Written Testimony of
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Before the Democratic Steering and Policy Committee and
House Committee on Natural Resources

On behalf of the National Council of Urban Indian Health, Native American Lifelines and the many American Indian/Alaska Native (AI/AN) patients that we serve annually, I would like to thank the Democratic Steering and Policy Committee and the House Committee on Natural Resources for this opportunity to testify on the government shutdown impacts on Indian Country. My name is Kerry Hawk-Lessard and I am Descendant of Absentee Shanwne. I am on the board of the National Council of Urban Indian Health(NCUIH) and I am the Executive Director of Native American Lifelines for Baltimore and Boston. NCUIH represents 41 urban Indian organizations providing health care services pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act. Urban Indian Health Programs see tribal members from all 573 federally recognized tribes and urban Indians as a part of the Indian Health Service System which consists of Indian Health Service, Tribally operated facilities and Urban Indian Health Programs, or I/T/U. UIHPs were created by Congress after the Relocation era in recognition that the trust obligation for healthcare follows Indians off reservations and wherever they go. UIHPs are define as outreach and referral, limited ambulatory, or full ambulatory. My UIHP, Native American LifeLines of Baltimore and Boston was established to meet health, dental and behavioral health needs of urban Indians residing in the Washington, D.C., Maryland, Virginia and Delaware. With a focus on direct substance abuse prevention and treatment services, LifeLines also provides health promotion/disease prevention activities designed to improve the health status of the community as well as case management services that facilitate and coordinate access to much needed care.
Lifelines is the only Title V Urban Indian Health Program (UIHP) providing services to AI/AN people in these areas. As an outreach and referral program, Native American Lifelines is tasked with linking American Indians to care, primarily because there are no urban ambulatory clinics on the east coast. A sizable number of our user population consists of tribal citizens working for the federal government or IHS employees who have access to IHS hospitals and clinics at home but not here where they are working and living.

The partial government shutdown is having dire consequences for American Indian and Alaska Native (AI/AN) health care, including urban Indian health. The federal government has an affirmative obligation to provide health care to AI/AN people. This trust responsibility stems from treaties and longstanding U.S. policy and jurisprudence. The shutdown of IHS is directly at odds with that obligation. To be clear, these impacts are being felt across the entire AI/AN health care delivery system – however, today, I am going to speak to you about the impacts it is having on urban AI/AN health care.

Approximately 78% of AI/AN people reside in urban areas, many due to government forced relocation policies or in search of economic or educational opportunities. Despite this, the urban Indian line item constitutes less than 1% of the total Indian Health Service (IHS) budget. Urban Indian Health Programs (UIHPs), like Native American Lifelines, thus depend on every

single dollar of funding in order to stretch the systematic underfunding to provide services to our AI/AN patients. Any time there is a lapse in funding or any funding is taken away from UIHPs, our facilities suffer and, ultimately, our patients suffer.

The impact of an IHS shutdown is that already chronically underfunded facilities are forced to make extremely difficult decisions without any other options. Facilities will not be able to provide care to patients.

At Native American Lifelines, we receive less than a million dollars from IHS for two facilities. IHS often provides late payments, with our last funding deposit coming in September. The money to operate our facility has effectively stopped coming in, but patients have not stopped needing health care. We routinely receive calls requesting purchase of care funding to pay for medical care, prescriptions, and other health care services. We also provide direct dental services for these individuals. We have thus far had to deny purchase of care requests that are critical to chronic care management - insulin, blood pressure medication, thyroid medication - thus impacting the quality of life for the individuals we serve. We provide behavioral health services to our community that will be interrupted shortly and the impacts will be devastating. We have had four clients overdose on opioids in the last two months. Two of these overdoses were fatalities. As an Outreach & Referral providing Substance Abuse counseling and referrals to care, in addition to support, it is unthinkable that we will not be available to assist in a time of such great need. As our UIHP is now closed, those struggling now have nowhere to go. Substance use will continue to occur and, no doubt, so will the overdoses. That we won't be in place to assist is deeply troubling.

We close our doors effectively 1/12/19, as that is when the funding absolutely ran out. Another program was in danger of closing today but will be receiving community support to remain open for a few more weeks. .We are not alone in feeling these impacts – many of the 41 UIHPs that span 22 states are struggling without adequate funds. A NCUIH survey found that of 13 UIHP-respondents, 5 could only sustain normal operations for one month or less. We are 24 days into the shutdown, most UIHPs will not be able to stay open much longer. . Several are having to resort to pause hiring, start staff layoffs or a forced reduction in services or clinic hours, thereby significantly limiting services available to their AI/AN patients. UIHPs will then lose quality staff and will continue having snowballing issues long after the shutdown is over. The impacts of the shutdown are real and immediate.

I would like to share real numbers with you to better illustrate how underfunded we are.

FY 2019 Recurring Base Funding			
Lifelines - By Location			
	BALTIMORE	**BOSTON**	**TOTAL**
URBAN	$ 286,803	$ 274,189	$ 560,992
MENTAL	$ 346	$ 345	$ 691
ALCOHOL	$ 81,445	$ 279,795	$ 361,240
		Total Recurring Base	$ 922,923

I want to highlight that we receive $922,000 for two clinics. Out of that funding, IHS only gives us $691 for mental health for both facilities. $691. That is not enough to take care of

any of our patients. Furthermore, UIHPs only receive money from one IHS line item, urban indian health. No facilities or hospitals money, no purchased and referred care, nothing. This only averages out to about $700 per patient that we receive from IHS, even though per capita health expenditures for the United States are almost $10,000. As a Native veteran patient once said, it is still legal for the federal government to kill Indians, even in 2019.

The only true way to resolve this is to restore funding to IHS and provide adequate funding to take care of our people. It is incumbent on the federal government to fund the Indian health system and provide health services to AI/AN people, as obligated under its trust responsibility. Congressional leaders must work together to restore funding to IHS by passing a budget or exempting IHS funds from government shutdowns. The lives of AI/AN people should not be put at risk due to disagreements over unrelated budget proposals. IHS must receive advanced (and mandatory) appropriations, similar to the VA, which also serves a population that critically needs health care access to reduce significant disparities. My grandfather died waiting for care at the VA. We didn't hear from the VA until 2 months after he walked on that they could serve him. Indians should not have to be treated with such sub-par care.

The need to rely on such relatively small levels of funding is extremely difficult for health facilities and the constant delays and uncertainties stemming from the current appropriations process result in inefficiencies and the utter inability to plan for long-term – something essential for health care. In addition to advance and mandatory appropriations for IHS, in order to create true parity in the IHS system for UIHPs specifically, 100% FMAP, VA-IHS (UIHP) MOU implementation, and FTCA (Federal Tort Claims Act) coverage for UIHPs as well as an increased urban Indian health line item of at least $81million is what Congress can do to really make some change and serve the entirely of Indian Country, both on and off the reservation. I therefore ask you to immediately work on these issues. The lives of AI/AN people depend on it and it is your trust obligation to see it through. Thank you for your time.