S. HRG. 113–94

NOMINATION OF YVETTE ROUBIDEAUX TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

JUNE 12, 2013

Printed for the use of the Committee on Indian Affairs

U.S. GOVERNMENT PRINTING OFFICE

85–220 PDF WASHINGTON : 2013

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NOMINATION OF YVETTE ROUBIDEAUX TO BE DIRECTOR OF THE INDIAN HEALTH SERVICE

WEDNESDAY, JUNE 12, 2013

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:34 p.m. in room 628, Dirksen Senate Office Building, Hon. Maria Cantwell, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. MARIA CANTWELL, U.S. SENATOR FROM WASHINGTON

The CHAIRWOMAN. The Senate Indian Affairs Committee will come to order.

Today, we are having a hearing on the nomination of Yvette Roubideaux to be the Director of the Indian Health Service for the U.S. Department of Health and Human Services.

Dr. Roubideaux was previously confirmed by the United States Senate on May 6, 2009 and served a four year term. On May 7, 2013, President Obama renominated Dr. Roubideaux for a second term. Dr. Roubideaux will remain the Acting Director of the Indian Health Service until the Senate acts on her confirmation.

Federal health care policy for Indian people in the United States has been a very complicated history. The first appropriation for Indian health care was in 1832 when Congress allocated $12,000 for smallpox immunization for Indians. At the time, Indian medical services were under military control because the Administration of Indian Affairs was based in the Department of War.

In 1849, Indian medical services were transferred to civilian control when the Bureau of Indian Affairs was transferred to the Department of the Interior. It wasn't until 1955 that the Indian Health Service was created and became a separate bureau that is now known as the Department of Health and Human Services.

Today, the Indian Health Service provides health care to approximately 2.1 million American Indians and Alaska Natives from 566 federally-recognized tribes in 35 States.

One thing has remained constant throughout this long history of Indian health care. That is that the Federal Government acknowledges the unique legal responsibilities and moral obligations to provide for the health and welfare of Indian people. These duties and obligations are grounded in the United States Constitution, treaties, Federal statutes and Supreme Court decisions.

We have come a long way in ensuring adequate health care to American Indians and Alaskan Natives but many challenges remain. The position of Director of Indian Health Services is vital. It is vital in developing and implementing policies and programs that are necessary to meet the serious health care needs of Native Americans.

American Indian and Alaska Native populations have long experienced lower health status compared with other Americans. The life expectancy of the Native groups is 4.1 years less than all other races in the United States. That is 73.6 years compared to 77.7. American Indians and Alaska Natives die from diabetes at a rate 182 percent higher than the general population. Unintentional injuries, that number is 138 percent higher, and the suicide rate is 74 percent higher than the general population. These statistics are staggering.

In the past several years, Congress has passed two pieces of legislation that are critical to improving the health care of American Indians. The Indian Health Care Improvement Act was made permanent as part of the Affordable Care Act and the Special Diabetes Program for Indians was reauthorized. The Committee will closely follow Indian Health service's implementation of these two pieces of legislation.

In addition, at the Committee's budget hearing, we discussed the fact that tribes have asked the Committee to take a more active role in the oversight of the contract support issue. Tribes do not support the Administration's proposal in the fiscal year 2014 budget. This is an issue in which the Committee will maintain a very active interest.

Dr. Roubideaux, I know in the past four years you have sought to improve communications with tribal governments and urban centers and have focused on improving preventative health care throughout the Indian health care system. Today, the Committee would like to hear your plans for the next few years because there is a great deal of work to be done.

Before I turn to you for your opening statement, I would like to turn to my colleague, the Vice Chairman of the Committee, for his opening statement.

STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

Senator BARRASSO. Thank you very much, Madam Chairwoman, for holding this hearing.

Welcome and congratulations. It is good to be with you again. Congratulations on being nominated once again to serve as the Director of the Indian Health Service.

As a doctor, I practice in a rural part of the country in Wyoming. I believe the Indian Health Service Director is one of the most challenging positions in the Federal Government. I don't think you can underestimate the importance of the job that you have and the responsibilities that are upon you.

Fulfilling the government's responsibilities to deliver health care to Indian people requires integrity, accountability, wisdom in leading people and making the most efficient use of Federal resources.

I appreciate that our Chairwoman has decided to prioritize accountability. I think that is a good move and an admirable effort.

In September 2010, Chairman Dorgan, at the time, myself and others on this Committee requested the Department of Health and Human Services and the Office of Management and Budget conduct an investigation of all the Indian Health Service areas. In a November 23, 2010 letter, Secretary Sebelius noted that an administrative review would be phased over two years, concluding in December 2012.

She also noted "unprecedented efforts were underway in ensuring program integrity." Those efforts included developing uniform tools and metrics to monitor program progress. I find it curious that these tools and metrics were "unprecedented" and being deployed for the very first time. I guess better late than never if it does actually bring unprecedented levels of health care to Indian people.

In any event, we have not heard the results of the review that Secretary Sebelius spoke of in 2010. Perhaps, Dr. Roubideaux, you will be able to discuss those with us today.

Thank you. Congratulations on your renomination.

Thank you, Madam Chairwoman.

The CHAIRWOMAN. Thank you for that statement.

Senator Johnson, did you want to make an opening statement and I think you want to make a more formal introduction?

STATEMENT OF HON. TIM JOHNSON,
U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Some of both.

Chairwoman Cantwell and Vice Chairman Barrasso, thank you for holding this nomination hearing.

I am happy to once again introduce Dr. Roubideaux as the Indian Affairs Committee considers her nomination for a second four year term as Director of the Indian Health Service.

Growing up in my home State of South Dakota and as a Rosebud Sioux Tribal member, Dr. Roubideaux was able to experience firsthand the health disparities and the quality of health care in Indian Country. The need to improve health care services propelled Dr. Roubideaux to achieve a Bachelor's Degree and Medical Degree from Harvard.

Prior to her confirmation as Director of IHS in 2009, her history of commitment to Indian country can be seen through her research on American Indian health issues, her service as a director of the Special Diabetes Program for Indians demonstration projects, and her position as Clinical Director of the IHS San Carlos Service Unit.

Throughout her first term, Dr. Roubideaux has made marked improvements to the Indian Health Service, especially in contract health service programs and accountability reforms. Her commitment to improve American Indian health is far from over.

I look forward to continuing our work with Dr. Roubideaux as we fulfill our Federal treaty and trust responsibilities to Indian country.

Thank you again for holding this hearing.

The CHAIRWOMAN. Thank you, Senator Johnson.

Dr. Roubideaux, welcome to the Committee again. Certainly congratulations on being renominated. We look forward to your statement.

STATEMENT OF HON. YVETTE ROUBIDEAUX, M.D., M.P.H., ACTING DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. ROUBIDEAUX. Thank you, Chairwoman Cantwell, Vice Chairman Barrasso and Senator Johnson, thank you so much for your kind introduction, and other members of the Committee.

I am Dr. Yvette Roubideaux, the Acting Director of the Indian Health Service. I am honored to appear before you today as President Obama's nominee to serve a second four-year term as Director of the Indian Health Service.

If confirmed, I look forward to working with you to continue our progress in improving health care for American Indians and Alaska Natives. In my confirmation testimony four years ago, I stated that we had a unique opportunity to begin the difficult work of restoring health and wellness to American Indian and Alaska Native communities. I talked about the significant and unique challenges that we faced and that while reforming the Indian Health Service would take some time, I was ready to begin the important work of bringing change to the Indian Health Service.

I do believe that we have made progress in changing and improving the IHS, but it is clear that there is much more to do. That is why, if confirmed, I would be honored to serve another four years to continue that progress. While the challenges have been enormous, we have made progress that serves as a solid foundation for continued improvement.

This progress has been achieved in partnership with this Committee and I am grateful for your support during the past four years. If confirmed, I look forward to working together with you on further progress.

Progress on the IHS budget has been critical to our progress in accomplishing our agency priorities and our work to change and improve the IHS. As stated in the Committee's recent budget oversight hearing, if the fiscal year 2014 presidential budget is enacted, IHS appropriations will have increased by 32 percent since fiscal year 2008.

The appropriations increases received in the past few years are making a substantial difference in the quantity and quality of health care that we are able to provide. However, it is clear that IHS continues to struggle to meet its mission with available resources. If confirmed, I am committed to continuing to work with you on the IHS budget.

IHS has also made considerable progress in addressing our agency priorities and reforms and details are available in my testimony from the recent budget hearing. However, we still have much more to do. If confirmed, I plan to continue to strengthen our efforts to reform the IHS during the next four years focusing on three main priority areas.

First, I plan to strengthen our partnership with tribes by continuing the improvements we have made in our tribal consultation process and by working with tribes to make further improvements.

Second, I plan to continue our priority to reform the IHS. This includes our focus on making sure that the patients we serve benefit from the new provisions of the Affordable Care Act and reauthorization of the Health Care Improvement Act.

I also plan to continue our internal IHS organizational and administrative reforms. While we have made significant improvements in budget planning, financial management and performance management, more consistent business practices throughout the agency and system-wide accountability for progress on agency reforms, there is much more to do.

Third, I plan to continue to focus on our priority to improve the quality of and access to care with continued emphasis on customer service and several quality improvement strategies, including establishment of a patient centered medical home model within the Indian Health system which is helping us make improvements such as reducing waiting times, better coordination of care, quicker scheduling of appointments, better continuity of care and improvements in quality measures.

Our focus on specific agency priorities has helped us make progress in outcomes. In 2011, the IHS successfully met all national Government Performance and Results Act, GPRA, clinical performance indicators, an accomplishment never before achieved by IHS.

The Special Diabetes Program for Indians has also resulted in improved access to quality diabetes care and has helped reduce diabetes complications such as end stage renal disease. Even with this progress, we have much more to do.

One of the most significant challenges we face is the current and potential future impact of sequestration on IHS. However, if the fiscal year 2014 presidential budget request is passed, our budget will continue to grow and sequestration will be eliminated.

While we continue to face enormous challenges, if confirmed, I will continue to fight as hard as possible to change and improve the Indian Health Service. The job of the IHS Director is certainly difficult, but my enthusiasm to continue to change and improve the IHS has not wavered, especially since I know the patients and tribes we serve are depending on us to continue this progress.

IHS has the solemn responsibility to honor the Federal trust responsibility of providing health care and we know that we have much more to do to ensure that our American Indian and Alaska Native patients and communities receive the quality health care that they need and deserve.

Thank you and I am happy to answer questions.

[The prepared statement of Dr. Roubideaux follows:]

PREPARED STATEMENT OF HON. YVETTE ROUBIDEAUX, M.D., M.P.H., ACTING DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Thank you, Madam Chairwoman, Vice Chairman Barrasso, and Members of the Senate Committee on Indian Affairs. I am Dr. Yvette Roubideaux, the Acting Director of the Indian Health Service. I am honored to appear before you today as President Obama's nominee to serve a second four-year term as Director of the Indian Health Service (IHS).

If confirmed, I look forward to working with you to continue our progress on improving health care for American Indians and Alaska Natives (AI/AN). In my confirmation testimony four years ago, I stated that we had a unique opportunity to

begin the difficult work of restoring health and wellness to American Indian and Alaska Native communities. I talked about the significant and unique challenges we face, and that while reforming the IHS would take some time, I was ready to begin the important work of bringing change to the Indian Health Service.

I do believe that we have made progress in changing and improving the IHS, but it is clear that there is much more to do. That's why, if confirmed, I would be honored to serve another four years to continue that progress. While the challenges have been enormous, we have made progress that serves as a solid foundation for continued improvement.

This progress has been achieved in partnership with this Committee, and I am grateful for your support during the past four years. If confirmed, I look forward to working together with you on further progress.

Progress on the IHS budget has been critical to our progress in accomplishing our agency priorities and our work to change and improve the IHS. As I stated in the Committee's recent budget oversight hearing, if the FY 2014 President's budget is enacted, IHS appropriations will have increased by 32 percent since FY 2008. The appropriations increases received in the past few years are making a substantial difference in the quantity and quality of healthcare we are able to provide. However, it is clear that IHS continues to struggle to meet its mission with available resources, and, if confirmed, I am committed to continuing to work with you on the IHS budget.

IHS has made considerable progress in addressing our agency priorities and reforms, and details are available in my testimony from the recent budget hearing. However, we still have much more to do. If confirmed, I plan to continue to strengthen our efforts to reform the IHS during the next four years by focusing on three main priority areas.

First, I plan to strengthen our partnership with Tribes by continuing the improvements we have made in our Tribal consultation process and by working with Tribes to make further improvements. Honoring the government-to-government relationship through meaningful consultation with the federally-recognized Tribes that we serve is an important IHS priority. We know we have more work to do to make this partnership stronger.

Second, I plan to continue our priority to reform the IHS. This includes our focus on making sure that the patients we serve benefit from the new provisions in the Affordable Care Act and the reauthorization of the Indian Health Care Improvement Act. We will also continue working in partnership with Tribes on education and outreach to Tribal communities.

I also plan to continue our internal IHS organizational and administrative reforms. While we have made significant improvements in budget planning, financial management, performance management, more consistent business practices throughout the agency, and system-wide accountability for progress on agency reforms, there is much more to do. We must continue to find ways to operate more efficiently and effectively and maintain our efforts to be good stewards of federal resources.

IHS has responded with corrective actions to the findings of the Senate Committee on Indian Affairs investigation of the Aberdeen Area, and we have conducted reviews in all other IHS Areas. We plan to continue progress in ensuring all of the corrective actions are implemented consistently across all IHS Areas. *

Third, I plan to continue our focus on our priority to improve the quality of and access to care with a continued emphasis on customer service and several quality improvement strategies including establishment of a patient centered medical home model within the Indian health system. This model, already implemented in 127 of our IHS, Tribal and Urban Indian health programs, is helping us make improvements such as reduced waiting times, better coordination of care, quicker scheduling of appointments, better continuity of care, and improvements in quality measures.

Our focus on specific agency priorities has helped us make progress on our outcomes. In 2011, the Indian Health Service successfully met all national Government Performance and Results Act (GPRA) clinical performance indicators, an accomplishment never before achieved by the IHS. Our system-wide focus on quality improvement has, for example, helped increase receipt of mammograms from the low 40 percent range to over 50 percent last year. The Special Diabetes Program for Indians has also resulted in improved access to quality diabetes care, and has helped to reduce diabetes complications such as end-stage renal disease. All of these efforts will contribute to our ultimate outcome of reducing health disparities for the patients we serve. Even with this progress, we still have much more to do.

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*The October 2011 Review—IHS Area Assessments—Findings and Actions has been retained in Committee files, see *http://www.ihs.gov/NDW/IHS*.

One of the most significant challenges we face is the current and potential future impact of sequestration on IHS. Tribes have expressed their concern and disappointment that our recent progress on the budget is being reduced by having to absorb the cuts from sequestration. However, if the FY 2014 President's Budget Request is passed, our budget will continue to grow and sequestration would be eliminated.

While we continue to face enormous challenges, if confirmed, I will continue to fight as hard as possible to change and improve the IHS. The job of the IHS Director is certainly difficult, but my enthusiasm to continue to change and improve the IHS has not waivered, especially since I know the patients and the Tribes we serve are depending on us to continue this progress. IHS has the solemn responsibility to honor the federal trust responsibility to provide health care, and we know that we have much more to do to ensure that our AI/AN patients and communities receive the quality health care that they need and deserve.

Thank you and I am happy to answer questions.

A. BIOGRAPHICAL INFORMATION

1. Name: Yvette Roubideaux.
2. Position to which nominated: Director, Indian Health Service.
3. Date of nomination: April 23, 2013.
4. Address: (List current place of residence and office addresses.)

Residence: 102 Ladyshire Lane, #B403, Rockville, MD 20850.
Office: Indian Health Service, 801 Thompson Ave, Suite 440, Rockville, MD 20852.

5. Date and place of birth: January 29, 1963—Pierre, South Dakota.
6. Marital status: (Include maiden name of wife or husband's name.) Single.
7. Names and ages of children: (Include stepchildren and children from previous marriages.) None.
8. Education: (List secondary and higher education institutions, dates attended, degree received, and date degree granted.)

Stevens High School, Rapid City, SD—1977–1981; Diploma 1981.
Harvard University, Cambridge, MA—1981–1985; B.A. 6/1985.
Harvard Medical School, Boston, MA: 1985–1989; M.D. 6/1989.
Harvard School of Public Health, Boston, MA: 1996–1997; M.P.H. 6/1997.

9. Employment record: (List all jobs held since college, including the title or description of job, name of employer, location of work, and dates of employment, including any military service.)

Internal Medicine Resident, Brigham & Women's Hospital, Boston, MA, 1989–1992.
Medical Officer/Clinical Director, San Carlos IHS Hospital, San Carlos, AZ, 1992–1995.
Medical Officer, Hu Hu Kam Memorial Hospital, Sacaton, AZ, 1995–1996.
Fellow, Commonwealth Fund/Harvard University Fellowship in Minority Health Policy, Harvard Medical School, Boston, MA, 1996–1997.
Senior Fellow, University of Washington School of Medicine, Seattle, WA, 1997–1998.
Assistant Professor, The University of Arizona, 1998–2009 (Arizona Prevention Center, 1998–2000;Zuckerman College of Public Health, 2000–2005; College of Medicine, Department of Family & Community Medicine, 2006–2009).
Director, Indian Health Service, Rockville, MD, 2009–present.

10. Government experience: (List any advisory, consultative, honorary or other part-time service or positions with Federal, State, or local governments, other than those listed above.)

Co-Chair, Indian Health Diabetes Workgroup, Indian Health Service (1997–1998).
Steering Committee, American Indian Subcommittee (Chair), Community Interventions Workgroup, Partnership Network Meeting Planning Committee, Operations Committee, Evaluation Workgroup, National Diabetes Education Program (a partnership of the National Institutes of Health and Centers for Disease Control and Prevention) (1997–2005).
Medical Epidemiologist, Division of Diabetes Translation, Centers for Disease Control and Prevention(1998–2002) (part time consultant/IPA).
Member, Planning Committee, Diabetes Translation Conference, Centers for Disease Control and Prevention (1998).
Consultant, National Diabetes Program, Indian Health Service {1999–2000).
Member, DHHS Secretary's Advisory Committee on Minority Health (2000–2002).
Member, NHLBI Working Group on Community Responsive Interventions, National Heart, Lung and Blood Institute {2001).
Member, Technical Workgroup, Tribal Leader Diabetes Committee, Indian Health Service (2001–2004).
Director, UA/ITCA Indians Into Medicine Program, The University of Arizona- funded by Indian Health Service (2001–2009).
Director, Student Development Core, ITCA/UA American Indian Research Center for Health, The University of Arizona—funded by Indian Health Service, National Institutes of Health—NARCH Initiative (2001–2009).
Consultant, Division of Diabetes Treatment Prevention, Indian Health Service (2002–2007).
Consultant, Office of Loan Repayment and Scholarship, National Institutes of Health {2002–2004).
Member, Conference Planning Committee, Indian Health Service Research Conference {2004).
Member, Conference Planning Committee, Prevention of Cardiovascular Disease and Diabetes AmongAIANs, Indian Health Service, National Heart, Lung and Blood Institute {2004–2005).
Chair, Grant Application Review Groups, Special Diabetes Program for Indians Diabetes and Cardiovascular Disease Demonstration Projects, Indian Health Service {2004).
Co-Director, Coordinating Center, Special Diabetes Program for Indians Diabetes and Cardiovascular Disease Prevention Demonstration Projects (2004–2009).
Member, Special Medical Advisory Group, Department of Veterans Affairs, 2009–present.

11. Business relationships: (List all positions held as an officer, director, trustee, partner, proprietor, agent, representative, or consultant of any corporation, company, firm, partnership, or other business enterprise, educational or other institution.)

Consultant, Henry J. Kaiser Foundation, Native American Health Policy Fellowship Program (2000–2003).

Consultant, The Commonwealth Fund, Project on Quality of Care in Indian Health (2003–2004).
Consultant, Association of American Indian Physicians, NDEP Move it! Pilot Grant Program (2003–2005).
Consultant, Novo Nordisk, Native American initiative {2005).
Consultant, TIV, Inc., Continuing Medical Education Video on Diabetes in AIANs (2005).
Consultant, National Indian Health Board, Public Health Accreditation Project (2008).

12. Memberships: (List all memberships and offices held in professional, fraternal, scholarly, civic, business, charitable and other organizations.)

Member (1989–present), Member at Large (1996–1997), Treasurer (1997–1998), President, Elect/Past (1998–2001), Association of American Indian Physicians, non-profit professional organization.
Member, American College of Physicians (1992–present).
Member, American Public Health Association (1996–present); Secretary, APHA American Indian, Alaska Native, Native Hawaiian Caucus (1997–1999).
Member (1998–2009), American Diabetes Association.
Member (1998–2009) and Chair (2004–2008), Awakening the Spirit Team, American Diabetes Association (1997–2008).
Member (2000–2009), Treasurer (2004–2005), Chair, Elect/Past, (2005–2007), Native Research Network, Inc., non-profit professional organization.
Member, Academy Health (2005–2006).
Member, Advisory Board, Policy Research Center, National Congress of American Indians (2005–2009).
Member, National Advisory Committee, RWJF Center for Health Policy at the University of New Mexico (2007–2009).

13. Political affiliations and activities: (a) List all offices with a political party which you have held or any public office for which you have been a candidate. None.
(b) List all memberships and offices held in and services rendered to all political parties or election committees during the last 10 years. None.
(c) Itemize all political contributions to any individual, campaign organization, political party, political action committee, or similar entity of $500 or more for the past 10 years. None.

14. Honors and awards: (List scholarships, fellowships, honorary degrees, honorary society memberships, military medals and any other special recognitions for outstanding service or achievements.)

Indian Health Service Scholarship (1983–1989).
Outstanding Performance Awards, Indian Health Service (1992–1996).
Exceptional Performance Award, Phoenix Area Council Of Service Unit Directors, Indian Health Service (1993).
Commonwealth Fund/Harvard University Fellowship in Minority Health Policy, Harvard Medical School, Boston MA (1996–1997).
Dr. Fang-Ching Sun Memorial Award for outstanding graduate student with a commitment to promote the health and well-being of the underserved, Harvard School of Public health (1997).
Indian Health Fellowship/Senior Fellow, Native American Center of Excellence, Department of Medicine, University of Washington, Seattle, WA (1997–1998).

Native Investigator Program selection, Native Elder Research Center, Resource Center for Minority Aging Research, University of Colorado Health Sciences Center, Aurora, CO (1998).
Award of Merit, National Diabetes Education Program, NIH/CDC (2000).
Outstanding American Indian Faculty Award, Native American Affairs, The University of Arizona (2002).
Indian Physician of the Year, Association of American Indian Physicians (2004).
National Impact Award, National Indian Health Board, For Awakening the Spirit Team, American Diabetes Association (Team Award, Chair of Team).
Addison B. Scoville Award for Outstanding Volunteer Service, American Diabetes Association (2008).
Physician Advocacy Merit Award, Institute on Medicine as a Profession, Columbia University (2008).
Top 25 Minority Executives in Healthcare, Modern Healthcare (March 2010).
100 Most Powerful People in Healthcare, Modern Healthcare (August 2010).
Community Spirit Award, 4th Disparities Partnership Forum, Reducing the Burden of Diabetes Complications, American Diabetes Association (April 6, 2011).
Special Recognition and Appreciation, Indian Health Service Direct Service Tribes Advisory Committee (August 2012).
Certificate of Appreciation, 15th Anniversary off the National Diabetes Education Program {2013).

15. Published writings: {list the titles, publishers, and dates of books, articles, reports, or other published materials which you have written.)

Published writings are included below by category:

Scholarly Books and Monographs (Peer Reviewed)

Dixon M, Roubideaux Y, eds. *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century.* American Public Health Association, 2001.

Chapters In Scholarly Books and Monographs

Original Research Featured

Roubideaux Y. The Impact on the Quality of Care. In: Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith Mala C. *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management.* Report for the Administration for Native Americans Grant Project, The National Indian Health Board, 1998.

Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith Mala C. *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management.* Report for the Administration for Native Americans Grant Project, The National Indian Health Board, 1998.

Research Reviews/State of the Field

Roubideaux Y. "Current Issues in Indian Health Policy." Background Paper for Conference "Native American Health and Welfare Policy in an Age of New Federalism." Morris K. Udall Foundation, Henry J. Kaiser Family Foundation and Udall

Center for Studies in Public Policy at the University of Arizona, October 1998.
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Dixon M, Mather DT, Shelton BL, Roubideaux Y. "Chapter 3. Economic and Organizational Changes in Health Care Systems." In: Dixon M, Roubideaux Y, eds. *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century.* American Public Health Association, 2001.
Roubideaux Y, Acton K. "Chapter 8. Diabetes in American Indians." In: Dixon M, Roubideaux Y, eds.*Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century.* American Public Health Association, 2001.
Roubideaux Y. "Chapter 9. cardiovascular Disease." In: Dixon M, Roubideaux Y, eds. *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century.* American Public Health Association, 2001.
Roubideaux Y, Dixon M. "Chapter 11. Health Surveillance, Research and Information." In: Dixon M,Roubideaux Y, eds. *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century.* American Public Health Association, 2001.
Roubideaux Y. "Current Issues in Indian Health Policy: Update 2002." Background Paper for Conference "Native American Health and Welfare Policy in an Age of New Federalism." Morris K. Udall Foundation, Henry J. Kaiser Family Foundation and Udall Center for Studies in Public Policy at the University of Arizona, 2002.
Roubideaux Y. "Current Issues in Health Disparities Common in American Indian Communities." Chapter in: *Measuring Diabetes Care. Improving Data Quality and Data Use in American Indian Communities.* Conference Proceedings, Seattle WA, August 20–22, 2002, Indian Health Service National Diabetes Program, 2003.
Lundgren P, Ross C, Roubideaux Y, Thompson R. Effective Diabetes Education: Creating Quality Programs. *Special Diabetes Program for Indians Regional Meetings 2004.* Conference Proceedings. Indian Health Service, 2004.
Roubideaux Y. Indian Health Care. In: *Native America in the New Millennium.* Harvard Project on American Indian Economic Development, Harvard Kennedy School of Government, 2005.
Roubldeaux Y. Health Care: A Trust Responsibility, A Sovereign Right. In: *The State of the Native Nations.* Oxford University Press, 2007.

Refereed Journal Articles (Peer Reviewed Publications)

Roubideaux Y, Moore K, Avery C, Muneta B, Knight M, Buchwald D. Diabetes Education Materials: Recommendations of Tribal Leaders, Indian Health Professionals, and American Indian Community Members. *Diabetes Educ.* 2000;26(2):290–4.

Hodge F, Weinmann S, Roubideaux Y. Recruitment of American Indians and Alaska Natives into Clinical Trials. *Ann Epidemiol* 2000;10(8 Suppl):S41–8.
Roubldeaux Y. Perspectives on American Indian Health. *Am J Public Health* 2002; 92(9):1401–3.
Roubideaux Y, Buchwald D, Beals J, Middlebrook D, Manson S, Muneta B, Rith-Najarian S, Shields R, Acton K. Measuring the Quality of Diabetes Care for Older American Indians and Alaska Natives. *Am J Public Health* 2004; 94:60–65. Erratum in: *Am J Public Health* 2004;94(4):520.
Zuckerman S, Haley J, Roubideaux Y, Lilli-Blanton M. Health Service Access, Use and Insurance Coverage Among American Indians/Alaska Natives and Whites: What Role does the Indian Health Service Play? *Am J Public Health* 2004; 94(1):53–9.
Moss MP, Roubideaux Y, Jacobsen C, Buchwald D, Manson S. Functional Disability and Associated Factors Among Older Zuni Indians. *J Cross Cult Gerontol* 2004;19(1):1–12.
Rhoades DA, Roubideaux Y, Buchwald D. Diabetes Care Among Older Urban American Indians and Alaska Natives. *Ethn Dis* 200;14(4):574–9.
Roubideaux Y. *A Review of the Quality of Healthcare for American Indians and Alaska Natives.* The Commonwealth Fund, New York, NY, 2004.
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Goins RT, Bogart A, Roubideaux Y. Service provider perceptions of long-term care access in American Indian and Alaska Native communities. *J Health Care Poor Underserved* 2010; 21(4):134D–53.

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Roubideaux Y. "Native American Health Challenges." *Arizona Prevention Center Newsletter*, August 1999.

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Roubideaux Y. "The National Diabetes Education Program American Indian Campaign." *The IHS Primary Care Provider*, 25(6): 97–100, June 2000.
Roubideaux Y, Helweg P. "The Kaiser Family Foundation Native American Health Policy Fellowship Program." *The IHS Primary Care Provider*, 26(7): 111–112, July 2001.
Roubideaux Y. "National Diabetes Education Program Adopts A1C Name for the Hemoglobin A1C Test." *The IHS Primary Care Provider*, 26(11): 154–5, October 2001.
Hernandez A, Parker M, Lewis J, Roubideaux Y. "Helping Arizona Students Enter the Health Professions." *Winds of Change Magazine*, American Indian Science and Engineering Society, Fall 2002.
Roubideaux Y. "Reforming the Indian Health Service." This Year in Federal Medicine: Outlook 2011. US Medicine (2011).
Roubideaux Y. "Transforming Care in the Indian Health Service." This Year in Federal Medicine: Outlook 2012. US Medicine (2012).
Roubideaux Y. "Moving Forward with Reforming the Indian Health Service." This Year in Federal Medicine: Outlook 2013. US Medicine (2013).

16. Speeches: Provide the Committee with two copies of any formal speeches you have delivered during the last 5 years which you have copies of on topics relevant to the position for which you have been nominated.

Presentations as the Indian Health Service Director (2009–present): (copies of speeches available at: *http://www.ihs.gov/PublicAffairs/DirCorner/index.cfm?module=speeches)*

Welcoming Remarks, Indian Health Service Tribal Self-Governance Conference, May 18–21, 2009.
Welcoming Remarks, Indian Health Service Tucson Awards Ceremony, June 5, 2009.
Remarks, Swearing-In Ceremony for Dr. Yvette Roubideaux, Indian Health Service Director, Department of Health and Human Services, June 29, 2009.
The Future of American Indian and Alaska Native Health Care, Association of American Indian Physicians Annual Meeting and National Health Conference, July 23, 2009.
Addressing Diabetes in the American Indian and Alaska Native Population, Special Diabetes Program for Indians Demonstration Projects Grantee Meeting, July 28, 2009.
The Future of American Indian and Alaska Native Health Care, IHS Behavioral Health Conference, August 4,2009.
The Role of Research in the Indian Health Service, Annual Native Research Conference, August 5, 2009.
The Future of American Indian and Alaska Native Health Care, Direct Service Tribes Sixth Annual National Meeting, August 18, 2009.
Working Effectively with American Indian and Alaska Native Communities, USDA Rural Development Policy Conference Panel, August 26, 2009.

The Indian Health Service and Health Reform, National Indian Health Board Consumer Conference, September 15, 2009.
Welcoming Remarks, Adolescent Suicide: Addressing Disparities Through Research, Programs, Policy, and Partnerships Meeting, September 21, 2009.
The Indian Health Service and Health Reform, California Rural Indian Health Board Anniversary Meeting (October 17, 2009).
Indian Health Service Update, Department of Health and Human Services' Advisory Committee on Minority Health Meeting, October 20, 2009.
Indian Health Service Update, United South and Eastern Tribes Annual Meeting, October 29, 2009.
Health Care Reform in Indian Country, Johns Hopkins Center for American Indian Health, American Indian and Alaska Native Heritage Month Celebration, November 17, 2009.
Indian Health Service Overview, Johns Hopkins Center for American Indian Health Winter Institute, January 7, 2010.
Priorities for Reforming the Indian Health Service, Native Investigator Development Program, University of Colorado's Resource Centers for Minority Aging Research, January 12, 2010.
Indian Health service in the Era of Reform, National Congress of American Indians Executive Council Winter Session, March 1, 2010.
Writing Women Back Into History, Women's History Month Commemorative Program, March 17, 2010.
Indian Health Service Reform Update, IHS National Combined Councils Meeting, March 22, 2010.
HHS Welcome Remarks, HHS Regions 6&7 Tribal Consultation, April 22, 2010.
Indian Health Care Reform, Advances in Indian Health Conference, April 30, 2010.
Indian Health Service Overview, Patty Iron Cloud National Native American Youth Initiative, June 21, 2010.
Leading Indian Health Service Reform, SACNAS Summer Leadership Institute, July 20, 2010.
Indian Health Reform, Nurse Leaders in Native Care Conference, July 20, 2009.
Indian Health Service Update, Indian Health Service/Bureau of Indian Affairs Behavioral Health Conference, July 27, 2010.
Indian Health Service Update, Native Health Research Conference, July 29, 2010.
Indian Health Reform, Arizona Rural Health Conference, August 3, 2010.
Indian Health Service Reform, Association of American Indian Physicians Annual Meeting and National Health Conference, July 27, 2010.
Update on the Affordable Care Act, Direct Service Tribes National Meeting, August 24, 2010.
Update on Indian Health Service Reform, Direct Service Tribes National Meeting, August 24, 2010.
Update on Indian Health Service Reform, National Indian Health Board Consumer Conference, September 21, 2010.

Update on the Affordable Care Act, National Indian Health Board Consumer Conference, September 23, 2010.
Indian Health Care Reform Update, Oglala Sioux Tribe Health Administration Annual Health Summit, October 8, 2010.
Indian Health Service Overview, National Institutes of Health Academy, October 12, 2010.
Update on Indian Health Reform, Long Term Care in Indian Country Meeting, November 1, 2010.
Indian Health Service Update, National Congress of American Indians Annual Conference, November 17, 2010.
Indian Health Service Overview, Harvard Medical School Brigham and Women's Hospital Grand Rounds, January 28, 2011.
Indian Health Service Update, United South Eastern Tribes Impact Week Meeting, February 9, 2011.
Indian Health Service Update, Advances in Indian Health Conference, May 4, 2011.
Indian Health Service Update, Tribal Self-Governance Annual Conference, May 5, 2011.
Indian Health Service Overview, Patty Iron Cloud National Native American Youth Initiative Meeting, June 20, 2011.
Indian Health Service Update, Native Health Research Conference, June 26, 2011.
Indian Health Service Update, IHS Tribal Consultation Summit, July 6, 2011.
Indian Health Service Update, IHS National Combined Councils Meeting, July 26, 2011.
Health Care Reform, IHS Nat ional Combined Councils Meeting, July 26, 2011.
Welcoming Remarks, IHS/BIA/BIE/SAMHSA Action Summit for Suicide Prevention, August 2, 2011.
Indian Health Service Update, Association of American Indian Physicians 40th Annual Meeting and National Health Conference, August 12, 2011.
The Future of the Indian Health Service and the Way Forward for Native Nursing Leaders, Nursing Leaders in Native care Conference, August 15, 2011.
Indian Health Service Update, Direct Service Tribes National Meeting, August 16, 2011.Remarks, IHS Eagle Butte Health Center Dedication, August 26, 2011.
Indian Health Service Update, National Indian Health Board Consumer Conference, September 27, 2011.
Welcoming Remarks, IHS/BIA/BIE/SAMHSA Action Summit for Suicide Prevention, October 25, 2011.
Remarks, IHS Baby Friendly Hospital Launch, October 26, 2011.
Opening Remarks, Improving Patient Care Program Learning Session Four, October 26, 2011.
Native Youth: Connecting Culture and Wellness, National American Indian and Alaska Native Heritage Month Opening Ceremony, November 2, 2011.
Indian Health Service Update, National Congress of American Indians 68th Annual Convention, November 3,2011.

Remarks, United South and Eastern Tribes Annual Meeting & EXPO, November 9, 2011.
Indian Health Service Overview, Johns Hopkins Center for American Indian Health 2012 Winter Institute, January 12, 2012.
Indian Health Service Update, IHS National Combined Councils Meeting, January 24, 2012.
Special Diabetes Program for Indians Update, Tribal Caucus Briefing on the IHS Special Diabetes Program for Indians, March 7, 2012.
Indian Health Service Update, IHS Tribal Consultation Summit, March 13, 2012.
Remarks, IHS National Indian Health Outreach and Education Meeting, April 18, 2012.
Indian Health Service Update, National Council of Urban Indian Health Annual Leadership Conference, April 25, 2012.
Indian Health Service Update, IHS 2012 Tribal Self-Governance Annual Conference, May 7, 2012.
Welcoming Remarks, IHS 2012 National Behavioral Health Conference, June 26, 2012.
Indian Health Service Update, Native Health Research Conference, July 16, 2012.
Indian Health Service Overview, XIX International AIDS Conference, July 20, 2012.
Indian Health Service Update, IHS Tribal Consultation Summit, August 7, 2012.
Indian Health Service Update, IHS Direct Service Tribes Annual Meeting, August 14, 2012.
Preventing and Treating Diabetes and its Complications in American Indians and Alaska Natives, University of Colorado School of Public Health Speaker Series, September 6, 2012.
Indian Health Service Update, National Indian Health Board Annual Consumer Conference, September 25, 2012.
Indian Health Service Update, National Congress of American Indians Annual Convention, October 24, 2012.

Presentations in 2008–2009 relevant to the position:

Scholarly/Research Presentations—Plenary/General Sessions

Health Care in Indian Country: Setting a Research Agenda for Health Care Improvement. Spring Lecture Series, RWJF Center for Health Policy at University of New Mexico, Albuquerque, NM, April 23, 2008 (Invited Presentation).
Measuring the Quality of Care in American Indian/Alaska Native Diabetes Education Programs. Resource Centers for Minority Aging Research Annual Conference, Ann Arbor/Detroit Michigan, May 9, 2008 (Invited Presentation).
Community Based Participatory Research: Relevance to Tribes. New Mexico Tribal Health Research Summit, University of New Mexico, Albuquerque NM, June 3, 2008 (Invited Presentation).
Health Policy and Research. New Mexico Tribal Health Research Summit, University of New Mexico, Albuquerque NM, June 3, 2008 (Invited Presentation).

Measuring the Quality of Care in American Indian/Alaska Native Diabetes Education Programs. CEED Conference, Denver CO, August 12, 2008 (Invited Presentation).
Special Diabetes Program for Indians Diabetes Prevention Program. Zia Association of Diabetes Educators Meeting, Albuquerque NM, September 26, 2008 (Invited Presentation).
Tribal Authority vs. Academic Freedom. Future Directions of Tribal Research in Arizona Conference, Inter Tribal Council of Arizona, Phoenix AZ, October 31, 2008 (Invited Presentation).

Workshops

Measuring the Quality of Care in American Indian/Alaska Native Diabetes Education Programs. American Association of Diabetes Educators Annual Meeting, Washington DC, August 7, 2008 (Invited Presentation).
Studying Diabetes in American Indians/Alaska Natives. Minority Affairs—Ethics Committee Workshop, American College of Epidemiologists Annual Conference, Tucson AZ, September 13, 2008 (Invited Presentation).
Special Diabetes Program for Indians Healthy Heart Project: Translating research into practice for American Indians and Alaska Natives with diabetes. American Public Health Association Annual Meeting, San Diego, CA, October 28, 2008 (Invited Presentation).

Special Diabetes Program for Indians Demonstration Project Grantee Meeting Presentations

Semi-Annual Progress Report. SDPI Competitive Grant Program/Demonstration Projects Steering Committee Meeting, Denver, CO, June 27, 2008 (Invited Presentation).

Local Outreach/CME Presentations:

Diabetes Prevention: Demonstrating we can do it! San Carlos Diabetes Prevention Program Conference, San Carlos AZ, January 9, 2008 (Invited Presentation).
Diabetes in American Indians/Alaska Natives. Tribal Librarians Gathering, Arizona Health Sciences Library, The University of Arizona, September 29, 2008 (Invited Presentation).

National Outreach/CME Presentations:

Diabetes Trends and Goals. Association of American Indian Physicians Diabetes Conference, Oklahoma City, OK, January 7, 2008 (Invited Presentation).
Special Diabetes Program for Indians. Call to Congress, American Diabetes Association, April 30, 2008 (Invited Presentation).
Awakening the Spirit—SDPI Reauthorization. Plenary Presentation and Workshop, Public Health Summit, National Indian Health Board, May 21, 2008 (Invited Presentation).
Diabetes Prevention. Association of American Indian Physician Annual Conference, Cor D'Alene, Idaho, July 28, 2008 (Invited Presentation).
Awakening the Spirit: Advocacy Outcomes. American Diabetes Association/Shaping America's Health 2nd Annual Partnership Forum, Washington DC, August 15, 2008 (Invited Presentation).

SDPI Reauthorization—Awaking the Spirit. National Indian Health Board Annual Consumer Conference, Temecula CA, September 25, 2008 (Invited Presentation).
Roundtable on Tribal Public Health Accreditation. National Indian Health Board Annual Consumer Conference, Temecula CA, September 25, 2008 (Moderator).
Diabetes Prevention. Zia Association of Diabetes Educators Meeting, Albuquerque NM, September 26, 2008 (Invited Presentation).

Student Presentations:

Research Poster 101: Design and Development. AIRCH Workshop, Arizona Health Sciences Center, March 26, 2008.
American Indian Health Today. Udall Scholars Orientation, Morris K. Udall Foundation, Tucson AZ, August 3, 2008 (Invited Presentation).

Courses—Individual Presentations/Sessions—University of Arizona

Diabetes. Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2009, CPH 520, March 23, 2008.
Diabetes Prevention. Racial and Ethnic Health Disparities: A Comparative Approach, Spring 2008, CPH 520, March 25, 2008.
American Indian Health. FACES in Health Professions Internship Class, Spring 2008, CPH 393A, March 25, 2008.

—Harvard Medical School

Current Issues in American Indian/ Alaska Native Health. Issues in Minority Health Policy Seminar, Harvard Medical School, Boston MA, April 28, 2008.

17. Selection: (a) Do you know why you were selected for the position to which you have been nominated by the President? The IHS Director position is a 4-year term by statute; I was nominated by the President to serve another 4-year term.

(b) What in your background or employment experience do you believe affirmatively qualifies you for this particular appointment? I served the past 4 years as the IHS Director; I came to that position with 20 years of experience in American Indian/Alaska Native health research, education, policy, administration and clinical practice.

B. FUTURE EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections with your present employers, business firms, business associations, or business organizations if you are confirmed by the Senate? N/A—currently employed as IHS Director

2. Do you have any plans, commitments, or agreements to pursue outside employment, with or without compensation, during your service with the government? If so, please explain. No.

3. Do you have any plans, commitments, or agreements after completing government service to resume employment, affiliation, or practice with your previous employer, business firm, association, or organization? No.

4. Has anybody made a commitment to employ your services in any capacity after you leave government service? No.

5. If confirmed, do you expect to serve out your full term or until the next Presidential election, whichever is applicable? Yes.

C. POTENTIAL CONFLICTS OF INTEREST

1. Describe all financial arrangements, deferred compensation agreements, and other continuing dealings with business associates, clients, or customers: University of Arizona Optional Retirement Plan/403(b) Thrift Savings Plan.

2. Indicate any investments, obligations, liabilities, or other relationships which could involve potential conflicts of interest in the position to which you have been nominated: In connection with the nomination process, I have consulted with the Office of Government Ethics and the Department of Health and Human Services designated agency ethics official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with the Department's designated agency ethics official and that has been provided to the Committee. I am not aware of any other potential conflicts of interest.

3. Describe any business relationship, dealing, or financial transaction which you have had during the last 10 years whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated: In connection with the nomination process, I have consulted with the Office of Government Ethics and the Department of Health and Human Services designated agency ethics official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with the Department's designated agency ethics official and that has been provided to the Committee. I am not aware of any other potential conflicts of interest.

4. Describe any activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat, or modification of any legislation or affecting the administration and execution of law or public policy: Prior to my appointment as IHS Director in 2009, I visited Congressional staff on a few occasions to educate about and request support for the Special Diabetes Program for Indians reauthorization. These activities were conducted as a private citizen and/or volunteer. As the IHS Director, I have on several occasions visited members of Congress and testified at Congressional hearings in my official capacity on matters related to the business of IHS.

5. Explain how you will resolve any potential conflict of interest, including any that may be disclosed by your responses to the above items. (Please provide a copy of any trust or other agreements.): In connection with the nomination process, I have consulted with the Office of Government Ethics and the Department of Health and Human Services designated agency ethics official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with the Department's designated agency ethics official and that has been provided to the Committee. I am not aware of any other potential conflicts of interest.

6. Do you agree to have written opinions provided to the Committee by the designated agency ethics officer of the agency to which you are nominated and by the Office of Government Ethics concerning potential conflicts of interest or any legal impediments to your serving in this position? Yes.

D. LEGAL MATTERS

1. Have you ever been disciplined or cited for a breach of ethics by, or been the subject of a complaint to any court, administrative agency, professional association, disciplinary committee, or other professional group? If so, please explain. No, except that as described below in response to question F. 13, two IHS employees filed EEO complaints against their supervisors that also named me as a party in my official capacity.

2. Have you ever been investigated, arrested, charged, or held by any Federal, State, or other law enforcement authority for violation of any Federal, State, county, or municipal law, regulation, or ordinance, other than for a minor traffic offense? If so, please explain. No.

3. Have you or any entity, partnership or other association, whether incorporated or unincorporated, of which you are or were an officer ever been involved as a party in an administrative agency proceeding or civil litigation? If so, please explain. No.

4. Have you ever been convicted (including pleas of guilty or nolo contendere) of any criminal violation other than a minor traffic offense? If so, please explain. No.

5. Please advise the Committee of any additional information, favorable or unfavorable, which you feel should be disclosed in connection with your nomination. None.

E. RELATIONSHIP WITH COMMITTEE

1. Will you ensure that your department/agency complies with deadlines for information set by congressional committees? Yes.

2. Will you ensure that your department/agency does whatever it can to protect congressional witnesses and whistle blowers from reprisal for their testimony and disclosures? Yes.

3. Will you cooperate in providing the Committee with requested witnesses, including technical experts and career employees, with firsthand knowledge of matters of interest to the Committee? Yes.

4. Please explain how if confirmed, you will review regulations issued by your department/agency, and work closely with Congress, to ensure that such regulations comply with the spirit of the laws passed by Congress: I will review regulations and work closely with Congress to ensure they comply with the spirit of the laws passed by Congress.

5. Are you willing to appear and testify before any duly constituted committee of the Congress on such occasions as you may be reasonably requested to do so? Yes.

F. GENERAL QUALIFICATIONS AND VIEWS

1. How does your previous professional experiences and education qualify you for the position for which you have been nominated? I have served as the IHS Director since May 2009, and came to that position with 20 years of experience in American Indian/ Alaska Native health policy, education, research, medical administration and clinical practice.

2. Why do you wish to serve in the position for which you have been nominated? I wish to continue to serve as the IHS Director to help further the mission of the organization, to continue ongoing progress to improve the organization; and to continue to help improve the quality of and access to healthcare for American Indians and Alaska Natives served by IHS.

3. What goals have you established for your first two years in this position, if confirmed? My goals would be to continue ongoing progress on IHS agency priorities: to strengthen partnerships with Tribes; to reform the IHS healthcare delivery system; and to improve the quality of and access to care.

4. What skills do you believe you may be lacking which may be necessary to successfully carry out this position? What steps can be taken to obtain those skills? I have served as the IHS Director since May 2009, and came to that position with 20 years of experience in American Indian/Alaska Native health policy, education, research, medical administration and clinical practice. This experience helped me lead the agency during a time in which we have made significant progress in reforming the administrative and clinical performance of the IHS with measurable outcomes and improvements in the basic functions of the agency.

5. Please discuss your philosophical views on the role of government. Include a discussion of when you believe the government should involve itself in the private sector, when society's problems should be left to the private sector, and what standards should be used to determine when a government program is no longer necessary: The role of government related to IHS is set by the U.S. Constitution, federal law, treaties, Presidential Executive Orders/Memoranda, and legislation. The U.S. government has a trust responsibility for members of federally-recognized Tribes, and the IHS is responsible for providing healthcare services for them within the available resources of the agency. The standards to determine when a government program is no longer necessary must include Tribal consultation on the need for the program, along with a clear evaluation of the program's effectiveness and the potential impact of terminating the program.

6. Describe the current mission, major programs, and major operational objectives of the department/agency to which you have been nominated: The mission of the IHS is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level. IHS provides clinical, preventive, and public health services that are managed by IHS, Tribes, and urban Indian health programs in a network of over 600 hospitals, clinics and health stations on or near Indian reservations. IHS serves approximately 2 million American Indians and Alaska Natives in 36 states. Primary care services are provided according to local resources, and specialty care and referrals for private healthcare services are provided through the IHS Contract Health Services program. The goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. Since 2009, four IHS agency priorities have guided activities to change and improve the organization: to renew and strengthen our partnership with Tribes; to reform the IHS; to improve the quality of and access to care; and to make all our work transparent, accountable, fair and inclusive. These agency priorities have served as a strategic framework for activities to improve the agency, and have also served as a framework to measure progress, objectives and performance measures/outcomes.

7. What do you believe to be the top three challenges facing the department/agency and why? The top three challenges are: (1) funding levels that do not meet the level of need; (2) a growing population to serve with increasing levels of chronic disease; and (3) recruitment and retention in light of a national shortage of primary care providers, particularly in rural areas.

8. In reference to question number six, what factors in your opinion have kept the department/agency from achieving its missions over the past several years? Continued limited resources to fully meet the needs of the growing IHS service population results in problems with access to care, provider turnover, denials/deferrals of needed care and challenges in meeting both the clinical and administrative functions of the agency with limited staff. Significant improvements in the management and efficiency of administrative and clinical activities over the past few years have helped IHS use its existing funding more efficiently and effectively, but the overall need is still significant and meeting the mission continues to be a challenge.

9. Who are the stakeholders in the work of this department/agency? Stakeholders include American Indian and Alaska Native patients, federally-recognized Tribes, health advocates (or non-profits), the U.S. government, the U.S. healthcare system and its providers (IHS purchases some services from the private sector), and Congress and its constituents (since federal funding is used to provide services).

10. What is the proper relationship between the position to which you have been nominated, and the stakeholders identified in question number nine? As a public servant, my job is to consult with tribes, listen and learn from their input, and carefully consider the viewpoints and wishes of these stakeholders in the work of the agency and in all decisions.

11. The Chief Financial Officers Act requires all government departments and agencies to develop sound financial management practices. (a) What do you believe are your responsibilities, if confirmed, to ensure that your department/agency has proper management and accounting controls? The IHS Director is responsible for ensuring that proper management and accounting controls are in place and that they are monitored on a regular basis.

(b) What experience do you have in managing a large organization? Serving as IHS Director since 2009, I have managed a $4.3 billion federal agency with approximately 17,000 employees. I also have 20 years of experience in American Indian and Alaska Native healthcare policy, education, research, medical administration and clinical practice and managed several large programs and projects in the past.

12. The Government Performance and Results Act requires all government departments and agencies to identify measurable performance goals and to report to Congress on their success in achieving these goals. (a) What benefits, if any, do you see in identifying performance goals and reporting on progress in achieving those goals? As IHS Director, I have set clear, consistent goals and objectives for performance, which have helped increase the level of accountability of all agency staff in their work towards achieving those goals, objectives and their associated measurable outcomes.

(b) What steps should Congress consider taking when a department/agency fails to achieve its performance goals? Should these steps include the elimination, privatization, downsizing, or consolidation of departments and/or programs? I believe that Congress should work with the agency to seek agreement on the stated goals and objectives of programs and also agree on realistic performance goals. The assessment of performance should be undertaken by both Congress and the agency together, along with a plan for improvement if needed. Tribal consultation is also key in this process to understand the impact of the program and what is needed to better serve the community.

(c) What performance goals do you believe should be applicable to your personal performance, if confirmed? The performance of the IHS Director should be based on whether there are achievements, improvements, and outcomes that indicate continued progress towards the mission of the organization over time.

13. Please describe your philosophy of supervisor/employee relationships. Generally, what supervisory model do you follow? Have any employee complaints been brought against you? My philosophy of supervisor/employee relationships includes a shared responsibility for good outcomes and performance. It is the supervisor's responsibility to make the goals, expectations and outcomes clear in order for the employee to be successful. Also, the employee must understand that once goals are clear, it is his or her responsibility to meet those goals or ask for help in meeting them. Good communication is the hallmark of a successful supervisor/employee relationship and participation of both in the discussion and setting of goals is preferable. I believe in the concept of progressive discipline for problem employees—i.e., problems are discussed, clear expectations are set, joint agreements for improvement are implemented, and progress is reassessed at specific times. Of the approxi-

mately 17,000 IHS employees, only two employees have filed EEO complaints against their supervisors that have also named me as a party in my official capacity. One of the two complaints has been dismissed; the second is pending.

14. Describe your working relationship, if any, with the Congress. Does your professional experience include working with committees of Congress? If yes, please explain. My working relationship with Congress has been positive and productive in my role as IHS Director. IHS works closely with the Senate Committee on Indian Affairs, the House Natural Resources Committee Subcommittee on Indian and Alaska Native Affairs, the Senate and House Appropriations Committees, and members of Congress interested in Indian health issues. I have testified at several hearings on the IHS budget and our agency reform efforts. Given that one of my top priorities is reforming the IHS, I appreciate the input and recommendations from Congress on how our agency can change and improve.

15. Please explain what you believe to be the proper relationship between yourself, if confirmed, and the Inspector General of your department/agency: The IHS Director and the Inspector General should have a business relationship and work together on issues to ensure an open and fair process for assessing and resolving any problems. The recommendations of the Inspector General are often helpful in IHS' work to change and improve the agency business and clinical practices.

16. In the areas under the department/agency's jurisdiction to which you have been nominated, what legislative action(s) should Congress consider as priorities? Please state your personal views: I believe that Congress should continue to consider strategies to address the significant and growing need for IHS services, work with IHS on solutions that help reform the agency and support legislation that helps further the IHS mission.

17. Within your area of control, will you pledge to develop and implement a system that allocates discretionary spending in an open manner through a set of fair and objective established criteria? If yes, please explain what steps you intend to take and a time frame for their implementation. If not, please explain why: I will continue IHS' current practice to consult with Tribes on funding allocations to establish fair and objective criteria for distribution of discretionary funding.

G. FINANCIAL DATA (NOT RELEASED TO THE PUBLIC.)

The CHAIRWOMAN. Thank you, Dr. Roubideaux.

You mentioned four priorities that you had and making progress on those. One of the things you mentioned was a medical home. What would you say the status of that is and have you attached a budget number or cost savings you will achieve from implementing that strategy?

Dr. ROUBIDEAUX. Our implementation of the patient center medical home as a part of our improving patient care initiative, when I first started as Director, there were about 40 programs. Now we have 127 programs and we plan, by 2015, to have all of our Federal and tribal programs volunteer to be a part of it.

In terms of cost savings, those are being measured individually at the programs because each program uses quality improvement practices to generate local improvements in the process and quality of care. If confirmed, I am happy to work with you in evaluating this initiative and looking at some of the cost savings we have.

The CHAIRWOMAN. Is it the whole objective of a medical home, as you said, to better manage care and reduce costs?

Dr. ROUBIDEAUX. Yes, and it will end up reducing costs and helping with efficiencies because it will help better coordinate care so that patients get the care when they need it, in a timely way and in a quality way. That should help us reduce costs and that will help us with our overall budget.

The CHAIRWOMAN. But, you do not have a targeted number?

Dr. ROUBIDEAUX. We actually are working on our evaluation of the initiative now that we have a larger number of programs in the initiative. I am happy to work with you on that if confirmed.

The CHAIRWOMAN. Following this Committee's investigation of the Aberdeen Area Office, the Indian Health Service completed a comprehensive review of 12 area offices identified with deficiencies in facility oversight, employee accountability and management. Recently, you stated the investigations have been concluded and corrective measures have been put in place where deficiencies were identified. What were the specific findings of those investigations and what corrective actions have you put in place?

Dr. ROUBIDEAUX. The area reviews that we conducted looked at the specific indicators requested by the Senate committee investigation of the Aberdeen area. When we looked at all 12 areas in general, the policies and procedures were in place. We found problems with inconsistency in implementation.

We have already taken corrective actions in some of the areas to make sure they are making those improvements. We are seeing improvements. We put those in the Senior Executive Performance Measure Plans so we can hold people accountable. Things like preemployment suitability, making sure that before they come onboard as a hire, everybody has a background check and the OIG exclusion lists is checked.

We are doing really well with that now. I actually checked that right after the investigation to make sure that none of our employees appear on the list that excludes them from Federal hire. Administrative leave is now in very rare use compared to the use in the past. It was being used inappropriately for disciplinary actions and prolonging those. We have markedly reduced that and require area director approval for more than eight hours of administrative leave. We are constantly monitoring that.

Administrative control of funds, reconciling our balances, we have actually been able to reduce our balances with no activity by 97 percent in the last couple of years.

We are improving our monitoring of contract health service funds. We are doing training and working with outside providers. We have been able to reduce balances owed to outside providers for contract health service.

For pharmacy security, we have installed cages, cameras, new policies and better accountability and separation of duties so that we actually have been able to reduce discrepancies in narcotic counts. For example, in the Aberdeen area, the number of narcotic discrepancies found on monthly audit in November 2010 was about 3,600 in that month. Now, it is less than 100 and has been for several months.

The CHAIRWOMAN. May I follow up? I also know we have asked a question relative to the whole oversight of area offices. I specifically requested that you analyze staffing levels and staff shortages in the Washington State service units. Those specific findings have not been received yet. I don't know if you can comment on them today?

Dr. ROUBIDEAUX. It wasn't a part of the original reviews but we are happy to work with you on that.

The CHAIRWOMAN. I think this request was dated 2010.

Dr. ROUBIDEAUX. Yes, the reviews were already in place and were focused on looking at the various findings found in the Aberdeen area. When I received your request, the reviews were in process, but we are very interested in working with you on staffing issues in the Portland area.

The CHAIRWOMAN. So investigation of the Portland area has happened, you have results or it hasn't even begun?

Dr. ROUBIDEAUX. Investigation of the Portland area happened based on the findings of the Aberdeen area. We have reviewed that and can share those findings with you. Looking at staffing is sort of a different process that we would have to define but we are happy to look at it.

The CHAIRWOMAN. Thank you.

Vice Chairman Barrasso?

Senator BARRASSO. Thank you, Madam Chairwoman.

In September 2010, members of this Committee requested a comprehensive investigation of potential substandard health care services and mismanagement of all Indian Health Service facilities. According to your prior testimony before the Committee, a review of all Indian Health Service areas has now been completed.

The Committee would like a comprehensive response on these reviews, including an explanation of the evaluation process, the findings, corrective action plans and performance metrics for evaluating compliance and progress.

I am wondering if you have any of the findings and recommendations you can share with us today and do you know if there will be a formal report? If so, when will we see it?

Dr. ROUBIDEAUX. We would be happy to provide a written update on the findings of the investigation. I think in all of the specific areas, we do have specific information on what the findings were for each area and what actions have been taken to address any problems that were found.

In terms of quality of care, we have made improvements in how we prepare for accreditation and we continue to be 100 percent accredited as well.

Senator BARRASSO. Will there actually be a formal report to Congress, to this Committee, so the Chairwoman and others on the Committee can actually go through, line by line specifically, the formal report?

Dr. ROUBIDEAUX. I would be happy to provide that information.

Senator BARRASSO. When will we see that report?

Dr. ROUBIDEAUX. We are happy to work with you on the timing of that report.

Senator BARRASSO. It was supposed to be done last year. I don't know exactly where to go with this Madam Chairwoman, but I am trying to find some answer on when we will actually see something rather than happy to work with us. We are looking for answers. People all around the country are looking for the answers. This is something requested in 2010.

Dr. ROUBIDEAUX. We did just complete the final area review in December 2012, so we are still working on compiling the results of some of the reviews in written format. We would be happy to provide a summary and an update.

Senator BARRASSO. When do you expect we will be able to see that?

Dr. ROUBIDEAUX. I would be happy to work with you on the timing of that.

Senator BARRASSO. I want to work with you now. I want to know when we are going to see it.

We have talked about contract health services and the potential for including morbidity and mortality rates as one of the several factors in the distribution formula when it comes to contract health services. As you know, the rates are unacceptably high on the Wind River Indian Reservation. The life expectancy in Indian Country is about 72.5 years. However, on the Wind River Reservation, the average age is somewhere around 49 years of life expectancy. It needs to change.

If contract health services are intended to provide care and extend life, then shouldn't these rates be considered in determining the need for contract health funding?

Dr. ROUBIDEAUX. Vice Chairman Barrasso, I appreciate your interest in mortality statistics in the Indian Health Service and your request for it to be considered as part of the formula. The Tribal-Federal Work Group did meet and they reviewed the distribution formula and the findings of the 2001 work group and their own discussion.

Their recommendations were to keep the formula the same because after looking at the data over the past couple of years, they felt the funding was going where it needed to be.

The discussion of mortality is a great indicator of health status but they feel the contract health service funding is to make up for discrepancies in services provided, for example, clinics that do not have hospitals attached may have more need for referral. They felt there were other indicators related to access which they preferred to focus.

In addition, if we were to look at mortality statistics at the local level, when you look at the numbers, the estimates vary from year to year so it is very difficult to have accurate estimates at the local levels, especially for smaller tribes.

We have the recurring problem of the data we get from vital statistics that the State often undercounts American Indians and Alaska Natives. With those concerns, the Contract Health Service Work Group looked at all the options for the formula and decided to keep it the same.

If confirmed, I am very much willing to work with you on how we can further look at mortality to help us improve our services.

Senator BARRASSO. Thank you.

As I mentioned, at your last nomination hearing, the primary health facility on the Wind River Indian Reservation was built in 1877, built for military use, so the Wind River facility is 136 years old and not ideal for modern health care delivery. I think most reasonable people would agree that after 136 years, it is time for a new clinic.

I know you agree with that. Do you think it is acceptable to continue using this centuries old facility and how do the facility needs fit into the Indian Health Service construction priorities or some master plan that you might have?

Dr. ROUBIDEAUX. Facilities construction is extremely important, with the average age of over 30 years of all of our facilities.

Senator BARRASSO. This 137 years is bringing up that average.

Dr. ROUBIDEAUX. Yes, it is. It is a challenge to maintain our accreditation requirements and provide good access to quality health care.

The most recent reauthorization of the Indian Health Care Improvement Act basically said the current health care priority construction list needs to be in place, needs to be funded and achieved before we add other facilities to that. The current need on that is $2.1 billion more needed to get through that list.

I know many more facilities need construction, so if confirmed, I am happy to work with you on this issue.

Senator BARRASSO. Thank you.

Thank you, Madam Chairwoman.

The CHAIRWOMAN. Senator Johnson.

Senator JOHNSON. Dr. Roubideaux, congratulations on your nomination to a second term as Director of the IHS.

In our home State of South Dakota, we have several programs benefiting from the Special Diabetes Program for Indians. The impact of diabetes in Indian country is truly devastating. What improvements has IHS implemented to further decrease the rate of diabetes in Indian country?

Dr. ROUBIDEAUX. The Special Diabetes Program for Indians has made dramatic improvements in access to prevention and treatment services for diabetes. We are seeing that the quality of care is improving and access to specific services that promote quality care has improved as well. Our 2011 report to Congress has related data.

The demonstration projects that we have on diabetes prevention and a healthy heart for cardiovascular disease prevention, the findings are showing that they did reduce the risk factors for diabetes and cardiovascular disease.

In the case of our diabetes prevention program initiative which replicated or translated the NIH diabetes prevention program research study, they actually were able to reduce the number of new cases of diabetes in a comparable way by reduction in weight through promoting healthy lifestyles, physical activity and improvements in dietary choices.

In addition, as we look at our data, all these improvements in access to care and quality of care over the last 15 years are starting to reduce diabetes complications. We are seeing reductions in wound problems, amputations and when you compare the new cases of end stage renal disease with other racial and ethnic populations in the country, American Indians and Alaska Natives are having the greatest level of decline.

It is during the period we had these funds, so the programs are doing an incredible job of implementing best practices and culturally appropriate programs in our communities. It is making a difference.

Senator JOHNSON. Dr. Roubideaux, your experience includes directing two University of Arizona programs to recruit "Native students" into the health professions. As you know, rural areas struggle to recruit and retain doctors, nurses and other Federal

health professionals. How is IHS addressing vacancy rates across Indian Health Service units?

Dr. ROUBIDEAUX. Senator Johnson, I know in the State of South Dakota, you see that challenge all the time in rural America of recruiting and retaining health care providers for the Indian Health Service. It is a significant challenge and I share your concern about this issue.

We have made a number of improvements in our recruiting and retention strategies including improved pay, improving access to our loan repayment programs and improving recruitment and retention tools. We have actually seen improvements in our vacancy rates for physicians for nurses and pharmacists and dramatically for dentists. We have been able to show with some focused activity, we can make improvements.

However, it is clear we are facing a shortage of primary care doctors in the future. If confirmed, I am definitely willing to work more with you on this issue because it is extremely important to our ability to provide care.

Senator JOHNSON. Is housing one of the key problems?

Dr. ROUBIDEAUX. Yes, housing for our health care providers and our staff for our hospitals is a significant issue. The only way we can get new funding for housing is through our health facilities construction process. I think you saw that at Cheyenne River. With the Recovery Act funds, they were able to build a number of new housing units which will definitely help them with recruitment.

Senator JOHNSON. In April, you stated in your budget hearing testimony that IHS will experience sequestration cuts to its budget totaling $220 million. You mentioned that these cuts will impact health services to tribal members. It is proposed that IHS will see an increase in its fiscal year 2014 budget, but tribal members will not see this impact until next year if it is even approved. What is your current proposal for dealing with the sequestration impacts?

Dr. ROUBIDEAUX. I share your concern about sequestration. We are doing everything we can to protect the core mission of the Indian Health Service. IHS, in fiscal year 2013, has to absorb $220 million in cuts. On the Federal side, we are making a number of administrative reductions in travel, conferences, purchasing and printing, delaying some hires and looking at ways to improve collections. We are working with our tribal partners on those issues.

We don't know what the future holds. That is why we are supportive of the President's 2014 budget which will find a balanced approach to deficit reduction which replaces sequestration and allows priorities to be funded. The Indian Health Service is one of them. I would be happy to work with you on this issue.

The CHAIRWOMAN. Senator Heitkamp.

STATEMENT OF HON. HEIDI HEITKAMP,
U.S. SENATOR FROM NORTH DAKOTA

Senator HEITKAMP. Thank you so much, Madam Chair.

It is absolutely with a kind of sad heart that we address these issues because those of us who live with Indian Country within our State borders know that among the whole host of issues, health care ranks very high and is a great concern for the betterment of Indian people in our States.

The job that you have is absolutely the most critical job to improving those conditions. This is an important hearing for not only Indian people in North Dakota but Indian people across the country.

As we look and as we are concerned because we spend a lot of time, especially members of this Committee, in Indian Country looking at our area offices and looking to the analysis and accountability, I think you know that this Committee undertook an investigation of the Aberdeen Area Office and that investigation uncovered serious deficiencies in management, employment accountability, financial integrity and oversight of facilities.

Specific findings included missing and stolen narcotics, misuse of contract health service funds, providers practicing with expired licenses and excessive use of administrative leave.

Tribal leaders in my State express a great deal of concern about the responsiveness of the Indian Health Service. They feel like the discussion is always with the Aberdeen office and not directly with the tribes. They feel disconnected to Indian Health.

This is a critical disconnect if we are going to look at reforms. We have heard at least two of the other members discuss a frustration with not getting responsiveness to these investigations. I am curious about what specific steps have been taken to address the issues at Aberdeen, whether you think the identified deficiencies have been addressed and if you are moving ahead to hire a permanent area director that could provide some of these answers directly to the tribal chairmen?

Dr. ROUBIDEAUX. Yes, absolutely. I want to reassure you that we have made a number of corrective actions in the Aberdeen area to correct many of the issues you mentioned. The background checks are now being done, administrative leave is rarely being used, pharmacy security has been improved and has reduced those discrepancies.

We have improved our administrative control of funds, contract health service, better tracking of licensure and also been able to maintain accreditation of our facilities which is the ultimate judge of quality of care in the area.

I have met with tribes in the Aberdeen area on several occasions and we have worked to address the issues they are raising. They are in one of our direct service areas where we are committed to honoring treaties and our Federal trust responsibilities. If confirmed, I look forward to working more with them on these improvements and helping them see the improvements we have made.

Senator HEITKAMP. I would suggest that the ultimate measure of your success is the health of Indian people, not necessarily accreditation.

A specific issue that we have seen plague Indian Country and it moves from our interest overall in mental health. You know that suicide is the second leading cause of death among Native children 15 to 24. Native teens experience the highest rate of suicide of any population group in the United States, 3.5 times higher than the national average.

If you look at suicide among Native American males, it is four times higher. The rate for females in the same age bracket, 15 to 24, is 11 times higher.

None of us can be happy with those statistics because they indicate a systemic problem within Indian Country and certainly with the delivery of mental health services. I am wondering what you will do in your second opportunity to increase Indian health mental service training and direct services to curb this ever growing and disturbing epidemic?

Dr. ROUBIDEAUX. Senator Heitkamp, this is an area of significant interest and priority for us in the next few years if confirmed. We have already set the stage with a suicide prevention strategic plan that has been developed with input we have gathered from tribes on best practices and promising practices. We have done a number of trainings of staff.

We have our methamphetamine suicide prevention initiative that is now starting to show results in terms of large numbers of individuals trained in communities to help recognize and help refer individuals to get the treatment that they need.

Along with implementing tele-behavioral health and other strategies, I think that we are beginning to get strategies in place that will help us make a difference in the future. We need to partner with our tribes, with our communities and our other Federal agencies. I am committed to doing that if confirmed.

Senator HEITKAMP. I do have some additional questions that I would like to submit for the record.

The CHAIRWOMAN. I am going to ask a few more questions, so we are going to have a second round.

Senator HEITKAMP. Thank you.

The CHAIRWOMAN. Dr. Roubideaux, the Administration proposed that for the Indian Health Service, Congress provide specific line item appropriations for each self-determination contractor, self governance agreement. However, tribes and tribal organizations have requested that the Administration drop this proposal.

What is the agency's view of whether additional consultation should be conducted prior to legislation being enacted?

Dr. ROUBIDEAUX. The Indian Health Service along with the rest of the Administration is definitely interested in consulting with tribes. We felt the fiscal year 2014 presidential budget proposal was an interim solution but we want to consult with tribes on a more long term solution.

The issue of how to fund contract support costs in a difficult budget climate with other budget priorities that are just as important to tribes is a very challenging issue that we have experienced. The Supreme Court did make recommendations to Congress on how to handle that issue. Even though the Administration has proposed this for fiscal year 2014, we want to continue that consultation.

I am working on releasing a letter today or tomorrow to further consult with tribes on this issue with more details and conversation over the next couple of months.

The CHAIRWOMAN. Will you support full funding for contract support in future budgets?

Dr. ROUBIDEAUX. I do everything I can to fight for tribal priorities in the budget. I can assure you that all views and all options were considered in the budget formulation process for fiscal year 2014. I will continue to carry the tribal priorities during our budget formulation process.

The CHAIRWOMAN. Are you saying that you were consulted with the Administration proposal?

Dr. ROUBIDEAUX. We understand that the tribes are feeling they were not consulted on the specific proposal.

The CHAIRWOMAN. I am saying were you consulted on the Administration's proposal?

Dr. ROUBIDEAUX. In terms of the consultation process with the tribes or with the Administration, it is a joint decision by the entire Administration. I want to assure you that all views were considered during the process and all options were considered as well.

The CHAIRWOMAN. What was your view?

Dr. ROUBIDEAUX. My view is that I support the President's budget proposal as an interim solution for handling the issue with contract support costs.

The CHAIRWOMAN. What does that mean, interim solution?

Dr. ROUBIDEAUX. We understand that the tribes don't like this solution, so it is being proposed for 2014 as one of the options the Supreme Court gave to deal with the CSC appropriation issue. We are willing to consult with tribes on a more long term solution. The Supreme Court identified there is this issue between the requirement and authorizing language to pay contract support costs, yet the history of congressional appropriations that have not fully funded it.

In the context of a difficult budget climate and also in the context of balancing contract support costs with other tribal priorities which I hear about in our tribal budget consultation process, this is a very challenging issue. If confirmed, we look forward to working with tribes on finding a more long term solution to CSC appropriations.

The CHAIRWOMAN. Senator Begich, did you have questions you would like to ask?

Senator BEGICH. I do, Madam Chair.

The CHAIRWOMAN. I will let you ask your questions since we have already had one round if you are ready.

Senator BEGICH. I would be happy to let Senator Heitkamp proceed and give me a couple of minutes as I rushed in from another meeting.

The CHAIRWOMAN. Senator Heitkamp.

Senator HEITKAMP. Thank you, Madam Chairwoman.

These are going to more generalized questions. We can talk about contracts, reviews, suicide, diabetes, chronic heart disease and all of the things that plague mental health services and all the things that plague Native American Indians and Indian Country in our States and in this country.

I would like a sense from you if you were going to evaluate Indian Health Service's delivery of services today on a scale of 1 to 10, with 1 being the highest quality, where would you rank Indian Health Service today?

Dr. ROUBIDEAUX. I think the providers and the staff of IHS are doing the best job they can with the resources they have but we have much more to do. If you look at our GPRA indicators, on a number of those indicators there has been improvement but we have room for movement.

An example is mammograms. It used to be 40 percent received but in the last few years with the budget increase and focused attention, it is now greater than 50 percent, but we want to get to 100 percent.

I think for most of our quality indicators, we are on track with national averages on those but we want to make those better. If I had to rank ourselves on a scale, we have made progress but we definitely need more improvement. If confirmed, I am committed to continuing the progress we have made.

Senator HEITKAMP. This is kind of turning over the coin and asking you to look at it from the perspective of families living in Indian Country. How do you think they would rank the delivery of health care services they receive in Indian country in the United States?

Dr. ROUBIDEAUX. I can tell you I hear that input every day, not only from our patients in general but from my family members specifically, often and frequently.

The problems and challenges we have in the Indian Health Service are enormous. We have made some progress but I feel we are just beginning to get to the important work of changing and improving the Indian Health Service.

We can demonstrate specific quantitative changes with the data but I am not going to rest until patients come up to me and say things are getting better, until tribes come up to me and say things are getting better. That does happen occasionally now but not all the time. The goal is every patient who walks into the Indian Health Service should be treated with respect, dignity, excellent customer service, and should receive the highest quality of health care and should be satisfied with the visit. It should result in improving their health status.

That is the ultimate goal. I have had that goal since I was a teenager of wanting to come and improve the Indian Health Service. That is our goal as we continue.

As I said in my original confirmation speech, these improvements will not happen in days, weeks, months or years, but it is time to begin those improvements. I can demonstrate that we have made significant progress with the numbers and some progress with the feedback, but I definitely will not rest until I hear more of our patients and tribes saying things are better.

Senator HEITKAMP. I can completely understand the need to be part of the Administration. My position is that if we had enough resources, we could do amazing things but we need to have advocacy for those resources. It is not good enough that we are part of an Administration; we want you to step out of the box. We want you to be the person who is fighting for those resources within this Administration because we all know here the squeaky wheel gets the grease.

If we play the loyal soldier all the time and say we are just going to march to this drum, we aren't going to improve these conditions.

There is no one in America, outside of Indian Country who would want to come into Indian Country and necessarily get health care services there—not in North Dakota. Many of the Indian people who live on the reservation frequently go off using their own health insurance to receive services someplace else.

We want to help you improve the Indian Health Service. We want to be partners with you but you need to be advocates for those people and the population you are serving.

Dr. ROUBIDEAUX. Thank you, Senator Heitkamp, for your offer of assistance. This is an enormous challenge. I appreciate that.

I want to reassure you I am constantly fighting, I am constantly trying to make everybody know what the tribes want as their goal in health care. I am constantly educating and making people aware of what the needs are in Indian Country.

Someone I work with who is very important said the adjective to describe me was tenacious. I think a lot of people would agree that I am not going to stop until we get better health care. If confirmed, I see this as an opportunity for us to continue that fight and that progress because our patients are depending on us.

The CHAIRWOMAN. Senator Begich.

STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you very much, Madam Chair.

Thank you, Dr. Roubideaux, for being here. I apologize I wasn't able to be here at the beginning so I didn't hear your opening statement.

If you recall, the last meeting we had was on the budget. You probably sensed a great frustration from me and if you didn't, you should have. I will be honest with you that many in my State, as well as other States I have talked to, are not satisfied with the leadership within the Indian Health Service.

I get the challenges you have but I want to add to what Senator Heitkamp said, and I don't want to put words in her mouth, but I feel at times being an advocate means truly stepping out of the box and telling people they are wrong on certain issues. I don't get that sense.

We had this conversation last time on contract support costs. I know there was a conversation just as I arrived. I asked you who came up with this proposal that I have yet to find anyone in the tribal community likes. You are the advocate, the person they turn to for protection from this bureaucracy that honestly has short-changed American Indians, Alaska Natives and Native Hawaiians for decades.

I am going to ask this again and help me get the answer I am looking for. How are you going to solve this problem when you have tribes that do not agree with the Administration's proposal in delivering contract support costs? How are we going to solve this?

You talk about tribal consultation, which I agree, but it is not just having tribal consultation. It is that you are taking their recommendations and making it happen. How are we going to solve this problem? I tell you, the Administration is wrong, absolutely wrong on this. You should be saying the exact same thing because

you know the tribes disagree with this. It is not the right way to do business and they know it.

Go ahead and comment. I will pause for a second or I'll get on a rant.

Dr. ROUBIDEAUX. Well, Senator Begich, I understand your frustration about this and I see the frustration in your words and your face. I know you are advocating for your constituents in Alaska.

I want you to know that the Administration has heard loud and clear that tribes do not like our proposal. That is why the Administration wants to consult with tribes. We have been consulting on contract support costs for some time. We anticipated that the tribes would not like that proposal, yet we are facing a difficult budget climate and other tribal priorities.

Just last week, I sat with a roomful of tribal leaders who talked about we need to have other tribal budget priorities being advocated as strongly as contract support costs. It is my job to bring the voices of tribal leaders back to the Administration and do what we can.

I can assure you that all views were heard in this conversation leading up to the Administration's decision. One of the strategies I think is we have to take a slightly different approach. I have actually been working with some tribal leaders on my advisory committees and they recognize the difficult problem of contract support costs, funding and other budget priorities and how we balance all those issues.

We are going to try some different types of meetings where we sit down and have some frank discussions about these issues. I really feel it is an attempt to step outside the box and find a solution to this because it is a challenge. If confirmed, I am willing to work with all our tribal leaders on this very challenging problem.

Senator BEGICH. On contract support services, I understand it is probably some past contracts, some efforts for settlement and negotiations. I keep hearing it is everyone's perception is it is slow moving. Again, this is not complicated. Here is what is owed, here is what is required, here is what the courts have said but tell me how you see the status of the settlement negotiations at this point from your view.

Dr. ROUBIDEAUX. The Indian Health Service is committed to making the settlement of these past claims as efficient as possible. The goal of settlement is possible. That is why we have been working with tribes and the tribal lawyers to try and find a more efficient process to settle those claims.

We don't have a class action. Therefore, we have to use our authorities under the Contract Disputes Act and through the judgment fund to get these settlements done.

We have been listening to the tribal lawyers. We now have a case management plan that has been agreed upon with tribal lawyers on all the cases currently under appeal. Based on our experience so far, we have now recommended two options to try to make the settlement more efficient and to reduce some of the paperwork the tribes have.

I feel because we don't have the class action, we are sort of working on it as we go and we are getting more efficient. We are mak-

ing progress. Again, it is our goal. We want to settle these past claims because we want to move forward.

Senator BEGICH. Where do you think the window is? How wide open in timetable is this window that you believe you can get to a settlement? Is it months, years or days? What do you think based on your description of what you just gave me?

Dr. ROUBIDEAUX. I have to go back to my lawyers and get their opinion on it. We have actually settled our first case since post-Ramah, so a tribe is actually getting paid from the judgment fund for the first claim. That has helped us a lot. It was sort of like the work was on the up front and I really do feel the cases are going to start getting settled a lot quicker, especially with our option of the Administration one time offer as a more simple approach. I will talk with my lawyers.

Senator BEGICH. Will you share that with us?

Dr. ROUBIDEAUX. We can share that with you.

Senator BEGICH. I know I am over my time, Madam Chair. I have a couple other questions I will submit.

Dr. Roubideaux, I want to make you successful because if you are successful, then we know our tribes will be successful. That is the bottom line, if you are a successful leader in your reconfirmation for your position.

There are a lot of issues, not just from my State, but every State I travel to, I try to meet with tribes in their communities. That is the responsibility of this Committee. I hear feedback and it is frustrating to me because they look to you as their advocate. That means not just behind closed doors but in public.

They come to us and they vent frustration. We don't run the government. We do policy, we do appropriations but at the end of the day, you have to do the day-to-day activity.

I would stress upon you the great desire by all of us to see you successful because it is having an impact. I spend too much time in my office with tribes from Alaska and outside of Alaska venting about their frustration. As a former mayor, as a manager of a big workforce, that is not a good sign for a manager. I will be very blunt with you.

I have some other issues I will share with you later, but again, thank you for being here today.

Dr. ROUBIDEAUX. Thank you.

The CHAIRWOMAN. Senator Heitkamp, did you have any other questions?

Senator HEITKAMP. No.

The CHAIRWOMAN. Dr. Roubideaux, you talked about listening that all issues were considered. I really think you are hearing from the Committee a great deal of dissatisfaction with the contract support issue. I would be like someone being in the hospital and saying we are not going to cover Medicare but somehow people think because it is Indian Country that you can get away with it.

The Supreme Court has told exactly what we are supposed to do. I don't consider this an interim issue; I consider it an ill thought-out policy response to a critical issue that the Supreme Court has said we need to take a different route on.

I understand your probable hesitancy in speaking on behalf of the whole Administration but as my colleagues said, we really do

need to understand the key priorities for improving health in Indian Country. I think contract support is one of those key issues.

Secondly, I think we really do need some of this information before we can move forward on your nomination to the floor of the United States Senate. I know my colleague, the Vice Chairman, Senator Barrasso, asked for written documented information.

I am noticing here that after our inquiry into the Portland Health Care Office in 2011, I got a letter in May 2012 assigning someone from the staff to look at these issues. As you indicated today, we still do not have written information.

I think we need to take a deep breath and get the information the committees need and get the answers. You are hearing from at least four different geographic regions today that have concerns about how we are going to move forward to improve those statistics you were so good at mentioning in your opening statement.

We appreciate you being here today and we appreciate your diligence in trying to deal with a very challenging situation, but I think getting this information will help bring a bit of focus to everyone about how we need to make sure that we are moving forward in the appropriate way.

Thank you for being here today and for your work on this very, very important issue.

The hearing is adjourned.

[Whereupon, at 3:29 p.m., the Committee was adjourned.]

A P P E N D I X

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BARBARA BOXER TO HON. YVETTE ROUBIDEAUX

Question 1. In 2009, I asked what steps you would take to address funding shortfalls for California's Contract Health Service area and you indicated that "in consultation with tribes, [you would] review the funding issues that are particular to California" and "make it a priority to review how IHS is handling referrals to determine how to improve the process, and to ensure that the rules in [California's Contract Health Service area] are clear and well understood by both patients and referral partners." Please detail the steps you've taken to accomplish this in your previous term, and what specifically you will do to continue addressing this issue if reconfirmed.

Answer. In the California Area, Tribal organizations exclusively provide all health care through contracts or compacts. IHS has provided the California Tribal CHS programs with the most up-to-date information on CHS best practices and regulatory changes that could improve California's CHS programs. IHS provides consultation, training, outreach and education for all CHS staff and Tribal Health Directors on CHS rules and regulations as requested by the Tribes. We have provided training for Tribal programs on calculating the Medicare Like Rates to assist them in their CHS business process. IHS holds annual meetings for the sharing of CHS practices and networking for Tribal CHS programs. The California Area Office also has quarterly conference calls with Tribal CHS staff to assist them in improving their CHS processes. The IHS/CAO conducts Contract Health Service listening sessions for tribal government officials during the area-wide budget formulation and at the Area Annual Tribal Consultation meeting. My Tribal Workgroup on Improving CHS has reviewed the national distribution formula for CHS funding increases and the effects of the formula on funding for each IHS Area including ensuring that Areas most in need of CHS funding are receiving relatively more of the available CHS funding increases. The workgroup concluded that the funding increases were going to the Areas that had the need for services as defined by the current distribution formula and recommended that the distribution formula remain the same. If confirmed, I will continue to implement the recommendations of the CHS workgroup to improve business practices in CHS programs and will ensure that Tribal CHS programs are kept aware of these improvements and are encouraged to implement them.

Question 2. Through the course of implementation of the Affordable Care Act, will the definition for American Indian/Alaska Native people be the same as it was for Section 5006 of the American Recovery and Reinvestment Act (ARRA) (also known as the "Medicaid definition")?

Answer. The Administration has thoroughly reviewed the varying definitions of the term "Indian" in the Affordable Care Act. At Congress' request, the Administration provided technical assistance to Congress to align the definitions referenced in the law with that used for IHS eligibility and Medicaid eligibility. The technical assistance to Congress is consistent with Tribal consultation on the subject. We will continue to work with Congress to ensure the needs of Indian Country are considered as implementation of the Affordable Care Act moves forward. Related to this issue, on June 26, 2013, the Administration released a final rule that granted an exemption for individuals who are eligible to receive services from an Indian health care provider from the shared responsibility payment for not maintaining minimum essential coverage.

Question 3. I understand that you have issued a verbal directive for all IHS facilities to carry and offer emergency contraceptives. I am pleased to hear of this progress at IHS, however a verbal directive can be rescinded at any time. We need a permanent policy that says that all IHS facilities—including those that serve Alaska Natives—shall carry and offer emergency contraceptives consistent with law.

Advocates for women's health have been pushing for such a policy for several years, and have continued to be told that IHS is "working on it." In fact, in May 2012 the IHS informed advocates in writing that it was "finalizing" such a policy, but that policy has still not been issued. Can you please outline for me your timeline for issuing and implementing this permanent policy?

Answer. A complete revision of the pharmacy chapter of the Indian Health Manual began in fall 2012 and is in progress. The revisions address the need to follow FDA labeling for medications such as emergency contraception. IHS plans to review comments from the most recent staff review and hopes to put the final updated policy in place soon. IHS has had a Sexual Assault Policy in place since 2011 that identifies the roles and responsibilities of Sexual Assault Nurse Examiners and Forensic Examiners, including providing access to emergency contraception.

Question 3a. In addition, can you please tell me what enforcement mechanisms IHS will have in place to ensure that IHS facilities comply with such a policy?

Answer. IHS already has performance management plans in place to hold employees accountable for providing appropriate care. IHS has monitored access to emergency contraception and confirmed that all federally operated IHS facilities offer it according to FDA labeling. Corrective action will be taken by each Area if the facility is found to be out of compliance with the policy, and IHS is requesting that if individuals experience difficulties accessing the medication, they contact IHS with the name of the relevant facility and provider.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO HON. YVETTE ROUBIDEAUX

Following this Committee's investigation of the Aberdeen Area Office, the Indian Health

Service completed a comprehensive review of all 12 Area Offices to identify deficiencies in facilities oversight, employee accountability, management, and other important areas. Recently, you have stated the investigations have concluded and corrective measures have been put in place where deficiencies were identified.

Question 1. What were the specific findings of the investigation and what specific corrective actions have been put in place?

Answer. IHS is providing a report under separate cover describing IHS's review of management issues in all twelve Areas. The report includes specific findings along with corrective actions to date for each IHS Area.

Question 2. What is the timeline for the release of these reports and when will they be made available to the Committee?

Answer. The requested report is complete and is being made available to the Committee.

Answer. part of the Agency's investigation of all Area Offices, I specifically requested that you analyze staffing levels and staff shortages in the Agency's Washington State service units.

Question 3. What were the Agency's specific findings in relation to staffing in the Portland Area Office, and are those findings representative across service areas?

Answer. IHS conducted a separate analysis of staffing levels in the three federally managed Service Units in Washington State: Colville, Wellpinit, and Yakama.

In order to analyze staffing levels at each Service Unit, standard IHS analytical tools and methods were used. Health Systems Planning (HSP) software generated workload estimates, and staffing calculation formulas in Resource Requirements Methodology (RRM) were applied to those estimates to yield recommended staffing levels. For the facilities that comprise the IHS service units of Washington State, the analysis identified the required staffing level at individual facilities based on existing space design and on the actual FY 2010 workload (as provided in the IHS "Report 1A-Ambulatory Care Visits by Provided & Month of Service").

The analysis of staffing levels at the three IHS service units in Washington State shows that current staffing is less than the calculated need for staffing as determined using the RRM methodology. However, IHS measures show that the staffing levels at these three service units are about the same as the IHS average across other service units. Even so, these staffing levels needs are significant, and IHS continues to work on recruitment and retention efforts on both the national and the local levels.

To address staffing disparities, IHS facilities may reallocate existing funds or may use additional appropriations as they become available for staffing such as when new staffing packages are requested for newly constructed facilities or Joint Venture facilities. Other sources of funding, such as the Indian Health Care Improvement

Fund that addresses disparities in funding for IHS facilities are not available to the Washington State federal IHS sites because they are funded at levels above the average benchmark used for assessment of facility resources compared to federal health insurance costs. Other options to increase services include increases in Contract Health Service funding for referrals, and the current distribution funding formula results in the Service Units in Washington State receiving allocations that are higher than the IHS average. Another option for increasing staffing is the use of third party collections. Sites are working to maximize their collections through more efficient billing and collection systems. The anticipated expansion of health coverage under the Affordable Care Act (ACA) may result in increased collections at local facilities that can help address staffing needs. The Yakama Service Unit CEO participates in the Washington State Health Benefits Exchange workgroup that has been established in part to enhance Tribal partnership and collaboration regarding the ACA for Washington State Tribes.

A summary of the staffing analysis for each of the three IHS federal Service Units in Washington State is included below.

Colville Service Unit

The Colville Service Unit (CSU) provides ambulatory care services to the communities of the Colville Reservation. The reservation, home to the Confederated Tribes of the Colville Reservation (Tribe), occupies just under 2,200 square miles in northeast Washington State.

Health facilities are located in the reservation communities of Nespelem, Omak, Inchelium, and Keller. CSU total health facility square-footage is 71,341 distributed as follows:

Nespelem: 30,731 sq. ft.
Omak: 10,774 sq. ft.
Inchelium: 21,634 sq. ft.
Keller: 8,202 sq. ft.

Of the total square footage, 39,738 sq. ft. (56 percent) is tribally owned and operated. IHS leases 27,469 sq. ft. (38 percent) from the Tribe, and directly owns 4,134 sq. ft. (less than 6 percent).

In FY 2012, the User Population was 8,481. The overall clinic space provides for a total of 32 exam rooms and 19 dental chairs across the four health facility locations. The CSU health program includes primary care, dental care, nursing, pharmacy, optometry, laboratory services, radiology services, podiatry, community health care, outpatient mental health and alcohol/drug services, environmental health, and a tribally operated 35-bed convalescent center.

Contract Health Service (CHS) funding in FY09 was $5,860,044. In FY 2012, it was $7,208,541, a 23 percent increase. CHS funds are used for specialty care not provided at the clinic, e.g. orthopedic, cardiology, neurology, nephology, obstetrics, ophthalmology, mammograms, colonoscopy, physical therapy, and ER visits that meet criteria of a true emergency. The nearest hospital is 20 miles south of Nespelem in Coulee Dam, WA. For specialty care, patients generally are referred to physicians in Spokane or Wenatchee. The most complex cases may be referred to Seattle.

Of 68 fulltime-equivalent, federal staff positions at the Colville Service Unit, 30 are provided through recurring funding of $2,675,322 (FY 2013 estimate), and 38 are funded through $1,905,719 in third-party collections (Medicare, Medicaid, and private insurance).

The CSU staffing shortage is summarized in the table below. The majority of the shortage is in Administrative Support and Ancillary Services, particularly the Business Office and Health Information Management. In Ambulatory Care, priority has been given to positions providing primary medical care services. Dental services are understaffed.

Summary Table

Budget Activity	Total Required Staff	85% Level	Current	Need
Hospital & Clinics	64.4	54.7	21	33.7
Dental	15.2	12.9	4	8.9
Public Health Nursing	0	0	0	0
Health Education	0	0	0	0
Mental Health	2.2	1.8	0	1.8

Summary Table—Continued

Budget Activity	Total Required Staff	85% Level	Current	Need
Alcohol/Substance Abuse	0	0	0	0
Facility Support	6.1	5.2	5	0.2
TOTAL	87.8	74.6	30	44.6

Wellpinit Service Unit

The Wellpinit Service Unit (WSU) provides ambulatory care services to the communities of the Spokane Indian Reservation. The reservation, home to the Spokane Tribe of Indians (Tribe), occupies 248 square miles in northeast Washington State.

Health facilities are located in the reservation community of Wellpinit, WA. The WSU total health facility square footage is 26,727, all owned and operated by IHS. IHS and the Tribe collaborated on a clinic addition, completed in 2001, that more than doubled the size of the original 1960 structure. The clinic space includes 10 exam rooms, a treatment room, three triage rooms, and five dental chairs. In FY 2012, the User Population was 1,681.

In FY09, Contract Health Service funding was $1,903,082. In FY 2012 it was $2,309,314, a 21 percent increase. WSU relies on hospitals and health specialists in Spokane, fifty miles to the southeast, for emergency hospitalization and specialty care.

The WSU health program includes primary care, dental care, nursing, pharmacy, radiology services, and podiatry. Specialty clinics include Ear, Nose and Throat, Pediatric, Women's Health, Orthopedics, Diabetes, and Oral Surgery.

Of 37 fulltime-equivalent, Federal staff positions, 14 are provided through recurring funding of $1,324,283 (FY 2013 estimate), and 23 are funded through $1,592,395 in third-party collections (Medicare, Medicaid, and private insurance).

The WSU staffing shortage is summarized in the table below. The majority of the staffing shortage is in Administrative Support, Facility Support, and Ancillary Services, particularly the Business Office, Administration, and Health Information Management. In Ambulatory Care, budgetary priority has been given to covering traditional primary medical care services. Dental services are understaffed.

Summary Table

Budget Activity	Total Required Staff	85% Level	Current	Need
Hospital & Clinics	42.9	36.5	9	27.5
Dental	7.1	6.0	2	4.0
Public Health Nursing	3.3	2.8	1	1.8
Health Education	0.4	0.3	0	0.3
Mental Health	4.2	3.6	0	3.6
Alcohol/Substance Abuse	2.4	2.0	0	2.0
Facility Support	9.7	8.3	2	6.3
TOTAL	70.1	59.5	14	45.5

Yakama Service Unit

The Yakama Service Unit (YSU) provides ambulatory care services to the communities of the Yakama Indian Reservation. The reservation, home to the Confederated Tribes and Bands of the Yakama Nation (Tribe), occupies approximately 2,100 square miles in south-central Washington State.

Health facilities are located in the reservation communities of Toppenish and White Swan. The YSU total health facility square footage is 72,698. Of the total square footage, 58,168 sq. ft. (80 percent) is IHS owned, the remaining 14,530 sq. ft. is tribally owned. Combined, the two health facility locations provide 27 exam rooms, three triage rooms, and 12 dental chairs. In 2012, IHS completed an expansion and remodel of the original 1992 clinic structure. In FY 2012, the User Population was 12,862. The YSU health program includes primary care, public health, dental services, mental health, optometry, audiology, internal medicine, women's health care, elder care clinic, and pediatrics.

Of 124 fulltime-equivalent, Federal staff positions, 72 are provided through recurring funding of $6,174,185 (FY 2013 estimate), and 52 are funded through $3,196,840 in third-party collections (Medicare, Medicaid, and private insurance).

In FY 2009, Contract Health Service funding was $7,119,774. In FY 2012 it was $9,638,415, a 35 percent increase. Inpatient services are obtained at a local private hospital.

The YSU staffing shortage is summarized in the table below. The shortages span all RRM staffing categories, impacting the direct provision of primary care services, but also contributing to decreased efficiency related to inadequate staffing in ancillary and administrative supports. Health Information Management and Business office staffing shortages potentially impact collections from third-party billing. Successful staffing in these areas would be expected to help improve revenue collection, supporting expanded staffing in other categories.

Summary Table

Budget Activity	Total Required Staff	85% Level	Current	Need
Hospital & Clinics	180.2	153.1	40	113.1
Dental	53.5	45.5	19	26.5
Public Health Nursing	18.8	16.0	5	11.0
Health Education	0	0	0	0
Mental Health	6.7	5.7	0	5.7
Alcohol/Substance Abuse	0	0	0	0
Facility Support	13.9	11.8	8	3.8
TOTAL	273.0	232.1	72	160.1

Affordable Care Act Definition

The Indian Health Care Improvement Act has three separate definitions of "Indian" throughout the Act. This could cause confusion regarding eligibility of American Indians and Alaska Natives for various provisions in the Act.

Question 4. What is your view of the potential impact on health services for American Indians and Alaska Natives if legislation is not enacted to ensure a consistent definition throughout the Act?

Answer. On June 26, 2013, the Administration released a final rule that granted an exemption for individuals who are eligible to receive services from an Indian health care provider from the shared responsibility payment for not maintaining minimum essential coverage. With respect to Health Insurance Marketplaces, however, definitions remain in the law that will require the use of different definitions for individual monthly enrollment periods and cost-sharing reductions. If legislation is not enacted, the IHS will follow the law as written while continuing to work with tribal leaders, tribal communities, and Congress to identify a solution that simplifies eligibility standards for individuals, Tribes, and Marketplaces. HHS has provided technical assistance to Congress on this issue that is consistent with Tribal consultation.

Forward Funding

In 2009, Congress provided forward funding for Veterans Administration programs. Tribes have requested that Congress provide forward funding for Indian Health Service programs.

Question 5. Do you support forward funding for Indian Health Service programs?

Question 5a. What would the one-time cost be to implement forward funding at the Indian Health Service?

Answer. The IHS currently is reviewing the concept of advanced appropriations, which Congress provided the VA Medical Care accounts in 2009, and plans to consult with Tribes on this proposal during its Tribal budget formulation consultation process this fall.

Indian Health Service Strategic Plan

The last strategic plan for the Indian Health Service covers the years 2006 to 2011. While the plan for the Department of Health and Human Services contains some goals for the Indian Health Service, it is not a complete plan specific to providing health care to American Indians and Alaska Natives.

Question 6. Is the Indian Health Service planning to update its strategic plan?

Answer. Yes, the IHS will be updating its performance goals and data as part of the forthcoming HHS Strategic Plan.

The Indian Health Service (IHS) developed a Strategic Plan for the period 2006 through 2011, which aligned IHS strategic objectives, goals, and performance measures with those developed in the Department of Health and Human Services (DHHS) Strategic Plan. Since that time, the Affordable Care Act (ACA) was enacted and the Indian Health Care Improvement Act (IHCIA) was permanently reauthorized, changing the landscape of national health care delivery as well as health services specifically for American Indians and Alaska Natives. As required by the Government Performance and Results Modernization Act (GPRMA), HHS has been working to update its strategic plan with input from multiple Operating Divisions, including IHS.

Given the recent statutory changes and pending updates to the HHS Strategic Plan, IHS is now in a position to continue to be a part of the HHS Strategic Plan. IHS contributes performance goals and data to the current HHS Strategic Plan. In addition, IHS currently uses its four Agency priorities as a strategic framework to guide agency reform and improvement efforts. The Agency priorities are a set of simple, easy to remember goals that help guide agency work by all staff and our Tribal partners. The use of this strategic framework of four agency priorities has resulted in a clearer focus on areas for improvement as well as a simple framework against which improvements can be measured and communicated. IHS plans to work with HHS on use of the IHS Agency priorities framework once the HHS Strategic Plan is completed.

Question 6a. If yes, when will it be completed?

Answer. The HHS Strategic Plan update is occurring this year.

The Budget materials submitted by your agency note the devastation of diabetes on the Native American population and the fact that the frequency of diabetes in this population is more than double the national average. Breakthroughs in FDA-approved advanced wound therapies which are designed to help heal diabetic foot ulcers and venous leg ulcers and which are reimbursed by Medicare, most State Medicaid programs, and numerous private insurers.

Question 7. Does the IHS utilize such therapies in its medical facilities?

Answer. Yes, many IHS, Tribal, and Urban (I/T/U) health sites have comprehensive wound care programs that utilize advanced wound treatment therapies when needed. Even many smaller sites with less specialized staff utilize at least some of the newer treatment options and also refer patients to outside providers when the care required exceeds the local staff's expertise.

Question 8. What are the barriers that exist to using such therapies in the Indian Health Service?

Answer. Many of the advanced wound treatment therapies are very expensive, which can place a strain on local budgets. These therapies should also be used within a comprehensive wound treatment program, which can be difficult for smaller sites to build and maintain. In order to make wound care training and treatment protocols available to more I/T/U sites, IHS has established a Wound Healing Steering Committee, which is developing a plan for disseminating wound care best practices, training, and technical support to I/T/U sites across the country.

Oral Health

The IHS Division of Oral Health has an operating budget in fiscal year 2013 that operates with $160.4 million. And it appears that the agency employs eighteen-hundred dentists, dental hygienists and dental assistants who deliver comprehensive oral health services to over 1.9 million American Indian and Alaska Native people through a network of 250 dental facilities located in 35 states. At least 699 employees are Federal employees according to the FY 2014 budget justification document.

The IHS reported its dental vacancy rate was 26 percent in FY 2009 (reported in the FY 2012 IHS Congressional Justification). In FY 2013, the IHS Congressional Justification did not report its dental vacancy rate. On March 19, 2013, in a hearing before the House Interior Appropriations Subcommittee, the American Dental Association, testified that the dental vacancy rate in the IHS had been reduced significantly.

Question 9. How many Dentist positions are vacant within the IHS and Tribal Dental Health Programs?

Answer. As of July 10, 2013, there are 51 known vacancies of which 46 are available immediately. The 51 vacancies are for 50 dentists and 1 dental hygienist. The current list of immediate and future dental health care professional vacancies is available and updated daily at *www.ihs.gov/dentistry.*

Question 10. Is there a dental hygienist shortage?

Answer. Nationwide there is one dental hygienist vacancy at Barrow, AK. Relative to the documented periodontal disease in the AI/AN population, additional Dental Hygiene personnel could be utilized but staffing needs are determined by local facilities in the context of patient needs and available resources.

Question 11. During your term, how many permanent FTE positions within the Dental Health Program have been reclassified to locum tenens, part-time, or contract positions?

Answer. During my 4-year term, the number of dentist vacancies for full-time hires has decreased from approximately 140 dentist vacancies to the 50 vacancies that exist today. Successful recruitment of full-time oral health care providers has reduced the need for locum tenens, part-time, and contractors to provide interim coverage. The use of interim providers is a local management decision and would be tracked at that level.

The Indian Health Care Improvement Act supports the Dental Health Aide Therapist Program, a mid-level provider who has improved oral health treatment and prevention in Alaska. Currently, there are 17 States, including Washington, New Mexico and Kansas who have introduced legislation to expand the DHAT model in their states that could serve tribal communities and the mainstream population.

Question 12. What is your position with regard to expansion of this mid-level provider as a means address primary care shortages in oral health care?

Answer. The Agency position concerning oral health care shortages for the American Indian/Alaska Native (AI/AN) population is derived from our mission. Our mission is to raise the health of AI/ANs to the highest level. In order to achieve this mission, all options with regard to the delivery of oral health care must be considered, and evidence-based decisionmaking encouraged. Information about DHAT's and other options to increase access to oral health care can be provided by the IHS Division of Oral Health (DOH) to tribes interested in exploring options. The use of mid-level providers, if authorized by the State, is a local decision made based on resources, need, and consultation with local Tribes. Based on Tribal input so far, some Tribes are supportive and some Tribes would prefer hiring more dentists rather than use dental health aids or other mid-level providers. Remotely located facilities that have difficulty recruiting dental providers may be more interested than programs near urban areas that have less difficulty recruiting dentists and dental hygienists. Therefore, we would be willing to work on this issue with tribes that would support this practice in their respective areas, where authorized by the State.

Question 13. If tribes in Washington State step forward to offer the DHAT Model under Tribal Self-Determination contracts or Tribal Self-Governance compacts, would the Indian Health Service support this expanded and innovative approach to address workforce shortages?

Answer. The IHS supports evidence-based decisions with regard to the delivery of oral health care. Since all options are considered, information about DHATs and other options to increase access to oral health care can be provided by the IHS to those tribes expressing interest in exploring options. The use of dental health aids is authorized in the Indian Health Care Improvement Act if the authority exists in the state, so the decision rests with the Tribe that manages the dental program under a contract or compact with IHS.

Staffing of New Facilities

Many Indian tribes have an acute need for health care facilities as well as chronic staffing shortages. Though the Indian Health Care Improvement Act directs IHS to consult with Indian tribes and tribal organizations in addressing these needs, existing IHS facility construction programs, such as the Small Ambulatory or Joint Venture programs, are funded sporadically if at all. Many tribes have used their own tribal funds to finance and build new health facilities, but do not receive additional staffing packages for these facilities.

Question 14. What has the Indian Health Service done to address the unmet need for construction of health facilities?

Answer. Provisions of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 directed the Secretary to submit a Report to Congress that provides a comprehensive ranked list of the health care facility needs for the IHS and eligible Indian Tribes and Tribal organizations. Categories of congressionally identified facilities include inpatient, outpatient, and specialized health care facilities (such as long-term care, alcohol, and drug abuse treatment), wellness centers, staff quarters, and any necessary renovation and expansion needs. The IHS submitted an interim report to Congress by the deadline of March 2011. This report documents the current estimated need for health care facility construction, which

includes the $2.1 billion need on the current Health Care Facility Construction Priority list, and an additional $5 billion estimate for all other facility needs.

The IHS developed the Joint Venture (JV) and Small Ambulatory (SA) programs to help address the need for health facility construction beyond the IHS Health Care Facility Construction Priority List. These unique programs represent a partnership with Tribes in which the Tribe and IHS collaborate on the project. In the Joint Venture program, Tribes agree to fund the construction of the facility, and IHS agrees to request the staffing funding from Congress. In the Small Ambulatory Program, IHS contributes a portion of the funding for construction and the Tribes fund the rest of the construction.

Question 15. How specifically does the Indian Health Service plan to address staffing shortages in health care facilities?

Answer.

While the need for new and replacement facilities is significant, staffing shortages continue to be an issue for many facilities as well. IHS and Tribal facilities work to address these shortages at the local level through a number of strategies. Existing facilities can add staff as needed with funds from third party insurance reimbursement or other sources. Additional funding for staffing can also occur through program increases and the Indian Health Care Improvement Fund. Once positions are established, the local facilities work with the Area and Headquarters recruiters to immediately begin the process of filling those new vacant positions.

IHS has implemented actions at the national level to improve recruitment and retention of health care providers in the past few years, and vacancy rates have improved. IHS continues to develop strategies for nationwide use that have helped reduce vacancy rates for several provider groups in the last few years. We continue to develop recruitment and retention strategies that include virtual job fairs, scholarship counselors/mentors, targeting scientific national recruitment events to establish relationships early in discipline training, recruitment and retention plans for all areas, development of a lead tracking system, mentoring programs for health professions schools, a military transition campaign, expansion of the externship program with assigned recruiter/mentors while in training and in general to increase our presence during the education and training of health professionals. Our partnership with the Health Resources and Services Administration (HRSA) National Health Service Corps has resulted in the addition of over 300 new health care providers in IHS, Tribal and urban Indian health programs since 2009. IHS has also focused loan repayment awards and improvements in pay authorities and salaries for providers with high vacancies. For example, focused efforts to recruit dentists over the last few years have reduced the vacancy rates for IHS from 35 percent to 10 percent. IHS reform efforts are also based on input from IHS staff and recommendations are being implemented to improve the overall business practices of the agency and improve the workplace conditions for staff, which will also help with retention.

For new and replacements facilities, the Administration requests from Congress funding at 85 percent of need in the President's annual budget proposal. These new or replacement facilities were built either with federal funds or Tribal funds through the Joint Venture program. Requested staffing is based on the Resources Requirements Methodology (RRM), an IHS staffing tool that projects staffing needs based on population, workload and services. The funding that IHS requests is usually for staff needed in addition to current staff since most construction is for replacement of existing facilities. Staffing requests are based on the estimated date of beneficial occupancy.

Question 16. Has the Indian Health Service made reports on health facilities and staffing shortages publicly available?

Answer. Yes, the Initial Report to Congress referenced above in response to question #1 is posted on the IHS website at *http://www.ihs.gov/newsroom/reportstocongress/*. The IHS regularly reports on vacancy rates for health care providers system-wide in its Congressional Justification for the President's Budget Proposal and in testimony to Congress.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO HON. YVETTE ROUBIDEAUX

Health Professions

According to recent Indian Health Service information, there are 15,600 employees, including 3,500 nurses, 900 physicians, 400 engineers, 600 pharmacists, 300

dentists, and 300 sanitarians. However, as of March, 2013, the Indian Health Service reports that there are still over 1,550 health care professional vacancies.

The Indian Health Service FY 2014 Justification of Estimates for Appropriations Committees noted that the National Health Service Corp had placed 305 clinicians/providers in Indian health programs to assist in reducing the number of vacancies within the Indian health system. This Justification further noted that the high vacancy rates for many provider groups may have significant negative impacts on access to care as well as the ability to achieve performance targets.

Question 1. What has been the most effective means of addressing the health care professional shortage in the Indian health system?

Answer. We use a multi-factored approach to recruitment and retention of health professionals. Both the IHS Loan Repayment Program and the National Health Service Corps Loan Repayment Program are effective means of addressing health care professional shortages. We continue to develop additional systems and tools for use at the local levels to decrease the shortages.

Question 1a. What is the length of the placement for these clinicians/providers?

Answer. According to the most recent retention data available, the average IHS Loan Repayment Program recipient stays with an Indian health program an additional 4.9 years beyond the obligated service period. Both the IHS and the National Health Service Corps Loan Repayment Program support requires an initial two-year service obligation that may be renewed on an annual basis if qualifying educational loan balances remain.

Question 1b. How have these placements reduced vacancies and for what positions?

Answer. Information is provided in the table below on the outcomes of all IHS improvements in recruitment and retention strategies since 2011.

	IHS Vacancy Rate		Turnover Rate	
	2011	April 2013	2011	April 2013
Physician	24%	20%	29%*	18%*
Pharmacist	6%	4.3%	Data Unavailable	4.3%**
Nurse	16%	15%	4%***	1%***
Advanced Practice Nurse	20%	14%	4%***	1%***
Dentist	12%	10%	Data Unavailable	Data Unavailable

* Rate calculated in the Physician Position Report includes I/T/U sites
** Data provided by Pharmacy
*** Rates calculated in the Nurse Position Report includes I/T/U sites

Question 1c. How have those remaining vacancies among the provider groups impacted the access to care and the achievement of performance targets? IHS Vacancy Rate Turnover Rate 2011 April 2013 2011 April 2013

Answer. Vacancy rates across the health care profession disciplines continue to impact the access to care for American Indian/Alaska Natives, necessitating the use of locum tenens providers onsite or Contract Health Services to purchase care from the private sector. The contract health service (CHS) program serves a critical role in addressing the health care needs of Indian people. When an IHS facility is unable to provide the care needed by patients, local facilities are able to purchase this care from local providers.

Staffing levels are one factor that impacts achievements of performance targets, and enhanced management focus, increased accountability, and additional funding also influence performance. In the context of funding increases during the past few years and declining vacancy rates, the Indian Health Service has met or exceeded virtually all of its clinical performance measures in 2011 and 2012. In 2012, three measures did not meet targets: Poor Glycemic Control, Childhood Immunizations, and Pap Screening. The Childhood Immunization measure did not meet the 2012 target, but its performance increased by 0.9 percent over 2011. Due to changing standards of care, the Pap Screen element and Poor Glycemic Control element were not met but are continuing to be addressed. IHS improvements in access to care include increasing provider visits through telebehavioral health visits and other telemedicine services including teleradiology and Joslin Vision Network diabetic retinopathy screening services. Telemedicine services help to optimize access to care while recruitment and retention efforts continue. Contract Health Service funding has also helped improve performance measures for receipt of services that depend on referrals to the private sector, such as mammograms and colonoscopies.

Question 2. Please identify the positions and numbers for the remaining vacancies among health and dental care professionals, including physicians, nursing profes-

sionals (including nurse practitioners, SANEs, etc.), pharmacists, radiologists and technicians, dentists, dental hygienists, psychiatrists and other behavioral health professionals.

Answer. IHS Headquarters tracks vacancy information for the following health disciplines in its federal programs system-wide—with FY 2013 data on the absolute number of current vacancies presented below:

Physicians—581
Nurse—587
Pharmacists—31
Dentists—48

Answer. shown in the table above, these numbers are improved over past vacancy numbers.

Information for the other health care disciplines is tracked at the Area and local levels. The data system currently used for tracking health disciplines is being improved to allow IHS Headquarters to track vacant positions for all health care disciplines electronically. The necessary system changes will be implemented in FY 2014.

Question 3. Besides reducing hiring delays and the time for processing employment applications, what is your plan for reducing the other 1,550 vacancies within the Indian health system?

Answer. IHS continues to develop strategies for nationwide use that have helped reduce vacancy rates for several provider groups in the last few years. We continue to develop recruitment and retention strategies that include virtual job fairs, scholarship counselors/mentors, targeting scientific national recruitment events to establish relationships early in discipline training, recruitment and retention plans for all areas, development of a lead tracking system, mentoring programs for health professions schools, a military transition campaign, expansion of the externship program with assigned recruiter/mentors while in training and in general to increase our presence during the education and training of health professionals. Our partnership with the Health Resources and Services Administration (HRSA) National Health Service Corps has resulted in the addition of over 300 new health care providers in IHS, Tribal and urban Indian health programs since 2009. IHS has also focused loan repayment awards and improvements in pay authorities and salaries for providers with high vacancies. For example, focused efforts to recruit dentists over the last few years have reduced the vacancy rates for IHS from 35 percent to 10 percent. IHS reform efforts are also based on input from IHS staff and recommendations are being implemented to improve the overall business practices of the agency and improve the workplace conditions for staff, which will also help with retention.

Question 4. How many of these vacancies are being filled by locum tenens or contract providers?

Answer. While vacancies for priority health care providers are tracked at the national level, information on the source of providers filling those vacancies (locum tenens) is a local service unit management decision. There is considerable variability in the local conditions and priorities necessitating the choice to use locum tenens to provide health care, including location, funding, and other recruitment considerations and challenges. The use of locum tenens could be brief, such as for one shift or day, or could be for longer periods of time such as weeks or months depending on local staffing issues. IHS does not manage these positions on a national level, as service units employ resources as local conditions dictate, and fluctuate. In order to reduce the need for locum tenens, IHS encourages local sites to proactively assess their turnover and potential vacancies and efforts to reduce hiring times and make the hiring process more efficient.

Question 5. What have been the costs and length of using these locum tenens or contract providers?

Answer. IHS obligated approximately $169.7 million in FY 2012 for contract providers. This amount includes locum tenens as well as other services such as part-time specialists. This was a 4 percent increase from FY 2011, a change that may be due to increased rates or increased frequency of use. The burdened labor rates and individual contract performance periods vary by discipline and location but the overall requirement for contracted medical professional support has been relatively constant.

Question 6. What would have been the costs if these positions had been filled by permanent employees rather than locum tenens or contract providers?

Answer. The cost, if the positions were filled with permanent providers, depends on the specific type of provider. For example, physicians would be more costly than

nurses, especially for specialists who are used on a short-term basis. In general, filling vacancies is more cost effective than hiring locum tenens, and IHS facilities are encouraged to hire providers rather than use locum tenens contracts if at all possible.

Question 7. What data do you have regarding the staffing needs by Service Unit?

Answer. The current reporting system provides information by discipline and specialty for the Area, rather than by Service Unit. Specific Service Unit information is incorporated throughout the report by discipline and specialty. For example, below is the most current summary from the Physician Position Report by Area.

Physician Position Report

Combined IHS/Tribal/Urban Facilities—July 2013

Area	Total Positions Allocated	Total Positions Filled	Total Positions Vacant	Total Accessions	Total Separations	Vacancy Rate	Turnover Rate
ABERDEEN	16	11	5	1	2	31%	18%
ALASKA	135	107	28	1	3	21%	3%
ALBUQUERQUE	74	56	18	1	0 24%	0%	
BEMIDJI	64	52	12	4	0	19%	0%
BILLINGS	44	27	17	2	0	39%	0%
CALIFORNIA	25	20	5	1	0	20%	0%
NASHVILLE						N/A	N/A
NAVAJO	52	38	14	5	1	27%	3%
OKLAHOMA	217	176	41	7	4	19%	2%
PHOENIX	128	99	29	8	2	23%	2%
PORTLAND	12	12	0	0	0	0%	0%
TUCSON						N/A	N/A

Question 8. How will you include staffing needs in the health status and resource deficiency report required by the Indian Health Care Improvement Act?

Answer. Across the range of IHS facilities and programs, the high degree of variation in clinical staffing limits its ability to serve as a useful measure in assessing health status and resource deficiency. A more general methodology, related to the Indian Health Care Improvement Fund, encompasses variations in IHS and tribally operated programs and assesses facility resource deficiencies more broadly compared to the Federal Employees Health Benefits program benchmark. Furthermore, assessment using clinical staffing as a measure is limited because local programs determine how to allocate these funds based on their highest priorities, which may include other needs.

According to the Indian Health Service FY 2014 Justification of Estimates for Appropriations Committees, the Health Professions Scholarship Program and the Loan Repayment Program play "a significant role" in the recruitment and retention of healthcare professionals at Indian health facilities.

Question 9. What enforcement mechanisms are in place to ensure that physicians participating in these programs serve their full, obligated time periods at Indian health facilities?

Answer. For the IHS Loan Repayment Program, obligated clinicians are required to provide proof of employment in an approved program prior to receiving an award. Proof of approved employment is also required for any subsequent release of funds. For the IHS Health Professions Scholarship Program, improvements have been implemented in tracking and monitoring the progress of students in school and their successful placement in a site for their service obligation. An annual status report is required of each participant by the IHS Health Professions Scholarship Program to monitor service related to their obligation. Physicians who fail to satisfy service requirements may be recommended by IHS for default proceedings. IHS has improved its tracking and consistent application of requirements for service obligations in both programs over the past few years. The total number of individuals who defaulted from the IHS health professions programs with a service obligation has decreased from 75 in 2008 to 13 reported to date for 2012.

Question 10. Has the Indian Health Service performed any assessment to measure the success of these programs at increasing retention, including the completion rates of the service commitment for these scholarship and loan recipients?

Answer. Yes, there have been retention studies done in the past for both the Loan Repayment and Scholarship Programs. The most recent study, performed in 2008, shows that the average loan repayment clinician remains employed for 4.9 years

after the end of the service obligation while IHS scholarship recipients remain an average of 3.7 years. In order to be able to track retention of obligated clinicians on an annual basis, a new module is currently in development for the Loan Repayment Program database. This will be implemented by the end of FY 2013.

Question 11. Please explain in detail how the Indian Health Service determines which Areas or Service Units will receive health care professionals serving their commitments under these programs?

Answer. Headquarters Recruiters assist the Scholarship and Loan Repayment Specialists in placing obligated clinicians. IHS uses a multi-factored approach that takes into account the candidate's preference for returning to her own Tribe to serve if she is American Indian, the Site Priority score/Health Professions Shortage Area (HPSA) score for sites with vacancies, the Director's designated "high need" areas, availability of vacancies in a particular area and candidate's preference among available high priority or need sites.

Question 12. If need is not taken into account in placing these professionals, please explain why.

Answer. Placement of Indian Health Service obligated scholars is always initiated with IHS priorities and Tribal health program needs in mind. IHS maintains updated lists of sites according to their level of need based on scoring for each program.

The President's Budget Request for FY 2014 proposes spending over $3.5 million for only 3 university programs to increase the number of Indian health professionals, most notably in the fields of nursing, medicine, and psychology.

Question 13. How can you expand these programs to other universities that devise innovative and collaborative approaches, working with either regional or national educational institutions, to address the health care personnel shortages in Indian Country?

Answer. The three programs (Indians Into Medicine, Indians Into Nursing, and Indians Into Psychology) were created as a result of past congressional earmarks; IHS estimates that among the three programs, 11 grants will be awarded. Funding availability is dependent on appropriations, and all universities have the opportunity to compete for funding when the project periods end for current grant programs. IHS plans to increase awareness of the programs by encouraging the funded universities to share successes with other similar programs and by broadening competition for grant awards through better dissemination of funding announcements.

Health Information Technology

One Indian Health Service goal is to improve health care through meaningful use of health information technology. A key outcome indicator for meeting this goal relates to incentive payments from the Centers for Medicare and Medicaid Services.

Answer. of February, 2013, Indian health care facilities received incentive payments as follows: twenty Indian Health Service hospitals received a total of $24 million, six tribal hospitals received $10 million, other Indian Health Service facilities received a total of $6.4 million for their eligible providers attesting to meaningful use, and other tribal facilities received a total of $10.1 million for their eligible providers. Monthly internal meetings are held to review progress and incentive payments received.

Question 14. How have the health status levels of Indian people been improved through this meaningful use?

Answer. The Meaningful Use incentive programs have only been in existence for two years, so it is still too early to attribute specific improvements in health status or outcomes directly to the incentives. However, the Indian Health Service has been an early adopter of health information technology (HIT) for decades, and all IHS facilities implemented the Resource and Patient Management System (RPMS) Electronic Health Record (EHR) by 2008, well before Meaningful Use became a national priority. HIT is deeply integrated into all clinical, quality, and performance activities in IHS, and as such it is difficult to separate the impact of the technology from the impact of the program innovations on the overall improvements in health care and outcomes. However, during their initial transitions to the RPMS EHR in 2004 and 2005, many sites reported increases in screening rates, reductions in waiting times, and other indicators of improved care. One Tribal hospital received the Health Information Management Systems Society (HIMSS) Davies Award for its use of the RPMS EHR to improve patient care services. Meaningful use of electronic records in general promotes improvements in the quality of care and the ability to measure those improvements.

The EHR serves as the platform to organize, document, measure and promote quality improvement activities. Most notably, the enhanced use of IHS EHR played

a role in helping IHS meet all of its clinical GPRA performance measures in 2011 and all the measures in 2012 that had stable baselines and definitions through the use of reminders, registries, and the ability to monitor performance on a regular basis. Other factors have contributed as well, such as increased performance accountability and enhanced management focus.

Question 15. Please describe the health information capabilities of the Indian Health Service facilities which employ this meaningful use of health information technology.

Answer. The IHS Resource and Patient Management System (RPMS) is a comprehensive health information suite that includes clinical, population and public health, and practice management capabilities. The RPMS Electronic Health Record (EHR) is the only federal government EHR that is certified for Meaningful Use. RPMS is based on the VistA system used by the Veterans Health Administration, but with numerous adaptations and enhancements to accommodate the clinical and business needs of the IHS. RPMS provides access to patient information at the point of care, clinical reminders and decision support, order checks for allergies and drug interactions, consultation and referral support, on-demand quality and performance reporting, population views, and revenue cycle applications. In 2014, IHS will be launching health information exchange capabilities and a personal health record portal for patients.

Question 16. How are you assisting those Indian Health Service facilities that are not currently eligible for incentive payments to improve their capabilities and eligibility to receive incentive payments?

Answer. All Indian Health Service hospitals are eligible for at least one of the Meaningful Use incentive programs, and most IHS providers meet the criteria for eligibility under the Medicare or Medicaid programs. Each IHS Area Office has a designated Meaningful Use Coordinator, and the IHS Office of Information Technology funds several consultants who work with the Areas to promote understanding of the Meaningful Use programs and to share information directly with the Areas and Service Units as well as through the IHS website. In addition, the IHS works closely with the National Indian Health Board (NIHB) Regional Extension Center (REC), which is funded by the Office of the National Coordinator for Health Information Technology (ONC) to assist Eligible Providers across Indian country to be successful in the Meaningful Use initiative.

Question 17. Are the Wind River Indian clinics and providers eligible for incentive payments?

Answer. Yes, there are 19 providers at the Wind River Service Unit who meet the CMS criteria for eligibility for the Meaningful Use incentive programs. To date, 17 of these providers have registered with CMS; the other two are new and have not yet registered.

Question 17a. If so, how much did they receive in incentive payments?

Answer. To date the Fort Washakie and Arapahoe health centers have received $191,250 on behalf of Eligible Providers working at those facilities from the Montana State Medicaid Program.

Question 17b. If not, what are you doing to improve their capabilities and eligibility for incentive payments?

Answer. IHS and the NIHB REC are working with the providers at this site to help them to take the steps they need to receive payments for those facilities and to meet the requirements for Meaningful Use.

Life Expectancy

According to the Indian Health Service, the average life expectancy at birth for Indian people is 72.5 years compared to the United States all race life expectancy of 77.5 years. However, the average age at death on the Wind River Indian Reservation has hovered around 49 years.

Question 18. To what causes are these early deaths on the Wind River Indian Reservation attributable?

Answer. The information is summarized below.

Indian Health Service, Billings Area—Wind River Service Unit

Leading Causes of Death—Years 2005–2007

Cause of Death	Death Rate
Unintentional Injuries	161.8
Malignant Neoplasm	90.7

Indian Health Service, Billings Area—Wind River Service Unit—Continued

Leading Causes of Death—Years 2005–2007

Cause of Death	Death Rate
Chronic Liver Disease and Cirrhosis	78.9
Diseases of the Heart	78.9
Diabetes	55.2
Suicide	51.3
Cerebrovascular Disease	23.7
Homicide	19.7
Chronic Lower Respiratory Diseases	19.7
Pnuemonia and Influenza	19.7

NOTE: Death rates are NOT adjusted for misclassification of AIAN race on the state death certificates. Indian Health Service has adjustment factors to the Area level not the service unit level.
Indian Health Service, Demographic Statistics Division—prepared: June 27, 2013.

The chart above provides crude death rates (per 100,000 population) for the Wind River Reservation's IHS Service Unit of the same name. Unintentional injuries (161.8/100,000) have the highest rate of death of any single cause, exceeding cancers (malignant neoplasm) at 90.7/100,000 and at 78.9/100,000 for chronic liver disease/cirrhosis and diseases of the heart. This pattern of mortality is different from the IHS national statistics because unintentional injuries are the third overall cause of death.

Question 19. What specific efforts are underway by the Indian Health Service to improve the life expectancy of Indian people on the Wind River Indian Reservation?

Answer. A number of services, programs and initiatives are provided across the Indian health system including clinical care, prevention including injury prevention, health education, screening, immunizations, public health and environmental support services, and community outreach. Key to our successes are tribal partnerships and interagency collaborations.

Given that unintentional injuries are the leading cause of death for the Wind River Service Unit, Injury Prevention services are provided and prioritized locally at the Wind River Reservation. The Eastern Shoshone tribe (Ft. Washakie Health Center) is a direct service tribe with Injury Prevention services provided through the IHS Environmental Health program. FY 2013 funding for Injury Prevention projects to the tribe totaled approximately $5,400. Services provided include rabies control clinics, bicycle rodeos/safety clinics, and car seat clinics. Northern Arapahoe Nation (Arapahoe Health Center) is an ISDEAA 638 contracted tribe which includes among the services they provide Environmental Health and Injury Prevention services. FY 2013 funding for Injury Prevention projects to the tribe totaled approximately $11,000.

The Indian Health Service FY 2014 Justification of Estimates for Appropriations Committees states that unintentional injury mortality rates, those who died by accidents, is an overarching performance measure for the Indian Health Service.

The most current age-adjusted, unintentional injury mortality rate, for calendar years 2005–2007, was 94.8 per 100,000 population. According to this Justification, even though the unintentional injury mortality rate has declined over the years, the Indian rate in the Indian Health Service Area is 2.4 times that of US all races.

Question 20. Please identify the unintentional injury mortality rates for each Indian Health Service Area and for the Wind River Indian Reservation.

Answer. In Calendar Year (CY) 2004–2006, the age-adjusted unintentional injury rate for the overall IHS service area population was 93.8 per 100,000 population. The AI/AN rate was 2.4 times higher than the U.S. all-races rate of 39.1 for CY 2005. The Billings Area has an age-adjusted unintentional injury rate of 126.3 per 100,000 population, and it ranks third highest after the Navajo (126.4) and Aberdeen (162.7) Areas. The Wind River Service Unit is part of the Billings Area. In CY 2005–2007, the most recent data available to IHS, the age-adjusted unintentional injury mortality rate was 176.2 per 100,000 population in Wind River Service Unit.

Question 21. What do you think are the primary causes of these rates for Indian Country and the Wind River Indian Reservation, specifically?

Answer. The primary cause of these high rates is Motor Vehicle Crashes, which occur in the Wind River Indian Reservation at an age-adjusted rate of 54.4 per 100,000 population (CY 2005–2007, most recent available to IHS). All other unintentional injuries were 121.8/100,000, of which the highest single category was accidental poisoning and exposure with a rate of 35.1/100,000. The chart below shows further details:

Indian Health Service, Billings Area—Wind River Service Unit

Unintentional Injuries aside from Motor Vehicle—Years 2005–2007

Cause of Death	Death Rate
Unintentional Injuries	176.2
Transport Accidents	104.5
Motor Vehicles	54.4
Other Land Transport	5
Water, Air, and Space	0
NonTransport Accidents	71.7
Falls	11.8
Accidental Discharge of Firearms	0
Accidental Drowning/Submersion	3.9
Accidental Exposure to Smoke, Fire	0
Accidental Poisoning and Exposure	35.1
Other and unspecified transport	20.6

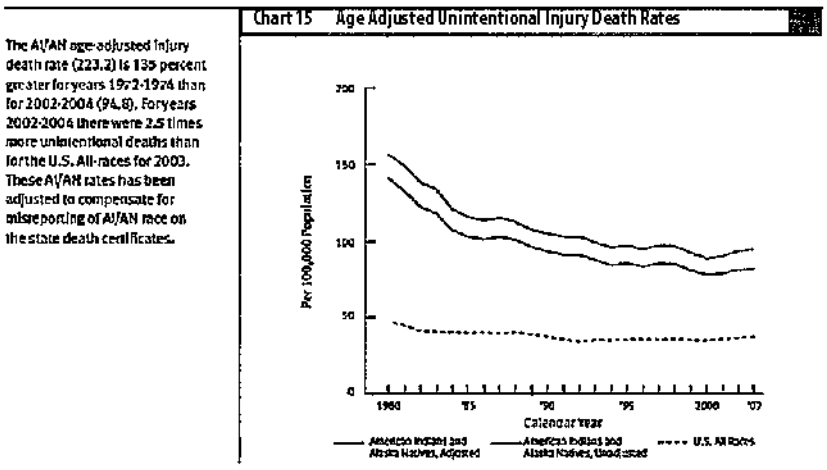
NOTE: Death rates are NOT adjusted for misclassification of AIAN race on the state death certificates. Indian Health Service has adjustment factors to the Area level not the service unit level.
Indian Health Service, Demographic Statistics Division—prepared: June 28, 2013.

Question 22. Please describe those overarching performance measures for the unintentional injury mortality rates.

Answer. There are two performance or budget measures being tracked for unintentional injuries: injury interventions and overall unintentional injury fatality rate.

The current national Injury Intervention measure focuses on Tribal Injury Prevention Cooperative Agreement Sites increasing seatbelt use rates by 5 percentage points. Baseline seatbelt use was measured in 2011 (at 33 sites in 7 Areas) revealing a usage rate of 57 percent. This measure will be re-evaluated in 2014.

The second measure tracks overall unintentional injury mortality with the understanding that, over time, activities of the IHS Injury Prevention Program will reduce the rate. The most current evaluation is given below.



Source: Indian Health Focus: Injuries, 2002-2003 Edition, U.S. Department of Health and Human Services, Indian Health Service, Rockville, MD.

Question 23. Please describe what specific activities or services the Indian Health Service provides or funds to meet these performance measures.

Answer. The IHS Injury Prevention Program is multi-faceted in it approach to meeting its mission "to decrease the incidence of severe injuries and death to the lowest level possible and increase the ability of Tribes to prevent injuries within their communities." Efforts to accomplish this are focused in three approaches: injury prevention capacity-building at the tribal level through cooperative agreements, developing competent injury prevention practitioners within tribes and IHS through training and competency development, and supporting special projects at the Area,

Service Unit and tribal levels. Since 1997, the Indian Health Service has awarded a total of more than $22 million in cooperative agreement grants to 91 tribal/urban/non-profit American Indian and Alaska Native organizations. The IHS Injury Prevention Program's Tribal Cooperative Agreement Program promotes capacity-building within Tribes and communities through training, local implementation of evidence-based strategies for prevention, and technical assistance.

To train practitioners in American Indian and Alaska Native communities, the IHS Injury Prevention Program has developed a series of core training courses and a 12-month advanced Fellowship training program. Since its inception in 1982, more than 800 tribal and IHS personnel have participated in the Fellowship program.

These efforts are supplemented by Health Promotion and Head Start activities that encourage seat belt use, child safety seats, bicycle helmets, and alcohol and substance use avoidance.

The 2011 Indian Health Service Report to Congress *"Making Progress Toward a Healthier Future"* for the Special Diabetes Program for Indians noted that many Indian diabetes programs link individuals with local social service programs to assist in addressing other stressors, such as depression and substance abuse, that impact a person's ability to care for their diabetes. Such collaborations are important in improving health status levels of Indian people.

Question 24. What other collaborations has the Indian Health Service developed with other Federal or local agencies, such as with the Department of Transportation, to address safety measures which may reduce the number of unintentional injuries in Indian Country?

Answer. Unintentional injuries account for more years of potential life loss (approximately 30 percent) than the next four causes combined (Suicide, Heart Disease, Malignant Neoplasms, Homicide, totaling approximately 28 percent). For almost thirty years, the Injury Prevention Program has worked closely with tribes and other partners to reduce the disproportionate impact of injuries on Indian people. The Injury Prevention Program facilitates capacity building of tribes and communities by increasing understanding about the injury problem, sharing effective strategies, and assisting communities in implementing prevention programs. Community-based injury prevention coalitions directed by tribal members and supported by tribal governments is a key prevention strategy. The effectiveness of the Injury Prevention Program is routinely monitored by IHS through performance and budget measures and is evidenced in the reduction of unintentional injury death rates by 58 percent since 1980. A key to the program's effectiveness is developing and maintaining strong injury prevention partnerships with Tribal programs, Tribal communities, other Federal agencies, and many others continues to be a focus of the IHS Injury Prevention Program. A few of the many partnerships are detailed below.

One good example is the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) that was established in 1997. This program funds tribal capacity development in injury prevention through competitive cooperative agreements. Since 1997, IHS has funded 91 Tribal organizations for a total of more than $22 million. Successes achieved through these partnership agreements include the Navajo Nation Highway Safety Program that was able to decrease motor vehicle-related fatalities by 65 percent, increase seatbelt use by 40 percent, and decrease motor vehicle-related injury hospitalization rates by 28 percent since the enactment and enforcement of seatbelt laws. The Sisseton-Wapheton Oyate Injury Prevention Program worked with the Tribe that implemented a primary occupant restraint law that allowed police to pull vehicles over and ticket drivers solely because occupants were not wearing seatbelts, increased seatbelt use from 25 percent to 45 percent within one year, and introduced a Victims' Impact Panel into the Tribal court system. The San Carlos Apache Tribe incorporated a media campaign, sobriety checkpoints, enhanced police enforcement, and local community events that resulted in a 30 percent decrease in the number of motor vehicle-related crashes involving injuries and/or fatalities.

Another example is the Ride Safe Program that IHS has conducted since 2002 with the primary goal to help tribal communities address motor vehicle injuries among AI/AN children ages 3 to 5 by promoting correct use of motor vehicle child safety seats among children and families participating in Region XI AI/AN Head Start programs. IHS has worked closely with the Administration for Children and Families (ACF), the National Highway Traffic Safety Administration (NHTSA), and the Health Resources Services Administration (HRSA) to conduct this program. More than 50 Head Start programs have received more than 10,000 child safety seats. The Ride Safe Program encourages Head Start Programs to develop partnerships with programs such as National and State Safe Kids, State Highway Patrols, State Transportation Departments, Tribal Health Departments, Police Departments, and Tribal Injury Prevention Programs.

A final example is IHS's work with the Bureau of Indian Affairs and NHTSA starting in 1993 to coordinate a systematic approach to implement successful strategies that reduce motor vehicle-related injuries and deaths. These collaborative efforts have produced a number of highway safety initiatives including the *None for the Road Campaign*, a video and resource directory on how to implement a DUI prevention program, and an inventory of Tribal traffic laws.

Facilities

According to the Indian Health Service FY 2014 Justification of Estimates for Appropriations Committees, third party reimbursements, such as from Medicare, Medicaid, and private insurance, are used for many expenses associated with the delivery of health care services such as personnel, transportation, supplies, equipment, land and structures, and other contractual services.

Question 25. Do you support the use of third party reimbursements for health care facility construction and replacement?

Answer. Current appropriations law allows IHS to use Medicare and Medicaid collections to achieve compliance with the requirements of titles XVIII and XIX of the Social Security Act. These collections cannot be used for planning, design or construction of new facilities but can be used for compliance at existing facilities. However, third-party collections can and have been used for smaller repair-by-replacement projects when it was more economical to replace an old building than do complete renovations. Specific collections-related construction decisions are made at the local level with technical assistance provided by IHS headquarters.

Question 25a. If so, how much has been used for such construction and replacement?

Answer. The IHS does not maintain a system-wide summary of the total use of third party reimbursements for construction or replacement; however, examples of recent projects funded by third party reimbursements in progress or complete include:

Laguna, NM dental building, $950,000
Santa Fe, NM Outpatient Renovation, $1,500,000
San Xavier, AZ Modular for AMB and Finance $465,000
Sells, AZ HVAC Replacement $1,300,000
Sells, AZ CT building $300,000
Sells, AZ Modular Office $550,000
Sells, AZ Lab Expansion $1,000,000
Sells, AZ Move Emergency Department $1,200,000
Santa Rosa, AZ interior space $600,000
Chinle, AZ Expansion Project $14,300,000
Many Farms, AZ Dental OEHE Building $2,000,000
Gallup, AZ OEHE Building $400,000
Pinon, AZ Planning for Expansion $125,000
Crownpoint, AZ $175,000
Gallup, AZ Emergency Department Planning $175,000
Chemawa, OR Modernization $38,000
Omak, WA Remodel $55,000
Colville, WA Dental $970,000
Yakama, WA New Building $1,730,000
Red Lake, MN Expansion/Renovation $4,650,000
Cass Lake, MN Expansion $818,000
White Earth, MN Parking Lot expansions $153,000

Note: Facilities that are managed by a tribe or health organization under the PL 93–638 authority may spend up to $1 million dollars of Medicare & Medicaid funding without notifying IHS.

The joint venture construction program assists in increasing available facilities for health care services whereby Indian tribes construct a health facility and the Indian Health Service provides for staffing and operations. Between FY 2001 and FY 2012, seventeen joint venture projects were initiated and nine have been completed.

Question 26. Please describe the factors that were used to evaluate and award these seventeen agreements.

Answer. Currently, fourteen projects have been completed. The evaluation and selection process for the Joint Venture Construction Program (JVCP) consists of two parts: pre-application, and final application.

Pre-application is an objective filter used to determine if the proposed project is eligible for consideration and has the potential for successful competitive selection

under the JVCP in compliance with the authorizing legislation, as amended. The factors considered in pre-application are needs-based:

1. *Size Deficiency:* The number of people to be served by the proposed facility is used to estimate the required size for a standard facility. This size is compared to the size of the existing facility, and a rating of the deficit is determined. The more deficient, the greater the need.

2. *Cost to Repair vs. Cost to Replace:* An assessment of the necessary repairs to the existing facility is prepared, and the overall cost to correct all deficiencies is compared to an estimated cost to replace the facility. This determines the facility's Condition Factor. The higher the condition factor, the greater the need.

3. *Distance to Emergency Care:* The population to be served by the proposed facility is looked at to determine the urgency service based on overall distance from the nearest Level I, II, or III Emergency Room. The farther from service, the greater the need.

4. *Tribally Provided Initial Equipment:* Additional points are given to tribes who opt to provide the initial startup equipment at their own expense rather than have that cost included in the request to Congress.

Tribes that achieve the top rankings for projects in the pre-application part of the application process will be asked to complete and submit final applications.

During the final application, applicants provide documentation of their administrative and financial capabilities to accomplish the proposed JVCP project. An evaluation panel reviews the final application packages to establish a ranking of applications. This part of the process only ranks the final applications and no eliminations happen at this phase.

The application process for the JVCP program was implemented a number of years ago following consultation with the tribes.

Question 27. How does current facility age factor into this evaluation and awarding of agreements?

Answer. The current facility age indirectly affects the factors in the pre-application provided above in factor 2, Cost to Repair vs. Cost to Replace.

Existing facility construction programs may not address all of the health care facilities needs in Indian Country. Several Indian tribes applying for the joint venture program were not awarded, despite their significant needs. In some cases, Indian tribes must build their own facilities but may not receive any staffing assistance from the Indian Health Service.

Recognizing the substantial health care facilities needs and challenges in meeting those needs, Congress enacted amendments to the *Indian Health Care Improvement Act* for the development of innovative approaches to address those needs, including the establishment of an area distribution fund and other approaches the Secretary determines appropriate.

Question 28. What innovative approaches, as contemplated by the *Indian Health Care Improvement Act*, have been developed or are being developed?

Answer. A few recent examples of innovative approaches IHS and Tribes have used to address facility needs include the following:

- The IHS-Tribal project at Arapahoe Health Center, Arapahoe, WY involved the expansion and renovation of the existing facility that was funded using a combination of a HUD Indian Community Development Block Grant (ICDBG) grant, IHS Maintenance & Improvement funds, and third party collections.
- IHS collaborated with the Alaska Native Tribal Health Corporation (ANTHC) to transfer 2.79 acres of land at Alaska Native Medical Center for two major construction projects. The first project is an Intermodal Bus/Parking Facility that uses a combination of Federal Transit Administration grant and ANTHC funding. The second project will construct new short-term patient housing on the campus using $35 million in funding from the State of Alaska.
- IHS assisted the Winslow Indian Health Care Center (WIHCC) Tribal Health Corporation with their planned Tribal project for a new $14 million Medical Office Building at Winslow, AZ. The action was accomplished using the new authorities granted by the IHCIA reauthorization (Section 145) that authorized the transfer of funds, equipment or other supplies from any source, including federal or state agencies, to HHS for use in construction or operation of Indian health care or sanitation facilities.

Question 29. Should these health care facilities built by tribes be included in determining the allocations for staffing funds for facilities? If so, how? If not, why not?

Answer. Currently, only IHS funded health facility construction and Tribally funded Joint Venture program construction are considered for requests to Congress for new/additional staffing and operating costs. If facilities that are constructed using other sources of funding or other mechanisms are considered for funding, Tribal consultation would likely be appropriate, and determinations of any allocations for staff funding should be consistent with current processes in place for other authorized programs. If additional programs are authorized then the comparable need for facilities and services should be considered. These needs must also be balanced where there are unmet needs in existing tribal and federal facilities.

Contract Health Services

In June, 2012, the Government Accountability Office issued a report entitled *"Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program,"* Report No. GAO–12–446, and found that, among other things, the funding of contract health services was not based on need. In addition, the Aberdeen Area investigation, Report of Chairman Byron L. Dorgan, *"In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area"*, dated December 28, 2010, also found surpluses in contract health service funding at certain facilities.

Question 30. If the funding is not based on need, then how can you ensure that the funding is being appropriately distributed among the Indian health facilities and that there are no surpluses?

Answer. Funding for each Service Unit does take into account local need and the possibility of surplus is remote.

The IHS allocates Contract Health Services (CHS) appropriations among local IHS and Tribally operated programs in two parts: base funding and any increased/expanded CHS funding received in a particular fiscal year. The base funding is recurring to the Service Unit each year, and the increases can occur as a part of current services increases or program funding increases. First, CHS funding can be increased by adding current services amounts such as inflation or population growth to the base amount to help maintain existing levels of services by issuing an allowance to each local program in their current services "base." Second, that portion of funds appropriated to increase or expand CHS program services—beyond services available with base funds—are issued in an allowance among the local programs by a formula that measures their needs in three ways: (1) need that is proportionate to the counts of AI/ANs served by the local program; (2) need that is proportionate to cost of medical care prevailing in their area; and (3) need that measures discrepant access to IHS and Tribally operated hospitals. The effect of the formula is to expand CHS services among IHS and Tribally operated programs in proportion to their local needs if the appropriation for that year includes a program increase.

The CHS base funds are only partially sufficient to fund the total need for referrals to the private sector. This resource gap often forces the local service unit to limit funding of services to only those of life or limb threatening (medical priority I) per CHS regulations. The medical priority restriction imposed by each IHS or Tribal facility is a balancing act throughout a year. The medical priorities funded may be expanded during periods when local demand is less than expected or tightened when local demand accelerates spending beyond that sustainable with base funds. With medical priorities restrictions on spending CHS funding in place, the possibility of a real surplus (defined as funds left over after paying for all needed services that are medically appropriate) is remote.

At the June 12, 2013, Committee hearing on the *Nomination of Yvette Roubideaux to be Director of the Indian Health Service, U.S. Department of Health and Human Services,* you testified that the Tribal-Federal contract health services workgroup met and reviewed the distribution formula. You further testified that the workgroup believed the contract health service funding was to make up for discrepancies in services provided. For instance, the funding is for clinics that do not have hospitals attached and may have more of a need for patient referral.

However, in June, 2012, the Government Accountability Office report entitled *"Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program,"* Report No. GAO–12–446, disputes this statement and found that the funding was sometimes not related to the areas' dependence on contract health inpatient services. Likewise, the level of need funding has been, in the past, the funding mechanism to make up for discrepancies in funding (and subsequently services) among the Indian health facilities.

Question 31. Please provide the Committee with a report on the qualitative and quantitative evaluation and analysis conducted by the Tribal-Federal workgroup.

Answer. The workgroup analyzed the CHS funding distribution formula and determined that it allocates funds to Areas and sites based on CHS needs, which the

formula defines based on user counts, relative costs, and access to inpatient services. The workgroup recommended that the formula remain the same.

CHS funds are appropriated for current services, program expansion, and Catastrophic Health Emergency Fund (CHEF) reimbursement. Most CHS funds are appropriated to maintain current services (including base funding, medical inflation, and population growth). The CHEF is a reimbursement program managed at IHS Headquarters for all Federal and Tribal CHS programs. Program expansion funds are initially allocated by the distribution formula and then are added to the recurring base for subsequent years.

The CHS distribution formula allocates program expansion funds based on CHS need, which is defined by three factors: user counts, relative costs, and access to inpatient services. The workgroup analyzed this formula and found that on average, the access factor approximately doubled the amount of funding per person that a Service Unit received if it lacked access to inpatient services in its facility. User counts were also very important, and cost factors had a smaller impact. For FY 2010 plus FY 2012 funding, the average site with hospital access received $60 per person under this formula, while the average non-hospital sites received $125 per person. As a result of its analysis, the workgroup concluded that the formula does allocate funds to sites with more CHS need when that is defined by having more users, higher costs, and lack of access to inpatient services.

You testified that mortality rates are a great indicator of health status, but for which it is difficult to obtain accurate data. You also indicated your willingness to further look at mortality rates to help improve services.

Question 32. Please describe what your views are on how a consideration of mortality rates can help improve services.

Answer. Mortality rates are often used as an indicator to measure the health and well-being of a nation or a population, because factors affecting the health of entire populations can also impact the mortality rate of the population. Examining mortality rates helps improve services by permitting a focus on the highest risk conditions to the health and wellbeing of populations. By identifying the highest risk conditions that may benefit from prevention and intervention, strategies can be designed and deployed such as increased screening, immunizations, patient and community education, specialty care referral, and other services to help reduce or prevent death to American Indians and Alaska Natives. This data can also help to strengthen existing programs by identifying subgroups that may be at higher risk such as elders and the immunosuppressed.

Question 33. What is the Indian Health Service doing to improve the data collection on the mortality rates of Indian people?

Answer. American Indian and Alaska Native mortality statistics are derived from data provided to the Indian Health Service by Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). NCHS obtains death records for all U.S. residents from state health departments, based on information reported on official state death certificates. The mortality data are only as accurate as the reporting by the states to NCHS. The records NCHS provides to IHS contain the same basic demographic items as the mortality records maintained by NCHS for all U.S. residents, but with names, addresses, and record identification numbers deleted. It should be noted that Tribal identity is not recorded on these records. When deaths occur on Tribal lands, the correct identification of individuals as American Indian or Alaska Native is more likely. However, when individuals die in areas with fewer American Indians or Alaska Natives and other racial and ethnic groups, and do not involve care in IHS facilities, the race of the individual is commonly misidentified and therefore mortality statistics are underreported/undercounted. IHS receives data from States and then conducts its own analysis using a methodology developed to correct for underreporting of American Indian and Alaska Native race on death certificates.

Diabetes

The Indian Health Service FY 2014 Justification of Estimates for Appropriations Committees states that the continued growth in the prevalence and incidence of diabetes in the Indian population and its associated co-morbidities greatly impact the resources available for care. Moreover, the disease increasingly affects Indian youth, threatening the health, well-being, and quality of life of future generations.

The Special Diabetes Program for Indians provides funding for diabetes treatment and prevention. This funding has increased since the program first began to the current amount of $150 million per year.

Question 34. Please explain why the prevalence and incidence of diabetes among Indian people continues to rise despite the continued and increased funding?

Answer. Type 2 diabetes is a complex disease with many factors contributing to its etiology, including many that are not easily amenable to clinical care alone. These include risk factors that are "programmed in" during pregnancy and the first few years of life, even though diabetes may not manifest until several decades later. These early life risk factors are then compounded by issues across the life course including poverty, food insecurity, depression, stress, and others which make adhering to a healthy diet and exercise plan difficult. As such, just as in the general population, it is difficult to change the trajectory of diabetes in just a few years. The prevalence of diabetes in the U.S. overall and by race has increased over time (See Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Health Interview Statistics, National Health Interview Survey, accessed at *http://www.cdc.gov/diabetes/statistics/prevalence*__national.htm).

However, since 1998, SDPI funding has made it possible for AI/AN communities to develop and sustain quality diabetes treatment and prevention programs. SDPI funding has enabled staff and programs at the local and national levels to dramatically increase access to diabetes treatment and prevention services throughout the Indian health system. At the same time that access to these services increased, key outcome measures for AI/AN people with diabetes showed achievement or maintenance at or near national targets. These results have been sustained since the inception of SDPI. These significant improvements in blood sugar, blood pressure, and cholesterol control are associated with a tremendous impact on reducing rates of diabetes complications. Notably, since SDPI was initiated, the rate of end-stage renal disease (ESRD) due to diabetes has decreased 28 percent in AI/AN people—this is a greater decline than for any other racial/ethnic group in the U.S. So the changes we are seeing in the trajectory of diabetes relate to people living longer with fewer complications.

The outcome of individuals with diabetes living longer due to better access to care and reduced complications paradoxically increases the overall prevalence of diabetes because the number of individuals in the numerator of this proportion actually increases over time as individuals live longer. Of note, the SDPI Diabetes Prevention Program demonstration project did follow a cohort of individuals over time and was able to demonstrate a reduction in the number of new cases of diabetes (incidence) in participants in the projects' translation of the NIH funded Diabetes Prevention Program. This demonstration project involved a rigorous recruitment, retention, intervention and evaluation project that had dedicated resources to track incidence in the participants that is just not possible in the SDPI Community Directed Programs which implement a wide variety of activities. The SDPI Diabetes Prevention Program demonstrated that it is possible to reduce the number of new cases of diabetes and the grant programs are now developing tools to share the best practices from their work for other programs. SDPI Community-directed programs that are implementing similar activities should be contributing to prevention of diabetes as well.

Question 35. What types of training and education are you providing to the diabetes health care professionals in advanced treatment methods and therapies?

Answer. Through its Division of Diabetes Treatment and Prevention (DDTP), IHS provides comprehensive training for clinicians on many aspects of diabetes care, including current treatment targets, medications, and interventions to prevent or treat complications. DDTP develops the IHS Diabetes Standards of Care, treatment algorithms, patient education materials, and continuing medical education (webinar and online) which it provides through its website (*www.diabetes.ihs.gov*). In the second quarter of FY 2013 alone, there were over 20,000 hits to the DDTP website, indicating that many people are availing themselves of the myriad diabetes trainings and resources to help them improve their clinical care and patient education.

Question 36. What types of cost-benefit analysis have you conducted regarding these types of advanced treatment methods and therapies?

Answer. As a clinical agency, IHS closely follows the published research related to different therapies and translates evidence-based strategies into real world settings. For example, the IHS National Pharmacy and Therapeutics Committee meets regularly to review the literature and make recommendations on medications for the IHS Core Formulary (including those for diabetes) based on the evidence of their cost effectiveness and safety in current research. In addition, DDTP trainings related to medications also discuss these same issues for clinicians to consider as they make treatment decisions with their patients.

According to the Indian Health Service, secular trends in diabetes and obesity prevalence, as well as risk factors and known behaviors that are difficult to change

in families and communities, continue to pose challenges for the Special Diabetes Program for Indians.

Question 37. Please describe those secular trends?

Answer. Prevalence of obesity and diabetes is increasing in the general population, just as it has in the AI/AN population. Similarly, risk factors, including sedentary lifestyles and unhealthy dietary choices are increasing in many populations. Together, these are creating significant burdens of not only diabetes, but also its complications in the U.S. American Indians and Alaska Natives live in the context of these secular trends in the U.S. The SDPI addresses as many of these factors as it can, although some are related to more general issues and trends that local programs are less able to influence.

Question 38. Please identify those risk factors and known behaviors that are presenting challenges to addressing diabetes in Indian Country?

Answer. Behaviors which are known to increase risk for diabetes and its complications include eating less healthy foods and being sedentary. SDPI programs have been providing education about these behaviors for years with the result that many patients have made healthy changes in these areas. However, many others face considerable obstacles to making these changes, including poverty, food insecurity, stress, depression, unsafe living environments, as well as lack of access to healthy food choices (food deserts). Even those who are able to make good changes often do not see the weight and diabetes reductions seen in clinical trials. Research is revealing that important risk factors for obesity and diabetes are "programmed in" during pregnancy and the first several years of life, long before people have the ability to make lifestyle choices. This research suggests that future comprehensive approaches to obesity and diabetes prevention will need to include interventions which reduce these early life risk factors in addition to those that are ongoing across the lifespan. IHS' Baby Friendly Hospital Initiative, a part of the First Lady's Let's Move in Indian Country initiative, is working to reduce childhood obesity by promoting breastfeeding in IHS hospitals with obstetric services. More general factors that promote sedentary lifestyles in the U.S. such as technology (computers, video games), trends towards less physical education in schools due to budget cuts, and more sedentary employment options (office work, more skilled jobs) are more difficult to overcome without many other options or significant resources. Nonetheless, the SDPI programs do focus on factors that patients have control over and take both a medical and public health approach to diabetes treatment and prevention that often involves community-wide activities to promote more healthy, active lifestyles.

Prescription Drugs

The *Indian Health Care Improvement Act* required the establishment of a prescription drug monitoring program at Indian health facilities to help prevent and detect the abuse of pharmaceutical controlled substances. The Indian Health Service plan to establish the electronic connectivity between its facilities and state prescription drug monitoring programs needed to meet this statutory requirement was to be completed by January 1, 2013.

Question . What is the status of the establishment of prescription drug monitoring programs at all Indian health facilities?

Answer. Of the 27 states with active prescription drug monitoring programs (PDMPs) and that have I/T/U facilities utilizing RPMS, IHS has been successful in developing reporting capacity in 18 (66 percent) of these states. IHS has partnered with the Office of National Drug Control Policy to assist with negotiating MOUs in the six remaining states (OK, UT, CO, AL, WY, NV).

Question 39. Are there any barriers these facilities face in implementing these programs? If so, what are they?

Answer. Challenges to full implementation include the need for standardization between state programs using the American Society of Automation in Pharmacy (ASAP) standard, and the reluctance of some states to execute an MOU for data sharing.

Question 40. What specific performance metrics are in place to measure the effectiveness of these programs?

Answer. At this time, IHS does not have a performance metric in place to measure the effectiveness of PDMPs. IHS has developed best practices for providers checking the state PDMPs and promoting routine checking of state PDMPs into their daily practice. The IHS prescription drug abuse workgroup plans to develop performance metrics to evaluate the effectiveness of PDMPs. Possible metrics could include the decrease in number of opioid-related overdose deaths. IHS may need to establish additional MOUs with States in order to query aggregate data from state PDMPs.

According to the Indian Health Service FY 2014 Justification of Estimates for Appropriations Committees, the Indian Health Service initiated consultation on prescription drug abuse. The purpose of this consultation is to result in better decisions for the future of the Indian Health Service and to help improve patient care.

Question 41. What issues have you been consulting on relating to prescription drug abuse?

Answer. A Tribal Prescription Drug Abuse Summit was held in the Bemidji Area in July 2012. The meeting was for IHS and tribal partners to develop action steps to address this growing problem in tribal communities. The purpose of the summit was to develop ways to help Tribes get needed information and education about prescription drug abuse, monitoring disposal, enforcement, and partnering. A workshop was held at the IHS Tribal Consultation Summit on prescription drug abuse and recommendations were gathered on how best to address this issue.

Question 42. Upon completion of this consultation, what are your next steps to improve patient care and the future of the agency?

Answer. An IHS prescription drug abuse workgroup is developing next steps based on input received to date and the issue is a priority of the IHS National Combined Councils' work on IHS reform efforts. Next steps include release of a national IHS Non Cancer Pain Management Policy and pain management website; further education of providers on recognizing abuse/misuse, managing pain and addiction, and proper prescribing of medication for pain; development of an educational campaign to increase awareness of prescription drug abuse to Tribal communities, and promotion of proper storage and disposal of medications by patients. This work will involve additional partnership and consultation with Tribes.

The IHS Telebehavioral Health Center of Excellence began a 15-session webinar course for providers in February 2013 on how to effectively manage pain and potential opioid addiction.

Behavioral Health

According to the most recent Indian Health Service (IHS) *Trends* publication (2002–2003), the alcohol-related death rate for Indian is 519 percent greater than the rate for the general population. In addition, the 2008 Indian Health Service Annual Report notes the serious problem of methamphetamine use in Indian country, stating that the methamphetamine use rate for Indians is over three times the rate for the general population.

These rates indicate that methamphetamine and alcohol abuse and related deaths and are significant concerns in Indian country. However, on the Wind River Indian Reservation, alcohol and substance abuse treatment is not available, and individuals can wait as long as two to three months to receive out-of-state treatment.

Question 43. Has the Indian Health Service engaged in an assessment of the need for alcohol and substance abuse treatment facilities, including inpatient services, in Indian country? What were the findings of any such assessment?

Answer. The IHS completed a Mental Health Care Needs Assessment as part of the Section 702 and 709 of the Indian Health Care Improvement Act. The assessment included a cost and availability analysis for inpatient mental health care and the potential conversion to psychiatric beds of underused existing hospital beds in the IHS. The findings of the Mental Health Needs Assessment demonstrated there is no single answer for all 12 Areas of the IHS, as each faces different challenges, service gaps, levels of State cooperation, and coordination between existing Federal and Tribal programs. There are significant opportunities that should be considered as additional treatment approaches such as telehealth and digital networks, intensive outpatient mental health treatment, and fostering more regional collaboration among psychiatric service systems that offer acute psychiatric care.

The IHS is currently working on an assessment of the scope and nature of mental illness, dysfunctional, and self-destructive behavior, including substance abuse, child abuse, and family violence as part of the Department of Interior and Indian Health Service Memorandum of Agreement on Indian Alcohol and Substance Abuse Prevention and Treatment as authorized by section 703 of the Indian Health Care Improvement Reauthorization and Extension Act of 2009.

Question 44. What is your plan for increasing access to treatment for alcoholism on the Wind River Indian Reservation? Please be specific.

Answer. The Wind River Indian Reservation is comprised of two Tribes—the Northern Arapaho and Eastern Shoshone Tribes. Each of those Tribes have chemical dependency services through the P.L. 93–638 Tribal Health Contract that includes funds for those services. All chemical dependency treatment, which includes alcoholism treatment, on the Wind River Reservation is managed by the Tribes themselves, with two separate treatment centers, one for Northern Arapaho and one

for Eastern Shoshone. Those treatment centers offer a variety of services, including assessment and diagnosis of substance abuse/alcoholism, outpatient treatment, adolescent treatment, aftercare services, Alcoholics Anonymous and Narcotics Anonymous classes, DUI classes and prevention education. Each facility has a budget to refer out those who need inpatient treatment. There are services in the state of Wyoming as well in the surrounding states.

Title VII of the *Indian Health Care Improvement Act* directs the Indian Health Service to establish a comprehensive behavioral health plan for Indians and to provide comprehensive behavioral health prevention, intervention, treatment, and outpatient and aftercare services. To address the problem of methamphetamine addiction, the Indian Health Service developed the Methamphetamine and Suicide Prevention Initiative.

Question 45. Are clinical treatment and drug rehabilitation services part of this Initiative?

Answer. Yes, many MSPI programs provide clinical treatment and drug rehabilitation services as part of their approved scope of work. Many of these programs focus on youth, such as Desert Visions Youth Regional Treatment Center in Arizona, which provides (and trains other providers on) Dialectical Behavioral Treatment. We also fund the only Tribal Inpatient Methamphetamine Treatment program, the Rosebud Methamphetamine Rehabilitation and Recovery Program.

Question 46. How is the Indian Health Service tailoring existing treatment and rehabilitation programs and developing new techniques, through this Initiative and other programs, to address the unique challenges of methamphetamine addiction on the Wind River Indian Reservation? Please be specific.

Answer. The Indian Health Service supports the Methamphetamine and Suicide Prevention Initiatives with the two Tribes of the Wind River Indian Reservation, the Northern Arapaho and Eastern Shoshone Tribes. The Northern Arapaho MSPI provides methamphetamine and suicide prevention programming focusing on community outreach and culturally adapted training. Trainings include recognizing and responding to suicide risk as well as educational awareness on the impact of methamphetamine abuse. The Program has developed and fostered partnerships with Tribal Health Care programs, Veterans' programs, local and community agencies and organizations providing services to residents of the reservation. The Eastern Shoshone Tribe Demonstration Project for Suicide Prevention focuses primarily on suicide prevention but includes screening for mental health and substance abuse as well as supportive therapy based on the Red Road to Recovery, a 12 step Alcoholics Anonymous model. The Program also offers a 16-hour DUI course for tribal members involved in the legal system due to charges resulting from substance abuse.

Property Management

On June 18, 2008, the Government Accountability Office issued its report entitled, *"Indian Health Service: IHS Mismanagement Led to Millions of Dollars in Lost or Stolen Property"*, Report No. GAO–08–727, and found that from Fiscal Years 2004 to 2007, the Indian Health Service had lost a combined $15.8 million in property, including new medical equipment. The Committee held an oversight hearing on the issue on July 31, 2008.

On June 2, 2009, the Government Accountability Office issued a second report, entitled *"Indian Health Service: Millions of Dollars in Property and Equipment Continue to Be Lost or Stolen,"* Report No. GAO–09–450, making six new recommendations to correct deficiencies in Indian Health Service operations, and finding an additional $3.5 million in lost property during the period from October, 2007 to January, 2009. According to the Government Accountability Office, to date the Indian Health Service has fully implemented only three of the six recommendations from the 2009 report.

Your written testimony received by the Committee for the hearing on the President's FY 2014 Budget Request on April 24, 2013, states that, in the last four years, the Indian Health Service has made significant improvements in the management and oversight of personal property. According to your testimony, these improvements generally include holding senior level executives accountable and structuring internal systems to prevent problems and detect fraud, waste, or abuse in a timely manner.

Question 47. Please describe in detail the deficiencies identified and specific measures taken to correct problems regarding property mismanagement at Indian Health Service facilities.

Answer. IHS submitted an update as of May 2012 to GAO on the implementation of GAO's 2009 recommendations regarding personal property management. Deficiencies that were identified by GAO have been corrected and are being continu-

ously monitored. Examples include assurance that annual inventories are completed, and accountability for shortages is tracked and enforced. This continues to be monitored as a high-risk management control area and receives focused attention and IHS headquarters (HQ) oversight each year in the IHS management control plan. Some of the measures taken to improve management control over personal property at IHS facilities include:

- Senior Executive Service performance plans now include an element that addresses timeliness and accountability of all personal property functions;
- There is an ongoing process to have a designated user assigned to every accountable asset in the property system and to enforce personal accountability by using a hand receipt system;
- Inventories are conducted annually at all IHS locations over the past few years and property losses have been reduced significantly. When losses do occur, they are promptly investigated and a determination is made regarding financial liability to the individual documented to be accountable for the property.

Question 48. What is the current status and timeline for implementation of all recommendations from the 2009 report?

Answer. Our 2012 update to GAO reported that five of GAO's six recommendations have been fully implemented. IHS continues to focus resources on problem-solving and corrective actions to ensure effective interface between the agency's financial systems and property management information systems. Ongoing reconciliation efforts between these two systems are a high priority, and we have created training programs to equip the relevant staff with the necessary tools and information. A "role-based" training video was developed in 2013 and will be implemented in all IHS Areas by the end of this fiscal year.

Question 49. Has the Indian Health Service conducted any internal assessments, reviews or audits across all Indian Health Service facilities to determine whether and to what extent the reforms that have been implemented have resulted in a reduction of property loss? If internal reviews or audits of Indian Health Service property have not been conducted, why not? If reviews or audits have been conducted, please provide the findings of such.

Answer. IHS HQ initiated an Internal Control Remediation Project in Fall 2012 that included site visits to four IHS Areas to conduct a "deep dive" risk assessment of the personal property program to evaluate management control processes at IHS Areas to identify any gaps, and to inform internal management control review activity under the Federal Managers Financial Integrity Act (FMFIA). Findings from these site reviews indicated that improvements were needed primarily in the area of property receiving and recording. A root cause of the identified deficiencies is a heightened need for review of "linkages" between purchasing, physical receiving, and financial receiving controls. Implementation of new global administrative systems in IHS in the past three years has prompted HQ to more closely monitor all related system interfaces that broadly or specifically affect property management in IHS. Corrective actions are under development and include strategies for training staff in 2013 to reinforce cross functional understanding of related roles and responsibilities.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TIM JOHNSON TO HON. YVETTE ROUBIDEAUX

Question. Dr. Roubideaux, you have continually noted that a goal for Indian Health Service is to increase accountability and transparency. After IHS was able to gather reports and data regarding the Aberdeen Service Area, how do you plan on using this knowledge to further improve all IHS service units across Indian Country?

Answer. As described in the report being provided to the Committee, IHS followed up on the Committee's Aberdeen Area investigation with a review of management practices at all twelve Areas. The Aberdeen Area investigation and the IHS Area Oversight Reviews provided important information on overall implementation of policies and procedures within the entire IHS system related to the original findings of the Aberdeen Area investigation and the extent of implementation of corrective actions in each IHS Area. The results have helped us greatly increase accountability and transparency.

Correction of the major findings are now included in the agency performance plan for senior leadership, with specific directions to hold responsible employees accountable for corrective actions and maintenance of reforms. The findings and corrective actions have also been incorporated into the recent implementation of several new

electronic systems to monitor and track management controls and performance across several business systems throughout the agency, such as budget, acquisitions, property, and status of funds for contract health services. These systems will make oversight and monitoring of progress more efficient and less costly. Updates on corrective actions are a regular part of senior leadership meetings and communications are sent to all employees on agency progress. An update was sent to Tribal leaders in July 2012 on the agency's progress with corrective actions.

While IHS oversight is focused on federally managed programs, the communication and updates about our progress is made available and of interest to self-governance tribes as they manage their health programs independently under the Indian Self Determination and Educational Assistance Act. The Committee's investigation and IHS's Area Oversight Reviews were helpful in promoting reforms of IHS business practices and in helping guide and manage change throughout the system towards a culture of continuous improvement and accountability to our stakeholders.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. YVETTE ROUBIDEAUX

It is my understanding that once the Affordable Care Act is implemented, many IHS-eligible American Indians will face a tax penalty for failure to purchase health insurance. Only AI/AN people who are enrolled in federally-recognized tribes will be exempted from this tax.

Question 1. How many American Indians and Alaska Native will be subject to this penalty?

Answer. Under the final rule issued on June 26, 2013, all individuals who are eligible to receive services from an Indian health care provider will have access to an exemption from the shared responsibility payment. This includes all members and descendants of federally-recognized Indian tribes that can demonstrate eligibility for IHS services. The current IHS service population is approximately 2.1 million American Indians and Alaska Natives who have access to IHS facilities.

Question 2. Given the broad discretion the Obama administration has in implementing the Affordable Care Act, why hasn't the administration issued regulations exempting IHS-eligible AI/AN patients from these penalties?

Answer. As described above, the Administration recently issued a final rule that allows all individuals who are eligible to receive services from an Indian health care provider to receive an exemption from the shared responsibility payment if they do not maintain minimum essential coverage under the Affordable Care Act.

Question 3. Does the IHS support the definition of Indian preferred by the tribes, which was used in implementing the American Recovery and Reinvestment Act (ARRA) (also known as the "Medicaid definition")?

Answer. The Administration has thoroughly reviewed the varying definitions of the term "Indian" in the Affordable Care Act. HHS and IHS note that the differing definitions will require Marketplaces to use different definitions for the monthly enrollment periods and cost-sharing reductions. At the request of Congress, the Administration, including the IHS, provided technical assistance to Congress that is consistent with Tribal consultation on this issue to align the definitions referenced in the law with that used for IHS eligibility. We will continue to work with Congress to ensure the needs of Indian Country are considered as implementation of the Affordable Care Act moves forward.

Question 4. What efforts has the IHS undertaken to resolve this issue? What has been the effect, if any, of efforts thus far to exempt IHS-eligible AI/AN people from these penalties?

Answer. As described above, the Administration, including the IHS, provided technical assistance to Congress to align the definitions referenced in the law with that used for IHS eligibility. We will continue to work with Congress to ensure the needs of Indian Country are considered as implementation of the Affordable Care Act moves forward. In addition, since passage of the Affordable Care Act in 2010, the IHS has been working with CMS as it develops policy and promulgates regulations to implement the Act. These efforts have resulted in the final rule described above, which ensures that individuals who are eligible to receive services from an Indian health care provider will have access to an exemption from the shared responsibility payment.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARK BEGICH TO HON. YVETTE ROUBIDEAUX

Partnership

Dr. Roubideaux, on the Indian Health Service's website, the first goal under your leadership is listed as: *"Renew and Strengthen Partnerships with Tribes"*.

Yet, Dr. Roubideaux you continue to support the Administration's proposal to have Congress appropriate contract support costs on a contract-by-contract basis. This recommendation is known to be widely opposed by tribes, NCAI, and the National Tribal Contract Support Cost Coalition and I understand they have been very vocal about their descent.

Question 1. How do you see the IHS meeting the goal of partnering with tribes, while working directly in opposition of what they desire?

Answer. I have consistently advocated for the needs of Tribes and have brought forward tribal budget priorities, including the importance of adequate CSC funding. Ultimately, the Administration's decision to include the interim CSC proposal in the FY 2014 budget was made after consideration of all views and weighing priorities across the government in this difficult budget climate.

I, and the Administration, remain committed to finding a long-term solution for CSC funding, and I am currently consulting with Tribes on CSC appropriations to try to find a long-term solution. Tribal leaders have indicated that these discussions may be more effective in smaller group settings, such as with the various IHS advisory groups, and those discussions have begun.

Our efforts to strengthen our partnership with Tribes includes being a strong advocate for Tribal priorities during the Administration's budget formulation process, and consulting with Tribes on how to address difficult issues. Recent conversations with Tribal leaders have reinforced that the discussions we plan to have over the coming weeks and months will help us work together on solutions to this challenge.

I am grateful for the work of the IHS Tribal Budget Formulation Workgroup, which has made helpful recommendations on Tribal budget priorities and has discussed prioritization of budget priorities in the event that all requests are not funded. While Tribes have indicated that their preference is for full funding of CSC, they have also indicated support for other budget priorities such as Contract Health Services, current services, and additional staffing for newly constructed and replacement health facilities.

If confirmed, I will continue to advocate aggressively for funding to address the urgent needs of Tribes, including finding a long-term solution to CSC funding.

Question 2. If confirmed, how will you as the Director of IHS manage and sustain this partnership with tribes and Tribal Health Organizations, in a meaningful way?

Answer. If confirmed, I will continue to work with the Tribes to manage and sustain the vital partnerships with Tribes and Tribal Health Organizations. The IHS conducts a variety of consultation activities with Tribal leaders and representatives of Tribal governments, including national meetings, regional inter-Tribal consultation sessions, meetings with delegations of leaders from individual Tribes, Area consultation sessions, and Tribal advisory workgroups. In recent years, Tribal leaders and representatives have come to play an important role in the IHS budget formulation process and setting health priorities at the national and regional levels.

The increased involvement of Tribes in advising and participating in the decision-making process of the Agency has resulted in stronger collaborations between the federal government and Tribal governments; innovations in the management of programs; and important issues being brought forward for consideration by IHS, the Administration, and Congress in a timely fashion.

At the beginning of my tenure as IHS Director, one of the first consultations I initiated was focused on the IHS Tribal consultation process itself. A Tribal workgroup generated recommendations that we have been implementing, including better communication about consultations, new resources on the IHS website, a new email address for consultation input, the new Tribal Consultation Summits, increased access to headquarters Tribal delegation meetings, and a summary of outcomes of the various consultations held since 2009. If confirmed, I plan to consult with Tribes again on our improvements and areas where further improvements may be needed.

Contract Support Costs

Dr. Roubideaux, I am sure you have heard the array of voices from Indian Country opposed to the Administration's proposal on contract support costs, as have I.

We discussed this issue before the Senate Indian Affairs Committee in April when you presented the IHS budget, and I have raised the issue with Secretary Jewell as well.

There are many questions that remain. Frankly, we have not received answers to these. This Committee pressed you on some of these questions in our budget hearing in April, and hope that you now have more information for us now.

Question 3. Which office or department decided to include this proposal in the budget? You have previously said it was an "Administration decision," but I would like you to be more specific.

Answer. The Executive Branch works collaboratively to formulate the President's Budget. As Director of IHS, my role has been to advocate for the funding necessary to raise the health status of American Indians and Alaska Natives to the highest level. As part of my role, I have consistently brought forward tribal budget priorities, including Tribes' request for full funding of the CSC incurred under their contracts and compacts. I can assure you that this view was fully considered during the FY 2014 budget process. Ultimately, upon weighing priorities across the government, the decision was made to include the interim CSC proposal in the Administration's budget.

Question 3a. When did you decide to pursue this proposal?

Answer. As described above, my role has been to advocate for the funding necessary to raise the health status of American Indians and Alaska Natives to the highest level. Upon consideration of all options, the Administration chose this option as a short-term approach that is consistent with the focus on reducing the federal deficit and with the Supreme Court's decision in *Salazar v. Ramah Navajo Chapter*. As part of the annual budget formulation process, final decisions on the President's Budget request typically are made during the December to January timeframe.

Question 3b. Did the Administration entertain using any other proposals?

Answer. During budget deliberations within the Executive Branch, it is customary to review a range of potential courses of action before formulating a proposal. In this case, the Supreme Court described a range of options in the *Ramah* decision. As described in more detail below, tribes also provided input, and in general expressed a preference for full funding for CSC. In my role as the IHS Director, I ensured that this input was considered.

Question 4. As I said, the decision came down last summer; why were tribes not consulted on the Administration's proposed response to the *Ramah* decision? After all, their contracts will be affected.

Answer. During the fall of 2012, the IHS requested input from Tribes on how to factor the *Ramah* decision into IHS budget priorities during its Area and National budget formulation process and in a letter to Tribes. At every opportunity, I encouraged and sought Tribal input through Tribal Delegation Meetings, letters, listening sessions and national conferences on a variety of topics and issues, including the *Ramah* decision and CSC appropriations. I also mentioned the Supreme Court options at various meetings with Tribal leadership and asked for their views. In general, Tribes reported their preference was for full funding of CSC incurred under their contracts and compacts, and they opposed all other options. I ensured that this input was considered during the Administration's budget formulation process.

Question 5. Is your department limiting the payments due to other, non-Indian contractors?

Answer. This proposal and the *Ramah* decision only applies to contracts authorized under the Indian Self-Determination and Education Assistance Act (ISDEAA) and its corresponding regulations, which is a unique contracting authority. Further, this proposal and the *Ramah* decision only applies to CSC funding, which is one of two categories of ISDEAA funding and is unique to the ISDEAA. Contractors performing under other authorities, such as the Federal Acquisition Regulation, adhere to the requirements of their other respective authorities and are funded pursuant to those authorities. Those contractors do not receive CSC funding, which Congress specifically authorized to cover unique costs that Tribes incur when they assume operation of Federal programs for Indians.

Staffing

Question 6. If confirmed, will you commit to do everything in your power to ensure that the staffing packages for new and replacement facilities, built with the expectation of being fully staffed, will meet that mark?

Answer. Yes, I will continue to advocate for staffing packages during the budget formulation process. In addition, I will ensure that decisions on funding for new health care facilities construction and on entering into new joint venture agreements are made prudently, taking into consideration projected construction completion dates and factors that may impact them, such as the budget climate and the status and trends of IHS appropriations. We have also received input from Tribes to clarify our Joint Venture agreements and discussions to ensure that Tribes create

contingency plans in case new staffing requests are not included in final appropriations or in case completion dates of facilities vary. If the FY 2014 President's Budget Request for IHS is enacted, the $77 million amount for new staffing will allow IHS to address the staffing needs in FY 2014, better setting the stage for budget formulation for new staffing needs for FY 2015.

Village Built Clinics

Once again, I must call attention to the issue of proper funding for upkeep and service in the Village Built Clinics. As I have written to you before on this is a crucial health issue facing clinics in Alaska. I continually hear from tribal and Alaska Native health leaders in Alaska that the IHS is unresponsive to them on the issue of VBCs.

Dr. Roubideaux, we have seen absolutely zero movement on your part to alleviate these problems which is troubling, to put it mildly.

Alaska Native leaders tell me that there must be an increase of $8.2 million for the IHS to meet the VBCs' needs for the next year. The VBCs are often Alaska Natives' only option for health care, yet you appear to have lent them a deaf ear on the issue.

Question 7. What concrete steps does the IHS plan to take in order to fully fund the VBCs?

Answer. Alaska Tribal Health Organizations (THOs) manage approximately 99 percent of the IHS funds allocated to Alaska under the Indian Self-Determination and Education Assistance Act (ISDEAA). THOs have flexibility to determine how these funds and any increases that are allocated to all their programs including the Village Built Clinic (VBC) program are used. IHS has offered to establish a workgroup to discuss next steps to address this issue, but the Tribes in Alaska have so far refused this offer of dialogue on the issue. IHS has considered the VBC in budget formulation but at the national level, Tribes did not include this as a priority increase. Given the difficult budget climate, inclusion of Area-specific budget priorities is a challenge and is generally not supported at the national level by Tribes. IHS is willing to work with the Alaska Tribes on this issue and to work to better understand how under the ISDEAA Tribes may have the option to reallocate and rebudget funding to meet the VBC leasing needs with available funding.

Question 8. If confirmed, will you take action and be an advocate within IHS to get these clinics the additional funding they need?

Answer. During the 2015 budget formulation, the National Tribal Budget Formulation Workgroup recommended a $119.6 million increase to the hospitals and clinics line item. With such an increase, or even with available funding, Alaska THOs could choose to allocate more funding to the VBC leases. I will continue to advocate for additional funding for health care clinics across the IHS, including in Alaska. If supported by Alaska Compact Co-Signers, the IHS will continue to explore options to address this issue, including forming and participating in a workgroup with Alaska THOs, to address the VBC funding issue notwithstanding obstacles posed by current litigation related to the Ambler VBC.

Drug Shortages

It is my understanding that Alaska tribal health organizations have identified that a problem exists with medical drug vendor shortages. When 3rd party vendors run out of a particular medical drug the facilities are forced to purchase these medical drugs at extremely high costs.

Question 9. If confirmed as the Director of the IHS, will you commit to put pressure on drug vendors to have medical drugs and supplies available; and/or to have additional venders available to avoid this costly dilemma?

Answer. IHS is committed to working with its tribal, federal and industry partners to understand the reasons for why the shortages occur and to arrive at solutions. As part of value-added services offered to Alaska Tribal Health Organizations (THO), the Alaska Area IHS manages the Pharmacy Prime Vendor Program (PPVP) for the Alaska Area including placing daily pharmacy orders and resolving discrepancies and problems in ordering, shipping and delivery. In managing the PPVP, the IHS recognizes the problems experienced by Alaska THOs in regard to drug shortages. The problems are faced across the nation by other THOs and IHS Areas as well as the national health care system in general. The problems require not only IHS contributions to a solution but federal and industry contributions. To achieve this, the IHS has provided THOs with information that will enhance their understanding of why drug shortages occur and what means are currently in place to address the shortages. A heightened understanding of the causes of the shortages may allow stakeholders to arrive at broader solutions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. AL FRANKEN TO HON. YVETTE ROUBIDEAUX

Question 1. It's estimated that American Indian and Alaska Native youth are nine times more likely to have type 2 diabetes than non-Hispanic white youth. But we know how to prevent type 2 diabetes. I championed a program in the health care law called the National Diabetes Prevention Program, which is a targeted intervention that's been proven to reduce the chances that a person with pre-diabetes will develop full diabetes by nearly 60 percent. The Special Diabetes Program for Indians has awarded grants to implement the Diabetes Prevention Program in Indian Country. In my state, these grants have gone to the Fond Du Lac Band of Lake Superior Chippewa, the Indian Health Board of Minneapolis, and the Red Lake Band of Chippewa Indians. Before serving as Director of IHS, you were an expert on diabetes in Indian Country. What have you learned about implementing diabetes prevention through the IHS? How will you continue to fight diabetes in a second term as IHS director?

Answer. We have learned a tremendous amount about the successes and challenges involved in providing diabetes prevention interventions. In 2004, Congress increased the Special Diabetes Program for Indians (SDPI) funding to $150 million per year and included the charge that we translate diabetes prevention science, such as the NIH Diabetes Prevention Program (DPP) clinical trial, into AI/AN communities. We have done so, first in 36 AI/AN communities as part of the SDPI Diabetes Prevention (DP) Demonstration Project, and now in the current 38 SDPI DP Initiative sites since 2010.

We learned that we could indeed translate the NIH DPP and that some of our participants would be able to adhere to the protocol and reduce their risk for developing diabetes. We also saw how difficult this is for many of our patients due to so many competing demands and challenges in their daily lives, including poverty, food insecurity, stress, and communities struggling with the effects of intergenerational trauma and poverty. Even some of the participants who were able to stay with the SDPI DP protocol did not see their diabetes risk decrease as much as in the NIH DPP. We have been reminded of the difference between a clinical research trial, which carefully selects its participants, and a translation project, which sets out to provide a similar program but in "real world" community settings. However, IHS recently published its findings from the evaluation of the SDPI Diabetes Prevention Program demonstration project, and the grant programs were able to reduce the new cases of diabetes to a similar degree as the original NIH research project. While a comparison between the NIH clinical trial and our translational project is difficult, our experience shows that the NIH clinical trial diabetes prevention intervention activities can be implemented in the real world settings of Tribal communities and that positive outcomes can be achieved. Of most interest in this translational effort was the importance of Tribal consultation, community involvement, adaptation of the activities to be culturally relevant, and the use of peer to peer learning to promote creative solutions to emerging challenges during implementation. The lessons of the demonstration projects are helping IHS implement other activities and the grantees are developing tools to share best practices with the other SDPI funded programs.

Recent research is delineating how much risk for later diabetes is "programmed in" while people are still in the womb and in the first few years of life—long before they join a SDPI DP program. As such, we are learning that, for some, we just need to make the SDPI DP programs available and they will be able to benefit similarly to those who were in the NIH DPP clinical trial. But for so many others, we need to work with them and their communities to help address many of the towering obstacles which increase their risk for diabetes and other chronic diseases.

If confirmed to serve a second term as IHS Director, I would take these lessons learned to expand and deepen our diabetes prevention efforts. I would also build on the tremendous successes we have had in the clinical care of people with diabetes. Many diabetes clinical measures have shown achievement or maintenance at or near national targets since SDPI started. This has led to reduced diabetes complications, including a reduction in the incidence of end stage renal disease (ESRD) due to diabetes of 28 percent between 1999 and 2006. We have made real progress and the lessons we have learned along the way are illuminating the path for the efforts yet to come, for both our current SDPI grantees, and potentially for other efforts in the U.S. IHS is willing to work with Congress on the upcoming need for reauthorization of the SDPI in FY 2015.

Question 2. The Indian Health Service has to work with very limited resources—your Department has been chronically underfunded. That means you've had to get creative about how to do more with less, and you've been providing quality care for

lower cost because you had no other choice. What lessons can IHS bring to the rest of the country looking for ways to lower health care costs?

Answer. The Agency priorities are aimed at system improvements within the Indian health system as a method to achieve its mission on a sustained basis. The Agency priorities are to strengthen tribal partnerships, reform the Indian Health Service, improve the quality of and access to health care, and to improve transparency, accountability, fairness and inclusiveness. These priorities, used as a strategic framework for improvement, have enabled IHS to reduce costs through greater collaboration, accountability, customer focused activities and improving how it conducts business. Through the application of these priorities, the IHS has achieved virtually all of its performance measures in 2011 and 2012 despite its limited resources. The use of system-oriented improvement models has benefitted the IHS in programs such as the Special Diabetes Program for Indians that uses evidenced based care and best practices for all of its Community Directed grant programs. The application of process mapping and continuous quality improvement strategies from our clinically focused Improving Patient Care initiative (patient centered medical home initiative) to improvements to other areas, including administrative processes, is helping IHS use a common strategy for improvement that encourages teamwork, critical review of processes, implementation of improvements and measurement of outcomes to guide further work. Programs that use these methods are successfully reducing patient waiting times, creating greater access to appointments and providers, improving the quality of care, and achieving greater patient satisfaction. The strategies are simple, can be replicated with no cost other than training, and can be reinforced system-wide. IHS has also looked at achieving economies of scale as a healthcare system; for example, IHS collaborates with the VA on a national Pharmaceutical Prime Vendor system to ensure access to lower cost medications for all sites.

A lot of attention has been focused recently on our nation's failed mental health care system, and the problem is even worse in Indian Country. The suicide rate among American Indian/Alaska Native youth ages 13 to 20 is more than double the national average. While most IHS and tribal facilities report offering mental health services, access to those services can be difficult because of workforce shortages and staffing issues.

Question 3. I've introduced a bill, the Mental Health in Schools Act, which would provide schools with the resources to partner with mental health providers, law enforcement, and other community-based organizations to provide access to mental health services to their students. How has IHS sought to improve access to mental health services for Native youth?

Answer. IHS has sought to improve access to mental health services for Native youth in several initiatives. The Indian Health Service supports the Methamphetamine and Suicide Prevention Initiative (MSPI) and the Domestic Violence Prevention Initiative (DVPI) which serve a critical role in increasing access to culturally appropriate prevention and treatment services for American Indian/Alaska Native youth. The MSPI accomplishments include more than 200,000 encounters with at-risk youth provided as part of evidence- and practice-based prevention activities.

IHS also provides recurring funding to 11 Tribal and Federally operated Youth Regional Treatment Centers (YRTCs) to address the on-going issues of substance abuse and co-occurring disorders among American Indian/Alaska Native youth.

IHS' development of its Telebehavioral Health Center for Excellence is helping expand the availability of telebehavioral health services to ensure access to diagnostic and therapeutic interventions for patients of all ages, including youth. Younger patients tend to have a very positive reaction to telebehavioral health due to their familiarity with technology and also the relative anonymity of the clinical encounter behind closed doors that does not identify that they are being seen for a behavioral health problem, which may inhibit some youth from seeking services.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. HEIDI HEITKAMP TO HON. YVETTE ROUBIDEAUX

Aberdeen Area Office

Question 1. Please provide a detailed summary and timeline of the steps the Indian Health Service has taken in response to each of the deficiencies identified in the 2010 Report "In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area" to the Senate Committee on Indian Affairs.

Answer. IHS is providing a report under separate cover describing IHS's review of management issues in all twelve Areas. The report includes specific findings along with corrective actions to date for each IHS Area.

Contract Health Care

Tribes in North Dakota rely on contract health care for those services not available at Indian Health Service facilities. While there have been some improvements, including increased funding to allow Indian Health Service to cover more than life or limb care, there are still many that are left without access to the care they need. Further, Indian Health Service has a record of not adequately reimbursing those hospitals that contract to provide health care. In my state, there are a number of hospitals that are still owed for care provided.

Question 2. You have noted that increased contract funding the last few years has allowed nearly half of the programs to fund referrals beyond life or limb care, allowing more patients to receive the care they need. Are any of the programs that are funding beyond priority one cases in the Aberdeen area?

Answer. Yes there is one program in the Aberdeen Area that is able to fund beyond Priority One care with funding for the Contract Health Service (CHS) program. The CHS program is proposed to be renamed Purchased/Referred Care (PRC).

Question 3. What changes do you intend implement to continue tackling the shortages in contract health care so patients in other areas receive the care they need and hospitals are paid for the care provided?

Answer. I strongly support increased CHS/PRC funding, which will have the most direct impact on addressing shortages in contract health care and ensuring patients get the services they need and that outside providers are paid for approved referrals.

To ensure the program uses funds most effectively, IHS has instituted a number of changes. For example, IHS has developed a new form for Service Units (required for federal service units and recommended for Tribally managed programs) to more accurately document the number of denied and deferred cases. IHS has also implemented a number of improvements in CHS/PRC business processes based on recommendations from a Tribal federal CHS workgroup, including having developed an online core-curriculum for CHS/PRC staff to provide continuous education for the improvement of CHS/PRC business processes. IHS will continue to aggressively pursue alternate resources for our patients and assist them in applying for these resources to conserve CHS/PRC resources that can be used to purchase additional services for more patients.

IHS began efforts to address the problem of unpaid charges for American Indian and Alaska Native patients at private sector hospitals in North and South Dakota with regular meetings between IHS and hospital staff to help educate them on the referral and payment approval processes for the CHS/PRC program. IHS reviews referrals and charges on a regular basis and help clarify which patients are eligible and approved for payment of their referrals and visits to reduce misunderstandings. We are able to make improvements in IHS federally managed programs directly; for Tribally managed programs, we can recommend improvements but the Tribes are responsible for resolving payment issues with the providers with which they work on a regular basis.

Question 4. Recognizing IHS does not reimburse for non-emergent care (Priority 2–4) provided in non-IHS emergency rooms, how are you working to minimize these episodes?

Answer. IHS continually works to improve the quality of and access to care at direct care facilities to help prevent and treat conditions before they become emergencies. Implementation of quality improvement strategies such as our Improving Patient Care initiative involves more team based care with better availability of outpatient services as well as better case management of complex health conditions that all contribute to better care and can help prevent emergency room visits and reduce the need for hospital admissions. IPC utilizes a patient-centered medical home model to achieve the objectives; to improve the quality of care through evidence based practice, enhance access to care across all ages and chronic conditions, improve patient experience of care and build a sustainable infrastructure for the spread of innovative improvement. Providing increased prevention activities at our facilities and improving our methods of health care delivery will result in improving the health and wellness of our population thus minimizing these episodes. Increased resources for CHS/PRC will help address the significant need for CHS/PRC by allowing for approval of funding for more priorities beyond Medical Priority 1 and helps IHS better meet its GPRA clinical quality indicators through improvements in process of care and by funding better access to services not provided directly by IHS but needed for prevention and quality treatment to avoid more significant problems in the future.

One of the concerns I have heard from hospitals that provide contract health care is the cumbersome pre-authorization system and paper claims.

Question 5. What steps do you intend to take to streamline the pre-authorization process and transition to electronic claims processing?

Answer. Currently the IHS Purchase and Referred Care fiscal intermediary accepts electronic claims for processing. Providers of care can view online the status of their claims. IHS encourages all providers of PRC to use the electronic filing process.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO HON. YVETTE ROUBIDEAUX

IHS estimates $2.2B needed to fully funding the facilities construction backlog, $427M to fully fund the facilities renovation/repair needs, and $3B for Sanitation Deficiency System. IHS requested $4.422B for FY 2014; an increase of $115.9M over FY 2012 enacted level. That includes $49M more to staff and operate newly constructed health facilities, including "638" Indian-owned health care facilities.

I want to see IHS fully funded, so that all American Indians can get the quality health care they need and deserve. This is why I've asked for full funding from the Appropriations Committee.

Question 1. In the meantime, I am concerned about the deteriorating health facilities. For how much longer will the Gallup Indian Medical Center be allowed to continue to deteriorate before IHS considers providing health care in a facility in that condition unacceptable?

Answer. The Gallup Indian Medical Center (GIMC) is currently on the IHS Health Facility Construction Priority List for replacement. The recent reauthorization of the Indian Health Care Improvement Act includes a new authority to ensure that all facilities currently on the IHS Priority List will remain on the list and receive funding before any new facilities are added. GIMC will require $490 million to complete, and four other hospitals are on the priority list above GIMC at a total cost of $947 million. This amount is less than estimated a few years ago because the American Reinvestment and Recovery Act appropriated $227 million to help complete two large facilities in a short time period (Nome, AK and Eagle Butte, SD). Otherwise, IHS has received funding for Health Care Facility Construction in the amounts of $81–85 million per year in the past few years so it is likely in this budget climate that it will be many years before the GIMC replacement facility will be completed at current funding levels. However, IHS will continue to work with Congress on Health Care Facility Construction funding needs and balancing other budget priorities and will continue to advocate for progress on these projects. The GIMC is operated and maintained to sustain accreditation with existing funding and third party collections while we work on the budget for the Health Care Facility Construction Priority List.

Question 2. How is IHS creatively rethinking how to renovate and construct health facilities with new materials and new systems to better address current needs?

Answer. IHS is continually looking at new ways to deliver health care and uses the latest technologies and materials to construct its health care facilities. The joint venture program and the small ambulatory programs have been very helpful to make progress on health care facility construction for facilities that are not on the current IHS Health Care Facility Construction Priority List by collaborating with our Tribal partners. IHS's goal is to use materials and systems that will last as many years as possible.

IHS is the first large federal healthcare system to have a certified electronic health record (EHR).

So far, 490 IHS, Tribal, and urban Indian health program sites are approved for provider placement and 221 additional providers have signed on to work in Indian health sites through this program.

Question 3. You mentioned in passing during the hearing the use of tele-behavioral health, but I don't have a sense of how frequently it is used. Given the vast distances between Indian health facilities, telehealth strategies can improve access to health information, to a health care provider, and to needed specialty consultation. How is IHS scaling up using telehealth for counseling, for consultation, for provider training and case management, and for other purposes?

Answer. In 2010 the IHS TeleBehavioral Health Center of Excellence (TBHCE) was established and is located in Albuquerque, NM. The TBHCE provides direct patient care services in the specialties of Adult Psychiatry, Child Psychiatry, and Addiction Psychiatry. In 2010 only one Area was served, with 200 patient encounters.

In 2012, TBHCE consultants conducted more than 2,800 patient encounters for four IHS Areas, a fourteen-fold increase in two years.

The TBHCE provides continued education trainings for providers on a board range of general and specialty behavioral health topics such as assessing and treating addictions and mental health disorders in the primary care setting, traumatic brain injury, developmental delays, and suicide and suicidality in AI/AN youth. The educational sessions have expanded from one hour per week to four- six hours per week. In 2012 more than 1,200 free continuing education credits were offered to participating providers, and the program currently reaches more than 600 training attendees per month.

In addition to direct care and continued education trainings the TBHCE provides technical support to sites within the Indian Health System interested in developing or improving telebehavioral health services. The support provided ranges from equipment set-up to day-to-day operational support.

There are over 90 I/T/U facilities in eleven IHS Areas offering some level of telebehavioral health services.

The IHS established the Methamphetamine and Suicide Prevention Initiative (MSPI) in recognition of the dual epidemics of methamphetamine and suicide. Four years after its implementation, the MSPI supports 130 programs across the country consisting of IHS, Tribal, and Urban awardees. The MSPI accomplishments included 7,000 substance abuse and mental health encounters via tele-health.

Question 4. Do you have a universal patient ID # system in place?

Answer. Yes, while patient ID numbers may vary among facilities, the IHS has implemented a Master Patient Index (MPI) system that is designed to work behind the scenes to uniquely match registration information for patients who have registered for care at different IHS facilities. This will be important for health information exchange, both within the IHS and with external providers. It will also be used by our Personal Health Record portal to allow patients to see information from any facility they have visited.

I appreciate the efforts to increase the numbers of American Indians serving in tribal health facilities and programs. At the same time, my constituents have expressed concerns about the turnover and the loss of experienced IHS professionals. IHS estimates almost 1,000 positions are vacant for doctors and nurses.

Question 5. What both the turnover of health professionals, and the vacancy rate by type of role at the ABQ Service Unit?

Answer. The following vacancy information was provided by the Albuquerque Area Chief Medical Officer. The turnover rates are not available at this time.

- Physicians—72.5 allocated positions; 15 vacant physician positions for a vacancy rate of 21 percent;
- Dentists—46 allocated positions; 1 vacant dental position for a vacancy rate of 2.2 percent;
- Registered Nurses—140 allocated positions; 17 vacant RN positions for a vacancy rate of 12 percent;
- Advanced Practice Nurses—5 allocated positions; 1 vacant APN position for a vacancy rate of 20 percent;
- Pharmacists—45 allocated positions; 2 vacant pharmacy positions for a vacancy rate of 4.3 percent.

These vacancy rates are consistent with IHS's national vacancy rates, which have improved from previous years for most provider groups.

Question 6. What are your plans to attract and retain experienced health professionals to make the IHS a career choice and shrink these vacancy rates?

Answer. IHS has been able to develop strategies that have helped reduce vacancy rates for several provider groups in the last few years. We continue to develop strategies for nationwide recruitment and retention efforts that include virtual job fairs, academic and community mentors, targeting national recruitment events to establish relationships early in discipline training, recruitment and retention plans for all areas, development of a lead tracking system, a military transition campaign for health professionals, expansion of the externship program with assigned recruiter/mentors while in training and in general to increase our presence during the education and training of health professionals. Our partnership with the Health Resources and Services Administration (HRSA) National Health Service Corp has resulted in over 300 new health care providers in IHS, Tribal and urban Indian health programs since 2009. IHS has also focused loan repayment awards and improvements in pay authorities and salaries for providers with high vacancies. For example, focused efforts to recruit dentists over the last few years have reduced the va-

cancy rates for IHS from 35 percent to 10 percent. IHS' reform efforts are also based on input from IHS staff and are being implemented to improve the overall business practices of the agency and improve the workplace conditions for staff which will also help with retention.

Question 7. How have you explored using mid-level and entry-level health workers to alleviate the shortage and allow trained health professionals to work to their full scope of practice?

Answer. The IHS has explored and has expanded recruiting efforts to include mid-level and entry-level practitioners. Recruiters currently attend national events to recruit physician assistants and nurse practitioners. The IHS Loan Repayment Program is an excellent tool to recruit entry-level providers right after they complete their training. Although we track mid-level vacancies, the decisions regarding actual positions, and how to advertise and hire for them resides exclusively with the local and Area levels. Expanding upon our recruitment and retention of these disciplines is an integral part of the new reporting system currently in development. In addition, IHS recently received approval from Office of Personnel Management to offer higher salary rates to physician assistants, which will greatly help with recruitment and retention efforts. IHS has for many years had a practice of allowing mid-level providers to work at the full scope of practice given the significant needs for providers in our clinics.

Question 8. Health professionals returning from Peace Corps volunteer assignments might be a good fit for IHS careers. Will you reach out to them to see what relationships can be developed?

Answer. Yes. IHS recruiters can consider establishing partnerships with Peace Corps recruiters to design a follow-on paid assignment with IHS after their completion of assignment. Peace Corps volunteers would be the ideal candidates for IHS as they are familiar with similar mission and activities and core competencies. This initiative is currently being developed, and IHS has been in contact with the Peace Corps since May 2013 as a part of our overall recruitment strategy.

Native Americans who have served in the military may be eligible for health care services from both VA and IHS. GAO recently studied the effectiveness of the existing MOU to improve coordination of care and made recommendations to improve accountability and tribal consultation. [VA and HHS agreed with these April 2013 recommendations.]

Question 9. How has IHS and VA improved care and coordination for veteran Indians?

Answer. Since the signing of the VA–IHS MOU in October 2010, VA and IHS staff have been working on twelve strategic objectives to improve AI/AN Veterans' health services and care. Improvements in coordination of care between the VA and IHS are a major goal of the MOU. Strategic objectives 3 and 4 highlight efforts to improve health care services:

Strategic Objective 3: Health Information Technology

Purpose: Development of Health Information Technology

Major Tasks: Share technology; interoperability of systems; develop processes to share information on development of applications and technologies; and develop standard language for inclusion in sharing agreements to support this collaboration.

The ability to share patient information between the VA and IHS will be critical to improving coordination of care for American Indian and Alaska Native veterans who use both the VA and IHS systems for their health care needs.

Accomplishments on Strategic Objective 3 include:

- Collaboration and consultation on EHR Certification and Meaningful Use requirements:
- Collaboration on ICD–10 Development and Implementation to jointly design system changes to VistA and
- Resource & Patient Management System (RPMS) in preparation for transition to ICD–10.
- Sharing Bar Code Medication Administration by meeting to define scope, support agreement, and needs to leverage VA experience with Bar Code Medication Administration in support of potential use in IHS and Tribal hospitals.
- Collaboration with VA and DOD inplanning for the Integrated Electronic Health Record (iEHR), and design of the EHR interface and care management functions. These activities will result in the ability of IHS and VA to share medical records with appropriate privacy protections and to better coordinate care for American Indians and Alaska Native Veterans that receive care in both health care systems.

- Collaboration on participation in health information exchange through the Nationwide Health Information Network (NwHIN). NwHIN is a group of federal agencies and private organizations that have come together to securely exchange electronic health information. NwHIN "onboarding" (process to join the Exchange) is underway in IHS and should be complete for all federal facilities by the summer of 2013. Through NwHIN Connect, IHS and Tribal providers will be able to download ("pull") summary of care documents for any VA patient (or, for that matter, any patient whose private sector provider participates in Health Information Exchange (HIE)), and vice versa. Also, as part of Meaningful Use, IHS will be adopting the Direct Exchange protocols, which will allow IHS providers to deliver patient records to any trusted entity such as a VA hospital or provider. This solution is scheduled for implementation in 2014.

Strategic Area 4: Implementation of New Technologies

Purpose: Development and implementation of new models of care using new technologies.

Major Tasks: Tele-health services; mobile communication technologies; enhanced telecommunications infrastructure; share training programs to support these models of care; and share knowledge gained from testing new models.

Sharing new technologies will help improve access to quality care for American Indian and Alaska Native veterans

Accomplishments:

- Completed best practices for providing telepsychiatry services to AI/AN Veterans.
- Established videoconferencing connectivity between Prescott VA and the IHS Chinle facility to implement telemedicine services, connection made Aug. 2011.
- Coordination of network-to-network connectivity for videoconferencing with Work Group 3—Health Information Technology.
- Explored mVET program (a VA program that targets prevention of acute crises which lead to death among homeless Veterans) within the context of the MOU collaborative (Work Group 4—to enhance access through the development and implementation of new models of care using new technologies), to provide homeless vets with a smart phone with "life-line" apps.

The VA and IHS also signed their national reimbursement agreement in December 2012. While the focus of this agreement is on VA reimbursing IHS for direct services provided to American Indian and Alaska Native veterans eligible for VA and IHS, the implementation of that agreement is helping efforts to improve coordination and collaboration of local VA and IHS facilities especially in the areas of case management and quality of care.

Question 10. What improvements are needed to the MOU between IHS and the VA to assure these improvements?

Answer. The 2010 MOU provides a framework for a broad range of IHS–VA collaborations which is national in scope, with implementation requiring local adaptation. As new opportunities present themselves, updates to the existing MOU may be appropriate. The VA/IHS MOU will also be reviewed on an annual basis by both agencies.

ACA Implementation

The Indian Health Care Improvement Act was permanently reauthorized when we passed health reform. As we get closer to 2014 and Medicaid expands and health insurance exchanges are available in states, tribes and other members of the public have questions about how the law affects them.

Question 11. What is your greatest challenge in fully implementing the act?

Question 11a. What is the IHS doing to inform American Indians about the benefits of the A–C–A and how it will affect them specifically?

Answer. One key challenge relates to the need to ensure that all IHS patients understand the new benefits of the law so that they can make informed decisions about choices related to their health coverage. IHS, working with CMS, is emphasizing in its outreach the distinction between IHS as a health care system available to its patients and the new choices for additional health coverage as a result of the Affordable Care Act.

The IHS has been focused on outreach and education since passage of the Affordable Care Act. The IHS has provided funding to three national tribal organizations, the National Indian Health Board (NIHB), National Congress of the American Indians (NCAI), National Council of Urban Indians (NCUI)), and 11 regional Outreach and Education projects to develop and distribute educational materials and tools for

decisions making. These projects have focused on four main stakeholder groups served by the ITU system: (1) Individual AIAN consumers, (2) Tribal Leaders as employers, (3) Tribal Leaders as the head of membership organizations, and (4) Health facility leadership and management. To date over 400 trainings have occurred all across Indian country focusing on providing information about Affordable Care Act changes to coverage and tools for decision-making.

The IHS also has long standing collaboration efforts with CMS to develop and disseminate information about program eligibility rules, which now incorporate the Affordable Care Act, through numerous trainings held throughout Indian country and at an annual national training. The IHS Director's Blog on the IHS website is another dissemination tool that provides continual information on expanded and new coverage options. Finally, the IHS provides ongoing Affordable Care Act information at regional and national tribal consultation meetings, the National Partnership Conference, and other national business office training sessions and participates in monthly Affordable Care Act outreach calls that reach a wide audience of tribal leaders, tribal program experts, and tribal health organizations.

Question 12. The Indian Health Care Improvement Act reauthorization encouraged IHS to collect from third-party health insurers. What progress has IHS made to increase collections and self-fund its needed programs and services?

Answer. A recent accomplishment is the development and implementation of a data system to identify deficiencies and monitor the third-party collections process for IHS operated facilities. This online data tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures so they can take necessary corrective actions and improve overall program activity.

Area Directors and Service Unit Chief Executive Officers now have access to improved online data reports that assist them with managing and making program improvements for IHS operated facilities. Over the past year, the Agency has had 100 percent of IHS facilities participate in completing the online tool.

The IHS continues to strengthen its business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training, and electronic claims processing. Priority efforts include the continued development of modifications to third-party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes and compliance with Medicare and Medicaid regulations. These improvements for IHS operated facilities will be coordinated with concurrent improvements in Contract Health Services business practices related to alternate resources.

In addition, IHS is working to incorporate legislative rules and regulations that impact third-party collections directly and indirectly. Some programs, such as the Medicare and Medicaid Electronic Health Record Incentive Program, which provides incentives for meaningful use of electronic health records by providers and facilities, will have a direct impact on improving availability of data used in revenue generation over the next few years. IHS' focus is to maximize enrollment and collections for all IHS, Tribal, and Urban Indian health care facilities.

IHS continues to work with CMS and state agencies to identify patients who are eligible to enroll in Medicare and Medicaid, the Children's Health Insurance Program (CHIP) and the Marketplaces. IHS works with CMS and the Tribes on a number of issues, including implementation of recent legislative changes, third-party coverage, claims processing, denials, training and placement of State Medicaid eligibility workers at IHS and Tribal sites to increase the enrollment of Medicaid eligible AI/AN patients. IHS is coordinating outreach, education, and training efforts in order to avoid duplication of efforts. IHS has partnered with CMS to provide a number of training sessions for Tribal and IHS employees, focusing on outreach and accessing the Medicare the Medicaid programs.

In December 2012, IHS and the Department of Veterans Affairs (VA) signed the VA IHS National Reimbursement Agreement. This agreement, which will facilitate reimbursement by the VA to the IHS for direct health care services provided to eligible American Indian and Alaska Native veterans in IHS facilities, is a significant step forward in ensuring implementation of Section 405 of the IHCIA. The agreement represents a positive partnership to support improved coordination of care between IHS and the VA and paves the way for future agreements negotiated between VA and tribal health programs. This agreement will result in increased collections that can help expand services for all patients at the local level.

IHS continues to work to enhance each IHS operated facility's capability to identify patients who have private insurance coverage and improve claims processing, particularly by utilizing a more robust program to monitor and follow up on outstanding bills. The local Service Units utilize the funds collected to improve services,

such as the purchase of medical supplies and equipment, and to improve local Service Unit business management practices. The IHS continues to make use of private contractors to pursue collections on outstanding claims from private payers.

Annually, IHS trains health care facility staff in the areas of accounts receivable, Unified Financial Management System (UFMS), coding and monitoring program activities. In April 2012, the IHS held its 13th Annual Partnership training conference where over 50 sessions were provided to over 500 IHS, Tribal, and Urban Indian organization staff on all aspects of the revenue cycle.

The IHS Director charged a multi-disciplinary working committee, with Federal, Tribal and urban Indian health program representatives, to develop a structured and consistent approach to analyze existing needs and opportunities to fully implement the Affordable Care Act at the regional and local level for both IHS direct and Tribally operated programs. The working committee developed this approach, in part, to enhance current practices in ongoing outreach and enrollment at the local Service Unit level. Service Units have had routine practices in place to encourage enrollment in Medicare, Medicaid, Private Insurance and VA coverage as a way to exhaust all other third party sources since IHS is by statute the payor of last resort. The working committee was convened to help provide guidance to local Service Units to prepare for the Marketplaces and Medicaid Expansion in 2014 by building on current IHS work to conduct outreach, education, and enrollment for Medicare, Medicaid and Private Insurance as a part of its business office and contract health service program functions. A standard implementation/business planning template was finalized by this committee. This important collaboration between agency staff and its external partners is intended to provide a template for monitoring ongoing accountability for preparation and implementation at all organizational levels in IHS, and should result in increased third-party collections in the future.

Prevention/Public Health

Question 13. As you have seen in ACA, where hospitals are expected to provide community needs assessments, and the Prevention Public Health Trust Fund supports community transformation grants, how is the IHS intervening on a population level to prevent disease and promote health on a wider scale than clinical services?

Answer. IHS has been using a population-based approach to prevention and treatment since its inception in 1955. The IHS is a comprehensive, primary care network of hospitals, clinics and health stations that implements both clinical and public health services and interventions to raise the health status of American Indians and Alaska Natives to the highest level. The combined approach of clinical and public health services makes IHS uniquely suited to address health on both an individual and community/population level.

One of the most important aspects of IHS in terms or promoting community transformation is its longstanding policy to consult with the Tribal communities it serves in the development and implementation of policies and strategies to improve the health of the community. IHS facilities consult with local Tribal leadership and provide education and awareness of health issues and needs. This in turn can help Tribal leadership play a more collaborative role with the IHS to address health issues in the community. Another aspect is the availability of the authority for Tribes to take over the management of health care services in their communities that were previously provided by IHS under the Indian Self-Determination and Educational Assistance Act, which is the ultimate expression of community engagement in population level health. IHS' budget funds both clinical and community services, including public health nurses and community health representatives that help the health facility extend its services and prevention activities directly to the community. IHS also focuses on preventing disease on a population level. For example, IHS developed initiatives such as the IHS Healthy Weight for Life initiative, the IHS Baby Friendly Hospital initiative as a part of the First Lady's Let's Move in Indian Country Campaign, and the Special Diabetes Program to address the epidemic of obesity in AI/AN community. These initiatives include both clinical aspects and community-based efforts to more effectively address risk factors and needed preventive services. These efforts help IHS address health and prevention beyond the clinical setting and provide a venue for maximum community involvement and engagement in creating healthier communities for the future.

Two years ago, the Justice Department reported that Indians were at least twice as likely to be raped or sexually assaulted as all other races in the United States. Indians living in remote areas may be days away from health care facilities providing medical forensic exams. GAO completed its study and made five recommendations to improve IHS's response to sexual assault and domestic violence, including a new sexual assault policy and required training and subpoenas or requests to testify.

Question 14. I appreciate your efforts to adopt the GAO report's recommendation for IHS to improve its response to domestic violence and sexual assault by increasing training and engagement. Increased awareness most likely also increases the numbers of identified cases of assault as screening and self-report increases. How will you know when your prevention efforts result in fewer actual incidents of assault and domestic violence?

Answer. Despite limited Native-specific data, it is critical not to wait to move forward in developing healthcare responses to violence. Until more is known about what works and for whom, the IHS is using prevention principles and evidence-based and promising practices to strengthen its approach and evaluation to determine the effectiveness of new or existing programs. In 2009, the Domestic Violence Prevention Initiative (DVPI) was established with the purpose of better addressing domestic and sexual violence (DSV) in American Indian and Alaska Native (AI/AN) communities. DVPI is gathering baseline data to evaluate future programming strategies aimed at reducing the prevalence of DSV. The IHS will use comparative effectiveness data from GPRA and DVPI outcomes measures to determine whether prevention efforts are resulting in fewer actual incidents of DSV.

Today, victims are much more comfortable disclosing abuse to a doctor or nurse than they would have been in the past. Regular face-to-face screening of women by skilled healthcare providers markedly increases identification of victims of domestic violence, as well as those who are at risk for verbal, physical, and sexual abuse. Assessment for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence.

The IHS Government Performance and Results Act (GPRA) measure for domestic violence is the percentage of AI/AN female patients ages 15 to 40 who have been screened for domestic and intimate partner violence during the year. Since 2008, the IHS has far exceeded the long-term goal of screening at a rate of 40 percent.

The DVPI promotes the development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to domestic violence and sexual assault from a community-driven context. In the first two years of programming, the DVPI impacted multiple individuals through a variety of services. The initiative resulted in over 151,000 screenings and more than 11,000 referrals for victims of domestic violence. Over 19,000 individuals received crisis counseling and related services and over 6,000 professionals were trained on domestic violence prevention at 478 training events. A total of 344 SAFE kits, which are used at hospitals to collect evidence, were submitted to Federal, State, and Tribal law enforcement.

We are very concerned about the rapid increase in HIV cases on the Navajo Nation in New Mexico and Arizona recently reported in the 2012 Navajo Area Indian Health Services HIV Annual Report, released in May 2013. The number of Navajo members newly infected with HIV has risen by over 400 percent in the past 13 years, when new cases are truly preventable. From 2011- 2012, 47 new cases of HIV infection have been diagnosed, an increase of 20 percent from the prior year and the highest number ever recorded among the tribe. Left untreated and uncontrolled, HIV can have devastating effects upon tribal communities and families, particularly those in isolated areas of the Navajo Nation.

Question 15. What is the IHS doing to address and reverse this growing problem?

Answer. For several years, the Indian Health Service has made substantial investments in the HIV care and prevention needs of the Navajo Area. HIV-specific pilot program funding to federal Navajo Area sites in FY 2010, FY 2011, and FY 2012 cumulatively totaled $1,020,000. Further, the Navajo Nation was a recipient of HIV testing and prevention cooperative agreements in FY 2010 and FY 2011 totaling $198,000. It is unknown what proportion of new diagnoses in recent years are a result of better testing or a true increase in cases, but this data helps guide prevention and treatment efforts in the community and in the clinic and hospitals located in the Navajo Nation.

IHS' investments have yielded measurable improvements in local prevention and care efforts. While many other IHS areas must send patients to other providers for HIV care, the Navajo Area offers HIV care in its facilities. Local health care increases continuity of care and patient satisfaction with HIV-related services when it is offered as part of accessible comprehensive healthcare. The 2012 mean CD4 cell count among new cases was 461 per cubic millimeter, a dramatic increase from the 2011 mean of 340 per cubic millimeter. Higher CD4 counts may reflect improved success in diagnosing cases early through increased screening efforts. A CD4 count is a laboratory method to assess the level of HIV disease activity. Lower numbers are more commonly encountered in persons at more advanced stages of HIV infection. Of the 436 people who have ever been diagnosed by Navajo Area facilities, 58 percent were either in care or intermittently in care in 2012. Of the people in care

with Navajo Area facilities, 54 percent had an undetectable viral load, meaning the HIV virus was treated to the point of being undetectable. Of the 47 people newly diagnosed with HIV in 2012, 87 percent were either in care or intermittently in care with Navajo Area facilities.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO HON. YVETTE ROUBIDEAUX

Ms. Roubideaux, last June the Supreme Court in *Ramah v. Salazar* held that under the current appropriations/contracting process, tribes are entitled to full contract support costs under their agreements with the Federal government. However, it wasn't until April, when the President released his budget that it became known to Congress and the tribes that the Administration proposed to create a separate appropriations account for contract support costs with the effect of preventing tribes from making claims again the full contract support cost amount.

Question 1. In all that time, between June 2012, and April 2013, why didn't the Administration consult with tribe's on the implications of the *Ramah* case? I understand this is an "interim solution". What is your long term solution?

Answer. During the fall of 2012, the IHS requested input from Tribes on how to factor the *Ramah* decision into IHS budget priorities during its Area and National budget formulation process and in a letter to Tribes. At every opportunity, I encouraged and sought Tribal input through Tribal Delegation Meetings, letters, listening sessions and national conferences on a variety of topics and issues, including the *Ramah* decision and CSC appropriations. I also mentioned the Supreme Court options at various meetings with Tribal leadership and asked for their views. In general, Tribes reported their preference was for full funding of CSC incurred under their contracts and compacts, and they opposed all other options. I ensured that this input was considered during the Administration's budget formulation process.

I have consistently advocated for the needs of Tribes and brought forward tribal budget priorities, including the importance of adequate CSC funding. Ultimately, the Administration's decision to include the interim CSC proposal in the FY 2014 budget was made after consideration of all views and weighing priorities across the government in this difficult budget climate.

Soon after the release of the FY 2014 President's Budget, the Administration heard from Tribes about the proposal for new appropriations language for CSC. At several events including a listening session on April 23, 2013 and a conference call on May 29, 2013, the Administration heard input from Tribes on this issue. The FY 2014 proposal is an interim solution; I remain committed to finding a long-term solution for CSC, and I am currently consulting with Tribes on CSC to try to find a long-term solution. Tribal leaders have indicated that these discussions may be more effective in smaller group settings, such as with the various IHS advisory groups, and those discussions have begun.

Dr. Roubideaux, I understand one of your priorities as Director of the Indian Health Service is to improve quality and access to health care. I would like to talk about two important programs to the health delivery system of rural Alaska. The Administration has been tasked with implementing the Indian Health Care Improvement Act. I believe the Indian Health Care Improvement Act affirmed the success of the Dental Health Aide Therapy program in tribal communities. It is essential that we see your support of the DHAT program in the budget process in order see the improvements in access to oral health in tribal communities.

The second program that is essential to delivering basic health services in some of our most remote Native communities is the Village Built Clinic Lease program. The Indian Health Care Improvement Act mandates that the Indian Health Service develop and operate the Community Health Aide Program, of which funding for Village Build Clinic leases are essential.

Question 2. May I have your commitment that you will find adequate budget resources for these two programs within the budget of the Indian health service?

Answer. I am committed to working with you and the Alaska Tribes during the budget formulation process on Tribal budget priorities at the Area and the national level. With regard to resources within the current IHS budget, I am willing to work with Tribes on identifying any flexibilities in available resources.

With regard to the Village Built Clinics Program, Alaska Tribal Health Organizations (THOs) manage approximately 99 percent of IHS funds allocated to Alaska under the Indian Self-Determination and Education Assistance Act (ISDEAA). THOs have flexibility to determine how these funds and any increases are allocated to all their programs including the Village Built Clinic (VBC) program. IHS has offered to establish a workgroup to discuss next steps to address this issue but the

Tribes in Alaska have so far declined this offer of dialogue on the issue. IHS has considered the VBC in budget formulation but at the national level, Tribes did not include this as a national priority increase. Given the difficult budget climate, inclusion of Area-specific budget priorities is a challenge and is generally not supported at the national level by Tribes. IHS is willing to continue working with the Alaska Tribes on this issue.

During the 2015 budget formulation, the National Tribal Budget Formulation Workgroup recommended a $119.6 million increase to the hospitals and clinics line item. With such an increase, Alaska Tribes could choose to allocate more funding to the VBC leases. If supported by Alaska Compact Co-Signers, the IHS will explore options, including forming and participating in a workgroup with Alaska THOs, to address the VBC funding issue notwithstanding obstacles posed by current litigation related to the Ambler VBC.

The Community Dental Health Aid Therapist (DHAT) has achieved remarkable success and progress in improving dental health for Alaska Natives and American Indians in rural Alaska. As is the case with the VBC program, Alaska THOs have flexibility in determining how IHS funds managed by them are allocated to their programs including the DHAT program. During the 2015 budget formulation, the National Tribal Budget Formulation Workgroup recommended a $20.4 million increase to the dental services line item. With such an increase, Alaska THOs could choose to allocate more funding to the DHAT program. If supported by Alaska Compact Co-Signers, the IHS will explore options to support increased funding to the DHAT program. In addition, the IHS is prepared to facilitate support offered by other partners and stakeholders who are prepared to contribute to the DHAT program.

Follow-up Questions

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BARBARA BOXER TO HON. YVETTE ROUBIDEAUX

Question 1. In 2009, I asked what steps you would take to address funding shortfalls for California's Contract Health Service area and you indicated that "in consultation with tribes, [you would] review the funding issues that are particular to California" and "make it a priority to review how IHS is handling referrals to determine how to improve the process, and to ensure that the rules in [California's Contract Health Service area] are clear and well understood by both patients and referral partners." Please detail the steps you've taken to accomplish this in your previous term, and what specifically you will do to continue addressing this issue if reconfirmed.

Answer. In the California Area, Tribal organizations exclusively provide all health care through contracts or compacts. IHS has provided the California Tribal CHS programs with the most up-to-date information on CHS best practices and regulatory changes that could improve California's CHS programs. IHS provides consultation, training, outreach and education for all CHS staff and Tribal Health Directors on CHS rules and regulations as requested by the Tribes. We have provided training for Tribal programs on calculating the Medicare Like Rates to assist them in their CHS business process. IHS holds annual meetings for the sharing of CHS practices and networking for Tribal CHS programs. The California Area Office also has quarterly conference calls with Tribal CHS staff to assist them in improving their CHS processes. The IHS/CAO conducts Contract Health Service listening sessions for tribal government officials during the area-wide budget formulation and at the Area Annual Tribal Consultation meeting. My Tribal Workgroup on Improving CHS has reviewed the national distribution formula for CHS funding increases and the effects of the formula on funding for each IHS Area including ensuring that Areas most in need of CHS funding are receiving relatively more of the available CHS funding increases. The workgroup concluded that the funding increases were going to the Areas that had the need for services as defined by the current distribution formula and recommended that the distribution formula remain the same. If confirmed, I will continue to implement the recommendations of the CHS workgroup to improve business practices in CHS programs and will ensure that Tribal CHS programs are kept aware of these improvements and are encouraged to implement them.

Question 2. Through the course of implementation of the Affordable Care Act, will the definition for American Indian/Alaska Native people be the same as it was for Section 5006 of the American Recovery and Reinvestment Act (ARRA) (also known as the "Medicaid definition")?

Answer. The Administration has thoroughly reviewed the varying definitions of the term "Indian" in the Affordable Care Act. At Congress' request, the Administration provided technical assistance to Congress to align the definitions referenced in the law with that used for IHS eligibility and Medicaid eligibility. The technical assistance to Congress is consistent with Tribal consultation on the subject. We will continue to work with Congress to ensure the needs of Indian Country are considered as implementation of the Affordable Care Act moves forward. Related to this issue, on June 26, 2013, the Administration released a final rule that granted an exemption for individuals who are eligible to receive services from an Indian health care provider from the shared responsibility payment for not maintaining minimum essential coverage.

I understand that you have issued a verbal directive for all IHS facilities to carry and offer emergency contraceptives. I am pleased to hear of this progress at IHS, however a verbal directive can be rescinded at any time. We need a permanent policy that says that all IHS facilities—including those that serve Alaska Natives—shall carry and offer emergency contraceptives consistent with law.

Advocates for women's health have been pushing for such a policy for several years, and have continued to be told that IHS is "working on it." In fact, in May 2012 the IHS informed advocates in writing that it was "finalizing" such a policy, but that policy has still not been issued.

Question 3. Can you please outline for me your timeline for issuing and implementing this permanent policy?

Answer. A complete revision of the pharmacy chapter of the Indian Health Manual began in fall 2012 and is in progress. The revisions address the need to follow FDA labeling for medications such as emergency contraception. IHS plans to review comments from the most recent staff review and hopes to put the final updated policy in place soon. IHS has had a Sexual Assault Policy in place since 2011 that identifies the roles and responsibilities of Sexual Assault Nurse Examiners and Forensic Examiners, including providing access to emergency contraception.

Question 3a. In addition, can you please tell me what enforcement mechanisms IHS will have in place to ensure that IHS facilities comply with such a policy?

Answer. IHS already has performance management plans in place to hold employees accountable for providing appropriate care. IHS has monitored access to emergency contraception and confirmed that all federally operated IHS facilities offer it according to FDA labeling. Corrective action will be taken by each Area if the facility is found to be out of compliance with the policy, and IHS is requesting that if individuals experience difficulties accessing the medication, they contact IHS with the name of the relevant facility and provider.

FOLLOW-UP QUESTIONS

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO HON. YVETTE ROUBIDEAUX

Question 1. In response to the question "Many Indian tribes have an acute need/or health care facilities as well as chronic staffing shortages. Though the Indian Health Care Improvement Act directs IHS to consult with Indian tribes and tribal organizations in addressing these needs, existing IHS facility construction programs, such as the Small Ambulatory or Joint Venture programs, are funded sporadically if at all. Many tribes have used their own tribal funds to finance and build new health facilities, but do not receive additional staffing packages for these facilities. How specifically does the Indian Health Service plan to address staffing shortages in health care facilities?"

Your response states "For new and replacements [sic] facilities, the Administration requests from Congress funding at 85 percent of need in the President's annual budget proposal".

Why is the Administration only requesting 85 percent of need for new and replacement facilities?

Is the same 85 percent reduced rate applied for existing service unit vacancies?

Answer. The IHS has a longstanding practice that establishes 85 percent as a standard at which full-time equivalent (FTE) staffing levels for newly constructed facilities is requested. In the mid 1980s, the IHS wanted to establish uniformity and pursue equity in budgeting for this resource need. The IHS recognized that it was unlikely that 100 percent of the staff, as determined by the IHS Resource Requirements Methodology (RRM), could be recruited and actually brought on board during the fiscal year that the new facility was completed and that it was also necessary

to adjust the FTE during the first year based on the number of months that the facility would be in operation.

An informal review of IHS staffing patterns and other personnel management related factors at the time indicated that 85 percent of the total level of staffing needs, adjusted to reflect the number of months of operations, was a reasonable estimate of the number of staff that could be recruited during the first year and that could ensure that all services for which the facility was designed and constructed could be provided. Accordingly, the IHS has been following this practice in the formulation of its budget for staffing for new and replacement facilities since the 1980s. It is also the practice of IHS to request the annualization of these resources in the subsequent year. Over the years, consultation with Tribes has not indicated a strong desire to change the 85 percent level of total level of funding for new staffing, and these estimates are routinely used in budget formulation discussions with Tribes.

The 85 percent methodology is not applied to staffing levels at existing facilities. The 85 percent of need standard is only used when requesting funds for additional staffing for newly constructed facilities. Staffing levels at existing facilities are determined locally by a number of factors, including available appropriations, third party revenues, user population needs, accreditation requirements, renovations and service changes and tribal consultation. Some facilities may determine, based on a variety of factors, that they will focus on specific types of staffing patterns that may differ from other facilities. Given population growth and inflation over time, without similar associated increases in the budget, the needs for staffing in existing facilities over time are often much less than the estimates for new facilities that are developed with the 85 percent methodology.

Question 2. Earlier in the response to the same question you state "focused efforts to recruit dentists over the last few years have reduced the vacancy rates for IHS from 35 percent to 10 percent".

Is the vacancy rate 10 percent of total need or is the 10 percent vacancy rate based on the 85 percent reduced level of need?

Answer. The vacancy rate fluctuates on a continual basis, as providers transition in and out of service and local facilities determine their staffing needs. The current rate reflects known vacancies reported by all IHS/Tribal/Urban (I/T/U) facilities and is based on the total number of oral health care provider positions currently planned for at I/T/U facilities. It is a ratio of the number of known vacant positions to the total number of available positions. The 85 percent of need standard is only used when requesting funds for additional staffing for newly constructed facilities. This standard is not used in calculating the vacancy rate.

Question 3. As part of the Agency's investigation of all Area Offices, I specifically requested that you analyze staffing levels and staff shortages in the Agency's Washington State service units. What were the Agency's specific findings in relation to staffing in the Portland Area Office, and are those findings representative across service areas?

Your response indicated that more than half of the staffing needs at the three facilities identified are provided for using third-party billing sources. As the Patient Protection and Affordable Care Act continues to come online and more Indian patients have access other options for medical care, causing third party collections to be reduced, does the Indian Health Service anticipate further staffing shortages?

Answer. The Indian Health Service's FY 2014 budget request projects a $95M increase as a result of Medicaid eligibility expansion in the Affordable Care Act. Once the Affordable Care Act is fully implemented, many of our patients may have access to additional health insurance coverage and but will choose to continue to access IHS and tribal facilities for health care. In addition, the IHS provides quality and culturally specific services to our patients, which make it a preferred source of care for many patients. Finally, in our rural locations, where transportation is often a challenge, IHS and Tribal clinics are the most accessible for many of our patients.

However, IHS recognizes that with additional health benefits coverage, some patients may pursue care outside of the IHS health care system, potentially reducing collections and decreasing staffing needs. IHS has required all federal Service Units to conduct local business planning using a suggested template to ensure they prepare for implementation of the Affordable Care Act by estimating the number of patients who will be newly eligible for health insurance coverage: anticipating the staffing and management resources needed to assist with enrollment, outreach, and education; making the billing and collections process more efficient, and improving customer service and retention. The goal of the business planning is to ensure robust collections and users, therefore preserving critical funding for services and staffing.

Facilities may use third party collections as one option for increasing staffing. Sites are working to maximize their collections through more efficient billing and collection systems, which may result in increased collections at local facilities. Facilities may use third party collections to fund other priorities in addition to staffing. The staffing shortages in Portland Area likely will continue into the next fiscal year due to competing priorities for funding at the local level, continued recruitment and retention challenges for many facilities, and a growing nationwide shortage of primary care providers. Staffing shortages are seen throughout the IHS due to the level of appropriations not meeting the overall need for services. IHS estimates that its programs are on average funded at 56 percent of the level of need when compared to per capita funding for federal health insurance, meaning there is not funding available to staff facilities at 100 percent. The President's Budget requests funding for additional staffing for newly constructed healthcare facilities and continued funding for and enhanced efforts on recruitment and retention of Indian Health Professionals. Increases in most IHS budget line items can result in increased staffing levels.

Question 4. How many Dentist positions are vacant within the IHS and Tribal Dental Health Programs?

Your response indicates that there are currently "51 known vacancies" at the Indian Health Service. Again, does this number reflect the 85 percent reduced level of need or total required staff? How many vacancies are located in the state of Washington?

Answer. The number represents the total number of known, funded opportunities currently vacant for dentists and hygienists. If a field program does not report or advertise a vacant position due to inadequate funding or other reasons, that vacancy would not be counted in the reported number of known vacancies. Therefore, the number of current known vacancies represents the number of vacant oral health care provider positions our field program administrators feel they can fund at this time. At present, Washington State has two known vacancies, both for dentists.

Question 5. As part of the Agency's investigation of all Area Offices, I specifically requested that you analyze staffing levels and staff shortages in the Agency's Washington State service units. What were the Agency's specific findings in relation to staffing in the Portland Area Office, and are those findings representative across service areas?

Your response identifies there are zero mental health professionals and a Total Required Staff need of 13.1 professionals. What is the Agency doing to address the lack of any mental health professionals in these service units?

How many vacancies, based on Total Required Staff and not based on the 85 percent reduced level, exist Agency-wide for mental health professionals?

Answer. The recruitment and retention of behavioral health providers is a priority and remains a significant challenge for the Indian Health Service. The IHS offers two financial incentive programs to behavioral health care students and providers that offer financial support in exchange for service in IHS-designated facilities. The IHS Health Professions Scholarship Program is designed for American Indian and Alaska Native (AI/AN) recipients. Scholarship recipients receive full or partial tuition support and a living stipend in exchange for a two- to four-year service obligation. Upon completion of their training and appropriate clinical licensure, scholars work in IHS-designated facilities located in designated health professional shortage areas.

The IHS Loan Repayment Program offers loan repayment awards for a two-year commitment, with the option of additional loan repayment for continued years of service. Loan repayment recipients can choose to work in one of the 283 health clinics and 45 hospitals operated by IHS, Tribal organizations, and urban Indian health programs.

The National Health Service Corps (NHSC), administered by the Health Resource and Services Administration (HRSA), is also an increasing source of service-obligated providers, including behavioral health professionals, for Indian health sites. IHS and HRSA have collaborated to increase the number of IHS, Tribal and urban Indian health program sites that are eligible for and employ NHSC providers.

The American Indians into Psychology Program—known as INPSYCH or Section 217 (of the Indian Health Care Improvement Act)—is a grant program that serves to increase psychological services provided to AI/AN communities. INPSYCH's goal is to raise awareness in Tribal communities about the field of psychology. The program provides stipends to undergraduate and graduate students pursuing careers in psychology, and establishes training opportunities for psychology graduate students within Tribal communities.

The IHS works collaboratively with the American Psychological Association, the National Association of Social Work, the American Counseling Association, the Mental Health Counselor Association, and the National Board of Certified Counselors to share and promote recruitment and retention opportunities. These professional organizations utilize their email listservs and social media outlets, such as Facebook, to promote IHS recruitment and retention information sharing, including through IHS virtual job fair announcements and current behavioral health vacancy announcements.

Staffing levels at existing facilities are determined locally by a number of factors, including available appropriations, third party revenues, user population needs, accreditation requirements, renovations and service changes and tribal consultation. Our review of staffing for the three Portland Area IHS-operated Service Units indicated no current mental health professionals employed by the Federal government at these sites. This is due to the behavioral health programs and services being assumed by the local Tribes under the Public Law 93–638 process, so all mental health professionals would be tribal hires, not federal hires. Therefore, the report shows zero federal hires, and the staffing need you cite above represents the estimated need if IHS were federally managing the program. A quick survey of those tribally managed behavioral health programs indicates they are staffed at levels above the recommendation for new facilities, but they would prefer more staff to meet the 15:1 recommended case load. These programs are currently staffed at about 30:1 cases per provider with available appropriations and collections.

Due to Tribal contracting and compacting, calculating the number of Agency-wide mental health vacancies is also difficult. Nationally, Tribes administer and deliver over 80 percent of their own mental health programs. The number of career opportunities that are currently announced through the IHS system represents current career opportunities; however, this number does not necessarily equate to overall vacancy rates. Presently, there is not a centralized system for tracking vacancies for federally-employed mental health professionals. IHS tracks vacancy rates for a limited number of professionals, such as physicians and dentists. However, IHS is developing a revised version of the physician position reports system. During the development, IHS will include requirements to track future vacancy rates for mental health professionals and other health professions.

Question 6. As part of the Agency's investigation of all Area Offices, I specifically requested that you analyze staffing levels and staff shortages in the Agency's Washington State service units. What were the Agency's specific findings in relation to staffing in the Portland Area Office, and are those findings representative across service areas?

Your response provided staffing needs for three federally-managed Service Units in the state of Washington. Does the Agency assess staffing needs for contracted and compacted facilities? What are the staffing needs of the Portland Region for all facilities in the state of Washington?

Answer. The IHS does not assess staffing needs for contracted and compacted facilities. Tribes that have chosen to manage their own programs are not required to provide this information.

Health Status and Resource Deficiency Report

Included in the permanent reauthorization of the Indian Health Care Improvement Act within the Patient Protection and Affordable Care Act, a provision required that the "Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service unit; including newly recognized or acknowledged Indian tribes."

Question 7. What is the status of that report? How does the Agency plan to address deficiencies, if any, identified in the report? Is there a timeframe to respond to deficiencies identified in the report?

Answer. The health status and resource deficiency report is in preparation. Following passage of the Affordable Care Act, the IHS evaluated the report's methodology and conducted tribal consultation on it. After review of the consultation input by a tribal workgroup, core components of the methodology were retained, numerous technical and data improvements were adopted, and a majority of tribes endorsed retaining the current form of resource allocation formula until funding for every tribe is raised to at least 56 percent. New data was collected including user counts, medical price factors, health status, and funding provided by IHS. Calculations are underway to revise resource deficiency estimates. The resource allocation formula, endorsed during consultation, is designed to address resource deficiencies. The formula allocates new appropriations to the Indian Health Care Improvement Fund in priority order to local health care programs with the greatest deficiencies. Appro-

priations are considered during the annual budget formulation process in consultation with Tribes.

This assessment occurs at a time of unprecedented potential change in America's health care systems. These major changes will also affect the American Indian and Alaska Native (AI/AN) health care system. The Affordable Care Act will extend affordable health insurance to millions of Americans including AI/ANs. Also, the Act provides to members of federally recognized tribes additional cost sharing waivers and the ability to enroll monthly. Newly affordable health insurance coverage in combination with expanded eligibility for Medicaid in some states and continuation of Indian Health Service programs has the potential to help reverse chronic deficiencies in health care available to AI/AN people. However, these important changes will take time to fully mature. The resource deficiency report now in preparation should be considered "transitional" and should be replaced when the combined effects of these major changes can be demonstrated with concrete data.

Epidemiology

Question 8. As the need for improved health status reporting continues to grow, how can we better utilize tribal epidemiology centers to meet the increased demand for improved health surveillance?

Answer. The Tribal Epidemiology Centers are tribally managed organizations that serve AI/AN Tribal and Urban communities by managing the epidemiologic needs of the Tribes that they serve. To increase health surveillance activities in Indian Country, the IHS continues to promote the use of the Tribal Epidemiology Centers (TEC) through collaborations with our federal partners. For instance, in August 2013, the IHS collaborated with the National Vaccine Program Office in the Office of the Assistant Secretary for Health by establishing an Interagency Agreement for a project to evaluate adult immunization coverage and the utility of a composite immunization measure for adults seen in the IHS healthcare system. The project will be carried out in partnership with the Northwest Portland Area Indian Health Board's TEC.

Question 9. A significant barrier identified by tribal epidemiology centers is the inability to access data sources from both within and outside of the IHS system. What efforts, if any, are being undertaken to assure better data access to assist the epidemiology centers?

Answer. The newly enacted IHCIA identifies tribal epidemiology centers (TECs) as Public Health Authorities; this status enables TECs to access significant data from other entities beyond the IHS. To further support this designation, a standardized data sharing agreement (DSA) template has been developed to facilitate data sharing while ensuring compliance with the Health Insurance Portability and Accountability Act (HIPAA) and Privacy Act regulations. The DSA template specifically provides TECs access to de-identified data from the IHS Epidemiology Data Mart (EDM)/National Data Warehouse (NDW). Currently eight of the twelve TECs have signed DSAs with IHS. IHS will continue to work with the TECs to develop public health data capacity for the benefit of the Tribes that they serve.

IHS continues to foster communications between public health entities, including other federal agencies and state and local health departments, and the TECs to address TEC concerns of accessing public use data. Strategies to reduce barriers to public health data access continue to be developed through national and regional meetings hosted by public health organizations including the Council of State and Territorial Epidemiologists (CSTE) and National Association for Public Health Statistics and Information Systems. IHS continues to be a partner in these collaborative initiatives.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO HON. YVETTE ROUBIDEAUX

Life Expectancy

At the April 23, 2009, Committee hearing on the Nomination of Yvette D. Roubideaux to be Director of the Indian Health Service, you were informed that the life expectancy on the Wind River Indian Reservation in Wyoming was 49 years. Yet, as of the June 12, 2013, Committee hearing on the Nomination of Yvette Roubideaux to be Director of the Indian Health Service, U.S. Department of Health and Human Services, the average age at death remained around 49 years.

In your written responses to Committee questions regarding the cause of the early deaths on the Wind River Indian Reservation, you state that unintentional injuries are the leading cause of death, most notably, motor vehicle crashes. You state that

injury prevention services are prioritized locally at the Wind River Indian Reservation.

According to your responses, in FY 2013, funding for injury prevention projects to the Eastern Shoshone tribe totaled approximately $5,400. You state that funding for injury prevention projects to the Northern Arapaho tribe totaled approximately $11,000. You further state that the effectiveness of the Injury Prevention Program is evidenced in the reduction of the overall unintentional injury death rates by 58 percent since 1980.

Question 1. Are the funding amounts of $5,400 to the Eastern Shoshone tribe and $11,000 to the Northern Arapaho tribe the only resources the IHS is dedicating to addressing the death rates from unintentional injuries?

Answer. No. These funding amounts are the Billings Area Injury Prevention (IP) "Special Project" dollars that are given to each tribe for Injury Prevention Activities. There are other resources such as staff that address unintentional injuries. The Eastern Shoshone tribe has a full time IHS Environmental Health Specialist whose duties include Injury Prevention. The Eastern Shoshone Environmental Health Program received approximately $77,000 for FY 2013 to fund this FTE. The Northern Arapaho Tribe has a P.L. 93–638 contract with the Billings Area IHS to provide Environmental Health services including Injury Prevention. The Northern Arapaho tribe has contracted all shares of the Environmental Health Program. The contract amount for Environmental Health Services in FY 2013 is $59,000. The Northern Arapaho tribe decides how these funds are spent. In addition, the Billings Area Office staffed a full time Injury Prevention Program Manager from 2005–2013 whose primary job was technical consultation to Service Unit Injury Prevention programs.

Question 2. Please provide the funding amounts for Injury Prevention projects to the Wind River tribes for each of FY 2003–FY 2013.

Answer.

Year	Northern Arapaho	Wind River	Total IP
2003	$0.00	$16,462.00	$16,462.00
2004	$0.00	$16,462.00	$16,462.00
2005	$10,844.00	$5,711.00	$16,555.00
2006	$10,838.00	$5,707.00	$16,545.00
2007	$10,869.00	$5,724.00	$16,593.00
2008	$10,869.00	$5,724.00	$16,593.00
2009	$11,281.00	$5,485.00	$16,766.00
2010	$11,368.00	$5,583.00	$16,951.00
2011	$11,493.00	$5,675.00	$17,168.00
2012	$11,493.00	$5,675.00	$17,168.00
2013	$10,894.00	$5,380.00	$16,274.00
Total	$99,949.00	$83,588.00	$183,537.00

Question 3. What is the funding formula and method used for allocating or distributing funding for Injury Prevention projects among IHS Areas and Service Units?

Answer. Resources for Injury Prevention projects are included within funding for each Area's Division of Environmental Health Services (DEHS) program. These funds are used for salary and benefits, travel, supplies, training, and related costs for permanent and contract staff in the DEHS Program at the area, district and field levels. Each Area receives a recurring amount which is adjusted based on the Area's share of calculated workload and other factors such as staffing changes. Injury Prevention project funding levels are determined differently in each Area. For the Billings Area, injury prevention special project funds are allocated to each service unit based on a funding formula that starts with the total Billings Area Injury Prevention project funds and divides these funds based on each Service Unit's user population. These funds are reflected in the table provided in response to question 2, above.

Question 4. If many of these motor vehicle crashes are alcohol related, what steps, if any, is the IHS taking to deal with impaired driving and alcohol abuse prevention on the Wind River Indian Reservation?

Answer. The IHS Environmental Health Services program at the Eastern Shoshone tribe in Wind River used their FY 2013 allocation of Injury Prevention project funds to purchase child passenger safety seats for distribution to tribal children ages 0–5 years. Nationally, the IHS Injury Prevention Program collaborates with the Indian Highway Safety Program, Bureau of Indian Affairs (BIA) and National Highway Traffic Safety Administration (NHTSA) to coordinate a systematic approach to implement successful strategies that reduce motor vehicle-related injuries

and fatalities. One success for impaired driving prevention is the use of the *None for the Road Campaign*, a video and resource directory (developed by the Alberta Motor Association) on how to implement a DUI/DWI prevention program, and an inventory of Tribal traffic laws. The Injury Prevention Program also partners with law enforcement agencies (tribal, BIA, State, etc.) to address impaired driving in tribal communities through special enforcement activities such as sobriety checkpoints and advocating for stricter DUI/DWI laws.

The Northern Arapaho and Eastern Shoshone Tribes each have chemical dependency services through the P.L. 93–638 Tribal Health Contract that includes funds for those services. All chemical dependency treatment, which includes alcoholism treatment, is managed directly by the Tribes. Services are provided in separate treatment centers, one for Northern Arapaho and one for Eastern Shoshone. Those treatment centers offer a variety of services, including assessment and diagnosis of substance abuse/alcoholism, outpatient treatment, adolescent treatment, aftercare services, Alcoholics Anonymous/Narcotics Anonymous classes, DUI classes, and prevention education. Each facility also receives funding for those individuals requiring inpatient treatment.

The IHS Methamphetamine and Suicide Prevention Initiative (MSPI) provides funding to the two Tribes of the Wind River Indian Reservation. The Wind River Service Unit Behavioral Health conducts chemical dependency (CD) evaluations, refers people to treatment, and works with the Tribal CD programs to organize transportation and payment, if necessary. The Northern Arapaho MSPI project provides methamphetamine and suicide prevention programming focusing on community outreach and culturally adapted training. Trainings include recognizing and responding to suicide risk as well as educational awareness on the impact of methamphetamine abuse. The project has developed and fostered partnerships with Tribal Health Care programs, Veterans programs, local and community agencies and organizations providing services to residents of the reservation. The Eastern Shoshone Tribe Demonstration Project for Suicide Prevention focuses primarily on suicide prevention but includes screening for mental health and substance abuse as well as supportive therapy based on the Red Road to Recovery, a 12-step Alcoholics Anonymous model. The project also offers a 16-hour DUI course for tribal members involved in the legal system due to charges resulting from substance abuse.

In your written responses to Committee questions regarding performance measures for unintentional injuries, you state that the two performance or budget measures being tracked by the IHS for unintentional injury mortality rates are: (1) injury interventions; and (2) the overall unintentional injury fatality rate, itself. You state that "[t]he current national Injury Intervention measure focuses on Tribal Injury Prevention Cooperative Agreement Sites increasing seatbelt use rates by 5 percentage points."

Question 5. Please clarify your explanation of the national Injury Intervention measure and its focus on seatbelt usage rates.

Answer. The leading cause of unintentional injury deaths for AI/AN, ages 1–44, is motor vehicle-related. Evidence-based research points to adult seat belt and child passenger safety seat use as the single most effective way to save lives and reduce serious injuries due to motor vehicle crashes. The use of seat belts can reduce serious injuries and deaths in motor vehicle crashes by at least 50 percent. The US national seat belt use for all races in 2012 was 86 percent (Traffic Safety Facts, NHTSA July 2013). AI/AN seat belt use ranges from 27 percent to 87.8 percent (Seat Belt Estimate Native American Tribal Reservations, DOT report, May 2008). Seat belt use is higher in states that have primary occupant restraint laws (88 percent) compared to states without (79 percent). A major factor of low seat belt use in AI/AN communities is the lack of occupant restraint laws or enforcement. There are nine Tribes with primary occupant restraint laws and the observed seat belt use rate is 73 percent. Tribes with secondary occupant restraint laws report 59.3 percent use rate. Tribes without occupant restraint laws report 37.2 percent seat belt use. The national IHS Injury Prevention program funds the Tribal Injury Prevention Cooperative Agreement (TIPCAP) sites to address the injury problem in tribal communities. Those sites that have identified raising seatbelt use as an objective contribute to the performance measure, which is to raise seatbelt use by 5 percent.

Question 6. Is seatbelt usage the only unintentional injury prevention performance indicator evaluated by the IHS? If so, please explain why. If not, please provide detail regarding other Injury Prevention Program performance measures being tracked.

Answer. Two IHS Injury Prevention performance measure indicators are: (1) injury intervention—seat belt use (see response to question 5, above); and (2) the overall unintentional injury mortality rate. The unintentional mortality rate is reported

through the IHS Office of Public Health Support, Division of Program Statistics. The most recent injury mortality data is reported in the IHS Disparities Fact Sheet for 2005–2007 (*http://www.ihs.gov/newsroom/factsheets/disparities/*).

Question 7. Please describe in detail the specific activities and services under the Injury Prevention Program provided or funded at the Wind River Indian Reservation to improve these performance measures, including any cooperative agreements. Please be specific.

Answer. None of the tribal entities on the Wind River Indian Reservation have applied for funding through the Tribal Injury Prevention Cooperative Agreements Program. As described in the response to question 4, above, the primary activity for Injury Prevention provided by IHS staff in the Wind River Indian Reservation is the distribution of child passenger safety seats to tribal children ages 0–5 years at the Eastern Shoshone tribe.

In your responses to questions regarding the unintentional injury rates in Indian country and the Wind River Service Unit, in particular, you state that the unintentional injury mortality rate for the Wind River Indian Reservation is 161.8 per 100,000 population. In a subsequent response and chart, you state the rate as 176.2 per 100,000 population.

Question 8. Please clarify or reconcile these unintentional injury mortality rates for the Wind River Indian Reservation.

Answer. The rate of 161.8 per 100,000 population is a crude death rate, and the rate of 176.2 per 100,000 population is the age-adjusted death rate. These two numbers use different assumptions and consequently provide slightly different information. In response to your previous round of questions, I ranked the leading causes of death using the crude death rate (161.8 per 100,000) in accordance with standard demographic conventions. Crude rates were used because they represent the whole population as a block rather than accounting for differences in exposure levels to an event (such as age). In response to a separate question, the age-adjusted rate (176.2 per 100,000 population) was used. Age-adjustment takes the range of ages of the members of the population and standardizes them according to the U.S. Standard Population (2000) so that the rates of individual kinds of injuries can be presented. The age-adjusted figure was used in a table to provide rates for individual components, rather than rankings. This table was used to show the prevalence rates of the different categories of injury so they could be compared against other groups for the same category of injury.

The second performance measure you describe in your response is the overall unintentional injury mortality rate, itself; however, the most current information you provide on this performance measure is 10 years old.

Question 9. Is more current data available? If current data is unavailable, how is the IHS evaluating efforts to decrease unintentional injury mortality and allocating resources effectively?

Answer. Updated information is currently in process. New versions of the IHS publications, Trends in Indian Health and Regional Differences, are anticipated to be released in the latter part of 2014. The Injury Prevention program of the Office of Environmental Health and Engineering collaborates closely with the Office of Public Health Support Division of Program Statistics (DPS) as well as its Area level staff to continue to monitor data produced by DPS or by the IHS National Data Warehouse. IHS and Tribal injury prevention staff are able to use health impact data, such as number of emergency room visits, number of motor vehicle crashes, number of arrests made during sobriety checkpoints, or number of car seats correctly installed, to evaluate the effectiveness of injury interventions.

Question 10. When will current data on this performance measure be available?

Answer. The most recently compiled data is available in a table, "Mortality Disparity Rates, American Indians and Alaska Natives (AI/AN) in the IHS Service Area 2005–2007 and U.S. All Races 2006 (Age-adjusted mortality rates per 100,000 population)." This is available on the web at *http://www.ihs.gov/newsroom/factsheets/disparities*. This table will be updated by the end of calendar year 2013.

Health Professions

In your written response to Committee questions regarding the most effective means of addressing the health care professional shortage in the Indian health system, you state that, in addition to the Indian Health Service (IHS) Loan Repayment Program and the National Health Service Corps Loan Repayment Program, IHS continues to develop additional systems and tools for use at the local levels to decrease these shortages.

Question 11. Please provide complete vacancy and turnover rate data by Area and each position within the respective Area Offices.

Answer. The IHS tracks aggregate vacancy rates at the national level for targeted critical disciplines (physicians, dentists, nurses, advanced practice clinicians, pharmacists, and optometrists) and is developing the capacity to track vacancy and turnover rates for all health professions. At the present time, only the physicians can be broken out by Area. The Physician Position Report is provided below. Presently, IHS headquarters does not track vacancies and turnover rates by all clinical position in each Area since many of these positions are recruited locally. The data for the discipline categories that we currently track is provided in aggregate from discipline representatives and is not broken out by Area.

Physician Position Report

Combined IHS/Tribal/Urban Facilities—July 2013

Area	Total Positions Allocated	Total Positions Filled	Total Positions Vacant	Total Accessions	Total Separations	Vacancy Rate	Turnover Rate
ABERDEEN	16	11	5	1	2	31%	18%
ALASKA	135	107	28	1	3	21%	3%
ALBUQUERQUE	74	56	18	1	0 24%	0%	
BEMIDJI	64	52	12	4	0	19%	0%
BILLINGS	44	27	17	2	0	39%	0%
CALIFORNIA	25	20	5	1	0	20%	0%
NASHVILLE						N/A	N/A
NAVAJO	52	38	14	5	1	27%	3%
OKLAHOMA	217	176	41	7	4	19%	2%
PHOENIX	128	99	29	8	2	23%	2%
PORTLAND	12	12	0	0	0	0%	0%
TUCSON						N/A	N/A

Question 12. Are the efficacies of these programs being evaluated by IHS in other ways? If so, how?

Answer. Yes, there have been retention studies and routine evaluation necessary for program management. The most recent retention study, performed in 2008, shows that the average loan repayment clinician remains employed for 4.9 years after the end of the service obligation while scholars remain an average of 3.7 years. In order to update this information the IHS recently implemented a Retention module in the Loan Repayment tracking system that will provide data on retention of Loan Repayment participants in the near future. This system will provide retention data on a real time basis with the first full year of data available at the end of FY 2014. Additionally, both the Loan Repayment and Scholarship programs solicit input annually from federal, tribal and urban Indian programs to update the list of disciplines covered and to inform the Loan Repayment priority site scoring process.

In your written response to a question which asked you to identify the positions and numbers of vacancies among health and dental care professionals, including physicians, nursing professionals (including nurse practitioners, SANEs, etc.), pharmacists, radiologists and technicians, dentists, dental hygienists, psychiatrists and other behavioral health professionals, you provide data only for physicians, nurses, pharmacists, and dentists. You state that the IHS data system used for tracking health disciplines is being improved to allow Headquarters to track vacant positions for all health care disciplines electronically.

Question 13. Please provide additional data available to you now on positions, vacancies, and length of these vacancies for radiologists and technicians, and behavioral health professionals.

Answer. IHS Headquarters tracks vacancies for the key health provider disciplines reported in the previous response. IHS is continuing to revise its tracking system to provide the capability to track all disciplines.

In your written response to Committee questions regarding the impact of vacancy rates on access to care and achievement of performance goals, you state that these vacancy rates necessitate the use of locum tenens providers and Contract Health Services. You further state that while vacancies for health providers are tracked at the national level, information on locum tenens is a local service unit decision. You further state that while the burdened labor rates and individual locum tenens contracts vary by discipline and location, the overall need for contracted medical professional support has been relatively constant and that IHS obligated approximately $169.7 million in FY 2012 for contract providers.

Question 14. How does the fact that the use of locum tenens is a local Service Unit decision prevent tracking and collecting data at the Area and National levels?

Answer. Decentralized decisionmaking at the local level makes it more challenging and costly to track and collect data on locum tenens. Contract award data is available by product service category and amount but the IHS finance system and the contract reporting system that collects and reports data to USASpending does not capture detailed data at the level of detail that would show labor categories and rates, or the number and identity of individual providers and locations. The total amount of funding spent at a Service Unit also must be interpreted in context of local need, available services, appropriations, third party collections, accreditation staffing requirements and the current capacity of the facility.

Question 15. Please provide complete data regarding the use of locum tenens across locations and disciplines during FY 2010–2013.

Answer. Decentralized decisionmaking at the local level makes it more challenging and costly to track and collect data on locum tenens. Contract award data is available by product service category and amount but the IHS finance system and the contract reporting system that collects and reports data to USASpending does not capture data at the level of detail that would show labor categories and rates, or the number and identity of individual providers and locations. The total amount of funding spent at a Service Unit also must be interpreted in context of local need, available services, appropriations, third party collections, accreditation staffing requirements and the current capacity of the facility.

Question 16. Has IHS completed any evaluation or cost-benefit analysis on the use of locum tenens at the Area or Service Unit level in order to maximize and allocate resources and recruitment and retention efforts accordingly? If not, why not?

Answer. While local decisionmaking may include evaluation and cost-benefit analysis in the context of budget planning, this information is location-specific and has not been routinely collected. However, contracting with locum tenens or a recruitment agency is rarely the Agency's first choice due to the known high cost compared to the use of Commissioned Corps physicians and direct federal hires. The cost and time to complete a national cost-benefit analysis is not likely justified since IHS already knows that locum tenens providers are more costly and are not preferred, and the goal of all facilities is to recruit and retain permanently hired providers. Resources would be better spent on recruitment and retention efforts.

The lack of a provider starts a chain reaction with increased burden to the facility and the Area so affected. With increased professional recruiting costs incurred until the vacancy is filled, aggravating effects on the CHS budget and other issues, the use of locum tenens are seen as a necessary but undesired solution to a compounding problem. Other compounders include the fact that the private sector can pay much more than our Title 38 or General payment schedules, opportunities for spouses are more attractive in metropolitan areas, and the nationwide shortage of physicians will exacerbate our issues as we juggle the next few years of limited human resources (HR) in the remote highly rural locations that we will need to fill with qualified physicians. Facilities also must ensure that they have adequate staffing for the services provided, and accreditation reviews often result in the need to use locum tenens providers, such as to adequately staff emergency rooms, or else risk loss of accreditation.

In response to these known compounders, the IHS has been using our own Scholarship and Loan Repayment programs to recruit to our hard to fill areas along with close collaboration with HRSA's National Health Service Corps and with the United States Uniformed Health Science (USUHS) Medical School graduating students being placed in these hardship areas. This has resulted in a significant improvement in the placement of permanent clinicians in our hardest to fill sites in 2013. We also continue to focus our recruitment and retention efforts through our National Combined Councils Work Group specific to HR and Workforce Development as we continue to see improvements in acquiring permanent clinical staff and less use of locum tenens. Increased and more effective use of pay authorities to make salaries more competitive is also having a positive effect on recruitment and retention. IHS External Affairs has also been working with various universities (e.g. Harvard University, Dartmouth College, Johns Hopkins, and University of Buffalo) to include involvement of undergraduate and professional students and residents in clinical rotations and informational programs to attract future candidates to support the IHS.

Question 17. Please describe the specific efforts you have made to reduce overall IHS use of locum tenens programs. Please provide data showing what results these efforts have had on reducing locum tenens obligations overall and at targeted locations.

Answer. As stated above, the IHS has been using our own Scholarship and Loan Repayment programs to recruit to our hard to fill areas along with close collaboration with HRSA's National Health Service Corps and with the United States Uniformed Health Science (USUHS) Medical School graduating students being placed in these hardship areas. This has resulted in a significant improvement in the placement of permanent clinicians in our hardest to fill sites in 2013. We also continue to focus our recruitment and retention efforts through our National Combined Councils Work Group specific to HR and Workforce Development as we continue to see improvements in acquiring permanent clinical staff and less use of locum tenens. IHS External Affairs has also been working with various universities (e.g. Harvard University, Dartmouth College, Johns Hopkins, and University of Buffalo) to include involvement of undergraduate and professional students and residents in clinical rotations and informational programs to attract future candidates to support the IHS.

In your written response to Committee questions regarding enforcement mechanisms for physicians' service obligation at Indian health facilities, you state that "[t]he total number of individuals who defaulted from the IHS health professions program with a service obligation has decreased from 75 in 2008 to 13 reported to date for 2012." However, you do not provide information regarding the total number of participants in the IHS health professions program for each of these two time periods. Without this information, a comparison of the number of defaults for these two years is not necessarily probative of any trend in program default rates.

Question 18. Please clarify your response by providing the ratios of total individuals participating in the program to individuals who defaulted for each of years 2008–2012.

Answer. The following table illustrates how the proportion of defaults per total awards has decreased over time from 8.6 percent of all awards in 2008 to 1.2 percent of all awards in 2012.

IHP Defaults and Awards (Awards are shown in parentheses)

	2008	2009	2010	2011	2012
Total Defaults	75 (874)	21 (932)	29 (962)	27 (954)	14 (1137)
LRP	30 (581)	5 (624)	13 (673)	15 (694)	5 (820)
SP 104	37 (234)	14 (249)	15 (233)	12 (221)	9 (280)
112 Nursing	4 (50)	5 (52)	11 (52)	8 (30)	0 (26)
217 INPSYCH	2 (9)	2 (7)	1 (4)	0 (9)	0 (11)

In your written response to Committee questions regarding how the Indian Health Service determines placing health care professionals to serve their commitments under the Loan Repayment and Scholarship programs, you state that factors taken into consideration in placing professionals include the Site Priority and Health Professions Shortage Area scores and the Director's designated "high need" Areas. You further state that IHS maintains updated lists of sites according to their level of need based on scoring for each program.

Question 19. How are the Site Priority and Health Professions Shortage Area scores calculated?

Answer. The Health Professions Shortage Area designation is provided by HRSA. The site priority score is a combination of the shortage designation from HRSA and vacancy experience of the particular site over the previous 12 months.

Question 20. How or by what criteria is a site designated by the Director as a "high need" Area?

Answer. Priority Areas are those with high vacancy rates and vacancies of long duration. The three Areas with the highest rates of the longest duration have been designated as priority Areas by the IHS Director since 2010.

Question 21. Do either of these factors take into account Area usage of tenens locum?

Answer. Areas compensate for the lack of clinicians over a long period of time by contracting for locum tenens. The criteria mentioned above incorporates the conditions that result in the use of locum tenens to accomplish the mission of the IHS.

Question 22. Please provide the most current IHS list of sites according to level of need for health professionals, as referenced in your initial response.

Answer. The highest need sites designated as priority Areas are:

1. Aberdeen Area
2. Billings Area
3. Navajo Area

Facilities

In your written response to Committee questions regarding the joint venture construction program, you provide a list of factors used to evaluate and award joint venture construction projects. According to your response, these factors include size deficiency; cost to repair versus cost to replace; distance to emergency care; and tribally provided initial equipment.

Question 23. Are each of these factors weighted equally? Please describe how each of these factors is evaluated or taken into account in the overall ranking of the respective joint venture construction projects.

Answer. The factors are not weighted equally. They are employed jointly to determine the relative need of a facility objectively compared to other applicant facilities.

The factors are combined in an integrated sequential manner, taking into account each through a unit conversion, ultimately comparing the needed facility to the existing facility.

1. The user population served by the facility is used to calculate the facility size which IHS would support, referred to as the Required Size.
2. The size of the existing facility, for calculation purposes, is reduced based upon the condition of the facility, utilizing estimates of the cost to repair the facility versus the cost to replace it.
3. This reduced existing facility size is further reduced based upon the age of the facility, i.e., the older the facility, the larger the size reduction.
4. The level of need factor for the new facility is then determined comparing the required size of the facility to the adjusted existing size.
5. This level of need factor is further adjusted based upon its Isolation Factor, i.e., its distance from the nearest source of emergency medical care. Increased distance corresponds to increased need.

Factors 1–5 are formulated so as to produce a single score for the applicant.

6. Additional points are added to the score if the Tribal entity opts to provide the funding for the facility's initial equipment.

This score is objectively determined based upon information provided by the applicants and then verified by the associated IHS Area Office. The scores of all applicants are calculated and the rank ordered by overall relative need.

In your written response to questions from Chairwoman Cantwell regarding construction of health facilities, you discuss the joint venture construction program as a primary means by which IHS is partnering with tribes to address the unmet need for construction of health facilities. The joint venture construction program assists in increasing available facilities for health care services whereby Indian tribes construct a health facility and the IHS provides for staffing and operations. However, during your tenure as Director of the IHS, there has been a 76.3 percent percent decrease in IHS's budget request for staffing for new joint venture construction projects-from $21.4 million in FY 2011 to $5.0 million in FY 2014.

Question 24. If funding is not requested to provide the requisite staffing for these projects, how does the joint venture program fit into your plan to address the unmet need for construction of health facilities?

Answer. Funding for staffing and operating costs for joint venture facilities is fundamental to the continuation of the joint venture program, and IHS has demonstrated its support of the program by continuing to enter into joint venture agreements with Tribes and through its budget request for new staffing and operating costs for joint venture facilities each year. The FY 2014 President's budget request included a new staffing request of $77.3 million for 10 facilities, of which 7 were constructed under the joint venture program, compared to the FY 2011 President's budget request of $38.8 million for five facilities, of which $28.4 million was for joint venture facilities. The amounts requested are dependent on construction schedules of the projects and how new staffing increases can be incorporated among competing priorities for other funding increases. In addition, IHS will continue to enter into joint venture agreements, after careful consideration of projected construction completion dates and new staffing needs

for joint venture facilities and facilities from the health care facility construction priority list constructed with federal funding in light of the current budget constraints.

Contract Health Services

You testified at the June 12, 2013, Committee hearing on the Nomination of Yvette Roubideaux to be Director of the Indian Health Service, U.S. Department of Health and Human Services that the Tribal-Federal Contract Health Service workgroup recommended to keep the CHS distribution formula the same. However, according to your Dear Tribal Leader letter dated May 6, 2013, you noted that the workgroup recommended that in FY 2015 or later, when the impacts of health care reform on the CHS program become clearer and a thorough analysis has been completed, the [IHS] conduct new Area and National Tribal Consultation sessions to receive input on options crafted to fit the future conditions.

Question 25. Did the workgroup change its position since your letter of May 6, 2013?

Answer. No, the Workgroup did not change its position since my last letter on May 6. The workgroup did not recommend immediate changes, but did recommend that the formula should be reviewed in the future.

Question 26. Can you clarify the difference in how you characterize or describe the workgroup recommendations?

Answer. In Round II of the Workgroup recommendations, recommendation (1) the Workgroup strongly recommended that all CHS programs be "held harmless," that base funding remain unchanged, and that future distribution of new CHS funding continue to be prioritized as follows:

- To cover medical inflation and population growth costs for CHS; and
- In the event of a program increase above medical inflation and population growth to utilize the current CHS distribution formula.

The Workgroup stated that future developments may trigger consideration of significant changes to the CHS formula, but that it is premature to recommend significant changes that would require speculation about future events and conditions. As a result, the Workgroup recommended that in FY 2015 or later, when the impacts of health care reform on the CHS program become clearer and a thorough analysis has been completed, the IHS conduct new Area and National Tribal Consultation sessions to receive input on options crafted to fit the future conditions.

Your written response to Committee questions regarding data collection on mortality rates states that IHS conducts its own analysis to correct for underreporting of Indian race on death certificates.

Question 27. Apart from the workgroup recommendations on changes to the CHS distribution formula, please explain why life expectancy, or morbidity and mortality rates cannot be a measure, factor, or element in determining the "need" for CHS funding or even in the "discrepancies" of service provided?

Answer. Years of Productive Life Lost (YPLL) or life expectancy and morbidity and mortality rates were not used because: YPLL does not relate to the cost of treating illness, but rather reflects the cost of disease to society in terms of lost productivity. YPLL is sensitive to premature death in younger populations, which does not actually cost more to treat than more prevalent chronic disease that occurs in elders. Health status measures based on mortality of small populations at a local level are less precise and subject to random fluctuation over time. Calculating annual funding based on unavoidable statistical fluctuations in small area data is unsound. Mortality statistics come from states. They often undercount AI/ANs, which results in skewed imprecise small area data. Health status statistics are reliable for large populations and are helpful in comparing the AI/AN population as a whole to the general U.S. population. But unavoidable random fluctuations for small area statistics make them less helpful in targeting funds to needs of individual tribes and communities.

In response to questions regarding the Contract Health Services (CHS) distribution formula and the evaluation and analysis conducted by the Tribal-Federal workgroup, you state that the CHS distribution formula distribution formula allocates program funds based on need, which is determined in part by access to inpatient services. According to your response, the Tribal-Federal workgroup found that, on average, the "access to inpatient services factor" approximately doubled the amount of funding per person that a Service Unit received if it lacked access to inpatient services in its facility.

In its report entitled *"Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program,"* Report No. GA0–

12–446, the Government Accountability Office (GAO) recommended that IHS consider and use variations in levels of available hospital services, rather than just the existence of a qualifying hospital, in considering the access to inpatient services component of the CHS distribution formula. According to the GAO, the IHS concurred with this recommendation.

In addition, the GAO reported that amounts allocated under the CHS distribution formula did not always correspond to an Area's dependence on CHS services based on the availability of IHS health care facilities in the Area. Although CHS funds are used to purchase services not accessible or available through direct care, according to the GAO report, in general, those Areas that were allocated lower amounts of per capita direct care funding were also allocated lower amounts of per capita CHS funding.

Question 28. Please explain your response to the GAO's finding regarding the lack of correlation between the funding and dependence on contract health inpatient services.

Answer. The CHS resource allocation formula blends 3 measures into a composite measure of need:

1.) Population proportionality, e.g., CHS cost for 10 people is 10 times more than CHS cost for 1 person,

2.) Purchasing power adjustment for price variation, e.g., CHS cost per person in one place can differ over a range of -40 percent to +40 percent compared to cost at another place, and

3.) Compensation for lack of hospital, e.g., CHS cost per person in a place without a hospital may cost 35 percent to 50 percent more than in a place with a hospital.

Because substantial variation occurs on all three measures (sometimes mutually reinforcing, sometimes mutually cancelling), correlation with any single measure, such as hospital dependency, is loose. However, these measures were determined by a Tribal workgroup in 2001 and reaffirmed for their continued use by the recent Tribal Workgroup recommendations.

Question 29. In its evaluation of the distribution formula, how did the Tribal-Federal workgroup evaluate the access to inpatient services component of the distribution formula?

Answer. The Workgroup evaluated the inpatient component together with the other two components of the formula. The lack of hospital component of the CHS formula supplements allocations to non-hospital sites by +45 percent.

Question 30. Did the workgroup take into account not only whether a hospital is in existence at a location, but what actual services are available at an inpatient facility? If not, why not?

Answer. The Workgroup acknowledged that IHS and Tribal hospitals do not all provide identical levels of services. It decided a relatively crude 45 percent supplement for CHS dependency was simple to administer and appropriate at this time. A more refined measure may be warranted in the future to fine-tune final closure of funding gaps if that prospect becomes realistic. The workgroup may take a closer look at this issue in the future.

Question 31. Please provide more detail on the qualitative and quantitative evaluation and analysis of the Tribal-Federal workgroup.

Answer. The Workgroup evaluated many charts and diagrams of both allocation results and impacts—see attachments: A–CHS program formula results; B–CHS formula technical results; and C–CHS formula 2012 allocations by site and area.

Question 32. Did the workgroup evaluate the impact of the distribution formula on funding for each Service Unit and whether funding received consistently corresponded to an assessment of need at each site?

Answer. The Workgroup evaluated the allocations for every site with respect to each of the 3 components of the formula (see attachments B and C). The Workgroup also considered statistical trends for CHS authorizations, denial, and deferral (see attachment A).

Question 33. Is it your position that, for purposes of determining whether CHS funds are currently allocated according to need, the premises, analyses, and findings of the workgroup are more correct than those of the GAO report referenced above? If so, please explain why.

Answer. The IHS has adopted with Tribal consultation from among many possibilities a CHS allocation formula which blends three policy objectives: population proportionality, purchasing power adjustment for price variation, and compensation for lack of a hospital. There exists no universally correct single policy or absolute

certainty that the adopted combination of objectives is optimal. Considering underlying program goals, historical and current circumstances, and regular recurring input of Tribal views, we consider the current CHS formula a rational and warranted balance of factors that have been deemed important to Tribes at this time. Future assessments of the formula factors in consultation with Tribes will help shape future decisions on the formula. The Tribal workgroup did review the findings of the GAO report and still recommended to keep the current formula for now.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO HON. YVETTE ROUBIDEAUX

We understand that officials of the Zuni Tribe and an Indian-owned air ambulance company met with IHS officials about their concerns with Navajo and Phoenix IHS Area offices procurement of air ambulance services. Their concerns included the Phoenix IHS Area office awarding a significant contract for air ambulance services under the Buy-Indian Act to a company with just one employee, who may have subcontracted 100 percent of the work to another company (national publically traded and not Indian-owned?).

Question 1. How does IHS ensure that their IHS Buy-Indian regulations prohibiting a Buy-Indian contractor from subcontracting 50 percent or more of the contract to a non-Indian company are enforced?

Question 1a. How does this enforcement prevail through the life of a contract and subcontract with self-certification and the requirement to list of all subcontractors?

Question 1b. How has IHS taken any additional steps in response to complaints and concerns?

Answer. Where there are anticipated subcontracting opportunities under a Buy Indian Set-Aside procurement, the contracting officer is responsible for determining the amount of dollars proposed for subcontracting to non-Indians as part of the contractor responsibility review prior to award. All IHS contracts over $50,000 ($100,000 in the case of construction contracts) with performance on or near an Indian reservation are required to include the Indian Preference Program clause that provides for a quarterly report that includes the dollar amount and distribution of subcontracts to Indian and non-Indian firms.

A revision to the Acquisition Management Chapter of the Indian Health Manual is in progress and will include improvements to standard Buy Indian procedures.

Question 2. How does IHS ensure that all successful contractors remain certified by the Commission on Accreditation of Medical Transport Services (CAMTS), in order to assure that air ambulance companies operate safely and competently?

Answer. IHS policy requires CAMTS certification as a standard contract requirement for this service. Routine contract administration by IHS contracting officers requires licenses and certifications to be submitted when contracts are awarded or renewed. In addition the IHS policy describes procedures for reporting unsafe conditions or passenger refusal to fly incidents.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARK BEGICH TO HON. YVETTE ROUBIDEAUX

Contract Support Costs

Question 1. IHS has only settled 2 claim years since the *Ramah* June 2012 decision. How many claim years does the agency plan to settle in each of the remaining months of this year?

Answer. The Agency recently settled an additional claim year with another tribe and is actively engaged in settlement discussions with several tribes. IHS has developed a business plan to efficiently address the large number of claims; the plan includes improving internal business practices and creating a priority process in order to efficiently address the claims. The Agency plans to devote additional resources to this effort and anticipates being able to address a large portion of the approximately 1,200 claims currently pending before IHS, as well as those that have been appealed to the Civilian Board of Contract Appeals (Board) or to Federal court, within the next fourteen months. Any matters that cannot be resolved through settlement may require additional time to resolve through litigation. In all cases, the Agency will work to resolve the claims and any subsequent appeals as expeditiously as possible.

Question 2. Do you agree that prior to a Senate confirmation to be Director of the IHS, you should demonstrate to Congress a commitment to settling all claim years on a prompt, fair and equitable basis?

Answer. One of the four Agency Priorities established under my administration includes: To renew and strengthen our partnership with tribes and to make all our work accountable, transparent, fair and inclusive. Our commitment to settling all claim years on a prompt, fair, and equitable basis is currently demonstrated not only through the number of claims settled to date, but also by several other activities, including: devoting increased significant resources to actively analyzing claims; developing a system for prioritizing review of claims, with nearly 70 tribes already added to the review list; working collaboratively with tribes to gather relevant documents and discuss the importance of those documents to the claims analysis; and discussing settlement with numerous tribes regarding claims at all levels of the process, including those pending before the contracting officer and those that have been appealed.

Question 3. How many claim years are currently pending against the Indian Health Service?

Answer. The claims against IHS are pending at multiple stages of the Contract Disputes Act process, including: (a) before the Agency's contracting officers; and (b) on appeal from the contracting officer to the Board or Federal court. We estimate that approximately 1,200 claims that span 20 years are pending before the Agency's contracting officers. Nearly 350 additional claims have been appealed to either the Board or a Federal court.

Question 4. How much is claimed in those claims?

Answer. The claims pending before the Agency's contracting officers total approximately $1.4 Billion. The appeals involve claims that total approximately $600 Million.

Question 5. How many claim years does the agency plan to settle in 2014? Does the agency have a plan to complete all claims within the next 12 months? If not, how long does IHS expect it to take?

Answer. The Agency plans to commit additional resources to this effort, which we anticipate will allow the agency to address a large portion of current claims, including those pending at IHS and on appeal, in 2014. IHS sent an update to Tribes on September 9 that described IHS' commitment to increase staff and resources towards settlement of CSC claims and also defined a new focus for consultation on CSC with Tribal leadership. Please see the attached copy of the letter.

Question 6. Does the agency lack sufficient legal resources to settle claims at a more rapid pace?

Answer. The Agency has evaluated its staff resources, including legal staff, to determine the resources necessary to analyze and settle claims and expects to make adjustments where necessary. The pace at which we are conducting this work is increasing over time.

Question 7. Does the agency lack sufficient technical resources, either in-house or on contract, to settle claims at a more rapid pace?

Answer. The Agency has evaluated its staff resources to determine the resources necessary to analyze and settle claims. IHS has devoted additional staff and hired a contractor to assist with financial analysis of claims. The pace at which we are conducting this work is increasing over time.

Question 8. In April you announced to Tribes an expedited and low-cost settlement process where no lawyers and no expert accountants would be needed, and the agency would develop a take it or leave it offer based upon existing documents. Is it true that the agency has since then stated that these offers will not be made ahead of other ongoing settlement negotiations that do involve lawyers and accountants?

Answer. In April the Agency announced an "alternate" process option under which IHS would review its records and then submit a one-time settlement offer to a Tribe that would be non-negotiable, unless the Tribe opted to return to the more traditional process in order to exchange documents and negotiate with IHS. In a June 12, 2013 Dear Tribal Leader Letter (DTLL), the Agency explained the alternate and traditional processes in more detail. For example, the DTLL explained that IHS conducts the same analysis of claims under both the alternate and the traditional processes, which is necessary to ensure that the Agency is processing all claims on a fair and equitable basis. The Agency therefore involves its technical staff, including accountants, in analyzing the claims and developing the one-time settlement offer for the alternate process. As explained in the DTLL, the primary benefit of the alternate process is that it is simpler and less time-consuming for Tribes. It is impor-

tant to note that the alternate process must still be consistent with the procedural requirements of the Contract Disputes Act and is available only for claims pending before the Agency's contracting officers. Tribes must submit a claim letter to IHS before engaging in either the alternate or traditional process; once the selected process is complete, IHS must issue a contracting officer's decision that can be appealed since the Judgment Fund is available to pay the claims only after such an appeal is filed.

The Agency is balancing requests to proceed under the alternate process with its collaboration with Tribes that are actively working with IHS under the traditional process. In the DTLL, the Agency asked for Tribal input on how best to balance the requests for the alternate process with those Tribes whose claims and appeals are proceeding under the traditional process, specifically asking whether Tribes that request the alternate process should be permitted to "jump ahead" of other Tribes. So far, Tribes indicate a preference for devoting equal resources and time to both options. IHS will continue to incorporate Tribal input when determining how best to devote the Agency's resources in order to reach a fair and equitable resolution of the claims of all Tribes.

Question 9. How many Tribes have requested these speedy offers? How many such offers have been made?

Answer. There are currently fourteen formal requests under review.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. HEIDI HEITKAMP TO HON. YVETTE ROUBIDEAUX

I appreciate IHS efforts to better coordinate and communicate with private sector hospitals to address reimbursement issues, including regular meetings with facilities in North Dakota. However, nonpayment continues to be a concern and frustration for many hospitals throughout the state.

Question 1. What are some of the action items you were able to identify in these meetings to reduce the incidence of nonpayment?

Answer. During the meetings with the North Dakota (ND) hospitals, it was identified that more timely responses on whether claims are approved or denied by the CHS Programs is required. Education on the payment authorization process and the specific types of documentation used by the CHS programs has been key information for resolving misunderstandings about which services are authorized for payment by IHS. IHS only pays for claims that meet eligibility requirements, and if funding is limited, claims that meet medical priority and are authorized for payment by IHS. Therefore, the Aberdeen Area is providing oversight through program reviews to ensure the appropriate document is issued to the hospitals authorizing a purchase order for payment for services or providing confirmation that a claim is denied and that payment is not authorized. The CHS Programs currently issue the appropriate document in accordance with Section 220 (a) of the IHCIA that requires the response to a notification of a claim by a provider of contract health services be issued within five working days after receipt of the notification.

IHS will continue to educate and communicate with ND hospitals on the CHS process. As patients are denied CHS coverage for their referrals or services received at outside hospitals and clinics due to not meeting medical priority, lack of funds, or other eligibility issues, it is important for hospitals to bill the patient appropriately and remove these accounts receivable from their IHS Outstanding Claims status. During discussions with the hospitals, it was discovered the denial letters were not being received at the hospitals so the patient(s) were still considered an IHS accounts receivable. Denial letters are being mailed to the attention of the Business Office Managers of the ND Hospitals so that they can more accurately track those services that are authorized for payment by IHS and those services that are denied and not authorized for payment. Once the denied referral information has been shared with the hospitals, the accounts receivable balance is significantly reduced.

Question 1a. Are there plans to make these meetings regular or quarterly?

Answer. Face-to-face meetings were held on multiple occasions with the ND hospitals during 2012 and 2013, and most recently in August 2013. Monthly calls will continue with the ND hospitals including: Trinity Hospital; Sanford Health; St. Alexius Medical Center; and Altru Hospitals.

Question 2. How can non-IHS facilities further collaborate to ensure prompt payment for services provided?

Answer. IHS continues to provide education and communication for non-IHS facilities on the payment and non-payment process for CHS services according to the

Indian Health Manual. Regular meetings are important given regular staff turnover at the non-IHS facilities requiring constant re-education on the CHS program. Encouraging regular communication and questions on specific claims between non-IHS facilities and IHS will help reduce misunderstandings and overestimates of outstanding claims.

Question 3. Are there alternative service delivery agreements that have been made within Aberdeen Area or other service areas that have been successful in addressing nonpayment issues?

Answer. There are no alternative service delivery agreements within the Aberdeen Area for addressing nonpayment issues. Agreements with outside facilities are usually focused on ensuring access to specific types of services.

I understand IHS is instituting a new reporting form for Service Units to more accurately document the number of denied and deferred cases.

Question 4. Will you be sharing the confirmed/denied data now tracked through the Service Unit forms in reports to Congress or with private hospitals?

Question 4a. How will this form better reflect non-emergent care or more accurately report rationale for denial or deferral from previous methods?

Answer. The forms for reporting the number of denied and deferred cases in a year were updated to more accurately track the data that is submitted by each IHS Service Unit and voluntarily submitted by Tribes. This permits our new methodology for estimating the unmet denied and deferred data to be more reliable, although submission of Tribal data is strictly voluntary. The forms report the aggregate number of cases that are denied or deferred and do not include costs or type of diagnosis or patient identifiers. This information is for internal use only and was intended to be used for estimates to reflect the shortfall resulting from the CHS appropriated funding levels compared to the total amount of CHS need during the budget formulation process and upon request by Congress. During FY 2014 Congressional budget hearings, the IHS Director shared the FY 2012 estimate of denied and deferred cases to equal $973 million of need beyond the current funding levels.

Nationally, it has been estimated nearly half of uninsured Native Americans will be eligible for coverage under the Medicaid expansion under the Affordable Care Act. This is a promising new revenue source for IHS facilities, and will go a long way in improving access to care for Native Americans living in areas without an IHS facility.

Question 5. What specific outreach activities is IHS undertaking in states expanding Medicaid eligibility, particularly North Dakota, to raise awareness and enroll eligible Indians in the program?

Answer. Implementation of the Affordable Care Act remains a high priority for the IHS. Our outreach and education efforts include developing local implementation plans, funding national and regional Tribal organizations, and offering presentations and training sessions on Affordable Care Act implementation.

A working committee was established to develop a business plan template to be used at the regional and local level for both IHS direct and tribally operated programs to conduct business planning for local implementation of ACA. The CEO for each federally operated program is expected to implement this plan at each site to maximize the benefits of Medicaid expansion and the Health Insurance Marketplaces. IHS has provided funding for the National Indian Health Outreach and Education Initiative (NIHOE), a national partnership including IHS, the National Congress of American Indians, the National Indian Health Board, the National Council of Urban Indian Health, and regional Tribal organizations (including the Great Plains Tribal Chairman's Health Board to serve the Aberdeen Area) to assist with Affordable Care Act outreach, education, and implementation. Funding is used to provide customer-centered outreach and education across Indian country, as well as policy review with Tribal participation. The Tribal organizations have provided over 330 training sessions as of June 2013. IHS has provided a number of presentations and training sessions at national meetings over the past 3 years. Most recently, IHS hosted an Indian Health Partnerships Conference to train key business office, contract health services and health information management staff on the ACA implementation requirements, including the new Health Insurance Marketplace, Medicaid expansion, and the impact on the provision of health care services to AI/ANs.

The IHS Aberdeen Area includes North Dakota, South Dakota, Nebraska and Iowa. The Aberdeen Area has contracted with the Great Plains Tribal Chairmen's Health Board (GPTCHB) to provide onsite Affordable Care Act outreach and education to all tribal locations including the North Dakota tribes. The GPTCHB has conducted open meetings in the tribal communities, provided presentations, open discussion, question and answer, and has disseminated educational pamphlets. All Aberdeen Area sites have identified two staff members that will be trained as cer-

tified application counselors and complete the Navigator training to prepare to provide patient education on enrollment in the Health Insurance Marketplaces. The GPTCHB recently received a Navigator Grant from HHS for North Dakota; the IHS Aberdeen Area works closely with them and will provide assistance with their outreach efforts.

Question 6. What is the total number of Native Americans in North Dakota that are eligible for Medicaid under the new expansion criteria?

Answer. Currently, the IHS does not have available data for the number of AI/ANs who may be eligible for Medicaid expansion in North Dakota. The IHS does not collect income data to identify the number of users that may qualify. For the IHS system as a whole, approximately 70 percent of the user population has health coverage such as private insurance, Medicare, Medicaid and the VA. Of the 30 percent who do not have other coverage or who rely solely on IHS, it is unknown what proportion will elect to purchase insurance in the Marketplaces, qualify for the Medicaid expansion, or take advantage of the statutory exemption from the mandate to maintain coverage and/or apply for the hardship waiver from the minimum responsibility payment.

Native Americans have made significant contributions to our armed forces and have a higher rate of military service than any other ethnic group in the U.S. The Veterans Administration (VA) has made great strides in recent years, such as improved access to care and advanced appropriations to fund health services. Implementing reimbursement agreements to reimburse IHS and THP health care facilities for direct care services they provide to eligible Native veterans is of particular importance, particularly in highly rural areas.

Question 7. How can we ensure that the implementation of VA–IHS reimbursement agreements in North Dakota move forward? How can we help to ensure their applications are processed in a timely manner?

Answer. The VA–IHS reimbursement agreements for federal facilities continue to move forward, including the sites in North Dakota. All implementation plans for the three North Dakota federal sites were submitted and approved by both the IHS and the Veteran Affairs (VA) and signed prior to July 1, 2013. All federal sites have been trained and have been instructed to commence with the billing and reimbursement process. All North Dakota federal sites are expected to submit bills this month and, once the payment process with the VA begins shortly after, the billing cycle will be complete and ongoing. Sites are provided with guidance and technical assistance throughout the implementation process, and IHS federal applications have cleared the VA process in a timely manner. Tribal Health Programs can follow the National Reimbursement agreement but are not required to do so; many are working with their local VA to establish implementation plans and begin the reimbursement process.

Question 8. What sort of outreach is being done to educate Native veterans about this new option?

Answer. American Indian and Alaska Native (AI/AN) Veterans have always been able to receive direct care services from IHS or VA; the reimbursement agreement does not impact the veteran's choice on where they obtain health care services as the reimbursement applies to veterans eligible for both VA and IHS who choose to use IHS direct care services, which are provided free of charge for the veteran. The reimbursement process happens administratively in the background and the veteran does not have to take any action themselves. However, if a veteran is eligible for VA services but is not currently enrolled, IHS staff will assist them with the enrollment process.

IHS efforts have focused on preparing and educating staff on this new reimbursement option for IHS direct care services to AI/AN Veterans. All North Dakota federal sites' benefits coordinators and staff have participated in the WebEx training on assisting our Veterans with the enrollment application. Training was also provided to all federal sites on how to obtain mass enrollment verification. All sites have taken advantage of this option and are populating their data base with enrollment information. If an AI/AN Veteran is not currently enrolled in the VA Medical Benefits Program, they are referred to the trained staff for assistance who will explain the purpose and importance of enrollment.

Contract support costs routinely comes up as a top priority for tribes. According to the IHS contract support cost shortfall reports, what was the shortfall in IHS contract support cost payments for each of the North Dakota tribes for fiscal years 2006 through 2012?

Question 9. Please list totals by year and by tribe, and totals for all years and all tribes.

Answer. The amounts reported in the annual shortfall reports for each of the North Dakota Tribes are listed below. IHS notes, however, that these amounts are estimates based on the information available at the time each report was completed and do not reflect actual costs information as reported in the Tribes' audited financial reports, as that information is not available to the Agency at the time it completes the reports. For those Tribes that have submitted contract claims for underpayment of their contract support costs, IHS is evaluating the audited financial reports to determine each Tribe's actual costs.

Indian Health Service

Contract Support Costs Shortfall—North Dakota Tribes FY 2006–2012

	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Totals by Tribe
Spirit Lake Nation	191,055	253,379	0	4,182	24,729	443,836	92,071	$944,140
Standing Rock Sioux Tribe	136,147	113,675	133,444	140,806	143,187	115,740	0	$737,096
Three Affiliated Tribes	406,207	428,097	1,016,962	1,175,721	56,073	649,828	1,969,451	$5,702,339
Trenton Indian Service Area	189,704	373,266	144,253	191,445	22,675	32,797	340,890	$1,295,030
Turtle Mountain Band of Chippewa	136,891	278,184	118,630	158,162	24,860	43,557	0	$752,153
United Tribes Technical College	84,139	60,020	36,370	45,104	72,066	55,892	22,312	$375,903
Totals by Year	$1,144,143	$1,506,621	$1,384,547	$1,715,420	$343,590	$1,341,650	$2,370,690	$9,806,661

Which of the North Dakota tribes have filed claims over contract support cost shortfalls, and how many claim years are covered by those claims? Please detail which tribes have filed claims for which years. What are the amounts of each of the claims filed by each of the North Dakota tribes? Please also list the total for all years and for all tribes.

Answer.

Indian Health Service

Contract Support Costs—Contract Disputes Act Claims—North Dakota Tribes

Fiscal Year	Spirit Lake Tribe	Standing Rock Sioux Tribe	Three Affiliated Tribes	Trenton Indian Service Area	United Tribes Technical College	Totals by FY
1995	273,826	5,288	15,867			$294,981
1996	188,082		177,947			$366,029
1997	111,878	62,622	368,770			$543,270
1998	356,994	205,585	235,049			$797,628
1999	121,119	21,454	159,906			$302,479
2000	223,686		331,491			$555,177
2001	424,911	10,859				$435,770
2002	818,244	66,197				$884,441
2003	1,065,167	90,772				$1,155,939
2005	613,230	190,997				$804,227
2006	776,197	215,974	406,207	473,964	84,139	$1,956,481
2007	768,755	202,995				$971,750
2008	556,100	222,474				$778,574
2009	678,645	240,421				$919,066
2010	698,588	163,233				$861,821
2011	602,845	156,217				$759,062
Totals by Tribe	$8,278,267	$1,855,088	$1,695,237	$473,964	$84,139	$12,386,695

Question 10. When were each of the claims identified in your answers to the above question filed? Which of these claims have been settled? Of the foregoing claims which have not been settled or resolved, how many of the claims are in active settlement discussions?

Answer. See the above tables for the requested data, which shows the amounts and years associated with the claims. The information reflects active claims received and logged by the IHS. Of the Tribes listed, the Spirit Lake Tribe has appealed some of its claims to the Civilian Board of Contract Appeals (Board), and the parties will engage in analysis and settlement discussions regarding those claims in the order identified in the Report to the Civilian Board of Contract Appeals regarding Appeals by Indian Tribes Alleging Underpayment of Contract Support Costs by the Indian Health Service, originally filed on April 16, 2013, and recently updated on August 1, 2013. None of the claims listed have been settled or are in active settlement discussions at this time, but they are in various stages of the Agency's Contract Disputes Act review and determination process.

Question 11. Fewer than 3 claim years have been settled in the 13 months that have elapsed since the Supreme Court's June 2012 decision in the *Ramah* and *Arctic* cases. Is IHS limited by resources from settling more claim years more quickly? If not, why has IHS not settled more claims?

Answer. IHS has developed a business plan to efficiently address the large number of claims; the plan includes improving internal business practices and creating a priority process in order to efficiently address the claims. The Agency plans to devote additional resources to this effort and anticipates being able to address a large portion of the approximately 1,200 claims pending before the Agency, as well as those that have been appealed to the Board or to Federal court, within the next fourteen months. Any matters that cannot be resolved through settlement may require additional time to resolve through litigation. In all cases, the Agency will work to resolve the claims and subsequent appeals as expeditiously as possible.

Furthermore, the Agency's commitment to settling all claim years on a prompt, fair, and equitable basis is demonstrated not only through the number of claims settled to date, but also by several other activities, including: devoting increased significant resources to actively analyzing claims; developing a system for prioritizing review of claims, with nearly 70 tribes already added to the review list; working collaboratively with tribes to gather relevant documents and discuss the importance

of those documents to the claims analysis; and discussing settlement with numerous tribes regarding claims at all levels of the process, including those pending before the contracting officer and those that have been appealed.

IHS sent an update to Tribes on September 9 that described IHS' commitment to increase staff and resources towards settlement of CSC claims and also defined a new focus for consultation on CSC with Tribal leadership. Please see attached copy of the letter.

Question 12. Is it true that IHS is currently only engaging in settlement negotiations over claims that are in litigation before a court or the Civilian Board of Contract Appeals? If so, why? If not, how many claims pending before contracting officers are in active settlement negotiations?

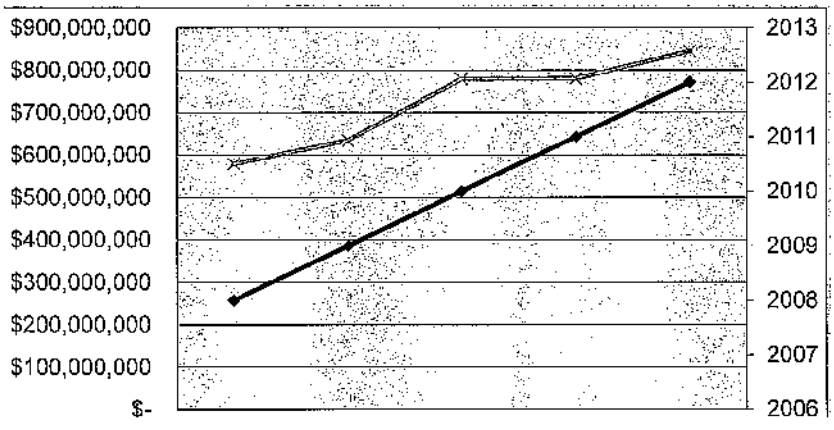
Answer. The Indian Health Service is analyzing claims and engaging in discussions with Tribes regarding claims at all stages of the Contract Disputes Act process, including claims pending before the Agency's contracting officers and claims that Tribes have appealed to the Board or in Federal court. Currently, the Agency has identified the claims of nearly 70 Tribes for which it is actively engaging in claims analysis and settlement discussions: 39 of those Tribes have appealed at least some of their claims to the Board or in Federal court and may also have claims pending before the Agency's contracting officers that are also being analyzed; 30 of those Tribes only have claims pending before the Agency's contracting officers and have yet to appeal any claims. As explained above, for Tribes whose claims are pending before the Agency's contracting officers, the IHS is devoting equal resources to those proceeding through the traditional and the alternate processes.

Attachment A

CHS FUNDING—CHS program results

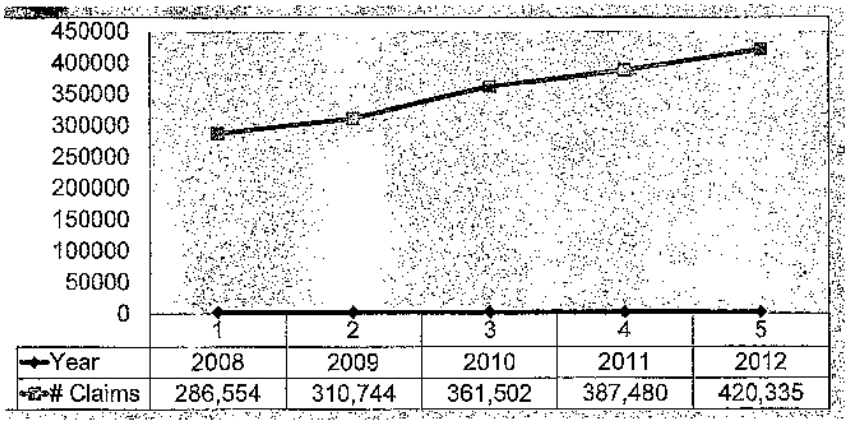
YEAR	CHS	CHEF	TOTAL	Increase	% chg
2008	$552,755,366	$26,578,800	$579,334,166	$36,235,166	6.67%
2009	$603,477,366	$31,000,000	$634,477,366	$55,143,200	9.52%
2010	$731,347,000	$48,000,000	$779,347,000	$144,869,634	22.83%
2011	$731,927,000	$48,000,000	$779,927,000	$580,000	0.07%
2012	$793,427,000	$51,500,000	$844,927,000	$65,000,000	8.33%

CHS FUNDING TREND



CHS Fiscal Intermediary Claim Trends

* 2009 -- 8.44%
*2010 -- 16.33%
*2011 -- 7.19%
*2012 -- 8.48%



Deferrals

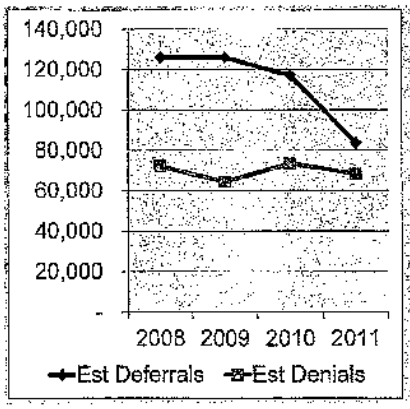
	Reported Estimate		Estimated Need	
	# Reported	Estimated Amt	# Estimated	Estimated Amt
2008	62,998	$227,989,762	125,996	$455,979,524
2009	72,416	$289,664,000	125,996	$455,979,524
2010	58,456	$259,429,811	116,912	$518,859,623
2011	59,455	$306,242,845	83,740	$431,330,241

Denials

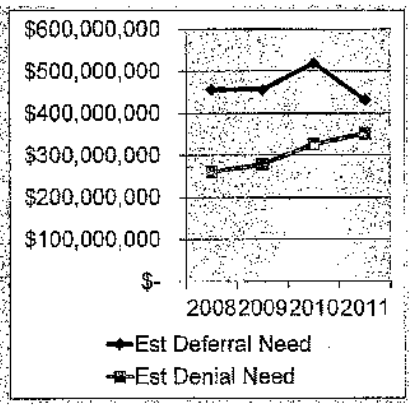
	Reported Estimate		Estimated Need	
	# Reported	Estimated Amt	# Estimated	Estimated Amt
2008	35,953	$130,113,907	71,906	$260,227,814
2009	32,209	$138,781,273	64,418	$277,562,546
2010	36,725	$162,986,285	73,450	$325,972,570
2011	48,431	$249,462,594	68,215	$351,362,529

Reported Deferral and Denial Information

Actual Deferrals and Denials Reported

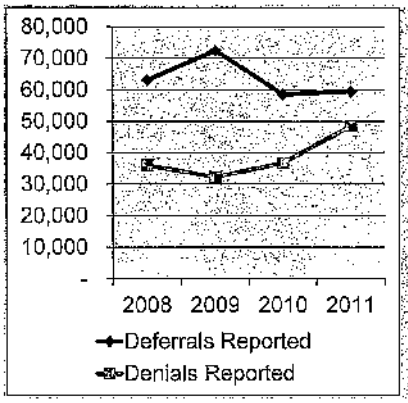


Estimated Cost of Actual Deferral & Denials Reported

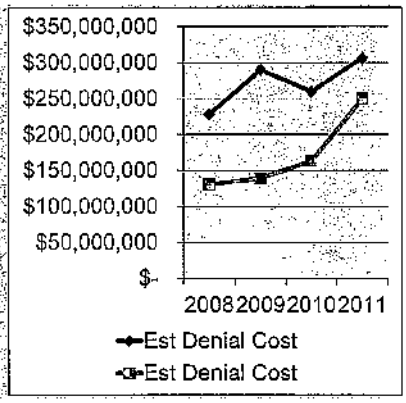


Estimated Deferral and Denial Information

Deferrals and Denials Estimate

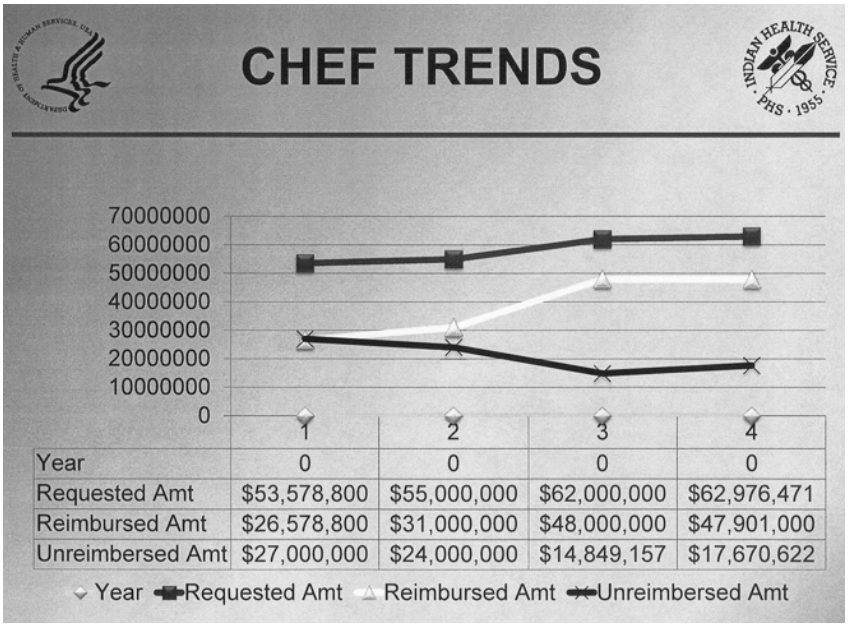


Estimated $ Need for Deferral & Denials



Catastrophic Health Emergency Fund (CHEF)

	Total Request		CHEF PAID		CHEF Not Reimbursed	
Year	#	Amount	#	Amount	#	Amount
2008	2,180	$53,578,800	1,084	$26,578,800	1,096	$27,000,000
2009	2,288	$55,000,000	1,240	$31,000,000	1,065	$24,000,000
2010	2,257	$62,000,000	1,747	$48,000,000	869	$14,849,157
2011	2,656	$62,976,471	1,745	$47,901,000	928	$17,670,622



Cost Per Case

Services	Average Cost per Claim	# of Deferred & Denied Cases	Amount
Inpatient—47%	$10,327	50,707	$523,651,189
Outpatient—42%	$247	45,312	$11,192,064
Transport—11%	$1,758	11,867	$20,862,186
Total		107,886	$555,705,439

Estimate Methodology

Methodology	Total Programs	# of Prog. Reported Data	% Reported	% of CHS Budget	Apply % of Data Reported
Federal CHS	66	66	100%	46% x	100%= 46%
Tribal CHS	177	83	54%	54% x	47%= 25%
Estimate of unmet need reported—71%					

Total Estimated CHS Need—All Categories—FY 2011

Denied	68,215	$351,362,529
Deferred	83,740	$431,330,241
Subtotal	151,955	$782,692,770
	928	$17,670,622
Total	152,883	$800,363,392

Medical Priority

- The increase in CHS funding has enabled most Areas to expand to pay for other than priority 1

• There are still Areas that are only able to pay for priority 1

• In most Areas the priority level funding varies depending on the CHS program I63

Attachment B

Figure 1—CHS Appropriations—5 Categories

CHS	CHS	CHS	CHS	CHEF	Total
CHS	Base Program Maintained	Stable recurring funds to maintain current levels of CHS services	$594 m	$732 m	$732m
CHS	Current Services (Pop. Growth & Rising Inflation)	Additional funds to maintain current CHS services given natural population growth and rising prices (inflation)	$36 m	$0	$26 m
CHS	Congressional Earmarks	Funds are designated for specific sites and purposes (e.g. new tribe)	$1 m	$0	$0 m
CHS	Program Expansion	Additional funds to expand beyond current CHS services—more services, fewer restrictions, expand "priorities"	$100 m	$0	$36 m
CHEF	CHEF Reimbursement	Reimburses catastrophic cases. Reduces local financial risks by smoothing unpredictable cost spikes.	$48 m	$48 m	$51 m
TOTAL			$779 m	$779 m	$843 m

Key point—Most CHS funds are appropriated to maintain current services and are not annually allocated by the CHS formula. CHS funds are allocated Areas and sites to manage locally. CHEF is centrally managed reimbursements.

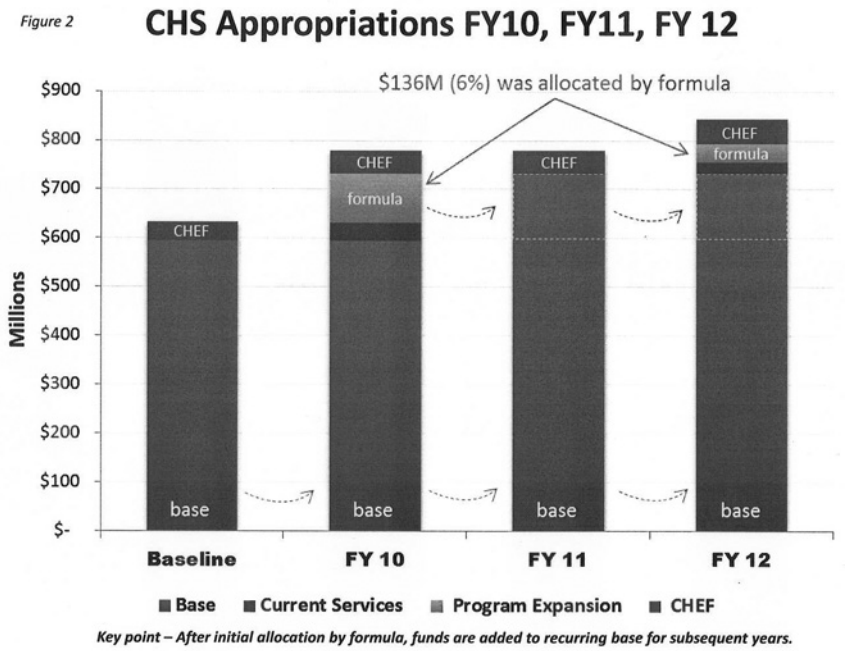


Figure 3—CHS Formula—3 Factors

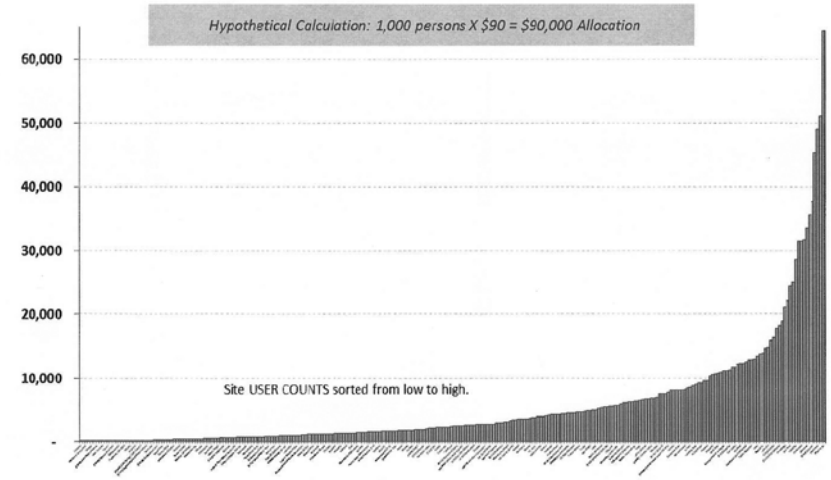
Factor	Principle	Measure	Calculation	Weight
(1) Number of active users	Expected costs are proportional to the number of patients	Active User Count (same count as the IHCIF formula)	Calculate allocation in proportion to the number of active users	75% of $ allocated to all sites calculated with factors 1 & 2 alone
(2) Medical prices in the vicinity.	Prices differ site-to-site. Adjust allocation to compensate (equalize buying power)	Health Care Price Index for nearest geographic area published by ACCRA	Calculate adjustment (+- to average) in proportion to price index	75% of $ allocated to all sites calculated with factors 1 & 2 alone
(3) Inpatient dependency (lack hospital)	Where no hospital exists, inpatient care is purchased with CHS. Supplement allocation to compensate.	Yes/No. Whether users have access to IHS funded hospital.	Calculate supplement for non-hospital sites only	25% of $ to non-hospital sites calculated with factors 1 & 2 & 3

Key point—funds appropriated to expand CHS services are allocated among sites in proportion to needs relative to users, prices, and inpatient dependency.

Figure 4

Formula Factor 1 – Number of Users

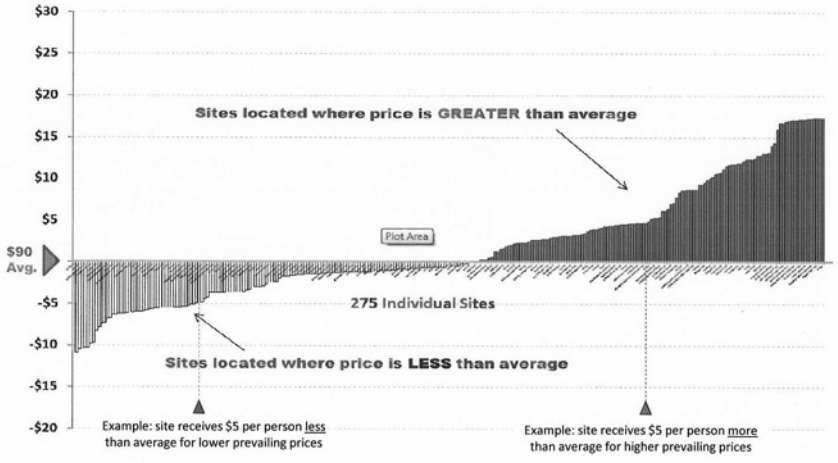
Without the Dependency and Price Adjustment factors in the CHS formula, total FY10 + FY12 CHS formula allocations per person would have been approximately $90 per person for every site.



Key point – User counts are critical for the formula. Results above show that counts vary widely among sites (<100 to >60,000). As Figure 7 below will demonstrate, the user count strongly determines allocations calculated for every site.

Figure 5

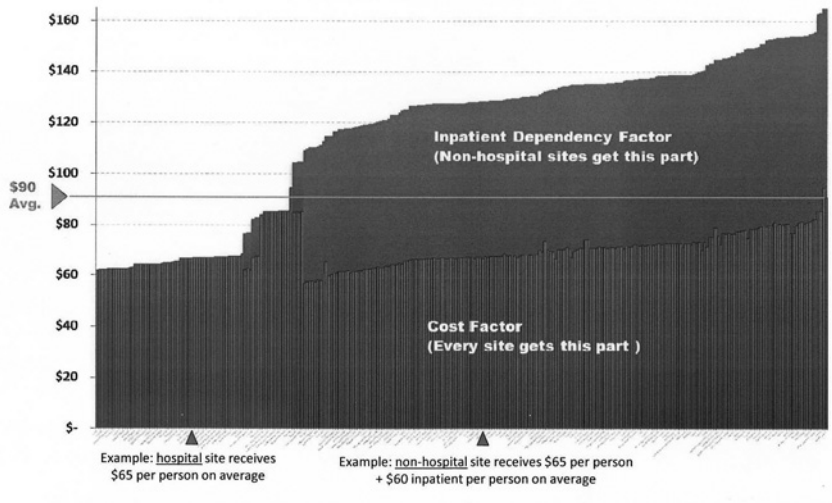
Formula Factor 2 – Prevailing Prices
Adjustment to equalize per person buying power



Key point – Calculated adjustments to equalize CHS buying power are shown. Price adjustment is not uniformly important among all sites. Adjustments are minimal for ⅓ of sites in the middle of the distribution.

Figure 6

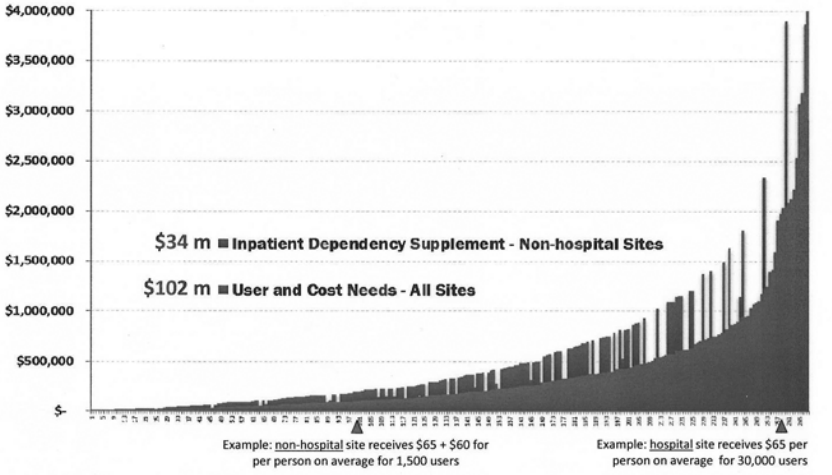
Formula Factor 3 – Inpatient Dependency
Results Per Person by Site (FY10 + FY12)



Key point – The inpatient dependency factor nearly doubles formula allocations per person. Clearly, inpatient dependency is a key factor in the formula.

Figure 7

CHS Formula Results for All Sites
Combined Results for All 3 Formula Factors – FY10 & FY12



Key point – Calculated allocations are strongly influenced by user counts and presence or absence of a hospital. As expected, prevailing prices also influence results but to a lesser extent (see figure 6).

Attachment C

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%) Price Index	Cost Points (Users Price Index)	Cost Part (75%) Allocation ($17.70 per cost point)	Access Part (25%) Hosp. Access? No, Yes	Access Points (Users Hosp. Access)	Access Part (25%) Allocation ($5.26 per access point)	Both Parts (rounded sum)
Standing Rock	9,097	101%	9,170	162,000	No=1	9,170	140,000	302,000
Cheyenne River	9,124	101%	8,189	145,000	YES=0	-	-	145,000
Crow Creek	3,810	102%	3,388	59,000	No=1	3,388	59,000	118,000
Flandreau	1,669	102%	1,599	28,000	No=1	1,599	26,000	54,000
Santee Of Nebraska	1,018	102%	1,036	18,000	No=1	1,036	16,000	34,000
Lower Brule	1,997	102%	2,038	36,000	No=1	2,038	31,000	67,000
Northern Ponca	2,676	102%	2,724	48,000	No=1	2,724	42,000	90,000
Omaha	3,769	102%	3,837	68,000	No=1	3,837	59,000	127,000
Pine Ridge	21,067	102%	21,446	380,000	YES=0	-	-	380,000
Rapid City	13,857	102%	14,117	250,000	NO=1	14,117	215,000	465,000
Rosebud	12,220	102%	12,440	220,000	YES=0	-	-	220,000
Sac & Fox	1,752	102%	1,784	32,000	No=1	1,784	27,000	59,000
Sisseton-Wahpeton	6,340	102%	6,441	114,000	NO=1	6,441	98,000	212,000
Spirit Lake (FT-SU)	5,322	102%	5,407	96,000	No=1	5,407	83,000	179,000
Three Affiliated (FB-SU)	5,535	102%	5,630	100,000	No=1	5,630	86,000	186,000
Trenton	1,857	101%	1,882	33,000	No=1	1,882	29,000	62,000
Turtle Mountain	12,838	102%	13,094	232,000	YES=0	-	-	232,000
Winnebago	4,833	102%	4,941	88,000	YES=0	-	-	88,000
Yankton-Wagner	3,933	102%	3,973	70,000	No=1	3,973	61,000	131,000
Aberdeen Area	121,903	98.8%	123,801	$ 2,191,000		63,651	$ 972,000	$ 3,163,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%) Price Index	Cost Points (Users Price Index)	Cost Part (75%) Allocation ($17.70 per cost point)	Access Part (25%) Hosp. Access? No, Yes	Access Points (Users Hosp. Access)	Access Part (25%) Allocation ($5.26 per access point)	Both Parts (rounded sum)
Aleutian Pribilof Islands Association	1,003	129%	1,309	24,000	YES=0	-	-	24,000
Arctic Slope Native Assn.	4,462	129%	5,734	101,000	YES=0	-	-	101,000
Bristol Bay Area Health	5,790	129%	7,446	132,000	YES=0	-	-	132,000
Chugachmiut Tribe	1,767	129%	2,271	40,000	YES=0	-	-	40,000
Copper River Native Association	692	129%	889	16,000	YES=0	-	-	16,000
Eastern Aleutian Tribe	1,042	129%	1,339	24,000	YES=0	-	-	24,000
Kenaitze Indian Tribe	2,614	129%	3,359	59,000	NO=1	3,359	51,000	110,000
Ketchikan Indian Corporation	2,751	129%	3,535	63,000	No=1	3,535	54,000	117,000
Kodiak	2,279	129%	2,931	52,000	No=1	2,931	45,000	97,000
Maniilaq	7,006	143%	10,140	179,000	YES=0	-	-	179,000
Metlakat a Indian Tribe	1,412	129%	1,814	32,000	NO=1	1,814	28,000	60,000
Misc. Anchorage Tribes	416	129%	535	9,000	YES=0	-	-	9,000
Nimiich k	1,445	129%	1,857	33,000	NO=1	1,857	28,000	61,000
Norton Sound	8,269	129%	10,626	188,000	YES=0	-	-	188,000
Seldovia	1,379	129%	1,772	31,000	NO=1	1,772	27,000	58,000
Southcentral Foundat on	45,375	129%	58,307	1,032,000	YES=0	-	-	1,032,000
Southeast Alaska Regional	12,585	129%	16,107	285,000	YES=0	-	-	285,000
Tanana Chiefs Conference	12,933	148%	18,481	327,000	No=1	18,481	282,000	609,000
Yukon Kuskokwim	24,976	129%	32,094	568,000	YES=0	-	-	568,000
Alaska Area	138,298	127.2%	180,605	$ 3,195,000		33,749	$ 515,000	$ 3,710,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%) Price Index	Cost Points (Users Price Index)	Cost Part (75%) Allocation ($17.70 per cost point)	Access Part (25%) Hosp. Access? No, Yes	Access Points (Users Hosp. Access)	Access Part (25%) Allocation ($5.26 per access point)	Both Parts (rounded sum)
[ZR-SU] Laguna	2,001	97%	1,945	34,000	YES=0	-	-	34,000
[ZR-SU] Zuni	8,772	97%	8,526	151,000	YES=0	-	-	151,000
Acoma-Canoncito-Laguna	11,193	97%	10,880	193,000	YES=0	-	-	193,000
Albuquerque	31,734	97%	30,845	546,000	No=1	30,845	471,000	1,017,000
Jicarilla	3,623	101%	3,674	65,000	No=1	3,674	56,000	121,000
Mescalero	4,625	95%	4,385	78,000	YES=0	-	-	78,000
Santa Fe	14,890	97%	14,473	256,000	YES=0	-	-	256,000
So Colorado Ute	5,757	101%	5,838	103,000	No=1	5,838	89,000	192,000
Taos	2,168	97%	2,107	37,000	No=1	2,107	32,000	69,000
Ysleta Del Sur	1,188	94%	1,117	20,000	No=1	1,117	17,000	37,000
Albuquerque Area	85,946	94.9%	83,789	$ 1,483,000		43,581	$ 665,000	$ 2,148,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%)			Access Part (25%)			Both Parts (rounded sum)
		Price Index	Cost Points (Users*Price Index)	Allocation ($17.70 per cost point)	Hosp. Access? No, Yes	Access Points (Users Hosp. Access)	Allocation ($5.23 per access point)	
Red River	1,839	103%	1,892	33,000	No=1	1,892	29,000	62,000
Bay Mills	1,900	97%	1,835	20,000	No=1	1,185	17,000	37,000
Bois Forte/Nett Lake (T-V)	1,384	101%	1,396	25,000	No=1	1,396	21,000	45,000
Fond Du Lac (T-V)	6,707	105%	7,049	125,000	No=1	7,049	108,000	233,000
Forest County	1,225	103%	1,261	22,000	No=1	1,261	19,000	41,000
Grand Portage	416	101%	420	7,000	No=1	420	6,000	13,000
Grand Traverse (T-V)	2,590	97%	1,398	25,000	No=1	1,388	21,000	45,000
Greater Leech Lake	10,324	101%	10,417	184,000	Yes=0	-	-	184,000
Greater Red Lake	7,628	101%	7,697	136,000	Yes=0	-	-	136,000
Greater White Earth	8,055	101%	8,127	144,000	No=1	8,127	124,000	268,000
Gun Lake	230	87%	201	4,000	No=1	201	3,000	7,000
Hannahville	771	103%	773	14,000	No=1	773	12,000	26,000
Ho-Chunk	4,472	102%	4,548	80,000	No=1	4,548	69,000	149,000
Huron Potawatomi	553	96%	530	9,000	No=1	530	8,000	17,000
Keweenaw Bay (T-V)	1,752	103%	1,756	31,000	No=1	1,756	27,000	58,000
Lac Courte Oreilles	3,448	103%	3,548	63,000	No=1	3,548	54,000	117,000
Lac Du Flambeau	2,780	103%	2,786	49,000	No=1	2,786	43,000	92,000
Lac Vieux Desert	432	103%	445	8,000	No=1	445	7,000	15,000
Little River Ottawa	1,267	87%	1,106	20,000	No=1	1,106	17,000	37,000
Little Traverse Odawa	2,667	87%	2,328	41,000	No=1	2,328	36,000	77,000
Lower Sioux	837	105%	880	16,000	No=1	880	13,000	29,000
Menominee	6,916	103%	6,930	123,000	No=1	6,930	106,000	229,000
Mille Lacs (T-V)	2,297	101%	2,318	41,000	No=1	2,318	35,000	76,000
Oneida (T-V)	11,765	103%	11,789	209,000	No=1	11,789	180,000	389,000
Pokagon Potawatomi	1,297	96%	1,239	22,000	No=1	1,239	19,000	41,000
Prairie Island	441	105%	463	8,000	No=1	463	7,000	15,000
Red Cliff	1,672	103%	1,720	30,000	No=1	1,720	26,000	56,000
Saginaw Chippewa	2,970	87%	2,593	46,000	No=1	2,593	40,000	86,000
Sault Sainte Marie (T-V)	10,050	87%	9,559	169,000	No=1	9,559	146,000	315,000
Shakopee	858	105%	907	16,000	No=1	907	14,000	30,000
Sokaogon	405	103%	417	7,000	No=1	417	6,000	13,000
St Croix	3,040	103%	1,688	30,000	No=1	1,688	26,000	56,000
Stockbridge-Munsee	1,551	103%	1,364	28,000	No=1	1,364	24,000	52,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%)			Access Part (25%)			Both Parts (rounded sum)
		Price Index	Cost Points (Users*Price Index)	Allocation ($17.71 per cost point)	Hosp. Access? No, Yes	Access Points (Users Hosp. Access)	Allocation ($5.26 per access point)	
Upper Sioux	328	105%	345	6,000	No=1	345	5,000	11,000
Bemidji Area	**102,782**	**98.9%**	**101,212**	**$ 1,791,000**		**83,098**	**$ 1,268,000**	**$ 3,059,000**

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%)			Access Part (25%)			Both Parts (rounded sum)
		Price Index	Cost Points (Users*Price Index)	Allocation ($17.71 per cost point)	Hosp. Access? No, Yes	Access Points (Users Hosp. Access)	Allocation ($5.26 per access point)	
Blackfeet	11,201	101%	11,299	200,000	Yes=0	-	-	200,000
Crow	13,439	101%	13,547	240,000	Yes=0	-	-	240,000
Flathead	10,752	103%	11,095	196,000	No=1	11,096	169,000	365,000
Ft Belknap	4,885	101%	4,924	87,000	Yes=0	-	-	87,000
Ft Peck	8,603	101%	8,677	154,000	No=1	8,677	132,000	286,000
No. Cheyenne	6,494	101%	6,546	116,000	No=1	6,546	100,000	216,000
Rocky Boy	4,703	101%	4,741	84,000	No=1	4,741	72,000	156,000
Wind River	10,778	101%	10,864	192,000	No=1	10,864	166,000	358,000
Billings Area	**70,863**	**98.5%**	**71,688**	**$ 1,269,000**		**41,924**	**$ 639,000**	**$ 1,908,000**

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%)			Access Part (25%)			Both Parts (rounded sum)
		Price Index	Cost Points (Users Price Index)	Allocation ($17,770 per cost point)	Hosp. Access? No, Yes	Access Points (Users Hosp. Access)	Allocation ($5.2k per access point)	
(CRIHB) Inaja Band of Miwok	58	110%	75	1,000	No=1	75	1,000	2,000
(CRIHB) Graton Rancheria	281	110%	308	5,000	No=1	308	5,000	10,000
(CRIHB) MACT	1,936	107%	2,130	38,000	No=1	2,130	33,000	71,000
(CRIHB) Shingle Springs	1,024	110%	1,100	19,000	No=1	1,100	17,000	36,000
(CRIHB) Sonoma County	4,547	110%	4,984	88,000	No=1	4,884	76,000	164,000
(CRIHB) United Indian Health Services	7,919	110%	8,679	154,000	No=1	8,679	132,000	286,000
(CRIHB) Warner Mountain	124	110%	136	2,000	No=1	136	2,000	4,000
(CRIHB) Chicken Ranch (CAO to adj)	-	0%	-	-	=0	-	-	-
(CTHP) Consolidated	1,910	110%	2,093	37,000	No=1	2,093	32,000	69,000
(CTHP) Coyote Valley Tribal Council	117	119%	139	2,000	No=1	139	2,000	4,000
(CTHP) Guidiville Indian Rancheria	52	119%	62	1,000	No=1	62	1,000	2,000
(CTHP) Hopland Band of Pomo Indians	219	119%	260	5,000	No=1	260	4,000	9,000
(CTHP) Pinoleville Band of Pomo India	67	119%	80	1,000	No=1	80	1,000	2,000
(CTHP) Sherwood Valley Band of Pomo	218	119%	259	5,000	No=1	259	4,000	9,000
(CVIHP) - Central Valley	6,903	107%	7,366	130,000	No=1	7,366	112,000	242,000
(CVIHP) Cold Springs Tribal Council	215	107%	229	4,000	No=1	229	4,000	8,000
(LCIHP) Scotts Valley Band of Pomo In	69	119%	82	1,000	No=1	82	1,000	2,000
(SCIHP) Lytton Rancheria	124	110%	136	2,000	No=1	136	2,000	4,000
Cabezon	6	101%	6	-	No=1	6	-	-
Chapa De	5,646	110%	6,188	110,000	No=1	6,188	94,000	204,000
Cofusa	98	110%	107	2,000	No=1	107	2,000	4,000
Feather River	4,324	110%	4,739	84,000	No=1	4,739	72,000	156,000
Greenville	1,282	110%	1,372	24,000	No=1	1,372	21,000	45,000
Hoopa	2,749	130%	3,013	53,000	No=1	3,013	46,000	99,000
Indian Health Council	4,549	113%	5,154	91,000	No=1	5,154	78,000	173,000
Karuk	1,822	110%	1,997	35,000	No=1	1,997	30,000	65,000
Lake County	1,908	110%	2,091	37,000	No=1	2,091	32,000	69,000
Modoc	167	110%	183	3,000	No=1	183	3,000	6,000
Northern Valley	2,158	110%	2,365	42,000	No=1	2,365	36,000	78,000
Pastenta (CAO to Adj)	-	0%	-	-	=0	-	-	-
Pit River	908	110%	995	18,000	No=1	995	15,000	33,000
Quartz Valley	168	110%	184	3,000	No=1	184	3,000	6,000
Redding Rancheria	3,097	110%	3,394	60,000	No=1	3,394	52,000	112,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%)			Access Part (25%)			Both Parts (rounded sum)
		Price Index	Cost Points (Users Price Index)	Allocation ($17,770 per cost point)	Hosp. Access? No, Yes	Access Points (Users Hosp. Access)	Allocation ($5.2k per access point)	
Riverside/San Bernardino	12,784	101%	12,912	229,000	No=1	12,912	197,000	426,000
Round Valley	1,213	110%	1,328	24,000	No=1	1,328	20,000	44,000
Santa Ynez	927	119%	1,102	20,000	No=1	1,102	17,000	37,000
Southern Indian Health Council	2,591	113%	2,936	52,000	No=1	2,936	45,000	97,000
Susanville	1,015	110%	1,112	20,000	No=1	1,112	17,000	37,000
Sycuan	114	113%	129	2,000	No=1	129	2,000	4,000
Table Mountain	33	107%	35	1,000	No=1	35	1,000	2,000
Tolyabe	2,747	110%	3,011	53,000	No=1	3,011	46,000	99,000
Tule River	2,426	107%	2,589	46,000	No=1	2,589	40,000	86,000
Tuolumne Me-Wuk	148	110%	162	3,000	No=1	162	2,000	5,000
California Area	78,582	105.5%	85,224	$ 1,507,000		85,224	$ 1,301,000	$ 2,808,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%) Price Index	Cost Points (Users PriceIndex)	Allocation ($17.70 per cost point)	Access Part (25%) Recv Access? No, Yes	Access Points (Users -Insp. Access)	Allocation (15.24 per access point)	Both Parts (rounded sum)
Alabama-Coushatta	806	94%	761	$ 13,000	No=1	761	$ 12,000	$ 25,000
Catawba	1,255	93%	1,171	$ 21,000	No=1	1,171	$ 18,000	$ 39,000
Cayuga	61	91%	55	$ 1,000	No=1	55	$ 1,000	$ 2,000
Cherokee	10,642	103%	11,004	$ 195,000	YES=0	-	$ -	$ 195,000
Chitimacha	498	102%	509	$ 9,000	No=1	503	$ 8,000	$ 17,000
Choctaw	9,258	101%	9,390	$ 166,000	Yes=0	-	$ -	$ 166,000
Coushatta	480	102%	491	$ 9,000	No=1	491	$ 7,000	$ 16,000
Houlton Band of Maliseet	424	93%	393	$ 7,000	No=1	393	$ 6,000	$ 13,000
Jena Band of Choctaw	146	102%	149	$ 3,000	No=1	140	$ 2,000	$ 5,000
Manilos (Onondaga)	428	92%	395	$ 7,000	No=1	395	$ 6,000	$ 13,000
Mashpee Wampanoag	1,472	114%	1,623	$ 29,000	No=1	1,623	$ 25,000	$ 54,000
Miccosukee	762	107%	815	$ 14,000	No=1	815	$ 12,000	$ 26,000
Micmac	468	106%	496	$ 9,000	No=1	495	$ 8,000	$ 17,000
Mohegan	1,306	111%	1,446	$ 26,000	No=1	1,446	$ 22,000	$ 48,000
Narragonsett	569	118%	736	$ 14,000	No=1	786	$ 12,000	$ 26,000
Oneida	1,340	92%	1,696	$ 30,000	No=1	1,696	$ 26,000	$ 56,000
Passamaquoddy-Ind. Township	743	93%	638	$ 12,000	No=1	888	$ 11,000	$ 23,000
Passamaquoddy-Pleasant Pt.	770	93%	808	$ 15,000	No=1	898	$ 14,000	$ 30,000
Penobscot	1,442	93%	1,248	$ 22,000	No=1	1,743	$ 19,000	$ 41,000
Pequot	351	111%	1,082	$ 38,000	No=1	1,681	$ 16,000	$ 54,000
Poarch Creek	2,269	86%	1,954	$ 35,000	No=1	1,554	$ 30,000	$ 65,000
Seminole	4,293	102%	4,396	$ 78,000	No=1	4,396	$ 67,000	$ 145,000
Seneca	4,043	91%	3,675	$ 65,000	No=1	3,675	$ 56,000	$ 121,000
St. Regis Mohawk	4,592	103%	4,707	$ 83,000	No=1	4,707	$ 72,000	$ 155,000
Tunica-Biloxi	329	102%	336	$ 6,000	No=1	336	$ 5,000	$ 11,000
Tuscarora	1,201	91%	1,092	$ 19,000	No=1	1,092	$ 17,000	$ 36,000
Wumpanoag of Gayhead	313	114%	357	$ 6,000	No=1	357	$ 5,000	$ 11,000
Nashville Area	51,491	97.5%	51,624	$ 913,000		31,160	$ 477,000	$ 1,390,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	USERS	Cost Part (75%) Price Index	Cost Points (Users PriceIndex)	Allocation ($17.70 per cost point)	Access Part (25%) Recv Access? No, Yes	Access Points (Users -Insp. Access)	Allocation (15.24 per access point)	Both Parts (rounded sum)
(C-SU) Chinle	16,335	101%	16,417	$ 291,000	YES=0	-	$ -	$ 291,000
(C-SU) Piñon	9,297	101%	9,343	$ 165,000	YES=0	-	$ -	$ 165,000
(C-SU) Tsaile	8,148	101%	8,262	$ 146,000	YES=0	-	$ -	$ 146,000
(CR-SU) Crownpoint	14,772	97%	14,358	$ 254,000	YES=0	-	$ -	$ 254,000
(CR-SU) Pueblo Pintado/Cuba	5,808	97%	6,617	$ 117,000	YES=0	-	$ -	$ 117,000
(FD-SU) Fort Defiance	18,252	97%	17,741	$ 314,000	YES=0	-	$ -	$ 314,000
(FD-SU) Gerado	12,132	97%	11,792	$ 209,000	YES=0	-	$ -	$ 209,000
(G-SU) Gallup	31,532	97%	30,649	$ 542,000	YES=0	-	$ -	$ 542,000
(G-SU) Tohatchi	7,612	97%	7,399	$ 131,000	YES=0	-	$ -	$ 131,000
(N-AU) Nahata Dziil	2,717	97%	2,641	$ 47,000	YES=0	-	$ -	$ 47,000
(K-SU) Inscription House	3,349	101%	3,386	$ 60,000	YES=0	-	$ -	$ 60,000
(K-SU) Kayenta	11,292	101%	11,348	$ 201,000	YES=0	-	$ -	$ 201,000
(K-SU) Monument Valley	2,569	101%	2,582	$ 46,000	YES=0	-	$ -	$ 46,000
(K-SU) Navajo Mountain	238	101%	239	$ 4,000	YES=0	-	$ -	$ 4,000
(S-SU) Dzilth Na O Dith Hle	5,543	101%	5,621	$ 99,000	YES=0	-	$ -	$ 99,000
(S-SU) Shiprock	37,685	101%	38,213	$ 676,000	YES=0	-	$ -	$ 676,000
(S-SU) Red Mesa	3,038	101%	3,081	$ 55,000	YES=0	-	$ -	$ 55,000
(S-SU) Utah Navajo	6,234	101%	6,321	$ 112,000	YES=0	-	$ -	$ 112,000
Tuba City	28,634	101%	28,777	$ 509,000	YES=0	-	$ -	$ 509,000
(W-SU) Dilkon	6,784	101%	6,818	$ 121,000	No=1	5,833	$ 104,000	$ 225,000
(W-SU) Leupp	3,953	101%	3,975	$ 70,000	No=1	3,975	$ 51,000	$ 121,000
(W-SU) Winslow	5,405	101%	5,432	$ 96,000	No=1	5,432	$ 83,000	$ 179,000
Navajo Area	242,331	98.9%	240,992	$ 4,255,000		16,225	$ 248,000	$ 4,503,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

		Cost Part (79%)			Access Part (19%)			Bott Parts
OperatingUnits in Area	LSERS	Price Index	Cost Points (Users PriceIndex)	Allocation ($17.70 per cost point)	Hosp Access? No, Yes	Access Points (Users Hosp. Access)	Allocation ($5.24 per access point)	(rounded sum)
Abs Shawnee	7,584	94%	7,159	127,000	YES=0	-	-	127,000
Cherokee	33,599	94%	31,516	558,000	YES=0	-	-	558,000
Chickasaw	31,545	94%	29,775	527,000	YES=0	-	-	527,000
Choctaw	35,725	94%	33,510	593,000	YES=0	-	-	593,000
Citizen Potawatomi	13,776	94%	13,003	230,000	YES=0	-	-	230,000
Claremore	49,057	94%	46,310	820,000	YES=0	-	-	820,000
Clinton	9,661	94%	9,120	161,000	No=1	9,120	129,000	300,000
Crook	17,782	94%	16,680	295,000	YES=0	-	-	295,000
Haskell	3,577	96%	3,434	61,000	No=1	3,434	52,000	113,000
White Cloud OU	662	98%	614	11,000	No=1	614	9,000	20,000
Iowa Of Oklahoma	960	94%	906	16,000	NO=1	906	14,000	30,000
Kaw	1,404	94%	1,320	23,000	No=1	1,320	20,000	43,000
Kickapoo Of Kansas	769	93%	731	13,000	No=1	731	11,000	24,000
Kickapoo Of Oklahoma	6,278	94%	5,926	105,000	Yes=0	-	-	105,000
Kickapoo Of Texas	225	104%	234	4,000	No=1	234	4,000	8,000
Lawton	22,235	94%	20,980	372,000	YES=0	-	-	372,000
Miami Consortium	3,112	94%	2,947	52,000	NO=1	2,947	45,000	97,000
Pawnee	9,676	94%	9,134	162,000	No=1	9,134	139,000	301,000
Ponca Tribe Of Oklahoma	3,633	96%	3,491	62,000	No=1	3,491	53,000	115,000
Prairie Band Potawatomi	1,538	94%	1,452	26,000	No=1	1,452	22,000	48,000
Sac And Fox Of Oklahoma	4,974	94%	4,695	83,000	YES=0	-	-	83,000
Tahlequah	51,197	94%	48,328	859,000	YES=0	-	-	859,000
Wewoka	8,487	94%	8,012	142,000	YES=0	-	-	142,000
Wyandotte / E Shawnee	1,417	94%	1,529	24,000	NO=1	1,329	20,000	44,000
Oklahoma Area	318,923	91.7%	300,315	$ 5,317,000		34,712	$ 528,000	$ 5,845,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

		Cost Part (79%)			Access Part (19%)			Bott Parts
OperatingUnits in Area	LSERS	Price Index	Cost Points (Users PriceIndex)	Allocation ($17.70 per cost point)	Hosp Access? No, Yes	Access Points (Users Hosp. Access)	Allocation ($5.24 per access point)	(rounded sum)
(CR-SU) Colorado River	6,006	95%	5,706	101,000	YES=0	-	-	101,000
(CH-SU) Peach Springs/Supai	2,578	93%	2,449	43,000	No=1	2,449	37,000	80,000
(DV-SU) Owyhee	1,275	103%	1,313	23,000	No=1	1,313	20,000	43,000
(E-SU) Duckwater	148	107%	159	3,000	No=1	159	2,000	5,000
(F-SU) Elko	2,214	107%	2,371	42,000	No=1	2,371	36,000	78,000
(E-SU) Ely	341	107%	365	6,000	No=1	365	6,000	12,000
(S-SU) Fallon/Lovelock/Yomba	1,851	107%	1,982	35,000	No=1	1,982	30,000	65,000
(S-SU) Ft. Mcdermitt	643	107%	689	12,000	No=1	689	11,000	23,000
(S-SU) Las Vegas/Moapa	2,725	107%	2,902	51,000	No=1	2,902	44,000	95,000
(S-SU) Pyramid Lake	1,790	107%	1,917	34,000	No=1	1,917	29,000	63,000
(S-SU) Reno-Sparks/Nevada Urban	4,176	107%	4,472	79,000	No=1	4,472	68,000	147,000
(S-SU) Schurz/Walker River	845	107%	906	16,000	No=1	906	14,000	30,000
(S-SU) Washoe	2,354	107%	2,521	45,000	No=1	2,521	38,000	83,000
(S-SU) Yerington	633	107%	677	12,000	No=1	677	10,000	22,000
Ft. Yuma	3,869	101%	3,896	69,000	NO=1	3,896	59,000	128,000
Gila River	24,458	98%	24,042	426,000	YES=0	-	-	426,000
Keams Canyon/Hopi	6,398	101%	6,480	114,000	No=1	6,480	98,000	212,000
Paiute Tribe-Utah	798	97%	775	14,000	No=1	775	12,000	26,000
Phoenix SU	64,384	98%	63,289	1,120,000	YES=0	-	-	1,120,000
San Carlos	11,801	98%	11,600	205,000	YES=0	-	-	205,000
Uintah-Ouray	3,080	97%	3,073	58,000	No=1	3,073	59,000	128,000
White River	15,890	98%	15,620	276,000	YES=0	-	-	276,000
Phoenix Area	159,166	96.7%	157,956	$ 2,795,000		37,698	$ 573,000	$ 3,368,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

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Operating Units in Area	USERS	Price Index	Cost Points (Users PriceIndex)	Allocation (@$17.70 per cost point)	Hosp. Access? No, Yes	Access Points (Users -hosp. Access)	Allocation ($15.24 per access point)	Bott Parts (rounded sum)
Burns Paiute	208	103%	214	4,000	No=1	214	3,000	7,000
Chehalis	1,278	122%	1,558	28,000	No=1	1,558	24,000	52,000
Coeur d'Alene	4,681	107%	5,027	89,000	No=1	5,027	77,000	166,000
Colville	8,076	107%	8,674	154,000	No=1	8,674	132,000	286,000
Coos, L Umpqua, Siuslaw	741	115%	855	15,000	No=1	855	13,000	28,000
Coquille	1,045	115%	1,206	21,000	No=1	1,206	18,000	39,000
Cow Creek	2,305	115%	2,660	47,000	No=1	2,660	41,000	88,000
Cowlitz	1,689	109%	1,834	32,000	No=1	1,834	28,000	60,000
Grand Ronde	3,535	109%	3,839	68,000	No=1	3,839	59,000	127,000
Hoh	30	122%	37	1,000	No=1	37	1,000	2,000
Jamestown S'Klallam	357	121%	433	8,000	No=1	433	7,000	15,000
Kalispel	410	107%	440	8,000	No=1	440	7,000	15,000
Klamath	1,775	115%	3,202	57,000	No=1	3,202	49,000	106,000
Kootenai	178	107%	191	3,000	No=1	191	3,000	6,000
Lower Elwha	799	121%	968	17,000	No=1	958	15,000	32,000
Lummi	4,321	121%	5,237	93,000	No=1	5,237	80,000	173,000
Makah	2,092	121%	2,536	45,000	No=1	2,536	39,000	84,000
Muckleshoot	4,328	118%	5,103	90,000	No=1	5,103	78,000	168,000
Nez Perce	3,626	107%	3,894	69,000	No=1	3,894	59,000	128,000
Nisqually	1,339	118%	1,579	28,000	No=1	1,579	24,000	52,000
Nooksack	1,013	121%	1,228	22,000	No=1	1,228	19,000	41,000
NW Band Of Shoshoni	39	95%	37	1,000	No=1	37	1,000	2,000
Port Gamble	1,499	121%	1,817	32,000	No=1	1,817	28,000	60,000
Puyallup	8,038	118%	9,548	169,000	No=1	9,548	146,000	315,000
Quileute	668	121%	810	14,000	No=1	810	12,000	26,000
Quinault	2,531	122%	3,085	55,000	No=1	3,085	47,000	102,000
Samish	521	121%	631	11,000	No=1	631	10,000	21,000
Sauk-Suiattle	76	121%	92	2,000	No=1	92	1,000	3,000
Shoalwater Bay	440	109%	478	8,000	No=1	478	7,000	15,000
Shoshone-Bannock	6,169	95%	5,885	104,000	No=1	5,885	90,000	194,000
Siletz	5,085	109%	5,522	98,000	No=1	5,522	84,000	182,000
Skokomish	761	118%	897	16,000	No=1	837	14,000	30,000
Snoqualmie	325	121%	394	7,000	No=1	334	6,000	13,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

		Cost Part (79%)			Access Part (19%)			
Operating Units in Area	USERS	Price Index	Cost Points (Users PriceIndex)	Allocation (@$17.70 per cost point)	Hosp. Access? No, Yes	Access Points (Users -hosp. Access)	Allocation ($15.24 per access point)	Bott Parts (rounded sum)
Spokane	1,651	107%	1,773	31,000	No=1	1,773	27,000	58,000
Squaxin Island	715	122%	872	15,000	No=1	872	13,000	28,000
Stillaguamish	127	121%	154	3,000	No=1	154	2,000	5,000
Suquamish	542	121%	657	12,000	No=1	657	10,000	22,000
Swinomish	1,125	121%	1,364	24,000	No=1	1,364	21,000	45,000
Tulalip	4,755	121%	5,763	102,000	No=1	5,763	88,000	190,000
Umatilla	3,018	109%	3,278	58,000	No=1	3,278	50,000	108,000
Upper Skagit	570	121%	691	12,000	No=1	691	11,000	23,000
Warm Springs	5,454	109%	5,923	105,000	No=1	5,923	90,000	195,000
Western Oregon (Chemawa)	2,809	109%	3,051	54,000	No=1	3,051	47,000	101,000
Yakama	12,298	117%	14,334	254,000	No=1	14,334	219,000	473,000
Portland Area	104,097	110.2%	117,769	$ 2,086,000		117,769	$ 1,800,000	$ 3,886,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

		Cost Part (79%)			Access Part (19%)			
Operating Units in Area	USERS	Price Index	Cost Points (Users PriceIndex)	Allocation (@$17.70 per cost point)	Hosp. Access? No, Yes	Access Points (Users -hosp. Access)	Allocation ($15.24 per access point)	Bott Parts (rounded sum)
Tohono O'Odham	19,015	99%	18,825	333,000	YES=0	-	-	333,000
Yaqui	6,547	99%	6,482	115,000	No=1	6,482	99,000	214,000
Tucson Area	25,562	96.4%	25,306	$ 448,000		6,482	$ 99,000	$ 547,000

FY 2012 CHS Formula ($36,348,000) - Allocation By Site and Area Total

Operating Units in Area	UEHS	Cost Part (75%)			Access Part (25%)			Both Parts (rounded sum)
		Price Index	Cost Points (Users x Price Index)	Allocation ($17.20 per cost point)	Hosp Access? No, Yes	Access Points (Users x hosp. Access)	Allocation ($5.24 per access point)	
Grand Total	1,590,044	142.68%	1,590,183	$ 27,350,000		595,273	$ 9,005,000	$ 36345,000

IHS-wide Rollup of Allocations by Area Office

Aberdeen Area	121,903	99%	123,801	$ 2,191,000	63,651	$ 972,000	$ 3,163,000
Alaska Area	138,298	127%	180,605	$ 3,195,000	33,748	$ 515,000	$ 3,710,000
Albuquerque Area	85,946	95%	83,789	$ 1,483,000	43,581	$ 665,000	$ 2,148,000
Bemidji Area	102,782	96%	101,212	$ 1,791,000	83,099	$ 1,268,000	$ 3,059,000
Billings Area	70,883	99%	71,688	$ 1,269,000	41,924	$ 639,000	$ 1,908,000
California Area	78,982	105%	85,224	$ 1,507,000	85,224	$ 1,301,000	$ 2,808,000
Nashville Area	51,491	97%	51,324	$ 913,000	31,160	$ 477,000	$ 1,390,000
Navajo Area	242,331	97%	240,992	$ 4,265,000	16,225	$ 248,000	$ 4,513,000
Oklahoma Area	316,923	92%	300,316	$ 5,317,000	34,712	$ 528,000	$ 5,845,000
Phoenix Area	159,166	97%	157,955	$ 2,795,000	37,893	$ 573,000	$ 3,368,000
Portland Area	104,987	110%	117,789	$ 2,086,000	117,789	$ 1,800,000	$ 3,885,000
Tucson Area	25,562	96%	25,305	$ 448,000	6,482	$ 99,000	$ 547,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES—PUBLIC HEALTH SERVICE—
INDIAN HEALTH SERVICE
Rockville, MD, September 9, 2013

Dear Tribal Leader:

I am writing to provide an update on Contract Support Costs (CSC). My letter to you on June 12, 2013 provided a detailed update on CSC appropriations and resolution of past CSC claims. The IHS continues to make progress on past CSC claims with bi-monthly updates to our case management plan regarding appeals to the Civilian Board of Contract Appeals, completion of settlements and submission of settlements to the Judgment Fund for payment to Tribes, and initiation of an alternative process for claims resolution. In terms of CSC appropriations, I have received input in multiple forums on the desire for an alternative solution to the fiscal year (FY) 2014 President's Budget's proposed appropriations language and anticipate that this topic will be discussed in depth during the IHS Tribal Budget Formulation Process this fall at both the Area and the National level.

I also wanted to provide an update on IHS' work to make the CSC claims process more efficient. I have heard that some Tribal representatives are concerned that there are many pending claims and want to see more progress on settlements. We have continued to develop our process for handling the claims, and IHS has recently committed funding for additional staff and resources dedicated to settling claims under both the traditional and alternative processes. We believe that the claims settlement process will become more efficient moving forward, in the context of available resources and the current budget climate.

I have also heard that Tribes would like to see more work on technical issues related to CSC. Given our experience since the *Salazar v. Ramah Navajo Chapter (Ramah)* decision, it is clear that there is some disagreement about how to generate estimates of CSC in the pre-award context during annual contract/compact negotiations. After the Ramah decision, IHS and Tribal lawyers agreed on CSC language that Tribes may use at their option, which includes an estimate of both direct and indirect CSC in the first paragraph of the language while continuing to identify the amount IHS will pay the Tribe from its annual appropriation. The IHS and Tribes have been successful in negotiating this language and the corresponding estimates in many funding agreements, but some have raised questions about how to define what types of costs qualify as CSC for inclusion in those estimates.

The Indian Self-Determination and Education Assistance Act (ISDEAA) defines the costs that qualify for CSC. 25 U.S.C. § 450j-1(a)(2). Although IHS's current policy provides practical negotiation guidance based on the statutory definition, more detailed guidance could be beneficial to negotiating the estimates in a consistent manner with all Tribes. For example, some agreed-upon principles would be helpful for applying the statutory principles of reasonableness, necessity of the activity/costs to ensure contract compliance and prudent management, and eliminating duplication of costs already paid to the Tribe in the Secretarial (106(a)(1)) amount.

Differences of opinion on the application of these principles have led to differing estimates and, in the end, prolonged discussions during negotiations.

There may also be a need to clarify the difference between indirect cost rates negotiated with a Tribe's cognizant agency, which covers all indirect costs and relies upon a methodology applied to non-ISDEAA contractors as well, versus the negotiation with IHS of indirect CSC for programs, services, functions and activities (PSFAs) included in ISDEAA contracts and compacts. The indirect cost rate that a Tribe negotiates for grants and contracts is related to but not the same as CSC, since some indirect costs are also funded through the Secretarial amount and those same costs must not also be funded as indirect CSC. For example, while Tribes' indirect cost pools often include rent and utilities, IHS incurs costs for rent and utilities as well and transfers the funding for those costs as part of the Secretarial amount; it would be duplicative to include the costs again in the CSC calculation. Discussions to clarify or improve everyone's understanding of the estimate of CSC in ISDEAA negotiations would help to resolve some of this confusion. Understanding these differences up front would help the entire contracting process, as well as development of the IHS Report to Congress on funding needs for CSC.

These principles may also be helpful to reducing litigation in the future. Our experience with the CSC litigation to date shows that we can eventually agree on the amount of CSC that is owed, even though the initial damages calculations by the Tribes and the IHS are often very far apart. We can reduce the litigation and the work required to reconcile these calculations if everyone can agree on a more accurate method for calculating CSC at the beginning of the process, i.e., at the time of negotiating the contract/compact, because we have reached agreement on how to calculate CSC from the very beginning. Moreover, such agreement will also lead to a more efficient and accurate process with respect to CSC funding and estimation of need. Reaching agreement on the relevant principles at the beginning of the process will help make every other part of the process go more smoothly.

Therefore, I would like to begin discussions on this topic using the following process: first, I will schedule a 2–3 hour session at the next IHS Tribal Self-Governance Advisory Committee meeting and the next IHS Direct Service Tribes Advisory Committee meeting to begin a policy discussion on this topic with Tribal leadership; and second, I will ask for 4–6 representatives to be selected from each Committee to meet together as one group to have more in-depth discussions on the topic and develop recommendations that will then be taken back to both Committees. I anticipate that it will only take one to two meetings of the group to develop recommendations to IHS on elaborating on the statutory principles for calculating CSC estimates. Once this process is complete, the IHS will review options for engaging all Tribes in consultation on this issue. While we may not reach complete agreement on the calculation, some agreement on these general principles is likely to save everyone on both the IHS and Tribal sides a lot of work in the end. Since having this clarification as soon as possible would be helpful, this process will help us be as inclusive and efficient as possible. Please give your input to your respective Area Tribal representative on each of these Committees prior to their next scheduled meetings in October.

Thank you for your assistance in this important matter.

Sincerely,

YVETTE ROUBIDEAUX, M.D., M.P.H.,
Acting Director.

Questions Asked at the Hearing

Question from Chairwoman Cantwell. You mention medical home in your opening statement, can you tell us how this has improved managed care and cost savings? Do you have a dollar amount of savings?

Answer. The aim of IHS' Improving Patient Care (IPC) Program is to transform the Indian health system to a more integrated, well organized, and higher performing model of care through implementation of patient centered medical home models in each Service Unit. To advance the health and wellness of patients who

utilize the Indian health system, participating sites work to improve the quality of and access to care across all ages and chronic conditions, assure all preventive care needs are met, and improve patient satisfaction. The IPC includes better use of team based care, better continuity of care, reduced waiting times, greater access to appointments, more case management and better care for a patient population with multiple chronic conditions, and implementation of process mapping strategies to identify areas for improvement in the process of care, implementation of improvements while measuring results and improvements in quality, and assessing the need for additional improvements. IHS has implemented the IPC initiative in 127 sites to date, and plans to implement it in all IHS sites by FY2015. Sites are initially trained on the concepts in the IPC and then they join the ongoing IPC quality and Innovative Learning Network to continue more advanced efforts.

IHS was not able to measure cost savings in a consistent manner since the implementation of specific IPC activities varied by site, making cost comparisons difficult. A relatively new goal has been set to encourage all sites to work towards formal accreditation as Patient Centered Medical Homes (PCMH) which may offer a better chance at measuring cost savings from implementation of defined activities. Research and evaluation studies have shown that PCMHs promote cost savings through implementation of more efficient processes of care, better team based care management that improves outcomes such as avoidable hospitalizations and reduces emergency care/urgent care usage.

IHS has conducted an evaluation of the IPC program with the assistance of the Institute for Healthcare Improvement and a preliminary analysis of 40 IPC sites from August 2012 to April 2013 has shown a 26 percent reduction in Emergency Room/Urgent Care Clinic visits per month, which is likely the result of better access to outpatient care. Given that the literature already shows that the PCMH results in cost savings, the focus of the IHS evaluation has been on improvements in quality of care measures and has not focused specifically on cost savings. However, programs do report greater efficiencies in the process of care and anecdotal evidence of cost savings. The complexity of measuring cost savings is illustrated by a facility that demonstrated a reduction in Emergency Room and Urgent Care utilization from the IPC implementation but also noted that the lower number of visits resulted in a reduction in third party collections. A full cost analysis would likely require more resources and collaboration with cost analysis experts outside of IHS.

Cost savings can also be achieved through the elimination of duplicative or other unnecessary steps, such as in patient processing. Such efficiency improvements can increase access to care and the delivery of more comprehensive care, and each IPC team assesses its system in order to eliminate waste in staffing, supplies, equipment, and processes. However, calculating the resulting savings of these types of improvements presents a challenge, and most IPC teams do not track these savings on a routine basis. IPC currently does not have a methodology to measure each team's short or long term cost savings as a result of enhanced efficiency.

IHS is committed to working with you to develop more specific measures to demonstrate the effectiveness of the IPC program.

Question from Senator Begich. Senator Begich asked for further information about the status of CSC settlement negotiations; a response is provided below.

Answer. Even before the Supreme Court's decision in *Salazar v. Ramah Navajo Chapter*, the Indian Health Service (IHS or Agency) devoted significant resources to resolving claims for unpaid contract support costs (CSC) in past years.

The Agency has made collaboration with Indian tribes a priority. IHS has communicated with tribes through Dear Tribal Leader Letters and listening sessions between the IHS and tribes. In addition, the Department of Health and Human Services (HHS), Office of the General Counsel (OGC) organized a meeting in January 2013 with more than thirty attorneys representing tribes with claims for unpaid CSC.

HHS OGC and attorneys representing tribes with appeals before the Civilian Board of Contract Appeals (Board) subsequently filed a joint "case management plan" addressing CSC claims appealed to the Board. HHS OGC has updated that plan on a bi-monthly basis.

Thus far, IHS has successfully negotiated settlement with 26 tribes, resolving CSC claims for almost 150 claim years. Most of the settlements predated *Ramah*, including 30 claim years settled with 9 tribes in 2012. IHS has settled two claim years with one tribe thus far in 2013.

Moving forward, IHS is committed to continuing to resolve claims through settlement wherever possible. For each claim, the Agency must comply with the multi-step process required by the Contract Disputes Act, 41 U.S.C. § 7101 *et seq.* Within these requirements and because the IHS is not part of a class action, the IHS is

devoted to reach efficient resolution of each claim by analyzing the claims to identify the CSC incurred under each contract.

For those claims already on appeal to the Board, OGC is following its joint case management plan to ensure a speedy and orderly resolution of claims. IHS is also actively analyzing the claims of those tribes that have appealed to Federal court, in order to assist the Department of Justice in settlement discussions with those tribes. Finally, for those claims pending before the contracting officer, IHS is devoting resources to gathering necessary claims documentation, analyzing the claims, and discussing the claims with the tribes. Ultimately, however, payment from the Judgment Fund can only be made after the contracting officer has denied a claim and the tribe has appealed.