Appropriations Testimony
House Sub Committee on Interior and Related Agencies
March 13, 2008

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I am a member of the Stewarts Point Band of Kashia Pomo and serve as their representative to the
Sonoma County Indian Health Board Inc. Board of Directors

The California Rural Indian Health Board Inc. (CRIHB) was founded in 1969 by Tribal Governments in California to serve as the focal point for the planning, design and implementation of an Indian controlled health care system in California. For the past quarter century CRIHB has operated under Tribal resolutions as a Tribal Organization under the authorities of the Indian Self Determination Act providing all levels of IHS funded services in cooperation with six locally operated Tribal Health Programs. From its earliest days CRIHB has continually provided services on a statewide basis funded through a variety of governmental and philanthropic sources. More recently CRIHB has begun assisting Tribes and Tribal Health Programs in Nevada, Utah, Oregon, and Washington through projects funded by SAMHSA and the Centers for Disease Control.

The California Rural Indian Health Board requests that Congress address the chronic under funding of the Indian Health Service (IHS) and provide a level of funding far beyond the Presidents FY 2009 requested amount of $3,180,097,000. Specifically, we are requesting that Congress identify $2,000,000 in CHS funds to section 211 of the Indian Health Care Improvement Act to address the inability of Tribal Health Programs in California to provide inpatient and specialty care for Native Americans in our Area. We assert that California is deferentially under funded by the Indian Health Service and that our most critical short fall is in Contract Health Service funding. This lack of CHS funds is compounded by a lack of access to the Catastrophic Health Emergency Funds which is limited by our general under funding and lack of service capacity associated with IHS constructed facilities which are generally available in other IHS Areas.

Because good decisions are made using the best available data, we will attempt to provide you with documentation from a number of IHS data sets, state data sets as well as CRIHB organizational sources including published peer reviewed studies.

Due to federal termination policy all IHS funded services were withdrawn from California in the 1950's. Later in 1972, services were reestablished through direct Congressional action. Initially these new tribal health programs were operated under the provisions of the Buy Indian Act and became a model for what is now known as the Indian Self Determination Act. At the time the IHS had no "New Tribes" funding policy resulting in a funding dispute between Tribes in California and the Department of Health and Human Services. This dispute, known as the Rincon Case, was found in favor of the Tribes and ultimately lead to the establishment of what is now known as the Indian Heath Care Improvement Fund. Tragically the under funding of the IHS program in California has continued. Today, the California Area of the Indian Health Service has an active user population of 77,000 American Indians and Alaska Natives. Uniquely, only half of these IHS eligible clients are members of one of the 109 federally recognized tribe's within the state. About 30% of the active users are members of tribes located outside of California and 20% are California Indians documented as descendants of Tribes resident in California in 1852 and listed on the California judgment rolls. IHS eligible clients in California are served by 30 Tribal Health Programs which operate one or more primary care clinics under the Indian Self Determination Contracts and Compacts. Collectively these Tribal Health Programs provide services within 37 contiguous counties of mostly rural California running from the Mexican border to the Oregon Border. An area of over 123,510 square miles of which less than 7% is land held in trust. The largest Tribal Health Program serves 13,000 active users the smallest serves less that one hundred. To date, there are no IHS constructed facilities of any kind in the California Area of the IHS. Most significantly there are no IHS funded Hospitals. This makes California one of four IHS areas termed "Contract Health Service Dependent." Two of the four CHS Dependent Areas have at least one IHS funded Hospital facility. California's lack of Hospital capacity comes with a concomitant lack of Pharmacy, Diagnostic Laboratory, and X-Ray capacity. There are only seven Tribal Health Programs that operate licensed Pharmacies', there is only one CLEA certified laboratory and only two operate limited X-ray services. The lack of infrastructure compounds the shortage of CHS funds by expanding the

range of services that must be purchased from non Indian providers. Many Tribal Health Programs are spending as much as 60% of their allotted CHS funds to cover prescription costs for individual clients.

The Tribally Operated IHS funded health care system in California has been very effective at utilizing all of the resources that are available to them. Aggressive measures are used to ensure enrollment of American Indian and Alaska Native clients into alternative coverage such as Medicaid, Medicare and S-CHIP. Many locations services are also provided to insured non Indians. All programs have active, long standing and creative prevention programs focused on diet, exercise, nutrition and risk taking behaviors.

Published research on IHS clients in California documents that very few hospitalizations are funded with IHS funds, but the over all hospitalization rate is among the highest in the IHS system. Specifically 15.7per 10,000 were funded with CHS funds compared an all sources hospitalization rate of 980 per 10,000. This study identifies major sources of payment were Medicaid funded 40% of the discharges followed by Medicare which accounted for 25% and private pay at 19%.

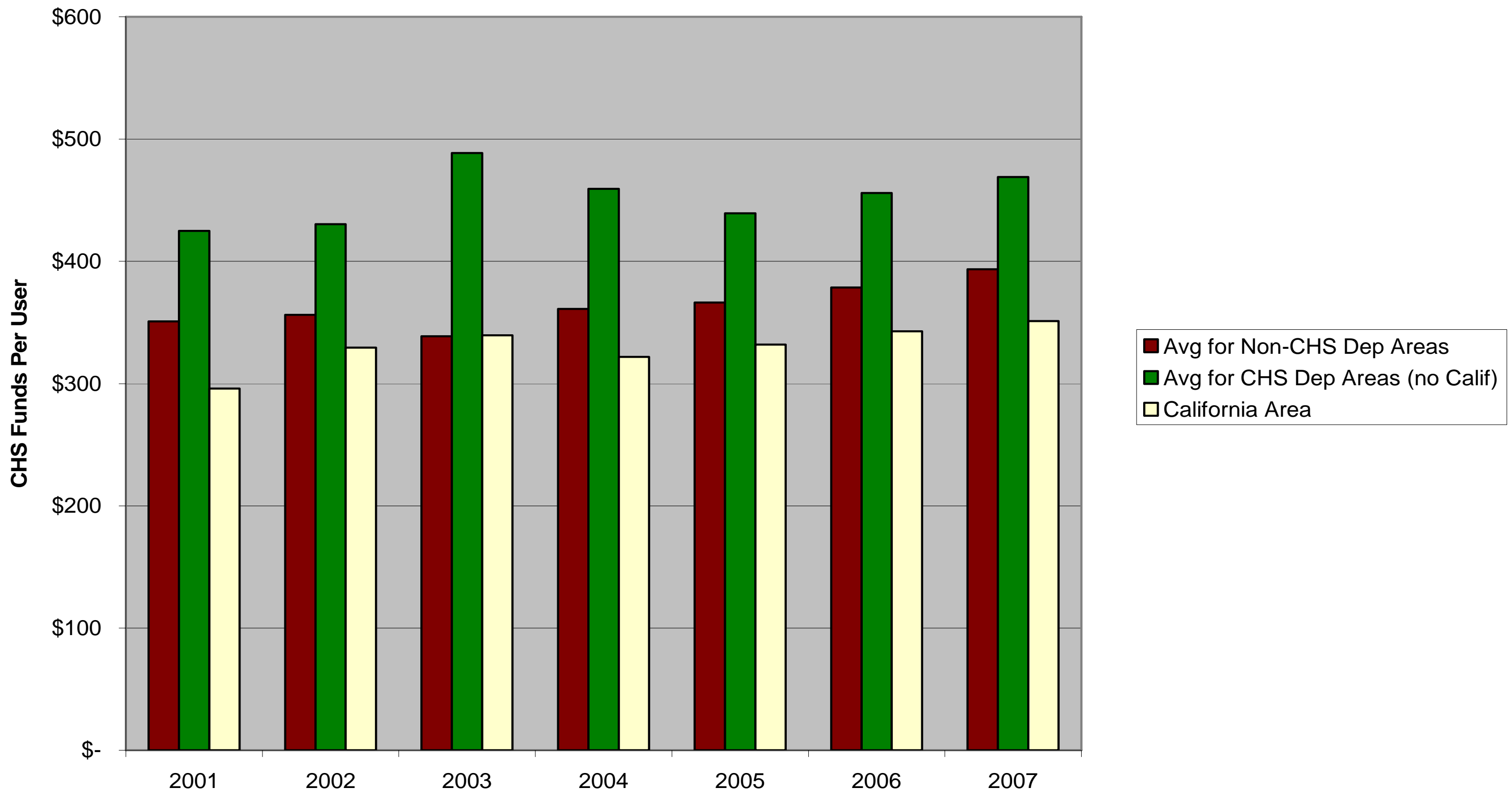
Today, with 77,000 active users we can expect 2800 hospital discharges annually of which 700 are identified as having no source of pay creating $19,355,000 in bad debt at licensed hospital facilities in California.

Understanding of the IHS program is not new information. For over a decade the IHS Indian Health Care Improvement Fund methodology has shown California to be generally underfunded with an Area wide level of need funded at 55%. However, only recently the complexities and multiple impacts of the under funded CHS program in California begun to be understood.

The central role of constrained CHS funding in California can best be addressed by providing funding to the California CHS Demonstration Project as authorized in Section 211 of the Indian Health Care Improvement Act which establishes an innovative intermediate risk pool that would target CHS costs below the threshold amount needed for reimbursement by the IHS operated Catastrophic Health Emergency fund (CHEF). The operation of such a fund by the California Rural Indian Health Board would increase access to inpatient and specialty care and reduce financial risk to local tribal health programs. It would also afford California an equitable opportunity to obtain funding through the IHS operated CHEF fund and help establish a more complete continuum of care.

Our analysis indicates that there is currently $19,355,000 in unfunded hospital costs from 700 unfunded hospital discharges for IHS Active Users in California. The requested $2,000,0000 for the California CHS Demonstration Project which would fund approximately 72 cases, given that the average cost of a hospital discharge in California is $27,650. Additionally, there could be as many as 20 high cost cases that would be newly eligible for CHEF reimbursement. A Congressional commitment to fully fund such an intermediate risk pool over a multi year period could easily serve as a model to address the issue of CHS dependency in other IHS Areas including Portland, Nashville and Bemidji. Initial funding for the California CHS Demonstration project should be in the range of $2,000,000 to allow for administrative efficiency. A sum is small compared to the “staffing packages” that routinely accompany the opening of new hospitals in other areas a benefit that will never accrue to thinly populated hospital rich California Indian country.

IHS CHS program management statistics document that the California Area consistently has fewer CHS resources even when compared to the other CHS Dependent Areas.



Similarly the California Area has had less access to the Catastrophic Health Emergency Fund of all the IHS Areas even when compared to the other “CHS Dependent Areas”