**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**STATEMENT OF**

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**ACTING DIRECTOR**

**INDIAN HEALTH SERVICE**

**BEFORE THE**

**COMMITTEE ON INDIAN AFFAIRS**

**UNITED STATES SENATE**

**FIELD HEARING ON**

**THE INDIAN HEALTH SERVICE:**

**ENSURING IHS IS LIVING UP TO ITS TRUST RESPONSIBILITY**

**BILLINGS, MT**

**May 27, 2014**

Good Morning Chairman Tester and Members of the Committee. I am Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS), and accompanying me is Mr. Randy Grinnell, Deputy Director for Field Operations. I am pleased to have the opportunity to testify before the Senate Committee on Indian Affairs at this Field Hearing in Billings, Montana.

As you know, IHS plays a unique role in the Department of Health and Human Services (HHS) because it is a health care system that was established to meet the Federal trust responsibility by providing health care to American Indians and Alaska Natives (AI/ANs). The mission of IHS, in partnership with AI/AN people, is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. IHS provides comprehensive health service delivery to approximately 2.1 million AI/ANs from 566 Federally-recognized Tribes in 35 states. The IHS system is organized and administered through its Headquarters in Rockville, MD, 12 Area Offices, and 168 Service Units that provide care at the local level. In support of the IHS mission, health services are provided directly by IHS Federally-operated facilities, through Tribally-contracted and -operated health programs, through services purchased from private providers, and through urban Indian health programs.

There has been a lot of discussion in Montana recently about the challenges faced by IHS. I am glad to have the opportunity to update you on the progress we have made and the work that remains.

IHS as a whole has an important mission. The population has grown in the communities we

serve, and we see a greater incidence of chronic conditions and their underlying risk factors, such as diabetes and childhood obesity. Moreover, the circumstances in many of our communities – poverty, unemployment, and crime – often exacerbate the challenges we face. In a constrained fiscal environment, IHS strives to meet these challenges and fulfill its role as the health system that often represents the only source of health care for many AI/AN individuals, especially for those who live in the most remote and poverty-stricken areas of the United States.

We have been working to change and improve the IHS for the last five years, all around Indian Country and in the Billings Area of IHS. We have made significant progress but as we know much work remains to be done.

IHS has substantially more resources than we did five years ago, thanks to the support of President Obama and congressional champions like Chairman Tester and other members of the Senate Committee on Indian Affairs. Since FY 2008, the overall IHS budget has increased by 33 percent through FY 2014. The FY 2015 President's Budget proposes an additional $199.7 million, a sign that IHS continues to be a priority in a tight fiscal environment.

At IHS, consultation with Tribes is an Agency priority. We have made improvements in our Tribal consultation process, which helps set Agency priorities for improvements and measure progress. In order to continue our commitment to Tribal consultation, I am in the process of personally conducting listening sessions in all IHS Areas this year to hear views from Tribes on how we can continue to make progress on our Agency reforms. I held a listening session on

March 31 in the Billings Area, and appreciate the input and recommendations of the Tribes which will help guide further improvements.

In fact, the Billings Area Tribes have strongly advocated for increased funding for referrals made through our Purchased/Referred Care Program (PRC), formerly known as Contract Health Service, and IHS funding for PRC has increased Agency-wide 60 percent since 2008. This increased funding has made a significant difference in the Billings Area. Four years ago, all PRC programs in the Billings Area were only paying for Medical Priority 1, or "life or limb" referrals. In FY 2010, all of the six Federally-operated PRC programs in the Billings Area were able to approve a number of referrals for payment *beyond* Medical Priority 1. Between FY 2010 and FY 2012, the total number of purchase orders issued for referrals approved for payment increased from approximately 107,000 to approximately 120,000; and, during the same time period, the number of denials decreased from approximately 28,000 to 23,000. However, the 2013 rescission and sequestration cuts reduced the Billings Area PRC budget by approximately three million dollars, and, by the end of FY 2013, three Service Units were only able to approve referrals for payments for Medical Priority 1. We are hopeful the increase in PRC in the FY 2015 President's Budget will help again increase the number of referrals approved for payment under the PRC program. The Billings Area Tribes have identified Purchased/ Referred Care, Mental Health, Hospitals and Clinics, Alcohol and Substance Abuse, and Health Education as the top priorities for funding.

My second priority to reform the IHS includes instilling accountability into the IHS management structure, setting goals for managers and then holding them accountable when targets are not achieved. An important element of this is improving our business practices, which is something the Billings Area tribes emphasized at the recent listening session. I have been working with our Area Directors to improve our financial management and how we plan and execute our budgets each year to maximize the care our patients receive. We are working to maximize collections from third party payers to bring more resources into our service units. We are making improvements in the hiring process, recruitment and retention efforts, and, for our third priority, are working on a number of initiatives to improve the quality of and access to care and promote healthy Tribal communities. One important new initiative is our hospital consortium which is working to improve quality and maintain accreditation requirements in all our hospitals by establishing a system-wide business approach to accreditation.

These reforms are being implemented throughout IHS at a national, system-wide level. However, I know that what matters to members of the tribes in the Billings Area is the day-to-day care they receive from our service units and hospitals. Within the Billings Area, IHS delivers health care to approximately 80,000 Indians living in both rural and urban areas. The Area Office located in Billings, Montana is the administrative headquarters for eight service units consisting of three hospitals, eleven ambulatory health centers, and four health stations. In addition, the Billings Area has an active research effort through the Epidemiology Program operated by the Montana-Wyoming Tribal Leaders Council. Research projects focus on diabetes, cardiovascular disease, cancer, and the application of health risk appraisals in all communities. Tribally managed healthcare facilities include health clinics operated by the

Chippewa-Cree Tribe of Rocky Boy Montana and the Confederated Salish and Kootenai Tribe. The remaining facilities are administered by the IHS, but Tribes operate some of the programs associated with those facilities.

In an attachment that I will share in follow up, I will provide a detailed listing of recent reforms and changes in the Billings Area, and, in particular, the steps being taken to improve IHS service to tribes in this Area as a result of the 2011 IHS Area Oversight Reviews. I would like to emphasize a few key points before concluding my testimony and answering your questions.

First, IHS is implementing corrective actions for findings from the 2011 Area Oversight Reviews conducted as a result of the Senate Committee on Indian Affairs investigation of the Aberdeen Area. Several improvements have been made in the Billings Area in the areas of policies and practices relating to hiring and human resources, funds management, purchased referred care, pharmacy controls, health professional licensure, and facility accreditation.

Second, IHS is focused on making local improvements in response to Tribal concerns. For example, IHS is directly engaged in improving the quality of care at Crow Hospital. When it became clear last year that the facility had significant challenges, we requested an outside team of experts from the Commissioned Corps conduct a review of the quality of care and provide us with a set of recommendations which we are now being implemented.

Third, we are implementing the 2010 MOU with the VA to improve coordination of care for Veterans eligible for both IHS and VA benefits, and we have implemented the 2012 VA IHS

reimbursement agreement in all Federal sites in the Billings Area which are now billing for and receiving VA reimbursements. So far in FY 2014, this has brought in nearly $700,000 in additional funding from reimbursements.

Fourth, we have now instituted a practice of providing to each Service Unit in the Billings Area a daily report of each clinical provider's productivity which has resulted in improved monitoring of clinic schedules and the number of patient visits. We can now use this information to increase provider appointments and improve scheduling processes to increase access for patients.

In conclusion, as I said at the beginning, while we are making progress in changing and improving the IHS, we know that more needs to be done. We are committed to working hard, and in partnership with Tribes, to improve the Billings Area IHS through our reform efforts, and we thank you for your support and partnership. By working together our efforts can change and improve the IHS to ensure our AI/AN patients and communities receive the quality health care they need and deserve.

Thank you and I am happy to answer questions.