HOUSE COMMITTEE ON
NATURAL RESOURCES
CHAIRMAN BRUCE WESTERMAN

To: House Committee on Natural Resources Republican Members
From: Indian and Insular Affairs Subcommittee staff, Ken Degenfelder (Ken.Degenfelder@mail.house.gov) and Jocelyn Broman (Jocelyn.Broman@mail.house.gov) x6-9725
Date: Thursday, July 27, 2023
Subject: Legislative Hearing on a Discussion Draft of H.R. ____ (Rep. Johnson of SD), "*Restoring Accountability in the Indian Health Service Act of 2023*"

The Subcommittee on Indian and Insular Affairs will hold a legislative hearing on a Discussion draft of **H.R. ____ (Rep. Johnson of SD)**, *"Restoring Accountability in the Indian Health Service Act of 2023"* on **Thursday, July 27, 2023, at 2:15 p.m. EDT in 1334 Longworth House Office Building.**

Member offices are requested to notify Ransom Fox (Ransom.Fox@mail.house.gov) by 4:30pm on Wednesday, July 26, 2023, if their member intends to participate in the hearing.

I. KEY MESSAGES

- The Indian Health Service (IHS) has long been plagued with issues of substandard medical care, high staff vacancy rates, aging facilities and equipment, and unqualified or predatory healthcare staff. Many of these issues first came to national attention in 2010 as the result of an investigation conducted by the Senate Committee on Indian Affairs.[1]
- The inability of the IHS to attract and retain quality health care professionals has been identified as a factor in the failure to provide quality care, leading to hiring sub-par candidates. Other factors include incentives to retain mediocre employees, and challenges to fully staff IHS facilities.
- The Restoring Accountability in the Indian Health Service Act would amend the Indian Health Care Improvement Act (IHCIA) to improve incentives for recruitment and retention of IHS employees, improve hiring practices, streamline processes for dismissal of Senior Executive Service and IHS employees for misconduct, and improve whistleblower protections.

II. WITNESSES

- **Ms. Cindy Marchand**, Secretary, Tribal Council, Confederated Tribes of the Colville Reservation, Nespelem, WA

[1] 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.

- **Mr. Lee Spoonhunter**, Billings Area Representative, National Indian Health Board Washington, D.C.
- **Ms. Jerilyn Church**, Executive Director, Great Plains Tribal Leaders Health Board, Rapid City, SD

III. BACKGROUND

The Restoring Accountability in the Indian Health Service Act would amend the Indian Health Care Improvement Act (IHCIA)[2] to improve incentives for recruitment and retention of Indian Health Service (IHS) employees, improve hiring practices for IHS, streamline processes for dismissal of Senior Executive Service (SES) and IHS employees for misconduct, improve data collection for IHS with the goal of improving quality of care, create standards to measure timeliness of care, and establish procedures to get and give relevant information from state medical boards regarding practitioners. The bill would also enhance whistleblower protections and clarify the right of IHS employees to petition Congress. Several provisions are included that would increase fiscal accountability and require reporting on the implementation of provisions of the bill to determine efficacy.

Background on Indian Healthcare and Issues with the Indian Health Service

The Federal government's role in providing health services to American Indians and Alaska Natives (AI/ANs) is based in the U.S. Constitution's Indian Commerce Clause,[3] treaties between the U.S. Federal Government and Indian tribes, and federal statutes. The modern statutory basis for the federal provision of healthcare to AI/ANs is the IHCIA.[4] First passed in 1976, IHCIA was reauthorized four times by Congress to work towards combatting the major health disparities seen amongst AI/ANs. The IHCIA was permanently reauthorized by the Patient Protection and Affordable Care Act in 2010.[5]

Issues with IHS direct service[6] providers and facilities have long been an ongoing topic of concern for Congress. In 2010, a major congressional review of the IHS Great Plains Area (GPA) by the Senate Committee on Indian Affairs (SCIA) detailed serious deficiencies at IHS facilities.[7] A hearing and its subsequent investigative findings were released by SCIA in the Dorgan Report in December 2010.[8] The Report described in vivid detail a wide range of deficiencies inside the GPA, related to both medical care and administrative procedures.[9]

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[2] P.L. 94-437.
[3] U.S. Const. Art. I, Sec. 8, Clause 3.
[4] 25 U.S.C. 1611 et seq.
[5] Indian Health Care Improvement Act. Indian Health Service. https://www.ihs.gov/IHCIA/.
[6] Direct Service means health care provided by IHS federal employees at IHS facilities to American Indians and Alaska Natives. *See*, "Direct Service Tribes" *Indian Health Service*, https://www.ihs.gov/odsct/dst/.
[7] U.S. Senate. Committee on Indian Affairs. In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area, 2010. https://www.govinfo.gov/content/pkg/CHRG-111shrg63826/pdf/CHRG-111shrg63826.pdf . 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.

Further issues in the GPA surfaced in July 2015, when the Centers for Medicare & Medicaid Services (CMS) terminated its provider contract with the Omaha-Winnebago IHS hospital in Nebraska, an action that CMS had previously threatened.[10] In 2015 and 2016, CMS also surveyed three IHS hospitals in South Dakota. The Rosebud, Pine Ridge, and Rapid City (Sioux San) service units[11] were subsequently cited for quality and safety problems.[12] At Rosebud, the quality of care in the Emergency Department was found to be so poor that 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 placed a serious physical and financial strain on the Rosebud ambulance system, resulting in at least nine patients dying during transit to those facilities during the seven months post emergency room closure.[13]

Other IHS Areas also continue to experience problems. In 2016 in the IHS Nashville Area, a residential treatment facility for Native youth operated by IHS failed to properly investigate or report allegations of sexual abuse of residents.[14] This finally came to light in 2019 with reports by Smokey Mountain News[15] and the Wall Street Journal.[16] In the Portland Area, for Fiscal Year (FY) 2021, 100 percent of dentist positions and 50 percent of senior physician and nursing positions were vacant.[17] These examples are illustrative of the longstanding issues of staffing[18] and healthcare provider misconduct, including sexual abuse and physical assault,[19] across all of IHS.

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[10] 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.

[11] IHS Service Units is an administrative unit in a defined geographical area through which services are directly or indirectly provided to American Indians and/or Alaska Natives. See, Elayne Heisler, "The Indian Health Service (IHS): An Overview" Congressional Research Service, https://crsreports.congress.gov/product/pdf/R/R43330. At 4

[12] 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/.

[13] 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/ and 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/.

[14] Holly Kays, "Report highlights bungled aftermath of sexual abuse claims at teen rehab center," *Smokey Mountain News.* Jun. 15, 2022. https://smokymountainnews.com/archives/item/33778-report-highlights-bungled-aftermath-of-sexual-abuse-claims-at-teen-rehab-center.

[15] Holly Kays, "Indian Health Service examines issues at Unit Healing Center," *Smokey Mountain News.* Aug. 14, 2019. https://smokymountainnews.com/archives/item/27455-indian-health-service-examines-issues-at-unity-healing-center.

[16] Christopher Weaver, "A Suicide Attempt, an Order to Keep Silent: A U.S. Agency Mishandled Sex-Abuse Claims," *Wall Street Journal.* June 7, 2019. https://www.wsj.com/articles/a-suicide-attempt-an-order-to-keep-silent-a-u-s-agency-mishandled-sex-abuse-claims-11559923793.

[17] Gemma DiCarlo, "New Indian Health Service funding provides stability, but long-standing issues remain," *Oregon Public Broadcasting*. Jan. 20, 2023. https://www.opb.org/article/2023/01/20/new-indian-health-service-funding-provides-stability-but-long-standing-issues-remain/.

[18] Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies." Aug. 2018. GAO-18-580. https://www.gao.gov/assets/gao-18-580.pdf.

[19] Government Accountability Office, "Indian Health Service: Actions Needed to Improve Oversight of Provider Misconduct and Substandard Performance." Dec. 2020. GAO-21-97. https://www.gao.gov/assets/gao-21-97.pdf.

In March 2017, the Government Accountability Office (GAO) listed IHS as "high risk." Programs listed on the GAO's High-Risk List are federal programs most vulnerable to waste, fraud, abuse, and mismanagement, or that need transformative change. For nearly a decade, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) and others have indicated 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.

In 2023, IHS finalized an agency work plan to address agency wide priorities of patient safety, human capital, operational capacity, financial capacity, compliance and regulatory improvement, and strategic planning. IHS states the goal of the plan is to "make an immediate impact on the Indian health system in alignment with the IHS mission and Strategic Plan."[20]

IV. MAJOR PROVISIONS

Discussion Draft of H.R. ____ (Rep. Johnson of SD), the *Restoring Accountability in the Indian Health Service Act of 2023.*

Improving Incentives for Recruitment and Retention of IHS Employees

The Restoring Accountability in the Indian Health Service Act would add to the IHS's current hiring and retainment practices by realigning the IHS pay system with the Veterans' Health Administration (VHA), establishing a temporary housing rental assistance program for IHS staff, and expanding the student loan repayment program.

Like many rural healthcare providers, IHS has historically faced challenges when it comes to hiring and retaining providers. In a 2018 GAO report, data showed vacancy rates between 13 to 31 percent across eight IHS geographical areas with an average of 25 percent for physicians, nurses, nurse practitioners, dentists, pharmacists, and other needed medical staff.[21] There are many reasons for these high vacancy rates including IHS facilities being in rural areas, lack of favorable scheduling options, and limited paid time off. Historically, IHS has relied upon recruitment, retention, and relocation incentives, as well as specific Title 38 pay authorities related to federal pay rates and systems, premium pay, classifications, and hours of work. IHS is not able to use all provisions under Title 38 due to specific restrictions implemented by 5 U.S.C. § 5371, which is the standing authority IHS abides.[22]

Compared to the private sector as well as the VHA, IHS lacks recruitment incentives that both the public sector and VHA can offer. VHA provides health care employees with one day of annual leave per pay period for all physicians, dentists, podiatrists, optometrists, and chiropractors and eight hours of annual leave per pay period for all nurses, physician assistants, and expanded-function dental auxiliaries. Under 5 U.S.C. § 5371, IHS is only able to provide

[20] "IHS 2023 Agency Work Plan," *Indian Health Service.* https://www.ihs.gov/quality/work-plan-summary/.
[21] Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies." Aug. 2018. GAO-18-580. https://www.gao.gov/assets/gao-18-580.pdf.
[22] IHS FY 2024 Justification. *Indian Health Service*. At CJ-287 https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ32223.pdf#page=302.

four to six hours of paid time off depending on the position. This disparity has led good candidates to take offers elsewhere and contributed to the lack of filled positions at IHS.[23] IHS continues to seek the discretionary use of Title 38 in relation to health care positions to compete alongside the VHA as well as private sector jobs.[24] Section 101 of the Restoring Accountability in the Indian Health Service Act amends IHCIA to create a comparable pay system that the VHA uses in chapters III and IV of chapter 74 of Title 38.

Housing availability is frequently one of the cited reasons that rural areas cannot attract or retain workers.[25] Housing is an essential amenity, and good housing near schools and other daily life attributes is essential for most Americans, especially those with families. Many IHS service areas are in rural areas where an individual would need to commute close to 60 miles one-way in order to live near every-day necessities.[26] Even if an employee is willing to forego these necessities, other challenges can arise when it comes to living on tribal land. For example, Navajo area officials have stated that non-native providers, who are not at least married to a tribal member typically must live off the reservation unless housing is provided by IHS.[27] Section 101of the legislation would create a tenant-based rental assistance program that would be an added benefit to critical employees who agree to work for at least one year at a specified IHS unit that has a shortage of health professionals. It would be a temporary program and HHS would be required to report on its efficacy after the program ends.

Section 104 of the legislation would expand the loan repayment program to part-time workers, requiring professionals to serve in half-time practice for up to four years to get the benefit. Currently IHS's loan repayment program is limited to individuals serving full-time for two years.[28] Comparatively, the National Health Service Corps (NHSC) allows its participants to work part-time for a longer period of time and receive the same benefit. NHSC's part-time option allows for flexibility not seen at IHS and attracts a higher number of participants. Flexibility is a large selling point for practitioners, especially those looking to maintain their private-practice work, or administrative roles. By providing an alternative pathway to repayment, IHS may attract more providers for their rural service areas.[29]

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[23] Id.
[24] Id.
[25] Jordan Lofthouse. "Improving Accountability and Performance in the Indian Health Service." *Mercatus Center.* January 31, 2022. https://www.mercatus.org/research/policy-briefs/improving-accountability-and-performance-indian-health-service and Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies." Aug. 2018. GAO-18-580. https://www.gao.gov/assets/gao-18-580.pdf.
[26] Summary of Recruitment and Retention Challenges. Indian Health Service. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2016_Letters/Enclosure2_IHSSummarySheet_WorkforceChallenges.pdf.
[27] Sara Heath. "Patient Care Access Suffers Under IHS Clinician Shortage Problems." *Patient Care Access News.* August 20, 2018. https://patientengagementhit.com/news/patient-care-access-suffers-under-ihs-clinician-shortage-problems.
[28] IHS FY 2024 Justification. At CJ-289. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ32223.pdf.
[29] Id.

Improving Hiring Practices for IHS Employees

IHS's 25 percent vacancy rate equates to roughly 1,400 vacancies,[30] which leads to a lack of quality patient care, stressed and disenfranchised employees, and a decrease in availability for patients to see providers. IHS has stated they need increased flexibility when it comes to hiring procedures. The Restoring Accountability in the Indian Health Service Act would build upon IHS's current hiring practices by suspending Indian Preference and granting a Direct-Hire Authority.

In their FY 2024 budget justification, IHS concluded that Indian Preference could have negative impacts on the timeliness by which a job opening is filled.[31] They cited examples during which the Indian Preference candidate is either unqualified or has a record of disciplinary measures. IHS would like the ability to waive Indian Preference requirements in a limited capability and for urgent situations in hopes of lowering the number of vacancies.[32] Section 105 of the bill allows for Indian Preference to be waived at the request of a tribe when there has been a constant staffing shortage impacting care.

Direct-Hire Authority allows agencies to bypass certain standard federal hiring procedures to appoint candidates directly to positions when there is a severe shortage of candidates or a critical hiring need to fill positions that the standard hiring procedures are not filling.[33] The standard hiring procedures that are usually bypassed include: the competitive rating and ranking, veterans' preference, and a "rule of three" selection requirement, which allows managers to only select from the three highest scoring applicants.[34] There is already a government wide authority in place, which allows the Office of Personnel Management (OPM) to issue Direct-Hire Authority in two ways: 1) an agency can submit a request to OPM for specific positions or 2) OPM can independently decide that a severe shortage or critical hiring need exists for specific positions in a specific location or government wide.[35]

As mentioned above, there is a dire need to fill many positions throughout IHS. The Restoring Accountability in the Indian Health Service Act would grant IHS Direct-Hire Authority. The bill still applies statutory requirements that candidates must have registered for the selective service and cannot be recommended by a Member of Congress, unless speaking to a candidates character or residence.

[30] Id. at CJ-293.
[31] Id.
[32] Id.
[33] "Direct Hire Authority Fact Sheet," OPM, https://www.opm.gov/policy-data-oversight/hiring-information/direct-hire-authority/#url=Fact-Sheet.
[34] Id. and David Scholl, "Direct Hire Authority for Federal Jobs" FederalJobs.Net, Jan. 14, 2022, https://federaljobs.net/blog/direct-hire-authority-for-federal-jobs/.
[35] "Direct Hire Authority Fact Sheet" OPM, https://www.opm.gov/policy-data-oversight/hiring-information/direct-hire-authority/#url=Fact-Sheet.

Streamlining Dismissal Processes for SES And IHS Employees

The Restoring Accountability in the Indian Health Service Act would make changes to the civil service systems for both IHS senior executives (SES) and employees to allow for quicker removal and penalty for misconduct as defined by the bill.

According to OPM, the federal workforce consists of an estimated two million civilian employees, categorized into three types of service—the competitive service, the excepted service, and the Senior Executive Service (SES)—that are distinguished by different selection, compensation, and other standards.[36] Title 5 of the U.S. Code contains most of the standards governing federal employment, and OPM is generally responsible for implementing these requirements.[37]

Federal employees receive statutory protections that differ from those of the private sector, including more robust limits on when they can be removed or demoted.[38] The Civil Service Reform Act of 1978 (CSRA) created a comprehensive system for reviewing actions taken by most federal agencies against their employees, and the act provides a variety of legal protections and remedies for federal employees. It also funnels review of agency decisions to the Merit Systems Protection Board (MSPB), subject to review by the United States Court of Appeals for the Federal Circuit (Federal Circuit).[39] Currently, most of these provisions cover IHS SES and employees.

Section 106 of the Restoring Accountability in the Indian Health Service Act would change the dismissal process to reduce the time it takes to file and get action on a grievance based on misconduct of an IHS senior executive or employee. The bill preserves several rights and procedures for SES and employees but condenses the timeline for IHS to act on possible misconduct. Under the bill, IHS would be required complete notice to SES or employee, allow a response from the SES or employee, and issue a decision on what punishment the SES or employee would receive for their misconduct in 15 business days. An SES or employee may challenge that decision and IHS must act on that challenge no later than 21 business days after the challenge process was initiated. An SES may then challenge that final decision through judicial review, while an IHS employee can appeal to the MSPB. Removing the ability for SES level personnel to appeal to the MSPB is a departure from current law. The legislation also details restrictions on how the MSPB can deal with employee appeals, including requiring MSPB to operate on a strict timeline to issue administrative law decisions and limiting the ability of MSPB to mitigate penalties put in place by IHS. Given the drastic misconduct that has occurred at IHS facilities in the past, there is reason to consider changing the current grievance system in place for IHS personnel to ensure those that commit misconduct are removed promptly.

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[36] Jon Shimabukuro and Jennifer Stamen, "Categories of Federal Service Employment: A Snapshot, *Congressional Research Service*, Mar. 26, 2019, *available at:* https://www.crs.gov/Reports/R45635
[37] Id.
[38] Jared Cole, "The Civil Service Reform Act: Due Process and Misconduct-Related Adverse Actions" *Congressional Research Service*, Mar. 29, 2017, *available at:* https://www.crs.gov/Reports/R44803.
[39] Id.

The bill also includes provisions that require IHS to get information from state medical boards about practitioners within the hiring process, as well as provide information about violations by the provider while they work at IHS. This type of requirement is necessary in light of a Wall Street Journal (WSJ) and Frontline analysis of 163 malpractice claims against the IHS that the agency settled or lost since 2006.[40] It found around 25% of doctors involved in those claims worked for IHS even though they had a medical practice history that should have raised concerns by IHS's own standards.[41]

Improving Quality of Care for IHS Patients

IHS's continued shortcomings impact the quality-of-care tribes receive. The unmet staffing needs at IHS have led the way for the concerning hiring practices seen at IHS. The lack of staff throughout Service areas has contributed to a lower quality of care for tribes. In a 2019 report, the vacancy rate for IHS physicians was 29 percent while the industry average was 18 percent.[42] IHS officials have stated that the unmet staffing needs have led to a negative impact on patient access, quality of care, and even employee morale.[43]

Section 108 of the Restoring Accountability in the Indian Health Service Act would establish a demonstration project to provide IHS service units with staffing resources. This demonstration project would sunset after four years, but the goal of the project would be for the supplemental staffing resources to lead way for a self-sustaining model that would work to combat the massive staffing shortages that have contributed to the subpar care seen throughout IHS.

Section 111 of the Restoring Accountability in the Indian Health Service would establish a compliance assistance program to provide on-site consultation and educational programming for facilities to ensure they meet conditions of participation under Medicare and are satisfactorily implementing quality initiatives established by IHS and CMS. The creation of such a program would assist in ensuring that the standards of care are matched.

Staffing shortcomings do not stop at the hiring process and plague IHS generally. During a Senate Committee on Indian Affairs (SCIA) hearing in June of 2017, then Acting Director of IHS Chris Buchanan testified that IHS recently awarded a contract for credentialing software with the goal of standardizing the credentialing system.[44] During FY 2022, IHS's Office of Quality continued implementing a standardized credentialing practices through both software implementation and process training across IHS areas.[45] IHS also issued a request for public comment in May 2023 related to the Indian Health Service Medical Staff Credentials Application, indicating IHS is still working to standardize some aspects of the current centralized

[40] Christopher Weaver, et. al. "The U.S. Gave Troubled Doctors a Second Chance. Patients Paid the Price," Frontline. PBS.2019. https://www.pbs.org/wgbh/frontline/article/u-s-indian-health-service-gave-troubled-doctors-second-chance-patients-paid-price/.
[41] Id.
[42] Id.
[43] Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies." Aug. 2018. GAO-18-580. https://www.gao.gov/assets/gao-18-580.pdf.
[44] Chris Buchanan Testimony. June 2017. https://www.indian.senate.gov/sites/default/files/upload/6.13.17%20Chris%20Buchanan%20Testimony.pdf.
[45] IHS FY 2024 Justification. At CJ-49, CJ-50.

medical credentialling system.[46] Continuously, IHS has promised changes to their medical credentialing service, acknowledging the shortcomings and the impact on their patients. The lack of a uniformed, standardized credentialing system has allowed doctors with a history of malpractice claims to find work at IHS facilities.

For example, Henry Stachura found a new career at IHS, one which resulted in the deaths of three of his patients, despite having faced his fifth malpractice lawsuit in five years after his patient died on the operating table at his previous employment.[47] The WSJ found that IHS managers did not always make basic inquiries about applicant work histories, when their investigation uncovered that the IHS official who approved Stachura's employment said he was unaware of the surgeon's malpractice history. A centralized, implemented credentialing system could have given IHS personnel more information about their applicant, which may have prevented IHS from hiring in the first place. Section 102 would direct IHS to establish a uniformed and centralized Service-wide credentialing system for anyone providing services at IHS.

Section 114 would require IHS to solicit from the medical board of each state in which an applicant is licensed the applicant's history as far as violations and settlements. This additional step could circumvent instances in which IHS has hired an individual with a long list of medical malpractices under one state license but maintained a clear license in another. Such is the case with Dr. Marrocco who was hired at an IHS hospital in New Mexico in 2012 despite disciplinary measures on her licenses in New York and Florida. IHS officials were concerned they could not hire Dr. Marrocco under IHS guidelines due to the marks on those licenses, but her Pennsylvania license was clean, so IHS was able to employ her. Dr. Marrocco went on to miss the early stages of a stroke for an eighteen-year-old patient who now is unable to walk or speak.[48]

Enhancing Whistleblower Protections

The Restoring Accountability in the Indian Health Service Act would increase protections of whistleblowers, and would clarify the right of a federal employee to petition Congress.

There are several statutes that apply to federal employees and detail their right to speak out about misconduct, mismanagement, and waste, fraud, and abuse, some are government wide, and some are tied to a specific agency.[49] Whistleblowers are also allowed to keep their anonymity,[50] and cannot be retaliated against.[51] Sections 201 and 202 of this bill would apply specific

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[46] Request for Public Comment: 60-Day Information Collection: Indian Health Service Medical Staff Credentials Application, 88 Fed. Reg. 30317 (May 11, 2023). *available at*: https://www.federalregister.gov/documents/2023/05/11/2023-09998/request-for-public-comment-60-day-information-collection-indian-health-service-medical-staff.

[47] Christopher Weaver, et. al. "The U.S. Gave Troubled Doctors a Second Chance. Patients Paid the Price," Frontline. PBS. Nov. 22, 2019. https://www.pbs.org/wgbh/frontline/article/u-s-indian-health-service-gave-troubled-doctors-second-chance-patients-paid-price/.

[48] Id.

[49] See, Andrea M. Muto, "Compilation of Federal Whistleblower Protection Statutes," *Congressional Research Service*. Available at: https://www.crs.gov/Reports/R46979.

[50] "Whistleblower Protection Laws for Federal Employee Whistleblowers" National Whistleblower Center. https://www.whistleblowers.org/whistleblower-protection-laws-for-federal-whistleblowers/.

[51] 5 U.S.C. § 2302(b)(8), (9).

whistleblower protections to IHS employees. These sections would require IHS employees that witness whistleblower retaliation or patient safety violations to submit a report to a non-IHS official, give IHS the authority to enhance whistleblower protections, and ensure that IHS employees have the right to petition Congress by subjecting IHS employees who interfere with a petition to Congress to penalties including suspension or pay grade reduction.

These specific protections for whistleblowers reflect the issues IHS has had in dealing with misconduct by IHS employees when it is brought to the agency's attention. For example, the horrific case of Stanley Patrick Weber, who had a shroud of concerns and questions surrounding him for over 20 years, but he remained employed by IHS. It wasn't until 2016 when he was under active investigation for sex-abuse allegations did Weber resign. Weber was convicted of sexual crimes involving children under his care at his in 2018 in Montana and again in 2019 in South Dakota.[52] A Frontline investigation published in February 2019 uncovered the years of warnings, whistleblowers, and evidence that was swept under the rug while Weber remained employed and actively abusing children.[53] Multiple attempts by whistleblowers were ignored, including Mark Butterbrodt who upon raising the alarm found himself transferred to another agency hospital, where he would later quit.[54]

While IHS has made strides to improve standards, such recent concerns with these sorts of deeply disturbing actions by even a few medical practitioners at IHS merit further oversight by Congress as well as consideration of stricter statutory requirements that could prevent cases like Weber from happening again.

Oversight and Technical Provisions

The Restoring Accountability in the Indian Health Service Act includes several oversight provisions including fiscal accountability requirements in section 203 and agency reporting requirements in sections 302 to 305. The bill also includes several provisions ensuring that certain provisions that may affect a 638 compact or contract authority with a tribe do not impact a previously established compact or contract unless agreed to by the tribe itself and would require tribal consultation on specific topics. In section 103, the bill would also extend liability protections to certain IHS volunteers mirroring what employees of IHS currently have.

V. SECTION-BY-SECTION

Title I—Indian Health Service Improvements

Section 101. *Incentives for Recruitment and Retention.* Requires HHS to establish a competitive pay system for physicians, dentists, nurses, and other health care professionals; authorizes HHS to establish a tenant-based housing rental assistance program for IHS employees who qualify as critical, and who agree to serve for at least one year. The housing rental program would sunset

[52] Christopher Weaver, "Former U.S. Indian Health Service Doctor is Found Guilty of Abusing Boys," *Frontline.* Sept. 27, 2019. https://www.pbs.org/wgbh/frontline/article/former-u-s-indian-health-service-doctor-is-found-guilty-of-abusing-boys/.
[53] Christopher Weaver, et. al. "A Pedophile Doctor Drew Suspicions for 21 Years. No One Stopped Him." *Frontline*. Feb. 8, 2019. https://www.pbs.org/wgbh/frontline/article/patrick-stanley-weber-sexual-abuse-pine-ridge-blackfeet-reservation/.
[54] *Id.*

after three years, and HHS will have one year to compile and provide to Congress a report detailing the cost and effectiveness of the program.

Section 102. *Medical Credentialing System.* Directs IHS to establish, in consultation with tribes and stakeholders, a uniformed and centralized Service-wide credentialing system for individuals providing services at IHS facilities; authorizes IHS to enhance and expand its existing credentialing system to meet the requirements listed; requires IHS to undergo a formal review of its credentialing service to ensure all guidelines are met. Current credentialed employee would be grandfathered into the new system and would not be re-credentialed until expiration date of current credentials.

Section 103. *Liability Protections for Health Professional Volunteers at Indian Health Service.* Extends liability protection under the Public Health Service Act (42 U.S.C. 233) to volunteer health care professionals volunteering at an IHS service unit.

Section 104. *Clarification Regarding Eligibility for Indian Health Service Loan Repayment Program.* Expands the eligibility of the Indian Health Service Loan Repayment Program (IHSLRP) to include individuals with master's degrees in certain business and health-related fields, and to professionals serving at IHS in a half-time capacity for up to four years.

Section 105. *Improvements in Hiring Practices.* Provides IHS with Direct-Hire Authority; requires IHS to notify tribes in the corresponding geographical area of personnel changes for Senior Executive Service positions and managing positions at Area offices and Service Units; gives tribes ten days to submit comments to HHS on the personnel change; allows a tribe to waive Indian Preference laws for open positions at IHS units with continue staffing issues.

Section 106. *Improved Authorities of Secretary to Improve Accountability of Senior Executives and Employees of the Indian Health Service.* Streamlines and shortens the timeline for HHS to suspend, remove, or otherwise penalize an IHS Senior Executive Service or employee for misconduct (defined as neglect of duty, malfeasance, failure to accept directed reassignment, and failure to accompany a position in a transfer of function). The section also establishes rights and procedures for covered individuals in Senior Executive Service positions and IHS employees subject to such a personnel action, including notice of action, legal representation, grievance of agency decision, judicial review, and in the case of IHS employees, Merit Systems Protection Board appeals.

Section 107. *Tribal Culture and History.* Mandates annual tribal culture and history annual training program for IHS employees.

Section 108. *Staffing Demonstration Program.* Directs HHS to establish a demonstration program for three years to terminate after 4 years to support staffing at Service units through additional resources with the goal of creating a self-sustaining unit; requires HHS to submit an evaluation of the demonstration project to Congress. Prioritization will be given to Service units with historical staffing shortages, whose states have certain Medicaid reimbursement policies, and whose facilities are built in part with Tribal funds or are in a Service unit's master plan.

Section 109. *Rule Establishing Tribal Consultation Policy.* Requires HHS to update its tribal consultation policy for IHS by December 31, 2023, and update the policy every five years after.

Section 110. *Treatment of Certain Hospitals.* Makes permanent the 2018 CMS inpatient prospective payment system (IPPS) Final Rule clarifying that eligibility for the IPPS low-volume hospital designation for IHS hospitals is not dependent upon its distance from the nearest non-IHS IPPS hospital, and vice versa. This policy would only apply to IHS hospitals' whose sole disqualifier is distance.

Section 111. *Enhancing Quality of Care in the Indian Health Service.* Requires HHS to consult with Indian tribes, governing boards, Area offices, Service units, and other stakeholders to establish best practices for governing boards that contain provisions related to facility compliance with IHS and CMS programs and requirements related to reporting, documenting, and responding to patient complaints, and documenting instances of professional misconduct by facility staff; requires HHS to establish best practices for Area offices with provisions related to strategies for how to properly monitor governing board activities regarding patient complaints and compliance with IHS and CMS program requirements.

Requires HHS, in coordination with the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), Tribes, and IHS, to undertake a review of quality and performance measures of Service facilities used in Government Performance and Results Act (GPRA) and CMS programs; requires HHS to submit a report to Congress on the suitability of these measures for IHS facilities and the extent to which they are outcome-based or process-based; Requires HHS to assist IHS facilities in adopting more suitable quality and performance measures under GPRA and CMS; requires GAO to submit a report to Congress on challenges relating to quality measure and data collection in IHS facilities, no later than one year after HHS submits a similar report to Congress.

Directs HHS, in coordination with CMS and Quality Improvement Organizations (QIO), to establish a compliance assistance program for underperforming Medicare-participating facilities operated by IHS; tribal facilities have the option to participate. Eligibility for the compliance assistance program considers staff turnover, severity and number of facility deficiencies, the history of provider misconduct and patient harm, and poor performance on quality measures. HHS shall select at least 25 percent of eligible facilities to participate in the compliance assistance program for two years, with the option for HHS to remove a facility from the program if it makes satisfactory improvement. The program provides on-site consultation and educational programming for facilities to ensure they meet conditions of participation under Medicare and are satisfactorily implementing quality initiatives established by IHS and CMS. This program terminates after six years, and GAO must submit a report to Congress evaluating its effectiveness upon termination.

Section 112. *Notification of Investigation Regarding Professional Conduct; Submission of Records.* Requires IHS to notify and provide relevant records to State Medical Boards no later

than 14 calendar days after starting an investigation into the professional conduct of a licensee practicing at an IHS facility.

Section 113. *Fitness of Health Care Providers.* Requires the IHS in the agency's hiring process to solicit from all medical boards of states where an applicant has a medical license information on the applicant's history of license violations or settlements over the previous 20 years; Requires IHS 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; Requires IHS submit a report to Congress regarding its compliance of these policies no later than 180 days after enactment.

Section 114. *Standards to Improve Timeliness of Care.* Requires IHS to establish regulatory standards to measure the timeliness of health care services provided in in IHS facilities; requires each Service unit to be provided these new standards and collect all necessary data; Requires Area offices to submit yearly reports to HHS on the standards.

Title II—Employee Protections

Section 201. *Employee Protections Against Retaliation.* Requires IHS employees who witness whistleblower retaliation or a violation of patient safety requirements to submit a report to a non-IHS official within HHS; authorizes HHS to remove an IHS employee from the civil service for whistleblower retaliation; authorizes HHS to take actions to enhance whistleblower protections.

Section 202. *Right of Federal Employees to Petition Congress.* Clarifies that an employee who interferes with the right to petition Congress may be subject to suspension or pay grade reduction; requires IHS to submit to the Inspector General of HHS a memorandum detailing the right of a covered employee to petition Congress within 30 days after enactment; requires the Inspector General to either approve or disapprove the memorandum within 30 days; requires HHS to provide an electronic copy to each IHS employee informing them of their right.

Section 203. *Fiscal Accountability.* Prohibits IHS from providing salary increases or bonuses for certain political appointees and Senior Executive positions if the agency does not submit required professional housing and staffing plans to GAO by the statutory deadline outlined in Section 302; Requires IHS to consult with tribes to use unobligated funds and third-party collections for any costs related to essential medical equipment, and staffing. These funds are expressly prohibited from being used to increase pay for Area office employees, or to remodel any Area offices.

Requires that no later than 90 days after the end of the fiscal year, the Secretary must submit a report describing its authorization, outlays, and transfers of funding of each level of IHS (headquarters, Area, Service, clinic/facility) to each Indian tribe and specified Congressional committees; Requires IHS to provide annual reports to the aforementioned entities regarding the safety, billing, certification, credentials, and compliance of each IHS-supported facility

Title III—Reports

Section 302. *Reports by the Secretary of Health and Human Services.* Requires HHS to develop, and make publicly available, plans related to providing for the housing needs for IHS employees and staffing needs for IHS facilities, including tribal health programs; requires HHS to submit these reports to Congress and GAO within one year of enactment.

Section 303. *Reports by the Comptroller General.* Requires GAO to submit reports to Congress assessing the housing needs and staffing needs reports described in Section 302 within two years of receiving the reports; requires GAO to issue a report on the efficacy of existing IHS whistleblower protections and accompanying policy recommendations within one year of enactment.

Section 304. *Inspector General Reports.* Requires the Inspector General of HHS to report to Congress and IHS patient harm events and deaths occurring in Service units and deferrals and denials of patient care, within two years of enactment; requires the Inspector General of HHS conduct an audit of IHS's reporting systems and provide recommendations and technical assistance to address such reporting systems within two years of enactment.

Section 305. *Transparency in CMS Surveys.* Requires CMS to conduct surveys, at least once every 2 years, of Medicare-participating hospitals' and skilled nursing facilities' compliance with conditions of participation and the Emergency Medical Treatment and Labor Act (EMTALA). Such surveys are to be publicly posted on the Internet, subject to HIPAA privacy protections.

Title IV—Technical Amendments
Section 401. *Technical Amendments.*

VI. CBO COST ESTIMATE

Unknown.

VII. ADMINISTRATION POSITION

Unknown.

VIII. EFFECT ON CURRENT LAW (RAMSEYER)

Discussion Draft, H.R. ____ *"Restoring Accountability in the Indian Health Service Act of 2023"*