



**Testimony of Moke Eaglefeathers, President of the National Council of Urban
Indian Health
House of Representatives
Appropriations Subcommittee on Interior, Environment, and Related Agencies
Native American Witness Day Hearings
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Good morning. My name is Moke Eaglefeathers. On behalf of the National Council of Urban Indian Health, and the more than 100,000 American Indian and Alaska Native patients our member programs serve each year, I am grateful to the Chairman for the opportunity to testify before the Subcommittee today.

The National Council of Urban Indian Health is disappointed that, for the third consecutive year, the Administration has rejected the tribes' recommendation for increased funding for urban Indian health, instead proposing a third year of funding at post-sequester funding levels. The Administration's FY2015 budget continues the sequestration of our line item, which in two years has already cut more than four million dollars from the baseline 43 million dollar figure for urban Indian health. The President's proposed budget would actually lock-in funding cuts for urban Indian health, despite tribal recommendations and the administration's stated commitment to remedying long-standing underfunding of urban Indian health care. NCUIH strongly urges members of Congress from both parties to exempt urban American Indians and Alaska Natives from the impact of these harmful sequester cuts.

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 FY2014 budget would mark the third straight year that funding for urban Indian health fell below 1% of total Indian Health Service funding. The FY2013 budget already funds urban Indian health at only 0.95% of total IHS funding – the lowest percentage rate in the 37-year history of the program. The President's FY2014 budget request would bring urban Indian health program funding to a new historic low as a percentage of total IHS funding, at a mere 0.92%. In 2009, Congress passed a long-overdue increase to the urban Indian health line item, after a decade of neglect. Since this last increase, urban Indian health programs have actually seen appropriations decrease, even as the rest of the Indian Health Service budget has grown. 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, and the continued negative economic impact of the Great Recession.

In FY2009, this Subcommittee directed the Indian Health Service to carry out a National Urban Indian Health Needs Assessment. Preliminary data from this Needs Assessment shows that the 41 million dollars that fund 38 urban Indian health programs meets only 18.6% of total need. The permanently reauthorized Indian Health Care Improvement Act made it a national 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 urban Indian health programs are funded from a single IHS line item, and do not have access to funding appropriated to other areas of the IHS budget. Thus, the \$200 million dollar increase the Administration has proposed for the broader Indian Health Service budget will not benefit urban Indian health programs or the Native communities they serve. It is critical that Congress direct resources to the urban Indian health line item in order to provide health care services to urban Indian patients.

All too often, urban Indians health programs are excluded from laws intended to benefit American Indians and improve their quality of health, because of a lack of understanding of the history of urban Indian communities and the complexity of the Indian health delivery 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. Urban programs have struggled for years without the benefits of these protections, compounding the problem of limited appropriations amid a general lack of understanding of the programs' critical role in fulfilling the federal Trust Responsibility.

The most urgent of these protections would be 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 services 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 now 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 about 5 million 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 require a legislative change, and again, we are more than happy to provide you with any assistance you may require to achieve this long-sought goal.

I appreciate this Subcommittee's dedication to Indian health care, and I appreciate your steadfast resolve to fulfill America's trust obligations to tribes during this era of fiscal austerity and limited resources. Urban Indian health programs are an excellent investment of federal resources, leveraging an average of \$1.50 for every dollar appropriated to our line item. We are at a critical juncture in the history of urban Indian health, as the challenges of the Affordable Care Act will require us to implement program-wide improvements in accreditation, third-party billing systems, and patient care coordination in order to remain competitive. NCUIH respectfully asks the Subcommittee to recommit itself to the success of this program, and to remedy years of inadequate appropriations by providing full funding of UIHPs at a rate of 231 million dollars annually. This goal could be achieved by annual increases of 19 million dollars over ten years. We also stand with National Indian Health Board in requesting full funding of the Indian Health Service at 27.6 billion dollars.. Thank you for the opportunity to speak, and I will be happy to take any questions you may have.