U.S. House of Representatives Committee on Appropriations
Subcommittee on Interior, Environment, and Related Agencies
Testimony of Lisa Elgin, Board Chair for the California Rural Indian Health Board
May 16, 2017

Good morning, Chairman and Committee members. My name is Lisa Elgin and I am the Board Chair of the California Rural Indian Health Board (CRIHB). Thank you for giving CRIHB the opportunity to testify about funding of the Indian Health Service. As authorized by the Indian Self Determination, Education, and Assistance Act (ISDEAA), CRIHB is authorized to provide ISDEAA services to seven Public Law 93-638 contracted Tribal Health Programs (THPs), with another five THPs as associate members. CRIHB serves twenty-six tribes under the ISDEAA contract, with an additional seven other tribes as associate members.

CRIHB 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 These services were withdrawn as a result of federal termination practices that began in the 1950s.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 a result 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 CRIHB was founded, California tribes have built a network of 32 THPs and serve more than 80,000 patients who are eligible for Indian Health Service (IHS) 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 (AI/ANs) are significantly more likely to report being overweight or obese, having diabetes or cardiovascular disease and experiencing frequent mental distress than other populations[1]. Additionally, according to the UCLA Center for Health Policy Research, those who self-report California tribal heritage are twice as likely to have been diagnosed with diabetes as individuals from tribes outside of California (31% versus 16%).[2] Here are our requests:

1. First, we respectfully request that the Committee **fully fund the IHS and ensure that the California IHS Area receives equitable funding, regardless of the overall funding level received by the IHS**. It is evident from numerous Government Accountability Office (GAO) reports and current funding levels that California does not receive equitable funding, despite having more AI/ANs and more federally recognized tribes than any other state. During the last several years, bipartisan collaboration between Congress and the Administration has resulted in a noticeable overall increase for the total IHS budget of 53% since FY 2008, sadly however, this has only resulted in a slight increase in the IHS services portion of the budget. Year after year, the federal government has failed AI/ANs by drastically underfunding the IHS far below the demonstrated need. 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 AI/ANs. The federal government has a legal, moral, and trust responsibility to uphold its part of the treaties and provide these services in order to serve our diverse AI/AN population. In light of this, it is clear that the IHS should be fully funded. In 2015, the

[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] UCLA Center for Health Policy Research. (2012). *American Indian and Alaska Native Diabetes: Critical Information for Researchers and Policy-Makers.*

IHS per capita expenditures for patient health services were just $3,136 compared to $8,517 per person for health care spending nationally. Conditions at the IHS have been referred to as being "in a state of emergency" and the Government Accountability Office has released reports on the IHS's high-risk status, which I will discuss next. For these reasons, we request full funding of the IHS at $30.8 billion, phased in over 12 years. This is the amount calculated by tribal leaders on the national Tribal Budget Formulation Workgroup of the IHS, representing all twelve IHS Areas, to develop the national IHS budget recommendations for the FY 2018 budget year. Funding IHS at $7.1 billion in FY 2018 will instill trust in Indian leadership that the recent gains we have made are real, and that we are truly working together to build a more equitable and quality-driven Indian health system.

2. We request that the Committee do everything in its power to **have all Government Accountability Office (GAO) recommendations related to Indian health care acted upon, particularly those recommendations related to ensuring equitable funding to underfunded Areas like California**. The GAO High-Risk Series report (GAO-17-317) published in February of this year added the "Management of Federal Programs That Serve Tribes and Their Members" to the GAO's High Risk List. The report details how the IHS has ineffectively administered Indian health care programs. In the past 6 years, the GAO has made 14 recommendations related to Indian health care that remain open. On page 204 of the High-Risk Series Report, it reads:

   > It is critical that Congress maintain its focus on improving the effectiveness with which federal agencies meet their responsibilities to serve tribes and their members. Since 2013, we testified at 6 hearings to address significant weaknesses we found in the federal management of programs that serve tribes and their members. *Sustained congressional attention to these issues will highlight the challenges discussed here and could facilitate federal actions to improve Indian . . . health care programs.* (Emphasis added.)

3. We ask that the Committee **increase funding of the IHS Facilities Maintenance and Improvement (M&I) program** to catch up with the amount of facility space in the IHS Facilities Inventory, including the California IHS Area. We respectfully request that the committee fund the IHS Facilities M&I 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 IHS 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. A national investment in federal and tribal construction funding is necessary. In California this funding is critically important because despite many years of trying and more than fifty applications, no tribal health clinic or hospital facility has ever made it onto the IHS Facility Construction Priority List nor Joint Venture program list. As a result, tribes in California 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.

4. We ask that the **Committee request a GAO report on the IHS Facilities Construction Priority system**, which has not been substantially revised since 1991. The 2016 IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress was delivered in July 2016. On page 19 of the Report, it states:
   a. The cost to increase IHS facilities to needed capacity is enormous, about $14.5 billion with expanded and active authority facility types.
   b. To maintain overall capacity at the current fraction of needed capacity (~52 percent) would require more than $300 million annually.
   c. In 2015, only two-thirds of the 1993 facility priority list is complete. At this pace, even that sub-set will not be completed until 2041.

   On page 3 of the Report, it states that at the current rate of Health Care Facility Construction (HCFC) appropriations and existing replacement rate, a new 2016 facility would not be replaced for 400 years. The current list creates a backlog that will prevent applications for new facilities for decades. It is important to note that there are no California tribal health facilities on the IHS priority list. (The Ft. Yuma, CA facility is in the Phoenix Area.) 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 other Areas receive significant facilities dollars for facility construction even though patients have immediate access to the large Indian hospitals. A professional and objective report by the GAO is needed to reevaluate the IHS Facility Construction Priority System.

5. We ask for your **support of the Special Diabetes Program for Indians Reauthorization Act of 2017 (S.747)**. The current authorization for the Special Diabetes Program for Indians (SDPI) ends September 30, 2017, so swift Congressional action is needed for continuity in staffing, medical supplies, prevention and education services, and other SDPI-related treatment efforts. SDPI is saving lives. The longer renewal in S.747 is critical to ensuring programmatic stabilization for Tribal communities when it comes to diabetes treatment and prevention. We are also pleased that S.747 would provide annual increases based on medical inflation. This would assist THPs keep up with the basic level of need for diabetes treatment equipment and services.

6. We ask that you support AI/AN mental health and substance abuse programs by **fully funding the Methamphetamine Suicide Prevention Initiative and the Domestic Violence Prevention Initiative**. These programs are currently funded through a competitive grant process that creates barriers to care and requires tribal programs to fight against each other for critical funding. We know that suicide, drug use and domestic violence are more prevalent among AI/ANs in comparison to other races and these funds are critical for THPs to serve their populations that are in such need. The health disparities that exist in our community require permanent funding for these programs. We also 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 AI/AN communities.

7. We ask the Committee to **ensure that the IHS Memorandum of Agreement (IHS-MOA) rate is not capped**. The 1996 memorandum of agreement between the federal Health Care

Financing Administration (now the Centers for Medicaid and Medicare Services (CMS)) and IHS provides that the IHS-MOA rate is negotiated annually between IHS and CMS, then approved by the Office of Management and Budget (OMB) before being published in the Federal Register. The IHS-MOA rate our THPs receive is an outpatient, per-visit rate that includes all on-site laboratory and X-ray services, as well as all medical supplies incidental to that visit. During the 2017 IHS California Area Office consultation with IHS headquarters officials in Sparks, Nevada, IHS indicated that the federal government may begin reviewing a change to the IHS-MOA rate, with a focus on reducing or capping the rate. A cut to or cap on the rate would negatively impact Tribal clinic care and the health of our patients. The ability for THPs to bill Medicaid is particularly important for California, as there are no IHS clinics or hospitals and THPs clinics lack the availability of no-cost ancillary and specialty services. The methodologies used to calculate the rate are not published or circulated. California THPs rely on the IHS-MOA rate to assist them in providing basic, needed health care services to their direct care clients and to augment their IHS funding. A reduction in the IHS-MOA rate will result in the THPs having to reduce the services provided to their clients.

8. Finally, we ask that the Committee **consider requiring IHS to develop and use a new method to allocate Purchased/Referred Care (PRC) funds to account for variations across IHS Areas**. CRIHB has testified before about lack of fundamental fairness in IHS allocation of program funding. 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 THPs in California strongly recommend receiving the maximum PRC funding afforded to them through existing law and all steps in the current formula. In the GAO-17-317 report on page 211, the GAO recalls its June 2012 finding that IHS had taken few steps to evaluate variations in the funds it allocates for the PRC program, which varied from $299 to $801 per capita across the 12 IHS Areas in fiscal year 2010. Additionally the report reads:

> IHS does not know the origin of the base funding formula, which, according to IHS officials, has existed since the 1930s and accounted for 82 percent of the funds allocated to the area offices that year. Annual adjustments for population growth and inflation are made as a percentage of base funding and are the same across all areas. Additional program increases are not large enough to alter funding variations because these additional increases have been a relatively small proportion of PRC funds that area offices receive. Because IHS continues to use this methodology, it cannot equitably allocate funds to meet the health care needs of Indians. In order to ensure IHS equitably allocates PRC funds, the GAO recommended that Congress consider requiring IHS to develop and use a new method to allocate funds to account for variations across areas.

In conclusion, on behalf of the California Rural Indian Health Board, I ask that the IHS appropriations be increased to fully fund its services and programs over the next 12 years and that you hold the IHS accountable for inequities in its funding distribution because it continues to impede our efforts to provide the level of care other IHS Areas provide. Thank you.