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Good morning, Chair and Committee members. My name is Dr. Mark LeBeau and I am a citizen of the Pit River Nation. I serve as the Chief Executive Officer of the California Rural Indian Health Board, Inc. (CRIHB). Thank you for providing me the opportunity to testify about funding and other needs of the Indian Health Service (IHS) and Tribal Health Programs (THP) in California.

CRIHB was established in 1969 and provides comprehensive healthcare related support to 19 THPs, sanctioned by 59 federally recognized Tribal governments, serving American Indians and Alaska Natives (AIAN) in California through 40 Tribal clinics. CRIHB is also an Indian Self Determination, Education, and Assistance Act contract administrator and provides several statewide programs.

AIANs continue to experience the worst health inequities of any ethnic population in the United States. The Department of Health and Human Services reports that AIANs suffer from significantly higher health disparities in relation to depression, suicide, obesity, substance abuse, hepatitis, infant mortality rates, and diabetes than other populations. The Kaiser Family Foundation reports similar findings, as well as higher health disparities in cardiovascular disease and experiencing frequent mental distress than other populations[1]. Furthermore, AIANs also suffered far worse health outcomes during the COVID-19. According to the National Library of Medicine, AIANs were 1.6 times more likely to be infected with COVID, 3.3 times more likely to be hospitalized, and 2.2 times more likely to die as a result of COVID-19 than non-Hispanic White persons.

These are our funding requests and other requests:

1. *Fully fund the IHS Agency and ensure each IHS Area receives an equitable amount of resources.* Fully funding the IHS honors the federal trust responsibility to Tribal governments. In 2022, the National Tribal Budget Formulation Workgroup calculated full funding for the IHS to be $51.42 billion. However, IHS just received $6.96 billion in funding for Fiscal Year 2023. The IHS has never received adequate funding. For example, in 2018, IHS spending for medical care per user in California was just $1,800. Conversely, the national average spending per Veteran's Health Administration user was about $10,700. This funding disparity has a direct correlation with the higher rates of premature deaths and chronic illnesses suffered throughout Tribal communities. While average life expectancy dipped for all races due to COVID-19, AIANs saw a dramatic decrease in life expectancy during this time. In 2021, the average age expectancy for female and male AIANs was 65 years, with males expected to live until age 62. These numbers are determinantal to the community, notwithstanding the emotional devastation that is felt by

[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

Native families when losing many of their relatives at such a young age. These deaths represent an irreparable damage to Tribal communities' ability to strengthen and support the passing of traditional and cultural ways. These deaths are an indirect way to constructively erode Tribes. Without proper, and equitable support for Tribes through IHS funding for California, not only will these deaths continue, Tribes may start to experience members dying at even younger ages. It is imperative for the survival of AIANs that IHS address these intergenerational problems.

2. *Ensure current IHS funding is distributed equitably.* CRIHB has repeatedly testified on the inequity of the IHS allocations for program funding. According to the IHS Fiscal Year 2023 Congressional Budget Justification document, of the 12 IHS Areas, the California IHS Area receives the fewest, or second fewest, funding resources on a per patient basis across nearly every IHS budget line item, including Dental Health, Alcohol and Substance Abuse, Public Health Nursing, Mental Health, Health Education, and the Community Health Representative budget line items. It is also true of total IHS spending. The Facilities Support Account (FSA) budget line item continues to be under funded. The FSA funds the staff responsible for updating the IHS Master Plans, collecting data and identifying deficiencies at Indian Health facilities and in Tribal communities, provide technical assistance to THPs, and drafts facilities proposals based on community needs and the data collected. Many of the facility proposals go unfunded due to insufficient FSA funding for an Area. These Areas are not capable of supporting these types of Tribal requests without the proper FSA funding. Up until this year, and for decades prior, the IHS provided the California Area with the fewest FSA funding of all 12 Areas. In 2020, the California Area received the second fewest FSA dollars, with an appropriation of $2.7 million to support 1.1 million square feet of clinical space. Contrast that with the Tucson Area, which receives $2.3 million to support 247,000 square feet of clinic space. This translates to the California Area receiving about $2.30 per square feet of space, while other similarly situated Areas receive about $9.00 per square foot of clinical space. Highly FSA funded Areas receive about $14.50 per square foot of clinical space, or over 6 times the amount the California Area receives. Due to the lack of FSA funding, California Tribes' facilities needs and technical assistance requests continue to go unanswered. Without this data California Tribes are unable to compete for IHS facilities resources. The lack of FSA funding places California Tribes at a disadvantage for other funding opportunities because, California Tribes are not prepared nor can they take advantage of available funding. The State of California has prioritized constructing Behavioral Health infrastructure. The State established a $350 million Tribal set aside for "shovel ready" Behavioral Health facility projects on Tribal lands. The $350 million has gone untouched due to the extremely limited FSA funding and personnel in the California Area. These Tribal set aside funds are now in danger of being revoked due to current economic conditions. The IHS continues to state that FSA funding are "historically funded" or that FSA funding is primarily for federal facilities, without acknowledging that the total IHS funding across the 12 Areas is also positively correlated with FSA funding. For decades, the IHS has controlled which Areas are highly competitive for federal resources by providing certain Areas with FSA funding and personnel. Other Areas, such as California, are removed or severely hindered from competition by the restricting of these funds. In fact, the lack of FSA personnel translated to California Tribes being eliminated from the 1993 Health Care Facilities Grandfathered

List. The Grandfathered List is still in effect, and likely will not be concluded for 40 years from the time was established. With California off that list, we have had zero opportunity to remedy this issue or compete for federal resources. We urge Congressional leaders to address this issue immediately and provide equitable FSA funding to those Areas that the IHS has left behind. The easiest way to accomplish this goal is for Congress to require the IHS to provide FSA funding parity between THPs and federal-IHS facilities. According to 2020 data provided by the IHS, THPs in California received $.56 per square foot of clinical space in FSA funding, while IHS facilities received about $18 per square foot of clinical space in FSA funding. This austere funding disparity perpetuates inequitable funding across nearly every IHS budget line item mentioned earlier. We urge Congress to require the IHS to provide FSA funding parity between Tribal and Federal facilities and an immediate appropriation to California Tribes.

3. *Purchased and Referred Care Funding*. For over 40 years the California Area has been refused the opportunity for IHS ambulatory resources. There are no IHS hospitals, health clinics, or other ambulatory services that exist within the Area. Since California Tribes do not have access to IHS-facilities, they rely entirely on Purchased and Referred Care funding for their hospital level and specialty health care needs. Additionally, 20 of California's 58 counties are excluded from the Purchased and Referred Care Delivery Area (PRCDA). These 20 counties account for about 63% of the state's total population. By excluding these counties from the PRCDA, the IHS has limited California THPs' ability to accurately count the number of Active Indian Patients served. For example, if an Indian patient lives within one of the excluded counties, it is not eligible to be counted as an Active Indian Patient by the THPs. These patients are still eligible for services at the THP but are not recognized by the IHS for purposes of resource distribution. This "patients-served versus patients-counted" discrepancy leads to further limitations on PRC funds to California Tribes. Most California Tribes must ration PRC funding for only the highest level, life or limb services. Frequently, PRC funding in California is depleted before the end of the year. Patients have a higher risk of death when the PRC funds are exhausted, as there is no other viable source of funding for the Tribes to access in order to provide lifesaving services. CRIHB requests a California-specific PRC funding appropriation to address the issues described today. We also request that Congress require the IHS to work with California Tribes to address the PRC Delivery Area issues and find reasonable solutions.

4. *Secure future advanced appropriations for IHS and ensure the funding is distributed equitably to all Areas*. CRIHB and our member Tribes are profoundly grateful for the Congresses' inclusion of an Advanced Appropriation for the IHS in the Consolidated Appropriations Act of 2023. However, if an Advanced Appropriation is not secured for future years, we will be back in the same place we were before. Advanced Appropriations for the IHS protect Tribal communities from government shutdowns, as funding is already in place. Advance Appropriations for IHS allows health administrators to continue treating patients without wondering if –or when– they will have the necessary funding. Additionally, IHS administrators do not have to waste valuable time and energy re-allocating their budget each time Congress passes a continuing resolution. The Advanced Appropriation allows Indian health providers to have certainty regarding how many physicians and nurses they can hire without wondering if funding will be available. Since

the Advanced Appropriation was adopted for Fiscal Year 2024, there would not be an additional cost to continue the program since Advanced Appropriations are more so a budget maneuver than actual federal spending. The protection Advanced Appropriations provide Indian Country are enormous, while the impact to the federal spending is minimal. Advanced Appropriations also make a big difference in THPs' ability to recruit and retain qualified medical providers. The COVID-19 pandemic greatly exacerbated recruitment and retention issues in Indian Country, so future Advanced Appropriations are more critical than ever to stop the loss of this rural and isolated workforce.

5. *Ensure IHS is not subject to sequestration* that occurs as a result of the Budget Control Act (BCA) of 2011 (P.L. 112-25), or any future laws passed by Congress. Congress designed the BCA so that the federal programs that serve the most vulnerable populations were exempt from the full sequester. When across-the-board sequestration occurred in 2013, all other federal programs that serve the health of our nation's highest need populations, such as Social Security, Medicare, Medicaid, the Children's Health Insurance Program, and the Veterans Administration, were exempt from the full effect of sequestrations. However, IHS or other programs serving Indian Country were not included in this list. Sequestration of the IHS budget translates into a reduction of primary health care, disease prevention, and other services for AIANs. As Congressional leaders consider slowing federal spending, we ask that the IHS budget be held harmless. The IHS already receives the fewest federal dollars of any federally funded health program that exist. In fact, on a per patient basis, the IHS receives less than 40% of the funding provided to the Veterans Health Administration. This critical lack of funding leaves Tribal communities in a precarious situation when funding cuts occur. We urge you to please hold the IHS budget harmless from spending cuts, or any future sequestrations that Congress considers.

On behalf of CRIHB, thank you for holding this important hearing on Tribal health and other programming. I look forward to the opportunity to provide further guidance on these issues.

Thank you.