

Subcommittee on Indian, Insular and Alaska Native Affairs  
Don Young, Chairman  
Hearing Memorandum

July 8, 2016

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. 5406 (Rep. Kristi Noem), To amend the Indian Health Care Improvement Act to improve access to tribal health care by providing for systemic Indian Health Service workforce and funding allocation reforms, and for other purposes.  
**July 12, 2016, 2:00pm 1334 Longworth HOB**

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**H.R. 5406, *HEALTTH Act* or  
*“Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act”***

**Bill Summary**

H.R. 5406 was introduced by Rep. Kristi Noem on June 8, 2016. The bill would amend the Indian Health Care Improvement Act<sup>1</sup> to improve the Indian Health Service (IHS) by reforming the agency’s personnel processes, resource allocation, and other operations. Specifically, the bill provides for a pilot project to test an alternative healthcare delivery model. Further, the bill provides IHS broader hiring authority, makes easier to discipline and fire underperforming employees. Additional Indian Health Service reforms include –

- Requiring all IHS employees and contractors to undergo cultural competency training
- Improving IHS doctor recruitments by making student loan repayment tax-free, expanding the loan repayment program, and expanding existing recruitment tools
- Streamlining the volunteer credentialing process, reducing paperwork burdens
- Codifying IHS rules capping Purchased/Referred Care (PRC) payments at Medicare rates
- Requiring the IHS to modify the current PRC allocation formula
- Requiring the IHS to prioritize unpaid PRC balances owed to private providers

H.R. 5406 has also been referred to the Committees on Energy and Commerce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. Neither of the other two committees has held a hearing on the bill.

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<sup>1</sup> 25 U.S.C. 1601 et seq.

## **Cosponsors**

Rep. Cramer (R-ND), Rep. Fortenberry (R-NE), Rep. Smith (R-NE), Rep. Cole (R-OK), Rep. McCollum (D-MN), and Rep. Ashford (D-NE).

## **Invited Witnesses**

### **Panel I:**

*The Honorable Kristi Noem (R-SD)*

### **Panel II:**

*Ms. Mary Smith*, Principal Deputy Director  
Indian Health Service  
U.S. Department of Health and Human Services  
Rockville, Maryland

*The Honorable William Bear Shield*, Chairman  
Rosebud Sioux Tribal Health Board  
Rosebud, South Dakota

*The Honorable Vernon Miller*, Chairman  
Omaha Tribe of Nebraska  
Macy, Nebraska

*Ms. Victoria Kitcheyan*, Secretary  
Winnebago Tribe of Nebraska  
Winnebago, Nebraska

*Ms. Jerilyn Church*, Chief Executive Officer  
Great Plains Tribal Chairmen's Health Board  
Rapid City, South Dakota

*Ms. Stacy Bohlen*, Executive Director  
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 650 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.<sup>2</sup> 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 (ISDEAA) to independently operate their health facilities.<sup>3</sup> 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.

The Snyder Act of 1921<sup>4</sup> 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 that were previously 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 was 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.<sup>5</sup> Government auditors have concluded that Congress should require IHS “to develop and use a new method to allocate all [PRC] program funds...”<sup>6</sup>

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<sup>2</sup> The twelve areas of the IHS include: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson.

<sup>3</sup> 25 U.S.C. 450 et seq.

<sup>4</sup> 25 U.S.C. §13

<sup>5</sup> 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>

<sup>6</sup> *Id.* at 26.

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 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.<sup>7</sup> 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.”<sup>8</sup> 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.<sup>9</sup>

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

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<sup>7</sup> 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. 111<sup>th</sup> Congress. S. HRG. 111-873. <http://www.indian.senate.gov/sites/default/files/upload/files/63826.PDF>

<sup>8</sup> 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. 111<sup>th</sup> Congress. (“Dorgan Report”). <http://www.indian.senate.gov/sites/default/files/upload/files/Chairman-s-Report-In-Critical-Condition-12-28-10.pdf>

<sup>9</sup> *Id.* at 5-6.

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 actions...”<sup>10</sup> Since 2013, that paragraph appears to have been copied from the previous year’s document.<sup>11</sup>

### Recent Developments in the Great Plains Area

The recent problems in the GPA surfaced again 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.<sup>12</sup> 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.<sup>13</sup> 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.<sup>14</sup> According to Rosebud Tribal leaders, approximately five babies were born and approximately nine patients have died in ambulances in transit to these facilities since December 2015.<sup>15</sup>

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. 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

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<sup>10</sup> 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>

<sup>11</sup> 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>

<sup>12</sup> 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](http://siouxcityjournal.com/news/officials-say-winnebago-hospital-will-operate-without-federal-funding/article_5f283bb1-c660-5848-a710-40fbc551796c.html)

<sup>13</sup> 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/>

<sup>14</sup> 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/>

<sup>15</sup> 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/>

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.<sup>16</sup>

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).<sup>17</sup> 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.<sup>18</sup>

Finally, 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.

### Indian Health Service Appropriations

Congress has increased IHS funding almost each year since the 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.

### **Section-by-Section Analysis of H.R. 5406**

*Section 1. Short title; table of contents.* This Act may be cited as the "Helping Ensure Accountability and Trust in Tribal Healthcare (HEALTTH) Act."

*Sec. 2. Findings.* Establishes the need for reform of the Indian Health Service (IHS) by listing several findings by Congress including a reaffirmation of the United States government's treaty responsibility to provide health care to American Indians and Alaska Natives and a description of

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<sup>16</sup> 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>

<sup>17</sup> 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/>

<sup>18</sup> 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/>

the fundamental, systemic failures in the Great Plains Area of the IHS, which has resulted in patient suffering and death.

#### TITLE I – Expanding Authorities and Improving Access to Care.

*Sec. 101. Service hospital long-term contract pilot program.* Provides authority to IHS to undertake a pilot project to test a “third way” health care delivery model, an alternative to full direct-service and full self-governance, with an emphasis on preparing tribes for self-governance. Under the pilot, three direct-service IHS hospitals will be fully contracted to a private sector health care company and a governance structure will be created and implemented, all in coordination with the tribe(s) served by the facility. The governance structure will be a hospital board modeled on private sector hospital boards. The boards will consist of IHS representatives, representatives of the tribe(s) served by the hospital, representatives of the contractor, as well as health and health administration experts to be chosen by the IHS and tribe(s) together. In order for a selected hospital to participate, the IHS must obtain the permission of the tribe(s) served by the hospital. The tribe(s) may end the pilot at any time if they wish to enter into a self-governance contract.

*Sec. 102. Expanded hiring authority for the Indian Health Service.* Provides hiring authority to the IHS that is similar to that of the Department of Veterans Affairs (VA).

*Sec. 103. Removal or demotion of employees.* Streamlines the IHS' authority to fire or demote underperforming employees in a way that is similar to broadly-supported proposals for such processes in the VA.

*Sec. 104. Improving timeliness of care.* Requires the IHS to develop and implement standards to measure the timeliness of care at direct-service IHS facilities, then develop and implement a process by which these facilities report data collected under those standards.

#### TITLE II – Indian Health Service Recruitment and Workforce.

*Sec. 201. Exclusion from gross income for payments made under Indian health service loan repayment program.* Amends the Internal Revenue Code to exclude from the definition of gross income payments made by the IHS student loan repayment program, effectively making these payments tax-free. This aligns the treatment of IHS student loan payments with the treatment of those made by the National Health Service Corps.

*Sec. 202. Clarifying that certain degrees qualify individuals for eligibility in the Indian Health Service Loan Repayment Program.* 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. 203. Cultural competency programs.* 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. 204. Relocation reimbursement.* Amends the IHS' existing authority to provide relocation reimbursement for employees by allowing the agency to provide up to 75 percent of base pay for relocation expenses without prior approval from the Office of Personnel Management in the following circumstances: 1) the employee is relocating to a rural or medically underserved area, 2) the position has not been filled by a full-time non-contractor for over six months, or 3) the position is for hospital management or administration.

*Sec. 205. Authority to waive Indian preference laws.* Grants the IHS the authority (after obtaining Tribal consent) to waive Indian preference laws for positions at any IHS facility that has a vacancy rate of over 20 percent. Also grants the IHS authority to waive an individual's ability to apply under Indian preference for up to five years when the individual is a former IHS or tribal employee who was removed for conduct or performance issues.

*Sec. 206. Streamlining licensed health professional volunteer credentialing process.* Requires the IHS to centralize its licensed health professional volunteer credentialing procedures at the agency level rather than the facility level to reduce the paperwork burden on licensed health professionals who wish to volunteer at IHS direct-service facilities. Allows the IHS to consult with public and private sector associations in the development of this system. Those tribes who operate their own facilities under self-governance laws may choose to participate in the centralized system.

TITLE III – Purchased/Referred Care Program reforms.

*Sec. 301. Limitation on charges for certain purchased/referred care program services.* Codifies the recent IHS rules that provide for the payment of Medicare-like rates for both hospital and non-hospital services obtained by IHS-eligible individuals outside the IHS system. Allows the Secretary, tribes, tribal organization, and urban Indian organizations discretion to negotiate above Medicare rates under certain circumstances. Requires the IHS to report to Congress within two years regarding access to care under the Purchased/Referred Care program, including recommendations for legislative action.



*Sec. 302. Allocation of Purchased/Referred Care Program funds.* Requires the IHS to develop and implement within three years a new Purchased/Referred Care allocation formula that accounts for a variety of factors. Allows for a three year transition period to the new system, during which the IHS will freeze 2016 base Purchased/Referred Care funding level for those facilities that have achieved Priority Level III- V for most services; facilities that have achieved Priority Levels I-II would receive the excess funding as determined by the IHS. The transition is mandatory for direct-service IHS facilities, but those operated by a tribe, tribal organization, or urban Indian organization may choose to participate. Requires IHS to report to Congress on access to care and financial stability under the new formula.

*Sec. 303. Purchased/Referred Care Program backlog.* Requires the IHS to develop and implement a prioritization of unpaid balances to private medical providers under the Purchased/Referred Care program for each service area.

*Sec. 304. Report on financial stability of Service hospitals and facilities.* Requires the Government Accountability Office to report to Congress on issues related to the financial stability of IHS hospitals and facilities that have experienced sanction or threat of sanction by the Centers for Medicare and Medicaid Services, focusing on the effects of any revenues lost as a result of those CMS actions.

**Cost**

Unknown at this time

**Administration Position**

Unknown at this time

**[Effect on Current Law \(Ramseyer\)](#)**