

House Committee on Natural Resources
Subcommittee for Indigenous Peoples of the United States
Legislative Hearing

H.R. 6237, PRC for Native Veterans Act

H.R. 6535, Coverage for Urban Indian Health Providers Act

H.R. 7119, Alaska Native Tribal Health Consortium Land Transfer Act of 2020

Statement by
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Good afternoon Chairman Gallego, Ranking Member Cook, and members of the Subcommittee for Indigenous Peoples of the United States. Thank you for the opportunity to testify on H.R. 6237, PRC for Native Veterans Act; H.R. 6535, Coverage for Urban Indian Health Providers Act; and H.R. 7119, Alaska Native Tribal Health Consortium Land Transfer Act of 2020.

As an agency within the Department of Health and Human Services (HHS), the Indian Health Service (IHS) mission is to raise the physical, mental, social, and spiritual health of American Indian and Alaska Native people to the highest level. This mission is carried out in partnership with American Indian and Alaska Native Tribal communities through a network of over 605 Federal and tribal health facilities and 41 Urban Indian Organizations (UIOs) that are located across 37 states and provide health care services to approximately 2.6 million American Indian and Alaska Native people annually.

H.R. 6237

H.R. 6237, Proper and Reimbursed Care for Native Veterans Act (PRC for Native Veterans Act), would amend Section 405(c) of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1645) to clarify that the Department of Veterans Affairs (VA) and Department of Defense (DOD) must reimburse IHS, Indian tribes, and tribal organizations for certain contract health care services,

including patient travel costs. The bill refers to these costs as contract health care, but these cost can be paid for through IHS' Purchased/Referred Care (PRC) program.

Currently, the VA reimburses the Indian health provider for direct services provided to an eligible veteran in an IHS, Indian tribe, or tribal organization facility. However, if a veteran needs services that are not available in one of these facilities, the veteran must either be referred back to the VA or the IHS pays for the contracted services through its PRC program. The IHS is not currently reimbursed for any PRC provided to our veterans. The IHS is working with the VA to improve the coordination of care process for veteran American Indian and Alaska Native patients that seek their primary care through IHS. The improvements will allow patients to be referred directly to a VA network provider from the IHS or tribal provider. A Healthcare Coordination Advisory Board was established on February 28, 2020, consisting of VA staff, IHS leadership, and 12 tribal representatives, has been established to assist in developing and implementing the standardized processes for care coordination.

We are committed to our American Indian and Alaska Native veterans in providing the best care possible and also committed to the VA in improving the care coordination efforts between our two agencies.

Similarly, IHS is not reimbursed for PRC when it is used to provide services to an active duty military member. Since non-active duty DOD beneficiaries are covered under TRICARE, IHS would not approve PRC payment for that patient. Patients who are DOD beneficiaries usually work through their TRICARE coverage for care beyond what IHS offers as a direct service. Direct care for DOD beneficiaries provided by IHS or a tribal program is currently reimbursed by supplemental care for active duty members and for TRICARE beneficiaries at TRICARE rates.

IHS is committed to continuing to work with our VA and DOD partners to strengthen the provision of health care to our Nation's veterans and DOD beneficiaries.

H.R. 6535

H.R. 6535, Coverage for Urban Indian Health Providers Act, would amend the IHCA to extend Federal Tort Claims Act (FTCA) coverage to UIOs by applying a section of the Indian Self-Determination and Education Assistance Act (ISDEAA) to deem the UIOs and their employees part of the Public Health Service.

Congress must specifically authorize, in statute, the extension of federal tort coverage to certain groups or individuals. Currently, Federal law extends FTCA coverage to ISDEAA contractors' employees and personal services contractors [25 U.S.C. § 5321(d)]. Federal law does not provide tort liability coverage for injuries to Urban American Indian and Alaska Native patients that result from the negligent acts of employees at UIOs providing health and medical services pursuant to a contract with or a grant from the IHS.

The IHS enters into limited, competing contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. In calendar year 2018, UIOs provided 731,349 health care visits for 72,243 American Indians and Alaska Natives, who do not have access to the resources offered through IHS or tribally operated health care facilities because they do not live on or near a reservation.

UIOs are purchasing liability insurance with resources that could be better utilized to expand services available to Urban American Indian and Alaska Native patients. The rising cost of liability insurance and the general cost of providing health care services adversely impact the ability of UIOs to provide needed services. As a result, UIOs have had to substantially reduce or eliminate certain kinds of staff and health services, such as dental services. UIOs are an integral part of the IHS health care system. They provide high quality, culturally relevant health care services and are often the only health care providers readily accessible to Urban American Indian and Alaska Native patients.

IHS endorses the policy to extend FTCA coverage to UIOs, which is consistent with the FY 2021 Budget request. However, such coverage is generally conveyed through the Public Health Service Act, and IHS prefers taking that approach to extend coverage to UIOs. The Public Health Service Act provides examples of how to extend coverage to entities such as UIOs. The ISDEAA, on the other hand, is a unique authority that governs the relationship between IHS and tribal governments and authorized tribal organizations. IHS would like to work with the committee on technical changes to the bill to address the issues raised above.

H.R. 7119

H.R. 7119, Alaska Native Tribal Health Consortium Land Transfer Act of 2020, sponsored by Representative Young, would convey land in Anchorage, Alaska, to the Alaska Native Tribal

Health Consortium (ANTHC) by warranty deed. H.R. 7119 would provide conveyance, by warranty deed, of certain property to the ANTHC, a tribal organization that has provided IHS-funded health care services since 1999 under the authority of the ISDEAA. The federal property described in H.R. 7119 would be used in connection with existing health programs in Anchorage, Alaska. Under H.R. 7119, the Consortium would not provide the Federal Government with any consideration for the property and the Federal Government would not be able to impose any obligation, term, or condition on the Consortium with regard to the property. In addition, the Federal Government would not retain any reversionary interest in the property. It also would require completing the conveyance no later than 180 days from enactment of the bill. HHS has determined this time frame would not provide sufficient time to fully complete the transfer.

H.R. 7119 would free the Consortium of any liability that it otherwise would have assumed for any environmental contamination that may have occurred on or before the date of the transfer. Notably, H.R. 7119 does not address liability during the period that the Consortium was using, occupying and/or managing the property prior to conveyance.

We have seen several bills of this sort move through Congress in recent years mandating transfer by warranty deed rather than by quitclaim deed, including S. 825, the Southeast Alaska Regional Health Consortium Land Transfer Act of 2017. As with previous bills, HHS is concerned about the details of H.R. 7119. Specifically, HHS does not prefer to make ISDEAA transfers by warranty deed as such deeds create the potential for liability if a competing property interest is subsequently discovered. In addition, barring retention of a reversionary interest (as is the standard practice with transfers of property for ISDEAA purposes) deprives HHS a means to ensure the property will continue to be used for health services in furtherance of the purposes of this bill.

With respect to environmental liability, H.R. 7119 does not protect HHS from liability for contamination that may have occurred subsequent to the time when administration of the facility was turned over to the Consortium.

With these concerns in mind, HHS supports the purposes of the bill to convey the property to the Consortium in order to facilitate providing improved health services to Alaska Natives. We would like to work with the subcommittee on technical changes to the bill to address the issues raised above. We remain firmly committed to improving quality, safety, and access to health care for

AIAN. We appreciate all your efforts in helping us provide the best possible health care services to the people we serve.

Thank you again for the opportunity to speak with you today.

H.R. 7119 Technical Comments

- **Section 2. Page 1, line 12:** Drafters may want to consider changing the deadline to complete the transfer of the property as follows to ensure the requirement can be met:
“not-later than two (2) years, after the date of enactment”
- **Section 2. Page 3, line 19:** Drafters may want to consider language immunizing IHS from any contamination which may have occurred during the period the property has been used, occupied and/or controlled by the Consortium.
“to the Consortium, except that the Secretary shall not be liable for any contamination that occurred after the date the Consortium controlled, occupied, and used the property.