TESTIMONY by Dr. Mark LeBeau

Assembly Health Committee
Dr. Jim Wood, Chair
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Informational Briefing: The Unique Health Care Needs of Rural Populations

How Health Care is Delivered: Indian Health Service Facilities

American Indians /Alaska Natives (AI/AN) in California face unique health challenges and disparities, from having the highest rates of diabetes, heart disease and asthma among any racial or ethnic group, to experiencing persistent barriers to health care and insurance. Census data reveals that approximately 30% of all AI/AN live in poverty, with more than half of AI/AN single mothers in poverty. AI/AN health leaders also experience a scarcity of resources and data on a broad range of health topics for planning, decision-making and advocacy.

The mission of the California Rural Indian Health Board (CRIHB) is to develop, advocate for, and deliver policies, plans, programs, and services that elevate the health status and social conditions of Indian People. Incorporated in 1969, CRIHB is one of the oldest health organizations serving AI/AN in California. CRIHB is sanctioned by California tribes to operate under the Indian Self-Determination and Education Assistance Act and is a non-profit Tribal organization. CRIHB's network of 12 Tribal Health Programs (THPs) with multiple satellite clinics serve over 28,000 patients representing 33 federally recognized tribes.

There are 109 federally recognized Tribal governments in California, with another 87 tribes petitioning for recognition, making it the state with the largest number of tribes and AI/ANs in the country. *(See enclosed sheet for more information.)* According to the 2010 U.S. Census, California accounts for roughly 14 percent (725,000) of the nearly 6 million population that identified themselves as Native American, either alone or in combination with one or more races. Of that number, approximately 2.2 million are eligible to receive services from the Indian health system.

The Bureau of Indian Affairs maintains a list of all federally recognized tribes, currently 567 in number nationally, which have a government-to-government relationship with the United States. In more recent times, California and many states have recognized a government-to-government relationship with tribes as well.[1] The Indian Reorganization Act of 1934 recognized the authority of tribes to enact Constitutions and organize their governments. Today, while tribes generally all enjoy the same sovereign status, each tribal government is unique both culturally and in the way its governing institutions operate.

Over the past 100 years, the federal Indian policy of Congress has been described as a pendulum because it has varied so widely between assimilation and termination on the one hand, and recognition of tribal sovereignty and restoration of homelands on the other. In 1852, the United States Congress voted not to ratify 18 treaties negotiated in 1851 and 1852, reserving millions of acres for more than 100 tribes in California. The incident of the "lost treaties," which rendered many Indians in California landless, is the foundation of many of the land tenure struggles Indians

[1] See, e.g., California Governor Jerry Brown's Executive Order B-10-11.

in California endure today.[2] In contrast to the 8.5 million acres promised to them in the treaties, today the 109 federally recognized tribes own less than 1% of land within California, including Reservations, Rancherias, individual trust allotments, and other forms of Indian land ownership.

Fortunately for tribal governments, since 1975, when the Indian Self Determination, Education and Assistance Act (ISDEAA) was passed, tribes are generally recognized as sovereigns. Thanks to the ISDEAA, tribes today--through contract or compact with the federal government--provide services and programs to their own communities on behalf of the federal government, including those provided by the Indian Health Service and the Bureau of Indian Affairs.

The federal Indian Health Service (IHS) is responsible for providing health services to American Indians and Alaska Natives (AI/AN). Health services for AI/ANs are based on a historical legal responsibility identified in treaties with the United States government. This "trust" responsibility includes the obligation to provide education, health, law enforcement, and many other services to tribal communities, and in exchange tribes relinquished most of their homeland to the United States. The federal trust responsibility is a legal and moral obligation to tribes that has been at the heart of many significant Indian law cases, making it a central principle of federal Indian law. California voluntarily accepted this responsibility by adopting Public Law 83-280 in 1954, which allowed for State jurisdiction over some Indian affairs.

As a result of displacement policies over centuries, much of our American Indian/Alaska Native population reside in isolated, rural, and frontier areas of the state. In many of the rural areas in Indian Country, the reservation or rancheria is some 20-50 miles or more from the nearest hospital. That is the case in the high deserts of southern and southeastern California, and around the mountains of the northern and eastern parts of California. There are also tribes close to the border region (or across borders) of other states, such as Arizona, Oregon, and Nevada.

All Tribal Health Programs (THPs) receive funding support from IHS. However, you may be unaware that they remain underfunded at 52% of current levels of need. This is a result of IHS's annual appropriations based on 1991 user data that fund operation budgets of health programs, and also owing to negligible increases over many decades to cover fixed costs. There are no IHS constructed facilities in California currently. Notably, the method to determine the IHS Facilities Construction Priority List has not been revamped since 1993. Only one AI/AN community in California made the "grandfathered priority list" of pre-1993 projects. In 2015, only two-thirds of the 1993 facility priority list was complete, with the remaining estimated for completion by 2041. According to the "2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress", the magnitude of need caused by an aging infrastructure and its rising maintenance coupled with accumulated unaddressed need is enormous. In fact, at the current rate of Health Care Facility Construction (HCFC) appropriations and existing replacement rate, a new 2016 facility would not be replaced for 400 years.[3]

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[2] William Wood, *The Trajectory of Indian Country in California: Rancherias, Villages, Pueblos, Missions, Ranchos, Reservations, Colonies, and Rancherias*, 44 Tulsa L. Rev. 317 (2008), p. 24 (citations omitted).

[3] The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress, p. 3.

California has the largest number of Tribes and AI/AN of any state in the country. In spite of these factors, the allocation of Indian Health Service (IHS) resources to the California IHS Area is inequitable. This inequity has resulted in compromised care for AI/AN. This resource imbalance is well-documented in numerous Government Accountability Office (GAO) reports, the most recent from June 2012. After reviewing the issue, the GAO wrote, "IHS's continued use of [its current] methodology undermines the equitable allocation of IHS funding to meet the health care needs of [the AI/AN population]". AI/ANs born today have a life expectancy that is 4.5 years less than the U.S. all races population (73.7 years to 78.2 years respectively)[4].

Counties, which calculate and receive funding through the state to serve all residents in their regions, often have cultural and other barriers to serving the AI/AN population and do not subcontract with the Indian clinics to provide these services. California providing Indian clinics with recurring state healthcare funding or requiring counties to contract with Indian clinics would resolve this issue. This would honor the State's trust responsibility to American Indians in the field of healthcare. California voluntarily accepted this shared responsibility by adopting Public Law 83-280 in 1954, which allowed for State jurisdiction over some Indian affairs. The state also continues to benefit today from the land transfers or appropriation of millions of acres and natural resources. As a result of displacement policies over decades and centuries, much of our AI/AN population reside in isolated, rural and frontier areas of the state. In many of the rural areas in Indian Country, the reservation or rancheria is some 20-50 miles or more from the nearest hospital. That is the case in the high deserts of southern and southeastern California, and around the mountains of the northern and eastern parts of the state.

Additionally, in order for Tribal providers to participate in the Targeted Case Management (TCM) program, the Welfare and Institutions Code Section 14132.44, which defines local governmental agencies as a county or chartered city, must be modified to include "Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization." Providers of TCM services are limited to Local Governmental Agencies (counties and chartered cities) under contract with the Department of Health Care Services, as identified in the California State Plan. The TCM program is funded with a combination of local and federal Title XIX (Medicaid) funds. The TCM program reimburses participating counties for the federal share of costs (typically 50%) for case management services provided to Medi-Cal beneficiaries in specific target populations. Participating counties use their certified public expenditures (CPEs) to draw down federal funds. Currently, no tribal health programs contract directly with the State or through subcontracts with Local Government Agencies who provide TCM services.

For multiple years in a row, CRIHB has assiduously argued for reinstatement of the Indian Health Program (IHP) run by the Department of Health Care Services (DHCS), at the Medi-Cal Tribal Designee Meetings. These programs included the Indian Health Program, American Indian Infant Health Initiative, and Tribal Emergency Preparedness Program. The IHP distributed state funds to a large number of Tribal Health Programs, to cover services for mental health and substance use disorders. Whereas the IHP used to be funded at $6.4 million, the bulk of the funding has been eliminated. In order for IHP to achieve its mission to improve the health status of AI/ANs living

[4] DHHS, Indian Health Service, Division of Program Statistics (DPS). Trends in Indian Health, 2014 Edition.

in urban, rural, and reservation or rancheria communities throughout California, funding of at least $6.4 million is required to restore Indian health initiatives.

In order for a tribal providers to participate in the Targeted Case Management (TCM) program, we need to modify the Welfare and Institutions Code Section 14132.44, which defines local governmental agencies as a county or chartered city, to include "Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization."

Tribal community-based clinics cannot afford to hire and maintain a number of provider types, including mental health providers, dentists, and other professionals, while at the same time upgrade their telehealth capabilities, keep up with industrial technology (IT) requirements, Health Insurance Portability and Accountability Act (HIPAA) and electronic health records. **They often have to make hard choices about which components of their clinic system to maintain and enhance.** It is axiomatic to underscore that, in hiring and retaining providers, Indian rural clinics often cannot compete with more lucrative health care systems in urban settings. In addition, many providers are not willing to live in rural communities, especially in the more remote areas of California.

Thus some of the recommendations that we would like to discuss are:

1) Through reinstatement of the Indian Health Program, expand the number of behavioral health professionals that provide high quality and culturally relevant mental health services to AI/AN communities.
2) Establish a supplemental crisis fund with the goal of providing assistance to prevent reoccurrences to Tribes experiencing behavioral health crises, including specialized crisis response staffing, technical assistance, and community engagement.
3) Fund expansion of substance use and/or suicide prevention programs to focus on hiring additional personnel to improve behavioral health services and prevention programming for AI/AN youth.
4) Amend the Welfare and Institutions Code to enable Tribal providers to participate in the Targeted Case Management program.

IN CLOSING, Tribal representatives have consistently expressed serious concern about the lack of fundamental fairness in IHS allocation of resources to California and how this is severely impacting the health and wellbeing of AI/AN in the California. State law and policy improvements are needed to address this inequity and minimize California AI/AN disparities in health outcomes.[5]

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[5] According to IHS data, AI/AN die at higher rates than other Americans from alcoholism (552% higher), diabetes (182% higher), unintentional injuries (138% higher), homicide (83% higher), and suicide (74% higher).

Demographic Characteristics of American Indians/Alaska Natives in California

How many Tribes are in California?

There are 109 federally recognized Tribes, with 87 seeking federal recognition. The latter figure includes about 44 tribal communities of formerly recognized Tribes that were terminated as part of the United States termination policy in the 1950s; in addition, there are also tribal communities that were never recognized by the federal government.

Where are the Tribes located?

In rural and frontier areas, often some 50 miles from the nearest hospital
In the mountains of northern and eastern California
In the high deserts of southern and southeastern California
On the coast, on the rivers, and around the lakes
Near highly populated cities like Los Angeles, San Francisco, San Diego, and Sacramento
Close to or straddling the borders of other states, such as Arizona, Nevada, and Oregon

How many Native Americans reside in California?

California has the highest Native American population in the country. According to the 2010 U.S. Census, California residents represent 12 percent (approximately 720,000) of the total population that identified themselves as Native American. Over one-half of the state's Native American population is composed of individuals (and now their descendants) who were relocated to large urban areas as part of the federal government's termination policy and the California Rancheria Termination Act of 1958.

How large are the Tribes?

California's tribes are as small as five members and as large as 5,000 members. Compare these numbers to those of Oklahoma's tribes, for example, which range from 200 to 315,000 members.

What Tribal programs are in place today?

There are no Indian Health Service (IHS) facilities in California. Tribes own and operate their own health programs through contracts and compacts with IHS under the federal Indian Self-Determination and Education Assistance Act. Many of these programs provide their own counseling and treatment programs. In urban areas, there are urban Indian health programs funded in part by federal dollars.