Great Plains Tribal Leaders Health Board

Testimony Re: Uniform Credentials for IHS Providers Act of 2024; Improving Tribal Cultural Training for Providers Act of 2024; and IHS Provider Integrity Act.

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 (HR 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 a**n 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.

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