan	\$0	\$80,926	\$0	\$0	\$2,687,664	\$0
Minnesota	\$0	\$4,196,203	\$8,897,185	\$0	\$5,161,349	\$349
Mississippi	\$0	\$3,896	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$19,990,921	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$1,205	\$118,756	\$0	\$0	\$4,766
New York	\$0	\$0	\$0	\$0	\$511,231	\$0
North Carolina	\$0	\$56,972	\$0	\$0	\$0	\$0
North Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$0	\$13,592	\$0	\$40,338,468	\$28,947
Oregon	\$0	\$0	\$0	\$0	\$15,999,334	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$61,138,157	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$628,237	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$1,501,336	\$37,682	\$0	\$43,609,620	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$0	\$2,300	(\$17)
Wyoming	\$0	\$0	\$0	\$0	\$9,103,050	\$56
Totals:	\$0	\$35,998,842	\$10,211,802	\$0	\$363,249,858	\$967,359

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Home Health Services Total Computable	Sterilizations Total Computable	Abortions Total Computable	EPSDT Screening Total Computable	Rural Health Total Computable	Medicare—Part A Total Computable
Alabama	\$209,282	\$21,200	\$0	\$166,164	\$96,404	\$0
Alaska	\$0	\$0	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$4,668	\$42,768	\$0	\$19,818	\$0	\$0
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$34,988,770	\$0
Colorado	\$0	\$0	\$0	\$0	\$3,425,564	\$0
Connecticut	\$0	\$0	\$0	\$2,796	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$186	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$54,897	\$0	\$0
Minnesota	\$1,599,133	\$67	\$0	\$84,512	\$82	\$0
Mississippi	\$0	\$0	\$0	\$532,843	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$350	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$17,410,900	\$0	\$0	\$100	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$56,364	\$0	\$0	\$0	\$0	\$0
North Dakota	\$468,338	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$399,021	\$240,752	\$0	\$250,930	\$0	\$0
Oregon	\$0	\$0	\$0	\$202,084	\$0	\$452
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$0	\$136,965	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$1,241,825	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$38,516	\$0	\$0	\$76,777	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$20,186,408	\$304,787	\$0	\$2,770,061	\$38,510,820	\$452

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Medicare— Part B Total Computable	120%–134% of Poverty Total Computable	Coinsurance Total Computable	Medicaid—MCO Total Computable	Medicaid MCO— Evaluation and Management Total Computable	Medicaid MCO— Vaccine Codes Total Computable
Alabama	\$0	\$0	\$0	\$0	\$0	\$0
Alaska	\$0	\$0	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$0	(\$295,139)	\$0	\$0
Arkansas	\$0	\$0	\$2,621	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$43	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$2,050,641	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$208,767	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$312	\$0	\$0	\$0
Minnesota	\$0	\$0	\$0	\$0	\$0	\$0
Mississippi	\$0	\$0	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$3,985	\$8,670,518	\$0	\$0
Nevada	\$0	\$0	\$0	\$1,965,059	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$3,195,638	\$44,000,544	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$55,519,995	\$0
North Carolina	\$0	\$0	\$5,268	\$0	\$0	\$0
North Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$0	\$0	\$0	\$0	\$0
Oregon	\$0	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$1,390	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$14,398	\$0	\$0	\$0
Wyoming	\$0	\$0	\$14,871	\$0	\$0	\$0
Totals:	\$0	\$0	\$3,447,293	\$56,391,623	\$55,519,995	\$0

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Medicaid MCO— Community First Choice Total Computable	Medicaid MCO— Preventive Services Grade A OR B, ACIP Vaccines and their Admin Total Computable	Prepaid Ambula- tory Health Plan Total Computable	MCO PAHP— Evaluation and Management Total Computable	MCO PAHP— Vaccine Codes Total Computable	MCO PAHP— Community First Choice Total Computable
Alabama	\$0	\$0	\$0	\$0	\$0	\$0
Alaska	\$0	\$0	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$0	\$0	\$0	\$0
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$0	\$0	\$0
Minnesota	\$0	\$0	\$0	\$0	\$0	\$0
Mississippi	\$0	\$0	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$0	\$0	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$0	\$0	\$0	\$0	\$0	\$0
North Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$0	(\$78,373)	\$0	\$0	\$0
Oregon	\$0	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$0	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$0	\$0	(\$78,373)	\$0	\$0	\$0

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	MCO PAHP—Preventive Services Grade A OR B, ACIP Vaccines and their Admin Total Computable	Prepaid Inpatient Health Plan Total Computable	MCO PIHP—Evaluation and Management Total Computable	MCO PIHP—Vaccine Codes Total Computable	MCO PIHP—Community First Choice Total Computable	MCO PIHP—Preventive Services Grade A OR B, ACIP Vaccines and their Admin Total Computable
Alabama	\$0	\$0	\$0	\$0	\$0	\$0
Alaska	\$0	\$0	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$0	\$0	\$0	\$0
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$0	\$0	\$0
Minnesota	\$0	\$0	\$0	\$0	\$0	\$0
Mississippi	\$0	\$0	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$727,632	\$0	\$0	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$0	\$0	\$0	\$0	\$0	\$0
North Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$0	\$0	\$0	\$0	\$0
Oregon	\$0	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$0	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$0	\$727,632	\$0	\$0	\$0	\$0

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Medicaid—Group Health Total Computable	Medicaid— Coinsurance Total Computable	Medicaid—Other Total Computable	Home & Commu- nity-Based Ser- vices—Reg. Pay. (Waiv) Total Computable	Home & Commu- nity-Based Ser- vices—St. Plan 1915(i) Only Pay. Total Computable	Home & Commu- nity-Based Ser- vices—St. Plan 1915(j) Only Pay. Total Computable
Alabama	\$0	\$0	\$0	\$288,087	\$0	\$0
Alaska	\$0	\$0	\$0	\$6,236,876	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$0	\$0	\$0	\$0
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$0	\$0	\$0
Minnesota	\$0	\$0	\$23,210	\$147,880	\$0	\$0
Mississippi	\$0	\$0	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$660	\$0	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$0	\$0	\$0	\$0	\$0	\$0
North Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$0	\$0	\$295,016	\$0	\$0
Oregon	\$0	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$1,969,178	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$0	\$0	\$23,870	\$8,937,037	\$0	\$0

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Home & Community Based Services State Plan 1915(k) Community First Choice Total Computable	All-Inclusive Care Elderly Total Computable	Personal Care Services—Reg. Payments Total Computable	Personal Care Services—SDS 1915(j) Total Computable	Targeted Case Management Services—Com. Case-Man. Total Computable	Case Management—State Wide Total Computable
Alabama	\$0	\$0	\$0	\$0	\$113,862	\$0
Alaska	\$0	\$0	\$99,373	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$79,435	\$0	\$0	\$0
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$48
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$0	\$0	\$0
Minnesota	\$0	\$0	\$0	\$0	\$0	\$6,156,206
Mississippi	\$0	\$0	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$0	\$0	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$0	\$0	\$46,398	\$0	\$15,807	\$0
North Dakota	\$0	\$0	\$0	\$0	\$18,392	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$3,240,698	\$0	\$0	\$0	\$0
Oregon	\$0	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$0	\$0	\$70
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$0	\$3,240,698	\$225,206	\$0	\$148,061	\$6,156,324

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Primary Care Case Management Total Computable	Hospice Benefits Total Computable	Emergency Serv- ices for Undocu- mented Aliens Total Computable	Federally-Quali- fied Health Center Total Computable	Non-Emergency Medical Transportation Total Computable	Physical Therapy Total Computable
Alabama	\$189,217	\$57,343	\$0	\$283,952	\$0	\$23,115
Alaska	\$0	\$0	\$0	\$0	\$375,018	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$0	\$36,884	\$7,499,635	\$1,317
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$29,608	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$56	\$0	\$0
Minnesota	\$0	\$0	\$0	\$5,447	\$0	\$441,435
Mississippi	\$0	\$0	\$0	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$225,607	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$693,031	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$0	\$508,747	\$39,314	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$0	\$0	\$0	\$0	\$40,984	\$0
North Dakota	\$34,560	\$0	\$0	\$0	\$3,942	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$459,243	\$0	\$11,709	\$0	\$797,370	\$0
Oregon	\$0	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$0	\$0	\$918,544	\$334
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$40,155,116	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$17,115,834	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$938,235	\$57,343	\$11,709	\$58,799,067	\$9,674,807	\$466,201

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Occupational Therapy Total Computable	Services for Speech, Hearing & Language Total Computable	Prosthetic De- vices, Dentures, Eyeglasses Total Computable	Diagnostic Screening & Pre- ventive Services Total Computable	Preventive Ser- vices Grade A OR B, ACIP Vaccines and their Admin Total Computable	Nurse Mid-Wife Total Computable
Alabama	\$0	\$1,701	\$17,446	\$0	\$0	\$170
Alaska	\$0	\$0	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$1,532	\$0	\$6,069	\$0	\$1,361,216
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$10,432	\$0	\$0	\$0
Minnesota	\$243,612	\$11	\$24,268	\$0	\$0	\$297,118
Mississippi	\$0	\$0	\$15,888	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	\$0	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$655	\$143	\$4,929	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$0	\$0	\$0	\$0	\$0	\$0
North Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$0	\$0	\$0	\$0	\$0
Oregon	\$0	\$0	(\$23)	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$0	\$0	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands0	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$933	\$0	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$243,612	\$3,899	\$69,087	\$10,998	\$0	\$1,658,504

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Emergency Hos- pital Services Total Computable	Critical Access Hospitals Total Computable	Nurse Practi- tioner Services Total Computable	School Based Services Total Computable	Rehabilitative Services (non- school-based) Total Computable	Private Duty Nursing Total Computable
Alabama	\$0	\$0	\$82,198	\$0	\$397,456	\$0
Alaska	\$0	\$0	\$0	\$0	\$0	\$0
Amer. Samoa	\$0	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$176,757	\$0	\$13,167,925	\$0
Arkansas	\$0	\$0	\$0	\$0	\$0	\$0
California	\$0	\$0	\$0	\$0	\$0	\$0
Colorado	\$0	\$0	\$0	\$0	\$0	\$0
Connecticut	\$0	\$0	\$0	\$0	\$0	\$0
Delaware	\$0	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$0	\$0	\$0
Illinois	\$0	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$0
Kansas	\$0	\$0	\$0	\$0	\$0	\$0
Kentucky	\$0	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$0	\$0	\$0
Maine	\$0	\$0	\$0	\$0	\$0	\$0
Maryland	\$0	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$0	\$0	\$0
Michigan	\$0	\$0	\$0	\$0	\$0	\$0
Minnesota	\$0	\$0	\$4,747,498	\$0	\$0	\$0
Mississippi	\$0	\$0	\$7,670	\$0	\$0	\$0
Missouri	\$0	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$0	\$0	\$0
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$0	\$0	\$0
Nevada	\$0	\$0	(\$1,655)	\$0	\$0	\$0
New Hampshire	\$0	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$0	\$0	\$0	\$0
New York	\$0	\$0	\$0	\$0	\$0	\$0
North Carolina	\$0	\$0	\$0	\$0	\$0	\$0
North Dakota	\$24,098	\$0	\$177	\$0	\$0	\$0
Ohio	\$0	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$0	\$302	\$0	\$0	\$0
Oregon	\$0	\$0	\$0	\$0	\$0	\$0
Pennsylvania	\$0	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$0	\$0
South Carolina	\$0	\$0	\$0	\$0	\$0	\$0
South Dakota	\$0	\$0	\$0	\$0	\$0	\$0
Tennessee	\$0	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$0	\$0
Utah	\$10,535	\$0	\$0	\$0	\$0	\$0
Vermont	\$0	\$0	\$0	\$0	\$0	\$0
Virgin Islands	\$0	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$0	\$0	\$0
West Virginia	\$0	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$0	\$0	\$0
Wyoming	\$0	\$0	\$0	\$0	\$0	\$0
Totals:	\$34,633	\$0	\$5,012,947	\$0	\$13,565,381	\$0

IHS BY CATEGORY OF SERVICE
YEAR: 2016

State	Freestanding Birth Center Total Computable	Health Home for Enrollees With Chronic Condi- tions Total Computable	Tobacco Ces- sation for Preg. Women Total Computable	Other Care Serv- ices Total Computable	Total Total Computable
Alabama	\$0	\$0	\$0	\$47,078	\$8,470,002
Alaska	\$0	\$0	\$0	\$16,366,151	\$377,112,040
Amer. Samoa	\$0	\$0	\$0	\$0	\$0
Arizona	\$0	\$0	\$0	\$10,046,143	\$590,270,498
Arkansas	\$0	\$0	\$0	\$0	\$323,773
California	\$0	\$0	\$0	\$0	\$48,511,089
Colorado	\$0	\$0	\$0	\$0	\$4,647,392
Connecticut	\$0	\$0	\$0	\$0	\$2,796
Delaware	\$0	\$0	\$0	\$0	\$0
District of Columbia	\$0	\$0	\$0	\$0	\$0
Florida	\$0	\$0	\$0	\$0	\$0
Georgia	\$0	\$0	\$0	\$0	\$0
Guam	\$0	\$0	\$0	\$0	\$0
Hawaii	\$0	\$0	\$0	\$0	\$0
Idaho	\$0	\$0	\$0	\$2,268,159	\$2,434,170
Illinois	\$0	\$0	\$0	\$0	\$0
Indiana	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	(\$5)	\$1,119,291
Kansas	\$0	\$0	\$0	\$0	\$2,085,198
Kentucky	\$0	\$0	\$0	\$0	\$0
Louisiana	\$0	\$0	\$0	\$24,027	\$24,027
Maine	\$0	\$0	\$0	\$1,685	\$2,361,924
Maryland	\$0	\$0	\$0	\$0	\$0
Massachusetts	\$0	\$0	\$0	\$5,540	\$228,829
Michigan	\$0	\$0	\$0	\$0	\$3,700,883
Minnesota	\$0	\$0	\$2,486	\$1,459,050	\$89,341,848
Mississippi	\$0	\$0	\$0	\$130,583	\$12,040,619
Missouri	\$0	\$0	\$0	\$0	\$0
Montana	\$0	\$0	\$0	\$624,010	\$64,576,972
N. Mariana Islands	\$0	\$0	\$0	\$0	\$0
Nebraska	\$0	\$0	\$0	\$64	\$14,388,834
Nevada	\$0	\$0	\$0	\$0	\$21,954,675
New Hampshire	\$0	\$0	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0	\$0	\$0
New Mexico	\$0	\$0	\$0	\$443,424	\$185,245,700
New York	\$0	\$0	\$0	\$3,700	\$56,063,822
North Carolina	\$0	\$0	\$0	\$67,360	\$12,622,759
North Dakota	\$0	\$0	\$0	\$1,170	\$12,150,377
Ohio	\$0	\$0	\$0	\$0	\$0
Oklahoma	\$0	\$0	\$0	\$178,268	\$129,477,113
Oregon	\$0	\$0	\$0	\$0	\$17,397,527
Pennsylvania	\$0	\$0	\$0	\$0	\$0
Puerto Rico	\$0	\$0	\$0	\$0	\$0
Rhode Island	\$0	\$0	\$0	\$0	\$9,306
South Carolina	\$0	\$0	\$0	\$0	\$29,429
South Dakota	\$0	\$1,128,124	\$0	\$0	\$69,761,618
Tennessee	\$0	\$0	\$0	\$0	\$0
Texas	\$0	\$0	\$0	\$0	\$55,036
Utah	\$0	\$0	\$0	\$0	\$3,803,046
Vermont	\$0	\$0	\$0	(\$623)	(\$596)
Virgin Islands	\$0	\$0	\$0	\$0	\$0
Virginia	\$0	\$0	\$0	\$0	\$0
Washington	\$0	\$0	\$0	\$15,608	\$93,019,449
West Virginia	\$0	\$0	\$0	\$0	\$0
Wisconsin	\$0	\$0	\$0	\$6,167	\$20,383,867
Wyoming	\$0	\$0	\$0	\$0	\$10,657,756
Totals:	\$0	\$1,128,124	\$2,486	\$31,687,559	\$1,854,271,069

Admiral Weahkee, you mentioned visiting Pine Ridge on your second day on the job. Did that visit include a meeting with the Tribal council?

Admiral WEAHKEE. Yes, sir. It did. In fact, we spent probably two and a half hours or more sitting down with President Weston from the Oglala Sioux Nation and four of his council members.

Part of the Secretary's request was that we hear from them first-hand what they have been experiencing with the care provided at Pine Ridge and they definitely did not hold back.

Senator UDALL. Yes, and they let you know how they felt about it.

Admiral WEAHKEE. Yes, sir.

Senator UDALL. Yes. Thank you.

Since you did not directly answer Senator Murkowski's question about funding needed for the Great Plains, I am left wondering would IHS have to pull resources from other service areas to resolve this crisis?

Admiral WEAHKEE. Well, sir, we have had resources from other locations such as staff members from Phoenix, subject matter experts, if you will, providing their expertise to the Great Plains area. We have had quality managers from the Oklahoma City area.

So we are not moving money around, but we are definitely sharing the expertise from throughout the rest of the agency with the Great Plains, spreading those best practices and those subject matter experts.

Senator UDALL. Now at the Senate Indian Affairs hearing, Admiral Buchanan, you told me that the leadership vacancies were one of the main barriers to seeking CMS recertification at the hospital.

Does Omaha Winnebago have a full leadership team in place?

Admiral BUCHANAN. They currently have a mixture of acting and permanent in place currently.

Senator UDALL. So they do have a full leadership team?

Admiral BUCHANAN. That is correct.

Senator UDALL. Admiral Weahkee, can you assure this subcommittee that IHS will seek CMS recertification of the Omaha Winnebago Hospital before the end of the summer?

Admiral WEAHKEE. Just as quickly as we can, sir. I think stable leadership is key. We are in a good place in Omaha Winnebago in terms of conditions of participation. We are close. End of summer we will be close.

Senator UDALL. Yes, but you have it on an aggressive timeline?

Admiral WEAHKEE. Yes, sir.

Senator UDALL. Yes.

Admiral WEAHKEE. Absolutely.

CONSTRUCTION BACKLOG

Senator UDALL. Mr. Hartz, I want to ask you a little bit about the construction backlog.

I was pleased that this request includes \$5 million to support the design for a new facility in Alamo, New Mexico. However, this budget cuts \$99 million from facility's line items when the IHS has an estimated backlog of \$10 billion.

Some of the facilities on the bottom of the priority list, including several in New Mexico, have been waiting for decades. Others, like those in the Great Plains service area, have lost accreditation because of the facility infrastructure issues.

Mr. Hartz, have you taken account of how far this cut sets IHS back on getting through the priority list?

Mr. HARTZ. Yes. Yes, I have.

You will note that in 2017, we got \$117 million to address projects and although funding the projects typically are being phased, we were able to still stay on track with the projects that we had identified to be moving along. That being the Rapid City project, with a portion of the \$100 million requested in fiscal year 2018, will complete the funding needed for that Rapid City facility. It will continue the funding for the Dilkon Alternative Care facility.

As you have highlighted, Senator, we will have additional resources going into Alamo that will allow us to wrap up the design and take a look at any foundations work.

Because of the way Congress has provided us funding on many of these projects on the phased approached, we look at how we can move them along as that phased funding comes in. Because with the priorities on healthcare delivery, it is really difficult to fund \$50 million, \$150 million, a \$200 million facility project at one time.

So we have been able to manage this. It is a slow process working down this list, but we really, really are making inroads. We would be happy to share with you and the subcommittee, how well we have progressed with the dollars we have received over the years.

Senator UDALL. Yes, and I am sure that if the \$99 million in cuts were restored to you, you could make progress on additional items also.

VILLAGE BUILT CLINICS

Thank you very much, Madam Chair.

Senator MURKOWSKI. Thank you, Senator Udall.

Let me ask about some of the Alaska-specific initiatives. As you know, and I have discussed with many of your predecessors here, Village Built Clinics have had an important role in Alaska. We have about 150 in Alaska with most of these being the only local option for healthcare. Most of them have some pretty significant maintenance needs.

In the past, the agency took the view that the Tribes were responsible for paying for these costs out of other funds that they get from the Service.

In 2016, we included \$2 million to help address this issue. Last year, the administration put \$11 million in its request for these clinics, which this subcommittee fully funded. Then this year's request takes us back to the 2016 amount of \$2 million.

So a couple of questions here regarding VBC's is how the agency plans to allocate the \$11 million for fiscal year 2017? When will these funds be distributed, and then just the rationale for cutting back to the \$2 million from the \$11 million that had been requested?

What I am trying to figure out here is just what is a sustainable level for us on an annual basis to fix the maintenance issues that we have with these clinics? We felt like we got our foot in the door back in 2016, but you cannot do much with \$2 million when you have a level of need as we have within the State.

So if somebody can speak to the issue of where we are with Village Built Clinics in this State?

Admiral WEAHKEE. Yes, ma'am. And definitely the VBC's or the Village Built Clinics are an integral part of our Indian Healthcare System.

I would like to ask Ms. Fowler to provide.

Senator MURKOWSKI. Sure.

Ms. FOWLER. So the \$11 million, we do appreciate that those funds were included in our fiscal year 2017 appropriation.

We have currently allocated \$6 million to the Alaska area. Two million dollars represents what was funded last year. And so those are being allocated to the same clinics on a recurring basis as last year.

The additional \$4 million has been allocated to date. It is undergoing Tribal consultation. There is about \$6 million specific to the Village Built Clinics.

There are additional Tribal clinic leases similar to the Village Built Clinics that also require funding, and so that meets the criteria for the funding.

The other \$5 million in the meantime has been set aside to determine, as we evaluate the need to fund those clinics, the majority of which are in Alaska at this time. All of them are in Alaska at this time.

And so, by the end of this fiscal year, we will be able to give you a complete accounting of how those funds were allocated.

Senator MURKOWSKI. So do you think that by the end of the fiscal year, you will have provided the schedule for the remaining balance of the \$5 million?

Ms. FOWLER. Yes.

Senator MURKOWSKI. Okay. And then to the question of what do you believe could be a sustainable number on an annual basis for meeting the maintenance needs for these Village Built Clinics?

Ms. FOWLER. So as I indicated, we have another group of Tribal clinic leases that have emerged as funding need and we are in the process of determining this, as some of the Village Built Clinics actually cross over and are part of this other group as well. And we are currently evaluating how much is needed to fully fund those leases.

I believe that the last estimate for the Village Built Clinics specifically was in the range of \$16 million, if I am not mistaken.

Senator MURKOWSKI. So it would be helpful for me if we can have that kind of an analysis in terms of what we have out there, what the need is, and building a schedule if we can, so that we can understand how we can best address this and mass something going forward. I think that that would be helpful. So if you would be willing to work with us on that.

AMBULATORY CARE PROGRAM

Ms. FOWLER. We are willing to work with you on that.

Senator MURKOWSKI. And then on our small ambulatory clinic program, again, in fiscal year 2017 we had \$5 million for the small ambulatory clinic. This was the first time that we had been successful in including money in the program since 2008. It has been very helpful and successful as we have used funds to construct facilities. We have them out in Chenega, Kay, and Hooper Bay. We

have also had many groups that are interested in submitting proposals for the funds that are provided in fiscal year 2017.

Can you tell me how many proposals you have received for the funding and if any decisions on funding allocations have been made yet?

Admiral WEAHKEE. Ma'am, we would like to ask Gary Hartz to weigh in on this one

Senator MURKOWSKI. Okay.

Mr. HARTZ. Thank you, Senator.

As you indicated, the small ambulatory program is extremely popular. And in fact in 2008, was when we did that last solicitation, it is the competitive program as well. When we did that solicitation, we got 67 applicants in varying levels of need to complete their plans for small facilities.

Our dollars, which were appropriated to IHS for this purpose, are often used to leverage other resources. And I can come up with examples of leveraging that went up to six times where \$2 million was put in, which is the cap that we would provide under this program, being part of a total funding package that would run \$10 to \$12 million.

Where are we at on the solicitation for this year? I will conservatively tell you that it will be on the street before the end of the fiscal year. It will be done before that, but I will tell you that based on the appropriations that passed and the fact that it included money for small ambulatory, we are in the final stages of review of the package to get it out on the street for solicitations.

Senator MURKOWSKI. Mr. Hartz, you have recognized that it is popular, that there is a need. Unfortunately, the budget proposal does not include funds in fiscal year 2018.

So again, this is an area where we think we have found a way to help address some of the needs that we have, particularly in our very remote and small areas. So I would like to think that we would be able to continue a level of support for our small ambulatory clinic program.

Mr. HARTZ. All of the authorities provided are helpful in addressing the needs across Indian country.

Senator MURKOWSKI. Thank you.

Mr. HARTZ. Thank you.

Senator MURKOWSKI. Senator Udall.

Senator UDALL. Admiral, I continue to have concern about the Service's ability to effectively recruit and retain qualified staff. I know that some of these facilities are especially hard to recruit for since they are in extremely remote areas.

I am disappointed that this budget does not invest more in loan repayment and scholarship programs. I understand that about one-third of qualified loan repayment candidates and 81 percent of scholarship applicants went unfunded in fiscal year 2015.

How many qualified applicants to the IHS loan repayment and scholarship program were turned down because of lack of funding in fiscal year 2016?

Admiral WEAHKEE. Sir, I do not have those numbers off the top of my head. I can say that moving forward that we are prioritizing the funding of both loans and scholarship awards to individuals who are already in the pipeline, continuing students.

I will ask Admiral Buchanan if he has any numbers off the top of his head.

Admiral BUCHANAN. I am sorry. I do not have those numbers off the top of my head, but we can definitely provide that response for the record.

Senator UDALL. Yes. Could you give us that for the record and then also your best estimate on how many people on both scholarship and the loan repayment program are not able to get into that program?

[The information follows:]

HOW MANY PEOPLE ON BOTH SCHOLARSHIP AND LOAN REPAYMENT PROGRAM ARE NOT ABLE TO GET INTO THE PROGRAM (UNDER THE BUDGET PROPOSAL)

The fiscal year 2018 proposed budget includes a \$5 million reduction to the scholarship and loan repayment programs. In order to prioritize direct healthcare services, these programs will scale back on new awards and primarily focus on continuation of existing award commitments. For example about 50 fewer scholarships would be awarded to new awardees and about 100 fewer loan repayment contracts would be executed.

Senator UDALL. Thank you very much, Madam Chair.

Senator MURKOWSKI. Thank you. I know that Senator Daines has a time crunch, so we are going to let him in here.

Senator DAINES. Thank you, Chair Murkowski, Ranking Member Udall. Thank you. I appreciate it. Thanks for yielding too.

I share my colleague from Montana's outrage over the state of affairs at IHS. Chairman Murkowski and Ranking Member Udall, I am not sure I have met a Member yet who is satisfied virtually in any way with IHS. And maybe we as leaders should rename the agency Indian Health Suffering until they start serving the people of Indian country again.

It is outrageous. It is heartbreaking. It is infuriating. These are real families, single moms, single dads, aunts and uncles, elderly Tribal leaders that are suffering greatly. It is a tragedy.

As we look at Montana Tribes, these serious, sometimes dire healthcare needs, they need adequate medical facilities. After all, you cannot provide healthcare if you do not have sufficient space to do it, as Chairman Murkowski and Ranking Member Udall have just highlighted.

The Fort Belknap Indian Community, for example, needs funding to expand their IHS clinic, which was constructed in 1998. It does not provide sufficient services according to an IHS environmental health and engineering department evaluation conducted just this May.

The Chippewa Cree Tribe, meanwhile, still needs millions to rebuild much of their clinic, which was destroyed by a flood 7 years ago in 2010.

As you note in your budget justification, and I quote, "The construction and modernization of IHS infrastructure through healthcare facilities construction is essential to improve healthcare, quality, safety, cost, and value."

Admiral Weahkee, I know this has already been part of today's discussion, but I would also like to ask, how do you expect these needs to be met while proposing to cut funding to the construction account? And what would you say to those Tribes within enduring healthcare facilities construction needs?

Admiral WEAHKEE. Thank you, Senator Daines.

I would like to first address what you started with, which is the level of commitment within our agency. More than 70 percent of our staff of 15,400 employees are American Indians and Alaska Natives themselves, so myself included.

The care that we are providing is very personal. It is our families. It is our moms. It is our aunts. It is our daughters. It is our wives. So we have one of the most committed workforces that you can ever imagine.

Senator DAINES. But let me just say, I do not dispute the commitment. But having spent 28 years in business where I was accountable for results, you can have the most committed team in the world, and that is a good start. But what really matters is outcomes and results, with all due respect.

Admiral WEAHKEE. Thank you, sir.

In terms of facility construction and maintenance costs, we have our expert here who I will definitely turn to.

Again, drawing on my experience as a Chief Executive Officer both in Phoenix and for a period at Rosebud, if you do not have the funds available through your appropriated accounts, you definitely rely on those third party resources to take care of life safety, environment of care concerns.

I will ask Mr. Hartz if he has anything else to add in terms of funding streams.

Mr. HARTZ. Thank you, sir. Senator Daines, good to see you again.

Senator DAINES. Likewise.

Mr. HARTZ. You and I probably think a whole lot alike as engineers.

Senator DAINES. We can form the geek caucus here, if you would like.

FACILITIES

Mr. HARTZ. We do provide products for the Indian Health Service. The products that I provide are part of accessing quality healthcare and that is the facilities that we build.

As you know, and all of you in the room probably know, 5-plus years ago, the American Society of Civil Engineers put out the report on the crumbling infrastructure across this country. That covered roads. That covered wastewater treatment plants, water plants. It covered everything related to infrastructure.

IHS has an infrastructure, as was pointed out earlier, in the report to Congress that we provided in 2011 and that 5 years later we reported to Congress per the law and the mandated report, we indicated what that need was for facilities. It is \$10.5 billion for existing plant for replacement and expansion. And then the new authorities are another \$4-plus billion. So in that report a year ago, it showed the need. There is no question about it.

When we come to presenting a budget, our priority is to provide the highest level we can for healthcare to the American Indian and Alaska Native with the resources available. You are right. We had to look at where could we address.

Senator DAINES. Yes, we are running out of time and thank you for the civil engineering perspective here. I will be working with the subcommittee—

Mr. HARTZ. Okay.

Senator DAINES [continuing]. For funding increases, so that we can get the Chippewa Cree, the Fort Belknap, and the other Montana Tribes' needs addressed.

INDIAN HEALTH BOARD—BILLINGS CONTRACT

As I am running out of time, I have one last question and that is the Indian Health Board in Billings, Montana. On May 2, the Indian Health Board of Billings closed until further notice because the contract with IHS expired.

This program delivered ambulatory care, substance abuse services, health education, and mental health and social services to about 860 Tribal members living in the area.

When we can expect that to reopen?

Admiral WEAHKEE. Thank you, sir. I have become aware in the first couple of weeks of this closure.

Admiral Buchanan is much closer to the specifics of the Billings Urban Indian program and I would like to ask him to respond.

Admiral BUCHANAN. Thank you, sir.

Of course, as you mentioned, the facility closed in April. We have been working closely with those 846 patients that you have identified. We have provided community and town hall meetings to address some of their concerns. We provided information and coordinated some of their care when the facility closed. They are currently receiving care through transporting them to the Crow service unit to provide that care.

To specifically answer your question related to when will that open. We are currently submitting a request for proposals to reopen a similar type facility.

Senator DAINES. When do we expect that to open, then?

Admiral BUCHANAN. It is currently going through the contracting process.

Senator DAINES. What is your best estimate?

Admiral BUCHANAN. It would just be a guess, so I would hate to guess for you right now.

Senator DAINES. A couple of months, a couple of years, a couple hundred years?

Admiral BUCHANAN. Less than 2 months.

Senator DAINES. Thank you. That brackets it. I appreciate that.

Well, I urge you to get that back up and running as soon as possible. Work with these affected Tribal members to ensure they are receiving the care they need in the interim.

Thank you.

Senator MURKOWSKI. Thank you, Senator Daines.

I just have a couple of more quick things and then we will be able to wrap here.

MANILAAQ VS. BURWELL

There was a recent case involving a Tribal clinic in Alaska. This is "Manilaaq vs. Burwell," and it established that Section 105(L) of the Indian Self-Determination Act mandates payment of leasing

costs when Tribal facilities are used to operate IHS programs. But the budget proposal would override this Section with the notwithstanding clause that would make such lease payments entirely discretionary within the agency.

Given that this language would affect one of the most important statutes governing Indian country, the question to you this morning is whether or not this proposal has been shared with the Chairman and the Vice Chairman of the Senate Indian Affairs Committee, both of whom are on this subcommittee. Of course, Senator Udall is the Vice Chair and Senator Hoeven is the Chair.

So has this been shared with the authorizing committee and what is their view on this issue?

Admiral WEAHKEE. I am not quite up on the specifics of this particular case. I will ask Miss Fowler to respond in our behalf.

Senator MURKOWSKI. Okay.

Ms. FOWLER. Thank you for the question.

This is the group of leases that I mentioned in my response about the Village Built Clinics. This has been emerging, it is an emerging issue. It has not been shared with the authorizers yet as we are still evaluating the impact and the full scope of funding needs that would be associated.

Senator MURKOWSKI. Let us separate it from the funding needs. But do you think that it is reasonable that Indian Tribes and Tribal organizations should essentially be required to donate the use of their space to operate healthcare programs that are a Federal responsibility according to this Federal court decision?

Ms. FOWLER. We do support the Indian Self-Determination and Education Assistance Act fully. But the issue at this point is the funding that is needed to implement it.

Senator MURKOWSKI. Well, yes. Let us go back a little bit, because we spent years arguing over Contract Support Costs. What would happen is Contract Support Costs would be short-changed, short-funded, and years of litigation, lots of money spent on good lawyers to argue that case.

The Supreme Court comes back and says, "Yes, in fact, you do have to pay full funding for contract support costs." And even with that directive, the budgets would come back at less than full funding.

So we are finally, I think, beyond that where we have had several years now of full funding. Again, I mention that we have the language out there that says you cannot rob Peter to pay Paul in the various accounts. So we have made headway there.

I would like to think that we are not going to be going down another path with the same situation where we acknowledge that there is a Federal responsibility. There is a Federal court decision that says, "You need to do this." And we say, "Well, we cannot do it because we are moving dollars in other areas."

So my hope is that we are not going to continue to spend a lot of money with lawyers and courts, but that we will recognize that there is a responsibility here on the Federal side.

I am looking through the rest of my questions here and, again, I come back to the concerns that so many of us have raised on the panel here this morning. That with this budget, whether it is the

facilities and maintenance backlog that we are dealing with and the real pressing need.

Whether it is the opioid crisis that is hitting our Native people at astonishing rates; we see it all over the country. We are looking at a 6 percent cut, almost \$13 million, in the budget for alcohol and substance abuse programs, within the domestic violence initiatives.

Again, I think about the headway that we have been making, that we must continue to make, and I find difficulty with this budget in terms of how we can advance that.

So know that you have a lot of passion, a lot of energy, a lot of purpose with this subcommittee to help you with delivery of the services and the support for our Native people.

I look with great pride at what Alaska has done. You mentioned the Nuka model. I think it is innovative and pioneering in a way that the rest of the country should look. If we want to reform our healthcare delivery, reduce costs, increase satisfaction amongst patients and providers, look no further than the Nuka model.

Unfortunately, we are not looking to the Nuka model. Other nations are looking at it. But within our own IHS system, we have allowed for that flexibility to do some astonishing and great things.

With the joint venture program, we have some facilities that are the model and the envy of providers and folks around the country. You go to Nome. You go to Bethel. We have an opportunity coming on in Bethel, but in other areas we have seen some great things.

But I feel like within IHS, there are two worlds going on here. Well, I have not had an opportunity to go out to Rosebud or to Pine Ridge. It breaks my heart to think that we have such disparities with how we are providing for healthcare for our Native peoples. And so if it is greater flexibility that we need, if we need to completely restructure the system.

I was speaking with my Ranking Member here. We have been on the subcommittee here for a while. We both have been on Indian Affairs, I think, since both of us came to the Senate. Year, after year, after year, it is the same, sad story and the frustration that Senator Tester has clearly portrayed here today followed up by Senator Daines. We are not getting mad at you as an individual.

There is anger. There is frustration, and rightly so, because as a government, as an agency, we are failing these people. And there is a lot of focus right now on healthcare around the country and what we do to make it right. But in the meantime, you have an injustice going on that is tucked away.

Look at how many people are in this hearing room. Ten. Who is paying attention to the failures? Not enough and apparently, that is why it is allowed to continue. But we cannot and we will not. We have got to get the attention of some folks within the administration. Maybe we need to get the President out to Rosebud or Pine Ridge. Maybe that will make a difference.

But we cannot allow this to continue and there is a lot of good will. I want to make sure that the people who have that good will are reinforced, are given the support that they need, and the belief in knowing that every day they are trying to do the right thing.

So work with us on this. We have a lot to do.

Senator Udall, any follow up there?

Senator UDALL. I think I am okay. Thank you very much.

Senator MURKOWSKI. Okay. Thank you.

The hearing record will remain open for 10 days. Senators may submit additional information or questions for the record within that time if they would like. The subcommittee requests all responses to questions for the record be provided in an expedited manner.

CONCLUSION OF HEARINGS

Senator MURKOWSKI. Thank you for being here and the subcommittee stands adjourned.

[Whereupon, at 11:18 a.m., Wednesday, July 12, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]