WRITTEN TESTIMONY OF JERILYN LEBEAU CHURCH,
GREAT PLAINS TRIBAL LEADERS HEALTH BOARD,
BEFORE THE
HOUSE NATURAL RESOURCES COMMITTEE
SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS
"CHALLENGES AND OPPORTUNITIES FOR IMPROVING HEALTHCARE DELIVERY IN TRIBAL COMMUNITIES"
MARCH 29, 2023

Introduction

Thank you for this opportunity to present testimony on current challenges and opportunities for improving healthcare delivery, and ultimately health care outcomes, for Indian people in our communities.

The Indian Health Service (IHS) is the primary source of health care for nearly 150,000 American Indians/Alaska Natives in the Great Plains Area. Of the six hospitals in the Great Plains, five are managed directly by IHS. Of the thirteen ambulatory health clinics in the Great Plains Area, seven are managed entirely by a tribe or a tribal organization under a Title I Self-Determination contract, five are managed directly by IHS, and one is tribally managed through a Title V Self Governance compact. In addition, the Indian Health Service is responsible for two substance abuse treatment centers and supports three urban health care programs.

As requested by the Committee, this testimony will review seven timely and meaningful challenges and opportunities for improving healthcare delivery in Tribal communities in the Great Plains Area:

1. Enacting full mandatory funding of the Indian Health Service,
2. Building IHS capacity through workforce development,
3. Expanding self-determination contracting and self-governance compacting into additional HHS programs,
4. Permanently reauthorizing the Special Diabetes Program for Indians (SDPI),

5. Enforcing existing law that mandates data sharing with Tribal public health authorities,
6. Ensuring that state and federal agencies cooperate with Tribes to continue Medicaid benefits to all eligible AI/AN beneficiaries, and
7. Integrating and supporting traditional Native American healing practices throughout the Indian Health system.

Seven Areas of Opportunity

1. Funding: strategies for full and mandatory funding of the Indian Health Service.

In January 2023, Indian Country celebrated the passage of the Fiscal Year 2023 omnibus spending package, which for the first time included advanced appropriations of just over $5 billion for the Indian Health Service. This historic achievement was clouded by the fact that $5 billion is only part of IHS's $7 billion budget, and by the fact that that $7 billion budget is less than half of what patients need.

Therefore, this Committee can use the momentum of this historic opportunity to:

a. Continue increasing the Indian Health Service's overall budget to fulfill its Treaty and trust responsibility for Indian healthcare. In July 2022, a report of the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, HP-2022-21, found that IHS's 2022 budget funded less than half of patient need. A similar 2022 report from the advisory body the Tribal Budget Formulation Workgroup calculated that IHS would need a $51.4 billion budget to meet the federal obligation to provide adequate health services in Native American communities (Office of the Assistant Secretary for Planning and Evaluation, 2022). According to a 2018 GAO report, GAO-19-74R, per capita spending on IHS patient health care was less than a third of Medicare per patient spending and less than a half of Medicaid per patient spending (Government Accountability Office, 2018). The Veteran's Administration, another non-entitlement program, spent 2.6 times more per patient than the Indian Health Service. Any equitable increase to the IHS budget would at least double the current amount, but with the current state of underfunding, any increase is meaningful.

b. Authorize mandatory funds for the remainder of the IHS budget, while prioritizing mandatory funding for all nondiscretionary items such as Contract Support Costs and 105(l) Lease Payments. While securing advanced appropriations for IHS is an historic success, extending advanced appropriations to the full IHS budget would be a better realization of the federal government's trust responsibility toward Indian County, and would better protect the delivery of necessary and basic health services from any gaps in the annual funding cycle. In the alternative, funding at least any remaining nondiscretionary budget items, in particular contract support costs and 105(l) leases, through advanced appropriations would be a meaningful step forward.

c. Protect the IHS budget from any further "sequestration" cuts. Any budget control measures implemented on the IHS budget are catastrophic in their effects on health programs

and services to Indian people. At the same time, the cuts do not have any significant benefit with regard to actual control of the federal budget. While we are sure that many small budget programs would like to request exemption from any future sequestration, budget cuts to Indian Health programs have an immediate effect on lives and health outcomes in our communities. Therefore, we urge the Committee to protect the IHS budget from further sequestration or other budget control measures.

2. **Staffing: workforce development will increase the Indian Health Service's capacity to deliver healthcare services and enable the agency to fulfill its mission to provide those services to Native communities.**

   Like most other IHS areas, hospitals and clinics in the Great Plains service area face enormous challenges with staff recruitment and retention, sometimes resulting in inability offer services, particularly specialty services, and always resulting in overdependence on expensive temporary contractors. As of March 27, 2023, there were over 250 open positions advertised in the Great Plains Area on the IHS website. This is very clearly a case where an ounce of prevention is worth a pound of cure. Front end investment in workforce development, in recruitment and retention of medical officers and staff will lead directly to savings by not having to use temporary contractors to fill those positions, and not having to use limited purchased and referred care dollars (PRC) to refer patients out for specialty care. Those savings can be reinvested in the workforce, both to attract and retain staff and to stabilize and expand services.

   Attached to this testimony is support from the Rosebud Sioux Tribe underscoring the federal government's established legal obligation to staff its facilities in the Great Plains Area. *See* Attachment 1, Comments from Rosebud Sioux Tribe Health Director Skyla Fast Horse, March 24, 2023. In 2021, the 8th Circuit Court of Appeals reaffirmed that the Indian Health Service did have a duty to provide "competent physician-led health care" at the Rosebud IHS Hospital. Rosebud Sioux Tribe v. United States, 8th Cir. 2021 (No. 20-2062). While it is heartbreaking that the Rosebud Sioux Tribe had to file suit in order to force IHS to staff its hospital, the court's conclusion lays bare the need both for additional funding for IHS and for geographically remote facilities in the Great Plains Area, and specifically for workforce development.

3. **Self-Determination Legislation: the Tribes of the Great Plains Area support and request legislation establishing a demonstration project to implement Title VI of the Indian Self Determination and Education Assistance Act (ISDEAA).**

   In 2000, Congress enacted Title VI of the Indian Self Determination and Education Assistance Act (ISDEAA). The purpose of the self-determination sections of the ISDEAA was to allow Tribes to assume management of IHS and Bureau of Indian Affairs (BIA) programs created for the benefit of Indian people, with the assumption that Tribes with their close knowledge of local culture, people, and resources, would be better suited to manage those programs. The vehicle for assumption of those federal programs was a contract under Title I, and later a compact under Title V. Because of the runaway success of both contracting and compacting, Congress imagined expanding Self-Governance under the

ISDEAA to include grant programs for Indians administered by other agencies within HHS. HHS conducted a feasibility study on this possibility and concluded in 2003 that such expansion was feasible. HHS identified eleven programs that could be integrated into Self-Governance under Title VI of the ISDEAA. That was twenty years ago. It is time, now, to promote Tribal sovereignty by taking this next step to improve health care delivery in our communities. Through this testimony and through the attached resolution of its Board of Directors, the GPTLHB respectfully requests that this Committee introduce legislation establishing a demonstration project to implement Title VI of the ISDEAA as described in the 2003 HHS recommendations. *See*, Attachment 2, GPTLHB Res. 2022-06, March 10, 2022.

4. **Diabetes Prevention: permanent reauthorization of the Special Diabetes Program for Indians (SDPI) before September 30, 2023.**

   The Special Diabetes Program for Indians (SDPI) is recognized as one of the most impactful and successful IHS programs.

   In its 2020 report to Congress, *Special Diabetes Program for Indians*, IHS found that besides reducing the incidence of Type 2 Diabetes overall, SDPI has reduced End Stage Renal Disease by an astonishing 54% and diabetic retinopathy by an equally staggering 50% (Indian Health Service, 2020). In 2019 HHS' report *The Special Diabetes Program for Indians: Estimates of Medicare Savings* determined that SDPI had resulted in an estimated $52 million in Medicare savings annually. SDPI's impact through patient and community education and prevention activities ripples through Indian Country and beyond. (Dept. of Health and Human Services, 2019).

   Therefore, the GPTLHB urges the Committee to propose and to advocate for the permanent reauthorization of the SDPI before September 30, 2023. Further, the GPTLHB joins in the National Indian Health Board's request that SDPI be reauthorized at a minimum of $250 million annually, with automatic annual funding increases matched to the rate of medical inflation, and that the Public Health Service Act be amended to permit Tribes and Tribal organizations to contract and compact under the ISDEAA for administration of SDPI funds.

5. **Data Sharing: enforce existing law and policy which recognizes Tribes and Tribal Epidemiology Centers (TECs) as public health authorities which authorizes HHS agencies, including IHS and CDC, provide complete and transparent sharing of public health data with Tribes and TECs at the same level that those agencies share public health data with states.**

   The COVID-19 pandemic was particularly devastating to Native communities. One CDC report found a decline in life expectancy of 6.6 years in AI/AN communities over the course of the pandemic – the largest decrease of any racial or ethnic group in the United States. A Native baby born in 2021 had a life expectancy of only 65.2 years (Arias et al., 2022) - the same of that to a baby born in the 1940s (Bastian et al., 2020). During the pandemic, tribal governments and TECs were unable to receive information from IHS about COVID-19 cases

and vaccinations that were provided to state and federal agencies. Tribal governments and TECs were not regularly provided life-saving information from IHS, other HHS Agencies, or state health departments, contributing to the significant loss of life from COVID-19 in Native communities.

Tribes and TECs are routinely denied access to information from IHS and non-tribal health departments in all areas of health – not just COVID-19. Nationally, there is currently a rise in sexually transmitted infections and we are seeing this increase in the GPA. Native babies are dying of congenital syphilis, a completely preventable disease. Tribes and TECs have the ability to address this outbreak and protect the health of Native people, if only we could access current data regarding cases in our Area. Yet despite a resolution from every tribal leader in our Area in support of IHS releasing data on STIs to the TEC, IHS has not provided the requested information as is required by federal law. Inaction by IHS is hindering the response to the outbreak and contributing to the spread of disease.

A 2022 GAO report documented the challenges TECs have in accessing public health data from HHS Agencies (Government Accountability Office, 2022). Despite the report's acknowledgement that HHS not only can, but is required to provide health information to TECs, a year later HHS has not provided any new health information to TECs. The

Congress can improve the health of Native people nationwide by ensuring HHS, including IHS, comply with current federal law and provide Tribes and TECs access to protected health information that is shared daily with local and state public health authorities. No new legislation needs to be enacted. All HHS agencies should immediately stop defying Congress and release public health data to Tribes and TECs as has been repeatedly requested. We urge the Committee to confirm that HHS provides requested data to Tribes and TECs in compliance with the Indian Health Care Improvement Act and ask the Committee to work quickly – before one more baby is lost to a preventable disease.

6. **Medicaid unwinding: direct CMS to work with states to share data with Tribes and Tribal organizations regarding American Indian/Alaska Native (AI/AN) beneficiaries and if possible to delay termination of benefits for AI/AN beneficiaries to allow Tribal/state coordination of redetermination efforts for those individuals.**

Another area of concern is the hot-button issue of Medicaid "unwinding" and the transition out of the Public Health Emergency. The end of the continuous enrollment requirement has the potential to cause confusion and loss of services for AI/AN Medicaid beneficiaries, as well as direct fiscal impact to Tribal health programs. The Medicaid program is a federal-state partnership, with wide variation in services and program rules according to the various state plans. That local variability has resulted in inconsistent and conflicting implementation of unwinding guidance from state to state in a manner that protects eligible Tribal members in some states, while quickly severing access to benefits in others.

For example, Oklahoma takes an "eligible until you fail to prove otherwise" approach by sending four letters to people at risk of ineligibility with instructions on reasons for possible ineligibility, instructions for recertification, and access to a helpline. South Dakota, by contrast, has the opposite policy. Individuals who are high risk of ineligibility are sent one letter informing them their Medicaid has been terminated, and giving them the number for the Health Insurance Marketplace. The GPTLHB is currently working with South Dakota Medicaid to get contact information for AI/AN enrollees at risk of ineligibility, so we can assist and coordinate with recertification efforts, but to date have only received incomplete data on Tribal member beneficiaries from the state.

We urge the Committee to exercise its oversight role to work with States, Tribes, and CMS to make sure that unwinding is accomplished cooperatively and without terminating services to eligible individuals. For example, we urge the Committee to (a) work to make sure that states share data on AI/AN enrollment throughout the unwinding process in order to help our health programs to assist with outreach efforts by identifying AI/AN Medicaid enrollees, and (b) work with CMS to provide financing mechanisms to assist in covering the costs that Tribes incur when working with the state on the unwinding process.

7. **Traditional medicine: integrating Native American healing practices into IHS services.**

Traditional Native American healing practices have never been part of the Indian Health Service. It is a delicate balance to achieve, to bridge two very different systems of medicine in a respectful, effective, and patient-centered way. However, research has indicated that when recommendations on how to integrate traditional Native healing systems into the IHS system have been led by traditional healers in our communities, it is possible for one system to enhance the other, with great benefit to our patients. These integrative methods have been shown to be both medically effective and cost effective at treating chronic physical illness, when used in conjunction with allopathic medicine (Mehl-Madrona, 1999). We strongly encourage you to direct IHS to work with Tribes at the Service Unit level to respectfully incorporate traditional cultural practices and cultural healing into the Indian Health treatment system.

Conclusion

Thank you again for allowing us to present this testimony on the most important and immediate opportunities for improving healthcare delivery in the Great Plains Area. While the last few years were painful and full of loss, at this moment in the Great Plains Area there is a great deal of forward motion in Indian Health care. Further, only the first of these seven opportunities requires significant new appropriations; the rest require mainly shifts in policy, enforcement, intergovernmental cooperation, and focus. Sometimes what it takes to improve healthcare delivery is money, but sometimes it is deep listening to the people most affected by the problem, and changing how we do things. I encourage you to listen and take action on all of these priorities and opportunities, so that we can continue moving forward together.

References

Arias E., Tejada-Vera, B., Kochanek, K.D., Ahamd, F.B. (2022). Provisional life expectancy estimates for 2021. *Vital Stat Rap Rel*, 23, 1-16. DOI: https://dx.doi.org/ 10.15620/cdc:118999.

Bastian, B., Tejada-Vera, B., Arias, E., et al. Mortality trends in the United States, 1900-2018. *National Center for Health Statistics.* 2020.

Dept. of Health and Human Services. (2019). The special diabetes program for Indians: Estimates of Medicare savings. ASPE Issue Brief. Retrieved from: https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf

Government Accountability Office. (2018). Indian Health Service: Spending levels and characteristics of IHS and three other federal health care programs. (GAO Publication No. 19-74R). Washington, D.C.: U.S. Government Printing Office. Retrieved from: https://www.gao.gov/assets/gao-19-74r.pdf

Government Accountability Office. (2022). Tribal Epidemiology Centers: HHS actions needed to enhance data access. (GAO Publication No. 22-104698). Washington, D.C.: U.S. Government Printing Office. Retrieved from: https://www.gao.gov/assets/gao-22-104698.pdf

Indian Health Service. (2020). Special diabetes program for Indians 2020 report to Congress. U.S. Department of Health and Human Services. Retrieved from: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI2020Report_to_Congress.pdf

Mehel-Madrona, L.E. (1999). Native American medicine in the treatment of chronic illness: developing an integrated program and evaluating its effectiveness. *Altern Ther Health Med*, 5(1), 36-44.

Office of the Assistant Secretary for Planning and Evaluation. (2022). How increased funding can advance the mission of the Indian Health Service to improve health outcomes for American Indians and Alaska Natives. (Report No. HP-2022-21). U.S. Department of Health and Human Services. Retrieved from: https://aspe.hhs.gov/sites/default/files/documents/1b5d32824c31e113a2df43170c45ac15/aspe-ihs-funding-disparities-report.pdf

ATTACHMENT 1

Rosebud Sioux Tribe
Health Administration
227 NORTH BIA 9 – SOLDIER CREEK ROAD
PO BOX 719
ROSEBUD, SD 57570-0719
W: (605) 747-5100
F: (605) 747-5412

Rosebud Sioux Tribe Health Administration Written Testimony Comments

In regards to upcoming testimony before the U.S. House Committee on Natural Resources on the performance of the Indian Health Service, The Rosebud Sioux Tribe Health Administration has the following comments:

- The Indian Health Service should actively work to support any ongoing efforts towards contracting or compacting by any tribes for the assumption of services from the Indian Health Service
- The Indian Health Service should actively work towards ensuring that "competent physician-led healthcare" is being provided to tribes, as called for in Rosebud Sioux Tribe v United States, 2021 (No.20-2062)
- The Indian Health Services needs to demonstrate significant improvement in collaborating with tribes on integrating cultural practices and cultural healing into the health system.
- There is a significant need for better date and information sharing policies that make it easier for tribes and tribal organizations to request and receive health information in a timely manner from the Indian Health Service
- A greater investment is needed in updating the health information technology of Indian Health Services facilities, including the Electronic Health Record and any modernization of telehealth or remote monitoring technology.

Skyla Fast Horse

Skyla Fast Horse, Health Director

ATTACHMENT 2

GREAT PLAINS TRIBAL LEADERS HEALTH BOARD
RESOLUTION 2022-06

PURPOSE: To approve supporting the legislation expanding Tribal Self-Governance in the Department of Health and Human Services

WHEREAS, the Indian Self-Determination and Education Assistance Act (ISDEAA) authorizes Tribes and Tribal organizations to be funded by the federal government to provide services that the Federal government would otherwise be obligated to provide due to the trust and treaty obligations of the United States; and

WHEREAS, self-determination and self-governance under the ISDEAA have led to a significant improvement in the daily lives of American Indians and Alaska Natives; and

WHEREAS, the success of the ISDEAA prompted Congress in 2000 to establish permanent Tribal Self-Governance in the Indian Health Service (IHS) in Title V of the ISDEAA; and

WHEREAS, Title V authorizes participating Tribes to redesign IHS programs, and redirect funds supporting those programs, in any manner that the Tribes determine is in the best interest of their communities; and

WHEREAS, in Title VI of the ISDEAA, enacted in 2000, Congress envisioned expanding Self-Governance to include grant programs administered by other agencies within the Department of Health and Human Services (HHS); and

WHEREAS, in 2003, HHS issued a study concluding such an expansion was feasible and identifying eleven HHS programs that could be integrated into Self-Governance; and

WHEREAS, in 2004, the Senate considered legislation to authorize a demonstration project implementing Title VI, but that legislation was not enacted; and

WHEREAS, expansion of Self-Governance within HHS is the next logical step to promote tribal sovereignty improve health care services and has remained a top legislative priority of Tribes; and

WHEREAS, Tribes have drafted legislation, modeled on the 2004 Senate bill, that would establish a demonstration project expanding Self-Governance to specified programs administered by non-IHS agencies within HHS;

NOW, THEREFORE, BE IT RESOLVED that Great Plains Tribal Leaders Health Board supports the introduction and enactment of legislation establishing a demonstration project to implement Title VI of the ISDEAA.

CERTIFICATION

This is to certify that this resolution was adopted by the Great Plains Tribal Leaders Health Board, (GPTLHB) Board of Directors through a duly convened meeting held at the March 10, 2022 Board of Director's Meeting held over Zoom by a vote of:

13 FOR 0 OPPOSED 5 NOT VOTING

MOTION CARRIED.

Roger Trudell
Chairman, GPTLHB
Chairman, Santee Sioux Tribe of NE

Date: 3/10/22

Victoria Kitcheyan
Chairwoman, GPTLHB
Chairwoman, Winnebago Tribe of NE

Date: 3/10/22