Restoring Accountability in the Indian Health Service Act of 2022
Section-by-Section

Section 101: Incentives for Recruitment and Retention

Sec. 101 adds a new section to Title I of the Indian Health Care Improvement Act. Specifically, Sec. 101 requires HHS to establish a competitive pay system, based off the Veterans Health Administration, for physicians and certain other health care professionals. Sec. 101 further authorizes HHS to establish a tenant-based rental assistance program, to sunset after 3 years, for IHS employees who agree to work at a Service unit designated as a HPSA for at least 1 year (or 2 years for part-time employees) and are considered critical employees. HHS must submit a report to Congress evaluating the cost and effectiveness of such rental assistance program.

Section 102: Medical Credentialing System

Sec. 102 adds a new section to Title I of the Indian Health Care Improvement Act. Specifically, Sec. 102 directs IHS to establish, in consultation with Indian tribes and stakeholders, a uniform, centralized, Service-wide credentialing system for health professionals providing services at IHS Service units. Health professionals credentialed in accordance with existing IHS policy are not required to be re-credentialed under the new system until they are otherwise required to be re-credentialed. Providers are prohibited from practicing within a Service unit if they are not credentialed in accordance with the provisions of Sec. 102. Finally, IHS is authorized to expand or enhance an existing credentialing system to meet the requirements set forth in this section.

Sec. 102 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.

Section 103: Liability Protections for Health Professional Volunteers at Indian Health Service

Sec. 103 amends Section 224 of the Public Health Service Act (42 U.S.C. 233) relating to civil actions against commissioned employees and officers. Specifically, Sec. 103 grants liability protections currently in place for Public Health Service employees (via the Federal Tort Claims Act) to sponsored and credentialed health professional volunteers at IHS Service units and UIOs receiving Title V IHCIA grants under certain conditions.

Sec. 103 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.

Section 104: Clarification Regarding Eligibility for Indian Health Service Loan Repayment Program

Sec. 104 amends Sec. 108 of the Indian Health Care Improvement Act relating to the Indian Health Service Loan Repayment Program (IHSLRP). Specifically, Sec. 104 expands eligibility for the IHSLRP to individuals with master's degrees in certain health care programs who are certified in certain business and health-related fields. It also expands eligibility to professionals willing to serve in half-time practice for up to 4 years (currently limited to individuals serving full-time for 2 years).

Section 105: Improvements in Hiring Practices

Sec. 105 adds a new section to Title VI of the Indian Health Care Improvement Act. Specifically, Sec. 105 provides HHS with direct hire authority for IHS positions, provided successful candidates meet OPM's qualification standards. It further requires HHS to notify Indian tribes of personnel changes for Senior Executive Service positions and managing positions at Area offices and Service units, and Tribes would have 10 days to submit comments regarding such personnel actions. Finally, Sec. 105 authorizes waivers of Indian preference laws, if first requested by a concerned Indian tribe, for a position in a Service unit experiencing continual staffing vacancies, as well as for former IHS or Tribal employees

removed or demoted for misconduct or performance in the 5 years after such incident (so long as such reason for removal was not a reportable event to the National Practitioner Data Bank).

Section 106: Improved Authorities of Secretary to Improve Accountability of Seniors Executives and Employees of the Indian Health Service

Sec. 106 adds two new sections to Title VI of the Indian Health Care Improvement Act. Specifically, Sec. 106 authorizes HHS, with respect to certain Senior Executive Service positions, to take various personnel actions, including suspension, removal from IHS, and removal from the civil service, in response to misconduct (defined as neglect of duty, malfeasance, failure to accept directed reassignment, and failure to accompany a position in a transfer of function). Sec. 106 also establishes rights and procedures for covered individuals in Senior Executive Service positions subject to such a personnel action, including notice of action, legal representation, grievance of agency decision, and judicial review.

Generally, and for non-Senior Executive Service and non-political appointees, Sec. 106 further authorizes HHS to take various personnel actions, including suspension, removal from IHS, decrease in pay grade, and removal from the civil service, in response to employee misconduct (defined above). Similar to Senior Executive Service positions, non-Senior Executive Service positions are entitled to certain rights and procedures, such as notice of action, legal representation, and an expedited appeal to the Merit Systems Protection Board.

Section 107: Tribal Culture and History

Sec. 107 amends Section 113 of the Indian Health Care Improvement Act by strengthening the training requirements for tribal culture and history. Specifically, Sec. 107 expands the types of providers required to complete such training and makes the training an annual requirement.

Section 108: Staffing Demonstration Program

Sec. 108 adds a new section to Title VIII of the Indian Health Care Improvement Act. Specifically, Sec. 108 directs IHS to carry out a demonstration project in which IHS may provide Service units with staffing resources. The goal of these supplemental staffing resources is for them to become self-sustaining, and prioritization is given to Service units with historical staffing shortages, whose states have certain Medicaid reimbursement policies, and whose facilities are built in part with Tribal funds or are in a Service unit's master plan. The demonstration project lasts for at least 3 years and terminates after 4 years. HHS must submit an evaluation of the demonstration project to Congress.

Section 109: Rule Establishing Tribal Consultation Policy

Sec. 109 adds a new section to Title VIII of the Indian Health Care Improvement Act. Specifically, Sec. 109 requires HHS to update and replace its 2006 Tribal consultation policy (or successor regulation) for IHS by December 31, 2023, and once every 5 years thereafter.

Section 110: Treatment of Certain Hospitals

Sec. 110 makes permanent a policy included in CMS' 2018 IPPS Final Rule clarifying that eligibility for the IPPS low-volume hospital designation for IHS hospitals is not dependent upon its distance from the nearest non-IHS IPPS hospital, and vice versa. This policy only applies to IHS hospitals' whose sole disqualifier is its proximity to the nearest non-IHS IPPS hospital (and vice versa).

Section 111: Enhancing Quality of Care in the Indian Health Service

Sec. 111 requires HHS to consult with Indian tribes, governing boards, Area offices, Service units, and other stakeholders and establish best practices for governing boards and Area offices. Specifically, governing board best practices must contain provisions relating to facility compliance with IHS and CMS program and reporting requirements, documenting and responding to patient complaints, and documenting instances of professional misconduct by facility staff. Similarly, best practices for Area offices must provide information on strategies for how to best monitor governing board activities relating to handling patient complaints and ensuring compliance with IHS and CMS program requirements.

Sec. 111 further requires HHS, in coordination with AHRQ, NQF, Tribes, and IHS, to undertake a review of quality and performance measures of Service facilities used in GPRA and CMS programs. HHS is required to submit a report to Congress on the suitability of this measures for IHS facilities and the extent to which they are outcome-based or process-based. HHS must also, to the extent practicable, assist IHS facilities in adopting more suitable quality and performance measures under GPRA and CMS. GAO must also submit a report to Congress on challenges relating to quality measure and data collection in IHS facilities.

Finally, Sec. 111 directs HHS, in coordination with CMS and QIOs, to establish a compliance assistance program for underperforming, Medicare-participating facilities operated by IHS (with the option for Tribal facilities to participate). Eligibility for the compliance assistance program considers, among other factors, staff turnover, severity and number of facility deficiencies, history of provider misconduct and patient harm, and poor performance on quality measures. HHS shall select at least 25% of eligible facilities to participate in the program for a period of two years, with the option for HHS to terminate a facility from the program if it makes satisfactory improvement. The program provides on-site consultation and educational programming for facilities to ensure they meet conditions of participation under Medicare and are satisfactorily implementing quality initiatives established by IHS and CMS. It terminates after 6 years, and GAO must submit a report to Congress evaluating its effectiveness.

Section 112: Notification of Investigation Regarding Professional Conduct; Submission of Records

Sec. 112 adds a new section to Title VIII of the Indian Health Care Improvement Act. Specifically, Sec. 112 requires IHS to notify and provide relevant records to State medical boards upon its beginning an investigation into the professional conduct of a licensee practicing at an IHS facility.

Section 113: Medical Chaperones; Office of Patient Advocacy

Sec. 113 adds a new section to Title II of the Indian Health Care Improvement Act. Specifically, Sec. 113 requires the IHS, at the request of a patient, to provide a medical chaperone during a medical examination, as well as to notify patients of such right to a medical chaperone. Sec. 113 further establishes an Office of Patient Advocacy within HHS that carries out a patient advocacy program for IHS. Such patient advocacy program employs and trains patient advocates to, among other things, assist patients in resolving facility complaints, collecting information and analyzing such information on patient complaints, facilitating the operation of a patient advocate tracking system, and ensuring Indians are aware of their rights as a patient.

Section 114: Fitness of Health Care Providers

Sec. 114 adds a new section to Title VIII of the Indian Health Care Improvement Act. Specifically, Sec. 114 requires IHS, as part of the hiring process, to solicit from the medical board of each state in which a provider has a medical license information on such provider's history of license violations or settlements over the previous 20 years. Additionally, Sec. 114 requires 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. Finally, Sec. 114 directs IHS to submit a report to Congress regarding its compliance with the aforementioned Sec. 114 policies.

Section 115: Standards to Improve Timeliness of Care

Sec. 115 adds a new section to Title IV of the Indian Health Care Improvement Act. Specifically, Sec. 115 requires IHS to establish, via regulation, standards to measure the timeliness of provision of health care services in IHS facilities. It further requires the provision of such standards to each Service unit and for the development of a process to collect such data.

Section 201: Employee Protections Against Retaliation

Sec. 201 adds a new section to Title VI of the Indian Health Care Improvement Act. Specifically, Sec. 201 requires IHS employees who witness whistleblower retaliation or a violation of patient safety requirements to submit a report to a non-IHS official within HHS. Sec. 201 further authorizes HHS to remove an IHS employee from the civil service for such

whistleblower retaliation, as well as provides HHS with authority to take actions as it deems necessary to enhance whistleblower protections.

Section 202: Right of Federal Employees to Petition Congress

Sec. 202 amends Sec. 7211 of Title 5, U.S.C. relating to the right to petition Congress. Specifically, Sec. 202 clarifies that a covered employee who interferes with such right may be subject to suspension or pay grade reduction, among other things. Sec. 202 also requires IHS to take certain steps to ensure IHS employees are aware of such right to petition Congress.

Section 203: Fiscal Accountability

Sec. 203 adds a new section to Title VI of the Indian Health Care Improvement Act. Specifically, Sec. 203 prohibits IHS from providing salary increases or bonuses for certain political appointees and Senior Executive Service positions if it does not submit required professional housing and staffing plans to GAO by the given statutory deadline (see Sec. 302). Furthermore, Sec. 203 requires IHS, in consultation with Tribes, to use unobligated funding and third-party collections for the costs of essential medical equipment, purchased or referred care, and staffing, as well as expressly prohibits such funds from being used to increase pay for Area office employees or remodel Area offices. Sec. 203 also requires HHS to provide annual reports to Congress describing its authorization, outlays, and transfers of funding of each level of the Service (headquarters, Area, Service, clinic/facility) to each Indian tribe and specified Congressional committees. Finally, Sec. 203 requires IHS to provide annual reports to the aforementioned entities regarding the safety, billing, certification, credential, and compliance status of each IHS-supported facility.

Nothing in this section 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.

Section 301: Definitions

Section 302: Reports by the Secretary of Health and Human Services

Sec. 302 requires HHS to submit written plans to Congress to address professional housing needs for IHS employees and related staffing needs for IHS facilities (including Tribal health programs).

Section 303: Reports by the Comptroller General

Sec. 303 requires GAO, within 2 years of receiving the housing needs and staffing needs reports described in Sec. 302, to submit reports to Congress including an assessment of such plans and projections of such needs, as applicable. Sec. 303 additionally requires GAO to issue a report, within 1 year of enactment, regarding the efficacy of existing IHS whistleblower protections and accompanying policy recommendations.

Section 304: Inspector General Reports

Sec. 304 requires the Inspector General of HHS, within 2 years of enactment, to issue a report to Congress and IHS regarding patient harm events and deaths occurring in Service units and deferrals and denials of patient care. It similarly requires, within 2 years of enactment, that the Inspector General of HHS conduct an audit of IHS' reporting systems and provide recommendations and technical assistance to address such reporting systems.

Section 305: Transparency in CMS Surveys

Sec. 305 amends Sec. 1880 of the Social Security Act relating to Indian Health Service facilities. Specifically, Sec. 305 directs CMS to conduct surveys, at least once every 2 years, of Medicare-participating hospitals' and skilled nursing facilities' compliance with conditions of participation and EMTALA. Such surveys are to be publicly posted on the Internet, subject to HIPAA privacy protections.

Section 401: Technical Amendments