DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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OVERSIGHT HEARING

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STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Subcommittee:

Good morning. I am Dr. Yvette Roubideaux, Director of the Indian Health Service (IHS). I am pleased to provide testimony on the accomplishments of the IHS in addressing our agency mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level.

The Indian Health Service is an agency within the Department of Health and Human Services (HHS) that provides a comprehensive health service delivery system for approximately 2 million AI/ANs from 566 federally recognized Tribes in 35 states. The IHS system consists of 12 Area offices, which are further divided into 168 Service Units that provide care at the local level. Health services are provided directly by the IHS, through tribally contracted and operated health programs, through services purchased from private providers, and through urban Indian health programs. The IHS fiscal year (FY) 2012 appropriation was $4.3 billion, with an additional $1 billion provided through health insurance reimbursement and mandatory diabetes funds.

Over the past few years, we have been working to change and improve the IHS. I want to thank you for our progress on appropriations for IHS. The IHS budget is critical to our progress in accomplishing our agency priorities and improvements. Since 2008, IHS appropriations have increased by 29 percent, which is making a substantial difference in the quantity and quality of healthcare we are able to provide to AIANs.

For example, Contract Health Service (CHS) funding, which is a top priority of IHS and Tribes, has increased by 46 percent since 2008. Four years ago, most programs were funding only Medical Priority 1, or "life or limb" referrals. Now, the increased CHS funding means that almost half (29 out of 66) of Federal CHS programs are now funding referrals beyond Medical Priority 1. This means these programs are paying for more than just life or limb care and more patients are accessing the health services they need, including preventive services such as mammograms and colonoscopies. The increased CHS funding also means that the IHS Catastrophic Health Emergency Fund (CHEF), which used to run out of funding for high cost cases in June, now is able to fund cases through August.

At this time, IHS faces uncertainty about its funding level for FY 2013, given the recent implementation of sequestration and the status of appropriations for the remainder of this fiscal year. The impact of sequestration will be significant for IHS; overall, the $220 million reduction in IHS' budget authority for FY 2013 is estimated to result in a reduction of 3,000 inpatient admissions and 804,000 outpatient visits for American Indians and Alaska Natives (AI/ANs). The implementation of efficient spending initiatives, e.g., reducing travel and conference spending, has also changed the way IHS conducts its business, and IHS is committed to continuing these efforts regardless of the current fiscal uncertainty.

IHS has made considerable progress in addressing our agency priorities and reforms. Our first priority is to renew and strengthen our partnership with Tribes. This priority is based on our belief that the only way we can improve the health of Tribal communities is to work in partnership with them. Over the past few years, we have made several improvements in national, Area, and local Tribal Consultation and communication. These improvements have resulted in better decision-making and more effective progress on our agency reforms.

For example, our Tribal Consultation for improving the CHS program has resulted in the implementation of several of our Tribal workgroup's recommendations to improve the business of the CHS program and the referral process. We have developed training modules for CHS staff in federal and Tribal programs, conducted annual best practices sessions, gathered more comprehensive and accurate data on denied and deferred services, conducted more meetings with outside providers, and are currently consulting with Tribes on whether to change the CHS funding distribution formula.

Tribal consultation has also helped IHS work more effectively with the Department of Veterans Affairs (VA) to improve coordination of care for AI/AN veterans eligible for both IHS and VA. In 2010, IHS and VA signed an updated Memorandum of Understanding (MOU) and implementation is ongoing at the national, Area and local levels. Tribal consultation was essential to the development of the IHS-VA National Reimbursement Agreement that was signed on December 5, 2012. This agreement, authorized by the Indian Health Care Improvement Act (IHCIA), allows VA to reimburse IHS for direct care services provided to eligible veterans who receive services from IHS. The VA and IHS are beginning to implement

the reimbursement agreement in federal and Tribal sites.

Our second agency priority is to bring reform to the IHS. The Affordable Care Act (ACA) is an important part of reform for IHS since the law has many new benefits for AI/ANs. The insurance reforms in the law protect those with insurance, and the State and Federally Facilitated Exchanges, or Marketplaces, will make purchasing affordable insurance easier in 2014. The Medicaid Expansion will cover more AI/ANs based on a higher income threshold, so more adults will have the option to enroll in Medicaid. And AI/ANs can still use IHS since the ACA extends authorizations of appropriations indefinitely. This year, IHS is focused on planning for implementation of the Exchanges and Medicaid Expansion in 2014.

IHS continues to make progress on implementation of the permanent reauthorization of IHCIA included in ACA. Several provisions are already in place, such as Tribal providers being able to be licensed in one State; outside providers not being able to go after patients who have referrals authorized to be paid by CHS; and third-party reimbursement resources staying at the Service Unit where they were generated. There are also provisions that require more work and more resources, such as long-term care and some of the demonstration projects.

IHS is also making progress on our internal IHS organizational and administrative reform efforts. We have set a strong tone at the top that we will change and improve, and we have made a number of administrative improvements, including improved budget planning, financial management, performance management and more consistent business practices throughout the agency. We are implementing improvements in human resources, including improving hiring times, supervisor training, and recruitment and retention strategies.

IHS has responded to the findings of the Senate Committee on Indian Affairs investigation of the Aberdeen Area and corrective actions and improvements have been implemented. Improvements in pre-employment background checks, credentialing of providers, reductions in use of administrative leave, improved administrative controls, improved pharmacy security and development of a more consistent, coordinated approach to training and maintenance of accreditation are among the areas of improvement in the Aberdeen Area. The Senate Committee on Indian Affairs also requested that IHS conduct reviews in all other IHS Areas on the same areas investigated in the Aberdeen Area, and those reviews have been completed and

corrective actions are in progress. The Agency is establishing an oversight focus to continue accountability and progress to date.

One area where IHS has made significant improvements is in the management and oversight of personal property. Much of the work in the past four years has concentrated on senior level accountability and policy level attention to improving agency-wide property management. National and local systems have been structured to prevent problems and/or to detect fraud, waste or abuse in a timely manner, and to hold individuals personally accountable. We have invested resources in personal property management over the past two years to implement new policies and internal control strategies. Corrective actions are ongoing to ensure that improvements over the past 4 years continue.

Our third agency priority is to improve the quality of and access to care. We have focused our efforts on a number of customer service and quality improvement strategies over the last few years. The Improving Patient Care (IPC) program aims to establish a patient centered medical home model within the Indian health system. In the past four years, IPC has completed two more phases and added 89 sites for a total of 127 participating sites. The IPC program implements a variety of strategies to provide patient centered care including the use of multidisciplinary provider teams, continuous quality improvement strategies, empanelment of patients (i.e., linking patients to specific providers) so that they see the same provider team each time they access the facility, improvements in the process and flow of the outpatient clinic, use of registries, case management and quality measures. In the most recent phase, IPC sites have increased access to care by empanelling 261,180 active patients to a primary care team, compared to 85,079 empaneled patients in the preceding phase. In addition, patient experience of care surveys from IPC sites have shown patients' satisfaction has increased overall from 55 percent in April 2011 to 72 percent currently.

In 2011, the Resource and Patient Management System (RPMS), the IHS' comprehensive health information system, became the first Federally-sponsored Electronic Health Record (EHR) to be certified under the criteria established by the Office of the National Coordinator for Health Information Technology. The RPMS is certified as a Complete EHR for use in both ambulatory and inpatient settings. IHS has also implemented the Electronic Dental Record through a commercial system that interfaces with the RPMS at 134 IHS, Tribal, and urban Indian health

programs.

In 2011, the Indian Health Service successfully met all national Government Performance and Results Act (GPRA) performance indicators, an accomplishment never before achieved by the IHS. Improvements in GPRA indicators have resulted from a system-wide focus on strategies to meet targets and increased access to care from recent funding increases. For example, receipt of mammograms by women for many years was in the low to mid 40 percent range, and by FY 2012 it had increased to over 50 percent. In 2012, 66.7 percent of our diabetic patients received follow up nephropathy assessments demonstrating a 26.7 percent increase over 2007.

The IHS Domestic Violence Prevention Initiative has resulted in over 151,000 screenings and more than 11,000 referrals for victims of domestic violence to date. 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. Medical forensic equipment necessary for evidence collection has been provided to 45 IHS and Tribal hospitals. A total of 344 Sexual Assault Forensic Examination (SAFE) kits have been submitted to Federal, State, and Tribal law enforcement.

The Methamphetamine and Suicide Prevention Initiative (MSPI) funding has resulted to date in nearly 5,000 individuals entering treatment for methamphetamine and the delivery of 7,000 substance abuse and mental health encounters via tele-health. More than 7,400 professionals and community members have been trained in suicide crisis response and more than 200,000 encounters with at-risk youth have been provided as part of evidence and practice-based prevention activities.

Our collaborations with other agencies have resulted in improvements such as our partnership with the Health Resources and Services Administration; more IHS sites are eligible for National Health Service Corps (NHSC) scholarship and loan repayment placement which helps fill critical provider vacancies. The collaboration with the NHSC resulted in an additional 96 Indian health facilities being approved by NHSC as placement sites and a corresponding increase of 85 clinicians serving during FY 2012.

Our final agency priority is to ensure that our work is transparent, accountable, fair, and

inclusive, and this includes more communication about agency progress and activities at the national, Area and local levels. We continue our focus on accountability of our staff and our programs, and IHS has implemented a performance management process that ensures all senior executives at Headquarters, the 12 Area Offices and all federal Chief Executive Officers have performance plans with specific and measurable objectives based on agency priorities. This improved performance management process serves as an important tool to ensure system-wide accountability for progress on agency reform efforts.

In summary, we are making progress in changing and improving the IHS. Thank you for your support and partnership – it has been essential to our progress thus far. Although we are in a time of uncertainty regarding resources, the work of the past few years has clearly established that by working together, our efforts can change and improve the IHS 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.