115TH CONGRESS
1ST SESSION

S. 465

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

IN THE SENATE OF THE UNITED STATES

FEBRUARY 28, 2017

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 "Independent Outside
5 Audit of the Indian Health Service Act of 2017".

6 **SEC. 2. INDEPENDENT OUTSIDE AUDIT OF THE INDIAN**
7 **HEALTH SERVICE.**

8 (a) DEFINITIONS.—In this section:

9 (1) REPUTABLE PRIVATE ENTITY.—The term
10 "reputable private entity" means a private entity
11 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 90 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.
19 (c) PROGRAM INTEGRATOR.—
20 (1) IN GENERAL.—If the Secretary enters into
21 contracts under this section with more than 1 rep-
22 utable private sector entity, the Secretary shall des-
23 ignate one such entity that is predominantly a
24 health care organization as the program integrator.

1 (2) RESPONSIBILITIES.—The program inte-
2 grator designated under paragraph (1) shall be re-
3 sponsible for coordinating the outcomes of the as-
4 sessments conducted by the reputable private enti-
5 ties under this section.
6 (d) AREAS OF STUDY.—Each assessment conducted
7 under subsection (b) shall address each of the following:
8 (1) Current and projected demographics and
9 unique health care needs of the patient population
10 served by the Service.
11 (2) Current and projected health care capabili-
12 ties and resources of the Service, including hospital
13 care, medical services, and other health care fur-
14 nished by non-Service facilities under contract with
15 the Service, to provide timely and accessible care to
16 eligible patients.
17 (3) The authorities and mechanisms under
18 which the Secretary may furnish hospital care, med-
19 ical services, and other health care at non-Service fa-
20 cilities, including whether it is recommended that
21 the Secretary have the authority to furnish such
22 care and services at such facilities through the com-
23 pletion of episodes of care.
24 (4) The appropriate systemwide access standard
25 applicable to hospital care, medical services, and

1 other health care furnished by and through the Serv-
2 ice, including an identification of appropriate access
3 standards for each individual specialty and post-care
4 rehabilitation.
5 (5) The workflow process at each medical facil-
6 ity of the Service for scheduling appointments to re-
7 ceive hospital care, medical services, or other health
8 care from the Service.
9 (6) The organization, workflow processes, and
10 tools used by the Service to support clinical staffing,
11 access to care, effective length-of-stay management
12 and care transitions, positive patient experience, ac-
13 curate documentation, and subsequent coding of in-
14 patient services.
15 (7) The staffing level at each medical facility of
16 the Service and the productivity of each health care
17 provider at such medical facility, compared with
18 health care industry performance metrics, which
19 may include an assessment of any of the following:
20 (A) The case load of, and number of pa-
21 tients treated by, each health care provider at
22 such medical facility during an average week.
23 (B) The time spent by such health care
24 provider on matters other than the case load of
25 such health care provider.

1 (C) The amount of personnel used for ad-
2 ministration compared with direct health care
3 in the Service being comparable to the amount
4 used for administration compared with direct
5 health care in private health care institutions.
6 (D) The allocation of the budget of the
7 Service used for administration compared with
8 the allocation of the budget used for direct
9 health care at Service-operated facilities.
10 (E) Any vacancies in positions of full-time
11 equivalent employees that the Service—
12 (i) does not intend to fill; or
13 (ii) has not filled during the 12-month
14 period beginning on the date on which the
15 position became vacant.
16 (F) The disposition of amounts budgeted
17 for full-time equivalent employees that is not
18 used for those employees because the positions
19 of the employees are vacant, including—
20 (i) whether the amounts are rede-
21 ployed; and
22 (ii) if the amounts are redeployed,
23 how the redeployment is determined.

1 (G) With respect to the approximately
2 3,700 Medicaid-reimbursable full-time equiva-
3 lent employees of the Service—
4 (i) the number of those employees who
5 are certified coders; and
6 (ii) whether that number of employees
7 is necessary.
8 (8) The information technology strategies of the
9 Service with respect to furnishing and managing
10 health care, including an identification of any weak-
11 nesses and opportunities with respect to the tech-
12 nology used by the Service, especially those strate-
13 gies with respect to clinical documentation of epi-
14 sodes of hospital care, medical services, and other
15 health care, including any clinical images and associ-
16 ated textual reports, furnished by the Service in
17 Service or non-Service facilities.
18 (9) Business processes of the Service, including
19 processes relating to furnishing non-Service health
20 care, insurance identification, third-party revenue
21 collection, and vendor reimbursement, including an
22 identification of mechanisms as follows:
23 (A) To avoid the payment of penalties to
24 vendors.

1 (B) To increase the collection of amounts
2 owed to the Service for hospital care, medical
3 services, or other health care provided by the
4 Service for which reimbursement from a third
5 party is authorized and to ensure that such
6 amounts collected are accurate.
7 (C) To increase the collection of any other
8 amounts owed to the Service with respect to
9 hospital care, medical services, and other health
10 care and to ensure that such amounts collected
11 are accurate.
12 (D) To increase the accuracy and timeli-
13 ness of Service payments to vendors and pro-
14 viders.
15 (10) The purchasing, distribution, and use of
16 pharmaceuticals, medical and surgical supplies, med-
17 ical devices, and health care related services by the
18 Service, including the following:
19 (A) The prices paid for, standardization of,
20 and use by the Service of, the following:
21 (i) Pharmaceuticals.
22 (ii) Medical and surgical supplies.
23 (iii) Medical devices.
24 (B) The use by the Service of group pur-
25 chasing arrangements to purchase pharma-

1 ceuticals, medical and surgical supplies, medical
2 devices, and health care related services.
3 (C) The strategy and systems used by the
4 Service to distribute pharmaceuticals, medical
5 and surgical supplies, medical devices, and
6 health care related services to medical facilities
7 of the Service.
8 (11) The process of the Service for carrying out
9 construction and maintenance projects at medical fa-
10 cilities of the Service and the medical facility leasing
11 program of the Service, including—
12 (A) whether the maintenance budget is up-
13 dated or increased to reflect increases in main-
14 tenance costs with the addition of new facilities
15 and whether any increase is sufficient to sup-
16 port the growth of the facilities; and
17 (B) what the process is for facilities that
18 reach the end of their proposed life cycle.
19 (12) The competency of leadership with respect
20 to culture, accountability, reform readiness, leader-
21 ship development, physician alignment, employee en-
22 gagement, succession planning, and performance
23 management, including—
24 (A) the reasons for a lack in transparency
25 in the culture of the Service, leading tribal lead-

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

(B) How the implementation of self-governance policies has impacted health care delivery.

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

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

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

1 (i) whether periodic or end-of-year
2 records document the actual distributions;
3 and
4 (ii) whether any auditing or evalua-
5 tion is conducted in accordance with gen-
6 erally accepted accounting principles or
7 other appropriate practices.
8 (14) Whether the Service tracks patients eligi-
9 ble for two or more of either the Medicaid program
10 under title XIX of the Social Security Act (42
11 U.S.C. 1396 et seq.), health care received through
12 the Service, or any other Federal health care pro-
13 gram (referred to in this section as ''dual eligible pa-
14 tients''). If so, how dual eligible patients are man-
15 aged.
16 (15) The number of procurement contracts en-
17 tered into and awards made by the Service under
18 section 23 of the Act of June 25, 1910 (commonly
19 known as the ''Buy Indian Act'') (25 U.S.C. 47),
20 and a comparison of that number, with—
21 (A) the total number of procurement con-
22 tracts entered into and awards made by the
23 Service during the 5 fiscal years prior to the
24 date of enactment of this Act; and

1 (B) the process used by the Service facili-
2 ties to ensure compliance with section 23 of the
3 Act of June 25, 1910 (commonly known as the
4 "Buy Indian Act") (25 U.S.C. 47).
5 (16) Any other items the reputable private enti-
6 ty determines should be addressed in the inde-
7 pendent assessment of the Service.
8 (e) REPORT ON ASSESSMENT.—
9 (1) SUBMISSION TO SECRETARY.—Not later
10 than 240 days after the date a contract is entered
11 into under subsection (b), the entity carrying out the
12 assessment under the contract shall—
13 (A) complete the assessment; and
14 (B) submit to the Secretary a report de-
15 scribing the findings and recommendations of
16 the entity with respect to the assessment.
17 (2) SUBMISSION TO CONGRESS.—Immediately
18 on receipt of the report under paragraph (1)(B), the
19 Secretary shall submit the report to—
20 (A) the appropriate committees of Con-
21 gress, including—
22 (i) the Committee on Appropriations
23 of the Senate; and
24 (ii) the Committee on Appropriations
25 of the House of Representatives;

1 (B) the Majority Leader of the Senate;
2 (C) the Minority Leader of the Senate;
3 (D) the Speaker of the House of Rep-
4 resentatives; and
5 (E) the Minority Leader of the House of
6 Representatives.
7 (3) PUBLICATION.—Not later than 30 days
8 after receiving the report under paragraph (1)(B),
9 the Secretary shall publish such report in the Fed-
10 eral Register and on an Internet website of the Serv-
11 ice that is accessible to the public.
12 (f) FUNDING.—The Secretary shall use, to carry out
13 this section, such amounts as are necessary from other
14 amounts available to the Secretary that are not otherwise
15 obligated.

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