RIVERSIDE – SAN BERNARDINO COUNTY
INDIAN HEALTH, INC.

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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 2021 Budget for the Indian Health Service
February 11, 2020

I am Teresa Sanchez and I am Vice-President of the Board of Directors for Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI), located in Southern California. I am also a member of the California Area Tribal Advisory Council and a Council member of the Morongo Band of Mission Indians. Also here today is Mr. Joseph Mirelez and Mr. Runningbear Ramirez. Mr. Mirelez is the Treasurer of the RSBCIHI Board of Directors and Vice-Chair of the Torres Martinez Band of Desert Cahuilla Indians. Mr. Ramirez is the Secretary of the RSBCIHI Board of Directors and a member of the San Manuel Band of Mission Indians. Our respective tribes are members of our Consortium. Thank you for the opportunity to testify.

105 (*l*) Lease Funding

I want to start by saying that the Indian Health Service's (IHS) 105(*l*) lease program has been very beneficial in our FY2019 and FY2020 budget years. Our Consortium puts the funding provided through this program to good use every day. Therefore, we strongly urge this Committee to continue to support the Tribes across the country on this critical funding issue by providing sufficient appropriations to fully-fund IHS' 105(*l*) lease obligations and by reclassifying 105(*l*) appropriations as an appropriated entitlement. This is especially important for Tribes in California because there is a general lack of funding for our California health facilities and these 105(*l*) lease monies help offset the present inequities stemming from that lack of funding. Simply put, California Tribes have not historically been funded to build Clinics and Hospitals in the ways that Tribes outside our state have been. Needless to say, this lack of facility and staffing funds has been a thorn in our sides for many decades.

Joint Venture Program

The Joint Venture Program, which provides monies to help Tribes build new Clinics, still continues to disappoint California Tribes. California has only had one Joint Venture Program funded in the state since the inception of the program. In the recent 2019 application process, seven tribal systems from California applied for this funding. However, we have been notified that none of those tribal health programs were asked to continue with the application process for consideration of the Joint Venture opportunity. This highlights another inequity issue for California; although the current Capital Projects for all of Indian Health Services are projected to be funded over the next 25 years, California does not have any projects on the current Capital Project Plan. This will

challenge us to use other sources of funding to improve our health clinics. The Joint Venture Program should be a strong tool for California Tribes to address current and future needs, but IHS does not appear to be seriously considering any California Joint Venture proposals. We urge the Committee to direct IHS toward addressing this problem.

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

Four of the twelve 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 a significantly higher cost. Our region, the California Area, has no tribal hospitals. However, the current PRC formula disproportionately affects California because it allocates PRC and hospital funding to those other 8 IHS Areas. This funding inequity tends to then treat our clinics the same as those in the remaining eight IHS areas who receive both PRC dollars as well as hospital funding. This impacts our specialty care access.

IHS does have an Access to Care "fairness factor" meant to remedy the funding inequities to the 4 PRC dependent areas. According to their own methodology, there are 3 levels of Priority. Our access to care factor is at the lowest priority level of 3. Unfortunately, the PRC monies run out before the access to care fairness factor can be calculated and distributed to benefit our area. The result is our Area rarely receive any access to care fairness PRC monies and therefore, falls further and further behind.

We ask this Committee to instruct IHS to move this Access to Care Factor from the lowest priority, Level 3, to Level 2 priority.

We thank you for your time and consideration.