HOUSE COMMITTEE ON
NATURAL RESOURCES
CHAIRMAN BRUCE WESTERMAN

To:	House Committee on Natural Resources Republican Members
From:	Indian and Insular Affairs Subcommittee, Ken Degenfelder (Ken.Degenfelder@mail.house.gov) and Jocelyn Broman (Jocelyn.Broman@mail.house.gov); ext. 6-9725
Date:	Wednesday, March 29, 2023
Subject:	Oversight Hearing: "*Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities*"

The Subcommittee on Indian and Insular Affairs will hold an oversight hearing: "*Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities*" on **Wednesday, March 29, 2023, 10:00 a.m. in Room 1324 Longworth House Office Building**.

Member offices are requested to notify Ransom Fox (Ransom.Fox@mail.house.gov) by 4:30 p.m. on Tuesday, March 28, 2023, if their member intends to participate in the hearing.

I. KEY MESSAGES

- The Federal government has assumed the responsibility of providing healthcare for American Indians and Alaska Natives (AI/ANs) through treaties and federal statutes. The Indian Health Service (IHS) is the primary agency charged with providing health services to AI/AN communities throughout the United States.

- AI/ANs currently have much lower health outcomes than the average American, including lower life expectancy and disproportionate disease burdens.[1]

- IHS has long been plagued with issues of substandard medical care, high staff vacancy rates, aged facilities and equipment, and unqualified or predatory healthcare staff. Many of these issues first came to national attention after a 2010 Senate report on the failings of IHS facilities in the IHS's Great Plains Area.

- In 2017, the Government Accountability Office (GAO) placed IHS on their high-risk list as one of the government programs and operations vulnerable to waste, fraud, abuse, or mismanagement, or in need of transformation.

[1] "Disparities" *Indian Health Service*. https://www.ihs.gov/newsroom/factsheets/disparities/.

- In 2023, IHS began developing and implementing an agency work plan to "make an immediate impact on the Indian health system in alignment with the IHS mission and Strategic Plan."[2]

- This hearing will explore solutions that can be implemented to modernize the IHS system and combat substandard medical care plaguing IHS facilities.

- Despite ample notice of the hearing date and the importance of the subject matter, the Indian Health Service has declined to appear before the Subcommittee to testify on the many issues facing the service and impacting the lives of millions of AI/ANs throughout the United States.

II. WITNESSES

- **Director Tso,** Director, Indian Health Service, U.S. Department of Health and Human Services, Washington, DC *[Invited]*

- **Ms. Janet Alkire**, Board Member, National Indian Health Board, Washington, DC

- **Ms. Jerilyn Church**, Executive Director, Great Plains Tribal Leaders Health Board, Rapid City, SD

- **Ms. Laura Platero**, Executive Director, Northwest Portland Area Health Board, Portland, OR

- **Ms. Maureen Rosette**, Board Member, National Council of Urban Indian Health, Washington, DC [Minority Witness]

III. BACKGROUND

Providing health services to AI/ANs is based in the U.S. Constitution's Indian Commerce Clause[3] and in treaties between the U.S. Federal Government and tribes. They form the basis of the trust relationship between the federal government and federally recognized tribes. The Snyder Act of 1921[4] provided the legislative authority to the Bureau of Indian Affairs (BIA) for the federal provision of health services and benefits to Indians because of their federally recognized tribal status. The Transfer Act of 1954[5] moved the responsibility to provide healthcare to tribes from the BIA into the Department of Health Education & Welfare, which was the precursor to the U.S. Department of Health and Human Services (HHS).[6] IHS was officially established in 1955.[7]

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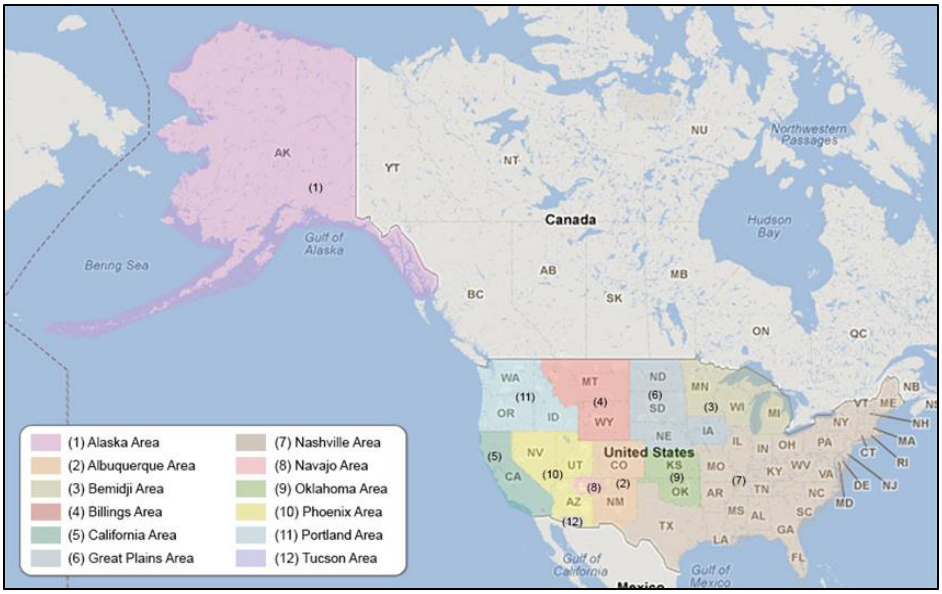
[2] "IHS 2023 Agency Work Plan," *Indian Health Service.* https://www.ihs.gov/quality/work-plan-summary/.
[3] U.S. Const. Art. I, Sec. 8, Clause 3
[4] 25 U.S.C. 13.
[5] P.L. 83-568, act of August 5, 1954, 68 Stat. 674, as amended; 42 U.S.C. §2001 et seq.
[6] "Agency Overview," *Indian Health Service*, https://www.ihs.gov/aboutihs/overview/.
[7] "'If You Knew the Conditions..." Health Care to Native Americans: Indian Health Service Today." *National Institutes of Health*, U.S. National Library of Medicine, last updated, Nov. 23, 2010. https://www.nlm.nih.gov/exhibition/if_you_knew/ifyouknew_02.html

The modern statutory basis for the federal provision of healthcare to Indians is the Indian Healthcare Improvement Act (IHCIA).[8] IHCIA was permanently reauthorized in Title X of the Patient Protection and Affordable Care Act.[9] Today, IHS is an agency of HHS that provides healthcare to approximately 2.7 million AI/ANs through a network of more than 600 hospitals, clinics, and health stations on or near Indian reservations.[10]

Organizationally, the IHS is composed of 12 regions, or "areas," with each area having a separate headquarters.[11] Each of the twelve areas serve the tribes within their region. These area offices report to IHS Headquarters based in Rockville, Maryland.



Source: Regional (Area) Offices *as of March 2022,* Indian Health Service, https://www.ihs.gov/aboutihs/organizationalstructure/

IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive healthcare in 37 States.[12]

The agency offers healthcare in two ways:
1) through "direct-service" healthcare, meaning care provided by federal employees employed by the agency; and
2) through 638 compacting or contracting authority, through which a tribe chooses to act as a conduit for federal funds and independently operate their own tribal health facilities under authorities provided by the Indian Self-Determination and Education Assistance Act (ISDEAA).[13] 638 compacts are implemented under Title V of ISDEAA, and 638 contracts are implemented under Title I of ISDEAA. Both Title V and Title I provide for tribal administration of programs that would normally be administered by the IHS. The major difference is a matter of oversight. Under Title V, a tribe may redesign or consolidate programs, services, functions, or

[8] 25 U.S.C. 1611 et seq.
[9] P.L. 111-148.
[10] Indian Health Service Budget Justification FY 2024 at CJ-2. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ31423.pdf.
[11] "Locations" *Indian Health Service*. https://www.ihs.gov/locations/.
[12] Indian Health Service Budget Justification FY 2024 at CJ-2. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ31423.pdf.
[13] 25 U.S.C. 5304 et seq.

activities and reallocate or redirect funding without IHS approval. In contrast, IHS must approve any substantial changes to a Title I contract. The programs are not exclusive. Tribes can choose which programs, services, functions, or activities (or portions thereof) to assume, a tribe may combine Title V, Title I, and direct services to best meet the needs of tribal members.[14]

While many tribes have chosen to take on the operation and administration of IHS healthcare programs, either completely or partially, 18 tribes are direct service tribes, which means their members only receive healthcare directly from federal employees of IHS. Members from approximately 219 tribes also receive direct service on an as needed basis depending on the care required.[15]

The IHS also administers programs for Indians in urban areas through Urban Indian Organizations (UIOs) that serve the approximately 70 percent of AI/ANs that live in urban areas.[16] IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive healthcare in 36 states.

In addition to providing direct-service healthcare to AI/ANs, the IHS also operates the Purchased/Referred Care (PRC) program, renamed from Contract Health Services in the Consolidated Appropriation Act of 2014.[17] This program is designed to ensure AI/ANs can obtain care when it is not available at IHS facilities, by paying private providers for services. It is similar to the Choice Program in the Veterans Administration. The PRC program is funded through annual appropriations and must operate within the limits of available appropriated funds.

Serious deficiencies exist in the PRC program. The IHS often denies PRC claims due to technicalities that are attributable to the program's complex and confusing referral process.[18] This results in uncompensated care costs for private providers. A 2020 HHS Inspector General Report found that out of a 100-paid claim sample, 18 PRC claims were paid in accordance with Federal requirements and 82 PRC claims were paid, but did not meet one or more of the nine eligibility criteria.[19] In these cases, IHS failed to implement controls to properly collect information required. IHS and providers also did not conduct timely tracking of certain processes.

Funding allocation is also a serious issue due in part to large cost overruns, including the provision of air and ground ambulance services to healthcare facilities in nearby cities that are often vast distances from remote reservations. When PRC funding is tight, AI/ANs may be

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[14] "Frequently Asked Questions," *Indian Health Service.* https://www.ihs.gov/selfgovernance/faq/.
[15] "Direct Service Tribes" *Indian Health Service.* https://www.ihs.gov/odsct/dst/
[16] "Urban Indian Health Program," *Indian Health Service.* https://www.ihs.gov/newsroom/factsheets/uihp/
[17] P.L. 113-76.
[18] *See*, "Can PRC pay for your referral medical care? Find out in 3 stages." Indian Health Service. https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/PRC-ProcessHandout.pdf
[19] U.S. Dept. of Health & Human Services, Office of Inspector General, "Most Indian Health Service Purchased/Referred Care Program Claims Were Not Reviewed, Approved, and Paid in Accordance With Federal Requirements." April 2020. Report. No. A-03-16-03002. https://oig.hhs.gov/oas/reports/region3/31603002.pdf at *Report in Brief.*

unable to obtain basic care except in the case of a life-or-limb emergency.[20] PRC's funding allocation 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.[21] In 2012, government auditors have concluded that Congress should require IHS "to develop and use a new method to allocate all [PRC] program funds…"[22] The GAO followed up these findings with a 2017 report that found IHS still needed to work on improving estimating PRC Program needs and making the allocation of PRC funds more equitable.[23]

Issues with IHS Direct Service

Issues with IHS direct service providers and facilities have been an ongoing topic of concern for Congress. In a 2010 major congressional review of the Great Plains Area (GPA), the Senate Committee on Indian Affairs (SCIA) detailed serious deficiencies in the GPA.[24] 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."[25] The congressional inquiry included the review of over 140,000 pages of documents from the IHS and HHS, visits to GPA facilities, and interviews with IHS employees. The report described in vivid detail a wide range of deficiencies inside the GPA, related to both medical care and administrative procedures. Specific deficiencies included:

- Various personnel issues, including overuse of transfers, reassignments, details, and administrative leave to deal with employees with records of misconduct or poor performance;
- Missing or stolen narcotics, as well as inconsistent pharmaceutical audits;
- Substantial and recurring diversions or reduced healthcare 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.[26]

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[20] *See*, Lindsey Bark, "Purchase Referred Care is affected by federal funding, third party payer options," Cherokee Phoenix, Jul. 18, 2022. https://www.cherokeephoenix.org/health/purchase-referred-care-is-affected-by-federal-funding-third-party-payer-options/article_447c0622-06e0-11ed-8071-a70240d11ad9.html

[21] 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 at 26.

[22] *Id.*

[23] Government Accountability Office. "Status of Prior Recommendations on Federal Management of Programs Serving Indian Tribes" September 13, 2017, GAO-17-790T. at 19-21.

[24] 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.

[25] 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.

[26] *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 in IHS budget justifications that the issues featured in the Dorgan Report were being addressed.[27]

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 threatened since the previous year.[28] In July 2018, largely because of the loss of CMS certification, the Winnebago Tribe assumed management of the Omaha-Winnebago Hospital through the IHS Tribal Self-Governance Program.[29] The hospital was renamed Twelve Clans Unity Hospital in honor of the 12 traditional clans of the Winnebago Tribe.[30] In January 2020, at Twelve Clans Unity Hospital, a consultant from Joint Commission Resources found that the safety and quality of healthcare had drastically improved in the year and a half since the tribe took over management.[31] The Winnebago Comprehensive Healthcare System has implemented a three year strategic plan to take significant steps toward CMS certification for the Twelve Clans Unity Hospital.[32]

In 2015 and 2016, CMS also surveyed three IHS hospitals in South Dakota. The Rosebud, Pine Ridge, and Rapid City (Sioux San) service units were subsequently cited for quality and safety problems.[33] 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.[34]

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[27] *See*, 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, and 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.

[28] 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.

[29] Twelve Clans Unity Hospital, "About Us," https://twelveclanshospital.com/about-us/

[30] *Id.*

[31] Twelve Clans Unity Hospital, *Press Release,* "Twelve Clans Unity Hospital Achieves Monumental Step Toward CMS Certification." Jan. 2020. https://twelveclanshospital.com/wp-content/uploads/2020/04/Twelve-Clans-Unity-Hospital-Achieves-Monumental-Step-Toward-CMS-Certification.pdf

[32] Winnebago Comprehensive Healthcare System. *2020 Annual Report.* https://winnebagohealth.com/wp-content/uploads/2021/12/2020-WCHS-Annual-Report.pdf

[33] 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/

[34] 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/

CMS then entered into a System Improvement Agreement with the Pine Ridge and Rosebud hospitals in April, 30, 2016, which was intended to help IHS avoid the imminent loss of its ability to bill CMS at the facilities.[35] The Pine Ridge Hospital ultimately lost its CMS certification in November 2017.[36] Rosebud and Sioux San did not lose CMS certification, but saw reductions in services while deficiencies in healthcare services were fixed by IHS.[37] Pine Ridge regained CMS certification in June 2020.[38] 80 percent of Sioux San Hospital was taken over by the Great Plains Tribal Chairmen's Health Board in the summer of 2019, which sparked controversy in the state.[39]

Other IHS Areas also continue to experience problems. In 2016 in 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.[40] This finally came to light in 2019 with reports by Smokey Mountain News[41] and the Wall Street Journal.[42] In the Portland Area, for Fiscal Year 2021 100 percent of dentist positions and 50 percent of senior physician and nursing positions were vacant.[43] This echoes the longstanding issue of staffing across all of IHS[44] as well as issues of healthcare provider misconduct, including sexual abuse and physical assault.[45] There are also longstanding issues with replacing aging medical equipment in the Great Plains Area.[46]

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 HHS inspector

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[35] "IHS, CMS enter Systems Improvement Agreements for Rosebud, Pine Ridge hospitals," *Indian Health Service,* May 2, 2016. https://www.ihs.gov/newsroom/ihs-blog/may2016/ihs-cms-enter-systems-improvement-agreements-for-rosebud-pine-ridge-hospitals/.

[36] Kevin Aboourezk "Indian Health Service cites strides in era of COVID-19 as challenges linger," *Indianz.com* June 22, 2020. https://www.indianz.com/News/2020/06/22/indian-health-service-cites-strides-in-e.asp.

[37] *Id.*

[38] "Remarks by IHS Great Plains Directory James Driving Hawk on the Accreditation Status of the Pine Ridge Hospital," *Indian Health Service.* June 18, 2020. https://www.ihs.gov/newsroom/pressreleases/2020-press-releases/remarks-by-ihs-great-plains-area-director-james-driving-hawk-on-the-accreditation-status-of-the-pine-ridge-hospital/.

[39] "Oyate Health Center launches new care model, looks for expansion," NewsCenter1. Jan. 22, 2020. https://www.newscenter1.tv/oyate-health-center-launches-new-care-model-looks-for-expansion/

[40] 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

[41] 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.

[42] 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.

[43] 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/.

[44] 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.

[45] 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

[46] Christopher Weaver, "U.S. Indian Health Service Struggles With Acquiring Basic Life-Saving Equipment," *Wall Street Journal.* May 5, 2022. https://www.wsj.com/articles/u-s-indian-health-service-struggles-with-acquiring-basic-life-saving-equipment-11651763874.

general 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 2018, the GAO completed a report on considerations for Congress in analyzing proposals to change the availability of the appropriations that IHS receives. The GAO interviewed IHS officials and tribal representatives about the effects of budget uncertainty caused by continuing resolutions and shutdowns. The main effects include: 1) difficulty recruiting and retaining healthcare providers; 2) tribes incurring additional administrative burdens and costs due to only proportional allocations being added to tribal contracts that don't match increased administrative costs for tribal health programs; and 3) adverse financial effects on tribes and tribal organizations, like higher interest rates for financing healthcare facilities.[47]

The GAO also highlighted that IHS was added to its High Risk List of federal programs that are especially vulnerable to waste, fraud, abuse, and mismanagement or that need transformative change in 2017 and that "proposals to change the availability of appropriations deserve careful scrutiny."[48] IHS remains on the High Risk List, along with the BIA and the Bureau of Indian Education (BIE).[49] The Department of Veterans Affairs is also currently on GAO's High Risk List despite currently receiving advance appropriations and a significant amount of congressional scrutiny.[50] Any change to how IHS receives appropriations should continue to be coupled with congressional oversight and structural and program improvements at IHS.

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."[51] Congress should continue to conduct oversight of IHS actions to ensure it is fulfilling its stated mission to provide quality healthcare for all AI/ANs.

Tribal 638 Contracts and Compacts

Direct service was historically the method by which IHS has provided healthcare to AI/ANs as a government run healthcare system. However, many tribes have chosen to contract or compact to operate and administer their own healthcare programs, usually due to failings of IHS and the flexibilities that running their own program provides, such as the ability to receive other additional funding sources outside of IHS.[52]

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[47] GAO Report, "Indian Health Services: Considerations Related to Providing Advance Appropriations," https://www.gao.gov/assets/gao-18-652.pdf.
[48] Id. p. GAO Highlights.
[49] GAO, "Improving Federal Management of Programs that Seve Tribes and Their Members," https://www.gao.gov/highrisk/improving-federal-management-programs-serve-tribes-and-their-members
[50] GAO, "Managing Risks and Improving VA Health Care," https://www.gao.gov/highrisk/managing-risks-and-improving-va-health-care.
[51] "IHS 2023 Agency Work Plan," *Indian Health Service.* https://www.ihs.gov/quality/work-plan-summary/.
[52] Mark Walker, "Fed Up with Deaths, Native Americans Want to Run Their Own Health Care," *The New York Times.* Oct. 15, 2019. Last Updated, Oct. 8, 2021. https://www.nytimes.com/2019/10/15/us/politics/native-americans-health-care.html.

In 1975, ISDEAA, also called Public Law 93-638, authorized Indian Tribes and Tribal Organizations to contract or compact for the operation and administration of certain Federal programs which provides service to Indian Tribes and their members.[53] Federally recognized tribes that choose to have 638 contracts or compacts 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 2020, approximately $2.7 billion of IHS appropriations were administered by a tribe or tribal organization through 109 separate ISDEAA self-governance compacts and 135 funding agreements.[54]

Under this system, IHS switches from a healthcare service provider to a fund manager and oversight system, which can result in its own challenges. IHS has been repeatedly cited for not overseeing federal funds according to Federal standards within agency programs[55] and there have been recent Inspector General reports that indicate that IHS needs to strengthen guidance to tribes and monitoring of programs and funds once tribes have received operational control and/or federal funds.[56]

Opportunities for Improvement

There are several areas Congress could assist with reforming IHS. Congress can look at providing further incentives for recruitment and retention, like establishing a competitive pay system for physicians and other healthcare professionals, like that of the Veterans Administration, and expanding eligibility for the IHS Loan Repayment Program. Any incentives to recruit and retain personnel provided by Congress should also be paired with reduced federal service protections and expedited timelines for personnel actions in response to employee misconduct, regardless of length of service. These and other possible solutions for Congress to consider were included in legislation introduced in the 117th Congress by Rep. Dusty Johnson (R-SD), the Restoring Accountability in the Indian Health Service Act.[57]

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[53] Indian Self-Determination and Education Assistance Act, P.L. 93-638, *specifically* Title I and Title V.
[54] Indian Health Service Budget Justification FY 2024 at CJ-190-191, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ31423.pdf
[55] See, e.g., Government Accountability Office, "Indian Health Service: Actions Needed to Improve Oversight of Federal Facilities' Decision-Making about the Use of Funds." Nov. 2020. GAO-21-20. https://www.gao.gov/assets/gao-21-20.pdf.
[56] See, e.g., HHS Office of Inspector General, "IHS Did Not Always Provide the Necessary Resources and Assistance To Help Ensure That Tribal Programs Complied With All Requirements During Early COVID-19 Vaccination Program Administration," Oct. 17, 2022. Report A-07-21-04125. *Available at:* https://oig.hhs.gov/oas/reports/region7/72104125.asp. And, HHS Office of Inspector General, "Although the Bemidji Area Office Had Adequate Procedures To Disburse Indian Health Service Funds, It Needs To Strengthen Its Procedures for Monitoring the Use of the Funds," Feb. 18, 2021. Report A-05-18-00019. *Available at:* https://oig.hhs.gov/oas/reports/region5/51800019.asp.
[57] H.R. 8937, the Restoring Accountability in the Indian Health Service Act of 2022. House of Representatives, 117th Congress. 2022. *Available at*: https://www.congress.gov/bill/117th-congress/house-bill/8937.

Congress could also work with IHS to centralize procedures to make sure all areas are providing the same information, guidance, and auditing services to their direct service facilities and to tribes that have 638 contracts or compacts. Several recommendations from GAO to IHS have involved reviewing and standardizing area policies and procedures.[58] Many tribes have had negative audit funding, which has mainly been a result of the IHS not sharing relevant information.

[58] *See, e.g.*, Government Accountability Office. "Indian Health Service: Actions Needed to Improve Oversight of Provider Misconduct and Substandard Performance" GAO-21-97, Dec. 2020. https://www.gao.gov/assets/gao-21-97.pdf at 27. *And* Government Accountability Office. "Indian Health Service: Actions Needed to Improve Oversight of Federal Facilities' Decision-Making About the Use of Funds" GAO-21-20, Nov. 2020. https://www.gao.gov/assets/gao-21-20.pdf at 21-22.