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TESTIMONY OF DAVID FLUTE, CHAIRMAN
SISSETON-WAHPETON SIOUX TRIBE

BEFORE THE UNITED STATES SENATE COMMITTEE ON INDIAN AFFAIRS
LEGISLATIVE HEARING TO RECEIVE TESTIMONY ON:

S. 465, THE INDEPENDENT OUTSIDE ASSESSMENT OF THE INDIAN HEALTH SERVICE and S. 1400, THE SAFEGUARD TRIBAL OBJECTS OF PATRIMONY ACT.

November 8, 2017

I. INTRODUCTION

Good Afternoon, Mr. Chairman, Mr. Vice Chairman, Senator Heitkamp and Members of the Committee, and Honored Guests. My name is David Flute, and I am the Chairman of the Sisseton-Wahpeton Oyate. I am pleased to testify in support of S. 465, Independent Outside Assessment of the Indian Health Service. Thank you for the opportunity to testify today.

As Native Americans, it is important for us to have respect for our Native Nations, treaty rights, and Indian lands because our right to self-governance and self-determination on our Reservations is the essence of Freedom and Liberty for us. Indian Health Care is an important treaty right, and we gave up millions of acres of land to non-Indian immigrants in return for our permanent homeland. Indian health care is intended to make our homelands, livable homes, but the Indian Health Service ("IHS") has not lived up to its mandate. IHS Administration is failing the Sisseton Wahpeton Sioux Tribe and the Great Plains Region, so we need Congress's help to turn the IHS around and provide good, reliable health care for our Native people. The introduction and passage of S. 465 is an important step towards that goal.

Senator Rounds is providing important leadership on the Indian Health Service for Native Americans in the Senate, as he did as Governor of the State of South Dakota to make the government accountable to the people. We thank him and the Committee for all of your hard work.

We also support the passage of S. 1400, the Safeguard Tribal Objects of Patrimony Act to protect our Tribal Cultural Items from wrongful transfer and sale.

II. BACKGROUND: THE SISSETON-WAHPETON SIOUX TRIBE

The Sisseton-Wahpeton Oyate (meaning Sisseton-Wahpeton Dakota Nation and we have been known historically as the Sisseton-Wahpeton Sioux Tribe) original homelands were in Minnesota, North and South Dakota. The Sisseton-Wahpeton Sioux Tribe is signatory to the 1851 Treaty with the Sisseton-Wahpeton Bands of Dakota Sioux (Traverse des Sioux) and the 1867 Lake Traverse Treaty, which set aside the Lake Traverse Reservation as our "permanent home"—

> Beginning at the head of Lake Travers[e], and thence along the treaty-line of the treaty of 1851 to Kampeska Lake; thence in a direct line to Reipan or the northeast point of the Coteau des Prairie[s], and thence passing north of Skunk Lake, on the most direct line to the foot of Lake Traverse, and thence along the treaty-line of 1851 to the place of beginning.

The Lake Traverse Reservation is located in the Northeastern part of South Dakota and a small portion of southeastern corner of North Dakota. The reservation boundaries extend across seven counties, two in North Dakota and five in South Dakota.[1]

Our 1867 Treaty continues our "friendly relations with the Government and people of the United States." Our Treaty also recognizes our people's right to self-government and to adopt "laws for the security of life and property," to promote the "advancement of civilization" and promote "prosperity" among our people.

Today, we have a total of 14,000 tribal members located throughout the United States and others serving overseas in the Armed Forces. Among the Sisseton-Wahpeton Sioux Tribe, we have maintain our treaty alliance with the United States, and we are rightfully proud of our volunteer service to the United States through the military. We are proud of our service to the United States through the military. Woodrow Wilson Keeble, one of our most respected tribal members, served in World War II and in Korea and was posthumously awarded the Congressional Medal of Honor by President George W. Bush.

III. IHS REALITIES, MEDICAL AND ADMINISTRATIVE ISSUES

The Indian Health Care administered by the IHS is ***rationed medical care*** for American Indians. Although Indian health care is based upon treaty obligations, American Indians have poor health and suffer premature death when compared with the general public. Our American Indian life expectancy that is 4.2 years less than Americans overall.

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[1] Under the Allotment Policy, significant tribal lands were sold as surplus lands against our wishes, but under the modern Indian Self-Determination Policy, Congress affirmed our efforts to recover those portion of our homelands, and treats our recovered Indian trust lands as "on-reservation" acquisitions within the original boundaries of the Lake Traverse Reservation. Public Law 93-491 (1974).

Our people die at higher rates than other Americans from alcoholism (552 percent higher), diabetes (182 percent higher), unintentional injuries (138 percent higher), homicide (83 percent higher), and suicide (74 percent higher). American Indians suffer from higher mortality from cervical cancer (1.2 times higher); respiratory disease (1.4 times higher); and maternal deaths (1.4 times higher). Our health care disparities in the Great Plains are greater than these national disparities.

Indian Nations Need Equity In Per Patient Health Care Funding: Per patient annual health care spending: Medicare $12,042. National health care spending is $7,713. Veterans Affairs $6,980. Bureau of Prisons $5,010. IHS spends only $2,849 per patient. The National Tribal Budget Workgroup estimates full funding for IHS would cost $30.8 Billion compared to the actual $4.8 Billion FY 2016 IHS Budget.

> **Real Life Situation at Sisseton Wahpeton:** *Without equity in per patient funding, Indian Health Service patients will present for urgent care at the CDP [Coteau des Prairies] emergency room. The IHS does not pay for urgent care in an ER. They only pay for the Priority I emergencies. This results in bills going unpaid and turned over to collection agencies. It is difficult for lay people to determine how urgent or emergent their situation is. Maybe their child could wait for IHS to be open, but how can the average person know?*

Indian Nations Need Telemedicine. Telemedicine requires technological investment. In the long run, telemedicine will provide greater access to proper medical care at reduced cost. Legislative support including authorization for appropriations, pilot projects, and dedicated funding will speed implementation. As a model for successful use of telemedicine being used today, health care providers in non-native rural hospital emergency rooms throughout eastern South Dakota, use eER, ePharmacy and eICU technology in Critical Access Hospitals throughout the state to extend Hospital emergency, pharmacy and internal medicine services to rural, geographically isolated communities.

Indian Nations Need Competitive Pay for Physicians and PAs. IHS must increase pay for its Physicians and increase overall efforts to recruit and retain physicians. Congress should also remember that our Physician Assistants (PA) also need increased competitive pay. PAs have been recognized by Congress and the President as crucial to improving U.S. health care. Congress has recognized our PAs as one of three healthcare professions in primary care. For all medical professionals, Physicians, Physician Assistants and Nurse Practitioners, as well as Registered Nurses, scholarships and loan forgiveness should be increased to improve recruitment of these medical professionals to the IHS.

Our Sisseton Wahpeton Tribal Government staff provided the following statement to give you specific examples of problems with access to Physicians and Physicians assistants.

> **Real Life Situation at Sisseton Wahpeton:** *One of the biggest issues with our health care is the fragmentation of services between IHS (which provides primary medical,*

dental, mental health, optometry, and physical therapy), Coteau des Prairies Health Care System (private facility in Sisseton that has an emergency department, OB delivery unit, and home health care services), Tribal Health Programs, and tertiary care facilities (where patients are typically sent for surgery and specialty care services). The IHS employs the Improving Patient Care model, which empanels patients to provider teams. However, the majority of the provider positions are vacant and filled with temporary staff (temporary doctors, physician assistants, and nurse practitioners who are contracted for short periods of time). As a result, there is also lack of continuity in care for our patients. People often do not know who their provider is. And the providers are not there for them when they are really sick. When they are really sick they present at the emergency room, and many who have an alternate resource, such as Medicaid or Medicare, stay with the provider at the private facility that is there for them in an emergency and who is familiar with their condition. IHS is sort of the "fair weather" friend type of provider to patients and often not substantively there for them when the going is tough.

Keep Our IHS Facilities Open. HHS must direct CMS and IHS to coordinate on IHS and tribal hospital, emergency room, and clinic staffing to ensure proper certification of our Indian country health care facilities. CMS and IHS should collaborate to provide technical assistance, emergency funding and temporary staffing when necessary to keep facilities open as long term operational plans are developed and implemented. Accordingly, S. 465 should include a study of CMS closures of IHS facility and a plan for CMS to assist IHS facilities to stay open with CMS training, technical assistance, and temporary staffing.

IHS Purchased/Referred Care—A Top Priority. The IHS is organized to provide only basic emergency and clinical care at tribal hospitals and clinics. In regard to Purchased/Referred Care ("PRC"), the IHS explains:

> Because IHS programs are not fully funded, the PRC program must rely on specific regulations relating to eligibility, notification, residency, and a medical priority rating system. The IHS is designated as the payor of last resort meaning that all other available alternate resources including IHS facilities must first be used before payment is expected. These mechanisms enhance the IHS to stretch the limited PRC dollars and designed to extend services to more Indians. This renders the PRC program to authorize care at restricted levels and results in a rationed health care system....

In short, IHS Purchased/Referred Care is limited and unless a patient will lose life or limb, services are denied. We need more funding for access to specialized care—especially high demand services such as respiratory care and psychiatric care. IHS medical denials are resulting in ***unwarranted deaths, disease and injury*** and ruining our people financially.

Medicare-Like Rates. Medicare-Like Rates must be applied to all outpatient care and referrals. S. 465 should be amended to study a requirement that medical providers to accept Medicare-Like Rates from the IHS and tribal governments.

Maximize Third-Party Revenue. The IHS must be able to bill third-party insurance when patients have coverage, and Congress should enact legislation to enhance the IHS billing system to make sure that Third-Party Insurers do not evade responsibility. Then our Third Party Revenue must stay at home to reimburse and enhance the facility that generated the funds through patient services. This is an extremely important aspect of the S. 465 study.

Cut HHS/IHS Bureaucracy. Central Office and Regional Office staff should be cut back with resources reallocated to Indian country. PHS Commission Corps medical providers should be sent to the field to practice medicine in Indian country.

IV. S. 465, INDEPENDENT OUTSIDE ASSESSMENT OF THE INDIAN HEALTH SERVICE.

S. 465, the Independent Outside Assessment of the Indian Health Service should be enacted into law. It is essential for Health Care funding to be effectively and efficiently used to provide patient care, promote health and positive community health outcomes to raise the standard of wellness and the life expectance of Native Americans. S. 465 seeks to take those initial steps towards efficiency, efficacy, accountability, and transparency.

Cooperation and Coordination with GAO. The Government Accountability Office (GAO) is an independent, nonpartisan agency that works for Congress. GAO's Mission is to support Congress and "help improve the performance and ensure the accountability of the federal government for the benefit of the American people" by providing "information that is objective, fact-based, nonpartisan, non-ideological, fair, and balanced." Under S. 465, HHS Office of Inspector General should conduct its review in cooperation and coordination with GAO. Hence, Section 2(b)(1) should start with the phrase, "In cooperation and coordination with the GAO," before "The Inspector General."

Consultation and Coordination with Indian Tribal Governments. In carrying out its responsibilities under this statute, HHS OIG and GAO should be directed to consult and coordinate with Indian nations and tribes in accordance with the principles of Executive Order 13175, concerning the formulation of the study, findings of the draft report, and the submission to Congress. HHS and GAO are familiar with the Executive Order and have policies to ensure compliance with its requirements.

Contracting with State and Local Health Care Institutions. The Snyder Act provides authority for the IHS to contract with State and local institutions for supplementary provision of governmental services to Indian country. The IHS explains:

> Snyder Act authorized funds "for the relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes throughout the United States." (1921). Transfer Act placed Indian health programs in the PHS. (1955)
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> The appropriation to IHS by Congress to provide medical services and health care programs are made available through the Snyder Act of 1921....

The term Purchased/Referred Care (PRC) originated under BIA when medical health care services were contracted out to health care providers. In 1955 the Transfer Act moved health care from BIA to the Department of Health Education & Welfare and established the IHS.

The PRC funds are used to supplement and complement other health care resources available to eligible Indian people. The funds is used in situations where: (1) no IHS direct care facility exists,(2) the direct care element is incapable of providing required emergency and/or specialty care, (3) the direct care element has an overflow of medical care workload, and (4) supplementation of alternate resources (i.e., Medicare, private insurance) is required to provide comprehensive care to eligible Indian people.

S. 465's study should include the possibility for development of better IHS strategies for partnering with local health facilities, rather than simply paying third party billing.

Recommendations from Tribal Staff on Relations with Local Third Party Health Care Providers: *The intent when we were planning for the Sisseton Wahpeton Health Center was for the IHS medical providers to get South Dakota licensed and credentialed and privileged at Coteau des Prairies Hospital. Sisseton IHS and Coteau des Prairies Hospital could have (and still could or should) enter into a partnership whereby the providers are cross-privileged and SIHS could use the resources appropriated by Congress for OUR PEOPLE to provide 24/7 urgent care services at that facility. However, there has been no initiative (as in motivation or effort) for the SWIHS to pursue a partnership, which would put IHS in the driver's seat as the true primary care coordinators for patients that are empaneled to the various provider teams. The benefit of a partnership would be: (1) continuity of care for our patients; (2) Tribal members would not be stuck with bills for non-emergencies; (3) IHS could cover expenses from other accounts, such as third party, instead of PRC (which are very precious); (4) CDP would not be caught with the big accounts receivable that (we understand) they have been complaining about; and (4) our patients wouldn't need to be made to feel like second-class patients (uninsured) when the reality is that health care is a Federal treaty and trust responsibility. The Sisseton IHS is probably the biggest payor and source of revenue for the Coteau des Prairies Hospital. IHS should leverage that buying power through partnership contracts so that the Indian patients are treated like other health care customers when they go to CDP and they are provided quality care, instead of sometimes being shuffled back to IHS or made to feel they are being "turned away."*

How Dual Patients Are Handled. The IHS explains that: "It is the policy of the Indian Health Service to charge Medicare and Medicaid for services provided to beneficiaries of the IHS program who are enrolled in Medicare and Medicaid. See Social Security Act Section 1911 [42 USC l396j], Section 1880 [42 USC 1395qq]." For IHS patients, who have private insurance or are eligible for Medicaid reimbursement, the IHS should be engaged in third party billing, and the receipts from third party billing inure to the benefit of the IHS facility, which generates the billed services. By statute, the IHS must keep the

proceeds of the third party billing at the IHS or tribal facility that generates the revenue, but in the Great Plains, our Tribes have experienced problems with IHS seeking to use Hospital & Clinics funding to cover special projects in other elsewhere, to cover budget shortfalls in other areas, and even to settle labor disputes! As a result, Sisseton Wahpeton Third Party collections were expended to replace regular IHS operating funding when the revenue should have been available for Sisseton Wahpeton facility improvement.

Whenever funds are available from Sisseton-Wahpeton IHS Third Party Collections, these revenues should be remitted to the Tribe or its facility in accordance with the Indian Health Care Improvement Act, which directs that the Secretary of HHS is acting as an agent for the Tribal Government when collecting Medicare and Medicaid fees from covered patients. We are entitled to "100 percent pass through of payments" due to our facilities to be used for health care facilities and service improvement. 25 U.S.C. sec. 641(c)(1)(A). Our IHS Region was wrongly going to divert our Medicare and Medicaid collections away from our Service Unit. ***IHS must follow the law by making our Medicare and Medicaid fees available for services, equipment and improvements at our Service Unit.*** This Third Party Billing Issue was a concern for the entire Great Plains Region. The Act's provisions should include a reference to this law and a study of IHS compliance with existing law.

V. CONCLUSION

The Sisseton Wahpeton Sioux Tribe maintains our alliance with the United States as a friend and ally of our Indian nation. We ask you to work with us to promote Indian Self-Determination and effective Federal and tribal government. The Indian Health Service has much to answer for because its bureaucracy has kept the doors closed on their operations. Our Native people need good, reliable health care, and the delivery of such health care requires funding, foresight, planning, and the recruitment and retention of solid personnel—the Physicians, PAs, and Nurses—equipment, and facilities. Working together, Congress and our Indian nations can improve the Indian Health Service and Indian health care. Let's build a partnership based upon objective facts and good, reliable, professional medical service through the enactment of S. 465.

Finally, I would like to express Sisseton Wahpeton Sioux Tribe's support for S. 1400, the Safeguard Tribal Objects of Patrimony Act. Traditionally, our Native people were spiritual people, who integrated our reverence for the Creator into our everyday lives. The United States, from the 1880s through 1978, enacted laws and regulations and kept them on the books to outlaw Native American religion and cultural observances. My father, together with many of our tribal leaders nationwide, worked with Congress to secure enactment of the American Indian Religious Freedom Act of 1978, 42 U.S.C. § 1996, to secure the Freedom of Religion to Native Americans. S. 1400, which protects our Tribal Cultural Items from wrongful transfer outside the Native American community is a further step towards full Religious Freedom for Native Americans.