Subcommittee on Indian, Insular and Alaska Native Affairs
Doug LaMalfa, Chairman
Hearing Memorandum

June 19, 2017

To: All Subcommittee on Indian, Insular and Alaska Native Affairs Members

From: Majority Committee Staff,
Subcommittee Indian, Insular and Alaska Native Affairs (x6-9725)

Hearing: Legislative hearing on **H.R. 2662 (Rep. Kristi Noem),** To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes.
June 21, 2017, 2:00pm 1324 Longworth HOB

H.R. 2662, "*Restoring Accountability in the Indian Health Service Act of 2017"*

Bill Summary

H.R. 2662 was introduced by Rep. Kristi Noem on May 25, 2017. The bill would amend the Indian Health Care Improvement Act[1] (IHCIA) to improve the Indian Health Service (IHS) by reforming the agency's personnel processes, timeliness standards, and other operations. Specifically, the bill provides IHS broader hiring authority, and making it easier to discipline and fire underperforming employees. Additional IHS reforms include:

- Requiring all IHS employees and contractors to undergo cultural competency training
- Improving IHS doctor recruitments by expanding the loan repayment program and existing recruitment tools
- Streamlining the volunteer credentialing process, reducing paperwork burdens
- Providing transparency in reports from the Center for Medicare and Medicaid Services
- Requiring regular reporting from the IHS, the Government Accountability Office, and the Department of Health and Human Services Office of Inspector General on patient care

Cosponsors

Rep. Rob Bishop (R-UT), Rep. Markwayne Mullin (R-OK), Rep. Cathy McMorris Rodgers (R-WA), Rep. Tom Cole (R-OK), Rep. Doug LaMalfa (R-CA) and Rep. Kevin Cramer (R-ND)

[1] 25 U.S.C. §1601 et seq.

Invited Witnesses

Panel I:
The Honorable Kristi Noem (R-SD)

Panel II:
RADM Chris Buchanan, REHS, MPH
Assistant Surgeon General, USPHS
Deputy Director
Indian Health Service

The Honorable William Bear Shield, Chairman
Rosebud Sioux Tribal Health Board
Rosebud, SD

The Honorable Andy Joseph, Business Council Member
Confederated Tribes of the Colville Reservation
Nespelem, WA

Mr. Robert TwoBears
District 5 Representative
Ho-Chunk Nation Legislature
Black River Falls, WI

Ms. Victoria Kitcheyan, Great Plains Area Representative
National Indian Health Board
Washington, D.C.

Background

The Indian Health Service (IHS) is an agency of the U.S. Department of Health and Human Services (HHS) which provides healthcare to approximately 2.2 million American Indians and Alaska Natives (AI/ANs) through 662 hospitals, clinics, and health stations on or near Indian reservations. The agency is headquartered in Rockville, MD and is composed of 12 regions, or "Areas," each with a separate headquarters.[2] The agency offers "direct-service" healthcare, meaning care provided by federal employees; it also acts as a conduit for Federal funds for Tribes that have utilized the Indian Self-Determination and Education Assistance Act[3] (ISDEAA) to independently operate their health facilities. The IHS also administers programs for Indians in urban areas. IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care in 36 states.

[2] The twelve areas of the IHS include: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson.
[3] 25 U.S.C. §5304 et seq.

The Snyder Act of 1921[4] provides the basic authority for the federal provision of health services and benefits to Indians because of their status as Indians. The modern statutory basis and framework for the federal provision of health care to Indians is under the Indian Health Care Improvement Act. This law was permanently reauthorized in Title X of the Patient Protection and Affordable Care Act. As noted, The ISDEAA authorizes tribes to assume the administration and program direction responsibilities are otherwise carried out by the federal government through contracts, compacts and annual funding agreements negotiated with the IHS. In FY15, more than $2.7 billion of IHS appropriations were administered by a tribe or tribal organization through contracts or compacts and related agreements.

In addition to providing direct-service healthcare to AI/ANs, the IHS also operates the Purchased/Referred Care (PRC) program (formerly "Contract Health Services," or "CHS"). This program is designed to ensure AI/ANs can obtain care when it is not available at IHS facilities; the program is somewhat similar to the Choice Program in the Veterans Administration. In short, the program will pay private providers to provide care to AI/ANs.

The PRC program is seriously deficient. The IHS often denies PRC claims due to technicalities that are attributable to the program's complex and confusing referral process. This results in uncompensated care costs for private providers. Funding allocation is also a serious issue due in part to large cost overruns, including the provision of air and ground ambulance services to nearby cities that are often vast distances from remote reservations. When PRC funding is tight, AI/ANs may be unable to obtain basic care except in the case of a life-or-limb emergency.

PRC's problems can primarily be attributed to the formula the IHS uses to distribute funds across the agency. The funding method is called "base funding," whereby each area is provided a "base" level – what it received the previous year – plus an annual adjustment for medical inflation and other items.[5] Government auditors have concluded that Congress should require IHS "to develop and use a new method to allocate all [PRC] program funds…"[6]

The Great Plains Area ("GPA" – formerly the "Aberdeen Area") includes North Dakota, South Dakota, Nebraska, and Iowa. Headquartered in Aberdeen, South Dakota, the Area serves over 120,000 tribal members and is home to some of the poorest and most rural counties in the United States. All IHS hospitals but one in the GPA are direct-service facilities.

For decades, federally-run IHS facilities within the GPA have been dogged by seriously low-quality health care, and the GPA headquarters office has been accused of impropriety, nepotism, and corruption. To make matters worse, the tribes served by the GPA are generally

[4] 25 U.S.C. §13.
[5] Government Accountability Office. "Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program." June 15, 2012. GAO-12-446. http://www.gao.gov/products/GAO-12-446
[6] *Id*. at 26.

located on large rural reservations that are plagued by long-term systemic non-healthcare problems like high unemployment, alcohol and drug abuse, a youth suicide epidemic, housing shortages, and lack of education.

The most recent major congressional review of the IHS GPA occurred in 2010. The Senate Committee on Indian Affairs (SCIA) held an oversight hearing detailing the serious deficiencies in the GPA.[7] The hearing and its subsequent investigative findings were included in a report released by the SCIA in December 2010, colloquially referred to as the "Dorgan Report."[8] The congressional inquiry included the review of over 140,000 pages of documents from the IHS and HHS, visits to GPA facilities, and interviews with IHS employees. The report described in vivid detail a wide range of deficiencies inside the GPA, related to both medical care and administrative procedures. Specific deficiencies included:

- Various personnel issues, including overuse of transfers, reassignments, details, and administrative leave to deal with employees with records of misconduct or poor performance;
- Missing or stolen narcotics, as well as inconsistent pharmaceutical audits;
- Substantial and recurring diversions or reduced health care services;
- PRC program mismanagement;
- CMS accreditation problems;
- Significant backlogs in billings and claims collection;
- Discouraging employees from communicating with Congress.[9]

The 2010 SCIA report temporarily brought the GPA's problems to light, but in the years that followed, the situation largely faded from public view. This was in part because the IHS repeatedly assured Congress that the issues featured in the Dorgan Report were being addressed. For example, for the last five years, the IHS budget justification accompanying the President's Budget has contained a paragraph related to the GPA, which says in part, "IHS places a high priority on the issues raised in the Senate Committee on Indian Affairs (SCIA) investigation of the IHS Aberdeen Area…in addition to implanting a corrective action plan to address findings…IHS will continue to implement and monitor improvements and corrective

[7] U.S. Senate. Committee on Indian Affairs. *In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area*, September 28, 2010. 111th Congress. S. HRG. 111-873. http://www.indian.senate.gov/sites/default/files/upload/files/63826.PDF

[8] U.S. Senate. Committee on Indian Affairs. *In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area*, December 28, 2010. 111th Congress. ("Dorgan Report"). http://www.indian.senate.gov/sites/default/files/upload/files/Chairman-s-Report-In-Critical-Condition-12-28-10.pdf

[9] *Id.* at 5-6.

actions…"[10] Each year, the paragraph appears to have been copied from the previous year's document.[11]

In March 2017, the Government Accountability Office listed Indian Health to its biennial "high risk" report. Programs listed in the report are federal programs most vulnerable to waste, fraud, abuse, and mismanagement, or that need transformative change. For nearly a decade, inspector general and others have inadequate oversight of healthcare continues to hinder the ability of IHS to provide an adequate quality of care despite continued increases in the agency's budget.

Recent Developments in the Great Plains Area

The recent problems in the GPA surfaced in July 2015, when Centers for Medicare & Medicaid Services (CMS) terminated its provider contract with the Omaha-Winnebago IHS hospital in Nebraska, an action that CMS had threatened since the previous year.[12] The termination remains in effect today, and the hospital struggles with basic patient safety and access.

Since that time, CMS has surveyed three IHS hospitals in South Dakota; these hospitals were subsequently cited for quality and safety problems. The hospitals include the Rosebud, Pine Ridge, and Rapid City (Sioux San) service units.[13] At Rosebud, the quality of care in the Emergency Department (ED) was found to be so poor that the IHS temporarily closed it, diverting all emergency cases to hospitals in Winner, South Dakota, and Valentine, Nebraska, 55 miles and 44 miles away from Rosebud, respectively. This diversion has placed serious physical and financial strain on the Rosebud ambulance system.[14] According to Rosebud Tribal leaders, approximately nine patients have died in transit to these facilities since December 2015.[15]

On April 30, 2016, in an unprecedented move, CMS entered into System Improvement Agreements (SIAs) with the IHS for the Pine Ridge and Rosebud hospitals. These agreements came on the heels of multiple corrective actions on the part of the IHS for both hospitals, and were intended to help the IHS avoid the imminent loss of its ability to bill CMS at the facilities.

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[10] Department of Health and Human Services: Indian Health Service. *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Pp. CJ-150.
https://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2017CongressionalJustification.pdf
[11] Department of Health and Human Services: Indian Health Service. *Justification of Estimates for Appropriations Committees, Fiscal Year 2016*. Pp. CJ-140.
https://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2016CongressionalJustification.pdf
[12] Kaufman, Kirby. "Officials say Winnebago hospital will operate without federal funding." *Sioux City Journal*, July 24, 2015.
http://siouxcityjournal.com/news/officials-say-winnebago-hospital-will-operate-without-federal-funding/article_5f283bb1-c660-5848-a710-40fbc551796c.html
[13] Ferguson, Dana. "IHS hospital in 'immediate jeopardy,' feds say. *The Argus Leader*, May 24, 2016.
http://www.argusleader.com/story/news/2016/05/23/reservation-hospital-immediate-jeopardy-feds-say/84812598/
[14] Ferguson, Dana. "Rosebud IHS: For some, the drive to the ER is too much." *The Argus Leader*, April 30, 2016.
http://www.argusleader.com/story/news/2016/04/30/rosebud-ihs-some-drive-er-too-much/83683940/
[15] Ferguson, Dana. "Death toll mounts 7 months after ER shuttered." *The Argus Leader*, July 7, 2016.
http://www.argusleader.com/story/news/2016/07/07/death-toll-mounts-7-months-after-er-shuttered/86783160/

While the agreements were generally considered a positive step, Rep. Kristi Noem, along with Sens. Barrasso, Thune, and Rounds, raised concerns about several provisions within the agreements. Specifically, the Members questioned the cost associated with the agreements' provisions, the lack of tribal consultation in the development of the agreements, and the legal basis for the IHS's authority to implement the agreements.[16]

The largest piece of the SIAs was the requirement that the IHS alleviate acute staffing shortages by fully contracting the entire Emergency Departments for the Pine Ridge, Rosebud, and Winnebago hospitals (reassigning their current Federal employees in the process).[17] On May 17, 2016, that contract was awarded to a staffing agency, AB Staffing Solutions, LLC, located in Arizona. While AB Staffing has a previous relationship with the IHS, many stakeholders expressed concerns that the IHS's request for proposals for the contract was quietly released without consulting Tribal leadership and without notifying major medical providers based in the region, leaving them unable to bid.[18]

On June 13, 2016, due to the sudden death of a critical staff member, an Advanced Practice Registered Nurse Anesthetist, the surgical and obstetric services at Rosebud were temporarily diverted to Valentine, NE, Martin, SD, and Winner, SD. The IHS is attempting to fill the position in order to restore surgical and obstetric services. As of June 2017, some of these services remain unavailable at Rosebud.

In September 2016, following a CMS survey, IHS announced the closure of yet another IHS hospital's emergency room, this time in Rapid City, SD. The Rapid City Service Unit, colloquially called "Sioux San" because historically, the building served as the "Sioux Sanitarium," is the primary IHS facility in Rapid City. Though IHS officials said this closure was temporary, the facility has not reopened, and all emergency patients are being sent to Rapid City Regional Health, a community hospital in Rapid City.[19] Meanwhile, the Sioux San facility is operating solely as a 24-hour urgent care.[20] This comes on the heels of months of negotiations between IHS and Rapid City Regional Health related to previous unpaid claims totaling in the tens of millions of dollars. That issue remains unresolved.

In 2016, in response to the spate of closures and deficiencies, HHS began marshalling resources and directing them toward the Great Plains. HHS, through IHS and CMS, began implementing procedures designed to connect IHS hospitals with high-performing community

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[16] May 13, 2016 letter from Representative Kristi Noem and Sens. John Barrasso, John Thune, and Mike Rounds, to HHS Secretary Sylvia Burwell. http://www.indian.senate.gov/news/press-release/barrasso-thune-rounds-and-noem-demand-answers-indian-health-service

[17] Ferguson, Dana. "Agreement on IHS hospital could hinge on privatization." *The Argus Leader*, April 26, 2016. http://www.argusleader.com/story/news/2016/04/26/agreement-ihs-hospital-could-hinge-privatization/83534836/

[18] Ferguson, Dana. "Tribal leaders say they were left out of IHS call for help." *The Argus Leader*, April 22, 2016. http://www.argusleader.com/story/news/2016/04/22/tribal-leaders-say-they-were-left-out-ihs-call-help/83386886/

[19] Ferguson, Dana. "Noem, Hawks criticize IHS after latest ER closure." *The Argus Leader*, September 14, 2016. http://www.argusleader.com/story/news/2016/09/14/noem-hawks-criticize-ihs-after-latest-er-closure/90346892/

[20] "IHS shuts down Sioux San emergency room." *KOTA TV*. September 13, 2016. http://www.kotatv.com/content/news/IHS-shuts-down-Sioux-San-emergency-room-393313781.html

hospitals throughout the country. For example, IHS announced a $6.8 million, one-year contract with Avera Health, a South Dakota-based hospital system, to provide telehealth technology to IHS facilities in the Great Plains. On June 7, 2017, HHS notified congressional staff that IHS has begun rolling out additional telehealth services in Nebraska, North Dakota, and South Dakota. The Agency intends to launch ED telehealth services for ED cases at Pine Ridge, and will extend those to other facilities by the end of June 2017.[21] Additionally, IHS partnered with CMS to include federally-operated IHS hospitals in the CMS "Hospital Engagement Network," or HEN program. According to IHS, HENs are designed "to help health care facilities deliver better care and to spend dollars efficiently."[22] The HEN program was established in the Affordable Care Act to connect high-quality hospitals with other facilities, in an effort to share best practices and encourage higher quality care at lower prices. Based on preliminary reports from the HEN in which Great Plains facilities are participating, the program has been moderately successful thus far.

However, despite the work of HHS, IHS, and CMS, conditions at these facilities remain unacceptable in 2017. In late April, CMS conducted another survey of Pine Ridge's hospital, finding several deficiencies related to credentialing, paperwork, and electronic health recordkeeping. These findings resulted in an immediate jeopardy finding. On May 22, 2017, Evan Burks, president of AB Staffing Solutions, the contractor providing ED staffing for the Pine Ridge, Rosebud, and Winnebago hospitals, wrote to the CMS regional office in Denver, CO. In the letter, Burks outlined several instances in which IHS refused to address or failed to address problems related to protocols. According to Burks, one of the most pressing problems at Pine Ridge is a lack of consistent leadership: "There have been as many as 4 CEOs and 9 CMOs at the Pine Ridge facility over the past 12 months."

Two pieces of legislation were introduced in the 114th Congress to address the deficiencies. Sen. John Barrasso (R-WY) introduced S. 2953, the IHS Accountability Act.[23] The bill received a legislative hearing in the form of a field hearing in Rapid City, SD, and was later marked up by the Senate Indian Affairs Committee. In the House, Rep. Kristi Noem introduced H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare – or HEALTTH – Act, with several bipartisan cosponsors. The bill received a legislative hearing in the Natural Resources Committee's Subcommittee on Indian, Insular, and Alaska Native Affairs.[24]

[21] Email to congressional staff from HHS Acting Asst. Sec. for Legislation, Barbara Pisaro Clark. June 7, 2017.
[22] Indian Health Service. "IHS and CMS partnership to strengthen hospital care quality." May 13, 2016. https://www.ihs.gov/newsroom/pressreleases/2016pressreleases/ihs-and-cms-partnership-to-strengthen-hospital-care-quality/
[23] S. 2953, IHS Accountability Act of 2016. https://www.congress.gov/bill/114th-congress/senate-bill/2953?q=%7B%22search%22%3A%5B%22ihs+accountability+act%22%5D%7D&r=2
[24] https://naturalresources.house.gov/calendar/eventsingle.aspx?EventID=400894

The Restoring Accountability in the IHS Act is a compromise bill that contains provisions of both S. 2953 and H.R. 5406. An identical Senate companion bill has been introduced as S. 1250 by Sen. Barrasso. A hearing was held on S. 1250 on June 13, 2017.[25]

Indian Health Service Appropriations

Congress has increased IHS funding almost each year since the 2010 Dorgan Report, and it continues to increase. In FY14 and FY15, Congress exceeded President Obama's budget request for the agency. Since 2008, funding for the Indian Health Service has increased by more than 50 percent. The House's FY17 proposed appropriation sits at approximately $1 billion over FY10 levels, yet the dangerous situation in the GPA and the staffing shortage problem throughout the twelve IHS areas continues to exist if not grow. In the FY17 Omnibus, Congress appropriated $2 million to address deficiencies in IHS hospitals with accreditation emergencies (which are primarily located in the Great Plains). In the FY17 Omnibus, Congress appropriated $29 million for the same purpose. President Trump's FY18 budget for IHS requests $4.7 billion, a reduction of $59 million below the FY17 level (note that the FY17 level in the President's budget was calculated based on an extrapolation of the continuing resolution, so it is not exact).

Section-by-Section Analysis of H.R. 2662

Section 1. Short Title; Table of Contents.

This section provides for the short title of the Act and table of contents.

TITLE I – INDIAN HEALTH SERVICE IMPROVEMENTS.

Section 101. Incentives for Recruitment and Retention.

This section amends the Indian Health Care Improvement Act (IHCIA) and adds a new section. The incentives provided to health care professionals include: establishing a pay system that is equal to other federal health systems, such as the Department of Veterans Affairs; and providing for relocation costs when an employee relocates to a Service area that experiences a high need for employees and when positions are difficult to fill.

The Secretary may establish a housing voucher program to provide rental assistance to any health care professional deemed a critical employee and who agrees to work at an Indian Health Service (IHS) service unit for no less than one year if a full-time employee and no less than two years if a part-time employee. This housing voucher program will sunset three years after its establishment.

[25] Legislative Hearing. https://www.indian.senate.gov/hearing/legislative-hearing-receive-testimony-following-bills-s-1250-s-1275.

Any health care professional who agrees to one of the provided incentives listed in this section must agree to serve with the IHS for no less than one year. The Secretary shall carry out this section in accordance with Office of Personnel Management (OPM) guidelines.

Sec. 102. Medical Credentialing System.

This section amends the IHCIA by adding a new section to require the IHS to centralize its licensed health care professional credentialing procedures at the agency rather than at individual service units to reduce the paperwork burden on licensed health professionals who want to practice their services at IHS direct-service facilities. This includes volunteers.

The IHS shall consult with public and private sector associations in developing and implementing this system.

Indian tribes who are involved in self-governance contracting or compacting may choose to participate in the centralized system.

Sec. 103. Liability Protections for Health Professional Volunteers at Indian Health Service.

This section provides liability protections under the Public Health Service Act to medical professionals looking to volunteer at an IHS hospital or service unit. These provisions would eliminate regulatory burdens that hinder a professional's ability to volunteer their services.

This section allows for health care professionals who volunteer at an IHS service unit to be considered an employee of the IHS in order to receive liability protections. The Secretary must approve of all determinations regarding a health care practitioner to be a volunteer and when to consider a service unit as a covered entity.

A health care professional must meet five conditions in order to provide health services at a covered entity, also known as an IHS service unit. The five conditions are: health care services by the professional are provided at an IHS service unit or through offsite locations carried out by the IHS; the covered entity sponsors the health care practitioner; the health care practitioner does not receive any compensation, other than recoupment of reasonable expenses incurred, from the individual or third party payer for providing health services; the health care practitioner must post a clear and conspicuous notice at the site where the services are provided of the extent to which the legal liability of the health care practitioner is limited; and the health care practitioner is licensed or certified to provide services.

Sec. 104. Clarification Regarding Eligibility for Indian Health Service Repayment Program.

This section explicitly includes health administration-related degrees in the list of those degrees eligible for participation in the IHS student loan repayment program. Allows IHS employees to utilize the program on a half-time basis.

Sec. 105. Improvements in Hiring Practices.

This section provides that the Secretary has direct hire authority and may appoint a candidate directly to a position within the Service for which the candidate meets the job description set by the OPM.

Notification must be sent to all Indian tribes that are served by an area office or service unit when appointing, hiring, promoting, transferring, or reassigning a candidate to a Senior Executive Service or position of manager. This notification must include an employment record of the employee.

Sec. 106. Removal or Demotion of Indian Health Service Employees Based on Performance or Misconduct.

This section amends the IHCIA and adds a new section. This section defines key terms, provides expanded removal authorities, and provides expedited procedures for employee removal and discipline. An employee seeking to challenge removal is provided an appeal through an expedited review by an Administrative Law Judge.

Sec. 107. Standards to Improve Timeliness of Care.

This section requires the Secretary within 180 days of enactment to promulgate regulations to establish standards to measure the timeliness of health care services at IHS facilities.

Sec. 108. Tribal Culture and History.

This section requires the IHS to develop and implement a cultural training program for each IHS Service Area to familiarize employees with the cultures of the Indian tribes they serve. Each Area's program must be developed in consultation with tribes. Training will be mandatory for certain IHS employees, locum tenens providers, and other contractors, and they will be tested annually. The provision applies to all contracts signed on or after the date of enactment.

Sec. 109. Staffing Demonstration Project.

This section provides for the Secretary to establish a demonstration project for health facilities of the IHS that are understaffed based on the staffing ratios created when a hospital was first built. These staffing ratios have not been updated since the hospitals were established and the goal of this demonstration project is to staff the facilities until self-sustaining by the Indian tribe.

TITLE II. Restoration of Accountability in Indian Health Service

Sec. 201. Right of Federal Employees to Petition Congress.

This section clearly states the right of employees to petition Congress and requires the HHS to notify all employees of the IHS of their statutory right to speak with members of Congress.

Sec. 202. Fiscal Accountability.

This section enhances fiscal accountability by ensuring that reports and plans required under this act are completed in a timely manner. Failure to comply with the requirements will restrict the ability of the Secretary to give salary increases and bonuses to specified individuals.

This section also requires the Secretary to prioritize spending related to patient care and provide spending reports to congressional committees of jurisdiction. The Secretary must also provide status reports to Congress on a quarterly basis.

TITLE III. Reports.

Section 301. Reports by the Secretary of Health and Human Services.

This section describes the reports that must be submitted to Congress from the Secretary of HHS. The reports will evaluate the professional housing needs of employees of the IHS, evaluate the full-time staffing levels at each IHS facility, assess the use of independent contractors, and provide for an assessment of the IHS staffing plan.

Sec. 302. Reports by the Comptroller General.

This section describes the reports that must be submitted to Congress from the Comptroller General. The reports will evaluate the status of the plans enumerated in Section 301, assess the status of staffing levels and staffing need in the IHS, and determine whether and to what extent the IHS prevents retaliation against whistleblowers.

Sec. 303. Reports by the Inspector General of Health and Human Services.

This section describes the reports that must be submitted to Congress from the Inspector General of the Department of HHS. The reports will analyze the causes and frequency of patient harm events in IHS facilities, evaluate the tracking of patient harm events in the IHS, and determine how to reduce deferrals and denials of care.

Sec. 304. Transparency in CMS reports.

This section requires that the Administrator of the Centers for Medicare and Medicaid Services shall conduct compliance surveys of each hospital or skilled nursing facility of the IHS not less than every two years, and requires that each completed survey be posted on the CMS website.

TITLE IV. Technical Amendments.

Sec. 401. Technical Amendments.

This section strikes "contract health service" and inserts "purchased/referred care" as the term contract health service is no longer used.

Cost

Unknown at this time.

Administration Position

Unknown at this time.

Effect on Current Law (Ramseyer)