Questions for the Record – House Natural Resources Committee
Subcommittee for Indigenous People of the United States

Legislative Hearing:
HR 6237, PRC for Native Veterans Act
HR 6535, Coverage for Urban Indian Health Providers Act
HR 7119, Alaska Native Tribal Health Consortium Land Transfer Act of 2020

July 22, 2020

Indian Health Service Responses

Rep. Gallego

1. IHS recently announced that it was reserving $95 million in CARES Act funding to support the expansion of telehealth activities across the IHS, Tribal and Urban Indian Organization health programs, including purchasing equipment, software, and services directly related to the delivery of telehealth. Will part [of] this money be disbursed to UIOs for this purpose? If not, how does IHS plan to improve telehealth activities across UIOs without funding individual programs?

IHS Response:
Prior to the COVID-19 pandemic, many health care providers did not offer remote health care visits to their patients. Additional federal payment and licensure flexibilities were granted to providers when the CDC developed mitigation strategies to help slow the transmission of the virus in communities. This relaxed restrictions to further support telehealth. The American Medical Association stated that "the use of telemedicine and remote care services are critical to the safe management of the COVID-19 pandemic, while also ensuring uninterrupted care for 100 million Americans with chronic conditions."

On April 8, 2020, the IHS expanded use of our Agency-wide videoconferencing platform that allows for synchronous telehealth on almost any device and setting, including the patients' homes. Since April's telehealth expansion, the IHS has experienced an eleven-fold increase of telehealth visits, from roughly 75 to 907 telehealth visits per week on average. This number also includes Tribes with access to the IHS network to use the Agency-wide platform. It does not include other telehealth modalities such as care provided over the telephone, which is common in the bandwidth-constrained environments of Indian country.

The IHS allocated $95 million from the CARES Act to support additional telehealth expansion. IHS plans to use the funding to build infrastructure, integrate telehealth delivery within our Health Information Technology environment, such as the patient portal and scheduling workflow, and explore other modalities of telehealth such as mobile health and remote patient monitoring. IHS will need to address the hardware, organizational/facilities structure and connectivity needs across the country, and consider how these capabilities can be sustained over the long-term.

In addition, the IHS has distributed $465 million to Tribal health programs and $50 million to UIOs from the CARES Act. Tribal and Urban Indian health programs can use these funds to support telehealth activities in the immediate term.

2. Does IHS keep full or partial data on how many Native Veterans use federal IHS or Tribal facilities for primary care? If so, can you share that with the committee?

IHS Response:
The IHS does maintain a record of patients who self-identify as a veteran. This information is provided by the patient, when asking about alternate resources. In fiscal year 2019, 48,641 self-identified veterans received health care services from Federal or Tribal programs. The vast majority of the visits for these veterans were for primary care services.

Rep. Bishop

1. According to your testimony for H.R. 6535, IHS would prefer Urban Indian organizations utilize the Public Health Service Act for Federal Tort Claims Act (FTCA) liability coverage. Please explain why the IHS recommends using the Public Health Service Act.

IHS Response:
The IHS endorses the policy of extending FTCA coverage to Urban Indian Organizations (UIOs), consistent with the FY 2021 President's Budget. However, such coverage is generally conveyed through the Public Health Service Act (PHSA). The Public Health Service Act (42 U.S.C. § 233) currently contains several extensions of FTCA coverage, including for community health centers and their staff, their boards, certain free clinics, health professionals administering smallpox vaccines, and certain health professional volunteers at health centers. Having all of these provisions in the same statute ensures consistent coverage of claims against covered individuals and immunity from personal liability for such individuals. The PHSA also provides examples of how to extend coverage to entities such as UIOs, e.g., to ensure inclusion of their board members and officers, not just their employees.

2. Currently, Urban Indian Organizations (UIOs) are not eligible to enter into contracts or compacts with the Indian Health Service pursuant to the Indian Self-Determination Education Assistance Act (ISDEAA). Because H.R. 6535 gives UIOs FTCA coverage under ISDEAA, could this legislation be construed as giving UIO's any other authority or benefit under ISDAAA?

IHS Response:
The Indian Self-Determination and Education Assistance Act (ISDEAA) is a unique authority that recognizes the government-to-government relationship between IHS and tribal governments (or authorized tribal organizations). In contrast, UIOs are nonprofit organizations that receive contract and grant awards under the authority of the Indian Health Care Improvement Act. UIOs are an important part of the Indian health system, but they are not tribes or tribal organizations

with authority to contract under the ISDEAA. As written, H.R. 6535 is unclear on the authority being extended, in part because the ISDEAA provision at issue (25 U.S.C. § 5321(d)) is itself difficult to decipher. As a result, H.R. 6535 could raise some uncertainty as to the authority or benefits being extended to UIOs.