TESTIMONY OF JERILYN CHURCH
ON BEHALF OF THE GREAT PLAINS TRIBAL LEADERS HEALTH BOARD
BEFORE THE HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES
REGARDING FY 2026 APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE
February 27, 2025

My name is Jerilyn Church. I am the President/Chief Executive Office of the Great Plains Tribal Leaders Health Board (GPTLHB) and am enrolled as a tribal member of the Cheyenne River Sioux Tribe.

The GPTLHB is the Area Indian Health Board for seventeen Federally recognized Tribes in South Dakota, North Dakota, Nebraska, and Iowa. In addition, GPTLHB, on behalf of three tribes: the Oglala, Rosebud, and Cheyenne River Sioux Tribes, provides through the Oyáte Health Center in Rapid City, SD, health care services to beneficiaries of the Indian Health Service (IHS) pursuant to a government-to-government compact with the United States under authority of the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

The Oyáte Health Center provides a broad range of health care services to nearly 23,000 IHS Beneficiaries. It has dramatically expanded the services being provided since its initial assumption from IHS in 2019. The growth is continuing: in the first four months of FY 2024 the monthly average number of patient encounters (excluding pharmacy and dental) was 6,149, in the same four months of FY 2025 the average number has grown to 7,617. For planning purposes, we now estimate the annual total encounter will grow from 70,000 in FY 24 to more than 91,000 in FY 25.

These programs are supported with a combination of direct IHS funding under its Compact and third-party revenue (Medicaid, Medicare, and private insurance) and grants like the Special Diabetes Program for Indians (SDPI) and others. This combination of fund sources is critical to sustaining the services it offers. Any diminution in its availability jeopardizes the effectiveness of the programs it can offer and thereby the fulfillment of the Federal trust responsibility.

As the Area Health Board, GPTLHB applies for, delivers and accounts for, in cooperation with Tribes within the Great Plains Area, grants that provide behavioral and other health services critical to meeting specific needs of the patient populations throughout the Area in which 150,000 American Indians and Alaska Natives reside and to diminishing preventable illnesses, injuries and deaths. These centralized, cooperative processes ensure efficiencies are achieved and that all expenditures are fully accounted for.

Thank you to the Subcommittee for the opportunity to once again address the ongoing funding needs of Indian health programs, and especially those of the Great Plains whether operated by the IHS or by tribal health programs like that of GPTLHB. It is truly important that

Congress takes this time to listen and to fulfill its responsibility to ensure that its appropriation decisions respect the trust responsibility the United States owes to Tribes and American Indian people and the commitments found in the ISDEAA, the Indian Health Care Improvement Act (IHCIA), and other laws enacted by Congress for the benefit of Tribes and American Indian and Alaska Native people.

1. **Advance Appropriations are critical to the stability of the tribal health care delivery system.**

GPTLHB appreciates the Appropriations Committee for providing advanced appropriations for the Indian Health Service for FY 2025. The Committee should continue authorizing advanced appropriations until permanent mandatory funding for the Indian Health Service is enacted. However, when authorizing advance appropriations sufficient funding to account for the cost of medical inflation and population growth in Tribal communities should also be considered by the committee. The failure to do so could result in a decrease in access to care.

The Indian Health Service was the only federally funded direct health care provider that was not protected when Congress failed to enact required appropriations bills. The FY 2020 government shutdown underscored the need for this change. The delays in funding had dire impacts in Alaska Native and American Indian communities across the country. Authorization of advance appropriations alleviated this problem.

Much has been said in this Subcommittee, year after year, about how the programs and departments subject to this appropriations process are reflections of the trust relationship the federal government has with American Indian and Alaska Native people. The problems that arise from shutdowns and other delays in the context of a *lack* of advance appropriations exacerbate the problems caused by the funding shortfalls and disparities. The current uncertainty regarding federal funding and potential upheavals to Medicaid and other federal healthcare programs underscores the continuing need for advance appropriations for the IHS.

2. **Mandatory Appropriations and exemption from sequestration would help to meet the Trust responsibilities of the federal government.**

Proposals to begin moving the entire IHS budget to a mandatory appropriation structure are laudable and should be considered. A move away from discretionary appropriation towards mandatory funding would help to stabilize and improve the services offered through the Indian health system and demonstrate the federal government's commitment to the health and well-being of Alaska Native and American Indian peoples across the United States. Combined with increases in funding amounts, it would help to meet the Trust responsibilities the federal government owes to Tribes and Tribal members.

In addition, to alleviate additional pressures on the IHS budget, and the budgets of Tribal entities that contract and compact with the IHS, the appropriations for the agency should be exempted from sequestration. The IHS is the only major federal health program that is not exempt from sequestration cuts. The possibility of these cuts, even if not realized, lead to uncertainty in budgeting for the agency and the Tribes that it works with.

3. **Section 105(*l*) Lease Payments**

The committee's careful attention to the issue of 105(*l*) leases is appreciated. GPTLHB strongly supports that these costs remain an indefinite appropriation, but with the goal to make sure these costs, along with contract support costs are made mandatory costs so that they do not continue to stress the limited funding allocation the subcommittee receives.

4. Health Workforce Stability and Development

The pandemic highlighted the drastic shortage of health care workers in America. The need is at every clinical level from doctors, nurses, dentists, mental health specialists, to medical assistants, and other medical technicians. Further, the pandemic has resulted in widespread professional burnout among health care workers throughout America. Solving this workforce crisis is a mission-critical priority. The GPTLHB is employing a range of strategies to recruit skilled individuals and foster the development of our current employees.

Our development extends from health professions to various support positions without which our programs cannot maintain their high standards for procurement, accounting, vendor payments and other administrative activities. Both as an Area Health Board and at Oyáte Health Center, and for that matter, at IHS directly operated health programs throughout the Area, administrative services are critical to effective timely operations. We work hard to recruit staff who we expect to become permanent employees. Because our salaries are rarely able to be fully competitive with other providers, and because many of the IHS and tribal programs are in locations that are rural and isolated, turnover is inevitable. We do everything we can to minimize turnover to avoid program disruptions and waste of training and orientation costs that result when an existing employee leaves. We believe this is critical for our effective operation and for that of the IHS.

The recent announcement of layoffs of probationary employees has been disruptive. To whatever extent it may be implemented, it disrupts the pipeline for filling vacant positions within IHS, which potentially affects the ability to deliver services. The possibility of this kind of disruption also affects Tribes considering assuming operations from the IHS since their authority to exercise the right to assume the Federal employees becomes uncertain. In all cases it discourages potential candidates from accepting positions in which termination seems likely even while the employee is performing at or above the expected level. We encourage the Appropriations Committee to include language in the Appropriations Act that discourages such notices and encourages the IHS and other related Federal agencies to work to stabilize their workforces.

We equally discourage reducing appropriations to account for savings from layoffs that may occur. The IHS is understaffed in all positions that provide or support direct care, including related administrative positions. In addition, if funds are removed from IHS to try to pare it down, the funds available for assumption by Tribes may also be diminished, which reduces the likelihood of Tribes being able to exercise their rights under the ISDEAA.

5. Behavioral Health Programs and Integration of All Services

Congress must protect and increase available funds for behavioral health. Alaska Native and American Indian people are disproportionately represented in substance misuse, especially

opioid addiction, and suicide statistics. Everyone in our communities is affected by these issues – directly or indirectly – in devastating ways.

The Oyáte Health Center has implemented systems of care developed by IHS and improved upon by the Southcentral Foundation to address this crisis with a new approach to behavioral services. The foundation of this new approach is the integration of behavioral health services into primary care clinics. This integration has allowed for earlier assessments and quicker access to behavioral health specialists.

We extend our integration of care to not only behavioral health, but also to access to dental care, specialty services, and community resources. All our employees are encouraged to work as a team for the benefit of each person we serve and the larger community we serve. Health conditions do not exist in isolation. When we consolidate our approach, we improve the outcomes of care, reduce the likelihood of crises, and become more efficient and cost effective.

Support for behavioral health and the systems-of-care model we are implementing throughout our recruitment, training, hiring, orientation, and delivery of all categories of care leads to short and long-term positive outcomes. Although we understand that the fiscal climate is challenging for FY 2026, budgetary restrictions should not be made on the backs of our most vulnerable populations.

6. Other Funding Sources

To achieve what we have and to continue to grow, and more fully meet the needs, the appropriations received through IHS are critical. However, unless appropriations are drastically increased, the Indian health programs of IHS and tribes cannot succeed without the resources earned through the Medicare and Medicaid programs and the costs paid by those programs for patients that require referral to other health providers, and the funds acquired through federally supported grants that focus on reducing and treating specific health issues. Only this past June the Supreme Court in *Becerra v. San Carlos Apache Tribe,* 602 U.S. 222 (2024) recognized the central role that revenues from Medicaid, along with Medicare and private insurance, play in the Indian health care system.

We urge that Indian health programs (tribal and IHS) be exempted from cuts to Medicare and Medicaid (and other federally funded programs) if cuts must occur.

7. Conclusion

GPTLHB is a successful story of the benefits of Tribes working together to support improved health care delivery through self-determination and self-governance in which tribes choose in some cases to operate programs themselves, such as the Oyáte Health Center, or through continued reliance on the IHS to deliver the services promised to them in treaties and federal law. We look forward to working with your Committee and the Administration to continue the progress that has been made and expand the opportunities for ever stronger growth.

Thank you again for the opportunity to provide testimony on behalf of the Great Plains Tribal Leaders Health Board, the 17 Tribes and the more than 150,000 IHS beneficiaries in the Great Plains Area.