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H.R. 2708:
Indian Health Care Improvement Act Amendments of 2009

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Good morning Chairman Rahall, Congressman Young and other Members of the Committee. Quyana (thank you) for the opportunity to testify today. My name is Valerie Davidson, and I am the Senior Director of Legal and Intergovernmental Affairs at the Alaska Native Tribal Health Consortium (ANTHC). I also serve as the Chair of the Centers for Medicare & Medicaid Services Tribal Technical Advisory Group (CMS TTAG) and a member of the National Steering Committee (NSC) on the Indian Health Care Improvement Act Reauthorization. I previously served on the Indian Health Service (IHS) Tribal Self-Governance Negotiated Rulemaking Committee.

I was privileged to work for seven years for the Yukon-Kuskokwim Health Corporation, the tribal health program that serves 58 tribes in a region roughly the size of Oregon, of which Bethel is the hub. For the past three years I have been honored to work for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 231 Tribes in Alaska, co-manages (with Southcentral Foundation) the Alaska Native Medical Center (ANMC), the tertiary care hospital for all American Indians and Alaska Natives (AI/AN) in Alaska, and carries out nearly all of the Area Office functions of the IHS, except for inherently federal functions.

First of all, thank you for holding this hearing on H.R. 2708, which was introduced earlier this month. I appreciate the efforts of this Committee to move the bill forward, both this year and in years past. I would also like to thank this Committee for its work in getting many AI/AN-specific Social Security Act amendments that were in past drafts of this bill into the American Reinvestment and Recovery Act of 2009 (ARRA) and the Children's Health Insurance Program Reauthorization Act (CHIPRA). Those amendments will go a long way toward expanding health coverage and services to AI/ANs.

Passage of the Indian Health Care Improvement Act Amendments (IHCIA) is nearly a decade overdue. The bill is lengthy, but not generally controversial. It is unacceptable that a bill that would improve health care delivery to the population with the most acute health care needs has stalled in Congress for nine years, even though it has already been considered at length by all interested parties. To allow the IHCIA and its authorization for appropriations to lapse for these crucial programs is shameful. I hope that the Committee will work with us this year to ensure that the bill is passed as soon as possible and that it is not derailed, as it has been in the past, by unrelated legislation or special interests groups.

I also hope the Committee will avoid the possibility of a similar lapse in the future by amending the bill to ensure that the authorization for appropriations is permanent, as recommended in Ms. Joseph's testimony. The ultimate policy documents of any government are its budget and appropriations laws. However strong Congress's commitment is to improving the health of AI/ANs, it cannot be realized without sufficient resources. Adequate appropriations to support these key programs are essential. Ensuring permanent appropriations authority would be a significant step in fulfilling this commitment, and we heartily support it.

This is especially important because the IHCIA is a comprehensive piece of legislation. Like the Indian health programs that it supports, the IHCIA addresses every aspect of a true system of health care for AI/ANs. In this it is unique among health programs in the United States. The IHCIA amendments address:

- Workforce issues
- A full range of health care services, including prevention services, nursing home services and end of life care, out-patient and inpatient services
- Behavioral health services, including a continuum of mental health and substance abuse services; and
- The public health infrastructure needed by IHS and Tribes to carry out this vast array of services, including health facilities, safe water and sanitation systems.

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In Alaska's experience and in Indian country throughout the United States, it is impossible to understand the diversity and challenges faced by Tribes without visiting their communities. We therefore welcome visitors from Congress and the Executive Branch. Nothing can replace first-hand knowledge. However, since not everyone can visit, I hope to help you understand why each part of this proposed law is so important to us. While I use many examples from Alaska, every Tribe in the United States experiences its own challenges and awaits passage of this critical legislation to assist it in responding.

Title I: Workforce with a Spotlight on the Community Health Aide Program.

We are often asked why the IHCIA needs to address human resources and development. Or put another way, why aren't other scholarship and loan programs supported by the Federal government sufficient? Why is there a need for special programs for AI/ANs? The answers are simple. Culturally competent care requires that the care providers understand and respect the language and culture of the people they are serving. Access to care, at its most basic, requires that there be enough providers who are willing to live in the remote communities where AI/ANs live, to work in facilities that are often out-of-date and over-crowded, and work for IHS or Tribal providers who cannot begin to compete with the private sector with regard to salaries.

Who better to take up these challenges than AI/ANs themselves? Each year, with the assistance of Title I programs, we see a few more Tribal members complete their education and move back home to serve their communities as nurses, doctors, social workers, and administrators. They fill critical jobs and, just as importantly, serve as role models throughout the Tribal community. To better support the effectiveness of these provisions, we endorse the NSC recommendation to make scholarships and loan reimbursements non-taxable to recipients, by inserting Section 124 from S. 212 (107th Congress) in the bill. Similarly, we support section 127, which exempts tribal employees from licensing, registration, and other fees imposed by a Federal agency to the same extent as Commissioned Corps Officers and other employees of the Indian Health Service.

But, Title I goes beyond support for mainstream education and financial relief for health professionals. It also provides for unique solutions to workforce challenges. One of the best

examples of this is found in section 121 of the Act, which addresses the Alaska Community Health Aide (CHA) Program. This innovative program was started in the 1950s by IHS in response to the tuberculosis epidemics in Alaska and the need for village-based health care providers who could provide vaccinations. Today, the program is carried out by Tribal health programs, with more than 500 CHAs providing primary health care services in more than 170 villages throughout Alaska. Typically, they are the only trained health care providers accessible to those living in remote communities.

The CHAs are trained through tribal programs that are certified by the Indian Health Service's CHAP Certification Board, which assures the quality of the curriculum and the *CHAP Manual* that guides day to day practice. The Certification Board also certifies individual CHAs.

The CHAs work under the general supervision of physicians located in regional hubs and other larger communities. The traditional CB radios have been largely replaced, first by telephones and, more recently, by sophisticated telehealth equipment which connects villages with regional providers on a real time basis. ANTHC, together with the Alaska Federal Health Care Access Network (AFHCAN), played an instrumental role in developing an innovative telehealth network for Alaska. Since 2001, ANTHC has realized over $14 million in savings by using telehealth, which was mainly achieved by reducing unnecessary travel costs and allowing more beneficial treatment due to early diagnosis.

The CHA Program is justifiably credited with saving innumerable lives and with providing essential health care in communities so small and remote that there is no viable alternative model for health care delivery due to limited resources and funding. Without the CHA Program, access to health care and continuity of care in rural and remote parts of Alaska simply could not be achieved.

The CHA Program proved so successful that it was expanded at the request of Tribes to address the growing oral health crisis. In Alaska, we needed a way to prevent young children from having to undergo surgery to have all of their irreparably decayed baby teeth removed long before their permanent teeth were ready to grow in and to prevent life-threatening dental infections that required patients to be medevaced from remote villages to ANMC for immediate surgery.

In response, the IHS CHAP Certification Board adopted standards for training, supervision, and certification of specialized health aides who provide a range of preventive and direct dental care services. At the highest level of certification, the Dental Health Aide Therapist (DHAT) can perform a number of dental procedures including fillings under the general supervision of a dentist. The supervising dentists and DHATs use the time proven CHA Program model of distance supervision and consultation along with the advances of telemedicine to help reduce the plague of dental caries in Alaska Native villages, while assuring high quality care.

More than eight graduates of the New Zealand program are currently working in their home villages, responding to the dental needs of their communities. With support from the Rasmuson Foundation, the Kellogg Foundation and many others, ANTHC and the University of Washington MEDEX program developed a two year DHAT training program based in Alaska.

This allows the DHAT students to stay in Alaska and near their home communities during their training. We were proud to have the first class trained in Alaska graduate last December in Anchorage.

The dental health aide initiative has engendered extensive debate and discussion in the last two Congresses. We are grateful for the assistance of Congressman Young who took a leadership role in helping Alaska Tribal leaders reach the compromise embodied in this bill in section 121. We look forward to the results of the study required in section 121. We believe it will demonstrate the efficacy of this model of care and reconfirm what early studies have shown, *i.e.* that the quality of care provided by DHATs within their scope of practice meets the standards expected of dentists and is having a meaningful, positive impact on the oral health problems of Alaska Natives.

Building further on these successes, the Alaska CHAP Certification Board has established certification standards for behavioral health aides. Here again, it is unrealistic to expect that master's level mental health and substance abuse providers will be available to make their home and work place in every village. The behavioral health aides rely on the proven models of integration described in Title VII of this bill and our experience with training members of the community to provide critical health services under the general supervision of more highly trained providers. Having behavioral health aides available in villages will contribute to the reduction of mental health and substance abuse problems in the communities through both routine, integrated mental health and substance abuse services and immediate intervention during the critical, early stage of a crisis.

We are grateful to the IHS for its leadership in the early development of the CHA Program and for its support as the program expands to meet the needs of Alaska Natives, who would otherwise have little, if any, access to primary care. It is truly an innovative solution to the overwhelming challenge of making quality health care available over enormous geographic regions with very limited resources. We look forward to seeing the new developments and successes that will surely arise as Tribes in other states develop their own CHA programs.

Title II: Health Services with a Spotlight on Long Term Care

Title II of the bill addresses the wide range of health programs that are essential to offering a continuum of care in which AI/ANs can receive care throughout every stage of their lives. The principal improvements in Title II of this bill simply authorize Tribes to fill a gap in the current Indian health care system and to catch up to the health care delivery improvements that have been made in the rest of the U.S., where health care delivery has moved away from inpatient and facility-based care toward home-and-community based care. Other changes reflect the positive impact of the Indian Self-Determination and Education Assistance Act (ISDEAA) under which Tribes have assumed direct operation of the programs previously operated by IHS and are meeting the needs and priorities of their own communities. We trust that the deletion of Section 202 of current law regarding the Catastrophic Health Emergency Fund was inadvertent and that it will be restored.
Section 206 will serve an important role in improving early detection and treatment of cancer. However, after consulting with the American Cancer Society and specialists at ANMC, we

suggest it be slightly revised to account for the fact that cancer screening is not readily available and is under-utilized in the AI/AN population and thus access to screening should not be solely based on the efficacy of randomized clinical trials which may not have included AI/ANs. The suggested revision is included in the attachment to my testimony.

Section 212 of the bill is especially important to achieving the modernization and changes that are required to meet the needs of tribal elders and those who suffer from debilitating conditions. Thankfully, due to improved health care services AI/ANs are living longer. But the growing population of tribal elders is still disproportionately affected by diseases such as diabetes and cancer, which require preventive, acute and chronic care in a variety of settings. Section 212 enables the Indian health system to assure that AI/ANs are not deprived of critical care or forced to move from their families and home communities when they most need their support. It would be a cruel irony if the price of living longer is to be forced to die away from family in remote non-Indian operated nursing homes, where providers do not speak their language and are not familiar with their values and customs. This can only be avoided by authorizing and investing in a full range of IHS and tribally operated long term care options that range from home- and community-based services through tribally operated nursing homes. Providing a continuum of culturally sensitive care is essential to improving services for this population. The definitions in Section 212 are all taken from other provisions of law assuring that, as these services are developed, they meet the same standards applicable to providers outside the Indian health system.

Section 220 guarantees funding to tribal programs on the same basis as it is provided to programs directly operated by IHS. The new House bill includes not just "health care programs and facilities" but also "health care programs, functions, services, activities, information technology, and facilities". This is a very positive development recognizing the breadth of activity and addressing inequities that occurred with regard to distribution of the ARRA HIT funds.

Section 221, which provides an exemption from state licensing law for employees of tribal health programs (similar to what federal employees already have) is an important recruitment tool. All too often State regulatory boards limit the number of practitioners in various ways that create real barriers to recruiting health practitioners. Requiring that providers be licensed in multiple states also imposes a cost on tribal health programs that the Federal programs do not incur. These are resources we can scarcely afford. We do note the need for a technical change in the draft. The scope of services that can be provided under the license exemption is limited by adding at the end the phrase "while performing such services." We recommend the version in the bill approved by this Committee in the last Congress and urge that this phrase be deleted.

Title III: Facilities with a Spotlight on the Enormous Unmet Need

Despite the significant efforts of IHS, tribal providers, and other federal and state agencies, there remains an enormous unmet need for investment in safe water and sanitation systems in AI/AN communities. In Alaska, through ANTHC tribes assumed management of statewide services in 1998 and have been able to increase the percentage or rural Alaska Native homes with water and sewer systems from 63 to 76 percent. This 13 percent improvement has led to a significant public health improvements for Alaska Natives. In villages where less that 10 percent of the

homes have in-home piped water services, the incidence of pneumonia among infants that require inpatient hospital care is 11 times higher than the All-US rate. Similarly, MRSA skin infections occur at a rate 10 times higher than that found in villages where 80 percent or more of the homes have in-home piped water services.

Despite our accomplishments, 24 percent of rural Alaska Native homes still have no access to a safe and reliable water supply, compared with just 1 percent of the general U.S. population that lack such access. These homes and more still rely on "honey buckets" for the disposal of human waste. There are even village clinics that have no source of running water. And, this problem is not exclusive to the remote communities of Alaska. The unmet need for safe water and sanitation is daunting throughout Indian country and it must be addressed. Passage of this bill will help.

The documented need for health care facilities in Indian country is also enormous. The real need is even greater. In Alaska, IHS and Tribal leaders have worked hard to build and operate what we believe is one of the finest facilities in the Indian health system—the Alaska Native Medical Center. ANMC has attained certification as Alaska's only level II trauma center. It has also achieved Magnet Status for nursing excellence, an honor achieved by only 1 percent of all U.S. hospitals. But, ANMC is also already over-capacity, with a constant need for renovation and maintenance. It is forced to operate with outdated medical equipment and insufficient infrastructure. And, at the same time there are other Areas in which there are no Indian hospitals. No matter how well Tribes manage their programs, inadequate funding and resources will limit their ability to meet all the health care needs of AI/ANs.

Congress cannot fully evaluate how well it is meeting its obligation to provide for the health care of AI/ANs without regular reports to it that describe the full unmet need for facility construction, renovation, replacement, and maintenance.

Section 302(c)(7) will promote leveraging funds from more than one Federal agency to support sanitation facility construction and allow Tribal Organizations to streamline program administration by applying IHS regulations instead of subjecting each construction project to multiple, potentially conflicting sets of rules and regulations of each funding agency. We recommend adding similar language to section 316(c) related to the construction of health facilities.

We support the recommendation of NSC to replace section 302(e) with the version contained in this Committee's bill in the last Congress. As currently written the section is regressive from current law. It is important to remove unnecessary limitations on the Secretary's ability to support sanitation facilities and enhance their sustainability following construction, even for the most financially disadvantaged communities.

Similarly, we request the phrase "on a short term basis" be deleted from section 302(f) since this unnecessarily limits the assistance that can be provided to tribal operators that face imminent failure or lack capacity to maintain the integrity or health benefits of the sanitation facility. There is strength in numbers. Under current IHS authorities, ANTHC has created an Alaska Rural Utility Collaborative, a multi-community utility cooperative that is directly managing or

providing management support services for 20 village water systems in remote locations across Alaska. By ensuring proper operations and maintenance, community public health is better protected and the Federal investment in public health system infrastructure is enhanced.

We support NSC's suggested revision to section 303, regarding Davis-Bacon requirements for all projects funded by the IHCIA.

Section 311(c) will expand the Joint Venture options available to Tribal Organizations. We also endorse the NSC position on section 309, calling for the restoration of a loan program to help Tribal Organizations construct health facilities by replacing the current language in section 309 with that of section 310 in S.212 (107th Congress).

Title IV of the Act and Related Amendments to the Social Security Act

Title IV of the bill addresses a different version of "Access to Health Services," as do the amendments to the Social Security Act found at the end of the bill. The federal government has a duty – acknowledged in treaties, statutes, court decisions and Executive Orders – to provide for the health and welfare of Indian Tribes and their members. In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to American Indians and Alaska Natives through a network consisting of the Indian Health Service, tribal health programs and urban clinics.

Despite this federal policy, the Indian Health Service has been consistently under-funded, a problem exacerbated over time by growing and shifting populations, ever increasing regulatory requirements and unfunded mandates, and inflation. The IHS Federal Disparities Index (FDI) estimates that the Indian health system is funded at only 60 percent of its total need. (The FDI measures the proportion of funding provided to the Indian health system, relative to its actual need, by comparing health care costs for IHS beneficiaries in relation to beneficiaries of the Federal Employees Health Benefits Plan.) Adequate money for Indian health care, especially preventive health care and modern facilities, is consistently absent from the federal budget.

In part because of this chronic under-funding, American Indians and Alaska Natives lag 20 to 25 years behind the general population in health status, and on the whole have the most severe health needs of any group in the United States. Diabetes, heart disease, alcoholism, teenage suicide and infant mortality rates are higher for American Indians than for any other minority, and far higher than the general American population.

While AI/ANs are entitled to health care through the IHS system because of treaty obligations and the trust responsibility, many also qualify for low-income programs such as Medicaid. When IHS and tribal providers are reimbursed by Medicaid for services provided to Medicaid eligible AI/ANs, the IHS or tribal providers can then use their limited resources to meet the pressing needs of other Indians and Alaska Natives. However, enrollment in Medicaid and Medicare among eligible AI/ANs is low. Furthermore, when eligible AI/ANs do enroll, difficulties associated with billing and reimbursement sometimes prevent them from receiving Medicaid and Medicare services in their home communities.

In order for these federal benefit programs to effectively serve eligible AI/AN people, it is important that:

1) being American Indian or Alaska Native does not act as a barrier to access to Medicaid services for which they qualify;
2) AI/AN individuals who use Medicaid are not charged for services that would otherwise be provided without a fee through Indian health programs; and
3) AI/AN people can receive Medicaid and Medicare services through health care programs operated by IHS and Tribes, as these programs are best suited to meet the needs of AI/ANs by providing continuity and culturally competent care.

The CMS has become a critical partner for the Indian health system. While we continue to develop the relationship and seek greater mutual understanding, we have made significant progress toward a true partnership. The CMS TTAG has been critical to this progress. The TTAG allows tribal leaders and their technical advisors to exchange information with CMS officials and staff about the often unintended consequences of its decisions on the Indian health system. The work of TTAG played an important role in getting Indian-specific Social Security Amendments included in the ARRA and CHIPRA bills.

Section 403, which provides for recovery from other third-party payors, has been very important to the financial stability of Indian health programs. The amendments here modernize this important provision and ensure that the premiums paid by and on behalf of AI/ANs to third-party insurers are used to offset the cost of health care provided to them by Indian health providers rather than providing unearned profits for insurance companies. We note that Sec. 403(a)(2) includes the phrase "or expenses." Since this phrase has been deleted throughout this section, in favor of just referencing "charges," we recommend the phrase be deleted here also.

We also support Section 401, but we believe that subsection (d)(1) requires a technical change to restore current law by also authorizing direct recovery "from any other third party payor." This language is missing from this section of the bill, which addresses direct recovery.

Title VII – Behavioral Health

Throughout AI/AN communities mental health and substance abuse problems are a plague that affects every member of the community and every part of the health care delivery system. We cannot achieve the improvements in health status that we seek without fully integrating behavioral health strategies and services in every aspect of our systems of care. We are very pleased this bill recognizes the importance of integrating services and assuring a continuum of care from prevention through residential and inpatient treatment.

Title VIII – Miscellaneous

A number of very important provisions are included in Title VIII of the bill.

We support section 802, which would restore negotiated rulemaking for nearly all of the provisions of IHCIA. Negotiated rulemaking under Title V of ISDEAA was very successful and

resulted in regulations that were far more responsive to the broad range of issues and circumstances encountered by tribal providers than could have been achieved through notice and comment processes.

We support the intent of Section 807, which would ensure Indian health system benefits are not treated as taxable income. We endorse the recommendation that subsection (c) be amended to insert "before, on or" prior to "after" to clarify that this new provision creates no inference about taxability of such benefits at any time.

A gap in federal law exists which undermines the efforts of IHS and tribal facilities to improve the quality of care for AI/AN patients through quality assurance and peer review activities by making them subject to discovery in lawsuits. To address this, we strongly support the inclusion of section 814, which would extend to IHS and tribal providers the same kind of protection from discovery that their colleagues in the Veteran's Administration and the private sector have. The provision will support the candid and robust dialog that is essential to effective quality assurance and peer review activities that are needed by all health care providers and that are essential within the Indian health system.

Conclusion

There are so many other provisions of this important bill that could be highlighted. I have chosen in my testimony to comment on only a few which highlight how important each title of this bill is to achieving the overall objectives of the bill. We fully support the NSC recommendations provided by Rachael Joseph, with the exception of the few minor differences I mentioned earlier in my testimony.

I am happy to respond to questions and to help you get more information if I cannot respond today. Thank you again for your prompt action on this critical and long overdue legislation. With your leadership we are hopeful that this bill will finally become law in 2009.

Suggest that section 206 be revised to read as follows:

Sec. 206. MAMMOGRAPHY AND OTHER CANCER SCREENING.

"The Secretary, acting through the Service or Tribal Health Programs, shall provide for screening as follows:

(1) Screening mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under accepted and appropriate national standards, and under such terms and conditions as are consistent with standards established by the Secretary to ensure the safety and accuracy of screening mammography under part B of title XVIII of such Act.

(2) Other cancer screening that

(A) receives an A or B rating as recommended by the United States Preventive Services Task Force established under section 915(a)(1) of the Public Health Service Act (42 U.S.C. 299b–4(a)(1)). The Secretary shall ensure that screening provided for under this paragraph complies with the recommendations of the Task Force with respect to—

(i)~~(A)~~ frequency;

(ii)~~(B)~~ the population to be served;

(iii)~~(C)~~ the procedure or technology to be used;

(iv)~~(D)~~ evidence of effectiveness; and

(v)~~(E)~~ other matters that the Secretary determines appropriate;

(B) is specified in current American Cancer Society guidelines for cancer screening of asymptomatic individuals, provided that all such screening, examinations, and tests are administered at a frequency no greater than that identified in such guidelines; or

(C) occurs under accepted and appropriate national standards for the individuals being screened."