EXAMINING THE PRESIDENT'S FISCAL YEAR 2024 BUDGET REQUEST FOR THE INDIAN HEALTH SERVICE

OVERSIGHT HEARING

BEFORE THE

SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS

OF THE

COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

Thursday, May 11, 2023

Serial No. 118–25

Printed for the use of the Committee on Natural Resources

Available via the World Wide Web: http://www.govinfo.gov
or
Committee address: http://naturalresources.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE
52–324 PDF WASHINGTON : 2023

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Thursday, May 11, 2023
U.S. House of Representatives
Subcommittee on Indian and Insular Affairs
Committee on Natural Resources
Washington, DC

The Subcommittee met, pursuant to notice, at 2:07 p.m., in Room 1324 Longworth House Office Building, Hon. Harriet M. Hageman [Chairwoman of the Subcommittee] presiding.

Present: Representatives Hageman, Radewagen, LaMalfa, González-Colón, Carl; and Leger Fernández.

Ms. HAGEMAN. The Subcommittee on Indian and Insular Affairs will come to order. Without objection, the Chair is authorized to declare recess of the Subcommittee at any time.

The Subcommittee is meeting today to hear testimony related to examining the President's Fiscal Year 2024 budget request for the Indian Health Service. Under Committee Rule 4(f), any oral opening statements at hearings are limited to the Chairman and the Ranking Minority Member. I therefore ask unanimous consent that all other Member's opening statements be made part of the hearing record if they are submitted in accordance with Committee Rule 3(o).

Without objection, so ordered.

I will now recognize myself for an opening statement.

STATEMENT OF THE HON. HARRIET M. HAGEMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Ms. HAGEMAN. Under the Constitution, Congress has the power to tax and to spend, and within those powers are Congress' responsibility to tax and spend wisely and make decisions on how best to prioritize finite Federal resources among all the programs and policies implemented across the United States and the world. It is also Congress' responsibility to conduct oversight of how Federal funds are spent and to hold agencies accountable for their spending and their prioritization of programs and policies.

This hearing will focus on the President's Fiscal Year 2024 budget request for the Indian Health Service and how best to allocate funds to the IHS and consider what changes need to be made. IHS, like every other agency, is accountable to the American people, and particularly to the tribal communities and Native people that they serve. Through treaties and Federal statutes, the Federal Government has assumed the responsibility of providing

healthcare for American Indians and Alaska Natives, and IHS is the primary agency charged with that responsibility.

IHS provides an array of medical services to Native people, including primary care, emergency services, public health nursing, and substance abuse care, just to name a few. As previous hearings have shown, IHS has not always delivered the best possible care and improvements must be made. Over the past several years, Indian Country has seen substantial Federal funding increases across agencies and programs that serve Native communities, including for tribal healthcare and health facilities.

The Federal Government has also increased its spending generally over the past decade and that means a higher deficit and intense concern for many Americans about the fiscal future facing our nation. In fact, I just did a poll this week as to some of the issues that are the most important to my constituents in the state of Wyoming, and the budget, and government, and Federal spending is at the top of the list.

The President's budget proposes a $2.45 billion increase for IHS in the next fiscal year. The budget also proposes to shift contract support costs in Section 105(l) Lease Funding to mandatory spending in Fiscal Year 2024 and then further shift all IHS funding to mandatory spending beginning in Fiscal Year 2025.

While I understand the need for consistent funding, I also believe that continued oversight and accountability of IHS is needed at this time. We need to see significant progress before how IHS is funded can significantly change.

The discretionary appropriations process helps to encourage and facilitate oversight as well as further discussion about what innovative approaches IHS should incorporate to ensure the healthcare provided to Native communities is not only of high caliber, but fiscally responsible. It is also important to note that IHS remains on the Government Accountability Office's high-risk list as one of the government programs in operations vulnerable to waste, fraud, and abuse. And while the Agency has made some progress on key recommendations, much more work remains.

Specifically, this Subcommittee has heard many concerns about the Purchased/Referred Care Program, including how claims are either accepted or denied, as well as how slowly these claims have been paid by IHS, which is then affecting the personal credit scores when the claims are sent to collections.

Ensuring effective care when IHS facilities cannot provide such services to tribal members is critically important and has life-changing implications. In short, equitable access to PRC funds must be a priority. There are also problems with the speed of completing the 1993 Priority List for Indian Health Facilities. It is now 30 years later, and the list has not yet been completed. That is unacceptable, and our tribal members have suffered as a result.

There are questions on how to best care for individuals suffering from substance abuse and mental health disorders, how to ensure full hiring and retention of IHS medical and support personnel, how to expand access to labor and delivery services for women in their home communities, and how to provide dental services. IHS medical staff and tribal health professionals are the boots on the

ground ensuring healthcare to Native peoples, and it is the best that it can be. Their work is needed now more than ever.

Continuing oversight of IHS to ensure they are fulfilling their mission to efficiently and effectively operate for the benefit of Native communities is a main priority of this Subcommittee, and it will help to make sure resources get to where they need to go. Today, that means having a good discussion about the Agency's budget and where resources should be allocated.

I want to thank the Director for being here to testify today, and I look forward to your testimony.

The Chair now recognizes the Ranking Minority Member for any statement.

STATEMENT OF THE HON. TERESA LEGER FERNÁNDEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Ms. LEGER FERNÁNDEZ. Thank you so much, Madam Chairwoman, for holding this hearing, for raising the issues that you do. I will try to talk about some of them, but I think that I really appreciate the fact that we already had a hearing in our oversight regarding healthcare, and what came across loud and clear was that IHS provides critical, culturally-competent healthcare services to American Indians and Alaska Natives across the United States either directly or through compacted and contracted tribal facilities.

Unfortunately, Congress and past administrations have failed to fund IHS at the level that IHS patients deserve. Reports from the GAO and the U.S. Commission on Civil Rights confirmed that reality: IHS is grossly undersized and underfunded compared to its current need.

At our last hearing, tribal health organizations made one thing very clear, we need to fully fund the IHS. Indeed, Chairwoman Alkire, from that table, told us that the National Indian Health Board estimates that IHS spending per patient is less than half of Medicaid's spending, less than half of Veterans' medical spending per patient, and less than one-third of Medicare spending per beneficiary, even after we include third-party revenue received by IHS. We know that each of these healthcare providers are already underfunded, but IHS receives even less so.

So, President Biden's Fiscal Year 2024 budget, which I think we should address and talk about, I agree with you, we need to talk about how it impacts deficit. But that 2024 budget would decrease the Federal deficit by $3 trillion over a 10-year period. And over the last 2 years, with Congress and Biden, we have reduced the deficit already by $1.7 trillion. So, there are ways to reduce the deficit while also investing in what is important.

This year's budget requests a 35.8 percent increase in funding. It still falls far short of parity with the other Federal healthcare programs, but it is a step in the right direction. The IHS request is $9.65 billion with an additional proposal to make funding for the Agency mandatory beginning in Fiscal Year 2025.

The budget request also would fully fund the remaining projects on the 1993 Healthcare Facilities Priority List. Let me say that again—1993 Priorities List. It is a disgrace that these priority

projects, 30 years out, have not been built yet. We also have $691 million to modernize the IHS electronic health records system which has also been in the planning stages for too long.

We would increase by $742 million the direct healthcare services and an additional $24.7 million for urban Indian health. And we know that more tribal members receive their healthcare in urban areas than not, so that is really important.

But in order to really provide these services, you need to address staff recruitment and retention concerns, which is why I am really pleased to see the IHS scholarship and loan repayment awards, the graduate medical education programs, nurse preceptorships, and the national Community Health Aide Program. Because everywhere I go in Indian Country, I hear over and over again, we do not have enough doctors, nurses, and health technicians. It is best if we can invest in the communities themselves so that we can create that pipeline of healers from our tribal communities.

At our last hearing as well, our tribal witnesses highlighted three additional areas: the facilities, contract support costs, and the Special Diabetes Program for Indians. So, this budget request actually responds to those issues that we heard in this hearing room. It includes a legislative proposal to reauthorize the Special Diabetes Program for Indians for 3 years, something I support and am co-sponsoring. These allocations would be historic for the Agency in its tribal service populations.

But I still want to highlight the gaps in funding that would still exist even with these increases. The cumulative budget request from the Tribal Budget Formulation Work Group says in order to cover salaries, inflation, population growth, we would need services and facilities program of $49.65 billion.

And I also want to touch on the Republican's proposed budget cuts. Their proposal would require at least a 22 percent budget reduction for IHS. The *New York Times* highlighted that that might be as high as 51 percent. Imagine, that would be 10,000 fewer inpatient admissions, nearly 4 million fewer outpatient visits. Also slashing dental health, mental health, alcohol, and substance abuse.

I want everybody to think of what it would be like for a tribal family of four. At least one member of that family would not get the healthcare, mental care, diabetes care that she needs. Who would we sacrifice? If we don't make needed investments now, it is going to actually cost us more later because we need to invest in healthy communities rather than just dealing with the health problems later.

I am so glad that last year we did pass on a bipartisan basis advanced appropriations for the Agency, and I look forward to doing that once again.

Thank you so much, Madam Chair, and I yield back.

Ms. HAGEMAN. Thank you. And just to make one correction, while the *New York Times* may argue that there would be a 22 percent reduction in the Republican's proposal, the reality is that the debt reduction package that the Republicans have put forward would be based upon spending in 2022 levels. Seeking an increase of $2.45 billion in this particular budget to a total of $9.65 billion,

I don't see how any math possible would show that that was a 22 percent reduction. Just wanted to make that correction.

I will now introduce the witness, Ms. Roselyn Tso, Director of the Indian Health Service out of Rockville, Maryland. And sitting with her today on the dais is Director, Office of Budget, Ms. Jillian Curtis. Let me remind the witness that under Committee Rules, they must limit their oral statements to 5 minutes, but their entire statement will appear in the hearing record.

To begin your testimony, please press the talk button on the microphone. We use timing lights, and when you begin the light will turn green. When you have 1 minute left, the light will turn yellow. And at the end of 5 minutes, the light will turn red, and I will ask you to please complete your statement. I will also allow all witnesses on the panel to testify before Member questioning.

The Chair now recognizes Director Tso for 5 minutes. Thank you.

STATEMENT OF THE HON. ROSELYN TSO, DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD, ACCOMPANIED BY JILLIAN CURTIS, DIRECTOR OF BUDGET, INDIAN HEALTH SERVICE

Ms. TSO. Good afternoon. Thank you, Madam Chair Hageman and Ranking Member Leger Fernández, and members of the Subcommittee. Thank you for the opportunity to testify on the President's Fiscal Year 2024 Request for the Indian Health Service.

Before I turn to the 2024 budget, I also want to restate and state again that we always welcome the opportunity to appear before the Subcommittee as part of our commitment to oversight and transparency. I know earlier we made every attempt to try to make the March meeting work, and we were unfortunately not able to do so. I look forward to our continued partnership in ensuring that IHS fulfills its mission to providing quality and safe care to our tribal communities.

Next, I want to acknowledge and thank you for the work that you have done over the years to grow the Indian Health Service budget and prioritize health throughout Indian Country. We are also especially grateful for your work in providing IHS advanced appropriations in the Fiscal Year 2023 bill that truly is an historic achievement and that will greatly improve lives of American Indians and Alaska Natives throughout Indian Country. I also appreciate the opportunity to share with you the steps that I have taken as the Indian Health Service Director to improve transparency, accountability, and oversight of the Indian Health Service.

As we seek additional funding and new funding authorities, it is critical that the Indian Health Service improve its internal operations to ensure safe, high-quality healthcare services and protect and support the relationships that we have with our tribes and our urban Indian organizations. To that end, I have posted for the first time an agency work plan to manage the high-priority topics including building an enterprise-wide risk system on January 15.

The agency work plan addresses a wide-range of topics including patient safety, human capital, finance, operations, compliance, and strategies. This work builds on our effort to meet the GAO criteria for removal from its high-risk list. The IHS has already achieved

two major accomplishments in the work plan. The first one was to designate and commission a team to look at the Agency's quality program in December 2022 with a primary focus of improving oversight and quality safe care for all of our patients.

Also in December 2022, we achieved a milestone as part of our plan to standardize governance structure throughout the IHS-operated healthcare facilities by adopting standardize governance bylaws at all 12 areas. Standardizing governance practices at direct health facilities further supports uniform oversight and accountability while increasing efficiencies.

With your support, the IHS budget has grown 68 percent in the last decade. We know that this type of growth is challenging to accomplish in a constrained discretionary funding environment. Over the years, the work with our tribal and urban partners underscore our shared goals to improve health outcomes for all American Indians and Alaska Natives.

With the shared goals in mind that the Administration has approached the Fiscal Year 2024 budget's request for Indian Health Service, we know that despite our shared efforts, IHS is still underfunded. This underfunding of the Indian Health Service system directly contributes to the stark health disparities in tribal communities.

American Indians and Alaska Natives born today have an average life expectancy that is 10.9 years fewer than all race population. Long-standing health disparities were compounded by the pandemic with American Indians and Alaska Natives experiencing disproportionate rates of COVID-19 infections, hospitalizations, and deaths. Addressing these inequities is a moral imperative for our nation, and it will require bold actions from all of us to ensure we are upholding the commitment to Indian Country.

This is why the budget proposes to build on the enactment of advanced appropriations by funding the Indian Health Service and facilities accounts as discretionary in Fiscal Year 2024. It also proposes to reclassify contract support costs in Section 105(l) to mandatory in 2024. We believe that this is the most appropriate funding source for these legally required payments to the tribes. Beginning in Fiscal Year 2025, we will be working to make the budget mandatory for Indian Health Service.

As we work together to secure stable, predictable, and adequate funding to meet the needs of Indian Country, we are committed to working closely with our stakeholders. Thank you for the opportunity to speak with you today, and I am happy to answer any questions.

[The prepared statement of Ms. Tso follows:]

PREPARED STATEMENT OF ROSELYN TSO, DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good afternoon Chair Hageman, Ranking Member Leger Fernandez, and Members of the Subcommittee. Thank you for your support and for inviting me to speak with you about the President's Fiscal Year (FY) 2024 Budget Request for the IHS.

IHS is an agency within the Department of Health and Human Services (HHS) and our mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level. This mission is carried out in partnership with AI/AN Tribal communities through a network of over 600 Federal and Tribal health facilities and 41 Urban Indian Organizations

(UIOs) that are located across 37 states and provide health care services to approximately 2.8 million AI/AN people annually.

On March 9, 2023, the White House released the President's FY 2024 Budget, which takes a two pronged approach to build on the historic enactment of advance appropriations for the IHS in the FY 2023 Omnibus. In FY 2024, the Budget proposes to fund IHS Services and Facilities accounts as discretionary, building on the enacted 2024 advance appropriations. It also proposes to reclassify Contract Support Costs and Section 105(l) Leases to mandatory funding in FY 2024, which is the most appropriate funding source for these legally required payments to tribal health programs. Beginning in FY 2025, the Budget would make all funding for IHS mandatory. The bold action proposed in the FY 2024 President's Budget demonstrates the Administration's continued commitment to strengthening the nation-to-nation relationship. This historic proposal addresses long-standing challenges that have impacted communities across Indian Country for decades.

Leadership Priorities

I have been traveling across Indian Country to visit the places where we are serving our people since my appointment last fall. These visits have provided me a better perspective on national and regional issues affecting the tribal members we serve and have informed my priorities for the agency. I have two key priorities as IHS Director: providing safe, high quality patient care; and improving our relationships with Tribes, Tribal Organizations, and Urban Indian Organizations.

To those ends, I have taken significant steps to increase transparency, accountability, and oversight at the IHS. The IHS published its first ever Agency Work Plan [1] to manage high priority, enterprise-wide risks on January 15. I hold quarterly strategic planning sessions with leadership from across the Agency to ensure progress on the Work Plan, and I have assigned a lead to each action on the Work Plan. These actions address a wide range of Agency-wide issues including patient safety, human capital, operations, finances, compliance, and strategy. This work builds on the IHS' efforts to meet the Government Accountability Office's (GAO) criteria for removal from its high risk list.

The IHS has achieved two major accomplishments on the Work Plan thus far. I initiated an evaluation of the Agency's quality program in December 2022, with a primary focus on improving oversight of quality and safe care for patients. In general, this evaluation included a continued focus on oversight and accountability through developing policies, standardizing the IHS governance structure and strengthening IHS' enterprise risk management program. Standardizing governing board practices at direct service facilities improves oversight and accountability while increasing efficiency and effectiveness of governing board meetings. These actions allow the Agency to be proactive on governance issues by being able to review information in an efficient manner. These efforts were led by a team of subject matter experts from across the Agency, with oversight and technical direction by the IHS Chief Medical Officer.

Funding issues directly contribute to challenges in providing safe, high-quality care for patients, and supporting productive relationships between the IHS and Tribes and Urban Indian Organizations. The Indian Health system is chronically underfunded compared to other healthcare systems in the U.S.[2,3] Despite substantial growth in the IHS discretionary budget over the last decade, 68 percent from FY 2013 to the current FY 2023 enacted level, the growth has not been sufficient to address the well-documented funding gaps in Indian Country. These funding deficiencies directly contribute to stark health disparities faced by tribal communities. AI/ANs born today have an average life expectancy that is 10.9 years fewer than the U.S. all-races population. AI/AN life expectancy dropped from an estimated 71.8 years in 2019 to 65.2 years in 2021—the same life expectancy as the general United States population in 1944.[4] They also experience disproportionate rates of mortality from most major health issues, including chronic liver disease and cirrhosis, diabetes, unintentional injuries, assault and homicide, and suicide. AI/AN people

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[1] Indian Health Service—2023 Agency Work Plan: https://www.ihs.gov/quality/work-plan-summary/

[2] Government Accountability Office Report—*Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs* https://www.gao.gov/assets/gao-19-74r.pdf

[3] U.S. Commission on Civil Rights Report—*Broken Promises: Continuing Federal Funding Shortfall for Native Americans* https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf

[4] Centers for Disease Control and Prevention (CDC) Report—*Life Expectancy in the U.S. Dropped for the Second Year in a Row in 2021* https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20220831.htm#:?:text=AIAN%20people%20had%20a%20life,total%20U.S.%20population%20in%201944

also have higher rates of colorectal, kidney, liver, lung, and stomach cancers than non-Hispanic White people.[5] The pandemic compounded the impact of these disparities in tribal communities, with AI/ANs experiencing disproportionate rates of COVID-19 infection, hospitalization, and death.

Building on the Historic Achievement of Advance Appropriations

The FY 2024 President's Budget builds on the historic enactment of advance appropriations for IHS in the FY 2023 Omnibus. For the first year of the proposal, the Budget includes $9.7 billion in total funding for the IHS, which includes $8.1 billion in discretionary funding, and $1.6 billion in proposed mandatory funding for Contract Support Costs, Section 105(l) Leases, and the Special Diabetes Program for Indians. This is an increase of $2.5 billion above the FY 2023 Enacted level. Advance appropriations represent an important step toward securing stable and predictable funding to improve the overall health status of AI/ANs, and ensuring that the disproportionate impacts experienced by tribal communities during government shutdowns and continuing resolutions are never repeated.

While the progress achieved through the enactment of advance appropriations will have a lasting impact on Indian Country, funding growth beyond what can be accomplished through discretionary spending is needed to fulfill the federal government's commitments to AI/AN communities. Funding for IHS has grown substantially in the last decade, but this growth is not sufficient to address the historic under investment and persistent health disparities in AI/AN communities.

The Administration continues to support mandatory funding for IHS as the most appropriate long-term funding solution for the agency and will continue to work collaboratively with tribes and Congress to move toward sustainable, mandatory funding. Until this solution is enacted, it is critical that Congress continue to provide advance appropriations for IHS through the discretionary appropriations process for FY 2025 and beyond.

Long-Term Funding Solutions

The Budget proposes to fully shift the IHS budget to mandatory funding in FY 2025. This mandatory formula culminates in a total funding level of approximately $44.0 billion in FY 2033. In total, the mandatory budget would provide nearly $288 billion for the IHS over ten years. When accounting for the discretionary baseline, the net-total for the proposal is $192 billion over ten years.

Under the proposed mandatory structure, IHS funding would grow automatically to address inflation factors to address the growing cost of providing direct health care services, including pay costs, medical and non-medical inflation, and population growth, as well as key operational needs, and existing backlogs in both healthcare services and facilities infrastructure.

Mandatory funding for the IHS provides the opportunity for significant funding increases that could not be achieved within discretionary spending levels. Further, this mandatory funding proposal ensuring predictability that would allow IHS, tribal, and urban Indian health programs the opportunity for long-term and strategic planning. This increased stability and ability to conduct longer-term planning will improve the quality of healthcare, promote recruitment and retention of health professionals, and enhance management efficiencies for individual health programs and the Indian Health system at large.

The Budget also exempts all IHS funding from sequestration, which is the legislatively mandated process of budget control consisting of automatic, across-the-board spending reductions to enforce budget targets to limit federal spending. Exempting the IHS budget from sequestration ensures funding for direct health care services for AI/ANs is not reduced and is consistent with the treatment of other critical programs such as veterans' health care and nutrition assistance programs.

Lastly, the Budget proposes to reauthorize the Special Diabetes Program for Indians and provide $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026 in new mandatory funding. This program has proven to be effective at reducing the prevalence of diabetes among AI/AN adults,[6] and is associated with an estimated net-savings to Medicare of up to $520 million over 10 years due

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[5] Centers for Disease Control and Prevention (CDC)—*Cancer Within American Indian and Alaska Native (AI/AN) Populations* https://www.cdc.gov/healthytribes/native-american-cancer.html

[6] 4 British Medical Journal—Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006–2017 https://drc.bmj.com/content/8/1/e001218

to averted cases of end-stage renal disease.[7] The budget's proposed increases will enable the program to expand to additional grantees, and allow the grantees to plan for larger and longer-term community-driven interventions more effectively. Without the reauthorization of this program in FY 2024 services would end for this successful program.

This request responds to the long-standing recommendations of tribal leaders shared in consultation with HHS and IHS to make IHS funding mandatory. The IHS recognizes that we must continue to work in consultation with Tribes and confer with urban Indian organizations, and with our partners in Congress. To this end, a joint OMB and HHS tribal consultation and urban confer will be conducted in June to review this proposal and receive feedback to inform further refinements to the mandatory formula structure.

Prioritizing High Quality Health Care

The Budget prioritizes investments that advance high quality health care and tackle the stark health care inequities AI/ANs face every day.

In FY 2024 the Budget provides +$742 million increase to expand access to direct health care services by increasing funding across IHS' direct health care service program lines. These resources will support efforts to reduce health disparities and improve the overall health status for AI/ANs by increasing the availability of health care services in Indian Country. Specifically, this funding level will support an estimated additional 45,670 inpatient admissions and 16,976,299 outpatient visits at IHS and Tribal facilities in FY 2024. This funding also expands access to the Purchased/Referred Care program for contract health care services that are not available in IHS or Tribal health facilities by providing an estimated 3,138 additional inpatient admissions, 92,248 additional outpatient visits, and 3,262 additional patient travel trips. The Budget also expands Dental health services, supporting an estimated 167,119 additional dental visits and 529,462 additional dental services in FY 2024. Within this total, the Budget includes an additional $21 million for the Urban Indian Health Program to expand access to culturally competent direct health care services through a network of 41 Urban Indian Organizations located in urban areas across the country. Expansion of these programs is essential to ensure that IHS can provide high quality medical services and support critical health care services that meet the unique needs of AI/AN communities.

In addition, Current Services, which offset the rising costs of providing direct health care services, are fully funded at +$346 million in FY 2024. These resources will help the IHS to maintain services at the FY 2023 levels by shoring up base operating budgets of IHS, Tribal, and urban Indian health programs in the face of increasing costs. Similarly, in FY 2024, the Budget includes +$82 million to fully fund staffing and operating costs for eight newly-constructed or expanded health care facilities. These funds support the staffing packages for new or expanded facilities, which will expand the availability of direct health care services in areas where existing health care capacity is overextended. The mandatory funding formula fully funds Current Services and staffing and operating costs for newly opening facilities in the out-years.

The Budget also makes targeted investments to address our Nation's most pressing public health challenges, which disproportionately impact AI/AN communities. For the first time ever, the Budget proposes dedicated funding to address disparities in cancer rates and mortality among AI/AN, providing $108 million for the Cancer Moonshot Initiative. Through this initiative, the IHS would develop a coordinated public health and clinical cancer prevention initiative to implement best practices and prevention strategies to address incidence of cancer and mortality among AI/AN. Similarly, the Budget requests funding to address HIV, Hepatitis C, and Sexually Transmitted Infections (+$47 million), improve maternal health (+$3 million), and address opioid use (+$9 million) in Indian Country.

The Budget also makes numerous investments in high priority areas, such as recruitment and retention of high quality health professionals, expansion of the successful Community Health Aide Program, and other activities that support high quality health care.

Likewise, from FY 2025 to FY 2029, the Budget requests an additional +$11.2 billion in mandatory funding for the Indian Health Care Improvement Fund to address the funding gap for direct healthcare services documented in the FY 2018

[7] HHS Assistant Secretary for Planning and Evaluation Issue Brief—*The Special Diabetes Program for Indians Estimates of Medicare Savings* https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf

level of need funded analysis.[8] The Budget would continue growth for direct services once the 2018 gap is addressed. This funding would be distributed using the Indian Health Care Improvement Fund formula. The formula is used to target the Indian Health Care Improvement Fund appropriations to the sites with the greatest need, as compared to the benchmark of National Health Expenditure Data, which is maintained by the Centers for Medicare and Medicaid Services. The formula is the product of long-standing consultation with Tribes.

The outyear mandatory formula also prevents a sharp reduction in services by providing an additional +$220 million in FY 2025 to partially sustain the one-time American Rescue Plan Act investments that were appropriated to expand access to mental health and substance abuse prevention and treatment services, and to expand the public health workforce in Indian Country.

Modernizing Critical Infrastructure

In addition to funding for direct health care services, additional investments are needed to address substantial deficiencies in physical and information technology infrastructure across the IHS system. Outdated infrastructure poses challenges in safely providing patient care, recruiting and retaining staff, and meeting accreditation standards. From FY 2024 through FY 2029, the Budget includes critical funding increases to reduce or eliminate existing facilities backlogs and modernize the IHS Electronic Health Record (EHR) system.

Specifically, in FY 2024, the Budget provides $913 million in discretionary funding for EHR modernization. The Budget then builds funding for EHR by +$1.1 billion each year from FY 2025 through FY 2029 under the proposed mandatory formula. Once the EHR modernization effort is fully funded, the Budget provides sufficient resources for ongoing operations and maintenance of the new system. The current IHS EHR is over 50 years old, and the GAO identifies it as one of the 10 most critical federal legacy systems in need of modernization. The IHS relies on its EHR for all aspects of patient care, including the patient record, prescriptions, care referrals, and billing public and private insurance for over $1 billion reimbursable health care services annually. Expected benefits from adopting and implementing a modernized system include, but are not limited to, improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, and agency performance reporting. Additionally, the new system will be interoperable with the Department of Veterans Affairs, Department of Defense, tribal and urban Indian health programs, academic affiliates, and community partners, many of whom are on different health information technology platforms.

The IHS system also faces substantial physical infrastructure challenges—IHS hospitals are approximately 42 years old on average, which is almost four times the age of the average hospital in the United States. Infrastructure deficiencies directly contribute to poorer health outcomes for AI/ANs. The Budget addresses these needs by fully funding the 1993 Health Care Facilities Construction Priority list over 5 years. The remaining projects on the list include the Phoenix Indian Medical Center, Phoenix, AZ; Whiteriver Hospital, Whiteriver, AZ; Gallup Indian Medical Center, Gallup, NM; Albuquerque West Health Center, Albuquerque, NM; Albuquerque Central Health Center, Albuquerque, NM; Sells Health Center, Sells, AZ; Alamo Heath Center, Alamo, NM; Bodaway Gap Health Center, The Gap AZ; and Pueblo Pintado Health Center, Pueblo Pintado, NM. After the 1993 Health Care Facilities Construction Priority List is completed, funding will continue to increase to begin addressing the full scope of Facilities needs as identified in the most recent IHS Facilities Needs Assessment Report to Congress.

Furthermore, the Budget includes +$10 million in discretionary funding in FY 2024 and +$454 million in mandatory funding over two years, from FY 2025 to FY 2026, to fully fund the medical equipment backlog. Many IHS hospital administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. The administrators also reported that aging buildings and equipment is a major challenge impacting recruitment and retention of clinicians.

Maintaining reliable and efficient buildings is also a challenge as existing health care facilities age and the costs to operate and properly maintain health care facilities increases. Many IHS and Tribal health care facilities are operating at or beyond

[8] Indian Health Service—*FY 2018 Indian Health Care Improvement Fund Workgroup Interim Report* https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2018/2018_IHCIF_WorkgroupInterimReport.pdf

capacity, and their designs are not efficient in the context of modern health care delivery. The Budget tackles this challenge by providing a +$10 million discretionary increase for maintenance and improvement in FY 2024 and fully funding the 2022 Backlog of Essential Maintenance, Alteration, and Repair for IHS and Tribal facilities of $1.02 billion over two years, from FY 2025 to FY 2026 under the mandatory formula.

The Budget ensures that these facilities investments can be rapidly addressed by providing sufficient administrative support increases. Specifically, the mandatory formula increases the Facilities and Environmental Health Support funding line at 13 percent of the rate of growth in Sanitation Facilities Construction (SFC) and 5 percent of the rate of growth in Health Care Facilities Construction, consistent with historical funding needs and IHS' current estimation methodology. This funding supports staff to oversee and implement facilities projects, as well as a comprehensive environmental health program within IHS. Within this increase, the Budget dedicates $10 million in FY 2025 to support a nation-wide analysis to understand the cost implications of implementing section 302 of the Indian Health Care Improvement Act (25 US.C. 1632), which authorizes funding for operations and maintenance costs for tribes who choose to directly compete their own SFC projects. The results of this analysis will be used and implemented as part of the updated mandatory formula structure. These funds would be used by IHS and tribes to ensure that existing SFC projects are reaching their maximum life-cycle and operations of these projects are sustainable for as long as possible. In FY 2027, the Budget provides an additional $250 million in mandatory funding to address operation and maintenance costs for complete sanitation facilities projects, addressing long-standing recommendations from Tribes.

Lastly, the IHS is grateful for the additional $3.5 billion in Sanitation Facilities Construction funding provided by the Infrastructure Investment and Jobs Act (IIJA). These funds will make a transformational impact on essential sanitation needs across Indian Country. To maintain existing project completion deadlines and support IHS and Tribes in successfully implementing IIJA resources, the Budget includes +$49 million in FY 2024 to support implementation of the $3.5 billion provided by the IIJA for Sanitation Facilities Construction (SFC). This funding is within the Facility and Environmental Health Support funding line and will support additional salary, expenses, and administrative costs beyond the 3 percent allowed in the IIJA. These funds would also be available to Tribal Health Programs, which is not currently permissible under the 3 percent set-aside for administrative costs in the IIJA.

Supporting Self-Determination

IHS continues to support the self-determination of tribes to operate their own health programs. Tribal leaders and members are best positioned to understand the priorities and needs of their local communities. The amount of the IHS budget that is administered directly by tribes through Indian Self-Determination and Education Assistance Act contracts and compacts has grown over time, with over 60 percent of IHS funding currently administered directly by tribes. Tribes design and manage the delivery of individual and community health services through 22 hospitals, 330 health centers, 559 ambulatory clinics, 76 health stations, 146 Alaska village clinics, and 7 school health centers across Indian Country. In recognition of this, the Budget proposes to reclassify these costs to a mandatory indefinite appropriation with estimated funding levels of $1.2 billion for Contract Support Costs and $153 million for Section 105(l) Lease Agreements in FY 2024. The Budget maintains indefinite mandatory funding for these accounts across the 10-year budget window to ensure these payments to ISDEAA contractors and compactors are fully funded.

COVID-19 Response and Future Emergency Preparedness

Throughout the COVID-19 pandemic, the IHS has made incredible achievements to save lives and improve the health of AI/ANs across the nation. The IHS has worked closely with our Tribal and Urban Indian Organization partners, state and local public health officials, and our fellow Federal agencies to coordinate a comprehensive public health response to the pandemic. Our No. 1 priority has been the safety of our IHS patients and staff, as well as Tribal community members.

COVID-19 has disproportionally impacted AI/ANs. Deficiencies in public health infrastructure exacerbated the impact of COVID-19 on AI/ANs. To address the long-term impacts of COVID-19, in FY 2025 the Budget provides a +$130 million mandatory funding increase to support IHS patients in recovery from the long-lasting effects of the COVID-19 pandemic, including treatment for long haul COVID-19. Based on data from 14 states, age-adjusted COVID-19 associated mortality among AI/AN was 1.8 times that of non-Hispanic Whites. In 23 states with adequate race

and ethnicity data, the cumulative incidence of laboratory-confirmed COVID-19 among AI/AN was 3.5 times that of non-Hispanic Whites. COVID-19 hospitalizations and mortality rates among AI/AN were 2.7 and 1.4 times those among White persons, respectively.

The Budget also establishes a new dedicated funding stream within the mandatory formula to address public health capacity and infrastructure needs in Indian Country. This funding will support an innovative hub-and-spoke model to address local public health needs in partnership with tribes and urban Indian organizations. Establishing a new program to build public health capacity is a key lesson learned from the COVID-19 pandemic, and a top recommendation shared by tribal leaders in consultation with HHS. This includes $150 million in FY 2025, and would grow in the out-years under the formula, for a total of $500 million over the ten-year window. Additional resources are necessary to develop appropriate public health and emergency preparedness capacity in AI/AN communities to prevent these disproportionate impacts in the future. As of 2021, only four tribal public health agencies are accredited through the Public Health Accreditation Board. Comparatively, 40 State and 305 local public health agencies were accredited as of 2021.[9]

Closing

The FY 2024 Budget makes bold strides toward the goal of ensuring stable and predictable funding to improve the overall health status of AI/AN communities. The Budget is a historic step and the start of an ongoing conversation with tribes to ensure the IHS system is meeting the healthcare needs in Indian Country. HHS looks forward to working in consultation with tribes, urban Indian organizations, and Congress to refine this proposal through the legislative process to strengthen the Nation-to-Nation relationship.

QUESTIONS SUBMITTED FOR THE RECORD TO THE HONORABLE ROSELYN TSO, DIRECTOR, INDIAN HEALTH SERVICE

The Honorable Roselyn Tso did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Questions Submitted by Representative Westerman

Question 1. Please further detail other ways IHS is addressing the GAO recommendations that are still open for the agency.

Question 2. The IHS Budget Justification included information about using a portion of the requested increased funding for FY 2024 to expand access to the Purchased/Referred Care program so that more patient visits and admissions would be covered. However, there was no mention of how those funds are distributed across IHS Areas, or whether the current distribution process needs to be revisited.

2a) How are Purchased/Referred Care program funds distributed among IHS Areas? And is this distribution is equitable?

2b) Does IHS plan to revisit those allocations in consultation with tribes in the near future? If so, when?

Question 3. Can you further elaborate on how IHS works with credit reporting agencies to make sure that negative credit consequences don't affect individual IHS patients with the following information:

3a) How is IHS informed of unpaid bills sent to collections for patients receiving Purchased/Referred Care?

3b) How long does it take IHS to send documentation to the credit reporting agency when this occurs?

3c) Does IHS have agreements with all credit reporting agencies to work with them when these situations do happen, so patient's credit score can be repaired?

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[9] Office of Disease Prevention and Health Promotion—*Increase the number of tribal public health agencies that are accredited* https://health.gov/healthypeople/objectives-and-data/browse-objectives/public-health-infrastructure/increase-number-tribal-public-health-agencies-are-accredited-phi-03/data

Question 4. What are IHS's plans for developing new facility construction priorities once the 1993 List is completed?

4a) Will IHS consult with Indian Country on this important issue before making any decisions on how to decide IHS and tribal health care facilities priorities?

Question 5. Agencies can budget the best when there is timely budget execution and when there is detailed budget formulation. Having the latest operational data from budget execution is crucial to make sure there is no confusion over how agencies operate.

5a) How is IHS tracking the appropriated dollars you receive to ensure they are all accounted for? And do improvements need to be made to that system?

5b) What is IHS doing to improve its estimates for Contract Support Costs and Payments for 105(L) leases? Have those improved over the past few fiscal years?

Question 6. Recruitment and retention continue to be challenges for the Indian Health Service, particularly in rural areas.

6a) Can you further expand on your written testimony about where IHS is making investments in recruitment and retention for medical personnel?

6b) What has IHS heard from medical personnel about what the barriers are to staying and working for IHS?

6c) How does IHS ensure there is a pipeline of new medical professionals that want to work at IHS?

6d) Are the recruitment incentives that IHS offers in line with the rest of the labor market for medical professionals?

Question 7. What is IHS's policy on telework? What percentage of the IHS workforce is back in the office full time?

Question 8. The FY 2024 IHS budget justification states that $220 million in ARPA funds were used to expand access to mental health and substance abuse prevention and treatment services.

8a) Could you provide a breakdown of how that funding was administered and the outcomes to Indian Country?

8b) How does IHS work specifically in conjunction with SAMSA and HRSA to provide the best care to AI/AN patients?

Question 9. As part of the IHS Strategic Plan, IHS states the agency is working to integrate behavioral health into the healthcare system and increase access to mental health and substance use disorder treatment and recovery services for individuals and families. Currently, IHS provides mental health services, but it appears that most inpatient services are purchased from non-IHS hospitals.

9a) Can you further detail how the IHS plan to expand access to mental health services within IHS facilities?

9b) What specific plans for recruitment and retention of mental health professionals and substance abuse professionals does IHS have in place?

Questions Submitted by Representative Grijalva

Question 1. Director Tso, I have introduced H.R. 630, the Urban Indian Health Confer Act, to create a Department-wide confer policy with urban Indian organizations. This bill would enable UIOs to provide input on Department policy decisions that impact urban American Indians and Alaska Natives. Are you able to state the agency's support for UIO input in relevant Department health policy decisions?

Questions Submitted by Representative Gallego

Question 1. The President's FY 2024 budget includes a $24.7 million increase in urban Indian programs. However, these would be jeopardized by the proposed Republican budget cuts in the debt ceiling bill. Can you elaborate further on what the reductions of services would look like for urban Indian communities?

Question 2. During this Subcommittee's last hearing on tribal health, tribal organizations highlighted the need for the reimbursement of traditional healing services. Are you able to detail the current resources that IHS offers in this space? Does the budget request for this year address this need?

Question 3. Can you speak to the current challenges that IHS faces regarding the recruitment and retention of personnel, and how this year's budget will address those challenges?

Ms. HAGEMAN. Thank you very much. The Chair will now recognize Members for 5 minutes of questioning, and I will recognize myself first.

We held a hearing in March on issues speaking with tribal members from around the country as to ways to improve IHS services, and I am sorry to say that the Director did not come to that hearing. I thought that the testimony was extremely enlightening and helpful, and I wish that you had been here to listen to the women who traveled across the country to provide us with that information.

This Committee has heard from tribes and tribal organizations about the importance of Purchased/Referred Care funds for specialty care, and these PRC funds are specially critical in areas without large IHS hospitals where costs can be internalized. We have learned from tribes in federally managed service units that there are multiple obstacles to their tribal members receiving referrals for specialty care, and this is one of the reasons identified by the GAO for IHS being on its high-risk list.

What steps has IHS taken to address the deficiencies identified in the GAO report?

Ms. TSO. Thank you for that question. And I also want to note that I support the comments that you make in terms of holding Indian Health Service accountable. To that, there are a number of steps that I have taken already. One, is the report that I have already noted that we have posted on the Indian Health Service website that describes the priorities that we are focusing on, including how we improve purchased and referred care for all of the patients that we serve.

There are other ways that we have done that. We have acknowledged fully not just the GAO report but the OIG, the White House report, and also internal reports that we have set out. And all of those recommendations that we received from those reports are similar in nature and those are also published on the IHS website. One, to first acknowledge what those recommendations are; and two, to ensure that they are incorporated into the work that we are doing today.

Ms. HAGEMAN. Thank you. Our Committee has also heard from tribes and tribal leaders that they have been referred to collection agencies because IHS does not timely pay the bills from the PRC providers. Is this supposed to happen in the first place, No. 1; and No. 2, what are you doing to address that?

Ms. TSO. Thank you. No, this should not happen at any place for the services that we provide. Unfortunately, at this point, we are looking at our system to streamline our PRC process to ensure that patients do not fall into this particular situation. There are a number of steps, and it is a complicated process, but there are still too

many steps in our process, and we are working to reduce those, so we do not have people that fall into this particular situation.

Ms. HAGEMAN. And when this happens, because we know that it does, and you have acknowledged that, what other procedures or mechanisms does IHS have in place to make sure that these issues are clarified with the credit reporting agencies so that IHS's failure to pay doesn't result in negative credit consequences for individual Native patients?

Ms. TSO. Thank you, Madam Chair. One of the first things that I did at the Indian Health Service, because I was also the director at the Navajo area and saw this gap between the regional and the IHS headquarters, upon my appointment as the Director, I immediately reduced that gap by bringing in area directors. We have 12 regions and 12 regional directors. Bringing them to the table and ensuring there are coordinated efforts to try to improve not just PRC but all of Indian Health Service and having my leadership team at one meeting to make sure that we all understand our responsibilities.

I now meet with my team on a quarterly basis. We are using the work plan to make sure that we are meeting the deliverables of that plan.

Ms. HAGEMAN. Recruitment and retention continue to be challenges for the Indian Health Service, particularly in rural areas. We have learned that one of the obstacles in recruitment is the IHS's personnel system. On average, how long does it take from job announcement to onboarding for IHS to hire health providers?

Ms. TSO. Too long.

Ms. HAGEMAN. What can be done to fix that?

Ms. TSO. So, at this point, we are looking at an overall 28 percent vacancy rate, and even in the mental health space, which is a very important topic for me, we are at 40 percent vacancy rate at the Indian Health Service. What we have done, and a couple examples of what we have done to rectify the situation is, of course, as part of the $3.5 billion water infrastructure bill, that we now have an agency-wide approach to this, meaning that we don't have 12 different areas trying to recruit, we are using one way to bring in people into the Indian Health Service and therefore, again, being more efficient.

The other thing that we are doing is we are standardizing and building out professional systems throughout our agency to really leverage the best practices that we have, again, to streamline and act as efficiently as possible. We have done that on the onboarding side, and we are now doing that on the hiring side.

Ms. HAGEMAN. Very quickly, because I am out of time. Have your changes or the efforts that you have made, are they having results?

Ms. TSO. Yes, ma'am.

Ms. HAGEMAN. OK. And I am now going to recognize Ms. Leger Fernández for 5 minutes for questioning.

Ms. LEGER FERNÁNDEZ. Thank you so much, Madam Chair.

Director Tso, your testimony notes the need to reauthorize the Special Diabetes Program because it is effective. I know too many of my good friends and colleagues who I have lost to diabetes, who have lost their limbs and their lives. But you also point out that

there would be an estimated net savings to Medicare of up to $520 million over 10 years.

Tell us real quickly, how does like an investment of that now save us money later?

Ms. TSO. Thank you. Specifically, the SEPI, the model that we have in place, really focuses on prevention. So, if we can get patients at the beginning or even before they are diagnosed as diabetics, then we can prevent that and use those strategies to help build a healthier patient outcome at the end of that. If we don't, that is where the cost incurs, that is where a higher level of care is needed.

Ms. LEGER FERNÁNDEZ. Thank you so very much. And I want to touch briefly on the debt ceiling proposals that would slash funding for IHS. The concern that we have is that if the Republicans say that the budget cuts are not going to impact defense spending and a few other agencies, that means that it needs to be spread out over other agencies and that is how we get to a 22 percent hit on the discretionary funding.

I kind of want to touch on two things. That kind of hit on funding, rather than an increase, a decrease, how would that affect IHS? And we had before, I need to be honest with you, I am a big fan of compacting and contracting so that tribes and tribal health boards run their own health facilities. I have seen the difference that it makes. Even as I know that the Navajo Nation is very pleased with how you helped them get through the pandemic. You were well-regarded in the Navajo Nation. The IHS was well-regarded in how it responded to the pandemic.

But do these kinds of cuts impact both the independent health boards and the IHS?

Ms. TSO. Yes, they do. I will give you one example. I just spent about 7 days in Alaska traveling through some of the smaller villages, and the only way that you can get to these villages is by air, permitted the weather and all of that. The cost in these locations for air transport for patient care has just about doubled. That is, again, if we can even get the flights in and out for these particular emergencies or situations that we have. So, that is not even taking into consideration when we are talking about any reduction in resources to the Indian Health Service.

So, in those particular examples, one of the things that we have seen is the increased cost of travel transportation for our patients. There is also going to be a direct impact to direct services that are provided, regardless if it is being provided by the Federal Government, or our tribal programs, or our urban programs.

Ms. LEGER FERNÁNDEZ. Thank you. And the issue about staffing I think is really important, and to have that high of a need for hiring, can you describe how in the past not having advanced appropriations impacted the ability to get people into the system and working for the IHS, and whether budget cuts would also have an impact on the ability to bring on the staffing we need to serve the patients?

Ms. TSO. Yes, ma'am. During the pandemic, again, we relied on that very fresh information where we relied on contractors to come into the Indian Health Service to help us do the work. If we don't have money on October 1 to be able to fully fund those contractors,

we cannot allow them to continue to provide services. So, there is an immediate, immediate decrease in services, a risk to the Agency in terms of not being fully staffed in many of our facilities, and therefore, having to, again, refer patients out to a higher level of care because we are not able to care for people in our healthcare facilities.

So, the contracting side, any kind of term positions that we might have where we rely on those resources to be in our bank on October 1, if we don't have those, we cannot allow those individuals to work for us.

Ms. LEGER FERNÁNDEZ. Well, I look forward to the fact that we are going to hit September and you are going to know you have the money on October 1. And, hopefully, we will be able to keep that, we have it for 2 years, and I know there is very strong bipartisan support for that advanced appropriations. I am going to look forward to asking you that same question next year and you telling us whether it made a difference.

Thank you very much, and I yield back.

Ms. HAGEMAN. The Chair will now recognize other Members for 5 minutes.

Ms. Radewagen.

Mrs. RADEWAGEN. Thank you, Chairwoman Hageman and Ranking Member Leger Fernández, for holding this hearing today. Thank you to the witness for your testimony.

Your written testimony mentioned the $3.5 billion for sanitation facilities construction that is still being implemented in tribal communities. How much of those funds have been spent so far, and what is the timeline for releasing all the funds to projects in Native communities?

Ms. TSO. Thank you for that question. Earlier in April, I posted for the very first time an interactive website on the IHS website that describes every project, where they are at in the process, and when we anticipate those projects to be completed. I am going to ask Jillian to talk specifically about the obligations that have been made to date.

Ms. CURTIS. Thank you very much for the question. The Fiscal Year 2022 funds provided by the bill are approximately 80 percent obligated at the IHS and we expect releasing the spend plan for the Fiscal Year 2023 funds in the coming weeks.

Mrs. RADEWAGEN. The GAO's most recent update of their high-risk series mentioned that there are concerns that IHS's 2022 action plan does not address root causes of substandard healthcare management weaknesses within your agency. Now, how is IHS working with GAO to make sure root causes of issues are addressed within the agencies, and what changes to the 2022 action plan is IHS looking to make based on this feedback from GAO?

Ms. TSO. Thank you. Great question. Let's use Patient Referred Care, PRC, as an example. We identified that as an area that needs to be reviewed by the Indian Health Service and improved. What we are doing now is we are using our leadership team to take a more deeper dive into what are those root causes, what do we need to change, how are we going to change them, and not only

that, to set milestones to make sure that we are evaluating ourselves to ensure accountability at the Indian Health Service.

Mrs. RADEWAGEN. Thank you. Madam Chairwoman, I yield back the balance of my time.

Ms. HAGEMAN. Thank you. The Chair now recognizes Mr. Carl for 5 minutes of questioning.

Mr. CARL. Thank you, Madam Chair.

Director Tso, thank you for joining us again. Good to see you. I appreciate your work; I appreciate you taking time to come talk to us. Don't take the lack of presence here for granted. We have multiple meetings going on in multiple places. I know you know that, but I want to tell you that.

Very early in 2020, I started screaming the Fentanyl issue. The Fentanyl issue—trying to get people to understand how big that was going to be. We are living it today. We have close to 300 people that are dying daily, and I know the Indian reservations have a higher percentage of that 300 people and a higher percentage of addiction.

So, let me just run through my questions here. It should be pretty easy for you. We are all aware of the Fentanyl crisis and major issues across the country. Fentanyl continues to pour into our southern borders, as you well know. And with today, the expiration of Title 42, it is only going to make it worse. That does not help any tribes, it doesn't help any of those 300 that are going to die today and tomorrow.

The CDC continues to report that overdose deaths among American Indians and Alaskan Natives continue to be above the national average. And I think you know that. The Fentanyl crisis is deeply concerning to me, and it is so disproportionately impacting the Native community. It is very troubling to me.

Can you please tell me specifically about how you are using money to target these illegal drugs?

Ms. TSO. Thank you for that question. Two things I would like to point to is, one, of course, we know that throughout the country, but even more so in our tribal communities, are the social determinants of health. That contributes to why maybe some of this is occurring on our tribal lands. That being said, we are doing everything that we can to make sure that we are addressing it.

In August already, we have a summit that will be held in the Northwest, and we are partnering with the tribes out in the Northwest to set up a summit. We need to have a more coordinated conversation about what do we do together, how does Indian Health Service and also reaching across HHS to my partners at SAMHSA and HRSA to make sure that they are at the table to help us develop results. Because, again, as these are occurring on tribal lands, the IHS does not just go in and decide how we are going to find solutions. We really have to work lock and step with tribes to make sure that we are a partner in finding solutions on this.

But there are a number of also treatment activities, risk reduction activities that we are working on. Really also sharing the 988 options and other options that we have throughout the government that could help our patients and our people.

Mr. CARL. Thank you. Another quick one here. What are you hearing on the ground from the tribes across the country about substance abuse funds, how are they being used?

Ms. TSO. A majority of the alcohol substance abuse and the behavioral health funds have been contracted and compacted by tribes, meaning that they operate their own programs.

What we are doing at the Indian Health Service, because the majority of those resources are with the tribes, is really looking at how do we build toolkits, how do we help them do it. A majority of my time since I have been in this role has been on the ground, and every community, every tribal leader that I have met with raises this concern and how it is taking their people away from them.

So, we have to find solutions of treatment programs, treatment options, culturally-appropriate care that we can build and integrate into our healthcare system. Again, working partnership with our tribes to make sure that we are addressing the whole person's need out in Indian Country.

Mr. CARL. So, I really try to make myself open to the different Indian tribes. I just find them fascinating, the history. I mean, being from Alabama, if you got roots in Alabama, you've got Creek or Cherokee in you, and I am very proud of that. Not enough to qualify to be that, but you know how that is.

But you will never fix that issue, the Fentanyl issue and the drug issue. Now, alcohol is a different story, but you will never fix it when you have some of these tribes that are covering thousands and thousands of acres, and they have seven police officers to enforce things. And I think it is going to take a combination of both, and I would love to work with you. I realize you are focused on the healthcare side, but between the dirt roads, between the law enforcement, it is going to be an endless fight. I mean, there is no way to stop the drug trafficking.

With that, thank you again for your time and coming and joining us.

Madam Chair, I return my time. Thank you.

Ms. HAGEMAN. Thank you. The Chair now recognizes Representative González-Colón.

Mrs. GONZÁLEZ-COLÓN. Thank you, Madam Chair, and thank you to our witnesses for being here today. I would like to echo Mr. Carl. There are many hearings and many things happening today, but we are happy that you are here.

I am going to question in terms of the Federal bureaucracy across the nation in many areas that make it harder and harder to operate in certain areas than it should be, and that is happening also not just with territories but with the Indian communities as well. And in that sense, I mean, having those healthcare situations back home, the lack of professionals, the lack of physicians that are available, the skills that healthcare programs are paying those providers is still a mess.

In telehealth, it has been one of the areas that is being used to try to compensate or give some access to those communities, so in that sense, the telehealth in Native communities is becoming more and more prevalent which makes sense given the geography in many parts of the Indian Country. So, my question to you will be,

can you go further into what investments in healthcare infrastructure like telehealth may help maintain services while IHS improves staffing and services for physical facilities?

Ms. TSO. Thank you for that question. I will say that certainly for telehealth, we have to have that, we have to maintain that within our tribal lands. Part of that is, of course, building out infrastructure and making sure that we can support those kinds of systems throughout.

As an example, though, when I first arrived in Navajo as the Area Director in 2019, we were recovering maybe about $19,000 worth of reimbursement for telehealth. When I left there, we were at more than $30 million. So, in a place where, again, challenging because of distances, and resources, and infrastructure, we thought, well, people are not going to use telehealth. No, that was just the opposite.

Mrs. GONZÁLEZ-COLÓN. Are you still investing in telehealth? Is the office still investing in telehealth?

Ms. TSO. Yes.

Mrs. GONZÁLEZ-COLÓN. In infrastructure. And that budget includes money for that?

Ms. TSO. Yes, we did include resources for that.

Mrs. GONZÁLEZ-COLÓN. What barriers are there to using telehealth now that you understand Congress can jump in to try to fix something?

Ms. TSO. I'm sorry?

Mrs. GONZÁLEZ-COLÓN. Do you believe that there are some barriers to improve telehealth to a good use, that Congress should jump in to fix it, or do you have all the resources necessary to manage telehealth in those communities?

Ms. TSO. No, we don't have all of the resources.

And, Jillian, if you can——

Ms. CURTIS. Absolutely. I think you have raised a really good question here. There are sort of two elements that create barriers for us beyond resources. The first is the availability of broadband in rural and remote locations. And secondly, we understand that after November we will likely not be able to bill for telephone only telehealth visits, which was allowable under the public health emergency. And the overwhelming majority of our telehealth visits are phone only because of those broadband issues. So, those are two key areas where we could use some additional help.

Mrs. GONZÁLEZ-COLÓN. How is the percentage of all the cases that you work in a telephone mode?

Ms. CURTIS. I think it is close to 90 percent, but we can get back and provide you that exact percentage.

Mrs. GONZÁLEZ-COLÓN. OK. So, 90 percent of your telehealth because of the broadband issues are going by phone. In mostly which areas, or is it all over the place?

Ms. CURTIS. It is really all over the place. It depends community to community.

Mrs. GONZÁLEZ-COLÓN. And when we are talking about mental health, which is a big issue, how does telehealth play a role in the mental health programs?

Ms. TSO. Certainly, mental health is a huge need throughout the whole country, but also especially in our Native American commu-

nities. One of the ways that we are addressing mental health is really looking at what we are calling the CHAP program, the Community Health Aides that we can build out. There is a great example out in Alaska where it has been operational for many, many years, and bringing that down to the Lower 48.

What that is, is that we are actually identifying individuals from the community that can serve and that can be trained, and serve and be certified to do these services on the ground, and that means that——

Mrs. GONZÁLEZ-COLÓN. Yes, but I am talking about telehealth to address mental health, not physical counseling.

Ms. TSO. As I said earlier, with regards to support, we are about 40 percent efficient in hiring at the Indian Health Service for mental health providers. So, that is already a challenge. And also, a reason why we rely heavily on building out our telehealth program.

Mrs. GONZÁLEZ-COLÓN. OK. Thank you. Madam Chair, I yield back.

Ms. HAGEMAN. In light of the fact that I think we have some extra time here, and I think that there were perhaps some follow-up questions that folks wanted to ask, we are going to have another round of questioning. I don't think it will last very long. I just have a few questions I would like to ask.

I would like to follow up on what Mr. Carl was talking about with regard to Fentanyl. That is one of the issues. And Wyoming has been hit hard with that as well, and we have two tribes in Wyoming, we have the Northern Arapaho and the Eastern Shoshone.

We have had over 14,000 pounds of Fentanyl cross the border over the last 2 years, and it is obviously something that has affected our ability to provide healthcare to our tribes. We have the addiction problems. So, I am going to ask you, until we start stopping the flow of Fentanyl, it is going to continue to be the scourge of our communities, whether it is on reservations, or it is in Portland, or Denver, or wherever it may be.

What has your agency done in terms of asking President Biden or Mr. Mayorkas to please help to control the border in order to stop the flow of illegal drugs coming across?

Ms. TSO. We have worked very closely with the Department of the Interior on tribal lands that they are the responsible party for, law enforcement, working with them to coordinate a number of efforts to make sure that we are addressing and bringing safe care to our Native reservations.

That being said, we are working very closely with Secretary Haaland on her Road to Healing, which is, of course, is a boarding school initiative, and then now the MMIP, which is the Missing and Murdered Indigenous People, and moving from that, really helping support and being that health arm of even as late as yesterday talking about how do we build out facilities in our Native communities where individuals that need to be incarcerated, and then how do we provide that healthcare if there is healthcare needed in that.

So, we are starting that conversation. We will continue that as we try to build out more resources for Native American lands.

Ms. HAGEMAN. So, Ms. Tso, would you agree with me that stopping the flow of illegal drugs across the border is probably one of the most important things we can do to address the drug crisis and Fentanyl crisis we have in this country?

Ms. TSO. Yes.

Ms. HAGEMAN. OK. I would also like to continue talking about some of the hiring issues associated with your agency. And the question I have is, is it possible for tribes with federally managed service units to contract or otherwise assume control of the hiring function to carry out those activities more efficiently for the IHS related to your job and employment situation?

Ms. TSO. Yes. At the Indian Health Service, any tribe that assumes their own healthcare program also does their own hiring of what was once operated as IHS programs, so about 60 percent of the Indian Health Service has been contracted. Tribe and tribal governments have responsibility for all the hiring in those areas.

We do some recruiting for them because we believe that we have a little wider span to be able to get job information out there.

Ms. HAGEMAN. In terms of the funding for those positions, is that part of the $9.65 billion that you are requesting, or do those tribes pay for those services or those employees themselves?

Ms. TSO. Our entire budget includes tribes and urban programs.

Ms. HAGEMAN. Even when they do their own hiring?

Ms. TSO. Yes, ma'am.

Ms. HAGEMAN. OK. For federally managed service units with very high vacancy rates, does IHS have the ability to deploy Commissioned Corps or other HHS health providers to those areas to address immediate needs?

Ms. TSO. Certainly, during COVID-19, and particularly when I was in Navajo, we had a number of resources that came to us, including the Commissioned Corps. Unfortunately, over the past few years, there has been a decline in Commission officers being brought on, and so we don't have always the luxury of having those. We have about 1,400 officers at the Indian Health Service right now that either work for IHS or are assigned to tribal or urban programs.

Ms. HAGEMAN. And, finally, at our previous hearing about IHS, one of the stories we heard was about a tribal member who studied to enter the medical profession with the intent of coming back to her community to work at the IHS facility there. But that was not an option for her when she was finally offered a job at IHS. Is there a specific policy in place to promote tribal members being able to serve in their own community as medical professionals?

Ms. TSO. We follow the Indian Preference Law which, of course, are members of federally recognized tribes that have tribal enrollments, that certainly they have preference at the Indian Health Service. Now, we can't specifically say or guarantee someone a job, that you can work at this particular location, but if there is a job open, that is certainly the place that they can apply to and be considered.

Ms. HAGEMAN. Thank you. I now recognize Ms. Leger Fernández for her second round of questioning.

Ms. LEGER FERNÁNDEZ. Thank you so very much, Madam Chairwoman.

And I really do appreciate learning the issue around the telephone telehealth. I didn't realize that that was a problem, and that is indeed an issue. The Bipartisan Infrastructure Bill, we are very hopeful that in 2, 3 years we will have the buildout, but we do not have it now, and there is the need to get that telehealth funding now. So, thank you for raising that, and I am hopeful that we will see if we can find a solution to that.

I wanted to touch a little bit about the 1993 Healthcare Facilities Construction Priority List. I represented several tribes who were on that list, and in the end, ended up deciding to do a joint venture agreement, build their own facilities. But not everybody is in a position to be able to do a joint venture agreement to be able to put up those funds. We have the Navajo-Gallup, which I think is going to be built. Is that correct?

Ms. TSO. Yes, it is on the list.

Ms. LEGER FERNÁNDEZ. But where is it in terms of the——

Ms. TSO. We have about $66 million of what was needed, but the entire project will be close to probably $1 billion.

Ms. LEGER FERNÁNDEZ. So, how would the budget request that you have put in now address, as an example, Navajo-Gallup?

Ms. CURTIS. Certainly. The President's budget requests a total of $10.3 billion for facilities construction over 10 years, so those dollars would allow us to fully fund the nine remaining projects on the priority list including the Gallup facility, and then, finally, start to get funding out to those facilities that are not on the list but are still critically needed.

Ms. LEGER FERNÁNDEZ. Right. And as I understand, am I correct that the Navajo-Gallup facility is the largest facility serving a Native American population?

Ms. TSO. We have two facilities that are, it is the Gallup Indian Medical Center and the Phoenix Indian Medical Center as well, and both of those projects are being considered.

Ms. LEGER FERNÁNDEZ. Yes. And I think that that is really a priority to think that a community has been waiting that long. Imagine, in order to get on that list, your building needs to be close to condemnable, right, and it doesn't fit, and it doesn't work. And to be on that list for 30 years, which this pushes you further, and further, and further along.

I wanted to ask, an issue that comes up a lot when I am out in Gallup and speaking with the community there is what role the Indian Health Service can play. I know it can play a really good role with regards to assisting members, people who are not members but married into a community, and you can do that, I have helped tribes subcontract in contracts, so they end up serving communities around them.

The limitations that IHS has on that, do you see a role for IHS, especially with third-party building, being able to expand in those places where there is not rural healthcare? I mean, we have a problem that we do not have enough rural healthcare facilities and sometimes the IHS is the only healthcare facility, but it has its limitations. Do you have a sense of how IHS might serve a role in addressing that rural healthcare?

And also, in terms of training the health professions, which is what you are concerned about as well, Madam Chair, because what

we understand is that you go back and work in the community you come from or where you were last trained. That is a really good way of getting people to serve in a community. Do you have any thoughts on a role IHS could play in that? Just kind of brainstorming a little bit.

Ms. TSO. Yes, absolutely. As I travel throughout Indian Country, I was also just in Oregon, and there are rural health facilities that are closing down, and the only healthcare system that is available is a tribally-operated program, and they have already opened up to serving all of the people that they can in their communities. Of course, it can't be everybody, but there is already that model that is in place for tribally-operated programs.

At the Gallup Indian Medical Center, and maybe similar facilities as well, as you know, our Rehoboth facility has struggled from time to time, and when they go on, we are the only other option there in that particular area. So, we already do that in rare circumstances. But making that fine balance there I think is really critical.

And I would like to take a look at more how much of these rural health facilities that are closing are now coming over and we are picking them up on the Indian Healthcare side, which is either tribally-operated programs or urban programs. So, I think there is a lot that can be done.

Ms. LEGER FERNÁNDEZ. Thank you. And thank you, Madam Chair, for allowing additional conversation around this urgent topic.

Ms. HAGEMAN. You bet. Thank you.

I will now recognize Mr. LaMalfa.

Mr. LAMALFA. Thank you, Madam Chair. I'm sorry I couldn't be in two committees at once, but I appreciate the opportunity to be here and be part of the hearing.

The issue with IHS's current base funding method, it is not appropriately allocating the funds across the Agency, which leads to large cost overruns that ultimately prevent our clients with the tribes from obtaining basic care except in more extreme situations. So, what has IHS been able to do to help develop a new method to get the program funds more appropriately allocated since there was a directive, my understanding is, back in 2012 to move in that direction?

Ms. CURTIS. Certainly, sir, thank you very much for this question. I think you may specifically be referring to funding for our Purchase and Referred Care Program, and this is a concern that we have heard from tribal leaders in many areas, including in the California area and other locations where there are not IHS-constructed healthcare facilities. We do have a Purchase/Referred Care tribal advisory committee. There is a work group to improve Purchase/Referred Care that we are convening on a regular basis, and this is a continuing topic of conversation for that group.

Mr. LAMALFA. How far along do you think that process is improved, what would the grading scale say is, from customer angles, how would they say that it is looking?

Ms. CURTIS. So, there are representatives from all 12 IHS areas on that work group, and there are some tribal leaders that feel strongly that the formula for distribution needs to be changed, and

there are some that feel strongly that it should not be changed, and that is much of the discussion of that group.

Mr. LAMALFA. So, you have to figure out how to be in the middle of that. All right, that is tough. As you mentioned, thank you for paying attention to California. Representing the far north part of the state, we have had a lot more in recent years due to the risk of wildfire in our forested areas, there has been a lot of de-energizing protocols for turning off the power because the wind comes up and it might blow a tree or a branch into a powerline. That is how we are dealing with things these days. They are almost Third World in that sense. We have to shut off the power because we are not doing enough in the forested areas to clear around powerlines.

So, they do help in limiting risk of wildfire, but obviously, they are a real interruption for those folks that are using electricity. I drive through whole counties of mine that are dark at night sometimes as I am traveling the district.

So, especially as this affects tribal health. And we know the facilities that many tribes are dealing with might be 60 years old or more and they may not have the backup generation or maybe they can't get it approved because we have air quality issues on who is running a diesel generator or not. So, obviously, the health clinics are going to have trouble. Hopefully, there is enough backup for a hospital with somebody being treated with a serious issue perhaps.

We know all tribal health programs provide vaccines and many others keep specialty drugs on hand, so there is just a whole litany of things that is important about having a good electricity supply that is steady, you know, proper temperature for storage of vaccines and other medical needs, blood, et cetera. It does threaten the stability of the medication, possibly making them unsafe. So, these power outrages of more than 4 hours can really mess them up.

These rural programs are not equipped with essentials, like backup generators, is what I am understanding. Do we believe now that funding needs to be ensured for the basic necessities such as generators that meet code and are completely reliable in a power outage situation, whether it is a purposely public safety power shutoff as they call it, or due to accident with an actual wildfire. Are we in a position to improve that availability?

Ms. TSO. Yes. Thank you for that. Of course, in the President's budget, we included $3 million specifically for generators. And more recently, in one of the tribes in the California area that experienced flooding, we also made sure that generators were available to them if they needed that for the reasons that they didn't have power.

Mr. LAMALFA. Did you say the figure was $3 million?

Ms. TSO. Yes, $3 million.

Mr. LAMALFA. OK. I hope that goes far enough with what we need. Has IHS been successful in executing its actual budget over the last few years, have you been able to stay close to that?

Ms. CURTIS. I apologize, sorry. Are you referring to the emergency generators funding?

Mr. LAMALFA. No, in general.

Ms. CURTIS. In general?

Mr. LAMALFA. Has its overall budget been able to come close to meeting goals at least?

Ms. CURTIS. I think that the most recent analysis that was performed by our Indian Healthcare Improvement Fund work group identified that the IHS is approximately 50 percent funded compared to the total funding level needed.

Mr. LAMALFA. OK. All right, a lot of work to do. Thank you.

I am a little over time. I yield back, Madam Chairman.

Ms. HAGEMAN. Thank you. The Chair now recognizes Representative Radewagen.

Mrs. RADEWAGEN. Thank you, Madam Chair.

Your written testimony mentioned that IHS had achieved two major accomplishments of the Agency's work plan. Can you further expand on the work and what next steps are according to IHS's strategic plan and the Agency's work plan, please?

Ms. TSO. Yes. Thank you again for that. As I shared earlier, the first accomplishment was really commissioning a team within IHS to help us look at and improve our quality program. We had some changes when I first came on with staffing, so we were able to take a deeper dive into the office of quality, which is really the heartbeat of any healthcare system, and making sure that we can evaluate the work that we are doing and ensuring quality and safe care.

So, we re-looked at that, and we looked at our structure, we looked at the work that we are putting out of that, again, to ensure accountability and to be able to monitor the work that we are doing and be able to communicate that back to our patients. So, that is now in process and we are taking a look at that and really trying to stabilize from the accountability standpoint, and compliance standpoint, and risk management standpoint.

The second thing that we did, which is critically important, is that we have 12 regions within the Indian Health Service. When I was the Director at the Indian Health Service, I sort of just worried about Navajo area, I didn't sort of worry about what was going on in my colleague's other regions and things like that. What we have done by standardizing governance within the IHS, is that we all now operate under one set of governance in our healthcare hospitals and our outpatient facilities.

What is important about that is I, as the Director, can scan the Agency now and look where we have best practices, look where we have improvements that need to be made so we can share those more easily across the Indian Health Service. Moreover, I want to be able to make sure that we are as efficient as possible when we are looking at clinical care and when we are looking at administrative operations.

So, building a more system approach to healthcare, it is going to maximize resources for us. It has already paid off for us to be able to do and to make some of the changes that we are doing. So, I don't have to worry about which area is doing what, I know now what we are all working toward, and that is what that work plan was intended to do, to help us come together. Because we don't have all of these resources, we can now evaluate safe and quality care.

When we are talking about credentialing of providers, before I would have to credential a provider at Navajo, and then if they went to Phoenix, they have to be re-credentialed over there. Now, that information can move with the provider instead of having to have the provider go through all those steps again for credentialing and privileging at another facility. So, it is more efficient now and operating as a system as we get smaller and smaller, whether it is recruiting, whether it is purchasing, whether it is providing the healthcare, it is now moving toward a system. And it is not moving as fast as I want it to go, but we are getting there, and we are looking at that in every aspect of the IHS, so we can then again evaluate across Indian Health Service to ensure that quality and safe care.

I will also say that by the end of January, we were able to review every physician's record that is at the Indian Health Service to ensure that the credentialing packet that was provided for that provider is still sound and that we can then ensure that providers at the Indian Health Service are providing the best in quality care and have the credentials to do what it is that we are asking them to do. We are now looking at the nursing because it is just as critical.

So, all of these steps that we are taking are really intended to strengthen the Indian Health Service so we can move forward in a more positive way.

Mrs. RADEWAGEN. OK. So, looking forward, is IHS also considering what their next 5-year strategic plan looks like? How will discussions of fiscal responsibility be a part of that planning?

Ms. TSO. Yes, moving forward, our strategic plan is through 2024, so we are already working on that to make sure that we set that in place. That will be accompanied by an additional work plan for 2024. Every day we are talking about fiscal responsibility. Every day we are making choices and decisions, and hard choices and decisions, about what we can do and what we can't do, and where we can, again, continue to streamline our processes to maximize the resources that we have.

Mrs. RADEWAGEN. Thank you, Madam Chair, I yield back.

Ms. HAGEMAN. Thank you. I want to thank the witnesses for your valuable testimony and the Members for your questioning today. I think that this has been very enlightening and very helpful for many of us sitting up here and looking at the budgeting issues that we are facing in this country right now.

The members of the Committee may have some additional questions for the witnesses, and we will ask you to respond to these in writing if we receive them. Under Committee Rule 3, members of the Committee must submit such questions to the Committee Clerk by 5 p.m. on Tuesday, May 16, 2023, and the hearing record will be held open for 10 business days for your responses.

If there is no further business, without objection, the Committee stands adjourned. Thank you.

[Whereupon, at 3:12 p.m., the Subcommittee was adjourned.]