Testimony of Ashley Tuomi
President Elect of the National Council of Urban Indian Health
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Appropriations Subcommittee on Interior, Environment & Related Agencies
Native American Witness Day Hearing
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Good morning my name is Ashley Tuomi, I am an enrolled member of the Confederated Tribes of Grand Ronde of Oregon and I am the Chief Executive Officer of the American Indian Health and Family Services of Southeastern Michigan, Inc., and the President Elect of the National Council of Urban Indian Health. On behalf of the 34 Urban Indian Health clinics and programs, which are located in 21 states, I am grateful for this opportunity to testify before the Appropriations Subcommittee.

As NCUIH has previously testified, 2010 Census data shows that over 75% of all American Indians and Alaska Natives live in urban centers. Unfortunately, the President's FY 2017 budget has marked the fourth straight year that funding for urban Indian health fell below 1%[1] of total Indian Health Service funding.

It is important to highlight that our 34 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 $377.4 million dollar increase that the Administration has proposed for the FY 2017 broader Indian Health Service budget does not directly provide the much needed boost to Urban Indian Health Programs or the Native communities we serve.

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 (I/T/U) Indian health system. Lack of information and bureaucratic complexity has led to the exclusion of Urban Indian Health Programs participation from a number of critical protections enjoyed by IHS and Tribal health providers. Urban programs have struggled for years

[1] Information accurate as based on calculation of data from FY 2016.

without the benefit of inclusion within legislation intended to improve the health status of all American Indians and Alaskan Natives, compounding the problem of limited appropriations and a general lack of understanding of the programs' critical role in fulfilling the Federal Trust Responsibility.

The most urgent of these provisions 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 service provided to American Indian Medicaid patients, rather than requiring the states to assume a percentage of the cost of Indian health care.

For example, as required by the Veterans Access, Choice, and Accountability Act of 2014, IHS and the Department of Veterans Affairs (VA) worked jointly to 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. According to the "Report on Enhancement of Collaboration Between the Department of Veterans Affairs and the Indian Health Service" a national Reimbursement Agreement for Direct Health Care Services was signed on December 5, 2012 between IHS and the Veterans Health Administration. Under this national agreement, VA reimburses IHS facilities for direct health care services provided to eligible Al/AN Veterans. As of January 2015, the national agreement between IHS and VA covers 108 IHS facilities, and VA has successfully negotiated 81 direct care services reimbursement agreements with Tribal Health Programs (THPs). Total reimbursements since December 5, 2012, exceeded $24 million covering over 5,500 eligible Veterans.VA does not currently have separate reimbursement agreements with UIHPs.

Urban Indian Health Programs have had a difficult time being included at the forefront of these and other types of consultations. For instance, UIHPs, unlike IHS and THPs are not under 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. Extending this coverage to Urban Indian Health Programs would also require a legislative change.

According to a data report from the IHS Office of Urban Indian Health Programs- in calendar year 2015 alone- Urban Indian Health Programs provided services to over 78,000 tribal members from 497 tribes. We are grateful for the increased backing from tribal nations. This has ushered in a new era and spirit of collaboration between Urban Indian Health Programs and Tribal governments. Specifically, we are appreciative of the Northwest Portland Area Indian Health Board and National Congress of American Indians resolutions to support Urban Indian Health Programs inclusion within the 100% FMAP. NCUIH stands with the National Tribal Budget Formulation Workgroup's recommendation in requesting the funding of UIHPs at an increased rate of 10 million dollars and full funding of the Indian Health Service at 29.96 billion dollars.

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

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