HOUSE COMMITTEE ON
NATURAL RESOURCES
RANKING MEMBER BRUCE WESTERMAN

To: House Committee on Natural Resources Republican Members
From: Subcommittee for Indigenous Peoples Republican Staff; Ken Degenfelder (Ken.Degenfelder@mail.house.gov) and Rob MacGregor (Robert.MacGregor@mail.house.gov)
Date: July 19, 2021
Subject: Legislative Hearing on H.R. 422, ttitled the "Southeast Alaska Region Health Consortium Land Transfer Act" and H.R. 3496, titled the "Urban Indian Health Providers Facilities Improvement Act"

The Subcommittee for Indigenous Peoples will hold a legislative hearing on H.R. 422 (Rep. Young), titled the "Southeast Alaska Regional Health Consortium Land Transfer Act," and H.R. 3496 (Rep. Gallego), titled the "the Urban Indian Health Providers Facilities Improvement Act," on **Tuesday, July 20, 2021, at 12:00 p.m. EDT** online via Cisco WebEx.

Member offices are requested to notify Rob MacGregor (Robert.MacGregor@mail.house.gov) by **4:30 p.m. on Monday, July 19, 2021**, if their Member intends to participate from his/her laptop in 1324 LHOB or from another location. Submissions for the hearing record must be submitted through the Committee's electronic repository at HNRCDocs@mail.house.gov. Please contact David DeMarco(David.DeMarco@mail.house.gov) or Everett Winnick (EverettWinnick@mail.house.gov) should any technical difficulties arise.

I. KEY MESSAGES

- The hearing will focus on two pieces of legislation impacting Indian healthcare.
- H.R. 442 would transfer 10 acres of federal land to the Southeast Alaska Regional Health Consortium which is part of the Mt. Edgecumbe Hospital campus in Sitka, AK.
- H.R. 3496 would amend current law to authorize the Indian Health Service to expand available funding to Urban Indian Health Organizations for construction, renovations, or expansion of Urban Indian health facilities.

II. WITNESSES

- **Mr. Michael E. Douglas,** Senior Vice President & Chief Legal Officer, Southeast Alaska Regional Health Consortium, Juneau, AK *[Republican Witness]*

- **Ms. Sonya M. Tetnowski**, President-Elect, National Council of Urban Indian Health, Washington, D.C.

III. BACKGROUND

The Indian Health Service (IHS) is an agency of the U.S. Department of Health and Human Services (HHS) that provides healthcare to approximately 2.6 million American Indians and Alaska Natives (AI/ANs) through 600 hospitals, clinics, and health stations on or near Indian reservations.[1] The agency is headquartered in Rockville, Maryland, and is composed of 12 regions, or "Areas," each with a separate headquarters.[2] The agency offers "direct-service" healthcare, meaning care provided by federal employees, and it also acts as a conduit for federal funds for tribes that have utilized the Indian Self-Determination and Education Assistance Act (ISDEAA)[3] to independently operate their health facilities. The IHS also administers programs for Urban Indian organizations (UIO's).[4] The IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care in 37 States.[5]

The Snyder Act of 1921[6] provides the basic authority for the federal provision of health services and benefits to Indians because of their federally-recognized tribal status. The modern statutory basis and framework for the federal provision of health care to Indians is under the Indian Healthcare Improvement Act (IHCIA).[7] This law was permanently reauthorized in Title X of the Patient Protection and Affordable Care Act.[8] 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.[9]

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[1] Indian Health Service Budget Justification FY 2022 at CJ-2. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf

[2] The twelve areas of the IHS include: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson. https://www.ihs.gov/locations/.

[3] 25 U.S.C. 5304 et seq.

[4] https://www.ihs.gov/urban/aboutus/.

[5] Indian Health Service Budget Justification FY 2022 at CJ-2. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf

[6] 25 U.S.C. 13.

[7] 25 U.S.C. 1601 et seq.

[8] Public Law 111-148.

[9] Public Law 93-638.

Health Care Facilities

To provide primary health care needs for American Indian and Alaska Native communities, the IHS system is a mostly rural outpatient system focused on primary care consisting of the following number and types of facilities:

	Hospitals	Health Centers	Alaska Native Village Clinics	Health Stations	Total
IHS Operated	24	51	N/A	24	99
Tribally Operated	22	229	59	79	389

Source: U.S. Dept. of Health and Human Services, Indian Health Service, as of August 2020.[10]

Generally, IHS facilities provide health and health education services that focus on primary and preventive care. Funding for facility construction is provided through the IHS Health Care Facilities Construction (HCFC) program. The HCFC program is funded based on an IHS list of priorities for construction projects.

In addition to IHS and tribally managed facilities, UIO's across the country provide health care services to AI/AN's living in urban areas. There are currently 41 non-profit programs nationwide that participate in the IHS Urban Indian health program.[11] The programs are funded through grants and contracts under Title V of the IHCIA through the Urban Indian Health budget line item. Approximately 45% of the UIHPs receive Medicaid reimbursement as Federally Qualified Health Centers (FQHC) and others receive fees for service under Medicaid for allowable services, i.e. behavioral services, transportation, etc. Over $28.8 million are generated in other revenue sources. In the Omnibus Reconciliation Act of 1993, Title V, and tribal 638 programs were added to the list of specific programs automatically eligible for FQHC designation.[12] A broad range of contract and grant funded programs are provided in facilities owned or leased by Urban Indian organizations. While UIO's receive some federal funding to provide care, they are only eligible to receive funding for minor renovations, construction or expansion, to maintain health facility accreditation.[13]

H.R. 442, the Southeast Alaska Regional Health Consortium Land Transfer Act (Rep. Young)

The bill would direct the Secretary of HHS to convey by warranty deed, within two years of enactment, two parcels totaling 10.87 acres of federal land in Sitka, Alaska, to the

[10] https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf
[11] https://www.ihs.gov/urban/
[12] *Id*.
[13] 25 U.S.C 1659.

Southeast Alaska Regional Health Consortium (SEARHC) for use in connection with health and social services related programs. The SEARHC is a tribal health organization that provides health services under a ISDEAA compact with the IHS. SEARHC's Mt. Edgecumbe Hospital (MEH) (Lot 7) and Community Health Services building (Lot 4), currently occupy the 10.87 acres. Site control would enable SEARHC to renovate existing facilities and construct new healthcare facilities to provide improved services.

SEARHC is a tribal non-profit consortium comprised of 15 federally recognized Alaska Native tribes and is among the oldest and most expansive Tribally maintained healthcare organizations in the country. With a service area covering more than 42,000 square miles across the southeast Alaska panhandle, SEARHC provides healthcare services in twenty-seven southeast Alaska communities and operates two critical access hospitals to serve tribal members across the region.[14]

Founded in 1975, SEARHC began by assuming management of the Community Health Aide Program for tribes in Alaska, through compact with the IHS in 1976 under Title V of ISDEAA. Similarly, in 1982 SEARHC took control of the IHS Juneau clinic (Ethel Lund Medical Center), and in 1986 it assumed responsibility over the clinic in Sitka, MEH.[15]

The MEH is a 25-bed critical access hospital that was constructed during the latter half of World War II. MEH provides acute care, critical care, obstetrics, surgery, and perioperative care, as well as outpatient primary care and emergency services.[16] In FY 2017, there were 183,493 outpatient visits organization-wide. However, the 75-year-old facility is in poor condition and in need of upgrading to provide healthcare services more adequately.[17]

The SEARHC intends to use the 10.87 acres to support future MEH replacement and expansion.[18] Without the conveyance of title by warranty deed, the SEARHC will be less likely to secure needed financing for the facility replacement and expansion of MEH.

Over the past several Congress's, substantially similar legislation has been enacted into law to transfer, by warranty deed, certain IHS property in other locations to Alaska Regional Health Consortiums.[19] In 2017, Southeast Alaska Regional Health Consortium Land Transfer Act of 2017 was signed into law.[20]

[14] Staff call with SEARHC. 7.15.21.
[15] www.searchc.org/about-us/our-story/
[16] Statement for the Record. of Charles Clement before S. Cmte. Indian Affairs 116th Congress. https://republicans-naturalresources.house.gov/UploadedFiles/2020.06.19_SEARHC_Clement_Written_Testimony_to_SCIA_on_S._3099.pdf
[17] *Id*.
[18] *Id*.
[19] Eg. P.L. 113-68.
[20] Public Law 115-619.

H.R. 3496, the Urban Indian Health Providers Facilities Improvement Act (Rep. Gallego)

The bill would amend the IHCIA to expand IHS authority to use UIO program funds to UIO's for renovating, constructing, and expanding urban health facilities. Under current law, the IHS is only authorized to provide funds to UIO's to make "minor" renovations, including at leased facilities, to meet or maintain Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards.[21]

According to the National Council on Urban Indian Health, only one out of the 41 UIO's maintain JCAHO accreditation.[22] UIO's seek or maintain accreditation from health care accreditation organizations other than JCAHO, including the Accreditation Association for Ambulatory Healthcare (AAAHC) and the Commission on Accreditation of Rehabilitation Facilities (CARF). Some UIO's have also achieved recognition as Patient Centered Medical Homes (PCMH), with additional UIO's currently working towards PCMH recognition, as well as AAAHC accreditation.[23] In addition, some UIO's must meet standards from the Centers for Medicare & Medicaid Services and/or their respective state departments of health.

The legislative history of section 509 of the IHCIA is unclear as to why JCAHO standards were chosen and the IHS policy since 1997 has supported UIO choice of accreditation among nationally accepted certifying bodies.[24] According to the IHS, JCAHO accreditation is common amongst most full service hospitals in the U.S. Most UIO's are typically limited in the services they provide, and it is more commonsense for them to seek accreditation from organizations that are more specific to their services. By removing this provision, UIO's will have more flexibility.[25]

IV. SECTION-BY-SECTION ANALYSIS

H.R. 442, the Southeast Alaska Regional Health Consortium Land Transfer Act (Rep. Young)

Section 1: Short title

Section 2: Conveyance of Property.

Subsection (a) directs the Secretary of Health and Human Services to convey, by warranty deed, the property described in Section 3 to SEARHC for connection with health and social programs.

Subsection (b) outlines conditions of conveyance.

[21] 25 U.S.C. § 1659.
[22] https://www.ncuih.org/action/document/download?document_id=398
[23] Id.
[24] https://www.ihs.gov/ihm/circulars/1997/accreditation-certification-of-hospitals-and-health-centers/
[25] Staff call with Indian Health Service. July 16, 2021.

Subsection (c) states the conveyance under subsection (a) renders no future effect on any quitclaim deed to property described in Section 3.

Section 3: Describes the property to be conveyed.

Section 4: Environmental Liability.

Subsection (a) states the Consortium shall not be liable for any contamination resulting from disposal, release, or presence of environmental contamination on the property on or before the date of the conveyance.

Subsection (b) Accords easement or access to the Secretary to the property conveyed as reasonably necessary.

Subsection (c) outlines the Secretary shall comply with subparagraphs (A) and (B) of Section 120 (h)(3) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

H.R. 3496, Urban Indian Health Providers Facilities Improvement Act (Rep. Gallego)

Section 1: Short title- "Urban Indian Health Providers Facilities Improvement Act"

Section 2: Expanding the Funding Authority for Renovating, Constructing, and Expanding Certain Facilities. Amends Section 509 of the Indian Health Care Improvement Act (25 U.S.C. 1659) by striking "minor" before "renovations," by striking "to assist such contractors or grant recipients in meeting or maintaining the Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards."

V. COST

H.R. 442 (Young)

A Congressional Budget Office (CBO) score for the legislation in the 117th Congress has not been completed. However, the CBO estimated that a substantially similar bill in the 116th Congress would not have an impact on the federal budget.[26]

H.R. 3496 (Gallego)

A CBO score for the legislation in the 117th Congress has not been completed.

VI. ADMINISTRATION POSITION

[26] S. 3099. 116th Congress. https://www.cbo.gov/system/files/2020-09/s3099.pdf

H.R. 442 (Young)

Unknown, however in the 116th Congress, the IHS submitted a statement for the hearing record for a substantially similar bill, stating that it supported the purposes of the bill but had concerns with transferring the property by warranty deed as liabilities could arise. The IHS also expressed concern that the legislation did not retain a a revisionary interest in the land for the federal government.

H.R. 3496 (Gallego)

Unknown.

VII. EFFECT ON CURRENT LAW (RAMSEYER)

H.R. 3496 (Gallego) Ramseyer

Showing Current Law as amended by H.R. 3496 (Gallego)

[new text highlighted in yellow; text to be deleted bracketed and highlighted in blue]

Section 509 of the Indian Health Care Improvement Act (25 U.S.C. 1659)

§1659. Facilities renovation

The Secretary may make funds available to contractors or grant recipients under this subchapter for [minor] renovations to facilities or construction or expansion of facilities, including leased facilities[, to assist such contractors or grant recipients in meeting or maintaining the Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards].

(Pub. L. 94–437, title V, §509, formerly §409, as added Pub. L. 101–630, title V, §506(c), Nov. 28, 1990, 104 Stat. 4566 ; renumbered §509 and amended Pub. L. 102–573, title V, §§501(b)(6), 505(b)(2), title IX, §902(5)(A), Oct. 29, 1992, 106 Stat. 4569 , 4571, 4591; Pub. L. 111–148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935 .)