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Good afternoon, Chairman and Committee members. My name is Mark LeBeau and I am CRIHB's Executive Director. Thank you for giving CRIHB the opportunity to testify about funding of the Indian Health Service today. CRIHB provides health care services and technical assistance to eleven member tribal health programs and is supported by thirty federally recognized tribes. We are proud members of the National Indian Health Board. We have also partnered with Covered California, the state's health marketplace, to ensure that effective education, outreach, and enrollment opportunities are provided to tribal communities and American Indian and Alaska Native patients.

CRIHB was founded in 1969 to bring health care services back to tribal communities in California. In the 1950s, during the termination era, California's Indian Health Service (IHS) facilities were shut down. They have never been restored. In the late 1960s, worsening infant mortality rates drove grassroots efforts of California Indians to ensure basic medical care for their communities. Since CRIHB was founded, California tribes have built a network of 32 tribal health programs and serve more than 80,000 users. A third of these tribal health programs are CRIHB members. In addition, eight urban Indian health clinics serve approximately 30,000 American Indians and Alaska Natives.

Today we have general appropriations requests as well as requests that are specific to the California IHS Area. The first general request is that you fund programs and services at levels that equal and exceed pre-sequestration levels. We know that the proposed budget is \$4.6 billion for the IHS, a \$200 million increase from FY2014. This is not enough to meet all unmet need, as it would take over \$14 billion to fully fund IHS. This increase should be in the billions, not the millions, in order to fulfill unmet need. Our second general request is full funding of Contract Support Costs (CSC). We thank you for increasing funding in the January 2014 Omnibus Appropriations Act to ensure more funding for CSC and partially restore funds lost to sequestration. Going forward, full funding of CSC continues to be critically important to quality and continuity of care for American Indian and Alaska Native patients. However, this must be achieved without reducing direct healthcare services or important line items within the Director's budget, such as the Special Diabetes Program for Indians (SDPI). We are concerned that IHS chose to reduce funding for the SDPI in order to fund CSC. SDPI effectively prevents diabetes, one of Indian country's most devastating "gateway" conditions. Diabetes frequently leads to permanent nerve damage and debilitating and costly diseases like heart disease and kidney disease. Reducing funding for successful preventative programs like SDPI may seem like a short term solution but will cost IHS far more in the long run.

We also have several requests that relate to the California IHS Area. CRIHB has testified about lack of fundamental fairness in IHS allocation of Contract Health Services (CHS) (now referred to as Purchased/Referred Care, or PRC) for many years. This inequity has been documented in numerous Government Accountability Office reports. It has resulted in compromised care for

American Indian and Alaska Native patients as well as over \$20 million in bad debt for California's licensed healthcare facilities. California is not the only IHS Area impacted by the CHS inequity. The Bemidji Area also suffers from this disparity. To a lesser degree, the Portland and Tucson Areas are also affected.

How did we get here? As I mentioned earlier, there have been no IHS Facilities in California since the 1950s. Because there are no IHS facilities, California is considered a "CHS-Dependent" area. This means that CHS funds must be used to pay for all ancillary outpatient services, such as x-rays, labs, and prescriptions. These ancillary services would be provided by IHS facilities in most other IHS regions. Because CHS must also cover these ancillary services in California, there is almost no funding left for emergency care and hospitalization for American Indian and Alaska Native patients in California. The limited funding available covers only very basic care.

You might think that based on level of need and the relatively high number of active users of the IHS system in California – hard facts, reliable data relevant to GPRA analysis – CHS funding might be adjusted to account for the lack of IHS facilities in California. Unfortunately, this is not the case. The lion's share of CHS funding, 82%, is distributed as "base funding." The sole basis for this method is "past funding history."

In its June 2012 report on CHS allocation, the GAO wrote, "According to IHS, base funding is intended to maintain existing levels of patient care services in all areas... IHS officials have told us they do not know the exact origins of the base funding policy, but that it dates back to the 1930s, when the health programs were under the Bureau of Indian Affairs." (U.S. General Accountability Office, p. 11). After thoroughly reviewing IHS administration of CHS funding allocation, GAO concluded, "IHS officials are unable to link variations in funding levels to any assessment of healthcare need. As we have reported in the past and found once again in this evaluation, IHS's continued use of the base funding methodology undermines the equitable allocation of IHS funding to meet the health care needs of American Indians and Alaska Natives." (Id. p. 24).

Despite the documented inequity of the CHS funding allocation formula, IHS does not appear to be making plans to reevaluate it. GAO also wrote: "IHS has taken few steps to evaluate the funding variations within the CHS program. IHS officials told us that they have not evaluated the effectiveness of base funding and the CHS Allocation Formula in meeting the health care needs of American Indians and Alaska Natives across the IHS areas and *they do not plan to do so* with respect to determination of base funding amounts. Without such assessments, IHS cannot determine the extent to which the current variation in CHS funding reflects variation in health care needs." (Italics added.) (Id. p. 21).

The GAO report documented that for the California IHS area, per capita CHS funding was in the lower half of the range nationwide, despite the lack of IHS facilities which makes patients almost entirely dependent on CHS funding for all care. (Id. p. 17). While there are two additional sources of funding besides "base funding," they constitute only 18% of the overall IHS budget and are not funded every fiscal year. Annual Adjustments are intended to account for population growth and inflation. Program increases are made based on cost adjustment and access to care.

Because these two methods do not result in consistent or significant funding compared to the base funding, they have done little to correct the inequity base funding has created for American Indians and Alaska Natives in California.

This inequity is compounded by a lack of access to the Catastrophic Health Emergency Fund (CHEF). The CHEF fund may only be accessed when care for a single episode of care for a particular patient exceeds a threshold of \$25,000. This threshold is not extremely difficult for tribal health programs with access to an IHS-funded hospital to meet. Unfortunately, because California tribal health programs are grossly underfunded and “under-facilitated” to start with, it is almost impossible for California’s tribal health programs to meet the spending threshold to access the fund. We don’t have enough funding to meet the CHEF threshold but it is not for lack of population or health care needs.

We’ve described the problem. The solution is more challenging. CRIHB endorses GAO’s recommendations. Today we ask Congress to require IHS to develop and use a new method to allocate all CHS program funds to account for variations across areas. We also agree that IHS should be required to use actual counts of CHS users in methods for allocating funding and that headquarters should make regional area offices accountable to comply with allocation formulas. This recommendation is consistent with the ruling in *Rincon v. Califano*, 464 F.Supp 934 (9th Cir. 1979) and reduces possible legal exposure of the IHS based on violation of equal protection. It’s also the right thing to do.

We also ask that Congress require IHS to reevaluate its facilities priority system. The current system is outdated; the list is more than 20 years old. It grandfathered in a priority list of facilities from 1991 to create a one billion dollar backlog that will prevent applications for new facilities for the next fifteen to twenty years. Most of the listed facilities would provide inpatient care that today is provided as outpatient care everywhere else. We also ask you to consider that California does not have a single IHS facility today and that there are no California facilities on the list. It’s not for lack of trying. In the absence of IHS facilities, California’s tribal health programs have devoted significant resources to obtaining clinic space. Unfortunately, this often diverts scarce resources from direct patient care. Today we ask you to require IHS to reevaluate their facilities priority criteria based both on current healthcare practices and equity between IHS areas.

We also request that the appropriation for facilities maintenance be significantly increased. Maintenance and Improvement funding is at its lowest level ever in the California IHS Area and is below the mandated federal level of funds necessary to maintain real property assets. Last, we ask you to fund the next phases of the Southern and Northern California Youth Regional Treatment Centers. California is the last of the IHS Areas to receive these facilities, first authorized by Congress in 1986. As defined by the Indian Health Service, the mission of Youth Regional Treatment Centers is “to provide quality holistic behavioral health care for American Indian/Alaska Native adolescents and their families ... in a residential environment that integrates traditional healing, spiritual values, and cultural identification.”

Treatment that is culturally appropriate and not located too far from tribal homelands is critically important in treating American Indian youth. As Chairman Mark Romero of the Mesa Grand Band of Mission Indians has said, “The problem that we have is that when our youth need to go

to a facility, we have to ship them out of state, to Arizona, Utah, Colorado, and it makes it hard for the families to visit. And it's our belief that family helps the healing process." Both California YRTC's will have five suites for families to facilitate their participation in treatment on-site. In addition, effective treatment is important not only for these youth and these families, but for the continued survival of their tribal communities. As Chairman Anthony Pico of the Viejas Band of Kumeyaay Indians has said, "We really have a lot at stake here. And that is the continuation of our culture, of our people, of our land and really who we are as a people. And if our youth are not able to carry on the traditions of our ancestors, the way we are doing the best that we can, we will then cease to exist as a people." Acquisition and construction funding is in place for the Southern California Youth Regional Treatment Center in Hemet, California. Land has been acquired for the Northern California facility in Davis, California, and we now request funding for the next phase of that project, including design and construction funding. We have asked IHS to build the funding for staffing, facilities M & I, and other operating needs of these facilities into its operating plans for future budget cycles. We thank you for funding the first phases of the YRTC's and request your continued support of this funding priority.

In conclusion, on behalf of CRIHB, thank you for your continued support of full funding of CSC. Tribes should not be treated as "second class contractors" and full funding is critically important to quality of healthcare services. We also ask that IHS appropriations be increased to more fully fund direct services and programs. We ask you to work to make IHS accountable for inequities in CHS that hobble our efforts to provide the level of care other IHS areas provide. It has to be rational, clear, and based on data, not based on a method no one understands from the 1930's, last year's budget levels, and maintaining the status quo between haves and have nots. We also think that the IHS Facilities backlog requires reevaluation because changing health care service models have made it irrelevant. Last, we ask you to continue to support funding for California's long-awaited YRTC's. Without our youth, our cultures and traditions will not survive. These facilities will give us a fighting chance to help them heal close to family and their homelands.