Testimony of D'Shane Barnett
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To the U.S. House of Representatives
Appropriations Subcommittee on the Interior, Environment, and Related Agencies
Oversight Hearing: Indian Health

March 19, 2013

Chairman Simpson, Ranking Member Moran, and Members of the Subcommittee: Good afternoon. On behalf of the National Council of Urban Indian Health, our thirty-eight member health programs, and the more than 100,000 American Indians and Alaska Natives we serve annually, it is an honor to appear before you today to speak on the state of health of American Indian and Alaska Native people living in cities across the United States. We also want to especially thank Congress for its recent passage of the Violence Against Women Act and for including the tribal protections. Given that much of our population migrates back and forth between reservations, rural towns, and urban areas these protections will also support many of the women we serve. Further, for those of us residing in urban areas, these protections support our mothers, aunties, sisters, daughters and granddaughters that live on tribal lands, as we are all related and represent the same people.

The plight of American Indians and Alaska Natives living in urban areas is a direct consequence of the failed federal policies that created these communities in the first place. Between 1952 and 1960, an estimated 160,000 American Indians were relocated off of their reservations to live in urban areas as part of the Bureau of Indian Affairs "Indian Relocation Program." This relocation policy was part of a larger effort to assimilate American Indians into the majority American society. Often induced and coerced into leaving their land, their community, their culture, and their support network, American Indians quickly joined the ranks of the urban poor. With job opportunities scarce, and little or no financial assistance from the BIA, American Indians developed significant health disparities that persist to this day. Despite the solemn obligation of the United States to provide health care services to American Indians in fulfillment of the federal Trust Responsibility, the health needs of urban Indian people went unaddressed for more than two decades.

In 1974, the Supreme Court decided in *Morton v. Ruiz* that assistance afforded to American Indians and Alaska Natives is not limited to those currently living on a reservation. In 1976, in recognition of the deplorable health status of American Indians and Alaska Natives located in American cities, Congress enacted Title V of the Indian Health Care Improvement Act to ensure that the health care services made available in fulfillment of Trust Responsibility reach all American Indians and Alaska Natives. Congress subsequently affirmed that the United States'

obligation under Trust Responsibility "for the provision of health care services…does not end at the borders of an Indian reservation." Most recently, in permanently reauthorizing the Indian Health Care Improvement Act, Congress declared, "it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to Indians, to ensure the highest possible health status for Indians *and urban Indians* and *to provide all resources necessary* to effect that policy." IHS-funded urban Indian health programs are both an attempt to mitigate the harm caused by the federal relocation policy and are an expression of the United States' trust responsibility to all American Indians and Alaska Native people – wherever they may reside.

The Indian Health Service currently provides funding to 38 Urban Indian Health Programs operating in 21 states. These IHS-funded health programs are not-for-profit organizations governed by a board of directors, 51% of whom must be urban Indians. With an IHS line item of only 43 million dollars, these health programs annually provide more than 275,000 high quality, culturally competent patient visits to American Indians and Alaska Natives that cannot be received at other safety-net health care providers. In addition to primary care services, our programs provide traditional health care services, behavioral health, residential substance abuse treatment, sexual assault and domestic violence prevention, and social services such as job placement and health insurance eligibility and enrollment. Given their modest IHS funding, which is estimated to represent roughly 18% of total need, Urban Indian Health Programs have become adept at leveraging this meager base funding to secure additional support from states, counties, and other federal agencies. Typically, Urban Indian Health Programs leverage 1.5 dollars for every dollar appropriated through the Indian Health Service's urban health line item. While 27 of our programs have implemented third-party billing systems to supplement their base IHS funding with payment from private insurance as well as public programs such as Medicare, Medicaid, and CHIP, the federal Trust Responsibility cannot be shifted onto states, counties, foundations, and private insurance reimbursement. The primary source of funding for the majority of our programs remains the Indian Health Service.

Urban Indian people, as well as Urban Indian Health Programs, face many difficult challenges. Although Urban Indian Health Programs operate in 38 urban centers, an additional 18 cities have been declared by IHS to have sufficient need for new Urban Indian Health Programs. According to the 2010 Census, 3.7 million AI/AN people live in American's cities, representing 71% of the total AI/AN population. However, the urban Indian health line item currently represents less than one percent of the total IHS budget. The more than 100,000 people served each year by the 38 Urban Indian Health Programs represent just a small fraction of the total urban Indian population and there has never been enough funding to expand the program to serve all urban American Indian people. It is critical to note that Title V funded Urban Indian Health Programs do not benefit from funding resources in other areas of the IHS budget, such as contract health services, facilities, contract support costs and others. Therefore it is critical that resources intended to improve the health status of American Indians in urban centers be appropriated to the IHS Urban Indian Health line item.

Even in cities where Urban Indian Health Programs operate, limited IHS funding means that many of our patients are either referred out for treatment, or go without care entirely. According to the most recent national diabetes audit of the Urban Indian Health Programs, while two-thirds

of patients received a foot exam in the past year, less than half received dental and eye exams during the audit period. These are critical standards of care for diabetes, a disease affecting urban AI/AN people at disproportionate rates, and many of the urban programs don't have the necessary resources to provide these standards of care for all patients. Only 17 Urban Indian Health Programs have dental services and only 4 have optometry services. While funding from the Special Diabetes Prevention for Indians project has been steady for years, the AI/AN diabetes population has still managed to increase. For example, five years ago there were 630 diabetics at the Indian Health Care Resource Center in Tulsa, OK; this year there are approximately 1,100. The number of pre-diabetic patients is estimated nationally to be three times higher than those with diabetes. While the Tulsa program is doing a great job in supporting standards of care, like foot and depression screenings, they can only provide dental exams to about 27% of the diabetes population, as there are not enough resources to support everyone.

As previously expressed, NCUIH is thankful to Congress for their robust support and reauthorization of the Violence Against Women Act. However, we regret that the Indian Health Service has eliminated Sexual Assault Prevention and Domestic Violence Prevention grants that helped our programs combat this problem in urban Indian households. Sample studies in New York City indicate that over 65% of AI/AN women experienced some form of interpersonal violence and, of those, 48% reported being raped and 40% reported multiple victimization experiences. This data mirrors what is happening in urban areas across the country. For example, the Friendship House Association of American Indians is one of our programs providing residential substance abuse treatment. They support holistic care to AI/AN people in urban areas as well as to tribes. Their program provides access to an on-site sweat lodge and use of traditional practitioners to support healing combined with evidence-based western practices and support services that serve to increase social determinants of health. In 2011, the Friendship House was able to increase employment of its participants by **115 percent** and increase abstinence from alcohol and/or drugs by **119 percent**. Within the same year, 65% of all patients entering Friendship House had co-occurring Post Traumatic Stress Disorder, indicating a demonstrable need in the community for treatment as well as highlighting the need for additional research. In light of this data, it is critical that programs such as Sexual Assault and Domestic Violence Prevention be restored to Urban Indian Health Programs.

Despite the existing health disparities and the incredible efforts of our programs to address these disparities, there are many instances in which federal policies or laws that were intended to improve the health of the entire American Indian and Alaska Native population inadvertently excluded urban Indian patients and providers. For example, Congress provided IHS and tribal health programs with 100% federal payment for Medicaid services provided through these health care facilities. The small omission of Urban Indian Health Programs from 100% FMAP has created significant barriers to health care for urban Indian people. Data provided by the Centers for Medicare and Medicaid Services show that inclusion of Urban Indian Health Programs in 100% federal Medicaid funding is estimated to cost somewhere in the range of only $5 million a year, but it would enable Urban Indian Health Programs to receive the significantly higher Medicaid reimbursement rate that IHS and tribal facilities receive. It would also enable urban Indian patients to receive optional Medicaid benefits – such as adult dental care – that IHS and tribal facilities can provide in certain states due to their inclusion in 100% FMAP. The challenges faced by limited IHS resources could be mitigated if Urban Indian Health Programs

were able to bill Medicaid for services not covered under the state plan, but this will only be possible if Congress passes legislation granting urban Indian health providers 100% FMAP. We urge Congress to take the lead on this issue and provide urban Indian Medicaid beneficiaries with the same opportunities for care that IHS and tribal patients enjoy.

Likewise, the Administration's determination that the definition of "Indian" in the Affordable Care Act is intended to include only members of federally-recognized tribes will have a detrimental and disproportionate impact on urban Indian communities and health providers. While Urban Indian Health Programs serve enrolled citizens from hundreds of federally recognized tribes, a significant number of our patients face obstacles to tribal enrollment, or are members of tribes that lost federal recognization as a result of the devastating federal termination policy of the 1940's. Although these American Indians and Alaska Natives are eligible to receive health care services from the IHS/Tribal/Urban health care delivery system, they will nevertheless be excluded from the American Indian exemption from the individual mandate, which requires individuals to maintain "minimum essential [health] coverage". The possibility of incurring this fine, as well as the confusion and hurt created by the different "classes" of Indian people who will be excluded from this penalty, will create extremely difficult barriers to care and frustrate our goal of increased health insurance coverage. On March 8th, HHS Secretary Kathleen Sebelius acknowledged for the first time that the Affordable Care Act must provide the benefits of health care reform to all American Indians and Alaska Natives. The Secretary has endorsed the tribal recommendation that the ACA definition be identical to the Medicaid definition of Indian – which explicitly includes urban Indians and other Native people who may not be enrolled members of federally recognized tribes. NCUIH stands with the tribes and urges, in the strongest possible terms, that Congress act quickly to ensure that the Affordable Care Act is implemented in a manner that lowers barriers to care for all American Indians and Alaska Natives.

I would like to conclude by sincerely thanking the Subcommittee for providing me with the opportunity to share our concerns with you today. In closing, I would like to emphasize that NCUIH supports the tribal recommendation for full funding of the Indian Health Service at 27.6 billion dollars, and that full funding be afforded to the Urban Indian Health line item at 231 million dollars. This shortfall in urban Indian health funding could be addressed by annual increases of only 18.8 million dollars over ten years. Further, we would like to urge you to consider extending 100% FMAP for Urban Indian Health Programs. Finally, we want to call your attention to the harmful effects of sequestration. We stand with the National Indian Health Board in calling for exemption of the Indian Health Service from sequestration and we ask the subcommittee to consider the impact of these cuts when determining IHS funding levels for FY2014 and beyond. Thank you very much for your time here today, and I would be happy to take any questions you may have.

Bio Sketch

D'Shane Barnett (Mandan/Arikara) has served as the executive director for the National Council of Urban Indian Health since January 2011. D'Shane has led NCUIH through a period of transition in which the operational budget for the organization has doubled and the organization has successfully began diversifying its funding, even during a historic national recession.

Previously, D'Shane worked at the Native American Health Center in Oakland, California, as Director of Planning & Policy, where his duties included strategic planning, fund development, public policy analysis, and community organizing. Throughout his career, he has also worked at the Inter-Tribal Council of California (Sacramento, CA) as well as the Native American Youth Association (Portland, OR).

D'Shane currently serves as Chairman of the Board of Directors for the National Native American AIDS Prevention Council and has previously served on the respective boards of directors for: California Consortium for Urban Indian Health (President); Sacramento Native American Health Center (Treasurer); and the Marin Museum of the American Indian (Treasurer).

Interior, Environment and Related Agencies

Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information, in addition to a C.V., as part of the written statement of prepared testimony submitted in advance of their appearance. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Title, Organization, Business Address, and Telephone Number:

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1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

Testifying on behalf of: National Council of Urban Indian Health

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2010?

☑ Yes ☐ No

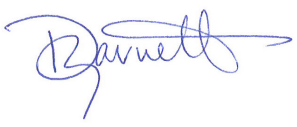
3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Grants/Contracts/Cooperative Agreements to National Council of Urban Indian Health:

HHS/Indian Health Service
- September 2011 – August 2012: $1,611,090
- September 2012 – August 2013: $1,761,578

HHS/Office of Minority Health
- September 2012 – August 2013: $200,000

HHS/Substance Abuse and Mental Health Services Administration
- September 2012 – August 2013: $57,097
- September 2012 – August 2013: $75,000

Signature: 

Date: March 14, 2013