

116TH CONGRESS
1ST SESSION

S. 498

To provide for an independent outside audit of the Indian Health Service.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 14, 2019

Mr. ROUNDS introduced the following bill; which was read twice and referred
to the Committee on Indian Affairs

A BILL

To provide for an independent outside audit of the Indian
Health Service.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Assessment of the In-
5 dian Health Service Act of 2019”.

6 **SEC. 2. ASSESSMENT OF THE INDIAN HEALTH SERVICE.**

7 (a) DEFINITIONS.—In this section:

8 (1) REPUTABLE PRIVATE ENTITY.—The term
9 “reputable private entity” means a private entity
10 that—

1 (A) has experience with, and proven out-
2 comes in optimizing the performance of, Fed-
3 eral health care delivery systems, the private
4 sector, and health care management; and

5 (B) specializes in implementing large-scale
6 organizational and cultural transformations, es-
7 pecially with respect to health care delivery sys-
8 tems.

9 (2) SECRETARY.—The term “Secretary” means
10 the Secretary of Health and Human Services.

11 (3) SERVICE.—The term “Service” means the
12 Indian Health Service.

13 (b) ASSESSMENT.—Not later than 180 days after the
14 date of enactment of this Act, the Secretary shall enter
15 into one or more contracts with a reputable private entity
16 to conduct an independent assessment of the health care
17 delivery systems and financial management processes of
18 the Service. The Secretary shall not be required to provide
19 a full and open competition in entering into such con-
20 tracts. Such independent assessment shall be made only
21 of Service-operated facilities.

22 (c) PROGRAM INTEGRATOR.—

23 (1) IN GENERAL.—If the Secretary enters into
24 contracts under this section with more than 1 rep-
25 utable private sector entity, the Secretary shall des-

1 designate one such entity that is predominantly a
2 health care organization as the program integrator.

3 (2) RESPONSIBILITIES.—The program inte-
4 grator designated under paragraph (1) shall be re-
5 sponsible for coordinating the outcomes of the as-
6 sessments conducted by the reputable private enti-
7 ties under this section.

8 (d) COORDINATION WITH GAO AND OIG.—As part
9 of planning or designing the assessment described in sub-
10 section (b), the Secretary (or the program integrator des-
11 ignated under subsection (c)(1) acting on behalf of the
12 Secretary) shall consult with the Comptroller General of
13 the United States and the Inspector General of the De-
14 partment of Health and Human Services to minimize du-
15 plications in the areas of study required under subsection
16 (e) and to incorporate the Government Accountability Of-
17 fice's and Office of Inspector General's prior, publicly re-
18 leased, and relevant report findings dated January 1,
19 2013, or later, as appropriate.

20 (e) AREAS OF STUDY.—Each assessment conducted
21 under subsection (b) shall address each of the following:

22 (1) Current and projected demographics and
23 unique health care needs of the patient population
24 served by the Service.

1 (2) Current and projected health care capabili-
2 ties and resources of the Service, including hospital
3 care, medical services, and other health care fur-
4 nished by non-Service facilities under contract with
5 the Service, to provide timely and accessible care to
6 eligible patients.

7 (3) The authorities and mechanisms under
8 which the Secretary may furnish hospital care, med-
9 ical services, and other health care at non-Service fa-
10 cilities.

11 (4) The appropriate systemwide access standard
12 applicable to hospital care, medical services, and
13 other health care furnished by and through the Serv-
14 ice, including an identification of appropriate access
15 standards for each individual specialty and post-care
16 rehabilitation.

17 (5) The workflow process at each medical facil-
18 ity of the Service for providing hospital care, medical
19 services, or other health care from the Service.

20 (6) The organization, workflow processes, and
21 tools used by the Service to support clinical staffing,
22 access to care, effective length-of-stay management
23 and care transitions, positive patient experience, ac-
24 curate documentation, and subsequent coding of in-
25 patient services.

1 (7) The staffing level at each medical facility of
2 the Service and the productivity of each health care
3 provider at such medical facility, compared with
4 health care industry performance metrics, which
5 may include an assessment of any of the following:

6 (A) The case load of, and number of pa-
7 tients treated by, each health care provider at
8 such medical facility during an average week.

9 (B) The time spent by such health care
10 provider on matters other than the case load of
11 such health care provider.

12 (C) The percentage of Service personnel
13 carrying out administrative duties compared to
14 direct health care duties, as compared to the
15 percentage of private health care institution
16 personnel carrying out administrative duties
17 compared to direct health care duties.

18 (D) The allocation of the budget of the
19 Service used for administration compared with
20 the allocation of the budget used for direct
21 health care at Service-operated facilities.

22 (E) Any vacancies in positions of full-time
23 equivalent employees that the Service has not
24 filled during the 12-month period beginning on
25 the date on which the position became vacant.

1 (F) The disposition of amounts budgeted
2 for full-time equivalent employees that is not
3 used for those employees because the positions
4 of the employees are vacant, including—

5 (i) whether the amounts are rede-
6 ployed; and

7 (ii) if the amounts are redeployed,
8 how the redeployment is determined.

9 (G) With respect to the approximately
10 3,700 Medicaid-reimbursable full-time equiva-
11 lent employees of the Service—

12 (i) the number of those employees who
13 are certified coders;

14 (ii) how that number of employees
15 compares with health care industry stand-
16 ards for staffing of certified coders; and

17 (iii) how much time is spent on train-
18 ing and participating in continuing edu-
19 cation courses once employed by the Serv-
20 ice.

21 (8) The information technology strategies of the
22 Service with respect to furnishing and managing
23 health care, including an identification of any weak-
24 nesses and opportunities with respect to the tech-
25 nology used by the Service, especially those strate-

gies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Service in Service or non-Service facilities.

(9) Business processes of the Service, including processes relating to furnishing non-Service health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(A) To avoid the payment of penalties to vendors.

(B) To increase the collection of amounts owed to the Service for hospital care, medical services, or other health care provided by the Service for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(C) To increase the collection of any other amounts owed to the Service with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

1 (D) To increase the accuracy and timeli-
 2 ness of Service payments to vendors and pro-
 3 viders.

4 (10) The purchasing, distribution, and use of
 5 pharmaceuticals, medical and surgical supplies, med-
 6 ical devices, and health care related services by the
 7 Service, including the following:

8 (A) The prices paid for, standardization of,
 9 and use by the Service of, the following:

10 (i) Pharmaceuticals.

11 (ii) Medical and surgical supplies.

12 (iii) Medical devices.

13 (B) The use by the Service of group pur-
 14 chasing arrangements to purchase pharma-
 15 ceuticals, medical and surgical supplies, medical
 16 devices, and health care related services.

17 (C) The strategy and systems used by the
 18 Service to distribute pharmaceuticals, medical
 19 and surgical supplies, medical devices, and
 20 health care related services to medical facilities
 21 of the Service.

22 (11) The process of the Service for carrying out
 23 construction and maintenance projects at medical fa-
 24 cilities of the Service and the medical facility leasing
 25 program of the Service, including—

1 (A) whether the maintenance budget is up-
 2 dated or increased to reflect increases in main-
 3 tenance costs with the addition of new facilities
 4 and whether any increase is sufficient to sup-
 5 port the growth of the facilities; and

6 (B) what the process is for facilities that
 7 reach the end of their proposed life cycle.

8 (12) The competency of leadership with respect
 9 to culture, accountability, reform readiness, leader-
 10 ship development, physician alignment, employee en-
 11 gagement, succession planning, and performance
 12 management, including—

13 (A) the reasons leading tribal leadership to
 14 request increased transparency and more open
 15 communication between the Service and the
 16 people served by the Service; and

17 (B) whether any checks and balances exist
 18 to assess potential fraud or misuse of amounts
 19 within the Service.

20 (13) The lack of a funding formula to distribute
 21 base funding to the 12 Service areas, including the
 22 following:

23 (A) The establishment of the current proc-
 24 ess of funding being distributed based on his-

1 torical allocations and not on need such as pop-
2 ulation growth, number of facilities, etc.

3 (B) The communication to area office di-
4 rectors on distribution decisionmaking.

5 (C) How the tribal and residual shares are
6 determined for each Indian tribe and the
7 amounts of those shares.

8 (D) The auditing or evaluation process
9 used by the Service to determine whether
10 amounts are distributed and expended appro-
11 priately, including—

12 (i) whether periodic or end-of-year
13 records document the actual distributions;
14 and

15 (ii) whether any auditing or evalua-
16 tion is conducted in accordance with gen-
17 erally accepted accounting principles or
18 other appropriate practices.

19 (14) Whether the Service tracks patients eligi-
20 ble for two or more of either the Medicaid program
21 under title XIX of the Social Security Act (42
22 U.S.C. 1396 et seq.), health care received through
23 the Service, or any other Federal health care pro-
24 gram (referred to in this section as “dual eligible pa-

1 tients”). If so, how dual eligible patients are man-
2 aged.

3 (15) The number of procurement contracts en-
4 tered into and awards made by the Service under
5 section 23 of the Act of June 25, 1910 (commonly
6 known as the “Buy Indian Act”) (25 U.S.C. 47),
7 and a comparison of that number, with—

8 (A) the total number of procurement con-
9 tracts entered into and awards made by the
10 Service during 2015, 2016, 2017, and 2018;
11 and

12 (B) the process used by the Service facili-
13 ties to ensure compliance with section 23 of the
14 Act of June 25, 1910 (commonly known as the
15 “Buy Indian Act”) (25 U.S.C. 47).

16 (16) An assessment of the availability of cancer
17 services for populations living on large, rural Indian
18 reservations, individual billing information, and re-
19 imbursement claims of patients.

20 (17) Any other items determined to be ad-
21 dressed during the course of the assessment.

22 (f) REPORT ON ASSESSMENT.—

23 (1) SUBMISSION TO SECRETARY.—Not later
24 than 240 days after the date that a contract is en-

1 tered into under subsection (b), the entity carrying
2 out the assessment under the contract shall—

3 (A) complete the assessment; and

4 (B) submit to the Secretary a report de-
5 scribing the findings and recommendations of
6 the entity with respect to the assessment.

7 (2) SUBMISSION TO CONGRESS.—Immediately
8 on receipt of the report under paragraph (1)(B), the
9 Secretary shall submit the report to—

10 (A) the appropriate committees of Con-
11 gress, including—

12 (i) the Committee on Appropriations
13 of the Senate; and

14 (ii) the Committee on Appropriations
15 of the House of Representatives;

16 (B) the Majority Leader of the Senate;

17 (C) the Minority Leader of the Senate;

18 (D) the Speaker of the House of Rep-
19 resentatives; and

20 (E) the Minority Leader of the House of
21 Representatives.

22 (3) PUBLICATION.—Not later than 30 days
23 after receiving the report under paragraph (1)(B),
24 the Secretary shall publish such report in the Fed-

1 eral Register and on an Internet website of the Serv-
2 ice that is accessible to the public.

3 (g) FUNDING FOR INDEPENDENT OUTSIDE ASSESS-
4 MENT.—The Secretary shall use such amounts as are nec-
5 essary from other amounts available to the Secretary that
6 are not otherwise obligated to fund the contract under
7 subsection (b). Such amounts shall not come from funds
8 available to the Indian Health Service.

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