HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES
HEARING ON THE PRESIDENT'S 2015 BUDGET REQUEST

Testimony of Brandie Miranda, Treasurer, Board of Directors
Riverside-San Bernardino County Indian Health, Inc.

I am Brandie Miranda and I am a member of the Pechanga Band of Luiseno Indians and the Treasurer of the Board of Directors of Riverside-San Bernardino County Indian Health, Inc. Thank you for opportunity to testify today as you develop the 2015 appropriation for the Indian Health Service.

Riverside-San Bernardino County Indian Health is a consortium of 10 Tribes located in Riverside and San Bernardino Counties. Our member Tribes are the Pechanga Band of Luiseno Indians, the Cahuilla Band of Indians, the Santa Rosa Band of Cahuilla Indians, the Ramona Band of Cahuilla Indians, the Soboba Band of Luiseno Indians, the Torres-Martinez Desert Cahuilla Indians, the Fort Mojave Indian Tribe, the Agua-Caliente Band of Cahuilla Indians, the Morongo Band of Mission Indians, and the San Manuel Band of Mission Indians. We operate several health centers under a self-governance compact with the Indian Health Service awarded under Title V of the Indian Self-Determination Act, and provide services which include medical, dental, optical, behavioral health, pharmacy, laboratory, environmental health, Community Health representative, and nutrition—just to name a few.

We currently serve over 15,000 Native Americans and 3,000 related family members, and experience over 100,000 patient visits each year. Our two counties are among the top 10 largest geographical counties in the contiguous United States. The 10 Tribes have joined together to economically and efficiently deliver health care to our Indian people. But we also provide health care services to three other local Tribes: the Twenty-Nine Palms Band of Mission Indians, the Cabazon Band of Mission Indians, and the Augustine Band of Cahuilla Indians. Almost two-thirds of our patients come either from these other Tribes, from California Tribal members who reside in our two county service area, or other tribal members from federally recognized Tribes who live in our service area.

Given our heavy patient caseload, IHS service funds must be stretched. Congressional funding is thus vital to ensuring the health and well-being of our Native American communities, consistent with the government's overarching trust responsibility. So thank you for holding this hearing and for considering the health needs of our people as you develop next year's appropriation.

The first thing I would like to do is to thank the Committee for its hard work last year in achieving full funding for our compact with IHS. This Committee worked heroically, not just to assure that our self-governance compact was honored just like any other government contract, but to defeat the Administration's effort to cap payments to Riverside in such a way that our compact would have amounted to little more than a discretionary grant. This Committee deserves high praise from throughout Indian Country for what I am certain must have been a very difficult battle. I hope that our repeated letters to the President, to this Committee, and to key Senators helped in some small way in the work you were trying to accomplish, and we at Riverside are deeply appreciative for all that you did.

Full funding of contract support costs is truly a dream come true. For decades we have fought to have our contracts honored like other government contracts. We have longed for that ONE day when this would happen, when we would no longer have to make hard choices about which programs to keep underfunded in order to balance our books. For years we have gone without doctors, nurses, dentists, chemical dependency and mental health counselors and other health care professionals who could have been on staff or could have been contracted from the private sector to meet our patient demand. When faced with cuts due to the sequester, we thought we would be forced to eliminate our entire Outreach department, including the Nursing Director, her secretary, five public health nurses, ten patient escorts, and nine community health representatives. On top of that, we were facing having to cut an additional $400,000 of services from our behavioral health program. Fortunately, we were able to use our reserves to maintain these programs, reserves that only exist due to our prudent management of the funds IHS does provide. However, just one million dollars more in the funding that was owed each year would have permitted us to add specialty care providers in areas such as orthopedics, cardiology, or physical therapy. Now, these are difficult choices we no longer have to make. For this, we cannot thank you enough.

Despite the Committee's achievement for 2014 and beyond, we are still left fighting for justice on our past claims. Twice, now, the Supreme Court has said that IHS breached our contracts. We actually know how much IHS failed to pay us because IHS told this Committee, year in and year out, exactly how much we were underpaid in a certified contract shortfall report. Using IHS's own reports, we filed claims against IHS in the summer of 2012. Yet today, our claims are still unresolved. Worse yet, we have been forced by IHS to hire lawyers and accountants to fight the agency over how much is due—more money spent from our patient care dollars—even though IHS already knows well from its certified reports how much is due. We have had to file a lawsuit to recover these underpayments. And then, when we went to Washington last week for a settlement session, IHS cancelled the session. This is ludicrous.

For years our tribal leaders watched as the situation seemed hopeless and IHS told us we had no claims. Believing IHS, we, like most Tribes, didn't even file claims (and for most years it is now too late). But after the Supreme Court ruled a second time for the Tribes, we submitted our claims. After nearly two years, it is high time the government squared up with us—not just because we have the rights of government contractors, but because the government has a sacred trust obligation to do right by the Indian people. It is high time that the government treat us the same way they would any other federal contractor—by paying the full amount owed in a timely and just manner. It is time for IHS to stop the delay game, to live up to its legal obligations, and to do the right thing.

I agree with others who are asking this Committee to force IHS to settle up now. IHS should do this based on its certified agency shortfall reports. It should also pay up the other losses we suffered, like reduced Medicaid collections. If there are math errors in those reports, let's fix them and be done with this. But this delay game has to come to an end. With 200 Tribes out there pursuing claims, and fewer than a dozen Tribes' claims resolved in 20 months, we'll be at this for years if something doesn't change, at enormous cost to everyone—even the agency. (In fact, information available on the internet reveals that the agency is seeking to hire a bunch of new contract lawyers right now to fight our claims – they are taking health care dollars to hire lawyers!)

If the agency wants protection from having to repay these claims to Treasury, then the agency in return needs to own up to its responsibilities and settle up these claims at once. We therefore ask the Committee to insert language that will require the agency use its certified shortfall reports to resolve the claims.

Aside from contract support cost issues, Riverside also respectfully urges the Committee to extend and approve the Medicare-like rates to <u>non-hospital</u> outpatient and specialty services. According to 42 C.F.R. 136 part D, there is a cap on the rates Tribes pay for hospital services, which is limited to the amount Medicare would pay for these same services (the Medicare-like rate). However, this regulation only extends Medicare-like rates to services rendered in hospitals, including inpatient visits, overnight stays, X-rays and lab tests. These visits only represent half the picture of services; the other half includes all of the <u>non-hospital</u> visits to specialists such as Cardiologists and Dialysis providers. These non-hospital visits are paid using Contract Health Services (CHS) dollars, and these CHS programs continue to pay the full billed charges, which are often several times higher than the Medicare rates. Thus, extending the Medicare-like rate cap for these outpatient medical services would substantially reduce the costs of providing care to Native American patients. This one, non-budgetary fix would allow Riverside to stretch its limited dollars and achieve a win-win-win situation for Tribes, the patients and the federal government.

Riverside also applauds the Committee for prioritizing funding for purchased and referred care, a funding stream upon which Riverside and other California tribal providers heavily depend upon for our patients. Unlike Tribes in other States, California does not have IHS funded hospitals and specialty facilities to care for our patients. We therefore have to refer our patients to outside specialists in the private sector, and of course pay those providers for those services—as I mentioned earlier, at full billing rates. This results in a much higher level of patient dependence in California on the purchased and referred care system (formerly CHS). Thank you for continuing to prioritize increases in this area.

Last, I would like to comment on the wonderful and positive effects of the Special Diabetes Program for Indians. Diabetes is our #1 diagnosis, and there simply is not enough money in the Indian Health Service budget to adequately treat the large number of our patients who suffer from this debilitating disease. The Special Diabetes program has been very successful for our Tribes, and it has proven to be a great addition that allows us to provide more specialized diabetic care. We strongly encourage the Committee to work with other Members of Congress to see this important initiative extended and, hopefully, made permanent.

Thank you once again for the sacred opportunity to discuss our health care needs with this distinguished Committee.