Statement by

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Before the

Committee on Indian Affairs
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Legislative Hearing
S. 465 "Independent Outside Audit of the Indian Health Service Act of 2017"

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Chairman and Members of the Committee:

Good afternoon, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee. I am Elizabeth A. Fowler, Deputy Director for Management Operations, Indian Health Service (IHS). I am an enrolled member of the Comanche Tribe with descendancy from the Eastern Band of Cherokee Indians. I am pleased to provide testimony before the Senate Committee on Indian Affairs on S. 465, the Independent Outside Audit of the Indian Health Service Act of 2017. I would like to thank you, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee for elevating the importance of accountability and transparency in the IHS.

IHS is a distinct agency in the Department of Health and Human Services (HHS), established to carry out the responsibilities, authorities, and functions of the United States to provide health care services to American Indians and Alaska Natives. It is the only HHS agency whose primary function is direct delivery of health care. The mission of IHS, in partnership with American Indian and Alaska Native people, is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS system consists of 12 Area offices, which oversee 170 Service Units that provide care at the local level. Health services are provided through facilities managed by the IHS, by Tribes and tribal organizations under authorities of the Indian Self-Determination and Education Assistance Act (ISDEAA), and through contracts and grants awarded to urban Indian organizations authorized by the Indian Health Care Improvement Act.

The IHS is steadfastly committed to responsible stewardship of the resources entrusted to us. We are working every day to overcome the longstanding systemic challenges that impede our efforts to meet our mission and provide the quality health care to American Indians and Alaska Natives that they expect. We are proud to report to you that our concerted efforts are producing results. On August 25, the official Patient Wait Times policy setting the IHS wait times standards for outpatient primary care visits in direct care IHS facilities was signed by the IHS Acting Director. In less than a year, we updated Governing Board Bylaws, acquired a credentialing software system, developed a standard patient experience of care survey, developed a quality assurance accountability dashboard, and awarded a master contract for accreditation of all of our hospitals. In the Great Plains Area, our efforts have brought positive results at the IHS Rosebud Hospital**.** As of September 1, the IHS Rosebud Hospital is no longer under a Systems Improvement Agreement after the Centers for Medicare & Medicaid Services (CMS) determined it had substantially met all the Medicare Conditions of Participation.

While we are making progress in the Great Plains, longstanding challenges remain. On November 3, the IHS Pine Ridge Hospital received a CMS notice of intent to terminate its provider agreement effective November 18, 2017 due to non-compliance with the Medicare Conditions of Participation for hospitals. The IHS immediately began instituting corrective actions at the Pine Ridge Hospital. For instance, we are enhancing staffing levels in the emergency department; deploying U.S. Public Health Service officers to reduce staff turnover; and continuing to improve emergency department operations through federal oversight and more effective utilization of telehealth consultation. These actions are in addition to the significant steps we have taken in the last year at the Pine Ridge Hospital. It remains an Agency priority to

bring the IHS Omaha Winnebago Hospital and the IHS Pine Ridge Hospital into full compliance with CMS standards. We are improving agency oversight of quality care at all levels of the IHS.

To better serve American Indians and Alaska Natives, we proactively pursue new ideas and innovative ways to improve how we do business in delivering quality care and accounting for the transparent administration of federal resources. Two innovative ways in which we are transforming the IHS is through implementing our Quality Framework and executing an IHS strategic plan. These tools will guide the development, implementation and sustainability of quality-focused, high-reliability programs at all of our hospitals and clinics. Core elements of the Framework focus on strengthening our organizational capacity, and improving transparency and communication to IHS stakeholders. The IHS strategic plan is currently being developed, with consultation and conferral from Tribes and urban Indian organizations. The strategic plan will sustain and build on the achievements of the Quality Framework and institute objectives such as providing comprehensive, culturally acceptable health services, promoting a quality performing organization through innovation of the Indian health system, and strengthening IHS program management and operations that securely and effectively manage assets and resources.

Efficient, Effective, and Transparent Stewardship

As responsible stewards of the resources entrusted to us, one of our most important duties is to practice fiscal responsibility and transparency. The Agency is focused on strengthening our program management and operations in order to improve communication with IHS stakeholders and securely and effectively manage assets and resources. We have taken solid steps to ensure

that our stewardship is efficient, effective, and transparent within the IHS and with our external stakeholders as well.

To help us reach our objectives, we are leveraging a widely used private sector tool to standardize and enhance budget planning throughout our agency. We are also in the process of using data analytics software to provide improved transparency of our financial information. This is software we purchased for use in health care delivery and quality assurance, and is now being effectively used for additional purposes to improve our communications with IHS stakeholders and management of our resources.

One application of the data analytics software being used for financial purposes is a dashboard for our third party collections, which is nearing deployment. While the agency has been able to provide summary or detailed reports for specific pieces of our collections data, we lacked the ability to rapidly review and report our data in a more efficient and automated manner. This new application enables us to review data from Fiscal Year (FY) 2010 forward, by location, insurance type, and month, for example, and easily do comparisons. We are also using the data analytics software to develop a standard financial report to enhance the transparency and communication of our financial data with tribal partners. This report can be run by Area Offices and Service Units to combine data on our funding allocations, actual spending, and collections. These tools will profoundly reshape the business of IHS and allow us to better utilize our existing financial and administrative systems to support our mission.

To better serve our stakeholders, the IHS continues to search for new ways to strengthen our overall internal control environment. The IHS is actively inspecting its system and programs to resolve any shortfalls that exist. Our Chief Financial Officer (CFO) will be expanding the role of internal audit staff within our enterprise risk management program. This includes augmenting existing annual audits and assessments performed by contracted external professionals so that we can target and examine key financial and administrative programs and address the areas of greatest risk. This audit program enables us to conduct our own reviews, complementing the important work of our Departmental Inspector General and the Government Accountability Office, and allows us to proactively resolve problems as they are identified.

As the IHS continues to expand our internal audit capabilities, this will also complement the current routine and statutorily required external audits and financial reporting. For example, IHS just participated in the annual CFO Audit Act audit of our financial statement, conducted by a nationally-known independent firm contracted by HHS. While we do not yet have the results for FY 2017, the audit opinion for FY 2016 was unqualified for the entire Department, meaning financial records and statements were fairly and appropriately presented, and in accordance with Generally Accepted Accounting Principles. In addition, the IHS complies with the Office of Management and Budget Circular A-11 which includes standard federal budget execution and budgetary resource reporting requirements, including quarterly reports that are publicly available. IHS meets the standards applicable to federal financial reporting as we continue our efforts to be more transparent and improve our utilization of financial information.

Another aspect of the IHS stewardship of resources is the Purchased and Referred Care (PRC) program. Improving the data reporting and measurement system is essential to assuring that PRC programs are efficient. IHS modified the data system that tracks PRC referrals and emergency self-referrals and expects to begin baseline reporting for calendar year (CY) 2017, which will be available in CY 2018.

The IHS offers the following comments on the draft amendment in the nature of a substitute to S. 465. The substitute to S. 465 provides authority for a comprehensive assessment of the IHS health care delivery systems and financial management process by the HHS Inspector General or a private entity. IHS is prepared to provide the Committee technical assistance on the legislation.

If the HHS Inspector General does not conduct the assessment, the legislation requires the Secretary to enter into contracts with one or more private entities to conduct the assessment no later than 180 days after the date of enactment. We are reviewing possible acquisition strategies that would allow us to obtain a qualified, quality provider expeditiously but would prefer that the deadline be expressed as a goal to ensure the process results in the identification and selection of the best provider, including adequate time to consider Indian Economic Enterprises as required under the Buy Indian Act.

If a contract is entered into by the Secretary with a private entity, the magnitude and detail of the assessments proposed by the bill may require significant financial resources. If the Secretary directs IHS to fund the cost of the contract with the independent entity, it is important to note that IHS's existing budget could not support a project of this scale without affecting direct health

services. With approximately 60 percent of the budget administered by Tribes and tribal organizations through ISDEAA agreements, there would be very little flexibility for reprogramming remaining resources to accomplish the proposed assessment.

Finally, S. 465 would require that the Secretary of HHS immediately submit the proposed assessment to several Congressional Committees and Members, then publish the report in the *Federal Register* and on a public HHS website. Requiring concurrent reporting and near-immediate publication of such a broad assessment may raise constitutional concerns about executive branch supervision and executive privilege. We recommend giving the Secretary a chance to review the report before it is submitted to Congress and made public.

Thank you for your commitment to improving quality, safety, and access to health care for American Indians and Alaska Natives. I will be happy to answer any questions the Committee may have.