

**TESTIMONY FOR THE SENATE COMMITTEE ON INDIAN AFFAIRS HEARING ON
“RE-EXAMINING THE SUBSTANDARD QUALITY OF
INDIAN HEALTH CARE IN THE GREAT PLAINS”**

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Chairman Barrasso, Vice Chairman Tester, and Members of the Committee, thank you for holding this important hearing on the substandard quality of health care experienced by Indians in the Great Plains and more specifically in my region, the Rocky Mountain Area which includes both the Chair and Vice Chair’s home states Montana and Wyoming.

On behalf of the Northern Cheyenne Tribe and the Tribes of Montana and Wyoming, I submit this testimony.

My ancestors, my great grandparents paid for goods and services in exchange for lands, our freedom and peace - with their blood. Their sacrifice was made for me, my grandchildren and their grandchildren into perpetuity. Because of our Treaties with the federal government and your promises to my people there is a trust responsibility for your government to provide health care to my People: Your trust responsibility is not being fulfilled! I come to you revealing a tragic and sad truth: health care is rationed and inadequate for the Northern Cheyenne and surrounding

Direct Service Tribes. We are required to utilize this inadequate, hostile system in our isolated and frontier parts of the United States - the places we call home.

IHS: A BROKE AND BROKEN SYSTEM

The Senate Committee on Indian Affairs should be experts now on the funding issues that plague the Indian Health Services (IHS). For years the data show that the IHS has continually operated on a close to 40% budget. IHS has never been fully funded based on need. In addition, the IHS Budget has never recovered from budget cuts, recessions and sequestration. We all should know by now that increased funding and advanced appropriations will make a huge and positive impact in the IHS healthcare system. Even more important, Congress needs to protect the IHS budget from discretionary funding and budget cuts. Of course these realities help create and sustain a health care system that the Northern Cheyenne and other DSTs are forced to utilize because it's the only game in town. No matter that it is substandard, lacks any real resources, and is not customer-friendly or culturally appropriate toward its patients. We need to be progressively aggressive in preventing and treating diseases in our communities, to remain eligible and mission driven to meet accreditation standards and to effectively compete with the private sectors. IHS is not a public health system.

IHS is not health insurance. We learned this the hard way with the implementation of the Affordable Care Act in Indian Country. This distinction about insurance was not made clear in our communities and the federal government missed an important opportunity to educate and empower tribes and Indians. Now that tribes have to subsidize the underfunded IHS system with other agency grants,

third-party revenue and even Tribal dollars, when possible. Tribes have to be more and more creative in providing support for the direct health care of our tribal citizens. I say direct care because the Tribes in our regions are still a majority direct service tribes.

Direct Service Tribes.

How many distinguished members of the committee know the dichotomy of the IHS Tribes? It is Public Law 93-638, the Indian Self-determination and Education Assistance Act of 1975, empowered and created authorities for to tribes to be truly sovereign nations in managing and governing federal resources for their people. In healthcare, PL-638 has shown that the levels of tribal government capacity in regard to self-governance varies within the 12 IHS regions. Most commonly, the Tribes in Montana, Wyoming, South Dakota and North Dakota remain Direct Service Tribes. And in the more recent decade, this label has had a negative connotation that is associated with the “do-nothing tribes, hand-out tribes, or the tribes who don’t have stable governments, lack tribal resources to hire consultants and lawyers, who lack funds to lobby and travel to the place of power – Washington DC.” The playing field for tribes is far from level.

Direct Services Tribes receive health care directly from the federal government and these areas that still have direct service tribes tend to be viewed by other Tribes and by IHS as unsophisticated and uneducated governments who lack the understanding to taken advantage of Title 5 of the Indian Self-determination Act. The scrutiny is that if we, the Direct Service Tribes of the Great Plains and Rocky Mountain Area complain so much about IHS, than why don’t we just take over the

clinics, hospitals and programs and run them ourselves? First of all, why should we have to? But, it's just not that easy to do.

Tribes like the Northern Cheyenne still have our language and our ceremonies, we still have customs and traditions that are original to this land and seem foreign to the federal government. The Northern Cheyenne were one of the last tribes to lay down our arms against the US Army. We resisted the longest and now we suffer the most.

Now when Tribe's in our areas want to contract or compact, we are met with resistance and red tape. Federal employees who work for the IHS would be working themselves out of a job if they help to ensure that the Tribes and Tribal Health Programs can properly manage their own health care functions, the purpose of PL-93-638. In the DST-dominant areas of IHS, our federal Indians are career driven and legacy minded professionals who are quick to hinder our efforts instead of helping our cause to be self-determined in our healthcare. Examples include the contracting of clinics, business office functions and the Patient Referred Care for tribal premium sponsorships programs under the ACA.

The healthcare system under the federal government is set-up as a divide and conquer tactic that can be compared to the "hang-around the fort Indians" concept where those who are in Washington, DC (the fort) get the help (the food and health rations) first.

Direct Service Tribes are pitted against the Self-governance Tribes annually when it comes to IHS and HHS Budget Formulation process. Priorities of one group versus another group are discussed and debated on where the already underfunded budget allocation (or increases) for IHS will go. The federal government has us fighting over scraps again and history is only repeating itself.

The problem with this and the difference between Direct Service Tribes and Self-Governance Tribes is capacity. As a direct service tribe, I know we are still making gains to build our capacity to be able to take over our clinic and run it the way we would like in a culturally significant manner, free of federal bureaucracy. But because we, ourselves, have been given a tribal government system through the Indian Reorganization Act that assures a revolving door of tribal instability, we continually have to start over every two years to make any real progress towards true self-governance. Yes, this portion of the situation is ours and we are moving towards tribal government reform and we will revise our tribal constitutions: we will get there.

Take for example the hot issues of Contract Support Cost (CSC). The fact is the IHS had to eat the cost of fully funding CSC last year and did so mostly at the expense of Direct Service Tribes. Then on May 22, 2015 we learned that the IHS paid out \$68 million to settle overtime disputes with 20,000 IHS employees. \$48 million came from the third party billing revenues Tribes fight to bring in to fund our system. Why was that funding sitting at Area IHS offices, available for re-purposing when our People are desperate for doctors and other health care providers? Again, 11 IHS doctors were sent to Africa to address the Ebola Virus outbreak – when our

own People are dying in a health system with nearly 40% vacancy rates for physicians in the Great Plains Area, alone. Here we have an already underfunded healthcare system being gouged to take from its coffers money funds and capacities that are supposed to be used to provide direct health care for tribes like the Northern Cheyenne. And now these funds are being used to pay for indirect cost for tribes who are empowered and experts of PL-638 and who provide their own tribal health care; back pay from a mis-managed personnel system and for Peoples overseas with whom the federal government does not have a trust responsibility!

In the case of the CSC case, the federal government with approval of Tribes (mostly self-governance tribes) agreed to support the taking money from the direct service tribes to pay for the majority of self-governance tribes contract support cost. Sure, the Northern Cheyenne will be settling our CSC claims but it is sad to think that the money is coming from our IT support shares from headquarters or the IHS nurses and doctors salaries in Lame Deer, Montana.

So why doesn't the committee question the system they authorize and fund? This system is still a paternalistic model of colonization. There are tribes at all different levels of success and self-governance. Take a look at the Tribes in the Great Plains and Rocky Mountain areas and see where our capacity is and see how our relationship with the federal government is. It has become normal and "ok" to: be misdiagnosed by locums who are contacted on the weekends to work in our ERs; to wait until you're going to lose a leg or your life in order to be referred out to receive the right healthcare you need; for a baby to be born in a car on the way to

the Northern Cheyenne hospital because IHS no longer delivers babies at Crow hospital. If you go out of IHS to make a life decision for your family or yourself that does not meet the IHS standard of “life or limb,” you will have to pay for it yourself. Many of my people have been sent to debt collectors or had their fixed incomes compromised because they could not pay for medical care that IHS denied. This protocol has administrators making business decisions over medical providers’ medical directions. Now you have doctors at the local level learning ways to game the system in order to ensure that a tribal member receives a CT scan that will eventually save their life versus waiting until one’s health erodes into a far more costly and life-threatening condition.

Since we cannot get referred out to for “Level 2 or Level 3” services under the PRC system, tribal members remain in pain or their diseases go undetected and untreated. Most become addicted to pain pills or lose faith altogether and resort to self-medication with alcohol or substance abuse. This vicious cycle, along with the circumstance I mentioned with the funding and capacity issues for Tribes, makes one believe that the Indian Wars are not over and that the treaties continue to be broken and that there is not “trust” worthy of our US Government’s responsibility.

In closing I want to point out some positives and solutions that seem to be working in Montana.

1. Montana, Medicaid Expansion and Tribal-State Relations

The Northern Cheyenne has a political and government-to-government relationship with the federal government and yet we are still being classified and grouped into race or ethnicity driven discussions. For example, in Montana, the state issued a report in 2013 identifying the mortality rate of American Indians to be 20 years less than that of our white, non-Indian neighbors. We die a whole generation before our white counterparts. This figure went unmentioned and was not addressed. With an alarming health disparity that is based on a denominator of race/ethnicity, the report and the figure neglected to acknowledge the political status First Montanans have in respect to State-Tribal relations. Montana responded and Governor Steve Bullock met with Tribes to create, by Executive Order, the Office of American Indian Health to address the health disparities Indian people face in the State.

As of January 1st, 2016 some 20,000 American Indians in Montana became eligible for Medicaid Expansion under the HELP Act. With Medicaid Expansion. Tribes and more importantly, IHS facilities are able to increase their billing opportunities for the services they provide to increase revenue that hopefully increases the PRC referrals and direct services. We thank the state for picking up the slack of the federal government

2. Recruitment and Retention

Recruitment and retention of qualified medical providers is a game changer. For example, the emergency rooms are difficult to staff with permanent ED physicians. Coverage is provided by contract doctors. Primary care doctors

then have to cover the ED, which destabilizes the primary care setting and that is our core function. I believe that if IHS fully staffed all the service units with providers many of their issues would disappear. IHS could then focus on optimizing the delivery model and improve access points for the patients. Again, speaking as a Direct Service Tribe, recruitment is more than just pay and with competing against the private sector, IHS should consider their own health care infrastructure (newer equipment, robust EHR, support staff, adequate space etc.), schools, housing, shopping, cell coverage and spouse satisfaction to name a few.

Fill all vacancies and streamline the selection and hiring process for positions. Work with Tribes on fillings positions and remove the PSA requirements for top-level positions. Too often the IHS is burdened with career-oriented and legacy minded individuals who lack any true commitment to the service of tribes and American Indians. Cultural competency should be a standard in recruitment also.

3. Transition toward Self-governance

Provide better technical assistance and funds for Direct Service Tribes to begin to transition into Self-governance. Begin a pilot project for Tribes in the Great Plains and Rocky Mountain areas to help build capacity and strategize a plan to increase contracting and eventually compacting services and function of the IHS.

4. Allow Tribes to be voting members on IHS Governing Boards

Tribal participation on IHS's Clinic/Hospital Governing Boards is limited to ex-officio status. Allow Tribal representatives to have full membership and insurance coverage to make decisions on these boards in a true government-to-government manner. This would also train and prepare Tribes to transition into self-governance.

Thank you for the opportunity to offer this testimony for the committee on this important topic that I am so passionate about. I express the Northern Cheyenne Tribe's support for the work that this Committee has previously done to support the Indian Country and look forward to working with you to find solutions for to achieve excellent health care delivery and status of our indigenous people.