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H.R. 1328:
Indian Health Care Improvement Act Amendments of 2007

House Committee on Resources
March 14, 2007

Good morning Chairman Rahall, Congressman Young and Members of the Committee. First of all, thank you for introducing H.R. 1328 last week. I appreciate this Committee's efforts to move the bill forward, both this year and in years past. The Indian Health Care Improvement Act (IHCIA) should have been reauthorized more than seven years ago when it was first introduced in this Committee. That a bill intended to improve health care delivery to the population with the most acute health care needs has stalled in Congress for so long is unacceptable. The IHCIA is overdue for reauthorization, and the bill – while long – is generally not controversial. For reasons it is difficult to understand, passage of the bill has been impeded each year by concerns about unrelated Indian legislation, by an uncooperative Administration, or by non-Indian interests groups. I hope that the Committee will work with us this year to ensure that the bill – which has already been considered at length by all interested parties – is passed as soon as possible.

The IHCIA is a comprehensive piece of legislation, like the Indian health programs that it authorizes. It addresses every aspect of what it takes to provide a true system of care for American Indians and Alaska Natives (AI/ANs). In this it is unique among health programs in the United States. The IHCIA reauthorization addresses workforce issues, a full range of health care services from prevention through services needed at the end of one's life and from services to be provided on an out-patient basis to inpatient services, nursing home services, and purchased services, facility needs, safe water and sanitation systems, behavioral health, including a continuum of mental health and substance abuse services, and the infrastructure needed by IHS and Tribes to carry out this vast array of services.

I have been privileged to work for the Yukon-Kuskokwim Health Corporation, the tribal health program that serves 58 tribes of which Bethel is the hub of a region roughly the size of Oregon. I now am honored to work for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 229 Tribes in Alaska, co-manages with Southcentral Foundation the Alaska Native Medical Center (ANMC), the tertiary care hospital for all AI/ANs in Alaska, and carries out all non-residual Area Office functions of the IHS that were not already being carried out by Tribal health programs as of 1994.

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 them. We therefore welcome visitors from Congress and the Executive Branch. Nothing has more impact. However, not everyone can visit. So today, I hope to help you understand why each part of this proposed law is so important to us using examples from

Alaska, knowing that 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.

During the course of the last seven years we have been asked many times why Title I of the Act, which addresses Indian Health Human Resources and Development, is necessary. 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 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, and to work in facilities that are often out-of-date, over-crowded 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, along with others who are willing to commit to this work in return for a little support provided . Each year helped by programs authorized under Title I we see a few more Tribal members complete their education supported in part by programs authorized under Title I and move back home to take important positions as nurses, doctors, social workers, and administrators. They fill critical jobs and serve as role models throughout the Tribal community.

But, Title I goes even beyond support for mainstream education. 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. Under this innovative program, begun by IHS in response to the tuberculosis epidemics in Alaska and need for village based health care providers who could provide vaccinations, and now carried out by Tribal health programs, more than 500 CHAs provide all levels of health care in villages where they are typically the only trained health care provider who lives in the community.

The CHAs work under the general supervision of physicians located in hub communities CHAs traditionally communicated with the supervising physicians by radio. Those radios have been largely replaced by telephones and, more recently, by sophisticated telehealth equipment that is creating new opportunities for connecting villages with regional providers on a real time basis.

The CHAs receive their training in modules of generally three or four weeks spent at training centers followed by periods of preceptorship. They are certified at five sequential levels by the Indian Health Service's CHAP Certification Board. An academic review committee of the Certification Board that includes CHAP directors, faculty of the University of Alaska, and CHAP training center directors assure that both the curriculum for training and the *CHAP Manual* that guides day to day practice are kept up-to-date.

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 and funding. Without the CHA Program access to health care and continuity of care in rural and remote parts of Alaska simply would not be could be achieved.

The CHA Program proved so successful generally that it was expanded at the request of Tribes to address new crises in access to other health services – specifically dental services. The 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 and the advances of telemedicine to help reduce the plague of dental caries in Alaska Native villages, while assuring high quality care.

While organized private practice dentistry has supported most of the DHA certification, the American Dental Association and the Alaska Dental Society have opposed the certain parts of the practice of the DHATS, who follow in the footsteps of mid-level dental practitioners in 42 other countries. By contrast, virtually every major public health organization, including those made up of dentists, have endorsed the DHAT component of the CHA Program.

In the first years of the program, students were required to obtain their two years of formal education in New Zealand. More than eight graduates of that program are now working back in their home villages responding to the dental needs of their communities. With support from the Rasmuson Foundation, the Kellogg Foundation and many others, the University of Washington MEDEX program, which pioneered in the training of physician assistants, has developed a two year training program for the DHATs based in Alaska. Seven Alaska Native students enrolled in the first class in January and are

doing very well in their training.

The dental component of the CHA Program 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 the last Congress in helping Alaska Tribal leaders reach the compromise embodied in this bill. We look forward to the study that is required. 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 limited scope of practice meets the standards expected of dentists and is having a meaningful impact on the oral health problems of Alaska Natives.

In the meantime, while organized private practice dentistry still has grave reservations, the Tribal health programs in Alaska and the American Dental Association continue to work to find common ground. We continue to work together with the ADA, Tribes from other parts of the country and IHS to identify additional strategies to improve oral health in tribal communities in Alaska and throughout the United States.

Building further on these successes, the Alaska CHAP Certification Board is expected to take up consideration of certification standards for specialized 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. Relying on the models of integration described in Title VII of the IHCIA as proposed and the experience with training members of the community to provide critical services under the general supervision of more highly trained provided, we expect to significantly improve village access to integrated mental health and substance abuse services on a routine basis and immediately when crises occur.

We are grateful to the Indian Health Service for its leadership in beginning the development of CHA Program. It is truly an innovative solution to the overwhelming challenge of how to distribute limited health resources over enormous geographic regions. We look forward to seeing the new developments that will surely arise as Tribes in other States are finally authorized to carry out the CHA Program.

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 changes from current law simply recognize the changes that have occurred throughout every part of health care delivery in the United States – that is

a move away from inpatient and facility based care toward home-and-community based care and filling the gaps in the current system of Indian health care. Other changes reflect the positive impact of the Indian Self-Determination and Education Assistance Act under which Tribes have assumed direct operation of the programs previously operated by IHS and are using the flexibility provided therein to determine and meet the priorities of their own communities.

Section 213 of the bill is especially important to achieving the changes that are required to meet the needs of tribal elders and those who suffer from disabilities. As health care services have improved, AI/ANs are living longer, but are still disproportionately affected by diseases such as diabetes and cancer, which require preventive, acute and chronic care in a variety of settings. Section 213 is intended to assure that at the most vulnerable periods in the lives of AI/ANs, they are not deprived of critical care or forced to move from their home villages to accept care far from people who do not speak their language and are not familiar with their traditional foods and customs. 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. This can only be avoided by authorizing and investing in IHS and tribally operated long term care options that encompass home based services through tribally operated nursing homes.

I am frankly puzzled by the objections and resistance from the Administration with regard to this provision. I was honored to serve on the Medicaid Commission and impressed by the persistent focus on the need for the very services we seek to have authorized in this Act. We are still reviewing the language in this bill, which is somewhat different than in other versions. We may provide additional comment to the Committee on it to assure that the full range of necessary services can be carried out under its authority.

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

Others providing testimony here will speak to the details of various provisions of Title III, which addresses the facility and sanitation and safe water system needs in Indian country. I want only to emphasize a couple of points. First, is that despite the significant efforts of IHS, tribal providers, and other funding sources, there remains an enormous unmet need for investment in safe water and sanitation systems in AI/AN communities. In Alaska, 28 percent of rural Alaska Native homes still have no access to a safe and reliable water supply. These homes and more still rely on “honey buckets” for the disposal of human waste. There are village clinics that have no source of running water. And, this problem is not exclusively one faced in 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 need for health care facilities is also enormous and insufficiently documented. The ultimate policy document of any government are its budget and appropriations laws. 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. We strongly endorse a requirement that such a list be kept up-to-date on a regular basis and be reported to Congress. We also believe that a range of options for funding facilities should be authorized, including annual Area Distributions in order to allow smaller priority projects to be funded and their operation supported so that all Areas have the opportunity to experience improvements in their facilities. We hope you will consider carefully the discussion of section 301 and the alternatives that may exist to improving the bill without delaying action on it. The extensive work of the Facilities Appropriation Advisory Board, which has worked on the development of distribution and priority setting methodologies, should not be ignored.

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 made up of the Indian Health Service, tribal health programs and urban clinics.

Despite this federal policy, the Indian Health Service is consistently under-funded, and even the minimal level of funding has remained flat, meaning that even normal inflation is outpacing the budget for Indian health care. For example, between 1998 and 2003, the IHS service population has increased at least 11.5 percent, and medical costs have grown 10-12 percent percent annually, yet the IHS has not received the annual budget increases that other IHS programs receive. Adequate money for health care, especially preventative 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 20-25 years before the general population in health status, and on the whole have the

most severe health needs of any group in the United States. As the other panelists have discussed, diabetes, heart disease, alcoholism, teenage suicide and infant mortality rates are higher for American Indians than for any other minority, and far higher than for the general American population.

While all AI/ANs are entitled to free 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 eligible Indians receive Medicaid benefits, limited IHS resources can be used to meet the needs of other Indians and Alaska Natives. However, enrollment 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 ready access to Medicaid services for which they qualify;

2. AI/AN individuals who use Medicaid are not charged for services that would otherwise be free through IHS; and

3. AI/AN people can receive Medicaid and Medicare services at health care facilities operated by IHS and Tribes that are best suited to meet their needs and provide continuity of culturally competent care.

The Centers for Medicare & Medicaid Services have become a critical partner for the Indian health system. While the relationship is rocky on occasion, a true partnership is and greater mutual understanding are developing. These improvements must be credited in significant measure to the creation of the Tribal Technical Advisory Group through which tribal leaders and their technical advisors can exchange information with CMS officials and staff to ensure that CMS appreciates the consequences of its decisions on the Indian health system. More work is needed, but progress is being made.

Although earlier versions of this reauthorization were much more ambitious in their proposals to amend the Social Security Act to provide for improved access to the resources of Medicare and Medicaid, this bill reflects tremendous progress in achieving consensus about critical improvements in access and operation of Indian health programs under the Social Security Act. Since other committees of the House will consider these

in more detail, I do not address them here. We are willing, however, to provide a section-by-section analysis to help with your understanding of each of these provisions and why they are so important to the successful operation of Indian health programs and their ability to meet the needs of AI/ANs.

I would also like to comment favorably on the language in section 403 which provides for recovery from other third-party payors. 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 truly available to offset the cost of health care provided to them by Indian health providers.

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 are very pleased with the recognition reflected in this bill of the importance of integrating services and assuring a continuum of care from prevention through residential and inpatient treatment. 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.

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 that provide examples of how important each title of this bill is to achieving the overall objectives of the bill.

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 2007.