

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**STATEMENT**

**OF**

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**PRINCIPAL DEPUTY DIRECTOR,**

**INDIAN HEALTH SERVICE**

**BEFORE THE**

**HOUSE NATURAL RESOURCES SUBCOMMITTEE ON INDIAN, INSULAR AND**

**ALASKA NATIVE AFFAIRS**

**LEGISLATIVE HEARING ON**

**H.R. 5406 – HELPING ENSURE ACCOUNTABILITY, LEADERSHIP, AND TRUST IN**

**TRIBAL HEALTHCARE ACT.**

**JULY 12, 2016**

Chairman Young, Ranking Member Ruiz, and Members of the Committee:

**INTRODUCTION**

Good Afternoon. Thank you for the invitation to join you today to testify on H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act (HEALTTH Act). We would like to start by thanking you and the Committee for your leadership and for elevating the importance of delivering quality care through the Indian Health Service. I would also like to thank Representative Noem for her leadership and partnership in focusing attention on the critical needs of health care for Native Americans. This Committee, IHS, and HHS share common goals of providing consistent, quality health care to the American Indian and Alaska Native communities. The Administration has concerns with some provisions in H.R. 5406 as drafted and looks forward to working with the Committee to improve the bill as it moves through the legislative process.

Earlier this year, we strengthened and refocused our resources within the IHS as part of an aggressive strategy to improve the overall quality of care in the Great Plains Area, and across the country. IHS is working to instill a culture of quality care, leadership, and accountability across the agency. We are committed to hearing directly from you and the communities we serve to focus sharply on how to best improve access to quality health care and, most importantly, improve the health status of American Indian and Alaska Native families and communities.

To be clear, the acute problems we are seeing right now are largely tied to chronic, longstanding issues, often spanning decades. Recognizing that, the focus of our work this year is to move aggressively to develop both systemic changes even while we're addressing immediate, short-term needs. We have significant efforts underway on both fronts.

It is not business as usual at IHS. Under my leadership, IHS is changing the way it approaches long-standing challenges. We are working to transform the process by which we recruit and retain staff; to create an organizational structure that supports sustained improvement and accountability; and, to strengthen our financial management infrastructure.

To ensure that dependable, quality care is delivered consistently across IHS facilities, three months ago, Secretary Burwell created the Executive Council on Quality Care and asked Acting Deputy Secretary Wakefield to lead it. This council includes senior executives from across HHS and draws on expertise from across the Department. We have some of HHS's top managers, clinicians, and program experts taking a fresh look at long-standing obstacles like workforce supply, housing, challenges to delivering quality of care, and addressing key operations issues. The council provides the framework to ensure that we are leveraging all the resources we can on behalf of tribal communities and the patients we serve.

IHS, in conjunction with the work of this Council, for the past three months, has been engaging our work through a five-prong strategy to address these challenges—many of the same obstacles like sufficient workforce, human resources issues, and care quality, that this legislation seeks to address. With this strategy, IHS and the Department are working to (1) surface issues so that we can work to resolve them; (2) improve service delivery; (3) strengthen IHS Area management; (4) infuse quality expertise; and (5) engage with local resources.

### **Surfacing Issues**

First, we are assessing and surfacing issues so that we can work to resolve them. We are taking a very close look at the quality of care delivered through direct-service hospitals at IHS facilities across the Great Plains Area as well as throughout Indian Country. We want to affirm and support facilities that are delivering quality care and work closely with facilities that need

improvement. It is important that IHS leadership from Headquarters to Area offices to our service units work closely with both tribal leadership and direct service hospitals in a transparent way that encourages open information exchange about improvement opportunities. We know from decades of experience across the health care continuum, that problems that are not acknowledged and fixed put patients at risk. For the past 20 years, health care systems across the nation have been embracing new models of improvement, and we are working to embrace those models through the assets of IHS and other HHS operating divisions.

For example, IHS has begun a system-wide mock survey initiative at all 27 of its hospitals to assess compliance with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation and readiness for re-accreditation. These mock surveys will be conducted by survey teams from outside each respective Area to reduce potential bias. The new mock survey initiative is being coordinated through the IHS Quality Consortium as a unified effort to reinforce standardization of processes. We are beginning in the Great Plains Area with assessments and, when appropriate, interventions through the provision of on-site assistance to hospital staff. Although some direct service hospitals currently conduct self-assessments, IHS is standardizing and improving this process so that direct-service hospitals receive a consistent assessment within the next few months and performance data is centrally tracked, not just at individual facilities but across all facilities.

Through this and other targeted strategies, IHS will move from being reactive to proactive in identifying and addressing performance issues early. Our first efforts were piloted May 10, 2016, at the Rosebud Hospital, and we will continue to do quality surveys at all direct service hospitals, excluding those that have been surveyed in the past year or are scheduled to be formally surveyed through other mechanisms during this timeframe. When our survey teams

identify problems, we will work swiftly to address these local problems and work to put systems changes in place to resolve the problems. Additionally, best practices that are identified will be shared across IHS facilities.

Another example of surfacing and addressing problems is IHS' enhanced drug testing interim policy. This policy was released on June 6, 2016, and it focuses on drug testing based on reasonable suspicion. The interim policy provides guidance to supervisors and managers on drug testing based on a reasonable suspicion of drug use. This effort was informed by tribal leaders' calls for additional IHS administrative actions in this area.

### **Improve Service Delivery**

Second, we are working to improve service delivery by focusing on workforce and clinical support infrastructure.

#### **Workforce**

The IHS continues to face significant workforce challenges with a chronic shortage of health care providers. While we have taken immediate steps to address some local shortages, and are in the process of adding more, such as telemedicine, these longstanding challenges require bolstering and expanding the training and deployment pipelines and full use of innovative approaches to delivering care. In the near-term, with Secretary Burwell, Deputy Secretary Wakefield, and the U.S. Surgeon General's support, over 60 Commissioned Corps clinicians have been deployed for temporary placements into the Great Plains hospitals with CMS findings. In addition, the National Institutes for Health (NIH) and the Health Resources and Services Administration (HRSA) have been helping IHS deploy strategies they have used to recruit applicants. IHS is also revising job announcements and deploying more comprehensive

recruitment plans around key positions, in an effort to recruit a greater number of qualified candidates. IHS is utilizing Title 38 pay increases for high-demand Emergency Department clinicians and has established eligibility for payment of relocation expenses for GS-12 and lower graded clinical positions. However, even with these and a number of other strategies that have been utilized during the past few months or that are in development right now, there is still much more work that needs to be done to attract and retain an adequate health care workforce. Some of these changes may require legislative action. In addition, we are working with Office of Personnel Management (OPM), the Office of Management and Budget (OMB), and other affected agencies to explore ways to enhance our current flexibilities. We are also combining efforts that leverage collaboration between tribal, public, and private academic institutions.

One of the most challenging areas to support is the availability of emergency services, particularly in the Great Plains Area. Because of this, on May 17, 2016, IHS initiated a new strategy through a contract award to provide both emergency department staffing and operations support and management services at three hospitals: Rosebud Hospital and Pine Ridge Hospital in South Dakota and Omaha Winnebago Hospital in Nebraska. This contractor will provide health care in these hospital emergency rooms while IHS reviews the administrative and clinical operations of its facilities across the region to develop long-term solutions. IHS's leadership both in the hospitals and at headquarters have direct oversight of this contractor and is responsible for holding this contractor accountable for providing consistent quality health care. However, because this is a new approach to Emergency Department staffing and management combined, a team of clinicians and attorneys, as well as the CEOs of the facilities, are tracking this initiative weekly to ensure that performance expectations are met.

As part of a longer term strategy, we are reexamining the scholarship and loan repayments program to make sure that we are maximizing their impact as well as introducing new strategies as well. We are working with the Peace Corps' Global Health Services program that fields clinicians to areas of critical workforce needs and most immediately, we are building communication channels about service to Indian Country to returning volunteers. By the end of last month, for example, 60 returning volunteers learned about opportunities to work in IHS direct service hospitals even as we are engaging other longer-term communication strategies with the broader Global Health Services program. Additionally, the U.S. Public Health Service Commissioned Corps has prioritized assignment of new officers to IHS with a particular focus on the Great Plains Area.

On a related front, on June 1<sup>st</sup>, IHS proposed to expand its Community Health Aide Program. Partnership and collaboration are part of our ongoing work to deliver quality health care to patients. Increased access to care is a top priority, which is why IHS is engaging in consultation with tribal leaders on this expanded effort. Community health aides are proven partners, and this important proposed change would bring more health workers directly into American Indian and Alaska Native communities.

### Infrastructure

In addition to addressing workforce challenges, the IHS is trying to lessen the loads on our emergency departments by establishing alternative avenues of care, such as urgent care clinics and telehealth services. IHS is working aggressively to reopen the Rosebud Emergency Department as soon as possible. In the meantime, in order to fill the temporary gap, the IHS has re-purposed existing ambulatory care space into an Urgent Care clinic staffed with emergency department and ambulatory providers. Given the types of illnesses that individuals present with

to the Rosebud Emergency Department, the Urgent Care clinic can manage the majority of non-emergent care needs.

Specialty services like behavioral health, cardiology, and diabetes care can be difficult to find in rural areas. IHS will also be using telehealth contracts to bring specialty services into the communities where individuals live so they do not need to travel. IHS issued a Telemedicine Request for Proposal on May 5, 2016. Proposals were originally due June 6, 2016; however, at the request of prospective offerors who needed more time to prepare comprehensive proposals, IHS extended the deadline to respond by 30 days.

### **Strengthening Area Management**

Third, we are working to strengthen area management. While we support the workforce at each hospital, we are taking a broader view to strengthen Great Plains Area management through the temporary deployment of high-quality managers from within other areas of IHS as well as deploying HHS experts to both IHS headquarters and the field to assist with finance, contracting, and management functions. IHS also established a Human Resources (HR) Steering Committee, which provides oversight and guidance on the implementation of system-wide HR improvements in IHS.

As part of these efforts, Rear Admiral Kevin Meeks spent three months leading the Area Office, and he continues to support the Great Plains Area in order to provide continuity of leadership. Captain Chris Buchanan joined the Great Plains Area leadership team in May and is serving as the Acting Director of the Great Plains Area Office. Captain Buchanan has extensive expertise working with complex health systems which are IHS directly-operated facilities as well as tribally-managed programs. In the longer term, the IHS is actively looking to find the best



possible candidate for the Great Plains Area Director position. We have taken steps to attract as broad a pool of well-qualified candidates as possible. We have also implemented a stronger search committee process for recruiting highly qualified managers and executives. This committee is charged with candidate outreach, assessment, and vetting. IHS is also more widely advertising vacancies through federal, state, and non-profit partners, and is actively seeking additional venues to help attract a broad and diverse applicant pool. Additionally, going forward, we have expanded tribal participation in filling vacant Area Director positions and members of a Tribe from each area will, for the first time, play a role in these search committees at the outset of the hiring process on these key positions.

Finally, IHS recently announced it is conducting a 90-day consultation with Tribal leaders to discuss the organization and operation of the Great Plains Area Office, to, in partnership with the Tribes, identify new approaches to better support patients and tribal community health in the Area. The first telephonic consultation was held on June 22, and the first in-person consultation will be held in Rapid City later this week on July 15.

### **Infusing Quality Expertise**

Fourth, we are infusing substantial quality expertise into informing and improving care quality in direct service facilities. In partnership with CMS, we have launched a Hospital Engagement Network (HEN) to provide evidence-based efforts in quality improvement. As we announced on May 13, 2016, this HEN is now available to all IHS direct service facilities and focuses on quality improvement methods intended to reduce avoidable readmissions and hospital acquired conditions (e.g. central line blood infections, pressure ulcers, falls, etc.). Hospitals in the network share successful practices and lessons learned to accelerate learning and change.

The HEN will prioritize working with the three Great Plains Area hospitals and is currently working with each hospital to schedule onsite meetings.

Additionally, we are bringing in targeted quality improvement assistance through CMS' Quality Improvement Organization (QIO) infrastructure. Among other support and training functions, QIOs assist with root cause analysis of identified problems, assist with the development of improvement plans, establish baseline data, and monitor data to ensure improvement plans are successful and sustained over time. Also through Secretary Burwell's Executive Council on Quality Care, HHS is deploying quality experts, as needed, from throughout the Department to consult with and help our IHS direct-service hospitals that are currently out of compliance with CMS Conditions of Participation and to monitor progress as the facilities come into compliance.

### **Engaging Local Resources**

And fifth, we aim to engage more robustly with local resources. We know that, in addition to our strong partnerships with Tribes and their leadership, local academic and health systems organizations can be valuable sources of expertise and partnership. We intend to strengthen our relationships with local and regional health care systems, local colleges and universities and tribal colleges, direct-service hospital leadership and tribal leadership to build stronger academic pipelines and health care connections to ensure we are working collaboratively and effectively to produce health related workers and health care services.

We also recognize that the health of communities is tied to the economic health of communities. Rates of unemployment and poverty matter. Consequently, we are committed to advancing the success of small businesses in tribal communities. The Department's Office of Small and Disadvantaged Business Utilization, in collaboration with the U.S. Small Business

Administration, is working to coordinate meetings with tribal leaders and small businesses owned by Native Americans, Indian Tribes, and the Native American community at large. Our team plans to have these meetings in or near the 12 Indian Health Service Area Offices and the events will focus on how to effectively pursue contract opportunities with HHS, IHS, and other Federal Agencies.

### **STRENGTHENING IHS**

We have been working to address challenges using new approaches on our end. First, we appreciate the authority we already have to use the pay flexibilities under chapter 74 of title 38. We are working with OPM, OMB, and other affected agencies to explore ways to enhance our current authorities to provide more tools to recruit and retain high quality staff.

Second, we are seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships. Currently, IHS loan repayment/scholarship awards are taxable, reducing their value. In contrast, participants in the NHSC scholarship program and Armed Forces Health Professions may exclude scholarship amounts used for qualifying expenses from income, and participants in the NHSC loan repayment program may exclude NHSC loan repayment amounts paid on their behalf from income. We recommend adopting the Administration's Fiscal Year 2017 Budget proposal which would conform the tax treatment of IHS repayments/scholarships to the tax treatment for NHSC and Armed Forces Health Professions repayments/scholarships.

Third, the Indian Health Care Improvement Act requires employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. However, the Affordable Care Act permits certain NHSC loan repayment and scholarship recipients to satisfy

their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a two-year service obligation. We would like similar flexibility in order to attract health care professionals who may not be able to work full-time to fulfill their service obligations.

Being able to access resources is key to amplifying our work. It is critically important that we receive the funding the President requested in his Fiscal Year (FY) 2017 Budget, which includes: an increase of \$159 million above FY 2016 to fund medical inflation, pay costs, and accommodate population growth for direct health care services; an increase of \$20 million for health information technology to fund the development, modernization, and enhancement of IHS' critical health information technology systems; \$2 million to create a new program which will focus on reducing medical errors that adversely affect patients; and \$12 million specifically for staff quarters at current facilities, in addition to staff quarters associated with new facilities.

#### **H.R. 5406**

H.R. 5406 addresses three broad areas and the paragraphs below include our feedback on various Sections of the bill.

#### Title I – Expanding Authorities and Improving Access to Care

Section 101 of the bill would establish a seven-year pilot project for long-term contracts to fully staff three hospitals. This is a concept IHS is exploring through our sources sought notice for at least two hospitals in the Great Plains that includes the option of contracting out the top senior management of the facility or the option to contract out the entire hospital. This Section of the

bill presents a third way between the current two methods of providing care through IHS funding, either full direct service or full self-governance.

IHS supports a Tribe's decision to receive services directly from IHS or to contract under the Indian Self-Determination and Education Assistance Act (ISDEAA). However, the agency is concerned that this provision while not impacting the right of a Tribe to contract under ISDEAA would not absolve IHS from contractual liability to the private sector contractor for up to seven years. While IHS has the current authority to contract out both the management and staffing of an entire hospital, IHS is concerned with the language in this section that IHS could be expected to fund both a private sector contractor and an ISDEAA tribal contractor, using the same source of funding. We suggest language be added to clarify that, in this situation, a Tribe would take over the contract, not be paid in addition. Finally, IHS would be open to further discussing a long-term pilot, and associated funding needs, with the impacted Tribes and the committee.

Subsection (d) establishes governance boards for the selected hospitals made up of representatives from IHS, Tribes, and experts in health care administration. IHS is concerned that such boards vest authority in individuals (elected tribal officials and other health care experts) who would not be accountable to IHS or the Secretary, who would retain the legal responsibility for running the hospitals. Tribes who want to assume full responsibility for the operation of their hospitals already have this authority under the ISDEAA. Instead, creation of an Advisory Board could ensure that Tribes have input into hospital operations and access to information about how the hospital is operated. Advisory boards could also bring in the perspective of outside health experts, benefiting both IHS and Tribes.

Section 102 would expand IHS's authorities under Chapter 74 of Title 38 to help IHS offer more flexible and competitive benefits to recruit employees. IHS appreciates the authority we already have to use the pay flexibilities under chapter 74 of title 38. We are working with OPM, OMB, and other affected agencies to explore ways to enhance our current authorities to provide more tools to recruit and retain high quality staff.

Section 103 addresses IHS authority to remove or demote employees. The specific provisions on removing or demoting an employee appear unnecessary as IHS already has authorities to implement adverse employment actions as contemplated by this section. While IHS already has these authorities, in an effort to bolster effective leadership and management accountability in addressing employee issues, we have taken the following actions during the past few months: issued a new drug testing policy based on reasonable suspicion; established that a new performance requirement focused on providing quality health-care be added to all applicable performance plans during the mid-year performance reviews; started providing Employee Relations and Labor Relations training to our managers beginning with the IHS Senior Staff; and issued policy guidance and expectations on reporting of any suspected fraud, waste, and abuse, and Whistleblower protection rights to all IHS employees. In addition, the Department of Justice (DOJ) advised us that it has serious constitutional concerns with the procedures in section 103, which appear to derive from section 707 of the Veterans Access, Choice, and Accountability Act of 2014, codified at 38 U.S.C. § 713. The Attorney General notified Congress in a recent letter that DOJ could not defend section 707 in litigation challenging that provision on Appointments Clause grounds. Section 103 could present similar concerns if enacted in its present form.

Finally, we believe there may be technical issues with some of the bill's language pertaining to applicability to the United States Public Health Service (USPHS) Commissioned Corps, and definitions and references to current personnel practices. We would be happy to provide any technical comments.

On expedited appeals, revoking Federal employee protections could lead to the unintended consequence of making IHS a less desirable place to work and thus compound staffing problems.

Section 104 requires IHS to develop and implement standards to measure the timeliness of care at direct-service IHS facilities. IHS believes this provision is unnecessary as IHS already is cascading annual Senior Executive Service performance standards that specifically address improving access to patient care by establishing accountability for all senior managers to implement at least two activities to improve wait times and access to quality health care for patients that are based on enhanced implementation of current quality initiatives or new quality initiatives and that have measurable goals, measures, and outcomes, and requiring improvements to be documented at Headquarters, Area Office and facility levels. In addition, IHS is developing a quality framework that will take action on timeliness of care and provide data analytics.

#### Title II- Indian Health Service Recruitment and Workforce

Section 201 would provide tax treatment, similar to the treatment provided to recipients of NHSC and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Services Health Professions Scholarships to be excluded from gross income under Section 117(c)(2) of the

Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income student loan amounts that are forgiven by the IHS Loan Repayment program under Section 108(f)(4) of the IRC. IHS appreciates the inclusion of this provision as it was requested as part of the President's FY 2017 Budget request.

Section 202 includes health care management or health care executive positions as eligible professions for loan repayment awards, including non-clinical service obligations. Management expertise is very important in a health system as large as IHS..

Section 203 adds specific requirements for implementation of annual mandatory cultural competency training programs for IHS employees, locum tenens providers, and other contracted employees engaged in direct patient care. Cultural competency in the IHS workforce is essential to the provision of quality care.

Section 204 addresses relocation reimbursement. IHS currently has ability to provide payment of relocation expenses. This section appears to combine payment of relocation expenses and relocation incentives. IHS already has the authority to pay Relocation expenses included in 5 CFR part 572 and in accordance with the Federal Travel Regulations, Chapter 302, Relocation Allowances. The authorized allowances are outlined in Chapter 302. We would like the opportunity to better understand why payments of 50-75 percent of an employee's salary would be required under this section of the bill.



IHS also has the authority to pay relocation incentives under 5 CFR part 575 - Recruitment, Relocation, and Retention (3Rs) Incentives. To help with difficult-to-fill positions, agencies may authorize an incentive of up to 25 percent of an employee's annual rate of basic pay times the number of years in a service agreement, which could amount to an incentive of as much as 100 percent of an annual salary for four years of service. Only OPM can authorize incentive payments above 25 percent based on a critical agency need so that larger incentives may be approved for shorter service obligations. Relocation incentives also can be paid in addition to providing reimbursement of relocation expenses. We would be happy to provide any technical comments in coordination with OPM.

Section 205, which permits a limited waiver of Indian preference, is more restrictive than current law. Impacted Indian Tribes and tribal organizations are already permitted to waive Indian preference laws with respect to personnel actions pursuant to 25 U.S.C. § 472a(c)(1). Current waiver authority is unconditional, unlike section 205, which requires the IHS service unit to have a personnel vacancy rate of at least 20 percent.

Section 206 requires a Service-wide centralized credentialing system to credential licensed health professionals who seek to volunteer at a Service facility. IHS shares the goal of this section to streamline and standardize credentialing across the entire IHS system. IHS is exploring options for either installing an enterprise IT system for tracking credentialing and privileging across IHS or for contracting out the credentialing function to a third party. It appears the intent of the bill is for the Secretary to establish a separate and different credentialing

system for volunteers. IHS's preference is to pursue the implementation of a single credentialing system for the entire agency, which would include volunteers.

### Title III – Purchase/Referred Care Program Reforms

Section 301 is similar to our Final Rule Medicare-like Rate payment for non-IHS, Tribal, or Urban (non-ITU) physician and other health care professional services associated with either outpatient or inpatient care provided at non-ITU facilities. If the intent of the legislation is to codify this regulation, we suggest using the language of the regulation, as there are a number of subtle changes that could drastically impact the meaning and implementation. However, if the intent is reinforcement of the rule then drafters could consider codified enforcement mechanisms, such as civil monetary penalties.

Section 302 requires that the Secretary promulgate regulations to develop and implement a revised distribution formula for the purchase/referred care program (PRC). To the extent that this provision is optional for 638 contractors and not optional for direct service Tribes, this proposed legislation will provide incentives for tribes to enter into 638 contracts to run their own PRC programs and essentially cause a race to contract for PRC in order to avoid a revised distribution formula. The Federal Government's legal responsibility is to all AI/ANs, regardless of whether the services are provided directly or through a 638 contractor. The direct service Tribes have a right to contract under the ISDEAA, but they also have a right not to do so and there is no basis in the law to penalize them for choosing to stay a direct service Tribe.

## **CONCLUSION**

IHS and HHS are committed to making meaningful and measurable progress in the way that IHS delivers care and to ensuring that this progress is sustainable over time. We have already taken significant steps, but there is much more work ahead, including the intense work underway to strengthen and stabilize the hospitals in South Dakota and Nebraska. We look forward to addressing those challenges and making lasting progress in close partnership with you. We look forward to working with the Committee on this legislation as it moves through the legislative process. Thank you, and we are happy to take your questions.