Testimony, House Appropriations Subcommittee on Interior and Related Agencies

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Good afternoon, Chairman and Committee members. My name is Mark LeBeau and I am CRIHB's Executive Director. Thank you for giving CRIHB the opportunity to testify about funding of the Indian Health Service. Standing in the shoes of the IHS, as authorized by the Indian Self Determination, Education, and Assistance Act, CRIHB provides health care services and technical assistance to eleven member tribal health programs. Our work is sanctioned by thirty federally recognized tribes.

CRIHB was founded in 1969 to bring federally funded health care services back to rural tribal communities in California. These services were withdrawn as a result of federal termination practices that began in the 1950's. Before CRIHB was established, many Indians in rural areas had no access to medical or dental services and child and maternal mortality rates were abysmal. Since CRIHB was founded, California tribes have built a network of 32 tribal health programs and serve more than 80,000 users. While our health has improved and our population is growing, we still face some of the worst health inequities of any underserved population in the United States. Here are our requests.

1. First, fund the Indian Health Service at or above the level proposed by the Administration, $5.1 billion. We appreciate that this is a $460 million increase from FY2015 but we are concerned that a large part of the increase will go toward contract support costs, shorting healthcare services line items. The healthcare services line items are still not fully recovered from sequestration. It is important to note that tribal health organizations have calculated that IHS needs over $18 billion to bring this system up to par with other comparable health delivery systems.

2. Second, we ask that you fund IHS Facilities Maintenance and Improvement in the amount of $105 million. This line item has flat-lined for many years at around $54 million despite the fact that millions of square feet of facility space have entered the IHS Facility Inventory during that same period. While the Administration has requested $89 million, this is not enough to maintain the national investment of millions of dollars of federal and tribal construction funding. In California this funding is critically important because despite many years of trying and more than 50 applications, no tribal health clinic or hospital facility has ever made it onto the IHS Facility Construction Priority List. As a result, tribes in California, a state with more American Indians and Alaska Natives and more federally recognized tribes than any other, have cobbled together funding and taken out loans in order to build health facilities for a growing population. If M&I funding is increased, our share will go a long way to help maintain and improve these tribal health clinics. We can do a lot with a little funding.

3. Third, a professional and objective reevaluation of the IHS Facilities Construction Priority system, which has not been substantially revised since 1991, is long overdue. The

current list creates a one billion dollar backlog that will prevent applications for new facilities for the next fifteen to twenty years. Most of the listed facilities would provide inpatient care that today is provided as outpatient care everywhere else.

4. Fourth, CRIHB has testified before about lack of fundamental fairness in IHS allocation of Contract Health Services, now referred to as Purchased/Referred Care. This inequity has resulted in compromised care for our service population. It has been documented in numerous Government Accountability Office reports, the most recent from June 2012. The foundation of the allocation method, the use of "base funding," is not tied to any measure of actual need. Instead it is based on what a given program received the year before.

   After reviewing CHS funding, the GAO wrote, "IHS's continued use of the base funding methodology undermines the equitable allocation of IHS funding to meet the health care needs of American Indians and Alaska Natives." (Id. p. 24).

   This inequity is compounded by a lack of access to the Catastrophic Health Emergency Fund (CHEF). The CHEF fund may only be accessed when care for a single episode of care for a patient exceeds a threshold of $25,000. This threshold is not as difficult for tribal health programs with access to an IHS-funded hospital to meet. Unfortunately, because California tribal health programs are grossly underfunded and "under-facilitied" to start with, it is almost impossible for California's tribal health programs to meet the spending threshold to access the fund.

   Today CRIHB asks Congress to require IHS to develop and use a new and equitable method to allocate all CHS program funds to account for variations across areas. We also agree with GAO that IHS should be required to use actual counts of CHS users in methods for allocating funding.

5. Last, we ask you to continue to support funding for the two Youth Regional Treatment Centers in California. This includes staffing for the Southern California Youth Regional Treatment Center, which is being built in Hemet, California and for the next phase of the Northern California Youth Regional Treatment Center in Davis, California. Both of these items are funded in the Administration's FY2016 budget. Culturally appropriate treatment that is close to home is critically important in treating American Indian youth. There is mounting evidence that nothing else works. In light of the crisis-level statistics on suicide and substance abuse among native youth, this project continues to be critically important to our children, our families, our communities, and our tribal governments.

   In conclusion, on behalf of CRIHB, thank you for your continued support of the YRTCs. We ask that IHS appropriations be increased to more fully fund direct services and programs. We ask that IHS Facilities M&I be increased to catch up with the amount of facility space in the IHS Facilities Inventory, including the California IHS Area. We also ask you to direct IHS to obtain an objective outside assessment of the IHS Facilities Construction Priority List and determine whether this program is being conducted in an equitable manner. We also ask that you make IHS accountable for inequities in CHS that

hobble our efforts to provide the level of care other IHS areas provide. It has to be rational, clear, and based on data.

Thank you. I am happy to answer any questions.