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Testimony of Donna Keeler, President of the National Council of Urban Indian Health
House of Representatives
Appropriations Subcommittee on Interior, Environment, and Related Agencies
Native American Witness Day Hearing
March 25, 2015

Good afternoon my name is Donna Keeler, I am enrolled member of the Eastern Shoshone Tribe from the Wind River reservation in Wyoming, and I am the Executive Director of the South Dakota Urban Indian Health Clinics, and the President of the National Council of Urban Indian health. On behalf of the 37 Urban Indian Health clinics and programs, which are located in 21 states and have 43 individual sites, I am grateful to the Chairman for this opportunity to testify before the Appropriations Subcommittee.

The National Council of Urban Indian Health is disappointed that, for the fourth[1] consecutive year, the administration has rejected the tribes' recommendation for increased funding for urban Indian health[2], instead proposing a third year of funding at post-sequester funding levels.

As NCUIH has previously testified, 2010 Census data shows that 71% of all American Indians and Alaska Natives live in urban centers. Unfortunately, the President's FY2016 budget has marked the fourth straight year that funding for urban Indian health fell below 1%[3] to total Indian Health Service funding. In 2009, Congress passed a long-overdue increase to the urban Indian health line item, after a decade of neglect. All the while, the number of American Indians living in American cities has continued to grow, in part because of the high unemployment and limited opportunities on tribal lands.

In FY 2009, this Subcommittee directed the Indian Health Service to carry out a National Urban Indian Health Needs Assessment. Preliminary data from the Needs Assessment shows that the 43.6 million dollars that fund 37[4] Urban Indian Health programs meets only 18.65% of total need. The permanently reauthorized Indian Health Care Improvement Act made it a national

[1] Testimony on, 'FY 2013 Budget Request of the Indian Health Service and of the Office of the Special Trustee for American Indians" for tribal recommendation, pages 7, 12. http://democrats.naturalresources.house.gov/sites/democrats.naturalresources.house.gov/files/content/files/2012-03-06testimony_jimnavajo.pdf .

[2] The Department of Health and Human Services Fiscal Year 2014, page 14.

[3] Information accurate as based on calculation of data from FY 2014.

[4] KRC, Indian Health Care Improvement Act (IHCIA) Written Testimony of Geoffrey Roth, Executive Director National Council of Urban Indian Health before House Committee on Energy and Commerce On National Health Care Reform June 24th, 2009. http://krc.ncuih.org/details?publication_id=315

policy of the United States to address the health disparities suffered by American Indians, including those living in urban areas. Achieving meaningful progress toward this goal will be impossible without a renewed commitment to urban Indian health care.

It is important to bear in mind that 33 urban Indian health programs (UIHPs) are solely funded from a single IHS line item, and do not have access to funding appropriated to the other areas of the IHS budget. Thus, the $486 million dollar increase that the Administration has proposed for the broader Indian Health Service budget will not directly benefit Urban Indian Health programs or the Native communities they serve. The UIHPs are there to provide health care for AI/AN patients when they live in urban settings, thus helping to form a complete circle of care with tribal and IHS health providers. Fulfilling its role in the circle of care for AI/AN patients, UIHPs provide culturally competent, non-duplicative health services to more than 150,000 enrolled members of federally recognized Tribes. It is crucial that Congress direct resources to the urban Indian health line item in order to provide health care services to urban Indian patients in the face of inflation, as well as to the much needed infrastructure expansion to accommodate an ever growing population of urban AI/ANs. The estimated potential user population of the UIHP is almost 1 million people, and that's just in cities that *already have* UIHPs. To continually underfund, or potentially zero out this line item, would be detrimental to the impact that UIHPs have tirelessly worked on to address serious health disparities experienced by urbans.

All too often, Urban Indian Health programs are excluded from laws intended to benefit American Indians and improve their quality of health, because of a lack of the understanding of the history of urban Indian communities and complexity of the Indian Health Services, Tribal and Urban Indian organization programs/providers system. Lack of information and bureaucratic complexity has led to the exclusion of Urban Indian Health Programs from a number of critical protections enjoyed by IHS and tribal health providers. For example, as required by the Veterans Access, Choice, and Accountability Act of 2014, IHS and the Department of Veterans Affairs are working to jointly submit a report to Congress on the feasibility and advisability of entering into and expanding certain reimbursement agreements for costs of direct care services provided to eligible Veterans who are not American Indian or Alaska Native. Urban Indian Health Programs have had a difficult time being included at the forefront of these types of consultations. Urban programs have struggled for years without the benefit of these protections and inclusions, compounding the problem of limited appropriations and a general lack of understanding of the programs' critical role in fulfilling the Federal Trust Responsibility.

Although, Urban Indian Health has already been included in protections such as Federal Employee Health Benefit Program which allows Tribes, Tribal Employers and Urban Indian Organizations carrying out programs under either the Indian Self Determination and Education Assistance Act (ISDEAA) or Title V of the Indian Health Care Improvement Act (IHCIA) to purchase the rights and benefits of the Federal Employees Health Benefits (FEHB) Program for their employees,[5] there is much more to be done. The most urgent of these protections would be

[5] Section 10221 of the Affordable Care Act incorporated and enacted S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009, resulting in the addition of § 409 to the Indian Health Care Improvement Act (IHCIA). IHCIA § 409 (now codified at 25 U.S.C. § 1647b) allowing Tribes, Tribal Employers

the inclusion of urban programs in 100% federal match for Medicaid services - a protection already enjoyed by IHS and tribal facilities. This protection – known as 100% FMAP- would provide states with 100% of the cost of payments made to urban Indian health providers for service provided to American Indian Medicaid patients, rather than requiring the states to assume a percentage of the cost of Indian health care. While Medicaid is a complex program and my time this morning is limited, I can illustrate the importance of 100%FMAP to urban programs by recounting how our California programs lost 3.5 million dollars of Medicaid revenue per year because the state no longer included adult dental care as a reimbursable service. Because tribal health programs receive 100% FMAP, these facilities are not able to once again bill Medicaid for adult dental services. Urban Indian Health Programs, however, will not be able to receive Medicaid payment for these services, because of their exclusion from 100% FMAP. The Department of Health and Human Services has estimated that providing Urban Indian Health Programs with 100% FMAP would cost only 5 million[6] dollars each year. Fulfilling this request for 100% FMAP would require a small legislative change. NCUIH would be more than happy to work with the Subcommittee to provide additional information to assist in this effort.

Urban Indian Health programs, unlike IHS and tribal health programs are excluded from the protections of the Federal Tort Claims Act. Consequently, Urban Indian Health Programs are required to spend thousands of program dollars each year to purchase malpractice insurance for their providers. Given the extremely sparse funding that is appropriated to serve American Indians in urban centers, urban Indian health programs should not be required to spend these precious resources on insurance coverage – especially since IHS and tribal programs have long been exempted from this burden. Extending this coverage to urban Indian health programs would also require a legislative fix.

I appreciate this Subcommittee's dedication to Indian health care, and I appreciate your steadfast resolve to fulfill America's trust obligation to tribes during this era of fiscal austerity and limited resources. Urban Indian health programs are an excellent investment of federal resources, levering an average of $1.50[7] for every dollar appropriated to our line item. We would like the urban line item to be considered mandatory due to this being the only defined line item source of funding for our programs. NCUIH also respectfully asks the subcommittee to recommit itself to

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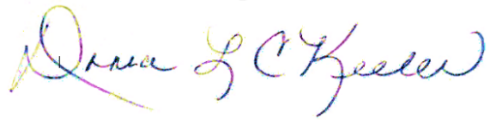
and Urban Indian Organizations carrying out programs under either under either the Indian Self Determination and Education Assistance Act (ISDEAA) or Title V of the Indian Health Care Improvement Act (IHCIA) to purchase the rights and benefits of the Federal Employees Health Benefits (FEHB) Program for their employees.

[6] Mark Merlis, "The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform." The Henry J. Kaiser Family Foundation, May 2003. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-federal-employees-health-benefits-program-program-design-recent-performance-and-implications-for-medicare-reform-report.pdf

[7] Testimony of D'Shane Barnett, Executive Director, National Council of Urban Indian Health To the U.S. House of Representatives Appropriations Subcommittee on the Interior, Environment, and Related Agencies Oversight Hearing: Indian Health, March 19, 2013. http://docs.house.gov/meetings/AP/AP06/20130319/100485/HHRG-113-AP06-Wstate-BarnettD-20130319.pdf

the success of this funding of UIHPs at rate of 284,620 million dollars. This goal could be achieved by annual increases of 23.7 million dollars over twelve years[8]. We also stand with the National Tribal Budget Formulation Workgroup's recommendation in requesting full funding of the Indian Health Service at 29.96 billion dollars. The Tribal budget formulation process does include urban participation and has for the past two years included recommendations for increases for the Urban line item ($10 million and $15 million, respectively).[9]In this same respect, we are grateful for the occasion to participate in Urban conferring opportunities (conferring letters submitted on the topics of Budget Formulation and Data Standards 12/31/14; Conferring session with IHS on 2/11/15 with Acting Director, Bob McSwain), as a tool to communicate with the federal government on specific Urban Indian health issues and concerns on our own behalf.

Thank you for the opportunity to speak, and I will be happy to take any questions you may have.



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[8] 29.96 billion (IHS Total Budget Recommendation for FY 2017) *0.95% = 289,620 million 28,620/12(years0= 23.7million a year

[9] The National Tribal Budget Formulation Workgroup's Recommendation on the Indian Health Service FY 2015 Budget, May, 2013.
http://www.nihb.org/docs/07112013/FY%202015%20IHS%20budget%20full%20report_FINAL.pdf