CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

March 25, 2009

Appropriations sub committee for the Interior and related agencies.

My name is James Allen Crouch I am Executive Director of the California Rural Indian Health Board Inc.

The California Rural Indian Health Board Inc.(CRIHB) is a Tribal Organization operating under the authorities of the Indian Self Determination Act, providing health care services and technical assistance to 21 tribes and their Tribally Operated Health Programs. We are a founding member of the National Indian Health Board (NIHB) and proud of the fact that our CRIHB Chairman, Reno Keoni Franklin (Kashia Pomo), was elected Chairman of the NIHB in January of this year. In addition to the services we provide to 21 tribes, CRIHB operates two programs funded by the CDC and one program funded by SAMHSA that benefit Indian people in Nevada, Utah, Washington, Oregon, and Idaho. We are also funded by the IHS to serve as the California Tribal Epidemiology Center and the Dental Support Center for the California Area. Finally, we operate a number of smaller statewide projects funded by the State of California and private foundations in California. These diverse responsibilities give us a unique "front line" perspective on the problems that confront Tribally Operated Health Programs in California and beyond.

We are specifically requesting $2,000,000 in Contract Health Service (CHS) funds to initiate the an intermediate risk pool to cover costs below the threshold of the Catastrophic Health Emergency Fund (CHEF) as authorized in Section 211 of the IHCIA and subsequent reauthorizations of that bill. Furthermore, we support an allocation of $100 million for the IHCIAF and the CSC line item, respectively.

CRIHB was founded in 1969 by Tribes in California to bring back IHS funded services to California after twenty years of being neglected as a result of federal termination policy. In 1972, this Committee overturned that policy and funded the first IHS programs in California. This October CRIHB will be forty years old -- but our work is not yet finished. Today the IHS program in California suffers from chronic under-funding, a lack of infrastructure, and burdened by debt; the initial promise remains unfulfilled. Today all IHS direct care services in California are provided by a network of 30 Tribally Operated Health Programs (TOHP) that provide services across thirty-seven mostly rural counties with an average operating unit size of 1,875 active users. These TOHP seek to meet the needs of 107 federally recognized tribes and approximately 77,000 American Indian and Alaska Native clients. Uniquely, 25% of those served in California are members of tribes located outside of the state and another 25% are Californian Indians whose tribes have yet to achieve federal recognition. The California Area is one of only two IHS Areas that have no IHS Hospitals to provide inpatient and specialty services. Of the four so-called "CHS Dependent Areas", California has the second lowest Level of Need Funded, the second lowest CHS allocation per active user, and the absolutely lowest CHEF utilization rate of the entire IHS system. These are not new facts -- rather an ongoing crisis reflected in a decade of IHS funding history.

Many health problems in California are similar to those of the National IHS service population. CRIHB research has documented a hospitalization rate of 290/100,000 which is comparable to

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that experienced in the Aberdeen Area of North and South Dakota. California AIAN are hospitalized 45% more often than Whites, indicating a lack of access to primary care services. Heart Disease, Cancer, Unintentional Injuries, Diabetes, and Chronic Liver Disease are the leading causes of death. Death rates due to diabetes are 350% higher for California AIAN than Whites; deaths due to alcohol are 280% higher. Of our SAMHSA Access to Recovery clients, 46% report Methamphetamine use - the highest reported rate in that national data set. These problems can and should be addressed. A recent CRIHB research project based on five years of IHS and State data documented that higher IHS funding of Tribally-Operated Health Programs in California was associated with lower hospitalizations for ambulatory care sensitive situation (HASC) for the AIAN who use them. Specifically, for Tribally-Operated Health Programs in California with less than 60% of health care costs funded, the HASC rate dropped 12% for every increase of 10% in funding of ambulatory care preventable hospitalizations.

The most effective method of addressing the lack of primary care across the whole IHS program would be a multi-year commitment to providing a significant portion of new IHS resources to be distributed throughout the Indian Health Care Improvement Fund. This historically under-utilized process adopts the Federal Employees Health Benefit Package (FEBP) as a benchmark to compare against the available IHS and CMS funds at the operating unit level. This focus on available funding allows for comparison across a diverse delivery system that spans multiple health service markets. The benchmark cost is actuarially adjusted for age sex and social economic factors to reflect the IHS client population. The difference between the adjusted FEBP costs and the available IHS and CMS resources is then calculated and is referred to as the Level of Need Funded, and all 269 Operating Units are ranked on this scale. With limited funds, Congress has tried to target their commitment to the least well funded: Operating Units with less than 40% of their need funded. However, to date, Congressional allocations to the IHCIF have failed to match medical cost inflation and have yet to lift the 47 poorest operating units to the 40% level. To bring this group to 40% would take an additional $9 million in new funds. To bring all units up to 45% would take only $45 million, to achieve 50% funding only $122 million, and to achieve 60% for all operating units would take only $388 million in new appropriations to the IHCIF. These threshold numbers may be reduced by increases in the other IHS health services line items, but only the IHCIF targets the vast inequity that exists within the system. Achieving a modest threshold of 60% Level of Need Funded should be done over a three year period, although inflation during that same three years could significantly increase the cost.

Contract Support Cost Funds are essential for maintaining program integrity to assure appropriate governance, financial management, and core operating costs. Tribally Operated Health Programs are the only class of governmental contractors who are not fully funded for these costs. National shortfalls prior to the allocation of the FY 2009 OBRA was documented by the IHS as $121,900.000. Of this amount, Tribally Operated Health Programs in California have a documented shortfall of $12,621,782. CRIHB and our subcontracting Tribal Health Programs are owed $2,993,949. Congress should address this shortfall and end this operational burden that falls on only a portion of the IHS program: those that choose to assume operational responsibility for their portion of the IHS program under the Indian Self Determination Act.

The IHS Facilities Construction has yet to build a single health facility in California. In truth, most of our facility construction needs are better met through a robust Contract Health Services program. We have 172,000 square feet of IHS supportable space, built with grants, loans, and third party collections. This strategy is born from desperation and has significant impacts as both loan repayment and sequestering third party funds result in an ongoing reduction in the level of health care services that can be provided to our clients. To address this distortion, Congress should increase their investment in the Joint Venture and Small Ambulatory Grant program. This is especially true if this Congress authorizes the Tribal version of the Indian Health Care Improvement Act, which would allow for the use of SAP funds to retire loan amounts used to create IHS supportable space. Clearly, there are interactions between the IHS services budget and the facilities budget. Potentially, there is a positive exchange between facility construction and CHS funding in the measurement of program equity; this needs to be more fully analyzed and developed. Similarly, there is a need to think more clearly about the annual impact on overall IHS program equity when significant amounts of scarce program funding must be allocated to staff the facilities of the luck few who acquire facility construction funds. This is especially true as the system prepares to staff up $227 million in ORRA construction projects.

The Indian Health Service has reported their budget justification document that 106 of their 400 provider sites have now made the transition to the new RPMS Electronic Health Record. CRIHB fully supports the move towards increased use of Health Information Technology within the IHS. What the IHS did not state in their justification was that nationally, over 20 Tribally operated health contractors have chosen an alternative to the IHS EHR and Practice Management system in favor of off-the-shelf products developed and supported by NextGen that more clearly meets both the Presidents standards for interoperability and CHITA certification. These THOP have been systematically excluded from staff and funding support from the IHS; at the same time the agency has invested millions into the RPMS system. RPMS has been greatly improved but it still falls short in three critical ways: 1) It does not yet support e-billing prescriptions, 2) it does not have a data scanning capacity to allow for medical records from non IHS providers to be shared, and 3) the Practice Management portion is still not CHIT Certified. Ironically, the IHS will soon be buying a NextGen owned Dental Practice software package to be the IHS standard Dental module. Tribal Health Programs that choose to move off the RPMS system to some other CHITA certified system should be supported by IHS technical staff and funded for the cost of licenses in some way comparable with the development costs that are now routinely invested into the RPMS system. This years' committee reports should direct the IHS to develop such a policy and begin sharing there resources on the same basis with non RPMS users.

Finally I would like to urge a commitment to addressing the ongoing lack of CHS funding in California and the resulting lack of access to the CHEF fund. CRIHB Research shows that our clients leave $18 million in bad debut at California hospitals. Below are charts that document the long history of this issue. The crux of the problem is that the IHS allocation process for CHS does not adequately respond to the lack of access to hospital services. The solution is direct funding for Section 217 as authorized in the IHCIA or its successor. Section 217 sets up an intermediate risk pool to cover costs of individual CHS cases over an establish threshold and below the threshold of the CHEF fund. This would mitigate the financial risk associated with operating a CHS program for very small operating units with out any access to directly operated hospital level services.

AREA OFFICE	CHEF Cases per 1000 Users [2001 -2008]								
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	AVERAGE
Aberdeen	1.10	1.08	1.01	0.66	0.58	0.65	0.75	1.01	0.85
Alaska	0.87	0.74	0.66	0.68	0.53	0.60	0.86	0.93	0.73
Albuquerque	0.57	0.46	0.60	0.28	0.35	0.32	0.25	0.63	0.43
Bemidji	0.20	0.19	0.13	0.48	0.10	0.28	0.32	0.22	0.24
Billings	3.01	2.67	1.99	1.83	1.98	1.55	2.18	2.64	2.23
California	0.12	0.16	0.06	0.22	0.10	0.19	0.05	0.04	0.12
Nashville	0.99	1.65	1.62	1.48	1.55	1.54	1.32	0.99	1.39
Navajo	0.28	0.32	0.39	0.33	0.28	0.35	0.28	0.69	0.37
Oklahoma	0.32	0.11	0.21	0.26	0.36	0.18	0.28	0.51	0.28
Phoenix	0.52	0.20	0.33	0.15	0.33	0.45	0.25	0.68	0.36
Portland	0.36	0.35	0.43	0.60	0.84	0.75	0.80	0.62	0.59
Tucson	0.04	0.51	0.17	0.08	0.25	0.08	0.20	0.79	0.27

California CHS Demonstration Project							
Decision Matrix							
AREA	Active Users	CHEF				CHS	
		# Cases	AMOUNT	CHEF Cases per 1000	CHEF $ per 1000	AMOUNT	Avg CHS $ per AU
Aberdeen	120,639	122	$2,582,498	1.01	$21,407	$63,520,134	$527
Alaska	136,065	127	$3,980,572	0.93	$29,255	$57,969,385	$426
Albuquerque	85,778	54	$868,987	0.63	$10,131	$27,397,482	$319
Bemidji*	101,022	22	$626,722	0.22	$6,204	$38,247,233	$379
Billings	70,507	186	$3,727,076	2.64	$52,861	$46,477,293	$659
California*	77,532	3	$45,721	0.04	$590	$28,280,641	$365
Nashville*	51,399	51	$1,750,175	0.99	$34,051	$22,381,890	$435
Navajo	239,814	166	$3,817,003	0.69	$15,917	$63,794,083	$266
Oklahoma	316,940	163	$4,488,980	0.51	$14,164	$69,153,183	$218
Phoenix	156,803	107	$2,634,050	0.68	$16,798	$47,566,578	$303
Portland*	101,690	63	$1,667,053	0.62	$16,393	$63,563,841	$625
Tucson	25,234	20	$389,963	0.79	$15,454	$13,879,895	$550

California	77,532	3	$ 45,721	0.04	$ 590	$28,280,641	$365
All CHS Dependent	331,643	139	4,089,671	0.42	$12,332	152,473,605	$460
All Non-CHS Dependent	1,151,780	945	22,489,129	0.82	$19,526	389,758,033	$338

*CHS Dependent = Bemidji, California, Nashville, Portland

Note: All data above is from FY 2008