

**Testimony, House Appropriations Subcommittee on Interior and Related Agencies  
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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 providing me the opportunity to testify about funding and other needs of the Indian Health Service (IHS) Agency and Tribal Health Programs in California.

CRIHB was established in 1969 and provides comprehensive healthcare related support to 16 Tribal Health Programs, sanctioned by 45 federally recognized Tribal governments, serving American Indians and Alaska Natives (AIANs) in California through 40 Tribal clinics. CRIHB is also an Indian Self Determination, Education, and Assistance Act contract administrator and provides a number of statewide programs.

AIANs continue to experience some of the worst health inequities of any underserved population in the United States. The Department of Health and Human Services (DHHS) reports that AIANs have significantly higher health disparities in depression, suicide, obesity, substance abuse, hepatitis, infant death rate, and diabetes than other populations. Kaiser Family Foundation reports similar findings, as well as higher health disparities in cardiovascular disease and experiencing frequent mental distress than other populations<sup>1</sup>.

Here are our funding and other requests:

1. *Fully fund the IHS Agency and ensure each IHS Area receives an equitable amount of the resources.* This honors the federal trust responsibility to Tribal governments. Recently the National Tribal Budget Formulation Workgroup calculated full funding to be \$36.8 billion, phased in over 12 years. The Agency has not received adequate funding. For example, in 2015, IHS spending for medical care per user was only \$3,136, while the national average spending per user was \$8,517. This correlates directly with the unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Tribal communities. While the average life expectancy is 4.2 years less for all AI/ANs than it is for other Americans, the disparity is much greater in certain Tribal communities. Unless sufficient funding is made available for Indian health programs, health disparities will never be eliminated as called for in Healthy People 2020.
2. *Ensure IHS is not subject to sequestration* that occurs as a result of the Budget Control Act of 2011 (P.L. 112-25) or any future laws passed by Congress. Congress designed the law 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 populations with the highest need, such as Social Security, Medicare, Medicaid, the Children's Health Insurance Program, and the

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<sup>1</sup> 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

Veterans Administration, were exempt from full effect of the funding reductions. But, not IHS or other programs serving Indian Country. This loss of funding translated into a reduction of primary health care, disease prevention, and other services for AIANs. The federal budget crisis is not due to the nation's obligation to Indian Tribes.

3. *Secure Advanced Appropriations for IHS.* If IHS had received advance appropriations, it would not have been subject to the government shutdown as FY 2019 funding would already have been in place. Adopting advance appropriations for IHS results in the ability for health administrators to continue treating patients without wondering if –or when– they have the necessary funding. Additionally, IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passed a continuing resolution. Indian health providers would know in advance how many physicians and nurses they could hire without wondering if funding would be available when the results of Congressional decisions funnel down to the local level.
4. *Enact Mandatory Appropriations for IHS.* Funding for IHS should be treated as “entitlement” or “mandatory spending.” This would be in alignment with the federal trust responsibility for health which is the direct result of treaties, federal law, and Supreme Court Cases. In order for this to be implemented, Congress should enact legislation to create a Tribally-driven feasibility study in order to determine the best path forward to achieve mandatory appropriations for IHS.
5. *Increase Appropriations to Indian Country outside of IHS.* Tribes and Tribal organizations receive a disproportionately low number of DHHS grant awards. One significant obstacle, is the fact that block grant funds typically flow directly to states who then pass funding on to Tribes. Sadly, these funds often do not make it to the Tribal level. Without having a state intermediary, Tribes would not only receive more adequate funding but could more easily tailor program needs to their people. Therefore, Congress should: grant awards directly to Tribes; create set-asides for DHHS block grants so that Tribal communities have access to these funds on a recurring basis; and where states receive funds to pass through to Tribes, Congress should require Tribal consultation on the use of those funds.
6. *Enact Long-Term Renewal for the Special Diabetes Program for Indians (SDPI) at \$200 Million.* It is paramount to pass legislation to renew SDPI. The current authorization expires on September 30, 2019. SDPI has not received an increase in funding since FY 2004 which means the program has effectively lost about 25 percent in programmatic value over the last 15 years due to the lack of funding increases corresponding to inflation. Few programs are as successful as SDPI at addressing chronic illness and risk factors related to diabetes, obesity, and physical activity. SDPI has proven itself effective, especially in declining incidence of diabetes-related kidney disease. The incidence of end-stage renal disease (ESRD) due to diabetes in AIANs has fallen by 54% - a greater decline than for any other racial or ethnic group. Treatment of ESRD costs almost \$90,000 per patient, per year, so this reduction in new cases of ESRD translates into significant cost savings for Medicare, IHS, and third party payers.

7. *Ensure current IHS funding is distributed equitable.* CRIHB has testified before about lack of fundamental fairness in IHS allocation of program funding. The California IHS Area is not receiving its fair share of Purchased/Referred Care; hospital, health center, staff quarter, and joint venture construction; and other program funds. This persistent problem needs to be remedied and CRIHB and Tribal Health Program representatives in California would like to work with the Committee to address the issues.

In conclusion, on behalf of CRIHB, we thank the Committee for holding this important hearing on Tribal health and other programming and look forward to the opportunity to provide further guidance.

Thank you.