CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

Testimony

Appropriations Sub Committee on the Interior and Related Agencies

March 28, 2012

My name is Michelle Hayward, I am a member of the Redding Rancheria, where I am elected Secretary of the Tribal Council, I am a Wintun Indian from northern California and I am here today to testify as Board Chair of the California Rural Indian Health Board (CRIHB) on the Indian Health Service FY 2013 Appropriations request.

The California Rural Indian Health Board founded in 1969 is a Tribal Organization operating under the authorities of the Indian Self Determination Act to provide health care services and technical assistance under tribal resolutions from 20 federally recognized Tribal Governments. Collectively our twelve member Tribal Health Programs represents 32 Tribal Governments and provide IHS funded services across 16 counties, an area equal in size to the state of Georgia, to approximately 28,000 active users of the IHS system. CRIHB also seeks non IHS grants and contracts to help augment the woefully underfunded IHS care in California. Last year we brought in an additional $16 million in service funding to the benefit of Tribes and Tribal Health Programs all across California. CRIHB also serves as the Area Health Board representing the California Area of the IHS to the National Indian Health Board.

Three fundamental facts shape our relationship with the IHS and the appropriations process that you oversee. The first is that all IHS funded services in California are directly operated by Tribes and Tribal Organizations under ISDEAA contracts and compacts. The second is that this Tribally operated delivery system includes no hospital inpatient capacity or hospital based specialty care capacity. Generally speaking the IHS program in California is a network of Tribally focused, public health oriented primary care clinics. We are therefore totally dependent on the Contract Care line item funds for all Hospital and specialty care. Lastly, because of the small size of the Tribes in California, the lack of population density and the relative proximity of non-IHS health care resources, the IHS Facilities program has systematically failed the Tribes in our Area. Over the past two decades there have been no IHS hospitals built only one Joint Venture Clinic Project and only four Small facility grants to serve a statewide Census population of 627,572 of which 255,544 live in the IHS Contract Health Care Delivery Area and 81,594 are listed as current Active Users.

Indian Health Care Improvement Fund:

CRIHB requests that $10,000,000 of the identified requested increase in the Hospitals and Clinics line item be set aside for distribution under the Indian Health Care Improvement Fund.

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The IHS has a legal obligation to provide equal access to health care services to its beneficiaries. Subsequent to Rincon v. Harris the federal courts have required that the IHS distribute its resources in a manner that is reasonable, rational and defensible. The court found that the historic use of base budget allocation to unacceptable. Yet even today less than 2% of the IHS appropriation has ever been set aside to address long standing issues of funding disparity. In FY 2013 the IHS will be making yet another mandatory report to Congress on their progress to date in achieving funding equity. I can predict with confidence that they will again report almost no progress over time in addressing this judicial mandate. They will however tell you that they have consulted with Tribal Governments on this issue and have refurbished the distribution methodology to bring it more in line with current costs and modern actuarial practices. But all of that without a commitment to funding is without meaningless. Lastly, on the subject of funding equity I must point out that national health reform will bring a tidal wave of new resources to Indian Country. The expansion of Medicaid coverage will be particularly important, but more important in some areas than in others. This does not mean that the IHS as a delivery system should lose any of its core funding, but it does provide Congress an opportunity to increase your commitment of funding equity. This could be achieved by placing the majority of all funds over last year's appropriation amount for the Health Services account into the Indian Health Care Improvement Fund until funding equity was more closely achieved.

Contract Health Care:

CRIHB requests that the CHS line item be increased by $50 million over current services, The IHS operated and Tribally operated health care delivery system varies in important characteristics from region to region. One important variable is the extent to which the system is vertically integrated from community focused prevention and primary care to secondary and even tertiary hospital based care. In recognition of this basic health planning concept, after more than a year of focused tribal consultation on these issues in 2001 the IHS adopted a new CHS allocation formula. The most important innovation in that formula was a co-factor recognizing that all IHS service units did not have access to IHS funded inpatient care. This is known as the CHS Dependency factor. In recognition of this difference, 25% of all funds over that amount necessary to fund medical inflation and population growth were reserved for those service units that had no access to IHS funded impatient services. In the past twelve years the CHS line item has been sufficiently well funded to trigger the so called CHS dependency factor exactly twice (2002 and 2011). This year the President has asked for an overall CHS increase of $54 million of which $20 million will be to fund expanded services and of that amount less than $2 million will be differentially allocated to those without access to IHS hospital level services. We urge Congress to increase this line item so that American Indians and Alaska Natives in California can receive a full continuum of health care services. Any CHS line item increase of less than $100 million fails to address the issue of comparable access for those without access to IHS Hospital services.

Youth Regional Treatment Facilities:

CRIHB requests $17 million in Facilities design and construction funds to initiate construction of a YRTC in Southern California on the Taylor Ranch site in Riverside County. Congress initially authorized the IHS in 1986 under P.L. 99-570 to establishment a network of inpatient addiction treatment facilities for American Indian Youth. Since that time the IHS has successfully renovated or constructed 13 YRTC facilities across Indian Country. Over the past 24 years the IHS has consistently failed to establish such a facility in California. A major source of this failure has been the simple fact that the real estate market in California moves faster that the federal real property acquisition process. Early this year the Government Services Administration successfully concluded the purchase of a 20 acre parcel in Riverside County known as the Taylor Ranch. This location and this long awaited project are broadly supported by Tribes in all sections of California. It is now time for Congress to appropriate $17 million in design and construction funds so that at least one YRTC in California can begin operating in FY 2016. Because of the lack of population density, as opposed to overall population size Tribes in California have received very little benefit from the IHS Facilities Construction program.

The Special Case of Smith River Rancheria and Curry County Oregon:

CRIHB requests that $342,248 in Contract Health Service funds be allocated to the Smith River Rancheria for allocation under the New Tribes process to serve their members in Curry County Oregon. The Smith River Rancheria, a federally recognized Tribal Government, is located in northern California in Del Norte County along highway 101. Their Tribal members receive their IHS funded care through a facility of the United Indian Health Services located on the Rancheria less than seven miles south of the Oregon border. The Tolowa people from whom the Smith River Tribal membership is drawn historically, and to this day continue to live on both sides of the state border. However, because the IHS program in California operates under a congressionally defined Contract Health Service delivery area that is contained within the borders of the state, no CHS funds allocated to California are currently available to serve the members of the Smith River Rancheria who live adjacent to the Rancheria in Curry County Oregon. Additionally, a review of historic IHS appropriation and allocation practice of the Portland Area Office of the IHS clearly establishes that no Portland Area IHS funds have been appropriated or allocated for the benefit of this population. In short, this is a population that is not currently served by the IHS and therefore this problem can be addressed through the established "New Tribes" process. This population of 174 Smith River tribal members actively and regularly receives primary care on the Rancheria where they are regularly denied CHS referral care in accordance with existing law and regulation. The solution to this predicament is for this Committee to authorize that a portion of the CHS expansion funds be appropriated to address this specific population.

CONTRACT HEALTH SERVICES - DISTRIBUTION BY AREA
FISCAL YEAR 1999 - 2010

Area Office	1999	2000	2001		2008	2009	2010	2011
Aberdeen	$ 42,272,400.00	$ 42,995,400.00	$ 47,639,457.00	TREND CONTINUES	$ 63,520,134.00	$ 67,932,811.00	$ 78,908,161.00	$ 78,981,101.00
Alaska	$ 40,206,100.00	$ 41,129,100.00	$ 46,438,344.00		$ 57,969,385.00	$ 63,065,563.00	$ 75,781,210.00	$ 75,851,244.00
Albuquerque	$ 19,007,800.00	$ 19,379,800.00	$ 21,673,540.00		$ 27,397,482.00	$ 29,830,959.00	$ 37,181,683.00	$ 37,216,024.00
Bemidji	$ 23,284,100.00	$ 24,555,600.00	$ 29,769,691.00		$ 38,247,233.00	$ 41,868,282.00	$ 52,364,546.00	$ 52,412,948.00
Billings	$ 33,361,900.00	$ 34,278,900.00	$ 38,531,117.00		$ 46,477,293.00	$ 49,214,400.00	$ 56,767,563.00	$ 56,820,021.00
California	$ 9,472,700.00	$ 11,808,700.00	$ 19,708,013.00		$ 28,280,641.00	$ 31,420,785.00	$ 40,773,077.00	$ 40,810,798.00
Nashville	$ 15,355,800.00	$ 15,550,800.00	$ 17,972,083.00		$ 22,381,890.00	$ 24,243,805.00	$ 30,205,260.00	$ 30,183,183.00
Navajo	$ 43,111,200.00	$ 44,091,200.00	$ 50,145,418.00		$ 63,794,083.00	$ 69,437,474.00	$ 84,986,329.00	$ 85,064,880.00
Oklahoma	$ 45,356,600.00	$ 45,800,600.00	$ 50,332,493.00		$ 69,153,183.00	$ 75,806,574.00	$ 95,265,179.00	$ 95,353,262.00
Phoenix	$ 32,533,400.00	$ 33,221,400.00	$ 37,418,859.00		$ 47,566,578.00	$ 51,563,659.00	$ 63,049,120.00	$ 63,107,391.00
Portland	$ 39,433,800.00	$ 41,464,800.00	$ 49,505,343.00		$ 63,563,841.00	$ 69,197,424.00	$ 83,216,850.00	$ 83,293,779.00
Tucson	$ 10,021,000.00	$ 10,242,000.00	$ 11,420,929.00		$ 13,879,895.00	$ 14,782,581.00	$ 16,986,338.00	$ 17,002,021.00
Sub-Total	$ 353,416,800.00	$ 364,518,300.00	$ 420,555,287.00		$ 542,231,638.00	$ 588,364,317.00	$ 715,485,316.00	$ 716,096,652.00
HQ Reserve	$ 14,339,900.00	$ 24,193,400.00	$ 11,200,713.00		$ 10,523,728.00	$ 4,077,930.00	$ 15,861,684.00	$ 4,378,336.00
Sub-Total	$ 367,756,700.00	$ 388,711,700.00	$ 431,756,000.00		$ 552,755,366.00	$ 592,442,247.00	$ 731,347,000.00	$ 720,474,988.00
CHEF-X0390	$ 12,000,000.00	$ 12,000,000.00	$ 15,000,000.00		$ 26,578,800.00	$ 31,000,000.00	$ 48,000,000.00	$ 48,000,000.00
TOTAL CHS	$ 379,756,700.00	$ 400,711,700.00	$ 446,756,000.00		$ 579,334,166.00	$ 623,442,247.00	$ 779,347,000.00	$ 720,474,988.00