Committee on Natural Resources
Rob Bishop Chairman
Markup Memorandum

May 19, 2018

To: All Natural Resources Committee Members

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

Mark-Up: **H.R. 5874 (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.
May 23, 2018, 10:15 a.m. 1324 Longworth HOB

H.R. 5874, "*Restoring Accountability in the Indian Health Service Act of 2018*"

Bill Summary

H.R. 5874 was introduced by Rep. Kristi Noem (R-SD) on May 18, 2018. 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 and reducing related 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. Doug LaMalfa (R-CA), Rep. Jennifer Gonzalez-Colon (R-PR), Rep. Aumua Amata Coleman Radewagen (R-AS), Rep. Markwayne Mullin (R-OK), Rep. Cathy McMorris Rodgers (R-WA), Rep. Tom Cole (R-OK), and Rep. Kevin Cramer (R-ND).

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[1] 25 U.S.C. §1601 et seq.

Background

The 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, Maryland, 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.

The Snyder Act of 1921[4] provides the basic authority for the federal provision of health services and benefits to Indians because of their federally recognized tribal status. The modern statutory basis and framework for the federal provision of health care to Indians is under the IHCIA. 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 are otherwise carried out by the federal government through contracts, compacts and annual funding agreements negotiated with the IHS. In Fiscal year 2015, 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 like 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 significant 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.

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[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.
[4] 25 U.S.C. §13.

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) includes North Dakota, South Dakota, Nebraska, and Iowa. Headquartered in Aberdeen, South Dakota, the GPA 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 extremely low-quality health care, and the GPA headquarters office has been accused of impropriety, nepotism, and corruption. Furthermore, the tribes served by the GPA are generally located on remote reservations that face long-term systemic problems such as 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:

- 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;
- Centers for Medicare & Medicaid Services accreditation problems;
- Significant backlogs in billings and claims collection; and
- Discouraging employees from communicating with Congress.[9]

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[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.
[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.

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 past five years, the IHS budget justification accompanying the President's budget request 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 [GPA]…in addition to implementing a corrective action plan to address findings…IHS will continue to implement and monitor improvements and corrective actions…"[10] Each year, the paragraph appears to have been copied from the previous year's document until the President's Fiscal Year 2018 request .[11]

In March 2017, the Government Accountability Office listed Indian Health in 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, the HIS Inspector General and others have concluded that 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 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

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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/

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. While the agreements were generally considered a positive step, Congresswoman Kristi Noem, along with Senators Barrasso, Thune, and Rounds, raised concerns about several provisions in the agreements. Specifically, the Members questioned the cost associated with the agreements, 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, Nebraska, Martin, South Dakota, and Winner, South Dakota. The IHS is attempting to fill the position 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, South Dakota. 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

[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/

[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/

City Regional Health, a community hospital in Rapid City.[19] Meanwhile, the Sioux San facility is operating solely as a 24-hour urgent care facility.[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 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 Emergency Department (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, Colorado. 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."

[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
[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/

Indian Health Service Appropriations

Congress has increased IHS funding almost each year since the 2010 Dorgan Report, and it continues to increase. In Fiscal Years 2014 and 2015, Congress exceeded President Obama's budget request for the agency. Since 2008, funding for the IHS has increased by more than 50 percent. The House's Fiscal Year 2017 proposed appropriation sits at approximately $1 billion over Fiscal Year 2010 levels, yet the dangerous situation in the GPA and the staffing shortage problem throughout the 12 IHS areas continues to exist if not grow. In the Fiscal Year 2017 omnibus appropriation act, Congress appropriated $2 million to address deficiencies in IHS hospitals with accreditation emergencies and $29 million to address the overall accreditation emergencies (which are primarily located in the Great Plains).[23] In the Fiscal Year 2018 omnibus appropriations act, Congress appropriated $5.5 billion (an increase of $497 million) for IHS, which includes $58 million for accreditation emergencies.[24]

Recent Legislative Action

Two bills were introduced in the 114th Congress to address IHS deficiencies. Senator John Barrasso (R-WY) introduced S. 2953, the IHS Accountability Act.[25] The bill received a legislative hearing in the form of a field hearing in Rapid City, South Dakota, and was later marked up by the Senate Indian Affairs Committee. In the House of Representatives, Congresswoman 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.[26] No further action was taken before the end of the Congress.

At the beginning of the 115th Congress, a bill entitled Restoring Accountability in the IHS Act of 2017 was introduced in both the House and Senate as H.R. 2662 and S. 1250, respectively. The bill made some modifications from the previous Congress and was a compromise bill that contained provisions of both S. 2953 and H.R. 5406 from the previous Congress. A hearing was held on S. 1250 on June 13, 2017,[27] and the bill was ordered reported on April 11, 2018. The House Natural Resources Committee held a hearing on H.R. 2662 on June 21, 2017.[28] Since the hearings, the committees of jurisdiction in the House and Senate have continued to receive feedback from Indian tribes, tribal organizations, the IHS and other stakeholders.

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[23] Public Law 115-31.
[24] Public Law 115-141.
[25] 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
[26] https://naturalresources.house.gov/calendar/eventsingle.aspx?EventID=400894
[27] Legislative Hearing. https://www.indian.senate.gov/hearing/legislative-hearing-receive-testimony-following-bills-s-1250-s-1275.
[28] Legislative Hearing: https://naturalresources.house.gov/calendar/eventsingle.aspx?EventID=402163.

On May 18, 2018, Congresswoman Noem introduced a revised version of H.R. 2662. The bill, H.R. 5874, is substantially similar to S. 1250, as ordered reported. The bill also contains clarifying and technical amendment language addressing comments received to date.

Section-by-Section Analysis of Major Provisions of H.R. 5874

TITLE I-INDIAN HEALTH SERVICE IMPROVEMENTS

Section 101. Incentives for Recruitment and Retention.

- Improves IHS' recruitment activities by permanently expanding IHS' authority to provide increased pay for certain medical providers and enables IHS to pay relocation costs for employees and provide housing vouchers for employees.

Sec. 102. Medical Credentialing System.

- Requires IHS to develop an agency-wide centralized credentialing system for licensed health professionals, which is to be developed and implemented no later than one year after the date of enactment.
- This system must be uniform throughout the agency and allow credentialed individuals to provide services throughout the IHS system.
- IHS must consult with tribes in developing the system.

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

- Deems health professionals who volunteer at IHS facilities employees of the Public Health Service.

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

- Expands the types of professionals eligible for the IHS student loan repayment program to include individuals with master's degrees in business administration with an emphasis in health care management, health administration, hospital administration, or public health.
- Requires program participants to work at IHS two years or longer, or four years or longer if working half-time.

Sec. 105. Improvements in Hiring Practices.

- Allows IHS direct hire authority.
- Requires IHS to provide a notice and comment period to a tribe before appointing, hiring, transferring, or reassigning a Senior Executive Service employee or a manager.
- Requires IHS to seek waivers of Indian preference hiring when 15 percent or more of an IHS facility's health professional positions are not filled by a full-time IHS employee for

six months or more, or if the only available applicant is a former IHS or tribal employee who was removed or demoted for performance or misconduct within the previous five years.

Sec. 106. Improved Authorities of Secretary to Improve Accountability of Senior Executives and Employees of the Indian Health Service.

- Expands IHS authority to reprimand, suspend, reassign, demote, or remove certain individuals from Senior Executive Service positions if it is determined that misconduct or performance warrants such action, and provides thorough due process for individuals subject to reprimand, suspension, reassignment, demotion, or removal.

Sec. 107. Tribal Culture and History.

- Requires IHS to develop a cultural training program that is mandatory for all IHS employees and IHS contractors.

Sec. 108. Staffing Demonstration Project.

- Requires IHS to establish a demonstration project to determine whether increased staffing resources for certain facilities results in self-sustaining resources.
- The demonstration may operate as IHS deems appropriate, but each staffing position shall be for a period of no less than three fiscal years.

Sec. 109. Rule Establishing Tribal Consultation Policy.

- Requires IHS to establish a tribal consultation policy.

Sec. 110. Treatment of Certain Hospitals.

- Retroactively applies the provisions of a rule from the Centers for Medicare & Medicaid Services related to low-volume hospital payment adjustments.

TITLE II – EMPLOYEE PROTECTIONS

Sec. 201. Employee Protections Against Retaliation.

- Provides a process for mandatory reporting for witnesses of retaliation against a whistleblower, or a patient safety requirement, or similar misconduct.
- Allows IHS to remove employees who have retaliated against whistleblowers.
- Enhances protections for whistleblowers.

Sec. 202. Right of Federal Employees to Petition Congress.

- Reiterates the right of federal employees to petition Congress.

- Expands the federal government's ability to punish employees who interferes with another employee's right to petition Congress.
- Requires IHS to provide each IHS employee a memorandum reiterating his or her right to petition Congress.

***Sec. 203. Fiscal Accountability*.**

- Provides that IHS may not provide raises or bonuses to certain high-ranking employees if it fails to submit the professional housing plan or staffing plan required by the bill.
- Requires IHS to spend unobligated and unspent amounts on patient care.
- Requires IHS to provide quarterly spending reports at each level of the agency to each tribe and Congress.

TITLE III – REPORTS

Sec. 302. Reports by the Secretary of Health and Human Services.

- Requires IHS to develop and publish a professional housing plan that comports with recommendations of the Government Accountability Office (GAO).
- Requires IHS to develop and publish a staffing plan.
- Requires IHS to develop and publish a report on certain data under section 108 of the IHCIA.

Sec. 303. Reports by the Comptroller General.

- Requires GAO to develop and submit to Congress a report regarding IHS housing needs.
- Requires GAO to develop and submit to Congress a report regarding IHS staffing needs.

***Sec. 304. Inspector General Reports*.**

- Requires the HHS Inspector General to develop and submit to Congress and IHS a report on patient harm events occurring in the agency.

***Sec. 304. Transparency in CMS Surveys*.**

- Requires CMS to conduct surveys of IHS facilities no less frequently than every two years and publish the results on the CMS website.

TITLE IV – TECHNICAL AMENDMENTS

Sec. 401. Technical Amendments.

- Replaces the term "contract health service" with "purchased/referred care" throughout the IHCIA.

Cost

Unknown

Administration Position

At the June 21, 2018, hearing on similar bill, H.R. 2662, the IHS testified that they welcomed the opportunity to work with the Committee as the bill moved through the legislative process.

Effect on Current Law (Ramseyer)