**U.S. House of Representatives Committee on Appropriations**
**Subcommittee on Interior, Environment, and Related Agencies**
**Testimony of Mark LeBeau, Chief Executive Officer for the**
**California Rural Indian Health Board**
**May 9, 2018**

Good morning, Chairman and Committee members. My name is Mark LeBeau and I am the Chief Executive Officer 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 eight Public Law 93-638 contracted Tribal Health Programs (THPs), with another seven THPs as associate members. CRIHB serves twenty-seven Tribes under the ISDEAA contract, with an additional seventeen other Tribes as associate members.

CRIHB was founded in 1969 to assist in bringing 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 These services were withdrawn as a result of federal termination practices that began in the 1950s.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 (AIANs) 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]

I thank the committee for supporting the IHS budget receiving an increase of $500 million (10%) over the Fiscal Year 2017 enacted level through the 2018 Consolidated Appropriations Act (H.R. 1625). This funding will definitely assist in providing necessary healthcare to AIANs. While the total amount for IHS in 2018 is $5.5 billion, $15 billion or more is needed to meet the overall costs. I also thank the committee for supporting $50 million for Tribes and Tribal organizations in the legislation to respond to the opioid crises that is plaguing Indian Country.

As part of this hearing, here are our current requests:

1. First, we respectfully request that the Committee do everything in its power to **ensure the California Indian Health Service (CA IHS) Area receives equitable construction and facility support funding**. This can be accomplished by, among other methods, including language in the infrastructure bill that provides such equity for Areas that are rarely serviced by the IHS. Language in the bill including forgiveness or absorption of federal loans when

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[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*.

Tribal clinics are built or purchased in California will help provide equity to Tribes. Another way to achieve this would be to increase the Small Ambulatory construction program funding, directing the IHS to lift its $2 million dollar cap on each project.

A national investment in federal and Tribal construction funding is necessary. The CA IHS Area has received zero funding from the IHS Health Care Facilities Construction Priority program. The IHS has built 10 hospitals, 25 health centers, and 11 housing projects for healthcare staff to live in in Areas other than California. The IHS has only funded one Joint Venture Construction Program staffing project in California; the other 18 awardees are located in other Areas. These two IHS programs have provided substantial construction and facility support funding to a number of Areas other than California since 1993. As a result, many Tribes in California have had to borrow funding or collect donations to renovate community buildings, buy or rent new or used modular trailers, or manufactured office units for use as healthcare facilities.

2. 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 CA IHS Area. We respectfully request that the committee fund the IHS Facilities M&I funding in the amount of $105 million. Millions of square feet of facility space are in the IHS Facility Inventory. If M&I funding is increased, our share will go a long way to help maintain and improve our Tribal health clinics.

3. We ask that the Committee **increase funding to the IHS Purchased/Referred Care (PRC) Program**. IHS Areas without IHS hospitals are termed PRC-Dependent Areas. This is because Tribal health facilities in these Areas only provide basic care services, forcing the Tribes to send patients to non-IHS hospitals or other specialty care facilities when they require more complex care. The cost of this care is expensive leaving patients with little options and exhausting Tribal PRC funds. Congressional guidance is needed in working with the IHS to provide more funding to PRC-Dependent Areas.

4. We ask that the Committee **support AI/AN mental health and substance abuse programs by funding the Methamphetamine Suicide Prevention Initiative and the Domestic Violence Prevention Initiative using a non-competitive method**. 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 AIANs in comparison to many other populations and these funds are critical for THPs to serve their populations that are in such need.

5. We ask that the Committee do everything in its power to **ensure the IHS clearly states that its new Contract Support Costs rule does not apply to annual re-issuances, including those of negotiated "indirect like costs."** During recent Tribal/IHS Contract Support Costs (CSC) meetings, Tribal representatives were under the impression IHS would only apply the new 97%—3% rule to new and expanded contracts and related renegotiated base amounts—not each time an Annual Funding Agreement is in the process of being reissued. Extending the new rule to straightforward yearly re-issuance is overly burdensome on a number of Tribes/Tribal organizations. It is not required under federal law and is unnecessary. In fact,

applying this rule to Annual Funding Agreements would subject Tribes to a decrease in their funding without the consent of Congress, since IHS is indicating that 3% of their base is for indirect CSC.

6. We ask that the Committee **support the continuation of the IHS Community Health Representatives (CHR) Program**. The President's proposed 2019 IHS budget calls for the elimination of the CHR program, which is currently funded at $60 million. CHRs are well-trained, medically guided Tribal community-based health care providers that make home visits while contributing to lowering mortality rates by providing education health promotion and disease prevention efforts.

7. We ask that the Committee do everything in its power to **ensure the IHS provides Commissioned Corps officers and practitioners without taking those funds out of Tribal clinics' contracts**. In providing U.S. Public Health Service Commissioned Corps officers and practitioners at Tribal clinics, the IHS extracts the funds for these workers from the Tribal clinics' contracts. The federal trust responsibility needs to include providing these workers to Tribal clinics in PRC-Dependent Areas at no cost to the clinics. Tribal clinics in a PRC-Dependent Area, lacking any IHS hospital, will benefit greatly from this operational savings. This is a matter of building equity where possible.

8. We ask that the Committee do everything in its power to **ensure the IHS provides ambulance services in rural and frontier regions of California**. Ambulance services are greatly needed by most Tribes in California located in rural and frontier regions; however, most do not have this option. For the few Tribes that do have ambulances, their ambulances can be rendered inoperable due to severe weather or maintenance needs.

9. We ask that the Committee do everything in its power to **ensure the IHS complies with the court order in *Rincon Band of Mission Indians v. Harris*, 618 F.2d 569 (1980)**. In this case, the U.S. Ninth Circuit Court of Appeals affirmed the district court's granting of summary judgment for plaintiffs. As a result, IHS must ensure equitable distribution of all existing and future IHS financial and other resources to Indians in the CA IHS Area.

In conclusion, on behalf of the California Rural Indian Health Board, I ask that you work with the IHS to ensure the Agency provides equitable services and funding to Tribes in the CA IHS Area.