115TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 115–1065
Part 1

RESTORING ACCOUNTABILITY IN THE INDIAN HEALTH SERVICE ACT OF 2018

DECEMBER 3, 2018.—Ordered to be printed

Mr. BISHOP of Utah, from the Committee on Natural Resources, submitted the following

R E P O R T

[To accompany H.R. 5874]

[Including cost estimate of the Congressional Budget Office]

The Committee on Natural Resources, to whom was referred the bill (H.R. 5874) to amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

PURPOSE OF THE BILL

The purpose of H.R. 5874 is to amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, and improve health services.

BACKGROUND AND NEED FOR LEGISLATION

The Indian Health Service (IHS) is an agency within the U.S. Department of Health and Human Services (HHS) which provides healthcare to approximately 2.2 million American Indians and Alaska Natives (AI/ANs) through 662 hospitals, clinics, and health stations on or near Indian reservations. The agency is headquartered in Rockville, Maryland, and is composed of 12 regions, or "Areas," each with a separate headquarters.[1] The agency offers "direct-service" healthcare, meaning care provided by federal

[1] The twelve areas of the IHS include: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson.

employees; it also acts as a conduit for federal funds for tribes that have utilized the Indian Self-Determination and Education Assistance Act (ISDEAA)[2] to independently operate their health facilities. The IHS also administers programs for Indians in urban areas. IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care in 36 States.

The Snyder Act of 1921[3] provides the basic authority for the federal provision of health services and benefits to Indians because of their federally-recognized tribal status. However, the modern statutory basis and framework for the federal provision of health care to Indians is under the Indian Health Care Improvement Act.[4] This law was permanently reauthorized in Title X of the Patient Protection and Affordable Care Act.[5] As noted, the ISDEAA authorizes tribes to assume the administration and program direction responsibilities that are otherwise carried out by the federal government through contracts, compacts and annual funding agreements negotiated with the IHS. In Fiscal Year 2015, more than $2.7 billion of IHS appropriations were administered by a tribe or tribal organization through contracts or compacts and related agreements.

In addition to providing direct-service healthcare to AI/ANs, the IHS also operates the Purchased/Referred Care (PRC) program. This program is designed to ensure AI/ANs can obtain care when it is not available at IHS facilities; the program is somewhat like the Choice Program in the Veterans Administration. In short, the program will pay private providers to provide care to AI/ANs.

The PRC program is seriously deficient. The IHS often denies PRC claims due to technicalities that are attributable to the program's complex and confusing referral process. This results in uncompensated care costs for private providers. Funding allocation is also a significant issue due in part to large cost overruns, including the provision of air and ground ambulance services to nearby cities that are often vast distances from remote Indian reservations. When PRC funding is tight, AI/ANs may be unable to obtain basic care except in the case of a life-or-limb emergency.

PRC's problems can primarily be attributed to the formula the IHS uses to distribute funds across the agency. The funding method is called "base funding," whereby each area is provided a base level—what it received the previous year—plus an annual adjustment for medical inflation and other items.[6] Government auditors have concluded that Congress should require IHS "to develop and use a new method to allocate all [PRC] program funds. . . ."[7]

The Great Plains Area (GPA) includes North Dakota, South Dakota, Nebraska, and Iowa. Headquartered in Aberdeen, South Dakota, the GPA serves over 120,000 tribal members and is home to some of the poorest and most rural counties in the United States. All IHS hospitals but one in the GPA are direct-service facilities.

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[2] 25 U.S.C. 5304 et seq.
[3] 25 U.S.C. 13.
[4] 25 U.S.C. 1601 et seq.
[5] 42 U.S.C. 18001.
[6] Government Accountability Office. "Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program." June 15, 2012. GAO–12–446. http://www.gao.gov/products/GAO-12-446.
[7] *Id.* at 26.

For decades, federally-run IHS facilities within the GPA have been dogged by extremely low-quality health care, and the GPA headquarters office has been accused of impropriety, nepotism, and corruption. Furthermore, the tribes served by the GPA are generally located on remote reservations that face long-term systemic problems such as high unemployment, alcohol and drug abuse, youth suicide epidemic, housing shortages, and lack of education.

The most recent major Congressional review of the IHS GPA occurred in 2010. The Senate Committee on Indian Affairs (SCIA) held an oversight hearing detailing the serious deficiencies in the GPA.[8] The hearing and its subsequent investigative findings were included in a report released by the SCIA in December 2010, colloquially referred to as the Dorgan Report.[9] The Congressional inquiry included the review of over 140,000 pages of documents from the IHS and HHS, visits to GPA facilities, and interviews with IHS employees. The report described in vivid detail a wide range of deficiencies inside the GPA, related to both medical care and administrative procedures. Specific deficiencies included overuse of transfers, reassignments, details, and administrative leave to deal with employees with records of misconduct or poor performance; missing or stolen narcotics, as well as inconsistent pharmaceutical audits; substantial and recurring diversions or reduced health care services; PRC program mismanagement; Centers for Medicare & Medicaid Services accreditation problems; significant backlogs in billings and claims collection; and discouraging employees from communicating with Congress.[10]

The 2010 SCIA report temporarily brought the GPA's problems to light but in the years that followed, the situation largely faded from public view. This was in part because the IHS repeatedly assured Congress that the issues featured in the SCIA report were being addressed. For example, the IHS budget justification accompanying the President's budget request has contained a paragraph related to the GPA, which says in part, "IHS places a high priority on the issues raised in the Senate Committee on Indian Affairs (SCIA) investigation of the IHS [GPA. . .in addition to implementing a corrective action plan to address findings. . .IHS will continue to implement and monitor improvements and corrective actions ." [11] Each year, the paragraph appeared to have been copied from the previous year's document under the Obama Administration.[12]

In March 2017, the Government Accountability Office listed Indian health in its biennial "high risk" report. Programs listed in the report are federal programs most vulnerable to waste, fraud,

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[8] U.S. Senate. Committee on Indian Affairs. *In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area,* September 28, 2010. 111th Congress. S. HRG. 111–873. http://www.indian.senate.gov/sites/default/files/upload/files/63826.pdf.

[9] U.S. Senate. Committee on Indian Affairs. In Critical Condition: *The Urgent Need to Reform the Indian Health Service's Aberdeen Area,* December 28, 2010. 111th Congress. ("Dorgan Report"). http://www.indian.senate.gov/sites/default/files/upload/files/Chairman-s-Report-In-Critical-Condition-12-28-10.pdf.

[10] Id. at 5–6.

[11] Department of Health and Human Services: Indian Health Service. *Justification of Estimates for Appropriations Committees, Fiscal Year 2017.* Pp. CJ–150. https://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2017CongressionalJustification.pdf.

[12] Department of Health and Human Services: Indian Health Service. *Justification of Estimates for Appropriations Committees, Fiscal Year 2016.* Pp. CJ–140. https://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2016CongressionalJustification.pdf.

abuse, and mismanagement, or that need transformative change. For nearly a decade, the IHS Inspector General and others have concluded that inadequate oversight of healthcare continues to hinder the ability of IHS to provide an adequate quality of care despite continued increases in the agency's budget.

Recent Developments in the Great Plains Area

The recent problems in the GPA surfaced in July 2015, when Centers for Medicare & Medicaid Services (CMS) terminated its provider contract with the Omaha-Winnebago IHS hospital in Nebraska, an action that CMS had threatened since the previous year.[13] The termination remains in effect today, and the hospital struggles with basic patient safety and access.

Since that time, CMS has surveyed three IHS hospitals in South Dakota; these hospitals were subsequently cited for quality and safety problems. The hospitals include the Rosebud, Pine Ridge, and Rapid City (Sioux San) service units.[14] At Rosebud, the quality of care in the Emergency Department (ED) was found to be so poor that the IHS temporarily closed it, diverting all emergency cases to hospitals in Winner, South Dakota, and Valentine, Nebraska, 55 miles and 44 miles away from Rosebud, respectively. This diversion has placed serious physical and financial strain on the Rosebud ambulance system.[15] According to Rosebud Tribal leaders, approximately nine patients have died in transit to these facilities since December 2015.[16]

On April 30, 2016, in an unprecedented move, CMS entered into System Improvement Agreements (SIAs) with the IHS for the Pine Ridge and Rosebud hospitals. These agreements came on the heels of multiple corrective actions on the part of the IHS for both hospitals and were intended to help the IHS avoid the imminent loss of its ability to bill CMS at the facilities. While the agreements were generally considered a positive step, Congresswoman Kristi L. Noem (R–ND), along with Senators John Barrasso (R–WY), John Thune (R–SD), and Mike Rounds (R–SD), raised concerns about several provisions in the agreements. Specifically, they questioned the cost associated with the agreements, the lack of tribal consultation in the development of the agreements, and the legal basis for the IHS's authority to implement the agreements.[17]

The largest piece of the SIAs was the requirement that the IHS alleviate acute staffing shortages by fully contracting the entire Emergency Departments for the Pine Ridge, Rosebud, and Winnebago hospitals (reassigning their current federal employees in the

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[13] Kaufman, Kirby. "Officials say Winnebago hospital will operate without federal funding." *Sioux City Journal,* July 24, 2015. http://siouxcityjournal.com/news/officials-say-winnebago-hospital-will-operate-without-federal-funding/article-5f283bb1-c660-5848-a710-40fbc551796c.html.

[14] Ferguson, Dana. "IHS hospital in 'immediate jeopardy,' feds say. *The Argus Leader,* May 24, 2016. http://www.argusleader.com/story/news/2016/05/23/reservation-hospital-immediate-jeopardy-feds-say/84812598/.

[15] Ferguson, Dana. "Rosebud IHS: For some, the drive to the ER is too much." *The Argus Leader,* April 30, 2016. http://www.argusleader.com/story/news/2016/04/30/rosebud-ihs-some-drive-er-too-much/83683940/.

[16] Ferguson, Dana. "Death toll mounts 7 months after ER shuttered." The Argus Leader, July 7, 2016. http://www.argusleader.com/story/news/2016/07/07/death-toll-mounts-7-months-after-er-shuttered/86783160/.

[17] May 13, 2016 letter from Representative Kristi Noem and Sens. John Barrasso, John Thune, and Mike Rounds, to HHS Secretary Sylvia Burwell. http://www.indian.senate.gov/news/press-release/barrasso-thune-rounds-and-noem-demand-answers-indian-health-service.

process).[18] On May 17, 2016, that contract was awarded to a staffing agency, AB Staffing Solutions, LLC, located in Arizona. While AB Staffing had a previous relationship with the IHS, many stakeholders expressed concerns that the IHS's request for proposals for the contract was quietly released without consulting tribal leadership and without notifying major medical providers based in the region, leaving them unable to bid.[19]

On June 13, 2016, due to the sudden death of a critical staff member, an Advanced Practice Registered Nurse Anesthetist, the surgical and obstetric services at Rosebud were temporarily diverted to Valentine, Nebraska, Martin, South Dakota, and Winner, South Dakota. The IHS is attempting to fill the position to restore surgical and obstetric services. As of June 2017, some of these services remained unavailable at Rosebud.

In September 2016, following a CMS survey, IHS announced the closure of yet another IHS hospital's emergency room, this time in Rapid City, South Dakota. The Rapid City Service Unit (colloquially called "Sioux San" because historically, the building served as the "Sioux Sanitarium") is the primary IHS facility in Rapid City. Though IHS officials said this closure was temporary, the facility has not reopened, and all emergency patients are being sent to Rapid City Regional Health, a community hospital in Rapid City.[20] Meanwhile, the Sioux San facility is operating solely as a 24-hour urgent care facility.[21] This comes on the heels of months of negotiations between IHS and Rapid City Regional Health related to previous unpaid claims totaling in the tens of millions of dollars. That issue remains unresolved.

In 2016, in response to the spate of closures and deficiencies, HHS began marshalling resources and directing them toward the Great Plains. HHS, through IHS and CMS, began implementing procedures designed to connect IHS hospitals with high-performing community hospitals throughout the country. For example, IHS announced a $6.8 million, one-year contract with Avera Health, a South Dakota-based hospital system, to provide telehealth technology to IHS facilities in the Great Plains. On June 7, 2017, HHS notified Congressional staff that IHS has begun rolling out additional telehealth services in Nebraska, North Dakota, and South Dakota. IHS intends to launch ED telehealth services at Pine Ridge and intended to extend those to other facilities in Nebraska and North Dakota by the end of June 2017.[22] Additionally, IHS partnered with CMS to include federally-operated IHS hospitals in the CMS "Hospital Engagement Network," or HEN program. According to IHS, HENs are designed "to help health care facilities

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[18] Ferguson, Dana. "Agreement on IHS hospital could hinge on privatization." *The Argus Leader,* April 26, 2016. http://www.argusleader.com/story/news/2016/04/26/agreement-ihs-hospital-could-hinge-privatization/83534836/.

[19] Ferguson, Dana. "Tribal leaders say they were left out of IHS call for help." *The Argus Leader,* April 22, 2016. http://www.argusleader.com/story/news/2016/04/22/tribal-leaders-say-they-were-left-out-ihs-call-help/83386886/.

[20] Ferguson, Dana. "Noem, Hawks criticize IHS after latest ER closure." *The Argus Leader,* September 14, 2016. http://www.argusleader.com/story/news/2016/09/14/noem-hawks-criticize-ihs-after-latest-er-closure/90346892/.

[21] "IHS shuts down Sioux San emergency room." *KOTA TV*. September 13, 2016. http://www.kotatv.com/content/news/IHS-shuts-down-Sioux-San-emergency-room-393313781.html.

[22] Email to congressional staff from HHS Acting Asst. Sec. for Legislation, Barbara Pisaro Clark. June 7, 2017.

deliver better care and to spend dollars efficiently."[23] The HEN program was established in the Patient Protection and Affordable Care Act to connect high-quality hospitals with other facilities to share best practices and encourage higher quality care at lower prices. Based on preliminary reports from the HEN in which Great Plains facilities are participating, the program has been moderately successful thus far.

Indian Health Service appropriations

Congress has increased IHS funding almost each year since the 2010 Dorgan Report. In Fiscal Years 2014 and 2015, Congress exceeded President Obama's budget request for the agency. Since 2008, funding for the IHS has increased by more than 50 percent. The House's Fiscal Year 2017 proposed appropriation sits at approximately $1 billion over Fiscal Year 2010 levels, yet the dangerous situation in the GPA and the staffing shortage problem throughout the 12 IHS Areas continues to exist, if not grow. In the Fiscal Year 2017 omnibus appropriation act, Congress appropriated $2 million to address deficiencies in IHS hospitals with accreditation emergencies and $29 million to address the overall accreditation emergencies (which are primarily located in the Great Plains).[24] In the Fiscal Year 2018 omnibus appropriations act, Congress appropriated $5.5 billion (an increase of $497 million) for IHS, which includes $58 million for accreditation emergencies.[25]

Recent legislative action

Action Two bills were introduced in the 114th Congress to address IHS deficiencies. Senator John Barrasso (R–WY) introduced S. 2953, the IHS Accountability Act.[26] The bill received a legislative hearing in the form of a field hearing in Rapid City, South Dakota, and was later marked up by the Indian Affairs Committee. In the House of Representatives, Congresswoman Kristi Noem introduced H.R. 5406, the Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act—or HEALTTH Act—with several bipartisan cosponsors. The bill received a legislative hearing in the Natural Resources Committee's Subcommittee on Indian, Insular, and Alaska Native Affairs.[27] No further action was taken before the end of the Congress.

At the beginning of the 115th Congress, a bill entitled Restoring Accountability in the IHS Act of 2017 was introduced in both the House and Senate as H.R. 2662 and S. 1250, respectively. The bill was a compromise that contained provisions of both S. 2953 and H.R. 5406 from the previous Congress. A hearing was held on S. 1250 on June 13, 2017,[28] and the bill was ordered reported on April 11, 2018. The House Natural Resources Committee held a

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[23] Indian Health Service. "IHS and CMS partnership to strengthen hospital care quality." May 13, 2016. https://www.ihs.gov/newsroom/pressreleases/2016pressreleases/ihs-and-cms-partnership-to-strengthen-hospital-care-quality/.

[24] Public Law 115–31.

[25] Public Law 115–141.

[26] S. 2953, IHS Accountability Act of 2016. https://www.congress.gov/bill/114th-congress/senate-bill/2953?q=%7B%22search%22%3A%5B%22ihs+accountability+act%22%5D%7D&r=2.

[27] https://naturalresources.house.gov/calendar/eventsingle.aspx?EventID=400894.

[28] Legislative Hearing. https://www.indian.senate.gov/hearing/legislative-hearing-receive-testimony-following-bills-s-1250-s-1275.

hearing on H.R. 2662 on June 21, 2017.[29] Since the hearings, the committees of jurisdiction in the House and Senate have continued to receive feedback from Indian tribes, tribal organizations, the IHS and other stakeholders.

On May 18, 2018, Congresswoman Kristi Noem introduced a revised version of H.R. 2662 as H.R. 5874. The reintroduced bill is substantially like S. 1250, as ordered reported. The bill also contains clarifying and technical amendment language addressing comments received to date.

H.R. 5874 would amend the Indian Health Care Improvement Act (IHCIA)[30] to improve the IHS by reforming the agency's personnel processes, medical credentialing system, fiscal accountability, and other operations. Specifically, the bill provides IHS broader hiring authority, and makes it easier to discipline and fire underperforming employees. Section 102 of this legislation prescribes that once a health care provider, who intends to volunteer their services, satisfies the requirements of the centralized credentialing system and obtains the requisite credentials from the IHS, those providers shall be deemed approved to provide services at any service unit under the control of the IHS without being further subjected to additional processes and procedures to obtain privileges at those units. It is the intent of this Committee that satisfying the requirements of the IHS's centralized credential system also satisfies the requirements of privileging for licensed professionals providing temporary medical services at each individual service unit.

Additional IHS reforms include requiring all IHS employees and contractors to undergo cultural competency training; improving IHS doctor recruitments by expanding the loan repayment program and existing recruitment tools; streamlining the volunteer credentialing process and reducing related paperwork burdens; providing transparency in reports from the Center for Medicare & Medicaid Services; requiring regular reporting from the IHS, the Government Accountability Office, and the HHS Office of Inspector General on patient care; and providing whistleblower retaliation protections for IHS employees.

SECTION-BY-SECTION ANALYSIS OF MAJOR PROVISIONS

TITLE I—INDIAN HEALTH SERVICE IMPROVEMENTS

Section 101. Incentives for recruitment and retention

- Improves IHS' recruitment activities by permanently expanding IHS' authority to provide increased pay for certain medical providers and enables IHS to pay relocation costs for employees and provide housing vouchers for employees.

Sec. 102. Medical credentialing system

- Requires IHS to develop an agency-wide centralized credentialing system for licensed health professionals, which is to be developed and implemented no later than one year after the date of enactment.

[29] Legislative Hearing: https://naturalresources.house.gov/calendar/eventsingle.aspx?EventID=402163.

[30] 25 U.S.C. 1601 et seq.

• This system must be uniform throughout the agency and allow credentialed individuals to provide services throughout the IHS system.
• IHS must consult with tribes in developing the system.

Sec. 103. Liability protections for health professional volunteers at Indian Health Service

• Deems health professionals who volunteer at IHS facilities employees of the Public Health Service.

Sec. 104. Clarification regarding eligibility for Indian Health Service loan repayment program

• Expands the types of professionals eligible for the IHS student loan repayment program to include individuals with master's degrees in business administration with an emphasis in health care management, health administration, hospital administration, or public health.
• Requires program participants to work at IHS two years or longer, or four years or longer if working half-time.

Sec. 105. Improvements in hiring practices

• Allows IHS direct hire authority.
• Requires IHS to provide a notice and comment period to a tribe before appointing, hiring, transferring, or reassigning a Senior Executive Service employee or a manager.
• Requires IHS to seek waivers of Indian preference hiring when 15 percent or more of an IHS facility's health professional positions are not filled by a full-time IHS employee for six months or more, or if the only available applicant is a former IHS or tribal employee who was removed or demoted for performance or misconduct within the previous five years.

Sec. 106. Improved authorities of Secretary to improve accountability of Senior Executives and employees of the Indian Health Service

• Expands IHS authority to reprimand, suspend, reassign, demote, or remove certain individuals from Senior Executive Service positions if it is determined that misconduct or performance warrants such action, and provides thorough due process for individuals subject to reprimand, suspension, reassignment, demotion, or removal.

Sec. 107. Tribal culture and history

• Requires IHS to develop a cultural training program that is mandatory for all IHS employees and IHS contractors.

Sec. 108. Staffing demonstration project

• Requires IHS to establish a demonstration project to determine whether increased staffing resources for certain facilities results in self-sustaining resources.
• The demonstration may operate as IHS deems appropriate, but each staffing position shall be for a period of no less than three fiscal years.

Sec. 109. Rule establishing tribal consultation policy

- Requires IHS to establish a tribal consultation policy.

Sec. 110. Treatment of certain hospitals

- Retroactively applies the provisions of a rule from the Centers for Medicare & Medicaid Services related to low-volume hospital payment adjustments.

TITLE II—EMPLOYEE PROTECTIONS

Sec. 201. Employee protections against retaliation

- Provides a process for mandatory reporting for witnesses of retaliation against a whistleblower, or a patient safety requirement, or similar misconduct.
- Allows IHS to remove employees who have retaliated against whistleblowers.
- Enhances protections for whistleblowers.

Sec. 202. Right of federal employees to petition Congress

- Reiterates the right of federal employees to petition Congress.
- Expands the federal government's ability to punish employees who interfere with another employee's right to petition Congress.
- Requires IHS to provide each IHS employee a memorandum reiterating his or her right to petition Congress.

Sec. 203. Fiscal accountability

- Provides that IHS may not provide raises or bonuses to certain high-ranking employees if it fails to submit the professional housing plan or staffing plan required by the bill.
- Requires IHS to spend unobligated and unspent amounts on patient care.
- Requires IHS to provide quarterly spending reports at each level of the agency to each tribe and Congress.

TITLE III—REPORTS

Sec. 302. Reports by the Secretary of Health and Human Services

- Requires IHS to develop and publish a professional housing plan that comports with recommendations of the Government Accountability Office (GAO).
- Requires IHS to develop and publish a staffing plan.
- Requires IHS to develop and publish a report on certain data under section 108 of the IHCIA.

Sec. 303. Reports by the Comptroller General

- Requires GAO to develop and submit to Congress a report regarding IHS housing needs.
- Requires GAO to develop and submit to Congress a report regarding IHS staffing needs.

Sec. 304. Inspector General reports

- Requires the HHS Inspector General to develop and submit to Congress and IHS a report on patient harm events occurring in the agency.

Sec. 304. Transparency in CMS surveys

• Requires CMS to conduct surveys of IHS facilities no less frequently than every two years and publish the results on the CMS website.

TITLE IV—TECHNICAL AMENDMENTS

Sec. 401. Technical amendments

• Replaces the term "contract health service" with "purchased/referred care" throughout the IHCIA.

COMMITTEE ACTION

H.R. 5874 was introduced on May 18, 2018, by Congresswoman Kristi L. Noem (R–SD). The bill was referred primarily to the Committee on Natural Resources, and in addition to the Committee on Energy and Commerce, the Committee on Ways and Means, and the Committee on Oversight and Government Reform. On June 13, 2018, the Committee on Natural Resources met to consider the bill. Congressman Paul A. Gosar (R–AZ) offered and withdrew amendment designated 114. No further amendments were offered, and the bill was ordered favorably reported to the House of Representatives by voice vote.

COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Regarding clause 2(b)(1) of rule X and clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee on Natural Resources' oversight findings and recommendations are reflected in the body of this report.

COMPLIANCE WITH HOUSE RULE XIII AND CONGRESSIONAL BUDGET ACT

1. Cost of Legislation and the Congressional Budget Act. With respect to the requirements of clause 3(c)(2) and (3) of rule XIII of the Rules of the House of Representatives and sections 308(a) and 402 of the Congressional Budget Act of 1974, the Committee has received the following estimate for the bill from the Director of the Congressional Budget Office:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 23, 2018.

Hon. ROB BISHOP,
Chairman, Committee on Natural Resources,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 5874, the Restoring Accountability in the Indian Health Service Act of 2018.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Robert Stewart.

Sincerely,

MARK P. HADLEY
(For Keith Hall, Director.)

Enclosure.

H.R. 5874—Restoring Accountability in the Indian Health Service Act of 2018

Summary: H.R. 5874 would change personnel practices of the Indian Health Service (IHS) to facilitate the recruitment and retention of employees, clarify eligibility for the IHS loan repayment program, allow the Secretary of Health and Human Services (HHS) to appoint qualified candidates directly to vacant positions that are difficult to fill, and require the IHS to implement new methods of measuring the timeliness of care. CBO estimates that implementing H.R. 5874 would cost $115 million over the 2019–2023 period, assuming appropriation of the necessary amounts.

H.R. 5874 also would apply the same liability protections available to all medical professionals employed by the Public Health Service to medical professionals who volunteer their service at IHS. CBO estimates that this provision would increase direct spending by less than $500,000 over the 2019–2023 period.

Because the bill would affect direct spending or revenues, pay-as-you-go procedures apply.

CBO estimates that enacting the legislation would not significantly increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2029.

H.R. 5874 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary effect of H.R. 5874 is shown in the following table. The costs of this legislation fall primarily within budget function 550 (health).

	By fiscal year, in millions of dollars—						
	2018	2019	2020	2021	2022	2023	2019–2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION *							
Incentives for Recruitment and Retention:							
Estimated Authorization Level	0	17	18	19	20	21	95
Estimated Outlays	0	17	18	19	20	21	95
Medical Credentialing System:							
Estimated Authorization Level	0	1	*	*	*	*	1
Estimated Outlays	0	1	*	*	*	*	1
Clarification Regarding Eligibility for the Indian Health Service Loan Repayment Program:							
Estimated Authorization Level	0	*	1	1	2	2	7
Estimated Outlays	0	*	1	1	2	2	7
Improvements in Hiring Practices:							
Estimated Authorization Level	0	1	1	1	1	1	5
Estimated Outlays	0	1	1	1	1	1	5
Tribal Culture and History:							
Estimated Authorization Level	0	*	*	*	*	*	1
Estimated Outlays	0	*	*	*	*	*	1
Rule Establishing Tribal Consultation Policy:							
Estimated Authorization Level	0	*	*	*	*	*	1
Estimated Outlays	0	*	*	*	*	*	1
Employee Protections Against Retaliation:							
Estimated Authorization Level	0	*	*	*	*	*	2
Estimated Outlays	0	*	*	*	*	*	2
Fiscal Accountability:							
Estimated Authorization Level	0	1	*	*	*	*	1
Estimated Outlays	0	1	*	*	*	*	1
Reports by the Comptroller General:							
Estimated Authorization Level	0	*	*	*	*	0	1
Estimated Outlays	0	*	*	*	*	0	1

	By fiscal year, in millions of dollars—						
	2018	2019	2020	2021	2022	2023	2019–2023
Transparency in CMS Surveys:							
Estimated Authorization Level	0	*	*	*	*	*	2
Estimated Outlays	0	*	*	*	*	*	2
Total Changes:							
Estimated Authorization Level	0	21	22	22	24	26	115
Estimated Outlays	0	21	22	22	24	26	115

Notes: * = less than $500,000; Components may not sum to totals because of rounding.
a. Enacting the legislation also would increase direct spending by less than $500,000 per year and over the 2019–2028 period.

Basis of estimate: For this estimate, CBO assumes that H.R. 5874 will be enacted near the end of fiscal year 2018 and that estimated amounts will be appropriated each year thereafter.

Spending subject to appropriation

Assuming appropriation of the necessary amounts, CBO estimates that implementing H.R. 5874 would cost $115 million over the 2019–2023 period.

Incentives for Recruitment and Retention. Section 101 of the bill would authorize the Secretary to pay all IHS employees with health care responsibilities according to pay scales used by the Department of Veterans Affairs (VA). Currently IHS uses that scale when compensating physicians and dentists but not nurses or pharmacists. The VA scale adjusts wages for the cost of living at the job location. CBO expects that with this new authority IHS would be more successful in recruiting and retaining employees, salaries would be more competitive across all of its service sites, and as a result, the number of nurses and pharmacists at IHS would increase gradually over time. Based on an analysis of data on the number of nurses and pharmacists employed by IHS and of the difference between the IHS and VA pay scales, CBO estimates that allowing IHS to compensate all health care employees at the VA pay scale would increase salaries for affected employees by an average of $11,000 to $14,000 annually (about 10 percent) and gradually would increase the number of nurses and pharmacists by 160 (about 5 percent) at a cost of $95 million over the 2019–2023 period.

Medical Credentialing System. Section 102 would require the Secretary to establish a credentialing process for health care practitioners who volunteer their services at IHS facilities. IHS allows volunteers to donate both medical and non-medical services to patients of the agency. Based on information provided by IHS, CBO expects that the agency would acquire an existing commercial credentialing system at a cost of approximately $500,000. Employees in IHS headquarters, various area offices, and hundreds of IHS facilities would coordinate and implement the system. In total, CBO estimates that the combination of the system's acquisition and the additional personnel time involved in its operation would cost about $1 million over the 2019–2023 period.

Clarification Regarding Eligibility for the Indian Health Service Loan Repayment Program. Section 104 would allow individuals with business administration and health management degrees to qualify for a repayment program for student loans through IHS. Under current law, IHS repays the student loans of some employees who are health care professionals in exchange for commitments

to work for IHS for at least two years. That loan repayment program costs about $28,000 per participating employee, on average. According to a 2016 HHS Office of the Inspector General (OIG) report, IHS has historically had difficulty recruiting and retaining health administrators. Providing loan repayments to management professionals could allow the IHS to be more successful in hiring additional management staff. However, many of the challenges to recruiting for IHS involve factors that are not related to financial compensation, such as the geographic isolation of many IHS facilities and a lack of nearby housing. CBO projects that permitting those with management and business degrees to receive loan repayments would gradually increase the number of loan recipients over time, reaching about 60 additional recipients by 2023. CBO estimates that this provision would cost $7 million over the 2019–2023 period.

Improvements in Hiring Practices. Section 105 would allow the Secretary to appoint a candidate directly to a position at IHS without regard to standard civil service practices as long as the candidate meets the job description of the Office of Personnel Management (OPM). CBO expects that the Secretary would use this authority rarely, mostly in situations when a qualified candidate is identified for a difficult-to-fill vacancy in a position of critical need. CBO estimates that there would be a small decrease in the roughly 1,500 currently unfilled vacancies at IHS, principally because direct Secretarial appointment would allow some candidates to start more quickly than they otherwise would. CBO estimates this provision would increase the number of employees at the agency by the equivalent of about 7 annually at a cost of $5 million over the 2019–2023 period.

Tribal Culture and History. Section 107 would require IHS to institute cultural competency training for any employee or contractor who has regular direct patient access. CBO expects that requirement to apply to most medical personnel and some administrative personnel. IHS would provide training annually, and completion would be a condition of employment with IHS. The agency uses an online system for conducting agency-wide training, including some cultural competency training, but the new requirement would involve more customization to account for specific tribes within the IHS territories. Based on information provided by IHS, CBO projects that developing the additional training would require the equivalent of about 3 full-time employees, and the annual administration of the training would require the equivalent of about one full-time employee at an average cost of $124,000 per employee. In total, CBO estimates that this provision would cost about $1 million over the 2019–2023 period.

Rule Establishing Tribal Consultation Policy. Section 109 would require the Secretary, within one year, to establish a rule to update and replace the current tribal consultation process. IHS currently consults with tribes through national, regional and local meetings between IHS and tribal officials regarding a variety of topics, such as improving patient care delivery, setting priorities for diabetes and behavioral health care, and developing information systems. The new policy would identify circumstances when the Secretary should notify tribes, describe how they should be notified, and define what actions constitute meaningful consultation.

CBO projects that the equivalent of three full-time employees would be required for the rulemaking process, both from the IHS headquarters and the IHS area offices. Once the rule is promulgated, CBO expects the new rule would require more frequent consultation with the tribes than under current law, resulting in the equivalent of 1 full-time employee per year in additional staff time at an average annual cost of $124,000. In total, CBO estimates that this provision would cost about $1 million over the 2019–2023 period.

Employee Protection Against Retaliation. Section 201 would require the Secretary to designate an agency-level employee to reach out to all employees of IHS about federal and departmental protections for reporting retaliation against whistleblowers and about the duty of employees of IHS to report violations of patient safety requirements or other similar misconduct. In addition, the designated employee would receive reports from employees of IHS who witness misconduct and, within three days of receiving such a report, provide the report to the Secretary, who must formally review it and provide a copy to the HHS OIG. Finally, the Secretary could take other actions to protect whistleblowers, including identifying appropriate IHS employees to complete the Office of Special Counsel's Whistleblower Certification Program.

CBO projects that the designated employee would spend the equivalent of half a full-time employee on their new responsibilities initially and then the equivalent of one-quarter of a full-time employee thereafter. In addition, CBO expects that implementing this section would lead to a small increase in complaints from IHS employees, and therefore to a small increase in OIG investigations. CBO also expects that the Secretary would designate additional employees within IHS area offices and important health care delivery sites to complete the Office of Special Counsel's Whistleblower Certification Program each year. Taken together, CBO estimates that this provision would cost $2 million over the 2019–2023 period.

Fiscal Accountability. Section 203 would require the Secretary to issue quarterly reports to all Indian tribes and to the Congress describing all authorizations, expenditures, outlays, transfers, financial reprogramming, and obligations at each level of the IHS. In addition, the section would require the Secretary to issue annual reports to all Indian tribes and the Congress regarding the safety, billing, certification, credential, and compliance status of each IHS facility. Should the status of any facility change, the Secretary would issue updates describing the change. Based on information from IHS, CBO expects that the reports would require a significant investment of staff time to compile the information into report form and to write accompanying explanatory text. The greatest level of effort would occur in 2019 as IHS develops the two reports and then be somewhat less thereafter for annual updates to the reports. CBO projects that section 203 would require the equivalent of five full-time employees in 2019, the equivalent of three full-time employees in 2020, and then the equivalent of one full-time employee in subsequent years. In total, CBO estimates that the provision would cost about $1 million over the 2019–2023 period.

Reports by the Comptroller General. Section 303 would require the Government Accountability Office (GAO) to submit three re-

ports related to housing needs for IHS employees, staffing needs for the agency, and whether IHS has done enough to prevent retaliation against whistleblowers. Based on historical spending for similar activities, CBO estimates that this provision would cost about $1 million over the 2019–2023 period.

Transparency in CMS Surveys. Section 305 would require the Administrator of the Centers for Medicare and Medicaid Services (CMS) to modify current practice with respect to inspecting IHS facilities. Specifically, the bill would require the Administrator to inspect IHS nursing facilities and hospitals at least once every two years. Under current law, CMS surveys hospitals every three years and nursing facilities annually; H.R. 5874 would thus increase the frequency of hospital inspections but would reduce the frequency of nursing facility inspections.

Survey activities are conducted in one of two ways: CMS contracts with state agencies, or facilities contract with accrediting organizations (AOs), including the Joint Commission on the Accreditation of Health Care Organizations. State agencies conduct nursing home surveys; hospitals may use either state agencies or AOs. Facilities that contract with AOs pay for their inspection and survey activities. State agencies inspect those facilities that do not contract with AOs, and CMS funding supports state activities in this area. The majority of IHS hospitals contract with AOs. There are currently no IHS nursing facilities.

Given the relatively small number of IHS hospitals that would be surveyed by state agencies using federal funds, CBO estimates that this provision increase spending by about $2 million over the 2019–2023 period.

Other Provisions. Other provisions in H.R. 5874 would each cost less than $500,000 over the 2019–2023 period, assuming appropriation actions consistent with the bill.

- Section 106 would allow the Secretary to remove or demote IHS employees without adhering to certain civil service rules that normally affect such actions for federal employees.
- Section 108 would require the Secretary to establish a demonstration project that authorizes IHS to provide IHS service sites with additional staffing resources with the goal that the sites become self-sustaining through increasing care to patients with Medicare or Medicaid.
- Section 110 would apply the Medicare low-volume payment adjustment applicable to certain hospitals operated by the IHS or tribes to patient discharges occurring in fiscal year 2011 and subsequent fiscal years.
- Section 202 would subject any federal employees who interferes with the right of other federal employees to petition the Congress to adverse actions under civil service rules.
- Section 302 would require the Secretary to develop plans and submit reports to the Congress that comport with GAO's recommendations for improving professional housing, workforce planning, and timeliness of care.
- Section 304 would require the HHS Office of the Inspector General to submit two reports to Congress on issues related to patient harm events at IHS service units and IHS reporting systems.

Direct spending

Section 103 of H.R. 5874 would deem health professionals who volunteer with the IHS to be employees of the U.S. Public Health Service (PHS), similar to other medical professionals at IHS. Under current law, the Secretary of HHS must estimate legal expenses (court judgements and settlements) that may be paid because of claims against employees of the PHS (typically for malpractice). The estimated amounts are transferred to the Judgement Fund in the U.S. Treasury, which is a fund that pays legal claims against the federal government.

Deeming volunteers to be employees of the PHS would grant those employees protection from malpractice claims against them and would require the Secretary to include such volunteers in the calculation of potential claims against PHS employees. Based on information provided by IHS, the agency expects that shielding volunteers from personal liability from malpractice claims would lead to an increase in medical professionals willing to volunteer at the IHS, leading to a proportional increase in Judgement Fund payments on behalf of IHS employees. The Judgement Fund is funded by a permanent indefinite appropriation, and outlays from the fund are considered direct spending. According to information from the Treasury Department, about $9.5 million has been paid annually over the past 5 years from the Judgement Fund, on average, for malpractice claims against IHS employees. Based on the small increase in full-time equivalent employees because of this section and based on the average rate at which IHS employees generate payments from the Judgement Fund, CBO estimates this provision would increase direct spending by less than $500,000 over the 2019–2028 period.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures would be insignificant.

Increase in long-term direct spending and deficits: CBO estimates that enacting the legislation would not significantly increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2029.

Intergovernmental and private-sector impact: CBO has determined that H.R. 5874 contains no intergovernmental or private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Costs: Robert Stewart—IHS, Lara Robillard—Medicare; Mandates: Zachary Byrum.

Estimate approved by: Leo Lex, Deputy Assistant Director for Budget Analysis.

2. General Performance Goals and Objectives. As required by clause 3(c)(4) of rule XIII, the general performance goal or objective of this bill is to amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, and improve health services.

EARMARK STATEMENT

This bill does not contain any Congressional earmarks, limited tax benefits, or limited tariff benefits as defined under clause 9(e), 9(f), and 9(g) of rule XXI of the Rules of the House of Representatives.

COMPLIANCE WITH PUBLIC LAW 104–4

This bill contains no unfunded mandates.

COMPLIANCE WITH H. RES. 5

Directed Rule Making. This bill does not contain any directed rule makings.

Duplication of Existing Programs. This bill provides reforms for programs that were identified as areas of potential duplication, overlap, and fragmentation, which if effectively addressed, could provide financial and other benefits. Such program was included in a report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139 or identified in the most recent Catalog of Federal Domestic Assistance published pursuant to the Federal Program Information Act (Public Law 95–220, as amended by Public Law 98–169) as relating to other programs.

PREEMPTION OF STATE, LOCAL OR TRIBAL LAW

This bill is not intended to preempt any State, local or tribal law.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

INDIAN HEALTH CARE IMPROVEMENT ACT

* * * * * * *

DEFINITIONS

SEC. 4. In this Act:

(1) AREA OFFICE.—The term "Area office" means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

(2) BEHAVIORAL HEALTH.—

(A) IN GENERAL.—The term "behavioral health" means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

(B) INCLUSIONS.—The term "behavioral health" includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

(3) CALIFORNIA INDIAN.—The term "California Indian" means any Indian who is eligible for health services provided by the Service pursuant to section 809.

(4) COMMUNITY COLLEGE.—The term "community college" means—

(A) a tribal college or university; or

(B) a junior or community college.

(5) CONTRACT HEALTH SERVICE.—The term "[contract health service] *purchased/referred care*" means any health service that is—

(A) delivered based on a referral by, or at the expense of, an Indian health program; and

(B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.

(6) DEPARTMENT.—The term "Department", unless otherwise designated, means the Department of Health and Human Services.

(7) DISEASE PREVENTION.—

(A) IN GENERAL.—The term "disease prevention" means any activity for—

(i) the reduction, limitation, and prevention of—

(I) disease; and

(II) complications of disease; and

(ii) the reduction of consequences of disease.

(B) INCLUSIONS.—The term "disease prevention" includes an activity for—

(i) controlling—

(I) the development of diabetes;

(II) high blood pressure;

(III) infectious agents;

(IV) injuries;

(V) occupational hazards and disabilities;

(VI) sexually transmittable diseases; or

(VII) toxic agents; or

(ii) providing—

(I) fluoridation of water; or

(II) immunizations.

(8) FAE.—The term "FAE" means fetal alcohol effect.

(9) FAS.—The term "fetal alcohol syndrome" or "FAS" means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

(A) Central nervous system involvement such as mental retardation, developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

(C) Prenatal or postnatal growth delay.

(10) HEALTH PROFESSION.—The term "Health profession" means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, pub-

lic health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.

(11) HEALTH PROMOTION.—The term "health promotion" means any activity for—

(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness regarding health matters and enabling individuals to cope with health problems by increasing knowledge and providing valid information;

(B) encouraging adequate and appropriate diet, exercise, and sleep;

(C) promoting education and work in accordance with physical and mental capacity;

(D) making available safe water and sanitary facilities;

(E) improving the physical, economic, cultural, psychological, and social environment;

(F) promoting culturally competent care; and

(G) providing adequate and appropriate programs, including programs for—

(i) abuse prevention (mental and physical);

(ii) community health;

(iii) community safety;

(iv) consumer health education;

(v) diet and nutrition;

(vi) immunization and other methods of prevention of communicable diseases, including HIV/AIDS;

(vii) environmental health;

(viii) exercise and physical fitness;

(ix) avoidance of fetal alcohol spectrum disorders;

(x) first aid and CPR education;

(xi) human growth and development;

(xii) injury prevention and personal safety;

(xiii) behavioral health;

(xiv) monitoring of disease indicators between health care provider visits through appropriate means, including Internet-based health care management systems;

(xv) personal health and wellness practices;

(xvi) personal capacity building;

(xvii) prenatal, pregnancy, and infant care;

(xviii) psychological well-being;

(xix) reproductive health and family planning;

(xx) safe and adequate water;

(xxi) healthy work environments;

(xxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

(xxiii) stress control;

(xxiv) substance abuse;

(xxv) sanitary facilities;

(xxvi) sudden infant death syndrome prevention;

(xxvii) tobacco use cessation and reduction;

(xxviii) violence prevention; and

(xxix) such other activities identified by the Service, a tribal health program, or an urban Indian organization to promote achievement of any of the objectives referred to in section 3(2).

(12) INDIAN HEALTH PROGRAM.—The term "Indian health program" means—

(A) any health program administered directly by the Service;

(B) any tribal health program; and

(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the "Buy Indian Act").

(13) INDIANS OR INDIAN.—The term "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 102 and 103, such terms shall mean any individual who (A), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (B) is an Eskimo or Aleut or other Alaska Native, or (C) is considered by the Secretary of the Interior to be an Indian for any purpose, or (D) is determined to be an Indian under regulations promulgated by the Secretary.

(14) INDIAN TRIBE.—The term "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(15) JUNIOR OR COMMUNITY COLLEGE.—The term "junior or community college' has the meaning given the term in section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

(16) RESERVATION.—

(A) IN GENERAL.—The term "reservation" means a reservation, Pueblo, or colony of any Indian tribe.

(B) INCLUSIONS.—The term "reservation" includes—

(i) former reservations in Oklahoma;

(ii) Indian allotments; and

(iii) Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

(17) SECRETARY.—The term "Secretary", unless otherwise designated, means the Secretary of Health and Human Services.

(18) SERVICE.—The term"Service" means the Indian Health Service.

(19) SERVICE AREA.—The term "Service area" means the geographical area served by each area office.

(20) SERVICE UNIT.—The term "Service unit" means an administrative entity of the Service or a tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

(21) SUBSTANCE ABUSE.—The term "Substance abuse" includes inhalant abuse.

(22) TELEHEALTH.—The term "telehealth" has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

(23) TELEMEDICINE.—The term "telemedicine" means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

(24) TRIBAL COLLEGE OR UNIVERSITY.—The term "tribal college or university" has the meaning given the term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

(25) TRIBAL HEALTH PROGRAM.—The term "tribal health program" means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(26) TRIBAL ORGANIZATION.—The term "tribal organization" has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(27) URBAN CENTER.—The term "Urban center" means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(28) URBAN INDIAN.—The term "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection (c)(1) through (4) of this section.

(29) URBAN INDIAN ORGANIZATION.—The term "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

TITLE I—INDIAN HEALTH MANPOWER

* * * * * * *

INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM

SEC. 108. (a)(1) The Secretary, acting through the Service, shall establish a program to be known as the Indian Health Service Loan Repayment Program (hereinafter referred to as the "Loan Re-

payment Program") in order to assure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

(2) For the purposes of this section—

(A) the term "Indian health program" means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

(i) directly by the Service;

(ii) by any Indian tribe or tribal or Indian organization pursuant to a contract under—

(I) the Indian Self-Determination Act, or

(II) section 23 of the Act of April 30, 1908 (25 U.S.C. 47), popularly known as the "Buy-Indian" Act; or

(iii) by an urban Indian organization pursuant to title V of this Act; and

(B) the term "State" has the same meaning given such term in section 331(i)(4) of the Public Health Service Act.

(b) To be eligible to participate in the Loan Repayment Program, an individual must—

(1)(A) be enrolled—

(i) in a course of study or program in an accredited institution, as determined by the Secretary, within any State and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

(ii) in an approved graduate training program in a health profession; or

[(B) have—

[(i) a degree in a health profession; and

[(ii) a license to practice a health profession in a State;]

(B) have—

(i)(I) a degree in a health profession; and

(II) a license to practice a health profession in a State; or

(ii)(I) a master's degree in business administration with an emphasis in health care management (as defined by the Secretary), health administration, hospital administration, or public health; and

(II) a license or certification to practice in the field of business administration, health administration, hospital administration, or public health in a State, if the Secretary determines such license or certification necessary for the Indian health program to which the individual will be assigned;

(iii) maintain credentials as determined by the system described in section 102; and

(iv) participate in the training described in section 107;

(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

(B) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

(C) meet the professional standards for civil service employment in the Indian Health Service; or

(D) be employed in an Indian health program without a service obligation; and

(3) submit to the Secretary an application for a contract described in subsection (f).

(c)(1) In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (l) in the case of the individual's breach of the contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Indian Health Service to enable the individual to make a decision on an informed basis.

(2) The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

(3) The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

(d)(1) Consistent with paragraph (3), the Secretary, acting through the Service and in accordance with subsection (k), shall annually—

(A) identify the positions in each Indian health program for which there is a need or a vacancy, and

(B) rank those positions in order of priority.

(2) Consistent with the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall give priority to applications made by—

(A) Indians; and

(B) individuals recruited through the efforts of Indian tribes or tribal or Indian organizations.

(3)(A) Subject to subparagraph (B), of the total amounts appropriated for each of the fiscal years 1993, 1994, and 1995 for loan repayment contracts under this section, the Secretary shall provide that—

(i) not less than 25 percent be provided to applicants who are nurses, nurse practitioners, or nurse midwives; and

(ii) not less than 10 percent be provided to applicants who are mental health professionals (other than applicants described in clause (i)).

(B) The requirements specified in clause (i) or clause (ii) of subparagraph (A) shall not apply if the Secretary does not receive the number of applications from the individuals described

in clause (i) or clause (ii), respectively, necessary to meet such requirements.

(e)(1) An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in subsection (f).

(2) The Secretary shall provide written notice to an individual promptly on—

(A) the Secretary's approving, under paragraph (1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

(B) the Secretary's disapproving an individual's participation in such Program.

(f) The written contract referred to in this section between the Secretary and an individual shall contain—

(1) an agreement under which—

(A) subject to paragraph (3), the Secretary agrees—

(i) to pay loans on behalf of the individual in accordance with the provisions of this section, and

(ii) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a tribe or Indian organization as provided in subparagraph (B)(iii), and

(B) subject to paragraph (3), the individual agrees—

(i) to accept loan payments on behalf of the individual;

(ii) in the case of an individual described in subsection (b)(1)—

(I) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training, and

(II) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training);

[(iii) to serve for a time period (hereinafter in this section referred to as the "period of obligated service") equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian health program to which the individual may be assigned by the Secretary;**]**

(iii) to serve for a time period (referred to in this section as the "period of obligated service") equal to—

(I) 2 years or such longer period as the individual may agree to serve in the full-time practice of such individual's profession in an Indian health program to which the individual may be assigned by the Secretary; or

(II) 4 years or such longer period as the individual may agree to serve in the half-time practice of such individual's profession in an Indian health

program to which the individual may be assigned by the Secretary;

(2) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under paragraph (1)(B)(iii);

(3) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

(4) a statement of the damages to which the United States is entitled under subsection (l) for the individual's breach of the contract; and

(5) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

(g)(1) A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

(A) tuition expenses;

(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

(C) reasonable living expenses as determined by the Secretary.

(2)(A) ⟦For each year of obligated service that an individual contracts to serve under subsection (f) the Secretary may pay up to $35,000 (or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act) on behalf of the individual for loans described in paragraph (1).⟧ *In the case of an individual who contracts to serve a period of obligated service under subsection (f)(1)(B)(iii)(I), for each year of such obligated service, the Secretary may pay up to $35,000 (or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act (42 U.S.C. 254l–1(g)(2)(A))) on behalf of the individual for loans described in paragraph (1). In the case of an individual who contracts to serve a period of obligated service under subsection (f)(1)(B)(iii)(II), for each year of such obligated service, the Secretary may pay up to $17,500 on behalf of the individual for loans described in paragraph (1)* ⟦In making a determination⟧

(B) In making a determination under this paragraph of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

(i) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

(ii) provides an incentive to serve in Indian health programs with the greatest shortages of health professionals; and

(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

[(B)] *(C)* Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

(3) For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary—

(A) in addition to such payments, may make payments to the individual in an amount not less than 20 percent and not more than 39 percent of the total amount of loan repayments made for the taxable year involved; and

(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

(4) The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

(h) Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic training, shall not be counted against any employment ceiling affecting the Department of Health and Human Services.

(i) The Secretary shall conduct recruiting programs for the Loan Repayment Program and other health professional programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

(j) Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

(k) The Secretary, in assigning individuals to serve in Indian health programs pursuant to contracts entered into under this section, shall—

(1) ensure that the staffing needs of Indian health programs administered by an Indian tribe or tribal or health organization receive consideration on an equal basis with programs that are administered directly by the Service; and

(2) give priority to assigning individuals to Indian health programs that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

(l)(1) An individual who has entered into a written contract with the Secretary under this section and who—

(A) is enrolled in the final year of a course of study and who—

(i) fails to maintain an acceptable level of academic standing in the educational institution in which he is enrolled (such level determined by the educational institution under regulations of the Secretary);

(ii) voluntarily terminates such enrollment; or

(iii) is dismissed from such educational institution before completion of such course of study; or

(B) is enrolled in a graduate training program, fails to complete such training program, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii),

shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract.

(2) If, for any reason not specified in paragraph (1), an individual breaches his written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (f), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula:

$$A=3Z(t-s/t)$$

in which—

(A) "A" is the amount the United States is entitled to recover;

(B) "Z" is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

(C) "t" is the total number of months in the individual's period of obligated service in accordance with subsection (f); and

(D) "s" is the number of months of such period served by such individual in accordance with this section.

Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.

(3)(A) Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach or such longer period beginning on such date as shall be specified by the Secretary.

(B) If damages described in subparagraph (A) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

(i) utilize collection agencies contracted with by the Administrator of the General Services Administration; or

(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

(C) Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

(m)(1) Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

(2) The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

(3) The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

(4) Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

(n) The Secretary shall submit to the President, for inclusion in each report required to be submitted to the Congress under section 801, a report concerning the previous fiscal year which sets forth—

(1) the health professional positions maintained by the Service or by tribal or Indian organizations for which recruitment or retention is difficult;

(2) the number of Loan Repayment Program applications filed with respect to each type of health profession;

(3) the number of contracts described in subsection (f) that are entered into with respect to each health profession;

(4) the amount of loan payments made under this section, in total and by health profession;

(5) the number of scholarship grants that are provided under section 104 with respect to each health profession;

(6) the amount of scholarship grants provided under section 104, in total and by health profession;

(7) the number of providers of health care that will be needed by Indian health programs, by location and profession, during the three fiscal years beginning after the date the report is filed; and

(8) the measures the Secretary plans to take to fill the health professional positions maintained by the Service or by tribes or tribal or Indian organizations for which recruitment or retention is difficult.

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TRIBAL CULTURE AND HISTORY

SEC. 113. (a) The Secretary, acting through the Service, shall establish **[**a program**]** *an annual mandatory training program* under which **[**appropriate employees of the Service**]** *employees of the Service, locum tenens medical providers, healthcare volunteers, and other contracted employees who work at Service hospitals or other Service units and whose employment requires regular direct 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) To the extent feasible, the program established under subsection (a) shall—

(1) be carried out through tribally controlled colleges or universities (within the meaning of section 2(a)(4) of the Tribally Controlled Colleges and Universities Act of 1978) 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 government, and

(3) include instruction in Native American studies.

(c) Notwithstanding any other provision of law, beginning with the year of the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2018, each employee or provider described in subsection (a) who enters into a contract with the Service on or after the date of such implementation shall, as a condition of employment, annually participate in and complete such training program. For purposes of the preceding sentence, participation in such training program may not be considered complete for the year involved until the individual satisfies each requirement, including testing, if applicable, of the training program for such year, as specified by the Secretary.

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SEC. 125. INCENTIVES FOR RECRUITMENT AND RETENTION.

(a) PARITY IN IHS HEALTH CARE WORKFORCE PERSONNEL AND PAY SYSTEM.—The Secretary shall establish a personnel and pay system for physicians, dentists, nurses, and other health care professionals employed by the Service that provides a personnel and pay system that, to the maximum extent practicable, is comparable to the pay provided to physicians, dentists, nurses, and other health care professionals, respectively, under subchapters III and IV of chapter 74 of title 38, United States Code.

(b) RELOCATION COSTS.—The Secretary may provide to an employee of the Service reimbursement for any relocation costs the employee incurs if—

(1) the employee relocates to a Service area experiencing a high level of need for employees, as determined by the Secretary; and

(2) the employee is filling a position that would otherwise be difficult to fill, as determined by the Secretary, in the absence of an incentive.

(c) HOUSING VOUCHERS.—

(1) IN GENERAL.—Subject to paragraph (2), not later than 1 year after the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2018, the Secretary may establish a program to provide tenant-based rental assistance to an employee of the Service who—

(A) agrees to serve for not less than 1 year at a Service unit designated by the Administrator of the Health Resources and Services Administration as a health professional shortage area, as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a)), with the greatest staffing need; and

(B) is a critical employee, as determined by the Secretary.

(2) SUNSET.—Any program established by the Secretary under paragraph (1) shall terminate on the date that is 3 years after the date on which any such program is established.

(d) ADMINISTRATION.—

(1) OPM GUIDELINES.—The Secretary shall carry out subsection (b) in accordance with any guidelines of the Office of Personnel Management relating to section 572 of title 5, Code of Federal Regulations (as in effect on the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2018).

(2) SERVICE AGREEMENTS.—The Secretary may only provide reimbursement for any relocation costs under subsection (b) or any other benefit under subsection (c) to—

(A) a full-time employee who agrees to serve for not less than 1 year in the Service, beginning on the date of the agreement; or

(B) a part-time employee who agrees to serve for not less than 2 years in the service beginning on the date of the agreement.

SEC. 126. MEDICAL CREDENTIALING SYSTEM.

(a) IN GENERAL.—

(1) DEVELOPMENT AND IMPLEMENTATION TIMELINE.—By not later than 1 year after the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2018, the Secretary, acting through the Service and in accordance with the requirements described in subsection (b), shall develop and implement a Service-wide centralized electronic credentialing system (referred to in this section as the "credentialing system") to credential licensed health professionals who seek to provide health care services at any Service unit, including physicians, nurses and physicians assistants.

(2) IMPLEMENTATION.—In implementing the credentialing system, the Secretary—

(A) shall not require re-credentialing of licensed health professionals who were credentialed using existing Service policy prior to the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2018; and

(B) shall—

(i) use the credentialing system for all new applications of licensed health professionals and the migration of credentials data that existed prior to implementation into the system;

(ii) maintain the established timeline for re-credentialing of licensed health professionals who were credentialed prior to implementation, as defined by Service policy; and

(iii) review credentials for all professionals in the system, based on updated policies, on a not less than yearly basis. Licensed health professionals whose credentials would not have been approved under the updated policies shall have 90 days to meet the new requirements.

(b) REQUIREMENTS.—In developing the credentialing system under subsection (a), the Secretary shall ensure the following:

(1) Credentialing procedures shall be uniform and integrated throughout the Service.

(2) With respect to each licensed health professional who successfully completes the credentialing procedures of the credentialing system, the Secretary may authorize each such professional to provide health care services at any Service unit.

(3) Credentialing procedures shall include verification of licensure, education, employment history, and criminal background checks and history.

(c) CONSULTATION.—In developing the credentialing system under subsection (a), the Secretary shall consult with Indian Tribes and may also consult with any public or private association of medical providers, any government agency, or other relevant expert, as determined by the Secretary.

(d) APPLICATION.—A licensed health care professional may not provide health care services at any Service unit, unless such professional successfully completes the credentialing procedures of the credentialing system developed under subsection (a).

(e) REGULATIONS.—The Secretary may prescribe such regulations as may be necessary to carry out the provisions of this section.

(f) RULE OF CONSTRUCTION.—Nothing in this section may be construed—

(1) to negatively impact the right of an Indian Tribe to enter into a compact or contract under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304 et seq.); and

(2) to apply to such a compact or contract unless expressly agreed to by the Indian Tribe.

TITLE II—HEALTH SERVICES

SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

(1) eliminating the deficiencies in health status and health resources of all Indian tribes;

(2) eliminating backlogs in the provision of health care services to Indians;

(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

(4) eliminating inequities in funding for both direct care and ⟦contract health service⟧ *purchased/referred care* programs; and

(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status deficiencies and resource deficiencies:

(A) Clinical care, including inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

(B) Preventive health, including mammography and other cancer screening.

(C) Dental care.

(D) Mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners.

(E) Emergency medical services.

(F) Treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.

(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

(H) Home health care.

(I) Community health representatives.

(J) Maintenance and improvement.

(b) NO OFFSET OR LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the "Snyder Act"), or any other provision of law.

(c) ALLOCATION; USE.—

(1) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to Service units, Indian tribes, or tribal organizations. The funds allocated to each Indian tribe, tribal organization, or Service unit under this paragraph shall be used by the Indian tribe, tribal organization, or Service unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian tribe served by such Service unit, Indian tribe, or tribal organization.

(2) APPORTIONMENT OF ALLOCATED FUNDS.—The apportionment of funds allocated to a Service unit, Indian tribe, or tribal organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes and tribal organizations.

(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

(1) DEFINITION.—The term "health status and resource deficiency" means the extent to which—

(A) the health status objectives set forth in sections 3(1) and 3(2) are not being achieved; and

(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

(2) AVAILABLE RESOURCES.—The health resources available to an Indian tribe or tribal organization include health resources provided by the Service as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian tribe or tribal organization.

(e) ELIGIBILITY FOR FUNDS.—Tribal health programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service unit, including newly recognized or acknowledged Indian tribes. Such report shall set out—

(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service or a tribal health program;

(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service or a tribal health program; and

(4) an estimate of—

(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service unit, Indian tribe, or tribal organization;

(B) the number of Indians eligible for health services in each Service unit or Indian tribe or tribal organization; and

(C) the number of Indians using the Service resources made available to each Service unit, Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the "Indian Health Care Improvement Fund".

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CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM

SEC. 211. (a) The Secretary shall establish a demonstration program to evaluate the use of a contract care intermediary to improve the accessibility of health services to California Indians.

(b)(1) In establishing such program, the Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred, during the period of the demonstration program, in providing medical treatment under contract to California Indians described in section 809(b) throughout the California [contract health services] *purchased/referred care* delivery area described in section 810 with respect to high-cost contract care cases.

(2) Not more than 5 percent of the amounts provided to the Board under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the Board during such fiscal year.

(3) No payment may be made for treatment provided under the demonstration program to the extent payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California [contract health service] *purchased/referred care* delivery area for a fiscal year.

(c) There is hereby established an advisory board which shall advise the California Rural Indian Health Board in carrying out the demonstration pursuant to this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under such demonstration, at least one half of whom are not affiliated with the California Rural Indian Health Board.

(d) The demonstration program described in this section shall begin on January 1, 1993, and shall terminate on September 30, 1997.

(e) Not later than July 1, 1998, the California Rural Indian Health Board shall submit to the Secretary a report on the demonstration program carried out under this section, including a statement of its findings regarding the impact of using a contract care intermediary on—

(1) access to needed health services;

(2) waiting periods for receiving such services; and

(3) the efficient management of high-cost contract care cases.

(f) For the purposes of this section, the term "high-cost contract care cases" means those cases in which the cost of the medical treatment provided to an individual—

(1) would otherwise be eligible for reimbursement from the Catastrophic Health Emergency Fund established under section 202, except that the cost of such treatment does not meet the threshold cost requirement established pursuant to section 202(b)(2); and

(2) exceeds $1,000.

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CONTRACT HEALTH SERVICES PAYMENT STUDY

SEC. 219. (a) The Secretary, acting through the Service and in consultation with representatives of Indian tribes and tribal organizations operating contract health care programs under the Indian Self-Determination Act (25 U.S.C. 450f et seq.) or under self-governance compacts, Service personnel, private [contract health services] *purchased/referred care* providers, the Indian Health Service Fiscal Intermediary, and other appropriate experts, shall conduct a study—

(1) to assess and identify administrative barriers that hinder the timely payment for services delivered by private [contract health services] *purchased/referred care* providers to individual Indians by the Service and the Indian Health Service Fiscal Intermediary;

(2) to assess and identify the impact of such delayed payments upon the personal credit histories of individual Indians who have been treated by such providers; and

(3) to determine the most efficient and effective means of improving the Service's [contract health services] *purchased/referred care* payment system and ensuring the development of appropriate consumer protection policies to protect individual Indians who receive authorized services from private [contract health services] *purchased/referred care* providers from billing and collection practices, including the development of materials and programs explaining patients' rights and responsibilities.

(b) The study required by subsection (a) shall—

(1) assess the impact of the existing [contract health services] *purchased/referred care* regulations and policies upon the ability of the Service and the Indian Health Service Fiscal Intermediary to process, on a timely and efficient basis, the payment of bills submitted by private [contract health services] *purchased/referred care* providers;

(2) assess the financial and any other burdens imposed upon individual Indians and private [contract health services] *purchased/referred care* providers by delayed payments;

(3) survey the policies and practices of collection agencies used by [contract health services] *purchased/referred care* providers to collect payments for services rendered to individual Indians;

(4) identify appropriate changes in Federal policies, administrative procedures, and regulations, to eliminate the problems experienced by private [contract health services] *purchased/referred care* providers and individual Indians as a result of delayed payments; and

(5) compare the Service's payment processing requirements with private insurance claims processing requirements to evaluate the systemic differences or similarities employed by the Service and private insurers.

(c) Not later than 12 months after the date of the enactment of this section, the Secretary shall transmit to the Congress a report that includes—

(1) a detailed description of the study conducted pursuant to this section; and

(2) a discussion of the findings and conclusions of such study.

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SEC. 226. CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.

(a) SUBMISSION OF REPORT.—As soon as practicable after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General of the United States shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives, and make available to each Indian tribe, a report describing the results of the study of the Comptroller General regarding the funding of the **[**contract health service**]** *purchased/referred care* program (including historic funding levels and a recommendation of the funding level needed for the program) and the administration of the **[**contract health service**]** *purchased/referred care* program (including the distribution of funds pursuant to the program), as requested by Congress in March 2009, or pursuant to section 830.

(b) CONSULTATION WITH TRIBES.—On receipt of the report under subsection (a), the Secretary shall consult with Indian tribes regarding the **[**contract health service**]** *purchased/referred care* program, including the distribution of funds pursuant to the program—

(1) to determine whether the current distribution formula would require modification if the **[**contract health service**]** *purchased/referred care* program were funded at the level recommended by the Comptroller General;

(2) to identify any inequities in the current distribution formula under the current funding level or inequitable results for any Indian tribe under the funding level recommended by the Comptroller General;

(3) to identify any areas of program administration that may result in the inefficient or ineffective management of the program; and

(4) to identify any other issues and recommendations to improve the administration of the **[**contract health services**]** *purchased/referred care* program and correct any unfair results or funding disparities identified under paragraph (2).

(c) SUBSEQUENT ACTION BY SECRETARY.—If, after consultation with Indian tribes under subsection (b), the Secretary determines that any issue described in subsection (b)(2) exists, the Secretary may initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate or promulgate regulations to establish a disbursement formula for the **[**contract health service**]** *purchased/referred care* program funding.

TITLE III—HEALTH FACILITIES

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SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

(a) PURPOSE AND GENERAL AUTHORITY.—

(1) PURPOSE.—The purpose of this section is to encourage the establishment of demonstration projects that meet the applicable criteria of this section to be carried out by the Secretary,

acting through the Service, or Indian tribes or tribal organizations acting pursuant to contracts or compacts under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.)—

(A) to test alternative means of delivering health care and services to Indians through facilities; or

(B) to use alternative or innovative methods or models of delivering health care services to Indians (including primary care services, [contract health services] *purchased/referred care*, or any other program or service authorized by this Act) through convenient care services (as defined in subsection (c)), community health centers, or cooperative agreements or arrangements with other health care providers that share or coordinate the use of facilities, funding, or other resources, or otherwise coordinate or improve the coordination of activities of the Service, Indian tribes, or tribal organizations, with those of the other health care providers.

(2) AUTHORITY.—The Secretary, acting through the Service, is authorized to carry out, or to enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations to carry out, health care delivery demonstration projects that—

(A) test alternative means of delivering health care and services to Indians through facilities; or

(B) otherwise carry out the purposes of this section.

(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section—

(1) may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services; and

(2) is authorized—

(A) to waive any leasing prohibition;

(B) to permit use and carryover of funds appropriated for the provision of health care services under this Act (including for the purchase of health benefits coverage, as authorized by section 402(a));

(C) to permit the use of other available funds, including other Federal funds, funds from third-party collections in accordance with sections 206, 207, and 401, and non-Federal funds contributed by State or local governmental agencies or facilities or private health care providers pursuant to cooperative or other agreements with the Service, 1 or more Indian tribes, or tribal organizations;

(D) to permit the use of funds or property donated or otherwise provided from any source for project purposes;

(E) to provide for the reversion of donated real or personal property to the donor; and

(F) to permit the use of Service funds to match other funds, including Federal funds.

(c) HEALTH CARE DEMONSTRATION PROJECTS.—

(1) DEFINITION OF CONVENIENT CARE SERVICE.—In this subsection, the term "convenient care service" means any primary health care service, such as urgent care services, nonemergent

care services, prevention services and screenings, and any service authorized by section 203 or 205(d), that is offered—

(A) at an alternative setting; or

(B) during hours other than regular working hours.

(2) GENERAL PROJECTS.—

(A) CRITERIA.—The Secretary may approve under this section demonstration projects that meet the following criteria:

(i) There is a need for a new facility or program, such as a program for convenient care services, or an improvement in, increased efficiency at, or reorientation of an existing facility or program.

(ii) A significant number of Indians, including Indians with low health status, will be served by the project.

(iii) The project has the potential to deliver services in an efficient and effective manner.

(iv) The project is economically viable.

(v) For projects carried out by an Indian tribe or tribal organization, the Indian tribe or tribal organization has the administrative and financial capability to administer the project.

(vi) The project is integrated with providers of related health or social services (including State and local health care agencies or other health care providers) and is coordinated with, and avoids duplication of, existing services in order to expand the availability of services.

(B) PRIORITY.—In approving demonstration projects under this paragraph, the Secretary shall give priority to demonstration projects, to the extent the projects meet the criteria described in subparagraph (A), located in any of the following Service units:

(i) Cass Lake, Minnesota.

(ii) Mescalero, New Mexico.

(iii) Owyhee and Elko, Nevada.

(iv) Schurz, Nevada.

(v) Ft. Yuma, California.

(3) INNOVATIVE HEALTH SERVICES DELIVERY DEMONSTRATION PROJECT.—

(A) APPLICATION OR REQUEST.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization within a Service area, the Secretary shall take into consideration alternative or innovated methods to deliver health care services within the Service area (or a portion of, or facility within, the Service area) as described in the application or request, including medical, dental, pharmaceutical, nursing, clinical laboratory, [contract health services] *purchased/referred care*, convenient care services, community health centers, or any other health care services delivery models designed to improve access to, or efficiency or quality of, the health care, health promotion, or disease prevention services and programs under this Act.

(B) APPROVAL.—In addition to projects described in paragraph (2), in any fiscal year, the Secretary is authorized under this paragraph to approve not more than 10 applications for health care delivery demonstration projects that meet the criteria described in subparagraph (C).

(C) CRITERIA.—The Secretary shall approve under subparagraph (B) demonstration projects that meet all of the following criteria:

(i) The criteria set forth in paragraph (2)(A).

(ii) There is a lack of access to health care services at existing health care facilities, which may be due to limited hours of operation at those facilities or other factors.

(iii) The project—

(I) expands the availability of services; or

(II) reduces—

(aa) the burden on Contract Health Services; or

(bb) the need for emergency room visits.

(d) TECHNICAL ASSISTANCE.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization, the Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section, including information regarding the Service unit budget and available funding for carrying out the proposed demonstration project.

(e) SERVICE TO INELIGIBLE PERSONS.—Subject to section 813, the authority to provide services to persons otherwise ineligible for the health care benefits of the Service, and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 813, may be included, subject to the terms of that section, in any demonstration project approved pursuant to this section.

(f) EQUITABLE TREATMENT.—For purposes of subsection (c), the Secretary, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities that are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

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TITLE IV—ACCESS TO HEALTH SERVICES

SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

(a) DISREGARD OF MEDICARE, MEDICAID, AND CHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an In-

dian health program or by an urban Indian organization under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

(b) NONPREFERENTIAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XI of the Social Security Act in preference to an Indian without such coverage.

(c) USE OF FUNDS.—

(1) SPECIAL FUND.—

(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of title XVIII or XIX of the Social Security Act shall be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary shall ensure that each Service unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service unit makes collections, are entitled by reason of a provision of either such title.

(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served by the Service unit, be used for reducing the health resource deficiencies (as determined in section 201(c)) of such Indian tribes, including the provision of services pursuant to section 205.

(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a tribal health program upon the election of such program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided by such program during the period of such election.

(d) DIRECT BILLING.—

(1) IN GENERAL.—Subject to complying with the requirements of paragraph (2), a tribal health program may elect to directly bill for, and receive payment for, health care items and services provided by such program for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

(2) DIRECT REIMBURSEMENT.—

(A) USE OF FUNDS.—Each tribal health program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act shall be

reimbursed directly by that program for items and services furnished without regard to subsection (c)(1), except that all amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and tribal health programs, any health care-related purpose (including coverage for a service or service within a [contract health service] *purchased/referred care* delivery area or any portion of a [contract health service] *purchased/referred care* delivery area that would otherwise be provided as a [contract health service] *purchased/referred care*), or otherwise to achieve the objectives provided in section 3 of this Act.

(B) AUDITS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to programs administered by an Indian health program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any tribal health program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such program receives such reimbursements or payments.

(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

(A) IN GENERAL.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under title XIX or XXI of the Social Security Act.

(B) COORDINATION OF INFORMATION.—The Service shall provide the Administrator of the Centers for Medicare & Medicaid Services with copies of the lists submitted to the Service under paragraph (2)(C), enrollment data regarding patients served by the Service (and by tribal health programs, to the extent such data is available to the Service), and such other information as the Administrator may require for purposes of administering title XVIII, XIX, or XXI of the Social Security Act.

(4) WITHDRAWAL FROM PROGRAM.—A tribal health program that bills directly under the program established under this

subsection may withdraw from participation in the same manner and under the same conditions that an Indian tribe or tribal organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

(5) TERMINATION FOR FAILURE TO COMPLY WITH REQUIREMENTS.—The Secretary may terminate the participation of a tribal health program or in the direct billing program established under this subsection if the Secretary determines that the program has failed to comply with the requirements of paragraph (2). The Secretary shall provide a tribal health program with notice of a determination that the program has failed to comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the program's participation in the direct billing program established under this subsection.

(e) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act.

SEC. 402. PURCHASING HEALTH CARE COVERAGE.

(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 404) to Indian tribes, tribal organizations, and urban Indian organizations for health benefits for Service beneficiaries, Indian tribes, tribal organizations, and urban Indian organizations may use such amounts to purchase health benefits coverage (including coverage for a service, or service within a **[**contract health service**]** *purchased/referred care* delivery area, or any portion of a **[**contract health service**]** *purchased/referred care* delivery area that would otherwise be provided as a **[**contract health service**]** *purchased/referred care*) for such beneficiaries in any manner, including through—

(1) a tribally owned and operated health care plan;

(2) a State or locally authorized or licensed health care plan;

(3) a health insurance provider or managed care organization;

(4) a self-insured plan; or

(5) a high deductible or health savings account plan.

(b) FINANCIAL NEED.—The purchase of coverage under subsection (a) by an Indian tribe, tribal organization, or urban Indian organization may be based on the financial needs of such beneficiaries (as determined by the 1 or more Indian tribes being served based on a schedule of income levels developed or implemented by such 1 ore more Indian tribes).

(c) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

(d) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

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TITLE VI—ORGANIZATIONAL IMPROVEMENTS

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SEC. 605. IMPROVEMENTS IN HIRING PRACTICES.

(a) DIRECT HIRE AUTHORITY.—The Secretary may appoint, without regard to subchapter I of chapter 33 of title 5, United States Code (other than sections 3303 and 3328 of such title), a candidate directly to a position within the Service for which the candidate meets the qualifications standard established by the Office of Personnel Management.

(b) TRIBAL NOTIFICATION.—Before appointing, hiring, promoting, transferring, or reassigning a candidate to a Senior Executive Service position or the position of a manager at an Area office or Service unit, the Secretary shall provide notice to each Indian Tribe located within the defined geographic area of such Area office or Service unit, as the case may be, of the content of an inclusion in an employment record. Each such Indian Tribe may submit comment to the Secretary during the 10-day period after the date of such notification regarding such content.

SEC. 606. IMPROVED AUTHORITIES OF SECRETARY TO IMPROVE ACCOUNTABILITY OF SENIOR EXECUTIVES OF THE INDIAN HEALTH SERVICE.

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary may, as provided in this section, reprimand or suspend, involuntarily reassign, demote, or remove a covered individual from a senior executive position at the Service if the Secretary determines that the misconduct or performance of the covered individual warrants such action.

(2) REMOVAL FROM CIVIL SERVICE.—If the Secretary removes an individual pursuant to paragraph (1), the Secretary may remove the individual from the civil service (as defined in section 2101 of title 5, United States Code).

(b) RIGHTS AND PROCEDURES.—

(1) IN GENERAL.—A covered individual who is the subject of an action under subsection (a) is entitled to—

(A) advance notice of the action and a file containing all evidence in support of the proposed action;

(B) be represented by an attorney or other representative of the covered individual's choice; and

(C) grieve the action in accordance with an internal grievance process that the Secretary shall establish for purposes of this subsection.

(2) NOTICE.—

(A) AGGREGATE PERIOD FOR NOTICE.—The aggregate period for notice, response, and decision on an action under subsection (a) may not exceed 15 business days.

(B) RESPONSE.—The period for the response of a covered individual to a notice under paragraph (1)(A) of an action under subsection (a) shall be 7 business days.

(C) DECISION.—A decision under this paragraph on an action under subsection (a) shall be issued not later than

15 business days after notice of the action is provided to the covered individual under paragraph (1)(A). The decision shall be in writing, and shall include the specific reasons for the decision.

(3) GRIEVANCE PROCESS.—The Secretary shall ensure that the grievance process established under paragraph (1)(C) takes fewer than 21 days.

(4) FINAL AND CONCLUSIVE DECISION.—A decision under paragraph (2) that is not grieved, and a grievance decision under paragraph (3), shall be final and conclusive.

(5) JUDICIAL REVIEW.—A covered individual adversely affected by a decision under paragraph (2) that is not grieved, or by a grievance decision under paragraph (3), may obtain judicial review of such decision.

(6) COURT REVIEW.—In any case in which judicial review is sought under paragraph (5), the court shall review the record and may set aside any Department action found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with a provision of law;

(B) obtained without procedures required by a provision of law having been followed; or

(C) unsupported by substantial evidence.

(c) RELATION TO OTHER PROVISIONS OF LAW.—Section 3592(b)(1) of title 5, United States Code, does not apply to an action under subsection (a).

(d) DEFINITIONS.—In this section:

(1) COVERED INDIVIDUAL.—The term "covered individual" means a career appointee (as that term is defined in section 3132(a) of title 5, United States Code).

(2) MISCONDUCT.—The term "misconduct" includes neglect of duty, malfeasance, or failure to accept a directed reassignment or to accompany a position in a transfer of function.

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services, acting through the Director of the Service.

(4) SENIOR EXECUTIVE POSITION.—The term "senior executive position" means a Senior Executive Service position (as that term is defined in section 3132(a) of title 5, United States Code).

SEC. 607. IMPROVED AUTHORITIES OF SECRETARY TO IMPROVE ACCOUNTABILITY OF EMPLOYEES OF THE INDIAN HEALTH SERVICE.

(a) IN GENERAL.—

(1) AUTHORITY.—The Secretary may remove, demote, or suspend a covered individual who is an employee of the Service if the Secretary determines the performance or misconduct of the covered individual warrants such removal, demotion, or suspension.

(2) ACTIONS.—If the Secretary removes, demotes, or suspends a covered individual pursuant to paragraph (1), the Secretary may—

(A) remove the covered individual from the civil service (as defined in section 2101 of title 5, United States Code);

(B) demote the covered individual by means of a reduction in grade for which the covered individual is qualified,

that the Secretary determines is appropriate, and that reduces the annual rate of pay of the covered individual; or

(C) suspend the covered individual.

(b) PAY OF CERTAIN DEMOTED INDIVIDUALS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, any covered individual subject to a demotion under subsection (a)(2) shall, beginning on the date of such demotion, receive the annual rate of pay applicable to such grade.

(2) RESTRICTIONS.—

(A) PROHIBITION ON ADMINISTRATIVE LEAVE.—A covered individual subject to a demotion under subsection (a)(2) may not be placed on administrative leave during the period during which an appeal (if any) under this section is ongoing, and may only receive pay if the covered individual reports for duty or is approved to use accrued unused annual, sick, family medical, military, or court leave.

(B) RESTRICTION ON PAY AND BENEFITS.—If a covered individual subject to a demotion under subsection (a)(2) does not report for duty or receive approval to use accrued unused leave, such covered individual shall not receive pay or other benefits pursuant to subsection (d)(5).

(c) PROCEDURES.—

(1) IN GENERAL.—

(A) AGGREGATE PERIOD.—The aggregate period for notice, response, and final decision in a removal, demotion, or suspension under this section may not exceed 15 business days.

(B) PERIOD FOR RESPONSE.—The period for the response of a covered individual to a notice of a proposed removal, demotion, or suspension under this section shall be 7 business days.

(C) REPRESENTATION BY ATTORNEY OR OTHER REPRESENTATIVE.—Paragraph (3) of subsection (b) of section 7513 of title 5, United States Code, shall apply with respect to a removal, demotion, or suspension under this section.

(D) PROCEDURES SUPERSEDING CBAS.—The procedures in this subsection shall supersede any collective bargaining agreement to the extent that such agreement is inconsistent with such procedures.

(2) FINAL DECISION.—The Secretary shall issue a final decision with respect to a removal, demotion, or suspension under this section not later than 15 business days after the Secretary provides notice, including a file containing all the evidence in support of the proposed action, to the covered individual of the removal, demotion, or suspension. The decision shall be in writing and shall include the specific reasons for the decision.

(3) PERFORMANCE APPRAISAL.—The procedures under chapter 43 of title 5, United States Code, shall not apply to a removal, demotion, or suspension under this section.

(4) APPEAL TO MERIT SYSTEMS PROTECTION BOARD.—

(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), any removal or demotion under this section, and any suspension of more than 14 days under this section, may be appealed to the Merit Systems Protection Board, which shall refer such appeal to an administrative

judge pursuant to section 7701(b)(1) of title 5, United States Code.

(B) TIME PERIOD.—An appeal under subparagraph (A) of a removal, demotion, or suspension may only be made if such appeal is made not later than 10 business days after the date of such removal, demotion, or suspension.

(d) EXPEDITED REVIEW.—

(1) IN GENERAL.—Upon receipt of an appeal under subsection (c)(4)(A), the administrative judge shall expedite any such appeal under section 7701(b)(1) of title 5, United States Code, and, in any such case, shall issue a final and complete decision not later than 180 days after the date of the appeal.

(2) UPHOLDING DECISION.—

(A) IN GENERAL.—Notwithstanding section 7701(c)(1)(B) of title 5, United States Code, the administrative judge shall uphold the decision of the Secretary to remove, demote, or suspend an employee under subsection (a) if the decision is supported by substantial evidence.

(B) PROHIBITION OF MITIGATION.—Notwithstanding title 5, United States Code, or any other provision of law, if the decision of the Secretary is supported by substantial evidence, the administrative judge shall not mitigate the penalty prescribed by the Secretary.

(3) APPEAL TO MERIT SYSTEMS PROTECTION BOARD.—

(A) IN GENERAL.—The decision of the administrative judge under paragraph (1) may be appealed to the Merit Systems Protection Board.

(B) UPHOLDING DECISION.—Notwithstanding section 7701(c)(1)(B) of title 5, United States Code, the Merit Systems Protection Board shall uphold the decision of the Secretary to remove, demote, or suspend an employee under subsection (a) if the decision is supported by substantial evidence.

(C) PROHIBITION OF MITIGATION.—Notwithstanding title 5, United States Code, or any other provision of law, if the decision of the Secretary is supported by substantial evidence, the Merit Systems Protection Board shall not mitigate the penalty prescribed by the Secretary.

(4) REPORT.—In any case in which the administrative judge cannot issue a decision in accordance with the 180-day requirement under paragraph (1), the Merit Systems Protection Board shall, not later than 14 business days after the expiration of the 180-day period, submit to the appropriate committees of Congress a report that explains the reasons why a decision was not issued in accordance with such requirement.

(5) APPEAL.—A decision of the Merit Systems Protection Board under paragraph (3) may be appealed to the United States Court of Appeals for the Federal Circuit pursuant to section 7703 of title 5, United States Code, or to any court of appeals of competent jurisdiction pursuant to subsection (b)(1)(B) of such section.

(6) PROHIBITION AGAINST STAYS.—The Merit Systems Protection Board may not stay any removal or demotion under this section, except as provided in section 1214(b) of title 5, United States Code.

(7) RESTRICTION ON PAY AND BENEFITS DURING APPEAL.—During the period beginning on the date on which a covered individual appeals a removal from the civil service under subsection (c) and ending on the date that the United States Court of Appeals for the Federal Circuit issues a final decision on such appeal, such covered individual may not receive any pay, awards, bonuses, incentives, allowances, differentials, student loan repayments, special payments, or benefits related to the employment of the individual by the Service.

(8) INFORMATION TO EXPEDITE APPEAL.—To the maximum extent practicable, the Secretary shall provide to the Merit Systems Protection Board such information and assistance as may be necessary to ensure an appeal under this subsection is expedited.

(9) BACKPAY.—If an employee prevails on appeal under this section, the employee shall be entitled to backpay (as provided in section 5596 of title 5, United States Code).

(10) APPLICABLE TIMELINES AND PROCEDURES.—If an employee who is subject to a collective bargaining agreement chooses to grieve an action taken under this section through a grievance procedure provided under the collective bargaining agreement, the timelines and procedures set forth in subsection (c) and this subsection shall apply.

(e) ALLEGED PROHIBITED PERSONNEL PRACTICE.—In the case of a covered individual seeking corrective action (or on behalf of whom corrective action is sought) from the Office of Special Counsel based on an alleged prohibited personnel practice described in section 2302(b) of title 5, United States Code, the Secretary may not remove, demote, or suspend such covered individual under subsection (a) without the approval of the Special Counsel under section 1214(f) of title 5, United States Code.

(f) TERMINATION OF INVESTIGATIONS BY OFFICE OF SPECIAL COUNSEL.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Special Counsel (established by section 1211 of title 5, United States Code) may terminate an investigation of a prohibited personnel practice alleged by an employee or former employee of the Service after the Special Counsel provides to the employee or former employee a written statement of the reasons for the termination of the investigation.

(2) ADMISSIBILITY.—The statement described in paragraph (1) may not be admissible as evidence in any judicial or administrative proceeding without the consent of the employee or former employee described in paragraph (1).

(g) VACANCIES.—In the case of a covered individual who is removed or demoted under subsection (a), to the maximum extent feasible, the Secretary shall fill the vacancy arising as a result of such removal or demotion.

(h) DEFINITIONS.—In this section:

(1) COVERED INDIVIDUAL.—The term "covered individual" means an individual occupying a position at the Service, but does not include—

(A) an individual occupying a senior executive position (as defined in section 606(d));

(B) an individual who has not completed a probationary or trial period; or

(C) a political appointee.

(2) GRADE.—The term "grade" has the meaning given such term in section 7511(a) of title 5, United States Code.

(3) MISCONDUCT.—The term "misconduct" includes neglect of duty, malfeasance, or failure to accept a directed reassignment or to accompany a position in a transfer of function.

(4) POLITICAL APPOINTEE.—The term "political appointee" means an individual who is—

(A) employed in a position described under sections 5312 through 5316 of title 5, United States Code (relating to the Executive Schedule);

(B) a limited term appointee, limited emergency appointee, or noncareer appointee in the Senior Executive Service, as defined under paragraphs (5), (6), and (7), respectively, of section 3132(a) of title 5, United States Code; or

(C) employed in a position of a confidential or policy-determining character under schedule C of subpart C of part 213 of title 5, Code of Federal Regulations, or successor regulation.

(5) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services, acting through the Director of the Service.

(6) SUSPEND.—The term "suspend" means the placing of an employee, for disciplinary reasons, in a temporary status without duties and pay for a period in excess of 14 days.

SEC. 608. EMPLOYEE PROTECTIONS AGAINST RETALIATION.

(a) EMPLOYEE ACCOUNTABILITY.—

(1) AGENCY REPORTING PROCESS REQUIREMENT.—The Secretary shall designate an official in the Department who is not an employee of the Service to—

(A) receive reports from an employee of the Service who witnesses retaliation against a whistleblower, a violation of a patient safety requirement, or other similar conduct; and

(B) conduct active and ongoing outreach to all employees of the Service about—

(i) Federal and Department systems for reporting retaliation against whistleblowers; and

(ii) the duty of individual employees of the Service to report violations of patient safety requirements and other similar conduct.

(2) OVERSIGHT.—Not later than 3 days after the date on which the official designated by the Secretary under paragraph (1) receives a report under paragraph (1)(A), the Secretary shall—

(A) formally review the report; and

(B) provide a copy of such report and any other relevant information to the Inspector General of the Department.

(3) REMOVAL FOR WHISTLEBLOWER RETALIATION.—The Secretary may remove for misconduct from the civil service (as defined in section 2101 of title 5, United States Code), in accordance with sections 606 and 607, an employee of the Service if the Secretary determines, after completing a report review de-

scribed in paragraph (2), that the employee has retaliated against a whistleblower and warrants removal.

(4) ENHANCING PROTECTIONS FOR WHISTLEBLOWERS.—The Secretary shall carry out any actions determined necessary by the Secretary to enhance protection for whistleblowers, including identifying appropriate Service employees and requiring the employees to complete the Office of Special Counsel's Whistleblower Certification Program.

(b) DEFINITIONS.—In this section:

(1) RETALIATION.—The term "retaliation"—

(A) means an adverse employment action or any significantly adverse action against a whistleblower, such as the refusal or delay of care provided through the Service; and

(B) includes instances where the adverse action described in subparagraph (A) is perpetrated against a family member or friend of the whistleblower because of the whistleblower's disclosure of information.

(2) WHISTLEBLOWER.—The term "whistleblower" means an employee of Service who discloses information—

(A) that the employee reasonably believes evidences—

(i) a violation of any law, rule, or regulation; or

(ii) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety; and

(B) if such disclosure is not specifically prohibited by law and if such information is not specifically required by Executive Order to be kept secret in the interest of national defense or the conduct of foreign affairs.

SEC. 609. FISCAL ACCOUNTABILITY.

(a) MANAGEMENT OF FUNDS.—

(1) IN GENERAL.—If the Secretary fails to submit the professional housing plan under section 301(a) of the Restoring Accountability in the Indian Health Service Act of 2018 or the staffing plan under section 301(b) of that Act, the Secretary may not receive, obligate, transfer, or expend any amounts for a salary increase or bonus of an individual described in paragraph (2) until the professional housing plan or staffing plan, as the case may be, is submitted.

(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph is an individual employed in a position in the Service that is a position—

(A) described under sections 5312 through 5316 of title 5, United States Code;

(B) placed in level IV or V of the Executive Schedule under section 5317 of title 5, United States Code;

(C) as a limited term appointee, limited emergency appointee, or noncareer appointee in the Senior Executive Service, as defined under paragraphs (5), (6), and (7), respectively, of section 3132(a) of title 5, United States Code; or

(D) under section 213.3301 or 213.3302 of title 5, Code of Federal Regulations.

(b) PRIORITIZATION OF PATIENT CARE.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall use amounts available to the Indian

Health Service that are not obligated or expended, including base budget funding and third party collections, during the fiscal year for which the amounts are made available, and that remain available, only to support patient care by using such funds for the costs of—

(A) essential medical equipment;

(B) purchased or referred care; or

(C) staffing.

(2) SPECIAL RULE.—In using amounts under paragraph (1), the Secretary shall ensure that, in any case where the amounts were originally made available for a particular Service unit, such amounts are used to benefit Indians served by that Service unit.

(3) RESTRICTIONS.—The Secretary may not use amounts described in paragraph (1)—

(A) to remodel or interior decorate any Area office; or

(B) to increase the rate of pay of any employee of an Area office.

(c) SPENDING REPORTS.—Not later than 90 days after the end of each quarter of a fiscal year, the Secretary shall submit a report describing the authorizations, expenditures, outlays, transfers, reprogramming, and obligations of each level of the Service, including the headquarters, each Area office, each Service unit, and each health clinic or facility, to—

(1) each Indian Tribe;

(2) in the Senate—

(A) the Committee on Indian Affairs;

(B) the Committee on Health, Education, Labor, and Pensions;

(C) the Committee on Appropriations; and

(D) the Committee on the Budget; and

(3) in the House of Representatives—

(A) the Committee on Natural Resources;

(B) the Committee on Energy and Commerce;

(C) the Committee on Appropriations; and

(D) the Committee on the Budget.

(d) STATUS REPORTS.—

(1) IN GENERAL.—Subject to paragraph (2), not later than 180 days after the end of each fiscal year, the Secretary shall provide to each entity described in paragraphs (1) through (3) of subsection (c) a report describing the safety, billing, certification, credential, and compliance statuses of each facility managed, operated, or otherwise supported by the Service.

(2) UPDATES.—With respect to any change of a status described in paragraph (1), the Secretary shall immediately provide to each entity described in paragraphs (1) through (3) of subsection (c) an update describing such change.

(e) RULE OF CONSTRUCTION.—Nothing in this section may be construed—

(1) to negatively impact the right of an Indian Tribe to enter into a compact or contract under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304 et seq.); and

(2) to apply to such a compact or contract unless expressly agreed to by the Indian Tribe.

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TITLE VIII—MISCELLANEOUS

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SEC. 808. ARIZONA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

(a) IN GENERAL.—The State of Arizona shall be designated as a [contract health service] *purchased/referred care* delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the State of Arizona.

(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if the curtailment is due to the provision of contract services in that State pursuant to the designation of the State as a [contract health service] *purchased/referred care* delivery area by subsection (a).

SEC. 808A. NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

(a) IN GENERAL.—The States of North Dakota and South Dakota shall be designated as a [contract health service] *purchased/referred care* delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the States of North Dakota and South Dakota.

(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if the curtailment is due to the provision of contract services in those States pursuant to the designation of the States as a [contract health service] *purchased/referred care* delivery area by subsection (a).

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CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 810. The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura shall be designated as a [contract health service] *purchased/referred care* delivery area by the Service for the purpose of providing [contract health services] *purchased/referred care* to Indians in such State.

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CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

SEC. 815. (a) The Secretary, acting through the Service, is directed to provide [contract health services] *purchased/referred care* to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

(b) Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the

scope of eligibility for such health services that applied on May 1, 1986.

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SEC. 830. OTHER GAO REPORTS.

(a) COORDINATION OF SERVICES.—

(1) STUDY AND EVALUATION.—The Comptroller General of the United States shall conduct a study, and evaluate the effectiveness, of coordination of health care services provided to Indians—

(A) through Medicare, Medicaid, or SCHIP;

(B) by the Service; or

(C) using funds provided by—

(i) State or local governments; or

(ii) Indian tribes.

(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General shall submit to Congress a report—

(A) describing the results of the evaluation under paragraph (1); and

(B) containing recommendations of the Comptroller General regarding measures to support and increase coordination of the provision of health care services to Indians as described in paragraph (1).

(b) PAYMENTS FOR CONTRACT HEALTH SERVICES.—

(1) IN GENERAL.—The Comptroller General shall conduct a study on the use of health care furnished by health care providers under the **[**contract health services**]** *purchased/referred care* program funded by the Service and operated by the Service, an Indian tribe, or a tribal organization.

(2) ANALYSIS.—The study conducted under paragraph (1) shall include an analysis of—

(A) the amounts reimbursed under the **[**contract health services**]** *purchased/referred care* program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for that health care through other public programs and in the private sector;

(B) barriers to accessing care under such **[**contract health services**]** *purchased/referred care* program, including barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under the program;

(C) the adequacy of existing Federal funding for health care under the **[**contract health services**]** *purchased/referred care* program;

(D) the administration of the **[**contract health service**]** *purchased/referred care* program, including the distribution of funds to Indian health programs pursuant to the program; and

(E) any other items determined appropriate by the Comptroller General.

(3) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthoriza-

tion and Extension Act of 2009, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations regarding—

(A) the appropriate level of Federal funding that should be established for health care under the [contract health services] *purchased/referred care* program described in paragraph (1);

(B) how to most efficiently use that funding; and

(C) the identification of any inequities in the current distribution formula or inequitable results for any Indian tribe under the funding level, and any recommendations for addressing any inequities or inequitable results identified.

(4) CONSULTATION.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Comptroller General shall consult with the Service, Indian tribes, and tribal organizations.

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SEC. 833. STAFFING DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary, acting through the Service, shall establish a demonstration project that authorizes the Service to provide federally managed Service units with additional staffing resources with the goal that the resources become self-sustaining.

(b) SELECTION.—In selecting Service units for participation, the Secretary shall consider whether a Service unit services an Indian Tribe that—

(1) has utilized or contributed substantial tribal funds to construct a health facility used by the Service or identified in the master plan for the Service unit;

(2) is located in a State or States with Medicaid reimbursements plans or policies that will increase the likelihood that the staffing resources provided will be self-sustaining; and

(3) is operating a health facility described in paragraph (1) under historical staffing ratios that have not been equalized or updated by the Service or any other Service program to reflect current staffing needs.

(c) DURATION.—Staffing resources provided to a Service unit under this section shall be for a duration that the Secretary, in consultation with the applicable Indian Tribe, determines appropriate, except that each staffing position provided shall be for a period of not less than 3 fiscal years.

(d) EFFECT OF STAFFING AWARDS.—No staffing resources provided under this section shall reduce the recurring base funding for staffing for any Indian Tribe or federally managed Service unit.

(e) REPORT.—Not later than 5 years after the Secretary ends the demonstration project under this section, the Secretary shall prepare and submit a report to the Committee on Indian Affairs and the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives, regarding the project, including—

(1) whether the staffing resources resulted in additional revenue for the Service unit sufficient to maintain the staff on a permanent basis;

(2) the levels to which the staffing resources reduced the unmet staffing need for the Service unit; and

(3) whether the demonstration project could be deployed to reduce unmet staffing needs throughout the Service.

SEC. 834. RULE ESTABLISHING TRIBAL CONSULTATION POLICY.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2018, the Secretary shall establish, after meaningful consultation with representatives of affected Indian Tribes, a rule establishing a tribal consultation policy for the Service.

(b) CONTENTS OF TRIBAL CONSULTATION POLICY.—The policy established under the rule described in subsection (a) shall—

(1) update, and replace, the tribal consultation policy established under Circular No. 2006–01 of the Service, or any successor policy; and

(2) include the following:

(A) A process for determining when the Service will notify Indian Tribes, and a description of how the Indian Tribes should be notified.

(B) A determination of what actions or agency decisions by the Service will trigger a requirement for meaningful consultation with Indian Tribes.

(C) A determination of what actions constitute meaningful consultation with Indian Tribes.

PUBLIC HEALTH SERVICE ACT

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TITLE II—ADMINISTRATION AND MISCELLANEOUS PROVISIONS

PART A—ADMINISTRATION

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DEFENSE OF CERTAIN MALPRACTICE AND NEGLIGENCE SUITS

SEC. 224. (a) The remedy against the United States provided by sections 1346(b) and 2672 of title 28, or by alternative benefits provided by the United States where the availability of such benefits precludes a remedy under section 1346(b) of title 28, for damage for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigation, by any commissioned officer or employee of the Public Health Service while acting within the scope of his office or employment, shall be exclusive of any other civil action or proceeding by reason of the same subject-matter against the officer or employee (or his estate) whose act or omission gave rise to the claim.

(b) The Attorney General shall defend any civil action or proceeding brought in any court against any person referred to in subsection (a) of this section (or his estate) for any such damage or injury. Any such person against whom such civil action or proceeding is brought shall deliver within such time after date of service or knowledge of service as determined by the Attorney General, all

process served upon him or an attested true copy thereof to his immediate superior or to whomever was designated by the Secretary to receive such papers and such persons shall promptly furnish copies of the pleading and process therein to the United States attorney for the district embracing the place wherein the proceeding is brought, to the Attorney General, and to the Secretary.

(c) Upon a certification by the Attorney General that the defendant was acting in the scope of his employment at the time of the incident out of which the suit arose, any such civil action or proceeding commenced in a State court shall be removed without bond at any time before trial by the Attorney General to the district court of the United States of the district and division embracing the place wherein it is pending and the proceeding deemed a tort action brought against the United States under the provisions of title 28 and all references thereto. Should a United States district court determine on a hearing on a motion to remand held before a trial on the merit that the case so removed is one in which a remedy by suit within the meaning of subsection (a) of this section is not available against the United States, the case shall be remanded to the State Court: *Provided*, That where such a remedy is precluded because of the availability of a remedy through proceedings for compensation or other benefits from the United States as provided by any other law, the case shall be dismissed, but in the event the running of any limitation of time for commencing, or filing an application or claim in, such proceedings for compensation or other benefits shall be deemed to have been suspended during the pendency of the civil action or proceeding under this section.

(d) The Attorney General may compromise or settle any claim asserted in such civil action or proceeding in the manner provided in section 2677 of title 28 and with the same effect.

(e) For purposes of this section, the provisions of section 2680(h) of title 28 shall not apply to assault or battery arising out of negligence in the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations.

(f) The Secretary or his designee may, to the extent that he deems appropriate, hold harmless or provide liability insurance for any officer or employee of the Public Health Service for damage for personal injury, including death, negligently caused by such officer or employee while acting within the scope of his office or employment and as a result of the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, if such employee is assigned to a foreign country or detailed to a State or political subdivision thereof or to a non-profit institution, and if the circumstances are such as are likely to preclude the remedies of third persons against the United States described in section 2679(b) of title 28, for such damage or injury.

(g)(1)(A) For purposes of this section and subject to the approval by the Secretary of an application under subparagraph (D), an entity described in paragraph (4), and any officer, governing board member, or employee of such an entity, and any contractor of such an entity who is a physician or other licensed or certified health care practitioner (subject to paragraph (5)), shall be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under subsection (k)(3) (subject to paragraph (3)). The remedy against the

United States for an entity described in paragraph (4) and any officer, governing board member, employee, or contractor (subject to paragraph (5)) of such an entity who is deemed to be an employee of the Public Health Service pursuant to this paragraph shall be exclusive of any other civil action or proceeding to the same extent as the remedy against the United States is exclusive pursuant to subsection (a).

(B) The deeming of any entity or officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Service for purposes of this section shall apply with respect to services provided—

(i) to all patients of the entity, and

(ii) subject to subparagraph (C), to individuals who are not patients of the entity.

(C) Subparagraph (B)(ii) applies to services provided to individuals who are not patients of an entity if the Secretary determines, after reviewing an application submitted under subparagraph (D), that the provision of the services to such individuals—

(i) benefits patients of the entity and general populations that could be served by the entity through community-wide intervention efforts within the communities served by such entity;

(ii) facilitates the provision of services to patients of the entity; or

(iii) are otherwise required under an employment contract (or similar arrangement) between the entity and an officer, governing board member, employee, or contractor of the entity.

(D) The Secretary may not under subparagraph (A) deem an entity or an officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Service for purposes of this section, and may not apply such deeming to services described in subparagraph (B)(ii), unless the entity has submitted an application for such deeming to the Secretary in such form and such manner as the Secretary shall prescribe. The application shall contain detailed information, along with supporting documentation, to verify that the entity, and the officer, governing board member, employee, or contractor of the entity, as the case may be, meets the requirements of subparagraphs (B) and (C) of this paragraph and that the entity meets the requirements of paragraphs (1) through (4) of subsection (h).

(E) The Secretary shall make a determination of whether an entity or an officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section within 30 days after the receipt of an application under subparagraph (D). The determination of the Secretary that an entity or an officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section shall apply for the period specified by the Secretary under subparagraph (A).

(F) Once the Secretary makes a determination that an entity or an officer, governing board member, employee, or contractor of an entity is deemed to be an employee of the Public Health Service for purposes of this section, the determination shall be final and binding upon the Secretary and the Attorney General and other parties to any civil action or proceeding. Except as provided in subsection

(i), the Secretary and the Attorney General may not determine that the provision of services which are the subject of such a determination are not covered under this section.

(G) In the case of an entity described in paragraph (4) that has not submitted an application under subparagraph (D):

(i) The Secretary may not consider the entity in making estimates under subsection (k)(1).

(ii) This section does not affect any authority of the entity to purchase medical malpractice liability insurance coverage with Federal funds provided to the entity under section 329, 330, or 340A.

(H) In the case of an entity described in paragraph (4) for which an application under subparagraph (D) is in effect, the entity may, through notifying the Secretary in writing, elect to terminate the applicability of this subsection to the entity. With respect to such election by the entity:

(i) The election is effective upon the expiration of the 30-day period beginning on the date on which the entity submits such notification.

(ii) Upon taking effect, the election terminates the applicability of this subsection to the entity and each officer, governing board member, employee, and contractor of the entity.

(iii) Upon the effective date for the election, clauses (i) and (ii) of subparagraph (G) apply to the entity to the same extent and in the same manner as such clauses apply to an entity that has not submitted an application under subparagraph (D).

(iv) If after making the election the entity submits an application under subparagraph (D), the election does not preclude the Secretary from approving the application (and thereby restoring the applicability of this subsection to the entity and each officer, governing board member, employee, and contractor of the entity, subject to the provisions of this subsection and the subsequent provisions of this section.

(2) If, with respect to an entity or person deemed to be an employee for purposes of paragraph (1), a cause of action is instituted against the United States pursuant to this section, any claim of the entity or person for benefits under an insurance policy with respect to medical malpractice relating to such cause of action shall be subrogated to the United States.

(3) This subsection shall apply with respect to a cause of action arising from an act or omission which occurs on or after January 1, 1993.

(4) An entity described in this paragraph is a public or non-profit private entity receiving Federal funds under section 330.

(5) For purposes of paragraph (1), an individual may be considered a contractor of an entity described in paragraph (4) only if—

(A) the individual normally performs on average at least 32½ hours of service per week for the entity for the period of the contract; or

(B) in the case of an individual who normally performs an average of less than 32½ hours of services per week for the entity for the period of the contract, the individual is a licensed or certified provider of services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

(h) The Secretary may not approve an application under subsection (g)(1)(D) unless the Secretary determines that the entity—

(1) has implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed by the entity;

(2) has reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed or certified health care practitioners, and, where necessary, has obtained the permission from these individuals to gain access to this information;

(3) has no history of claims having been filed against the United States as a result of the application of this section to the entity or its officers, employees, or contractors as provided for under this section, or, if such a history exists, has fully cooperated with the Attorney General in defending against any such claims and either has taken, or will take, any necessary corrective steps to assure against such claims in the future; and

(4) will fully cooperate with the Attorney General in providing information relating to an estimate described under subsection (k).

(i)(1) Notwithstanding subsection (g)(1), the Attorney General, in consultation with the Secretary, may on the record determine, after notice and opportunity for a full and fair hearing, that an individual physician or other licensed or certified health care practitioner who is an officer, employee, or contractor of an entity described in subsection (g)(4) shall not be deemed to be an employee of the Public Health Service for purposes of this section, if treating such individual as such an employee would expose the Government to an unreasonably high degree of risk of loss because such individual—

(A) does not comply with the policies and procedures that the entity has implemented pursuant to subsection (h)(1);

(B) has a history of claims filed against him or her as provided for under this section that is outside the norm for licensed or certified health care practitioners within the same specialty;

(C) refused to reasonably cooperate with the Attorney General in defending against any such claim;

(D) provided false information relevant to the individual's performance of his or her duties to the Secretary, the Attorney General, or an applicant for or recipient of funds under this Act; or

(E) was the subject of disciplinary action taken by a State medical licensing authority or a State or national professional society.

(2) A final determination by the Attorney General under this subsection that an individual physician or other licensed or certified health care professional shall not be deemed to be an employee of the Public Health Service shall be effective upon receipt by the entity employing such individual of notice of such determination, and shall apply only to acts or omissions occurring after the date such notice is received.

(j) In the case of a health care provider who is an officer, employee, or contractor of an entity described in subsection (g)(4), section 335(e) shall apply with respect to the provider to the same extent and in the same manner as such section applies to any member of the National Health Service Corps.

(k)(1)(A) For each fiscal year, the Attorney General, in consultation with the Secretary, shall estimate by the beginning of the year the amount of all claims which are expected to arise under this section (together with related fees and expenses of witnesses) for which payment is expected to be made in accordance with section 1346 and chapter 171 of title 28, United States Code, from the acts or omissions, during the calendar year that begins during that fiscal year, of entities described in subsection (g)(4) and of officers, employees, or contractors (subject to subsection (g)(5)) of such entities.

(B) The estimate under subparagraph (A) shall take into account—

(i) the value and frequency of all claims for damage for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by entities described in subsection (g)(4) or by officers, employees, or contractors (subject to subsection (g)(5)) of such entities who are deemed to be employees of the Public Health Service under subsection (g)(1) that, during the preceding 5-year period, are filed under this section or, with respect to years occurring before this subsection takes effect, are filed against persons other than the United States,

(ii) the amounts paid during that 5-year period on all claims described in clause (i), regardless of when such claims were filed, adjusted to reflect payments which would not be permitted under section 1346 and chapter 171 of title 28, United States Code, and

(iii) amounts in the fund established under paragraph (2) but unspent from prior fiscal years.

(2) Subject to appropriations, for each fiscal year, the Secretary shall establish a fund of an amount equal to the amount estimated under paragraph (1) that is attributable to entities receiving funds under each of the grant programs described in paragraph (4) of subsection (g), but not to exceed a total of $10,000,000 for each such fiscal year. Appropriations for purposes of this paragraph shall be made separate from appropriations made for purposes of sections 329, 330 and 340A.

(3) In order for payments to be made for judgments against the United States (together with related fees and expenses of witnesses) pursuant to this section arising from the acts or omissions of entities described in subsection (g)(4) and of officers, employees, or contractors (subject to subsection (g)(5)) of such entities, the total amount contained within the fund established by the Secretary under paragraph (2) for a fiscal year shall be transferred not later than the December 31 that occurs during the fiscal year to the appropriate accounts in the Treasury.

(l)(1) If a civil action or proceeding is filed in a State court against any entity described in subsection (g)(4) or any officer, governing board member, employee, or any contractor of such an entity for damages described in subsection (a), the Attorney General,

within 15 days after being notified of such filing, shall make an appearance in such court and advise such court as to whether the Secretary has determined under subsections (g) and (h), that such entity, officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section with respect to the actions or omissions that are the subject of such civil action or proceeding. Such advice shall be deemed to satisfy the provisions of subsection (c) that the Attorney General certify that an entity, officer, governing board member, employee, or contractor of the entity was acting within the scope of their employment or responsibility.

(2) If the Attorney General fails to appear in State court within the time period prescribed under paragraph (1), upon petition of any entity or officer, governing board member, employee, or contractor of the entity named, the civil action or proceeding shall be removed to the appropriate United States district court. The civil action or proceeding shall be stayed in such court until such court conducts a hearing, and makes a determination, as to the appropriate forum or procedure for the assertion of the claim for damages described in subsection (a) and issues an order consistent with such determination.

(m)(1) An entity or officer, governing board member, employee, or contractor of an entity described in subsection (g)(1) shall, for purposes of this section, be deemed to be an employee of the Public Health Service with respect to services provided to individuals who are enrollees of a managed care plan if the entity contracts with such managed care plan for the provision of services.

(2) Each managed care plan which enters into a contract with an entity described in subsection (g)(4) shall deem the entity and any officer, governing board member, employee, or contractor of the entity as meeting whatever malpractice coverage requirements such plan may require of contracting providers for a calendar year if such entity or officer, governing board member, employee, or contractor of the entity has been deemed to be an employee of the Public Health Service for purposes of this section for such calendar year. Any plan which is found by the Secretary on the record, after notice and an opportunity for a full and fair hearing, to have violated this subsection shall upon such finding cease, for a period to be determined by the Secretary, to receive and to be eligible to receive any Federal funds under titles XVIII or XIX of the Social Security Act.

(3) For purposes of this subsection, the term "managed care plan" shall mean health maintenance organizations and similar entities that contract at-risk with payors for the provision of health services or plan enrollees and which contract with providers (such as entities described in subsection (g)(4)) for the delivery of such services to plan enrollees.

(n)(1) Not later than one year after the date of the enactment of the Federally Supported Health Centers Assistance Act of 1995, the Comptroller General of the United States shall submit to the Congress a report on the following:

(A) The medical malpractice liability claims experience of entities that have been deemed to be employees for purposes of this section.

(B) The risk exposure of such entities.

(C) The value of private sector risk-management services, and the value of risk-management services and procedures required as a condition of receiving a grant under section 329, 330, or 340A.

(D) A comparison of the costs and the benefits to taxpayers of maintaining medical malpractice liability coverage for such entities pursuant to this section, taking into account—

(i) a comparison of the costs of premiums paid by such entities for private medical malpractice liability insurance with the cost of coverage pursuant to this section; and

(ii) an analysis of whether the cost of premiums for private medical malpractice liability insurance coverage is consistent with the liability claims experience of such entities.

(2) The report under paragraph (1) shall include the following:

(A) A comparison of—

(i) an estimate of the aggregate amounts that such entities (together with the officers, governing board members, employees, and contractors of such entities who have been deemed to be employees for purposes of this section) would have directly or indirectly paid in premiums to obtain medical malpractice liability insurance coverage if this section were not in effect; with

(ii) the aggregate amounts by which the grants received by such entities under this Act were reduced pursuant to subsection (k)(2).

(B) A comparison of—

(i) an estimate of the amount of privately offered such insurance that such entities (together with the officers, governing board members, employees, and contractors of such entities who have been deemed to be employees for purposes of this section) purchased during the three-year period beginning on January 1, 1993; with

(ii) an estimate of the amount of such insurance that such entities (together with the officers, governing board members, employees, and contractors of such entities who have been deemed to be employees for purposes of this section) will purchase after the date of the enactment of the Federally Supported Health Centers Assistance Act of 1995.

(C) An estimate of the medical malpractice liability loss history of such entities for the 10-year period preceding October 1, 1996, including but not limited to the following:

(i) Claims that have been paid and that are estimated to be paid, and legal expenses to handle such claims that have been paid and that are estimated to be paid, by the Federal Government pursuant to deeming entities as employees for purposes of this section.

(ii) Claims that have been paid and that are estimated to be paid, and legal expenses to handle such claims that have been paid and that are estimated to be paid, by private medical malpractice liability insurance.

(D) An analysis of whether the cost of premiums for private medical malpractice liability insurance coverage is consistent

with the liability claims experience of entities that have been deemed as employees for purposes of this section.

(3) In preparing the report under paragraph (1), the Comptroller General of the United States shall consult with public and private entities with expertise on the matters with which the report is concerned.

(o)(1) For purposes of this section, a free clinic health professional shall in providing a qualifying health service to an individual, or an officer, governing board member, employee, or contractor of a free clinic shall in providing services for the free clinic, be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (6)(D). The preceding sentence is subject to the provisions of this subsection.

(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a free clinic health professional if the following conditions are met:

(A) The service is provided to the individual at a free clinic, or through offsite programs or events carried out by the free clinic.

(B) The free clinic is sponsoring the health care practitioner pursuant to paragraph (5)(C).

(C) The service is a qualifying health service (as defined in paragraph (4)).

(D) Neither the health care practitioner nor the free clinic receives any compensation for the service from the individual or from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program). With respect to compliance with such condition:

(i) The health care practitioner may receive repayment from the free clinic for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

(ii) The free clinic may accept voluntary donations for the provision of the service by the health care practitioner to the individual.

(E) Before the service is provided, the health care practitioner or the free clinic provides written notice to the individual of the extent to which the legal liability of the health care practitioner is limited pursuant to this subsection (or in the case of an emergency, the written notice is provided to the individual as soon after the emergency as is practicable). If the individual is a minor or is otherwise legally incompetent, the condition under this subparagraph is that the written notice be provided to a legal guardian or other person with legal responsibility for the care of the individual.

(F) At the time the service is provided, the health care practitioner is licensed or certified in accordance with applicable law regarding the provision of the service.

(3)(A) For purposes of this subsection, the term "free clinic" means a health care facility operated by a nonprofit private entity meeting the following requirements:

(i) The entity does not, in providing health services through the facility, accept reimbursement from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).

(ii) The entity, in providing health services through the facility, either does not impose charges on the individuals to whom the services are provided, or imposes a charge according to the ability of the individual involved to pay the charge.

(iii) The entity is licensed or certified in accordance with applicable law regarding the provision of health services.

(B) With respect to compliance with the conditions under subparagraph (A), the entity involved may accept voluntary donations for the provision of services.

(4) For purposes of this subsection, the term "qualifying health service" means any medical assistance required or authorized to be provided in the program under title XIX of the Social Security Act, without regard to whether the medical assistance is included in the plan submitted under such program by the State in which the health care practitioner involved provides the medical assistance. References in the preceding sentence to such program shall as applicable be considered to be references to any successor to such program.

(5) Subsection (g) (other than paragraphs (3) through (5)) and subsections (h), (i), and (l) apply to a health care practitioner for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (6) and subject to the following:

(A) The first sentence of paragraph (1) applies in lieu of the first sentence of subsection (g)(1)(A).

(B) This subsection may not be construed as deeming any free clinic to be an employee of the Public Health Service for purposes of this section.

(C) With respect to a free clinic, a health care practitioner is not a free clinic health professional unless the free clinic sponsors the health care practitioner. For purposes of this subsection, the free clinic shall be considered to be sponsoring the health care practitioner if—

(i) with respect to the health care practitioner, the free clinic submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care practitioner is deemed to be an employee of the Public Health Service.

(D) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a free clinic health professional, this subsection applies to the health care practitioner (with respect to the free clinic sponsoring the health care practitioner pursuant to subparagraph (C)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

(E) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in pro-

viding health services to an individual, each of the conditions specified in paragraph (2) is met.

(6)(A) For purposes of making payments for judgments against the United States (together with related fees and expenses of witnesses) pursuant to this section arising from the acts or omissions of free clinic health professionals, there is authorized to be appropriated $10,000,000 for each fiscal year.

(B) The Secretary shall establish a fund for purposes of this subsection. Each fiscal year amounts appropriated under subparagraph (A) shall be deposited in such fund.

(C) Not later than May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to the Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of free clinic health professionals, will be paid pursuant to this section during the calendar year that begins in the following fiscal year. Subsection (k)(1)(B) applies to the estimate under the preceding sentence regarding free clinic health professionals to the same extent and in the same manner as such subsection applies to the estimate under such subsection regarding officers, governing board members, employees, and contractors of entities described in subsection (g)(4).

(D) Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subparagraph (B) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (C) for the calendar year beginning in such fiscal year, subject to the extent of amounts in the fund.

(7)(A) This subsection takes effect on the date of the enactment of the first appropriations Act that makes an appropriation under paragraph (6)(A), except as provided in subparagraph (B)(i).

(B)(i) Effective on the date of the enactment of the Health Insurance Portability and Accountability Act of 1996—

(I) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (5)(C); and

(II) reports under paragraph (6)(C) may be submitted to the Congress.

(ii) For the first fiscal year for which an appropriation is made under subparagraph (A) of paragraph (6), if an estimate under subparagraph (C) of such paragraph has not been made for the calendar year beginning in such fiscal year, the transfer under subparagraph (D) of such paragraph shall be made notwithstanding the lack of the estimate, and the transfer shall be made in an amount equal to the amount of such appropriation.

(p) ADMINISTRATION OF SMALLPOX COUNTERMEASURES BY HEALTH PROFESSIONALS.—

(1) IN GENERAL.—For purposes of this section, and subject to other provisions of this subsection, a covered person shall be deemed to be an employee of the Public Health Service with respect to liability arising out of administration of a covered countermeasure against smallpox to an individual during the effective period of a declaration by the Secretary under paragraph (2)(A).

(2) DECLARATION BY SECRETARY CONCERNING COUNTERMEASURE AGAINST SMALLPOX.—

(A) AUTHORITY TO ISSUE DECLARATION.—

(i) IN GENERAL.—The Secretary may issue a declaration, pursuant to this paragraph, concluding that an actual or potential bioterrorist incident or other actual or potential public health emergency makes advisable the administration of a covered countermeasure to a category or categories of individuals.

(ii) COVERED COUNTERMEASURE.—The Secretary shall specify in such declaration the substance or substances that shall be considered covered countermeasures (as defined in paragraph (7)(A)) for purposes of administration to individuals during the effective period of the declaration.

(iii) EFFECTIVE PERIOD.—The Secretary shall specify in such declaration the beginning and ending dates of the effective period of the declaration, and may subsequently amend such declaration to shorten or extend such effective period, provided that the new closing date is after the date when the declaration is amended.

(iv) PUBLICATION.—The Secretary shall promptly publish each such declaration and amendment in the Federal Register.

(B) LIABILITY OF UNITED STATES ONLY FOR ADMINISTRATIONS WITHIN SCOPE OF DECLARATION.—Except as provided in paragraph (5)(B)(ii), the United States shall be liable under this subsection with respect to a claim arising out of the administration of a covered countermeasure to an individual only if—

(i) the countermeasure was administered by a qualified person, for a purpose stated in paragraph (7)(A)(i), and during the effective period of a declaration by the Secretary under subparagraph (A) with respect to such countermeasure; and

(ii)(I) the individual was within a category of individuals covered by the declaration; or

(II) the qualified person administering the countermeasure had reasonable grounds to believe that such individual was within such category.

(C) PRESUMPTION OF ADMINISTRATION WITHIN SCOPE OF DECLARATION IN CASE OF ACCIDENTAL VACCINIA INOCULATION.—

(i) IN GENERAL.—If vaccinia vaccine is a covered countermeasure specified in a declaration under subparagraph (A), and an individual to whom the vaccinia vaccine is not administered contracts vaccinia, then, under the circumstances specified in clause (ii), the individual—

(I) shall be rebuttably presumed to have contracted vaccinia from an individual to whom such vaccine was administered as provided by clauses (i) and (ii) of subparagraph (B); and

(II) shall (unless such presumption is rebutted) be deemed for purposes of this subsection to be an individual to whom a covered countermeasure was

administered by a qualified person in accordance with the terms of such declaration and as described by subparagraph (B).

(ii) CIRCUMSTANCES IN WHICH PRESUMPTION APPLIES.—The presumption and deeming stated in clause (i) shall apply if—

(I) the individual contracts vaccinia during the effective period of a declaration under subparagraph (A) or by the date 30 days after the close of such period; or

(II) the individual has resided with, or has had contact with, an individual to whom such vaccine was administered as provided by clauses (i) and (ii) of subparagraph (B) and contracts vaccinia after such date.

(D) ACTS AND OMISSIONS DEEMED TO BE WITHIN SCOPE OF EMPLOYMENT.—

(i) IN GENERAL.—In the case of a claim arising out of alleged transmission of vaccinia from an individual described in clause (ii), acts or omissions by such individual shall be deemed to have been taken within the scope of such individual's office or employment for purposes of—

(I) subsection (a); and

(II) section 1346(b) and chapter 171 of title 28, United States Code.

(ii) INDIVIDUALS TO WHOM DEEMING APPLIES.—An individual is described by this clause if—

(I) vaccinia vaccine was administered to such individual as provided by subparagraph (B); and

(II) such individual was within a category of individuals covered by a declaration under subparagraph (A)(i).

(3) EXHAUSTION; EXCLUSIVITY; OFFSET.—

(A) EXHAUSTION.—

(i) IN GENERAL.—A person may not bring a claim under this subsection unless such person has exhausted such remedies as are available under part C of this title, except that if the Secretary fails to make a final determination on a request for benefits or compensation filed in accordance with the requirements of such part within 240 days after such request was filed, the individual may seek any remedy that may be available under this section.

(ii) TOLLING OF STATUTE OF LIMITATIONS.—The time limit for filing a claim under this subsection, or for filing an action based on such claim, shall be tolled during the pendency of a request for benefits or compensation under part C of this title.

(iii) CONSTRUCTION.—This subsection shall not be construed as superseding or otherwise affecting the application of a requirement, under chapter 171 of title 28, United States Code, to exhaust administrative remedies.

(B) EXCLUSIVITY.—The remedy provided by subsection (a) shall be exclusive of any other civil action or proceeding for any claim or suit this subsection encompasses, except for a proceeding under part C of this title.

(C) OFFSET.—The value of all compensation and benefits provided under part C of this title for an incident or series of incidents shall be offset against the amount of an award, compromise, or settlement of money damages in a claim or suit under this subsection based on the same incident or series of incidents.

(4) CERTIFICATION OF ACTION BY ATTORNEY GENERAL.—Subsection (c) applies to actions under this subsection, subject to the following provisions:

(A) NATURE OF CERTIFICATION.—The certification by the Attorney General that is the basis for deeming an action or proceeding to be against the United States, and for removing an action or proceeding from a State court, is a certification that the action or proceeding is against a covered person and is based upon a claim alleging personal injury or death arising out of the administration of a covered countermeasure.

(B) CERTIFICATION OF ATTORNEY GENERAL CONCLUSIVE.—The certification of the Attorney General of the facts specified in subparagraph (A) shall conclusively establish such facts for purposes of jurisdiction pursuant to this subsection.

(5) COVERED PERSON TO COOPERATE WITH UNITED STATES.—

(A) IN GENERAL.—A covered person shall cooperate with the United States in the processing and defense of a claim or action under this subsection based upon alleged acts or omissions of such person.

(B) CONSEQUENCES OF FAILURE TO COOPERATE.—Upon the motion of the United States or any other party and upon finding that such person has failed to so cooperate—

(i) the court shall substitute such person as the party defendant in place of the United States and, upon motion, shall remand any such suit to the court in which it was instituted if it appears that the court lacks subject matter jurisdiction;

(ii) the United States shall not be liable based on the acts or omissions of such person; and

(iii) the Attorney General shall not be obligated to defend such action.

(6) RECOURSE AGAINST COVERED PERSON IN CASE OF GROSS MISCONDUCT OR CONTRACT VIOLATION.—

(A) IN GENERAL.—Should payment be made by the United States to any claimant bringing a claim under this subsection, either by way of administrative determination, settlement, or court judgment, the United States shall have, notwithstanding any provision of State law, the right to recover for that portion of the damages so awarded or paid, as well as interest and any costs of litigation, resulting from the failure of any covered person to carry out any obligation or responsibility assumed by such person under a contract with the United States or from any grossly neg-

ligent, reckless, or illegal conduct or willful misconduct on the part of such person.

(B) VENUE.—The United States may maintain an action under this paragraph against such person in the district court of the United States in which such person resides or has its principal place of business.

(7) DEFINITIONS.—As used in this subsection, terms have the following meanings:

(A) COVERED COUNTERMEASURE.—The term "covered countermeasure" or "covered countermeasure against smallpox", means a substance that is—

(i)(I) used to prevent or treat smallpox (including the vaccinia or another vaccine); or

(II) used to control or treat the adverse effects of vaccinia inoculation or of administration of another covered countermeasure; and

(ii) specified in a declaration under paragraph (2).

(B) COVERED PERSON.—The term "covered person", when used with respect to the administration of a covered countermeasure, means a person who is—

(i) a manufacturer or distributor of such countermeasure;

(ii) a health care entity under whose auspices—

(I) such countermeasure was administered;

(II) a determination was made as to whether, or under what circumstances, an individual should receive a covered countermeasure;

(III) the immediate site of administration on the body of a covered countermeasure was monitored, managed, or cared for; or

(IV) an evaluation was made of whether the administration of a countermeasure was effective;

(iii) a qualified person who administered such countermeasure;

(iv) a State, a political subdivision of a State, or an agency or official of a State or of such a political subdivision, if such State, subdivision, agency, or official has established requirements, provided policy guidance, supplied technical or scientific advice or assistance, or otherwise supervised or administered a program with respect to administration of such countermeasures;

(v) in the case of a claim arising out of alleged transmission of vaccinia from an individual—

(I) the individual who allegedly transmitted the vaccinia, if vaccinia vaccine was administered to such individual as provided by paragraph (2)(B) and such individual was within a category of individuals covered by a declaration under paragraph (2)(A)(i); or

(II) an entity that employs an individual described by clause (I) or where such individual has privileges or is otherwise authorized to provide health care;

(vi) an official, agent, or employee of a person described in clause (i), (ii), (iii), or (iv);

(vii) a contractor of, or a volunteer working for, a person described in clause (i), (ii), or (iv), if the contractor or volunteer performs a function for which a person described in clause (i), (ii), or (iv) is a covered person; or

(viii) an individual who has privileges or is otherwise authorized to provide health care under the auspices of an entity described in clause (ii) or (v)(II).

(C) QUALIFIED PERSON.—The term "qualified person", when used with respect to the administration of a covered countermeasure, means a licensed health professional or other individual who—

(i) is authorized to administer such countermeasure under the law of the State in which the countermeasure was administered; or

(ii) is otherwise authorized by the Secretary to administer such countermeasure.

(D) ARISING OUT OF ADMINISTRATION OF A COVERED COUNTERMEASURE.—The term "arising out of administration of a covered countermeasure", when used with respect to a claim or liability, includes a claim or liability arising out of—

(i) determining whether, or under what conditions, an individual should receive a covered countermeasure;

(ii) obtaining informed consent of an individual to the administration of a covered countermeasure;

(iii) monitoring, management, or care of an immediate site of administration on the body of a covered countermeasure, or evaluation of whether the administration of the countermeasure has been effective; or

(iv) transmission of vaccinia virus by an individual to whom vaccinia vaccine was administered as provided by paragraph (2)(B).

(q)(1) For purposes of this section, a health professional volunteer at a deemed entity described in subsection (g)(4) shall, in providing a health professional service eligible for funding under section 330 to an individual, be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (4)(C). The preceding sentence is subject to the provisions of this subsection.

(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a health professional volunteer at an entity described in subsection (g)(4) if the following conditions are met:

(A) The service is provided to the individual at the facilities of an entity described in subsection (g)(4), or through offsite programs or events carried out by the entity.

(B) The entity is sponsoring the health care practitioner pursuant to paragraph (3)(B).

(C) The health care practitioner does not receive any compensation for the service from the individual, the entity described in subsection (g)(4), or any third-party payer (including

reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program), except that the health care practitioner may receive repayment from the entity described in subsection (g)(4) for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual, which may include travel expenses to or from the site of services.

(D) Before the service is provided, the health care practitioner or the entity described in subsection (g)(4) posts a clear and conspicuous notice at the site where the service is provided of the extent to which the legal liability of the health care practitioner is limited pursuant to this subsection.

(E) At the time the service is provided, the health care practitioner is licensed or certified in accordance with applicable Federal and State laws regarding the provision of the service.

(F) At the time the service is provided, the entity described in subsection (g)(4) maintains relevant documentation certifying that the health care practitioner meets the requirements of this subsection.

(3) Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to a health care practitioner for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (4), and subject to the following:

(A) The first sentence of paragraph (1) applies in lieu of the first sentence of subsection (g)(1)(A).

(B) With respect to an entity described in subsection (g)(4), a health care practitioner is not a health professional volunteer at such entity unless the entity sponsors the health care practitioner. For purposes of this subsection, the entity shall be considered to be sponsoring the health care practitioner if—

(i) with respect to the health care practitioner, the entity submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care practitioner is deemed to be an employee of the Public Health Service.

(C) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a health professional volunteer at such entity, this subsection applies to the health care practitioner (with respect to services performed on behalf of the entity sponsoring the health care practitioner pursuant to subparagraph (B)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

(D) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

(4)(A) Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection.

(B)(i) Not later than May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to the Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of health professional volunteers, will be paid pursuant to this section during the calendar year that begins in the following fiscal year.

(ii) Subsection (k)(1)(B) applies to the estimate under clause (i) regarding health professional volunteers to the same extent and in the same manner as such subsection applies to the estimate under such subsection regarding officers, governing board members, employees, and contractors of entities described in subsection (g)(4).

(iii) The report shall include a summary of the data relied upon for the estimate in clause (i), including the number of claims filed and paid from the previous calendar year.

(C) Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subsection (k)(2) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (B) for the calendar year beginning in such fiscal year, subject to the extent of amounts in the fund.

(5)(A) This subsection shall take effect on October 1, 2017, except as provided in subparagraph (B) and paragraph (6).

(B) Effective on the date of the enactment of this subsection—

(i) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (3)(B); and

(ii) reports under paragraph (4)(B) may be submitted to Congress.

(6) Beginning on October 1, 2022, this subsection shall cease to have any force or effect.

(r) CERTAIN INDIAN HEALTH SERVICE VOLUNTEERS DEEMED PUBLIC HEALTH SERVICE EMPLOYEES.—

(1) IN GENERAL.—For purposes of this section, an employee of an IHS urban Indian health program and a health professional volunteer at a Service unit shall, in providing a health service to an individual, be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (4)(C). The preceding sentence is subject to the provisions of this subsection.

(2) CONDITIONS.—In providing a health service to an individual, a health care practitioner shall, for purposes of this subsection, be considered to be a health professional volunteer at a Service unit if all of the following conditions are met:

(A) The service is provided to the individual at the facilities of a Service unit, or through offsite programs or events carried out by the Service unit.

(B) The Service unit is sponsoring the health care practitioner pursuant to paragraph (3)(C).

(C) The health care practitioner does not receive any compensation for the service from the individual, the Service unit, or any third-party payer (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program), except that the health care practitioner may receive repayment from the

Service unit for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

(D) Before the service is provided, the health care practitioner or the Service unit posts a clear and conspicuous notice at the site where the service is provided of the extent to which the legal liability of the health care practitioner is limited under this subsection.

(E) At the time the service is provided, the health care practitioner is licensed, certified, credentialed, and privileged in accordance with Service policy and applicable law regarding the provision of the service.

(3) APPLICABILITY.—Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to an employee of an IHS urban Indian health program and to a health care practitioner at a Service unit for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (4) and subject to the following subparagraphs:

(A) Each reference to an entity in subsections (g), (h), (i), and (l) shall be considered to be a reference to an IHS urban Indian health program or a Service unit, as applicable.

(B) The first sentence of paragraph (1) applies in lieu of the first sentence of subsection (g)(1)(A).

(C) With respect to a Service unit, a health care practitioner is not a health professional volunteer at the Service unit unless the Service unit sponsors the health care practitioner. For purposes of this subsection, the Service unit shall be considered to be sponsoring the health care practitioner if—

(i) with respect to the health care practitioner, the Service unit submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care practitioner is deemed to be an employee of the Public Health Service.

(D) In the case of a health care practitioner who is determined by the Secretary pursuant to this subsection and subsection (g)(1)(E) to be a health professional volunteer, this subsection applies to the health care practitioner (with respect to services performed on behalf of the Service unit sponsoring the health care practitioner pursuant to subparagraph (C)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes that determination.

(E) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions described in paragraph (2) is met.

(4) FUNDING.—

(A) IN GENERAL.—Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection.

(B) ANNUAL ESTIMATES.—

(i) IN GENERAL.—Not later than May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of employees of an IHS urban Indian health program or health professional volunteers, will be paid pursuant to this section during the calendar year that begins in the following fiscal year.

(ii) APPLICABILITY.—Subsection (k)(1)(B) applies to the estimate under clause (i) relating to employees of an IHS urban Indian health program or health professional volunteers to the same extent and in the same manner as that subsection applies to the estimate under that subsection relating to officers, governing board members, employees, and contractors of entities described in subsection (g)(4).

(C) TRANSFERS.—Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subsection (k)(2) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (B) for the calendar year beginning in that fiscal year, subject to the extent of amounts in the fund.

(5) DEFINITIONS.—

(A) IHS URBAN INDIAN HEALTH PROGRAM.—In this subsection, the term "IHS urban Indian health program" means an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.).

(B) SERVICE UNIT.—In this subsection, the term "Service unit" has the meaning given the term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(6) RULE OF CONSTRUCTION.—Nothing in this subsection may be construed—

(A) to negatively impact the right of an Indian Tribe to enter into a compact or contract under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304 et seq.); and

(B) to apply to such a compact or contract unless expressly agreed to by the Indian Tribe.

(7) EFFECTIVE DATES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), this subsection shall take effect on October 1, 2019.

(B) REGULATIONS, APPLICATIONS, AND REPORTS.—Effective on the date of the enactment of the Restoring Accountability in the Indian Health Service Act of 2018, the Secretary may—

(i) prescribe regulations for carrying out this subsection; and

(ii) accept and consider applications submitted under paragraph (3)(C)(i).

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ACT OF DECEMBER 15, 1979

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SEC. 2. (a) For purposes of applying reduction-in-force procedures Reductions in under subsection (a) of section 3502 of title 5, United States Code, with respect to positions within the Bureau of Indian Affairs and the Indian Health Service, the competitive and excepted service retention registers shall be combined, and any employee entitled to Indian preference who is within a retention category established under regulations prescribed under such subsection to provide due effect to military preference shall be entitled to be retained in preference to other employees not entitled to Indian preference who are within such retention category.

(b)(1) The Indian preference laws shall not apply in the case of any reassignment within the Bureau of Indian Affairs or within the Indian Health Service (other than to a position in a higher grade) of an employee not entitled to Indian preference if it is determined that under the circumstances such reassignment is necessary—

(A) to assure the health or safety of the employee or of any member of the employee's household;

(B) in the course of a reduction in force; or

(C) because the employee's working relationship with a tribe has so deteriorated that the employee cannot provide effective service for such tribe or the Federal Government.

(2) The authority to make any determination under subparagraph (A), (B), or (C) of paragraph (1) is vested in the Secretary of the Interior with respect to the Bureau of Indian Affairs and the Secretary of Health, Education, and Welfare with respect to the Indian Health Service, and, notwithstanding any other provision of law, the Secretary involved may not delegate such authority to any individual other than an Under Secretary or Assistant Secretary of the respective department.

(c)(1) Notwithstanding any provision of the Indian preference laws, such laws shall not apply in the case of any personnel action respecting an applicant or employee not entitled to Indian preference if each tribal organization concerned grants, in writing, a waiver of the application of such laws with respect to such personnel action.

(2) The provisions of section 8336Q) of title 5, United States Code (as added by the preceding section of this Act), shall not apply to any individual who has accepted a waiver with respect to a personnel action pursuant to paragraph (1) of this subsection or to section 1131(f) of the Education Amendments of 1978 (25 U.S.C. 20110; 92 Stat. 2324).

(3) IHS WAIVERS.—The Secretary of Health and Human Services may, at the request of an Indian Tribe, seek from each Indian Tribe concerned, a waiver of Indian preference laws for a personnel action that is with respect to—

(A) an Indian Health Service unit in which 15 percent or more of the total positions or specific health professionals in the Service unit are not filled by a full-time employee of

the Indian Health Service for a period of 6 months or longer; or

(B) a former employee of the Indian Health Service or a former tribal employee who was removed from such former employment within, or demoted for performance or misconduct that occurred during, the 5-year period following the date of such personnel action.

(d) The Office of Personnel Management shall provide all appropriate assistance to the Bureau of Indian Affairs and the Indian Health Service in placing non-Indian employees of such agencies in other Federal positions. All other Federal agencies shall cooperate to the fullest extent possible in such placement efforts.

(e) For purposes of this section—

(1) The term "tribal organization" means—

(A) the recognized governing body of any Indian tribe, band, nation, pueblo, or other organized community, including a Native village (as defined in section 3(c) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(c); 85 Stat. 688)); or

(B) in connection with any personnel action referred to in subsection (c)(l) of this section, any legally established organization of Indians which is controlled, sanctioned, or chartered by a governing M y referred to in subparagraph (A) of this paragraph and which has been delegated by such governing body the authority to grant a waiver under such subsection with respect to such personnel action.

(3) The term "Bureau of Indian Affairs" means (A) the Bureau of Indian Affairs and (B) all other organizational units in the Department of the Interior directly and primarily related to providing services to Indians an4 in which positions are filled in accordance with the Indian preference laws.

TITLE 5, UNITED STATES CODE

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PART III—EMPLOYEES

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SUBPART C—EMPLOYEE PERFORMANCE

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CHAPTER 43—PERFORMANCE APPRAISAL

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SUBCHAPTER I—GENERAL PROVISIONS

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§ 4303. Actions based on unacceptable performance

(a) Subject to the provisions of this section, an agency may reduce in grade or remove an employee for unacceptable performance.

(b)(1) An employee whose reduction in grade or removal is proposed under this section is entitled to—

(A) 30 days' advance written notice of the proposed action which identifies—

(i) specific instances of unacceptable performance by the employee on which the proposed action is based; and

(ii) the critical elements of the employee's position involved in each instance of unacceptable performance;

(B) be represented by an attorney or other representative;

(C) a reasonable time to answer orally and in writing; and

(D) a written decision which—

(i) in the case of a reduction in grade or removal under this section, specifies the instances of unacceptable performance by the employee on which the reduction in grade or removal is based, and

(ii) unless proposed by the head of the agency, has been concurred in by an employee who is in a higher position than the employee who proposed the action.

(2) An agency may, under regulations prescribed by the head of such agency, extend the notice period under subsection (b)(1)(A) of this section for not more than 30 days. An agency may extend the notice period for more than 30 days only in accordance with regulations issued by the Office of Personnel Management.

(c) The decision to retain, reduce in grade, or remove an employee—

(1) shall be made within 30 days after the date of expiration of the notice period, and

(2) in the case of a reduction in grade or removal, may be based only on those instances of unacceptable performance by the employee—

(A) which occurred during the 1-year period ending on the date of the notice under subsection (b)(1)(A) of this section in connection with the decision; and

(B) for which the notice and other requirements of this section are complied with.

(d) If, because of performance improvement by the employee during the notice period, the employee is not reduced in grade or removed, and the employee's performance continues to be acceptable for 1 year from the date of the advance written notice provided under subsection (b)(1)(A) of this section, any entry or other notation of the unacceptable performance for which the action was proposed under this section shall be removed from any agency record relating to the employee.

(e) Any employee who is—

(1) a preference eligible;

(2) in the competitive service; or

(3) in the excepted service and covered by subchapter II of chapter 75,

and who has been reduced in grade or removed under this section is entitled to appeal the action to the Merit Systems Protection Board under section 7701.

(f) This section does not apply to—

(1) the reduction to the grade previously held of a supervisor or manager who has not completed the probationary period under section 3321(a)(2) of this title,

(2) the reduction in grade or removal of an employee in the competitive service who is serving a probationary or trial period under an initial appointment or who has not completed 1 year of current continuous employment under other than a temporary appointment limited to 1 year or less,

(3) the reduction in grade or removal of an employee in the excepted service who has not completed 1 year of current continuous employment in the same or similar positions, [or]

(4) any removal or demotion under section 714 of title 38[.], *or*

(5) any removal or demotion under section 607 of the Indian Health Care Improvement Act.

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SUBPART F—LABOR-MANAGEMENT AND EMPLOYEE RELATIONS

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CHAPTER 72—ANTIDISCRIMINATION; RIGHT TO PETITION CONGRESS

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SUBCHAPTER II—EMPLOYEES' RIGHT TO PETITION CONGRESS

§ 7211. Employees' right to petition Congress

[The right of] *(a) IN GENERAL.—The right of* employees, individually or collectively, to petition Congress or a Member of Congress, or to furnish information to either House of Congress, or to a committee or Member thereof, may not be interfered with or denied.

(b) ADVERSE ACTION.—An employee who interferes with or denies a right protected under subsection (a) shall be subject to any adverse action described in paragraphs (1) through (5) of section 7512, in accordance with the procedure described in section 7513 and any other applicable procedure.

SOCIAL SECURITY ACT

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART E—MISCELLANEOUS PROVISIONS

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INDIAN HEALTH SERVICE FACILITIES

SEC. 1880. (a) A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for

payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this title.

(b) Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this title which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) Notwithstanding any other provision of this title, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 403 of such Act) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.

(e)(1)(A) Notwithstanding section 1835(d), subject to subparagraph (B), the Secretary shall make payment under part B to a hospital or an ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined for purposes of subsection (a)) for services described in paragraph (2) (and for items and services furnished on or after January 1, 2005, all items and services for which payment may be made under part B) furnished in or at the direction of the hospital or clinic under the same situations, terms, and conditions as would apply if the services were furnished in or at the direction of such a hospital or clinic that was not operated by such Service, tribe, or organization.

(B) Payment shall not be made for services under subparagraph (A) to the extent that payment is otherwise made for such services under this title.

(2) The services described in this paragraph are the following:

(A) Services for which payment is made under section 1848.

(B) Services furnished by a practitioner described in section 1842(b)(18)(C) for which payment under part B is made under a fee schedule.

(C) Services furnished by a physical therapist or occupational therapist as described in section 1861(p) for which payment under part B is made under a fee schedule.

(3) Subsection (c) shall not apply to payments made under this subsection.

(f) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).

(g)(1) Not less frequently than once every 2 years, the Administrator of the Centers for Medicare & Medicaid Services shall conduct surveys of participating Indian Health Service facilities to assess the compliance of each hospital or skilled nursing facility of the Indian Health Service with—

(A) section 1867; and

(B) conditions of participation in the program under this title.

(2) Each survey completed under this subsection shall be posted on the Internet website of the Centers for Medicare & Medicaid Services. Such posting shall comply with the Federal regulations concerning the privacy of individually identifiable health information promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

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