WRITTEN TESTIMONY OF JERILYN LEBEAU CHURCH,
GREAT PLAINS TRIBAL LEADERS HEALTH BOARD,
BEFORE THE
HOUSE NATURAL RESOURCES COMMITTEE
SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS
"RESTORING ACCOUNTABILITY IN THE INDIAN HEALTH SERVICE ACT OF 2023"
JULY 27, 2023

Thank you for this opportunity to present testimony on the discussion draft of the "Restoring Accountability in the Indian Health Service Act of 2023" on behalf of the Great Plains Tribal Leaders Health Board (GPTLHB). GPTLHB serves as a liaison between the Great Plains Tribes and the various Health and Human Services divisions, including the Great Plains Area Indian Health Service (IHS), and works to reduce public health disparities and improve the health and wellness of American Indian people and Tribal communities across the Great Plains. In our region, 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, and five are managed directly by IHS. 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.

Therefore, at GPTLHB, we are acutely aware of the difficulties and challenges the IHS faces in improving healthcare delivery and healthcare outcomes for Indian people in our communities. In fact, just this spring, I testified before this Subcommittee on these current challenges and opportunities. We appreciate the members of this Subcommittee' placing an emphasis on improving the IHS and its operations. This draft legislation raises several important issues and proposes

important improvements to the system, including;

- improvements to IHS management;
- employee whistleblower protections;
- the provision for housing vouchers for recruitment and retention;
- strengthening the training requirements for tribal culture and history;
- the establishment of a compliance assistance program; and
- providing for transparency in CMS surveys.

We do, however, have concerns about the legislation as drafted. These include the need to make sure that the legislation does not confer additional unfunded mandates on the already seriously under-resourced IHS and that additional administrative requirements (including agency reporting requirements) will not be so burdensome as to take time and resources away from patient care. Concerning improvements to IHS operations, ensuring the agency has sufficient resources to do its job is the most crucial factor. It is also essential to make sure that the legislation does not duplicate authorities that IHS already has and that it maintains parity between Tribally operated healthcare facilities and programs where appropriate. It is also essential that Tribal facilities and programs are allowed to opt into or not participate in certain IHS-specific requirements imposed by the bill, such as the proposed uniform medical credentialing system. As legislation is passed to ensure that it is implemented in ways most appropriate to balancing IHS and tribal concerns, we recommend that the legislation require negotiated rulemaking where representatives of IHS and tribes around the country can meet together to determine the most effective implementation.

GPTLHB is happy to work with the Members of the Subcommittee on suggestions for improvements to the legislation as drafted, but the discussion draft—and the issues underlying it—raise the larger question of the process of including Tribal voices in potential legislative improvements through amendments to the Indian Healthcare Improvement Act (IHCIA). In the past, these legislative efforts would primarily be driven by input from the knowledge, wisdom, and difficult decision-making of the Tribal leaders who made up the National Steering Committee (NSC) on the Reauthorization of the IHCIA. Now that the IHCIA has been made permanent, that mechanism for critical Tribal input no longer exists. We strongly urge the Members of the Subcommittee to work with your colleagues to direct IHS to reinstate the NSC and to provide sufficient appropriations to support its critical work.

Thank you for the opportunity to provide testimony today on this critical issue and for your efforts to improve healthcare delivery to all our People and communities.