President Ashley Tuomi, National Council of Urban Indian Health
Testimony for House Committee on Appropriations, Subcommittee on Interior, Environment,

My name is Ashley Tuomi, and I am the President of the National Council of Urban Indian Health (NCUIH). NCUIH 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."*

Chairman Calvert and Ranking Member McCollum, your Subcommittee is best positioned to understand the health care-related needs of unban Indians. I am heartened at your words during the House Appropriations Subcommittee hearing on Indian Health FY2019 budget where you promised that "The subcommittee will continue to place the Indian Health Service budget among its highest priorities for 2019."

Increase Funding for IHS

I first, would like to take a moment to thank you for support in the FY 2018 omnibus spending bill. Your work to prioritize UIHPs above and beyond what the Administration saw fit to meet the needs of urban Indian health and reverse proposed cuts to the Urban Health programs are greatly appreciated. Although we have become adept at doing more with less, the resources truly make a difference when making difficult decisions about the service our members can provide. We are thankful for your efforts to prevent additional hardship that budget cuts would visit upon UIHPs, however, we must address the real issue: IHS has been chronically under-resourced.

The National Tribal Budget Formulation Workgroup (NTBFWG), of which NCUIH is a part, has found that IHS has been traditionally funded at 50-to-60% of need; which of course falls short of meeting the health care demands of Urban Indians. IHS per capita health care spending in 2016 was $2,834 compared to $9,990 nationally; of this, UIHPS receives $721 per patient. Additionally, IHS only spends little more than 1% on the provision of health care to urban Indians which comprises more than 70% of the Indian population. The amount which would bring IHS health resources to parity with the rest of the nation, is currently $32.7 billion. Compare this to the current FY 2017 appropriation of $5 billion. The urban line item alone

would have to multiply by almost 1400% to begin to correct the disparity, and that is only one line item.

Medicaid and the Trust Responsibility

Congress sought to address the lack of IHS funding when it amended the Social Security Act (SSA) in 1976 to authorize the IHS to bill Medicaid "as a much-needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian." In authorizing IHS to bill Medicaid, Congress also took steps to ensure that the Federal government did not shift responsibility for Indian health care to the States. Congress amended the SSA to provide for 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS or Tribal facility. This provision ensures that all Medicaid services provided to AI/ANs that are received through an IHS or Tribal facility are reimbursed to the States at a 100% match by the United States. It was an express recognition of the federal government's treaty obligations for Indian health.

AI/ANs are a unique population and are owed health care benefits under the Trust obligation of the U.S. government which has long been established via contract and treaty.

> *The Constitution recognizes that Indian tribes have a unique political status within our federal system. The federal government is said to have broad "plenary" power over Indian affairs drawn explicitly from the Constitution, including the Indian commerce clause[1], the treaty clause[2], and other provision, as well as "the Constitution's adoption of pre-constitutional powers necessarily inherent in any Federal Government" and the general relationship between the United States and Indian tribes[3].*

AI/AN should not be subjected to disparate rules from state to state which is not in-line with the relationship with the federal government. The federal government must protect access to health care for AI/AN by any means necessary as part of the trust responsibility.

Federal Medical Assistance Percentage (FMAP) for UIHPs

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 as a response to Tribes that wanted to ensure their members would receive quality health care off of reservations as part of the trust obligation. This is particularly true for those forced to leave during the Relocation Era. Indeed, because the Trust Responsibility extends beyond the borders of the reservation, so too does the federal government's obligation to provide health care.

---

[1] U.S. CONST., art.I, § 8, cl.3.

[2] U.S. CONST., art.II, § 2, cl.2.

[3] United States v.Lara, 541 U.S. 193, 200-01 (2004); see also Morton v. Mancari, 417 U.S. at 551-52; McClanahan v State Tax Comm'n of Arizona, 411 U.S. 164, 172n.7 (1973); United States v Holliday, 70 U.S. 407, 418(1865); H.R. CON RES. 331, 100th Cong. (1988) (reaffirming government-to-government relationship with Indian tribes recognized in Constitution).

Having 100% FMAP coverage has provided a tremendous benefit to states and Tribes alike, and would expand the services UIHPs are able to provide to their patients. 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.

If UIHPs remain starved of this resource, facilities will remain unable to provide the full scope of services necessary to their patients.

Reinstate the Special Diabetes Program for Indians in the Mandatory Budget

The Special Diabetes Program for Indians (SDPI) grant program provides funding for evidence-based diabetes treatment and prevention to 301 IHS, tribal, and Urban Indian health programs. To ensure sustained and additional improvements for the health of American Indians and Alaska Natives, the FY 2019 Budget continues funding for this essential program at $150 million and shifts funding from mandatory to discretionary.

The SDPI program has been instrumental in improving access to diabetes treatment and prevention services for American Indians and Alaska Natives. Since 1997, SDPI has made positive strides to improve the landscape for many major cost-drivers including:

- Reversing the trend of increasing diabetes rate in AI/AN communities
- Increasing AI/AN access to diabetes clinical teams by 67%
- Increasing AI/AN access to culturally tailored diabetes education programs by 59%.
- Decreasing diabetes-related kidney failure by 54%
- Increasing blood sugar control for diabetes patients by 8% and,
- Decreasing End-Stage Renal Disease by 43%

With all of the success of the SDPI program, we are pleased that the administration has chosen to include it in the FY2019 Budget. However, we are greatly concerned that the administration has moved this program's funding from mandatory to discretionary. This raises thought as to the administration's future plans for this program. Your support would ensure the continued success of this essential program.

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

The FTCA provides medical malpractice coverage for certain covered individuals (i.e., governing board members, officers, employees, and certain individual contractors) working for FTCA covered entities. The Health Center FTCA Medical Malpractice Program is intended to increase the funds available to health centers by reducing or eliminating health centers' malpractice insurance premiums, which frees up these resources and instead allows them to go towards furnishing additional services.

IHS and Tribal providers, as well as other comparable federal health care centers are covered by the FTCA. UIHPs however, have been denied this coverage and must purchase their own

expensive insurance on the open market. For example, there are two highly regarded UIHPs in Oklahoma which are represented by NCUIH and each pays $250,000 per year for malpractice insurance. If UIHPs are provided FTCA coverage, $500,000 in insurance costs would instead be available for the provision of additional services in just these two facilities. This change would maximize the value of your appropriations to IHS. Any help your Subcommittee can provide, including prompting the relevant House authorization committee, would be greatly appreciated.

Fully implement the Memorandum of Understanding between UIHPs and the Department of Veterans Affairs (DVA).

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 the availability of traditional healing services. I appreciate the support the Subcommittee expressed last year when I testified, but I regret to report that the VA states they cannot reimburse UIHPs without a legislative change, 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 impact its ability to serve. The ramifications of these services can be addressed if AI/AN veterans can instead elect to receive care at UIHPs.

Given their sacrifices for and dedication to our country, AI/AN veterans should have access high-quality, culturally-competent health care by UIHPs. By working with your colleagues on the House Appropriations Subcommittee for Military Construction, Veterans Affairs, and Related Agencies, NCUIH is confident that you will 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 FY19:

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. Protect Medicaid for Tribal and urban Indians;
3. 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;
4. Support the reinstatement of SDPI, under mandatory funding which, insures future success 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;
5. 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
6. 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.