



RIVERSIDE – SAN BERNARDINO COUNTY INDIAN HEALTH, INC.

11980 Mt. Vernon Ave, Grand Terrace, CA 92313 • (909) 864-1097

House Committee on Appropriations
Subcommittee on Interior, Environment and Related Agencies
Testimony of Teresa Sanchez, Board Vice-President
Riverside-San Bernardino County Indian Health, Inc.
Concerning the FY 2020
Budget for the Indian Health Service
March 6, 2019

I am Teresa Sanchez and I am the Board Vice-President for Riverside-San Bernardino County Indian Health, Inc., located in Southern California. I am also a member of the California Area Tribal Advisory Council and a member of the Morongo Band of Mission Indians. Mrs. Brandie Miranda Greany is also a member of the California Tribal Advisory Council and a member of the Pechanga Band of Luiseno Indians. Thank you for the opportunity to testify concerning the health needs of Native Americans funded through appropriations to the Indian Health Service (IHS).

Increased Funding for Tribal Clinics

There is a desperate need for increased funding for tribal clinics to keep pace with inflation and population growth. Despite the large increases in the overall IHS budget in FY 2018, we received no increase from FY 2017. We had anticipated a \$1.5 million to \$2 million increase based on the national IHS budget receiving an overall 9.9 percent increase that year, but instead we were flat funded. Even worse, we did not find out the final amount we would receive until the last day of the fiscal year—after services had been provided and costs had been incurred. This situation is untenable if we are going to continue providing the same level of services to the over 15,000 patients we serve each year.

This problem has been exacerbated by agency decisions to reallocate funds that were appropriated to ensure tribal clinics can keep up with the rising costs of medical care. For instance, in FY 2018, the Acting IHS Director reallocated \$25 million of inflation funding to pay for the unfunded costs of new section 105(l) leases. These funds should have come to the clinics for base direct services funding. Instead, IHS issued a consultation request with only 12 working days to respond after the July 4th holiday. That is not meaningful consultation. And, to compound matters, IHS did not inform the Tribes of its final funding decision until mid-September. Moreover, IHS had \$33 million

of unspent funding in the discretionary CHEF account (more on that below), which they could have used to cover this shortfall, but instead chose to roll that over into the next fiscal year, leaving tribal clinics coming up short. We raised the lack of transparency at the national IHS level with the Acting Director and have received only unsatisfactory responses. We ask that funds be appropriated for general base increases for population growth and inflation rather than specific targeted increases that the agency considers “non-recurring” or that only benefit special projects.

Increased Purchased/Referred Care (PRC) Funding for “PRC Dependent” Areas

Four of the 12 Indian Health Services (IHS) Areas are designated “PRC dependent,” meaning they 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 significantly higher cost. Our region, the California Area, has no tribal hospitals and since we receive only limited PRC funding, we often run out well before the end of each fiscal year. This leads to the outright denial or rationing of critically-needed inpatient and other specialty services. However, the formula used to allocate PRC funding to different IHS Areas tends to treat our clinics just like those in the remaining eight IHS areas, where PRC dollars are used to supplement care provided at nearby IHS hospitals.

The current IHS PRC allocation formula places the “PRC Dependent” designation and ability to access care factor in the lowest-priority Program Increases category. Since the Base Funding category gets funded first, followed by the Annual Adjustment category and then the Program Increases category, the Program Increases category hardly ever receives an increase. The large appropriations for the Indian Health Care Improvement Fund in recent years has failed to change this situation, even though eliminating inequities in funding for PRC is a key goal of that Fund. See 25 U.S.C § 1621(a)(4). We ask that IHS be directed to address access to care issues and prioritize this factor in the PRC formula so we no longer have to deny necessary care due to funding shortfalls.

Changing the Threshold for CHEF Funding

For years, tribal advocates have pushed for lowering the threshold to access the Catastrophic Health Emergency Fund (CHEF). This fund pays for catastrophic medical costs that rise above \$25,000; any bills that do not reach that limit are the sole responsibility of tribal clinics using their limited PRC funding. The IHS Acting Director has not moved forward on the recommendation to reduce the threshold from \$25,000 to \$19,000, which would provide some relief to tribal PRC budgets, even though the issue has gone out for comments twice in the Federal Register. The Acting IHS Director justified his actions by stating that in order to change the threshold, the agency must consider an inflation factor and with the inflation factor they were using, it would take ten years to catch up to the existing threshold of \$25,000, leaving access to the funds limited by Tribal clinics in the meantime. However, tribal representatives pointed out that a great deal could change over the next 10 years and the program had a \$33,000,000 surplus for FY 2018, so there is no reason to starve tribal programs

that in turn have to cut services or deny care entirely due to a lack of funding. We ask that you instruct the agency to lower the CHEF threshold.

We thank you for your time and consideration.