

**Chairman Lisa Murkowski Opening Statement
Committee on Appropriations Subcommittee on Interior, Environment,
and Related Agencies**

Review of the FY2018 Budget Request for the Indian Health Service

July 12, 2017

(As prepared for delivery)

I'd like to welcome everyone this morning to the final budget hearing of the Interior Appropriations Subcommittee for Fiscal Year 2018. Today we will examine the budget request for the Indian Health Service (IHS). I want to thank Rear Admiral Michael Weahkee, the new Acting Director for the Indian Health Service, for appearing before us today. The head of the IHS is a tough job. It is also a critical one for us in Alaska, where all of the health care for Native Alaskans is delivered through compacts between tribal organizations and the IHS.

Director Weahkee is accompanied by Rear Admiral Chris Buchanan, the Deputy Director for the IHS, Gary Hartz, the Director of the Office of Environmental Health and Engineering, and Elizabeth Fowler, the Deputy Director for Management Operations.

The IHS budget request for FY2018 is \$4.7 billion for programs within this subcommittee's jurisdiction. This is a decrease of \$300 million, which is 6 percent below last year's enacted level. By comparison, other agencies within the Department of Health and Human Services were reduced by an average of 18 percent, so I appreciate that some effort was made to mitigate the impacts on the IHS budget relative to other agencies.

I'm also pleased that the budget request provides full funding for Contract Support Costs by maintaining the indefinite appropriations language that I first included in the fiscal year 2016 appropriations bill. This has helped provide certainty for tribes and protected other IHS programs in case additional funds are needed to meet the government's legal obligations.

But I am very concerned that the budget request does not adequately meet the needs for health care in Indian Country. The disparities between health outcomes for American Indian and Alaska Native people compared to the population at large are staggering. For example, American Indians and Alaska Natives are three times more likely to die from diabetes. The drug-related death rate for Native Americans has increased 454 percent since 1979 to almost twice the rate for all other ethnicities. And, the suicide rate among our First Peoples is roughly twice that for the rest of the population.

In order to improve health care delivery, the IHS must do a better job at hiring and retaining an adequate number of qualified doctors and nurses. The IHS must also do a better job of maintaining a large facilities infrastructure that serves 2.2 million American Indians and Alaska Natives. This requires significant resources. Currently, the vacancy rate for Indian Health Service doctors, dentists, and physician assistants is roughly 30 percent. The backlog of facilities maintenance at IHS hospitals is over half a billion dollars, and according to the

agency's own budget documents, the average age of its facilities is roughly four times that of its private sector counterparts.

Additional resources are not the only answer – the agency must also do more to improve the quality of its existing work force. Two articles appeared in the Wall Street Journal on July 7th, which detail the deplorable conditions at several IHS hospitals in the Great Plains. The stories are heartbreaking. In one case, a 35-year-old man stopped breathing in his hospital room. Nurses responding to the emergency couldn't find a crucial medical device used to prop open airways in his lungs. That device should have been stored in their emergency supply cart. The problem cost the team of nurses and doctors a critical 20 minutes, and sadly, an internal report found that the 20-minute delay cost the patient his life. The investigation also revealed that the responding nurses were unfamiliar with how to use the hospital's intercom system or defibrillator.

In another case, a 45-year-old woman died 10 hours after IHS nurses ignored a doctor's orders to stop giving the patient a powerful cocktail of narcotics. A federal inspection report found that two different doctors told staff they were concerned that the patient was being over sedated. One of the doctors ordered nurses to stop giving the patient morphine and to remove a patch that dispensed Fentanyl, a highly potent synthetic narcotic. The patch was never removed and when the patient fell off her bed that night, nurses gave her even more pain medicine including a sleeping pill and oxycodone. As she fell into a catatonic state, coughing and frothing at the mouth, nurses failed to alert doctors and she was later found dead.

Last year, I asked the Acting Director of IHS, Mary Smith, what the agency was doing to fix the serious problems in the Great Plains region at the Pine Ridge, Rosebud, and Winnebago hospitals – all of which were mentioned in the Wall Street Journal article. She indicated that the agency was committed to doing “whatever it takes” to deliver quality care.

I believe the agency is sincere in its desire to fix these problems, but a year later the problems remain and appear to be more serious than ever. The Winnebago hospital has not received recertification from the Center for Medicare and Medicaid Services (CMS). The Rosebud Hospital and the Pine Ridge Hospital are still operating under System Improvement Agreements with CMS.

In the FY2017 Omnibus Appropriations bill, the subcommittee provided an additional \$29 million to address problems at these facilities. I hope that you can describe for us today how the agency is allocating these funds and why you did not request further funding for the problems in the Great Plains region for FY2018. This situation is simply intolerable and we need to hear a specific plan on how you plan to fix it.

Thank you all for being here today. I now turn to Ranking Member Udall for any comments that he would like to make.

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