

Testimony of the National Council of Urban Indian Health
Maureen Rosette, President
House Interior Appropriations Subcommittee
February 11, 2020

My name is Maureen Rosette, I am a citizen of the Chippewa Cree Nation, and I serve as the President of the National Council of Urban Indian Health (NCUIH), which represents the 41 urban Indian health care organizations (UIOs) across the nation who provide high-quality, culturally-competent care to urban Indians, constituting approximately 70% of all American Indians/Alaska Natives (AI/AN). Thank you Chairwoman McCollum and Ranking Member Joyce for holding this public witness hearing.

I would like to begin by stating it is the opinion of NCUIH that among the most sacred of the duties encompassed within the federal trust responsibility is the duty to provide for Indian health care. The federal trust responsibility extends not only to tribal governments but also to individual Indians to include those individuals who live in urban settings. Urban Indian refers to any American Indian/Alaska Native (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 the federal government's obligation to provide health care for AI/AN people follows them off reservations and in 1976 affirmed this obligation by formally recognizing urban Indian organizations in the Indian Health Care Improvement Act (IHCA) declaring: *"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"*. Yet, the legacy of the disastrous termination-era policies continue to shape life for urban Indians. Chronic underfunding from the federal government, impacts the fulfillment of the federal obligation to AI/AN people – an obligation at which the government is failing.

The life expectancy for AI/ANs is more than four years below the national rate and data has proven urban Indians have greater rates of mortality from chronic disease compared to all other ethnic groups living in urban areas nationally. This includes a diabetes death rate 1.2 times greater, a chronic liver disease death rate 2.1 times greater, and a tuberculosis death rate 3 times greater. Infant mortality is also higher among urban Indians than non-Indian urban population, with 7.8 deaths per 1,000 live births to urban Indians compared with 6.4 deaths per 1,000 live births of non-Indian urbans. Urban Indians also have greater suicide rates, at 13 per 100,000 compared with their non-Indian counterparts 9.2 per 100,000. Urban Indians are less likely to receive preventive care compared with the non-Indian urban population and less likely to have health insurance.

NCUIH is appreciative for the Subcommittee's strong leadership and continued support for Indian health care. We were encouraged to see Congress come together in December of last year to pass a roughly \$1.3 trillion spending deal that gave the IHS \$6.047 billion, an increase of 4% above the FY 2019 enacted level and \$138 million above the President's budget request. Most noteworthy for NCUIH was the long overdue increase to the urban line item within the IHS budget of approximately \$6 million, however more work is needed.

Currently, UIOs receive *less than* 1% of the IHS budget through **only one line item** – the urban Indian healthcare line item, and the IHS budget is currently underfunded at much less than 50% of need. IHS has repeatedly testified before Congress acknowledging the significant growth of the urban Indian population and recognizing there are “real issues” in meeting the health needs of urban AI/AN people. The federal trust responsibility to provide health care has never been appropriately funded, and inflation or population growth in urban Indian communities has never been addressed. NCUIH requests that IHS be fully funded to ensure our people have access to quality healthcare for the whole I/T/U system, and not redistributing tribal funds.

Funding for the overall IHS budget must be significantly increased. We know IHS is underfunded at around \$3,000 per patient, we know for urban Indian health patients that number is less than \$400 per patient. We know for a fact that urban Indian health patients receive even less funding per patient because not only do they receive less than 1% of the total IHS budget but they don't have access to the other line items in the funding budget. To fill gaps in IHS funding, many UIOs must rely on supplemental sources of funding, including grants, to provide vital services to their AI/AN patients. NCUIH advocates and supports an increase in funding to a minimum of \$81 to \$106 million for the Indian Health Services (IHS) urban Indian healthcare line item, constituting 2% of the total IHS budget. \$106 million is what the IHS Tribal Budget Formulation Workgroup requested minimum is for this year.

In addition, IHS has considered restructuring 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 (ISDEAA) contracts and compacts, for which UIOs are not eligible. It is widely known that behavioral health is a major issue in the AI/AN community. If IHS is allowed to transfer distribution of its behavioral health initiatives to ISDEAA contracts and compacts, there must be a UIO set-aside of approximately \$12.2 million for Title V UIOs. 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. Despite Congress urging IHS to make a quick decision regarding the distribution mechanism, there was a lack of direction to ensure that UIOs remain eligible for grant funding, and there remains uncertainty for UIOs ability to provide critical behavioral health services.

We know that the lawmakers on this Subcommittee have fought for more IHS funding, and NCUIH expresses our thanks for those efforts.

Provide Protections from Shutdown Impacts with Funding Uncertainties. When limited UIO funding is delayed or cut off during events such as a government shutdown, there are devastating effects upon a UIOs ability to provide health care. IHS and funded programs must receive advance appropriations. To illustrate, UIOs are so chronically underfunded that during the 2018-2019 shutdown, several UIOs had to reduce services, lose staff or close their doors entirely, forcing them to leave their patients without adequate care. In a UIO shutdown survey, 5 out of 13 UIOs indicated that they could only maintain normal operations for 30 days. For instance, Native American Lifelines of Baltimore is a small clinic that received **three overdose patients** during the last shutdown, two of which were fatal. IHS gives them just **less than \$1,000 total** for mental health services 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.

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.

At present, UIOs and their staff are forced to deal with an incredibly tight budget. According to a NCUIH survey, many UIOs report that small numbers of staff are expected work long hours and they experience high levels of employee burnout and turnover. Also, due to constrained funds, some UIOs aren't able to pay their already small staffs an appropriate and competitive living wage for their area. Furthermore, UIOs were more susceptible to closing during times of funding uncertainties 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.

Protect Medicaid and Provide UIOs with 100% Federal Medical Assistance Percentage (FMAP). Medicaid is crucial to Indian health and for UIOs. Just recently, the Administration along with the CMS Administrator announced a plan to let states convert a portion of Medicaid funding into block grants. Moving Medicaid to a block grant system, will have major fiscal impacts on health reimbursements, and would devastate Indian health. If the program is to be reformed in order to impose greater financial burdens on states, there should be a carve-out in order to preserve the existing Medicaid benefit for AI/AN, consistent with the federal government's responsibility for their health care

The amount of Medicaid service costs paid by the federal government is set by law at 100% for IHS and Tribes, but not for UIOs, because UIOs did not exist when that law was written. Although Congress intended 100% FMAP to support the Indian Health system, the same consideration is not provided for the high-quality, culturally-competent care provided by UIOs. Consequently, the failure to provide UIOs with 100% FMAP harms facilities that already do not have access to many resources, and it severely limits services for patients. Unfortunately, CMS needs Congress to add UIOs to 1905(b) of the Social Security Act to create parity. Therefore, we ask that you correct this problem in FY21. Receiving 100% FMAP would have a huge impact on the financial stability of UIOs and would protect them from block granting.

Include UIOs 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. However, UIOs must buy their own expensive malpractice insurance. Two large, highly-regarded UIOs 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.

Include Urban Indian Organizations in language for ALL health programs. UIOs are a critical part of the IHS I/T/U system. However, often times UIOs do not receive parity because they are not specifically mentioned in programmatic language and then are most often excluded

from participating in programs intended for the entire I/T/U system. Urban Indian Organizations are not considered Tribal organizations, which is a common misconception. All too often, Urban Indian Health programs are excluded from laws intended to benefit American Indians and improve their quality of health, because of a lack of the understanding of the history of urban Indian communities and complexity of the Indian health delivery system. Until such time as Congress acts to include UIOs in their definitions of the IHS system, Congress must expressly mention UIOs to ensure the whole I/T/U system is included.

Implement the VA and Indian Health Services' Memorandum of Understanding (VA-IHS MOU) and Reimbursement Agreement for Direct Health Care Services. Despite an embattled history between tribal people and the United States government, and as an inherited responsibility to safeguard the lands of their ancestors, AI/ANs serve this country at a higher rate than any other group in the nation. Many of these Veterans who live in urban areas will seek out and 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 UIOs. An 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 UIO 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 access to health care to any veteran. Please consider language that would include UIOs in the VA-IHS MOU.

Hold UIOs Harmless from Unrelated Cost Assessments. UIOs are faced with chronic and severe underfunding and depend on every federal dollar they receive to provide urban AI/AN patients. Funds for Medical inflation and pay costs are necessary to cover the intended purpose; these costs often increase at high rates in urban areas where UIOs are located, thereby straining UIOs' already constrained budgets. In 2018, IHS utilized a portion of the inflation funding increases from the FY 2019 appropriations for a purpose distinct from inflation – to cover costs of Indian Self-Determination and Education Assistance Act (ISDEAA) Section 105(l) leases. As a result, UIOs only received a small portion of the amount of inflation funding designated to be dispersed to UIOs. We are thankful that the recent budget measure included a substantial boost to funds for 105(l) lease obligations, in the amount of \$125 million, which is \$89 million above the FY 2019 enacted level.

Despite this new allocation IHS has once again indicated plans to reprogram inflation funding to cover costs for 105(l) leasing. ***Inflation funding for UIOs should not be the solution to cover an unrelated budgetary constraint.*** UIOs are not eligible for, nor are they otherwise beneficiaries of, Section 105(l) leases and thus derive no benefit from this program. UIOs are not eligible for IHS to cover their leases, yet IHS has taken over \$1.5 million dollars from UIOs to cover those leases. We respectfully request language that would restrict IHS to take UIO designated funds for their own purpose that cannot benefit UIOs. We do not receive facilities funding or many of the other IHS line items, and receive much less than the \$4,000 per patient that IHS receive per patient. Every dollar counts for UIOs and their money must be reserved for them. All UIO funds should not be impacted by this budget shortfall.

Reauthorization of the Special Diabetes Program for Indians. The Special Diabetes Program for Indians (SDPI) is critical to urban American Indian and Alaska Native communities who experience a higher prevalence of diabetes and a greater diabetes mortality rate than the general U.S. population living in those areas. Since the SDPI program began in 1997, UIOs have seen improvements in key diabetes care outcome for AI/ANs at their urban facilities over a 10 year period, from 2001-2011. It is imperative that SDPI be reauthorized before its expiration in May 2020.

We thank the committee for its efforts towards prioritizing funding to Indian Country and for holding this hearing. The staff at NCUIH is available to follow up on any future inquiries related to the submitted testimony or other urban Indian health care issues of policy or service.