RIVERSIDE – SAN BERNARDINO COUNTY
INDIAN HEALTH, INC.

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I am Catalina VillaMontes and I am the Treasurer of the Board of Directors for the Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI), located in Southern California. I am also a member of the Pechanga Band of Indians, one of nine consortium Tribes of RSBCIHI and I also serve on the California Rural Indian Health Board. The health and welfare of my people, the Indian Communities served by RSBCIHI, is my highest priority. Therefore, I am honored to have the opportunity to testify today.

First, I would like to start by thanking Congress for providing advance appropriations for the Indian Health Service beginning in FY 2023. This mechanism will help our Tribal health programs maintain consistency and continuity in our programs, without the threat and disruption of potential shutdowns and continuing resolutions.

Increasing the IHS Budget

The Fiscal Year 2023 President's budget included a 10-year proposal to fully fund the Indian Health Service. "Full funding" meant raising the IHS budget to approximately $36.7 billion. Only a year later, due to inflation and rising health care costs, that top line number has skyrocketed to $54 billion. Yet, the total agency appropriation remains less than $10 billion. While we provide specific comments below, we cannot overemphasize the fact that our health programs are not adequately funded and patient care suffers as a result. If we are going to make good on the Indian Health Care Improvement Act's lofty goals of eliminating health disparities between Alaska Natives and American Indians and the general population of the United States, we simply need more resources to do so. An agency created by the federal government based on existing treaties funded at 1/6th the level of need will continue to hold us back.

We also need new resources to be made available through self-determination contracts and compacts, rather than through grants, so all programs can benefit from the additional amounts. Doing so will also simplify the allocation and payment process, and will ensure overhead costs are covered by the Contract Support Cost (CSC) appropriation.

Simplifying Contract Support Cost Administration

We continue to support the full funding of contract support costs—the funding that covers our program overhead and administrative costs so the program funds we receive can remain dedicated toward healthcare services to our Indian communities. We respectfully request the Committee move the contract support cost and 105(l) lease appropriation subaccounts to the mandatory side of the budget, again providing greater

certainty for our health care programs.

We also ask Congress to simplify the IHS calculation, payment and reconciliation of contract support costs to alleviate the significant burden on Tribes and the growing bureaucracy at IHS necessary to implement current contract support cost policy. In response to full funding of contract support costs, both the BIA and IHS took divergent approaches to calculating the amounts owed. The BIA relied on Tribal costs incurred and the federally-negotiated indirect cost rates, whereas IHS added a number of carve outs and caveats that complicated the calculations. Indeed, one of these lesser-known "triggers" in the IHS contract support cost policy was relied upon by the agency when it drastically cut the funding of the Fort Defiance Indian Health Board by over 90% in 2021. We support the enactment of H.R. 409 sponsored by Representative Tom Cole of Oklahoma to protect Tribal programs from such drastic reductions.

We also ask the Committee to order IHS to eliminate its burdensome "reconciliation process," which happens years later after our books are closed. The amount of resources spent on the reconciliation process on both the Tribal and IHS side do not make sense given that our indirect cost rate adjusts each year based on any over or under-recovery.

<u>Increasing Purchased/Referred Care (PRC) Funding</u>

I reside in California, one of the four Indian Health Service Areas that are designated "PRC dependent," meaning we have little or no access to an IHS or tribally-operated hospital and therefore must purchase all or a large portion of inpatient and specialty care from non-tribal providers at a significantly higher cost. However, our current PRC funding is insufficient to meet the need for specialty care, especially without access to a Tribal hospital. The result is that our patients are simply asked to go without the higher level care they need unless they have alternate resources. We ask this Committee to provide additional PRC funding for PRC-dependent areas, and to ensure that "access to care" is appropriately accommodated as resources are distributed.

IHS is currently conducting "feasibility studies" regarding two new Regional Specialty Care Centers that are intended to alleviate the pressure on our PRC budgets without impacting our already scarce clinic shares of PRC dollars. We support these facilities as to what they can bring to our patients and ask for prompt funding of any requests relating to these Centers that may come before this Committee in the future.

We thank you again for your time and consideration.