NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
50 Years of Indian Health Leadership

Testimony of Laura Platero
The Northwest Portland Area Indian Health Board
Before
House Natural Resources Subcommittee on Indian and Insular Affairs
Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities
March 29, 2023

Chair Hageman and Ranking Member Fernandez, and Members of the Subcommittee, I appreciate the opportunity to present this testimony on "Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities."

My name is Laura Platero, and I serve as the Executive Director of the Northwest Portland Area Indian Health Board (NPAIHB or Board). NPAIHB was established in 1972 and is a tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638. The Board advocates on specific health care issues in support of the 43 federally-recognized Indian tribes in Idaho, Oregon, and Washington (Northwest or Portland Area). The Board's mission is to eliminate health disparities and improve the quality of life for American Indians and Alaska Natives (AI/AN) by supporting Northwest Tribes in the delivery of culturally-appropriate, high-quality health care. "Wellness for the seventh generation" is the Board's vision. We thank the Subcommittee for their continued support in improving the delivery of healthcare services in Indian Country.

I provide the following testimony to address opportunities and challenges for improving healthcare delivery in the Northwest:

Northwest Tribes have been strong advocates in requesting that the federal government uphold trust and treaty obligations to Tribal Nations, including full funding for the Indian Health Service (IHS). They are also known for their long history in IDSEAA Self-Determination contracting and Self-Governance compacting. There are 13 ISDEAA Title I Contract Tribes, 25 ISDEAA Title V Compact Tribes, five federally-operated IHS facilities and three urban Indian facilities. In the Portland Area, there are 200,000 AI/AN users[1] of the Indian health system. There are no IHS or tribally-operated hospitals in the Portland Area. The lack of an IHS or tribally-operated hospital limits AI/AN people's access to the breadth of inpatient care and specialty services provided by hospitals. To fill this gap in services, tribal health programs purchase all in-patient and specialty care not provided in their outpatient clinics with IHS Purchased and Referred Care (PRC) dollars. In 2025, IHS, with the Portland Area Tribes Facilities Advisory Committee (PAFAC), will stand up the first Regional Specialty Referral Center ("Center") in the Indian health system, a specialty outpatient care facility in Puyallup, Washington. Two more Centers in other parts of the Portland Area will ensure outpatient access to care across the region. No funding has been allocated for the two additional Centers yet.

[1] In the Portland Area Indian Health Service system, there are approximately 218,000 users registered, with 114,000 active users.

Health Disparities, COVID-19, and Tribal Innovation in the Northwest

Like AI/AN people across Indian Country, AI/ANs in the Northwest experience significant health disparities when compared to other populations. They have a life expectancy that is about 7 years lower than that of non-Hispanic Whites (NHW). They also experience disparities at all stages of life and are particularly vulnerable to chronic diseases such as heart disease and diabetes, injuries, violence, substance misuse and overdoses. In the past year, there has been an alarming increase in Fentanyl overdoses in Northwest Tribal communities. AI/AN people in the Northwest are also less likely to have health care coverage and access compared to their NHW counterparts which, in part, explains the low rates of preventative health care services accessed by AI/AN people. Chronic health disparities[2] and lack of access to care, resulted in COVID-19 disproportionately impacting AI/AN people. AI/AN people had significantly higher rates of COVID-19 cases (3.5x)[3], hospitalizations (5.3x), and deaths (1.8x) [4] than non-Hispanic Whites.

While COVID-19 was devastating to many Tribal communities, it also highlighted the resilience and innovation of Tribal communities to respond to the pandemic. When Tribes have adequate resources and control of those resources, Tribes know how to respond to public health emergencies and to address the healthcare needs of their community members. For example, Tribes were successful in quickly rolling out COVID-19 vaccinations in their communities. AI/AN people were the most vaccinated ethnic and racial group in the U.S. early in the pandemic. Many Northwest Tribes also provided vaccines to non-Natives in and around their communities.

Based on this experience, NPAIHB recommends that the Subcommittee:

Expand the use of ISDEAA Self-Determination contracts and Self-Governance compacts. Northwest Tribes have had longstanding requests to the IHS and HHS to move away from grant funding and allow tribes the option to receive funds through their contracts and compacts. Self-determination and Self-governance contracts and compacts honor tribal sovereignty and the government-to-government relationship. IHS continues to provide funding through grant programs, such as the Special Diabetes Program for Indians and several IHS Behavioral Health grant initiatives. Grant programs result in IHS administrative costs to operate the grant program and reduce funds to tribes. This Subcommittee must support an option for tribally-operated facilities to receive grant funds through their ISDEAA contracts and compacts.

In addition, during the pandemic, HHS agencies allocated funding to IHS that was distributed to tribes through existing formulas and ISDEAA contracts and compacts (e.g., Centers for Disease Control and Prevention). This process successfully allowed tribes to receive funds quickly from

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[2] Chronic health disparities among AI/AN people is the result of significant underfunding of the Indian Health Service. U.S. COMM'N ON CIVIL RIGHTS, BROKEN PROMISES: CONTINUING FEDERAL FUNDING SHORTFALL FOR NATIVE AMERICANS AT 19 (2018) *available at* https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.
[3] Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 among American Indian and Alaska Native persons—23 states, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1166–9.
[4] Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1853–1856. DOI: http://dx.doi.org/10.15585/mmwr.mm6949a3

CDC and to use those funds to best meet the needs in their communities. All HHS funding should be allocated to Tribes through this mechanism. This Subcommittee must support legislation expanding ISDEAA contracting and compacting to HHS and its agencies.

Maintain advance appropriations.
IHS was provided advanced appropriations for the first time in Fiscal Year 2024. This is essential to ensure that the IHS has stable funding year after year to shield our tribal health programs from potential government shutdowns and continuing resolutions. Tribal health programs cannot budget for future years and plan for expansion of services without stable funding year after year. We thank members for supporting advance appropriations that was included in the Consolidated Appropriations Act, 2023.

Support mandatory funding for Contract Support Costs and ISDEAA 105(l) Leases.
Mandatory appropriations is needed for contract support costs (CSC) and the ISDEAA 105(l) leasing program to ensure that discretionary appropriations for other IHS subaccounts are not impacted by the growing costs of these programs. If CSC and 105(l) programs do not receive mandatory appropriations, IHS program increases, medical inflation and population growth will continue to be underfunded and result in increased health disparities and increased chronic healthcare needs.

Create workforce opportunities through the Community Health Aide Program.
The Community Health Aide Program (CHAP) is a program that was designed and implemented by the Alaska Native Health system over 60 years ago. In nationalizing it to the rest of the country, tribes everywhere have an important opportunity to tackle social determinants of health while improving healthcare workforce and retention. CHAP is unique because it not only increases access to care but creates access points to health education so that tribal citizens can become health care providers with professional wage jobs on reservations and in tribal health programs throughout the country; thus, addressing poverty and supporting economic viability in Tribal communities. The education programs associated with CHAP are the foundation of the program.

In the Northwest, we have established a Dental Therapy Education Program, two Behavioral Health Aide Education Program, and are in the process of developing the Community Health Aide Education programs. We have also worked with the Portland Area IHS Office to standup a CHAP Certification Board to certify our Portland Area CHAP providers. Approval of the certification process is in process. Portland Area Tribes and NPAIHB have been innovative and creative in securing funding for CHAP expansion despite only receiving one IHS grant of $1 million (of the $20 million appropriated to IHS for the expansion of CHAP in the lower 48). This Subcommittee must consider this crucial opportunity to address workforce shortages in Tribal communities.

Consider innovative approaches to address facility construction needs.
At the current rate of appropriations for construction and the facility replacement timeline, a new 2021 facility would not be replaced for 290 years. Many tribes and tribal organizations in the Northwest have assumed substantial debt to build or renovate clinics for AI/AN people to receive

IHS-funded health care. This Subcommittee should consider opportunities to utilize the demonstration authority under the Indian Health Care Improvement Act to provide flexible funds to Tribes to address unmet construction needs for health facilities.

Reauthorize and increase funding for Special Diabetes Program for Indians (SDPI).
Diabetes impacts AI/AN people at significantly higher rates. Nationally, 8.2% of the population has diabetes (all populations, over 18 years old)[5] compared to 14.7% of AI/AN people across the country with diabetes. This is significantly higher than any other national demographic, with Hispanic people the next highest at 12.5%. COVID-19 continues to be a threat to our diabetic patient populations. Recent data shows that there are higher rates of long COVID in people with diabetes and an increased risk of diabetes with individuals with long COVID.[6]

Congress reauthorized the SDPI program at $150 million per fiscal year until Fiscal Year 2023.[7] SDPI funding has remained stagnant at $150 million and has not increased in pace with inflation and population growth. This program has been successful in creating positive health outcomes that reduce costly care for more chronic conditions and hospitalizations. We request that this Subcommittee reauthorize SDPI at $250 million for FY 2024, exempting the program from mandatory sequestration, and increase the funding to $260 million in FY 2025 and $270 million in FY 2026 in order to expand our diabetes programs. Lastly, this Subcommittee should consider creating an option for tribes to receive SDPI funds through their ISDEAA contracts and compacts.

Provide Health IT Modernization funds to reimburse tribes.
The Resource and Patient Management System (RPMS) is now a legacy system and is inconsistent with emerging architectural electronic health record (EHR) standards. NPAIHB recognizes that the Veterans Administration's (VA) decision to move to a new Health Information Technology solution will create a gap for the parts of RPMS that are dependent on core coding from the VA. RPMS cannot meet these evolving needs without substantial investment in IT infrastructure and software. COVID-19 has really highlighted the challenges with RPMS and has required double entries of data for reporting purposes. Many Tribes have had to use their own revenues and incur substantial debt to purchase electronic health record systems to interface with local hospital systems to improve patient care. However, since IHS has been appropriated hundreds of millions of dollars in recurring and one-time funding for EHR, Tribes have not received any funding to support Tribal health IT investments. This Subcommittee must support IT modernization efforts with priority for Tribes that have purchased commercial off the shelf systems.

Support Access to Care Factor in Purchased and Referred Care Allocations.

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[5] National Diabetes Statistics Report 2020, Estimates of Diabetes and its Burden in the United States. Centers for Disease Control and Prevention.
[6] *See* Raveendran AV, Misra A. Post COVID-19 Syndrome ("Long COVID") and Diabetes: Challenges in Diagnosis and Management. Diabetes Metab Syndr. 2021 September-October; 15(5): 102235. https://doi.org/10.1016/j.dsx.2021.102235
[7] *See* Consolidated Approps. Act 2021, Pub. L. No. 116-260, 134 stat. 2923 (2020).

The PRC program makes up over one-third of the Portland Area budget because we have no IHS or tribally-operated hospital. Year after year, PRC receives nominal increases often less than 1% despite this being the second rated priority of the National Tribal Budget Formulation Workgroup every year. Areas with IHS hospitals can absorb these costs more easily because of their infrastructure and large staffing packages.

When there are increases to the PRC budget, the Portland Area Tribes receive additional funding to account for the lack of an IHS/Tribal hospital in the Area, often referred to as the access to care factor. However, Congress through the IHS budget has only ever funded this access to care factor three times in the past 12 years—in FY 2010, 2012, and 2014. Without year-to-year increases to PRC to fund the access to care factor, inpatient care for Portland Area Tribes goes severely underfunded. We request this Subcommittee support annual funding for the access to care factor.

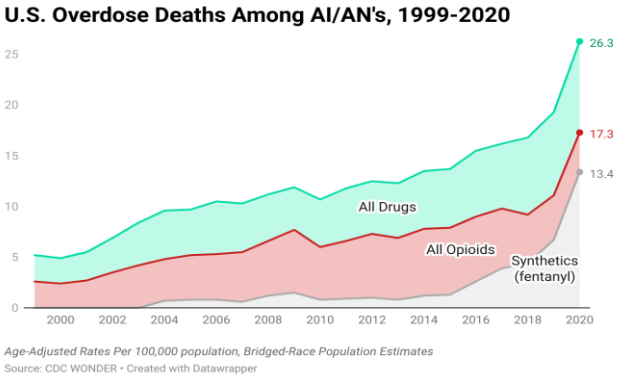
H.R. 409 IHS Contract Support Cost (CSC) Amendment Act

The federal appeals court decision in *Cook Inlet v. Dotomain* that decided tribal overhead costs are disqualified from being reimbursed if the IHS would "normally" incur that same cost in running the contracted programs undermines the longstanding understanding of the ISDEAA. The Northwest Tribes have been relentless advocates for Tribal Self-Determination and Self-Governance Title I and Title V contracts and compacts. However, the *Cook Inlet* decision can destabilize our tribal health program operations and threaten our Tribal Self-Determination and Self-Governance to provide health care to our people by significantly reducing our contract support cost recovery.

In *Fort Defiance Indian Health Board v. Becerra*, 604 F.Supp.3d 118 (D. NM 2022), IHS cut a tribal contractor's Contract Support Cost (CSC) FY 2022 payments by 95% or nearly $17 million arguing that historic overpayment has occurred relying on the Cook Inlet decision. Although *Fort Defiance* has been settled, there still remains an urgency to swiftly enact H.R. 409 to reverse the *Cook Inlet* decision. The Northwest Tribes are concerned that IHS will not fully reimburse tribes for their CSC payments and assert claims for past payments just as the agency has done in the *Fort Defiance* case. We urge the Subcommittee to swiftly enact H.R. 409 to reverse *Cook Inlet* and restore the longstanding interpretation of the Indian Self-Determination Act related to CSC payments.

Opioid Epidemic

The Northwest Tribes are facing an alarming opioid and Fentanyl epidemic that is disproportionately affecting Indian Country. The rate of illicit drug use for AI/AN's use is nearly twice as high compared to the rate for non-Hispanic Whites in the U.S. Recently, from 2020 to 2021, AI/ANs experienced a 33.8% increase in all drug overdose deaths compared to a 14.5% increase among the total U.S. population for the same period.



The Northwest Tribes need increased funding to address the opioid epidemic through self-governance and self-determination compacts and contracts. The IHS Special Behavioral Health grants and SAMHSA Tribal Opioid Response grants are difficult to access with the many administrative requirements of applying for and receiving grant funding. Grants do not provide administrative flexibility to allow the Tribes to establish programs that meet the needs of their own communities. Many tribes do not have grant specialists and the grant programs make tribes compete with each other for limited resources. This Subcommittee should consider ways to provide funding for behavioral health and opioid response through their contracts and compacts to address this growing opioid crisis in Indian Country.

The Northwest Portland Area Indian Health Board will be hosting a National Tribal Opioid Summit at the Tulalip Tribes, Washington on August 22-24, 2023. We invite the Subcommittee Members to come together in partnership with tribes to have meaningful discussions across federal, regional, and state decision-makers to address this epidemic.

Medicare and Medicaid

Medicaid and Medicare third party reimbursements are vital sources of revenue for the sustainability of tribal health programs. Tribal health programs continue to face barriers in recovering these third-party reimbursements to their full capacity despite federal law authorizing reimbursement. Some of these challenges include managed care plans inappropriately reimbursing tribal health programs, states that have not expanded Medicaid under the Affordable Care Act, lack of partnership between state and tribal health programs on eligibility. These challenges have resulted in high rates of uninsured AI/AN people. According to recent data, AI/AN adults had the highest rate of uninsured than any other race –25% of AI/AN nonelderly adults are uninsured.[8]

NPAIHB makes the following legislative requests related to Medicaid and Medicare:

Make permanent Medicare reimbursement for telehealth for tribal health programs.

[8] SAMANTHA ARTIGA, KENDAL ORGERA, & ANTHONY DAMICO, *Changes in Health Coverage by Race and Ethnicity since the ACA, 2010-2018*, HENRY J. KAISER FAMILY FOUND. (Mar. 5, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/

The NPAIHB, Affiliated Tribes of Northwest Indians, and National Congress of American Indians have called upon the states and the Centers for Medicare and Medicaid Services (CMS) to make Medicaid and Medicare reimbursement permanent for telehealth, including the use of audio-only calls beyond the COVID-19 Public Health Emergency (PHE).[9] The use of telehealth has expanded access to vital healthcare services to our AI/AN people. In order to maintain these services in tribal health programs, Northwest Tribes need to be able to continue to receive Medicaid and Medicare reimbursements at the OMB encounter rate. The Consolidated Appropriations Act of 2023 extended certain Medicare telehealth flexibilities through December 31, 2024. However, we ask this Subcommittee to enact legislation that permanently expands those Medicare telehealth flexibilities, including access to telehealth in patients' homes and through audio-only, and to remove any in-person requirements for mental health or substance use disorder treatment or any other services.

Expand Part B coverage to include pharmacists and community health providers.
Congress recently expanded Part B coverage for marriage and family therapists and mental health counselors in the Consolidated Appropriations Act of 2023. Although this was an important first step to expand behavioral health services for Medicare, we request that Part B is expanded to include Tribal pharmacists, certified community health aides and practitioners, behavioral health aides and practitioners, and dental health aide therapists.

Authorize Medicaid reimbursements for Qualified Indian Provider Services.
The Northwest Tribes request that the Subcommittee enact legislation that authorizes all Indian Health Care Providers to bill Medicaid for all Medicaid optional services as well as specified services authorized under the Indian Health Care Improvement Act regardless of whether the State authorizes those services in their Medicaid program for other providers. It's important that Congress honors their federal trust and treaty responsibility to provide healthcare to AI/AN people and that that responsibility and obligation should not be passed through states to provide healthcare.

Provide Medicaid reimbursements for services furnished by Indian Health Care Providers outside of an IHS or tribal facility (Four Walls Issue).
In 2016, CMS informed states that they have updated their payment policy for services received by AI/AN people through Indian Heath Care Providers (IHS or tribal health programs). Through further guidance in 2017, CMS clarified that IHS or tribal clinics could not receive reimbursement for services furnished to AI/AN people outside the "four walls" of their clinic. CMS has provided a grace period (which ends nine months after the end of the COVID-19 public health emergency) to allow states and tribes to come into compliance with this updated policy and to implement revisions to state Medicaid programs to create a Tribal Federally Qualified Health Center (FQHC) workaround. Many Tribal health programs provide health care services to their people in their community, such as community schools, community events, or in their

[9] *See* Nw. Portland Area Indian Health Bd. Res. 2022-03-03, *Call on Ctrs. for Medicare and Medicaid Servs. and States to Permanently Expand Telehealth* (2022); Affiliated Tribes of Nw. Indians Res. 2022-20, *Call on Ctrs. for Medicare and Medicaid Servs. and States to Permanently Expand Telehealth* (2022); Nat'l Cong. of Am. Indians Res. ANC-22-024, *Call on Ctrs. for Medicare and Medicaid Servs. and States to Permanently Expand Telehealth* (2022).

homes. Providing healthcare services in community and not just in the brick and mortar clinic has become an essential part of healthcare delivery in tribal communities.

In order to fix this "four walls" issue, we request this Subcommittee enact legislation that amends the "clinic services" definition to ensure that reimbursements for services furnished by IHS and tribal clinic services providers will be available wherever the service is delivered.

Conclusion

Thank you for this opportunity to provide testimony on our challenges and opportunities to improve the delivery of healthcare in honor of trust and treaty obligations to Tribal Nations. As evidenced by our testimony, when tribes are given control of health care funding and grant funding, tribes are creative, innovative and can reduce health disparities in their communities.

I invite you to visit the Northwest to learn more about our health care needs in our Area. I look forward to working with the Subcommittee on our requests and we are happy to share proposed legislative language for our requests.[10]

[10] For more information, please contact Laura Platero, NPAIHB Executive Director, at lplatero@npaihb.org or (503) 523-8723 or Liz Coronado, Senior Policy Advisor, at ecoronado@npaihb.org or (559) 289-9964.