HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES
HEARING ON THE PRESIDENT'S 2016 BUDGET REQUEST

Testimony of Brandie Miranda Greany, Treasurer
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I am Brandie Miranda Greany and I am a member of the Pechanga Band of Luiseno Indians and the Treasurer of Riverside-San Bernardino County Indian Health, Inc. Thank you for the opportunity to testify about the 2016 appropriations for the Indian Health Service.

Riverside-San Bernardino County Indian Health is a consortium of nine 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 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 and we are very proud of the vast array of services offered at our clinics, including medical, dental, optical, behavioral health, pharmacy, laboratory, environmental health, community health representative, and nutrition services.

We serve over 15,000 Native Americans and 3,000 related family members, and experience over 100,000 patient visits each year. Our service area includes two of the largest counties in the contiguous United States, so our member Tribes have joined together to develop a way to economically and efficiently provide health care services for our people. We also provide health care for 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 three local Tribes or from members of other non-consortium Tribes who reside in our two-county service area.

Given the number of patients we treat, our IHS dollars can only go so far. But we are thankful for the support of Congress and the funding provided to ensure our people are healthy. We also cannot thank you enough for listening to the tribal representatives that appear at these hearings to share their experiences. We were pleased that last year's appropriations signaled that Congress heard our voice and we hope you will continue to pressure IHS to honor the government's trust responsibility to provide culturally-competent and high-quality health care for Native Americans.

Mandatory CSC appropriations. Last year, I thanked the Committee for its hard work in achieving full funding for our compact with IHS. This year we have a lot more to be thankful for due to the support of this Committee. Not only did Congress's instructions to IHS ensure that

our contract support costs were paid in full, but Congress encouraged the agency to reverse the hostile position it had taken with Tribes in the past. And perhaps more importantly, the agency has committed to working with tribal leaders to develop long-term solutions to ensure our contracts are never underfunded again. We are extremely appreciative of your support and your efforts to bring about this long-overdue change.

I had hoped to report that despite extremely contentious negotiations, we were finally able to reach a settlement of our prior year claims against the agency. And while we did reach a tentative settlement with the agency back in September following several rounds of in-person negotiations, our settlement agreement has yet to be signed by the government. We are ready to put these claims behind us, so we cannot understand the cause for this seemingly endless delay in just signing our agreement.

All that said, 2014 was a truly historic year. But, our gains came at a price, because when the agency realized it had not accurately estimated the total contract support cost need for 2014, it was forced to reprogram service funds to cover its obligations. This meant that while self-governance Tribes received full contract funding for the first time ever, our brothers and sisters that receive direct services at IHS facilities faced program reductions due to IHS's faulty predictions. Tribes made clear that we wanted our contracts paid in full, but not at the expense of reducing services for other Tribes. And throughout the year of consultation on long-term solutions, Tribes made clear the way to prevent this situation was with a permanent mandatory appropriation for CSC. Only that vehicle would separate CSC payments from the IHS services budget, protecting vital program funds, while also ensuring our contracts are always paid in full. There really could be no better solution to this predicament than a mandatory appropriation.

The agency listened to tribal requests and included a proposal to move CSC to a mandatory appropriation beginning in 2017. We believe the details of the proposal could use some improvement, but the message is right on—CSC must be moved to a mandatory appropriation. The Supreme Court has already ruled that the government must fulfill its statutory and contractual obligation to pay CSC in full, so these amounts must be paid regardless of the type of appropriation. A mandatory appropriation will meet this goal and also ensure service funds are not reduced to cover this obligation.

The agency proposed a three-year appropriation, but we believe the measure should actually be permanent. A permanent appropriation would obligate the government to fund only the amounts necessary to pay the full requirement each year, and no more; however, if the appropriation has a limited duration, IHS would have to estimate the total cost to fully fund CSC each year, and like any estimates these totals will necessarily be imprecise. Erring on the high side uses more money than is necessary in a tight budget climate.

Lastly, the Administration's proposal sets aside up to 2% of the appropriation for program administration. This provision should be eliminated. The appropriation is meant to

cover CSC and provide funds for Tribes, not the agency. Additionally, if the agency adopts the instruction from Congress to simplify CSC calculations, these changes will reduce bureaucracy, eliminating the need for this set aside. Our goal is to simplify this process, not build up a large monitoring bureaucracy that requires us to devote even more administrative resources to CSC calculations, negotiations and reconciliations.

In any event, the proposal is a historic first step. And we ask this Committee to ensure this proposal becomes law—a law that will complete the fight for CSC that Tribes have been waging for decades.

Medicare-like rates for outpatient services. Our IHS dollars can only go so far. However, they would go much farther if we were able to pay Medicare-like rates through the Purchased and Referred Care program (contract care) for the non-hospital outpatient and specialty services our patients need and that we are unable to provide in our clinics. The regulation at 42 C.F.R. 136 part D limits the amounts Tribes pay for hospital services to the amount Medicare would pay for these same services (the Medicare-like rate provision). For years, Tribes have been fighting for the implementation of a similar provision that covers outpatient services—the other half of the services we must send patients out to access, such as cardiology, pain management, nephrology, endocrinology and dialysis. Without such a provision, our contract care dollars are drained to pay the full billed charges, which are often several times higher than the Medicare rates.

Congress can fix this issue. Congress has already done so for the health programs administered by the Department of Defense, and the Department of Veterans Affairs issued a final rule to limit the amount its health programs pay for comparable services. Similarly, this past year IHS proposed a regulation to try and fix this issue and extend Medicare-like rates for outpatient services. However, IHS's proposal—while better than nothing—had some issues. First, the proposed regulation was mandatory, meaning it may interfere with contracts that Tribes have already negotiated. Second, the proposal did not have any flexibility, so Tribes could never negotiate a higher rate in case of emergency or the absence of providers willing to provide services at these lower rates. While we truly appreciate the agency's willingness to tackle this issue in response to tribal concerns, we believe a legislative fix is necessary because only legislation can address the enforcement mechanisms that will be needed to implement this reform.

In summary, a provision to extend Medicare-like rates for all contracted services could increase tribal buying power between an estimated $100 million to $340 million nationwide. For our program alone, access to Medicare-like rates for our outpatient referrals would save us on average 33% of the charges we are currently billed—an amount which would translate into approximately $500,000 in savings each year that could be used for additional health care. This legislation would expand and enhance tribal access to care and improve the health status of all

served. It is therefore no surprise that support for this legislation has been affirmed by a variety of organizations that are familiar with our programs, including the IHS California Area Office; National Congress of American Indians; National Indian Health Board and the IHS Office of Tribal Self Governance. We also note this change would be "budget neutral" to the federal government, so we ask you to take action on this measure as swiftly as possible.

YRTC Funding. The IHS 2016 budget includes $17.8 million for staffing and operating costs for newly-constructed facilities and Youth Regional Treatment Centers (YRTC). In 2014, the California Area Office finally started construction on the Southern California YRTC. That construction is scheduled to be completed in December 2015, so full funding for FY 2016 staffing needs are essential to ensure the facility opens on time and can serve a maximum number of patients. Additionally, the agency plans to start construction of the Northern California YRTC and this facility, too, will need funds for staffing and operation. Together, these facilities will provide much-needed care for our Native youth.

For example, when our Native children need this care we currently have to send them out-of-state for intensive care services. These programs are costly and we pay up to $10,000 per month for these intensive care services. Even worse, our families are forced to travel long distances to places like St. George, Utah for family visits. Large distances also impact the continuity of care because there are few opportunities for medical providers and families to interact on an ongoing basis. The California YRTCs will provide these crucial services locally in an environment where families and children can work together. These opportunities will allow the whole family to heal together.

For instance, the California YRTCs will provide residential chemical dependency treatment for Native youth from 12 to 17. Each facility offers comprehensive three to four month treatment programs, which incorporate mental health services, medical care, education, aftercare planning, and family therapy. They are also designed to respond to the unique cultural needs of our youth. These facilities will be critical for treating youth that are struggling, ensuring they can get back on track and lead healthy productive lives as adults. But, our new facilities will be meaningless without the talented professionals that will be needed to staff them. Therefore, we ask that Congress fully fund this line item and ensure our YRTCs live up to their potential.

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Thank you once again for the opportunity to appear in front of this distinguished Committee and share our concerns.