H.R. 6489, H.R. 8942, H.R. 8955, AND H.R. 8956

LEGISLATIVE HEARING

BEFORE THE

SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS

OF THE

COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES

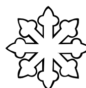
ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

Wednesday, July 24, 2024

Serial No. 118–140

Printed for the use of the Committee on Natural Resources



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56–400 PDF WASHINGTON : 2025

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To: House Committee on Natural Resources Republican Members

From: Indian and Insular Affairs Subcommittee staff, Ken Degenfelder (Ken.Degenfelder@mail.house.gov), Jocelyn Broman (Jocelyn.Broman@mail.house.gov), and Kirstin Liddell (Kirstin.Liddell@mail.house.gov) x6-9725

Date: Wednesday, July 24, 2024

Subject: Legislative Hearing on 4 Bills

The Subcommittee on Indian and Insular Affairs will hold a legislative hearing on four bills: H.R. 8942 (Rep. Hageman), "*Improving Tribal Cultural Training for Providers Act of 2024*"; H.R. 8955 (Rep. Johnson of SD), "*IHS Provider Integrity Act*"; H.R. 8956 (Rep. Newhouse), "*Uniform Credentials for IHS Providers Act of 2024*"; and H.R. 6489 (Rep. Peltola), "*Alaska Native Village Municipal Lands Restoration Act of 2023*" on **Wednesday, July 24, 2024, at 10:15 a.m. in 1334 Longworth House Office Building.**

Member offices are requested to notify Haig Kadian (Haig.Kadian@mail.house.gov) by 4:30 p.m. on Tuesday, July 23, 2024, if their member intends to participate in the hearing.

I. KEY MESSAGES

- H.R. 8942 would amend the Indian Health Care Improvement Act[1] (IHCIA) to require mandatory annual training for specified Indian Health Service (IHS) employees on the history and culture of tribes that they are serving.
- H.R. 8955 would require the IHS to solicit the history of any applicant from the medical board of each state in which the applicant is licensed. Additionally, the IHS would be required to notify and provide the necessary documentation to state medical boards once an investigation of a licensee has started.
- H.R. 8956 would establish a uniformed and centralized Service-wide credentialing system at the IHS for health care providers.
- H.R. 6489 would amend Sec. 14(c)(3) of the Alaska Native Claims Settlement Act[2] (ANCSA) to return lands currently held in trust by the State of Alaska for future municipalities back to Alaska Native village corporations. Only eight villages out of 101 that conveyed lands under this section have created a municipality since ANCSA was passed in 1971. The bill would also eliminate the requirement for an Alaska Native village corporation to convey land to the state Alaska under Sec. 14(c)(3) if that has not already occurred.

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[1] 25 USC 1601 et seq.
[2] 43 USC 1601 et seq.

II. WITNESSES

- **Mr. Benjamin Smith**, Deputy Director, Indian Health Service, U.S. Department of Health and Human Services, Rockville, MD [H.R. 8955, H.R. 8942, and H.R. 8956]
- **The Hon. Jarred-Michael Erickson**, Chairman, Confederated Tribes of the Colville Reservation, Nespelem, WA [H.R. 8955, H.R. 8942, and H.R. 8956]
- **Ms. Amber Torres**, Chief Operating Officer, National Indian Health Board (NIHB), Washington, DC. [H.R. 8955, H.R. 8942, and H.R. 8956]
- **Ms. Jerilyn Church**, Executive Director, Great Plains Tribal Leader's Health Board (GPTLHB), Rapid City, SD [H.R. 8955, H.R. 8942, and H.R. 8956]
- **Mr. Ben Mallott**, Vice President for External Affairs, Alaska Federation of Natives (AFN), Anchorage, AK [H.R. 6489] [Minority Witness]

III. BACKGROUND

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

H.R. 8942 would amend the IHCIA to require mandatory annual training for specified IHS employees on the history and culture of the tribes that they are serving. Currently, IHS employees are required to participate in a program on the tribal history and culture of the tribes they serve, but it is not an annual requirement.

Because IHS's mission is to work with American Indian and Alaska Native (AI/AN) people to promote their physical, mental, social, and spiritual health, IHS medical providers need cultural competence to work toward the best AI/AN health outcome.[3] Culture competence is defined by the Center for Disease Control and Prevention (CDC) as "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes."[4] If a health care practitioner provides care that is culturally sensitive and well-versed, the patient often gains a sense of security and satisfaction which can lead to a more transparent relationship and improved health outcomes.[5]

While American Indian life expectancy has increased by approximately 10 years since 1973, AI/ANs still generally have a lower life expectancy than the United States's general population.[6] That life expectancy is even lower for AI/ANs that have chronic liver disease, diabetes mellitus, and experience assault or homicide or commit self-harm or suicide.[7] Health care practitioners practicing culturally competent care can remove disconnect between patient and practitioner, ensuring patients are heard, seen, and understood. When the relationship between patient and practitioner is strained, the level of care is decreased, which can be attributed to the higher rate of death among American Indians.[8] Studies have shown a correlation between perceived discrimination and the rates of hypertension, cardiovascular disease, and diabetes throughout racial minorities.[9]

For example, an American Indian child who avoids eye contact or takes longer than average to respond to a question could be diagnosed with autism. However, this behavior may actually be culturally appropriate with their tribal community.[10] AI/AN patients who discuss their mental health struggles in spiritual terms could be misdiagnosed with drug-related psychosis, when that is the way the individual

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[3] Quality at IHS. https://www.ihs.gov/quality/#:~:text=The%20mission%20of%20the%20Indian,AN)%20to%20the%20highest%20level.

[4] CDC. Cultural Competence in Health and Human Services. https://npin.cdc.gov/pages/cultural-competence-health-and-human-services#what

[5] McKesey et al. (2017, December) Cultural Competence for the 21st Century Dermatologist Practicing in the United States. Journal of the American Academy of Dermatology. https://assets.ctfassets.net/1ny4yoiyrqia/5czczxfoQvg0P0JoDcuIsh/da49853b61635975925a99813dd790f2/Cultural_competency_21st_century_.pdf

[6] IHS. Quick Look Fact Sheet. https://www.ihs.gov/newsroom/factsheets/quicklook/

[7] Id.

[8] Melissa L. Walls, et. al. *Unconscious Biases: Racial Microaggressions in American Indian Health Care*. The Journal of the American Board of Family Medicine. March 2015. https://www.jabfm.org/content/28/2/231.long. Accessed July 10, 2024.

[9] Id.

[10] American Psychological Association. *The Healing Power of Native American Culture is Inspiring Psychologists to Embrace Cultural Humility*. October 2023. https://www.apa.org/monitor/2023/10/healing-tribal-communities-native-americans.

processes what is occurring.[11] If a practitioner is trained in the history and culture of the demographic they are treating, they can better understand the nuances associated with providing care for the whole person.

Currently the IHCIA requires IHS to have a program educating "appropriate employees" with an "educational instruction in the history and culture" of tribes.[12] However, this program is not mandatory nor required annually by statute. H.R. 8942 would amend the current culture and history program provision under IHCIA to a mandatory annual program for IHS employees. The legislation also specifies which employees should be required to have the annual training, including IHS employees, locum tenens medical providers, health care volunteers, and other contracted employees working at IHS facilities that have direct patient access.

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H.R. 8955 (Rep. Johnson of SD), "*IHS Provider Integrity Act*"

H.R. 8955 would require the IHS to notify state medical boards when an investigation is undertaken into an IHS health care provider licensed by a state medical board, and also requires IHS to provide information on any health care provider's medical license violations to any state medical boards the provider is licensed under. Additionally, the bill requires that during the hiring process of a health care provider, IHS must receive information on any violation of a provider's medical license dating 20 years, as well as information on any settlement agreements that the provider entered into for a disciplinary charge related to their medical practice.

The IHS has long been plagued with issues, particularly when it comes to direct service providers and facilities.[13] In 2010, a major congressional review of the IHS Great Plains Area Region (GPA) by the Senate Committee on Indian Affairs (SCIA) detailed serious deficiencies at IHS facilities.[14] A hearing and its subsequent investigative findings were released by SCIA in the Dorgan Report in December 2010. The report detailed major deficiencies ranging from medical care to administrative procedures.[15] It was found that IHS lacked a proper system to detect practitioners using revoked, suspended, or otherwise inadequate licenses.[16] The investigation requested the IHS to provide all information pertaining to healthcare providers with disciplinary actions on their licenses. The IHS submitted information relating to two providers, but the investigation revealed that there were more practitioners than previously disclosed or known.[17] There continues to be instances of lack of care ranging from quality and safety of patients,[18] extreme vacancies,[19] and misconduct in the IHS.[20]

The IHS has historically had a history of hiring individuals with a history of medical malpractice. In some instances, this negligence occurred because the individual had flags under one state license, but not the other. Such was the case with Dr. Marrocco who was hired at an IHS hospital in New Mexico in 2012. Dr. Marrocco had disciplinary flags on her licenses in New York and Florida, but her Pennsylvania license was clean, so the IHS went ahead and hired her. Dr. Marrocco

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[11] Id.

[12] P.L. 94-437.

[13] 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/.

[14] 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.

[15] Dorgan Report, p. 5-6.

[16] Dorgan Report, p. 6.

[17] Dorgan Report, p. 29 and 67.

[18] 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/.

[19] 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/.

[20] 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.

went on to play a role in the development of a stroke in an eighteen-year-old patient.[21]

Other instances have shown that the IHS has failed to fully investigate their applicants before hiring. In 2019, the Wall Street Journal studied 171 doctors who had allegedly provided negligent care at the IHS. Of the 171 sample, 44 doctors should have raised red flags by the IHS's own standards of care, yet they were hired at the detriment of patients.[22]

The guidelines self-imposed by the IHS emphasize the need to investigate applicants for past malpractice, sanctions, and criminal convictions.[23] However, an official who approved Henry Stachura's appointment was unaware of his problematic employment history. Stachura, who had a career littered with malpractice settlements, was employed by IHS after being suspended from Memorial Medical Center in New Mexico.[24] Prior to his service at the IHS, Dr. Stachura performed surgery resulting in a bile duct injury. Once at the IHS, he operated on Ms. Jeanise Livingston which resulted in a cut bile duct and a subsequent coma for Ms. Livingston. Dr. Stachura retired in 2019 with three deaths and $1.8 million in settlement payments paid by the U.S. government to round out his time at the IHS.[25]

While IHS does have challenges filling medical provider positions, as the entire health care industry faces),[26] ensuring the providers hired by IHS meet standards is essential to ending substandard care at IHS facilities. H.R. 8955 would require the IHS to solicit the history of any applicant from the medical board of each state in which the applicant is licensed. Additionally, the IHS would be required to notify and provide the necessary documentation to state medical boards once an investigation of a licensee has started. To ensure compliance, the IHS would also be required to submit a report to Congress showcasing implementation no later than 180 days after enactment.

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H.R. 8956 (Rep. Newhouse), "*Uniform Credentials for IHS Providers Act of 2024*"

H.R. 8956 would require the IHS, in consultation with tribes and stakeholders, to establish a uniformed and centralized IHS-wide credentialing system, while authorizing the enhancement and expansion of its existing system to ensure all requirements are met. Additionally, the IHS would be required to undergo a formal review of the system to ensure compliance every five years at minimum.

Credentialing is the process of assessing the qualifications of specific types of health care providers to show they have the proper education, training, and licenses to care for patients.[27] The Centers for Medicare and Medicaid Services (CMS) requires a credentialing process before a provider can be eligible for Medicare or Medicaid reimbursement within the health care industry.[28] Because IHS provides health care directly to AI/ANs at IHS facilities, they have their own process of credentialing health care providers which requires that medical staff must meet the credentialing and privileging standards of a national accrediting body like the Joint Commission or CMS.[29]

However, IHS has a history of concerning and inadequate credentialing with IHS leadership touting improvement. The 2010 Dorgan report revealed that the IHS had failed to ensure that all healthcare practitioners in the Aberdeen Area had an active license, in one case the nurse had her license indefinitely suspended in 2005 but

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[21] 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/.

[22] Id.

[23] IHS. Indian Health Manual. Parts and Chapters. Part 3-1.4 https://www.ihs.gov/IHM/pc/part-3/p3c1/

[24] Weaver, "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/.

[25] Id.

[26] Caitlin Owens, "The health care workforce crisis is already here" AXIOS. Jun. 7, 2024. https://www.axios.com/2024/06/07/health-care-worker-shortages-us-crisis.

[27] "Why Provider Credentialing is a Necessary Hassle and a Vital Safeguard," CAQH. April 7, 2021. Accessed July 16, 2024. https://www.caqh.org/blog/why-provider-credentialing-necessary-hassle-and-vital-safeguard.

[28] CMS certification process. https://www.cms.gov/Medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/certandcomplianceprocess.pdf.

[29] IHS. Indian Health Manual Part 3-1.3 A. https://www.ihs.gov/ihm/pc/part-3/p3c1/

was employed by the IHS.[30] Ensuring health care providers have the necessary licenses is a part of the credentialing process, and health care facilities that do not meet these licensing requirements can have their accreditation revoked and find themselves unable to bill Medicare and Medicaid for services unlicensed providers perform.[31]

During a Senate Committee on Indian Affairs (SCIA) hearing in June of 2017, then Acting Director of the IHS Chris Buchanan testified that the IHS recently awarded a contract for credentialing software with the goal of standardizing the credentialing system.[32] The *Presidential Task Force on Protecting Native American Children in the Indian Health Service System* report, published in July 2020, noted inconsistencies between facilities in their credentialing, privileging, and hiring processes.[33] Some hiring committees prioritized filling a vacant spot "over a thorough background and credentialing check."[34] A lack of shared information increased the practice of hiring individuals with otherwise questionable history and qualifications from one facility to another.[35]

An April 2024 Government Accountability Office (GAO) report[36] found that IHS was not adhering to its current credentialing requirements. GAO pulled 91 clinician files who were employed at an IHS facility as of 2022 for review. Of the sample, 12 percent of the files did not meet IHS's requirement to verify all licenses held by the clinician, and in three of those files the IHS had not verified any licenses.[37] In eight of the files, it was found that IHS verified one license held by the clinician but did not verify the licenses for other states.[38]

The IHS concurred with GAO's recommendation to develop a single, authoritative source for credentialing and privileging requirements, and defining the steps necessary to meet national credentialing requirements. Elaborating further, IHS noted that the Indian Health Service Manual has been updated with a new credentialing policy which would continue through the approval process ending in a standard operating procedure in September 2024.[39]

The IHS has consistently acknowledged the need for a centralized medical system and has shown strides toward that goal. The Draft Indian Health Service Strategic Plan for Fiscal Years 2024–2028 has a performance goal of standardizing credentialing software and applications across the agency.[40] The IHS requested public comment on the new credentialing policy in May 2023.[41] In the FY 2025 Budget Justification, IHS noted that they had implemented a nationwide electronic provider credentialing system within federally operated hospitals and clinics.[42]

However, IHS has not been fully transparent while it is creating this new system. H.R. 8956 would place the requirement for IHS to establish a uniformed and centralized IHS-wide credentialing system in statute, providing Congress the opportunity to ensure the standardized credentialing system is put in place.

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[30] Dorgan Report, p. 45 and 68.
[31] Id. at 27.
[32] Chris Buchanan Testimony. June 2017. https://www.indian.senate.gov/sites/default/files/upload/6.13.17%20Chris%20Buchanan%20Testimony.pdf.
[33] Department of Justice. *Presidential Task Force on Protecting American Children in the Indian Health Service System Report*. July 23, 2020. at 16, https://www.justice.gov/usao-ndok/press-release/file/1297716/dl?inline
[34] Id.
[35] Id.
[36] Government Accountability Office, "Indian Health Service: Opportunities Exist to Improve Clinical Screening Adherence and Oversight." April 2024. GAO-24-106230. https://www.gao.gov/assets/d24106230.pdf.
[37] Id.
[38] Id.
[39] Id.
[40] Indian Health Service. Draft Indian Health Service Strategic Plan for Fiscal Years 2024–2028. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2024_Letters/Enclosure_DTLL_DUIOLL_050224.pdf
[41] 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.
[42] IHS Budget Justification, FY25, at CJ-8. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf.

H.R. 6489 (Rep. Peltola), "*Alaska Native Village Municipal Lands Restoration Act of 2023*"

In 1971, ANCSA[43] was enacted to settle the aboriginal land claims of Alaska Natives. Through ANCSA, Alaska Native Corporations (ANCs) were established to receive land under the settlement and disperse the payments to Alaska Natives. Alaska Natives received a $962.5 million settlement payment and roughly 44 million acres of land, which were divided between almost 200 village corporations and 12 regional corporations established by the legislation.[44]

Section 14(c)(3) of ANCSA requires that an Alaska Native Village Corporation receiving land under ANCSA conveys some lands to an existing municipality for use by the municipality. If no municipality exists, then these lands are conveyed to the State to be held in trust for a future municipality.[45] However, most Alaska Native villages have not established municipalities, and these lands remain undeveloped.

Since 1971, a total of 101 Alaska Native Village Corporations have seen their lands held in trust by the State for the purpose of a future municipality, but only eight have seen a municipality created, with the last being created in 1995. Ten Alaska Native Village Corporations have reached agreements with the State to have these lands returned without forming a municipality, but 83 Alaska Native Village Corporations still have approximately 11,500 acres held in trust and unable to be developed with no end in sight, since ANCSA did not have a sunset date for this provision.[46]

The estimated 11,500 acres held in trust by the State remain nearly impossible to develop since the lands must be reserved for future municipalities. If the municipality requirement was lifted, Alaska Native villages would be able to consider developing the lands for housing, community, expansion, and other economic development plans. Some Alaska Native Village Corporations did not reconvey land under 14(c) due to concerns with the 14(c)(3) provision and land being held in trust for perpetuity, resulting in murky land titles.[47]

H.R. 6489 would amend ANCSA to return the land conveyed back to the village corporation that conveyed to the State, while eliminating the requirement for an Alaska Native village corporation to convey land under the ANCSA 14(c)(3) provision.

There is wide support for the reconveyance within the state of Alaska. The Alaska State Senate unanimously passed Senate Joint Resolution No. 13 on May 9, 2024, which encourages the United States Legislative and Executive branches to pass and sign legislation to return certain land in trust back to affected Alaska Native village corporations.[48] Alaska Governor Mike Dunleavy is also supportive of the legislative fix that H.R. 6489 would provide.[49]

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IV. MAJOR PROVISIONS & SECTION-BY-SECTION

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

Section 2. *Tribal Culture and History*

Requires an annual mandatory training program related to tribal culture and history for specified IHS employees.

H.R. 8955 (Rep. Johnson of SD), "*IHS Provider Integrity Act*"

Section 2. *Notification of Investigation Regarding Professional Conduct; Submission of Records.*

Requires the 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 3. *Fitness of Health Care Providers.*

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[43] 43 U.S.C. 1601, et seq.
[44] Id.
[45] 43 U.S.C. 1613.
[46] Senate Energy and Natural Resources Committee. S. Rept. 118-177-Alaska Native Village Municipal Lands Restoration Act. May 16, 2024. https://www.congress.gov/congressional-report/118th-congress/senate-report/177/1
[47] Id.
[48] The Alaska State Legislature. Bill History for "Amend Alaska Native Claims Settlement Act." SJR 13. 33rd Legislature. https://www.akleg.gov/Basis/Bill/Detail/33?Root=SJR%2013
[49] IIA Subcommittee has Letter of Support on file.

Requires the IHS during the agency's hiring process to solicit an applicant's history of license violations or settlements over the previous 20 years from any state's medical board in which the applicant is medically licensed. Requires the 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. Requires the IHS to submit to Congress a report detailing its compliance with these policies no later than 180 days post enactment of this act.

H.R. 8956 (Rep. Newhouse), "*Uniform Credentials for IHS Providers Act of 2024*"

Section 2. *Medical Credentialing System*

Requires IHS, no later than one-year post-enactment, to establish, in consultation with tribes and stakeholders, a uniformed and centralized Service-wide credentialing system for individuals providing services at IHS facilities. Authorizes the IHS to enhance and expand its existing credentialing system to meet the requirements listed. Requires the IHS to undergo a formal review of its credentialing service to ensure all guidelines are met at least every five years. Current credentialed employees would be grandfathered into the new system and would not be re-credentialed until expiration date of current credentials.

H.R. 6489 (Rep. Peltola), "*Alaska Native Village Municipal Lands Restoration Act of 2023*"

Section 2. *Reversion of Certain Land Conveyed in Trust to the State of Alaska*

Amends ANCSA to remove the requirement that an Alaska Native village corporation must convey land into trust to the State of Alaska for future municipal governments. Additionally, provides village corporations the opportunity to regain title to the lands held in trust by dissolving the trust through a formal resolution by the village corporation and the residents of the Native village.

V. CBO COST ESTIMATE

None of the bills received a formal cost estimate from the Congressional Budget Office.

VI. ADMINISTRATION POSITION

During a Senate Energy and Natural Resources Committee hearing on S. 2615, the Alaska Native Village Municipal Lands Restoration Act, an identical bill to H.R. 6489, Principal Deputy Director Nada Wolff Culver of the Bureau of Land Management testified in support of the overall goal of the bill. Citing mild concerns with a lack of a timeline for village corporations to initiate and complete the entire 14 (c) process, which is beyond the scope of this bill.[50]

The administration position on the remaining legislation is unknown at this time.

VII. EFFECT ON CURRENT LAW (RAMSEYER)

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

https://naturalresources.house.gov/uploadedfiles/bill-to-law_hagema_265_xml.pdf

H.R. 8955 (Rep. Johnson of SD), "*IHS Provider Integrity Act*"

https://naturalresources.house.gov/uploadedfiles/bill-to-law_johnsd_079_xml.pdf

H.R. 8956 (Rep. Newhouse), "*Uniform Credentials for IHS Providers Act of 2024*"

https://naturalresources.house.gov/uploadedfiles/bill-to-law_newhou_083_xml.pdf

H.R. 6489 (Rep. Peltola), "*Alaska Native Village Municipal Lands Restoration Act of 2023*"

https://naturalresources.house.gov/uploadedfiles/h.r._6489_-_ramseyer.pdf

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[50] Senate Energy and Natural Resources Committee. S. Rept. 118-177-Alaska Native Village Municipal Lands Restoration Act. May 16, 2024. https://www.congress.gov/congressional-report/118th-congress/senate-report/177/1.

LEGISLATIVE HEARING ON H.R. 6489, TO AMEND THE ALASKA NATIVE CLAIMS SETTLEMENT ACT TO PROVIDE THAT VILLAGE CORPORATIONS SHALL NOT BE REQUIRED TO CONVEY LAND IN TRUST TO THE STATE OF ALASKA FOR THE ESTABLISHMENT OF MUNICIPAL CORPORATIONS, AND FOR OTHER PURPOSES, "ALASKA NATIVE VILLAGE MUNICIPAL LANDS RESTORATION ACT OF 2023"; H.R. 8942, TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO ENSURE THAT CERTAIN EMPLOYEES, PROVIDERS, AND VOLUNTEERS ASSOCIATED WITH THE INDIAN HEALTH SERVICE RECEIVE EDUCATIONAL TRAINING IN THE HISTORY AND CULTURE OF THE TRIBES SERVED BY SUCH PERSONS, AND FOR OTHER PURPOSES, "IMPROVING TRIBAL CULTURAL TRAINING FOR PROVIDERS ACT OF 2024"; H.R. 8955, TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO ENSURE THAT, WHENEVER THE INDIAN HEALTH SERVICE UNDERTAKES AN INVESTIGATION INTO THE PROFESSIONAL CONDUCT OF A LICENSEE OF A STATE, THE SERVICE NOTIFIES THE RELEVANT STATE MEDICAL BOARD, AND FOR OTHER PURPOSES, "IHS PROVIDER INTEGRITY ACT"; AND H.R. 8956, TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT FOR THE DEVELOPMENT AND IMPLEMENTATION OF A CENTRALIZED SYSTEM TO CREDENTIAL LICENSED HEALTH PROFESSIONALS WHO SEEK TO PROVIDE HEALTH CARE SERVICES AT ANY INDIAN HEALTH SERVICE UNIT, "UNIFORM CREDITIALS FOR IHS PROVIDERS ACT OF 2024"

Wednesday, July 24, 2024
U.S. House of Representatives
Subcommittee on Indian and Insular Affairs
Committee on Natural Resources
Washington, DC

The Subcommittee met, pursuant to notice, at 10:17 a.m., in Room 1334, Longworth House Office Building, Hon. Harriet M. Hageman [Chairwoman of the Subcommittee] presiding.

Present: Representatives Hageman, Radewagen, LaMalfa, Westerman, Newhouse, Johnson; Leger Fernández, Sablan, and Peltola.

Ms. HAGEMAN. The Subcommittee on Indian and Insular Affairs will come to order.

Without objection, the Chair is authorized to declare recess of the Subcommittee at any time. The Subcommittee is meeting today to hear testimony on four bills, H.R. 8942, H.R. 8955, H.R. 8956, and H.R. 6489.

Under Committee Rule 4(f), any oral opening statements at hearings are limited to the Chairman and the Ranking Minority Member. I therefore ask unanimous consent that all other Member's opening statements be made part of the hearing record if they are submitted in accordance with Committee Rule 3(o).

Without objection, so ordered. I ask unanimous consent that the gentleman from South Dakota, Mr. Johnson; the gentleman from Washington, Mr. Newhouse; and the gentlewoman from Alaska, Ms. Peltola, be allowed to sit and participate in today's hearing.

Without objection, so ordered.

I will now recognize myself for an opening statement.

STATEMENT OF THE HON. HARRIET M. HAGEMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Ms. HAGEMAN. Today, the Subcommittee is meeting to consider four bills. Three of the bills will improve the Indian Health Service or the IHS, and the fourth would return lands to Alaska Native village corporations that have been held by the state of Alaska for unfulfilled purposes.

First, I want to especially thank Congressman Dusty Johnson for working with this subcommittee on improving IHS and being a champion for improving the tribal health system for all tribes.

Last July, the Subcommittee held a hearing on Congressman Johnson's restoring accountability in the Indian Health Service Act in draft form. After much discussion, this Subcommittee and Congressman Johnson decided to take three key elements from the larger bill and introduce them as individual bills that we think get at specific issues that we can improve right now.

The first bill is H.R. 8942, the Improving Tribal Cultural Training for Providers Act of 2024, of which I am very proud to sponsor. H.R. 8942 would require a mandatory annual training program for specific employees of the IHS on the history and culture of the tribes that they are serving.

Because IHS's mission is to work with American Indian and Alaska Native people to promote their physical, mental, social, and spiritual health, IHS healthcare providers need cultural competence to best serve their patients.

Several studies have indicated that culturally appropriate healthcare can improve doctor-patient relationships and improve health outcomes for patients.

Currently, IHS employees are required to have training on the history and culture of the tribes they serve, but it is not an annual requirement.

My bill would also explicitly state which IHS employees should have annual training requirements. Each of our 574 federally recognized tribes has a unique history and culture.

It is vital that healthcare providers receive the education they need to connect with the patients that they serve, and that this training requirement has the flexibility needed to avoid a one-size-fits-all approach.

Many tribally run healthcare programs already provide this education for their healthcare providers, and we can learn from them to make this requirement work.

The second bill is H.R. 8955, the IHS Provider Integrity Act, introduced by Congressman Dusty Johnson. H.R. 8955 would require the IHS to solicit the history of an applicant from every state medical board where the applicant is licensed.

The IHS would also be required to notify each state medical board where a provider is licensed if IHS begins an investigation into the provider.

The IHS has consistency issues surrounding healthcare provider licensing, including providers being hired without full review of all of their licenses and IHS providers with lapsed licenses continuing to work at IHS facilities.

This long-standing issue first came to national attention in 2010 when the Senate Committee on Indian Affairs investigated the many issues surrounding IHS facilities operating in the Great Plains area.

That investigation found that the IHS lacked a proper system to detect practitioners using revoked, suspended, or otherwise inadequate licenses. Later investigations continued to show that doctors were hired without full license checks at IHS facilities in violation of IHS policies, thereby imperiling patients.

It is important that the IHS holds providers to a high level of care. H.R. 8955 would work to ensure all parties have the information necessary to keep their patients safe and make the best hiring decisions possible.

The third bill, H.R. 8956, the Uniform Credentials for IHS Providers Act of 2024, introduced by Congressman Newhouse, would require the IHS to establish a uniform and centralized service-wide credentialing system. This system would be formally reviewed at least every 5 years.

Credentialing is the process by which healthcare providers are evaluated to show that they have the proper education, training, and licenses to fulfill a position at a healthcare facility.

IHS has its own process of credentialing providers that requires medical staff to meet the credentialing and privileging standards of a national accrediting body like the Centers for Medicare and Medicaid Services.

However, the credentialing process has not been in practice the same across all IHS facilities and has specifically not caught issues of lapsed licenses, as previously mentioned.

While the IHS has initiated the process to create a centralized credentialing system in recent years, Congress has a responsibility to conduct oversight on the process and ensure that it meets the highest standard and is implemented consistently.

The final bill up for discussion today is H.R. 6489, the Alaska Native Village Municipal Lands Restoration Act of 2023 introduced by Congresswoman Peltola, this bill would amend Section 14(c)(3) of the Alaska Native Claims Settlement Act, or ANCSA, to return lands back to the Alaska Native Village corporations that are currently held in trust by the state of Alaska for future municipalities.

ANCSA was enacted to settle the aboriginal land claims of Alaska Natives, and Alaska Native corporations were created to receive land and disburse payments to Alaska Natives.

The settlement also included a provision requiring Alaska Native village corporations to convey some land to an existing municipality. However, if no municipality existed, the land was conveyed to the state of Alaska to be held in trust for a future municipality.

As of today, 83 village corporations still have land held in trust for the purposes of a municipality which has not yet been created

and likely never will be. There was no sunset date for this provision, so this land remains in limbo, unable to be developed.

Village corporations would anticipate developing this land if returned for housing, community buildings, and other economic development projects. H.R. 6489 would also amend ANCSA to return this land and eliminate the requirement in statute.

I want to take the time to thank our witnesses for being here today, and I look forward to today's discussion.

The Chair now recognizes the Ranking Minority Member for her statement.

STATEMENT OF THE HON. TERESA LEGER FERNÁNDEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Ms. LEGER FERNÁNDEZ. Good morning to our witnesses and thank you for joining us. Thank you, Representative Johnson, for the good work that you did on the bill from which we are pooling many of the legislative proposals today, including Chair Hageman's H.R. 8942, which would provide Indian Health Service employees with educational and cultural training to better serve their tribal communities.

I also appreciate the written testimony that we have received, that points out that each tribe is going to have unique cultural traditions, and it is important that IHS develop that training in consultation with the tribes that they serve.

We would love to see that added to this legislation. Representative Johnson's H.R. 8955, which would make sure that the Indian Health Service is transparent with state medical boards, which are the professional conduct of a licensed health provider.

The sad history of the issues where they have not been transparent are suffered by the patients. We will also consider H.R. 8956 from Representative Newhouse, which would establish a service-wide, centralized credentialing system at the Indian Health Service.

These three bills sound familiar, as noted, because they are all sections of Representative Johnson's Restoring Accountability in Indian Health Service Act, which this Subcommittee had a hearing on last July and was reintroduced earlier this month.

I will repeat what I said in that hearing, we cannot continue to ignore the lack of funding that tribes and the Indian Health Service have to deal with on a daily basis.

None of these bills have the funding necessary to support these important efforts. As we noted in the earlier hearing, the average spending for Americans on healthcare is $9,726.

The average spending for a patient at IHS is $4,078. And sadly, only 672 of you are in urban areas. It is important that we begin to address this as well as include funding resources when we take on important reform bills.

In that hearing, the witnesses also shared their concerns about the lack of resources when creating new mandates. They suggested that this could ultimately hurt tribes' ability to provide the care.

There are also many other positive sections of Representative Johnson's larger bill that we should discuss today but aren't

included in these bills, particularly the efforts to better recruit and retain IHS staff and streamline their hearing process.

I hope that we can address the issues that tribes have raised in the last hearing and make a real change at the Indian Health Service to support providing culturally competent care to American Indians and Alaska Natives across the United States.

The final bill today on the agenda is Representative Peltola's H.R. 6489, the Alaska Native Village Municipal Lands Restoration Act. This bill would amend the Alaska Native Claims Settlement Act to retire the requirement for village corporations of unincorporated communities to reconvey lands to the state entrust for a future city for municipal purposes.

I look forward to hearing from our witnesses about this bill and their impacts it will have in Alaska. Before I end, I also want to note that this is our last legislative hearing before the August recess.

And when we get back, we have a lot of legislation from Democratic Members that haven't had any hearings yet, and we have bipartisan legislation that hasn't seen a markup. So, I look forward to having a very productive session in September so that we can address some of those wonderful bipartisan bills.

With that, I want to once again and always thank the witnesses, because especially on a day like today, it is not easy to get here. It is not easy to get in here. So, thank you for your patience, and I yield back, Madam Chair.

Ms. HAGEMAN. Thank you.

I will now recognize Mr. Johnson from South Dakota for 5 minutes to speak on his legislation.

STATEMENT OF THE HON. DUSTY JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Mr. JOHNSON. Thanks, Madam Chair, Madam Ranking Member, I just want to start by thanking you. This is actually how Washington is supposed to work.

We worked with your teams for a long time together on the discussion draft that you both referenced, the Restoring Accountability to IHS Bill. And then we kept working on it. We realized that politics is the art of the possible.

You all had coached us about the value of breaking this into smaller pieces so we could get some movement, gain some traction. So, it is really the fruits of those labors that bring us here today.

And I just want to thank you for this hearing, as well as the diligence of this Committee in trying to make sure that we are moving the ball in the right direction and trying to improve the quality of care in IHS. It is just an incredibly important obligation we have that we are not always doing a very good job of meeting.

In South Dakota, the average age of death is 78 years old. For Native American enrolled members, it is 58 years, just a remarkable 20-year gap. And there are a lot of reasons for that, and we should address all of them. But one of the reasons for that is the poor quality of healthcare in Indian Country, and that is something that we have trust and treaty obligations to address.

And we also know that part of the problem with the healthcare is we also have a provider problem. Now, to be clear, there are

tremendous human beings who choose to serve in Indian Country because they have huge hearts, and they want to make a difference.

But we also know that there have been times that IHS has been a refuge for providers who are not good, who should not be practicing medicine. And study after study has shown us that. I would refer to the 2021 report, which we have to give some credit to IHS for independently commissioning that report.

So often in government, you see people try to cover up their errors. But IHS, in this 2021 report, was able to uncover that IHS had willfully ignored and actively suppressed efforts to go out and identify this particular provider who had been later convicted of a series of sexual misconduct.

The kind of person who should not be practicing medicine. And, obviously, we have a lot of work to do on that front.

There are also instances where you have a provider who gets rejected to practice medicine off reservation because of malpractice, and then they apply for a job on IHS, and they get hired.

And clearly, if they are not a provider that should see non-enrolled members, they are not a provider who should see enrolled members either.

So, the bills before you today are really an attempt, particularly the bill that I am talking about, is an attempt to get at both of those issues with two things:

(1) strengthening the information sharing practices between the state medical boards and IHS so we can figure out who the bad actors are and make sure we don't hire them.

And then (2) requiring IHS to gather information on medical license violations so they can consider that before hiring somebody to work at an IHS facility.

And I know that there are some conversations ongoing about, OK, how do we do these things while still providing due process to providers? And, obviously, let's make sure that we are striking the right balance here. Those conversations are ongoing.

I am not under any illusions that the bills before us today are perfect. Let's continue to work on them so we do strike that right balance.

I want to thank the witnesses for being here, a number of whom we have heard from before. But, of course, I have to call out my friend from South Dakota, Jerilyn Church. She is incredibly respected as the head of the Great Plains Tribal Chairman's Health Board. She has done as much as anybody to educate the South Dakota politicians about why this matters and what we can do together to make it happen.

So, of course, I am going to be interested to hear her remarks as well. And I will close where I began, by thanking you all for the incredibly collaborative efforts that we are engaged in.

We so often talk about what doesn't work in Washington, DC, but today is a pretty good day because we are moving closer to making progress. It is a little progress, and we need a lot of progress, but let's celebrate the little progress when we get it. With that, I yield.

Ms. HAGEMAN. Thank you, Congressman.

And the Chair will now recognize Mr. Newhouse from Washington for 5 minutes to speak on his legislation.

STATEMENT OF THE HON. DAN NEWHOUSE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. NEWHOUSE. Thank you very much, Chair Hageman, Ranking Member Leger Fernández, and members of the Committee for allowing me the opportunity to speak on and be part of something that is, like my colleague from South Dakota described, making some real progress on a very, very important issue.

I am just proud to be a part of this and look forward to not only accomplishing these important steps, but much, much more.

So, thank you for everybody's efforts today. Before I talk about my legislation at all, though, I am very proud to be able to see on the witness stand Chairman Erickson from the Colville Reservation, Chairman of the Confederated Tribes there.

Jarred is a good friend and has been working very hard on these issues for several years, many years. And I just want to point out that while this is important stuff, literally home fires are burning.

There are two major fires going on right now on the reservation. So, I very much appreciate Chairman Erickson's presence here to talk about these issues, while I am sure his thoughts are back home with his people.

To get to my part of this legislation, which I think covers a very important aspect of it, it is the Uniform Credentials for IHS Providers Act, which is part of the larger package, and I am very happy to have reintroduced this legislation with my colleague Dusty Johnson.

IHS is responsible, as we all know, for providing direct medical and public health services to members of the federally recognized Native American tribes and the Alaska Natives.

This duty includes reviewing and verifying professional quality qualifications of clinicians through a process that is known as credentialing and privileging.

Currently, this process involves meeting credentialing requirements that are spread across multiple and sometimes conflicting documents, making it quite challenging for officials to effectively and efficiently credential incoming medical providers.

This lack of a standardized credentialing system has led to issues for the IHS and for those who utilize its services.

In my district, my constituents have reported instances in which the current IHS credentialing system has truly negatively impacted health provider recruitment and our onboarding efforts, including one instance in which providers who were interested in working for the local service unit only to pursue an opportunity elsewhere because of the slow pace of the credentialing process.

So, given that the health disparities that exist in Tribal Nations around the United States, recruitment of quality health personnel should be of utmost priority.

On top of that, there have been reports of inconsistencies between facilities and their credentialing, privileging, and hiring process in which hiring committees have prioritized filling vacant positions over thorough background and credentialing checks.

And on top of that, it has been reported that a lack of shared information increases the practice of hiring individuals with otherwise, shall we say, questionable history in qualifications from one facility to another.

A recent GAO report described the effect of the lack of a centralized system. In one instance, the report found that at an IHS facility that was reviewed, 12 percent of clinician files that were analyzed did not meet IHS's requirement to verify all licenses held by the clinician, and in three of those files, the IHS had not verified any licenses.

My bill seeks to address such issues by requiring the Indian Health Service, in consultation with tribes and stakeholders, to establish a uniformed, centralized, service-wide credentialing system for individuals providing services at IHS facilities.

The development of such a system, I think, would ensure that IHS providers are equipped with the tools that they need to efficiently and effectively hire qualified personnel in their facilities and ensure that all of them are thoroughly vetted.

I think this is of utmost importance, that all patients receive the highest quality of care, no matter where they are. And I believe that this legislation, my legislation, is a step in the direction that we should be taking and certainly urge the Committee to support this important measure.

Again, thank you very much for allowing me to be part of the Committee hearing today.

Ms. HAGEMAN. Thank you, Congressman.

I do have to report, and I apologize about the fact that we are going to be disrupted because we are going to have to go vote.

I did note that it is going to be a bit shorter than what we initially thought the voting process would take, but I am going to go ahead and have Representative Peltola do her opening statement to describe her bill.

As soon as she is finished with that, we will go ahead and go over and vote. We anticipate we will be coming off the Floor at 11:10. We should be back in our seats about 11:15, and then we will reconvene and continue to discuss these bills.

Representative Peltola, you have 5 minutes to discuss your bill.

STATEMENT OF THE HON. MARY SATTLER PELTOLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALASKA

Ms. PELTOLA. Good morning. And thank you, Madam Chair and Ranking Member Leger Fernández. I appreciate you hearing my bill today. H.R. 6489, the Alaska Native Village Municipal Lands Restoration Act.

I greatly appreciate the support and advocacy of our witness, Ben Mallott from the Alaska Federation of Natives, as well as the Chenega Corporation. We have Greg Renkes with us, our former Alaska Attorney General, many folks at the state of Alaska, and our state legislature, among a lot of other folks, for their expertise and eagerness to rightfully restore Alaskan lands to the entities they were derived from, Alaska Native village corporations.

Though Section 14(c)(3) of the Alaska Native Claims Settlement Act intended to support the future development of Alaskan

municipalities, the lands given to the state to be held in trust have instead become largely unavailable for development.

In response, communities across Alaska have been arbitrarily hamstrung from practicing the self-determination promised to them by ANCSA. Everyone agrees that the land now held by the state ought to be free from this obligation to be made available for the economic and social well-being of Alaskans.

And I again want to thank you for the opportunity to move this bill forward, and I look forward to working with all of you to move this across the finish line.

And Madam Chair, I would like to cede the rest of my time.

Ms. HAGEMAN. Thank you. And we will be back in about 30 to 40 minutes. The hearing is recessed.

[Recess.]

Ms. HAGEMAN. We are going to go ahead and get started, and I am now going to introduce our witnesses for our panel.

Mr. Benjamin Smith is the Deputy Director, Indian Health Service, U.S. Department of Health and Human Services, Rockville, Maryland; the Honorable Jarred Michael Erickson, Chairman, Confederated Tribes of the Colville Reservation, Nespelem, Washington; Ms. Amber Torres, Chief Operating Officer, National Indian Health Board, Washington, DC; Mr. Ben Mallott, Vice President for External Affairs, Alaska Federation of Natives, Anchorage, Alaska; and Ms. Jerilyn Church, Executive Director, Great Plains Tribal Leaders Health Board, Rapid City, South Dakota.

Thank you all for being here. I am sorry about the disruption. I don't think that we will have another one and we should be able to finish our hearing today.

Let me remind the witnesses that under Committee Rules, they must limit their oral statements to 5 minutes, but their entire statement will appear in the hearing record.

To begin your testimony, please press the "talk" button on the microphone. We use timing lights. When you begin, the light will turn green. When you have 1 minute left, the light will turn yellow. At the end of 5 minutes, the light will turn red, and I will ask you to please wrap up your statement.

I will also allow all witnesses on the panel to testify before Member questioning.

The Chairman now recognizes Mr. Benjamin Smith for 5 minutes.

STATEMENT OF BENJAMIN SMITH, DEPUTY DIRECTOR, INDIAN HEALTH SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MARYLAND

Mr. SMITH. Good morning Chair Hageman, Ranking Member Leger Fernández, 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 and the Department of Health and Human Services to improve the health and well-being of American Indians and Alaska Natives.

Your consideration today of H.R. 8942, Improving Tribal Cultural Training for Providers Act of 2024; H.R. 8955, the Indian Health

Service Provider Integrity Act; and H.R. 8956, the Uniform Credentials for Indian Health Service Providers Act of 2024, underscores that commitment to improving the quality of healthcare provided by the Indian Health Service.

Again, my name is Benjamin Smith and I serve as the Deputy Director at the Indian Health Service. The Indian Health Service has worked hard over the past several years to train our providers that work in our Indian Health Service and tribal facilities.

This includes American Indian and Alaska Native culturally appropriate training to all our IHS employees, including all healthcare providers, whether Federal employees, contractors, or volunteers.

This helps to meet our goal to ensure our licensed providers meet professional standards required for their discipline before authorizing them to provide healthcare in our Indian Health Service facilities.

In addition, we continue to ensure our credentialing system filters out providers that are not licensed or who are professionally unfit to provide healthcare in our facilities.

We thank Representative Leger Fernández for raising workforce issues. In fact, the impacts of the workforce challenges experienced at the Indian Health Service rank among the top concerns that we hear from both tribes at the Indian Health Service and the Department of Health and Human Services.

And I want to point out that our written testimony points and discusses some of these workforce challenges and recommendations in greater detail.

At the Indian Health Service, we continue to support new strategies to develop the workforce and leverage advanced practice providers and paraprofessionals to improve the access to quality care in American Indian and Alaska Native communities.

As the Subcommittee is aware, the Indian Health Service executes its mission in partnership with our tribal communities through a network of over 600 Federal and tribal health facilities and to 41 urban Indian organizations that are located across 37 states and provide healthcare on an annual basis to approximately 2.87 million American Indian and Alaska Native peoples.

The Indian Health Service operates under the authority of the Indian Healthcare Improvement Act. The three legislative proposals before the Subcommittee would amend that Act by: (1) to ensure that certain employees, providers, and volunteers associated with the Indian Health Service receive educational training in the history and culture of the tribes served by the Indian healthcare system; (2) to ensure that whenever the Indian Health Service undertakes an investigation into the professional conduct of a licensee in a state, that the Indian Health Service notifies the relevant state medical board; and finally (3) to develop and implement a centralized system for credentialing licensed healthcare professionals seeking to provide healthcare services at any of our IHS facilities.

I want to immediately jump into sharing with this Subcommittee some of the comments and concerns that we have with the three bills, but point this Subcommittee to our written testimony for details and examples.

For H.R. 8942, the Training for Providers Act, the Indian Health Service recommends the drafters consider whether conditions of employment is feasible when applicable to contractors and volunteers.

The Indian Health Service is concerned with creating a condition of employment that depends on the Indian Health Service setting up the program, which might be different, or a separate training module for each tribe.

Thus, an employee, contractor, or volunteer could be violating the terms of their agreement through no fault of their own.

Moving to H.R. 8955, the Provider Integrity Act, the Indian Health Service 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 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.

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 also refer this Subcommittee to see our recommendations and our written testimony on this bill regarding the Freedom of Information Act and the 14-day timeline.

For H.R. 8956, the Credentials Act, the drafters may want to note that the non-duplication 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, the Indian Health Service already has the authority to create such a credentialing system and has established and is fully implementing the new system.

To conclude, again, I want to refer you back to our written testimony. At the Indian Health Service, we are committed to providing quality healthcare consistent with its statutory authorities and its government-to-government relationship with each Indian tribe.

Thank you for the opportunity to provide technical assistance, and I am happy to answer your questions. Thank you.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF BENJAMIN SMITH, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON H.R. 8955, H.R. 8942, AND H.R. 8956

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 Data bank, 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 Data bank, 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

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

[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.

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.
- 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

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

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 recredentialed under the new system until they are otherwise required to be recredentialed. 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.

QUESTIONS SUBMITTED FOR THE RECORD TO MR. BENJAMIN SMITH, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Smith did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Questions Submitted by Representative Westerman

Question 1. During the hearing you noted the importance of any culturally competent care training being tailored to each individual tribal population an IHS facility is serving. In what way could this be accomplished, and how should H.R. 8942 be amended to reflect this initiative?

Question 2. In your written testimony you note that the requirements of H.R. 8955 are not new requirements because the IHS always reviews all licenses of a provider that are credentialed in the IHS healthcare system. Yet, there have been various reports of this procedure not being followed. Please expand on your testimony and provide more information about how IHS is improving this system and ensuring that the hiring personnel are meeting IHS's stated requirements?

Question 3. Under its current authority, would IHS review their centralized credentialing system at least every five years?

3a) How often does the IHS currently review its credentialling systems?

Question 4. Your written testimony noted that IHS will focus on publishing guidance and manuals containing the Service's standard operating procedures related to the centralized credentialing, and then move on to staff education. What is the timeline for both final publication of guidance and manuals as well as implementing the new training program?

4a) How long does IHS estimate it will take to educate all appropriate IHS personnel?

Ms. HAGEMAN. We appreciate your testimony and being willing to identify some potential tweaks that we could make to the legislation. I know it is in your written testimony. There may be additional questions as well.

Obviously, we want to work to make these bills the best that they can be. So, thank you for that information.

The Chair now recognizes the Honorable Jarred-Michael Erickson for 5 minutes.

STATEMENT OF THE HON. JARRED-MICHEAL ERICKSON, CHAIRMAN, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION, NESPELEM, WASHINGTON

Mr. ERICKSON. Thank you. Good afternoon, Chairwoman Hageman, Ranking Member Leger Fernández, and members of the Committee.

My name is Jarred-Michael Erickson. I am the Chairman for the Colville Business Council, the governing body of the Colville Tribes. Thank you for inviting me to testify on the three Indian Health Service-related bills that are the subject of today's hearing.

I want to extend my thanks to one of the Colville Tribes' Congressional Representatives, Dan Newhouse, for introducing the Uniform Credentials for IHS Providers Act of 2024.

I would also like to thank Chairwoman Hageman and Congressman Dusty Johnson for introducing two other bills and for their continued interest in Indian health issues.

Congressional oversight of IHS is especially important to direct service tribes like Colville. Unlike tribes that have contracted or compacted IHS functions, direct service tribes are not able to directly control IHS operations on our reservations. I will briefly discuss each of the three bills.

The first bill, the Uniform Credentials for IHS Providers Act, requires IHS to develop and implement an IHS wide, centralized credentialing system in consultation with Indian tribes.

Credentialing refers to the process that IHS engages in to review and verify the professional qualifications of health providers, such as verifying medical licenses. The Colville Tribe supports the credentialing bill because it requires IHS to establish a uniform credentialing that would apply nationwide.

The Colville Tribes has expressed instances where the lack of uniformity in IHS processes have negatively impacted Indian beneficiaries. I previously informed this Subcommittee about some of these examples, specifically with the Purchase, Referred, and Care Program. When the IHS Portland area office took the PRC program away from the local Colville Service Unit and began administering it remotely in Portland from 2017 to 2022, the Portland area imposed an eligibility requirement that was not required by the IHS Indian Health Manual to PRC users at the Colville Service Unit.

We have traced these in additional unwarranted eligibility requirements to patient deaths. Having a credentialing system that applies uniformly to all IHS areas would help prevent the situation from being repeated in the credentialing context.

The second bill, the IHS Provider Integrity Act, will require IHS to notify the state medical boards within 14 days after the date

that IHS undertakes an investigation of professional conduct of a licensed health provider.

The bill would also require IHS to obtain information on license violations or settlement agreements that health providers may have been involved in before hiring those health providers in the IHS system.

As the Colville Tribes and other tribes and organizations have previously informed the Subcommittee, IHS's onboarding process for health providers takes an unreasonably long time.

We have had health providers that our tribal employees have recruited in their own districts on their own express interest in working at the Colville Service Unit only to accept other employment elsewhere when IHS's background process extended 6 months or longer.

The Colville Tribe supports this bill and suggests that the Committee consider requiring deadlines for IHS to initiate requests for information from state medical boards at the beginning of the background check process.

This would ensure that the new background requirement does not contribute to existing delays in the IHS onboarding health providers.

The third bill, the Improving Tribal Cultural Training for Providers Act, will require IHS to implement a mandatory annual tribal culture and history training program for the IHS employees and volunteers whose duties involve direct patient access.

The Colville Tribe supports this bill because the training program, if implemented correctly, would improve IHS customer service to Indian beneficiaries. We recognize the tribal culture and history topics in any training program will vary across the Lower 48 states and Alaska.

What may be an appropriate training program for IHS employees working in the Southwest may not be applicable to the IHS Service Unit employees in the Pacific Northwest or the Great Plains areas.

We suggest the bill include language that directs IHS to consult with Indian tribes in each IHS area in developing the training program that will be required in those IHS areas.

We further recommend the bill include language that requires IHS area offices to revisit and update their training programs every 5 years. This concludes my testimony. I would be happy to answer any questions that the Committee may have. Thank you.

[The prepared statement of Mr. Erickson follows:]

PREPARED STATEMENT OF THE HONORABLE JARRED-MICHAEL ERICKSON, CHAIRMAN, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

ON H.R. 8955, H.R. 8942, AND H.R. 8956

The Confederated Tribes of the Colville Reservation ("Colville Tribes" or the "CCT") appreciates the Subcommittee holding today's hearing on three bills related to the Indian Health Service ("IHS"). All three bills were derived from provisions of the "Restoring Accountability in the Indian Health Service Act of 2023." The CCT worked extensively with the committees of jurisdiction when the original version of the bill was first being developed in 2016 and appreciates the Subcommittee's attention to issues relating to IHS and the health of Indian people.

The CCT supports all three bills and is pleased to provide some suggestions for the sponsors and the Subcommittee to consider that we believe will improve them.

The CCT is a direct service tribe, which means that health care and associated billing and administrative support is provided by IHS employees. The CCT is in the

beginning stages of contracting all IHS functions, but this process will take time. In the meantime, we must rely on IHS to provide quality health care to our tribal citizens. These bills focus on IHS issues that are most relevant to direct service tribes and we appreciate the Subcommittee's attention to and consideration of them.

The Colville Tribes is a confederation of 12 aboriginal tribes from across eastern Washington state, northeastern Oregon, Idaho, and British Columbia. The 12 constituent tribes historically occupied a geographic area ranging from the Wallowa Valley in northeast Oregon, west to the crest of the Cascade Mountains in central Washington state, and north to the headwaters of the Okanogan and Columbia Rivers in south-central and southeast British Columbia. Before contact, the traditional territories of the constituent tribes covered approximately 39 million acres.

The present-day Colville Reservation is in north-central Washington state and was established by Executive Order in 1872. The Colville Reservation covers more than 1.4 million acres, and its boundaries include portions of both Okanogan and Ferry counties, two of the lowest median income counties in the state. Geographically, the Colville Reservation is larger than the state of Delaware and is the largest Indian reservation in the Pacific Northwest. The Colville Tribes has just under 9,300 enrolled members, about half of whom live on the Colville Reservation.

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

This bill would require IHS, in consultation with Indian tribes, to develop and implement an IHS-wide centralized credentialing system to credential licensed health care professionals that seek to provide health care services at IHS Service Units. The bill would require formal review of the credentialing system at least every five years in consultation with Indian tribes.

Credentialing refers to the process that IHS engages in to review and verify the professional qualifications of health providers, such as verifying medical licenses. The intent of the credentialing process is to ensure qualified and skilled providers in the IHS system. There are many health provider vacancies at the Colville Service Unit and throughout the IHS system. This makes credentialing a critical process to ensure that those providers who are currently working at IHS facilities are qualified to provide quality health care.

The Colville Tribes supports H.R. 8956 because it would address several longstanding problems with IHS's credentialing process. In April 2024, the Government Accountability Office ("GAO") released a report on IHS's credentialing process that stated, among other things, the following:

> [GAO] identified two primary causes for why IHS failed to consistently meet all of the credentialing and privileging requirements we reviewed. First, IHS does not have a single comprehensive document that clearly specifies all the agency's credentialing and privileging requirements in one place. Second, IHS headquarters' oversight of credentialing and privileging processes conducted by facilities and area offices is not sufficient to identify nonadherence to requirements.[1]

The CCT has experienced instances where the lack of uniformity in IHS's processes has negatively impacted Indian beneficiaries. We have previously informed this Subcommittee about some of these examples, specifically with the Purchased and Referred Care ("PRC") program. When IHS's Portland Area Office took the PRC program away from our local Colville Service Unit and began administering it remotely in Portland from 2017 through 2022, the Portland Area imposed eligibility requirements that were not required by IHS's Indian Health Manual to PRC users at the Colville Service Unit. The CCT has traced these additional and unwarranted eligibility requirements to patient deaths. Having a credentialing system that applies uniformly to all IHS Areas would prevent such a situation from being repeated in the credentialing context.

We understand that IHS is continuing to work to develop an IHS-wide credentialing system. IHS apparently has been undertaking this effort since at least 2017, when IHS officials testified before Congress on a prior version of the Restoring Accountability in the IHS Act that the agency had "awarded a contract for credentialing software that will provide enhanced capabilities and standardize the credentialing process across IHS."[2]

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[1] U.S. Gov't Accountability Off, GAO-24-106230, *Opportunities Exist to Improve Clinician Screening Adherence and Oversight* (April 2024), available at https://www.gao.gov/assets/gao-24-106230.pdf

[2] S.Hrg. 115-89, at 14 (June 13, 2017) (prepared statement of Rear Admiral Chris Buchanan, Acting Director of IHS).

Depending on how IHS's efforts have progressed, the CCT recommends that the bill include language that clarifies that, in addition to the bill's other requirements, IHS must have all credentialing and privileging requirements in a single document in a single location. Because IHS's current credentialing process is lengthy and consumes significant staff time, the CCT recommends that the Subcommittee work with IHS to identify reasonable timelines for completion of the credentialing process for health providers.

B. H.R. 8955, the "IHS Provider Integrity Act"

H.R. 8955 would require IHS to notify state medical boards within 14 days after the date that IHS undertakes an investigation of professional conduct of a licensed health provider. The bill would also require IHS to obtain information on license violations or settlement agreements that health providers may have committed or entered into before hiring those health providers in the IHS system.

The CCT supports the intent of this bill, which is intended to address instances where a provider engages in professional misconduct and can move to other locations in the IHS system without their respective state medical boards knowing. For example, an October 5, 2021, *New York Times* article reported that an independent report commissioned by IHS found that IHS officials "silenced and punished whistleblowers in an effort to protect a doctor who sexually abused boys on several Native American reservations for decades." There are other similar, unfortunate examples of health providers in the IHS system. To the extent that IHS initiates misconduct investigations, this bill would provide an additional level of accountability with state medical boards.

As the CCT and other tribes and organizations have previously informed this Subcommittee, IHS's onboarding process for health providers takes an unreasonably long time. The CCT has had health providers that tribal employees have recruited on their own express interest in working at the Colville Service Unit only to accept employment elsewhere when IHS's background process exceeded six months.

The CCT recommends the bill include deadlines for IHS to initiate requests for information from state medical boards at the beginning of the background check process to ensure that this requirement does not further contribute to delays in hiring health providers.

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

This bill would require IHS to implement a mandatory, annual tribal culture and history training program for IHS employees and volunteers whose duties involve direct patient access. The CCT supports this bill because the training program, if implemented correctly, would improve IHS customer service to Indian beneficiaries. At the Colville Service Unit, we are aware of a tribal member who experienced a health care provider tell them, "You're fat," during a medical appointment. This type of comment should never happen in any professional health setting. The CCT hopes that annual, mandatory training for IHS employees would help ensure that these types of patient interactions are not repeated.

The Colville Tribes notes that the substantive tribal culture and history topics in any training program will vary across the lower 48 states and Alaska. What may be an appropriate training program for IHS employees working in the southwest may not be as applicable to IHS Service Unit employees in the Pacific Northwest or Great Plains Areas. The CCT suggests that the bill include language that directs the IHS to consult with Indian tribes in each IHS area in developing the training program that will be required in those IHS areas. We further recommend that the bill include language that requires IHS Area Offices to revisit and update the training programs every five years.

QUESTIONS SUBMITTED FOR THE RECORD TO THE HON. JARRED-MICHAEL ERICKSON, CHAIRMAN, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

The Honorable Jarred-Michael Erickson did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Questions Submitted by Representative Westerman

Question 1. H.R. 8955 would ensure that state medical boards would be notified of medical provider investigations and requires IHS to obtain information of license violations and settlements of providers during the hiring process. How would implementation of H.R. 8955 impact the overall attitude toward IHS units around the Colville Reservation?

Question 2. Would H.R. 8942 impact the hiring or onboarding process for IHS providers, and if yes, what language could be added to the bill to mitigate that concern?

Ms. HAGEMAN. Thank you.

The Chair now recognizes Ms. Amber Torres for 5 minutes.

STATEMENT OF AMBER TORRES, CHIEF OPERATING OFFICER, NATIONAL INDIAN HEALTH BOARD (NIHB), WASHINGTON, DC

Ms. TORRES. [Speaking Native language]. Good morning everyone, my name is Amber Torres. I am a tribal citizen of the Walker River Paiute Tribe in Schurz, Nevada, a previous NIHB board member, and I now serve as the interim chief operating officer for the National Indian Health Board.

Chairman Hageman, Ranking Member Leger Fernández, and distinguished members of the Subcommittee, on behalf of the National Indian Health Board and the 574 sovereign federally recognized Tribal Nations we serve, thank you for this opportunity to provide testimony on three pieces of legislation aimed at improving the healthcare workforce at the IHS.

The healthcare workforce is a critical component of the Indian Health System that directly meets the trust and treaty obligation to provide for the healthcare of our people.

The legislation before the Committee today seeks to address several important components of the workforce issues IHS faces, which includes the staffing, hiring, and onboarding process.

Overall, we are thankful to the Committee for taking the time to consider these bills. We support the purpose and intent of the legislation. The pieces of legislation being considered address several concerns that the tribes have raised.

We feel the language of the proposed bill would benefit from a deeper dialogue with tribes and IHS to ensure they fully meet the intent of Congress to improve the hiring and onboarding processes for providers, the healthcare experience, and the outcome for tribal citizens.

It is also important that the legislation does not infringe on the sovereignty of tribes operating their programs through self-governance agreements.

As the Committee considers these bills, it is important to acknowledge the current provider vacancy rates and the timeline for hiring providers to fill vacancies. Additional requirements to the

hiring and onboarding process creates the possibility of slowing the current onboarding of critical providers.

As of February 2024, IHS had a vacancy rate of 36 percent for physicians, 44 percent for behavioral health, 37 percent for dentists, and 35 percent for nurse practitioners.

In some areas, vacancy rates are as high as 78 percent. Lower levels of staffing in IHS and tribal facilities can impact access to care, reduce overall quality, and contribute to increased burnout for providers.

Reducing staff can make it difficult to get referrals for specialty care to treat acute or chronic conditions. Reliance on low levels of staffing can undoubtedly impact the quality of care.

IHS has been working to improve its HR recruitment, hiring, and onboarding experience through a centralized process known as One HR. Additional statutory requirements for system changes to improve hiring and onboarding also need to come with the appropriate resources to ensure the successful implementation of those changes.

The House Appropriations Committee has moved to increase funding to IHS in support of new facility staff, recruitment tools, and construction of staff quarters.

However, we must work to ensure that the increase to the IHS budget goes to support that work. Contract support costs and 105(l) lease payments have been determined by the Supreme Court to be required costs regardless of the appropriation levels.

Therefore, Congress must first pay these costs before other areas of the IHS and Bureau of Indian Affairs Budgets can be considered. The increases to CSC and 105(l) leases have limited growth in direct services, facilities, and other administrative support to the IHS budget that could have otherwise gone to support maintaining current staffing and service levels.

Following the recent ruling in the *Becerra v. San Carlos Apache Tribe*, are costs that are likely to increase, further straining the IHS in the Interior Appropriations Bill.

We continue to request that CSC and 105(l) leases be appropriately classified as mandatory spending by Congress. This will allow any increases to the IHS budget to go toward important agency needs, such as improving staff and to continue meeting the Federal trust and treaty responsibilities to Tribal Nations.

In conclusion, we thank the Committee for the consideration of these bills. We look forward to working with the Committee staff and the bill sponsors to ensure that the language does not negatively impact the efficiency of the IHS hiring process and that tribal sovereignty is upheld.

[Speaking Native language] for the time.

[The prepared statement of Ms. Torres follows:]

PREPARED STATEMENT OF AMBER TORRES, INTERIM CHIEF OPERATING OFFICER, NATIONAL INDIAN HEALTH BOARD

ON H.R. 8955, H.R. 8942, AND H.R. 8956

Chairwoman Hageman, Ranking Member Leger Fernández, and distinguished members of the Subcommittee, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally recognized American Indian and Alaska Native Tribal nations we serve, thank you for this opportunity to provide testimony on three pieces of legislation, H.R. 8956, the Uniform Credentials for IHS Providers Act of 2024, H.R. 8942, the Improving Tribal Cultural Training for Providers Act of 2024, and H.R. 8955, the IHS Provider Integrity Act. My name is Amber Torres. I am a member of the Walker River Paiute Tribe of Nevada and I serve as the Interim Chief Operations Officer for the National Indian Health Board (NIHB).

Healthcare workforce is the critical component of the Indian health system that directly meets the trust and treaty obligation to provide for the healthcare of our People. The legislation before the committee today seeks to address several important components of the staffing and provider hiring and onboarding process. The Uniform Credentials for IHS Providers Act of 2024 proposes to streamline the hiring process and the ability for providers to move around the Indian Health Service's network of hospitals and clinics. Uniform credentialing promises to improve the ability of IHS to quickly address staffing shortages across its system by more quickly deploying providers to areas which may have high vacancy rates. NIHB has shared feedback with the committee to ensure that the legislation includes definitions that would be appropriate to only IHS-operated facilities.

The Improving Tribal Cultural Training for Providers Act of 2024 would require IHS staff to receive cultural training. This bill would ensure that those working in our communities have a better understanding of our cultures and our ways to improve the experience that our Tribal citizens receive their care. This is critical to improving the patient experience and improving outcomes. When patients feel that they are understood and their concerns are received in a culturally informed manner, they are more likely to return for their follow up care and feel that their healthcare provider has their best interests at heart and the best interests of the community's overall health. Many tribal health providers already conduct this type of training, and we would encourage IHS to utilize these models as best practices as they implement the requirements of this bill.

Finally, H.R. 8955 would require in statute that providers under investigation be reported to their licensing boards. Further, the bill requires that as part of the hiring processes, IHS contact licensing boards to verify the good standing of provider's licensure, particularly seeking disciplinary actions or findings made by the licensing board. This legislation would address quality of providers to ensure that they can appropriately meet the needs of the IHS. NIHB has shared feedback with the Committee and the bill's sponsors that would streamline the legislation so as not to make this onerous on the hiring process of the IHS. Often, state licensing boards can be under-staffed and it is possible this could create delays in the hiring process. It is also important to consider how long IHS and other providers keep personnel records. The 20 years outlined in the legislation may not be a feasible timeline to access records. Additionally, we would encourage the legislation to share only investigations that have reasonable findings, as investigations can often be started and there is found to be no wrongdoing by the provider.

As the Committee considers these bills, it is important to consider the current provider vacancy rates and the timeline for bringing on providers to fill vacancies. Additional requirements in the hiring and onboarding process creates the possibility to slow the current onboarding of critical providers. As of February 2024, IHS had a vacancy rate for physicians of 36 percent; for behavioral health providers, that rate is 44 percent. The dentist vacancy rate is 37 percent, and nurse practitioner vacancy is 35 percent. When we look at specific Areas, individual rates go as high as 58 percent vacancy rate for physician assistants in Billings Area, 63 percent vacancy rate for physicians in Great Plains and 78 percent for behavioral health providers in the Albuquerque Area. These incredibly high vacancy rates correspond to low staffing levels on the ground.

Lower levels of staffing in IHS and Tribal facilities can impact access to care, reduce overall quality, and contribute to increased burnout for providers. Reduced staffing can make it difficult to get referrals for specialty care to treat chronic or comorbid conditions, which can have both individual and larger, enterprise-level impacts. Reliance on low levels of staffing also can impact quality of care. Providers working through burnout can miss important symptoms, but further, it creates reliance on particular providers that can leave huge gaps in service delivery if and

when a provider moves on. IHS and Tribal providers also work in an environment that requires cultural competence, sensitivity and awareness. Tribes have long requested that providers, employees, and Commissioned Officers go through cultural training to better serve and understand the communities in which they live and work. Cultural competence training for positions that work in Indian country is vital for the IHS, but there are positions across many federal departments and agencies which need this type of training to properly understand Tribal communities and the Indian health system.

The IHS has been working to improve its human resources, recruitment, hiring, and on-boarding experience through a centralized process known as One HR. Additional statutory requirements for systems changes to improve hiring and onboarding also need to come with appropriate resourcing to ensure the successful implementation of those changes. The House Appropriations Committee has moved to increase staffing funding to IHS in support of new facilities staff, recruitment tools, and staffing quarters to improve the current staffing crisis the Agency has been facing.

The pieces of legislation being considered address several concerns Tribes have raised. The language of the proposed bills would benefit from deeper dialog with Tribes and IHS to ensure they fully meet the intent of Congress to improve the hiring and onboarding process for providers and the healthcare experience and outcomes for Tribal citizens. It is also important that the legislation is clear in its intent to improve the operations of the IHS, and that it does not infringe on the sovereignty of Tribes which operate their programs through agreements under the Indian Self-Determination and Education Assistance Act (25 U.S.C. ch. 14, subch. II § 5301 *et seq*).

There are also other legislative initiatives which are currently pending before Congress which would improve the tools already available to the IHS and Tribes to improve the recruitment and retention of a culturally competent and trained workforce. Although the Indian Health Program received a substantial increase in the House's Interior, Environment, and Related Agencies bill, the scholarship and loan repayment programs are not treated equally to other equivalent programs offered within HHS which enjoy tax-exemption, which allows all of the available funding to support recruitment. Additional funding for this program will be an important part of any multipart strategy to improve the workforce difficulties facing the Agency. NIHB supports language included in H.R. 8318, the Tribal Tax and Investment Reform Act of 2024, that would make IHS scholarship and loan repayment programs tax exempt. We encourage the House Natural Resources Committee members to voice their support for this legislation.

Expansion of midlevel provider types and grow-your-own education programs are another critical piece to the workforce development reform that is necessary to support the whole Indian health system. IHS has been working to expand the successful Community Health Aide Program, better known as CHAP, to help smaller communities have providers in their community even when it is difficult to hire a physician level provider. Tribal programs to encourage and educate youth and young professionals in healthcare careers need to be supported and resourced to ensure we are developing a larger pool of providers to meet current and future staffing needs.

Finally, we must work to ensure that the increases to the IHS budget go to support this work. Contract support costs and 105(l) lease payments have been determined by the U.S. Supreme Court to be required costs, regardless of the appropriation levels. Therefore, Congress must essentially pay these costs first before other areas of the IHS and Bureau of Indian Affairs budgets can be considered. In recent years, increases to CSC and 105(l) leases limited growth in direct services, facilities and other administrative support to the IHS budget that would have otherwise gone to support maintaining current staffing and service levels. Following the recent ruling in the *Becerra v. San Carlos Apache Tribe*, the costs are likely to increase, further straining the IHS and the Interior appropriations bill. As part of long-term support for addressing IHS workforce needs, it is critical that these costs, which are essentially already a mandatory cost provided as an "indefinite discretionary", be is addressed through common sense reform by appropriately classing them as mandatory appropriations. This will allow increases to the IHS budget to meet the important staffing needs to continue meeting the federal treaty and trust responsibility to Tribes. These funds are already required to be paid, and the Appropriations Committee does not have input in how much to allocate to these accounts. Without this change, the administrative funds that IHS would use to implement the changes outlined in these bills, will not be possible.

Conclusion:

In conclusion, we thank the Committee for their consideration of these bills that address important challenges to IHS staffing and cultural competency at IHS-operated facilities. As the process moves forward, we look forward to working with Committee staff and the bill's sponsors to ensure that the language would not inadvertently impact Tribally operated health systems, and would not have a deleterious impact on the efficiency of the IHS hiring process (a process that is already exceedingly slow and overburdened by bureaucracy). We also encourage the House Natural Resources Committee to support changes that would categorize CSC and 105(l) leases as mandatory funding. This will make it possible for they agency to allocate additional funds for activities to support staffing at IHS-operated facilities.

QUESTIONS SUBMITTED FOR THE RECORD TO MS. AMBER TORRES, CHIEF OPERATING OFFICER, NATIONAL INDIAN HEALTH BOARD (NIHB)

Ms. Torres did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Questions Submitted by Representative Westerman

Question 1. Would H.R. 8942 impact the hiring or onboarding process for IHS providers, and if yes, what language could be added to the bill to mitigate that concern?

Question 2. Please expand from your testimony as to why H.R. 8942, H.R. 8955, and H.R. 8956 should only apply to IHS direct service facilities.

Ms. HAGEMAN. Thank you for your testimony.

The Chair now recognizes Mr. Ben Mallott for 5 minutes.

STATEMENT OF BEN MALLOTT, VICE PRESIDENT FOR EXTERNAL AFFAIRS, ALASKA FEDERATION OF NATIVES (AFN), ANCHORAGE, ALASKA

Mr. MALLOTT. Good morning and thank you Chair Hageman, Ranking Member Leger Fernández, and members of the Subcommittee on Indian Affairs.

My name is Ben Malott. I have had the honor of serving as Vice President of General Affairs for AFN and also the president elect of AFN. I would like to thank you for the opportunity to provide testimony in support of H.R. 6489, the Alaska Native Village Municipality Lands Restoration Act.

Also, I would like to thank Congresswoman Mary Peltola for her work on this bill.

For background, AFN is a large statewide Native organization in Alaska. Our membership includes 177 tribes, 154 village corporations, 9 of our 12 village corporations, and 9 of our regional tribal consortiums.

As Chairman Hageman outlined earlier, ANCSA as passed in 1971, included a provision called 14(c)(3). At the time, many of our communities at passage in 1971 were unincorporated lands.

Section 14(c)(3) was included in the bill in case there was an opportunity or that community wanted to establish a city, government, or municipality. It required every Alaska Native business corporation to give about 1,200 acres of land and sometimes the most viable land within the community at the center of the

community for this purpose, and that was about 50 years ago. Currently, there are 83 communities of the 101 communities within the program and since then only 8 of those communities have established the city government, the last one being 1995.

The State of Alaska Municipal Land Trust, or the MLT, has approximately 11,500 acres of valuable lands in each of our communities. This is land that is in central communities.

It is land that could be used for housing, could be used for student services and other purposes that are right now currently managed by the state and can be an underfunded and overtasked office.

Lands to transfer out program, under the current system, is very burdensome and troublesome. It hinders our village corporations from using this land for community development and work with our tribes to figure out what is best for communities to grow.

Additionally, as our tribes and ANCs figure out what to do with these lands, if the corporation wants to transfer lands out, the state still has to transfer over lands because the state as a trust has an obligation under current law to manage those lands in the tribes' best interests or in the state's best interest for a future city government.

As such, the MOT takes this job seriously and continues to hinder our communities to expansion. Many of our state MOT communities have expressed a strong interest in removing this provision of 14(c)(3), a resolution was passed at AFN for many years, and to expand this program and to sunset the provision.

H.R. 6489, as I mentioned, sunsets the supporting 14(c)(3) provision. It also empowers corporations and communities that make the best decisions for the communities.

These two components are significant because, as I mentioned, according to Save Alaska, of the original 101 villages conveyed in the program, only 8 have been incorporated.

As mentioned, for many communities where cities have not been formed, these lands sit vacant, empty, and not being used for community purposes. And, additionally, moving the Section 14(c)(3) provision eliminates the need for future conveyances.

So, as a community wants to or ANC wants to convey lands, I want to recognize my village corporation's manuka's testimony, which is also on the record for a community of Rampart or Chenega, or other community villages, if the city wants to move, or the village wants to move those lands for purposes of economics, the state still has a title over those lands for 14(c)(3) provisions.

So, it still holds the lands even for purposes under pretty much overworked and under tasked office. I am sorry, I am tired and am starting to stutter. I apologize.

So, H.R. 6489 still has that burdensome hurdle. Overall, 14(c)(3) is a 50-year-old relic of its day. As mentioned, the last municipality was set up in 1995. H.R. 6489 sunsets the provision encourages our communities to make the best decision for the community. As such, AFN fully urges Congress to pass this bill. [Speaking Native language.]

[The prepared statement of Mr. Mallott follows:]

PREPARED STATEMENT OF BENJAMIN MALLOTT, ALASKA FEDERATION OF NATIVES ON H.R. 6489

Chair Representative Harriet Hageman, Ranking Representative Teresa Leger Fernández, Ranking Member Lee, and members of the House Natural Resources Subcommittee on Indian and Insular Affairs, thank you for the opportunity to provide written testimony for the hearing record in support of H.R. 6489, the "Alaska Native Village Municipal Lands Restoration Act of 2023."

My name is Benjamin Mallott, and I am honored to serve as the President-Elect of the Alaska Federation of Natives (AFN). AFN was formed to achieve a fair and just settlement of Alaska Native aboriginal land claims. Today, AFN is the oldest and largest statewide Native membership organization in Alaska. Our membership includes 177 Alaska Native tribes, 154 for-profit village Native corporations, 9 for-profit regional Native corporations established pursuant to the Alaska Native Claims Settlement Act (ANCSA), and 9 regional nonprofit tribal consortia that contract and compact to administer federal programs under the Indian Self-Determination and Education Assistance Act. The mission of AFN is to advance and enhance the political voice of Alaska Natives on issues of mutual concern.

Today, I want to submit written testimony supporting H.R. 6489, the "Alaska Native Village Municipal Lands Restoration Act of 2023." Resolutions passed by AFN that support H.R. 6489 are attached to this testimony.

For background, ANCSA was signed into law on December 18, 1971. Alaska Natives were compensated with fee simple title to 44 million acres of land and $962.5 million. ANCSA created 13 regional for-profit corporations and more than 200 village corporations. Alaska Native Corporations received land and monetary entitlements. In addition, Congress charged ANC with providing for their people's economic, social, and cultural well-being in perpetuity.

ANCSA was a complicated act and laid out multiple types of land conveyances. Most of our communities at the time were in unincorporated portions of the state. Section 14(c) of ANCSA was included if a community wanted to establish a municipality. Section 14(c)(3) required every Alaska Native Village Corporation to turn a portion of their lands over to the State of Alaska to be held in trust for a possible future municipal government. These lands conveyed to the State include "the surface estate of the improved land on which the Native village is located and as much additional land as is necessary for community expansion, and appropriate rights-of-way for public use, and other foreseeable community needs," with the amount of lands to be transferred to "be no less than 1,280 acres unless the Village Corporation and the Municipal Corporation or the State in trust can agree in writing on an amount which is less than 1,280 acres." Less than half of our village corporations came to an agreement with the State on lands to be turned over to the trust, and in only a few instances has a municipality been established.

For nearly 50 years, the State Municipal Land Trust (MLT) has managed 14(c)(3) lands in Alaska, an underfunded and overtasked office. Despite decades of administration, only eight ANCSA villages have formed new municipalities, the last one established in 1995. It is evident that, for many remote Native Villages in Alaska, forming a municipality is not foreseeable.

Currently, 83 communities across Alaska have their lands tied up under the MLT program, which is approximately 11,550 acres. The land transferred under 14(c)(3) requires an overly burdensome and almost impossible process to transfer lands into private hands or back to the Alaska Native Village Corporation. Some village corporations defied the law and never transferred land into the MLT. Other than the original initiative by the BLM, there was no enforcement mechanism at the state level to require participation. However, for these village corporations that chose not to participate, the title remains on their lands, and they are subject to ANCSA 14(c)(3). Any land use authorized by the Village Corporation requires the State's written disclaimer of interest and has resulted in the current law having a broader negative impact beyond the 83 communities currently tied up with lands held in the MLT.

The State's view of its trust responsibilities is that conveyance in fee simple is not possible under current law. Because the MLT is a trust, it has a legal and fiduciary obligation to manage the lands in the best interests of the municipality or, in the absence of one, the future municipality. The MLT takes this trust responsibility seriously, and this obligation severely limits the available uses of what are often the most important parcels of land in these remote rural villages, many of which desperately need facilities and economic development. Many MLT communities have indicated a strong interest in having the lands they transferred to the State returned to expand economic development in their communities.

H.R. 6489, the “Alaska Native Village Municipal Lands Restoration Act of 2023,” sunsets the Alaska Native Claims Settlement Act (ANCSA) 14(c)(3) provision. AFN supports H.R. 6489 because removing the 14(c)(3) provision will empower Alaska Native corporations and communities to make informed decisions about best utilizing their lands and resources, leading to greater economic prosperity and self-sufficiency.

Essential components of this legislation are removing the 14(c)(3) provision and restoring lands conveyed to the MLT to the appropriate Alaska Native Village Corporation. These two components are significant because, according to the State of Alaska, of the original 101 villages covered by the MLT program, eight villages have been incorporated into a municipality. For the many communities where a municipality has not been formed, and the village corporation conveyed all or partially required land to the MLT, the property conveyed to the MLT will revert to the village corporation under H.R. 6489. Additionally, the sunset of the 14(c)(3) provision eliminates the need for future conveyances, thereby reducing the barriers for Alaska Native communities to decide what they want to do with their lands without having to go through a bureaucratic hurdle.

H.R. 6489 is the right step forward for continued support for the economic empowerment and self-sufficiency of Alaska Native communities. It is important to note that ANCSA came into existence during the era of Indian self-determination. ANCSA reflects this policy approach by providing Alaska Native people the resources necessary for economic, cultural, and political self-determination. As such, I urge full consideration of H.R. 6489 before Congress and its passage into law. Over 50-year-old legislative loose ends need to be addressed to fulfill the promise of self-determination embodied in the 1971 ANCSA settlement.

Thank you for your consideration.

Quyana, Gunalchéesh, Haw’aa, Baasee, Taikuu, Thank you.

Ms. HAGEMAN. Thank you, Mr. Mallott, for your testimony.

The Chair now recognizes Ms. Jerilyn Church for 5 minutes.

STATEMENT OF JERILYN CHURCH, EXECUTIVE DIRECTOR, GREAT PLAINS TRIBAL LEADER’S HEALTH BOARD (GPTLHB), RAPID CITY, SOUTH DAKOTA

Ms. CHURCH. [Speaking Native language.] Thank you, Ranking Member Leger Fernández, Chairwoman Hageman, Representative Johnson, and Representative Newhouse for allowing me the opportunity to provide testimony this afternoon on behalf of the Great Plains Tribal Leaders Health Board.

The Health Board serves as a liaison between the Great Plains tribes and various agencies of the HHS, including the IHS. We work to reduce public health disparities, improve the health and wellness of our American Indian people and tribal communities, and we also administer nearly all IHS funded health services in Rapid City through the Oyate Health Center.

We recognize that IHS faces difficulties and challenges in improving healthcare delivery and outcomes for our tribal communities. I have testified several times before to the Subcommittee on proposed legislation and appreciate the members of the Subcommittee and their work emphasizing the improvement of Indian Health Service and its operations.

As the Subcommittee is considering these bills, we emphasize the need to make sure that they and other legislation do not confer additional unfunded mandates on the already seriously under resourced Indian Health Service.

Concerning the Uniform Credentialing for IHS Providers, the bill should be amended to clarify that tribally operated facilities and programs are not subject to the mandated IHS centralized

credentialing system unless the tribal health program has expressly opted into that system.

It would also be helpful to clarify when IHS and tribally operated service units can accept credentials of licensed health professionals who were credentialed by the tribal health programs.

We have provided some amended language in our written testimony to address those issues. We are concerned with the use of the term licensed health professionals in the bill, that it may be broader than it is intended.

Centralizing the credentialing for various types of providers that are included in that term, as defined by a YDE, the Indian Healthcare Improvement Act, with all the various requirements, might be particularly challenging.

Finally, we strongly urge that Subsection (c)(1) be amended to add tribal organizations and inter-tribal consortia after Indian tribes as entities with which IHS must consult.

Regarding Tribal Cultural Training for Providers, we are concerned that the bill might be interpreted to apply to employees of tribal health programs, including Federal employees assigned to work for tribal health programs under an interpersonal agreement or memorandum agreement.

That requirement would be disruptive, expensive, and duplicative for tribal programs, so we want them to not have to be required in addition to what we already implement as a tribal health program. We have included proposed language in our written testimony to address this issue as well.

Regarding the IHS Provider Integrity Act, the Great Plains Tribal Leaders Health Board appreciates the Subcommittee's emphasis on making sure IHS hires the best and most qualified individuals to care for our relatives.

However, we are concerned with the proposed 20-year look back requirement because providers are often licensed in several states over the course of long careers.

We suggest that the Subcommittee work collaboratively with the Indian Health Service to determine whether the mandated exchange of information can be accomplished without creating additional delays or barriers for filling critical provider positions.

As you all know, there is a great need to fill many, many positions, and we just don't want to see an overreach, and we want to find that balance between ensuring that there is due diligence but also filling positions as quickly as possible.

And finally, these proposed amendments to the Indian Healthcare Improvement Act provide another opportunity for us to urge members of the Subcommittee to work with your colleagues to direct IHS to reinstate the National Steering Committee on the reauthorization of the Indian Healthcare Improvement Act.

Thank you very much for the opportunity to provide testimony today on these vital issues and appreciate your efforts to improve health care delivery to all of our people. [Speaking Native language.]

[The prepared statement of Ms. Church follows:]

PREPARED STATEMENT OF JERILYN CHURCH, MSW PRESIDENT/CEO, GREAT PLAINS TRIBAL LEADERS HEALTH BOARD

ON H.R. 8955, H.R. 8942, AND H.R. 8956

Thank you for the opportunity to testify at today's legislative hearing on behalf of the Great Plains Tribal Leaders Health Board (GPTLHB). GPTLHB serves as a liaison between the Great Plains Tribes and the various Health and Human Services divisions, including the Great Plains Area Indian Health Service (IHS), and works to reduce public health disparities and improve the health and wellness of American Indian people and Tribal communities across the Great Plains. The GPTLHB also administers nearly all IHS-funded health services in Rapid City, SD through the Oyate Health Center.

In our region, the Indian Health Service (IHS) is the primary source of hospital care for 150,000 American Indians/Alaska Natives in the Great Plains Area. Of the six hospitals in the Great Plains, five are managed directly by IHS, with one operated by a tribal health program under a Title V Self-Governance compact. Ambulatory care is increasingly carried out by tribal health programs, except in the five locations where IHS still operates hospitals. Tribal health programs deliver ambulatory health services, with seven programs managed entirely by a tribe or a tribal organization under a Title I Self-Determination contract and two more tribally managed through a Title V Self-Governance compact. The Indian Health Service is responsible for two substance abuse treatment centers and supports three urban health care programs.

At GPTLHB, we are acutely aware of the difficulties and challenges that the IHS faces in improving healthcare delivery and healthcare outcomes for American Indian people in our communities. Over the last few years, I have testified several times before this Subcommittee on these current challenges and opportunities and legislation targeted at improving healthcare delivery through the IHS system. We appreciate the members of this Subcommittee emphasizing improving the IHS and its operations.

As the Subcommittee is considering these bills, we emphasize the need to make sure that they—and any other related legislation—do not confer additional unfunded mandates on the already seriously under-resourced IHS and that additional administrative requirements (including agency reporting requirements) will not be so burdensome as to take time and resources away from patient care. Regarding improvements to IHS operations, the most crucial factor is ensuring the agency has sufficient resources to do its job.

With these general concerns in mind, we turn to the specific legislation before the Committee.

The Uniform Credentials for IHS Providers Act of 2024 (H.R. 8956)

Application to tribal health programs. GPTLHB believes it is essential to clarify that Tribally-operated facilities and programs are not subject to the mandates of the IHS's centralized credentialing system this bill requires unless the tribal health program has expressly opted to participate in the IHS's credentialing system fully or in part. Section 125(f)(1) appears to intend that result to achieve this by providing that nothing in the section [125] "negatively impacts the right of an Indian tribe to enter into a compact or contract under the [ISDEAA]." If read narrowly, IHS may interpret this exemption as not applying to tribal organizations or inter-tribal consortia. The risk of this is elevated by the language in subsection (f)(2), which limits the application of Section 125 to "a compact or contract unless expressly agreed to by the Indian tribe." There is a significant risk that IHS might require that the tribal resolutions that authorized a tribal organization or inter-tribal consortia carry out programs of the Service expressly address the credentialing system.

It would also be helpful to expressly describe some of the circumstances under which a centralized credentialing system could be useful to tribal health programs without imposing the entire process on the tribal health program, as well as when the Service and tribally-operated Service units can accept the credentials of licensed health professionals who were credentialed by a tribal health program.

The exemption currently in the bill can be clarified and the additional objectives achieved by amending the proposed subsection (f) to read, as follows:

"(f) Effect.—Nothing in this section——

"(1) negatively impacts the right of an Indian tribe, **tribal organization, or inter-tribal consortium (as those terms are defined at 25 U.S.C. §§ 5304(e) and (l) and 5381(a)(5) and (b))** to enter into a compact or

contract under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5301 et seq.);

"(2) applies to **the programs, services, functions, and activities (or portions thereof) carried out by an Indian tribe, tribal organization, or inter-tribal consortium under** such a compact or contract unless expressly agreed to by the **contracting or compacting** Indian tribe, **tribal organization, or inter-tribal consortium**;

"(3) prevents an Indian tribe, tribal organization, or inter-tribal consortium from partially participating in the credentialling system by accepting the credentials of a Service licensed health professional without independently verifying them; and

"(4) prevents the Service from allowing a licensed health professional who has been credentialed by a health program carried out by an Indian tribe, tribal organization, or inter-tribal consortium under a contract or contract as described in subsection (1) to provide health care services at any hospital or ambulatory directly operated by the Service or at any tribally operated Service unit if approved by that Service unit.

Scope of "licensed health professionals." It is not clear how broadly the sponsors of this bill intend it to reach. The term "licensed health professional" may apply more broadly than intended. The term "health profession" is defined very broadly in the IHCIA to mean "allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession." The fact that centralized credentialing would apply only to licensed health professionals is still quite expansive. Nurses, social workers, optometrists, optical dispensers, social workers, marriage and family therapists, chiropractors, other behavioral health providers (e.g., three states license mental health technicians), pharmacists (and possibly pharmacy assistants) are subject to state regulation with most requiring a license. The licensing requirements vary by state, so the people subject to these credentialing requirements may differ from state to state. This will be a particularly challenging process.

Consultation. Finally, we are very concerned that subsection (c) neglects to include tribal organizations and inter-tribal consortia among entities with which the Secretary must consult. We urge that subsection (c)(1) be amended to add "tribal organizations and inter-tribal consortia" after "Indian tribes."

Tribal organizations and inter-tribal consortia have been authorized by Indian tribes to carry out health programs on their behalf. While carrying out that work, the tribal organizations and inter-tribal consortia acquire significant expertise in technical health care administration matters, including credentialing. That should not be ignored or given less weight than other entities listed.

Improving Tribal Cultural Training for Providers Act of 2024 (H.R. 8942)

GPTLHB appreciates the emphasis on expanding the reach of IHS' Tribal culture and history training.

We are concerned, however, that the bill may be interpreted to apply to employees of tribal health programs, including Federal employees assigned to work for a tribal health program under an IPA (Intergovernmental Personnel Agreement) or MOA (Memorandum of Agreement). The list of types of employees in subsection (a) extends not only to those working in "Service hospitals" but also in "other Service units." "Service unit" is a defined term in the IHCIA (25 U.S.C. § 1603(20)). The term "means an administrative entity of the [Indian Health] Service or a tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area."

The requirement for all these employees to participate in annual training under Subsection §§ (c) if applied to tribal health programs, including federal employees assigned to a tribal health program under the Indian Self-Determination Act, is likely to be very disruptive to tribal health programs and potentially expensive since that training will likely be duplicative and more general than training the tribal health program already delivers to its employees. We also believe that regardless of whether tribal health programs are subject to the mandatory provisions of this section, deference should be given to tribal culture and history programs developed by Indian tribes and tribal health programs and that the access to such training should be as flexible as possible. These concerns can be readily addressed, if it is amended to read:

Sec. 2. Tribal Culture and History. (§ 113 of the IHCIA; 25 U.S.C. § 1614f)

(a) Program established. The Secretary, acting through the Service, shall establish **an annual mandatory training** program under which **employees of the Service, locum tenens medical providers, health care volunteers, and other contracted employees who work at hospitals or other Service units operated directly by the Service and whose employment requires regular patient access** who serve particular Indian tribes shall receive educational instruction in the history and culture of such tribes and in the history of the Service.

(b) Tribally controlled community colleges. To the extent feasible, and in the absence of training programs available to the Service that were developed by Indian tribes, tribal organizations, or inter-tribal consortia, the program established under subsection (a) shall——

(1) be carried through tribally controlled colleges or universities (within the meaning of section 2(a)(4) of the Tribally Controlled Colleges and Universities Act of 1978 [25 USCS § 1801(a)(4)]) and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h (2)),

(2) be developed in consultation with the affected tribal governments, and Indian tribes, tribal organizations, and inter-tribal consortia delivering health services in the geographic area in which the employees described in subsection (a) are located; and

(3) include instruction in Native American studies.

(c) Requirement to Complete Training Program.—Notwithstanding any other provision of law, beginning on the date of enactment of the Improving Tribal Cultural Training for Providers Act of 2024, each employee or provider described in subsection (a) who enters into a contract with the Service, shall, as a condition of employment, annually participate in and complete the program established under subsection (a).

(d) Exemption.—Nothing in this section shall prevent a health program operated by an Indian tribe, tribal organization, or inter-tribal consortium from obtaining the training developed under this section for its employees, including those assigned to it under provisions of the Indian Self-Determination and Education Assistance Act.

IHS Provider Integrity Act (H.R. 8955)

GPTLHB appreciates the Subcommittee's emphasis on making sure that IHS hires the best and most qualified individuals to take care of our family members. It is important that IHS knows that the providers it hires do not have serious disciplinary records. We do, however, have some concerns regarding the proposed 20-year lookback requirement. Many providers have, over the course of long careers, been licensed in multiple states. We also have concerns about the notification of any open investigation into the professional conduct of a licensee. We think it is essential to consider trigger points for reporting depending on the severity of professional conduct requiring investigation.

We recommend that the Subcommittee work collaboratively with the IHS to determine whether it is feasible to interface with several State medical boards (including receiving information in a timely manner) during the hiring process without creating additional delays and barriers to filling critical provider positions.

These bills and the underlying issues raise the larger question of the process of including Tribal voices in potential legislative improvements through amendments to the Indian Health Care Improvement Act. In the past, these legislative efforts would be driven by input from the knowledge, wisdom, and difficult decision-making of the Tribal leaders who made up the National Steering Committee (NSC) on the Reauthorization of the IHCIA. Now that the IHCIA has been made permanent, that mechanism for critical Tribal input no longer exists. We urge the Members of the Subcommittee to work with your colleagues to direct IHS to reinstate the NSC and provide sufficient appropriations to support its critical work.

Thank you for the opportunity to provide testimony today on these crucial issues and for your efforts to improve healthcare delivery to all our People and communities.

QUESTIONS SUBMITTED FOR THE RECORD TO JERILYN CHURCH, EXECUTIVE DIRECTOR, GREAT PLAINS TRIBAL LEADERS HEALTH BOARD

Ms. Church did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Questions Submitted by Representative Westerman

Question 1. Reports have shown a lack of accountability when it comes to IHS employees and misconduct. Anecdotally, can you provide any examples of instances in which a practitioner used the IHS's negligence to work elsewhere despite past malpractice?

Question 2. During the hearing you brought up the importance of relying on tribal elders when it comes to culture and history. Could you provide the Committee with what you think best practices would be for ensuring tribal elders and healers are included in the implementation of a tribal culture and history training for all relevant IHS staff?

Question 3. Would H.R. 8942 impact the hiring or onboarding process for IHS providers, and if yes, what language could be added to the bill to mitigate that concern?

Ms. HAGEMAN. Thank you for your testimony and for your suggestions as well.

The Chair will now recognize the Members for 5 minutes for questioning, beginning with me.

On H.R. 8942, I am going to direct my first couple of questions to Mr. Benjamin Smith. H.R. 8942 would require mandatory annual training on the history and culture of the tribes involved for specific employees.

Mr. Smith, what is the current format for tribal history and culture training for IHS employees?

Mr. SMITH. Thank you, Chair, for the question. As we know, the Indian Health Service is one of the primary healthcare providers to American Indians and Alaska Natives.

But we are not the only Federal agency that works with American Indian Alaska Native governments. So, our approach in looking at training and as you can see in our testimony, we do recommend that each IHS Service Unit develop a unique orientation for all staff regarding cultural training appropriate to each tribe served by an Indian healthcare facility.

Understanding that some facilities serve multiple tribes and there could be distinct differences——

Ms. HAGEMAN. Let me just ask it in a little bit different way. Is there any standard within IHS specific to the format for tribal history and culture training?

Mr. SMITH. Absolutely. And the lens that we have taken and have implemented over the past 3 years is a trauma informed care approach.

As we know, trauma resulting from violence, victimization, colonization, and systematic racism have played a part in American Indian and Alaska Native lives.

On an annual basis, all of our employees are required to take a mandatory training to become trauma informed.

Ms. HAGEMAN. Specific to this issue. But that is specific to trauma?

Mr. SMITH. Correct. Which covers the historical trauma and history of American Indians and Alaska Natives in this country, as well as some of the intergenerational trauma for those who may have not personally experienced what previous generations have done.

But that approach really sets a common framework across our system to have a basic understanding of the history and experience of American Indians and Alaska Natives in this country.

Ms. HAGEMAN. I am going to direct my next couple of questions to Ms. Torres. H.R. 8942 includes in the list of employees mandated to take the annual mandatory training, locum tenens, providers, or medical providers or practitioners that temporarily fill a need at the facility.

Can you expand on whether this type of medical employee needs to receive cultural training, and if so, should they be added to the annual requirement?

Ms. TORRES. I appreciate the question.

H.R. 8942 includes the list of employees mandated to take the annual mandatory training. It also includes locum tenens providers or medical practitioners that temporary fill in at a facility.

I believe that all providers that are placed in those communities need cultural training to learn the best approach possible for competent care.

Also gaining the trust of the patient so that you can continue to have that good experience going forward and continue to combat the healthcare comorbidities in conjunction with the patient so that the overall care is achieved.

[Speaking Native language.]

Ms. HAGEMAN. OK, and I am going to direct my next questions to Chairman Erickson, Ms. Torres, and Ms. Church.

Several written statements that were provided highlighted that each federally recognized tribe has its own history and culture, and any mandated tribal and cultural training should be flexible enough to accommodate the area the IHS facility and employees are serving. By that, I mean geographical area.

Can each of you expand on what you think are the best practices that IHS should follow as they offer their current training, and if there are specific ideas we should add to H.R. 8942 to improve it?

Chairman Erickson, you first, please.

Mr. ERICKSON. Thank you for that question. And you are right, here at Colville, there are 12 different tribes into one tribe now. So, there are four different languages. We are very unique in that.

There are a lot of culturally involved things that are different for each respective tribe that we represent. I think there are multiple ways you can go about this. You can do online modules, in-person classes, but I think the best approach would be community-immersive training because it is very specific to each tribe, and the tribes are similar to us that are confederation, that it is not a one-size-fits-all, even within our tribe.

So, again, that is, I think getting those involved in the community and our elders will help with that a lot in creating that training for those individuals.

Ms. HAGEMAN. Ms. Church, if you can briefly give your thoughts on this.

Ms. CHURCH. Certainly. There are shared values across many of the tribes. There is diversity, but there are also shared values. So, emphasizing those shared values, I think is very important.

Additionally, I think looking to our elders as we do to provide that guidance. At the Great Plains Tribal Leaders Health Board, we have a [speaking Native language] committee of respected elders across the Great Plains who guide us as we not only do our orientation, but also incorporate traditional cultural values and traditional healing into our work.

So, looking to those wisdom keepers is an important part of the process.

Ms. HAGEMAN. Ms. Torres, very briefly, if you have any ideas?

Ms. TORRES. Yes, thank you so much. I would just want to make sure that they are consulting with tribes early and often on what that process will be, and again, making sure to include our youth and elders, as those are our most precious commodities, and we want to get that feedback and that buy in from our communities.

[Speaking Native language.]

Ms. HAGEMAN. OK, thank you.

I do appreciate all of you giving us ideas, and I would hope that you would continue to stay engaged on this very important issue.

I am going to recognize Representative Johnson for 5 minutes of questioning. Thank you.

Mr. JOHNSON. Thanks very much, Madam Chair. Mr. Smith, I want to come to you because I think we are all trying to make the legislation better.

You talked about concerns with the timeline on the 14 days. Kind of coach me, where is a better spot for us to land?

Mr. SMITH. Yes, thank you very much for the question, Representative Johnson.

What we wanted to share and underscore first is that at the Indian Health Service, today, all IHS direct healthcare facilities have fully implemented the uniform credentialing software.

Mr. JOHNSON. Can you move that mic a little closer?

Mr. SMITH. Again, we have fully implemented a uniform credentialing software, but it is also important to note that the Indian Health Service is committing to ensure safe and high-quality patient care through appropriate hiring, credentialing, peer review, and professional review processes for licensed providers, practitioners, and that we hold them to the highest standards for——

Mr. JOHNSON. So, Deputy Director, do we have a sense of what timeline might be more appropriate?

Mr. SMITH. Yes. This is what we would like to investigate further and discuss with this Subcommittee. We are aware of other Federal agencies that have longer timelines, such as the Veterans' Health Administration, and we just want to make sure that we are setting tenable dates to afford somebody who is being investigated due process, but also to be similar to other standards across the healthcare industry.

Mr. JOHNSON. I am unaware, what does the Veteran Health Service utilize?

Mr. SMITH. To my knowledge, and I will have to verify this, we would be happy to follow up with you, but we understand it is around 30 days.

Mr. JOHNSON. Around 30 days?

Mr. SMITH. Yes.

Mr. JOHNSON. OK. So, as you all have talked internally, just, again, trying to make sure it is workable, if 14 is clearly not workable, or it would be workable some of the time?

I mean, here is why I am asking. I wonder if there is a scenario under which you could have a standard amount of time in the statute and then kind of an extra bonus time in extraordinary circumstances where you all determined that you needed extra time.

I know that deadlines drive achievement, and, of course, when we push timelines out further, just as a matter of course, we don't get the urgency we generally want. We see that all the time here in Washington.

We only really act when we have to. Any thoughts? I mean. And would 14 days be workable any of the time?

Mr. SMITH. Well, we would urge the Subcommittee to also contemplate the fact that the Indian Health Service works in multiple states.

We understand that 50 different states with 50 different internal timelines and knowing that their boards meet at different frequencies does pose a challenge of really trying to simmer down to a concrete timeline.

Mr. JOHNSON. And I know I won't put you on the spot anymore, I mean, I understand the discomfort with 14 days, and I am totally willing to work with you all.

It is hard for us to make legislation fit if we don't get some specificity, right? I know why 14 doesn't work. What I don't know is, does 18 work? Does 21 work? Does 25 work?

So, as you said, we will continue to dive in and work together. You did note that you inform folks when you identify problems with providers. Does that include state licensing boards?

Mr. SMITH. Absolutely. If an appropriate investigation occurs and is deemed valid, then, yes, we follow the protocols as outlined in our policies.

Mr. JOHNSON. And then, Ms. Church, I thought you made some great points about not wanting to interrupt the hiring process, because I think the percentage of vacant positions is in excess of 25 percent.

And, again, to your point, there is a lot of regional variability in those numbers. So, what can we do to make sure that we don't interrupt the hiring process?

Ms. CHURCH. I think we have to take a look at the global picture of what is required to onboard a provider and ensure that we are not adding additional burden onto that process that would create more delays.

The thing that stood out to me was going back 20 years. I don't know how many institutions even keep records for 20 years.

Mr. JOHNSON. Is there a better spot to land?

Ms. CHURCH. I would defer to Ben on that one. I would use common sense. Look at when did they start? When did they graduate?

When did they start in the workforce? And I would say at least 5 years, but 20 years seems a little bit.

Mr. JOHNSON. Very good. Thanks.

I yield back.

Mr. WESTERMAN [presiding]. The gentleman yields back.

The Chair now recognizes the gentlelady from New Mexico, Ms. Leger Fernández.

Ms. LEGER FERNÁNDEZ. Thank you so much, Mr. Chairman. And once again, thank you very much for your presence here today. And sorry that there are so many things happening here at the Capitol.

Ms. Torres, in your testimony, you highlighted the Supreme Court decision in *Becerra v. Northern Arapaho Tribe* that made it a requirement for contract support costs to be paid regardless of appropriations level.

This will have a significant impact on the delivery of health services in Indian Country. Can you talk a bit more about that and how we need to think about that funding requirement now as we look at funding the Indian Health Service?

Ms. TORRES. Yes, thank you.

Again, I think the Supreme Court decision is so crucial to making sure that CSC and 105(l) are taken into perspective and that they do not cut into the IHS budget as a whole.

Again, we know that those are federally mandated costs that need to be taken care of. We shouldn't have to stretch all the dollars to make it work. I think making sure that it is part of the mandatory funding is going to be crucial moving forward so that we can continue to build on what we need to take care of first and then continue to advocate for more funding going forward.

So, again, making sure that CSE and 105(l) are in the mandatory funding.

Ms. LEGER FERNÁNDEZ. I completely agree with you with regards to that, because we cannot be letting this requirement, which is a requirement the Supreme Court has already told us that, we cannot let that requirement then sap resources from the rest of IHS.

And I see all the nodding heads over there, let the record reflect that the witnesses are nodding their heads because they recognize the importance of adequate funding for IHS.

And we, as I mentioned in my opening statement, we were following way too low on that with about half, right. And worse for rural areas.

Ms. Church, we love having you here because you bring such a great perspective of what it is like on the ground. And I really appreciate as well the recent studies we have done, some in New Mexico that point out that the health boards make such a difference, right? Because they are able to gather the expertise.

You mentioned the fact that there were 150,000 American Indian and Alaska Natives in the Great Plains area. Can you speak a bit more to what it would mean for your area if we did not make these changes we are talking about and why it is so important that we address the concerns you mentioned in your written testimony?

Ms. CHURCH. We want to make sure that we are getting not only the most qualified providers in our Indian Health System providing services to our relatives, but also to ensure that our relatives can connect to them, that they have a relationship with them, that they

are able to fully disclose when they are having challenges, not only with their health, but in their communities.

Our relatives come in with a wide range of issues that they are dealing with. And sometimes those other issues, socioeconomic issues, stand in the way of them getting the basic health care that they need.

So, having culturally sensitive, culturally informed, as well as highly qualified, because of the enormous health disparities that are within our population, we are the worst of the worst, oftentimes. So, we need that expertise as well.

Ms. LEGER FERNÁNDEZ. And I like the way you talk about our relatives. This is what we are talking about, families. You know everybody and you care for everybody.

And that is the beauty of the tribal communities, right? Is that there is a sense that we are one. We are all related, and thank you for being related to the rest of us as well.

But addressing the entire health aspect, it does not stop at any one part of the body. It includes the mind and includes your surroundings, which lead to some of those health disparities. I really appreciate that.

Mr. Mallott, you spoke to the impact Section 14(c)(3) of ANCSA has on tribal communities and the need to remove this provision. I appreciate that.

Can you provide the Committee with examples of specific projects that community is seeking, but are precluded from as a result of the lands being held in trust?

Mr. MALLOTT. Thank you for that question. I am going to cite a couple of our member testimonies. My village corporation, my mom's home village of Rampart, has dealt with 14(c)(3) for a while, most recently with the city dump.

We actually had leased a land to the tribe, which couldn't go through a 14(c)(3) process. That is just a community growth project that communities did grow. Our current dump is by the airport. It is actually hazardous because seagulls fly through the planes.

So, we had to have leased the land to the tribe, I believe, instead of going to ports and (c)(3) process, because it was taking too long.

Another example in my mom's home, Rampart, the ANC actually leased land to the tribe for a satellite telecom site.

We wanted to go through the 14(c)(3) process, but then we also want to make sure that the tribe has economic benefits as well. So, if we lease to the state, the state will actually get the money for the lease site for a satellite, not the tribe.

So, actually a lease to the tribes. This tribe actually gets a little bit of money from the satellite dish. In Chenega, for example, the 14(c)(3) land is where the cemetery is at. So, the community doesn't even own their own cemetery, and they had to go through that process with the state MOT.

As mentioned, most of these lands are in the most valuable part of our communities. So, if a town or a city that is not incorporated wants to create a new subdivision for homes, they have to go through the process.

And right now, it is a very, very slow and burdensome process that really slows down our community development.

Ms. LEGER FERNÁNDEZ. Thank you. I come from New Mexico, so the imagination of seagulls going around is, like, OK, I have to get my head around that. And with that Mr. Chair, I yield back.

Mr. WESTERMAN. The gentlelady yields back.

I now recognize myself for 5 minutes of questioning and also want to thank the witnesses for being here today.

As I listened to your testimony, my mind started thinking about a lot of things from past experiences, and I know Ms. Torres mentioned the difficulty of getting positions filled in IHS.

I come from a very rural district. I don't have any IHS facilities in my district, but I know it is a challenge in rural areas. Many IHS facilities are in rural areas, and it is critical to get those positions filled.

From traveling around the country and visiting different IHS facilities, I have seen some really good examples of how IHS works, and I have seen some examples that are not so good in IHS facilities.

But the one thing that is common when an IHS facility is working well is that they have good staff. And that is true, I think, about any kind of healthcare facility.

I have seen some big failures in publicly funded healthcare facilities. When I was a State Legislator in Arkansas, we had an issue with a Medicaid provider that was a child abuser who kept practicing as a pediatrician and billing Medicaid for the services.

Since being in Congress, I saw a VA pathologist back home in Arkansas who was impaired on the job, misdiagnosed many people, and people died because of that. But he remained employed in the VA.

So, there are lots of challenges. There is a desire to be able to fill positions. We also have to make sure that we have quality people in those positions.

And Chairman Erickson, I had the great pleasure to visit the Colville Tribe and spend some time with you. But you mentioned a lot of times about timelines, and you mentioned that in all three of the bills in your testimony.

Can you expand more on why deadlines and timelines are important to include in these bills, and if there are any specific timelines, you think that will be beneficial for us to consider adding to the bills on top of what is already there?

Mr. ERICKSON. Thank you for that question. The shortest answer is accountability, right? If we don't hold our Federal agencies accountable with timelines, nothing will get done.

I see dragging of the feet, and I am not trying to be rude or anything, but that is what we run into with BIA, any department, we just have a lot of issues. If we don't put timelines on things, accountability is not had, and then things just drag on.

So, I think with the hiring process, as far as the medical boards go, I think the biggest or the easiest thing to implement there is really starting that process right at the beginning of the hiring process, the background check process.

That way, it is not making that process any longer for them to go through. They are already doing that with the background check. I don't think those should take as long as they do.

At Colville, we are supposed to have five doctors, and we have one right now. We finally have a dentist, and that took years to fill, and he has only been there 6 months. And we hope he stays. We hope we don't lose our last doctor.

Anytime these processes take long, we have had lots of employees that were potential good employees left because the hiring process took too long. And a lot of that was background checks and other things.

So, I think implementing that right at the beginning of the background check process will reduce having any added time to the hiring process.

Mr. WESTERMAN. And we all understand what it is like to work under deadlines, and we know that a lot of times people just wait until the last minute when they have a deadline.

Have you or your tribal members seen any issues when it comes to cross state licenses and the hiring process for IHS applicants at the Colville Service Unit?

Mr. ERICKSON. That is a good question. I will get back to you on that. I don't have an answer for that right now. I apologize.

Mr. WESTERMAN. Ms. Torres, H.R. 8955 would require the IHS to solicit any applicant's history from all medical boards in which they are licensed, going back at least 20 years.

Can you expand on your written statement about why 20 years cannot be a feasible timeline and maybe also suggest what other length of time we should consider?

Ms. TORRES. Thank you for the question. I appreciate that.

H.R. 8955 would require the IHS to solicit any applicant's history from all medical boards in which they are licensed going back at least 20 years. It was presented here that some areas may not have 20 years' worth of history on that.

But I think, again, it is important to try to go back as far as possible. The suggestion was made of 5 years, but I think at NIHB, we could come up with some further suggestion and follow up to make sure that you get a copy of that, because we are not just looking at now. We are looking at the future as well for those that are still yet to come. And we want to make sure that we implement good, solid changes, but we also don't affect tribes that are self-governance and self-determined.

Mr. WESTERMAN. All right, I see that I am out of time. We may have more questions that will get submitted for the record.

Again, I want to thank the witnesses for your valuable testimony and the Members for the questions today.

The members of the Subcommittee may have some additional questions for the witnesses, and we will ask you to respond to these in writing.

Under Committee Rule 3, Members of the Subcommittee must submit questions to the Subcommittee Clerk by 5 p.m. on Monday, July 29, 2024. The hearing record will be held open for 10 business days for these responses.

If there is no further business without objection, the Subcommittee stands adjourned.

[Whereupon, at 12:14 p.m., the Subcommittee was adjourned.]

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