RIVERSIDE – SAN BERNARDINO COUNTY
INDIAN HEALTH, INC.
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I am Teresa Sanchez and I am a long-standing member of the Board of Directors for the Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI), located in Southern California, as a representative of the Morongo Band of Mission Indians, one of nine consortium Tribes of RSBCIHI. I represent Native Americans in California on the California Area Tribal Advisory Committee, and care deeply about improving health care for Tribal citizens living in California. I am honored to have the opportunity to testify today.

Last year, RSBCIHI thanked Congress for providing advance appropriations for the Indian Health Service (IHS) beginning in FY 2023. The volatility of the appropriations process in the past few years have emphasized the importance of this mechanism, which has provided some ability to carry on services despite pauses, delays, partial funding and near shutdowns. Now is the time to go one step further to protect these vital funds and move the full IHS budget to mandatory appropriations. These are treaty and trust-based obligations historically agreed to by the United States and the Tribes that are not and should not be subject to discretionary or broad-based reductions.

The Current IHS Budget is Insufficient and Cutting it Will Only Exacerbate Long-Standing Disparities.

The Fiscal Year 2023 President's budget included a 10-year proposal to fully fund the Indian Health Service at $36.7 billion. Only a year later, due to inflation and rising health care costs, that top line number increased to $54 billion. With tariffs and stubborn inflation, the top line number has surely gone up, but the total agency appropriation remains less than $10 billion. We cannot close patient care obligations and gaps with programs that are severely underfunded. And since we must always operate our programs in an environment of scarcity, potential deficits, funding freezes—even temporary ones—have outsize consequences for our program. We have no means to float or replace federal funds, we simply have to reduce services.

We also ask that all direct care resources, including behavioral health care initiative funding, be made available through self-determination contracts and compacts, rather than through grants, so all programs can benefit and so it is understood these are not discretionary pilot or grant programs, but required behavioral health funding. We face a public health crisis given the impact of the opioid epidemic, the devastating fires that blanketed our region in smoke a few weeks ago, which resulted in clinic closures due to the Public Safety Power Shutoffs (done by our utilities provider), and the higher incidences of diabetes, COVID and respiratory viruses, and other diseases our patients face. None of our funding is expendable.

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 to 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, to provide certainty and stability for our health care programs. These overhead costs are fixed—without the resources to pay them or without receiving those resources in a timely manner, funds must be taken from services to close the gap. These two discretionary budget items are vitally important to meet our patient and staffing obligations.

We also ask Congress to simplify the calculation, payment and reconciliation of contract support costs to alleviate the significant burden on Tribes and the growing bureaucracy at IHS necessary to implement IHS's contract support cost policy. For instance, IHS just updated its policy in December 2024, but it is still working on negotiations with "pilot Tribes," meaning it could be months before they even start to engage with our programs to determine the full need for FY 2025. We also ask the Committee to order IHS to eliminate its burdensome "reconciliation process," which happens years later after our books are closed. It is burdensome enough to go back and forth with agency representatives to determine an amount to be paid up front, we should not have to redo the same negotiation years later. The amount of resources spent on the reconciliation process on both the Tribal and IHS side does not make sense given that our indirect cost rate adjusts each year based on any over or under-recovery of costs.

Increasing Purchased/Referred Care (PRC) Funding

California has always been one of the four Indian Health Service Areas that are "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. This means our PRC funding never goes far enough, even when the agency maintains large PRC surpluses in other areas. Tribes had asked the Director to distribute these surplus funds to Tribal programs that need the funds to eliminate the surpluses that had developed throughout COVID, but that never happened. This means programs like ours, that need additional PRC funding, suffer year after year as there have been no PRC increases since 2017. Thus, in California, our members still have to live with the direction not to get sick or injured in the fourth quarter of the year because we will have no funds to pay for the higher level care they need. We also support full funding for the Regional Specialty Care Centers that are meant to alleviate the pressure on our PRC budgets. The support of Congress would allow us to fulfill our mission and obligation to our Indian communities and is appreciated.

Supporting the Reauthorization of the Special Diabetes Program for Indians

Last, we ask for your support for the reauthorization of the Special Diabetes Program for Indians (SDPI). Since 1997 the SDPI has been Indian Country's most comprehensive and effective program to combat diabetes and its complications. As a result, Indian communities are the only demographic group that have seen a decrease in the prevalence of Diabetes. This is a huge success for our people.

That said, at a rate of approximately twice the national average, Native Americans and Alaskan Natives have the highest prevalence of diabetes. In some of our Indian communities over 50% of adults have been diagnosed with type 2 diabetes. Without the necessary funding to support our Diabetes Health Educators, our successes will mostly be lost. We cannot afford to lose our patients to this disease.

We thank you again for your time and consideration.