



CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

For Immediate Release
June 26, 2019

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Forty Congressional Representatives Send Sign-On Letter to the Indian Health Service Requesting Answers and More Equitable Funding for Tribal Health Care Programs in CA

Roseville, CA — Tribes, Tribal Health Programs, and the California Rural Indian Health Board, Inc. (CRIHB), collaborated with forty Congressional Representatives this week to fight for more equitable health care funding for the 723,225 American Indians and Alaska Natives (AIANs) who live in California. Led by Representative Ken Calvert and Representative John Garamendi, a sign-on letter was sent to the Principal Deputy Director of the Indian Health Service (IHS) outlining four critical issues re: the substantial gaps in the IHS' ability to fund the California area to include: the facilities construction priority program, 105(l) lease program, joint venture facilities construction program, and Purchased/Referred Care (PRC) program.

Dr. Mark LeBeau, CRIHB's CEO, said, "I applaud the leadership our California Congressional Representatives have shown in supporting the sign-on letter to IHS. The IHS operates and/or indirectly resources hospitals, health centers, and staff living quarters in nearly every IHS service area, but has no such facilities in California. The California Area currently only has one IHS treatment center; Tribes in California have a right to equitable support and funding from the IHS."

The following forty California Representatives signed the letter requesting more equitable funding for the California IHS service area: Ken Calvert; John Garamendi; Doug LaMalfa; Pete Aguilar; Col. Paul Cook (Ret.); Raul Ruiz, M.D.; Tom McClintock; Jared Huffman; Harley Rouda; Norma J. Torres; Judy Chu, Ph.D.; Ted W. Lieu; Mark Takano; Mike Thompson; Tony Cárdenas; Gilbert R. Cisneros, Jr.; TJ Cox; Katie Porter; Salud Carbajal; Devin Nunes; Alan Lowenthal; Jimmy Gomez; Jim Costa; Zoe Lofgren; Josh Harder; Juan Vargas; Katie Hill; Doris



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Matsui; Julia Brownley; Lucille Roybal-Allard; Jackie Speier; Scott H. Peters; Ami Bera, M.D.; Susan A. Davis; Mark DeSaulnier; Brad Sherman; Nanette Diaz Barragán; J. Luis Correa; Duncan Hunter; and Linda T. Sánchez.

A copy of the letter is included below, beginning on page 3.

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CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

Congress of the United States

Washington, DC 20515

June 17, 2019

Rear Admiral Michael D. Weahkee
Principal Deputy Director
Indian Health Service
5600 Fishers Lane
Rockville, MD 20857

Dear Rear Admiral Weahkee:

We write regarding substantial gaps in the Indian Health Service's (IHS) ability to serve the more than 723,225 American Indians and Alaska Natives (AIANs) residing in California. IHS operates and/or indirectly resources 10 hospitals, 25 health centers, and 11 staff living quarters in nearly every service area, but has no facilities in California.¹ The Youth Regional Treatment Center in Hemet, California is the only IHS facility in the entire state.

While we understand that IHS plans to build additional healthcare facilities in the years ahead, the California service area is not listed to receive any despite encompassing the largest number of federally recognized Tribes and greatest AIAN population of any state. IHS must not continue to ignore Tribes who have repeatedly expressed the dire need for these facilities in California.

Due to poor IHS support and insufficient federal funding, Tribes in California have taken on sizable federal and additional loans to build facilities and renovate old community buildings so that IHS-care can be provided to AIANs in local service delivery areas. In order to lessen this significant financial burden, IHS must ensure that the Tribes in the California service area have access to the Health Care Facilities Construction Priority Program or a comparable program providing additional federal support. **The Agency is obligated to create pathways of access to Tribes in the California Area. How will IHS ensure that Tribes in the area can access construction program funding of this type?**

Regarding 105(l) leases, IHS must compensate a Tribe or Tribal organization for reasonable facility expenses that include rent; principal and interest paid or accrued; and operation and maintenance expenses. **IHS must also ensure that California Tribes are afforded equitable access to this program. How will IHS accomplish this? Will IHS commit to increasing the FY 2021 IHS top line budget to reflect increased utilization of this authority?**

Tribes in the California service area have persistently called for IHS to also provide access to the IHS Joint Venture Construction Program. This program funds the staffing for primary care health centers or inpatient hospitals if a Tribe can fund the construction of the facility. Since 2003, IHS has denied all California applications submitted by six Tribal Health Programs that serve twenty two Tribes. Only one project in California has been approved, while different service areas have received support for multiple projects.² IHS must ensure that applications from Tribes in California are treated fairly and without bias in the review and decision-making process. **How will IHS accomplish this and work to expand access to this important program for California Tribes?**

¹ Indian Health Service (IHS). *Indian Service Health Care Facilities Construction Program Summary Report*, Rockville, MD June 2017
https://www.ihs.gov/dfpc/includes/themes/newihstheme/display_objects/documents/projects/VerticalSummaryReport92toNow.pdf

² *Ibid.*



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As California has no IHS-funded hospitals, it is designated as a Purchased/Referred Care (PRC) Dependent Area. Tribes in the California service area must use their extremely limited PRC funding to cover the costs of placing patients in non-IHS/Tribal hospitals and/or buying other specialty care services.

The 2012 Government Accountability Office (GAO) report, *Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program*, notes that the distribution of PRC funding amounts varies widely across Areas and provides recommendations for remedying inequitable funding.³ The report states:

“Per capita PRC funding for fiscal year 2010 ranged across the Area offices from \$299 to \$801. In addition, per capita PRC funding was sometimes not related to Areas’ dependence on PRC for the provision of IHS-funded inpatient services. For example, California received a level of per capita funding that was in the lower half of the range for all Areas, while AIANs in that Area rely entirely on PRC for their IHS-funded inpatient services because there are no IHS or Tribally-operated hospitals... IHS can improve the equity of how it allocates program increase funds to Areas through improvements in its implementation of the PRC Allocation Formula [by refining among other factors]...the access to care factor to account for differences in available health care services at IHS and Tribally operated facilities.”

Tribes in California have urged IHS and Congress, the PRC Dependent/Access to Care Factor should be moved from the Programs Increases category to the Annual Adjustment category in the PRC Funding Distribution Formula. By moving this factor, IHS will increase the potential for PRC Dependent Areas to receive funding, thereby reducing funding inequities as specifically authorized in the Indian Health Care Improvement Act (25 U.S.C. 1621(a)(4)). **Will IHS implement this change, as requested by California Tribes and as referenced by the GAO report?**

We respectfully request that IHS provide a written response to the issues outlined in this letter. Thank you for your leadership and attention to our request.

Sincerely,

KEN CALVERT
Member of Congress

JOHN GARAMENDI
Member of Congress


DOUG LAMALFA
Member of Congress

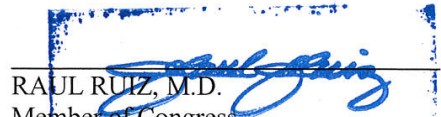
PETE AGUILAR
Member of Congress


³ Government Accountability Office (GAO). *Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program* (PRC), Washington, D.C. June 2012. <https://www.gao.gov/assets/600/591631.pdf>




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