

DEPARTMENT OF THE INTERIOR, ENVIRONMENT AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2020

WEDNESDAY, MAY 1, 2019

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

The subcommittee met at 9:38 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Lisa Murkowski (Chairman) presiding.

Present: Senators Murkowski, Hyde-Smith, Daines, Udall, Tester, and Van Hollen.

INDIAN HEALTH SERVICE

OPENING STATEMENT OF SENATOR LISA MURKOWSKI

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

Today we are examining the fiscal year 2020 budget request for the Indian Health Service. I would like to thank Rear Admiral Michael Weahkee, who is the Principal Deputy Director, for joining us here this morning. The head of IHS is a pretty tough job.

Accompanying Rear Admiral Weahkee is Rear Admiral Michael Toedt, who is the Chief Medical Officer. Good to have you here. We have Ann Church, the Acting Director for the Office of Finance and Accounting, and Gary Hartz. Gary, you have been before this subcommittee for so many years running. How many years? A long time. Well, we appreciate that service. Gary is the Director of the Office of Environmental Health and Engineering. Thank you all for being here today.

The IHS budget request for fiscal year 2020 is \$6 billion for programs within this subcommittee's jurisdiction. This is an increase of \$140 million, or a 2.4 percent increase above the fiscal year 2019 enacted.

There are some bright spots in this year's budget proposal to take steps to address important health concerns in our Native American and Alaska Native communities, and a few other areas where we need some additional information that we hope to receive today.

The IHS budget proposes \$25 million to focus on hepatitis C and HIV, \$25 million to support electronic health record modernization, fully funds contract support costs, and includes funding for the staffing packages for newly constructed healthcare facilities. I am

going to ask about the Yakutat facility on that as well. There is also a slight \$1.2 million increase for sanitation facilities construction. This is important for us in the State of Alaska.

While there are important increases in this budget and the Agency's budget has less reductions than others that we have seen in this subcommittee's jurisdiction, I am concerned about the proposed \$78 million decrease for healthcare facilities when we know that the need for construction across Indian Country is estimated at \$14.5 billion. I also want to make sure that we are using our resources efficiently and effectively to address the opioid epidemic. This has been especially acute for American Indians and Alaska Natives, and we need to make the right investments to help remove the Agency from the GAO high-risk list. I will explore these issues in more detail when we move to questions.

Before we do that, there is one issue that I would like to raise. Unfortunately we hear from media, more notably the "Wall Street Journal," about matters that have happened within the Agency, and we learn about them and we raise them in these budget hearings. It is not a good thing when it seems like it is almost an annual reference point for us. The most recent investigative report does not involve the Great Plains, as we have discussed in previous hearings, but is one that revealed how the Agency mishandled and routinely transferred a now convicted pedophile, Dr. Stanley Patrick Weber. Quite frankly, there are just not enough words to describe the anger, the disappointment, and the empathy for the victims.

I am hoping to find out today exactly what is being done by the Health and Human Services Office of Inspector General, the White House task force, and IHS to address this intolerable situation. I want to go on record that I am requesting any and all policy requirements that come out of the ongoing investigations. I think we recognize that our number one priority around here should be protecting people, especially our children, and this should come before anything else. So I want to make sure that we are taking steps to ensure that we never see situations like this again.

So, Admiral Weahkee, I look forward to your testimony.

I am now going to turn to Senator Udall, and then we will open it up. Senator Udall.

STATEMENT OF SENATOR TOM UDALL

Senator UDALL. Thank you, Madam Chairman.

I am pleased to join Chairman Murkowski in conducting this hearing on the fiscal year 2020 budget for the Indian Health Service.

I would like to welcome back Rear Admiral Michael Weahkee before the subcommittee this morning. Thank you for appearing before us, and thank you for sharing the Service's budget priorities. And I see you are joined by Rear Admiral Michael Toedt, the Chief Medical Officer; Rear Admiral Gary Hartz, Director of the Office of Environmental Health and Engineering; and Ms. Ann Church, Acting Chief Financial Officer. Welcome to all of you.

I am proud this subcommittee has made major investments in Tribal healthcare over the past several years, including increasing the Indian Health Service budget by 25 percent since fiscal year

2015. And a lot of that credit is due to the leadership of our Chairman, Senator Murkowski, and I have been honored to fight for funding alongside her as Ranking Member of this subcommittee. I am proud of our funding accomplishments, but clearly there is more work to do in fiscal year 2020.

With that in mind, I must note my concern that we are beginning work on fiscal year 2020 appropriations bills without the benefit of a budget agreement. While I am confident that Congress will ultimately negotiate a budget deal to prevent a devastating repeat of sequestration, it is imperative we put a budget deal in place that provides increased top line spending levels. Without a deal in place, we cannot move forward with funding essential agencies like the Indian Health Service and ensure that we continue to make good on our Nation's trust and treaty obligations to Native Americans. And that is all the more ironic because, while the overall Trump budget is lacking, the budget request for the Indian Health Service actually puts forward important investments that we ought to enact into law.

And I am happy to see a better budget request this year than we have seen in recent years from this administration. The request fully funds contract support costs and staffing for newly constructed healthcare facilities, expands clinical care programs and access to substance abuse and mental health treatment, proposes beginning a new community health aide program to train healthcare paraprofessionals in the Lower 48 States, just as the IHS currently does in Alaska, and asks for resources to continue integrating newly federally recognized Tribes into the Indian healthcare system and for the administration's initiative to reduce HIV and hepatitis C infections, two preventable and treatable diseases that disproportionately impact Native populations.

The budget request also includes \$25 million to initiate replacement of the Service's electronic health record system, a down payment on what is likely to be a multi-billion dollar investment in a long overdue project Tribes and Congress have been concerned about for years.

These proposals, combined with the 2 percent overall for the Agency and a 4 percent increase for medical services programs, are certainly a step in the right direction.

But the overall budget still falls short of meaningfully addressing the healthcare needs of Indian Country. And I am concerned by some of the tradeoffs, cuts, and false choices that are proposed in the budget. Funding for health education is eliminated completely, and the urban Indian health programs are cut by 5 percent.

Line item construction is slashed by one-third, a retreat from important investments that this subcommittee has made over the last few years. I reject the notion that cutting construction makes any kind of sense when some of these projects, like the replacement of the Gallup Indian Medical Center in New Mexico, has been on the priority list for nearly 3 decades. There are more than \$2 billion worth of construction projects in total on the current priority list and billions more in additional facility needs once those are completed.

I am also disappointed that the budget does not continue the \$10 million for Tribal grants to combat opioid addiction that were funded by this subcommittee in fiscal year 2019.

And although some new funding is devoted to recruitment and retention initiatives, like special pay authorities and housing subsidies, the budget request cuts funding for scholarship and loan repayment programs by nearly one-quarter, or \$14 million, even though the Service's inability to recruit and retain healthcare professionals is a major reason why the Agency has been part of the GAO high-risk list for the past several years.

Another administration proposal related to recruitment and retention in the budget asks to expand the use of Title 38 authorities used by the Veterans Administration at the IHS. In previous years, this subcommittee has encouraged you to make use of incentive programs like those found in Title 38. But this year's legislative request proposes access to a much broader set of authorities. We need to fully understand what impact these authorities would have on the workplace rights of employees. God bless you, Mr. Hartz.

The administration's request would also cut funding for the community health representatives program by 60 percent, in part to help pay for the proposal to establish the new community health aide program. Tribes in New Mexico and across the country use this program to provide frontline health education and wellness services and to transport patients in my State to doctors' appointments that can be hundreds of miles away from Tribal members' homes. We should not cut the community health representative program to fund the health aide program when both programs fill different but important gaps in healthcare service in Indian Country.

There are other challenges that the Service faces that we need to address. I want to hear from the Service about what steps the Agency has taken to protect Indian Country from horrifying misconduct like that of Stanley Patrick Weber, who was convicted of assaulting young patients over the course of several decades while serving as an IHS pediatrician. And I join the Chairman in her statements as to how disappointed and discouraged she is with what happened there. As part of that, I expect the Service to discuss the steps it is taking to improve its employee screening and credentialing system and to ensure that any workplace incidents are properly reported and documented. Employees with histories of egregious misconduct must not slip through the cracks.

And finally, given the recent partial government shutdown and potential for ongoing uncertainty during the fiscal year 2020 budget cycle, I look forward to having the opportunity to discuss advanced appropriations with you, Admiral Weahkee. Even though a few months have passed, I want to make sure that Indian Country knows that we have not forgotten the hardships caused by the government shutdown earlier this year. I saw what happened in New Mexico, and I heard from Tribal members across the country about the terrible price of the 35-day lapse in funding, whether it was medical providers working without pay, urban organizations forced to cut services and even close their doors or Tribes struggling to keep ambulance services running. The impacts of the shutdown were far-reaching and caused enormous suffering. I want to make

sure that Tribes never have to worry again whether basic healthcare services will be provided in the event of a shutdown.

And that is why I was proud to introduce legislation, the Indian Programs Advanced Appropriations Act, that would provide funding certainty for the Indian Health Service and the Bureau of Indian Affairs by allowing their budgets to be funded a year in advance. I know that my colleague, Senator Murkowski, has sponsored similar legislation in past Congresses and has been a leader on this issue. I am hoping that we can work together on a bipartisan basis to pass legislation to authorize advance appropriations, and I look forward to working together on this critical goal.

Admiral Weahkee, I look forward to hearing your testimony.

Thank you very much, Madam Chairman. Sorry for going a little longer but we have a lot before us here today.

Senator MURKOWSKI. We do and I appreciate that. I also appreciate your leadership on some of these legislative initiatives that will supplement or complement so much of what we are trying to do here within the subcommittee.

With that, Rear Admiral Weahkee, we welcome any comments that you would share before the subcommittee and that of any of your colleagues that are at the table with you.

STATEMENT OF REAR ADMIRAL MICHAEL D. WEAHKEE, PRINCIPAL DEPUTY DIRECTOR

ACCOMPANIED BY:

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

Admiral WEAHKEE. Thank you and good morning, Chairman Murkowski, Ranking Member Udall, and Members of the subcommittee.

I am Rear Admiral Michael Weahkee, Principal Deputy Director of the Indian Health Service and a member of the Zuni Tribe out of New Mexico and Arizona.

I want to thank you for your support and for the opportunity to testify on the President's budget for fiscal year 2020.

The budget advances our Indian Health Service mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The President's fiscal year 2020 budget proposes \$5.9 billion for the Indian Health Service, and this includes \$25 million to eliminate hepatitis C and to end the HIV epidemic in Indian Country. With the resources and tools that we have available to us today, we have an unprecedented opportunity to make a real difference in reducing hepatitis and HIV infections.

The budget also proposes \$25 million to begin transitioning to a new and modernized replacement of IHS's electronic health record, the Resource and Patient Management System, or RPMS. Our current aging system exists as more than 400 separate instances that are maintained at individual locations throughout the country. Replacing this antiquated system with a single modern national system would enable IHS to enhance medical quality, maximize the time that our doctors, our nurses, and other healthcare profes-

sionals have to provide direct patient care and increase the security of our patients' medical records.

We have also requested \$20 million to launch a national expansion of our paraprofessional program, the Community Health Aide Program. This program of certified health, behavioral health, and dental health aides will enable us to fill critical care gaps throughout Indian Country. The program has been used for decades in Alaska to great success, and I believe its expansion into the rest of the country would be extremely beneficial.

Our budget proposes an additional \$8 million to recruit and retain medical professionals which are critical to addressing gaps in care.

To complement the increase, legislative changes are also proposed to provide tax exemption for our Indian Health Service scholarship and loan repayment programs, allowing us to provide \$7 million in additional awards and provide discretionary use of all Title 38 personnel authorities, which would provide parity with other Federal healthcare systems like the VA.

The budget prioritizes direct clinical healthcare services and maintains commitments for staffing of newly constructed healthcare facilities, which required some difficult choices, including a reduction in our facilities investments, phasing out of the funding for our community health representatives program, and two proposed program discontinuations for our health education line and for our Tribal management grants.

The budget will enable us to implement our new IHS strategic plan for fiscal years 2019 to 2023, which includes three overarching goals to increase access to care, improve the quality of the care that our system provides, and to improve our management and operations of the Agency. Our plan is the result of robust collaboration with our Tribes and with our urban Indian organization partners over an 18-month consultation and confer period, and it is the first strategic plan that the Agency has had in almost a decade.

The Indian Health Service has also realized significant improvements to quality of care, including the establishment of a new Office of Quality at Indian Health Service headquarters.

We implemented a new standardized provider credentialing and privileging software system agency-wide that now includes the files for all licensed independent practitioners working either directly as Federal employees or as contractors.

And we have recently awarded a new adverse events reporting system that replaces an older legacy system known as WebCident.

I am also happy to report that since October of 2018, we have had more than 16 of our IHS facilities undergo surveys, all of which were successful, and with the support of the new Office of Quality, we expect continued improvement and enhancement of quality of care for American Indians and Alaska Natives served across the Nation.

Regarding the recent media reports on patient abuse by a former Indian Health Service employee, I recently met with the Tribal leaders from both of the impacted Tribal communities to discuss the steps that the Indian Health Service has taken to ensure the protection of patients at all Indian Health Service facilities. I expressed my personal sincere regret that children were victimized by

those who were entrusted to care for them, and I made it absolutely clear that IHS will not tolerate sexual assault or abuse in any of our facilities. Our workforce understands how serious this issue is, and I am proud of the efforts and the commitments of our staff for the progress we have made and we will continue to press forward on this issue.

The IHS remains firmly committed to improving quality, safety, and access to care for American Indians and Alaska Natives and we appreciate all of your efforts in helping us to provide the best possible healthcare to the people that we serve.

With that, Chairman, I am happy to answer any questions that the subcommittee may have.

[The statement follows:]

PREPARED STATEMENT OF REAR ADMIRAL MICHAEL D. WEAHKEE

Good morning Chairman Murkowski, Ranking Member Udall and Members of the subcommittee. I am Rear Admiral Michael Weahkee, Principal Deputy Director of the Indian Health Service (IHS). Thank you for your support and for the opportunity to testify on the President's fiscal year 2020 budget. The budget advances our mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level. As an agency within the Department of Health and Human Services, the IHS provides Federal health services to approximately 2.6 million AI/AN from 573 federally recognized Tribes in 37 States, through a network of over 605 hospitals, clinics and health stations.

The President's fiscal year 2020 budget proposes \$5.9 billion in total for IHS, which is \$392 million above the fiscal year 2019 annualized continuing resolution funding level, or \$140 million above the fiscal year 2019 Consolidated Appropriations Act. The President's budget grows the resources available to meet the nation's commitment to AI/AN in a constrained budget environment, reflecting a strong commitment to Indian Country. Specifically, the budget prioritizes direct clinical healthcare, providing a 7 percent increase and makes crucial investments in the fight against Hepatitis C and HIV/AIDS, launches a national expansion of our health paraprofessional program and provides resources for planning and key infrastructure improvements for a replacement electronic health record system (EHR). The budget also proposes to extend our successful Special Diabetes Program for Indians (SDPI) through fiscal year 2021, at \$150 million per year.

The President's budget provides \$25 million to expand partnerships between IHS and Native communities to eliminate Hepatitis C and end the HIV epidemic in Indian Country. With the resources and tools we have available today, we have an unprecedented opportunity to make a real difference in reducing hepatitis and HIV transmission. I'm pleased that IHS is taking part in the "Ending the HIV Epidemic: A Plan for America" initiative.

The budget also provides \$25 million to begin transition to a new and modernized replacement of IHS's electronic health record system, Resource and Patient Management System (RPMS). These resources are critical to allow IHS to conduct planning for this transition and address key infrastructure gaps necessary to implement a modern EHR. Our current system exists as more than 400 separate local instances rather than a single system, hobbling our efforts to share medical information efficiently, improve monitoring of medical quality, and recover critical third party financial resources.

A modern system would enable IHS to enhance medical quality, maximize the time our doctors, nurses and other health professionals are providing direct patient care, and increase the security of our patients' medical records. I believe this transition represents an opportunity to meaningfully impact the care received by our patients.

We have also requested \$20 million to launch a national expansion of our paraprofessional program, the Community Health Aide Program (CHAP). This program of certified health, behavioral health, and dental aides will enable us to fill critical care gaps. This program has been used for decades in Alaska to great success and I believe its expansion into the rest of the country will be beneficial and an important tool in meeting the health needs of AI/ANs, as part of a mix of services determined at the local level.

In addition to these key initiatives, our fiscal year 2020 budget includes:

- \$147 million to expand direct clinical health services, including dental, mental health, alcohol and substance abuse services;
- \$8 million to recruit and retain medical professionals, critical to addressing gaps in care;
- \$2 million to bolster the Office of Quality;
- \$11 million to fund the healthcare of six newly federally recognized Tribes;
- \$98 million to fully fund staffing at four newly completed or expanded healthcare facilities, including 3 joint venture facilities and a youth regional treatment center;
- \$69 million to support current services, including pay costs, inflation, and population growth; and
- \$855 million for Contract Support Costs, which currently aligns with our estimate of those costs.

The budget prioritizes funding for key investments in support of direct clinical health services, and in doing so proposes some program adjustments. A net reduction of \$66 million in Facilities ensures continued priority focus on maintaining existing facilities and addressing continuing sanitation facilities construction projects. Phase out of funding for the CHR program is contemplated with a funding level of \$24 million, as part of proposed reforms to current community-based care. The President's budget also proposes two program discontinuations, including the Health Education and Tribal Management Grants programs, which total \$23 million.

The budget will enable us to implement our newly released Indian Health Service Strategic Plan for fiscal year 2019–2023. The Strategic Plan will improve the management and administration of the IHS and sets the strategic direction of the agency over the next 5 years. The Strategic Plan includes three goals that will guide our efforts—access to care, quality of care, and strengthening management and operations. The final plan is the result of collaboration with our Tribal and urban Indian organization partners who offered their feedback and expertise.

Aligning with the IHS Strategic Plan, four legislative proposals are included within the budget to increase access to care by: providing tax exemption for IHS scholarship and loan repayment programs, providing discretionary use of all Title 38 personnel authorities, meeting loan repayment and scholarship service obligations on a half-time basis, and providing Federal Tort Claim Act coverage for IHS volunteers. These proposals focus on parity with authorities provided to other Federal agencies providing healthcare services and seek to strengthen agency efforts to recruit and retain healthcare professionals.

The IHS has also realized significant improvements to quality care for AI/ANs, including:

- Establishing the Office of Quality as an elevated national oversight component within IHS Headquarters;
- Implementing a new standardized professional provider credentialing and privileging software agency-wide for all applicants; and
- Awarding a new contract for an adverse events reporting and tracking system that replaces an older legacy system.

I can also report to you that since October 2018, 16 IHS healthcare facilities have had surveys by either the Centers for Medicare & Medicaid Services (CMS), the Joint Commission (TJC) or the Accreditation Association for Ambulatory Health Care (AAAHC). All surveys have resulted in CMS certification or TJC and AAAHC accreditation. This includes both Rosebud and Rapid City hospitals, and the IHS is preparing to send a request to CMS for a certification of the Pine Ridge Hospital.

Lastly, I want to take this opportunity to talk about an important issue to all of us at the IHS. Regarding the recent media reports on patient abuse by a former IHS employee, we have taken every opportunity to speak with our Tribal and urban partners, as well as our Federal employees, about how this conduct is unacceptable and will absolutely not be tolerated at IHS.

Recently, I met with the Oglala Sioux Tribal Council in Pine Ridge, South Dakota, to discuss steps IHS has taken to ensure the protection of patients at IHS healthcare facilities. I expressed my sincere regret that children were victimized by those entrusted to care for them and have made it absolutely clear that IHS will not tolerate sexual assault and abuse in its facilities.

This opportunity followed a similar meeting I had in February with the Blackfeet Nation in Montana. These two communities were victimized by the actions of the former IHS employee. I want to thank the leadership of the Oglala Sioux Tribe and the Blackfeet Nation for their partnership as we work to re-establish trust with our patients.

As shared in my October 2018 letter to Tribal leaders, I can promise you that IHS will continue our efforts to ensure safe and quality care for our patients. We are

committed to doing whatever it takes and will continue to work closely with our Tribal and urban Indian partners in transforming healthcare for AI/ANs across the Country. Some of the actions I have already taken include implementing new professional standards and stronger requirements for IHS employees to report suspected sexual abuse and exploitation of children. The implementation of our new centralized credentialing system will enable us to monitor the practice history of licensed healthcare professionals across the agency.

The Presidential Task Force on Protecting Native American Children in the Indian Health Service System announced in March will complement our ongoing efforts to identify areas for improvement and implement changes to strengthen our systems. IHS is in the process of identifying an outside, independent contractor to conduct a medical quality assurance review to examine whether laws, policies and procedures have been followed, and to identify any further improvements IHS can implement to better protect patients. The HHS Office of the Inspector General has also been tasked with reviewing the effectiveness of the actions we have taken.

I assure you that our workforce understands how serious this issue is, and I am proud of the efforts and commitment of our staff for the progress we've made, and we continue to press forward. We remain firmly committed to improving quality, safety, and access to healthcare for AI/AN, 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.

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

Senator MURKOWSKI. Thank you, Admiral. And I take it then that the others are standing by to answer questions and do not have statements. Very good.

VILLAGE BUILT CLINICS AND 105(L) LEASES

Let me begin with an issue that I talk about every year, and that is village-built clinics. As you know, we see great benefit from that in Alaska, but there is the issue of the 105(l) leases. Since the Maniilaq decision a couple years ago, we have been trying to figure out what the impact of the costs that are mandated for leasing when Tribal facilities are used to operate IHS programs.

The fiscal year 2019 omnibus provided \$36 million to support both the 105 leases and the VBCs. As I understand it, the budget that we have in front of us does not include separate funding for the leases. I am trying to understand how we are going to address the need for village-built clinics with this mandate under the 105(l) leases.

Can you update me on what you anticipate the estimate for 105(l) costs are for this year, and what funding are you planning on using to support these? And is this a tradeoff situation here between providing clinical services and meeting the lease funding requirements? Walk me through where we are with VBC versus 105(l)s.

Admiral WEAHKEE. Thank you, Chairman Murkowski.

And this is definitely an area that we have been working on very closely over the last 2 years. We have had funding provided in the past, as you noted, for village-built clinics, \$11 million 2 years ago. Our area director in the Alaska area, Mr. Chris Mandregan, held formal consultation on the use of those funds, and it was determined that \$6 million of that \$11 million would be set aside specifically for village-built clinics. The other \$5 million would be used for this new requirement to fund 105(l) leases.

Since that time, with Congress' support, we have now got additional funds to address 105(l) leases. We have initiated Tribal consultations—

Senator MURKOWSKI. Where have those come from? Have those come from the village-built clinic account? What I am trying to understand is how we are meeting the needs on both accounts, and if you are taking from the VBC account to supplement your requirement under 105(l), I am going to have a little bit of heartburn with that. How are we distributing the funding between the two responsibilities that we have here?

Admiral WEAHKEE. Thank you.

We are using \$5 million of that \$11 million that was identified for village-built clinics for 105(l) leases. Many of the village-built clinics have pursued 105(l)——

Senator MURKOWSKI. Right.

Admiral WEAHKEE [continuing]. As their option as opposed to the VBC specific money. So in that sense, the \$5 million that has been put forward towards VBCs is being used for the same clinics.

In the most recent years, we have been consulting with Tribes on what other funding source that we have the discretion to use—should we use to meet the unmet need for 105(l) leases. Last year, the total need grew to about \$25 million by the end of the fiscal year.

Senator MURKOWSKI. Right.

Admiral WEAHKEE. So we were put into a situation where we ended up having to pull from our inflation increases to make up for that gap.

And this year, we have initiated consultation with the Tribes to ask again what are your recommendations on both the short-term and the long-term fixes to meet this need.

Senator MURKOWSKI. As I understand it, we can anticipate that that number is going to increase from year to year. If it was \$25 million last year, what do we expect it to be in the next fiscal year?

Admiral WEAHKEE. Thank you, Senator.

As of today, that need has grown to \$54 million. In our initial conversations with finance and Tribal leaders, we do anticipate that that number could be as high as \$138 million in fiscal year 2020.

Senator MURKOWSKI. Walk me through that then. If \$54 million is the need now, how are we funding to meet that need, and if we know that that is effectively going to more than double in the following year, how are we seeing that reflected in the budget in the breakdown?

Admiral WEAHKEE. Currently it is very difficult for us to assess what that dollar amount is going to be because we do not have any single inventory of the buildings that are owned by Tribes throughout the country and how many leases are going to come forward. So we are putting together a technical work group to help us come up with a methodology for identifying the out-year costs. But at this point, we are really looking to make up that funding source with discretionary funding that we have available to us without taking money away from any existing annual funding agreements or from direct services.

Senator MURKOWSKI. I want to make sure that I understand where we are right now. How much will you be looking to take out of a discretionary account to backfill to make sure that we are meeting the needs within this budget?

Admiral WEAHKEE. I am going to turn to my CFO to give me a quick count.

Ms. CHURCH. Currently based on our need of \$54 million as of the end of April, we anticipate that, with the generosity of Congress and certainly the support of this subcommittee that the \$36 million in total, again as Admiral Weahkee mentioned—\$6 million of that already goes on a recurring basis to the VBCs. So the remainder of those funds, along with—

Senator MURKOWSKI. So you got \$5 million there.

Ms. CHURCH. Plus the \$25 million increase. So we have a total of \$30 million in the Tribal clinic funding line. And what we are looking to do is, through the Tribal consultation and urban confer, determine what the next steps would be. Part of the consultation included a proposal that we may need to use those inflationary dollars similar to what we did in 2018, but that decision has not yet been made. So you can expect that we will certainly be in contact with the subcommittees.

Senator MURKOWSKI. I guess my frustration is we had the same conversation last year and said we do not know what it is going to be the next time we come before the subcommittee for the ask on this, but we know for a fact that it is going to be more and we are going to have to start to grapple with it. We are now grappling with it, but it does not sound like we have any better funding solutions, which is concerning, and you do not see it wrapped into the budget when you are looking to take it out of some vague discretionary account.

Know that I am very worried about this because I only see this number growing, and until we can figure out how we are going to meet this obligation, it is going to be a situation not unlike what we faced for years with our failure to comply with the obligation to fully fund contract support costs. We have got to get our arms around what is happening with this, the requirements, the obligations, and how we budget accurately for it.

Senator Udall.

Senator UDALL. Thank you, Madam Chair.

DR. STANLEY PATRICK WEBER

Admiral Weahkee, when you came before the Senate Indian Affairs Committee in March, we had the opportunity to talk to you about the failure of the IHS management to take action against and stop Dr. Stanley Patrick Weber who, as you know—and you spoke to it in your opening statement—abused his position working as a pediatrician in the Indian Health Service facilities to prey on children for 2 decades.

Although evidence has been uncovered by the “Wall Street Journal” that shows facility and service area managers were aware of the reports of Weber’s egregious misconduct, the Service is still unable to explain why more immediate action was not taken when these allegations were brought forward multiple times, why Dr. Weber was simply moved around rather than face disciplinary action, and whether Agency staff have access to the right policies, training, and culture to make sure that a situation like this never happens again.

After that hearing, you assured Members of the subcommittee that the Agency planned to undertake a quality assurance review of Dr. Weber's case to determine what systems broke down and you also flagged several termination actions that the Agency had undertaken as a result of your broader efforts to root out misconduct similar to Dr. Weber's.

We asked you to provide follow-up on these issues. However, to date, the subcommittee has not received any follow-up from you on either one of these matters. I would like to renew the request and make sure the Appropriations Committee is also fully briefed.

Has the Agency issued a contract for its formal review, and how long will it take to receive the results?

Admiral WEAHKEE. Thank you, Vice Chairman Udall.

I want to assure you that the Agency is moving forward full force on all fronts to address this issue. And the testimony I provided in March about both the medical quality assurance review, in which the finalization of a contract is imminent, we have solicited and gone through the full formal solicitation process, reviewed vendor qualifications, and we are now at the point where a selection should be named just any day.

I want to point to Mr. Jonathan Merrell, who is here with us in the audience. He is our new Office of Quality Director. He will have oversight responsibility for this contract and the follow-up work as part of the medical quality assurance review oversight. And he will also be the one selecting and being the contract officer representative on this contract.

So it is imminent. We cannot probably name names in a hearing like this, but I expect that we will be able to share that vendor name with you very soon.

With regard to the personnel actions, there are a number that have been effected and that are still underway, some of them leading all the way up to termination. I am happy to provide more specifics for the record when we have those personnel actions completed.

Senator UDALL. Okay.

Finally, your written testimony notes that IHS has implemented new professional standards and reporting requirements. Can you share the details of the actions you have taken with us?

Admiral WEAHKEE. Thank you, sir.

I would like to point to a couple of policies that we have put in place for the Agency requiring that all Indian Health Service employees be considered mandatory reporters. In the past, the Agency has only really had licensed practitioners who, as a result of being licensed, had a requirement to be a mandatory reporter.

I mentioned in my opening statement the credentialing software system that we put in place that helps us to track provider qualifications and performance history. That information is now portable and viewable not only at the local site, which it has been historically through a paper record, but it is now viewable at the area office and at headquarters level and others who need to take a look.

I am going to ask Dr. Toedt, who has also provided some Indian Health Service All emails elevating the expectation of all of our employees about reporting and inappropriate relationships, to speak a

little bit about his communications and anything else you would like to add that I may not be thinking of off the top of my head here.

Admiral TOEDT. Thank you, sir.

We have been working with the American Academy of Pediatrics Committee on Native American and Child Health, CONACH Committee, specifically on guidance for providers and health professionals with respect to preventing sexual abuse from health providers. It is completely unacceptable and will not be tolerated in the Indian Health Service. So we have been working very closely with them to develop those guidelines. They have been published. They are available on the IHS website. And now we have extended that requirement not only to health practitioners but to any employee aware of any allegations of abuse, that those be reported and they be reported through multiple reporting lines so that we have the greatest sensitivity and ability to manage those complaints, to investigate them, and to get to the bottom of any allegations.

Senator UDALL. Thank you, Madam Chair.

Senator MURKOWSKI. Senator Tester.

Senator TESTER. Thank you, Madam Chair and Ranking Member Udall. I appreciate you having this hearing.

I appreciate you all being here. I appreciate the job you do.

As you all know better than I, we have trust responsibility to the folks who are in Indian Country, our Native Americans, and we have to have somebody who is willing to fight for them and their budget. And that is in your guys' job description in my opinion. I have been through three different administrations, and I do not think any of those three administrations—and I want you to prove me wrong on you guys—have fought hard enough to make sure that the budget meets the needs of Indians in Indian Country. Let me give you an example.

URBAN HEALTH

More than 70 percent of the Native population lives in urban areas. More than 70 percent of our Native American population lives in urban areas. Yet, through this budget, 1 percent is proposed for urban health clinics, and there is a cut of that 1 percent of \$544 million in this budget. Tell me how you can justify those numbers. And from a Montana perspective—and they are all large land-based Tribes in Montana. I have been to our urban Indian clinics. They do incredible work, and that is no understatement. That is a fact. But they got no money, and you cannot do it on air. So tell me how this budget squares with the population in Indian Country.

Admiral WEAHKEE. Thank you, Senator Tester.

Our urban Indian programs are definitely a significant part of our Agency. We consider it the third leg of our stool, in combination with our federally operated sites and our Tribal operated sites. There are 41 urban Indian organizations funded throughout the Agency. As you noted, less than 1 percent of the Indian Health Service budget goes to fund those programs.

We definitely have other sources of funds that urbans are able to access through competitive grant processes. There are also sev-

eral of those programs that have sought funding through other parts of the Department of Health and Human Services such as the Health Resources and Services Administration (HRSA) 330 funding or CDC research grants.

Senator TESTER. And those grants are not in your budget. They are in HHS's budget.

Admiral WEAHKEE. Yes.

Senator TESTER. Okay. Keep going.

Admiral WEAHKEE. We do know, in working with our urban Indian health program, that there are many other urban sites throughout the country that would benefit from having an urban Indian program in their metropolitan area.

Senator TESTER. Yes. So I guess the point is—and I know that you guys do not make the final call. I think you guys probably put a budget up, and it ends up on Mulvaney's desk and he may take the axe to it a little bit. And I may be generous with those comments.

But the point here is we have trust responsibility. And if we want to address the issues of poverty in Indian Country, what is the motivation of getting off the reservation if you lose any healthcare benefits you have because urban Indian healthcare is funded at such a low level?

Admiral WEAHKEE. Well, the motivation is jobs and educational opportunities, all the social determinants.

Senator TESTER. But you see there is a push factor back. I mean, if I am going to lose benefits and uproot my family, those are big things. All I ask you to do is take another look at those numbers and see if they really do meet the needs of folks in Indian Country.

RECRUITMENT

One more question really quick, and I will do this very, very quickly because we went round and round about this a year ago. But I know for a fact that you guys are short on docs. You are short on nurse practitioners, all of the above. It is just the way it is. And it is a huge problem. It is a huge problem particularly in rural areas, and most of the Indian Country is in the rural areas.

Does this budget meet the needs for you guys to be able to go out and aggressively recruit more docs and nurses in Indian Country?

Admiral WEAHKEE. Thank you, Senator Tester.

We have included several items in the budget that will help us meet that goal, including legislative requests like the access to Title 38 authorities, taxability on our scholarships and loans. We have also identified the need to expand the incentive programs that we already have. Housing is another big issue. So we have asked for quarters funding. We have a housing subsidy that Congress has authorized for us to be able to help address the lack of housing in our rural sites. So we are moving forward on several of these fronts. Parity with the VA is big. Having that Title 38 authority so we can pay more, incentivize better is a key ask.

Senator TESTER. So I am going to have some additional questions, and most of those are going to be focused around what is being done with IHS and VA. I know there have been some successes, particularly in Alaska, but I think there is some oppor-

tunity for both agencies to be able to maximize one another's ability to serve the same population.

Did I hear you—and then I am going to go. But did I hear you say that you do not have any inventory of buildings within IHS? That was a question that Senator Murkowski asked.

Admiral WEAHKEE. I will clarify that the inventory that we are lacking is the tribally owned buildings. So we definitely have an inventory of our federally owned—

Senator TESTER. So you know what you have got.

Admiral WEAHKEE. We know what we have. We do not know what the Tribes own.

Senator TESTER. Okay, all right. Thank you very much.

Senator MURKOWSKI. Senator Hyde-Smith.

Senator HYDE-SMITH. Thank you, Madam Chairman.

SDPI

Under the current law, Admiral, the Special Diabetes Program for Indians is set to expire at the end of the 2019 fiscal year, as we are well aware. And I have very recently received a letter from the Chief of the Mississippi Band of Choctaw Indians, Phyliss J. Anderson, outlining how truly important that program has been for the Mississippi Choctaws and for Tribes throughout the entire Nation.

But according to her letter, nearly a quarter of the Native Americans living in the Nashville Indian Health Service area, which includes Mississippi, have diabetes. And given these challenges, I am glad that your budget supports extending this very important program to this population.

What are some of the positive outcomes that Tribes have experienced because of this program? We are looking for any bright light for any hope, and we are sure hoping there is improvement. Can you share some of that with me?

Admiral WEAHKEE. Thank you, Senator Hyde-Smith.

And I am definitely going to turn to our clinical expert pretty quickly on this to share some of the great stories.

I think that our Special Diabetes Program for Indians is one that can be pointed to with great success and the efficient, effective, accountable use of the funds that have been provided to Indian Country. We do have some great success stories, peer-reviewed journal articles that tout that success. So if Dr. Toedt does not mind sharing some of that great success, we appreciate it.

Admiral TOEDT. Yes. Thank you so much, Senator, for the question.

There has been great success with the Special Diabetes Program for Indians, and it is a bright spot for the Indian Health Service. We have seen a 54 percent reduction in renal failure, kidney failure, among patients with diabetes. And that is the only racial or ethnic group that has had a decline in kidney failure in diabetes. So the special diabetes program for Indians is definitely a bright spot and I think a model for other health programs.

And we have also seen a reduction in eye disease, which could lead to blindness from diabetes, and we have seen a reduction in new cases of diabetes. So there are definitely bright spots.

There is still much work to be done. We are still a population that is severely disproportionately affected by diabetes. I worked in the Nashville area. I was the chief medical officer in that area prior to being Chief Medical Officer at headquarters, and I know that with the Eastern Band of Cherokee, 50 percent of their elders have diabetes. And so it is still very prevalent and still very much a problem, but we are making great success with the resources that Congress has provided.

Senator HYDE-SMITH. Thank you.

Senator MURKOWSKI. Thank you, Senator, for raising that very important program. We certainly support that special diabetes program.

OPIOIDS

Let me ask about opioids. This is not unique to Indian Country, and we are seeing the impact of opioids throughout the country. But unfortunately, we look to some of the highest death rates from drug overdoses within Indian Country as we compare them to other groups.

There was a \$50 million set-aside in fiscal year 2018 and 2019, and we provided \$10 million to coordinate the Department's Assistant Secretary for Mental Health and Substance Abuse to create a special behavioral health pilot program in the Interior bill in fiscal year 2019.

How is IHS coordinating with other agencies within Health and Human Services to ensure that our Tribes and our Tribal organizations and our IHS facilities are able to receive funding to address the opioid epidemic? If you can speak specifically to the special behavioral health pilot program and how funding for that is being awarded and the level of coordination that we are seeing with that program and utilization by Tribes and Tribal organizations.

Admiral WEAHKEE. Thank you, Chairman Murkowski.

The Indian Health Service is one component of a large HHS-wide five-point strategy that Secretary Azar has rolled out under the leadership of Admiral Brett Giroir, who is our Assistant Secretary for Health. Within the Indian Health Service, Admiral Toedt is our lead, and we have a Heroin, Opioids and Pain Efforts Committee that was developed and leads many of the efforts in policy development, provider training, medication-assisted treatments. So I will ask Dr. Toedt to really give some more specifics.

But with regard to your question on cross-agency collaboration, much of that cross-agency collaboration is being done under Admiral Giroir's leadership. We have forums where we come together at the Department on a regular basis to ensure that we are covering the various points of that five-point strategy and not overlapping, making the best use of the funding that has been provided. As an example, CDC's focus is really on data and surveillance; NIH on research; FDA on identifying alternative pain management methodologies. So everybody has really got their niche, and we, as a service agency providing direct healthcare, are really focused on creating best practice protocols and meeting the needs of patients.

So I wanted to talk about one other example with the Substance Abuse and Mental Health Services Administration (SAMHSA). You mentioned the \$50 million that was provided to the Substance

Abuse and Mental Health Services Administration for Tribal opioid response grants. And we worked very closely with SAMHSA to help them devise a formula-based distribution methodology. One thing that we have heard from Tribes often is that they do not like competitive grants and that those who tend to succeed in obtaining competitive grants do so because they have greater capacity, they can afford a grant writer where other Tribes may not be able to compete at the same level. So competition—they would rather have the money directly provided without having to go through that.

So we worked with SAMHSA to devise something similar to what we do with our special diabetes program and getting as much of that funding into Indian Country and then allowing communities to develop prevention, treatment, and recovery support programming that best meets the needs of the local community.

So I will stop there and ask Dr. Toedt additional aspects on the opioids front.

Senator MURKOWSKI. Dr. Toedt, if you can speak to the special behavioral health pilot, if you are involved with that.

And I am going to expand the question a little bit more. We are talking about opioids and the response, but I think we recognize that it is just not addiction to the opioids. Meth has reared its ugly head again, and it is decimating communities. How we are dealing with other substances as well, whether it be meth or the perennial problem back in my State? It all begins with alcohol.

Admiral TOEDT. Thank you, Senator Murkowski.

Certainly I will quickly talk to what activities the Indian Health Service is doing, and then we will address also the issue about what we plan to do with the funding for the special behavioral health pilot program.

So the HOPE Committee, the Heroin, Opioids and Pain Efforts Committee, is our lead committee focusing on heroin and opioids, and then our alcohol and substance abuse program is the lead on alcohol issues and other substances abuse.

We do have a significant number of trainings that are available both live and online. We work on providing prescriber support so that the prescribers, the physicians, the nurse practitioners, the physician assistants are all aware of the latest evidence and trained on essential training in pain and addiction. And we require all of our prescribers to complete that training.

We have developed guidelines for chronic non-cancer pain management, dental acute pain management, addressing all of those issues.

With respect to treatment, we are trying to expand access, partnering with SAMHSA, partnering with HRSA on access for medication-assisted treatment therapy, and that is making sure that individuals have the support they need and the best evidence for a successful recovery.

With respect to harm reduction, certainly addressing first responders, making sure they have access to naloxone, law enforcement, Tribal law enforcement, BIA law enforcement, and making sure that communities have access to safe disposal services as well for those substances.

We are working to reduce maternal and perinatal substance exposure as well. So we have been working with the American Col-

lege of Obstetrics and Gynecology and have recently published guidelines specific for American Indian and Alaska Native women to reduce exposure and to treat those who are perhaps addicted to substances. We are also working with the American Academy of Pediatrics on similar work on the side of infants who are born addicted, and that continues to be a big problem in Indian Country.

And then finally we are working on improving our metrics. We have a great challenge in getting data that is accurate and responsive not only for the Federal side but for Tribes and supporting Tribes in their work in applying for funding. They have got to have the data they need to address the issue. So we are looking at improving our metrics and our data capabilities as well.

SPECIAL BEHAVIORAL HEALTH PILOT PROGRAM

With respect to the special behavioral health pilot program, we are engaging in Tribal consultation, and we want to make sure that we are responsive to the issues. Tribes tell us it is not just about opioids. It is often about methamphetamine. We see predominantly in Montana and Wyoming still a large prevalence of methamphetamine. Babies born to moms who are addicted to methamphetamine continues to be a big problem as well.

Alcohol continues to be a huge problem in Indian Country. Just looking at sheer numbers, that is certainly the greatest substance of abuse, and 3.8 times is the number that we still report for liver failure death rates in American Indians and Alaska Natives compared with all races. So there is still a great concern about alcohol and its effects and deadliness in Indian Country.

And then in some areas, we continue to see transition of patients from prescription drugs to injectable drugs, heroin, other substances of abuse.

So we recognize there is variation across Indian Country and the approaches need to be tailored for those Tribes. So engaging in that Tribal consultation is extremely important to get the feedback and direction from Tribes on how to spend that money.

Senator MURKOWSKI. Thank you for that update.

Senator Udall, we will defer to our colleague, Senator Van Hollen.

Senator VAN HOLLEN. Madam Chairman, thank you and the Ranking Member for all your work on this subcommittee.

Thank you all for being here.

MEDICAID

Admiral Weahkee, you probably will not be surprised to hear me ask this question because I have asked it in previous hearings, and that relates to the issue of the importance of Medicaid funding to the Indian Health Service. And as you know, we have had debates here in Congress over the last many years over proposed major cuts to Medicaid. The Affordable Care Act proposed elimination would have severely cut Medicaid funding, and even if you look at the budget that has been submitted by the administration this time, it calls for hundreds of billions of dollars of cuts to Medicaid.

If you could just remind the subcommittee what share of overall healthcare expenditures in Indian Country come from Medicaid. I believe it is close to 70 percent.

Admiral WEAHKEE. Thank you, Senator Van Hollen.

The percentage is 68 percent of our third party resources are coming from Medicaid programming. Approximately \$1.2 billion of third party is collected nationally by our federally operated sites, and 68 percent of that number is Medicaid.

Senator VAN HOLLEN. Got it.

So 2 years ago, I asked if you could provide us with an analysis of what impact the proposed cuts to Medicaid would have on the Indian Health Service. And I have the transcript here. You assured us on the subcommittee that we would get that information. The Chairman of the subcommittee asked for it at the same time. It has now been 2 years, and my understanding is we still do not have that analysis.

So I am going to ask you again. Is that almost ready? Are we going to get this analysis? Because we are debating this every year, and the Indian health system relies more on Medicaid than a lot of our other public health systems in the country. So I think it is fair to ask you for an analysis of what impact this would have. I am not going to read the transcript. For 2 years, we have been told that we are going to get this information. The fact that the Chairman of the subcommittee asked for it on an urgent basis at the time we were debating the repeal of the Affordable Care Act, we asked for it again last year. So when are we going to get it?

Admiral WEAHKEE. Thank you, Senator.

I have seen the data. I know we have the analytic capabilities. There are a lot of caveats that go with that information. Just to give you an example, when we analyzed an expansion State like the State of Arizona, we actually saw a decline in the Medicaid numbers. It was not a result of there being less Medicaid money. It was actually a result of Tribal programs contracting. I will name a couple of the big programs at that time. San Carlos and Sells, the Tohono O'odham Nation, both contracted in that year. And so when the Tribes take over the programs, we no longer capture those reports. And so it looked like a decrease in Medicaid funding when, in fact, we saw at most of our Federal sites a significant increase. So just being able to—

Senator VAN HOLLEN. Admiral, if I could, that is because it has not been cut. Right? I mean, I am not suggesting you do not have adequate Medicaid funding today because the Congress did not support the proposal to cut Medicaid by hundreds of billions of dollars.

What we are asking for is your assessment of what the impact of those cuts would be. Again, I am reading from 2 years ago where your response to my question was we will undertake that assessment and provide you with the information. We look forward to partnering with you.

Again, the Chairman has been asking for this information. And I had been led to believe that maybe you were on the cusp of actually providing the information to the subcommittee. Is that not the case?

Admiral WEAHKEE. I am hopeful that we are able to provide that information to you just as quickly as possible.

Senator VAN HOLLEN. Are we going to get the information?

Admiral WEAHKEE. From my standpoint, yes, sir.

Senator VAN HOLLEN. Thank you.

Senator MURKOWSKI. Senator, thank you for raising the issue yet again. I think we recognized at the time that that question was asked, there was great debate on where we were with the ACA and that impact. And you are right. I do recall saying that would be very, very helpful for us at that time.

We are no longer entangled in the immediacy of the discussion about the ACA, but from my perspective, coming from the State of Alaska, I know that we as a State are looking at ways that working with the Federal piece to understand how we can do better when it comes to providing a level of services in Alaska. This type of information would be helpful to us to understand the impact of the Medicaid payments and how it flows through the IHS system.

I can appreciate that there is entanglement there, but it really would be helpful to get a better handle on these numbers. I know that we were very frustrated a couple years ago because we could not discern it, and we figured that there has to be somebody who works within the hierarchy here who can figure that out. I think it was a reasonable request then and I still think it is a reasonable request. I will back Senator Van Hollen in his request for a greater understanding on that.

Admiral, yes.

Admiral WEAHKEE. Thank you, Chairman Murkowski and Senator Van Hollen.

I was reminded by our Chief Financial Officer that we have recently initiated an engagement with the Government Accountability Office specifically looking at the issue of impact of Medicaid for the Indian Health Service. So that is an engagement that is underway. Anything you would want to add on the scope?

Ms. CHURCH. Just in terms of that, so we do have data on the third party collections and what we have been able to collect for Federal facilities. For example, we have seen a 51 percent increase in Medicaid collections from 2010 to 2018. And what we hope is through our active participation in GAO's current engagement on looking at the effects of the Affordable Care Act on health coverage and funding for American Indians and Alaska Natives, that we will be able to help to address more of these questions that you have been asking.

So in addition to the data that we can provide on the third party collections State by State and looking at those trends, of course with the qualifiers of where we do not have access to Tribal collections data and there may be some other socioeconomic factors that contribute to those differences, but we hope with the GAO's study in progress that that will help address more of these questions.

Senator MURKOWSKI. When would you anticipate we should get that GAO report?

Ms. CHURCH. I know they have been working on it very steadily. And I think the initial anticipation was during the summer, but we do not control their schedule. We too are anxious to see the results. And I know they are working very hard on that.

Senator MURKOWSKI. I would ask that you report back to the subcommittee, and not a year from now when we have the next budget hearing, but as that report becomes available and we are able to review that, in conjunction with the data that you have col-

lected. We will be checking back in with you in, let us just say, 3 months or so to see where we are because I think this information would be helpful.

Senator Udall.

Senator UDALL. Thank you, Madam Chair.

TITLE 38

Admiral Weahkee, I noted the Service's proposal to extend special personnel authorities provided to the Department of Veterans Affairs under Title 38 of the United States Code to its employees, the Service's employees. The law already allows the Office of Personnel Management to delegate certain authorities regarding pay and hours of work to the Service. And you are seeking a legislative change to expand IHS access to all Title 38 authorities, including those that govern collective bargaining and adverse personnel. You seem to focus on the Title 38 authorities' pay incentives, but IHS already has those.

Given the service's longtime track record of whistleblower retaliation and reports of nepotism going back to the 2010 Dorgan report, Congress needs to fully understand the Service's intentions before it can consider this proposal.

Can you tell us precisely which Title 38 authorities the Service can and cannot access currently? Why is this legislation necessary when you already have many of these authorities?

Admiral WEAHKEE. Thank you, Senator Udall.

Related to Title 38, our major focus is on pay bands and incentives.

Senator UDALL. But you already have those.

Admiral WEAHKEE. We have the ability to access via a very administratively burdensome process, and we have to submit individual requests that take months and sometimes years to develop. To give you some recent examples, we created pay bands for our certified registered nurse anesthetists, CRNAs. And the packages that our HR Office has to put together gathering the justification information—all of that work would be alleviated. Those months of work would be alleviated if we could just access directly the Title 38 VA pay tables.

Senator UDALL. But you said the IHS needs access to Title 38 employee discipline authorities. Can you state why you believe access to these specific authorities is necessary and how the administration believes they will directly benefit the Service?

Admiral WEAHKEE. Thank you, Senator.

I think one good example is the 2-year probationary period that comes with Title 38. We currently have 2-year probationary authority in the Indian Health Service for Indian preference employees hired under excepted service. We do not have that same authority for a 2-year probationary period for clinicians who are hired into clinical positions. If we identify an issue with that provider's performance early on in the first 2 years, we would be able to address it much more readily.

Another authority that comes with that Title 38 authorization is that cases for clinical competency, clinical concerns would not have to go to the MSPB, the Merit Systems Protection Board. They could be handled within the Agency with the expertise of a healthcare

system that understands healthcare operations, hospital operations. So having the ability to assess clinical competency by a healthcare entity as opposed to a Merit Systems Protection Board would be another good example and I think one of the reasons why the VA has that same authority.

GALLUP INDIAN MEDICAL CENTER

Senator UDALL. Now, shifting over quickly here to the Gallup Indian Medical Center (GIMC), I know they have gotten \$2 million in planning funds for fiscal year 2019. A replacement of this facility, as you know, is desperately needed, as you saw last year when the facility's issues contributed to the GIMC nearly losing its accreditation.

I understand there have been discussions with the Navajo Nation about finalizing a site for the project, which is critical, given that the project is finally ready to start moving. Could you please let us know what the status of those discussions are and what steps IHS is taking to finally break ground on the facility replacement?

Admiral WEAHKEE. Thank you, Senator Udall. And we appreciate the fact that Gallup is, after all these years, now close to the top of our grandfathered healthcare facility replacement list.

After being here last year and sharing with you some of the concerns that we faced with accreditation and certification at that location—GIMC was built in the late 1950s, opened its doors in the early 1960s. So it is one of our most aged facilities and very much due for replacement.

Admiral Hartz can provide us with the site selection reviews that have been underway. I know that I met just about a month ago with President Nez from Navajo Nation, and he came with a new proposal regarding the Gallup Indian Medical Center site selection. And we know that there is a lot of interest from the City of Gallup Mayor, the New Mexico State Governor's Office. We have had a lot of interest in this particular project. So I am going to ask Admiral Hartz if he can give the latest update on where we are at.

Admiral HARTZ. Thank you, Senator Udall. Good to see you again. We had two daughters born at GIMC. So I am very familiar with that facility.

As Admiral Weahkee has indicated, this facility has been on the list for quite some time. We did go through an initial site selection evaluation in 2005. We looked at 10 sites within and near Gallup and from that, identified the top couple sites. Then more recently with President Begaye, of the Navajo Nation offered an alternative site, which we embarked on a couple years ago another site evaluation based on the site that the Nation was proffering.

Based on that review, we went back and looked at the top three sites, added the newly recommended site, and the number two site in the previous evaluation became the number one site.

And then about 4 to 6 months ago, the current president proffered another site. We are currently looking at the viability of that. We have not progressed to a formal site evaluation. We are looking at the viability. We are anxious to move forward on the construction of this much-needed facility. This subcommittee has given us tremendous resources to move forward, and all of the projects that are on the grandfathered list now have money in them to move

them off the list. And this is a big project. And that planning money is in a position now so we can actually start thinking about what it is going to be regardless of the site, but we need to make that decision, and we are looking forward to moving this project along.

Senator UDALL. Thank you.

Senator MURKOWSKI. Thank you, Senator Udall.

Senator DAINES. Thank you, Chairman Murkowski and Ranking Member Udall.

Admiral Weahkee, good to see you again. Thanks for coming today.

STANLEY PATRICK WEBER

I would like to start out with Stanley Patrick Weber, a topic of much discussion today. As you well know, Mr. Weber was a former IHS pediatrician, was convicted of sexually abusing children on the Blackfeet Reservation in Montana. Despite numerous reported suspicions of Weber's inappropriate behavior, IHS turned a blind eye and enabled Weber to continue his unspeakable action for years. IHS failed to protect the children they were entrusted to care for. Accountability must be demanded.

I applaud President Trump for creating a task force on protecting Native American children in the IHS system with the aim of investigating the systemic and institutional breakdown that enabled Weber to sexually abuse children for decades.

I am also aware that the Inspector General at HHS is conducting a review, and an outside independent contractor is looking into as well. It is good to see action being taken.

Admiral Weahkee, I know Ranking Member Udall asked for an update on the quality assurance review. Could you provide an update on the findings of the presidential task force?

Admiral WEAHKEE. Thank you, Senator Daines.

The initial review—this group has met one time, and they have had a form and storm meeting. We are fortunate that we do have one of our Indian Health Service clinicians, a pediatrician, who has some sexual assault background, as a member of this task force. She comes from our Navajo area, Shiprock Service Unit, and so she will be involved as a subject-matter expert supporting this group that has very broad cross-representation, Department of Justice and other stakeholders from the White House Office of Management and Budget.

So their first meeting was really meant to scope their project. We anticipate that they will be taking a much bigger picture view of not only the situation and how the Indian Health Service has dealt with it, but also potentially some jurisdictional issues, crossover from FBI and Tribal law enforcement and how the Agency communicates and hands information back and forth between law enforcement and healthcare. So I anticipate that the White House review is going to be a much more bigger picture view. We do not have a lot of insight into where they are going to be and when they are going to be there, but we do anticipate that their review will be complementary to that of the Office of the Inspector General's and to our own medical quality assurance review.

Senator DAINES. Admiral Weahkee, thank you.

I want to thank you for responding to my letter. It was a letter I sent to you back in February asking what steps can prevent it to ensure this never happens again, what happened with Stanley Weber and what steps you will be taking regarding accountability to prevent this systemic failure from ever happening again. You sent me a letter back. I received it yesterday. So thank you for that. I appreciate it.

I also sent a letter in March to Secretary Azar urging him to take whatever action necessary within his authority to prevent Mr. Weber from receiving his government pension. It is reported to be around \$100,000 per year. That is outrageous.

I understand Weber was part of the U.S. Public Health Service commissioned corps, which falls under the Surgeon General.

With that said, could you provide an update on IHS's and the Department's efforts to remove Weber's pension?

Admiral WEAHKEE. Thank you, Senator Daines.

We have been working closely with the Office of the Assistant Secretary for Health and the Office of the Surgeon General who have oversight for the commissioned corps personnel system. I have personally submitted a letter requesting that Dr. Weber's retirement pay be discontinued, and we are working through with legal counsel whether or not we have the authority to do that. Dialogue continues as we evaluate whether or not we have current authority or if we are going to need to seek legislative support to make those changes.

Senator DAINES. We will be working on the legislative support as well. And I want to encourage you and Secretary Azar to continue pursuing every possible avenue to hold Mr. Weber accountable and to strip Mr. Weber of his pension. It is shocking that a government employee can still receive a pension after being convicted of sexually abusing children. That is unacceptable, which is why I am going to be taking action, introduce in fact that bill today to fix this very flawed system. It is called the Denying Pensions to Convicted Child Molesters Act, and it will do exactly that. Any monster who is guilty of the unspeakable crimes that Stanley Patrick Weber was convicted of in Montana will not receive a Federal Government pension. A convicted pedophile should not receive 1 cent of taxpayer money in retirement benefits.

MISSING AND MURDERED NATIVE WOMEN AND GIRLS

Lastly, this Sunday will be May 5. It is an important date because it is the birthday of Hanna Harris. Hanna was a 21-year-old mom, a member of the Northern Cheyenne who was reported missing and found murdered in July of 2013. Hanna would have turned 27 this year. I have introduced a resolution that designates May 5, Hanna's birthday, as the National Day of Awareness for Missing and Murdered Native Women and Girls. More light must be shed on this crisis of missing and murdered indigenous women.

METHAMPHETAMINES

In fact, in Montana, part of the bigger issue with violent crime is the dramatic increase we are seeing in meth use. Indian Country is especially suffering from the influx of highly potent, cheap meth that comes across our southern border from Mexican cartels. In

fact, according to a 2018 CDC report, reported meth use among American Indians or Alaska Natives aged 12 and older is twice that of the overall population in the United States.

Admiral Weahkee, how is IHS helping Indian Country cope with the devastating impacts of meth in our communities, and how can we work together to combat this crisis?

Admiral WEAHKEE. Thank you, Senator Daines.

First, I want to applaud you for your work on murdered and missing indigenous women. We know that we have heard a lot about what we, as a healthcare system, can and should be doing to help support that effort, and working with law enforcement and identifying solutions to that problem. So I applaud you for your work.

With methamphetamine use specifically, I had the opportunity to tour Blackfeet Nation with Chairman Tim Davis, the Chairman of Blackfeet, and he drove us through his communities and pointed out all of the houses that have been shut down because they were used as meth houses and were no longer inhabitable. It was a large number.

And I think that one of the major strategies that we have used as an agency is to provide our Tribes with the discretion to use their substance abuse funding as flexible as possible so that if money comes down—and we are talking opioids—that Tribes also be able to use that funding for methamphetamine or heroin or other issues.

I am going to ask Dr. Toedt with methamphetamine support specifically, do you have some specific programming you would like to talk about?

Admiral TOEDT. Thank you for the question, Senator Daines.

So certainly we agree methamphetamine continues to be a large problem in Indian Country, and we shared earlier about how in different parts of Indian Country, different conditions prevail. And methamphetamine certainly is of great concern in Montana and Wyoming, but also in other parts of the country.

We do see great success in identifying those who need treatment and recovery. That is on the healthcare access side. But we have to do more on the prevention side as well, trying to prevent individuals from ever starting on meth. We have to do work on eliminating poverty, joblessness, homelessness, and the social determinants of health that lead individuals to turn to meth or other substances. So there is much more work to be done, but we have had some great successes on the treatment and recovery side.

Senator DAINES. Well, on the education side, I think of education, enforcement, and treatment, those three prongs of this battle. When you start hearing about 10, 11-year-old kids who are addicted to meth, it tells us we cannot go too far upstream. We have to go way upstream to grade school now thinking about educating these kids about the dangers of methamphetamines.

And lastly, I was at a community health clinic in Montana last week, and they told me their meth mouth—they call it “meth mouth”—prevalence has actually decreased significantly. Now, at face value, you would say, well, that is good news. Well, it is not, and here is what is going on.

Once upon a time, the meth was generated in homegrown labs with Drano and Sudafed and so forth. So it was that corrosive substance in the mouth with this lower potency meth, 25 to 35 percent potency homegrown meth, that created meth mouth.

Why is meth mouth decreasing significantly while meth usage is increasing dramatically? Because it is now Mexican cartel meth. It is 95 to 100 percent potent. It has a different way of producing the meth, and it eliminates meth mouth but it is so much more potent and toxic that this is the crisis that we are seeing right now in Montana. It is out of control.

Thank you.

Senator MURKOWSKI. Thank you, Senator. It is Montana. It is Alaska. It is all points in between, unfortunately, and it is lethal, as you indicate.

FACILITIES

Let me go back to some of the facilities maintenance issues that were raised by others previously. As you know, we have a \$2.02 billion backlog on priority facility construction projects at IHS, with a further estimate of \$14.5 billion to meet all of IHS construction needs. And yet, the healthcare facility construction request is \$77.7 million less than what was provided in fiscal year 2019. I think it goes back to Senator Tester's question about how you address this within this year's budget.

With what has been proposed, and given the extraordinary backlog that we face on construction projects, how do we clear this up with this level of funding? I worry about the backlog, but I also worry that if we are not able to catch up on backlog, this will have impact on ongoing construction projects as well. Where we are with the backlog issue and how this funding level really meets the needs?

Admiral WEAHKEE. Thank you, Chairman Murkowski.

I would definitely categorize our request for healthcare facility construction funding this year as one of those difficult choices that we had to make with rules-based budgeting.

I am going to ask Admiral Hartz to speak more specifically about what the dollar amount that we requested means to our timeline and being able to meet the grandfathered list, and I am also going to ask him to speak to, beyond the grandfathered list, the other facility types that we have heard many of our Tribal leaders tell us that they would like to begin to propose, things like detoxification centers and residential treatment centers and specialty referral centers. So if you could add that as well.

Admiral HARTZ. Thank you, sir, and thank you, Chairman Murkowski.

As I have previously indicated, as far as our grandfathered list is concerned, with the continuation of the big increase we got in 2018 and 2019, up to \$243 million, we now have resources into all of the projects that are on the grandfathered list. So at least we have touched all of them that total that \$2 billion.

Although we are looking at a—

Senator MURKOWSKI. Let me ask you about that, because we all know that it is one thing to say, okay, we are going to throw a few million dollars here to get something started on design, but then

if you do not have funding beyond that, is this throwing good money at something that is not going to see fruition? I mean, this is my worry when you have this kind of a backlog and now you have put some money towards it. It is an ongoing project, but you are significantly delaying the implementation of that project if you cannot adequately fund it going forward.

Admiral HARTZ. Actually of that \$2 billion, three projects account for over \$1.5 billion.

Senator MURKOWSKI. Okay. And how far along are those three?

Admiral HARTZ. One of them has \$15 million in it. We are just getting to the top list of the inpatient facilities. We put a priority on ambulatory now for a number of years. That is how we got to a number of the major projects in the Southwest and in Alaska. And with ARRA money, with other resources, we have been able to do that.

But Phoenix Indian Medical Center, White River, and Gallup Indian Medical Center are the three big ones on the list right now. And of those three, two of them, Phoenix and Gallup, we are looking at site issues. We put the \$2 million in just to get that—update all of the planning because they have been sitting there for a long time. Let us get that updated. Let us see what we need to have, whether it is multistory, et cetera. I will not go into any more details on that.

The authorities that the committees have given us to do phased funding is how we have tried to progress on these projects. So with that money that is in the White River project, it is adequate to do the design and get started on foundations. But we would rather have the resources to be able to roll right into construction, but we just do not expect we are going to get a half a billion dollars on some of these projects in one shot. So we will have to do it on a phased approach. And that is what we have done on all these others. We work through phases.

As far as the projects right now that we are looking at, everything is on track for Bodaway-Gap, for the Albuquerque projects. So we got two of them that will be going there.

And how will we keep up at that level of \$243 million? We have been getting what we refer to as Nonrecurring Expenses Fund (NEF) money, non-expensed funds, from other appropriations within HHS. We have gotten a sizable amount of money over the last few years to address not only these federally owned projects but also for projects of Maintenance and Improvement (M&I) of various types. And we are optimistic, based on what we have been advised, that we will be able to supplement this appropriation request with additional NEF monies to sustain hopefully that same level.

Senator MURKOWSKI. Let me ask you about the Alaska-specific projects because in the 2019 omni bill, we directed you to work with the State of Alaska to do an assessment of the updated facility needs in the State and then provide recommendations for alternate financing options. That report was supposed to be submitted 180 days after enactment of that bill. Are we going to be getting this report? What is the status on that?

Admiral HARTZ. I would like to say yes because whether it is the 5-year report or a sanitation facility report, we do quite well at getting our reports in on time. On that particular one, I am going to

have to defer to the Alaska Native Tribal Health Consortium since they have 638'ed (Public Law 93-638) and compacted the entire program from the Indian Health Service. They and the corporations are the ones that can best identify what those needs are. We are available to provide them technical assistance as they embark on gathering that information. As I sit here, I am not prepared to—I do not have an answer for that one, Senator.

Senator MURKOWSKI. And that is fair. But if you can check on that because, again, that was a directive to IHS. I understand the contracting role there, but it was more than just identifying the needs. It was working to see if we cannot figure out some ways to address the financing side.

JOINT VENTURES

In Alaska, joint ventures have proven to be very effective. We have not seen Joint Venture Construction Program (JVCP) awards since 2016. Are you planning on moving forward with any new joint venture solicitations?

Specific to Alaska, whether or not the initial estimate that you have on Yakutat Tlingit project—it is in the administration's proposal, which I appreciate. You have the staffing package of \$3.8 million. Is that an accurate number for staffing? Do you anticipate that we are going to get a revised estimate on that? It is really helpful to try to understand if we are on the money when it comes to that staffing package.

So where are we with JVs and where are we with Yakutat Tlingit?

Admiral HARTZ. Okay. Responding to your initial question as far as the joint venture program, we concur with your statement that it is a highly popular program across Indian Country and it helps reduce the Federal capital investment.

We plan to do a solicitation this fall. We put out the small ambulatory solicitation, and those are due at the end of June—for the funding received in 2019, they are due June 28. We did not want them out concurrently. So we will be putting it out probably in the last quarter of this fiscal year for the JV.

And then the other one was specific to Yakutat. Right?

Senator MURKOWSKI. Right.

Admiral HARTZ. On Yakutat, they have recently separated from Southeast Alaska Regional Health Corporation, and as a result of that, there are some PSFAs, programs, services, functions, and activities, that they would like to roll into their new facility. So they are now in the process of modifying, expanding a bit of what they would provide in their facility. And I believe we will have to, once we get that information, have to assess whether that is going to equate to more staff or not. It is a dynamic activity that we will need to communicate with our CFO and others to make sure that when that project is finished, that the staffing is in sync with it being available upon completion. We are speculating that completion could be delayed.

Senator MURKOWSKI. Okay. Well, let us keep in touch on that one. The timing is key, but so is making sure that we are hitting it right in terms of what will be required.

SMALL AMBULATORY CLINICS

And I was going to end my questions, but you mentioned the small ambulatory clinic and that you are going to go out on that in September. As I look at the budget, it does not include funds for small ambulatory clinic programs in 2020. So what is the status? Because in 2019, there was \$15 million that we provided for small ambulatory clinics. It has been very, very helpful for us. So what is your plan with small ambulatory clinics funding?

Admiral HARTZ. You are correct. It is a very popular program. Not counting the number of applicants we will get in in 2019, we have got 42 awards that have occurred over a number of years related to that program. And as Admiral Weahkee indicated, there were a number of places that we had to prioritize in healthcare delivery that we had to make difficult decisions, and that was one of the places that ended up getting tapped.

Senator MURKOWSKI. Well, we will keep going here. I have a lot more questions. I know that Senator Udall does.

We keep coming back to these hard decisions to make from a budget perspective, but when you take these programs completely offline, it is not as if the need goes away. It just shifts it to somewhere else where you have more stressors on a system, and that trust responsibility that I think Senator Tester articulated very, very clearly we fail on.

If you were to tell me we do not need that program anymore, and that we have really helped address some of these issues, that is one thing. But we all agree that these are important programs, and the reason they are being utilized at the rate and at the level that they are is because they are so necessary. To hear that the funding for them is being completely eliminated is really hard. So that is something the subcommittee will consider.

Senator Udall, I am sorry that I am well over my time. I may have to duck out of here to take a quick question over in Defense Appropriations, but I know that you got this.

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

INMED

Last year, the subcommittee provided \$125,000 in new funding to expand the Indians Into Medicine Program to an additional location for a total of four programs. There has been significant interest in expanding this program for many years in my home State, and we are hoping that the University of New Mexico will become the fourth location.

Could you please share the status of the program expansion, and when will IHS select the location?

Admiral WEAHKEE. Thank you, Chairman Udall.

We definitely appreciate the addition of \$195,000 into the 2019 budget.

We expect that we will be soliciting through the competitive process the opportunity for the expansion of the Indians Into Medicine (INMED) program to a fourth site, and I will have to ask Ann if she knows off the top of her head when we expect that solicitation on the street.

Ms. CHURCH. That solicitation should be coming out pretty soon. It will announce another 5-year competitive award cycle, and that would start in the fall. So current awards continue through September of this year—excuse me—August of this year.

Senator UDALL. Thank you very much for that answer.

CHAP AND CHR

Shifting over to the Community Health Aide Program (CHAP) versus the Community Health Representatives Program (CHR), Admiral Weahkee, I want to talk about the proposal in the budget to cut the community health representative program by nearly two-thirds. Over the past year, the Congress has heard from Tribes in New Mexico and across the country about their support for the CHR program. These communities rely on the CHR program to provide wraparound services like health education, case management, and transportation to medical appointments for elders and other members of Tribal communities. And I understand that the administration heard the same message. Yet, here we are again with a budget request that proposes a significant cut to the program.

I understand that you proposed a new community health aide program which would train Tribal members to provide basic medical, dental, and behavioral health services. And this is a worthy goal. But it strikes me that these activities do not replace the need for community health representatives.

Do you agree that the CHR program fills a needed gap in services in Tribal communities and that the CHAP program you have requested would complement rather than replace the need for community health representatives?

Admiral WEAHKEE. Thank you, Chairman Udall.

I have heard from many Tribal leaders in the past 2 years now about their heavy reliance on their community health representatives for not only transportation, which I think is a misnomer in Indian Country that CHRs only provide transportation, but the vital services that they provide to bedridden patients, delivering medications—there is just so much that the CHRs do.

I think the introduction of CHAPs is meant as a way to elevate community health workers, paraprofessionals who are extenders of physicians. That CHAP program also includes behavioral health aides and dental health aides. Many of our Tribes, especially in the Pacific Northwest and in the Great Lakes area and now down in the Southwest in Arizona, are really pushing us to advance the CHAP agenda, get a program put together, the policy, the training, infrastructure, the certification processes so that they can begin to include CHAP programming into their annual funding agreements because they see the value when we cannot recruit and retain physicians in some of our most rural, remote locations. We can train our own community health workers to fill these gaps.

And so I think the proposal is really meant to be a conversation starter and to provide our Tribal communities with options to be able to dedicate their resources to best meet the needs of their local communities. We do still run into the challenge with our community health representatives of justifying workload. I have said before I think that this is as much a data problem that can be re-

solved through our IT modernization as it is a workload issue. There is no doubt that the community health representatives continue to work. We are just not capturing their workload in our data systems.

Senator UDALL. So there is such a need out there is what you are saying. And the CHRs are doing very good work. This new introduction which, as you have said, serves as a conversation piece and probably is going to provide good services too. But it seems to me that they complement each other and that the cut here to the CHR program is not one that we should be pursuing.

ADVANCED APPROPRIATIONS

But let me shift over here to advance appropriations. The Indian Programs Advance Appropriations Act, which I have introduced, provides budgets for the Indian Health Service and other Tribal programs a year in advance so that Tribes do not have to live through the effects of another disastrous and entirely preventable government shutdown. I know that Chairman Murkowski has also been a leader on this issue for several years, and I am hoping that the two of us can work together and with our colleagues in the House to pass legislation and ultimately get these advance appropriations included in a budget deal.

Admiral Weahkee, I know that the administration does not have an official position on legislation, but I wanted to ask you to confirm whether you have heard the same clamor from Tribes to move IHS to advance appropriations and prevent the impacts of another shutdown.

Admiral WEAHKEE. Thank you, Senator Udall.

And I want to confirm that I have heard robust support for advance appropriations from both our Tribal and our urban constituents, very specific stories of the heartbreak that occurred during the 35-day shutdown, programs having to curtail services, having to lay off staff, all of that information very recent and raw. I have also heard comparisons to the Veterans Health Administration where they do have advance appropriations and where services are not interrupted when something like a government shutdown or a continuing resolution occurs, that they are saved from those types of instances impacting healthcare.

Senator UDALL. Well, I think from what you have said today, from what I have heard, from what my staff has heard, it is really clear that we need to move in the direction and pass the Indian Programs Advance Appropriations Act. This would put the Indian Health Service in a much better position when we get to another shutdown, which we hopefully do not ever get in that situation again.

ELECTRONIC HEALTH RECORD

I wanted to ask a little bit about electronic health records. Your budget includes \$25 million in new funding to begin planning for a new electronic health record system. If VA's estimates are any guide, implementing a system like this could cost billions of dollars. Does IHS have a preliminary estimate on how much a system like this will cost and how long it will take to implement?

Admiral WEAHKEE. Thank you, Senator Udall.

We appreciate and have been using a lot of the work that the DoD and the Veterans Administration have done on their electronic health record modernization efforts to inform our own efforts. Mr. Mitch Thornbrugh, who is our Acting Chief Information Officer, is working with the Department of Health and Human Services Chief Technology Office on a yearlong health IT modernization research project, which is meant to help inform our future budget requests and the direction that the Agency would like to move in.

As part of our 2020 request, we are also asking for some significant changes to the structure of our budget so that we create an IT line item and, at the same time, that we centralize our IT systems. As mentioned in my opening statement, we currently operate as a system with 400 separate instances of the Resource and Patient Management System (RPMS), and we would like to change that structure to a centralized structure where an update or a change could be made once at the national level and replicated throughout the Agency. So it is a significant undertaking that we have ahead of us. And I do believe that the “B” word, the billion word, is well in range, and we are learning from the VA’s acquisition how much we should anticipate.

I also want to note that we have had that team traveling out to many of our Tribal communities, those who have already invested in new electronic health records like NextGen or Epic or Cerner and pulling information from them as well on what is working, what is not, what can be improved, what they learned through their transitions. So a lot of great work, and we are hoping to save as much money as possible for the American taxpayer, but we do anticipate with the number of systems that we will be replacing that this will be a sizable request.

Senator UDALL. Admiral, I hope you also acknowledge that these investments, the investments we are making, in technology like this must be made without compromising increased funding for patient care.

Admiral WEAHKEE. Yes, sir, absolutely. And we look forward to working with Congress on how to ensure that remains the case.

Senator UDALL. And who will manage the acquisition and the implementation of such a massive investment? How will the Service make sure that it avoids the problems that have plagued VA’s transition, including lack of consistent leadership and difficulty decommissioning legacy IT systems?

Admiral WEAHKEE. I mentioned, Senator Udall, our Chief Information Officer, Mr. Mitch Thornbrugh, who is leading the efforts on behalf of the Agency. But we are definitely not doing it in a vacuum. We have a lot of support from the Department, both the Chief Information Office and the Chief Technology Office, as well as a sizable contract with an entity that includes experts, some of whom have worked within our system before and have great insight into our RPMS system.

Dr. Toedt oversees our informatics and information systems. Anything that you would like to add in that regard?

Admiral TOEDT. I would just like to add that we will also be looking at and have been in communication with VA and DoD about best of breed governance models. We want to make sure that we have got the voice of our clinicians so we can decrease provider

burden. We want to make sure that we improve the revenue cycle management. So we will be highly engaged with our Office of Resource Access and Partnerships to make sure that we maximize the electronic record's ability to bill and generate revenue that goes back into the system and provides more healthcare. And we will be working with our patients to make sure that they have a voice and access for things that really are standard outside now like electronic scheduling and access to electronic medical records, personal health records, and things that we need to advance for American Indian and Alaska Native peoples.

Senator UDALL. Thank you for that answer.

And you mentioned a little bit about visiting with Tribes on this technology issue. What will Tribal consultation on this new system look like? How will you integrate Tribes who have developed their own electronic health record system and ensure that the systems are interoperable?

Admiral WEAHKEE. Thank you, Senator Udall.

The modernization research project team has been traveling out to multiple sites. We want to visit not only those who have already transitioned to a new system but also those who continue to use RPMS to hear their feedback. We are in the information gathering phase. As we move forward into future phases of the transition, we will be robustly dialoguing with both our Tribal stakeholders and our urban Indian organization partners about how to use the resources that we request and how to include their systems. A big focus will be on interoperability with all of the systems that are being used throughout Indian Country, as well as interoperability with our VA and Department of Defense and other healthcare systems that we work with frequently. So much more consultation and urban confer to come, as we move down this 7 to 10-year transition period.

IT INFRASTRUCTURE

Senator UDALL. Admiral Weahkee, the Tribal healthcare system serves some of the most—you know this well—remote locations in the United States. So the Service is going to face the additional challenge of implementing its health record system in areas where access to broadband is limited or even nonexistent.

How does IHS expect to address the lack of infrastructure as it modernizes its electronic health record system? Will this be an opportunity to help Tribes improve IT infrastructure in other ways?

Admiral WEAHKEE. Thank you, Senator Udall.

And broadband access has definitely been one of our major challenges and barriers. We have not been able to move forward on the use of technology like telemedicine as quickly as we would like to because of some of the limitations that we have in many areas.

We did a lot of work last year discussing with the FCC and others how we can leverage resources throughout government to create greater broadband access. I do anticipate that our IT modernization is going to be broad-based and far-reaching. We are not just focused on replacing an electronic health record system within the Agency. There is so much more that is going to be captured under this umbrella, and expanding broadband access, although not specifically cited recently, is probably one piece of that.

Anything you would like to add on that?

Admiral TOEDT. Certainly. We know that increasing broadband access lifts all ships in native communities because if we can get broadband access, not only for the health system, but for the educational system, that really helps with the entire community. It helps with jobs. And so broadband is a big issue for Indian Country.

Specific to the electronic medical record and to our health IT investment, we also have to think about the actual investment in the computer systems themselves, the servers, the monitors, the keyboards, and then all the biomedical equipment that interfaces with those systems. We want to make sure that they are safe and protect access, but at the same time, let us make technology work for us not against us.

Senator UDALL. Yes. The other thing that I hope all the Members here at the table will be advocates for—you know, yesterday they had a meeting at the White House. They talked about an infrastructure package of \$2 trillion. And I think it is really important, you know, if we start moving down that road, which I think there is a lot of bipartisan support, that all of you weigh in and let them know that part of that package ought to have to do with Indian Country, the things we have been talking about, and making sure that there are the kind of needs that we know that are there that are fulfilled in Indian Country with a significant infrastructure package.

RECRUITMENT AND RETENTION

Now, talking a little bit about recruitment and retention incentives, last year this subcommittee was able to increase funding for the Indian Health Professions Program by \$8 million for a total of \$57 million. How many additional providers were able to receive assistance because of this increase, and how will this increase impact your ability to recruit?

Admiral WEAHKEE. Thank you, Senator Udall.

And I am going to ask Ms. Church to provide us the specific numbers. I do know it was a sizable increase in the number of awards that we were able to make. She has probably got the numbers off the top of her head here.

Ms. CHURCH. For 2019, we greatly appreciate that increase of funds. We anticipate that will give an additional 170 loan repayment awards during this year. We have also been working on our scholarships in addition. So we expect some additional awards there.

Senator UDALL. Great. Thank you.

And I would like to know more about how the Service plans to allocate the \$8 million proposed in the budget for recruitment and retention incentives, how many providers would receive increased incentives as a result of these funds. What types of providers would you recruit most aggressively, and which geographic areas would you expect to see the most impact from these funds?

Ms. CHURCH. With the \$8 million that is proposed in the 2020 budget, we were envisioning a very flexible ability to focus on recruitment and retention efforts. So that includes some funds for housing subsidies, if we were to gain authority for the Title 38, but

then also the scholarship and loan repayment, and then in addition to those funds, to increase awards there with the tax exemption that would enable us to save about \$7 million. So with those two investments combined, we think we could make over 160 additional awards, likely much more than that if those resources were provided.

Senator UDALL. Great.

Admiral Weahkee, go ahead.

Admiral WEAHKEE. Thank you, Senator Udall.

I just wanted to add on the second part of your question there where we would focus those resources. And we have heard, in consultation with Tribes, an interest in expanding our scholarships and loans to other professions, to include hospital administrators. CEOs up in Alaska have recommended as a strategy to advance alternative pain management, we have heard requests to include chiropractors and acupuncturists as a few examples of additional professions that Tribal leaders would like to see us expand those programs for.

Senator UDALL. Good.

EQUIPMENT

Talking about equipment now, Admiral Weahkee, I was pleased to see your budget include a very modest increase to the equipment replacement program, rather than a reduction. That said, we all know that IHS facilities are facing increasing outdated medical and diagnostic equipment, and the Agency needs a more aggressive funding level to keep pace with actual needs on the ground.

Could you please estimate what the annual equipment replacement needs are at IHS facilities and talk about the problems that facilities face in providing adequate care given their existing resources?

Admiral WEAHKEE. Thank you, Senator Udall.

And Dr. Toedt reminds me all the time let us talk patient impacts first. The impacts to our patients, when we do not have access to the latest and greatest medical technology, is that we have delayed diagnoses, we have delayed care. When new students are being trained using the most recent technology and then come to our facilities, it is a step back for them. And so sometimes we lose recruitments as a result of not having the latest and greatest.

I will ask Dr. Toedt, anything else you want to add on the clinical aspects, and then Admiral Hartz has the numbers in terms of our equipment replacement schedules and the needs there.

Senator UDALL. Admiral Toedt.

Admiral TOEDT. Thank you, Senator.

So certainly equipment like mammography units and ultrasound units that impact women's health and impact pregnancy evaluation and reduce maternal morbidity and mortality by having those diagnostics are extremely important, making sure that we have got access to modern CT scanners and MRIs to assist with cancer diagnoses. Cancer continues to be the number two killer of American Indians and Alaska Natives, second only to heart disease. Making sure that we have got nurse call systems, central monitoring systems, ER crash carts, you know, I could go on and on. But obviously, the impacts are that we are not able to diagnose things as

accurately or as quickly. There could be delay in care and delay in providing those services when we do not have that equipment.

And then as Admiral Weahkee mentioned, the recruitment and retention aspect. When you are recruiting a new doctor and you take them on a tour of the facility, they are looking around to see what they are going to have to work with. And while we know our providers are mission-focused and they are dedicated and they are out there doing the best they can, they tell me every day that they need to have better equipment to take better care of our patients.

Senator UDALL. Admiral Hartz.

Admiral HARTZ. Thank you, Senator.

As they have already talked about the medical impact, there are even some specific examples of what a difference it makes to have equipment come in. Recently in the Crow Agency service unit in Billings, Montana, they replaced all 12 operatories there in the dental suite, new chairs, new delivery units, new lighting, et cetera. That existing equipment was 22 years old and well past its life expectancy to be used as operatories for dental care.

You know, with the requirements in 2015, if you have old radiology equipment that you are going to get reimbursed at a lower rate if you do not have that changed—and currently it is a 7 percent reduction. If it is not replaced by 2023, it is going to drop to 10 percent on the reimbursement rates. So not only does it affect the actual care and our ability to give quality healthcare, but it reduces even, potentially, the resources we would get to do more.

So we have looked at the numbers, and it is across not just Federal but also the Indian Country operated facilities under self-determination. From a surge standpoint, we are looking at \$100 million to \$150 million, and then on a recurring basis, we are probably in that range of \$50 million to \$70 million.

But as we have talked about our aged facilities, we have aged equipment, and to get new technology in there, we have got to get the technology that is in here (Admiral Hartz holds up a smartphone). And that is expensive technology. It is not just the broadband. It is not just all of that to get going, but it is the basics of the guts of this. And we have to have security to deal with all this medical equipment. So we are talking big bucks and then the recurring effort that needs to sustain that.

Senator UDALL. Admiral Weahkee, did you have anything else to add there?

The points you make on the \$150 million and then the replacement costs and everything—I mean, we are reminded here of this responsibility to provide healthcare to Native Americans. And it seems to me that—and I know you cannot get into—we have a budget before us, but I think it is very important that all of you advocate up the process and make sure everybody knows that we do not have the kind of equipment to take care of the needs that are out there.

And I am not going to ask an additional question on that. The Chairman is back, and so I am going to yield back to her.

Thank you very much for your testimony today. I really appreciate all your hard work on behalf of Native Americans.

Senator MURKOWSKI. Senator Udall, thank you for asking a lot of the questions. I was just given a list of all the things that you

raised: community health aide and community health representatives. I appreciate that one because that is one that I have an interest in. Advance appropriations, electronic health records, recruitment and retention, and medical equipment. You clicked off a lot on my list.

I just have one more, really maybe two, that I would like to ask. Thank you for helping out with this so ably and getting responses that you and I both know are important for us and for the subcommittee.

EHR

I wanted to ask about the electronic medical records just a little bit. As you know, in Alaska we have had to work through issues with IHS, with VA, and with DoD in order to best serve the needs of the people that are there. And sometimes it means that we work outside of the bigger, broader VA or the bigger, broader IHS or DoD to make sure that we are all talking on the same systems.

I have to admit that when I hear that we are going to modernize or reform or refresh the electronic medical records, I worry that, once again, we are going to be in a situation where you have a more national system that is not going to mesh well with what we have tried to facilitate on the ground, particularly in a State where we really have had to be pretty innovative and creative with how our systems are talking to one another.

I ask that as you are looking to ensure that the new IHS system is interoperable with the VA's, that we are looking specifically at Alaska IHS, Alaska VA and making sure that it works within our systems there. I am not saying that we are special, but sometimes we have had to carve out different things just because of what goes on up there. So this is kind of a very personal ask here to spend a little more attention to the Alaska-specific intersect because we think we have got a relatively good system going on right now between IHS and the VA.

And the VA is going through its own level of overhaul. I was in VA Approps yesterday. So they are fixing things over here, and you are fixing things over here. I am just a little afraid as to where we are going to end up. So I am putting that on everyone's radar screen to make sure that we are doing this jointly and from my perspective, through the lens and the focus of Alaska. Are we good with that?

CHAP

Then on the community health aides and the community health representatives, this program that we developed, the CHAP program, is something that we are really proud of and I think rightly so. I am curious to know how the CHAP program expansion impacts is going to impact the currently funded CHAP program in the State? Will Alaskans see any impact from what you are doing nationally? Does this extension that you are proposing encompass certification or expansion for dental health aide therapists, similar to what we are using in Alaska?

Admiral WEAHKEE. Thank you, Chairman Murkowski. I appreciate both questions.

I want to just touch very briefly on the work that we are doing with the VA and assure you that we do have Alaska representation on our team. Stewart Ferguson is a member of our Information Systems Advisory Committee. He comes to us from Alaska. So he brings the needs and interests of many of the programs there to those discussions.

And I do not know whether or not the modernization research team has already made their trip to Alaska or not. They are coming up. Dr. Toedt tells me they will be traveling to Alaska to look specifically at some of the systems being used. And we do have robust discussions with the VA on a regular basis.

Senator MURKOWSKI. Good. Very important. Thank you.

Admiral WEAHKEE. We want to learn their lessons since they are a little bit ahead of us in this transition.

With community health representatives and CHAP, I appreciate all of the history of the CHAP program in Alaska. It is touted as best practice, and many of the Tribal leaders there in Alaska are very proud of their program.

I think that the impact will be, if anything, positive as we expand into the Lower 48 and we start to realize some synergies with the entire Indian healthcare system using CHAPs. We know that Congress has made it very clear there is to be no negative impact to the existing CHAP program in Alaska. So we have been cognizant not to burden them with the limited training capacity that already exists. We have definitely borrowed some of their experts to inform our process as we move forward and how they set up their training and how they set up their certification. We want to replicate as much as possible that great program. So the expansion is meant to be supportive and, hopefully, with a larger program, we will have more synergy.

I would like to ask Dr. Toedt who oversees the CHAP Tribal advisory group I guess not directly, but in our structure he has oversight as the clinical lead. Anything you want to add on CHR CHAP transition and the work with Alaska?

Admiral TOEDT. Yes, thank you, Senator.

Certainly the community health aide program has been demonstrated to be successful, sustainable, and culturally appropriate in Alaska, and we want to replicate that success outside of Alaska. And we will make sure that the implementation in the Lower 48 has no negative impact and is not taking from any resources that are provided to the CHAP program in Alaska. That is paramount for us.

The community health aide program Tribal advisory group has been advising us on development of policy, and that policy is nearing the point of us going out with consultation for Tribal input. And then we intend to implement the community health aide program, expanding it outside of Alaska, and set up those governing bodies and the certification boards so that those processes are replicated in an area-like fashion similar to how it is done in Alaska.

We are heavily drawing from the successes in Alaska, looking at adopting much of the training, much of the training materials because we really see it as best practice. And we recognize that it will need to be tailored and adapted for use in other regions where there are different health needs and health systems in place. But

having those extenders for physicians through the community health aide providers, extenders for behavioral health for the behavioral health aide providers, and extenders for dental care through the dental health aides, including dental health aide therapists, is very important for us.

Senator MURKOWSKI. Well, it is a point of pride for us in Alaska that we created that program out of necessity and that the training that went with it was truly grassroots. You mentioned culturally appropriate. It was because it was designed by so many who lived in the village that they worked in and knew the needs of their community and trained themselves and others for that. To be able to go out to a village and speak with a community health aide who helped develop the curriculum and the training that is still in place and still being worked on makes us pretty proud.

GAO HIGH RISK LIST

Last question very quickly. In 2017, GAO put IHS on the list of agencies at high risk due to vulnerabilities to fraud, waste, abuse, and mismanagement. When are we going to get off the list? Because we have addressed all of the concerns that were raised in that report. What is your progress report on that?

Admiral WEAHKEE. Thank you, Senator Murkowski.

We have just recently provided testimony about our current status and are working closely with the GAO to close even more of the open recommendations. Most recently, we reported that we had closed seven of the open 14 recommendations. So we were at the halfway point. We have since asked the GAO to close an additional four, which would leave us with three open. All three of those—let me strike that. Two of those the GAO has identified that they want to monitor us for an extended period of time to ensure that the changes that we have made are sustainable. And the last open recommendation is a new recommendation related to provider workforce and recruitment and retention of providers. So it is a brand new recommendation that they added in the most recent hearing.

So I do anticipate that we will be getting good news from the GAO soon on our requested closures. Most of those were regarding our purchased and referred care program. We have just updated our PRC manual, and many of those updates were a direct response to the GAO's open recommendations.

Senator MURKOWSKI. Well, it is good to hear that you are moving through that list. I think we were all disappointed when you make that blacklist. It is not a good one. To know that you are moving through those various issues and resolving them is important on a lot of different levels. So thank you for that.

Senator Udall.

Senator UDALL. Senator Murkowski, could I just follow up?

What are the two extended that they want to extend on the monitoring? I do not think you named those. Is that correct? What are those two areas?

Admiral WEAHKEE. I will name them quickly, if I can recall them.

The first is on patient wait time standards. So they want to monitor to ensure that the national accountability dashboard for quality that we put in place and that we are monitoring all of our hos-

pitals and service units on, that that monitoring continues and that we are improving on it.

And, Dr. Toedt, do you remember the other ongoing monitoring or, better yet, our quality directive?

Admiral TOEDT. Quality oversight.

Admiral WEAHKEE. Incident reporting system. We have newly purchased this new incident reporting system to replace WebCident. We have not yet fully implemented, and once that system is fully implemented, we expect that we will be going to GAO to request closure.

Senator UDALL. And, Senator Murkowski, thank you for asking that question.

And I think this highlights and I hope you all take this high-risk status as a real opportunity. And once again, I would urge you, you know, with your request for budget and getting the President's budget out, to ask for the monies you need and press them to put it in there to make sure that you can use this opportunity being on the GAO high-risk to get these things done. Thank you very much.

And thank you.

Senator MURKOWSKI. Thank you, Senator Udall.

And again, these hearings that we have to review the budget, to go over the questions that we may have really is just so top line. And I know that after this, our staffs spend a lot of time with yours to go through more of the details.

But I know that, Senator Udall, you and I have worked really hard over the years as partners on this Committee to make sure that we do right by the IHS budget. It is one of the things that I am able to point to with some degree of satisfaction that we have really been working to bring the budget to a better place so that we can work to address the needs, because the needs are so significant in so many different areas. And I know that in the other budgets that we are working on, we are not seeing increases. These are tougher budget times, and I understand that. We all understand that. But when you listen to some of the conditions and the situations that we continue to face within the IHS system or within BIA, I think we know that we have got a long way to go before we are truly doing right by our Native peoples. And so this will remain a priority for me. But I appreciate your support on this and that of the other committee members.

You probably sit in front of us and do not necessarily enjoy defending a budget when you know that we need to do more when it comes to the facilities construction and maintenance accounts. You know we need to do more by the ambulatory. You know we need to address some of the deficiencies that we see, and yet, you are sent here to defend a budget. So we just ask you to work with us as best we can to really address the very significant needs that must, must, must be met.

Anything further, Senator Udall.

Senator UDALL. I think that is good.

Senator MURKOWSKI. All right. With that, we stand adjourned. Thank you all.

SUBCOMMITTEE RECESS

[Whereupon, at 11:55 a.m., Wednesday, May 1, the subcommittee was recessed, to reconvene subject to the call of the Chair.]