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The Special Counsel

May 29, 2014

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-13-3495

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find an agency report based on a whistleblower disclosure regarding the Department of Health and Human Services, Indian Health Service (IHS), Portland Service Area[1], Portland, Oregon. The whistleblower, who chose to remain anonymous, disclosed that IHS Contract Health Service (CHS) funds were improperly approved to pay for federal salaries, vendor payments, and other inappropriate expenditures, in violation of federal law and agency policy.

The agency did not substantiate the allegation that federal law was violated by employees in the Portland Service Area, but did find that the expenditure of CHS funds to pay for drugs through a Department of Veterans Affairs program is not specifically authorized by IHS policy. As a result, IHS is evaluating whether the permissible uses of CHS funds must be updated or clarified, and whether any additional training is needed. The agency anticipates that this supplemental review will be completed at the end of 2014. The whistleblower declined the opportunity to comment on the agency's report in this matter. Based upon my review of the allegations and the agency's report, I find that the report is reasonable. However, I am closing this matter conditionally, pending the receipt of the agency's supplemental report.[2]

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[1] The Portland Service Area oversees a number of Service Units, including the Colville, Wellpinit, and Western Oregon Service Units. Each Service Unit administers several health facilities within its jurisdiction.

[2] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions

The whistleblower's allegations were referred to Secretary of Health and Human Services Kathleen Sebelius to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). The Secretary delegated to IHS the authority to issue a report of investigation. On January 31, 2014, the IHS Acting Director submitted the agency's report to this office. Pursuant to 5 U.S.C. § 1213(e)(1), the whistleblower was offered the opportunity to comment on the findings of the Secretary's office, but declined to do so. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the report to you.

I. The Allegations

CHS is defined by 42 C.F.R. § 36.21(e) as "health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service." The whistleblower explained that CHS funds are used to purchase services from private health care providers when no IHS direct care facility exists, the available direct care provider cannot provide the required emergency or specialty care or has an overflow, and supplemental funding is required to provide care to eligible individuals. CHS funding is separate from general IHS funding in the congressional budget and must remain available until expended.[3] The whistleblower alleged that both federal appropriations law and agency policy restrict the use of CHS funds to the purposes anticipated by § 36.21.

The whistleblower disclosed that Portland Service Area CHS funds have been used since 2007 for unlawful purposes. Specifically, the whistleblower alleged that the IHS Clinic in Omak, Washington (Omak Clinic), part of the Colville Service Unit, was created around 2006 using CHS funds entirely. Approximately $384,906 of CHS funds were used to start the Omak Clinic, which is not a specialty clinic, according to the whistleblower. Further, between 2009 and 2012, CHS funds were used to pay providers' salaries, taxes, and benefits, including those of Dr. Paul Phillips, DDS, and Dr. Kim T. Stewart, DDS, who were contract dentists in the Omak dental clinic, Candy Ives, a registered nurse in the Omak Clinic, and Dr. Ute Wilcox, a permanent family practice physician at the Omak Clinic.

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exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c).

Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

[3] Consolidated Appropriations Act of 2012, Pub. L. No. 112-74, 125 Stat. 1027 (2011).

The whistleblower further alleged that CHS funds were regularly used to pay the "Prime Vendor," McKesson Corp. McKesson provides pharmacy items to IHS inpatient facilities and clinics. In 2012, the IHS Colville Service Unit budgeted $878,000 in CHS funding to pay for the Prime Vendor, listing it as the "Clinic Pharmacy" for the Omak Clinic. In fact, the whistleblower disclosed that between 2003 and 2013, the Colville, Wellpinit, and Western Oregon Service Units together spent $7,469,575.43 of CHS funds on payments to the Prime Vendor. The whistleblower asserted that under agency policy the Prime Vendor should be reimbursed from Hospital and Clinic funds, not CHS funds, because the Prime Vendor does not furnish "an existing ongoing direct care activity that the service unit has been unable to provide through direct hire." The whistleblower alleged that the nature, length, and cost of these expenditures indicate that the dental clinic in Omak does not constitute a specialty clinic.

Generally, an appropriation is available only for the purpose for which it was made.[4] CHS funding is specifically appropriated by Congress in the IHS budget. For example, in the 2012 Consolidated Appropriations Act, Congress allocated $844,927,000 for "contract medical care." Pursuant to the specific appropriation, agency policy limits the use of CHS funds to CHS-only purposes. HHS Circular 91-07, *Contract Health Service Fund Control* (June 13, 1991), Sec. 3., states that IHS areas and service units should manage and administer CHS funds within the budget authority specified in official advice documents. In a memorandum dated February 23, 1993, from Michael E. Lincoln, former IHS deputy director (February 23 memo), the agency clarified that when services are provided within IHS facilities by anyone but physicians employed as independent contractors, the IHS must use hospital and clinic funds to pay for those services. CHS funds may not be used for the establishment of new services or the re-establishment of discontinued services. When services are provided by non-IHS physicians serving in a *locum tenens* capacity or staffing specialty clinics in IHS facilities, CHS funds may be used to pay for the services, provided the responsible area director receives prior approval from the headquarters CHS branch chief. The February 23 memo notes that specialty clinic physicians must function as independent contractors and must possess qualifications in a sub-specialty that IHS cannot or does not usually retain. Thus, the use of CHS funds to retain any other staff would not be permissible.

The agency further clarified its position on the use of CHS funding in a February 2, 1994, memorandum from then-acting director Michael E. Lincoln (February 2 memo). Mr. Lincoln revised the agency's original policy on CHS funding to allow hospitals and clinics to use CHS funds to procure non-physician medical care provider services required to maintain direct care services. This would include nurse anesthetists and midwives. The required service must be "an existing ongoing direct care activity that the service unit has been unable to provide through direct hire." The February 2 memo also

[4] Purpose Statute, 31 U.S.C. § 1301(a). *See also* Government Accountability Office (GAO), Principles of Federal Appropriations (The Redbook), GAO-04-261SP, Ch. 4 (2004).

lifted the requirement that CHS funding requests for *locum tenens* physicians be submitted to headquarters for approval.

The whistleblower alleged that the expenditures described above are in violation of both the Purpose Statute and agency policy. The whistleblower further asserted that the use of CHS funding likely goes beyond the limited examples listed above, and that concerns about alleged improper expenditures have been brought to the attention of management on multiple occasions, but no action has been taken. Rather, the whistleblower stated that the agency's justification for the use of CHS funds for pharmacy items was that a very high percentage of the service unit's patients are CHS-eligible, so the patients have prescriptions filled in the clinics, rather than using CHS funds for reimbursement to an outside pharmacy. The whistleblower asserted that this justification is not sufficient; thus, any expenditure of CHS funds similar to those above is in violation of federal law and agency policy.

II. The Agency Report

The agency determined that although no violation of law or policy occurred, IHS practice in using CHS funds was neither uniform nor fully consistent with agency policy. Specifically, the agency asserted that by statute IHS is authorized to spend appropriated funds for the "conservation of health" of Indians.[5] Under such authority, IHS and tribes use CHS funds to pay for medical care to beneficiaries from public and private providers. The agency report notes that earlier in its history, eligibility for CHS was established informally by local offices, causing inconsistency in application. A 1976 federal court decision ruled that the IHS CHS policies had no effect because they were not published in the Federal Register or issued in accordance with rulemaking procedures. In response, IHS issued rules to establish uniform eligibility for the provision of contract health services.[6]

Nevertheless, the report states that IHS does not limit the use of funds allocated for contract health services to individuals who qualify under the revised CHS eligibility rules, nor does it prohibit the use of CHS funds to pay for goods and services procured outside IHS. For example, the report notes that in its annual budget justification to Congress, IHS describes using CHS funds to support the delivery of direct care, such as medical referrals, diagnostic services, or consultants.

The report states that since 1992, Congress has included contract medical care as a line item budget appropriation in order to make funds available for a period longer than the appropriation cycle. The agency found that while the language alters the temporal availability of the funds, it does not limit the funds to CHS expenditures. The agency

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[5] *See* 25 U.S.C. § 13; 42 U.S.C § 2001(a).
[6] Lewis v. Weinberger, 415 F. Supp. 652, 661 (D N.M. 1976).

notes that the subsequent IHS budget justifications indicate that IHS will expend the funds through contracts in support of direct care. IHS refers to this as "Contract Health Services to Support Direct Care," defined in the Indian Health Manual as "medical services provided in an IHS facility when the patient is under the direct supervision of an IHS physician or contract physician practicing under the auspices (or authority) of an IHS facility."

The report acknowledges that IHS has issued additional guidance on the permissible uses of CHS funds, including the February 23 and February 2 memoranda discussed above. The agency found that although IHS has authorized certain non-CHS expenditures through the Indian Health Manual and various memoranda, there is no legal basis to distinguish these expenditures from other non-CHS contract expenditures in the context of Congress' contract medical care budget line item. Thus, the agency's guidance to employees serves only to clarify the type of medical care that may be purchased by contract, and who may be served by the contracts.

The agency found that the Portland Service Area does not use CHS funds to pay salaries of federal employees in the Omak Clinic. The salaries of federal employees are paid for with Hospitals and Clinics funds and Medicare revenue, while the contract providers are paid with contract medical care funds. The report asserts that this is in line with the February 2 memo, which allows the use of CHS funds to procure physician services and non-physician medical care without regard to whether such services are provided on a full-time equivalent basis.

The agency also found that the Omak Clinic was not created with CHS funds. The Confederated Tribes of the Colville Reservation (the Tribe) financed and managed the construction of the Omak Clinic because the community lacked a federal facility. Shortly thereafter, IHS leased a section of the Clinic building from the Tribe to provide dental and pharmacy services. In 2010, IHS increased the size of its leased space to provide primary care services.

The agency determined that the Portland Service Area does use CHS funds to procure medical and pharmaceutical supplies through the Department of Veterans Affairs (VA) Pharmaceutical Prime Vendor Program (PPV). The Portland Service Area stated that the CHS funds used to pay the VA PPV would otherwise be expended by individual CHS-eligible patients to have their prescriptions filled elsewhere. The report noted that although IHS policy does not specifically authorize the purchase of medications from PPV using funds appropriated for contract medical care, IHS policy does allow for Service Units to contract with community pharmacies to provide pharmaceutical care for eligible patients. Nonetheless, while community contracts are permitted, Service Units are discouraged from utilizing them, as they are not cost-effective. The report notes that IHS can generally obtain discounted pharmaceuticals through other contract channels, including through the VA. IHS pharmacies access the VA PPV through a national contract and interagency agreement, but most purchases are reimbursed with non-CHS

sources of funding. However, because the purchases are considered contract acquisitions, the agency determined that they may be viewed as expenditures for contract care consistent with the language of the appropriation.

While the agency found no violation of law, it did find that the whistleblower's allegations suggest that the IHS guidelines for the use of contract medical care funds are neither uniform nor consistent with agency policy. As a result, IHS has undertaken a review of its practices to determine whether it must update or clarify permissible uses of such funds, as well as provide additional agency-wide training on policy updates or clarifications. The agency indicated that its review is expected to take approximately one year. It will submit a supplemental report on the outcomes of its evaluation and include a timeframe for implementing any resulting changes to its policies.

III. The Special Counsel's Findings

I have reviewed the original disclosure and the agency report. Based on that review, I have determined that the agency's report contains all of the information required by statute, and the findings appear to be reasonable. However, as noted above, I am closing this matter on a conditional basis, pending the outcome of the agency's review of its policies on the use of contract medical funds. I expect a supplemental report on this matter by the end of this year.

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As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency's report to the Chairs and Ranking Members of the Senate Committee on Indian Affairs and the House Committee on Natural Resources. I have also filed copies of the report in our public file, which is available online at www.osc.gov.

Respectfully,

Carolyn N. Lerner

Enclosure