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YANKTON SIOUX TRIBE

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES

TESTIMONY ON AMERICAN INDIAN/ALASKA NATIVE PROGRAMS
HEALTH CARE

March 6, 2019

Greetings Madam Chair and Members of the Subcommittee. My name is Robert Flying Hawk and I am the Chairman of the Yankton Sioux Tribe Business and Claims Committee. I also serve as the Treasurer of the Great Plains Tribal Chairman's Health Board as well as the Great Plains Representative on the Centers for Disease Control Tribal Advisory Committee. The Yankton Sioux Tribe appreciates this opportunity to propose funding priorities for the Fiscal Year 2020 Federal Budget. Our top priority is to reopen our 24-hour emergency services and hospital at our local Indian Health Service (IHS) service unit.

Like many in the Great Plains, the *Ihanktonwan* or "Yankton" band of the *Oceti Sakowin* (Seven Council Fires) or "Sioux" is a resilient treaty tribe having entered into numerous treaties with the United States as well as other tribes. The first known treaty between the "Sioux Nation" and the United States was in 1805, and the Sioux Nation granted nine square miles to the United States at the mouth of the St. Croix River near St. Anthony Falls for the establishment of a military post. One of the purposes of Fort Saint Anthony, later (and currently) known as Fort Snelling, was to keep Indian lands free from white settlement. The United States affirmed its trust responsibility in 1815, when the Yankton entered into a treaty of "peace and friendship" with the United States, who was represented by William Clark, by the Tribe's acknowledgment that it would be under the protection of the United States. In 1825, Yankton and the United States again agreed by treaty that all trade and intercourse with Yankton shall be regulated by the United States. Perhaps unknown to the Tribe, the United States had declared for many years preceding these treaties that no sale or grant of Indian lands would be valid unless it was made in a public treaty that was held under the authority of the United States. Indian Nonintercourse Acts of 1790, 1793, 1796, 1799, 1802, and 1834. While one could recite the remaining treaties, the point in reciting this statutory and treaty history is to put the United States' choice to undertake the statutory and trust responsibility to provide health care to tribal members into context. These statutory and trust responsibilities include a duty to ensure that care is provided in accordance with minimum standards of care. Naturally, providing adequate funding for the IHS is necessary to meet these standards of care.

The IHS is the principal health care provider and health advocate for all native peoples within the country and, in that role, the IHS provides health care and related services to over 2.3 million American Indians and Alaska Natives from 573 different federally recognized tribes in 12 regions. According to the IHS' own fact sheet, the per capita health care expenditure on its user population is $3,851 compared to the U.S. National Health Expenditure of $10,348 per person. I hope these figures adequately demonstrate how inadequate the funding is for the IHS.

The Tribe requests, in the strongest terms possible, that health care not be targeted for cuts, eliminations, or reductions in the FY 2020 budget. The funding levels for Indian health care are quite often the difference between life and death for our people. After funding specific items or projects, past budgets left little to no funding remaining for the IHS to attempt to remedy the severe shortcomings that it has been experiencing for years. These shortcomings include lack of services for opioid and methamphetamine users, lack of direct services for our members such as a 24-hour emergency room and hospital, lack of monies for purchase referred care, among many others. Although funding is not the key to solve all concerns at IHS, adequate funding is incredibly important to remedy current issues. Any cuts in such funding will only stand to further exacerbate problems for years to come.

Government Shutdown

As an initial matter, I must raise the Tribe's concerns about health care delivery and the income of federal employees from the recent government shutdown and other funding interruptions such as sequestration. While our local service unit was able to reclassify all but 8 of its 69 employees to be paid from third-party billing and avoid the devastating income interruptions experienced by other federal employees, it should not have had to make those adjustment if IHS would just be treated as other government-provided healthcare. The federal government has insured that other federal programs that serve the Nation's most vulnerable populations, such as Medicaid and veteran's assistance benefits, were spared from sequestration, indiscriminate budget cuts, and government shutdowns. It would be unconscionable for the United States to continue to treat IHS with less consideration, given the federal government's trust responsibility obligations. There remain outstanding questions including whether the third party billing monies the service unit used to pay its employees during the shutdown will be replenished by the federal government, or whether that stands as a net loss for that service unit. As we all know, third-party billing monies are often the only available source of funds to allow the service unit to continue to provide direct services and referred care once the budget monies run out.

Service Unit Inpatient and Emergency Room

In 1992, the IHS hospital at the Wagner Service unit was closed to inpatient care, yet there was no increase in funding for contract health services ("CHS") (now known as purchase referred care). IHS removed services and provided no additional funding to purchase the services elsewhere. It was unthinkable, not only to our tribal members that depend on the inpatient care, but also on the Wagner Service Unit that was left to balance the books without any increase in CHS or other funding to bridge the gap. The Tribe was against this decision not only as an immediate concern but also with concern for the future viability of the Wagner Service Unit. In spite of the Tribe's objections, the IHS made the decision to stop inpatient care. Next, the IHS made the decision to close the 24-hour ER, and to open an urgent care facility in its place. The Tribe was forced to challenge the closure. While the Tribe was initially successful in its lawsuit, once the IHS met the statutory requirement that it produce a report to the Congress, it was free to close the ER.

In 2005, the IHS commissioned such a report to conduct a final evaluation of the Wagner Service Unit. "The Sharpless report recognized there would be significant hardships to tribal members if the emergency room were closed, but nevertheless recommended partial closure of the Wagner emergency room by replacements with an urgent care facility. The report notes that 'it could be forecasted that lives would certainly be lost' if the Wagner emergency room closed." *Yankton Sioux Tribe v. United Stated Dep't of Health & Human Services*, CIV 07-3096 (8th Cir. 2008). In March 2008, the IHS closed the 24-hour emergency room and compensated the Wagner Service Unit budget by adding $64,000 for "Priority I" care for the remainder of the year.[1] There have not been

[1] Pursuant to 42 C.F.R. 136.23(e), each Area establishes the medical priority of care when CHS/purchase referred care is insufficient (it is insufficient every year). Priority I is emergent or acutely urgent care services that IHS defines as "diagnostic or therapeutic services that are necessary to prevent the immediate death or serious

additional funds awarded to the Wagner Service Unit budget since that time to compensate for the additional CHS or purchase referred care services. It then became the norm that tribal members would seek emergency health care at the local non-IHS community emergency room. Tribal members were forced to seek this care even without knowing whether the IHS had the funds available to pay for those emergency services or whether the tribal member would become personally liable for payment of those medical bills. Unfortunately, it is more frequently the latter, leading many of our tribal members to simply attempt to wait until the Wagner Service Unit IHS clinic opens rather than face the possibility of medical bills that could cripple their household's finances. Similarly, if tribal members are in need of CHS/purchase referred care and they do not meet the "Priority I" threshold, they are forced to suffer through the pain until funding becomes available. The real-life implications are that it is common-place to meet tribal members that live for months at a time or permanently with broken limbs and other ailments that are not treatable at the Wagner Service Unit clinic and yet do not amount to Priority I. This state of healthcare would be unacceptable in any other context, yet it is what our tribal members face every day. Eventually, the prediction contained in the Sharpless report was realized when a tribal member lost his life in the parking lot while waiting for the IHS to open.

It was widely reported that funding was the reason the IHS closed the 24-hour emergency room because the facility did not meet the emergency room criteria as defined by the Center for Medicare and Medicaid Services, and therefore the facility would not receive reimbursement from Medicare and Medicaid for those patients eligible for that third-party coverage. The Wagner Service Unit has a difficult time attracting and retaining licensed medical professionals. IHS allows non-licensed medical professionals that hold degrees from medical schools outside of the U.S. to practice in IHS facilities as long as there is a licensed doctor at the facility. There have been times when we did not even have that. IHS would bridge this gap by temporarily re-assigning commission corps, but that is a temporary fix and it is costly. We need to attract permanent licensed doctors to our service unit. I would also like to point out that while funding was the reason the IHS closed the 24-hour emergency room, there are more employees at IHS now than there were when the 24-hour emergency room was open. The IHS has experienced intermittent hiring freezes which have exacerbated the situation. When any rumors of budget cuts in HHS and IHS funding circulate, we have noticed IHS essentially shuts down recruitment efforts. We already start out at a disadvantage because the salary is often below what a doctor could receive elsewhere, but coupled with the remote location and the possibility of reductions in staff, salary freezes, and limits on procurement, it becomes nearly impossible. Finally, I would be remiss if I did not inform you that the lack of 24-hour emergency services and in-patient hospital services at our IHS service unit have been negatively affecting not only our tribal law enforcement, but also the local non-Indian hospital. These effects were predicted in the Sharpless report, yet the closures still happened. We operate our own law enforcement under an Indian Self-Determination and Education Assistance Act Contract and the federal government operates a detention facility on our reservation. Law enforcement is required to seek medical care for certain inmates when conducting intake overnight. This is to ensure the safety of those inmates as well as to protect the liability of law enforcement and the detention facility. However, IHS refused to pay the purchase referred care costs of the medical treatment leaving law enforcement with a large bill and the local non-Indian hospital with large accounts receivables. This set-up is not working for any of the interests involved and will only be exacerbated if there are funding cuts.

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impairment of the health of the individual, and which, because of the threat to the life or health of the individual necessitate the use of the most accessible health care available and capable of furnishing such services. Diagnosis and treatment of injuries or medical conditions that if left untreated, would result in uncertain but potentially grave outcomes." https://www.ihs.gov/chs/index.cfm?module=chs_requirements_priorities_of_care

The Tribe seeks solutions that will serve the best interest of the Tribe and its members. In the context of health care, the Tribe wishes to ask for your help in reopening the 24-hour emergency care at the Wagner Service Unit as well as help in reopening the in-patient hospital services even as modestly as a few beds. It is also imperative that IHS recruit and maintain licensed medical doctors.

Referred Care

Because our service unit consists of a small clinic, every day our people receive "referrals" from IHS physicians to specialists, labs, and hospitals. Tribal members used to go to those referrals assuming that any costs incurred would be borne by the IHS. Unfortunately, that is no longer the case. At Yankton, we have an ever increasing number of tribal members who have received thousands of dollars in medical bills in the mail that they did not expect, and that they cannot pay. This has become so prevalent that we now have tribal members who are refusing to seek the referral care that is necessary to protect their health, and in some cases even their life, because they fear the possibility of being bankrupted by unpaid medical expenses. This is especially true for our veterans. A veteran may not initially want to drive 100 miles or wait three months to see a specialist, especially when the IHS is offering him a specialist which is closer and an earlier appointment. He might feel differently, however, if he knew that he was going to receive a large bill for taking IHS up on its referral offer instead of the Veteran's Affairs. In addition to fully funding purchase referred care needs, we are asking that IHS implement a policy that includes a process to notify a patient in advance when IHS is not prepared to pay for a referral care visit and related costs. The IHS needs to acknowledge that unpaid medical bills can literally bankrupt a family, and our people have a right to make an informed decision about the care that they choose to seek. It can even be as simple as indicating the amount of coverage IHS is offering on the referral form itself. That way our members can make informed decisions.

Opioids and Methamphetamines

The Tribe is losing entire and perhaps multiple generations of our members to drugs such as opioids and methamphetamines. During the years 2013-2015, the rate of fatal opioid overdoses was nearly three times higher among American Indian and Alaska Native populations. Similarly, American Indians and Alaska Natives have the highest rate of substance use disorders, including alcohol abuse and methamphetamine use, compared to any other racial/ethnic population. We cannot fight and win the battle against opioids and meth in Indian County with little or no funding opportunities.

Conclusion

The Yankton Sioux Tribe is well aware of how hard this Committee fights day in and day out to preserve tribal priorities in the federal budget, including IHS Services, DOI services and programs, and more. We sincerely thank you for your time and hard work regarding these issues, and I hope the testimony I have provided you with today will stand as a stark reminder of the importance of these federal programs and services to tribal people. In many cases, it is the difference between life and death. The decisions you make that are reflected in the federal budget directly impact the lives of hundreds, if not thousands, of Yankton Sioux tribal members. Thank you for allowing me the opportunity to appear here today and I will be happy to answer any questions or discuss anything from my testimony in further detail.