

DEPARTMENT OF THE INTERIOR, ENVIRONMENT, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2019

WEDNESDAY, MAY 23, 2018

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

The subcommittee met at 9:30 a.m., in Room SD-124, Dirksen Senate Office Building, Hon. Lisa Murkowski (Chairman) presiding.

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

INDIAN HEALTH SERVICE

STATEMENT OF REAR ADMIRAL MICHAEL D. WEAHKEE, ACTING DIRECTOR

ACCOMPANIED BY:

**REAR ADMIRAL MICHAEL TOEDT, M.D., CHIEF MEDICAL OFFICER
GARY HARTZ, DIRECTOR OF THE OFFICE OF ENVIRONMENTAL
HEALTH AND ENGINEERING
ANN CHURCH, ACTING DIRECTOR OF THE OFFICE OF FINANCE
AND ACCOUNTING**

OPENING STATEMENT OF SENATOR LISA MURKOWSKI

Senator MURKOWSKI. Good morning, everyone. The subcommittee will come to order. Today we will examine the fiscal year 2019 budget request for the Indian Health Service. I would like to thank Rear Admiral Michael Weahkee, the Acting Director for the Indian Health Service, for appearing before us today. I think we all know that the head of IHS is a tough job. It is a hard job, but it's also a very critical one for us, whether you're in Alaska, New Mexico, or wherever. Certainly, in Alaska, where healthcare for Alaska Natives is delivered through compacts between Tribal organizations and the IHS, we take a very keen look at all that goes on through IHS, and, Admiral, you certainly know that.

Director Weahkee is accompanied by Rear Admiral Michael—am I saying it right, Toedt?

Admiral TOEDT. Yes.

Senator MURKOWSKI [continuing]. Who is the Chief Medical Officer at IHS. Gary Hartz has been before the subcommittee multiple times. He is the Director of the Office of Environmental Health and Engineering. And we're also joined by Ann Church, who is the Acting Director for the Office of Finance and Accounting. We welcome all of you.

The IHS budget request for fiscal year 2019 is \$5.4 billion for programs within this subcommittee's jurisdiction. This is a decrease of \$114 million, which is 2 percent below last year's enacted level. The budget proposes to change the Special Diabetes Program, which provides \$150 million annually from a mandatory spending program to one subject to the discretionary appropriations process. However, Congress has already passed legislation to maintain this program as mandatory funding for fiscal year 2018 and fiscal year 2019. This is a course going forward that I certainly support.

I'm pleased that the budget request provides full funding for Contract Support Costs by maintaining the indefinite appropriations language that I first included in fiscal year 2016 appropriations bill. This has helped provide certainty for Tribes and protected other IHS programs in case additional funds are needed to meet the Government's legal obligations.

While this is an important area of agreement and this budget has less reductions than others we have seen in this subcommittee's jurisdiction, I am very concerned that the budget request does not adequately meet the needs for healthcare delivery in Indian Country.

The facilities appropriation is cut by 42 percent from \$867 million to \$506 million. This is a tough one for me to understand when we have a current backlog of facilities on the Service's construction list at over \$2 billion. The total need for facilities construction across Indian Country is estimated at \$14.5 billion. Again, you've got incredible need, and we're seeing a pretty significant cut being proposed.

I'm also concerned that the budget does not adequately address the opioid epidemic. This has been especially acute for American Indians and Alaska Natives. Unfortunately, the statistics that we see are shocking, they're intolerable, and they must be addressed. According to the Service's budget justification, American Indians and Alaska Natives had the highest drug overdose death rates in 2015. Equally distressing, the justification shows a 519 percent increase in drug overdose deaths from 1999 to 2015, which is the largest percentage increase of any population out there. This population of our Native people are dying of overdose deaths at a greater rate and a greater percentage than any other population in the country.

The CDC has also reported that American Indians and Alaska Natives consistently had the highest drug overdose death rate by race every year from 2008 to 2015. When we're looking at opioids specifically, overdoses have increased fourfold during this time-frame. I know it's an epidemic. It's hitting us all across America, but when we see the impact to this population, it does cause us to question what we are doing because it certainly is not adequate.

Your budget request indicates that the IHS will receive \$150 million if the overall \$10 billion request for opioid treatment programs through the Department of Health and Human Services Department is provided. But given the scale of this problem in Indian Country, I would have preferred that these funds were requested directly within the IHS budget so that this subcommittee would have more control over ensuring that you have adequate resources to address this issue.

For the last 2 years at these budget hearings, I have asked what steps the agency is taking to address the chronic problems with healthcare delivery in the Great Plains region, and I have yet to be convinced that the Service has put in place an effective plan to address this issue. At last year's budget hearing with you, Admiral Weahkee, we discussed at length an article that had just been published in the *Wall Street Journal*. It was an investigation that documented multiple instances of patient deaths and deplorable conditions at the Winnebago, Pine Ridge, and Rosebud Hospitals. The Centers for Medicare & Medicaid Services (CMS) removed the certification for some of those facilities so they could no longer bill Medicare or Medicaid. As of July of last year, the Winnebago Hospital had not received recertification from CMS, and the Rosebud and Pine Ridge Hospitals were still operating under System Improved Agreements with CMS. So I'll have an opportunity to ask further about that in my questions.

In the omnibus appropriations bill, the subcommittee took a number of steps to address the situation in the Great Plains and elsewhere in IHS. We doubled the amount of funds to address accreditation emergencies from \$29 million to \$58 million. We provided \$11.5 million for staffing quarters to alleviate housing shortages for healthcare professionals. And we gave the agency new statutory authority to directly pay for housing subsidies for medical personnel to help with recruitment and retention in remote locations like the Great Plains.

I'll be asking you for an update on the situation there and what specific steps you're taking to address those problems. I think the reality is that this quality of care—and I wouldn't call it quality, I would say it's a shameful quality of care—has gone on for far too long. I hope that this morning you'll be able to give some assurances to the subcommittee that the agency is on a path to finally resolve this situation. We have many questions for you. We appreciate your appearance before the subcommittee. I now turn to my friend and Ranking Member, the Senator from New Mexico.

STATEMENT OF SENATOR TOM UDALL

Senator UDALL. Thank you very much, Chairwoman Murkowski. And, Senator, you mentioned this whole issue of prescription drug and opioids, and I really look forward to working with you on that issue and working with our leaders at the Indian Health Service to see that we really tackle that issue.

And I'm also happy to welcome the Acting Director of the Indian Health Service, Rear Admiral Michael Weahkee.

Welcome back, Admiral Weahkee. I am very pleased to remind the subcommittee, my subcommittee colleagues, of your New Mexico roots.

I'd like to acknowledge the other officials, which the Chairwoman also did, but I'll do it again: Rear Admiral Toedt, Rear Admiral Gary Hartz, and also Ms. Ann Church. Thank you all for being here with us today.

I would also like to recognize the important work that my chair, Senator Murkowski, has done in support of the IHS budget. Since I joined this subcommittee in 2015, I'm proud that we have in-

creased funding for the Indian Health Service by 19 percent. We've done some good work, but we have much more to do.

And speaking of that, let's turn to the budget. I appreciate that the administration's proposal for the IHS is relatively generous by comparison to the rest of the President's budget request, but the budget before us is still wholly insufficient to meet this Nation's trust and treaty responsibilities and provide quality healthcare to American Indians and Alaska Natives. All told, the budget decreases funding for the Indian Health Service by 2 percent.

Within that amount, the budget does increase funding for contract support costs, which is very important. It also recognizes the need to pay for staffing for new healthcare facilities and the need to continue investments to address urgent accreditation issues at the IHS facilities in the Great Plains and, as of late last year, the Gallup Indian Medical Center in New Mexico.

But to fund these priorities, the Executive takes an ax to other critical programs. Facilities programs are cut by 42 percent. Line item construction funding that's needed to build hospitals and health centers for Tribal communities in New Mexico and other States have been waiting for decades is cut by two-thirds. Funding for the Indian Health Professions program, dollars that go directly towards filling vacancies and improving access to quality healthcare, are cut by 12 percent. Urban Indian programs, purchased and referred care, and self-governance programs are all reduced. Preventive programs are cut in half, even though Native Americans face some of the biggest challenges when it comes to access to healthcare.

And much to the dismay of many Tribes in New Mexico that I've heard from, the budget even proposes discontinuing Federal funding for community health representatives. These are Tribal members who provide essential healthcare services when health clinics are closed or too far away. These tradeoffs are unacceptable, especially when we think about the work that remains to improve health outcomes in Indian Country.

Despite the fact that this subcommittee has fought to increase the Indian Health Service budget, we're still not where we need to be. We're still not providing all the resources on the ground we need to address preventive care or to attack the epidemic level of mental health and addiction issues that Native communities are fighting to overcome, which I think my chairman was very eloquent about in her opening. We still have an unacceptable number of facilities dealing with accreditation problems, a problem that seems to be growing instead of shrinking. We're still seeing double-digit vacancy rates for doctors, nurses, and other clinical personnel. And despite some important increases just gained in the omnibus, we're not making the progress we need to replace the Service's aging healthcare facilities. This is a matter of setting priorities, and my view is that this administration needs to work with Congress and make funding for Tribal health programs a greater priority.

While we're talking about priorities, I also want to stress a subject that's important to all of us on this dais, and that's respect for government-to-government relationship that the United States Government has with Tribal nations. I have been deeply concerned by certain administration policies reflecting this relationship. This

includes rejecting requests from Tribal leaders who ask to be exempted from State Medicaid proposals that would take healthcare coverage away from Tribal members who do not meet new work requirements.

That's why I joined a number of Members in January of this year to write the Department. We questioned the Department rejecting the request based in part on the rationale that granting such requests would, and quote, this is the quote, raise civil rights issues, end quote. I recognize decisions related to Medicaid are made by the Centers for Medicare and Medicaid Services, and not the IHS, but the question of how the administration views government-to-government relationships with Tribes is much bigger and more significant than any one program or bureau. I want assurances that the Tribal leaders, and the Tribal leaders deserve assurances, that this administration views its relationship with Native Americans as trust-based, not race-based. Taking the latter position would reverse two centuries of law and Supreme Court decisions that have very firmly underscored the political nature of this unique relationship. That would be a nonstarter. I know that I'm not alone in this position, and I expect this administration will face stiff bipartisan opposition if it tries.

It also bears emphasis that any changes that discourage Tribal participation in Medicaid would also impact the Service's bottom line. Thanks to Medicaid expansion under the Affordable Care Act, IHS has expanded access to healthcare for Tribal members and greatly increased its third-party reimbursements. So I would also have serious concerns, both legal and fiscal, and about any effort to limit the ability to use Medicaid funds to supplement IHS doctors—IHS dollars—and doctors, of course.

I look forward to talking more about this issue and many others when it's time for questions.

And thank you very much, Madam Chair. I yield back.

Senator MURKOWSKI. Thank you, Senator.

With that, we will now turn to testimony.

Admiral Weahkee, again welcome. And, ladies and gentlemen, thank you for being here.

You may proceed, Admiral, with your comments. Do the other members of the panel also wish to make statements this morning?

Admiral WEAHKEE. Just myself starting, ma'am.

Senator MURKOWSKI. Very good. Well, we will use them as your backup resources.

Admiral WEAHKEE. Excellent.

Senator MURKOWSKI. Excellent. Why don't you proceed.

SUMMARY STATEMENT OF REAR ADMIRAL MICHAEL D. WEAHKEE

Admiral WEAHKEE. Thank you. Good morning, Chairman Murkowski, Ranking Member Udall, and Members of the subcommittee. I'm Rear Admiral Michael Weahkee, Acting Director of the Indian Health Service. I want to thank you for your support and for the opportunity to testify on the President's 2019 budget.

This budget advances our mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. And the IHS provides Federal health

services to approximately 2.2 million American Indians and Alaska Natives from 573 federally recognized Tribes in 37 States.

The President's fiscal year 2019 budget proposes \$5.4 billion in total discretionary budget authority for the IHS, which is an increase of \$413 million above the continuing resolution, which was the comparison level at the time that the budget request was developed.

The budget reflects the administration's strong commitment to Indian Country by protecting direct clinical healthcare investments. It increases IHS's discretionary budget authority by 8 percent. In order to prioritize direct clinical healthcare services, the budget also proposes to discontinue the Health Education Programs and the Community Health Representatives Program.

The budget request includes \$58 million to address accreditation emergencies within IHS and to improve the quality of care, \$955 million for the Purchased and Referred Care program, \$80 million for the construction of two facilities on the healthcare facility construction priority list, \$159 million to staff six new or replacement healthcare facilities, including three joint venture projects, and an estimated \$822 million to fully fund contract support costs, which remains a separate and definite appropriation to guarantee the full funding.

The IHS remains committed to addressing behavioral health challenges, including high rates of alcohol and substance abuse, mental health disorders, and suicide in Native communities. The proposed budget for these services is \$340 million, and, further, the budget provides \$10 billion across the entire Department of Health and Human Services to combat the opioid epidemic and serious mental illness. As part of this effort, the budget includes \$150 million specifically for the IHS for grants based on need for opioid use prevention, treatment, and recovery support in Indian Country.

The Special Diabetes Program for Indians is instrumental in improving access to diabetes treatment and prevention services in Indian communities. And diabetes-related health outcomes have improved significantly. The long-time trend of increasing rates of diabetes ended in the year 2011, and we've observed a 54 percent decrease in new cases of kidney failure due to diabetes among Native adults. The budget continues funding for this program at \$150 million.

We're working aggressively to address the quality of care issues across our system, and in spite of ongoing challenges that we face involving recruitment and retention of providers, aging infrastructure, rural health facilities, we are able to report some progress.

At the Pine Ridge Indian Hospital, a February CMS survey found the hospital to be in compliance with the condition of participation for emergency services. Since that time, the IHS has self-identified some additional deficiencies that will require more time for remediation before a full resurvey can occur.

The Rosebud Indian Hospital satisfied the requirement of the Systems Improvement Agreement with CMS in September of 2017. And we're now awaiting resurvey by the Joint Commission at that site.

And at the Indian Health Service Omaha-Winnebago Hospital, we're actively working with both Tribes to discuss Tribal assumption of the hospital operations by this summer.

We're also addressing concerns in the Navajo Area at the Gallup Indian Medical Center. Both the Joint Commission and the CMS have conducted surveys and found the hospital emergency department to be out of compliance with standards and conditions of participation. We moved quickly to address those findings, and efforts to restore accreditation of all their services surveyed by the Joint Commission continue. The facility is now awaiting results of a recent resurvey by CMS.

We've achieved progress in the areas of oversight and management of quality at the national level and some key accomplishments include a credentialing and privileging, policy and process modernization, development of a standardized patient experience survey, and the establishment of primary care patient wait time standards.

I'm proud of the efforts and commitment of the staff for the progress that has been made so far, and we're firmly committed to improving quality, safety, and access to healthcare for American Indians and Alaska Natives. We appreciate all of your support. And I'm happy to answer any questions that you may have. So thank you.

[The information follows:]

PREPARED STATEMENT OF REAR ADMIRAL MICHAEL D. WEAHKEE

Good morning Chairman Murkowski and Members of the subcommittee. I am Rear Admiral (RADM) Michael D. Weahkee, Acting Director of the Indian Health Service (IHS). Thank you for your support and for inviting me to speak with you this morning about the President's fiscal year 2019 budget request for the IHS. This budget supports and advances our mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

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 American Indians and Alaska Natives from 573 federally recognized Tribes in 37 States. The IHS system consists of 12 Area offices, which oversee 168 Service Units that provide care at the local level. Health services are provided through more than 850 facilities managed directly by the IHS, by Tribes and Tribal organizations under authorities of the Indian Self-Determination and Education Assistance Act (ISDEAA), 41 Urban Indian health organizations, and through services purchased from private providers.

Our budget plays a critical role in providing for a healthier future for American Indian and Alaska Native people. Likewise, it helps us maintain the progress we have made over the years. The President's fiscal year 2019 budget proposes \$5.4 billion in total discretionary budget authority for IHS, which is \$413 million above the fiscal year 2018 Annualized Continuing Resolution, which was the comparison level at the time the budget request was developed. It also proposes Program Level funding of \$6.6 billion, which is \$263 million above the fiscal year 2018 Annualized Continuing Resolution.

PRIORITIZING CLINICAL 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. The budget reflects the administration's strong commitment to Indian Country. Specifically, the budget protects direct clinical healthcare investments and increases IHS's discretionary budget authority by 8 percent. In order to prioritize direct clinical healthcare services and the staffing of newly-constructed healthcare facilities, the budget proposes discontinuation of the Health Education Program and Community Representatives Program.

The budget requests an increased level of funding to address accreditation issues in the IHS system and improve quality of care. An additional \$29 million is requested over the fiscal year 2018 Annualized Continuing Resolution level for a total of \$58 million in funding to assist IHS-operated hospitals that are at risk or out of compliance with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation. These funds will be used to address CMS findings and may be used to sustain operations of any affected service unit.

The budget increases Purchased/Referred Care program funding that is essential for ensuring access to care by our patients by providing \$955 million, which is \$32 million above the fiscal year 2018 Annualized Continuing Resolution. This program provides critical healthcare services through contracts with hospitals and other healthcare providers to purchase specialized or critical care when IHS and tribally-managed facilities are unable to provide the services directly. In addition, it supports high-cost medical care for catastrophic injuries and specialized care.

ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH DISORDERS, AND SUICIDE

The IHS remains committed to addressing behavioral health challenges, including high rates of alcohol and substance abuse, mental health disorders, and suicide in native communities. The proposed budget for these services is \$340 million, which is \$30 million above the fiscal year 2018 Annualized Continuing Resolution. Further, the budget provides \$10 billion in new resources across HHS to combat the opioid epidemic and address serious mental illness. As part of this effort, the budget includes an initial allocation of \$150 million for IHS to provide multi-year grants based on need for opioid abuse prevention, treatment, and recovery support in Indian Country.

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. These funds have been instrumental in improving access to diabetes treatment and prevention services for American Indians and Alaska Natives. Since 1997:

- 97 percent of American Indians and Alaska Natives have access to diabetes clinical teams, a 67 percent absolute percentage increase.
- 95 percent of American Indians and Alaska Natives have access to culturally tailored diabetes education programs, a 59 percent absolute percentage increase.

These efforts have had an impact. Diabetes-related health outcomes have improved significantly in Indian communities since the inception of the SDPI. Within our communities, the longtime trend of increasing rates of diabetes ended in 2011. The diabetes program has proven successful and has contributed to a decline in new cases of kidney failure due to diabetes of 54 percent among Native adults from 1996 to 2013. In addition, there has been an 8 percent reduction in the average blood sugar level of American Indians and Alaska Natives with diagnosed diabetes between 1997 and 2015. Improved blood sugar control reduces complications from diabetes.

The SDPI grant program provides funding for diabetes treatment and prevention to 301 IHS, Tribal, and Urban Indian health programs. To ensure sustained and additional improvements for the health of American Indians and Alaska Natives, the fiscal year 2019 budget continues funding for this essential program at \$150 million and shifts funding from mandatory to discretionary. Your continued support of these funds is saving lives, improving quality of life, and reducing the cost of care across Indian Country.

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. It also allows IHS to expand the provision of healthcare services by funding staff positions, purchasing new medical equipment, and maintaining and improving healthcare facilities.

ACCESS TO QUALITY HEALTH CARE SERVICES THROUGH IMPROVED INFRASTRUCTURE

The budget proposes \$159 million for staffing of newly constructed healthcare facilities. This funding will support staffing and operating costs for three Joint Venture Construction Program (JVCP) projects: Muskogee (Creek) Nation Health Cen-

ter, the Cherokee Nation Regional Health Center in Oklahoma, and the Yukon-Kuskokwim Primary Care in Alaska. Through JVCP agreements, IHS has partnered with the Tribes to provide funds for staffing and facility operations while the Tribes have invested in the design, construction, and equipment costs associated with the new facilities. These funds will allow the new facilities to expand access to healthcare.

These funds also provide staffing for new or expanded IHS constructed facilities, including Hau'pal (Red Tail Hawk) Health Center in Arizona, the Fort Yuma Health Center Replacement, and the Northern California Youth Regional Treatment Center in California.

The Health Care Facilities Construction budget includes funding to continue construction of two facilities on the priority list: the Alamo Health Center in New Mexico and the Dilkon Alternative Rural Health Center in Arizona. A total of \$80 million is requested, \$38 million below the fiscal year 2018 Annualized Continuing Resolution.

SUPPORTING INDIAN SELF-DETERMINATION

The budget supports self-determination by continuing the separate indefinite appropriation account for contract support costs (CSC) through fiscal year 2019. Authorized 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 \$822 million to fully fund CSC, which is \$22 million above the fiscal year 2018 Annualized Continuing Resolution estimate. 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.

QUALITY OF CARE

We are working aggressively to address quality of care issues across our system. In spite of ongoing challenges involving recruitment and retention of providers, aging infrastructure, and rural health facilities, we are able to report progress.

At the Pine Ridge Hospital, CMS notified us that its survey on February 13–15 found the hospital in compliance with the Condition of Participation for Emergency Services. Since that time, the IHS has self-identified additional deficiencies that will require time for remediation. We have also made several significant leadership changes. Following remediation activities, a full certification survey will be conducted by CMS to ensure compliance.

At Rosebud Hospital, after satisfying the requirements of the Systems Improvement Agreement with CMS in September 2017, the hospital is preparing for Joint Commission accreditation this summer. Our application for survey was submitted to the Joint Commission in January, and we look forward to their review.

The IHS Omaha-Winnebago Hospital is also in a transitional phase as discussions with local Tribes occur related to Tribal assumption of facility operations as early as this summer. We are actively working with Tribal leaders to discuss the status of the hospital and ensure maximum success as they exercise their self-determination rights for operation of the hospital.

In the Navajo Area, we are addressing concerns at Gallup Indian Medical Center. Specifically, the concerns derive from a Joint Commission unannounced survey in November 2017 that also triggered a CMS survey in December 2017. The surveys found the hospital Emergency Department out of compliance with the Joint Commission standards and CMS Conditions of Participation. We moved quickly to address these issues, and the hospital remedied the findings. Efforts to restore accreditation of all services surveyed by the Joint Commission continue. The facility also shifted under CMS's survey authority for Medicare Program compliance and just received a full CMS survey.

We developed the Quality Framework with Tribal input, and brought together people and expertise from across the Department of Health and Human Services to focus efforts on improving the quality of care and patient safety. The Quality Framework has been a blueprint for system level improvements of processes and infrastructure to improve quality and safety throughout the agency. We have achieved remarkable progress in the areas of oversight and management of quality, modernizing credentialing and privileging policy and processes (aided by new, system-wide software), accreditation master contracts for hospitals and ambulatory health centers, development of a standardized patient experience survey, and the establishment of primary care patient wait time standards. Following a year of implementation of the Quality Framework, IHS is moving toward sustainment of the gains and

improvements with the development of a 5-year strategic plan to enhance quality in all aspects of agency operations.

I especially want to thank the Congress for the funding that has been provided for accreditation emergencies. These funds have been critical to giving IHS the flexibility to address quality issues at impacted facilities and to offset lost third-party revenue, which is critical to the operating tempo of our facilities. The requested \$58 million will be used to build on the improvements we have made to date. IHS does not have another reserve of funding to meet any significant emergency or emergent issues, and our existing reserves are simply not designed to meet a challenge of this magnitude.

Despite all of the challenges, we are firmly committed to improving quality, safety, and access to healthcare for American Indians and Alaska Natives, in collaboration with our partners in HHS, across Indian Country, and Congress. We 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.

RECERTIFICATION/ACCREDITATION

Senator MURKOWSKI. Thank you, Admiral. Let me begin; I'll just follow on what you have just now raised with regards to the facilities in the Great Plains. If I understand, Rosebud is in the process then of recertification, as well as Winnebago. Pine Ridge still has more work to be done before you can get to certification there. For purposes of the satisfaction of certification and then more work to be done, what kind of a timeline can you give me that these facilities are at a point that you would consider to be not only bare minimum, but that you're doing right by the Native people that you're serving there?

Admiral WEAHKEE. Thank you, Senator Murkowski for that question. And I think it varies based on location. If you look at the Omaha-Winnebago site, I think our most challenging issue there has been with the recruitment and retention of permanent stable leadership. So the CEO position, the chief medical, chief nurse officer positions, really that's the top button for all of the other activities that need to be completed.

So with the Winnebago Tribe proposing assumption of that site, they have already, through their own hiring process, obtained a new CEO, and they've got advertisements and plans together to bring on the rest of their C-Suite. Much of the work that has already been accomplished at the Omaha-Winnebago Hospital will prepare them to, very soon after assumption, obtain accreditation on their own.

Senator MURKOWSKI. We doubled the support for accreditation to address these accreditation emergencies, bumping it from \$29 million to \$58 million in fiscal year 2018. Is this sufficient as you address these issues? Do you see the need for us to add to that or, because of the progress that you are seeing, will these costs that are required for this accreditation recertification decrease? I'm trying to understand where we need to be from a budget perspective.

Admiral WEAHKEE. Thank you. Our current projections, we expect to utilize all of the funds that we've been provided, and this is somewhat of a difficult question to answer because we have a lot of unknowns out there. Again, the average age of our facilities being 40 years, many of the issues that we're contending with, a good example being at Pine Ridge, the heating and air conditioning system does not enable us to do enough air exchanges and main-

tain humidity controls, temperature controls, in the operating room suites, and this is a direct result of the facility being built in a previous era.

The standards that we have to meet, the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) standards, continue to get higher—continue to be a higher and higher bar. And so we have to meet the same standards in these 40-year-old facilities that a facility that was just built yesterday has to meet. And so in some cases, that requires the complete renovation of the heating, ventilation and air conditioning (HVAC) system. So in a facility that's aged, Gallup being another great example, was built in the 1950s, our Phoenix facility was built in the late 1960s, at any time there could be a major catastrophic issue with a generating system or a heating and air conditioning system that is very expensive.

OPIOIDS

Senator MURKOWSKI. Let me shift to opioids. As I mentioned in my opening statement, what we're seeing with the opioid epidemic in Indian Country is just shocking. The efforts that you have outlined include \$150 million devoted to opioids in the budget request. I mentioned that my concern is that these funds are not directly in your budget, but that you're relying on funds being appropriated to DHS, and then those funds being transferred to the agency. Is that correct?

Admiral WEAHKEE. Not exactly. The funds that have been provided up to this point, the 2018 omnibus provided the Substance Abuse and Mental Health Services Administration—

Senator MURKOWSKI. Right.

Admiral WEAHKEE [continuing]. With \$50 million targeted to Indian Country. And we had been providing technical assistance to the Substance Abuse and Mental Health Services Administration (SAMHSA) about the mechanisms that we've used, the funding distribution formulas for our Special Diabetes Program for Indians (SDPI) program as an example, so that they can make the best use of those funds and get them out to help as much of Indian Country as possible. So there is no contemplation of moving that \$50 million over to the Indian Health Service, but we are providing them with a lot of expertise and the way that we put money out to Indian Country.

Senator MURKOWSKI. Again, I'm not sure why we are not being more aggressive in this budget, in your budget, with regards to those resources directly to your budget rather than through DHS. My concern is if there is extraordinary need out there all over the country, and if you don't think that every one of us is not going to be fighting for a significant share of those dollars within the budget to go towards opioids, you know, you haven't talked to everybody else out there because it's very keen because the need is so high.

My concern is that IHS will not get the resources that it needs. Again, we're talking about a population here that is more significantly impacted than any other population in the Nation right now. And so the fact that we would not be addressing it more aggressively to ensure that those dollars come here is a concern of mine.

I have more that I want to speak to on this, but let me turn to my Ranking Member.

Senator UDALL. Thank you, Madam Chair.

GOVERNMENT-TO-GOVERNMENT RELATIONSHIP

Admiral Weahkee, I mentioned in my opening statement that I am deeply concerned by some policy statements made by HHS officials that call into question the administration's views of the government-to-government relationship between the United States and Tribes. Specifically, I was alarmed to hear from a number of Tribal leaders earlier this year that CMS wrote a letter rejecting a Tribal-specific Medicaid request because it would, quote, "raise civil rights issues". I understand that CMS recently began walking back this statement as a mischaracterization, but I need, and the Tribes are rightfully demanding, more assurances that the administration understands the Federal Government's unique trust relationship with American Indians and Alaska Natives. And this is a pretty simple yes or no: Did you believe—do you believe that the Federal programs or policies undertaken for the benefit of Tribes are race-based?

Admiral WEAHKEE. Thank you, Senator Udall. My simple yes/no answer would be, no, it's not only race-based, there is a special political and legal relationship between the Federal Government and American Indian Tribes.

Senator UDALL. And prior to Ms. Verma's most recent comments walking back CMS's civil rights issue statements, did you speak with her, Secretary Azar or anyone at HHS Office of General Counsel to educate them about the inaccuracy of describing Tribal-specific considerations as race-based?

Admiral WEAHKEE. There has been robust conversation within the Department at all levels, including not only CMS, but also the Office of Civil Rights within HHS. We've also had our IHS Office of General Counsel heavily engaged in those conversations, educating and informing, and also at the Secretary's Tribal Advisory Committee meeting, of which he's had two since coming into office that he's participated in or that Deputy Secretary Hargan has participated in. There has been a lot of conversation with Tribes about this particular issue as well.

Senator UDALL. That's good. Well, I just—I would emphasize those of you in the Indian Health Service really educating the people in the rest of Government, especially CMS and HHS, which you work with all the time about these specific responsibilities and how, you know, this is in the Constitution, this is a relationship that's a longstanding one, and so we just—we just need to make sure they don't try to head down that road.

THIRD-PARTY COLLECTIONS

This budget estimates that third-party collections at IHS will remain at \$1.2 billion for fiscal year 2019 with more than two-thirds of that coming from Medicaid reimbursements. It's obvious that Medicaid, and specifically the Medicaid expansion, authorized under the Affordable Care Act, contributes significant funding toward Tribal healthcare. Medicaid is not a substitute for full funding for IHS, but until we can address funding shortfalls in the

Service, Medicaid is one of the most important stopgaps we have. That's why I'm concerned that recent actions by CMS allowing some States to impose extra eligibility barriers would take away Medicaid access for Native communities.

Admiral Weahkee, has IHS looked at the potential impact the proposals to take health coverage away from people who do not meet new work requirements could have on Native health systems? What about impacts on IHS's opioid response efforts or on Native families with school age children?

Admiral WEAHKEE. Thank you, Senator Udall. Since last year's hearing, we've put a lot of investment and time and energy into the development of better business analytics, looking specifically at third-party reimbursements with a close eye on Medicaid reimbursements on a State-by-State and even at a facility-by-facility basis. We've leveraged some technology called Qlik, QlikView, which has enabled us to drill down into the data and look at the differences between Tribal programs that are within States that have expanded versus those that are not. And there's definitely—we can identify some trends in terms of better reimbursement in those States that did move forward with expansion.

There are some anomalies in the data, a lot of asterisks and caveats, if you will. Our data is available through our fiscal intermediary, and only those Federal sites that report through that system are available to us, and a very small handful of Tribal sites.

So a good anomaly to point out would be the State of Arizona, which had an expansion, and yet we saw a decline in our data in the amount of funding that was received, and that was a result of some of the large programs, like San Carlos and the Sells Hospital contracting or compacting their facilities. So they've moved outside of our datasets. And very likely if we had—if we were privy to their data, we would see an increase, but these are just the types of caveats that we've got to report.

And, of course, we looked at the CMS data last year, and they don't get into the level of specificity that's helpful to us. They report out what is paid for American Indians and Alaska Natives at the State level regardless of which facility they receive their services in.

Senator UDALL. Yeah. And I also hope that you've spoken with CMS Administrator Verma about how the agency's efforts could repress healthcare access in Native communities. I think it's important for you and your team to educate them on how the Indian Health Service has really been lifted up by the Affordable Care Act.

Thank you, Madam Chair.

Senator MURKOWSKI. Thank you, Senator.

Senator Van Hollen.

Senator VAN HOLLEN. Thank you, Madam Chairman.

And welcome to all of you.

Admiral Weahkee, great to have you before the subcommittee. And I'm very proud of the fact that the Indian Health Service is based in Rockville, Maryland, and I look forward to continuing to work with you.

COMMISSIONED CORPS

I have a couple questions as to how other parts of the administration's budget impact the operations for the Indian Health Service. One has to do with the role of the Public Health Service Commissioned Corps. I think the Ranking Member mentioned the large vacancy rate for clinicians at the Indian Health Service. The last data I've seen is for September 2016, which showed a 19 percent vacancy rate.

So my first question is, Is there an updated figure for the vacancy rate with respect to clinicians? Are you still experiencing roughly 19 percent shortfall?

Admiral WEAHKEE. Thank you, Senator. Yes, right about 20 percent for all—all clinical professions, and much higher in some areas, such as physicians and PAs and nurse practitioners—

Senator VAN HOLLEN. Right.

Admiral WEAHKEE [continuing]. Up to 34 percent in some cases.

Senator VAN HOLLEN. Thank you. My understanding is that in the last fiscal year, there were 1,869 members of the U.S. Public Health Service Commissioned Corps providing clinical care and managing IHS programs. There's not a line item anywhere in the entire budget for the Public Health Service Commissioned Corps. I just want to get your assessment of how important those officers are to providing health through the Indian Health Service.

Admiral WEAHKEE. It cannot be overstated, in my opinion, sir. Being a member of the Commissioned Corps myself, three of the Members here at the table are either current or retired Commissioned Corps officers. We do employ approximately one-third of all Commissioned Corps officers in the Federal Government within the Indian Health Service. And the manner in which those officers are paid are directly from the agency's budget or from the Tribes' budgets once they've 638'd their facilities. They pay through a memorandum of agreement, full cost recovery, for the use of those officers.

Senator VAN HOLLEN. Well, we're working in other subcommittees to make sure that the budget for the Public Health Service Corps is adequate.

MEDICAID

I'm going to ask you a question that came up at the hearing last year with respect to the proposed administration cuts to Medicaid. The budget proposes getting rid of the Medicaid expansion. It also proposes deep cuts to Medicaid over the next 10 years. It essentially tracks what is called the Graham-Cassidy proposal on Capitol Hill. Every Member of this subcommittee, the Chairman, Ranking Member, myself, have been very concerned about the impact of Medicaid cuts on providing healthcare.

And last year at this subcommittee hearing, I asked you, and I think Senator Tester asked you, for an analysis of the impact of the proposed administration Medicaid cuts on the services that are provided to individuals in Indian Country, because I believe—and let me know if this has changed—that about 70 percent of the third-party payers for healthcare come from Medicaid. Is that still correct?

Admiral WEAHKEE. The most recent figure is 68 percent, sir.

Senator VAN HOLLEN. All right. So 68 percent of the third-party payments come from Medicaid. So clearly cuts to the Medicaid program would have a harmful impact on providing healthcare through the Indian Health Service, right?

Admiral WEAHKEE. We are very much reliant upon all third party including Medicaid specifically.

Senator VAN HOLLEN. So what I would like is an analysis, an actual analysis, of that impact. And last year I asked for that impact, and the Chairman of the committee said it would be important to have. It turns out that what we received was completely non-responsive. I asked for an impact of the proposed administration Medicaid cuts, and the response I have, and I will share it with the Chairman and Ranking Member, didn't even mention Medicaid, right? It was just a reiteration of the budget of the Indian Health Service. So what I'm going to ask you today, and I hope the Chairman and Ranking Member will support this, is for you to give us, if you don't have it already handy, an analysis of what the impact of the Medicaid cuts proposed in this budget would be on your ability to carry out the mission of the Indian Health Service. Can we get that?

Admiral WEAHKEE. As mentioned, there is a lot of variation State by State. We have invested heavily in our data analytics capabilities. We do have the ability to provide much better data than what was provided last year, and we'll be happy to provide you with a State-by-State or even facility-by-facility look.

[The information follows:]

MEDICAID REIMBURSEMENTS TO INDIAN HEALTH SERVICE—DIRECT AND TRIBALLY OPERATED FACILITIES AS REPORTED VIA CMS 64 REPORTS, FISCAL YEAR 2016 TO FISCAL YEAR 2019

For additional details regarding Medicaid, summary reports of each State's total IHS expenditures for the year from CMS, known as the "CMS 64 Reports," for fiscal year 2016–fiscal year 2019 has been prepared and is enclosed. The reports include Federal reimbursement to State Medicaid programs for services eligible for 100 percent Federal Medical Assistance Percentage provided by IHS and Tribal Health Programs operated under Public Law 93–638, the Indian Self-Determination and Education Assistance Act. The reports identify State-reported expenditures that include all adjustments for the year. Negative totals for the year may occur when the negative adjustments (amount of funds returned to CMS) are greater than expenditures claimed during that year. States may request adjustments in expenditures up to 2 years after the respective quarter of expenditures. Regarding instances of relatively high year-to-year variability, States have flexibility in reporting expenditures to CMS and may need to make increasing or decreasing adjustment throughout the year which may affect the yearly total expenditures reported. In addition, as stated previously, States have up to 2 years to adjust their expenditure claims for prior quarters due to incorrect reporting issue or unreported claims.

The enclosed report was created on December 2, 2019.

MEDICAID REIMBURSEMENTS TO INDIAN HEALTH SERVICE—DIRECT AND TRIBALLY OPERATED FACILITIES AS REPORTED VIA CMS 64 REPORTS, FISCAL YEAR 2016 TO FISCAL YEAR 2019

As of December 2, 2019

[Amounts in Dollars]

State	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019
Alabama	8,470,002	435,062	– 400,238	7,438
Alaska	377,112,040	557,109,533	678,881,269	718,667,999
Amer. Samoa	0	0	0	0
Arizona	590,270,498	684,469,755	667,663,919	750,806,090

MEDICAID REIMBURSEMENTS TO INDIAN HEALTH SERVICE—DIRECT AND TRIBALLY OPERATED FACILITIES AS REPORTED VIA CMS 64 REPORTS, FISCAL YEAR 2016 TO FISCAL YEAR 2019—Continued

As of December 2, 2019
[Amounts in Dollars]

State	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019
Arkansas	323,773	568,309	415,103	471,290
California	48,511,225	43,116,935	52,548,916	22,398,157
Colorado	4,647,392	2,435,071	4,747,335	4,773,787
Connecticut	2,796	6,464	22,625	32,055
Delaware	0	0	— 1,076	0
Dist . Of Col.	0	0	0	0
Florida	0	0	0	0
Georgia	0	0	0	0
Guam	0	0	0	0
Hawaii	0	0	0	0
Idaho	2,434,170	3,238,813	3,345,203	3,918,063
Illinois	0	573	0	0
Indiana	0	— 7	2	0
Iowa	1,119,291	1,620,331	1,829,339	2,500,777
Kansas	2,085,198	1,745,596	1,969,819	507,424
Kentucky	0	— 53	0	0
Louisiana	24,027	213	161	1,054
Maine	2,361,924	2,805,569	3,660,661	5,067,450
Maryland	0	0	0	0
Massachusetts	228,829	23,723	235,281	469,195
Michigan	3,700,883	14,296,929	8,753,307	17,843,628
Minnesota	89,341,848	101,903,551	144,506,324	155,425,892
Mississippi	12,040,619	11,847,852	11,338,167	11,662,456
Missouri	0	0	0	0
Montana	64,576,972	91,531,956	116,875,715	128,589,320
N. Mariana Islands	0	0	0	0
Nebraska	14,388,834	6,427,877	11,853,911	16,352,794
Nevada	21,954,675	18,161,599	19,825,021	20,450,693
New Hampshire	0	0	0	0
New Jersey	0	0	0	0
New Mexico	185,245,700	308,778,309	160,660,683	194,165,488
New York	56,063,822	1,958,788	2,050,730	2,142,373
North Carolina	12,622,759	13,582,123	16,809,483	19,762,701
North Dakota	12,150,377	18,002,497	18,023,091	18,296,276
Ohio	0	0	0	0
Oklahoma	129,477,113	184,245,949	218,388,948	242,473,797
Oregon	17,397,527	17,518,429	30,283,306	47,343,288
Pennsylvania	0	0	— 91	— 5,759
Puerto Rico	0	0	0	0
Rhode Island	9,306	4,048	1,104	0
South Carolina	29,429	— 152,777	133,413	59,806
South Dakota	69,761,618	71,644,245	84,500,585	95,059,750
Tennessee	0	0	0	0
Texas	55,036	36,104	57,936	50,512
Utah	3,803,046	8,158,050	5,160,024	10,792,539
Vermont	— 596	— 118	0	0
Virgin Islands	0	178	0	0
Virginia	0	0	— 266,685	0
Washington	93,019,449	110,365,845	138,328,274	141,366,086
West Virginia	0	0	0	0
Wisconsin	20,383,867	29,262,365	21,188,806	37,861,729
Wyoming	10,657,756	15,055,951	30,625,389	29,703,061
Other				
Totals	1,854,271,205	2,320,205,637	2,454,015,760	2,699,017,209

Senator VAN HOLLEN. Thank you. That would be very helpful. I know that you had just been recently sworn in last year, so I'm glad that in the meantime you've upgraded those capabilities because I really think it's important when we're having these conversations to know what the impact of a budget proposal will be. It may not be in this particular subcommittee, but it has a direct bearing, as you indicated——

Admiral WEAHKEE. Yes.

Senator VAN HOLLEN [continuing]. Close to 70 percent, 68 percent to be precise, of the payments that are received come from Medicaid. So I appreciate that and thank you for your—thank you for your service, all of you.

Admiral WEAHKEE. Thank you.

Senator MURKOWSKI. Senator, thank you for raising that. You know, just a year ago there was a lot of focus on various proposals that were being considered as we looked to address some aspects of the Affordable Care Act. One of my great frustrations at the time was trying to get exactly the data that you have referenced broken out that would be specific to my State, which has some unique issues when it comes to delivery of healthcare and the costs associated with it. And we could not get it—and it was not because people were stonewalling us, I think that they just really had not accumulated the data that was necessary to make an informed decision about the impact of the various proposals that were out there. As you know, I ultimately said I can't support any of them because I believe that this is not going to be good for me, but it could not be confirmed nor denied what that actual impact was going to be to our State. So being able to gather the data to be able to count on it, for CMS to be able to count on it, is very important, and I appreciate you raising that again.

Senator VAN HOLLEN. Thank you.

OPIOIDS

Senator MURKOWSKI. Let me go back to the issue of opioids and those issues that are facing us in Indian Country, and facing Alaska Natives. We talk about jobs and workforce development and education, but if we are dealing with a level of addiction that is debilitating to our communities, it makes it really hard to focus on a job, it makes it hard to focus on raising your kids, and it makes it hard to focus on education. Again, I mention my concerns about what we have in this budget with regards to specifically directed towards the opioid issue.

PRESCRIPTION DRUG MONITORING PROGRAM

I want to raise an issue that has come to my attention based on conversations with providers up in the State of Alaska and in Senator Udall's State of New Mexico, relating to the Prescription Drug Monitoring Program. The PDMP, which is focused specifically on how we can deal with the problem of opioid prescriptions, and part of the problem is that if you don't know where an individual has gone before they have come to your facility in trying to access a prescription, then you're operating somewhat blindly. And we now have technologies, we now have the ability to interconnect within our systems to help us be smarter in how we track the prescrip-

tions that are being written. And I think in Alaska, we're a pretty clear example of you have an IHS facility, you've got an emergency room out in the Mat-Su Valley, you've got a clinic, you've got a VA, a Community Based Outpatient Clinic (CBOC) that's there, and you could literally have an individual going from facility to facility to facility almost, if you will, venue shopping for prescriptions.

It has come to my attention that within the State of Alaska, we've got the vast majority of hospitals and pharmacies that are participating in this system, they are being able to upload so that a doctor can tell when a patient already has a prescription. I'm told that within the VA, the DoD, and the IHS, there is reluctance to be a participant in what we are seeing in terms of the sharing through the PDMPs.

DoD and VA we'll deal with. I understand they're coming along, but my information is that IHS has been resistant to participate. And the question is, is that so? And if so, why? Why would you not view this as a tool to really help those that are struggling with this addiction?

If you can speak to that, Admiral, and tell me where we are and whether you believe that this could be an effective tool to combat opioid abuse.

Admiral WEAHKEE. Well, thank you, Senator Murkowski. And just off the bat, I want to assure you that it's a misnomer that IHS is not supportive of reporting to PDMP and participating in a PDMP. In fact, back as far as 2016, we put in place a Prescription Drug Monitoring Program that requires all Federal Indian Health Service practitioners to check the PDMP.

Dr. Toedt has participated in a panel specifically around opioids and can speak very specifically to our work in this area.

Senator MURKOWSKI. Okay.

Admiral TOEDT. Thank you for the question, Senator Murkowski. Certainly, IHS shares the concern about the opioid epidemic, and we appreciate all of the support that appropriators have given to IHS for connecting with PDMPs. We have—of our Federal pharmacies, 82 of the 83 pharmacies are connected, so we're all but one, and that last one we have a Memorandum of Agreement (MOA), or a Memorandum of Understanding (MOU), that's going through the process in Nebraska to connect our final Federal pharmacy. The connections for reporting happen, so the provider gives a prescription to the pharmacy, and the pharmacy reports that data to the State. And we know that in Alaska, our pharmacies are Tribal pharmacies, and we have checked with all of the Tribes in Alaska, and they are all able to connect and report their data to the PDMP.

As far as the providers checking the PDMP to see prescriptions from other pharmacies and other providers, again, each of the States has a different process for access and different ability to do that. So the Alaska PDMP program, any licensed provider in the State of Alaska is able to register. Issues around perhaps individuals having licenses in other States or support staff and what delegations are allowed by what licenses. I think those are the details that need to be worked out. It's not just an IHS issue, it is a broader national issue about access.

And also connectivity. So in border States, we know that the four corners area where you've got Colorado, Utah, Arizona, and New

Mexico, that being able to access all of the data conveniently and in one way is extremely important.

And it's much bigger than an IHS issue. We don't want to have a silo, separate, program that looks at our prescriptions. We entirely support connectivity and appreciate anything that—you know, we will certainly participate and provide any technical assistance if there are additional resources.

Senator MURKOWSKI. Well, I appreciate that, and I would like to understand a little more clearly about how it all intersects, whether it's within Alaska or otherwise. I will just note that there's a couple people that have joined the subcommittee in the audience today, including emergency room physicians that are back here at a conference that were able to present to me yesterday, one from New Mexico, one from Alaska. And the information that I have received is a little bit out of sync with what you have outlined. So I would like to just better understand if it's an issue of licensure, or if there are things that we can do to again reduce these silos. Everything that I have seen leads me to believe that this is one tool, this is one way, that we can work cooperatively amongst our agencies with our providers, with our hospitals, with our pharmacies, to really get at this issue of prescription oversupply, if you will. If we can follow up with this and connect you with the folks that we've been talking to, I would greatly appreciate that. Thank you. Thank you.

Senator Udall, and then we will go to Senator Daines.

MEDICAID CUTS

Senator UDALL. Thank you, Madam Chair. And let me just emphasize what was said earlier. You know, last year we all requested this information when it came to these Medicaid cuts and the impact repealing the Affordable Care Act would have. And when—it seems to me it's incumbent on you when you put forward a budget that has Medicaid cuts in it, you analyze all the impacts, and you're able to tell us specifically, very specifically, what impact is going to happen with specific facilities so that we can know what the result is going to be.

PREVENTIVE HEALTH FUNDING

As I mentioned in my opening, I've heard from a number of Tribes in New Mexico who are particularly concerned about IHS's proposed budget that would cut preventive health funding by \$81 million from fiscal year 2018 levels, including a complete zeroing out of IHS Health Education and Community Health Representatives funding.

As one pueblo leader recently reminded me, community health representatives come from the communities they serve, which means that they have the necessary cultural understanding to identify and respond to their members. That cultural understanding is key to addressing the toughest public health issues on the ground, including substance abuse and addiction. And I would note that one of the key pieces of combating the opioid epidemic is putting more resources towards prevention, both addiction prevention and prescription misuse.

Admiral Weahkee, do you see a misalignment between the goal of addressing prevention as part of a comprehensive opioid response plan and cutting preventive healthcare funding at IHS? Could you talk about the importance of these preventive health programs in addressing the opioid crisis?

Admiral WEAHKEE. Thank you, Senator Udall. And I'll start and then ask Dr. Toedt to support me in this as well.

With regards to the proposed cuts for both the Community Health Representative and the Health Education Programs, there are some concerns that have been expressed internally with the data that was available to be able to justify that these programs were efficient, effective, and accountable. Since this proposal has been released, we've had robust discussions with Tribal leaders and other external stakeholders about the importance of the Community Health Representative (CHR) programs and how they play a major role in our interdependent system of care. And they are the ones who are out in the community checking on elders and others with chronic healthcare conditions in some of the most rural, remote locations.

So I've come to realize that there's a significant concern with the workload not being reported adequately. And so we're not receiving a full picture of what's actually being done by the CHRs and the health educators. So our data identifies that we've had more than a million fewer encounters or patient visits. However, we do know that those 1,600-plus CHRs that are working hard every day are doing their jobs, but they may be documenting their visits on a paper, Patient Care Component (PCC) is what we call it. It's a paper document that identifies the work that they did. And that information may not be getting captured when they return to the service unit.

Also, we have interconnectivity issues with different Electronic Health Records (EHRs) being used. Our CHR line, about 95 percent of the community health representatives have been contracted or compacted, and so the majority of that work is taking place in Tribal communities. And in the health education side, about 70 percent of the Health Education Program has been contracted and is being run by the Tribes. So I think we have a data issue in not being able to capture all of the work that is taking place. And I would ask Dr. Toedt to share a little bit more about some of the vital services that are provided by our CHRs and our system of care.

COMMUNITY HEALTH REPRESENTATIVES

Admiral TOEDT. So we definitely value our CHRs. So we have more than 1,600 community health representatives representing over 250 Tribes in all 12 areas. And we know that the services they provide include patient visits related to diabetes, dialysis, hypertension, nutrition, and heart services for elders. And we've heard loud and clear from Tribes that they value this program. The budget priorities were to prioritize direct care services and are no reflection on the value of the CHR program.

Senator UDALL. Yes. Thank you very much.

And I would just emphasize again, I mean, I've heard from many of my Tribes, and I would just add—like to add several letters from my pueblos to the record, Madam Chair.

Senator MURKOWSKI. They will be included.

[The information follows:]

LETTER FROM DWAYNE HERRERA, GOVERNOR, PUEBLO DE COCHITI

April 16, 2018

Congressman Steve Pearce
2432 Rayburn House Office Building
Washington, DC 20515

Senator Tom Udall
110 Hart Senate Office Building
Washington, DC 20510

Congresswoman Michelle Lujan Grisham
214 Cannon House Office Building
Washington, DC 20515

Senator Martin Heinrich
702 Hart Senate Office Building
Washington, DC 20510

Congressman Ben Ray Lujan
2446 Rayburn HOB
Washington, DC 20515

Re: The Elimination of IHS Community Health Representative (CHR) and Health Education programs in President's 2019 IHS Budget.

DEAR HONORABLE SENATORS, CONGRESSWOMAN, CONGRESSMEN:

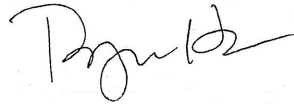
As the Governor of the Pueblo de Cochiti, I write this letter based on the understanding that the President's 2019 IHS Budget has eliminated the Community Health Representative (CHR) and the Health Education line items. In a small rural reservation like Cochiti Pueblo, I know the CHR program allows us the only health providers that we have to address almost all of our health issues. They are the only health providers that live in our community and provide all types of services or give the community the knowledge and access to services. This Pueblo only receives 2 primary care clinic days a week from the Indian Health Service. The CHRs are available for many and any health questions we have as Tribal leaders and educate us about Obamacare, Medicare, IHS, MCOs and any research and outside providers giving our community members healthcare. They have been doing this since the program was started in 1968. We recently testified about the CHR program elimination at the DHHS Tribal consultation but to date, have not heard any response from the agency. Therefore let me re-emphasize some critical points of both line items by the following points:

- The CHR program is a 50 year old line item in the IHS. The CHR program is authorized under the Indian Health Care Improvement Act (IHCIA) and this legislation is now permanent Federal legislation. Attached is the NMSCCHRA testimonies and the Pueblo wholeheartedly support both testimonies. As Tribal leaders we expect Federal agencies to follow funding guidelines established by Appropriations Committees especially those line items that have a significant Tribal impact nationally.
- The CHR program is familiar to all Tribal members and use the CHRs for their various health issues and needs. The Cochiti CHR program has always been administered, operated and staffed by 'Community based' Tribal health providers under our Public Law 93-638 contract. The CHR program is a basic public health service providing direct medical services, prevention and intervention under the Pueblo's management structure. We have daily access to our CHR staff as they speak our Tribal language and know all the community members of Cochiti Pueblo. The Cochiti staff serve as dental assistants, enrollment guides for Medicaid, Medicare and Private insurance, Emergency Management coordinators, health educators, transportation to dialysis/medical appointments, translators, homecare advocates and many other community health services that are started and completed by the staff.
- Cochiti is a small Tribe and not a gaming Tribe. We rely on Federal funds to not only provide services but also have benefitted from the Public Law 638 funding including Contract Support Costs funding—Direct Contract support and Indirect Cost on a yearly basis. The overhead funds pays for the Tribal leadership, HR, Finance, Housekeeping salaries in addition to facilities and Other ad-

ministrative costs such as audits, trainings, travel, supplies out of Indirect costs. For a small Pueblo like Cochiti, it sustains and impacts our Tribal government immensely. I can attest to the fact that I rely on the CHRs on assistance and clarification when outside health agencies, governments, vendors, MCOs, IHS, Veterans Administration and other interested health partners approach our Tribal administration. Our staff are community members and I trust their input on health matters and services.

The elimination of the two line items will have a major impact to the Pueblo de Cochiti as our Public Law 638 contracted programs. As the Governor of Cochiti Pueblo, I respectfully request the CHR and Health Education line items remain in the IHS budget and be increased in the overall IHS budget. Furthermore, I support the two testimonies submitted by the NMSCCHRA which are attached with this letter.

Respectfully submitted,



Dwayne Herrera, Governor
Pueblo de Cochiti

LETTER FROM GLENN TENORIO, GOVERNOR, PUEBLO OF SANTA ANA

May 7, 2018

Chairman Lisa Murkowski
Senate Interior Approps. Subcommittee
131 Dirksen Senate Office Building
Washington, DC 20510

Ranking Member Tom Udall
Senate Interior Approps. Subcommittee
131 Dirksen Senate Office Building
Washington, DC 20510

Chairman Ken Calvert
House Interior Approps. Subcommittee
2007 Rayburn House Office Building
Washington, DC 20515

Ranking Member Betty McCollum
House Interior Approps. Subcommittee
2007 Rayburn House Office Building
Washington, DC 20515

Re: Maintaining Community Health Representatives and Health Education Funding in the Fiscal Year 2019 Federal Budget

DEAR HONORABLE SENATORS AND REPRESENTATIVES,

I write to you today on behalf of the Pueblo of Santa Ana to express our support for the Community Health Representative (CHR) and Health Education programs administered by the Indian Health Service (IHS) as part of its Preventive Health Services. CHR and Health Education programs provide critically needed and culturally responsive healthcare services to our Pueblo, as well as to American Indian and Alaska Native (AI/AN) communities across the Nation. To further the twin goals of promoting AI/AN health and advancing Tribal self-determination, we respectfully urge you to maintain full funding for the CHR and Health Education programs in fiscal year 2019.

Background. The CHR program is authorized under the Indian Health Care Improvement Act to advance community welfare through the development of an AI/AN paraprofessional healthcare workforce. Tribal governments contract with the IHS under Public Law 93-638 (638) contracts to manage the program and train CHRs to meet their Tribal members' specific needs. Today almost CHRs serve in over 250 Tribal communities across the country. CHRs provide medical assessment screening, vital signs monitoring, health education, and transportation to appointments, among other services. CHRs are seen as trusted sources of basic medical and disease prevention services because they are often recruited from and placed in their home communities. Their unique knowledge of local cultural norms and practices, coupled with their high-quality medical training, make CHRs an invaluable asset in the Indian healthcare system.

CHR's Provide an Array of Critically Needed Services in Indian Country. Zeroed out or reduced funding of the CHR and Health Education programs would cause sig-

nificant harm to the Santa Ana people, who already suffer from high rates of diabetes and other serious medical conditions along with a lack of reliable access to quality healthcare facilities. Given the chronic underfunding of the Indian healthcare system, access to CHRs has been critically important to our people. Congress has taken steps to diversify the types of services available in our home communities by establishing the CHR program within the IHS and granting Tribal nations the authority to administer and manage its services. CHRs reduce incidences of disease and illness by providing the following services, among others:

Direct Medical Services	Preventive Health Services	Intervention Services
Patient home visits Diabetes monitoring Emergency care coordination Immunization clinics Translation services Transportation to appointments Health screenings Community first aid training Elder health monitoring Caregiver and hospice support Medicaid/Medicare enrollment	Community health education Promotion of health literacy Educational campaigns on: —Mental health —Behavioral health —Healthcare benefits —Elder and child abuse —Sexual health —Public health crises —Disease prevention	Home safety assessments Monitoring chronic conditions Child safety assessments Traffic and playground safety Medication monitoring Environmental assessments Third-party payer issues Insurance and federal services Reporting patient health Motivation and encouragement

The value of these services cannot be overstated. Access to care is a notorious and well-documented challenge in Indian Country, especially in rural and remote communities. Because they are based in the local community, CHRs are available—often around the clock—to provide care to Tribal members. CHRs also serve as the point of contact on behalf of patients with many outside healthcare providers, including the IHS, Department of Veterans Affairs, and managed care organizations.

Elimination of CHRs and Health Education Programs Harms Tribal Communities. We are deeply troubled by the President's proposal to zero out the CHR and Health Education line items of the IHS budget in fiscal year 2019. CHR programs are only operated by Tribal governments pursuant to 638 contracts—there is no other CHR workforce within the IHS. As a result, elimination of the line item funding for CHRs and Health Education would shift the entire financial burden for operating these programs to Tribal governments that are already dangerously under-resourced in many cases. Without Federal funding, the health and welfare of our communities will necessarily be harmed as the fundamental core of our community health system will cease to exist.

Support for the CHR Program Advances Tribal Self-Determination. Tribal nations have benefitted from Public Law 93–638 funding to manage and carry out critical services in Indian Country. Annual Contract Support Costs have been a financial engine in driving self-determination projects, especially for smaller Tribal nations. 638 funds support local Tribal governments, human resources, financial and administrative services, and the salaries of associated program staff, including CHRs. Maintaining full funding for the CHR program in fiscal year 2019 would further these efforts and advance the United States' policy of advancing the interests of Tribal nations on a government-to-government basis.

Stand with Tribal Health by Maintaining Full Funding for CHRs and Health Education in Fiscal Year 2019. CHRs serve as the cornerstones of health in Indian Country. If Federal funding for these positions is eliminated or significantly reduced, we are afraid that the entire healthcare system of our Pueblo will be destabilized, putting our people at unacceptable risk. We respectfully, yet strongly, urge you to reject these proposals and maintain full funding for the Community Health Representative and Health Education programs in the fiscal year 2019 budget.

On behalf of my people and my Pueblo, we thank you for the opportunity to share our deep concerns on these pressing issues. We appreciate your hard work and dedication to protecting the interests of Indian Country in the annual formulation of the Federal budget. Please know that our Pueblo stands ready to work with you on addressing these critical matters going forward.

Sincerely,

 Pueblo of Santa Ana
 Glenn Tenorio, Governor

LETTER FROM RUSSELL BEGAYE, PRESIDENT, NAVAJO NATION

May 21, 2018

Chairwoman Lisa Murkowski
 Senate Appropriations Committee
 Interior, Environment, and Related
 Agencies
 131 Dirksen Senate Office Building
 Washington, DC 20515

Ranking Member Tom Udall
 Senate Appropriations Committee
 Interior, Environmental, and Related
 Agencies
 131 Dirksen Senate Office Building
 Washington, DC 20515

Re: Fiscal Year 2019 Budget Cuts to Community Health Representative Program

DEAR CHAIRWOMAN MURKOWSKI AND RANKING MEMBER UDALL,

On behalf of Navajo Nation, the largest land-based Tribe in the United States, I am requesting your support to fully fund the IHS Community Health Representative (CHR) and Health Education Programs in opposition to the President's Proposed budget fiscal year 2019 that recommends eliminating funding for the programs. The CHR program has been in existence since 1968 and has been highly effective for preventative health measures on the Navajo Nation.

As the President of the Navajo Nation, we represent a Tribe that spans over 27,000 square miles across three separate States with over 300,000 enrolled members. Today, the Nation suffers from unemployment rates of 42 percent and one third of our households have annual income levels dipping below \$15,000. These shocking statistics illustrates our need for continued Federal funding for healthcare services for Navajo citizens, including the vital community-based CHR and Health Education programs.

The Navajo CHR Outreach and Health Education programs initiated the extension of the Indian Health Service's (IHS) service delivery to the Navajo People who reside in 107 communities in eight Navajo Area IHS Service Units. In fiscal year 2017, the program treated about 8,000 people and was highly successful in both preventing disease and promoting healthy lifestyle choices.

Our CHR and Health Education program is the largest in Indian Country and includes the following programs: Community Health Representative (CHR) Program; Tuberculosis Control (TB) Program; Injury Prevention; Maternal Child Health education; Social Hygiene Program; Navajo Birth Cohort Study Project; Oral Health Initiative; Johns Hopkins Family Spirit, Emergency Response FEMA, Suicide Post-Venture Team; Substance Abuse Education Program; Youth Risk Behavior Surveillance Survey; and Sexually Transmitted Disease (STD) Prevention Program. Each of these programs represent necessary services delivered directly to Navajo people.

In fiscal year 2018, IHS allocated \$157 million to all federally recognized Tribes for preventative health services, including funding for CHR and Health Education. IHS allocated \$18.3 million to Health Education and \$58.9 million to CHR, which is \$1.23 million increase above the fiscal year 2017 appropriation. However, in the President's fiscal year 2019 budget request, funding for both the Community Health Representative and Health Education programs has been eliminated. The elimination of this funding would have significant negative impacts on Navajo Nation. Currently, the CHR and Health Education Outreach Program is the only Tribal program that conducts STD/HIV/AIDS education, HIV Screening, Counseling, Referral, and correctional facilities services. Between 2014-2017, Navajo Health Education

Program (NHEP) has exceeded target benchmarks in HIV Screening and Education by reaching over 17,000 of our Navajo youth. Additionally, the program has provided more than 307,000 individuals with prevention education services during these same years that has resulted in keeping the infectious diseases (TB and STD) to a minimum and preventing outbreaks.

These are only a few of the positive contributions that the Navajo CHR and Health Education Outreach Program has contributed to our community and reduction in healthcare costs through preventative measures. The Navajo Nation is thankful for the partnership and support of this vital program that provides the funding that is necessary for preventative health measures and health education for our citizens.

We strongly advocate that the Community Health Representative and Health Education Program funding for fiscal year 2019 is not eliminated and it remains funded at current levels to make progress on preventative health measures. We appreciate your time and attention to this matter. If you have any questions, you or your staff can contact the Navajo Nation Washington Office executive director Jackson Brossy via email or phone: jbbrossy@nnwo.org or (202) 682-7390. Thank you.

Ah'éhée'.

THE NAVAJO NATION



Russell Begaye, *President*

Senator UDALL. Thank you.

GALLUP INDIAN MEDICAL CENTER

A couple of questions about the Gallup Indian Medical Center. I know my time is running out here, but, Admiral Weahkee, I remain concerned about the continued identification of deficiencies in some IHS facilities, including the Gallup Indian Medical Center, which would put their accreditation status at risk. This subcommittee asked for a formal report and update on the situation in Gallup, and we look forward to getting that report, but I'd still like to get an update from you this morning on where things stand. So could you give me just a brief update on that? And then I'll follow up with some additional questions.

Admiral WEAHKEE. Yes, sir. Thank you, Senator Udall. I think the best report is an objective report, which is we just recently had CMS in the facility 2 weeks ago. They came in with 11 surveyors, a very robust team, and spent an entire 5 days onsite. At their verbal closeout, there were no reported EMTALAs, no reported immediate jeopardy findings. We are still awaiting their written report. There's not always congruence between the verbal closeout and the written report, but we are waiting to see what is put to print. A very thorough more than 400 man-hours of review were conducted, and we believe we're on track to have both Joint Commission certification—or Joint Commission accreditation and CMS certification back in place at Gallup in the very near future.

Senator UDALL. Great. Thank you very much.

Thanks, Madam Chair.

Senator MURKOWSKI. Senator Daines.

Senator DAINES. Thank you, Chairman Murkowski and Ranking Member Udall. I'm proud to join my colleagues in leading the

charge to improve the IHS through the Restoring Accountability in the Indian Health Service Act. This bill would improve transparency, it would improve accountability, it would improve recruitment and retention of personnel within the IHS system. This is the most comprehensive legislation pending before Congress to reform a broken system, but it's going to need some bipartisan support to go anywhere in this chamber. I'm asking my colleagues on both sides to support this bill.

Regarding the additional \$150 million to combat opioid abuse, I see that Chairman Murkowski has already brought this up, and I want to ensure that the more pressing drug crisis among Montana's Tribes gets the attention it needs, and that's meth. Let me illustrate what this problem looks like for you in my State of Montana.

METHAMPHETAMINES

The Fort Belknap Indian Community is currently in a state of emergency due to the meth crisis on the reservation. In discussing their healthcare needs, the Fort Peck Tribes describe their reservation as, and I quote, "plagued by methamphetamine abuse," and then they state, "this drug has destroyed families and is tearing at the very fabric of [their] society." That's why I introduced the Mitigating METH Act, which was the first bipartisan legislation to propose that Indian Tribes be included as direct beneficiaries of funding authorized by the 21st Century Cures Act to combat opioid abuse. My bill also proposes that that funding also be made eligible to combat meth.

Admiral Weahkee, will any of the new proposed opioid funding help combat meth use, too?

Admiral WEAHKEE. Thank you for the question, Senator Daines. One of the first objectives that we expect to conduct, should we receive the \$150 million, is consultation with our Tribes to hear first-hand from them where they see the funds can best be used. And in the proposal, we identify use for prevention, treatment, and recovery support specific to opioids in this case, but through consultation, I would expect to hear needs such as those expressed by the Tribes in Montana. We also hear from other Tribes that heroin is still a significant concern as well as alcohol. So we know that we have a lot of afflictions within our communities.

We also have an existing Substance Abuse and Suicide Prevention program, which is available to Tribes as a grant. We just kicked off consultation with our Tribes about putting those funds out through a different mechanism other than competitive grants. And, again, the Tribes have a lot of discretion in the use of those funds—

Senator DAINES. So just to be clear, if the Tribal consultation suggests that meth is the issue, and the resources need to be devoted toward fighting that epidemic, the answer is you would work with them to be able to do that?

Admiral WEAHKEE. Yes, sir. I believe we have the discretion and latitude to be able to do it.

Senator DAINES. All right. Thank you.

SUICIDE

I want to shift gears and talk about another very sobering issue, and it's not unrelated to the issue of meth in Montana in our Tribes, and that's suicide. Montana's Native youth ages 11 to 24 commit suicide five times the statewide suicide rate for the same age group. And we also know that Native youth suicide goes under-reported.

The question for you, Admiral Weahkee, is suicide in Indian Country increasing or decreasing?

Admiral WEAHKEE. I don't have the latest statistics off the top of my head, and I will turn to my colleague, Dr. Toedt, to see if he may. We do know that there continue to be significant concerns with social determinants—lack of available jobs, lack of housing, lack of—you know, on and on and on—which do impact upon people having hope and having other activities to be engaged in. We have engaged in partnerships with—for our youth with the Boys and Girls Clubs of America to begin to build strategies to help inspire our youth and to engage them in healthy activities.

Dr. Toedt, do you have stats on suicide available?

Admiral TOEDT. So I don't have a broad number for the Indian Health Service, but I do want to make a comment about suicides. So certainly we know that suicides are affecting American Indians and Alaska Natives at a much greater rate, particularly in younger ages, than amongst other populations. So it is an area of great concern.

One of the challenges that we have with data is the correct classification of race on death certificates. Another significant challenge is actually categorizing when unfortunately we lose a member of a Tribe to an opioid overdose. It could have been a suicide and could not be recorded as a suicide. So challenges in the accuracy of the data. But I will commit to following up on the statistics.

Senator DAINES. Yeah. The data that we've seen, in fact, a study from the CDC published just this last March, says American Indians and Alaska Natives have the highest rates of suicide of any demographic group in the U.S., and it states the rates of suicide among Native populations has been increasing steadily since 2003.

I hear about the activities that are suggested to try to combat this, but the bottom line and the results is not improving. So with stats like this, my question, back to the Admiral, would you say the agency is accomplishing its mission with respect to suicide prevention?

Admiral WEAHKEE. It definitely sounds like more work needs to be done and new strategies need to be developed, sir.

Senator DAINES. I would suggest a short answer to that would be no, in looking at the numbers.

Admiral Weahkee, you have a long history of service, and the bureaucracy and brokenness of this agency predates your time, but it won't get you off the hook for moving the ball forward to fix it, to hit it head on. Frankly, I remain outraged, heartbroken, over the overall lack of care that IHS is providing Montana's Indian Tribes, especially when hearing after hearing we don't seem to see significant progress in provision and improvement of care or health outcomes.

I've said it before, and I'll say it again, in reality, I think "IHS" stands for "Indian Health Suffering." And I refuse to stand for this very harsh reality. I'm going to continue the charge in support of the Restoring Accountability in the IHS Act, and on behalf of Montana Tribes, I call on your agency to do better because I believe IHS is failing them.

Thank you, Madam Chair.

Senator MURKOWSKI. Thank you, Senator. I think we all recognize, as you say, the sobering statistics, the sobering reality that far too many of our Native people around the country face, whether in Montana, New Mexico, or Alaska. It is not acceptable. And I think your challenge directly to IHS, that it is not acceptable and must be addressed is our challenge. You raise the issue of opioids, and where does meth fit? And heroin is part of it.

But we had a community, a very small community, ask our Governor to declare a state of emergency to shut down a liquor store in an adjoining community because the village was dry, people were going into the larger community to get alcohol, and their resolution was pretty clear and pretty simple, "Alcohol continues to kill us."

So while there's a great deal of focus right now on opioid and the opioid response, we can't lose sight of all of the other scourges that we're dealing with, and in your recognition that the suicide rate amongst our young people is shocking, but it is tied to what we are seeing with the drugs, with the alcohol, the substance abuse.

When we say \$150 million if the Department of Health and Human Services determines that they're going to shift this over here in the IHS account, to me that's not acceptable. I do think that there needs to be a more directed focus.

In Alaska, I'm told that when it comes to suicide rates amongst young Alaska Native males, we're 10 times the national average. And we just kind of get to the point where it's like, oh, throw around these statistics, we're 10 times the average, we're 4 times the national average, and it doesn't even become real because it's just so out of check, out of alignment, and yet we're not able to get our arms wrapped around it.

One of the challenges that we face when we think about suicide is the ability to provide behavioral health and mental health services, and we don't have it in our big communities, much less in our rural communities. This is something that I'm working with Senator Smith on the Indian Affairs Committee, behavioral health funding. We'd like to put it into the mandatory funding side of the ledger, just as the Special Diabetes Program was on the special side of the ledger, because we feel we've got an obligation to address some of these problems, and when it's discretionary, it's just exactly that, it's discretionary. So I thank you for raising these critically, critically important issues.

Senator DAINES. Madam Chair, thank you for your leadership and working with Ranking Member Udall. We must do better.

Senator MURKOWSKI. Yes, we do.

Senator DAINES. Yes. Thank you.

SPECIAL DIABETES PREVENTION PROGRAM

Senator MURKOWSKI. Let me ask on that, Admiral. You have mentioned that with the Special Diabetes Prevention Program, there's \$150 million. You're continuing that, but you're moving that from the mandatory side to the discretionary side, and I'm assuming your rationale is you had indicated that diabetes health outcomes have improved. I have asked folks in Alaska if we have seen improvements sufficient to kind of take the foot off the gas when it comes to the efforts that I'm still waiting for, for more information.

Can you provide information to us on what we're seeing with diabetes rates, not only in Alaska, but I think around the country, as it relates to American Indians/Alaska Natives? I worry that as we're making headway, that we're going to cut back on the funding and we're going to lose that. We just put this in place just several years ago. So if you have any comments that you'd like to make on that. Otherwise, I'll move on to my next question.

Admiral WEAHKEE. Thank you, Senator Murkowski. Just a quick comment in terms of your characterization of taking the foot off the pedal. I think the administration fully acknowledges and supports that this is a successful program, and we desire to continue funding it at the \$150 million mark. I think the move from the mandatory to discretionary is part of a greater administration proposal to move the macra extender funds over into the discretionary side to give the administration more discretion in addressing priority areas.

Senator MURKOWSKI. That might be something that we can visit on later again, not only as it relates to Special Diabetes Program, but some of the behavioral health issues that we're focused on.

COMMUNITY HEALTH REPRESENTATIVE/COMMUNITY HEALTH AIDE PROGRAM

Let me follow on a question that Senator Udall raised in regards to the Community Health Representative, the Community Health Aide Program. It seems to me that you have acknowledged that this is a valuable program; we need to do a little bit better job with regards to the data. And I certainly would agree with you.

I just want to put on your radar the issue that we're dealing with in Alaska when it comes to connectivity issues. As you know, we have broadband in Alaska that is spotty at best. In some areas, you've got the machine in the corner of the room, but the hookup just doesn't work, it freezes, it's no value, and it is an issue for us. Hopefully, we're moving forward and we're going to see advances coming, but in the meantime, in the present day, what we have in Alaska are many of our rural clinics that are looking at a situation where their provider may no longer be providing them Internet because of issues within the FCC relating to the Rural Health Program and the subsidies. FCC hasn't distributed the payments to the providers for 11 months. The community of Cordova, not your area within IHS, has said that they may have to shut their hospital down because payments are being requested that would basically fill this gap. We've got a real issue at play.

You mentioned that part of your problem in gaining data is people are relying on paper. Well, in many of our rural areas, paper is the only thing that you can rely on. And so I hope that we're able to work together in making sure that you get the data that you need, but, again, until we have a more reliable broadband system throughout our State and into our smaller villages, I worry about you getting the data there.

I wanted to just confirm, though, that your focus on the Community Health Representative Program will not affect the CHAP program, the Community Health Aid Program, that is absolutely critical. You know the value to our State. CHAP isn't going to be impacted by this proposed reduction and elimination, will it?

Admiral WEAHKEE. No, ma'am. And the CHAP program is funded separately out of the "Hospitals and Clinics" line item, so completely separate and distinct program.

Senator MURKOWSKI. Okay. I just wanted to make sure because we would completely erode the underpinnings of how we provide for healthcare in these villages if we didn't have CHAP. So thank you for that.

Senator Udall.

Senator UDALL. Thank you, Madam Chair.

GALLUP INDIAN MEDICAL CENTER

Back to the Gallup Indian Medical Center, Admiral Weahkee. First, were any services offered by Gallup Indian Medical Center ever suspended for any amount of time as a result of the findings of CMS and the Joint Commission?

Admiral WEAHKEE. So not exactly tied to the findings of CMS and Joint Commission, although we have intermittently had to divert or suspend operating room procedures because of humidity control issues. So there have been episodic suspensions of service as a result of facilities issues.

Senator UDALL. And how were those cases handled then?

Admiral WEAHKEE. Usually by staff onsite adjusting the system to reach the minimum threshold controls. And part of it is due to I guess the weather in Gallup.

Senator UDALL. Yes. Okay.

Admiral WEAHKEE. I've got an engineer to my left who may be able to help us more here.

Senator UDALL. Mr. Hartz, do you want to weigh into this?

Mr. HARTZ. Actually, it's variable by—

Senator UDALL. Could you do your microphone, please?

Mr. HARTZ. I apologize.

Senator UDALL. Thank you.

Mr. HARTZ. It's actually very variable depending on, you know, the weather conditions. And it's really not common, but when the humidity might go up in Gallup, the capacity for the HVAC to deal with it isn't always as good as it should be.

Senator UDALL. Yes. I understand that CMS conducted a full hospital survey of the Gallup Indian Medical Center (GIMC) starting on May 9 to inspect whether previously found deficiencies have been corrected. First, are you confident that IHS has resolved all the items identified in last year's survey and outlined the Correc-

tive Action Plan submitted to both the Joint Commission and CMS?

Admiral WEAHKEE. So there are a number of items included in that list. Some were able to be taken care of on the spot. Others, the team took care of in very short order. One example was the waiting room for the Emergency Department (ED) had patients who were also waiting for primary care in the same waiting room. So they had to actually separate those two clinics. They did it over a weekend. And they are now providing services out of a different location in the hospital, so it resolved that finding. But some of the longer term fixes with the environment of care and life safety will take longer to remediate, and those are mainly with the facilities infrastructure with the heating and air conditioning and other renovation work that needs to take place.

Senator UDALL. Do you anticipate any new findings that will need to be addressed? And if so, could you share with us what your planned next steps are?

Admiral WEAHKEE. With specificity, probably not at this point since we don't have CMS's report back to us. I think we're expecting that to come within the next couple of days, and then we'll have 90 days to develop the Corrective Action Plan for those longer term fixes. But we'd be happy to have a side conversation with some additional detail.

Senator UDALL. Okay. Should CMS identify additional deficiencies, how will you pay for the needed improvements? Are you confident that the \$58 million proposed in your fiscal year 2019 budget is sufficient to meet these needs and still address other accreditation emergencies? Would the proposed reductions to the facilities have any impact on your ability to respond to these accreditation issues?

Admiral WEAHKEE. Thank you, Senator Udall. Well, with regards to Gallup specifically, and I think as a result of the expanded reimbursements through Medicaid, that facility has additional financial reserves that some of the other facilities in South Dakota did not have access to. And so they have a greater ability to take care of some of their own needs. But we do and would also have available the accreditation emergency funds should there be a large-ticket item that needs to be addressed.

Senator UDALL. Okay. Admiral Weahkee, I can't emphasize enough how important it is to address any remaining issues at the Gallup Indian Medical Center and address them promptly and completely. I'd like your commitment that you will provide the report that this subcommittee requested on time, and that you will work with me to provide updates and make sure that this facility has the resources it needs to address these challenges going forward. Will you make that commitment to me?

Admiral WEAHKEE. Yes, sir, I will.

Senator UDALL. Thank you very much.

ALCOHOL AND SUBSTANCE ABUSE

Madam Chair, let's see, I'm also encouraged to hear—shifting over now to substance abuse and the Na Nizhoozhi Center Inc. (NCI) Detox—I'm encouraged to hear that the Preventing Alcohol-Related Deaths program has contributed critical resources, the Og-

lala Sioux Tribe and the City of Gallup, through the NCI Detox to combat alcohol and substance abuse. I understand that IHS officials recently convened with both programs in Gallup to conduct a site visit. Can you briefly update us on the progress these programs have made as a result of this funding and technical assistance from IHS? And comment briefly on how the new high-risk unit established by NCI Detox, which coordinates with the Gallup Indian Medical Center to provide medically complex patient triage has been helpful to improving patient care?

Admiral WEAHKEE. Thank you, Senator Udall. We did have members of our headquarters behavioral health team there in Gallup. They brought Oglala Sioux down and had a joint meeting to share best practices across the two sites, as you identified. Dr. Toedt is going to provide a little more specificity. In general, the visit went very well, and both locations are doing great. We do expect to provide the next year's funding by the end of this fiscal year, so nothing that we saw that would get in the way of that continued support for those two programs.

Admiral TOEDT. Yes, sir. We definitely appreciate the funding in the Preventing Alcohol-Related Deaths program. And absolutely the site visits show that there are promising signs of increasing access to treatment, and good quality, high quality, culturally appropriate care. We were really encouraged to see the collaboration between the programs and the sharing of best practices as well.

Senator UDALL. Great. Thank you very much.

Thank you, Madam Chair.

Senator MURKOWSKI. Thank you, Senator.

VILLAGE BUILT CLINICS AND 105(L) LEASES

Let me raise the issue that I raise every year, Village Built Clinics. We've had this conversation a lot. For so many of the clinics built by IHS, we've got 150 of them in Alaska, so many of them are really the only option for any level of care out there. Most have serious maintenance needs. In prior years, the agency took the view that Tribes were responsible for paying these costs out of other funds that they got from the Service. We have included \$11 million in the 2018 omnibus to help address this issue.

So a couple questions this morning. First, how are you all planning to allocate the \$11 million? And when will the funds be distributed? And then further to this is the concern that has been raised that some of these funds are now being used to pay for other leasing costs because of the legal case that came out of—it was the *Maniilaq v. Burwell* case that mandates payment of leasing costs when Tribal facilities are used to operate IHS programs. So how much of this \$11 million is being used to pay for these new legal obligations versus the traditional Village Built Clinic arrangement? If someone can please address that and give me an update.

Admiral WEAHKEE. Thank you, Senator Murkowski. And I'll start, and I'll ask Ms. Church to provide some additional specificity.

Of the \$11 million, we currently, through Tribal consultation with the Tribes in Alaska, have identified \$6 million of that to go specifically to Village Built Clinics, and the remaining \$5 million to be available for 105(l) leases. And the majority of those 105(l)

leases have been, up to this point within the State of Alaska, we are starting to receive 105(l) lease requests from the lower 48 and now have several Tribes who have requested leases in Navajo, Nowell Phoenix, Portland, and Nashville areas.

So I'll ask Ms. Church to provide a little more specificity in terms of when and the impacts of the 105(l) objections.

Ms. CHURCH. Thank you for that question. Consistent with the distribution in 2017 when we first received the \$11 million, which we greatly appreciate the support of this subcommittee in receiving those funds, as Admiral Weahkee mentioned, we are using \$6 million for the Village Built Clinics, and we have the \$5 million for this other additional lease requirement under the Indian—or the ISDEAA.

So we do know that within Alaska in particular, we have seen a bit of a shift in how the Village Built Clinics are electing to move forward with these leases, and so far, we've seen about 33 of those Village Built Clinics shift from that standard formula under the Village Built Clinics, and moving over to this other leasing opportunity. As Admiral Weahkee mentioned, we are beginning to see additional interest from other areas throughout the United States, and we do see the financial impact of that increasing exponentially over time.

Senator MURKOWSKI. As I understand the budget proposal, it effectively overrides the 105(l) with this “notwithstanding” clause that would make these lease payments entirely discretionary within the agency, effectively overturning the *Maniilaq* decision. This is a pretty significant shift because it would impact probably one of the most important statutes that govern Indian Country. I have not had a conversation with the Chairman of the Indian Affairs Committee, but this is something that from the authorizer's perspective, does beg the question as to whether or not this proposal has been shared with the Chairman and the Vice Chairman, and then further to the point, what their view is of this. Have those discussions been had?

Ms. CHURCH. There have been some preliminary discussions with the staff of our authorizing committees to talk about this issue. The language I think that you're referring to is proposed in our 2018 congressional justification as well as 2019, and we would hope that this would be a starting point for discussions about an appropriate way to ensure that we can honor the commitment for this unfunded requirement and come up with a good solution moving forward.

Senator MURKOWSKI. Let me ask what that good solution might be because it's my understanding that the budgetary impact of this decision nationwide is going to blow things out of the water, that you've indicated that in Alaska, we've got some 33 Tribes.

Admiral, you mentioned that several nationwide are looking to this. What's going to happen?

Admiral WEAHKEE. I believe projection-wise, it could be in the hundreds of millions of dollars mark if something is not done.

Senator MURKOWSKI. Well, okay. So if something is not done, what would you propose that we do? Because hundreds of millions of dollars, we're sitting here looking at the needs and recognizing that you've got a budget that at least the Ranking Member and I

are looking at, and certain categories are simply not adequate, and now we're talking about something that could shift the priorities dramatically. What—help us out here.

Admiral WEAHKEE. Well, right now the agency's only discretion is with those direct service funds for the Federal-operated facilities that we have oversight for. Some possibilities might include a separate funding line for this particular cost or to make the contract support costs available for lease payments, just a couple off the top of my head. I'll turn to Ms. Church.

Any ideas you might have as a financial expert within the agency?

Ms. CHURCH. Aside from additional funds, other discussions could be related to some sort of legislative discussion that we would be open to conversations on how that might work. But as it currently stands, there would be a need for additional resources to cover this issue.

Senator MURKOWSKI. So what you're telling me now is that with the 2018 funds, \$11 million total, \$6 million is going to go to the Village Built Clinic (VBCs), \$5 million then to these 105(1)s, but that is just a drop in the bucket in terms of what we may be facing next year. And we clearly don't have enough to address it with these fiscal year 2018 funds either, right?

Admiral WEAHKEE. Correct.

Senator MURKOWSKI. Yes.

Admiral WEAHKEE. Yes, ma'am.

Senator MURKOWSKI. And so I don't know if you told me when the funds would be distributed, the \$11 million?

Ms. CHURCH. We're working on getting those funds out as we speak.

Senator MURKOWSKI. So how do you prioritize the \$5 million then amongst the 33 Alaska Tribes that have sought to use those funds, and then the several that are being considered from other Tribes around the country?

Ms. CHURCH. As the lease proposals are coming in, they're being addressed in as timely a fashion as we can. It involves negotiations to make sure that we have full understanding of what's included in the proposal and going through all of the different items that have been included for assessing those reasonable costs.

So at the moment, we are proceeding as they come in, in that priority order. And so right now we have been able to use the \$11 million at this point exclusively for the Alaska proposals that are coming in. We're still working on additional proposals from other locations.

Senator MURKOWSKI. Well, I would suggest that this is one of those issues that we need to engage as many of you within the agency that are involved from a policy perspective. We need to be sitting with you from the appropriating perspective because we've got an issue that is very readily moving out of control from a spending perspective. How we work together to address it is going to be something that we need a little coordination on, and I hope you would agree with that.

Admiral WEAHKEE. We'd be happy to provide any technical assistance or coordination needed, yes, ma'am.

Senator MURKOWSKI. Thank you.

Senator Udall.

Senator UDALL. Thank you very much, Madam Chair.

And as we know, I mean, this case was originally Alaska, but it's starting to have an impact, I think, all over the country. And we haven't had, Chairwoman Murkowski, the extended conversations we need to have with IHS. We need you to come back and talk to us and give us the specifics here. We haven't gotten updates about the impacts of this case. And we would encourage you very much to talk with us also at Indian Affairs—both of us are on the Indian Affairs Committee—and give us an update as well as this subcommittee here.

HEALTH FACILITIES CONSTRUCTION FUNDING

On the health facilities construction funding for New Mexico, I'm very pleased that this subcommittee was able to provide the largest ever appropriation for facilities construction and maintenance programs in fiscal year 2018. There are a number of projects in New Mexico that have been waiting a very long time for funding, including health clinics in Alamo and Pueblo Pintado, as well as facilities in Albuquerque and Gallup, an obvious priority, given the issues we have already discussed today. Can you please provide an update of what the fiscal year 2018 funding level will mean for these specific facilities?

Admiral WEAHKEE. Thank you, Senator Udall. And I know that Admiral Hartz has been dying to share some good news, so I'd like to—

Senator UDALL. Go ahead, please, Admiral Hartz. That would be good.

Mr. HARTZ. I thought I was going to get a break today.

[Laughter.]

Mr. HARTZ. I, first of all, thank you very much for the question, Senator. And thank you for the opportunity to speak to the subcommittee.

We—Indian Country and the Indian Health Service much appreciate the increases to the facilities appropriation in 2018. And following down the priority list that we've worked with this subcommittee and the authorizing committees for some time and present annually, there will be funds, for Alamo, with the 2018 appropriations that will wrap up the needed funding that will be going into that project, and we can provide, for the record, the details of the dollar amounts, but that will be wrapped up with that \$48 million, so it will be ready to move forward as long as they—the site—we don't have unusual site conditions. And Pueblo Pintado, the resources going in there, we'll be ready to finalize the planning and initiate the site selection review activities there, about \$10 million. And then for the Albuquerque Central and satellite facility, we've put about three-quarters of \$1 million in each one to proceed forward with the planning for those.

Essentially, a broader answer to your question is that we now have resources in all of the outpatient facilities on the priority list. There are resources to move along on every project on that list from an ambulatory standpoint.

SANITATION FACILITIES CONSTRUCTION

Senator UDALL. Now, this subcommittee nearly doubled funding for sanitation facilities construction in the recent omnibus, and I know that this funding is very important for Alaska Native villages in the Chairwoman's State, and that we also have particularly significant sanitation needs in New Mexico, including a large number of homes on the Navajo area that lack access to clean drinking water and waste disposal facilities. Could you talk about the impact that these additional funds will have from a public health perspective? How many additional homes will you serve with these funds?

Admiral Hartz, I think you're a good one to jump into that there.

Mr. HARTZ. Well, there's no question that we will make significant inroads with that additional \$90 million that you provided to the Indian Health Service for this purpose. The exact number of those homes are actually yet to be determined, sir, and we will provide that for the record. The projects have been identified, and they're now going down the priority list to submit that information to us. We'll have that at year end. We may be able to get it sooner. But we will definitely provide that for the record.

Senator UDALL. Great. Please do. Thank you very much.

Mr. HARTZ. You bet.

OPIOIDS

Senator UDALL. I was pleased that we were able to fund \$50 million for Tribal opioid grants through the Substance Abuse and Mental Health Services Administration budget in last year's omnibus. And I note that the budget request includes additional funding for the Office of the Secretary to fund opioid-related needs, what appears to be missing in the direct resources for the Indian Health Service's own budget, however. Could you tell us what impact the opioid crisis has had on the Service's budget and what the greatest operating need you have as a result? Has the IHS worked with SAMHSA to ensure that the grant resources that Congress provided are being used for the highest priority needs?

Admiral TOEDT. Thank you for the question, Senator Udall. The Indian Health Service has been making its Substance Abuse and Suicide Prevention funds, which was formerly the Methamphetamine and Suicide Prevention Initiative (MSPI), available for, among other conditions, methamphetamine, heroin, opioid abuse, suicide prevention activities. So that amount for previous funding has been at \$27.9 million. And the majority of those projects are focused on youth and youth suicide and substance abuse prevention.

The funding for the President's budget that is the \$150 million proposed for IHS, we absolutely want to get the voice of Tribes, so as we stated before, we would have consultation with the Tribes about how we can best use that money to serve their communities.

With respect to the Substance Abuse and Mental Health Services Administration (SAMHSA) funding, the \$50 million, and the coordination with getting the money to Tribes, we have had several meetings with SAMHSA leadership, and we've been having conversations about funding distribution methodology that the IHS

uses and sharing those ideas and techniques with SAMHSA. Also, on Monday I was at a joint listening session with SAMHSA and NIH in Minneapolis addressing the opioid issue, and SAMHSA was directly consulting with Tribes with IHS present as well.

Senator UDALL. Great.

Thank you, Madam Chair.

Senator MURKOWSKI. Thank you.

STAFFING

Let me ask about staffing packages. Again this is kind of an annual question for me, just making sure that we're tracking. Last year, the agency really underestimated the staffing packages need in the President's request. It was \$20 million when the actual need was over \$60 million. We ultimately provided that in the omnibus.

As you know, we are close to finishing the facility up in Bethel. This is operated by the Yukon-Kuskokwim Health Corporation (YKHC). This was selected as a joint venture project, and we've obviously seen great success with our Joint Venture (JV) projects, but we need to make sure that IHS provides for the funds for staffing the facility is going to be your end of the arrangement here. But really this has proven to be a good way, a great way, to lower the cost of building these new facilities for the government. Can you assure me that the full amount needed by YKHC for fiscal year 2019 for the staffing package is going to be sufficient?

Admiral WEAHKEE. Thank you, Senator Murkowski. And with regards to the YKHC facility, we've identified \$57.3 million. That is our best estimate as of the current date, and as we get closer to beneficial occupancy and the opening of that facility, we will revise those numbers. But with all information provided to the agency as of this date, that number represents full funding of their staffing needs.

Senator MURKOWSKI. Okay. Good. That's good to hear.

The Yakutat Tlingit Tribe also has a joint venture project under development. I was briefed by them just a few weeks ago now. I don't see a staffing package for them in the fiscal year 2019 request. Can you give me an update or a status on that project?

Admiral WEAHKEE. Thank you, Senator. We also recently met with the Yakutat, and Admiral Hartz would like to provide feedback here.

Senator MURKOWSKI. Great. Thank you.

Mr. HARTZ. In the initial joint venture agreement that we signed with the Yakutat Tribe, their projections were for the first quarter of fiscal year 2020, for the completion of the facility and the staffing package. We recognize, based on the meeting that we had with the Tribe, that they're projecting sooner, but at the same time, they also appear to be—still looking for financing. And we're not aware that there's been groundbreaking yet on the facility nor an award. So, as Admiral Weahkee said, we will want to continue to monitor that, Senator, and, you know, communicate accordingly, depending on how that project does develop.

Senator MURKOWSKI. All right. Well, I appreciate that. They're very anxious, as you probably realized when you were discussing with them. I told them it's great to get that building, but you have to have the staffing that goes with it. We just want to make sure

that we are in line with you so that when it is timely, that they are in that queue. So thank you for your engagement on that.

Mr. HARTZ. Yes. And we will do that. Thank you.

Senator MURKOWSKI. Good.

SMALL AMBULATORY CLINICS

We included \$15 million in the omnibus for the Small Ambulatory Clinic Program. This was built on funding that we provided for the first time in fiscal year 2017. Well, it wasn't the first time, but it was the first time since 2008. This has been a very important program in some of our smaller villages as we've seen Tribes in places like Toksook Bay, Chenega, Kake, and Hooper Bay take advantage of that. Can you tell me how many proposals you receive for funding through the Small Ambulatory Clinic Program and if we've got any updates with regards to awards for the programs and how funds might be allocated going forward?

Mr. HARTZ. Thank you, Senator, for the question. And we did receive 20 applicants when we did the solicitation based on the fiscal year 2017 appropriation, considering when the resources came, it was late in the year, and we decided that for the amount that we had there, we would, depending on what happened in fiscal year 2018, and thank you again for those resources—we merged the two for the \$20 million to be available for the distribution. And after an objective review team, of which there were no members from any area that had submitted an application.

So we have completed all of that, and all of the recipients of the awards have been notified. They were notified either late last week or early this week. And I'll just quickly run through the numbers. Later, I can give specifics as to the location. And there was no representative from the Alaska area, nor Albuquerque area, on the review team that did this. Alaska has five recipients that will receive this. One of them will be partial amount because of the total amount, we were not able to get to all five in Alaska. New Mexico has three; and then we go California, one; Utah, one; Arizona, one; and Washington State, one. And that is—that accounts for 12 of the 20 applicants that will receive resources.

Senator MURKOWSKI. Let me ask the question because you had submissions that clearly indicate that this is a valued program, and yet the budget request doesn't include any funds going forward in fiscal year 2019. What's the rationale for not funding the Small Ambulatory Clinic Program?

Mr. HARTZ. The Small Ambulatory Program is part of the appropriation under the "Healthcare Facility Construction" line item. And as you note, it has significantly been reduced, and that is consistent with our desire to maintain the high priority for healthcare delivery, and that's always been the case over the many years of facilities. But, once again, we really want to thank you for the inroads we've been able to make with the increases in fiscal year 2018.

Senator MURKOWSKI. Well—

Mr. HARTZ. And why did we put the \$79.5 million into the two projects that are identified on the list that we've requested? And the reason is, is one of them will complete the quarters for the Dilkon projects so we can—you know, if we get those resources we

will then proceed forward with a contract to get those constructed. And then the other \$20 million will be to move along as we get further into the design for Pueblo Pintado, that we will be able to then move toward construction.

Senator MURKOWSKI. Well, know that when we see programs like this that are designed to help, again, some of these very small clinics in very remote areas where healthcare options are simply not available, it's this or nothing, know that I am going to continue to place a priority from a budget perspective. This is the beauty of being on the Appropriations Committee and being able to set these priorities out there.

When I look at what you have done in other areas of the budget to reduce funds, whether it's the facilities construction or the maintenance accounts, and then I see good programs with clearly a level of interest that is making a difference in these smaller communities, I'm concerned that we are once again shortchanging the IHS system.

We haven't really talked about the shortages that we face in the healthcare workforce, but I would contend that when you have sub-par facilities, places that not only people don't want to go for their care, but no provider wants to work there, it's really difficult to do right by the men and women that we're serving and their families. So I'm going to keep fighting for the small and ambulatory clinics, and I would just encourage you to work with us on some of these priorities.

I'm well over my time, Senator Udall.

Senator UDALL. Thank you, Madam Chair.

INDIAN HEALTH PROFESSIONS

Admiral Weahkee, I'm perplexed by the decision in this budget to cut funding from the Indian Health Professions Program by 12 percent. These are programs that provide scholarships and loan forgiveness to recruit the next generation of providers at IHS facilities. It's my understanding that even at current funding levels, IHS is turning away students seeking assistance. Could you please share with us what number of qualified applicants to the scholarship and loan forgiveness programs are going unfunded at current levels? And wouldn't your budget request mean that even fewer applicants would make the cut?

Admiral WEAHKEE. Thank you, Senator Udall. I also want to reference as part of my remarks some of the proposals that we've made which would help to provide greater numbers of both scholarships and loans, one of which is to deal with the taxability issue of our scholarships and loans. Right now, a lot of our funding is going towards reducing the tax burden on recipients, and we'd like to have the same parity with the Armed Forces scholarship loan program, National Health Service Corps, and make those non-taxable. That would enable us to provide more scholarships and loans.

But to get specifically to your question and what we've received this year, for the loan repayment program, we had 1,267 health professionals receive IHS loan repayment. That's 434 new 2-year contracts, and 396 1-year extension contracts, with 437 starting

their second year. So we had 788 applicants go unfunded at an estimated cost of \$39.4 million.

And then for scholarships, we had 805 new applicants. Three hundred thirty-one of these were eligible for scoring, and of those, 108 were awarded.

An estimated \$3.3 million would have been the need to fund all of the qualified new applicants. So we had 154 continuation awards funded in that most recent year.

Senator UDALL. Yes. Thank you for that answer.

IT MODERNIZATION

I want to shift over here with a final couple of questions on the IHS and health IT modernization. I know that health records and billing IT needs at the IHS have grown over the years, and I've heard from Tribes concerning about what IHS's plan is to replace the Resource and Patient Management System (RPMS) since the VA will discontinue support of it soon. This year's budget request acknowledges RPMS replacement as one of IHS's top IT challenges. And I quote here from the budget, The loss of the VA as a source of software code will raise the cost of continuing to use the RPMS system and require IHS to procure commercial off-the-shelf replacements for RPMS, end quote there. It goes on to say that efforts are underway to look at replacement systems.

Admiral Weahkee, what specific efforts are underway at IHS to replace the RPMS?

Admiral WEAHKEE. Thank you, Senator Udall. And our IT office has been in very robust conversations with internal HHS stakeholders and directly with the VA and the DoD on their experience in evaluating electronic health record solutions.

As an agency, we put out a Request for Information for the public to provide us with their thoughts on what the IHS should do. We received responses from the big ticket vendors who were interested in coming in and replacing RPMS. We also had a number of responses for people who were willing to come in and maintain the existing RPMS system for us. And we've also received a number of add-ons, if you will, bells and whistles that could be added onto RPMS to make it more interoperable or provide better reports.

So I would characterize our current situation as doing robust evaluation. We are watching closely, and we saw just last week that VA signed the contract with Cerner, so they are all in, if you will. But we do continue to have robust conversations with our HHS Chief Technology Officer about what IHS and HHS should do moving forward.

One last thought and some additional conversation we've had is with our Tribes. And many of them have already made the investment and have moved forward to go on to commercial off-the-shelf EHRs already, and so we are leveraging the lessons that they've learned in making those conversions and also the investment information, how much it's cost them to make those transitions to help inform our future budget requests and how we'd like to move forward.

Senator UDALL. Given the budgetary concerns outlined in the budget justification, does the administration's fiscal year 2019 health IT requests reflect RPMS replacement planning?

Admiral WEAHKEE. For the stage of evaluation that we're in currently, I believe that we are still predecisional in being able to justify a specific amount, but we will be closing up this initial phase of evaluations soon, and we'll be able to provide some harder and justifiable dollar amounts to proceed forward.

Senator UDALL. Admiral Weahkee, based on your summary of IHS's efforts to look at RPMS replacements, do you think the agency has done enough to preplan as much as possible for the difficulties of an IT systems deployment?

Admiral WEAHKEE. I believe that there is a lot of planning that will be needed, and we are—we are operating on a shoestring within our existing IT, and to be able to go through as robust of a transition as will be needed, we will need additional resource, either contracts or a surge in capacity on our IT side of the house. So additional resources will be needed.

Senator UDALL. Yeah. Well, I think it's really important that you make clear the resources you need to do this because it's obviously very important in going through the stage we're going through.

Admiral Hartz, did you have anything to say here?

[No audible response.]

Senator UDALL. That's fine.

Admiral WEAHKEE. Actually, Dr. Toedt is our previous CMIO—

Senator UDALL. Dr. Toedt.

Admiral WEAHKEE [continuing]. So he may have some additional insights.

Senator UDALL. Oh, good. Well, that would be great.

[Laughter.]

Admiral TOEDT. Thank you, Senator. We know that there are significant challenges with RPMS. We have them at our Federal sites. We've heard from Tribes. And we know that the VA, having made its decision, you know, just last week gives us even more incremental clarity on some of the issues surrounding it. So having a robust and accurate proposal is the work that we're undergoing right now to make sure that when we put a request forward, that it has sufficient information. But I concur that significant additional resources would be required to make a transition.

Senator UDALL. Yeah. Thank you very much, Madam Chair.

Senator MURKOWSKI. Thank you. Thank you, Senator. It's a good thing we didn't have more of our colleagues show up because—

Senator UDALL. We had a lot to do.

Senator MURKOWSKI [continuing]. We had plenty to talk about here this morning.

HEALTH FACILITIES CONSTRUCTION FUNDING

I just have a couple more if I may. And I want to take it back to the facilities and facilities construction and maintenance and my concern. I mentioned the backlog in my opening statement at over \$2 billion for the facilities that are currently on the priority list. The total need for construction is estimated to be over \$14 billion. Your own budget justification indicates that the facilities are roughly four times the age of their private sector counterparts. The maintenance backlog is also over a half a billion dollars.

I don't understand how, in all good conscience, you can recommend such a significant reduction to this account, over 40 per-

cent. I guess the question that I would ask is, do we all agree that the maintenance—the construction and maintenance—well, let's start with the construction, that the need is over \$14 billion? Is that what we acknowledge? It's a lot.

Mr. HARTZ. The answer is affirmative.

Senator MURKOWSKI. Affirmative. And with the backlog also over a half a billion dollars?

Mr. HARTZ. \$569 million for backlog of essential maintenance, alteration, and repair.

Senator MURKOWSKI. And that's over half a billion. The age of most of the facilities is far in excess of the age of other private sector facilities. So the need, we all acknowledge that the need is clearly there.

Mr. HARTZ. Yes.

Senator MURKOWSKI. When we look at a reduction to this account, as significant as this is, is it a prioritization that we're going to place dollars elsewhere in the budget? And do we have a longer term plan that is perhaps not shared with us about how we're going to address this? What's the plan going forward? Because the need is clearly there, it's clearly established.

Admiral WEAHKEE. Yes. And thank you, Senator. And definitely it's a prioritization of direct healthcare services and basically kicking the can down the road on expansion, capacity expansion, greater access. We know that our needs will continue to grow, and the \$104 to \$208 million that we would ideally be putting aside for facilities maintenance, you know, it will end up resulting in the situations like we have at Gallup and in the Great Plains with HVAC systems going down, generating systems going down. So without the additional funding, we can expect to see those problems persist and need to have additional funds such as through the Accreditation Emergency Fund.

Senator MURKOWSKI. Well, it seems to me that we know what the answer is here. You've got these facilities in the Great Plains that have just been struggling. You mentioned that you can't get the certification that you need if you can't get the HVAC system up to where it needs to be. So you spend a lot of money throwing good money after bad with a facility that is costing more to maintain to try to get it up to standards, and if you can't get it up to standards, then you're not able to provide the service here. So it just seems to me that there has to be a longer term plan.

When it comes to one of our other accounts, we have jurisdiction over our national parks. Our national parks have a maintenance backlog that is—what?—you know, \$11, \$12 billion, not insignificant. I don't know why we get stuck with all of the maintenance backlog issues that are so significant in this country. I don't know that we should say we're stuck with them, but where we're struggling with them.

And what we've been trying to do with the Secretary there is to figure out the longer term plan. What are the proposals that could help us have a funding stream to address it? But it doesn't seem to me that we have a plan here. And we have been the beneficiary of some good efforts in the State through the likes of the joint venture program that allows the Tribes to pay for the construction of new facilities. That has helped us there. But I'm not seeing that

we have a strategy. And if we don't have a strategy, I take it back to what Senator Daines challenged us all with, right now what is being provided to our Native people around the country is not adequate, and we must do better.

I don't know if you can address what the longer term strategy is or whether it's a wish and a prayer that we have more money that comes our way, but you can't have a construction backlog of \$14 billion and a maintenance backlog of over half a billion dollars if you're just limping by year to year and hoping that you're going to be able to keep your facilities open.

Admiral WEAHKEE. Thank you, Senator. And I want to assure you that we do have very thorough plans, prioritized plans, for both our healthcare facilities construction and our backlogs. They're needs based—

Senator MURKOWSKI. Can you get to that plan with a 40 percent reduction in funding?

Admiral WEAHKEE. Not immediately, no, ma'am.

Senator MURKOWSKI. Can you get to it even in the long term? How do you get to it if you're going downwards instead—you're not even holding steady.

Admiral WEAHKEE. Right. It's a growing need. It's a growing need.

Senator MURKOWSKI. It doesn't work. I think you just have to admit it doesn't work. We need to work to address that, but I can't have you defending a 40 percent reduction and saying, "You know, we'll figure it out." We're going to have to address it.

STAFF QUARTERS

One more question, and this is relating to housing. I mentioned that when it comes to our healthcare professionals, you simply cannot attract them if you have substandard facilities, and you can't attract them if you have housing issues. And far too many places in Alaska, there is no place to rent, there is no place to buy, and so staffing quarters are an important thing.

We provided \$11.5 million for staffing quarters in the fiscal year 2018 omnibus. Once again, we're working to make these good things happen. And I appreciate my colleague and teaming up with us, but with that, that was new authority to directly subsidize housing costs for medical personnel.

So can you give me an update as to how the funds for these quarters have been allocated, whether they're going to help with some of the issues in the Great Plains, kind of where you are with that?

Admiral WEAHKEE. Thank you, Senator. Of the \$11.5, we have looked across the agency at the areas of greatest need and have identified the Great Plains area, Navajo area, and the Alaska area as the locations with the greatest housing deficiency need currently. With the Navajo area, we had a site whose housing unit actually burned down, and so that's an acute need. So we've identified \$3 million of that \$11.5 to go to the Navajo area, another \$3 million to the Great Plains area for their area of greatest need, and the Alaska allocation would be \$5.5, and our thought is that that would go to the Barrow region.

Mr. HARTZ. Yes. There are some great needs there, and the costs are much higher in Alaska. And the one in the Navajo was an

apartment building burned down. So that gives you, you know, a general idea of—well, not general, a specific idea—excuse me—of where we’re looking to put that \$11.5 million. And thank you very much for providing that to us. Much needed.

Senator MURKOWSKI. Much needed. I think we would all acknowledge wholly inadequate in terms of being able to meet the needs and the costs, but again that’s an area where we will just continue to work with you on.

Admiral, you’re in a difficult job. You know that. We know that. I just get very frustrated because it doesn’t seem to make a difference whether we have a Republican administration or whether we have an administration that’s led by a Democrat leader. Our reality is that we have not done right by American Indians, Alaska Natives, and Native Hawaiians. We have not done right when it comes to funding through the IHS and through our programs, whether it’s BIA or BIE, we have not done what we need to do in order to meet our trust responsibilities.

I’ve been on the Indian Affairs Committee for the full 15 years that I’ve been here in office, and I’ve been on the Appropriations Committee now for about a half dozen years. It seems that we have the same conversations and we express the same level of frustrations. Good men and women come in front of us and try to make a case for budgets that simply do not address the need.

I know that part of your job is to defend a budget that your heart might not be into. I don’t know how you do that because I’m sure all of you care for those that you are serving, but this budget does not help to address the true needs when it comes to so many who are in a very vulnerable place, and we keep them in that vulnerable place when we don’t make the funding commitments that we need to them.

So know that we’re going to continue to work in this Committee as well as Indian Affairs, where Senator Udall is again a very strong leader there. We will keep at it, but I would like to have some further conversations with you and your team on some of these issues that we’ve raised here today.

With that, final comments? You get the last word, Senator.

Senator UDALL. No, I’m not going to do the last word. You should have the last word, but—

Senator MURKOWSKI. You’re getting it.

Senator UDALL. Yes. Just—I—and I think she said it very, very strongly, that when we get in this backlog area, it is—you know, consistently it just gives us the sense we’re not moving. And historically, I’ve kind of seen—and it doesn’t matter Democrat or Republican—some administrations have stepped forward with 5-year plans to wipe out backlogs, and, you know, that’s the kind of leadership I think we need from the administration, is just stepping forward and saying, you know, “We’re going to take care of this backlog within a certain period of time and we’re going to ask the Congress, we’re going to make a proposal and we’re going to ask the Congress to participate with us and try to wipe it out.” But we need that kind of leadership, and I really appreciate your comment on that.

So I’m not trying to get the last word, I’m just trying to fold into the words that you said, which were really the last words.

Senator MURKOWSKI. Well said.

CONCLUSION OF HEARINGS

With that, the subcommittee stands adjourned.

[Whereupon, at 11:55 a.m., Wednesday, May 23, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]