Testimony of Reno Franklin, Chair, California Rural Indian Health Board, Inc.
Submitted to the House Committee on Appropriations
Subcommittee on Interior, Environment, and Related Agencies
February 27, 2025

Good morning, Chair and Subcommittee members. My name is Reno Franklin, and I am Chairman Emeritus of the Kashia Band of Pomo Indians. I also serve as the California Rural Indian Health Board, Inc., (CRIHB) Board of Directors Chair. Thank you for providing me the opportunity to testify about funding and other needs of the Tribes and Tribal Health Programs (THPs) in the California (CA) Indian Health Service (IHS) Area.

CRIHB was established in 1969 and provides healthcare-related support to 21 THPs, sanctioned by 76 federally recognized Tribal governments, serving American Indians and Alaska Natives (AIANs) in CA via 50 Tribal clinics. CRIHB implements several statewide programs and is a contract administrator under the Indian Self-Determination, Education, and Assistance Act.

I respectfully request this subcommittee's efforts to ensure the sustainability of the longstanding government-to-government relationship between the United States and Tribal governments. This sacred relationship is forged in the Constitution, ratified in treaties, and upheld by the Supreme Court. In short, Tribes are governmental and political entities, not racial groups.

The provision of healthcare for Tribes and their citizens is inherent to the Federal government's trust responsibility. Despite the persistent underfunding of Indian healthcare, particularly in the CA IHS Area, Tribes have assisted Federal agencies with delivering services that result in healthier Native people, communities, and families. Nevertheless, more work remains necessary to further improve the health of Tribal communities.

In 2022, the average AIAN life expectancy at birth was 67 years, compared to 77 years for the majority population. In 2023, 22% of AIANs reported being in fair or poor health – the highest rate among all groups. In 2021, the leading causes of death for AIANs were heart disease, coronavirus, cancer, unintentional injuries, and chronic liver disease. The Department of Health and Human Services reports that, compared to other populations, AIANs suffer from significantly higher health disparities in relation to depression, suicide, obesity, substance abuse, hepatitis, infant mortality, and diabetes.

There are 12 IHS Areas across the United States that provide health services to Tribes as part of the Federal government's trust responsibility. The CA IHS Area is one of the few that has not received hospitals, health clinics, nor staff to operate such facilities from the IHS Headquarters. Congressional leadership is necessary to ensure that essential services are provided for the Tribes and AIANs in the CA IHS Area.

Without adequate Federal engagement, Tribes in the CA IHS Area have been forced to take on loans and/or cobble together resources from foundations and other sources to fund the facilities necessary to deliver health services. Many CA Tribes have had no alternative but to use limited third-party revenue generated by their providers to cover the costs of renting healthcare facilities. IHS Headquarters has the exact same legal trust obligation to Tribes in the CA Area as it does to

Tribes in all other Areas; yet, IHS Headquarters routinely shirks its responsibility to CA Tribes. Given this stark reality, I respectfully request the subcommittee include language in the current appropriations bill under consideration that authorizes the IHS to build health clinics for Tribes in the CA Area, as it continues to do in other Areas. This is a critical need for CA Tribes.

Related to the lack of IHS facilities in the CA Area, there is an urgent need for Purchased/Referred Care (PRC) resources. Lacking access to IHS hospitals, CA Tribes rely exclusively on PRC funding for their specialty and non-primary healthcare needs. Areas (like CA) without access to IHS hospitals are known as PRC Dependent and are supposed to receive a greater share of PRC funding. However, on a per-Indian patient basis, the CA Area receive the sixth-lowest level of PRC funding among all IHS Areas, including fewer PRC dollars than three non-PRC Dependent Areas where Tribes do have access to federally funded IHS hospitals.

PRC Dependent Tribal communities are subject to an increased risk of death when limited PRC funding is expended prior to the end of the fiscal year. For the majority of Tribes in the CA IHS Area, this scenario plays out on an annual basis and requires Tribal communities to ration care. CA Tribes are left with the impossible choice of saving PRC funds for only the most essential services or providing other necessary care while putting Indian patients' lives at greater risk. In serious cases, such as a car accident or complications during childbirth, annual PRC funds are often expended *after just one event*.

An increase in PRC funding for the IHS CA Area will bring it in line with other PRC Dependent Areas and provide CA Tribes the lifesaving resources they need. The enacted PRC Budget for FY24 for all areas totaled $996,755,000. The IHS CA Area's share of PRC funding was $58,000,000 in FY23.

In light of the chronic underfunding of PRC in the IHS CA Area, I respectfully request the subcommittee include language in the current appropriations bill under consideration that increases these resources to $82,980,000. This funding request will provide CA Tribes with about $940 per Indian patient – a realistic amount that will help save more AIAN lives. CA Tribes are working closely with Congressman Kevin Kiley and other Representatives to support the movement of this request forward.

CRIHB has repeatedly testified on the need for parity in IHS allocations. According to the IHS Fiscal Year 2023 Congressional Budget Justification document, of the 12 IHS Areas, the CA 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. This is also true of total IHS spending.

The IHS Facilities Support Account (FSA) budget line item continues to be underfunded. The FSA funds the staff responsible for updating IHS Master Plans, collecting data and identifying deficiencies at Indian Health facilities and in Tribal communities, providing technical assistance to THPs, and drafting facilities proposals based on community needs and the data collected. A lack of FSA funding means a lack of data and technical assistance, leading to facility proposals going unfunded.

Up until this year, and for decades prior, the IHS provided the CA Area with the least FSA funding of all 12 Areas. In 2020, the IHS CA 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 another area, which receives $2.3 million to support 247,000 square feet of clinic space. This translates to the CA Area receiving about $2.30 per square feet of space, while other similarly situated IHS Areas receive about $9.00 per square foot of clinical space.

Highly FSA funded IHS Areas receive about $14.50 per square foot of clinical space, or over six times the amount the CA Area receives. Due to the lack of FSA funding, CA Tribes' facilities needs and technical assistance requests continue to go unanswered. Without this data CA Tribes are unable to compete for IHS facilities resources.

The IHS continues to state that FSA funds are "historically funded" or that FSA funding is primarily for Federal facilities, without acknowledging that the total IHS funding across the 12 Areas is 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 CA, are removed or severely hindered from competition by the restricting of these funds.

In fact, the lack of FSA personnel translated to CA 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 CA off that list, we have had zero opportunity to remedy this issue or compete for Federal resources.

I respectfully request the subcommittee include language in the current appropriations bill under consideration that provides a fair share of 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 IHS facilities. According to 2020 data provided by the IHS, THPs in the CA Area 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 drastic funding disparity perpetuates inequitable funding across nearly every IHS budget line item previously mentioned.

There are many additional programs within IHS that are critically important to maintain. They include:

- Special Diabetes Program for Indians
- Domestic Violence Prevention Programs
- Behavioral Health Programs
- Tribal Epidemiology Program
- Injury Prevention Program for American Indians and Alaskan Natives
- Tribal Self-Governance Program: IHS Compacts/Funding Agreements
- Tribal Self-Governance Program: Planning and Negotiation Cooperative Agreement

- Community Health Aide Program
- Sanitation Facilities Construction Program
- Demonstration Projects for Indian Health
- Health Professions Pre-graduate Scholarship Program for Indians
- Educational Loan Repayment Program
- Health Professions Recruitment Program for Indians
- Health Professions Preparatory Scholarship Program for Indians

I respectfully request the subcommittee include language in the current appropriations bill under consideration to preserve these programs.

On behalf of the California Rural Indian Health Board and the 76 federally recognized Tribes and 21 Tribal Health Programs in our membership, thank you for holding this important hearing on IHS and other programming. I look forward to the opportunity to provide further guidance on these issues.

Thank you.