Testimony, House Appropriations Subcommittee on Interior and Related Agencies
March 17, 2016

Mark LeBeau, PhD, MS
California Rural Indian Health Board CEO

Good morning, Chairman and Committee members. My name is Mark LeBeau and I am the Chief Executive Officer at the California Rural Indian Health Board. Thank you for giving the California Rural Indian Health Board the opportunity to testify about funding of the Indian Health Service. As authorized by the Indian Self Determination, Education, and Assistance Act, the California Rural Indian Health Board provides health care services and support to twelve member tribal health programs. Our work is sanctioned by thirty-three federally recognized California tribes.

The California Rural Indian Health Board was founded in 1969 to bring federally funded health services back to tribal communities in California. These services were withdrawn as a result of federal termination practices that began in the 1950s. As results of these termination practices, many American Indians in rural areas had no access to medical or dental services and child and maternal mortality rates were abysmal. Since the California Rural Indian Health Board was founded, California tribes have built a network of 32 tribal health programs and serve more than 80,000 patients who are eligible for Indian Health Service services. 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. According to the Kaiser Family Foundation, American Indians and Alaska Natives are significantly more likely to report being overweight or obese, having diabetes or cardiovascular disease and experiencing frequent mental distress than other populations[1]. Here are our requests:

1. First, we respectfully request that the committee fully fund the Indian Health Service at $30 billion, which is national Budget Formulation Workgroup’s calculation of unmet need in the tribal healthcare system. We appreciate that the Administration’s proposal of $6.6 billion is a $402 million increase from FY2016. The treaties entered into between the tribes and the federal government establish a responsibility for the federal government to provide health care to tribes and American Indians/Alaska Natives. It is a trust responsibility of the federal government to uphold their part of the treaties and provide these services in order to serve our diverse American Indians/Alaska Native population. In light of this, we believe that the Indian Health Service should be fully funded. In 2015, the Indian Health Service per capital expenditures for patient health services were just $3,136 compared to $8,517 per person for health care spending nationally. Conditions at the Indian Health Service have been referred to as “in a state of emergency” and these conditions need to improve immediately. For these reasons, we request full funding of the Indian Health Service at $30 billion, which would meet the calculated unmet need in the tribal healthcare system.

[1] Kaiser Commission on Medicaid and the Uninsured analysis of the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2011

2. Second, we respectfully request that the committee fund the Indian Health Service Facilities Maintenance and Improvement funding in the amount of $105 million. This line item previously flat-lined for many years at around $54 million despite the fact that millions of square feet of facility space have entered the Indian Health Service Facility Inventory during that same period. Even with recent increases to this funding that raised the amount to $74 million, we believe work still needs to be done on this issue. Furthermore, we believe that the $3 million increase proposed by the Administration is still 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 Indian Health Service Facility Construction Priority List. As a result, tribes in California, a state with more American Indian/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 Maintenance and Improvement 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, we request that the committee support a professional and objective reevaluation of the Indian Health Service Facilities Construction Priority system, which has not been substantially revised since 1991. The current list creates a one billion dollar backlog that will prevent applications for new facilities for the next fifteen to twenty years. It is important to note that there are no California tribal health facilities on the Indian Health Service priority list. Most of the listed facilities would provide inpatient care that today is provided as outpatient care everywhere else. Many clinics in California are in serious need of repair and/or are too small to meet the growing need. Access to care in California is a significant problem, whereas the Phoenix Area receives significant facilities dollars for facility construction. However, the Phoenix Area has immediate access to the largest Indian hospital in the country.

4. Fourth, the California Rural Indian Health Board has testified before about lack of fundamental fairness in Indian Health Service allocation of program funding. This inequity has resulted in compromised care for our service population. It has been documented in numerous Government Accountability Office reports, including the 2012 report on Purchased/Referred Care. 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. Many tribal health programs in California strongly recommend receiving the maximum Purchased/Referred Care funding afforded to them through existing law and all steps in the current formula.

   Today the California Rural Indian Health Board asks the committee to fund the tier 2 step in the allocation formula taking into consideration the expanded population of American Indian/Alaska Natives in California and the cost of medical inflation. When these costs are factored for the California Indian Health Service Area, there are a significant number of American Indian/Alaska Natives who should be eligible for Purchased/Referred Care. The tribal clinics haven't been able to keep up with medical inflation costs on their own

and we believe that is part of the federal governments trust responsibility to provide this support.

Additionally, Medicaid estate recovery has been mentioned as a likely barrier to Purchased/Referred Care funds. Federal law requires California to recoup costs of Medi-Cal patients who utilized long-term care services by filing claims against patients' estates. Although current federal law exempts certain kinds of Indian property, including trust and reservation land, from estate recovery, many forms of property owned by American Indians/Alaska Natives are not exempt. Because this has been identified as an obstacle to enrollment in health coverage, tribal health advocates are working to achieve a broader exemption from Medi-Cal estate recovery for all American Indian/Alaska Native property. If individuals do not apply for Medicaid because they are concerned about estate recovery, those individuals may also lose out in accessing Purchased/Referred Care funds since it is the payer of last resort. In light of this, we respectfully request the committee recommend the Center for Medicaid and Medicare Services provide an exemption for American Indian/Alaska Natives who participate in long-term care services. We believe the federal trust responsibility needs to be extended to these American Indians/Alaska Natives.

5. The California Rural Indian Health Board respectfully requests the committee provide an additional $50 million in funding for the Special Diabetes Program for Indians and also to fully fund the Methamphetamine Suicide Prevention Initiative and the Domestic Violence Prevention Initiative. These three programs are Congressionally-appropriated demonstration pilot projects, which are currently funded through a competitive grant process. This competitive grant process creates barriers to care and requires tribal programs to fight against each other for critical funding. We know that diabetes, suicide, drug use and domestic violence are more prevalent among the American Indian/Alaska Native populations in comparison to other races and these funds are critical for tribal health programs to serve their populations that are in such need. The health disparities that exist in our community require permanent funding for these programs.

6. We respectfully request the committee support funding for California tribal health programs to create a tribal drug Medi-Cal delivery system. Specifically, we ask the committee to request the Centers for Medicaid and Medicare Services and the U.S. Department of Health and Human Services to support the implementation of the tribal drug Medi-Cal delivery system including initial funding for the administration and set up of the program. Managed care implementation has created many difficult challenges for tribal health programs in California, as has the delegation of behavioral health authority to the counties. Tribes, tribal clinics, and the California Rural Indian Health Board ask for your support for funding to support tribal health and Indian Health Service programming and specifically funding for the Drug Medi-Cal delivery system as allowed through the Federal waiver process. We ask you to support this program to allow tribal health programs to provide these services. We ask for your support to recognize tribal healthcare delivery systems within individual states. Significant barriers can widely vary between the same federal provisions within different state oversight and we need your help to implement this important system.

In conclusion, on behalf of the California Rural Indian Health Board, thank you for your continued support of the California Indian Youth Regional Treatment Centers. Your support will assist Indian youth with their recovery journey and help to strengthen American Indian/Alaska Native communities. We ask that the Indian Health Service appropriations be increased to more fully fund direct services and programs. We ask that Indian Health Service Facilities M&I be increased to catch up with the amount of facility space in the Indian Health Service Facilities Inventory, including the California Indian Health Service Area. We also ask you to direct the Indian Health Service to obtain an objective outside assessment of the Indian Health Service Facilities Construction Priority List and determine whether this program is being conducted in an equitable manner. We also ask that you make the Indian Health Service accountable for inequities in Indian Health Service funding throughout its system because it continues to impede our efforts to provide the level of care other Indian Health Service areas provide. Lastly, we request full funding and permanent authorization for the three existing demonstration projects in our community as well as funding for the Drug Medi-Cal delivery system. Thank you.