Testimony

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Legislative Hearing before the
House of Representatives
House Natural Resources Subcommittee on Indian and Insular Affairs

H.R. 8942, *"Improving Tribal Cultural Training for Providers Act of 2024";*
H.R. 8955, *"IHS Provider Integrity Act"; and*
H.R. 8956, *"Uniform Credentials for IHS Providers Act of 2024"*

July 24, 2024

Good morning Chair Hageman, Ranking Member Leger Fernandez, and Members of the Subcommittee. Thank you for the opportunity to provide testimony on three legislative proposals before the Subcommittee, and for your continued support for the efforts of the Indian Health Service (IHS) and the Department of Health and Human Services (HHS or Department) to improve the health and well- being of American Indians and Alaska Natives (AI/AN). Your consideration today of H.R. 8942, Improving Tribal Cultural Training for Providers Act of 2024; H.R. 8955, IHS Provider Integrity Act; and H.R. 8956, Uniform Credentials for IHS Providers Act of 2024, underscores that commitment to improving the quality of health care provided by the IHS.

I am Benjamin Smith, the Deputy Director at IHS. The Biden-Harris Administration, the Department and IHS have worked hard over the past several years to not only provide needed training for our providers that work in our IHS and Tribal facilities, but to also provide American Indian and Alaska Native culturally appropriate training to all our IHS employees, including all health care providers, whether federal employees, contractors, or volunteers. We have also worked hard to ensure that our licensed providers meet professional standards required for their discipline before authorizing them to provide health care in our IHS facilities, and we have worked to ensure our credentialing system filters out providers that are not licensed or who are professionally unfit to provide health care in our facilities.

It should be noted that the President's Fiscal Year (FY) 2025 budget request includes a proposal to allow for withholding or revoking of annuity and retiree pay for retired civil service employees convicted of moral turpitude – including sexual abuse – during the commission of their federal duties. This proposed amendment is in line with the Department's mission of protecting vulnerable, underserved populations, and the Presidential Task Force on Protecting Native American Children in the Indian Health Service System.

Workforce challenges – and the impacts on care that come with them – are one of the top concerns raised to the Department by tribes. The IHS continues to support new strategies to develop the workforce and leverage advanced practice providers and paraprofessionals to improve the access to quality care in AI/AN communities. Ultimately, the Indian Health Service needs additional authorities and resources to build out their workforce pipeline. That is why the President's budget

also included a number of proposals, some dating back to FY 2019, that have sought to make the IHS more competitive with other federal agencies in their hiring process and reduce systemic barriers to recruitment and retention. HHS looks forward to working with Congress on policy solutions to this effect. For example, the IHS seeks a tax exemption for Indian Health Service Health Professions Scholarship and Loan Repayment Programs to increase the number of health care providers entering and remaining within the IHS to provide primary health care and specialty services. The agency is also seeking the discretionary use of all Title 38 Personnel authorities that are currently available to the Veterans Health Administration. The IHS also seeks permanent authority to hire and pay experts and consultants. Hiring experts and consultants is another tool IHS can use to strengthen its workforce and better serve the AI/AN population, and IHS seeks legislative authority to conduct mission critical emergency hiring needs beyond 30-day appointments.

As the Subcommittee is aware, the IHS executes its mission in partnership with AI/AN tribal communities through a network of over 600 federal and tribal health facilities and 41 Urban Indian Organizations that are located across 37 states and provide health care services to approximately2.87 million AI/AN people annually.

As you know, the IHS operates under the authority of the Indian Health Care Improvement Act (IHCIA). The IHS receives annual appropriations to carry out its authorities, including those under the Snyder Act and IHCIA. The three legislative proposals before the Subcommittee would amend the IHCIA to 1) ensure that certain employees, providers and volunteers associated with the IHS receive educational training in the history and culture of the Tribes served by the Indian health care system; 2) ensure that, whenever the IHS undertakes an investigation into the professional conduct of a licensee in a State, the IHS notifies the relevant State medical board; and 3) develop and implement a centralized system for credentialing licensed health professionals seeking to provide health care services at any of our IHS facilities.

IHS Credentialing Process, Professional Conduct Investigations, Tribal Cultural Training for Providers

IHS Credentialing Process

Over many decades, all IHS federal facilities and programs have utilized various tracking and management systems to manage large volumes of provider credentialing and privileging data. There was no formal process or standardization. However, IHS began the evolutionary process of transforming into a paperless medical staff credentialing environment that would support standardization and centralized document and verification efficiencies to strengthen patient safety by implementing an enterprise-wide credentialing software system and hiring a certified credentialing specialist at IHS Headquarters.

Currently, all IHS direct service health care facilities have fully implemented the credentialing software, which includes centrally sharing licensed practitioners' files where federal law, accrediting bodies, and organizational terms of use allow. Use of a centralized system has significantly reduced the time to credential licensed practitioners. As of June 2024 year, 181 initial and reappointment applications were processed in IHS, with an average application processing time of 28 days.

The IHS currently maintains credentialing and privileging of 3,308 licensed practitioners at 10 IHS Areas, 23 hospitals, 49 health centers, 26 health stations, 8 treatment centers, and 1 dental clinic; this includes telemedicine providers. Of the 3,308 licensed practitioners in the IHS, 603 are credentialed and privileged at more than one facility. There are 98 Medical Doctor-Staff end users, including Medical Staff Professionals (Credentials), Clinical Directors, Chief Medical Officers, and Quality Managers. The IHS processed 1,778 licensed practitioners initial and reappointment applications over the past 12 months (July 2023 – June 2024).

In addition, the use and standardization of the credentialing software have increased inter-departmental collaboration with pharmacy, nursing, human resources, and information technology modernization efforts to identify practitioners' compliance with training requirements, staffing trends, and emerging needs and standardize quality credentialing metrics across the IHS.

Additionally, the IHS is in the final stages of updating and publishing the *Indian Health Manual*, Chapter 3 Clinical Credentials and Privileges policy for the agency. We anticipate publishing the revised policy by the end of August 2024. Following the policy issuance will be the update of the IHS Credentialing and Privileging Standard Operating Procedures. These documents provide additional guidance and support to the medical staff professionals in assuring credentialing processes are clearly defined and implemented.

The IHS will next begin to create, develop, and provide credentialing staff development and strengthening quality improvement activities at all levels of the organization. Per the 2025 Budget, IHS plans to hire an additional credentialing specialist who is dually certified in credentialing, to enhance effective training and develop and integrate additional quality standards and metrics into governance, management, and operations.

Tribal and urban Indian health programs operating under the Indian Self-Determination and Education Assistance Act and IHCIA, respectively, are encouraged to adopt IHS policy as appropriate but are not required to do so, especially to the extent they are governed by other legal or policy requirements that do not apply to federal agencies.

IHS Professional Conduct Investigations

The IHS is committed to ensuring safe and high-quality patient care through appropriate hiring, credentialing, peer review, and professional review processes for licensed providers/practitioners as part of a comprehensive clinical risk management system. Licensed providers/practitioners are held to the highest standards for conduct and performance. When provider misconduct or poor clinical performance is identified through appropriate review, the IHS notifies relevant authorities (e.g., state licensing boards, the National Practitioner Databank, specialty boards). For example, the IHS activities in this area are:

- Hiring, credentialing, conducting focused and ongoing professional practice evaluation, and professional peer review processes are all part of a comprehensive IHS vetting system and continuous oversight of provider competence, clinical performance, and professional conduct.

- The IHS encourages reporting suspected misconduct or substandard performance of licensed providers.
- Reports of alleged provider misconduct and/or substandard clinical performance are promptly investigated by service unit leadership with referral to the area leadership through governance. If there is merit it will be forwarded to the Headquarters (HQ) Quality and Risk Management (QARM) committee for review by the QARM committee.
- Certain egregious incidents of provider misconduct (e.g., sexual abuse, physical assault) or poor performance (e.g., impairment threatening patient safety) are grounds for immediate reporting to appropriate authorities, including the state licensure board.
- The Medical Staff Bylaws detail processes for suspending and terminating provider privileges for misconduct, poor clinical performance, and impairment of licensed providers/practitioners.
- For the sake of quality/safe patient care, it is essential to set a low threshold for reporting alleged misconduct, poor performance, and/or impairment.
- Upon investigation, when allegations of misconduct or poor performance are found to be without merit, they should not result in any adverse action.
- Reporting to State Licensure Boards and other authorities (e.g., National Practitioner Databank, specialty boards should be based on confirmed evidence of misconduct, poor performance, and/or impairment.
- As part of a comprehensive system of clinical risk management, the IHS has established criteria[1] for reporting by its healthcare entities to authorities such as state licensure boards, to include:
    - Any professional review action that adversely affects the clinical privileges for more than 30 days.
    - Acceptance of the surrender of clinical privileges or any restriction of such privileges,
        - While the (provider/practitioner) is under investigation by the healthcare entity relating to possible incompetence or improper professional conduct or
        - In return for not conducting such an investigation or proceeding
    - In the case of a healthcare entity that is a professional society, when it takes a professional review action.
- While safety and clinical quality are always the priority, determinations regarding adverse actions must afford the provider due process rights.
- Processes for investigating and reporting alleged provider misconduct, poor performance, and/or impairment should remain consistent with standards for other healthcare organizations to ensure fairness and support for a robust clinical workforce in the IHS, as well as requirements that apply to federal employees.

As with the Credentialing policy, the Tribal and urban Indian health programs operating under the Indian Self-Determination and Education Assistance Act and IHCIA are encouraged to adopt IHS policy as appropriate. However, they are not required to abide by it, especially to the extent they are governed by other legal or policy requirements that do not apply to federal agencies.

Tribal Cultural Training for Providers

[1] Risk Management and Medical Liability, A Manual for Indian Health Service and Tribal Health Care Professionals, Third Edition, Paul R. Fowler, DO, JD, FCLM, FAOCOPM, FAAFP, Risk Management Program, Office of Clinical and Preventive Services, Indian Health Service Headquarters, August 2018.

The IHS acknowledges the role that trauma resulting from violence, victimization, colonization, and systemic racism plays in the lives of AI/AN populations, specifically AI/AN youth who are two and a half times more likely to experience trauma compared to their non-Native peers. Delivering trauma-informed services requires an understanding of the profound neurological, biological, psychological, spiritual, and social effects trauma and violence can have on individuals, families, and communities. The IHS workforce must be aware of the high prevalence of trauma in AI/AN populations and be prepared to respond effectively to this trauma, which affects many individuals who seek services in IHS facilities. It is also important to recognize and build on the resiliency of AI/AN people, which comes, at least in part, from their cultures and spirituality.

Creating policies and services that support a trauma-informed perspective that appreciates the frequency of trauma, understands the impact at the individual and community level, and supports appropriate response is critical for improving the many health conditions experienced by the AI/AN population. IHS can enhance its capacity for promoting relational well-being and improving patient outcomes by increasing understanding of the direct and transgenerational impacts traumatic experiences have on a patient's health and how the patient engages in healthcare, by using trauma-informed policies, practices, and interventions.

Delivered with cultural humility and sensitivity, a trauma-informed care organization emphasizes physical, psychological, and emotional safety for patients and providers. Trauma-informed care helps survivors rebuild a sense of control and empowerment. IHS has been expanding its work as a trauma-informed care organization with a variety of efforts[2]:

- In FY 2020, the IHS released the *Indian Health Manual* Chapter 37, Trauma-Informed Care policy and implemented trauma-informed care principles to ensure the agency understands the prevalence and impact of trauma, facilitates healing, avoids re-traumatization, and focuses on strength and resilience.
- In FY 2021, the IHS updated the policy to align with current trauma informed care best practices.
- The Trauma-Informed Care policy reflects training requirements and guidance to support IHS's efforts of providing patient-focused, driven, recovery-oriented care, integrating cultural humility and appropriateness, and providing trauma-informed care services.
- Trauma-informed care training is mandated for all IHS employees, including contractors and volunteers, and is to be completed annually. Compliance is enforced.
    - The training content includes information on impact of trauma, including historical trauma and the importance of trauma informed care approach. A knowledge check is a requirement to pass the training.
- The IHS is updating the training to ensure all trauma informed care information is up-to-date and aligned with best practices. The IHS anticipates this training will be available to all employees by the end of 2024.
- In FY 2022, the IHS formed a multidisciplinary workgroup comprised of subject matter experts representing all IHS Areas, aiming to understand the agency's readiness and identify resources to support a trauma-informed care agency.

[2] Indian Health Service, Indian Health Manual, Part 3, Chapter 37.

- The IHS is developing a readiness assessment to assist facilities in meeting the agency policy "to ensure policies, practices, and protocols are Trauma Informed" and will identify existing/developing evidence-based activities, including cultural factors.

It is also highly recommended that each service unit develop a unique orientation for all staff regarding tribal cultural training appropriate to each tribe served by the healthcare facility.

H.R. 8942, *"Improving Tribal Cultural Training for Providers Act of 2024"*

The *Improving Tribal Cultural Training for Providers Act of 2024* would amend 25 U.S.C. §1616(f), titled "Tribal culture and history," in the IHCIA to direct the Secretary of HHS to establish an annual mandatory training program where all employees of IHS, locus tenens medical providers, health care volunteers, and other contracted employees who work at IHS hospitals or service units whose employment requires regular direct patient access, and require such annual participation and completion of this annual mandatory training program.

As noted prior, the IHS is highly recommending that each IHS service unit develop a unique orientation for all staff regarding cultural training appropriate to each tribe served by the IHS healthcare facility. H.R. 8942 would complement the existing IHS activities regarding Tribal cultural training of providers in the IHS system. However, IHS recommends the drafters consider whether "condition of employment" is feasible when applicable to contractors and volunteers. IHS is concerned with creating a "condition of employment" that depends on IHS setting up the program, which might be different, or a separate training module for each Tribe. Thus, an employee/contractor/volunteer could be violating the terms of employment/contracting/volunteering, through no fault of their own.

H.R. 8955, *"IHS Provider Integrity Act"*

The *IHS Provider Integrity Act* would amend IHCIA by adding a new section to Title VIII of the Indian Health Care Improvement Act. Specifically, H.R. 8955 would require IHS to notify, not later than 14 days, the State medical board of an investigation, and thereafter require the IHS to provide relevant records to State medical boards within 14 days upon generation of such relevant records into the professional conduct of a licensee practicing at an IHS facility.

H.R. 8955 also would add to Title VIII of the IHCIA, a requirement, as part of the hiring process, that the Director of the IHS solicit from the medical board of each state in which a provider has a medical license information on such provider's history of license violations or settlements over the previous 20 years. Additionally, H.R. 8955 would require IHS to provide to the medical board of each state in which a provider is licensed detailed information regarding any violations by the provider in their IHS capacity, and would direct the IHS to submit a report to Congress regarding its compliance with H.R. 8955.

The IHS appreciates the intent of H.R. 8955, but notes, as stated prior, the IHS is committed to ensuring safe and quality patient care through appropriate hiring, credentialing, ongoing monitoring, and professional peer review and the IHS already notifies relevant authorities when provider misconduct or poor clinical performance is confirmed through appropriate review. The IHS has concerns about the proposed timeline requirement for notice and providing relevant

documentation to State medical boards. We would like to further explore this requirement to ensure that it contemplates the amount of time needed to complete a required appropriate investigation before reporting an adverse event, as well as to ensure that providers have a right to due process and an appropriate investigation and that medical quality assurance records are properly safeguarded, consistent with section 805 of the Indian Health Care Improvement Act (25 U.S.C. § 1675). The drafters of H.R. 8955 should consider clarifying what constitutes "an investigation into the professional conduct." It is unclear whether this is limited to peer review for activities related to medical care or could it include any sort of Human Resources review for the person's conduct as an employee.

We would also urge Congress to consider standards that exist in other agencies or health care systems. Additionally, Congress should also consider adding language to make it clear that any records or documents provided pursuant to this statute shall be exempt from disclosure under the Freedom of Information Act (FOIA), section 552 of title 5. This would ensure that H.R. 8955 would be construed a statute described in subsection (b)(3)(B) of section 552 (records exempt from mandatory disclosure in response to a FOIA request. Additionally, Congress should consider adding language that protects the confidentially of the employee and their personnel documents.

The IHS would not be able to report within 14 days because it is not feasible to complete a full review and investigation within this time frame. An appropriate investigation is required before reporting an adverse event. All providers have a right to due process and an appropriate investigation. If the investigation concludes that the provider is acting in an inappropriate or unsafe manner, then the findings will be immediately reported to the licensing boards where the provider holds a license. The IHS recommends the drafters propose a longer timeline that is triggered not by the initiation of an investigation but by the conclusion of an adequate investigation. In addition, the IHS recommends that the drafters limit the documentation to be shared with the state boards, consistent with section 805 of the Indian Health Care Improvement Act (25 U.S.C. § 1675). It would be impossible to provide due process to the provider and complete an adequate investigation in the proposed 14-day time frame. The proposed time frame would require IHS to meet a standard that does not exist in other agencies or healthcare systems.

Further, the IHS advocates timely reporting requirements consistent with the reasonable standards of other healthcare organizations, which prioritize evidence over allegations. Also, the proposed requirements in H.R. 8955 are actually not new requirements because IHS always primary source reviews all licenses of each provider that is credentialed in the IHS healthcare system.

H.R. 8956, *"Uniform Credentials for IHS Providers Act of 2024"*

The *Uniform Credentials for IHS Providers Act of 2024* would amend the IHCIA. Specifically, H.R. 8956 would direct IHS to establish, in consultation with Indian tribes and stakeholders, a uniform, centralized, Service-wide credentialing system for health professionals providing services at IHS Service units. Health professionals credentialed in accordance with existing IHS policy are not required to be re-credentialed under the new system until they are otherwise required to be re-credentialed. Providers are prohibited from practicing within a Service unit if they are not credentialed in accordance with H.R. 8956. Finally, IHS is authorized to expand or enhance an existing credentialing system to meet the requirements set forth in this section.

H.R. 8956 also specifies that nothing in its provisions negatively impacts the right of an Indian tribe to enter into a compact or contract under the Indian Self-Determination and Education Assistance Act or applies to such a compact or contract unless expressly agreed to by the Indian tribe.

The drafters of H.R. 8956 may want to note that the nonduplication of efforts language states the Secretary is not required to establish a new medical credentialing system under the proposed legislation, if the Service has begun implementing or has completed implementation of a system that otherwise meets the requirements of this section. Taking this text into consideration, IHS already has the authority to create such a credentialing system, and has established, and is fully implementing the new system. Additionally, the requirements imposed by the new proposed legislation, particularly the requirement for tribal consultation, would result in duplication of effort and create additional, resource-intensive hurdles to implementation without improving on the IHS's current process, and the consultation requirement could open inherent federal functions to tribal consultation and make it challenging to meet the deadline for implementation in H.R. 8956.

The drafters of H.R. 8956, should also be aware that the requirements imposed by this proposed legislation would create conflict with current and existing CMS and accreditation standards. IHS has established the policy and procedures for medical staff credentialing and clinical privileging of health care providers working in IHS health facilities. The governing body is the only authority that can grant full medical staff membership and/or clinical privileges. In the case of IHS, under current federal law (section 601 of the Indian Health Care Improvement Act (25 USC 1661)), the person(s) legally responsible for the conduct of the hospital is the Secretary, acting through the IHS Director. This operational authority is extensive, including approval and implementation of procedures for employee hiring, recruitment and dismissal.

The drafters of H.R. 8956 should be aware, the quoted text in H.R. 8956, "the Secretary may authorize licensed health professionals to provide health care services at any service unit," is inconsistent with existing CMS standards regarding credentialing and privileging of medical providers. Only the Governing Board has the authority to authorize Licensed Independent Practitioner (LIPs) to provide health care services at their Service Unit per accrediting bodies and CMS CoPs. IHS recommends the drafters consider deleting this text to avoid duplication of effort with the Governing Board.

We look forward to continuing our work with Congress on these bills, and as always, welcome the opportunity to provide technical assistance as requested by the Subcommittee or its members. Thank you again for the opportunity to testify today, and I am happy to answer any questions you may have.