



# Choctaw Nation of Oklahoma

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**TESTIMONY OF MELANIE FOURKILLER, SENIOR POLICY ANALYST  
CHOCTAW NATION OF OKLAHOMA  
ON THE FISCAL YEAR 2020 BUDGETS FOR IHS AND BIA  
TO THE U.S. HOUSE COMMITTEE ON APPROPRIATIONS  
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES  
March 6, 2019**

On behalf of the Choctaw Nation of Oklahoma, I am submitting this written statement for the Hearing Record on the FY 2020 budgets for the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA). This testimony identifies health care funding priorities and budget issues important to the Choctaw Nation and its citizens.

First, and foremost, the Choctaw Nation requests that Congress exempt Tribal Government Services and Program Funding from Sequestrations, Unilateral Rescissions and Budget Cuts in all future appropriations. We also request that Congress continues to fully fund Contract Support Cost (CSC) without impacting direct program funding.

The Choctaw Nation requests that the Subcommittee works to approve timely appropriations for FY 2020, and we trust all efforts will be made to have a Federal appropriation prior to the beginning of the Fiscal Year. However, in FY 2019, the Interior appropriations, including funding to provide direct health care services for our people, was severely delayed due to the longest partial government shutdown in our history. The Indian Health Service (IHS) system (including Tribal) was the only Federal direct healthcare system that was affected by the partial government shutdown, leaving IHS and Tribes alike scrambling to ensure that patients continued to receive access to critical health care services during this time. Tribes, with the inability to be paid any of its compact funds during the partial shutdown period, found themselves in the awkward position of finding a way to continue to administer services that are Trust obligations of the Federal government for which the government was not providing funding. This situation is untenable.

The Government Accountability Office (GAO) finalized a report in September, 2018 analyzing the possibility of Advanced Appropriations for Indian Health Service. IHS Advanced Appropriations would eliminate the negative effect of any government shutdown and allow these critical health services to operate uninterrupted. It is time for Advanced Appropriations to be enacted for IHS, and we look to the Subcommittee for leadership and support to make it a reality this year.

Thank you for continuing to appropriate funds in 2017 for the Joint Venture Project (JVP), a proven, successful model for leveraging Federal resources to improve access to care in Indian country. We most recently opened the Choctaw Nation Durant Regional Medical Clinic, in

**Choctaws – growing as one with pride, hope and success**

February 2017. We were the first Tribal or IHS program to have an ambulatory surgery suite in an outpatient facility. Other services also include primary care, dental, pediatrics, lab, diabetes care, community health nurses, optometry, radiology services (including MRI, CT, bone density, mammography, ultrasound, fluoroscopy and x-ray), pharmacy, behavioral health, physical therapy, and numerous specialty care services. This JVP with IHS has been an invaluable exercise in partnership and investment in improved quality healthcare for Native American people.

Although there are many facility needs in the Choctaw Nation and Oklahoma City Area, none are included on the IHS Health Facilities Construction program listing. The current backlog would take decades to construct at the current pace of appropriations and yet it will still not address any needs in Oklahoma. The only viable option for Tribal health facilities in Oklahoma is the JVP, which is a very small and highly competitive program. IHS has not held a competition for the program since 2014 and has created a similar 'queue' as the large Health Facilities Construction program, which is both bureaucratic and ineffective. ***The IHS should be strongly encouraged to abandon this failed approach and compete the JVP on at least a bi-annual basis to address the highest facility priorities.***

We strongly urge the Committee to protect the Federal trust and treaty obligations that are funded in the Federal domestic budget. Federal funding that meets Federal Indian treaty and trust obligations also provides significant contributions to the economy. The Department of the Interior (DOI), the BIA and Bureau of Indian Education (BIE) contribute substantially to economic growth in Tribal areas through advances in infrastructure, strategic planning, improved practices of governance, and the development of human capital.

### **The Choctaw Nation of Oklahoma**

The Choctaw Nation of Oklahoma is the third largest Native American Tribal government in the United States with over 230,000 members. The Choctaw Nation territory consists of all or part of 10 ½ counties in Southeast Oklahoma, and we are proudly one of the state's largest employers. The Nation operates a hospital at Talihina, Oklahoma, and a system of eight (8) outpatient health facilities, along with a broad range of ancillary services.

The Nation also administers referred specialty care and sanitation facilities construction; higher education; Johnson O'Malley program; housing improvement; child welfare and social services; law enforcement; and, many other programs and services. The Choctaw Nation has operated under the Self-Governance authority in the DOI since 1994 and in the Department of Health and Human Services' IHS since 1995. As a Self-Governance Tribe, the Nation is able to re-design programs to meet Tribally-specific needs without diminishing the United States' trust responsibility.

### **NATIONAL BUDGET REQUESTS – INDIAN HEALTH SERVICE**

1. **Special Diabetes Program for Indians** – Support reauthorization of \$200 million/year for 5 years (IHS): The Administration's budget proposes to move SDPI from "mandatory funding" which Congress must authorize from time to time to "discretionary spending" which would allow Congress to control the funding going to SDPI as part of the annual

appropriations process. That means SDPI will compete with other Indian programs annually, as opposed to being funded automatically outside of that environment today. Indian Country has not been consulted on this proposal and the rationale for the request has not been made available to us. We request no changes until such consultation occurs.

2. **Contract Support Costs – Indian Health Service and Bureau of Indian Affairs (IHS and BIA)** - The Nation appreciates the continued support of the Committees to fully fund CSC requirements without impacting direct Indian health programs. Beginning in FY 2014, fully funding CSC has made a tremendous improvement and properly retained important health program funding to direct services. We request that IHS and BIA be instructed to consult with Tribes on every provision of the CSC Policy until both sides reach consensus; and if at any time the agencies seek to unilaterally make changes, they should be directed to consult with Tribes prior to any changes in the CSC Policy.
3. **Purchased and Referred Care (PRC)** -- The Purchased/Referred Care (PRC) program pays for urgent and emergency, specialty care and other critical services that are not directly available through IHS and Tribally-operated health programs when no IHS direct care facility exists, or the direct care facility cannot provide the required emergency or specialty care, or the facility has more demand for services than it can currently meet. Although the Nation operates a hospital facility, the hospital is located in a very rural area, we are the only provider in the community and services are limited. In fact, our hospital does not have an intensive care unit, which requires patients to be flown to another facility using PRC. Therefore, PRC is a significant need to provide intensive care and tertiary care, as well as emergency transportation.
4. **IHS Mandatory Funding (Maintaining Current Services)**-- Existing funding levels must keep pace with population growth, inflation and the like, or the result is similar to a reduced budget with less purchasing power. One very good example are the extraordinary rise in pharmaceutical costs. Over the last three years, the IHS has seen an increase of 8.8% in pharmaceutical expenditures alone.
5. **Workforce Development – permanent funding for Graduate Medical Education** – The Choctaw Nation has operated an accredited and successful Graduate Medical Education program, or GME since receiving a grant from the Health Care Resources and Services Administration (HRSA) in 2010. The Nation has found the GME program to be integral to our physician recruiting and retention efforts in a rural, remote area. As a Teaching Health Center, our residents are very likely to practice following their residency in our health system, or close by in rural Oklahoma, which is also underserved. Physicians considering employment are often interested in GME and it becomes a recruitment tool outside the residents themselves. Other benefits are: (1) becoming a THC is a marker of quality; (2) improved in-house physician coverage; (3) “growing your own” medical staff from nearby rural communities; (4) high retention and satisfaction rates of residency graduates; (5) promotes an environment of life long learning; (6) provides enhanced continuing medical education opportunities; (7) encourages Medical Staff to be up on current literature and topics; and (8) Engages the existing staff and is seen as a “breath of fresh air”. While the HRSA funding has been helpful, it is competitive and sporadic – sometimes with unknown

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future appropriations. GME programs should be funded permanently in the Indian health system so that IHS and Tribal sites with hospitals can address some of the dire challenges in recruiting and retaining health professionals in rural areas.

6. **Opioid Funding** – We appreciate the set asides for Indian health that have been made in various initiatives for funding addressing the opioid epidemic. Increase funding and include Tribal set asides rather than to make it funding through states. Addressing the opioid epidemic is a nationwide priority. American Indians and Alaska Natives (AI/AN) face opioid related fatalities three times the rate of non-Natives.
  
7. **Information Technology** -- The IHS health information technology (HIT) program continues to face increased demand for systems improvements and enhancements, rising costs, and increased information technology (IT) security requirements driven in part by medical advances, and ever-growing and more complex requirements for HIT capabilities. Virtually any new program initiative has IT requirements for functionality, modality, data collection, and reporting which then must be added to a clinician’s work flow and managed within the HIT portfolio. In addition to the overall increased demand, the HIT program must also plan for a change in Electronic Health Record platforms resulting from the decision by the Veteran’s Administration (VA) to replace their current legacy HIT platform, VistA. To prepare for this transition that is expected to occur over the next five years, the IHS HIT program will be required to devote additional budgetary resources for infrastructure modernization, training, and support.

Thank you for accepting my written statement on behalf of the Choctaw Nation of Oklahoma.