Testimony of
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Hearing Regarding
Indian Health Care Improvement Act Amendments of 2005
Home Health, Dental Health Aide Therapists,
FTCA Protection and Negotiated Rulemaking

INTRODUCTION

Mr. Chairman and members of the Committees on Indian Affairs ("SCIA") and Health, Education, Labor and Pensions ("HELP"), thank you for the opportunity to testify on S. 1057, the Indian Health Care Improvement Act ("IHCIA") Amendments of 2005, which will revise and amend the IHCIA. The commitment of the SCIA to ensuring the passage of this important legislation has only been surpassed by that of Tribal leaders and American Indian and Alaska Native ("AI/AN") Tribes throughout the United States.

I appear today as the Chair of the Tribal Self-Governance Advisory Committee ("TSGAC"). The TSGAC consists of Tribal leaders convened by the Indian Health Service ("IHS") to address the health needs of all eligible AI/ANs, especially those served by the Tribal health programs operated through self-determination contracts and self-governance compacts under the Indian Self-Determination and Education Assistance Act ("ISDEAA").

My testimony also reflects my own experience as an Aleut and beneficiary of services provided directly by the IHS and by Tribal health providers, as well as the knowledge I have gained by serving AI/ANs in many capacities, including as President of my own 400 member Federally recognized Tribe – the Seldovia Village Tribe; President and Chair of the Board of the Alaska Native Tribal Health Consortium ("ANTHC") – the largest self-governance program in the United States, serving over 130,000 Alaska Natives; Director of the Alaska Native Health Board ("ANHB"); and Co-Chair of the IHS Tribal-Urban Budget Workgroup. Each of these roles contributes to my understanding of the importance of the bill being considered here today.

ANTHC carries out all non-residual IHS Area Office functions in the Alaska Area. These include a wide range of community health programs, Community Health Aide training and support, administrative support for the Community Health Aide Certification Board, training of personal care attendants and other allied health care providers, development of behavioral health aide training and standards, epidemiology and public health research, cutting edge telehealth development and operation, and construction of sanitation and health facilities in rural Alaska.

ANTHC also co-manages the Alaska Native Medical Center ("ANMC") with Southcentral Foundation ("SCF"). ANMC is the premier tertiary care hospital in the Indian health system and is the only certified Level II Trauma Center in Alaska. In addition to the fine primary care and behavioral health services SCF provides at ANMC, ANTHC provides emergency services and a wide range of specialty care, including internal medicine, ophthalmology, orthopedic, otolaryngology, surgery, cardiology, hematology, and oncology. SCF and ANTHC collaboratively provide women's health and dental services at ANMC. Ancillary services, including pharmacy, laboratory, and imaging services, are also available.

The breadth of these programs contrasts strikingly with the experience we have at the Seldovia Village Tribe where until 4 years ago only contract health services ("CHS") were available to pay for limited care from private physicians for members who could not travel in to Anchorage to receive direct care at ANMC. For all the differences in scope of services, however, we share with ANTHC, and other Tribal health programs throughout the Indian health system, the most important characteristic of self-determination and self-governance Tribes – that of determination, of assessing the health needs of our people and redesigning and expanding our programs to improve the available care. Since the Seldovia Village Tribe assumed its program from IHS, it has established a clinic, providing an expanding range of culturally appropriate primary, preventive and wellness services. It also began offering community health services, including programs to encourage children and teens to develop healthy lifestyles and discourage substance abuse. Just last week, the Seldovia Village Tribe opened the doors of its new clinic and anticipates expanding its services to include behavioral health and dental services.

Similarly, ANTHC has made numerous changes to the programs it administers to better address the needs of Alaska Natives. To cite just a few examples, ANMC developed a pediatric intensive care unit, adding a perinatologist and two pediatric intensive care specialists to the medical staff. Our Division of Environmental Health and Engineering changed the foundation of its service delivery so that it was aligned with the Tribal regions, where it builds health and sanitation facilities and provides a wide range of environmental health services. ANTHC developed and expanded more responsive community health services, including its traditional food safety program, which monitors the level of contaminants in subsistence food sources. ANTHC increased its emphasis on injury prevention and preventive care measures, including HIV prevention and tobacco cessation programs. At the same time ANMC reorganized its specialty departments to increase access for patients traveling to Anchorage, the AFHCAN project developed telehealth technology that allowed more Natives living in rural areas to receive care in their own villages.

I mention these accomplishments not to convince you about the worth of the ISDEAA. I know the achievements of Tribes operating programs under the ISDEAA are well known to the members of the SCIA. I describe them instead to provide a backdrop for the importance of the amendments proposed to the IHCIA.

HOME HEALTH

S. 1057 amends the IHCIA in ways that reflect the recognition that fundamental changes have occurred in health care delivery since the last significant consideration of the IHCIA in the 1980s. Since then health care delivery has been transformed.

- Throughout the nation, hospitals used to be the centerpiece of health care delivery, but now the focus is on delivering care in homes and communities. This change results from the development of new modalities in health care delivery, the need to address more chronic conditions of an aging population, and the recognition that the cost of institutionally based care is simply unaffordable. These are all factors that apply equally in the AI/AN community and Indian health system.

- The health status of AI/ANs remains lower than that of other populations in the United States, but the causes of morbidity and mortality have changed. It is no longer neo-natal mortality and communicable diseases that rank among the highest causes of death, but rather diseases like cancer, heart disease, and diabetes – all conditions that can be affected by life style and, which must ultimately be addressed through strong prevention and early intervention programs. In the meantime, there are huge challenges in meeting the treatment needs with those who are afflicted.

- In the Indian health system, reliance on third-party reimbursement and other funding sources has become increasingly important since appropriations to IHS fail even to keep up with inflation, let alone to address population growth, the cost of new pharmaceuticals, and increased morbidity. Third-party payors limit the number of hospital days for which they will provide reimbursement believing that better, more appropriate care can be achieved in non-hospital settings at a substantially lower cost. States have obtained "waivers" from Medicaid allowing expanded non-hospital based services where they can demonstrate cost savings.

  This is important from two points of view in the Indian health system. First, to the extent home based care is not embraced, for those AI/AN patients with Medicaid, Medicare or other third-party coverage reimbursement is not available for days of hospital care in which the patient could have received adequate care in another lower cost setting. Secondly, the IHS and Tribal facilities are bearing the cost of the most expensive level of care, when if the resources were deployed in other types of care substantial savings could be achieved.

- Due to the successes in the Indian health system AI/ANs are living longer, and, now need a wider range of services including home health, personal care attendants, assisted living, and, in some cases, nursing home care. At ANMC about twenty-five percent of bed days could be in a less acute setting if the resources existed to support our patients through

skilled nursing, home care, personal care attendants, assisted living, and, near the end of life, hospice. These resources would include specially trained health professionals such as personal care attendants, case managers and others who can meet the needs of AI/ANs in their homes and villages under the direction of physicians, rather than relying solely on facility based care.

- Home- and community-based care also provides opportunities for AI/AN elders to receive the most culturally competent care. The constraints of hospital based care are many. For AI/AN elders, having to choose between leaving their home and community to receive care and doing without that care is very difficult. Leaving home often means being surrounded by providers who do not speak the elder's language, eating non-traditional foods, and losing contact with family who may live far from the hospital. Providing a wide range of supportive and skilled services at home delays or forestalls the need for hospitalization and shortens the stays when they must occur.

Indian health programs throughout the country are working to address these dynamics. More express authority in the IHCIA will assist the Indian health system and provide clearer direction that Congress is serious about its commitment to supporting the Indian health system in delivering the best mix of services to AI/ANs in the most cost effective way.

This is a very cost effective approach, as well. The Indian health system is still plagued with old, out-of-date facilities that desperately need replacement. At the same time, due to continued high birth rate and changing patterns of disease and longer life spans, the demands on even new hospitals to increase the number of beds is relentless. Even ANMC, one of the newest facilities, will fall short by 20 beds by 2015 given current trends. The need for expansion can be affected substantially, however, by investments in home care and other levels of community-based care that are expressly described in S. 1057. *See, e.g.,* Section 201(a)(5)(A) and (H), Section 205, and Section 213. The comprehensive range of care described in S. 1057 is critical to meeting the evolving needs of AI/ANs.

DENTAL HEALTH AIDE THERAPISTS

Section 121 of the IHCIA, 25 U.S.C. § 1616*l*, expressly authorized the Alaska Community Health Aide Program ("CHAP") through which village residents have been trained since the 1960's to provide health services. These health services have always included dental services. The CHAP has been a critical factor in making health care services available to 85,000 Alaska Natives who otherwise would be without any direct access without, in most cases, having to be flown to another community. Community health aides and practitioners are certified by a Federal board that also adopts standards for training and for certification.

In 2002 the CHAP Certification Board *Standards and Procedures* were amended to provide for certification of a specialized class of community health aides called dental health aides. This was done to address a crisis in dental disease among Alaska Natives and a lack of adequate

providers to address the problem. Among the four classes of dental health aides authorized to be certified upon completion of all of the requirements are dental health aide therapists ("DHATs"). A person may not be certified as a DHAT without completing a two year college dental training curriculum that includes 2400 hundred hours of classroom and clinical experience, of which about 760 hours are spent in a clinic treating patients. Upon successful completion of this training and a preceptorship in which the DHAT must demonstrate under the direct supervision of a dentist the ability to perform each of the procedures for which she will be certified to the same standard as is expected of a dentist, the DHAT may be certified to practice in villages under the general supervision of a dentist.

Six village residents were selected initially by the Yukon-Kuskokwim Health Corporation ("YKHC") and Maniilaq Association to obtain DHAT training. Training is currently being provided at the University of Otago in New Zealand because no United States dental school offers mid-level dental training despite its demonstrated success in reducing unmet need in 42 countries, including Canada, Australia, Great Britain, New Zealand, and Hong Kong. They are all back from training now and are in various stages of their preceptorships and certification. Another cohort of trainees began a year ago and will complete training another year from now.

Tribes in Alaska and around the country have been taken aback by the vehement opposition by the American Dental Association ("ADA") to the certification and practice of DHATs. Their opposition is couched in concerns about quality of care and concern about prevention, but fundamentally appears to be focused on preventing any form of mid-level practice, even in the most remote locations where the alternative is no dental care at all, or seeing a dentist once a year when one can be flown in to the village to conduct a clinic.

The reasons for the program and the legal underpinnings of it are well-explained in a letter written by the Sonosky, Chambers Law Firm LLP on behalf of a number of Alaska Native health programs to the Alaska Attorney General. A copy of this is attached. Also attached are a one page briefing on the issue and a letter from the Director of IHS regarding the services provided by DHATs.

S. 1057 provides for a study of the work of DHATs and limits certification of DHATs in IHS Areas outside Alaska for the four years allocated to complete the study and report to Congress. This is reasonable. Alaska Tribal health programs are completely committed to open evaluation of the work of DHATs, which in Canada has been found to be the equivalent of dentists within the DHAT's scope of practice.

Other witnesses will be addressing this issue in more detail during this hearing. I chose to include it in my comments, both as a representative of ANTHC and the TSGAC, because we believe the issues that underpin this program are so important to achieving the objectives of the IHCIA and of self-governance. IHS and Tribal health programs have been able to have positive impacts because they have looked creatively at health delivery issues and found ways to overcome institutional and funding barriers. There will never be enough dentists to provide

routine dental care in Alaska Native villages or in other Indian communities. The populations are too small to support a resident dentist and the locations too isolated to attract them. Mid-level practitioners made a substantial contribution to overcoming limitations in access to primary health care despite early opposition and fears expressed by physicians. We are convinced that DHATs will prove equally important in solving the dental crisis that plagues AI/ANs. Being able to evaluate health delivery issues and make these decisions after examining the best information is central to the IHS and to self-governance.

FEDERAL TORT CLAIMS ACT COVERAGE

We understand that the Administration, and in particular the Department of Justice ("DOJ"), has expressed concerns about the scope of Federal Tort Claims Act ("FTCA") coverage available under existing law and the impact the amendments in S. 1057 might have on such coverage. These concerns have not been expressed directly to the TSGAC or other bodies of Tribal leaders and, thus, Tribal leaders are somewhat at a loss about how to respond. I believe it may be helpful to provide some background about FTCA and the critical importance it plays in the opportunity to making the limited health care dollars available through appropriations to IHS and other funding sources go as far as possible.

Throughout the ISDEAA, Congress has taken care to assure that programs assumed by Tribes will continue to receive the same level of direct and indirect Federal support as when they were directly operated by the IHS. Direct program funding for the programs must "not be less than the appropriate Secretary would have otherwise provided for the operation of the programs." 25 U.S.C. § 450j-1(a)(1). Tribes are guaranteed access to certain "in kind" supports on essentially the same basis as the IHS (*e.g.*, access to Federal sources of supply and interagency motor pool vehicles, etc.) By these provisions, Congress intended "to assure that there is no diminution in program resources when programs, services, functions or activities are transferred to tribal operation," and to ensure that Tribes would not be compelled "to divert program funds to prudently manage the contract, a result Congress has consistently sought to avoid." S. Rep. 103-374, at 9 (1994).

Among the "in kind" supports made available to Tribal organizations is the right to be regarded as an agency of the United States for FTCA purposes with respect to tort claims that arise from carrying out their ISDEAA agreements.

Congress initially extended the FTCA tort claim coverage to ISDEAA contractors on a limited basis, following the failure of the Secretary of the Interior to meet his legal obligation to procure liability insurance on their behalf, Pub. L. 100-472, § 201(c) (1988), and pending the Secretary's investigation of the feasibility of procuring such insurance or providing alternative protection. When the Secretary failed to investigate the cost and availability of liability insurance, Congress made the FTCA coverage permanent:

> The Committee has included language to make the extension of the Federal Tort Claims protection to P.L. 638 contractors permanent. It is unfortunate that the Department did not respond in a timely manner to the Committee's direction last year to undertake a study to show if other means of meeting the legal requirement for the Secretary [of the Interior] to provide liability coverage for tribal contractors would be preferable. However, since the Department delayed taking action to respond to this directive, the Committee has no choice but to provide the required liability coverage on a permanent basis by extending the Federal Tort Claims Act coverage.

H.R. Rep. No. 101-789, Oct 2, 1990 at 72. *See also* S. Rep. 101-534, Oct. 16, 1990 at 65 ("This step is necessary due to the failure of the Bureau to conduct the necessary study and analysis of alternatives requested by the Committees.")

Through § 314 of Pub. L. 101-512 and other laws, Congress extended to Tribal contractors the same protective provisions of the FTCA that limit the United States' exposure in its own FTCA litigation. In 1987, when Congress began enacting the series of public laws that extended FTCA and other protections to Tribal contractors, it was especially concerned that ISDEAA has inadvertently shifted extraordinary risk of liability to the Tribal contractors by effectively requiring each one

> to waive its immunity from suit up to the policy limits of its insurance, and then to be subjected to litigation without any of the protective and very restrictive provisions which apply to litigation under the Federal Tort Claims Act.

S. Rep. 100-274 at 2646.

The legislative history indicates that Congress understood that Pub. L. 101-512 and its predecessors simply restored the status quo by making the Federal government responsible for any legal liability associated with the performance of Federal functions.

> It is clear that tribal contractors are carrying out federal responsibilities. The nature of the legal liability associated with such responsibilities does not change because a tribal government is performing a Federal function. The unique nature of the legal trust relationship between the Federal Government and tribal governments requires that the Federal Government provide liability insurance coverage in the same manner as such coverage is provided when the Federal Government performs the function. Consequently, section 201(c) of the Committee amendment

> provides that, for purposes of the Federal Tort Claims Act, employees of Indian tribes carrying out self-determination contracts are considered to be employees of the Federal Government.

S. Rep. 100-274, Dec. 21, 1987 at 2645.

Further, Congress recognized the high cost of liability insurance that Tribes were forced to bear, but from which the Government was exempt:

> Further, tribal governments must carry liability insurance, premiums for which have skyrocketed in the last few years, just as they have for other units of government. The Federal Government, because it is covered under the provisions of the Federal Tort Claims Act, does not have to incur the cost of purchasing such insurance.

S. Rep. 100-274, Dec. 21, 1987 at 2628 (regarding discussion of indirect costs). The Government also recognized the high cost of "tail coverage."

> A patient claiming an injury in connection with the provision of direct services is limited to the remedies available under the Federal Tort Claims Act in any action against the United States. This provision is intended to cover claims against a tribal contractor for acts or omissions that occurred prior to the bill's enactment but for which the statute of limitations has not yet expired. Under current law, the contractors are required to carry malpractice insurance coverage for such past claims. This so-called "tail liability" coverage is even more expensive than coverage for current claims.

S. Rep. 100-274, Dec. 21, 1987 at 2646.

In 1994 the Congressional Budget Office reported to Congress that the extension of the Federal government's liability to include malpractice and other health-care related claims against subcontractors for Tribal organizations that perform Indian Health Service functions under self-determination contracts would have "no significant effect on the federal budget." S.Rep. 103-374 at 15. The GAO concluded that "[i]n aggregate the percentage of tribal claims approved [by the DOJ] and the amount awarded are comparable with the resolution of other FTCA claims at the Department of Health and Human Services." Statement of Barry T. Hill, testimony before the SIAC, Tuesday July 31, 2001.

Limiting the coverage of FTCA protection would require Tribal contractors and compactors to incur the substantial and extraordinarily burdensome expense for liability insurance, legal representation, and legal liability. If these costs are not born by the DOJ, they will simply shift to the IHS. The IHS will be legally obliged to provide adequate contract support funds to cover these expenses. If it failed to do so, funds would have to be diverted from direct services. The result: AI/ANs will suffer from diminished health care services, contrary to Congress' intent and to their great detriment:

> As originally enacted, the Self-Determination act authorized either Secretary to require [] tribal contractors to obtain liability insurance. The Act also precluded insurance carriers from asserting the tribe's sovereign immunity from suit.
>
> In practice, the costs of such liability insurance have been taken from the amount of funds provided to the tribal contractor for indirect costs. The Committee is concerned that tribal contractors have been forced to pay for liability insurance out of program funds, which in turn, has resulted in decreased levels of services for Indian beneficiaries.

S. Rep. 100-274, Dec. 21, 1987 at 2645. Limiting the FTCA coverage provided by Pub. L. 101-512 and other laws would not only harm the AI/ANs, but could amount to a breach of the Federal government's trust responsibility:

> The United States has assumed a trust responsibility to provide health care to Native Americans. The intent of the Committee is to prevent the Federal government from divesting itself, through the self-determination process, of the obligation it has to properly carry out the responsibility.

S. Rep. 100-274, Dec. 21, 1987 at 2646.

Tribes did not ask for changes in the scope of FTCA coverage even though there are areas where the FTCA coverage of ISDEAA contractors could be improved; nor does S. 1057 propose any changes. While ANTHC, for example, currently expends considerable resources to procure malpractice insurance to cover any "gaps" that may exist in FTCA protection, the cost of full malpractice insurance would be exorbitant, easily running five times as much (or about as much as it costs to pay several full time specialty physicians to provide services for an entire year). ANTHC would have to make corresponding reductions in direct services. Reductions in FTCA coverage are wholly unacceptable, as is trying to limit the delivery of necessary health services to AI/ANs merely because there might be more exposure.

I look forward to hearing the testimony of the Justice Department representative and reading their written testimony. To the extent it triggers the need to provide additional information, I will submit additional testimony or be glad to respond to supplementary questions Committee members may have.

NEGOTIATED RULEMAKING

S. 1057 provides for negotiated rulemaking regarding most sections of Title I and Titles II, III, and VII. Rulemaking under the Administrative Procedures Act ("APA") is provided for other sections and for Titles IV and V. *See* Section 802. In the past, the Administration has expressed reservations about negotiated rulemaking. Tribal leaders took the Administration concerns to heart and proposed the compromise in which only certain parts were subject to negotiated rulemaking. We hope that the limitations on the scope of negotiated rulemaking have resolved the concerns.

The TSGAC has especially strong views on this topic given the enormous success of the negotiated rulemaking to implement Title V of the ISDEAA. The provisions found in Section 802 mirror those applicable to that effort, except that a somewhat longer period has been provided for given the number of issues.

Negotiated rulemaking is a critical component of a true government-to-government relationship. The issues that must be addressed in rulemaking are at the heart of a Tribal program's ability to deliver health care services for AI/ANs. In the course of the negotiated rulemaking process, true understanding among Tribes and with IHS is achieved. These insights have positive impacts that go beyond the final rules, and which also assure that the rules will be based on a more complete understanding of the variability in health delivery challenges that face Tribes and across the nation. The role of Tribes should not be limited to that of any other citizen responding to proposed regulations. To produce a good outcome there must be the give and take that worked so well with regard to the self-governance regulations.

OTHER ISSUES

Findings. The TSGAC was disappointed that S. 1057 did not include some of the findings recommended by the National Steering Committee ("NSC") and included in earlier versions of this bill considered in the last Congress. We strongly believe that the Congress should acknowledge expressly the cession of more than 400,000,000 acres of land in exchange for promises made to AI/ANs and their Tribes and all too often broken. We hope the Committee will amend the bill to include the language found in S. 556, Sections 2(2) through (4).

Avoiding Regression. Fundamental to the consideration of S. 1057 must be a close examination to determine whether any provision of it causes a "regression" in authority compared to current law. We believe there are some instances where that occurs. For instance, in Section 403 (current law Section 206), Indian health programs may only bill third-party payors for reasonable

charges as determined by the Secretary. Tribes have advocated for substituting "reasonable charges" for "reasonable expenses" in order to reflect more common health care industry practice, however we are very concerned about inserting the Secretary into the process. The Department of Health and Human Services has no mechanism for making such determinations regarding literally thousands of potential charges or for the periodic amendment of them. This change would have the effect of reducing Tribal autonomy, increasing bureaucracy, and limiting desperately needed revenue.

We are continuing to closely evaluate the bill and may submit additional remarks before the close of the comment period on other provisions.

CONCLUSION

Thank you again for the leadership you are showing in trying to move this important legislation forward. We especially appreciate the willingness of the Health, Education, Labor and Pensions Committee members to sit in on a joint hearing with the Indian Affairs Committee. We hope this level of collegial consideration will finally lead to passage.

Thank you also for offering me the honor of testifying on these important issues. If there is any other information I can provide, or that other members of the TSGAC, staff of ANTHC, or of the Seldovia Village Tribe can offer, please let me know.

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