



## Testimony of Walter Murillo, President of the National Council of Urban Indian Health

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My name is Walter Murillo, and I am a member of the Choctaw Nation of Oklahoma. I serve as the Board President of the National Council of Urban Indian Health (NCUIH) and I am the CEO of Native Health in Phoenix. Today, I will share the experiences of the 41 urban Indian organizations (UIOs) in the country in responding to the COVID-19 pandemic. Let me start by saying thank you to Chairman Schatz, Vice Chair Murkowski, Members of the Committee and your staff who have worked tirelessly to help equip the Indian health system with essential resources.

NCUIH represents 41 UIOs in 77 facilities across 22 states. UIOs provide high-quality, culturally competent care to urban Indian populations, constituting more than 70% of all American Indians and Alaska Natives (AI/ANs). UIOs were recognized by Congress to fulfill the federal government's health care- responsibility to Indians who live off of reservations. UIOs are a critical part of the Indian Health Service (IHS), which oversees a three-prong system for the provision of health care: IHS facilities, Tribal Programs, and UIOs. This is commonly referred to as the I/T/U system.

### COVID-19 Impact on Urban Indian Organizations

Native Health and the other 40 UIOs have risen tremendously to the challenges of the last year. Our annual budget for FY20 was \$57.7 million for 41 UIOs to serve the over 70% of American Indians and Alaska Natives that reside in cities. Because the Indian health care system and UIOs have never been properly funded, we started from an extreme deficit going into the pandemic. In fact, we faced significant additional obstacles unrelated to COVID-19 as well: two UIOs had fires, another endured an earthquake, our Minneapolis UIO was at the center of civil unrest, and 10 UIOs in California dealt with wildfires and air quality issues. Despite these additional challenges, we kept our doors open as best we could, with only four UIOs temporarily closing because they did not have PPE for their staff.

Urban Indians have been an afterthought for far too long. This is something we're far too used to in the Indian health care system and even more so as an urban Indian health provider. We are asking Congress to prioritize the fulfillment of its trust obligation through the full funding of the Indian health system and urban Indian organizations.





In many ways, the past 12 months have reminded us not only how resilient our people are, but also highlighted how critical our Indian health care system is to the lives of American Indians and Alaska Natives. Tragically, we have planned many funerals and lost far too many members of our communities. Native deaths continue to be the highest in the world and we're not out of the woods yet, which is why Congress must continue to prioritize Indian Country for annual and future pandemic response packages.

### Vaccines Distribution by UIOs

We always knew that UIOs would serve a vital role in hard-to-reach communities and UIOs have gone above and beyond to stretch their limited budgets in order to serve their communities during this unprecedented pandemic. UIOs have continuously provided services in the hardest hit urban areas during the entire pandemic. Over half a million AI/AN people live in counties that are both served by UIOs and have the greatest number of COVID-19 deaths and new cases.

UIOs have overcome significant barriers to support their communities in responding to COVID-19. For instance, although planning for the vaccine distribution began last fall, without an urban confer policy at the Department of Health and Human Services, UIOs were excluded in all national communications regarding Indian health facilities deciding between distribution through the state or through IHS, leading to inconsistent messaging and forcing numerous UIOs to make a decision of the utmost importance immediately.

In addition, the only UIO that serves the Baltimore-Washington area – an outreach and referral facility (as deemed by IHS) operating on an annual budget of less than \$1,000,000 – only began to receive vaccines this week, despite months of coordination that even saw several other UIOs offering to fly out staff to administer vaccines to the Baltimore-Washington Indian community.

Our programs have been providing COVID-19 vaccines for an outpouring of community members. Urban Indians in our areas have been able to come to our facilities rather than traveling long distances to reservations by plane to get vaccinated. In fact, we are seeing record numbers of patients that we hope to retain following the pandemic, which will require adequate levels of funding. Nearly every UIO has complimented IHS and their Area Office for their work on vaccine distribution.





UIOs have also filled the gaps that exist in the federal government as it relates to care for Native Veterans. In one community, Native Veterans stood in lines for hours at the VA and were ultimately turned away – refused service and told to “go to the urban Indian clinic” instead. The VA is funded drastically higher than Indian health and UIOs, yet UIOs are the ones stepping up to help them. We have also stepped up to help other systems: one UIO in Montana vaccinated 180 teachers, another shared vaccines with the NAACP and a local LatinX organization, and many have partnered with other local organizations to reach other vulnerable communities hit by COVID-19.

Although UIOs have stretched every resource to respond to the pandemic, the central problem remains: years of underfunding do not allow us to fully meet the needs of our communities. We need to capitalize on this opportunity while we have the engagement from our community members. And we need our partners in Congress to make that happen.

### Successes in the Past Year

We have made enormous strides including enacting medical malpractice coverage for our health care workers and enabling UIOs to be reimbursed for services that we’ve been providing to veterans, as well as the American Rescue Plan that included two years of 100% FMAP for services provided at UIOs (a priority I’ve been working on for over 20 years).

The supplemental funding from COVID-19 relief have enabled UIOs to make significant changes, which have included: optimizing the dental clinic to meet CDC guidelines, reconfiguring facilities to enable social distancing, hiring staff, funding a vaccine location facility, creating communication and PSA campaigns to increase vaccine acceptance, purchasing of PPE and medical supplies, purchasing a pod for testing, creating contact tracing programs, hiring behavioral health staff for increased workload of anxiety and depression from COVID-19, creating a weather-appropriate outside testing space, upgrading electronic health records to accurately and effectively enter vaccine and testing data, installing a new HVAC, purchasing a mobile unit for testing, new training for staff, and expanded behavioral health including victim services. We must continue this pattern of success by getting closer to adequate funding of UIOs.

### Request: \$200.5 million for Urban Indian Health in FY22

While the American Rescue Plan provided the largest investment ever for Indian health and urban Indian health, it is important that we continue in this direction to build on





our successes of the past year. The single most important problem remains the same and that is for the federal government to establish a baseline of funding that meets the actual need for health care for Natives. The average national health care spending is around \$12,000 per person; however, Tribal and IHS facilities receive only around \$4,000 per patient. UIOs receive just \$672 per IHS patient – that is only 6 percent of the national health care spending average. That’s what our organizations must work with to provide health care for urban Indian patients. The federal trust obligation to provide health care to Natives is not optional. The Tribal Budget Formulation Workgroup recommendation for the Indian Health Service budget for FY22 is just under \$13 billion with \$200.5 million for urban Indian health – a step in the right direction towards achieving full funding (calculated this year at \$48 billion and \$749.3 million, respectively).

Each year, tribes and urban Indian organizations dedicate countless days to preparing a comprehensive document of recommendations related to the annual budget for Indian health, but Congress and the Administration have failed to provide the funding requested. With the ongoing conversations about equity and prioritizing tribal consultation and urban confer, it is important that our leaders are actually listening to our recommendations.

### **Request: Extend Full (100%) Federal Medical Assistance Percentage for UIOs Permanently**

The federal government has long recognized that the Medicaid program supplements the IHS system, and that it’s consistent with the trust responsibility for the federal government to pay 100% of Medicaid costs for American Indians and Alaska Natives, including urban Indians.

Because services provided at UIOs have not been reimbursed by the federal government at 100%, UIOs receive less third-party funds, limiting their ability to collect additional reimbursement dollars that can be used to provide additional services or serve additional patients. In the I/T/U system, only UIOs have been excluded from the 100% FMAP rate. In effect, the federal government only covers 100% of the cost of Medicaid services for AI/ANs receiving those services at an IHS or tribal facility and skirts full responsibility if an individual happens to receive the service in an urban area. 100% FMAP reimbursement has enabled: (1) IHS and Tribes to receive higher rates for services, (2) IHS and Tribes to provide additional services, and (3) states to reinvest the money they have saved into the Indian health system. UIOs providing services to tribal





members residing in urban areas are unable to receive these benefits because the services they provide are not included in the 100% FMAP policy.. The American Rescue Plan Act temporarily authorized 100% FMAP for services at UIOs for the next two years, however, the need for 100% FMAP is continuous and does not end when the pandemic ends. We urge the Senate Committee on Indian Affairs to act to pass permanent 100% FMAP for UIOs this year.

### **Request: Remove Facilities Restrictions on UIOs**

Unfortunately, a restriction prohibits UIOs from using our IHS funds to make critical repairs or upgrade HVAC and sanitation systems – this even included supplemental COVID-19 funds. With your help, the last two bills enacted allowed UIOs to finally use COVID-19 funds to make COVID-19 related repairs and upgrades that were badly needed. However, we continue to experience long bureaucratic discussions that last weeks, and even months, to make even minor upgrades to our facilities. We hope that a new bill will help fix this provision meant to help UIOs have more resources, not fewer.

Facility-related use of funds remains the most requested priority for UIOs. UIOs do not receive facilities funding, unlike the rest of the IHS system. One UIO stated that facility funding would enable them to create a space that allows for social distancing during smudging healing activities. Another UIO stated that “our facility remains in dire need of support for updates and remediation so we may pursue a safe space.” Not only is this lack of funding detrimental to facility sanitation, it also drastically reduces the number of patients UIOs can see due to social distancing, furthering compounding health issues of Indian Country.

These restrictions, which are outlined in Section 509 of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1659), extend beyond COVID-19 – they prohibit our health care providers from making any renovations using IHS funds solely because they are Urban Indian Organizations. This provision limits renovation funding to facilities that are seeking to meet or maintain Joint Commission for Accreditation of Health Care Organizations (TJC) accreditation (only 1 of 41 even have this type of accreditation), leaving most UIOs forced to use their limited third-party funds for necessary facility improvements. Thankfully, our advocates on this Committee were able to assist with loosening restrictions regarding infrastructure upgrades as they related to the COVID-19 pandemic. We are working on a permanent legislative fix to the facilities restrictions and ask for your support of that bill when introduced.





## Request: \$21 Billion for Indian Health Infrastructure including UIOs

For the upcoming infrastructure package, we request \$21 billion in infrastructure funds for the Indian health system. We were disappointed to see that the Biden plan did not include any money for Indian health infrastructure. The LIFT Act from the House Energy and Commerce Committee currently includes \$5 billion for Indian health infrastructure, however, UIOs are not currently eligible for that funding as written. We have informed the Committee and will push for an amendment but encourage this Committee to further pursue \$21 billion for Indian health infrastructure that includes UIOs.

Many UIO facilities are well beyond their anticipated and projected lifespan, the need to adequately fund the upkeep is essential to prolonging the usability of such facilities. When patients and providers lack access to well-functioning infrastructure, the delivery of care and patient health is compromised. A national investment in Indian health facilities construction funding continues to be a long-term discussion of need despite the recent investment of \$600 million through the American Rescue Act, UIOs continue to be excluded and are unable to receive funding from the IHS Health Care Facilities Construction Priority program, the Maintenance & Improvement IHS budget line item, or participate in the agency's Joint Venture Construction Program. Moreover, UIOs are even restricted from using their limited IHS appropriation for facilities. As a result, UIOs have had to take out loans and collect donations in order to build and maintain health facilities for a growing population. UIOs thus must spend millions to build, repair, and maintain their facilities—millions that could be going to increased services for their patients. Many UIOs are in aging buildings – for example, the facility in Denver, CO is in a more than 50-year old building.

Without access to facilities funding like that available to IHS and tribal facilities, UIOs must use their already limited resources on facilities. Equitable construction and facility support funding for UIOs can be accomplished by including language authorizing a new budget line item to address UIO infrastructure needs. Allowing the continued deterioration of critical health facilities goes against the mission of the Indian Health Service and Urban Indian Organizations to provide quality healthcare to all American Indians and Alaska Natives. When patients and providers lack access to well-functioning infrastructure, the delivery of care and patient health is always compromised.





## Request: Establish a UIO Confer Policy for HHS

Under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, in 2000, all government agencies were mandated to submit procedures to consult with tribes when implementing policies that have Tribal implications. Unfortunately, this Executive Order as written did not include Urban Indian Organizations. Currently, only IHS has a legal obligation to confer with UIOs. It is imperative that the many branches and divisions within HHS and all agencies under its purview establish a formal confer process to dialogue with UIOs on policies that impact them and their AI/AN patients living in urban centers. Urban confer policies do not supplant or otherwise impact tribal consultation and the government-to-government relationship between tribes and federal agencies.

We commend IHS for the agency's invaluable partnership and tireless efforts to disseminate resources to Tribes and UIOs as expeditiously as possible. Unfortunately, funds were needlessly tied up for weeks – and in more than one instance, months – by other agencies, thereby creating unnecessary barriers to pandemic response at UIOs. Compounding on this, only IHS has a statutory requirement to confer with UIOs, which has enabled other agencies to ignore the needs of urban Indians and neglect the federal obligation to provide health care to all AI/ANs – including the more than 70% that reside in urban areas. In fact, NCUIH has only been able to coordinate conversations with the VA, CDC, and other agencies by involving IHS due to a lack of urban confer. . This is not only inconsistent with the government's responsibility but is contrary to sound public health policy. Agencies have been operating as if only IHS has a trust obligation to AI/ANs, and that causes an undue burden to IHS to be in all conversations regarding Indian Country in order to talk with agencies. It is imperative that UIOs have avenues for direct communication with agencies charged with overseeing the health of their AI/AN patients, especially during the present health crisis.

## Request: Include UIOs in Advisory Committees with Focus on Indian Health

When UIOs are not expressly included within a statute enabling them to participate in tribal advisory workgroups or committees, they are prohibited from participating in a voting role or excluded altogether. UIO inclusion in critical advisory committees on Indian health is necessary to reflect the reality of much of the AI/AN population, as more than 70% of AI/ANs living in urban centers today. Without explicit inclusion of UIO representation in statute, workgroups using the Federal Advisory Committee Act (FACA) intergovernmental exemption exclude UIO leaders in their charters by default.





For UIO leaders to participate in advisory committees that directly impact their provision of health care services to AI/AN patients, Congressional action is needed.

### **Request: Include UIOs in the National Community Health Aide Program**

Although UIOs are eligible for the Community Health Aide Program (CHAP) under the national expansion policy IHS implemented pursuant to authorization in the Indian Health Care Improvement Act (IHCIA), and IHS officially initiated Urban Confer on CHAP with UIOs in 2016, IHS changed its position in 2018 and further excluded UIOs from the consultation and confer process. IHS asserts that UIOs are excluded simply because they are not explicitly included in specific statutory language. UIOs are eligible for other similarly situated programs under IHCIA, including the Community Health Representative program, and Behavioral Health and Treatment Services programs. UIOs are explicitly named in the statement of purpose in IHCIA, included throughout its Subchapter 1 on increasing the number of Indians entering the health professions and to assure an adequate supply of health professionals involved in the provision of health care to Indian people. Some states, such as mine here in Arizona, already have laws on the books reflective of UIOs being eligible for CHAP. Furthermore, CHAP is a fully proven program and utilizing it as permissible within the entire Indian health system will increase the availability of health workers in AI/AN communities. It is therefore imperative that Congress fix this oversight and clarify that UIOs are indeed eligible for CHAP so they may begin to participate in this vital program.

### **Request: Advance Appropriations**

The Indian health system is the only major federal provider of health care that is funded through annual appropriations. For example, the Veterans Health Administration (VHA) at the Department of Veterans Affairs (VA) receives most of its funding through advance appropriations. If IHS were to receive advance appropriations, it would not be subject to government shutdowns, automatic sequestration cuts, and continuing resolutions (CRs) as its funding for the next year would already be in place, and the provision of critical services would not be jeopardized by these unrelated budgetary disagreements.

According to the Congressional Research Service, since FY1997, IHS has only once (in FY2006) received full-year appropriations by the start of the fiscal year. Last year, during the pandemic ravaging Indian Country, Congress enacted two continuing resolutions. When funding occurs during a CR, the IHS can only expend funds for the duration of a CR, which prohibits longer-term, potentially cost-saving purchases. In







addition, as most of the Indian health services provided by tribes and UIOs under contracts with the federal government, there must be a new contract re-issued by IHS for every CR. Instead, IHS was forced to allocate resources to contract logistics twice in the height of the pandemic when the resources could have better spent equipping the Indian health system for pandemic response.

In addition, lapses in funding can have devastating impacts on patient care. During the most recent 35-day government shutdown at the start of FY 2019 –the Indian health system was the only federal healthcare entity that shut down. 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 without funding. For instance, Native American Lifelines of Baltimore is a small clinic that received five overdose patients during the last shutdown, four of which were fatal. Shutdowns mean deaths in our communities. We urge this Committee to support the President’s request for advance appropriations for the Indian Health Service including UIOs.

## Conclusion

These requests are essential to ensure that urban Indians are properly cared for, both during this crisis and in the critical times following. It is the obligation of the United States government to provide these resources for AI/AN people residing in urban areas. This obligation does not disappear amid a pandemic, instead it should be strengthened, as the need in Indian Country is greater than ever. We appreciate your support for urban AI/ANs in the Consolidated Appropriations Act, American Rescue Plan Act and request your support of the policy requests contained herein. We urge you to honor the trust obligation and provide UIOs with all the resources necessary to protect the lives of the entirety of the AI/AN population, regardless of where they live.

