Testimony Before
The Senate Committee on Indian Affairs

Hearing on Health Care Reform
by
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on Behalf of Self-Governance Tribes

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Good afternoon. Quyana (thank you) for the opportunity to be here 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 Service Tribal Technical Advisory Group (CMS TTAG) and as a member of the National Steering Committee on the Indian Health Care Improvement Act Reauthorization. I previously served on the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee and on the Title V 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 federally-recognized Tribes in a region roughly the size of Oregon, of which Bethel is the hub. I am now honored to work for over 3 years for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 231 federally-recognized 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/ANs) in Alaska, and carries out almost all of the Area Office functions of the IHS, except for inherently federal functions.

My testimony today addresses the issue addressed to me in the invitation from the Committee: ***how health care reform may affect Tribes and tribal organizations exercising the rights of Self-Determination and Self-Governance under Titles I and V of the Indian Self-Determination and Education Assistance Act (ISDEAA) by providing health care services to AI/ANs that would otherwise be provided by the IHS.*** On behalf of all of the Tribes in Alaska and throughout the United States, I want to express our appreciation for your foresight in asking this question.

On a more personal note, my testimony addresses what American Indian and Alaska Native families want from health reform. Indian families want what every American family wants. We want our children and family members to be healthy, happy and safe. However, because our history, political status, and circumstances are different, we may need to do things differently from others to be able to achieve those goals. Likewise, what works for one Tribe may not work for another.

Indian Health System is Unique

The Indian health system is a unique delivery system within the United States. It is strong because it is a system; it arises out of the unique relationship between Indian tribes and the United States, is grounded in the enduring commitment of Tribes and their leaders to assure that the responsibilities of the United States to Tribes are satisfied, and relies on a partnership among Tribes and the IHS to provide culturally competent and appropriate care to AI/ANs. It is vulnerable because of the persistent under-funding that restrict its ability to meet the needs of a

population that experiences extraordinary disparities in health status and because of the same pressures that affect all other health providers.

Health care reform provides opportunities for improvement and risks of damage. If in the process of considering this important but complex legislation, the Congress can take time out to assure that the unique needs of the 1.9 million American Indians and Alaska Natives who rely on the IHS and Tribes and tribal organizations that serve them, then we expect that health reform will advance the interests of this country's first citizens.

Guiding Principles Indentified by Tribal Leadership in Health Care Reform

Because the first health reform bill, the 615 page legislation offered by the Health, Education, Labor and Pensions (HELP) Committee became available for review literally on the day this testimony was being prepared, there has been no opportunity to closely review or analyze it. I understand this Committee is in the same position. Please understand that the remarks included in this testimony should not be considered my final views. Rather they are offered as preliminary comments and recommendations on potential proposals for national health care reform legislation that have been discussed.

Finally, as a preliminary matter, not all Tribes will be affected in exactly the same way by any piece of legislation, including health care reform. However, tribal leaders have been coming together since the beginning of the Clinton Administration to discuss health reform and its potential impacts. Certain principles have emerged clearly. These principles guide my testimony today and include:

Trust Responsibility: Health care reform initiatives must be consistent with the federal government's trust responsibility to Indian tribes acknowledged in treaties, statutes, court decisions and Executive Orders.

Government-to-Government Relationship: Indian tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. Based on the government-to-government relationship with the federal government, tribes need to be at the table in any discussions on health care reform initiatives that affect the delivery of health services to AI/AN people.

Special Legal Obligations: It is the policy of the United States, in fulfillment of its legal obligation to tribes, to meet the national goal of achieving the highest possible health status for AI/ANs to provide the resources necessary for the existing health services to affect that policy.

Tribal Control and Management: The legal authority of tribal governments to determine their own health care delivery systems, whether through the Indian Health Service (IHS) or tribally-operated programs, must be honored.

Distinctive Needs of AI/AN People: A community-based and culturally appropriate approach to health care is essential to preserve Indian cultures and eliminate health disparities. The extremely poor health status of Indian people demands specific legislative provisions and increased funding to break the cycle of illness and addiction that began with the destruction of a balanced tribal lifestyle.

> **Access to Care:** Indian health care services are not simply an extension of the mainstream health system in America. Through the IHS, the federal government has developed a unique system based on a public health model that is designed to serve Indian people in remote reservation communities. The Indian health delivery system must be supported and strengthened to enhance access to health care for AI/ANs.[1]

These principles have been restated so frequently over the last fifteen years that they may seem like mere platitudes or merely a defense of the status quo. Nothing could be further from the truth. Instead, they are the bedrock on which the work of tribal health programs (and that of the IHS) rests.

American Indian/Alaska Native (AI/AN) Health Disparities

No one understands the challenges facing AI/ANs better than the Tribes that serve them. American Indian and Alaska Natives have among the highest rates of disease and poorest health status of any other group in the United States. In the first half of the twentieth century, AI/ANs had a much shorter life expectancy than the general population and routinely suffered from markedly higher rates of diseases. Over the past 50 years, the AI/AN population diseases have transitioned, along with the U.S. general population, from infectious diseases pandemics to those of aging and lifestyle disease, such as diabetes and cardiovascular disease, cancer, and alcohol and drug abuse. Data for the AI/AN population is often incomplete. However, some of the comparisons with the non-Native population are dramatic:

- AI/ANs die at higher rates than other Americans from: alcoholism (517%), tuberculosis (533%), motor vehicle crashes (203%), diabetes (210%), unintentional injuries (150%), homicide (87%) and suicide (60%);
- AI/ANs born today have a life expectancy that is almost 4 years less than the U.S. all races population (72.9 years to 76.5 years, respectively; 1996-98 rates), and AI/AN infants die at a rate of 8.8 per every 1,000 live births, as compared to 6.9 per 1,000 for the U.S. all races population (1999-2001 rates);
- AI/AN adults have a 15.3% higher diabetes rate compared to the 7.3 percent rate among all U.S. adults;
- Heart disease is now the leading cause of death among AI/ANs;
- Suicide and homicide among AI/ANs nationally were almost twice that of the U.S. population of all races;
- The death rate for all unintentional injuries was more than three times that of U.S. all races;
- Alaska Natives and the Northern Plains Indians have a higher mortality rate from all cancers than the U.S. all race rate; and
- AI/ANs nationally have higher death rates from stomach, renal, and liver cancers.

These are not only statistics. They are the daily reality in my family and in the family of every American Indian and Alaska Native. They are the daily challenge of every Indian health provider – tribal and IHS. They shape the way I, and every other leader in the delivery of Indian health, thinks about health delivery. I know they weigh on each of you on this Committee.

These dreadful numbers are a constant reminder about why so many Tribes have chosen to assume responsibility under the ISDEAA for delivery of their own health programs. The decision to do so is not an indictment

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1/ National Indian Health Board, "The Indian Health Perspective in Health Care Reform," http://nihb.org/docs/the_indian_perspective_in_health_care_reform.pdf.

of the IHS, but rather a positive statement about the power of Self-Determination and Self-Governance. Tribal governments, directly and through the tribal organizations they authorize, have demonstrated their success in focusing health care services on the most pressing needs in each of their tribal communities and in emphasizing the need to invest in prevention and early intervention.

Self-Determination and Self-Governance

Since implementation of the first Self-Governance compact and funding agreement on September 30, 1993, the interest and growth in Self-Governance has been dramatic. According to the IHS, there are 73 Title V compacts, funded through 94 Funding Agreements, totaling over $1 billion representing 323 Tribes, representing 57% of the federally recognized tribes. There are also 238 Tribes and tribal organizations that contract under Title I of the ISDEAA, with a total funding of $425 million. In total, over 40 percent of the IHS budget authority appropriation is administered by tribes, primarily under agreements entered into under the ISDEAA.

Collectively, tribes and tribal organizations operate 14 hospitals, 227 health centers, 166 Alaska village clinics, 102 health stations, and 13 school health centers. IHS by contrast operates only 31 hospitals, 61 health centers, 30 health stations, and 2 school health centers. Tribes and tribal organizations also operate youth residential treatment facilities and residential and outpatient mental health and substance use disorder programs.

All of these hospitals are accredited by The Joint Commission or certified by the Centers for Medicare & Medicaid Services (CMS). Most large clinics and many smaller ones are accredited by The Joint Commission or the Accreditation Association for Ambulatory Health Care (AAAHC). In additions most of the residential treatment programs are accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. This was not the case when tribes and tribal organizations assumed responsibility for many of these facilities (first under Title I, then for many, under Title V).

One reason Self-Governance and Self-Determination are successful is because the funds, control and accountability for programs are pushed as close to the delivery of the services as possible. At the local level, tribal leaders and tribal citizens best know the needs of their people and communities. Given the opportunity to make decisions regarding priority of funding and the subsequent design and delivery of program services, tribal governments will do what is best for their members and community.

A one size fits all approach does not work in Indian country. This was recognized by ISDEAA which addressed this problem by allowing Tribes the flexibility to choose the best way to administer their programs. Tribes have used the flexibility that Self-Governance provides to create innovative programs that better serve their beneficiaries. This was not possible before Self-Governance.

Success of Tribal Self-Determination and Self-Governance

There have been remarkable accomplishments throughout Indian Country as tribes and tribal organizations have assumed responsibility for delivering health services in their own communities. In Alaska, we are especially proud of the multi-faceted, interdependent Native health care system with sophisticated patterns of referral developed over 40 years. This system which is controlled by the 231 Tribes in Alaska provides health care to more than 130,000 Alaska Natives, half of whom live in remote communities stretched over 586,412 square miles of largely

road-less land. The system includes seven hospitals, including the Alaska Native Medical Center, the only Level II Trauma Center in Alaska. It also includes village-based services where the addition of a mid-level practitioner is a huge accomplishment. The system is well known for both its close connection to the IHS and also for its innovations, which include development of the community health aide program, certification of dental health aide therapists, and telemedicine.

Other tribes have similar stories – such as the Cherokee Nation, which was able to establish the first tribal Program of All Inclusive Care for the Elderly (PACE) program (in fact, the first rural PACE program) after it assumed responsibility for the majority of the health programs previously operated by IHS. It is a capitated benefit authorized by the Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The Nation's PACE program offers the full range of long term care to the people who live in its service area. Similar success stories are prevalent across Indian Country.

These accomplishments are representative of the achievements of tribal health programs under the ISDEAA. Achieving these improvements has only occurred through careful exercise of the rights available under the ISDEAA – mostly funded through increased third-party revenue, NOT increased appropriations.

Indian Health Service/Tribal and Veterans Administration Facilities

While we are excited by the promise of health care reform, we naturally get nervous as we hear about some changes that are contemplated. We know from experience that as resources get tighter, individual American Indians/Alaska Natives and the IHS facilities that provide their care will feel the impact more than any other. Why? The highest rates of unemployment occur in Indian Country. We have some of the lowest income levels. We have the poorest health status of any other population in the country. Tribal communities are often rural communities where access to care is a problem. There is a higher cost of providing care and with the high cost of living, so limited incomes get stretched even further. What this means is that when our people do finally get the care they need, they have traveled farther with money they simply don't have, are sicker than the average person, are seen in clinics / hospitals that have fewer resources than most other clinic / hospitals in the country that also, have a higher cost of providing care, and when people return to their rural community, they often need of follow-up care that is not available in the community.

We appreciate this Committee's efforts to address the very important issue on behalf of AI/AN veterans and their families and other veterans who live in Indian Country. Every veteran, regardless of race or geographic location who needs medical care (including primary and behavioral health care) should have access to culturally appropriate care. In much of Indian Country, the main barriers to local access to care are the lack of Veterans Administration (VA) infrastructure in rural communities, the lack of funding to support the already existing rural health system, and the lack of systems providing meaningful medical information between health systems.

Rather than build additional VA health infrastructure in rural Alaska and other parts of Indian country, for example, it makes more sense to use our limited federal resources wisely to complement the existing system of culturally relevant services that are available through the Indian health system.

The most effective and efficient way to extend the VA's capacity to provide health care to veterans who live in Indian country, is by enhancing the existing tribal health system's capacity to provide care for those veterans. Specifically, we recommend the creation of a VA clinical encounter rate to reimburse IHS

(including tribally operated) facilities that provide care to veterans and their families. The clinical encounter rate should be flexible enough to extend to behavioral health and telemedicine encounter rates. Since tribal providers are often the only health care services available in local communities, we should ensure that non-Native veterans can also access care there. The precedent for such extensions of care for contracted community-based services has already been established by the VA in other locations through the VA's Community Based Outpatient Clinic Program.

Funding Disparities

The point about third-party revenue is critical to the discussion about how health reform may affect tribal health programs. No amount of determination or commitment can overcome completely the barriers the Indian health system experiences as a result of persistent under-funding.

The IHS Federal Disparity Index (FDI) measures the proportion of funding provided to the Indian health system, relative to its actual need, by comparing healthcare costs for IHS beneficiaries in relation to beneficiaries of the Federal Employee Health Benefits (FEHB) plan. This method uses actuarial methods that control for age, sex, and health status. In 2006, per capita healthcare spending totaled $2,130 for AI/ANs, compared to $3,903 in other federal sector financing programs serving the non-elderly population. It is estimated by the FDI, that the IHS system is funded at less than 60% of its total need. To fully fund the clinical and wrap-around service needs of the Indian healthcare system, the IHS budget would need to be $18 billion. The FDI workgroup determined that at least $10 billion is needed for health services, and an additional $8.7 billion as a non-recurring facilities request.

If health reform legislation is fully inclusive of Indian health providers and creates opportunities for expanded coverage of AI/ANs (without breaking the promises in the trust responsibility), it will help to overcome the extraordinary gap between what is needed and what is available. Health reform must include AI/ANs without imposing penalties on those who use the Indian health system; it must assure Indian health programs are given the opportunity to be full participants so they can continue to provide culturally appropriate and competent care; it must assure that opportunities for increasing the number of providers – particularly AI/AN providers – are extended specifically to the Tribes and tribal organizations; and, it must extend to tribal health programs all of the resources made available to other safety net providers.

It is also crucial to ensure that there is adequate funding to support the entire system and continuum of care. The IHS/tribal system is just that – a system. Relying on a fee-for-service reimbursement model, for example, would undermine the IHS/tribal system by ignoring preventive, community, environmental and other types of care essential to a true public health system. It also tends to neglect crucial infrastructure that is still lacking in much of Indian country, where clean water and basic sanitation lag 20 years behind the rest of the country.

Specific Health Reform Recommendations

Tribal leadership has been working as quickly as possible to review concept papers regarding health reform and to articulate specific suggestions about how Indian health should be addressed. I participated in, and endorse, the recommendations made by the National Indian Health Board, National Congress of American Indians, and the National Council of Urban Indian Health in their recent paper, "Health Care Reform: *Indian Country*

Recommendations".[2] I also endorse the recommendations made by the Affiliated Tribes of Northwest Indians and the Northwest Portland Area Indian Health Board in their June 4, 2009, letter to the Chair of the Senate Finance Committee, and the Oklahoma City Area Inter-Tribal Health Board Health Care Reform Paper. All documents are attached to my testimony. Please consider each of the recommendations in those papers in their entirety and inclusive herein as part of my formal written testimony.

As you examine the recommendations, you will note the common themes derived from the principles set out earlier that stress the unique relationship between the United States and Tribes, the importance of retaining the culturally appropriate and competent system of care provided by tribal health programs and IHS, and from the tremendous need to overcome the funding limitations that plague Indian health. It is our hope that expansion of Medicaid and other coverage made available under health reform, combined with increased direct appropriations[3], will assist us in closing the gap between what is needed to provide a robust array of health services and the current funding levels.

As the recommendations I enclose demonstrate, however, funding alone is insufficient. Current protections for the Indian health system need to be continued and expanded to new structures that may exist under health care reform. Outreach and enrollment must be supported so that all AI/ANs know about what may be available to them. Tribal health systems must be afforded the opportunity to fully participate in workforce development and support options may available to other safety net providers. Health information technology must be expanded and facilities improved by creating as wide a range of options for Tribes and tribal organizations, as possible. And, authorization and encouragement must be provided for expanding access to behavioral health services that can address mental health and substance use disorders; domestic violence, sexual assault and child abuse and neglect services; and long term care options (home-based and residential).

Title VI of the ISDEAA

True health care reform cannot occur in an environment in which medical care is divorced from the rest of the needs to the individual. One of the reasons tribal health programs are successful is that they build from the understanding that the body and the spirit cannot be separated. A hungry person will not be able to take care of his

or her health needs, nor can a person who has experienced violence or suffers from a mental health or substance

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2/ It has been extremely challenging to use words that have meaning in one context accurately in another. There is universal agreement among tribal leaders that "Indian people should not be barred from qualifying for subsidies due to their eligibility for care from the Indian health delivery system." "*Indian Country Recommendations*," p. 3 Subsidies, section 1. Similarly, there is universal support for the objection "to imposition of a penalty on an Indian individual who fails to obtain [mandatory] insurance". *Id*., p. 2, Personal Responsibility Coverage Requirement (Individual Mandate. In the paper, these statements translated into the phrase: "IHS is not creditable coverage." *Id*., p. 3, Subsidies, section 1. References to "creditable coverage" frequently are references to a term of art that takes on specific meaning that may be contrary to the two underlying statements. Therefore, I avoid trying to say whether access to Indian health programs should constitute "creditable coverage" or not, and focus instead on advising about the outcomes we seek (no penalties imposed on individuals or tribes and maximum access to subsidies and other support), not the words by which to achieve those outcomes.

3/ Direct appropriations must include funding for contract support costs so that the administrative needs of tribal health programs can be addressed without reducing services.

use disorder. Tribal health programs work as diligently as they can, within the constraints of lack of funding and the law, to integrate the services that address the whole person. Much more is possible however.

Congress enacted Title VI as part of the Tribal Self-Governance Amendments of 2000.[4] Title VI required the Secretary of Health and Human Services to conduct a study to determine the feasibility of a demonstration project under which Tribes could include in Self-Governance agreements non-IHS programs, services, functions, and activities within DHHS. The Secretary was to consult with Tribes and other stakeholders, and consider a number of factors: effects on program beneficiaries, statutory or regulatory impediments, likely costs or savings, quality assurance and accountability measures, and others. In short, should Congress authorize Tribes to compact non-IHS programs, just as Title IV allows Tribes to compact certain non-Bureau of Indian Affairs programs within the Department of the Interior?[5]

Over the next few years, tribal representatives worked with DHHS to ensure that core Self-Governance principles—such as redesign and reallocation authority—informed the feasibility study. In its final report to Congress in 2003,[6] DHHS concluded that it was feasible and desirable to extend tribal Self-Governance within the Department. The report listed eleven programs from three non-IHS agencies that could be included initially.[7]

Beneficiaries of these programs would likely benefit from their inclusion in the demonstration project, the report concluded. Stakeholders such as state and local governments did not oppose the demonstration project. The Department's recommendation was to move forward with legislation implementing the demonstration project.

Shortly after the feasibility study was released, the Senate Committee on Indian Affairs (SCIA) crafted legislation, the Tribal Self-Governance Demonstration Project for the Department of Health and Human Services

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4/ Pub. L. No. 106-260, § 5 (Aug. 18, 2000).

5/ *See* 25 U.S.C. § 458cc(b)(2).

6/ DHHS, Office of the Ass't Sec. for Planning and Evaluation, *Tribal Self-Governance Demonstration Feasibility Study* (March 12, 2003).

7/ The programs (and DHHS agencies) identified by the IHS for inclusion in the demonstration project were the following:

Administration on Aging
- Grants for Native Americans

Administration for Children and Families
- Tribal Temporary Assistance for Needy Families (TANF)
- Low Income Home Energy Assistance
- Community Services Block Grant
- Child Care and Development Fund
- Native Employment Works
- Head Start
- Child Welfare Services
- Promoting Safe and Stable Families
- Family Violence Prevention: Grants for Battered Women's Shelters

Substance Abuse and Mental Health Services Administration (SAMHSA)
- Targeted Capacity Expansion

which basically tracked the recommendations of the DHHS feasibility study. The demonstration project would run for five years. The eleven programs identified by DHHS would be eligible, along with Substance Abuse and Mental Health Services Administration (SAMHSA) block grants regarding mental health and substance abuse and the Health Resources and Services Administration (HRSA) community health center grant program. The Secretary could add up to six additional programs annually. DHHS would prepare annual reports for Congress on the costs and benefits of the demonstration project using evaluation and reporting data provided by participating Tribes, with additional funding to be made available to Tribes for that purpose.

The Committee held a hearing and several tribal leaders and representatives testified in strong support of the bill. Despite an invitation from the Committee, however, no representative from DHHS appeared at the hearing. This absence was perplexing since the bill largely reflected the agency's own recommendations from just one year before. While some provisions departed from the DHHS recommendations, those provisions were not unlike similar ones in Title V.

On June 16, 2004, this Committee favorably reported out the bill to the full Senate and recommended passage. In its committee report on November 16, 2004, the Committee chronicled the success of the self-determination policy, and described the extension of these successes to other programs beyond BIA and IHS as "the next evolution in tribal self-governance."[8] With its goals of minimizing federal bureaucracy and maximizing tribal authority in decision-making, [S. 1696] "continues the steady march of meaningful tribal control of programs affecting their communities."[9]

Despite the favorable Senate report and strong support from Tribes, the bill died at the end of the session. The prior administration's lack of support carried forward through a second term, with DHHS flatly refusing to participate in any discussion of the bill. Under a new SCIA the Committee shifted its legislative focus to reauthorization of the Indian Health Care Improvement Act, and tribal leadership did the same.

The time is now right to revive this or a similar Title VI bill. Direct tribal operation of non-IHS DHHS programs would be a major achievement, yet it should also be relatively non-controversial. The Department's own study demonstrates the feasibility of the Title VI demonstration project. And as this Committee recognized six years ago, Title VI represents simply the next logical step in the "evolution in tribal self-governance."[10] Self-Governance Tribes strongly support legislation to create a demonstration project under Title VI.

It may seem odd that I include this discussion of Title VI in my testimony about health care reform. But, in fact, it is integral to reform. Economic and employment security are closely linked with health status. Under TANF, Tribes have an opportunity to provide both. TANF also provides important access points for individuals to obtain benefits – not just cash, but also Medicaid. Head Start and child care programs include opportunities for early identification of health issues and outreach – both to get people enrolled in benefits like Medicaid, but also in direct contact with health providers. Safe, violence free environments are essential to improving health status. If we are to achieve savings in the cost of administration and improvements in the delivery of services, then the artificial barriers among these funding sources and programs must be broken down.

8/ S. REP. NO. 108-412 at 2 (2004).
9/ *Id*. at 4.
10/ S. REP. NO. 108-412 at 2 (2004).

Support for Passage of the Indian Health Care Improvement Act

Finally, we strongly urge that health care reform not replace the Indian Health Care Improvement Act. We urge you to support this legislation that has been the lifeline for the delivery of health care for a nation of people that would otherwise be comprised or neglected.

Conclusion

Thank you again for focusing on Self-Governance and Self-Determination and how health care reform will affect them. The members of Congress hold the key to finding the answers. If the Indian health system is a full participant in health care reform with no diminishment in the trust responsibility, then health reform will both support Self-Determination and increase the opportunities for Tribes to meet the needs of their members. If the Indian health system is ignored or undercut, then Self-Governance will be undercut. More importantly, the opportunity to improve the health status of AI/ANs will be put on hold again. That must not be allowed to happen.
I count on each member of this Committee to endorse the recommendations for specific Indian provisions that should be part of health care reform and for the expansion of Self-Governance authority.

Thank you for the opportunity to testify. I am happy to respond to questions and to help you get more information if I cannot respond today.