**NCUIH Testimony before House Interior Appropriations Subcommittee**
**on FY20 Interior Appropriations Bill**
**March 6th, 2019**

My name is Maureen Rosette, I am a citizen of the Chippewa Cree Nation, and I am the President of the National Council of Urban Indian Health (NCUIH), which represents the 42 urban Indian health care programs (UIHPs) across the nation that provide high-quality, culturally-competent care to urban Indians, who constitute approximately 78% of all American Indians/Alaska Natives (AI/AN). I would like to thank the Chairwoman McCollum and Ranking Member Joyce for holding this public witness hearing and hope this year is the year we will truly see funding level changes. My testimony today will focus on the Indian Health Service (IHS).

As a preliminary issue, "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 in search of economic or educational opportunity. Congress has long recognized that the federal government's obligation to provide health care for AI/AN people follows them off of reservations. Recently, the Centers for Medicare and Medicaid Services chose to depart from decades of legal jurisprudence and countless federal policies as well as its own regulations when it decided to insert the narrowest definition possible of AI/AN with respect to Medicaid work requirements in its approval of Arizona's Medicaid waiver. Despite the fact that Congress stated in the Indian Healthcare Improvement Act that it is the goal of the U.S. "to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy," CMS ignored centuries of law in its extreme narrowing of the definition—an action that will hinder access to care across the country and further burden an already overwhelmed and underfunded Indian health system. We respectfully request Congress work with CMS to ensure that the Trust obligation is met and there are no additional barriers to healthcare imposed on all AI/AN people. If CMS continues down this flawed path, UIHPs will need additional funding to supplement the loss of one of the largest secondary sources of funding for urban AI/AN health care. To be clear, AI/AN patients will suffer if a portion of this critical funding is no longer in the Indian health system – consistent with Congressional intent. Medicaid represents in some UIHPs over 90% of their patients, and those patients will still need healthcare even after Medicaid is taken away.

Here are NCUIH's other recommendations to the House Interior Appropriations Subcommittee for FY20:

## 1. Increase Funding for the urban Indian line item and access to other sources of funding

I would like to start by conveying our deep appreciation for the Subcommittee's strong leadership and continued support for Indian health care. However, IHS remains funded at less than of need, and is significantly under-resourced. Additionally, less than 1% of these already strained funds are spent on healthcare for urban Indians, despite being over 70% of the AI/AN population. UIHPs also don't have access to other line items like IHS and Tribal facilities. UIHPs do not receive hospitals and health clinics money to operate their facilities, they do not receive purchase and referred care dollars to ensure access to healthcare is met, and do not receive IHS dental services dollars, and they aren't even eligible for facilities dollars. UIHPs operate from one line item in the IHS budget, 42 programs with $51.3 million. We do want to thank you for the $2,000,000 increase

to our line item. The solution is not to take money from the Tribes to address the unmet needs of urban Indians; rather, IHS' overall budget must be increased in order to allow the agency to, among other things, better serve AI/AN people who live in all areas. Tribes have requested our line item increase to at least $81 million, which we are grateful for. If we were at least 2% of the IHS budget, our line item would be at $116 million. While that would be a sliver of the money Congress appropriates every year, it would make a significant difference in our communities. As further detailed in NCUIH's 2017 correspondence to Congress on infrastructure investment needs in UIHPs, providing additional funding for infrastructure would help UIHPs address critical needs and enable their limited funding to stretch farther to reach more patients with more services– for instance, the Indian Health Board of Minneapolis must expend considerable resources on maintaining compliance in a facility housed in a 50 + year old building – resources that could be used for other purposes like health care services if UIHPs received facilities funding. We thus respectfully request that Congress, at a minimum, set aside a one-time infrastructure fund of $2-3 million per UIHP (for a total of less than $130 million).

At present, UIHPs and their staff are forced to deal with an incredibly tight budget. According to a NCUIH survey, many UIHPs report that small numbers of staff are expected work long hours and the facilities thus experience high levels of employee burnout and turnover. Also, due to constrained funds, some UIHPs aren't able to pay their already small staffs an appropriate and competitive living wage for their area. Furthermore, UIHPs were more susceptible to closing during the shutdown than the rest of the IHS system due to being omitted to expansions Congress made to the IHS system. UIHPs do not have 100% FMAP, Federal Torts Claims Act coverage, and the VA will not reimburse UIHPs despite Congress' desire for that to happen. Two programs closed during the last shut down, and at least 3 had to reduce hours and lay off staff. Six programs stated they could only operate normally for a maximum of 30 days. Our facilities go to great lengths to provide care to Indian Country, some have even put a lean on their personal houses to help their facilities. Congress cannot continue to let this happen and must create true parity for UIHPs.

An increase would allow UIHPs to hire more staff; pay staff appropriate wages; and expand services, programs, and facilities. This would also enable UIHPs to provide services to the growing demand of health care for urban Indians, a need which is growing. We have programs in areas such as Minneapolis, Minnesota, for instance, where there is a homeless crisis for AI/AN people, many of whom suffer from diseases, addiction, and other serious health complications associated with homelessness. Increased funding is needed to combat the senseless deaths of vulnerable urban Indian communities. Our programs need real funding to start to tackle these issues.

In addition, IHS is currently considering moving its behavioral health initiatives, including the Domestic Violence Prevention Program and Suicide and Substance Abuse Prevention Program, from grants to direct distribution through Indian Self Determination Education and Assistance Act contracts and compacts, for which UIHPs are not eligible. It is widely known that behavioral health is a major issue in the AI/AN community. Thus, if IHS transfers distribution of its behavioral health initiatives to ISDEAA contracts and compacts, there must be a UIHP set-aside of approximately $12.2 million for Title V UIHPs. This amount would enable all Title V UIOs to receive the current average level of behavioral health grant funding available to urban organizations, as if rightfully available only to IHS-certified Title V UIOs. In addition, I'd like to express appreciation for inclusion of UIHPs in the Special Behavioral Health Program for Indians. We

support this being structured similar to SDPI, which has been a resounding success for many UIHPs. If this funding is instead transferred to direct funding to tribes, there must be a set-aside of at least 20% to ensure this funding reaches urban AI/AN communities.

Finally, it is essential that UIHPs do not continue to be left out of the discussion with respect to federal opioid programs. The opioid epidemic has devastating impacts on AI/AN communities – in both tribal and urban settings. Despite this, UIHPs were not eligible to apply to the Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Opioid Response Grants – funding that could have enabled UIHPs to expand services or workforce, for example, to help address the catastrophic impacts of the opioid epidemic in Indian Country. Because UIHPs were left out yet again, they could not receive any of this funding even though SAMHSA did not receive enough applications for the funding amount. It is paramount that when Congress is providing funding for Indian Country, the eligibility includes Tribes, tribal organizations and urban Indian organizations. UIOs cannot apply otherwise and Congress loses the opportunity to provide resources to almost 80% of the Indian Country population

As a whole, by inadequately funding IHS, Congress has 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 expresses our thanks for those efforts.

**2. Protect IHS from Funding Uncertainties**

When the limited UIHP funding is delayed or cut off in the event of funding uncertainties, like shutdowns, UIHPs suffer greatly. IHS and funded programs must receive advance appropriations. The lives of AI/AN people depends on this funding, and their health care should not be subject to unrelated government shutdowns.

For instance, Native American Lifelines of Baltimore is a small clinic that received three overdose patients the week the last shutdown was announced, two of which were fatal. As the shutdown continued, they were forced to limit services and couldn't provide care to the individuals that relied on them. They only receive $922k from IHS to operate two facilities, one in Baltimore, one in Boston. Out of that funding, IHS only gives them $691 for mental health for both facilities. To say the funding is inadequate is an understatement.

Similarly, my program, the NATIVE Project in Spokane Washington, found that inconsistent funding makes it difficult to administer substance use intensive outpatient services, which requires patients to come in for treatments, group therapy, and other services. When forced cut backs on hours and staff occur, patients are less likely to show up, increasing risk of relapse and overdose.

Most programs are the only health care facilities in their area for AI/AN people, like the Bakersfield Area Indian Health Program (BAIHP). When BAIHP almost closed due to prolonged funding delays, it would have deprived care for all AI/AN people in Kern County, California. It was only because the community stepped in to help the facility that it did not close its doors.

For these reasons, we urge you to ensure that the IHS is treated similarly to other agencies that provide healthcare to American citizens, such as the Department of Veterans Affairs (VA), in receiving adequate and advance appropriations.

**3. Provide UIHPs with 100% Federal Medical Assistance Percentage (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 tribal citizens would receive appropriate 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 to provide health care extends beyond the borders of the reservation.

Consequently, the failure to provide UIHPs with 100% FMAP harms facilities that already don't have access to many resources, and it severely limits services for patients. Unfortunately, CMS needs Congress to add UIHPs to 1905(b) of the Social Security Act to create parity. Therefore, we ask that you correct this problem in FY20. Receiving 100% FMAP has a huge impact on the financial stability of UIHPs. One of NCUIH's two Oklahoma facilities (the only two UIHPs in the country that get 100% FMAP) reported that in the event of a prolonged shutdown they could remain open for 18 months; whereas 6 of 13 UIHP-respondents reported that they could only sustain normal operations for one month or less.

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

Under FTCA, a facility's employees and eligible contractors are considered federal employees and are immune from lawsuits for medical malpractice. 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 each pay $250,000 per year for malpractice insurance.

Any help your Subcommittee can provide would maximize the value of your appropriations to IHS and we would profoundly appreciate any assistance, including prompting relevant committees.

**6. Implements the Memorandum of Understanding (MoU) between IHS and the VA for the Provision of Health Care to AI/AN Veterans**

The VA 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. The VA sometimes experiences surges in demand, which can often be satisfactorily offset through the use of UIHPs. A recent Office of the Inspector General report found that 215 deceased veteran patients at the Phoenix VA Health Care System were awaiting specialist consultations on the date of their deaths. Native Health, a UIHP that provides comprehensive services, is within walking distance of the Phoenix, AZ VA facility, and could have provided these services to AI/AN veterans, enabling the VA to focus on specialty services and reduce some of these wait times, in turn reducing the number of patient deaths that occur.

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 ensure that AI/AN veterans receive the health care their profound sacrifices have earned.