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MEMORANDUM

July 20, 2016

To: Tribal Health Clients

From: Hobbs, Straus, Dean & Walker LLP

Re: ***House Subcommittee on Indian, Insular and Alaska Native Affairs holds legislative hearing on HEALTTH Act to reform the Indian Health Service***

On July 12, 2016, the House Subcommittee on Indian, Insular and Alaska Native Affairs held a legislative hearing on H.R. 5406, the Helping to Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act (or "HEALTTH Act"). The HEALTTH Act was introduced on June 8, 2016 by Representative Kristi Noem of South Dakota, and is described in more detail in our memorandum to Tribal Health Clients dated June 15, 2016.

Subcommittee Chairman Don Young (R-AK) and Ranking Member Raul Ruiz (D-CA) began the hearing with brief opening statements. Chairman Young referenced the 2010 Report of the Senate Committee on Indian Affairs, which uncovered egregious mismanagement and other problems in the Aberdeen Area (now the Great Plains Area) of the Indian Health Service (IHS). He remarked that since that report was released in 2010, the IHS has repeatedly assured Congress that the problems were being addressed—and yet, last year the same IHS was found by the Center for Medicare and Medicaid Services (CMS) to have serious ongoing deficiencies in hospitals across the Great Plains Area. Chairman Young stated that the HEALTTH Act does not fix every problem in the IHS, but is "a step in the right direction."

Ranking Member Ruiz stated that Congress has been presented with an opportunity to "take a hard look" at the future of health care in Indian Country, to think about how the United States ought to be implementing its trust responsibility to Tribes, and to figure out how to bring the Indian health care system into the 21st century. Representative Ruiz emphasized the need for "permanent" solutions and adequate funding for the Indian health care system, stating that it is "hypocritical" to complain about the level of service provided, then to turn around and consistently underfund the agency responsible for providing that service. Representative Ruiz indicated that he supports a majority of the provisions in H.R. 5406 but has some reservations, though he was not specific about what those reservations were. Representative Ruiz also indicated that his vision for the future of tribal health care is to empower tribes to exercise tribal self-governance over health care services; in response, Chairman Young noted that the IHS's only role in Alaska is to contract with Native tribes and organizations, and that

Alaska may well have the best health care system in Indian Country.

The first witness to testify was Representative Noem, the sponsor of H.R. 5406. She described the ongoing problems in the IHS Great Plains Area, emphasizing that there is a serious health care crisis in the region and that the IHS is "broken." She pointed out that both CMS and the IHS operate under the umbrella of the Department of Health and Human Services, underscoring how bad the situation must be for CMS as a sister agency to deem the IHS's level of performance as unacceptable. Echoing Chairman Young's earlier statement, Representative Noem said that the IHS has promised again and again to make changes, but has failed to do so. Representative Noem added that Congress has delivered funding increases to IHS consistently since the 2010 Senate report was issued, and yet the situation is "as bad as ever," leading her to conclude that "we know for a fact that money alone is not going to solve this problem."

With respect to self-governance, Representative Noem said that Tribes in South Dakota have stated they are not currently ready to operate their own hospitals and do not have the resources to do so, though they would consider the option in the long-term if resources are made available. She pointed to the long-term contracting pilot project in H.R. 5406 as an interim step, between full direct-service and full self-governance. Representative Noem stated that she has received "widespread support" for the bill and that Tribes in the region are happy with the legislation, but also indicated that she welcomes further input. Both Representative Noem and Chairman Young expressed displeasure with the IHS's level of cooperation, with Representative Noem stating that she had been waiting for weeks to receive input from IHS on the draft bill and Chairman Young stating that the Subcommittee did not receive testimony from the IHS until 8 pm the previous evening. Representative Noem said that the IHS has been "slow-walking" their efforts to address the third-world health conditions in Indian Country and cited the Federal government's treaty obligations to Tribes in the Great Plains region.

Committee Member Paul Gosar (R-AZ) added to the remarks, commenting that the IHS is supposed to operate in consultation with tribes, but has not been meeting that expectation. He also commented that, in Arizona, tribal operation of health care services under P.L. 93-638 (the Indian Self-Determination and Education Assistance Act, or ISDEAA) has been quite successful and that tribal health facilities in that State are quite sophisticated. Representative Noem agreed with respect to the lack of consultation on many occasions, and reiterated that the Great Plains tribes do not have the resources now to take over operation of their hospitals but that self-governance is a long-term goal. Ranking Member Ruiz noted that "there is no one-size-fits-all" solution in Indian Country, and that while the IHS management in the Great Plains Area is clearly not working, the bill should consider that unique local dynamics in different regions mean that different models can work in different areas. Representative Noem agreed, stating that is why the bill is drafted as a pilot program for the Great Plains Area.

Representative Noem was also asked to explain her proposal to reform the Purchased/Referred Care (PRC) program funding allocation. She responded that the current PRC funding distribution does not work; Tribes in the Great Plains, she said, run out of funding by June, whereas other areas have enough funds to last throughout the year. Representative Noem stated that this occurs because the PRC funding distribution formula has never been updated to account for changes in population. In contrast, she said, her proposal would allocate PRC funding according to current need. She also pointed out that the requirement in H.R. 5406 that IHS PRC programs pay Medicare-like rates would stretch PRC dollars further by reducing the rates that IHS must pay for contract care. Representative Noem stated that she has not received any pushback to date on the Medicare-like rates proposal in the bill.

The second panel of witnesses consisted of Mary Smith, Principal Deputy Director for the IHS, as well as the following representatives of Tribes and tribal organizations: The Honorable William Bear Shield, Chairman, Rosebud Sioux Tribal Health Board; The Honorable Vernon Miller, Chairman, Omaha Tribe of Nebraska; Victoria Kitcheyan, Secretary, Winnebago Tribe of Nebraska; Jerilyn Church, Chief Executive Officer, Great Plains Tribal Chairmen's Health Board; and Stacy Bohlen, Executive Director, National Indian Health Board. The tribal representatives each shared compelling stories of substandard care from their Reservations and Service Units, and Mr. Bear Shield noted that over the past two years the quality of care in the area "has declined to an all-time low" as evidenced by the CMS findings. The tribal testimonies highlighted federal treaty obligations to provide health care to the Tribes, and also emphasized that additional resources in the form of Congressional appropriations are needed as badly as management reform. The tribal testimonies were supportive of H.R. 5406 and Ms. Bohlen likewise testified that the National Indian Health Board supports the bill. However, Ms. Bohlen warned that there must be national input from Tribes since the bill amends the Indian Health Care Improvement Act, which is the foundation of health care services for all tribes across the country, not just the Great Plains Area. Ms. Bohlen also pointed out that the permanent reauthorization of the Indian Health Care Improvement Act includes several authorities that could address many of the problems that H.R. 5406 is designed to address, but that many of those authorities have not been implemented because they have never been funded.

In her testimony, Deputy Director Smith acknowledged "longstanding and systemic" challenges faced by the IHS and said that the agency welcomes Congressional attention to the issue. In particular, Deputy Director Smith said that the IHS faces severe operation and staffing challenges and that the IHS needs to be able to support its staff with the resources to do their job—for example, she said, the lack of housing in many areas is a serious barrier to recruitment. She briefly discussed the IHS's new quality improvement strategy, which was introduced in a June 15, 2016 Dear Tribal Leader

Letter and includes efforts in five major areas: (1) assessing quality of care, including mock surveys in all IHS hospitals; (2) improving delivery of care by working to build up a "training and deployment pipeline"; (3) strengthening Area management; (4) consultation with quality experts from other areas of the Department of Health and Human Services; and (5) collaboration and partnership with Tribes and other local organizations, including local and regional health care systems and colleges and universities. Deputy Director Smith said that in addition to the specific measures being adopted, she is committed to instilling "a culture of quality care, leadership, and accountability" within the IHS.

In her oral testimony, Deputy Director Smith noted that the Administration has some concerns with H.R. 5406 as drafted, but did not comment specifically on the bill. Rather, the concerns were outlined in Ms. Smith's written testimony. The written testimony notes that the IHS already has authority to implement some of the measures proposed in H.R. 5406, including certain hiring flexibilities utilized by the Veterans Health Administration and authority to remove or demote employees; the authority to pay relocation incentives; the ability to waive Indian preference laws with written permission of the Tribe; and the ability to implement systems to monitor and address timeliness of care issues. The written testimony also states that the Department of Justice has raised constitutional concerns with the proposed removal and demotion provisions, and noted that revoking Federal employee protections could have unintended consequences for recruitment by making the IHS a less desirable place to work.

The written testimony also notes some objections to the long-term contracting pilot project: First, the testimony states that the provision could be interpreted as expecting the IHS to fund both a private sector contract and an ISDEAA contract at the same time, should the Tribe decide to exercise its ISDEAA contracting rights after a private contract is put in place. The IHS therefore suggests that language be added to clarify that a Tribe exercising its ISDEAA contracting rights would take over the private contract, not be paid its own contract in addition. Second, the testimony expresses concern that the proposed hospital governing boards—which would consist of IHS, tribal, and other health care experts—would not be accountable to the IHS or to the Secretary of Health and Human Services even though it is the Secretary who would retain the legal responsibility for running the hospitals. The IHS thus suggests Advisory Boards in place of the proposed governing boards.

The IHS written testimony likewise raises some objections to the PRC provisions in H.R. 5406. First, the testimony notes that the Medicare-like rate provision in the bill is similar to the recent IHS regulations, but includes subtle changes that could impact interpretation and does not include enforcement mechanisms, like civil monetary penalties, for providers who refuse to accept those rates. Second, the IHS testimony points out that the bill makes participation in the revised PRC funding formula optional

for 638 contractors, leading to questions about how it will impact direct service tribes. The written testimony predicts that the 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."

During the question and answer period, Representative Noem asked Deputy Director Smith why, if the IHS already has authority to implement some of the measures proposed in the bill, it had not done so already. Ms. Smith responded that she has only been in her position at the IHS for about three months and cannot speak for prior IHS leadership, but she acknowledged the importance of the issue and again pointed to new measures being implemented by the IHS as part of its quality improvement strategy. Representative Noem acknowledged the timing of Ms. Smith's appointment but responded that certainty is needed even as IHS leadership changes, given that IHS leaders have been stating for years that they will fix these problems. Representative Noem seemed to be suggesting that, even if the IHS already has the authorities it needs, Congressional action may be necessary to make sure that authority is appropriately used.

Representative Dan Benishek (R-MI) questioned whether political appointees should be in a primary leadership role when it comes to health care services at all, adding that the issues in the IHS are similar to those currently faced by the Veterans Health Administration. Representative Benishek suggested that perhaps a long-term management board and CEO should be put in charge of management at IHS, as has been proposed for the VA, "so that there is continuity and skill involved in this management process." Ms. Smith agreed that continuity of leadership and strong governance organization is important, but did not directly respond to the suggestion of a management board. Ms. Smith also responded to questioning from Representative Benishek on whether the IHS keeps a balance sheet tracking funds in and out on the hospital level, stating that the IHS is implementing those systems now. Finally, Representative Benishek asked Ms. Smith about the recent IHS employee grievance settlement and where the settlement funds came from. Ms. Smith responded that the settlement was entered into prior to her arrival, but she agreed to look into why the settlement was not paid from the United States Judgment Fund and to get back to Representative Benishek with an answer.

In closing remarks, Subcommittee Chairman Don Young acknowledged the uncomfortable situation that Ms. Smith, who took over responsibility for the IHS only a few months ago, is in, and encouraged her to seek assistance from the Subcommittee. He stated that these problems have spanned multiple administrations and neither the agency nor Congress can fix them alone. In her final comments, Representative Noem made clear that she is open to further input on H.R. 5406, stating, "I'm not married to this bill exactly the way that it is. I want to pass a bill that fixes problems and that everybody can get behind."

The hearing record is open until July 26, 2016, and the Subcommittee will accept written testimony until that time. If you would like any assistance or further information regarding the HEALTTH Act, please contact Elliott Milhollin at (202) 822-8282 or emilhollin@hobbsstraus.com; Geoff Strommer at (503) 242-1745 or gstrommer@hobbsstraus.com; or Caroline Mayhew at (202) 822-8282 or cmayhew@hobbsstraus.com.