

My name is Ashley Tuomi. I am an enrolled member of the Confederated Tribes of Grand Ronde of Oregon, the CEO of American Indian Health and Family Services of Southeast Michigan, and the President of the National Council of Urban Indian Health. On behalf of 43 clinics and programs located in 21 states, I am grateful for this opportunity to once again testify before the Appropriations Subcommittee.

Urban Indian Healthcare represents culturally competent, quality healthcare clinics in urban environments across the country. Currently over 70% of American Indians and Alaska Natives live in these areas, often because of the federal government's Relocation Policy or lack of economic opportunity.

Before I ask for additional funding for FY18, I must convey our profound appreciation for the funding increase for urban Indian health care which was included in the FY17 bill, thanks to this Subcommittee's strong leadership. However, as you know, even with that increase, IHS is still significantly under-resourced, and usually funded at between 50% and 60% of need. While health care spending per capita across the nation was more than \$9,990 in 2016, IHS spending on health care per user was just \$2,834. Even with the much-appreciated FY17 increase, IHS spends little more than 1% of its budget on the provision of health care to urban Indians. In addition, Urban Indian Healthcare acquired 7 new National Institute for Alcohol Addiction programs over the past year, bringing the number of programs and clinics from 36 to 43 with a minimum budget to work with. Unlike I.H.S and tribal facilities, Urban Indian Programs can only draw from one line item for funding. Taking money from Tribes, who are also underfunded, is not the answer, as Indian Healthcare as a whole is in need of more government funding.

Last year, I discussed the need for Urban Clinics to be at 100% in regards to Federal Medical Assistance Percentage. Urban Indian Healthcare Programs were not in existence when the law giving 100% to I.H.S. and Tribes was written, but that hardly excludes Urban Programs, considering they are providing the same services and care as those that are living on reservations. Trust Responsibility extends beyond reservation borders, and failure to provide Urban Indian Health Programs with 100% FMAP harms clinics and programs. Fulfilling this 100% would reaffirm Trust Responsibility, as well as encouraging states that may feel compelled to restrict Medicaid eligibility. The cost to do this would be minimal at approximately 2.3 million per year.

One of the great programs that has helped tremendously is the Special Diabetes Program for Indians. Grants made to help this program have seen a reduction in diabetes cases, as well as subsequent healthcare costs. This program expires on September 30<sup>th</sup>, and due to its success, we would like to see it renewed. SDPI supports over 330 diabetes education, treatment, and prevention programs in 35 states. The failure to reauthorize this program would severely undermine the promising progress UIHPs have made against diabetes. American Indians and Alaska Natives are 1.6 times at higher risk of diabetes than the general population, and over the past 11 years, the program has helped to reduce End-Stage Renal Disease by 43%. ESRD is a major driver of healthcare costs, and this program will help to offset costs not only in HIS but in Medicaid and Medicare as well.

IHS and Tribal providers, as well as other comparable federal health care centers, are covered by Federal Tort Claim Act. However, Urban programs were left out and must purchase their own malpractice insurance which is costly. Two large, highly-regarded UIHPs in Oklahoma which are represented by NCUIH each pay \$250,000 per year for malpractice insurance and while this may seem unrelated to this subcommittee, it would allow programs and clinics to focus their funding on helping patients and resources.

Finally, we would ask that a Memorandum of Understanding be reached between Indian Health Services and the Division of Veterans Affairs. The DVA and I.H.S. have this with Tribes, but not with Urban Indians. Many AI/AN vets prefer using Urban Indian Programs because of accessibility and cultural reasons. There are also times when Veterans Services suffer high traffic, and Urban Indian programs can help offset this stress. After their sacrifice for this country, it's our responsibility to make sure all of our vets are taken care of. I appreciate the support the Subcommittee expressed last year when I testified, and I regret to report that our efforts to work with the agencies involved have not been successful, and that is why I am back again this year asking for your help

Thank you for your time today.