HOUSE COMMITTEE ON APPROPRIATIONS SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES

HEARING ON THE PRESIDENT'S 2018 BUDGET REQUEST

Testimony of Mark Jensen, Chief Financial Officer
Riverside-San Bernardino County Indian Health, Inc.

I am Mark Jensen and I am the Chief Financial Officer for Riverside-San Bernardino County Indian Health, Inc. located in Southern California. Thank you for the opportunity to testify about the 2018 appropriations for the Indian Health Service.

Riverside-San Bernardino County Indian Health, Inc. is a consortium of nine California 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 also serve members of 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. Nearly two-thirds of our patient population is comprised of members from these local Tribes or other non-consortium Tribes who live in our two-county service area. Overall, we serve over 15,000 Native Americans and 3,000 related family members, and experience over 100,000 patient visits each year.

Our consortium operates 7 health clinics at different locations under a self-governance compact with the Indian Health Service. We are proud to offer a broad range of services at our clinics, including medical, dental, optical, behavioral health, pharmacy, laboratory, environmental health, community health representative, outreach and health education services.

We are thankful for the support of Congress and the funding provided to improve the health status of our people. We are especially thankful for your invitation to return each year to share our experiences as you weigh the coming year's funding decisions. In doing so you honor the Nation-to-Nation relationship between the federal government and Indian tribes. Thank you for taking so seriously IHS's mission to honor the government's trust responsibility to provide culturally-competent and high-quality health care for all Native Americans.

Ensuring Funds for Tribally-Operated Programs

This Committee has been a steady supporter of tribally-operated health care programs because tribally-driven health care works. The success of the IHS self-governance and self-determination contracting programs shows the monumental impacts Tribes have when they are able to take control of the health care system serving their members. Indeed, the programs that struggle the most in the IHS system are, unfortunately, those that are still operated by IHS.

Despite the advances achieved through tribal self-determination, history teaches that when budgets stay flat or drop, health care suffers—as occurred with the 2013 sequester. The same can happen when budget increases go to bureaucratic oversight or special IHS projects that never filter down to Tribes. This is the case with the Joint Venture Construction Program, which provides a boon for a few individual sites but provides no benefit to other Tribes. For example, California Tribes have submitted 50 applications to the Program over the past 10 years, but only 1 has been granted. In addition, there are no Capital Projects for any of the California Tribes on the National IHS Capital Project List. While we do not doubt that these projects are highly deserving, we ask the Committee to ensure that general health care increases are not ignored.

Budgetary instability, coupled with excessive bureaucracy, is also a problem when IHS chooses to classify funds as "non-recurring," including as "grant" funds. This designation forces Tribes to compete with one another and injects budgetary uncertainty from year to year. Worse yet, the unnecessary designation of funds as "grants" forces us to follow an entirely separate award process and reporting mechanism whose only purpose seems to be to keep grant administrators employed. As this Committee knows, the Methamphetamine and Suicide Prevention Initiative (now called the "Substance Abuse and Suicide Prevention program") and Domestic Violence Prevention Initiative funds used to flow easily through our Self-Governance Compact. But 4 years ago former IHS Director Yvette Roubideaux unilaterally changed that nicely-working process, without any consultation and over tribal objections. Now we work under extremely burdensome reporting conditions, IHS carves aside funds for bureaucratic oversight, and we too are forced to carve out funds to meet new administrative burdens instead of serving our community. Even desperately needed Special Diabetes funds are set aside to fund Area diabetes coordinators who do nothing to enhance our programs on the ground.

We have seen a pattern in recent years where IHS reclassifies funds previously considered to be annually "recurring" monies, into the "non-recurring" categories. At first, IHS claimed this was necessary to provide full contract support cost funding in 2014 and 2015, which made no sense. But even long after Congress eased the burden on program funding by moving contract support costs into a separate appropriation, the agency continues its practice. The result is IHS seizes greater discretion over how it spends these funds to the detriment of the Tribes. As a result, tribal budgets cannot grow to meet the increased needs of our members or even to keep pace with our expanding population. Worse yet, IHS denies us the contract support costs to which we are entitled to administer these funds, forcing us to divert more program dollars away from services.

We ask this Committee to instruct IHS (1) to restore funds moved from the recurring to non-recurring category, (2) to direct that these and new funds shall be distributed as "tribal shares" through self-governance compacts and self-determination contracts (and not through grants or other non-recurring funding mechanisms), and (3) to direct IHS to pay contract support costs on these funds. This is especially important given Congress's removal this year of the "notwithstanding" clause IHS had relied upon to argue that these funds were not subject to the requirements of the Indian Self-Determination and Education Assistance Act (ISDA). The ISDA

works; much of IHS's bureaucracy does not. IHS should not be permitted to undermine the ISDA—the best thing Congress ever did to improve the state of Indian health.

PRC Funding Formulas that Account for Geographic Need

We are grateful that the Committee recognizes that "IHS does not provide the same health services in each area" and that "[h]ealth services provided to a community depend upon the facilities and services available in the local area . . . ." House Committee Report on Dep't of the Interior, Environment and Related Agencies Appropriations Act, 2017, H.R. REP. NO. , Division G, at *54, *available at* https://rules.house.gov/sites/republicans.rules.house.gov/files/115/OMNI/DIVISION%20G%20-%20INT%20SOM%20FY17%20OCR.pdf. We in California have never had access to a tribal hospital and we lack access to the specialty services that come when such facilities are available in other IHS Areas. As a result, we spend far more dollars than we receive for Purchased/Referred Care (PRC) because we must refer our patients to a private provider for specialty care instead of, for example, sending them to an IHS funded facility as exists in Phoenix or Anchorage.

The IHS PRC distribution formula needs to be adjusted to address this location factor, so it favors Areas where tribal and IHS specialty providers and hospitals simply do not exist. Today IHS uses a 3-tier system: Tier 1 is base PRC funding based on the prior year's allocation, and Tier 2 is for medical inflation and population growth. Although Tier 3 is for Areas lacking hospitals and for cost of living adjustments, in 7 of the last 15 years Tier 3 was never reached.

We ask that the "no access to hospitals" factor be moved to the Tier 2 allocation category so that programs lacking access are not disproportionately impacted by PRC shortages. Two GAO reports have also recommended similar changes to make the formula more equitable.

Exempt IHS Funds from Any Block Grant Proposals

We understand that many health reform proposals being considered in Congress would transform the Medicare and Medicaid payments for tribal health providers, or turn these programs and federal grant programs into block grants to be provided to individual States. Our Tribes are sovereign and have a Nation-to-Nation relationship with the Federal government. No State should be placed in the middle of that relationship. Health reform funds for tribal programs must be exempt from any block grants made to States.

Reauthorize the Special Diabetes Program for Indians

Our patient population has a high incidence of diabetes and the Special Diabetes Program for Indians has been a great success for our organization. That said, this funding has consistently been in jeopardy due to the need for annual or bi-annual reauthorizations and separate appropriations. The Special Diabetes initiative has been one of the most successful of all Indian health programs. We therefore ask Congress to make the next reauthorization permanent and to increase the annual amount to $200 million.

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We thank you for your time and consideration. The needs of the Indian health system are great, but Tribes have proven they can efficiently maximize the resources provided. We ask that you continue to increase funds for the IHS budget so that Native Americans one day will receive the same quality health care afforded to all other Americans.