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April 17, 2012

Richard C. Holm, Chair
Board of Pharmacy
P.O. Box 110806
Juneau, AK 99811-0806

Re: License requirements for individual pharmacists working for tribal health programs, AGO No. AN2009102500

Dear Mr. Holm:

You have asked whether Alaska professional licensing requirements apply to pharmacists working for Alaska Native tribal health programs. As explained in the following opinion, because of a federal law enacted in March 2010, pharmacists employed by tribal health programs do not need to be licensed in Alaska as long as they are licensed in another state. This federal law, sometimes called Section 221, reads:

Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).¹

Section 221 expressly preempts—i.e., overrides—state licensing requirements for a pharmacist who qualifies for the exemption.²

The conclusion that pharmacists employed by tribal health programs are exempt from Alaska licensing requirements relies entirely on the existence of Section 221. Section 221 was enacted along with the Patient Protection and Affordable Care Act (PPACA). PPACA has been challenged in multiple lawsuits, and the U.S. Supreme

¹ 25 U.S.C. § 1621t.

² See subsection III(A) of opinion.

Court may ultimately decide that it is unconstitutional. If the court strikes down all of PPACA, including the Indian health provisions, Section 221 will no longer be the law and the analysis of the licensing question will change. As of the date of this opinion, however, Section 221 is in effect.

To qualify for a Section 221 exemption, a pharmacist must be employed by a tribal health program operating under an Indian Self-Determination and Education Assistance Act (ISDEAA) agreement between the federal Indian Health Service (IHS) and a tribal organization. The exemption applies only to a pharmacist with a current, valid out-of-state license. The licensing exemption only applies during time spent working for the tribal health program—if a pharmacist wishes to “moonlight” working elsewhere, an Alaska license is required.³ A pharmacist who works for a tribal health program as a contractor rather than a regular employee may be entitled to the exemption, but this will depend on the specific facts of the situation.⁴

The Board may require a pharmacist to provide proof of out-of-state licensure and tribal health program employment status before recognizing a Section 221 licensing exemption.⁵ Licensing boards who need help determining whether a particular person in a specific factual scenario qualifies for a Section 221 exemption should contact the Department of Law.

Section 221 does not prevent state licensing boards from exercising authority over their own licensees. A tribal pharmacist who holds an Alaska license is still subject to discipline by the Board.⁶

Finally, as the Department of Law concluded in 2005 with regard to dental health aides,⁷ federally certified community health aides do not have to obtain pharmacist or pharmacy technician licenses even if they are performing pharmacy-related functions as

³ *Id.*

⁴ *See* subsection III(B) of opinion.

⁵ *See* subsection III(C) of opinion.

⁶ *See* subsection III(D) of opinion.

⁷ *See* 2005 Inf. Op. Att’y Gen. (Sept. 8; 663-05-0152), 2005 WL 2300398 (Alaska A.G.).

long as they are acting within their scope of practice.⁸ Requiring community health aides to obtain state professional licenses would pose an obstacle to the federal community health aide program, which is intended to increase health services in remote areas through the use of paraprofessional aides. This conclusion does not depend on Section 221 and would not be affected if PPACA were struck down.

OPINION

I. INTRODUCTION

You have asked whether Alaska professional licensing requirements apply to individual pharmacists working for Alaska Native tribal health programs. Because of an express federal statutory exemption enacted in March 2010, pharmacists employed by tribal health programs that are operated under Indian Self-Determination and Education Assistance Act (ISDEAA) agreements need not obtain Alaska licenses as long as they are validly licensed in another state.⁹ Additionally, as the Department of Law previously determined with regard to dental health aides,¹⁰ federally certified community health aides need not be state licensed even if they are performing pharmacy-related functions as long as they are acting within their scope of practice.

II. FACTUAL OVERVIEW OF ALASKA NATIVE HEALTH CARE

The federal government recognizes itself as having special obligations towards Native Americans and Alaska Natives, including providing them with health care.¹¹ Historically, federal agencies like the Bureau of Indian Affairs (BIA) and later the Indian Health Service (IHS) directly administered Indian health care services in Alaska and elsewhere. Federal employees are generally not subject to state professional licensing

⁸ See section IV of opinion.

⁹ 25 U.S.C. § 1621t.

¹⁰ 2005 Inf. Op. Att’y Gen. (Sept. 8; 663-05-0152), 2005 WL 2300398 (Alaska A.G.) (hereinafter, “2005 AG opinion.”).

¹¹ See 25 U.S.C. § 1601(1) (“Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people”).

requirements such as those contained in Alaska's Pharmacy Act.¹² The IHS has its own pharmacy standards and requires its pharmacists to have a current license from any state.¹³

However, since the passage of the ISDEAA in 1975,¹⁴ tribal groups¹⁵ in many areas have taken over administration of Indian health care services. The ISDEAA entitles tribal groups to enter into agreements with the federal government under which they receive federal funding to provide services to Native Americans and Alaska Natives, such as health care, that a federal agency like the IHS would otherwise provide.¹⁶ The purpose of the ISDEAA is to give tribal groups more control over Indian services, helping tailor

¹² See 1992 Inf. Op. Atty. Gen. 149 (March 31; 663-91-0104), 1992 WL 564898 (Alaska A.G.) at n.1 (recognizing licensing exemption for federal employees); see also *Sperry v. Florida*, 373 U.S. 379, 385 (1963) (“A State may not enforce licensing requirements which, though valid in the absence of federal regulation, give ‘the State’s licensing board a virtual power of review over the federal determination’ that a person or agency is qualified and entitled to perform certain functions,” and may not enforce requirements “which impose upon the performance of activity sanctioned by federal license additional conditions not contemplated by Congress.”); *Johnson v. Maryland*, 254 U.S. 51, 57 (1920) (holding that a state could not require the driver of a United States Postal truck to obtain a state driver’s license in order to perform his federal job); *United States v. Virginia*, 139 F.3d 984, 987-88 (4th Cir. 1998) (holding that a state could not require private investigators under contract with the FBI to obtain state private investigator licenses); *Taylor v. United States*, 821 F.2d 1428, 1431-32 (9th Cir. 1987) (noting that a state could not require Army hospital personnel to be licensed under state law).

¹³ See IHS Manual, Part 3, Chapter 7.2B(1)(b) (“All pharmacists delivering pharmaceutical care to American Indians/Alaska Natives shall be currently licensed by at least one of the fifty State boards of pharmacy in the United States.”).

¹⁴ 25 U.S.C. § 450 et seq.

¹⁵ For simplicity, this opinion uses the term “tribal group” as an all-inclusive term to refer to a tribe, Alaska Native village, tribal health care organization, or inter-tribal consortium.

¹⁶ *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 634 (2005).

programs to better fit community needs.¹⁷ A tribal group providing health care services under an ISDEAA agreement is not bound by IHS internal agency guidelines, policies and manuals unless it expressly agrees to be bound.¹⁸

Thus, now that Indian health care services are increasingly controlled by tribal groups rather than by the federal government, the question naturally arises whether tribal health care professionals are subject to state licensing requirements or are exempt from those requirements like the IHS employees they've replaced. This section provides a brief overview of the tribal health system as background for the analysis of this question.

A. The Indian Self-Determination and Education Assistance Act (ISDEAA)

A tribal group that wants to take control of Indian health care services may enter into a “self-determination contract” under Title I of the ISDEAA or a “self-governance compact” under Title V of the ISDEAA.¹⁹ The federal government must accept a tribal group’s Title I contract proposal or provide written findings detailing why the proposal is unacceptable under specified statutory criteria.²⁰ Title V compacts give tribal groups

¹⁷ See 25 U.S.C. § 450a(b) (committing to a policy “which will permit an orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services”).

¹⁸ 25 U.S.C. § 458aaa-16(e); 25 U.S.C. § 450l (sample contract at (b)(11)); 42 C.F.R. § 137.5.

¹⁹ Title V was added to the ISDEAA in 2000 by Public Law 106-260, 114 Stat. 711 and is codified to 25 U.S.C. §458aaa–25 U.S.C. §458aaa-18. Title V made permanent a demonstration project authorized by Title III of the ISDEAA. H.R. Rep. No. 106-477 at 16 (1999), *reprinted in* 2000 U.S.C.C.A.N. 573, 574.

²⁰ 25 U.S.C. § 450f(a)(2), (4).

more control over the structuring of programs than Title I contracts,²¹ but have more stringent eligibility requirements.²²

A tribal group that has entered an ISDEAA contract or compact must negotiate a funding agreement with the IHS detailing the services it will provide and the federal funds it will receive. In order to allow a transfer of control without a reduction in services or a transfer of the financial burden of providing services, the ISDEAA requires the federal government to provide tribal groups with the same level of funding that the IHS would have received if it were providing services directly, plus funds to cover reasonable overhead costs.²³ To further reduce the potential financial burden on tribal groups that take over IHS functions, the federal government provides coverage under the Federal Tort Claims Act (FTCA) for personal injury suits arising out of the performance of services under ISDEAA contracts and compacts.²⁴

B. The ISDEAA in Alaska

In Alaska, 99% of IHS funding has been transferred to tribal control under ISDEAA contracts, compacts, and funding agreements, and the IHS no longer provides any direct health services. According to the IHS, as of December 2011, 25 tribal groups operate health programs in Alaska under Title V, and 14 do so under Title I. The Title V groups are signatories to the Alaska Tribal Health Compact, the umbrella Title V

²¹ See 25 U.S.C. §458aaa-5(e) (under Title V, tribal groups may redesign programs and re-direct funding “in any manner which the Indian tribe deems . . . best,” so long as eligible persons receive care).

²² See 25 C.F.R. § 1000.17 (requiring, among other things, a “demonstration of financial stability and financial management capability for the previous 3 fiscal years”).

²³ 25 U.S.C. §450j-1(a)(1); 25 U.S.C. §458aaa-15(a) (making section 450j-1(a)(1) applicable to Title V compacts).

²⁴ 25 U.S.C. § 450f (d); 25 U.S.C. § 458aaa-15(a) (making section 450f(d) applicable to Title V IHS compacts); see *Snyder v. Navajo Nation*, 382 F.3d 892, 897 (9th Cir. 2004) (“Congress wanted to limit the liability of tribes that agreed to these arrangements. Congress therefore provided that the United States would subject itself to suit . . . for torts of tribal employees hired and acting pursuant to such self-determination contracts under the ISDEAA.”).

compact for all of Alaska developed in 1994.²⁵ Each signatory to the Compact negotiates its own funding agreements with the IHS. The Compact is revised periodically to account for changes in law, new signatories, and other amendments.

C. Tribal health care providers

Health professionals working for tribal programs may be tribal group employees, federal employees, or contractors.

The IHS is authorized to hire health professionals under “personal services contracts” rather than through normal federal hiring processes.²⁶ A personal services contract is supposed to be “characterized by the employer-employee relationship it creates between the Government and the contractor’s personnel.”²⁷ The Alaska Area IHS used to enter into numerous personal service contracts to send health professionals to work for tribal health care programs in Alaska under nominal federal supervision. The IHS required these health professionals to be licensed in some state, but did not require them to have an Alaska license. The IHS took the position that these health professionals were essentially federal employees and thus exempt from state licensing requirements. Recruiting out-of-state health professionals to come to Alaska is easier if they do not need an Alaska license.

Since 2010, the Alaska Area IHS reports that it has stopped sending health professionals to work for tribal health care programs under personal services contracts. Relying on a new provision of federal law discussed below, the IHS now takes the position that health professionals that are hired directly by tribal groups are exempt from state licensing requirements as long as they are licensed in some state. Thus, the IHS believes there is no longer any need for it to serve as a hiring intermediary.

Some people working for tribal health programs in remote areas in Alaska are paraprofessionals who are not licensed in traditional health professions such as pharmacy. They are called “community health aides.”²⁸ Community health aides are certified under

²⁵ See IHS website, <http://www.ihs.gov/facilitieservices/areaoffices/alaska/> (last visited March 15, 2012).

²⁶ 25 U.S.C. § 1638c.

²⁷ 48 C.F.R. 37.104(a).

²⁸ 25 U.S.C. § 1616l.

a special federal program.²⁹ In 2005, the Department of Law concluded that Alaska licensing laws otherwise applicable to dental hygienists do not apply to dental health aides certified under the federal community health aide program.³⁰

D. Alaska licensing law

In Alaska, health professionals, including pharmacists, are licensed by professional licensing boards supported by the Department of Commerce, Community, and Economic Development, such as the Board of Pharmacy, the State Medical Board, and the Board of Nursing. The licensing statutes and regulations applied by these boards generally specify that federal employees are exempt from their reach.³¹ But no existing Alaska statutory or regulatory provision specifically exempts tribal health professionals from any of Alaska's professional licensing requirements.

III. TRIBAL HEALTH PROFESSIONALS

In March 2010, the Indian Health Care Improvement Reauthorization and Extension Act was enacted into law as part of the Patient Protection and Affordable Care

²⁹ 25 U.S.C. § 1616l(b).

³⁰ 2005 AG opinion.

³¹ See AS 08.64.370 (1) (exemption from medical licensing requirements for “officers in the regular medical service of the armed services of the United States or the United States Public Health Service while in the discharge of their official duties”); AS 08.68.800(a)(1) (exemption for “a qualified nurse licensed in another state employed by the United States government or a bureau, or agency, or division of the United States government while in the discharge of official duties”); AS 08.36.350 (exemption for “a dentist in the employ of the United States Public Health Service, United States Department of Veterans Affairs, Alaska Native Service, or other agency of the federal government, in the discharge of official duties”).

Act (PPACA).³² It included a new provision, often referred to as Section 221, creating an explicit exemption from state licensing requirements:

Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).³³

The term “health profession” is defined to include “pharmacy.”³⁴ Thus, Section 221 purports to exempt from state licensing requirements any pharmacist with an out-of-state license who is “employed by” a “tribal health program” with an ISDEAA agreement.

The legislative history of Section 221³⁵ suggests that Congress enacted it to help tribal health programs attract out-of-state personnel by extending to tribal health

³² Pub. L. No. 111-148 at § 10221, 124 Stat. 119 (2010). PPACA incorporated by reference and enacted into law (with several amendments) S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009 “as reported by the Committee on Indian Affairs of the Senate in December 2009.” PPACA has been challenged in multiple lawsuits, and the U.S. Supreme Court heard oral argument on the law’s constitutionality in March 2012. *See Dep’t of Health & Human Services v. Florida*, 132 S. Ct. 604 (2011) (granting certiorari). Although the S. 1790 Indian health provisions are not at issue in these lawsuits, they would be struck down in the event that the court holds PPACA unconstitutional and further concludes that the unconstitutional provisions cannot be severed from the remainder of the law. That result would change the analysis of the licensing issue.

³³ S. 1790 at § 134 (codified at 25 U.S.C. § 1621t).

³⁴ 25 U.S.C. § 1603(10) (“The term ‘health profession’ means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.”).

professionals the same license portability enjoyed by IHS employees.³⁶ Congress recognized that tribal health programs have difficulty filling positions and hoped to make these positions more attractive.³⁷

A. Section 221 preempts state licensing requirements.

The Supremacy Clause of the U.S. Constitution dictates that federal law is the supreme law of the land.³⁸ Thus, federal law can preempt—i.e., override—state law.³⁹ Section 221 expressly exempts certain people from state licensing requirements. This

³⁵ Section 221 was included within many different bills seeking to reauthorize the Indian Health Care Improvement Act that were introduced every year from 1999 until 2010. Section 221’s text remained largely unchanged throughout this process; the legislative history of prior versions of the bill is thus relevant to its interpretation.

³⁶ S. Rep. No. 110–197 at 12 (2007) (“The Committee has been made aware of the need to increase the number of licensed health professionals in the Indian health system and included provisions in S. 1200 to address that need. S. 1200 provides for portability of current licenses for tribal health professionals consistent with other Federal health licensing provisions.”); S. Rep. No. 109–222 at 14 (2006) (“The Committee has been made aware of the need to increase the number of licensed health professionals in the Indian health system and included provisions in S. 1057 to address that need. S. 1057 provides for portability of current licenses for tribal health professionals consistent with other Federal health licensing provisions.”); H.R. Rep. No. 108–791(I) at 89 (2004) (“The new IHICIA section 221 extends the right enjoyed by IHS to exempt from licensing requirements in the state which the Indian health program is carried out, so long as the provider is licensed in at least one other state.”); S. Rep. No. 108–411 at 22 (2004) (noting that Section 221 “extends similar current authority for the IHS to tribal health programs”).

³⁷ S. Rep. No. 108–411 at 10 (2004) (stating purpose “to ensure an adequate supply of health professionals to the IHS, tribal and urban Indian health programs.”); *see* 154 Cong. Rec. S1150-02, S1154 (daily ed. Feb. 26, 2008) (comments of Sen. Russell Feingold) (“Recruiting talented and dedicated professionals to serve in IHS facilities, whether urban or rural, is a key challenge facing many tribal communities . . .”).

³⁸ U.S. Const. art. VI, cl. 2.

³⁹ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995).

clear Congressional statement is sufficient to preempt state law.⁴⁰ Thus, pharmacists who are covered by the Section 221 exemption need not obtain Alaska licenses.

In a preemption analysis, Congress’s intent “is the ultimate touchstone”—in other words, the main question is whether Congress intended a statute to override state law.⁴¹ There are several different types of preemption.⁴² Sometimes it is difficult to figure out whether federal law preempts state law because Congress has not clearly stated its intent. A court may find that Congress has implicitly preempted state law because the state and federal laws cannot effectively coexist—this is known as “implied” preemption.

But where the text of a federal statute explicitly announces that it overrides state law, Congress’s intent is clear and no complex analysis is necessary. This is known as “express” preemption. Section 221 is an example of express preemption. Section 221 expressly declares that certain health professionals “shall be exempt” from state licensing requirements. This language is not susceptible to alternative interpretations that leave room for state licensing law. Section 221’s clear preemptive language is reinforced

⁴⁰ Only a valid federal law that is within Congress’s constitutional power can preempt state law. See Laurence H. Tribe, *American Constitutional Law*, § 6-28 (“So long as Congress acts within an area delegated to it, the preemption of conflicting state or local action . . . flow[s] directly from the substantive source of whatever power Congress is exercising, coupled with the Supremacy Clause.”). The federal government’s power to exempt the off-reservation activities of tribal entities from state law is not without limits.

⁴¹ *Wyeth v. Levine*, 555 U.S. 555, 565 (2009) (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996)).

⁴² See *Allen v. State, Dep’t of Health & Soc. Servs., Div. of Pub. Assistance*, 203 P.3d 1155, 1162-64 (Alaska 2009) (summarizing types of federal preemption).

by statements in the legislative history acknowledging that it would preempt state law.⁴³ Accordingly, Section 221 expressly preempts state licensing requirements for the health professionals it covers.

B. Scope of the Section 221 licensing exemption

The logical next question is the extent of Section 221's preemption of state law—i.e., who is covered by the licensing exemption, and under what circumstances? Under the terms of Section 221, in order to qualify for the exemption a person must: (1) be a “licensed health professional” who is “licensed in any State” and (2) be “employed by a tribal health program.”⁴⁴ Some aspects of these requirements are easy to interpret. For instance, the term “tribal health program” is specifically defined in statute to mean a health program operated by a tribal group under an ISDEAA agreement with the IHS.⁴⁵

⁴³ See 150 Cong. Rec. S12052-02, S12055 (Dec. 8, 2004) (Congressional Budget Office cost estimate noting that Section 221 “would preempt state licensing laws in cases where a health care professional is licensed in one state but is performing services in another state under a funding agreement in a tribal health program”); H.R. Rep. No. 109–661(I) at 131 (2006) (noting that Section 221 “would preempt state licensing laws in cases where a health care professional is licensed in one state but is performing services in another state under a contract or compact with a tribal health program”); H.R. Rep. No. 109–661(I) at 132 (2006) (noting that the 2006 version of the bill containing Section 221 was “not intended to preempt any State, local or tribal law other than State licensing laws in certain cases where a health care professional is licensed in one State but is performing services in another State under a contract or compact with a tribal health program”); S. Rep. No. 110–197 at 88 (2007) (noting that Section 221 “would preempt state licensing laws in cases where a health care professional is licensed in one state but is performing services in another state under a contract or compact with a tribal health program”). Cf. 154 Cong. Rec. S993-08, S997 (daily ed. Feb. 14, 2008) (Senator Coburn proposes an amendment “[t]o ensure tribal members have access to the highest levels of quality and safety,” which would have deleted Section 221 and replaced it with the language “Nothing in this Act preempts any State requirement regarding licensing of any health care personnel.”).

⁴⁴ 25 U.S.C. § 1621t.

⁴⁵ 25 U.S.C. § 1603(25) (“The term ‘tribal health program’ means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the [Indian Health] Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).”).

But Section 221 may contain ambiguities, and it has not been around long enough to have been thoroughly interpreted by courts or government agencies. This subsection provides some guidelines that may be helpful in determining the applicability of Section 221 in borderline cases.

First, the legislative history suggests that Section 221 was intended to put tribal health professionals on similar footing to IHS health professionals with regard to state licensing requirements.⁴⁶ An IHS pharmacist must hold a current, valid state license, but it need not be from the state in which she is practicing.⁴⁷ If questions arise regarding the scope of the Section 221 exemption, it may be useful to look at the details of the licensing requirements that the IHS imposes on its own personnel.

In addition, consulting the scope of FTCA coverage for tribal health professionals may be instructive. The federal government extends FTCA liability coverage to tribal health programs and their employees.⁴⁸ FTCA coverage is not directly related to Section 221 or state licensing requirements. But by providing a legal remedy for a patient who is injured by a negligent tribal health professional, FTCA coverage provides some protection for patients even if the tribal health professional is not subject to the oversight of the local state licensing board due to Section 221. Because FTCA coverage provides some protection for patients where Section 221 has removed the protection of local state

⁴⁶ See sources cited, *supra* note 36.

⁴⁷ See U.S. Dep't of Health and Human Servs., Public Health Servs., *Commissioned Corps Instruction, "Category Specific Appointment Standards"* at 3 ¶6-1.a.(1) (May 6, 2011) (available at http://dcp.psc.gov/ECCIS/documents/CCI2_3_1_03.pdf) (detailing qualifications for an IHS pharmacist who is a member of the Public Health Service Commissioned Corps); IHS Manual 3-7.2(B)(1)(b) (June 26, 1995) (available at http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c7) (detailing qualifications for an IHS pharmacist hired through the civil service system). The pharmacy section of the IHS Manual states that "Pharmacists hired directly by tribes or tribal organizations pursuant to [the ISDEAA] are subject to licensure requirements of the State in which their practice is located." IHS Manual 3-7.2(B)(1)(b) (June 26, 1995) (available at http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c7). However, this manual section has not been updated since the enactment of Section 221 and appears to have been superseded.

⁴⁸ 25 U.S.C. § 450f (d); 25 U.S.C. § 458aaa-15(a) (making section 450f(d) applicable to Title V IHS compacts).

oversight, it may make sense to consult the boundaries of FTCA coverage when determining the boundaries of Section 221. FTCA coverage generally extends to tribal health program employees and tribal personal services contractors while they are performing services under an ISDEAA agreement.⁴⁹ It may not cover an independent contractor for a tribal health program or services that are not provided under an ISDEAA agreement.⁵⁰

These considerations may help answer some questions regarding the scope of Section 221. For example, is a health professional who works for a tribal health program covered by the Section 221 exemption while “moonlighting” for a non-tribal employer? The considerations outlined above suggest that she is not. An IHS employee who moonlights is not exempt from state licensing requirements when performing a non-federal job, because the federal exemption is tied to the federal job. Similarly, the Section 221 exemption should be considered tied to the tribal health program and its ISDEAA agreement. This conclusion is also supported by the fact that FTCA coverage does not extend to work performed outside the scope of an ISDEAA agreement.⁵¹ Thus, if a tribal health professional wishes to provide services outside the scope of an ISDEAA agreement, she must obtain an Alaska license.

Other questions regarding the scope of Section 221 may need to be decided based on specific facts. For example, determining whether Section 221 covers a tribal health professional who works as a contractor rather than a regular tribal health program employee may require an examination of the contract at issue. If the contract is akin to a federal personal services contract—which creates a relationship very similar to a traditional employer/employee relationship⁵²—the Section 221 exemption might apply, but if the contract creates an independent contractor relationship, the exemption would

⁴⁹ 25 U.S.C. § 450f (d); 25 C.F.R. § 900.193; 25 C.F.R. § 900.192; 25 C.F.R. § 900.206.

⁵⁰ 25 U.S.C. § 450f (d); 25 C.F.R. § 900.189; 25 C.F.R. § 900.195; 25 C.F.R. § 900.183(b)(4); *see, e.g., Wooten v. Hudson*, 71 F. Supp. 2d 1149, 1154 (E.D. Okla. 1999) (holding that physician was covered by FTCA during hours he worked for tribal health program but not during hours he worked for private company); *Tsosie v. United States*, 452 F.3d 1161, 1167 (10th Cir. 2006) (holding that independent contractor physician was not covered by FTCA).

⁵¹ 25 U.S.C. § 450f (d).

⁵² 48 C.F.R. § 37.104(a).

probably not apply. This distinction is suggested by the fact that personal services contractors are supervised in the same manner as employees⁵³ and the fact that the FTCA generally covers personal services contractors⁵⁴ but not independent contractors.⁵⁵ A licensing board presented with a contractor for a tribal health program claiming a Section 221 exemption should examine the relevant contract in consultation with the Department of Law.

Other specific fact situations might reveal further questions regarding the scope of Section 221. Licensing boards who need help determining whether a particular person is entitled to a Section 221 exemption should contact the Department of Law.

C. A state licensing board may require proof of a tribal health professional's entitlement to a Section 221 exemption.

State licensing boards aren't completely without authority over tribal health professionals because tribal health professionals are not federal employees. If a tribal health professional does not meet the requirements of Section 221, she is subject to the licensing requirements of the state in which she is practicing. Accordingly, state licensing boards may require tribal health professionals to provide proof of out-of-state licensure and employment by a tribal health program before recognizing the exemption. Boards may use this residual authority to ensure that nobody is engaging in unlicensed practice by checking to make sure out-of-state licenses are current and valid. A board may cease recognizing a Section 221 exemption if a person's out-of-state license is suspended or revoked. Taking these actions would not interfere with federal law—indeed, it would support federal law by enforcing Section 221's policy determination that all tribal health professionals should have a license from a state.

⁵³ Cf. 48 C.F.R. § 37.104(c)(2) (providing that in determining whether a contract is a federal personal services contract, “[e]ach contract arrangement must be judged in the light of its own facts and circumstances, the key question always being: Will the Government exercise relatively continuous supervision and control over the contractor personnel performing the contract?”).

⁵⁴ 25 U.S.C. § 450f (d); *see also* 25 C.F.R. § 900.193.

⁵⁵ *See* sources cited *supra* note 50.

D. A state licensing board may discipline a tribal health professional who holds an Alaska license.

Although Section 221 means that a tribal health professional working in Alaska may not need to have an Alaska license, it does not mean that one who *does* hold an Alaska license is exempt from the requirements of that license. Even federal employees who hold Alaska licenses must comply with the terms of their licenses or face discipline. Indeed, the federal government has chosen to rely on the state licensing boards by requiring that federal and tribal health professionals be licensed by a state board, rather than by creating a federal professional licensing scheme. A state board's enforcement of its standards against its licensees who are federal or tribal employees does not obstruct any federal purpose—indeed, it furthers federal purposes by ensuring that the state licenses on which the federal government relies properly signal their holders' qualifications. Thus, federal law does not preempt a state board's power to discipline one of its own licensees when that licensee works for a tribal health program.

IV. COMMUNITY HEALTH AIDES

Community health aides are paraprofessionals who work in remote clinics and are not licensed in traditional health professions.⁵⁶ They are certified under a federal program that has operated in Alaska for many years.⁵⁷ As is the case with dental health aides,⁵⁸ as long as community health aides are acting within their scope of practice authorized by federal law, they need not comply with state professional licensing requirements, including those found in Alaska's Pharmacy Act.

Congress has directed the IHS to “provide[] for the training of Alaska Natives as health aides or community health practitioners” and “use[] those aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska.”⁵⁹ Congress instructed the IHS to create a training curriculum and certification board for community health aides with an eye

⁵⁶ 25 U.S.C. § 1616l.

⁵⁷ 25 U.S.C. § 1616l(b); *see also* CHAP website, <http://www.akchap.org/html/about-chap.html> (last visited March 15, 2012) (history of community health aide program).

⁵⁸ 2005 AG opinion.

⁵⁹ 25 U.S.C. § 1616l(a).

toward meeting Congress's Indian health goals.⁶⁰ The Community Health Aide Program Certification Board, established under this law,⁶¹ sets standards and certifies community health aides and practitioners, dental health aides, and behavioral health aides and practitioners.⁶² Each type of community health aide is subject to specific training and education requirements and has a scope of practice set forth in the Community Health Aide Program Certification Board Standards and Procedures.⁶³ The Alaska Community Health Aide/Practitioner Manual sets detailed guidelines and protocols that community health aides must follow.⁶⁴

In 2005, the Department of Law issued an opinion concluding that Alaska licensing laws otherwise applicable to dental hygienists do not apply to dental health aides certified under this federal program.⁶⁵ The opinion observed that one objective of the community health aide program "is to provide dental care to Alaska Natives through paraprofessionals because there are too few dentists and hygienists available to provide those services in remote areas."⁶⁶ The opinion noted that "[i]f federal dental health aides are forced to comply with state law before they can lawfully provide dental treatment, the congressional purpose to increase dental treatment in remote areas through the use of paraprofessional aides will be defeated."⁶⁷ The opinion reasoned that application of state law to dental health aides would "stand as an obstacle to Congress' objective to provide dental treatment to Alaska Natives by using non-dentist, non-hygienist

⁶⁰ 25 U.S.C. § 1616l(a), (b)(2)(C), (b)(3).

⁶¹ 25 U.S.C. § 1616l(b)(3).

⁶² Community Health Aide Program Certification Board Standards and Procedures at pg. 1 (amended June 19, 2008) (available at http://www.akchap.org/resources/chap_library/CHAPCB_App_Docs_BHA/CHAPCB_Standards_Procedures_Amended_06-19-08_final.pdf).

⁶³ *Id.*

⁶⁴ Alaska Community Health Aide/Practitioner Manual (2006 edition).

⁶⁵ 2005 AG opinion.

⁶⁶ *Id.* at *6.

⁶⁷ *Id.*

paraprofessionals.”⁶⁸ The opinion thus concluded that 25 U.S.C. § 1616l implicitly preempts state law.⁶⁹

The state superior court agreed with this analysis, rejecting a challenge brought by a group of dentists.⁷⁰ The superior court explained:

It is clear that Congress intended to circumvent state licensing laws and have the community health aides trained, certified, and supervised under a separate federal statutory scheme. To find otherwise would deem the legislation, in which Congress specifically directs the Secretary to create and implement the Community Health Aide Program for Alaska, entirely futile and unnecessary; it is unlikely that Congress would be so careless.⁷¹

Although the 2005 attorney general opinion and 2006 superior court opinion specifically addressed only dental licensing requirements, the same analysis applies to pharmacist and pharmacy technician licensing requirements that would pose an obstacle to the federal community health aide program. Federal law provides that community health aides should be instructed on “efficient and effective management of clinic pharmacies.”⁷² Requiring a community health aide to obtain an Alaska pharmacist license before performing these duties would obstruct the federal program because such a license requires a college degree and other advanced qualifications that community health aides are unlikely to have.⁷³ The requirements for a pharmacy technician license are not as stringent,⁷⁴ but requiring health aides to become licensed pharmacy technicians could nonetheless pose an obstacle to the federal program because Alaska law restricts what a

⁶⁸ *Id.*

⁶⁹ *Id.* at *7.

⁷⁰ Order, *Alaska Dental Society v. State of Alaska*, Case No. 3AN-06-04797CI (Alaska Super. Ct., June 27, 2006) (hereinafter, “2006 order”).

⁷¹ *Id.* at 18.

⁷² 25 U.S.C. § 1616l(b)(2)(B).

⁷³ AS 08.80.110.

⁷⁴ See 12 AAC 52.140 (requiring a high school education, fluency in English, and a clean criminal history).

pharmacy technician may do.⁷⁵ Moreover, imposing state requirements on top of the requirements created by the federal program could be seen as interfering with federal purposes even if those requirements are not very difficult to meet. Accordingly, the Pharmacy Act does not prevent community health aides from performing services within their federally certified scope of practice, even if those services would normally require state licensure.

Nonetheless, although community health aides may provide some medication-related services, they have a limited scope of practice. The Community Health Aide Manual provides detailed descriptions of everything community health aides are certified to do. If a community health aide goes beyond the scope of her federal certification, she is not exempt from state law.

V. CONCLUSION

Because Section 221 expressly preempts state law, pharmacists working for tribal health programs under ISDEAA agreements need not obtain Alaska licenses as long as they are validly licensed in another state. The Board of Pharmacy may require a tribal pharmacist who is not licensed in Alaska to provide proof of entitlement to a Section 221 exemption.

Additionally, federally certified community health aides need not obtain pharmacist or pharmacy technician licenses as long as they are acting within their scope of practice under federal law.

Sincerely,

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ATTORNEY GENERAL

By:

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⁷⁵ 12 AAC 52.230.