NCUIH Testimony before House Interior Appropriations Subcommittee on FY18 Interior Appropriations Bill
May 16, 2017

Introduction

My name is Ashley Tuomi, and I am the President of the National Council of Urban Indian Health (NCUIH), which represents urban Indian health care programs (UIHPs) across the nation that provide accessible, high-quality, and culturally-competent health care to urban Indians, a category which comprises more than 70% of American Indian/Alaska Native (AI/AN) people. My testimony today will focus on the Indian Health Service (IHS).

"Urban Indian" refers to any AI/AN person who is not living on a reservation, either permanently or temporarily—often because of the federal government's forced relocation policy or lack of economic opportunity. Congress has long recognized that the federal government's obligation to provide health care for AI/AN people follows them off of reservations:

> *"The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land does not end at the borders of an Indian reservation. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there."*

No other Congressional panel better understands the health care-related concerns of urban Indians than your subcommittee, Chairman Calvert and Ranking Member McCollum. As you perceptively noted in report language to the FY17 Interior Appropriations Bill, urban Indians are

> *"entitled to receive vital culturally-appropriate health services from urban Indian organizations, just as they would have received health services from IHS-run and tribally-run facilities if they lived on or near a reservation. Unfortunately, urban Indian health organizations are struggling to recover their costs because they are not designated in relevant statutes as eligible providers on an equal par with IHS and Tribal Health Program facilities."*

Here are NCUIH's recommendations to the House Interior Appropriations Subcommittee for FY18:

1. Increased Funding for IHS

Before I ask for additional funding for FY18, I must convey our profound appreciation for the funding increase for urban Indian health care which was included in the FY17 bill, thanks to this Subcommittee's strong leadership. However, as you know, even with that increase, IHS is still significantly under-resourced, and usually funded at between 50% and 60% of need; and some facilities run out of money in the middle of the fiscal year, which can force patients to forego serious health care and delay basic health care. While health care spending per capita across the

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nation was more than $9,990 in 2016, IHS spending on health care per user was just $2,834. NCUIH, as part of the National Tribal Budget Formulation Workgroup (NTBFW), has highlighted both IHS' inadequate funding and its inevitable consequences.

Even with the much-appreciated FY17 increase, IHS spends little more than 1% of its budget on the provision of health care to urban Indians. Furthermore, because IHS' Office of Urban Indian Health Programs now oversees an additional seven National Institute on Alcoholism and Alcohol Abuse (NIAAA) programs, spending on urban Indian health care must take into account that the number of programs being funded by the line item have increased from 36 to 43.

Unlike IHS and Tribal facilities, UIHPs have no access to other line items, including those for referred care and construction. Tribes, whether they receive health care directly or indirectly from IHS, are already being short-changed, so the solution is not to take money from the Tribes to address the unmet needs of urban Indians; rather, IHS' overall budget needs to be increased in order to allow the agency to, among other things, better serve AI/AN people who live in urban, suburban, and rural areas.

NCUIH is very appreciative that Tribes, through the NTBFW, strongly support increases in funding for urban Indian health care. As a whole, Congress, has, by inadequately funding IHS, put the federal government in clear violation of the Trust Responsibility to provide health care for AI/AN people. We know that the lawmakers on this Subcommittee have fought for more IHS funding, and NCUIH gives them our profound thanks.

2. Provide UIHPs with 100% Federal Medical Assistance Percentage (FMAP)

FMAP, the amount of Medicaid service costs paid by the federal government is set by law at 100% for IHS and Tribes, but not for UIHPs, because UIHPS did not exist when that law was written. However, UIHPs were created by Congress at the urging of Tribes to ensure that their members would receive good health care off of reservations. This is particularly true for those forced to leave during the Relocation Era, because it is understood that the Trust Responsibility extends beyond the borders of the reservation, as does the federal government's obligation to provide health care.

Consequently, the failure to provide UIHPs with 100% FMAP harms facilities that already don't have access to many resources and severely limits services for patients. Unfortunately, the Center for Medicare and Medicaid Services and IHS have not worked together to correct this unintended oversight. Therefore, NCUIH asks the House Interior Appropriations Subcommittee to correct this problem in the FY18 bill.

100% FMAP for UIHPs would reaffirm the federal government's Trust Responsibility; help states which, due to overall health care obligations, may otherwise feel compelled to restrict Medicaid eligibility; allow UIHPs to provide additional services to their AI/AN patients and therefore improve their health care outcomes; and supplement the funds of historically under-resourced IHS.

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According to IHS, which has recommended 100% FMAP for UIHPs in their budget proposals, the cost would be minimal: $2.3 million annually. Achievement of this objective would help to stretch the precious dollars this Subcommittee is able to provide to IHS, thus allowing the agency to provide more and better services to Indian Country.

3. Reauthorize the Special Diabetes Program for Indians (SDPI)

It is imperative that SDPI be reauthorized before its expiration on September 30. Grants to health care providers in Indian Country made pursuant to SDPI have been instrumental in the marked reduction in the incidence rate of diabetes—and the related savings to Medicare, IHS, and third party providers. SDPI supports over 330 diabetes education, treatment, and prevention programs in 35 states. The failure to reauthorize this program would severely undermine the promising progress UIHPs have made against diabetes.

Congress is very familiar with the grim statistics of the toll inflicted on Indian Country by diabetes. AI/AN adults are 2.3 times more likely to have diabetes compared with non-Hispanic whites and the death rate due to diabetes for AI/AN people is 1.6 times higher than the general U.S. population. And the costs in dollars are also extraordinary—in 2012 alone 11% of AI/AN people with diabetes accounted for 37% of all IHS adult treatment costs. However, Congress also knows that grants awarded under SDPI achieve outstanding results and that the program ultimately saves significant money and saves lives in the long run.

This objective is of particular interest to your Subcommittee because the savings from investments in the fight against diabetes more than pay for themselves in better health outcomes for AI/AN people. In just 11 years, largely thanks to SDPI, the incidence rate of End-Stage Renal Disease (ESRD) in AI/AN people with diabetes declined by 43%--a greater decline than any other racial or ethnic group. Significantly, ESRD is a major driver of health care costs in Indian Country—for Medicare, Medicaid, third party providers, and IHS. Your support for SDPI's reauthorization helps make your IHS appropriations go farther.

4. Include UIHPs in the coverage of the Federal Tort Claims Act (FTCA)

Under FTCA, a health center, its employees, and eligible contractors are considered federal employees and are made immune from lawsuits for medical malpractice. A patient who alleges acts of medical malpractice by a covered health center must instead sue the federal government, which assumes responsibility for costs related to a claim resulting from the performance of a medical, surgical, dental, or related function. And, most significantly, there is no cost to a covered health center or its providers.

IHS and Tribal providers, as well as other comparable federal health care centers, are covered by the FTCA. Arbitrarily denied FTCA coverage, however, UIHPs must buy their own expensive malpractice insurance. Two large, highly-regarded UIHPs in Oklahoma which are represented by NCUIH each pay $250,000 per year for malpractice insurance.

This objective may seem unrelated to your Subcommittee's work, but extension of FTCA coverage to UIHPs would allow them to devote more resources to caring for their patients and

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maximize the value of your appropriations to IHS. Any help your Subcommittee can provide, including prompting the relevant House authorization committee, would be profoundly appreciated.

5. Implement the Memorandum of Understanding (MoU) between IHS and the Department of Veterans Affairs (DVA) for the Provision of Health Care to AI/AN Veterans

DVA and IHS have implemented this MoU for IHS and Tribal providers, but not for UIHPs. AI/AN veterans often prefer to use Indian health care providers for reasons related to performance, cultural competency, or availability of non-health care-related but Indian-specific services. I appreciate the support the Subcommittee expressed last year when I testified, and I regret to report that our efforts to work with the agencies involved have not been successful, and that is why I am back again this year asking for your help. It is understood that AI/AN veterans are more likely to receive adequate health care if they are allowed to determine how, when, and where they are served. DVA sometimes experiences surges in demand which understandably impacts its ability to serve, and these surges can often be satisfactorily addressed through the use of UIHPs.

Given their sacrifices, it is grievously wrong to oppose the provision of accessible, high-quality, culturally-competent health care by UIHPs to AI/AN veterans. Working with your colleagues on the House Appropriations Subcommittee for Military Construction, Veterans Affairs, and Related Agencies, NCUIH is confident that sufficient pressure can be applied to the two agencies in question to ensure that AI/AN veterans receive the health care their profound sacrifices have earned.

Conclusion

Thank you for this opportunity to testify before the Interior Appropriations Subcommittee. In review, here are our requests of the Subcommittee for FY18:

1. Continue to increase funding for IHS in order to address the general spending shortfall for AI/AN health care and allow for an increase in the line item for urban Indian health care;
2. Provide UIHPs with the same 100% FMAP already received by IHS and Tribal facilities, which, at minimal expense, would improve health care outcomes and stretch further your appropriations for IHS;
3. Support the reauthorization of SDPI, which, in fighting the scourge of diabetes in Indian Country, ultimately saves lives and generates significant savings and maximizes the value of this Subcommittee's funding for IHS;
4. Urge your colleagues on the House Judiciary Committee to support the inclusion of UIHPs under the Federal Tort Claims Act, as IHS and Tribal facilities already are, so that they can invest your appropriations in patient care instead of expensive malpractice insurance; and
5. In collaboration with your colleagues on the DVA funding panel, please direct IHS and DVA to finally implement the MoU for UIHPs so that AI/AN veterans can receive the health care their sacrifices have earned.

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