116TH CONGRESS
1ST SESSION

# S. 498

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

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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

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# A BILL

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

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Assessment of the Indian Health Service Act of 2019''.

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

(a) DEFINITIONS.—In this section:

(1) REPUTABLE PRIVATE ENTITY.—The term ''reputable private entity'' means a private entity that—

(A) has experience with, and proven outcomes in optimizing the performance of, Federal health care delivery systems, the private sector, and health care management; and

(B) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) SERVICE.—The term ''Service'' means the Indian Health Service.

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

(c) PROGRAM INTEGRATOR.—

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

ignate one such entity that is predominantly a health care organization as the program integrator.

(2) RESPONSIBILITIES.—The program integrator designated under paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the reputable private entities under this section.

(d) COORDINATION WITH GAO AND OIG.—As part of planning or designing the assessment described in subsection (b), the Secretary (or the program integrator designated under subsection (c)(1) acting on behalf of the Secretary) shall consult with the Comptroller General of the United States and the Inspector General of the Department of Health and Human Services to minimize duplications in the areas of study required under subsection (e) and to incorporate the Government Accountability Office's and Office of Inspector General's prior, publicly released, and relevant report findings dated January 1, 2013, or later, as appropriate.

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

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

(2) Current and projected health care capabilities and resources of the Service, including hospital care, medical services, and other health care furnished by non-Service facilities under contract with the Service, to provide timely and accessible care to eligible patients.

(3) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Service facilities.

(4) The appropriate systemwide access standard applicable to hospital care, medical services, and other health care furnished by and through the Service, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(5) The workflow process at each medical facility of the Service for providing hospital care, medical services, or other health care from the Service.

(6) The organization, workflow processes, and tools used by the Service to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

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

(A) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

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

(C) The percentage of Service personnel carrying out administrative duties compared to direct health care duties, as compared to the percentage of private health care institution personnel carrying out administrative duties compared to direct health care duties.

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

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

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

(i) whether the amounts are redeployed; and

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

(G) With respect to the approximately 3,700 Medicaid-reimbursable full-time equivalent employees of the Service—

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

(ii) how that number of employees compares with health care industry standards for staffing of certified coders; and

(iii) how much time is spent on training and participating in continuing education courses once employed by the Service.

(8) The information technology strategies of the Service with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology 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.

(D) To increase the accuracy and timeliness of Service payments to vendors and providers.

(10) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Service, including the following:

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

(i) Pharmaceuticals.

(ii) Medical and surgical supplies.

(iii) Medical devices.

(B) The use by the Service of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

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

(11) The process of the Service for carrying out construction and maintenance projects at medical facilities of the Service and the medical facility leasing program of the Service, including—

(A) whether the maintenance budget is updated or increased to reflect increases in maintenance costs with the addition of new facilities and whether any increase is sufficient to support the growth of the facilities; and

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

(12) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management, including—

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

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

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

(A) The establishment of the current process of funding being distributed based on his-

torical allocations and not on need such as population growth, number of facilities, etc.

(B) The communication to area office directors on distribution decisionmaking.

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

(D) The auditing or evaluation process used by the Service to determine whether amounts are distributed and expended appropriately, including—

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

(ii) whether any auditing or evaluation is conducted in accordance with generally accepted accounting principles or other appropriate practices.

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

tients''). If so, how dual eligible patients are managed.

(15) The number of procurement contracts entered into and awards made by the Service under section 23 of the Act of June 25, 1910 (commonly known as the ''Buy Indian Act'') (25 U.S.C. 47), and a comparison of that number, with—

(A) the total number of procurement contracts entered into and awards made by the Service during 2015, 2016, 2017, and 2018; and

(B) the process used by the Service facilities to ensure compliance with section 23 of the Act of June 25, 1910 (commonly known as the ''Buy Indian Act'') (25 U.S.C. 47).

(16) An assessment of the availability of cancer services for populations living on large, rural Indian reservations, individual billing information, and reimbursement claims of patients.

(17) Any other items determined to be addressed during the course of the assessment.

(f) REPORT ON ASSESSMENT.—

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

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

(A) complete the assessment; and

(B) submit to the Secretary a report describing the findings and recommendations of the entity with respect to the assessment.

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

(A) the appropriate committees of Congress, including—

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

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

(B) the Majority Leader of the Senate;

(C) the Minority Leader of the Senate;

(D) the Speaker of the House of Representatives; and

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

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

eral Register and on an Internet website of the Service that is accessible to the public.

(g) FUNDING FOR INDEPENDENT OUTSIDE ASSESSMENT.—The Secretary shall use such amounts as are necessary from other amounts available to the Secretary that are not otherwise obligated to fund the contract under subsection (b). Such amounts shall not come from funds available to the Indian Health Service.

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