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Here's my comment to the supplemental report. In paragraph 'g' of the supplemental report it indicates IHS management confusion regarding the appropriate use of Purchased/Referred Care (PRC) funds, that this confusion is due to "a number of separately issued discreet documents issued over a period of several years." They also indicate it was "The isolated nature of these policy issuances ...." that contributed to their confusion.

Paragraph "g" is misleading. The IHS PRC funds are approximately 20% of the IHS budget. PRC funds are about $850,000,000.00 plus annually, and this paragraph "g" makes IHS look like there is no one keeping track of PRC requirements and policy regulations. However, there is an enormous amount of PRC information on the IHS website (http://www.ihs.gov/chs/) accessible for the IHS, Tribes, and the general public. The IHS Director at that time, Dr. Roubideaux also did a 6 paragraph blog specifically on the PRC Program. In fact it was Dr. Roubideaux's decision to change Contract Health Service (CHS) to Purchased/Referred Care (PRC) to better describe what this important IHS program mission is about. Also, there are IHS HQ PRC staffs that communicate with Area Purchased/Referred Care Officers (PRCO) weekly/monthly, daily if necessary to insure all 12 IHS Areas are kept abreast of PRC regulations and policy.

Further, each of the PRCOs (formerly known as Contract Health Service Officer), have specific Position Descriptions. There are also on the IHS CHS website PRC/CHS Prototype Position Descriptions for Area Office PRC/CHS Staff (http://www.ihs.gov/chs/index.cfm?module=chs_program_staff. In each of these PRCO's Position Descriptions and also on the prototype PDs is the verbiage like "The position provides technical assistance and training on CHS policy, procedures, and program issues to ensure adherence to applicable guidelines and regulations of the CHS Program" or words to that effect, throughout the position descriptions. It is the job of each

Area PRCO to keep track and be the experts and consultants of the PRC Program throughout their respective Areas in policy, procedures, and program federal regulations, and consult with Area management if a program is not adhering to policy and regulations. I believe the Area PRCOs do this, but at times, for whatever the reason, the IHS Portland Area Office (PAO) Area management decided not to listen to their PRC expert consultant. In this case, the IHS PAO misused PRC patient care funds totaling in the millions of dollars of patient care PRC funds.

In September 2010, because of an email from the Portland Area Director (Doni Wilder) I advised my supervisor that using PRC (CHS) patient care funds for Prime Vendor was inappropriate and was contrary to congressional intent; however her response was "As your supervisor, I overrule you." Those six words in effect overruled congressional intent, and PAO Finance continued to utilize CHS patient care funds in the millions for Prime Vendor, all the while CHS eligible patients were being denied health care for the reason of "Care Not within IHS Medical Priority". IHS as a whole is not fully funded by Congress. As a result of not being fully funded, IHS PRC has to operate within established Medical Priority levels. That means there is not sufficient PRC funds to operate at all Medical Priority levels, so consequently lower Medical Priority level health care cannot be approved for funding, and therefore those lower level health care needs are issued denial letters as health care "Not within IHS Medical Priority". PRC denied health care is in the millions of dollars annually. All you have to do is look at the national IHS denial statistics for any Fiscal Year.

For the IHS PAO, the misuse of PRC patient care funds ceased for a time shortly after Randy E. Grinnell's (IHS/HQ) email dated January 31, 2013 in which he indicated "Areas need to follow up with their Service Unit Management and their CHS programs to ensure that CHS funds are not being used to pay federal salaries or purchase drugs from the prime vendor for direct care and that CHS funds are being used appropriately." So, key IHS officials knew that PRC funds had restrictions on expenditure of these Congressional appropriated funds. Because of this email, I pointed this inappropriate use of PRC patient care funds to the Area Executive Officer. However, at a later date this PAO Area Executive Officer via email wanted me to write a supporting

statement justifying the use of these PRC (CHS) patient care funds supporting the FMO's decision to use PRC funds for Prime Vendor. However, as the IHS PAO PRCO I wrote a non-supporting statement with citations and sent the reply via email to the Area Executive Officer. As far as I know, there was no action after that, and the Area PRC funds were still at the discretion of the PAO Financial Management Officer.

If IHS PAO management chose not to utilize Hospital and Clinic funds for Prime Vendor, there was an alternative source of funding for Prime Vendor instead of PRC funds. IHS PAO management could have used the accumulation of excess funding in the PAO Executive Budget line item which totaled in the millions.

There are some very serious systemic problems within IHS, similar to key leadership problems experienced by the Veterans Administration Medical Centers. If the systemic IHS problems are not addressed, this is a stroke waiting to happen. Purposely ignoring systemic problems leads to hidden "Blacklists", which are not supposed to be in any federal agency. Further, and just as important, the Indian people are already doing without health care because of these IHS systemic problems.

For the future, there should be a stronger/stricter safeguard put in place, where this misuse of PRC patient care funds does not occur again. I would like to suggest for the future, that Area PRCOs should not be supervised by IHS Area Finance Management Officers.

Thank you for allowing me to comment.

Respectfully,

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