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# GREAT PLAINS TRIBAL CHAIRMAN'S ASSOCIATION

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## Health Reform Oversight Hearing Senate Committee on Indian Affairs Thursday, February 5, 2009

Testimony Provided  
Ron His Horse is Thunder, Chairman  
Standing Rock Sioux Tribe,  
Great Plains Tribal Chairman's Association (GPTCA)  
Aberdeen Area Tribal Chairman's Health Board (AATCHB)

### Introduction

Mr. Chairman and other Members of the Committee, we thank you for your hard work to ensure that the appropriate authority and funding for healthcare services is available to meet the needs of the 17 Tribal Nations of the Great Plains. I am Ron His Horse Is Thunder, Chairman of the Standing Rock Sioux Tribe of South Dakota, and Chairman of the GPTCA & AATCHB—an Association of seventeen Sovereign Indian Tribes in the four-state region of SD, ND, NE and IA. The Great Plains Tribal Chairman's Association is founded on the principles of unity and cooperation to promote the common interests of the Sovereign Tribes and Nations and their Members of the Great Plains.

### Great Plains Region

The GPTCA stands on the Fort Laramie Treaty of 1868 (15 Stats. 635) Articles V and IX that guaranteed that the United States will provide services at the local level to our people and reimburse the Tribes for any services lost. It was clearly understood by the Indian signers of that Treaty that necessary assistance would be provided to the signatory Tribes by a local agent (or Superintendent or Director of Indian Health in the modern era) and that sufficient resources would be made available to the agent to allow him to discharge the duties assigned to him.. Indian Healthcare is a Treaty fulfillment which our Tribal people take very seriously.

The Great Plains Region, aka Aberdeen Area Indian Health Care has 18 I.H.S. and Tribally managed service units. We are the largest Land based area served of all the Regions with land holdings of Reservation Trust Land of over 11 Million acres. There are 17 Federally Recognized Tribes with an estimated enrolled membership of 150,000. To serve the healthcare needs of the Great Plains there are 7 I.H.S. Hospitals, 9 Health Centers operated by I.H.S. and 5 Tribally operated Health Centers. There are 7 Health Stations under I.H.S. and 7 Tribal Health Stations. There is one Residential Treatment Center and 2 Urban Health Clinics. **The Tribes of the Great Plains are greatly underserved by the I.H.S. and other federal agencies with the I.H.S. Budget decreasing in FY 2008 over the FY 2007 amount. This is in spite of increased populations and need.** The GPTCA/AATCHB is committed to a strengthening comprehensive public healthcare and direct healthcare systems for our enrolled members.

### Health Data and Overview

As documented in many Reports, the Tribes in the Great Plains region suffer from among the worst health disparities in the Nation, including several-fold greater rates of death from numerous causes, including diabetes, alcoholism, suicide and infant mortality. For example, the National Infant Mortality Rate is about 6.9 per 1,000 live births, and it is over 14 per 1,000 live births in the Aberdeen Area of the Indian Health Service—more than double the National rate. The life expectancy for our Area is 66.8 years—more than 10 years less than the National life expectancy, and the lowest in the Indian Health Service (IHS) population. Leading causes of death in our Area

include heart disease, cancer, unintentional injuries, diabetes and liver disease. While these numbers are heart-breaking to us, as Tribal leaders, these causes of death are preventable in most cases. They, therefore, represent an opportunity to intervene and to improve the health of our people.

Additional challenges we face, and which add to our health disparities, include high rates of poverty, lower levels of educational attainment, and high rates of unemployment. All of these social factors are embedded within a healthcare system that is severely underfunded. As you have heard before, per capita expenditures for healthcare under the Indian Health Service is significantly lower than other federally funded systems.

In FY 2005, IHS was funded at \$2,130 per person per year. This is compared to per capita expenditures for Medicare beneficiaries at over \$7,600, Veterans Administration at over \$5,200, Medicaid at over \$5,000 and the Bureau of Prisons at nearly \$4,000. Obviously, our system is severely underfunded. It is important to note that as Tribal members, we are the only population in the United States that is born with a legal right to healthcare. This right is based on treaties in which the Tribal Nations exchanged land and natural resources for several social services, including housing, education and healthcare. Tribes view the Indian Health Service as being the largest pre-paid health plan in history.

### **Positives**

In spite of significant underfunding, we do have some positive news in terms of successful programs. The Aberdeen Area Tribal Chairmen's Health Board operates a Healthy Start program that is funded by the Health Resources and Services Administration (HRSA). Healthy Start is a Targeted Case Management program whose goal is to reduce infant mortality. In recent years, the Infant Mortality Rate for participants in the Healthy Start program has been about 6.5 per 1,000 live births—this is lower than the National Infant Mortality Rate of 6.9, and it is in the population of highest risk pregnancies.

In a critical example of how we have tried to utilize various federal agency resources to a combined effort, we received a grant of \$1.25 million per year from HRSA to operate sixteen Healthy Start sites in our Area. Sadly, the \$1.25 million for sixteen sites is not enough funding for all of these sites. This circumstance is driven by the vast and rural nature of many of our reservations, and the time-intensive nature of case management services. In the past, we received additional funds from IHS, to join with the HRSA funds, to operate the Healthy Start program at full capacity.

Regrettably, IHS is no longer able to contribute additional resources to this effective and essential program. In a frustrating cascade effect, we have been told by HRSA that we need to secure an additional \$450,000 from other sources by March 1st, or we will need to start closing down Healthy Start sites in our region. Mr. Chairman, Committee Members, which communities should lose Healthy Start sites due to this funding cutback? Healthy Start is successful in our region in reducing Infant Mortality. But it will become less successful without adequate resources. These cutback decisions will lead directly to more infant deaths.

In another vital step forward, the Health Board operates an Epidemiology Center that is focused on studying disease patterns in our Area. We will be addressing the impact of behavioral health issues on chronic diseases like diabetes and on health generally. We consider our Epi Center a successful program directly due to its numerous partnerships and programs. It would be much more successful if we had adequate resources to improve information technology and electronic health records.

### **Issues of the Day**

**National Health Care Reform** should be set up as an umbrella not straight jacket. Many of the current proposals for full insurance coverage, tax breaks and regional purchasing cooperatives are not an easy fit in Indian country or rural American. We would like to see that Tribal Nations have strong input, beyond those from Indian "health experts or organizations". As you are aware, Tribes have multiple roles, as other sovereigns, to regulate and provide services, and as employers. These different roles require careful thought on how a National plan will impact the Great Plains and other Tribes with strained resources and broad expanse of territory and population to protect.

**Self Determination should be viewed as multi-faceted.** The current IHS view of Indian Self Determination is that Tribes must assume 100% control of their health programs, under a "638 compact" to be able to enact innovative changes. Self Determination, however, also means that Tribal Nations can choose not to "compact", and can make

major decisions affecting course of their program by using other means than a “compact”. There are cooperative agreements and other “mechanisms” available to permit Tribes, who are choose to rely on Federal “direct service”, to have significant input into their health programs’ policy decisions. (i.e. particular staffing needs for physical therapist or other specialty care, emphasis on home health care beyond CHR’s).

### **Core Policy Principles**

**Government to Government** is intended to recognize Tribal Nations’ sovereign status. This should not be diminished, whether by the expansion of governmental treatment to more than federally recognized Tribes, including non-profits, or by those federal departments who “listen” but do not act on Tribal suggestions and concerns.

**Enrollment and Eligibility Issues** are at the heart of Tribal Nation sovereignty. Federal efforts to enter into this arena, especially with a one-size-fits-all approach or side-stepping Tribal internal proceedings, is a dangerous step. For example, the Cherokee Freedman dispute should not be a matter attached to any Indian health bill. If one Tribe wishes to restrict health services to only their enrolled citizens, then Tribal Citizens who are not served in such a restricted Tribal community need to be accommodated, through appropriate resource allocation adjustments in another venue (Tribal, CHS).

**Self Determination Scope.** We are aware that some Tribes wish to impose sliding fees upon their members (Susanville Rancheria decision) for certain health services. We are opposed to using federal legislation as way to institute the “billing of Indians” for their health care. Under current federal Indian legal principles, and in accord with our treaty rights, our Tribal Nations and their citizens are to receive certain benefits for lands transferred to the United States. This principle ensures, and the current Indian health care improvement act has enunciated, that there is no individual Indian financial liability for health services when the IHS or Tribes bill such individual Indian’s third party resources.

**Department of Health and Human Services (DHHS) Wide Application of Self Determination.** Tribal access to other Departmental programs has improved. Meaningful consultation can be improved. Improved Tribal access is very useful in our efforts to complement the IHS health care delivery system. We need to continue this department-wide agency resource access, and with more direct Tribal funding and less Tribal Subordination to State block grants. Programs and resources provided by other agencies in DHHS, such as HRSA, SAMHSA, CDC and others are essential components of the Indian Health system, and we need continued facilitated access to these resources. We have been, overall, pleased with our Tribal input into the Center for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) and recommend this approach with strong Tribal Nation emphasis, as well as establishing a strong DHHS level Tribal Affairs office.

### **Key Program, Resource Issues**

**Sufficient Resources.** What would it take to give the Indian Health Service (IHS) sufficient resources to address our health needs? The current appropriation for IHS clinical services is about \$3.4 billion. Our estimated funding percentage based on level of need is approximately 50-60%. In order to bring IHS up to a more appropriate level of funding, an additional \$2 billion for clinical service would be needed and making our annual appropriation closer to \$5.4 billion. This would be a major increase, but a small one relative to the \$700 billion budget for the Department of Health and Human Services (DHHS).

We applaud the Committee Chairman and others for pushing for greater funding in the Economic Stimulus bill, in last Congress’s Global AIDs health bill, in budget reconciliation amendments attempts, and appropriation increases. We hope that this hearing, our testimony and others, will assist you in your efforts to continue this good fight.

Other areas that could function more effectively with full funding and clearer guidance include:

- **Contract Health Services (CHS)** timely approval (and appeals) for all priorities, prompt private provider payment, and assistance to I.H.S. Clients who have found out too late their healthcare wasn’t taken care of by I.H.S. with their bills were turned over to Creditors
- **Transportation Coverage** for Patients and Families when a patient needs private provider care, and Emergency Medical Transportation improvements (maintenance, gas, equipment) ;

- **Access to contemporary Prescription Drugs Formulary** to ensure effective drug treatment to complement direct or private health care;
- **Administrative Improvements** in Management Accountability in hiring and placement decisions, in particular; and
- **Establishing a Direct Service Tribes' (DST) Office** within the Indian Health Service, beyond a cosmetic name change.

**Facility Funding.** The Committee Chairman, and other Members, are aware of the great need for inpatient and outpatient facility funding. However, the Great Plains does not support fragmenting the current facility funding into regional pots, and by the equal area distribution of facility amounts. This is simply the reallocation of a small amount into equally smaller amounts. Such move would leave our large land based and direct service Tribes with insufficient funds to even do necessary repairs to aging facilities.

Most of our facilities are old, outdated structures unsuited for current medical technology and are in need of replacement. The estimated average age of IHS facilities is about 37 years as compared to about 9 years in the private sector. We are hoping that numerous facilities will be funded through the economic stimulus package being developed as we speak. There are two major facilities on the IHS "Ready List" for facilities construction in the Aberdeen Area—the facility in Rapid City and the facility in Eagle Butte. Unfortunately, the budget for IHS facilities construction has been significantly decreased over the last eight years, adding to our disparities, and I urge you to invest in new facilities in addition to our clinical services budget.

**Specialty Clinics.** We have a significant need for expansion into preventive and specialty chronic care facilities. We also have great need for Long Term Care services for the elder and disabled population. Long Term Care is not currently provided by IHS, and access to these services is simply not available on most of our reservations. With appropriate funding, we could serve our most vulnerable community members with adequate Long Term Care. Wellness and diabetes clinics are examples of preventive or intervention style facilities. We need to identify processes to expand our workforce and identify other resources to focus on prevention. We also need to surmount State barriers to establishing reservation-based facilities which rely on Medicare or Medicaid.

**Catastrophic Funding Needs.** As in other populations, our Indian population is seeing the unfortunate increase in cancer and other serious illnesses or diseases. The IHS's Catastrophic fund is a good start but is inadequately funded and has a major coverage gap between when a patient and service unit can tap into this National fund, and after it has depleted all of its local funding. This arrangement makes our local IHS service units reluctant to authorize funding for the initial treatment of serious diseases. The result is that these illnesses take root and become fatal when they might have been halted with early treatment. The Catastrophic Fund needs to be reviewed for ways of improving this system, to overcome reluctance to spend all local funds on one severe case.

**Veterans Needs.** HIS cooperation with Veterans Administration is not occurring to the depth hoped for. S.1200 proposed some fixes to this problem, and should be followed through on, including the IHS authority to make the VA individual co-payment in order to collect reimbursement for services rendered to an eligible Indian veteran, when such authorized service is performed in an IHS or Tribal facility.

**Violence Against Women.** The Congress enacted the Violence Against Women's Act, and also incorporated Tribal provisions. These provisions are a large and important step but, in our implementation efforts, we have learned that we still face hurdles to helping our Indian women victims. The IHS funding priorities have excluded the provision for rape kits, to enable their health professionals to properly document and assist in these crimes. Nor are the IHS health care professionals, who have treated our women in these traumatic events, often available immediately after such assaults to document them to any degree.

This delayed or absent documentation, and delayed treatment, results in health professionals who are unwilling to testify in court on their "findings" when these are so minimal and unable to meet court evidentiary standards. This becomes a more dangerous situation when the perpetrator is a non-Indian assaulting an Indian, as non-tribal courts are even less willing to consider stand-alone victim testimony, absent such evidence. Our women are, thus, victimized several times by

- (1) their initial assault and perpetrator,
- (2) the lack of timely and effective treatment,

- (3) the dismissal of their complaint, should they find the strength to do so in absence of supporting documentation, and
- (4) the likelihood of reprisal or continued sexual assault.

Your help in this particular issue is strongly sought, for both adequate agency treatment guidance, sexual assault funding, and tribal court strengthening.

### **Summary**

We have demonstrated that we can operate successful programs in spite of under-funding. We have shown that we can utilize complementary resources to the greatest benefit, and to further our direct health care delivery system goals.

In closing, we have the opportunity in the new Congress and the new Administration to address many of the root causes of health disparities in American Indian communities. We seek to attack, not band-aid, the terrible disparities that make our population's health status comparable to a third world country. The above are our initial thoughts and can be refined as other health care reform initiatives are identified, and as Tribal Nations continue their own work in this regard. Thank you, again, for this opportunity and your attention to these vital matters.