DEPARTMENT OF THE INTERIOR, ENVIRONMENT, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2017

WEDNESDAY, MARCH 9, 2016

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

The subcommittee met at 10:03 a.m., in Room SD–124, Dirksen Senate Office Building, Hon. Lisa Murkowski (chairman) presiding.

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

INDIAN HEALTH SERVICE

STATEMENT OF MARY SMITH, PRINCIPAL DEPUTY DIRECTOR

ACCOMPANIED BY:

ELIZABETH FOWLER, DEPUTY DIRECTOR FOR MANAGEMENT OPERATIONS

GARY HARTZ, DIRECTOR OF THE OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING

OPENING STATEMENT OF SENATOR LISA MURKOWSKI

Senator MURKOWSKI. Good morning. We will call to order the Senate Appropriations Subcommittee on Interior, Environment, and Related Agencies.

Today's hearing is on the fiscal year 2017 budget request for Indian Health Service (IHS).

Before I begin my comments and welcoming, we do have the chairman of the full Committee on Appropriations. So at this time, Chairman Cochran, I would defer to you if you would like to make any opening comments.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Thank you, Madam Chair. I appreciate the recognition and to join you in welcoming our witnesses this morning, reviewing the budget request for the Indian Health Service. Specifically in our State of Mississippi, we're pleased to host the Mississippi Band of Choctaw Indians' state-of-the-art medical center. It is a new health center, and I know that people are still getting adjusted to the fact that there's such a fine facility that is available for healthcare services for the Mississippi Band of Choctaw Indians in particular. I hope we can continue to stay in touch with the management of the hospital, and we hope we will learn

from this hearing how it's being received and whether the needs are being met for appropriated dollars that are necessary.

Thank you.

Senator MURKOWSKI. Thank you, Mr. Chairman.

At this time, I again would like to welcome all.

Today we will examine the budget request for Indian Health Service. I want to thank Mary Smith, the Principal Deputy Director for IHS, for appearing before us today.

Ms. Smith was named to the top position at the agency just last week, so we wish you well. The head of the IHS, I think we recognize, is a tough job. It's a critical job for us in Alaska, where all of the healthcare for Native Alaskans is delivered through compacts between tribal organizations and the IHS.

Ms. Smith is accompanied by Elizabeth Fowler, who is the Deputy Director for Management Operations, as well as Gary Hartz, Director of the Office of Environmental Health and Engineering. We welcome all of you.

Last year we started what I hope will be a tradition. We held the first IHS budget hearing in over 5 years. These issues are too important in terms of your work to have such a lapse, so I'm pleased that we are having this hearing.

With a budget of over $5 billion, a seemingly limitless number of needs for healthcare delivery for Native Americans, it's critical that this subcommittee exercise a strong oversight role to make sure scarce resources are spent as efficiently as possible. The IHS budget request for fiscal year 2017 is $5.185 billion for programs within this subcommittee's jurisdiction. This is an increase of $377 million, or 8 percent, above last year's enacted.

There are worthy increases in this budget, including $82 million for contract support costs. I'm pleased that this budget fully funds these costs and adopts the approach that I put forward in the Senate bill for fiscal year 2016, which establishes a separate indefinite appropriation for contract support costs to ensure these legal obligations are met and other programs will not be affected.

Other important increases include $132 million to address the more than $2 billion backlog on the current healthcare facilities construction list, as well as $15 million for the substance abuse and suicide prevention program, with a particular focus on youth. I'm particularly interested in the initiatives in your budget to address substance abuse, suicide, and domestic violence. These are enormous problems within Indian Country and are particularly acute in Alaska.

I think we look at the statistics and are just truly overwhelmed by them. One out of every three American Indian or Alaska Native women will be sexually assaulted in her lifetime. The alcohol-related death rate for Native Americans is six times greater than the rest of the population, and the suicide rate for 15 to 24-year-olds is 2.5 times the rate for other ethnicities.

We've had a very courageous group of young people from Tanana, Alaska who have spoken out about these issues in their community over the past few years. They stood before several thousand Alaska Natives at our largest gathering at the Alaska Federation of Natives conference. They've written what is known as the Tanana

Pledge to encourage Native Alaskans around the State to stand together against suicide, against substance abuse.

It was just a few weeks ago there was an article in our newspaper and on the radio about dozens of young people from the village of Kwethluk who took a stand against alcohol and drugs in their community. They marched through the streets of the village with homemade signs basically saying enough is enough. So when your children stand in front of you, stand in front of the adults and say stop it, enough is enough, it is well past time to act.

In an effort to push for more effective ways to address issues like suicide among Indian youth, I sent a letter last December to Secretary Burwell with 11 other senators, including our ranking member here, concerning the issue of complex trauma. In that letter we asked Department of Health and Human Services to develop a coordinated interagency approach that incorporates the growing evidence that complex childhood trauma is often the underlying cause of substance abuse and youth suicide.

I see that your budget discusses trauma-informed care and indicates that the agency's mental health and social service program provides training and workforce development to IHS and tribal healthcare providers to incorporate culturally relevant and trauma-informed approaches.

When we get to the time for questions, I'd like to learn more about what IHS and the Department of Health and Human Services as a whole are doing in this area. I think it's critical that we continue to make progress on these issues.

And then finally, I'm very concerned with the situation that we have at the IHS Rosebud Hospital on the Rosebud Indian Reservation in South Dakota. Conditions at the hospital are so bad that IHS sent out a notice on March 1, indicating that the Center for Medicare and Medicaid Services will terminate its provider agreement with the hospital effective March 16. This means that IHS can no longer bill for Medicare and Medicaid services and that in many instances tribal members will have to travel long distances to get care.

There have been cases reported in the press where employees at Rosebud were washing surgical instruments by hand because the hospital sterilization machine was broken for 6 months. Also, a case where staff members left a pregnant woman unattended and she delivered her premature baby on the floor of a hospital bathroom—absolutely, absolutely unacceptable.

So we need to hear from you today what the Indian Health Service and Health and Human Services is doing to rectify this situation and when the hospital can restore its provider agreement with the Center for Medicare and Medicaid Services (CMS).

So again, thank you for being here.

I would now like to turn to my ranking member, Senator Udall, for his comments this morning.

STATEMENT OF SENATOR TOM UDALL

Senator UDALL. Thank you, Madam Chair.

Let me also welcome Mary Smith, the new Principal Deputy Director of the Indian Health Service, to this hearing before the subcommittee. Deputy Director Smith, congratulations on your new

leadership role within the agency. We're glad you're able to join us to share your perspective on the President's 2017 budget request for the Indian Health Service and to hear from members of the subcommittee about our particular priorities for the Service and about its budget.

I also want to welcome Elizabeth Fowler, Deputy Director for Management Operations, and Mr. Gary Hartz, Director of the Office of Environmental Health and Engineering. We appreciate you being here today and look forward to hearing from you.

Before we turn to the 2017 budget, I want to thank Chairman Murkowski for working with me to produce a very solid budget for the Service this year. Overall, we were able to support a 3.5 percent increase for the Service, including important investments in facilities and substance abuse treatment. I also want to applaud the Chairman for coming up with a more sustainable way to fund contract support costs so that these costs aren't funded at the expense of other programs.

Madam Chairman, you've been a great champion for programs that are so critical to Native communities in both our States and throughout Indian Country, and I'm proud of this entire subcommittee and the effort it has made to fund tribal health programs and make them a priority.

But more is clearly needed. Indian Country needs better access to clinical services. This is especially true for preventive care, and also for mental health and substance abuse programs. These are critical services. We want to see IHS build more hospitals and health clinics, and we need to make sure the agency has the right tools to staff its facilities with qualified doctors and nurses.

All of these issues affect tribes in New Mexico. We see it in the lack of funding for substance abuse treatment in Gallup. We see it there in Gallup. We see it in the staffing shortages in Crownpoint, which forced the closure of emergency medical services last year. The challenges are very clear.

So I look forward to hearing more about possible solutions. I also want to hear how the agency plans to address serious problems we're seeing in other areas, including in the Great Plains, as the Chairman has mentioned, where some IHS facilities are at risk of losing accreditation and have been forced to cut back vital medical services. This budget request takes on some of those challenges by requesting an 8 percent overall increase for the agency.

It's going to be an uphill battle for this subcommittee to fully fund your proposal given the flat budget caps in 2017, but we will do everything we can to support you, Deputy Director Smith, and to support Indian Country. Your appearance today to share some of the details of the budget is critical to helping the subcommittee do its work.

Again, congratulations on your new position, and thank you for providing testimony to us today.

Senator MURKOWSKI. Thank you, Senator Udall.

With that, let us go to you, Ms. Smith. Welcome again, and I will repeat the ranking member's comments about congratulations for the appointment to this position.

So if you would like to begin your comments, I understand that it will just be you testifying and that Ms. Fowler and Mr. Hartz are there to answer questions.

Ms. SMITH. Yes, that's correct.

Senator MURKOWSKI. Very good. If you can begin, please.

SUMMARY STATEMENT OF MARY SMITH

Ms. SMITH. Good morning. Thank you, Chair Murkowski and Ranking Member Udall, and all the members of the subcommittee, for allowing us to be here today to talk about the fiscal year 2017 IHS budget request. As was mentioned, accompanying me today are Elizabeth Fowler, Deputy Director for Management Operations, and Gary Hartz, Director of the Office of Environmental Health and Engineering.

I've only been in my job as Principal Deputy Director for a little over 1 week, and although I've been at the agency for a little bit longer, about 5 months in the role of Deputy Director, it has become quite clear to me that while the IHS is firmly committed to the mission of providing quality healthcare for American Indians and Alaska Natives, we face steep operational and quality of care challenges. This situation is unacceptable.

I appear before you today to underscore my commitment to fixing these challenges, including those in the Great Plains, and the more systemic issues that we face at the agency such as staffing and housing. We are committed to fixing these issues not simply in the short term but so that these changes are sustainable over time. I and the rest of the team at IHS are committed to creating a culture of quality, leadership, and accountability. It is far from business as usual at IHS.

With that preamble, I am pleased to present testimony on the President's proposed fiscal year 2017 budget for IHS, which will allow us to continue to make a difference in addressing our agency mission. I'm committed to working with our partners, including those on this subcommittee, to provide access to quality healthcare to Native Americans.

The fiscal year 2017 President's budget proposes to increase the total IHS program budget to $6.6 billion, which will add $402 million to the fiscal year 2016 enacted funding level. If appropriated, this funding level would represent a 53 percent increase in funding for the IHS since fiscal year 2008.

The overall funding increases proposed in the President's budget are consistent with tribal priorities and would continue to address longstanding health disparities among American Indians and Alaska Natives compared to other Americans.

Specific investments include expanding behavioral and mental health services, improving healthcare quality, capacity and workforce, and supporting self-determination by fully funding contract support costs.

The President's budget proposal includes funding for pay costs, inflation, and population growth increases totaling $159 million, which are critical to maintaining the budgets of IHS and tribal hospitals, clinics, and other programs at current-year levels.

The budget also includes program increases of $49 million, of which $46 million will be focused on critical behavioral health serv-

ices, including generating indigenous substance abuse and suicide prevention projects to increase the number of child and adolescent behavioral professionals; continued integration between medical care, behavioral health, and tribal community organizations, and domestic violence prevention programming, to name a few.

The budget also includes an HHS-wide, 2-year mandatory proposal to address mental and behavioral health. For the IHS, the proposal includes a new $15 million Tribal Crisis Response Fund which would allow IHS to expeditiously assist tribes experiencing behavioral health crises, and an additional $10 million to increase the number of behavioral health professionals through the American Indians Into Psychology Program and IHS scholarships and loan repayment programs.

The budget proposes an additional investment for healthcare information technology to fund improvement, enhanced modernization and security of health IT systems; and also $2 million for IHS Quality Consortium, which will coordinate quality improvement activities among the 28 IHS hospitals, critical access hospitals, and the over 200 outpatient ambulatory clinics.

The budget includes funds for infrastructure that is critical to healthcare delivery, including to fund additional staff for five newly-constructed facilities, for tribal clinic leases and maintenance costs, specifically in Alaska, and to address the backlog of $473 million at Federal and tribal facilities.

In addition, the budget proposes funding of $12 million for the replacement and addition of new housing quarters in isolated and remote locations to enhance IHS recruitment and retention of healthcare professionals.

As was mentioned, the budget supports self-determination by continuing the separate indefinite appropriation account for contract support costs through fiscal year 2017. Additionally, the budget proposes to reclassify contract support costs as a mandatory 3-year appropriation.

Finally, I do want to acknowledge that we are working aggressively to address quality of care issues at our three facilities in the Great Plains. The challenges there are longstanding, especially around recruitment and retention of providers, but the deficiencies cited by CMS are unacceptable. We have an intense effort underway. We have brought in Commissioned Corps officers to help. We have the full support of the Department of Health and Human Services. We have established a Council on Quality, staffed by people throughout the Department of Health and Human Services, and we have established a new Deputy Director of Quality, who is Dorothy Dupree. We are working diligently to address those issues.

We look forward to working in partnership with you to enact the President's budget, and I want to say that we take these challenges seriously, and you have my commitment that we will work tirelessly to make meaningful, measureable progress. Thank you so much.

[The statement follows:]

PREPARED STATEMENT OF MARY SMITH

Chairman and members of the subcommittee:

Good morning. I am Mary Smith, Principal Deputy Director of the Indian Health Service (IHS). Accompanying me today are Elizabeth Fowler, Deputy Director for Management Operations, and Gary Hartz, Director of the Office of Environmental Health and Engineering. I am pleased to provide testimony on the proposed fiscal year 2017 President's budget for the IHS, which will allow us to continue to make a difference in addressing our agency mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level.

The IHS is an agency within the Department of Health and Human Services (HHS) that provides a comprehensive health service delivery system for approximately 2.2 million AI/ANs from 567 federally recognized tribes in 36 States. The IHS system consists of 12 Area Offices, which are further divided into 170 Service Units that provide care at the local level. Health services are provided through facilities managed directly by the IHS, by tribes under authorities of the Indian Self-Determination and Education Assistance Act, through services purchased from private providers, and through Urban Indian Health Programs.

As an agency we are committed to ensuring a healthier future for all AI/AN people, and the IHS budget is critical to our progress in accomplishing this. From fiscal year 2008 through fiscal year 2016, IHS appropriations have increased by 43 percent thanks in part to your subcommittee, and these investments are making a substantial impact in the quantity and quality of healthcare we are able to provide to AI/ANs. The fiscal year 2017 President's budget proposes to increase the total IHS program level to $6.6 billion, which will add $402 million to the fiscal year 2016 enacted funding level, and if appropriated, this funding level would represent a 53 percent increase in funding for the IHS since fiscal year 2008.

The overall funding increases proposed in the President's budget are consistent with tribal priorities and would continue to address long-standing health disparities among AI/AN, compared to other Americans. Specific investments include expanding behavioral and mental health services, improving healthcare quality, capacity, and workforce, supporting self-determination by fully funding Contract Support Costs (CSC) of tribes who manage their own programs, and ensuring increased healthcare access through addressing critical healthcare facilities infrastructure needs.

PRIORITIZING HEALTH CARE SERVICES

More specifically, the President's budget proposal includes funding for pay costs, inflation and population growth increases totaling $159 million, which are critical to maintaining the budgets of our IHS and tribal hospitals, clinics and other programs at current year levels, and ensure continued support of services that are vital to improving health outcomes.

The budget also includes program increases of $49 million to grow healthcare services by targeting funding increases to help close the gap in health disparities experienced by AI/AN and improve their overall health and well-being. Of the $49 million, $46 million will be focused on critical behavioral health services, including $15 million for Generation Indigenous substance abuse and suicide prevention projects to increase the number of child and adolescent behavioral professionals; $21 million to fund continued integration between medical care, behavioral health, and tribal community organizations to provide the entire spectrum of prevention to impact health outcomes; $4 million to fund implementation of pilot projects for the Zero Suicide Initiative in IHS, Tribal, Urban (I/T/U) organizations; $2 million to fund a youth pilot project to provide a continuum of care for AI/AN youth after they are discharged and return home from Youth Regional Treatment Centers; and $4 million for domestic violence prevention to fund approximately 30 additional I/T/U organizations. And $3 million to expand services provided through the Catastrophic Health Emergency Fund and Urban Indian Health Programs.

IMPROVING THE QUALITY OF HEALTH CARE DELIVERY

The budget includes funding increases intended to strengthen the provision of high-quality care. The budget proposes an additional $20 million for health information technology (IT) to fund improvement, enhancement, modernization, and security of health IT systems used for patient care data. And an additional $2 million for the IHS Quality Consortium, which will coordinate quality improvement activities among the 27 IHS Hospitals, Critical Access Hospitals and over 200 Outpatient Ambulatory Clinics to reduce hospital acquired conditions, avoidable readmissions, support the IHS Quality Consortium Work Plan with associated buildup of profes-

sional Quality staff and development of a National Quality Manager Council. Additionally, this funding would help to address recent standard of care issues at three of our Great Plains Area hospitals.

INCREASING ACCESS TO QUALITY HEALTH CARE SERVICES THROUGH IMPROVED INFRASTRUCTURE

The budget includes funds for infrastructure that is critical to healthcare delivery. Funding increases totaling $43 million are proposed as follows: $33 million to fund additional staff for five newly constructed facilities opening between 2016 and 2017, including three Joint Venture facilities where tribes funded the construction and equipment costs; $9 million for tribal clinic leases and maintenance costs, specifically where tribal space is ineligible for IHS Maintenance and Improvement funds, such as Village Built Clinics in Alaska; $.5 million to provide additional funds in reducing the maintenance backlog of $473 million at Federal and tribal facilities.

In addition, a total budget of $133 million is proposed, (1) to complete construction of the Phoenix Indian Medical Center Northeast Ambulatory Care Center ($53 million), (2) to begin design of the White River Hospital ($15 million), (3) to continue construction of the Rapid City Health Center ($28 million), (4) to continue construction of the Dilkon Alternative Rural Health Center ($15 million), (5) to fund the Small Ambulatory Grants Program ($10 million), and (6) to fund the replacement and addition of new staffing quarters in isolated and remote locations to enhance IHS recruitment and retention of healthcare professionals ($12 million).

Public and private collections represent a significant portion of IHS and tribal healthcare delivery budgets and are critical to support the IHS priority to improve the quality of and access to care. Third party collections from Medicare, Medicaid, the Veterans Health Administration, and private insurance allows IHS and contracting tribes to provide additional healthcare services, purchase new equipment, hire necessary medical staff, and make essential building improvements. IHS estimates that in fiscal year 2017 it will collect approximately $1.2 billion in funds from Medicare, Medicaid, private insurance companies, and the Department of Veterans Affairs.

SUPPORTING INDIAN SELF-DETERMINATION

The budget supports self-determination by continuing the separate indefinite appropriation account for CSC through fiscal year 2017. Additionally, the budget proposes to reclassify CSC as a mandatory, 3-year appropriation in fiscal year 2018, with sufficient increases year over year to fully fund the estimated need for both the IHS and the Bureau of Indian Affairs. This funding approach continues the policy to fully fund CSC and helps to support self-determination.

MANDATORY FUNDING PROPOSAL FOR MENTAL HEALTH INITIATIVES

The budget includes a HHS-wide 2-year mandatory proposal to address mental and behavioral health. For the IHS, the proposal includes a new $15 million Tribal Crisis Response Fund, which would allow the IHS to expeditiously assist tribes experiencing behavioral health crises, and an additional $10 million to increase the number of AI/AN behavioral health professionals through the American Indians into Psychology program and IHS scholarships and loan repayment programs.

LEGISLATIVE PROPOSALS

I would also like to highlight two of our legislative proposals. First, IHS is seeking a consistent definition of "Indian" in the Affordable Care Act (ACA). Currently, the ACA includes different definitions of "Indian" when outlining eligibility requirements for certain coverage provisions. These definitions are not consistent with eligibility requirements used for delivery of other federally supported health services to AI/AN under Medicaid, the Children's Health Insurance Program, and the IHS. The budget proposes to standardize ACA definitions to ensure all AI/ANs will be treated equally with respect to the Act's coverage provisions, including access to qualified health plans with no cost sharing.

IHS is also seeking permanent reauthorization of the Special Diabetes Program for Indians (SDPI). The SDPI grant program provides funding for diabetes treatment and prevention to approximately 301 I/T/U health programs. Most recently, the SDPI has been reauthorized through September 2017. Reauthorization of the SDPI beyond fiscal year 2017 will be required to continue progress in the prevention and treatment of diabetes in AI/AN communities. Permanent reauthorization allows the programs more continuity and the ability to plan more long term interventions and activities.

GREAT PLAINS HOSPITALS

Finally, I want to acknowledge that we are working aggressively with the full support of the HHS to address quality of care issues at three of our facilities in the Great Plains Area—Winnebago, Rosebud, and Pine Ridge. The challenges there are long-standing, especially around recruitment and retention of providers, but the deficiencies cited in the reports by the Centers for Medicare and Medicaid Services (CMS) are unacceptable. We have an intense effort underway right now through our corrective action plans to address the problems cited by CMS at these three hospitals. We brought in independent third-party reviewers to advise us on addressing the specific deficiencies found by CMS. The equipment identified in the CMS findings has already been replaced or procurement actions are underway. To further assist with addressing and implementing corrective actions, additional U.S. Public Health Service officers are supplementing IHS personnel in the Great Plains Area. I am also pleased to report that as part of our continuing workforce improvement efforts we recently received approval for an emergency department physicians' pay package. At the same time, we are working to improve communications with the tribes impacted. More broadly, we are redoubling their efforts to ensure that sustained, quality care is delivered consistently across IHS facilities. The HHS Secretary established the Executive Council on Quality Care, in which IHS is an active participant, and we are partnering with CMS to establish an agreement that will address systemic issues. As part of these longer-term efforts to make sustained change, we transformed our Hospital Consortium into a Quality Consortium and I have a new Deputy Director, Dorothy Dupree, who will work across the IHS to solely focus on quality improvement. We are also developing a strategic framework and sustainability plan for the Great Plains Area, in consultation with the tribes, that is agile and will be used to evaluate and ensure quality across the entire system.

I close by emphasizing that even with all the challenges we face, I know that, working together throughout HHS, with our partners across Indian Country and in Congress, we can improve our Agency to better serve tribal communities. I appreciate all your efforts in helping us provide the best possible healthcare services to the people we serve, and in helping to ensure a healthier future for American Indians and Alaska Natives.

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

Senator MURKOWSKI. Thank you, Ms. Smith. I appreciate your comments, and we will now move to questions from those of us here on the dais. It looks like the clock is 6 minutes.

CONTRACT SUPPORT COSTS

Contract support costs, as you have mentioned and as I have mentioned that this has long been a priority of mine to make sure that full contract support costs are without question, and the separate appropriations account that we developed I think is going to be important to make sure that, again, we're honest with this, we're not taking from one account to help meet this obligation.

You mentioned the mandatory 3-year approach here that you are laying out. Frequently we've seen the administration make some general statements about providing mandatory funding for certain programs, but then it never sends up the legislative proposal. Last week we talked about mandatory proposals by the administration for accounts like the Land and Water Conservation Fund (LWCF) and the National Parks, but there were no offsets for those.

So a question for you this morning is whether or not you do plan to send the Congress the proposal for mandatory funding for contract support costs, and if so when, and then whether or not there will be any offset identified.

Ms. SMITH. Thank you, Senator Murkowski. Yes, we are committed to fully funding contract support costs. As you mentioned, in our fiscal year 2017 budget proposal we are proposing to make contract support costs mandatory for 3 years starting in fiscal year 2018, and we are committed to sending up language. We look for-

ward to working with this subcommittee and others to provide language throughout the process.

I will defer to Liz Fowler. I am not sure about the offset question.

Senator MURKOWSKI. Ms. Fowler.

Ms. FOWLER. Good morning. The overall President's budget takes care of the offset for all of the mandatory proposals that are in the President's budget request. There's not a one-to-one offset within the IHS budget, so it's addressed by the President's budget overall.

Senator MURKOWSKI. Well, that may continue to be an issue. As you know, there have been many concerns raised by those of us that are looking at the President's budget and how they are proposing to address specific offsets. I have had a lot of constituents coming to me over the years expressing some frustration about contract support costs and, again, making sure that there is that full funding.

So now we got to full funding, and the push has been can we make this mandatory? And I think it will be met with good news that the proposal is that we do see it on the mandatory side. But as we all know, this is the last year of a two-term President, and I think there are many that have said there has been time that was wasted here, and it's unfortunate that we're just seeing it on the way out.

Now, I am told that the agency has still failed to settle about 30 percent of all the contract support cost claims filed against it by tribes, and this dates back many years. Where are you on prioritizing the conclusion of all the outstanding claims that are currently on file? If you can just give me an update on that.

Ms. SMITH. Yes. Thank you, Senator, for asking about the settling of the contract support cost claims. You are about right. My understanding is we have settled about 75 percent of those, and my understanding is that a majority of the remaining ones are ones for more recent years. So I understand that we have worked through the longer-standing disputes, and we are working on more recent cases as a general matter. So we are committed to continuing to resolve those and paying full contract support costs.

Senator MURKOWSKI. Who is in charge of executing that plan just in terms of making sure you move through as many of them as quickly as possible?

Ms. SMITH. I think that, obviously, as head of the agency, ultimate responsibility is with me. But I know that Ms. Fowler, in her role in Management and Operations, oversees and works very closely with our Office of General Counsel to ensure that these are a priority, and we continue to make progress on the settlements.

Senator MURKOWSKI. I know that that continues to be a very, very high priority.

VILLAGE BUILT CLINICS

In my last minute here, I want to raise the issue of village-built clinics. As you know, this is an issue that I have raised for years with your predecessor and, quite honestly, gotten nowhere, gotten nowhere, which was very, very frustrating. Last year we were able to include $2 million to help address the issue of village-built clinics. We've got about 150 in my State, many of them being the only

local options for any healthcare. Many have serious maintenance needs, and again the frustration was your predecessor said basically that the tribes are responsible for paying these costs out of other funds that they get from the Service. That just was not right.

So again, we've got $2 million to help address it, but this issue I hear more from local folks than just about anything else when I'm out in the villages. So can you tell me how the agency plans to allocate these funds and when they will be distributed?

Ms. SMITH. Thanks, Senator, for that question. I'm glad you asked about it because one of the first things that I was looking into when I started last fall was I did see that you had spent over a year asking about this issue.

Senator MURKOWSKI. It was like every hearing on an annual basis.

Ms. SMITH. Yes, yes, and I read all your correspondence, and I started talking to people at the agency, including Ms. Fowler, and it seemed to me that there was a gap there of something that we needed to address.

So we worked out a way—there's $2 million in the fiscal year 2016 budget, but I'm pleased to say also we have now created a line item in the fiscal year 2017 budget for $9 million to fund clinics of this type. As you pointed out, a majority of them, I believe, are in Alaska, but I do believe there might be some in the other 48 States, and we wanted to make sure that everyone who was in this gap category would be covered.

So with respect to the $2 million in the fiscal year 2016 budget, we are going to start a tribal consultation to ensure that these funds are distributed where they're needed, and equitably. As you mentioned, there are quite a number of clinics in Alaska, and I have also personally read—I know the Alaska Health Board wrote a fantastic report just on the maintenance that's needed on these village-built clinics.

So I know that our area director in Alaska will be doing a consultation to——

Senator MURKOWSKI. Will that be pretty soon, then?

Ms. SMITH. Yes, it will be soon.

Senator MURKOWSKI. All right. Well, we will look forward to that. I appreciate working with you on it. As you are aware, the need is great, and we appreciate the increase that we will see in this account.

Let me turn to my ranking member.

Okay, Senator Tester.

Senator TESTER. Thank you, Madam Chair, and I want to thank the ranking member for his courtesy.

IHS BUDGET

There is an expectation that Indian Health Service provides the healthcare that we expect. It's a direct responsibility. We've heard issues of life and limb in the past where IHS has run out of money, and then there have been the issues with contract care that the Chairman brought up.

This budget is increased by $377 million, which is a lot of money. But is it enough when you consider that IHS is currently at 50 percent of what we spend on veterans and probably the least amount

of money we spend for healthcare of any group that the Federal Government supports? So tell me about this budget. Tell me where it's at. Tell me if it's adequate.

Ms. SMITH. Senator Tester, thanks so much for your question. As you mentioned, this budget has a total of $402 million increase, and as I mentioned in my opening statement, if enacted, that would represent a 53 percent increase since fiscal year 2008.

We believe that this budget is a strong budget put forth by the President that focuses on critical needs such as staffing, behavioral health issues, and critical needs in housing and facilities. So we do believe that it makes important progress.

STAFFING

Senator TESTER. Let's talk about staffing for a second, because that's a problem. What is the plan? What is the plan to get folks on and retain those folks?

Ms. SMITH. Thanks, Senator. Yes, what I want to say at the outset, and I want to be very honest with this committee, we, I think along with any agency that provides services in rural remote locations, we have problems with staffing, including recruiting and retaining staff, particularly medical staff.

Senator TESTER. That's correct. So what are we going to do about it?

Ms. SMITH. We have to have, I think, a multi-prong approach. So what we are doing, for instance in the Great Plains now, in the very short term we are working with deployments of Commissioned Corps. We are also looking into contracting for staffing, and then we are also working very vigorously on permanent staffing. Just last week, I'm pleased to report, we were able to get an approval and a pay package for emergency rooms so that we are able to pay more now.

Senator TESTER. So can I ask you, is what you pay your staff for equivalent capabilities competitive with the VA?

Ms. SMITH. Not in all instances, Senator, no.

Senator TESTER. And why is that?

TITLE 38

Ms. SMITH. We use Title 38, which is also the pay scale that VA uses. We have some of the authorities in the pay scale. We can pay certain special salaries. We can pay some market pay. But we don't have the full Title 38 authorities.

Senator TESTER. Have you guys made a recommendation to give yourselves some more flexibility in that area?

Ms. SMITH. We are discussing it and we have, like I said, done some proposals, and I know we are working on a number of items.

STAFFING

Senator TESTER. Look, healthcare in Indian Country is a great experience because you get to deal with a myriad of problems, but it's very difficult to get people to come if they know they've got to take a pay cut to come. So if you need flexibility, I wish the Department would make that recommendation to the Chair and ranking member so we could analyze that and maybe pursue it, and the

same thing with the Indian Affairs Committee, Senator Barrasso and myself.

MEDICAID EXPANSION

Let me talk about Medicaid expansion very quickly. Some States have done it, some States haven't. Montana just did it. I think it's a good thing. I think it's a good thing for Native Americans. This budget is for the whole country. Some States don't have Medicaid expansion. I understand that States that do have Medicaid expansion, these IHS dollars have been able to go further. Is that correct? Yes?

Ms. SMITH. Yes, that's correct, Senator.

Senator TESTER. So what about the States that don't have Medicaid expansion? What do we do about that from an Indian health standpoint? Because it appears to me we could have two classes of Native Americans out there.

Ms. SMITH. No, Senator, thanks so much for your question, and you are correct. I do think that in States where Medicaid has been expanded, we are able to leverage our dollars further, particularly with respect to our purchase referred care program, and your point is well taken. We do not want to create different classes of Native Americans because everyone who is eligible for IHS should receive the same standard of quality care.

So I know we are working very intensely on that and making sure that the provider agreements we have create equity among the people that we serve.

THIRD-PARTY BILLING

Senator TESTER. Okay. How much success are you having with tribes and third-party billing? If they don't bill third party, then the dollars can't be extended out further. Are tribes on board with this or are they balking at it?

Ms. SMITH. You mean when they run their own program?

Senator TESTER. Yes, that's correct.

Ms. SMITH. I do believe that they are doing that, but we don't actually have a lot of information on which tribes run their programs.

Senator TESTER. All right. How about IHS themselves?

Ms. SMITH. Yes. Every year I think we have steadily increased our third-party billing, and we have adopted a number of practices at our business office that we are disseminating across the field to further leverage——

Senator TESTER. Do you have the figures on how much that third-party billing has brought into the program?

Ms. SMITH. Yes. I think for fiscal year 2017, I think we're estimated to be at about $1.2 billion of third-party billing.

Senator TESTER. And how much of that is your total budget, then?

Ms. SMITH. Our total budget is $6.5 billion, including the mandatory——

Senator TESTER. It's significant.

Ms. SMITH. Yes.

Senator TESTER. Okay. Thank you, Mary.

Thank you, Madam Chairman.

Thank you, ranking member.
Senator MURKOWSKI. Senator Daines.
Senator DAINES. Thank you, Madam Chair.
It's very good to have you here today.

HEALTHCARE OUTCOMES

Recently we had Jace Killsback from Indian Affairs Committee. He's Executive Health Manager for Northern Cheyenne Tribal Board of Health. In IHS testimony last month he said, and I quote, "It has become normal and okay to be misdiagnosed and to wait until you're going to lose a leg or your life to receive the right healthcare that you need."

I know as I travel around Indian Country in Montana, there aren't a lot of folks back home that are real happy with the outcomes. We've heard a lot today about spending on various programs, not much on concrete outcomes for tribal communities.

Just a question. What would you say are two or three of the most important metrics you look at in terms of outcomes in terms of improving Indian health that you evaluate here in terms of whether it's working or not?

Ms. SMITH. I think we have very important outcomes in several areas. One is I think we have made tremendous strides with addressing diabetes in Indian Country. The childhood obesity rate is going down, and also I think the incidence of Type II diabetes has stabilized over the past few years. That's one example.

Senator DAINES. If you were to try to take it up to the—I mean, you quote a couple where we have made some progress, but if you just kind of step back and try to evaluate the success or failures of a program, what are the top three outcomes you say really are good measures in terms of whether or not we're improving health in Indian Country?

Ms. SMITH. I think, Senator, one top-line measure would certainly be the overall life expectancy in Indian Country, where I think we've shown progress over the years, over a long term. That would be one high-level measure.

Senator DAINES. What else?

Ms. SMITH. I think looking at health disparities across other populations would be a good measure. I know that there has been some progress made, but more progress needs to be made on those health disparities.

Senator DAINES. My concern in looking at the testimony here is we've invested another $2 billion in IHS. It looks like round numbers here. You mentioned the 53 percent increase if funded at the President's request versus 2008. So if we put approximately $2 billion more, plus or minus the programs, and that's relative to about a $4 billion base, roughly, add another $2 billion, the question is what's improved because of that? I hear, again, a lot of concerns about outcomes in Indian Country. I don't hear a lot of feedback to say we're very pleased with IHS. To the contrary, I think virtually everywhere I go I hear about the challenges and the failures of the program.

Ms. SMITH. Yes, Senator, I share your concerns. I know that there are a lot of issues. I know that I have heard personally myself from a number of patients and people in tribal communities,

but I do think there are a lot of dedicated people who work at IHS as well, and I know that there's also a lot of good work. But that's not to diminish the challenges that you are talking about.

Senator DAINES. My request would be when we look at budgets, of course you've got to look at where the spending is going to be, but also to bring the outcomes, bring the metrics. Let's go back to 2008, or let's say a 5-year timeline, are we getting better or not. What are the top three to five measures that really help us understand better is Indian health getting better or is it getting worse as we look at the investment choices and prioritizing on it.

ADMINISTRATIVE COSTS

And along that line, when Dr. Roubideaux was here, she cited the IHS admin costs at around 10 to 11 percent of the total. It looks like now—well, let me ask you, what are the admin costs as a percentage of the overall budget for this year?

Ms. SMITH. I think the IHS-wide administrative costs are at 12 percent, and then some of the areas are lower than that.

Senator DAINES. Overall. I'm just looking at what Dr. Roubideaux told us, the 12 percent. It looks like the percentage of administrative costs are actually going up versus going down. And typically when budgets are increasing oftentimes, because you have a bigger denominator, the admin costs will start going down. Having spent many, many years doing budgets in the private sector, why are admin costs going up?

Ms. SMITH. Senator, I'd have to look back at the number that Dr. Roubideaux gave you. I'm not aware that they're going up between 11 and 12, but we can certainly look at that, and I will say that we are committed to—I think your points are well taken. We are committed to ensuring that we are efficient in how we spend the funds and that we have deliverable outcomes and metrics and timelines for achieving results.

Senator DAINES. Yes, and part of the overall challenge here, I'd like to see some clear goals set, that we want to take admin costs as a percentage—if they're at 12 percent today, how do we get to 11 percent, 10 percent, and 9 percent over the course of the next 3 or 4 years? Because every dollar that's spent in admin arguably is a dollar getting taken out of the help that people here who need it the most in Indian Country.

Ms. SMITH. Yes, Senator, thank you so much, and we definitely can take a look at that. I share your thoughts on that.

Senator DAINES. And again, this is just my concern. This disproportionate spending on admin costs doesn't translate into better care in Indian Country. A recent study showed in Montana that white men live 19 years longer than American Indian men, and white women live 20 years longer than American Indian women. I know there are other factors involved, but I do believe it's unacceptable that we've reached disparities like these under the watch of IHS, and I urge you to address the real health challenges facing Indian Country and really turn the focus back to results versus just activities.

Ms. SMITH. Thank you, Senator, and I totally agree, and that is a point well taken.

Senator DAINES. All right. Thank you.

Senator MURKOWSKI. The ranking member has asked that we defer to Senator Merkley from Oregon.

Senator MERKLEY. Thank you very much to the ranking member, I appreciate that.

HEALTHCARE COSTS

I appreciate this conversation about the Indian Health Service. It certainly serves a vital role in many parts of my home State of Oregon. One thing I was looking at was a number I found very interesting, and that is the number that, per patient, the Indian Health Service spends about $3,100 compared to, say, Medicare, at almost $12,000, or the national average for those who are not in either Medicaid, Medicare, Veterans, et cetera, of about $8,100. So $3,100 sounds like a very low number.

Is that so low in part because there are lots of folks who qualify who don't actually utilize the Indian Health Service, they live in urban areas and have other health service providers, or is that just a reflection of how desperately underfunded IHS is?

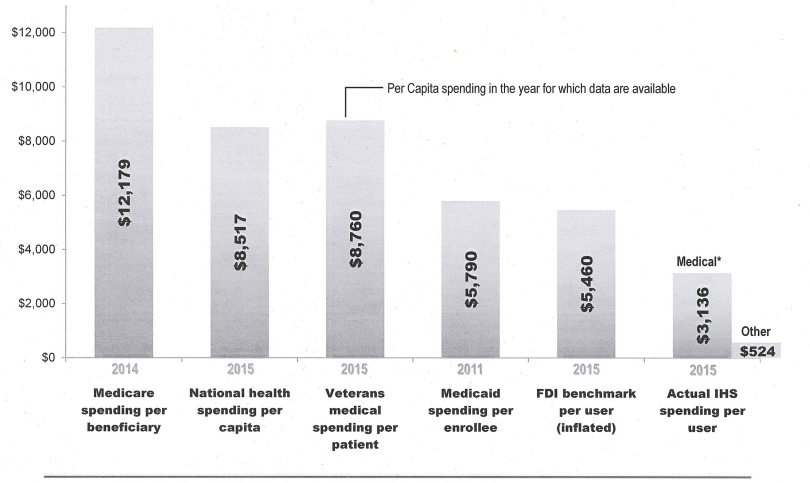
Ms. SMITH. Thank you, Senator. I think the number that you are referencing is the per capita funding for certain Federal programs that provide healthcare. The per capita funding for IHS is, as you correctly stated, about $3,100 per capita. I think the number is derived from our total population served, about 2.2 million, and then dividing out our budget. So I think that's how the number is derived.

Senator MERKLEY. So of those 2.2 million who are eligible, how many in a given year utilize the IHS as their primary health provider?

Ms. SMITH. Senator, I would have to get back with you on that, but we're happy to provide an answer.

[The information follows:]

2015 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



*Payments by other sources for medical services provided to AIANs outside IHS is unknown.

12/29/2015

Data Sources and Calculations -- Health Care Expenditures Per Capita

1. $12,179—2014 AVERAGE MEDICARE BENEFIT PER ENROLLEE: Source—2015 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS; available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf in Table II.B1 Medicare Data for 2014, page 11.

2. $8,517—PROJECTED 2015 NATIONAL HEALTH CARE EXPENDITURES PER CAPITA: Source—Table 5 Personal Health Care Expenditures; Aggregate and per Capital Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2014-2024; available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2014tables.zip.

3. $8,760—2015 CURRENT ESTIMATE OBLIGATIONS PER UNIQUE PATIENT: Source—Volume II—Medical Programs and Information Technology Programs—Congressional Submission, available http://www.va.gov/budget/docs/summary/FY2016-VolumeII-MedicalProgramsAndInformationTechnology.pdf (page VHA–23).

4. $5,790—2011 MEDICAID SPENDING PER ENROLLEE. Spending per enrollee calculations includes both state and federal payments to Medicaid. These figures represent the average (mean) level of payments across all Medicaid enrollees, including those receiving full or partial Medicaid benefits, during federal fiscal year 2011, based on date of payment. Available at http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/.

5. $5,460—FDI BENCHMARK PER IHS USER (Interim Inflated to 2015): The ACA expands health care resources potentially available to AIANs. IHS' long standing methodology projecting per-capita resource needs has not yet incorporated these factors due to unavailable data. In the interim, the last benchmark was inflated to 2015 pending future methodological adjustments for ACA effects.

6. $3,136—2014 IHS MEDICAL CARE EXPENDITURES PER USER*: Source—IHS appropriations for 2015. Appropriations spent for personal health care services plus IHS collections from third parties are totaled and divided by 2015 user counts (1,613,450). IHS spends an additional $524 per person for *OTHER public health, community programs, sanitation and environmental projects, education, and other purposes unrelated to personal medical care. An unknown additional amount of spending occurs outside the IHS system when patients obtain a portion of their medical services elsewhere, e.g. payments by private insurance, Medicare and Medicaid to non-IHS providers for services to Indians who also use the IHS.

*Payments by other sources for medical services provided to AIANs outside IHS is unknown.

Senator MERKLEY. That would be helpful to try to understand really how this compares to other healthcare settings.

TELEMEDICINE

I wanted to turn to telemedicine. I believe that in Alaska, and the Chair will correct me if I'm wrong about this, that they have piloted the Dental Health Aide Therapist Program to provide telemedicine in dental care. This trains tribal members to become mid-level dental professionals, 2 years of training. It provides care such as oral exams, cleaning, fluoride treatments, sealants, x-rays, crowns, extractions, while doing it through a video conference with a dentist. Has this worked well in Alaska?

Senator MURKOWSKI. Well, I will let Ms. Smith speak to it. I think everything that you have said is correct, although the dental health therapists don't do the extractions necessarily, but it has proven to be phenomenally successful to get mid-level providers out in areas where we would never find the full provider.

Senator MERKLEY. Well, the reason I wanted to raise this is I'd heard rave reviews about Alaska, and Oregon is the first State outside of Alaska to provide this. I believe that we had to pass a State law to authorize it. Given the success and the cost-effectiveness of this, is this something that the Indian Health Service is hoping to expand substantially?

Ms. SMITH. Thank you, Senator, for your question. I agree with the premise of your question. I think they're doing some amazing, innovative things in Alaska and serving the community well, and this is one example. I think your question, you mentioned it in the dental context, but I think the premise of your question I think expands more broadly on how can we leverage resources and how can we leverage the use of telemedicine. I can tell you that we are very committed to doing that because, as was mentioned earlier, we have significant staffing challenges, and we have to think creatively, and everything has to be on the table. I think telemedicine is one of the ways, along with a lot of other things, that we can leverage those resources.

I know that we are using telemedicine for behavioral health. We have the Telehealth Center of Excellence that's in partnership with the University of New Mexico, and we are doing several sites in the Great Plains, for instance. We actually just—we're going to do a telemedicine area-wide contract in the Great Plains that is in process now, and one of the things last week we actually had our budget formulation workgroups, and I think one of the things we would like to see on a going-forward basis is a more concerted effort nationally to focus on telemedicine.

Senator MERKLEY. Well, thank you. I think that's an area where we can help address some of the concerns that Senator Daines was

mentioning in terms of how do we get more outcomes for the dollars invested.

CONTRACT SUPPORT COSTS

I did want to ask about contract support costs. My understanding is that this budget line pays for tribes for things such as financial management accounting, training, program startup, but that pretty much it has had a substantial shortfall, and you're recommending an $82 million increase. Is that based on a certain percent of assistance to tribes for administrative overhead? How is that calculated, and how much of a difference will that make?

Ms. SMITH. Thanks, Senator. I will answer at a high level, and if you need more detail we're happy to get that to you. I understand that there was an estimate made in consultation with tribes, and after the Supreme Court's decision in Ramah we are obviously fully supportive of the full contract support costs, and I personally actually have spent a lot of time. We are actually going to be putting forth a new contract support cost policy this year with IHS. But I've spent a lot of time with the Contract Support Cost Working Group and I understand, even from our tribal partners, that the number that we have put forward is on the generous end of the estimate, and I do believe that it will fully fund contract support costs.

Senator MERKLEY. Thank you very much, and thank you for your very—you said you hadn't been there that long, but you're presenting very thorough responses to all of our questions, and it gives me great confidence in IHS going forward. Thank you.

Senator MURKOWSKI. Thank you, Senator Merkley.

Senator Udall.

SUBSTANCE ABUSE

Senator UDALL. Thank you, Madam Chair and Deputy Director Smith. I'm very pleased to see that you've included a 14 percent increase for alcohol and substance abuse programs as part of your 2017 budget request. I've already had the chance to visit with you about a particular issue in New Mexico that has to do with the Gallup detox center. It's also called NCI (Na'nizhoozhi Center Inc.). I wanted to raise this issue again this morning and ask for your help.

As I've mentioned, the center has been providing detoxification services to the Gallup community for more than 20 years. In a community struggling to reduce exposure deaths related to alcohol and substance abuse, the services it provides literally mean the difference between life or death.

Twenty-five people have died from alcohol-related exposure incidents between this winter and last winter, with the recent report of another death just 2 weeks ago. There were five deaths this January alone. According to the center's director, they have admitted more than 2,500 individuals since October 2015, which is approximately 10 percent of the population of Gallup.

The need is clearly there, and the community is desperate to maintain these life-saving services. Over the past few years NCI has lost some of the funding that it received from Indian Health

Service and other sources, and the center has been on the brink of closure ever since.

I'm grateful that the Indian Health Service just stepped up to the plate to provide some emergency funding to help keep the center open through June 30, funding that was particularly critical to keep it open through the coldest winter months, when the risk of weather-related deaths is the highest. But that's just a temporary fix, and we must do more.

I want to work with all the partners involved with NCI, IHS, the tribe, the State and the city to come up with a plan to provide sustainable funding. Senator Heinrich and Congressman Ben Lujan have been great partners on this issue, and we have all been working together to find a way forward and to encourage communication between the local stakeholders.

Can I have your commitment that you will work with me and with members of the delegation to develop a long-term plan to keep the center open so it can continue to provide essential services?

Ms. SMITH. Senator, first I want to thank you for your leadership and all that you've done to help that situation, and you do have my commitment. As we've talked about at this hearing, there are great issues of alcohol and substance abuse in Indian Country, and since we talked I've been thinking about this issue a lot, and to me it's similar to the village-built clinic. This is like a gap that we're not addressing, and I am committed to working with you to find a sustainable solution.

Senator UDALL. Thank you so much for that. We've talked specifically about the needs in Gallup, but obviously, as you've just said, substance abuse treatment is a critical need in many of our Native communities, and I continue to hear from tribal leaders in New Mexico, including the Mescalero Apache Tribe and others who are concerned for the well-being of their people. That's why I'm pleased to see we were able to provide a $10 million increase for alcohol and substance abuse treatment as part of the 2016 omnibus.

Could you tell us more about how these increased funds will be used, what improvements in counseling and treatment services will these additional resources provide, and how soon will these improvements be available to tribes?

BEHAVIORAL HEALTH

Ms. SMITH. Thank you, Senator, so much for highlighting the great need we have for behavioral health issues in Indian Country, and we appreciate all your help and leadership on that issue.

Our fiscal year 2017 budget, we actually have $46 million to focus on critical behavioral health needs. $15 million of that is for the generation of indigenous substance abuse and suicide prevention projects to increase the number of child and adolescent behavioral health professionals. We have $21 million to fund continuing integration of behavioral health services throughout our IHS system. We have $4 million to fund pilot projects for Zero Suicide Initiative. We have $2 million to fund another gap that I think we realized is for after-care, after people leave regional youth treatment centers. So we have a $2 million pilot project for that, and then we

have $4 million for domestic violence prevention to fund 30 additional organizations.

Senator UDALL. Are you able, when you ramp up like this, able to get the funds and the resources down to the ground quickly?

Ms. SMITH. I think we are able to do that. I know that even since the time that I've been at IHS, we have had a number of tribes who have had what I'll call behavioral health crises, and one of the things I know a number of us have been working on at IHS as well is that sometimes grant programs are timed a certain way and you cannot time when a behavioral health crisis happens. So one of the things that I am particularly excited about in our budget is we have $15 million for a new Tribal Crisis Response Fund so that those funds will be immediately available upon the request of a tribe when they're having a behavioral health crisis in their community.

Senator UDALL. Thank you very much.

Thanks, Madam Chair.

SUICIDE AND SUBSTANCE ABUSE

Senator MURKOWSKI. Thank you, Senator Udall. I appreciate your focus on these issues of suicide, substance abuse. Know that this is something that I really want us to try to focus on within this IHS budget. I think there are so many other areas that we can look to. We're going to have a hearing this afternoon in Indian Affairs on the budget as it relates to Indian Affairs. I think about the job creation programs and the other things that we will do, education. But if, in fact, our Native peoples are not healthy, it makes it difficult to really be there to provide much else. So making sure that they have hope, that they do not view suicide as an answer or that they turn to substance abuse that not only takes them down but their families down and their whole communities is just so key.

I mentioned complex trauma in my opening remarks. Your budget request talks briefly about it, but know that, again, that's something where we'd like to have better understanding.

You mentioned this integrated approach to addressing primary healthcare, mental health and substance abuse disorders. I know that you have made some commitment to some of our tribes to perhaps come up to Alaska sometime this summer, but I do hope that you will take full advantage of visiting with the folks at South Central Foundation to really come to understand what they have done with the Nuka model, which is truly this integrated, whole-person approach to providing healthcare services. It's a model that is not only being built on within the State of Alaska but really around the country and as an international model. It's not too often that in Alaska we are leading the way in healthcare reform, but I view what Katherine Gottlieb and those at South Central have done over the years with the Nuka model as not only innovative and pioneering, it's the way of the future. I would certainly commend that to you as you're talking about this integrated approach.

I mean, if you'd care to make any comments about that, I'm happy to hear them.

Ms. SMITH. Senator, I completely agree. Healthcare needs to be integrated in all facets of life, and it's family, tribe, and commu-

nity. I look forward to a trip to Alaska. I'm committed, and I certainly look forward to learning more about that because I have heard of all the innovative things that are happening in Alaska and I hope to learn a lot and see if there's any way we can replicate some of those best practices elsewhere in the country. So, thank you so much.

DEFINITION OF INDIAN

Senator MURKOWSKI. We certainly believe we can, and we're ready to show you.

Let me ask about a technical thing. This is the definition of "Indian" under the Affordable Care Act. We continue to hear the complaints about the inconsistent definition that is contained in that Act that has caused confusion and inconsistent treatment, unfortunately. A person who is an Indian for purposes of Indian Health Service programs and for Medicaid is not treated as an Indian for purposes of the ACA—incredible. And yet we knew that this was an issue coming forward. The National Congress of American Indians (NCAI) weighed in, the National Indian Health Board, and yet the administration chose to interpret the legislation in a way that really created a problem.

We believe that there is authority within the administration to grant regulatory waivers, but it hasn't taken action to ensure that the benefits of open enrollment and protection from cost-sharing would be available to all Indians. We asked the administration to fix this administratively, but they haven't. We included report language in the fiscal year 2015 omnibus containing a directive to work together to establish a consistent definition of "Indian" for purposes of providing health benefits.

What's the administration going to do this year to fix the problem? Because it really needs to be addressed.

Ms. SMITH. No. Thank you so much, Senator, for your leadership. I know you have also been advocating for this for a long time, and I have also looked into this since I've been there. The definition definitely should be consistent, and as part of our fiscal year 2017 budget proposal we have a legislative proposal to make the fix. I think there's been a determination that this needs to be done legislatively.

Senator MURKOWSKI. Well, I understand that. But I also understand that the ACA passed at the beginning of this administration. It is now the end of this administration. And I understand that it didn't come into play until a couple of years ago. But in the interim, again, you have American Indians, Alaska Natives that are just kind of caught in this back and forth. It was just so, so unnecessary.

So I appreciate the administration coming forward and saying, well, now we think we need legislation. Before they were looking at administrative fixes. So I know that I'm just taking on the messenger here, but I think it needs to be made very clear that this became a problem when it didn't need to be a problem, and it could have been remedied. If the administration determined it needed legislation, we've been prepared to address it, and it's just been a failure, so know that it's been a priority.

PRIORITY LIST AND CONSTRUCTION

Let me ask a question about two very small communities in Alaska, Gambell and Sevoonga. They are located on St. Lawrence Island out in the middle of the Bering Sea. You want to talk about remote, it does not get any more remote than Gambell and Sevoonga. They are communities that have roughly 700 people each. The only way you can get there is by airplane, and more often than not the weather is not very forgiving. The existing facilities are old, old, old and really rundown. I have seen the facility there at Sevoonga, but they are simply unacceptable in terms of their condition.

The Norton Sound Health Corporation, along with some very dedicated folks from Gambell and Sevoonga, have tried to get Federal financing to construct new clinics. They were in to visit with me about a month ago. We sent a letter to the Department and were told that the current IHS healthcare facilities priority list has a $2 billion backlog of projects and that you can't add any new projects to the list, which for the people of Gambell and Sevoonga is incredible. You've got to be kidding me. There's no way to possibly provide some upgrades to a situation that is in desperate need.

So, first of all, I want to know whether or not that is still your position, that they cannot be added to the list. And second, I want to ask about the small ambulatory clinic program. For the first time since 2008, the agency has requested funds for this program. There's $10 million in it. Would Gambell and Sevoonga be eligible for funding for this program if funds were to be provided? As you can probably understand, the people in these two communities are really most desperate and are seeking some answers. So if you could provide me something here today, that would be helpful.

Ms. SMITH. Thanks, Senator. I certainly can appreciate your frustration. I get frustrated, too. As you correctly mentioned, we have a list of priority projects that actually gets approved by Congress, and there is a $2 billion backlog. I wish that we had more flexibility with the list. Unfortunately, that's the way the system is set up. So I think adding to the list, we don't actually have flexibility at IHS. Congress dictates how we have to move through the list. So I appreciate your frustration.

In terms of other options or trying to think creatively how to address this issue, and I know you've raised the small ambulatory clinic, if I may defer to Mr. Hartz to see IHS thoughts on that.

Senator MURKOWSKI. Mr. Hartz.

SMALL AMBULATORY PROGRAM

Mr. HARTZ. Thank you, Senator. The small ambulatory program is one of the programs to be considered for Sevoonga and Gambell. There are criteria, and we'd be happy to send in advance of even the solicitation, we would go ahead and send to Manilick what the criteria were when we last implemented the program so that they can get some idea of the specifics of that.

Furthermore, we understand that those two locations are considering applying under the tribally built program for equipment, and

they certainly would be strongly considered for equipment dollar support should they move forward as a tribally built facility.

JOINT VENTURE

So there are some options available, and the most popular program is the JV, the joint venture program that's been utilized throughout Indian Country, and that would be another option should they consider the next solicitation.

Senator MURKOWSKI. Thank you, Mr. Hartz and Ms. Smith. Know that we will continue to try to work with you on this.

Ms. Smith, I know it is a long way out of the path of Anchorage or Fairbanks where you will likely be, but I do think that when you visit it would be most important to get out to some of our smaller villages and see the needs and how isolation really makes imperative the need to have some facilities out there.

Let me turn to my colleague here, Senator Udall.

STAFFING

Senator UDALL. Thank you, Madam Chair.

Deputy Director Smith, New Mexico emergency medical services were halted last year at an IHS medical center in Crownpoint, New Mexico. This was due in part to staffing issues, though some emergency services were ultimately restored. I'm told the hospital is still unable to provide certain medical services like labor and delivery. My concerns about this situation are amplified by the problems that the service is having in other areas like the Great Plains, where multiple facilities are on the brink of losing their accreditation, and other tribes there have faced the loss of emergency services as well as substandard care.

It goes without saying that patients deserve competent and timely care. It's absolutely intolerable for any IHS emergency facility to close for any amount of time, and cutbacks to essential services like obstetrics are also unacceptable.

Can you talk about what the IHS is specifically doing to address staffing shortages at Crownpoint and other facilities in New Mexico?

Ms. SMITH. Thank you, Senator. Yes, we certainly agree with you on access to quality care and certain services being provided. I know that across the agency, including at Crownpoint, we are looking at staffing issues, like I said kind of in three simultaneous ways, in the short term, in the intermediate term and the longer-term sustainable solutions. So we are definitely working on that and it is certainly a priority for us.

Senator UDALL. And are you able to tell me today anything specific about Crownpoint, or would you rather do that——

Ms. SMITH. Yes, I have one specific. I know that the quarters are being upgraded out at Crownpoint, so I'm able to tell you that today.

Senator UDALL. Okay, thank you. Maybe you can update me on additional things in the record for specifically what we're doing out at Crownpoint.

Ms. SMITH. I certainly will.

Senator UDALL. On a related note, I'd like to raise the concerns I'm hearing about service reductions at the Santa Fe Indian Hos-

pital. This is an issue that was brought to my attention recently by the Pueblo of Tesuque. Deputy Director Smith, I'd like to ask for your help in reviewing the situation with the hospital, and I'm going to ask you to provide some data for the record regarding services and staffing levels so that we can get to the bottom of these concerns. Would you work with me on this issue?

Ms. SMITH. Senator, we will certainly work with you and your staff on this issue and get you whatever answers and work together to find a solution. Thank you.

Senator UDALL. Great, thank you.

LOAN REPAYMENT AND STAFF QUARTERS

On the issue of loan repayment and staff quarters and things like that, as you know the Indian Health Service currently spends an estimated 30 percent of its health professions account to pay taxes to the Federal Government, taking needed funding away from investments in skilled medical professionals. I've introduced a bill with the Chairman, Senator Murkowski, that will make the IHS Health Professions Awards Program exempt from a Federal income tax requirement, and I'm pleased to see that your budget includes a similar proposal.

Can you talk about the importance of this specific issue for recruitment purposes? And if this proposal would be enacted, how many additional scholarships and loans could IHS provide with the existing resources?

Ms. SMITH. Thank you so much, Senator, and thank you so much for your leadership on this issue. All 100 percent of the dollars for both the scholarships and loans can go for the purposes for which they're intended rather than taxes. As you mentioned, we do support that proposal. I understand that if the proposal went forward, that would free up $11 million, $8 million of it for loan repayment and $3 million for scholarships, and I think that would allow us to do 200 more loan recipients. So, thank you so much.

Senator UDALL. Well, we haven't gotten it done yet, but we look forward to working on this and actually accomplishing this. It helps a lot that the Chairman is also the chairman of the authorizing committee.

FACILITIES CONSTRUCTION

I'm pleased that this subcommittee was able to provide $63 million in new funds for construction and maintenance needs as part of the 2016 omnibus, and I'm pleased to see that you build on that request in your 2017 budget by asking for another 9 percent increase. We really need these kinds of things to happen in Indian Country. The issue is particularly important to me because there are a number of tribal health facilities in New Mexico that have been waiting their turn on the IHS priority list for years. These include outpatient facilities in Alamo, Pueblo Pintado, and Albuquerque. And, of course, we also have the replacement of the Gallup hospital on the list.

How long will it take at current funding levels to complete work on the current priority list? Is it fair to say that should additional resources become available, that you would be in a position to accelerate this timetable?

Ms. SMITH. Senator, thanks so much for your question. Yes, I do understand, I think. This is a ballpark estimate. I think it's in the nature of 18 to 20 years to fully fund all the needs that there would be, and certainly if there were more funding we would be able to do more projects.

Senator UDALL. And I understand that the Alamo facility is next up for funding on the priority list, but it's not part of your fiscal year 2017 request. What's the earliest we can expect to see funding for that project?

Ms. SMITH. I will defer to Mr. Hartz on this question.

Mr. HARTZ. Thank you, Senator. You are correct, it is the next project on the outpatient list. Based on the current level of funding, it would probably be reached within the next 2 years.

Senator UDALL. Thank you.

Maybe I'll come back with this one. Thank you, Madam Chair.

Senator MURKOWSKI. Thank you.

FACILITIES CONSTRUCTION

I want to ask one more Alaska-specific question, and then I want to turn my attention to what I raised in my opening, which is the situation at Rosebud.

But first, I want to ask specifically about Southeast Alaska. The Mount Edgecombe service unit is an area, it's about 35,000 square miles but entirely tribally operated, mostly by the Southeast Alaska Regional Health Consortium, SEARHC. It is anchored by about a 70-year-old hospital there in Sitka that was built just after World War II by the War Department. It's in pretty tough shape. I will just tell you that. It's ill-suited to the 21st century model of healthcare that's dominated by primary and ambulatory care facilities. What we have seen in Southeast in particular has been more facilities focused on localized care provided through 13 clinics serving 18 Alaska communities.

What is Indian Health Service doing to collaborate with SEARHC in the development of a plan moving forward for how we provide for healthcare across Southeast Alaska, and then dealing with the situation with Mt. Edgecombe Hospital there and the deteriorating conditions? Is this on anybody's radar?

Ms. SMITH. Yes, Senator. Let me again defer to Mr. Hartz to speak to that issue.

Senator MURKOWSKI. Okay.

Mr. HARTZ. Thank you, Senator. You're taking me back a number of years because I worked in that service unit.

Senator MURKOWSKI. Ah, then you know well, you know well.

Mr. HARTZ. I know well that facility. I was stationed at the time in Ketchikan, so I got in there to work with Art Wallman, bless his heart, for many, many, many years.

You are absolutely correct regarding the age and the condition of that facility. I know SEARHC has been a major force in all of Southeast Alaska in providing coordination for healthcare in the outlying areas and probably left that Federal facility pretty much intact.

As was discussed earlier about the existing priority list, we have to work our way down through that. We have prepared, are prepared to implement a new priority system or a modified priority

system to address the needs across Indian Country, and we will soon be providing a report to Congress talking about all of the needs in Indian Country. That's required of us every 5 years. That facility, along with a number of others, even though not specifically identified, are part of that significant need in Indian Country.

Upon working our way down further on that existing priority list, we would essentially then create a new list that would not last so many years. We would prioritize those that are of the highest rank and address them maybe over a 3-year period so we wouldn't have this ongoing list and reassess what's the greatest need in Indian Country as we move forward in healthcare facility construction.

ROSEBUD HOSPITAL

Senator MURKOWSKI. Well, thank you for that. It kind of dovetails with my questions here about the Rosebud Hospital. I indicated that the Center for Medicare and Medicaid Services (CMS) is intending to terminate the hospital provider agreement effective March 16, and I mentioned some of the issues, allegations concerning sanitary conditions, instances of drug theft, lack of infection control measures, clearly a fundamental lack of oversight within the hospital.

So the question to you this morning is—I mean, I suppose we could talk about how we got here, but that's not our problem. What we really need to know is that there is a plan going forward. How does the agency intend to address this situation, and what management reforms or changes are being put in place as we go forward? Because I think we would all agree that this is simply not tolerable, it's not acceptable. If CMS does terminate, you've got individuals that are going to have to travel long distances to get urgent care that they would have received.

This is not a tolerable situation. What are you doing?

Ms. SMITH. Thank you, Senator. I certainly agree, and I know that the team at IHS does as well. This is simply not tolerable, it's unacceptable. I do want to give you an update and then segue into what we are doing to address it.

We did receive that notice from CMS with the potential termination date of March 16. At IHS we requested an extension on that date, which CMS has now granted. We requested an extension to be able to work with CMS collaboratively on what's called a Systems Improvement Agreement, and this type of agreement is different than the normal corrective action plans that are developed when you get these types of notices from CMS because they address systemic root-based causes for how the issues developed. They are very specific types of agreements that have, as I know was mentioned earlier in this hearing, measureable outcomes and timelines for when they will be addressed.

So this agreement will address issues such as staffing, housing, and quality and compliance, and creating a culture of accountability and compliance and leadership, even leadership skills and issues with the governing board. So as we speak we are working very closely with CMS on developing such an agreement. It will involve a major commitment of time and resources and a new sense of leadership I think out at Rosebud Hospital. But that is our plan to address it.

Senator MURKOWSKI. So you sound relatively certain that the hospital provider agreement will not be terminated, that services will still continue as you are working through these issues; is that correct?

Ms. SMITH. Yes. So, just to be very clear, CMS has responded in writing that we're happy to give to any members of the subcommittee that we have an extension until May 16, a provisional period to work on the systems improvement agreement, and in the letter from CMS the agreement actually has to be entered into by April 29, because if we have not entered into the agreement by that point there's a 10-day notification period. So that is the extension we have been granted.

Of course, I do want to make clear it's not only in the purview of IHS. CMS has to approve the agreement, and that would be part of the regulatory duties. But we are heartened that they are at least talking to us and working closely with us on this agreement.

PINE RIDGE HOSPITAL

Senator MURKOWSKI. Well, then let me ask about another, because I understand that CMS has raised similar questions with regards to Pine Ridge Hospital, also in South Dakota, and they've also received a termination letter. Is this the same situation where you're able to work something out with CMS? That's one question, but it really does beg the question as to whether or not we've got some systemic failures within IHS to have Rosebud and also Pine Ridge in this situation. Are there others that are also in a similarly precarious situation?

Ms. SMITH. Thank you, Senator. I guess what I'll say just as a general matter, we are committed to doing whatever it takes. This is not an option. We need to ensure that these hospitals are delivering quality care, and that is I think the top priority for all of us at the agency right now. But as you mentioned, I think there are systemic problems, not just at those hospitals but throughout our system, things that we've talked about in terms of staffing and housing. One of the things we are working on also is establishing a system of quality across the agency.

With respect to Pine Ridge specifically, we did actually receive two notices from CMS. One was on the hospital, and one was on the emergency services. We did receive notice from CMS that with respect to the hospital we had met the requirements. We are still waiting on the emergency department, but we are committed to doing whatever it takes to ensure that these hospitals are providing quality care.

Senator MURKOWSKI. Very discouraging because, again, you don't get these notices unless there has been a long buildup, and what that long buildup means is that these people have been left behind, their health has potentially been compromised or put at risk. And again, it is just not acceptable.

Senator Udall.

Senator UDALL. Great. Thank you, Madam Chair.

SANITATION FACILITIES CONSTRUCTION

I just have one additional question on sanitation improvements. As you know, the subcommittee provided a 25 percent increase

there, and nearly half of all homes in Indian Country are in need of sanitation improvements. I frequently hear from the tribes in my State such as the Navajo Nation about the importance of these funds. The Nation is unique because the tribe is making its own aggressive investments to upgrade water infrastructure on the reservation, and they are particularly interested in leveraging IHS sanitation funds to provide service to their members.

Can you talk about the progress you expect to make with the increased funds provided in the omnibus? How specifically are you working with tribes specifically like the Navajo Nation to ensure that the additional funds are being used strategically to take care of the most critical needs?

Ms. SMITH. Thank you, Senator, and thanks for the funding to address the urgent sanitation needs. We certainly agree with you, and I know we have another commitment in our fiscal fear 2017 budget. With respect to the specific measures, I again will refer to my colleague, Mr. Hartz.

Mr. HARTZ. Thank you, Senator. First of all, I thank the subcommittee for the additional $20 million in fiscal year 2016. Nationwide, that's going to provide over 3,000 additional homes with improved water and sewer facilities, or new water and sewer facilities, because there are many places where potable water is not available in the home as we know it.

As far as the collaboration with the Navajo Nation, I guess I would say it's not unique because we do it with all tribes and all corporations across the country in providing water and sewer facilities, but it is unique from the standpoint of the Navajo Nation coming forward with such a substantial plan to support funding for projects on the sanitation facilities priority list. They have actually worked directly with our staff scattered around the Navajo reservation and the area office to look at the sanitation deficiency system, and they actually use that list, Senator, to start identifying how they would provide resources to projects.

So I guess they're leveraging. It's kind of a mutual leveraging to see these projects be addressed and work down the list. My understanding is they're planning to address their contributions over the next 5 years, and even address the large infrastructure projects, large transmission mains where they really are very remote in parts of the Navajo reservation. It's always been a good relationship, and you touched my heart, just like Senator Murkowski did, because I started on the Navajo reservation.

Senator UDALL. That's great. A lot of challenges out there.

Mr. HARTZ. Absolutely.

Senator UDALL. But interesting things going on. Thank you very much.

Thank you, Madam Chair.

SANITATION FACILITIES CONSTRUCTION

Senator MURKOWSKI. Thank you, Senator Udall.

I will conclude my comments in thanking you all. You raised the issue, Senator Udall, about the water and sanitation, and I had an opportunity a few weeks ago to bring the Secretary of Energy and five of our colleagues to Bethel, Alaska in mid-February, and then we went to the little community of Oscarville. Oscarville is about

80 people, and it's just down river, down the Kuskokwim River from Bethel. Out in that area, there are no roads. So in order for us to get there, we were going to take snow machines, but there wasn't enough snow cover, so we took trucks on the ice, which kind of freaked some of my colleagues out, but the ice was nice and thick.

But we got to Oscarville, and Oscarville is a community that has no running water, it has no sanitation facility. Human waste disposal is through the honey bucket. Usually it's the younger kids in the family that are given the job of dumping the honey bucket outside and digging a pit and hoping it freezes over quick.

Talking to the elementary school teacher there—there are only two teachers in the school. One is elementary and the other is everybody else. But she has five kids, and I asked her, how do you do the laundry for your family, and she very matter-of-factly described that during the summertime you just go down—usually it's the kids that haul the water up from the river. During the winter, when the ice is thick enough that you can drive your trucks on it, you chop ice and you put it on a sled and haul it up to the house and you heat it on the stove. Basically, it's no different than way back when. This is a community of Alaskans, of Americans who are figuring out how to deal with the challenges of the day-to-day world, trying to get Internet and broadband, but at the same time literally dumping their human waste in a pit, in a hole, and hauling their water from a river.

So the issues of disease and the concerns that are associated when you cannot keep clean, when you do not have safe drinking water, when you just have a level of exposure, these are issues that are very close to my heart because there are far too many communities in my State and, unfortunately, still around the country where we have these issues.

So know that I want to work with you on so many of them. And to those of you that work every day on these issues, know that we appreciate your work. We've got a lot to do in this area. But when I look at that segment of the Interior budget that you all represent through IHS, these are very serious commitments that we make to our Native peoples, that the healthcare that they receive will be good and adequate and equal. I think some of the questions that you heard raised here today suggest that that care is not yet adequate nor equal. So we've got a ways to go, but know that we're committed to doing that. We appreciate you being here.

SUBCOMMITTEE RECESS

With that, we stand adjourned.

[Whereupon, at 11:30 a.m., Wednesday, March 9, the subcommittee was recessed, to reconvene subject to the call of the Chair.]