GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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WASHINGTON, DC 20515–6115
Majority (202) 225–2927
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February 22, 2017

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Michael C. Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Walden and Chairman Burgess:

We are writing to urge you to hold a hearing on the Indian Health Service (IHS), the federal agency within the Department of Health and Human Services (HHS) responsible for providing health services to American Indians and Alaska Natives. An IHS hearing is both timely and critical after the Government Accountability Office (GAO) recently added "Improving Management of Federal Programs that Serve Tribes and Their Members" to its 2017 High Risk List. GAO took this action due to, among other things, ineffectively administered Indian health care programs that hindered IHS's ability to ensure quality care to Indian communities.[1] Furthermore, recent deficiencies found at certain IHS facilities in the Great Plains Area also raise questions about the quality of care IHS beneficiaries are receiving, and whether reforms made in recent years are improving the services that IHS provides.[2]

The Energy and Commerce Committee plays an important role in ensuring that the 2.2 million American Indians and Alaska Natives who get health services through the IHS receive high-quality care. Unfortunately, it has been over eight years since we last held a hearing in this area.[3] It is clear, based on GAO's recent action and the incidents in the Great Plains Area, that a hearing is necessary soon so that we can explore ways to improve health care services for American Indians and Alaska Natives.

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[1] Government Accountability Office, *High-Risk Series Progress on Many High-Risk Areas, While Substance Efforts Needed on Others*, (Feb. 2017) (www.gao.gov/assets/690/682765.pdf).

[2] Congressional Research Service, *The Indian Health Service (IHS): An Overview* (Jan. 12, 2016).

[3] House Committee on Energy and Commerce, *Hearing on H.R. 2708, the Indian Health Care Improvement Act Amendments of 2009,* 111th Cong. (Oct. 20, 2009).

In 2010, the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) became law. As you know, the IHCIA authorizes the provision of health care services through the IHS to American Indians and Alaska Natives. The permanent reauthorization included several provisions to improve the IHS such as increasing services available at IHS facilities and expanding the number and type of programs that provide behavioral health and substance abuse treatment to American Indians and Alaska Natives.[4] It is important that this Committee assess the implementation of the law and determine whether gaps remain.

Additionally, in 2010, then-Senator Byron Dorgan (D-ND) released an investigative report that concluded that IHS's Aberdeen region, now known as the Great Plains Area, was in a state of crisis and in need of urgent reform.[5] As part of that report, Senator Dorgan found that, among other concerns, five IHS hospitals were at risk of termination from Medicare and Medicaid; IHS lacked an adequate system to detect providers whose licenses had been revoked, suspended or under other disciplinary actions by licensing boards; and three service units had a history of missing or stolen narcotics.[6] HHS announced its commitment to improving the quality of care provided in the Great Plains Area as well as to specific corrective actions to remedy the concerns identified in the Dorgan report.

However, the quality of care provided by health facilities in the Great Plains Area has once again received national attention. As the result of deficiencies found during surveys to assess compliance with various Medicare Conditions of Participation (CoPs) and Emergency Medical Treatment and Labor Act (EMTALA) requirements, CMS has terminated the Winnebago Indian Health Service Hospital's participation in Medicare and Medicaid effective July 23, 2015.[7] Subsequently, three additional hospitals in the Great Plains Area, the Rosebud

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[4] Congressional Research Service, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by ACA: Detailed Summary and Timeline* (Jan. 3, 2014).

[5] United States Committee on Indian Affairs, *In Critical Condition: The Urgent Need to Reform the Indian Health* Services (Dec. 29, 2010) (www.indian.senate.gov/sites/default/files/upload/files/ChairmansReportInCriticalCondition122810.pdf).

[6] *Id.;* Letter from Captain Linda Bedker for Steven Chickering, Associate Regional Administrator, Western Consortium Division of Survey & Certification, to Rick Sorensen, Administrator, PHS Indian Hospital at Rapid City – Sioux San (May 23, 2016) (www.indianz.com/News/2016/05/23/cmssiouxsan052316.pdf).

[7] United States Senate Committee on Indian Affairs, *Hearing on Reexamining the Substandard Quality of Indian Health Care in the Great Plains*, 114th Cong. (Feb. 3, 2016) (written statement of Andy Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services).

Indian Health Service Hospital, PHS Indian Hospital at Pine Ridge, and PHS Indian Hospital at Rapid City – Sioux San faced termination.[8]

Last year, IHS and HHS announced corrective actions that they would take to improve the quality of care provided by health facilities in the Great Plains Area. We believe it is important that we understand whether these actions are sufficient to bring the Winnebago Indian Health Service Hospital into compliance, keep the other hospitals in compliance, and ensure that beneficiaries in the Great Plains Area have access to quality health care services.

In addition, HHS has implemented other changes aimed at improving access to care and the quality of health care services provided by IHS facilities. For example, in 2011, the Health Resources and Services Administration (HRSA) made all IHS facilities eligible National Health Service Corps (NHSC) sites.[9] This eliminated the requirement that Tribal sites apply to be NHSC sites and resulted in an increase in the number of NHSC approved sites and NHSC clinicians working at IHS sites: from 100 approved sites with approximately 150 NHSC clinicians in July 2011 to 670 approved sites with more than 420 NHSC clinicians today.[10] IHS also announced the establishment of a new Deputy Director, Quality Health Care, to oversee and focus on quality improvement[11] and instituted the IHS Quality Framework to guide efforts to improve the quality of care IHS facilities provide to patients.[12] It is important that members have an opportunity to understand these and other changes made by IHS and other HHS agencies and assess whether such changes are improving the care delivered at IHS facilities nationwide.

Finally, the GAO just declared "Improving Federal Management of Programs that Serve Tribes and Their Members" as a High Risk area. As you know, at the beginning of each Congress, GAO releases a High Risk list to call attention to "agencies or programs that are high risk due to their vulnerabilities to fraud, waste, abuse, and mismanagement, or are most in need

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[8] *Id.*

[9] United States Senate Committee on Indian Affairs, *Hearing on Reexamining the Substandard Quality of Indian Health Care in the Great Plains*, 114th Cong. (Feb. 3, 2016) (written statement of Mary Wakefield, Acting Deputy Secretary, Department of Health and Human Services).

[10] *Id.*

[11] Letter from Robert G. McSwain, Principal Deputy Director, Indian Health Service, to Tribal Leaders (Dec. 14, 2015) (www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2015_Letters/54891-1_DTLL_Deputy_Director_Quality.pdf).

[12] Indian Health Service, *New Quality Framework to Guide Delivery of Care at Indian Health Service* (www.ihs.gov/newsroom/index.cfm/pressreleases/2016pressreleases/new-quality-framework-to-guide-delivery-of-care-at-indian-health-service/).

of transformation."[13] GAO added the management of tribal programs to this list due to nearly a decade of reports that federal agencies are ineffectively administering tribal programs, including "inadequate oversight of health care that hindered IHS's ability to ensure quality care to Indian communities."[14] Additionally, GAO has made 14 recommendations in the past six years to improve IHS that remain open.[15] It is important that the Committee take action to better under GAO's findings and understand steps needed to improve the administration of IHS.

More than 2.2 million American Indians and Alaska Natives rely on IHS to meet their health care needs. We urge you to schedule a hearing on this important public health matter as soon as possible.

Thank you for your consideration of this request.

Sincerely,

Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce

Gene Green
Ranking Member
Subcommittee on Health

Ben Ray Luján
Member of Congress

Kurt Schrader
Member of Congress

Raul Ruiz, M.D.
Member of Congress

[13] Government Accountability Office, *High Risk List Overview*, (www.gao.gov/highrisk/overview).

[14] Government Accountability Office, *High-Risk Series Progress on Many High-Risk Areas, While Substance Efforts Needed on Others*, (Feb. 2017) (www.gao.gov/assets/690/682765.pdf).

[15] *Id.*