2018-2019 Government Shutdown: Impacts on Urban Indian Organizations

General Report prepared by the National Council of Urban Indian Health (NCUIH)

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Introduction

The United States federal government shutdown of 2018-2019 occurred from midnight Eastern Standard Time on December 22, 2018 until January 25, 2019. This shutdown became the longest federal government shutdown in United States history, lasting thirty-five days and causing severe and detrimental impact on the Indian healthcare delivery system. The interruption in funding precipitated by the shutdown had dire consequences for Urban Indian Organizations (UIOs) and consequently on American Indians and Alaska Natives (AI/ANs) across the country. The impact on AI/ANs, many of whom depend on UIOs for their healthcare needs, ranged from patients unable to get vital medication for chronic conditions to fatal overdoses. UIOs had to make difficult decisions regarding cancellation of certain services, staff hours, staff retention, facility operation, and whether to use savings earmarked for other purposes to shield staff and patients from the impact of the shutdown. As Senator Tom Udall said on the Senate floor, “Every day the President continues to treat tribal health and public safety programs like hostages for political gain endangers families across Indian Country.”

The National Council of Urban Indian Health (NCUIH) shifted its policy and advocacy focus during the shutdown to limit the disruptions to the daily operations of the UIOs it represents and urged Congress and the administration to immediately end the shutdown and restore funding to IHS. Following the shutdown and restoration of funding, NCUIH remains dedicated to establishing safeguards for UIOs against potential shutdowns in the future. NCUIH is working with Congressional officials to raise awareness for bills that would provide the Indian Health Service (IHS) with advance appropriations and provide 100% Federal Medical Assistance Percentage (FMAP) for UIOs.

1 https://www.pbs.org/newshour/nation/shutdown-puts-strain-on-hundreds-of-native-american-tribes
This report summarizes and presents the results of a survey NCUIH circulated during the 2018-2019 shutdown to capture important metrics and narratives regarding its impacts. Nineteen out of forty-one UIOs reported. The responses from this survey were used in NCUIH’s policy and legislative advocacy initiatives during and after the shutdown. Although the Indian health care delivery system consists of three prongs — IHS, Tribal Health Programs, and UIOs — this report focuses on UIOs. This report begins with a summary of the key findings of the survey, followed by background information to support a more detailed analysis of the findings, including key comments from our member UIOs, and proposed policy fixes aimed at avoiding the negative impacts of a government shutdown in the future.
Summary of Key Findings

The 2018-2019 Government Shutdown: IMPACTS ON YOUR PROGRAM survey was circulated to UIOs on January 2, 2019 and responses were collected through January 15, 2019. This section provides an overview and summary of key analytical points of the survey.

UIOs operate on very low margins.

• UIOs operate on very low margins such that even very minor changes to their funding structures lead to devastating impacts on the services they provide to AI/ANs and even affect their abilities to keep their facilities operational.

All aspects of the urban Indian healthcare delivery system were impacted by the shutdown, but the UIO workforce was the first to experience its disastrous effects.

• The survey results point to a pattern which suggests that among the difficult decisions UIOs were forced to make during the 2013 and the 2018-2019 shutdowns, delaying hiring, reducing hours, and laying off staff were typically the first decisions made.

UIOs services were greatly impacted.

• Another pattern the survey highlighted is that UIOs were forced to cut back on services that were not as consequential as others, such as dental services, transportation, case management, and community outreach services. However, some UIOs were forced to cut even the essential services such as substance abuse services and purchase requests for diabetes and blood pressure medications.

UIOs were forced to use savings designated for other purposes to shield staff and patients from the impact of the last two government shutdowns.

• Yet another pattern illustrated in the survey results suggests that UIO leaders made an effort to protect their staff and current services by using savings earmarked for program growth.
Background

Trust Responsibility

Treaties signed by the federal government in exchange for Indian land established a trust relationship and a government responsibility for providing health care services to Indian people.2 The relationship has been formed and defined in the U.S. Constitution and case law and distinguishes Indians from racial classification and other laws that provide health programs for the general public. The trust responsibility mandates that the government has a fiduciary duty to act in the best interest of tribes and AI/ANs. That responsibility is not restricted to the borders of reservations, and it includes issues related to healthcare.3

The IHS is not a health insurance nor welfare program; it works to partially fulfill the trust obligation of the United States. More than 70% of AI/ANs now live in urban areas, as compared with 45% in 1970 and 8% in 1940. This migration has occurred for several reasons, but mainly because of federal government policies of forced relocation during the Relocation Era (1945-1968) and subsequently due in part to the lack of economic or educational opportunities on reservations. The current residence of an AI/AN person is immaterial to the federal obligation; in fact, Congress has consistently affirmed that the federal government’s responsibility to provide healthcare to Indians follows them off-reservation.

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2 Indian Health Service Fact Sheets, Indian Health Services, Sep. 13, 2011.
3 See e.g., 25 U.S.C. § 1602 (“Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy”); See also S. Rep. 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, at 25 (“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”).
IHS Funding Flow

The authority of IHS to provide health care services to AI/AN people derives primarily from two statutes. The Snyder Act, 25 U.S.C. § 13, is a broad statutory mandate authorizing the IHS to spend money as authorized by Congress for the “relief of distress and conservation of [Indian] health.” 4 The Indian Healthcare Improvement Act (IHCIA), 25 U.S.C. §§ 1601-1683, established numerous programs specifically created by Congress to address particular Indian health initiatives, including UIOs to address Urban Indian health. 5 The IHS carries out this authority through contracts with, and grants to, UIOs. 6

Since its initial passage, amendments to the IHCIA have strengthened UIOs by expanding the IHS’s contract and grant authorities to include direct medical services, alcohol and substance abuse services, mental health services, human immunodeficiency virus (HIV) prevention and treatment services, and health promotion and disease prevention services. 7 Despite this, the IHS remains drastically and chronically underfunded. -resourced, however, and it is presently funded at less than 50% of need. 8 Although UIOs rely on the IHS for funding, they are only allocated one line item, equating to less than 1% of its annual budget. Given that there do not currently exist advance appropriations or other legal protections for IHS funding, and that UIOs operate on very low margins, the impacts of a government shutdown hit UIOs severely and rapidly.

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4 New Needs Assessment of the Urban Indian Health Program and the Communities it Serves, U.S. Department of Health and Human Services Indian Health Service (2009).
5 Id.
7 Id.
8 “In January 2018, IHS updated the existing FEHB [Federal Employees Health Benefits] Program benchmark formula, and the result showed on average IHS Service Delivery Areas (SDAs) had 46.6 percent of needed resources (LNF) Level of Need Funded] to provide health care services comparable to the FEHB Program. This assumed alternate resources at 25 percent, resources needed at $7,599 per person, and available IHS appropriations at $2,656; however, it does not include all of the IHCIA authorities that represent unfunded programs by Congress.” Indian Health Service, Indian Health Care Improvement Fund Workgroup Interim Report, June 2018, page 8.
The National Council of Urban Indian Health

NCUIH is a national 501(c)(3) organization devoted to the support and development of quality, accessible and culturally competent health services for AI/ANs living in urban settings. As such, NCUIH provides UIOs with training, technical assistance and research support to help them implement and evaluate quality, accessible and culturally appropriate healthcare services. NCUIH also educates Congress and federal agencies about the health and wellness issues experienced by Urban Indians and the UIOs that serve them.

When the government shutdown in 2018, NCUIH circulated a survey to capture important metrics and narratives and compiled the results to be used in policy and advocacy efforts both to encourage an end to the then-current shutdown and to raise awareness about the need for IHS advance appropriations and 100% FMAP for UIOs. Below are the detailed findings and key comments compiled from that survey.

Detailed Findings

Impacts of the 2013 Government Shutdown

The 2013 government shutdown lasted for 16 days, from October 1 - 17, and had a large impact on the UIO workforce. Nearly 50% of the respondents reported that they were either forced to lay off staff or significantly reduce their hours, while others had to delay hiring for open positions. Certain services offered by UIOs were also adversely impacted by the shutdown with nearly 40% of respondents indicating that they were forced to cancel important programs and services. While some programs cancelled non-essential services such as community outreach, other programs were forced to cancel critical services such as outpatient substance abuse services, increasing the risk that patients enrolled in these services would relapse. Lastly, several individual respondents indicated that they were forced to use savings and emergency funds to protect their staffs (and the services they provide) from being impacted by the shutdown.
The graph below illustrates the findings of how the 2013 shutdown impacted UIOs.

**What was the impact of the 2013 government shutdown on your clinic(s)?**

- Close clinic(s), 12.50%
- Reduce hours, 18.75%, 19%
- Lay off staff, 31.25%, 31%
- Cancel programs/services, 37.50%, 38%
Impacts of the 2018-2019 Government Shutdown

At One Week

The 2018-2019 government shutdown lasted for 35 days, from December 22, 2018 until January 25, 2019, with serious detrimental impacts felt by UIOs throughout its entirety. The NCUIH survey was circulated during the first week of the shutdown and respondents were asked how the shutdown had impacted them thus far. Nearly 65% of the respondents indicated that at that point, they had already needed to use savings designated for other purposes (e.g. expanding facilities and hiring new staff) or emergency funds to remain operational. Some respondents also indicated that they had already been forced to close their clinics, lay off staff, and/or reduce hours.

The graph below illustrates the results to the survey question addressing the impacts at one week of the 2018-2019 government shutdown. (The ‘other’ category is captured by some of the key comments flowing this section.)
If Prolonged

The next question asked UIOs what actions they would take if the shutdown continued for several weeks. Nearly all of the respondents indicated here that they would either reduce staff hours or lay off staff, which is comparable to the actions respondents took during the 2013 government shutdown. Nearly 70% of the respondents also reported that they would cancel certain services or take out a loan if the shutdown extended over several weeks. While some respondents indicated that they would cancel certain non-essential services such as community outreach, others reported that they would be forced to cancel, or had already canceled, critical services such as prescription management and mental health and substance use disorder services.

The graph below illustrates the results to the survey question addressing the impacts to UIOs if the shutdown continued for several weeks. Given that the 2018-2019 government shutdown continued on to last several weeks, it is important to note that many of these responses reflect the reality these facilities faced.

![Pie chart showing the impacts of the shutdown on UIOs.](image)
Key Comments

The key comments below were submitted as part of the NCUIH survey and serve to substantiate the responses illustrated above.

- We will be forced to close 1/12/19 if there is no resolution.

- If a short shutdown can be a reality we will be OK. We will be ok, but if it continues and our funds are depleted we will look at pulling back with our Outreach service and that includes SDPI, MSPI, DVPI, Youth Program and PHN [Public Health Nursing]. For one month that would cost us $34,500. We would channel Title V funds toward the medical and behavioral health clinics.

- The shutdown has ceased the processing of our pending invoices of over $340k from Title V, which is what funds the majority of our clinical operations. We learned from the last shutdown to have a set aside in the event this happens again. Although we have the set aside, it doesn’t help when we still have outstanding invoices from fiscal year ‘18 that are not paid. We are fortunate enough to keep our doors open, however, once we hit our strategic fund, we may need to lay a few employees off. We are currently reassessing our supply need and providing supplies for services where programs are still operational such as SDPI. This impact changes the decision-making of our providers to include another layer of need to consider when providing care.

- We can maintain normal operations through February.

- Revenue from IHS represents approximately 13% of our funding. Given the level of uncompensated care we support, we are very dependent on these funds to support our patient services. Our business is low margin so there is little room to absorb an impact such as this.

- Without our contract we cannot survive.

- If this continues, we will not be able to sustain the programs that are funded by the grants. It will mean closing programs and laying off staff.
As an outreach and referral program, our program is tasked with linking American Indians to care, primarily because there are no Urban ambulatory clinics in our area. A sizeable number of our user population consists of tribal citizens working in this area who have access to IHS hospitals and clinics at home but not here where they are working and living. 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.

Our funding from Title V comes very slowly as it is. Adding a shutdown to the timeline of when we will expect the 340k from FY18 makes it that much more difficult to operate a program.

If staff hours are reduced, programs and services will have to be cancelled. I currently have multiple patients enrolled in substance use intensive outpatient treatment who are managing outside of an inpatient setting through the consistency of having daily access to services such as peer support, group counseling, and individual substance use and/or mental health counseling. Losing this consistency puts them at heightened risk for relapsing on substances and if relapse occurs it would require we refer them to a high level of care.

We planned for the shutdown as much as possible so we didn’t lose any staff but we would have if the 2013 shutdown continued. We are funded differently now and the impact would have twice the impact.

We have been able to function on our current federal funds, however we anticipate if the shutdown continues, we may end up going into our reserve account by the end of this month.
The week the shutdown was announced, our community experienced 3 opioid overdoses, 2 of them fatalities. This is in addition to three prior fatalities in the last 90 days. 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.

Delay hiring for open positions, relying on other funding sources to cover staffing.

Consistency needed for substance use intensive outpatient services will be disrupted. Patients enrolled in these services are often high risk for relapsing on substances and count on access to daily groups and individual sessions to keep themselves accountable and on-track with their recovery.

We had to be extra cognizant of our budget and tighten up our extra community activities, e.g. examine our community responsibilities of outreach services.

Reduction in the agency’s emergency reserve funds.

These comments illustrate the gravity of the impacts of government shutdowns on the ability of UIOs to provide essential services, retain employees, serve the AI/AN population, and even stay open.
Proposed Solutions to Maintain Critical Health Care for AI/ANs

IHS must be funded at need

First and foremost, as part of its trust responsibility to provide for the healthcare and well-being of AI/AN people, Congress needs to fund IHS at need. Additionally, an increase in the Urban Indian Health line item would enable UIOs to increase their operating margins and reduce their vulnerability to fluctuations in funding.

Advance Appropriations

NCUIH has been working to educate Congress on the need for advance appropriations for IHS. Advance appropriations would enable funds to be available one year or more after the year of the appropriations act in which the budget is contained, and provide a necessary buffer for the Indian health system in the case of future appropriations lapses or shutdowns. Congress recognized the need for advance appropriations for the Veterans Health Administration of the Department of Veterans Affairs (VA) in 2009, finding that the severity of gaps in care caused by lapses in appropriations without advance appropriations endangered the VA’s ability to “provide timely and quality care.”

As a result of our efforts and those of our national partners, U.S. Senator Tom Udall (D-NM), Vice Chairman of the Senate Committee on Indian Affairs introduced S. 229 Indian Programs Advance Appropriations Act (IPAAA) on January 25, 2019 and U.S. Representative Betty McCollum, Chair of the Interior Appropriations Subcommittee, introduced its companion bill H.R. 1128 on February 8, 2019. These identical bills would protect essential federal, tribal, and UIO programs from budgetary uncertainty caused by government shutdowns and short-term funding packages. Since the introduction of these bills, NCUIH has worked with Congressional offices in the House of

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Representatives and the Senate to urge them to support the IPAAA. NCUIH continues to work towards ensuring that UIOs are protected from disruptions in funding.

100% FMAP

Thirdly, NCUIH has been working to provide education and raise awareness of the necessity of 100% Federal Medical Assistance Percentage (FMAP) Medicaid reimbursement rate for services provided at UIOs. Currently, if an AI/AN Medicaid beneficiary receives services through an IHS or tribally-operated health facility, the Centers for Medicare and Medicaid Services (CMS) matches the amount paid for those services at 100%, as authorized by Section 1905(b) of the Social Security Act. However, if the AI/AN Medicaid beneficiary receives Medicaid covered services from a non-IHS/tribal provider, including a UIO, CMS matches at the state’s regular FMAP rate (ranging from 50% to 76.29%)\(^10\), in turn leaving UIOs deprived of the supplemental funds they need to provide essential care to Urban Indians. Currently, there are only two UIOs where services are reimbursed to the state at 100% FMAP. One of these facilities had the largest margin reported of the respondents surveyed here – evincing a significant disparity that exists because of the lack of 100% FMAP eligibility.

On April 11, 2019, Senator Tom Udall introduced S. 1180 the Urban Indian Health Parity Act (UIHPA), which would update the IHCIA to rightly include and acknowledge UIOs as a necessary and critical part of the Indian health care delivery system by providing for 100% FMAP. U.S. Representative Ben Ray Luján, Assistant Speaker of the House, introduced the House version of the bill, H.R.2316. The UIHPA is a necessary fix that would increase the operating margins of UIOs and decrease their vulnerability to another government shutdown.

Conclusion

The longest U.S. government shutdown in history had instant, longstanding, and severe negative impacts on UIOs and the AI/ANs they serve across the country, as illustrated by the NCUIH survey findings and key comments laid out in this report. The federal trust responsibility to provide for the healthcare of all AI/ANs mandates that federal funding problems be fixed so that the impacts of any future shutdowns are minimized, and the lives of AI/ANs are not put at risk. Because UIOs operate on very low margins, every aspect of their abilities to deliver essential healthcare was affected by the 2018-2019 shutdown, including their abilities to hire and retain staff, to provide direct services, and, in some cases, even to remain open and available for their patients. IHS funding at the level of need, an increase in the Urban Indian Health budget line item, advance appropriations, and 100% FMAP for UIOs are all necessary fixes to protect the delivery of healthcare to Urban Indians. NCUIH will continue work with Congress and with the UIOs they serve to help ensure that there are protections in place against another government shutdown’s interruptions in funding.
Appendix

NCUIH Letters

January 7th, 2019

Dear Congress:

On behalf of the National Council of Urban Indian Health, I am writing to respectfully urge you to work with Congressional leaders to end the partial government shutdown, which is having dire consequences for urban Indian health.

The Indian Health Service (IHS) has now been unfunded for 17 days. This has already profoundly impacted Urban Indian Health Programs (UIHPs) and the American Indians and Alaska Natives (AI/ANs) that depend on them for health care. The situation is critical. We respectfully request your urgent action to restore funding to IHS and save AI/AN lives.

UIHPs are an integral part of the AI/AN health care delivery system. Despite the fact that approximately 78% of AI/AN people live in urban areas, the urban Indian line item constitutes less than 1% of the IHS budget, making every dollar of funding absolutely critical to the fulfillment of the national obligation for the provision of health care to AI/ANs. The partial government shutdown is having profound impacts on UIHPs, which will lead to devastating impacts on AI/ANs if funding is not promptly restored.

As the premier national representative of UIHPs, we respectfully request your cooperation in restoring funding to IHS. For your reference, some of the negative repercussions of an IHS shutdown are below, based on a NCUIH survey of 13 UIHPs. Should you have any questions or require technical assistance, please do not hesitate to contact me at jdrever@ncuih.org or NCUIH’s Director of Federal Relations, Julia Drever, at jdrever@ncuih.org.

Sincerely,

Francys Drever
Executive Director
January 17th, 2019

Vice Chairman Tom Udall
Senate Committee on Indian Affairs
531 Hart Senate Office Building
Washington DC, 20510

Re: Support for the Indian Programs Advanced Appropriations Act

Dear Vice Chairman Udall:

On behalf of the National Council of Urban Indian Health (NCUIH)\(^1\) and the Urban Indian Health Programs (UIHPs)\(^2\) we represent, we strongly support the Indian Programs Advanced Appropriations Act (IPAAA) that will provide advanced appropriations to the already grossly underfunded Indian Health Service and Bureau of Indian Affairs and the programs they support. The passing of this bill will be a critical measure in fulfilling the trust obligation and is a large step in the right direction of taking care of American Indian and Alaska Native people. The services provided under these programs are for essential services such as health services, education, food and law enforcement on reservations, as well as other services.

The Indian Health Service includes three facets of the Indian health care system – IHS facilities, Tribes and Tribal organizations, and UIHPs or I/T/U. This bill is critical to ensure the U.S. trust responsibility for the provision of health care to all AI/ANs is upheld and that the Indian Health System is on parity with other agencies that provide healthcare to American citizens, such as the Veterans Administration (VA).

When Congress passed a similar bill that provided for advanced appropriations for the VA, S.R. Rep No. 11-41, at 2 (2009) they found that:

For 19 of the past 22 fiscal years, funds have not been appropriated to VA on time, causing serious difficulties for VA in planning and providing health care to veterans. Further, that these difficulties endanger VA’s ability to provide timely and quality care, and that they disrupt VA’s ability to plan which programs and services can be funded.

\(^1\) NCUIH is the premier national representative of UIHPs receiving contracts under Title V of the Indian Health Care Improvement Act (IHCIA) and the AI/ANs they serve. Founded in 1998, NCUIH is a 501(c) organization created to support the development of quality, accessible, and culturally sensitive health care programs for AI/ANs living in urban communities. NCUIH fulfills its mission by serving as a resource center providing advocacy, education, training, and leadership for Urban Indian health care providers. NCUIH strives to improve the health of the over 70 percent of the AI/AN population living in urban settings, supported by quality, accessible health care centers.

\(^2\) NCUIH represents urban Indian health programs operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.).
from year to year. The Congress also finds that providing sufficient, timely and predictable funding would help VA plan and manage their health care system more effectively, thus improving their ability to meet the health care needs of veterans.

IHS and other Indian programs have had the very same issues identified in the Senate report cited in 2009. We are grateful to Senator Udall for championing this long standing issue in an attempt to create true parity for American Indians and Alaska Natives. If you have any questions, please contact NCUIH Executive Director Francys Crevier at FCrevier@ncuih.org or (202)544-0344.

Sincerely,

Maureen Rosette, J.D.
President
National Council of Urban Indian Health
Written Testimony of Kerry Hawk-Lessard, MAA Executive Director, Native American Lifelines National Council of Urban Indian Health Board Member 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 defined 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 NCUIIH 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.

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<th>FY 2019 Recurring Base Funding</th>
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<tr>
<td>Lifelines - By Location</td>
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<td>BALTIMORE</td>
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<td>URBAN</td>
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<td>MENTAL</td>
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<td>ALCOHOL</td>
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<tr>
<td>Total Recurring Base</td>
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</table>

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 advance (or 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 or 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 $81 million 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.