NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
Indian Leadership for Indian Health

Public Witness Testimony of Nickolaus Lewis, Chairman
Northwest Portland Area Indian Health Board
House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies - FY 2022
May 19, 2021

Chair DeLauro, Ranking Member Cole, and Members of the Subcommittee: My name is Nickolaus Lewis, and I serve as a council member of the Lummi Indian Business Council, Chair of the Northwest Portland Area Indian Health Board (NPAIHB or Board), Vice-Chair of the National Indian Health Board (NIHB), I also serve on multiple federal agencies' Tribal Advisory Committees. I thank the Subcommittee for the opportunity to provide testimony on the FY 2022 Department of Health and Human Services (HHS) budget.

NPAIHB is a tribal organization, established in 1972, under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, that advocates on behalf of the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on specific health care issues. The Board's mission is to eliminate health disparities and improve the quality of life of American Indian and Alaska Native people by supporting Northwest Tribes in the delivery of culturally appropriate, high quality health care.

COVID-19 has dramatically impacted our tribes, states, the r nation, and the world. We are grateful for the diligent work and leadership of our Congressional representatives, ensuring that our tribal governments have access to federal and state resources to battle this pandemic. This pandemic has shown us the gaps in our responses, but we know that working together improves our ability to take care of our people. Tribal public health infrastructure is lacking, and in many instances, completely missing. This pandemic disproportionately impacted s our people with us being 3.5 times more likely to be infected, 5.3 times more likely to be hospitalized, and 1.8 times more likely

to die than non-Hispanic whites. This must not happen again so we bring recommendations that will help rebuild and repair the foundation needed to improve the Indian health care system.[1][2]

HHS AND ITS AGENCIES

For FY 2022, we ask this Committee to make the legislative changes needed across all HHS agencies to move away from grants and allocate funding to tribes through Indian Self-Determination and Education Assistance Act (ISDEAA) compacts and contracts. There must also be Tribal set-asides, and direct funding to tribes, not through state block grants.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Tribal Opioid Response. Tribal Opioid Response funding has allowed our tribes to develop programs to address this crisis with positive outcomes. For example, the Lummi Tribe has brought on success coaches for those using or in recovery. We need more funding for this program so request an increase in Tribal Opioid Response funding to at least $75 million; and an increase in the Tribal MAT funding to at least $20 million. The NPAIHB Northwest Tribal Epidemiology Center (NWTEC) has played a critical role in ensuring that Portland Area Tribes receive their share of the Tribal Opioid Response (TOR) funding. Tribal Epidemiology Centers are not allowed to directly apply for TOR funding for staffing, trainings or to provide technical assistance to subgrantees. For FY 2022, we request that SAMHSA set aside at least $2.5 million for Tribal Epidemiology Centers to administer TOR consortium grants, conduct trainings, and to provide technical assistance to subgrantees.

[1] 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.
[2] 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

Other Grant Programs. Thank you for the increases in the AI/AN Zero Suicide funding, the Tribal Behavioral Health Grants, the AI/AN Suicide Prevention Initiative, and the AI/AN Medication Assisted Treatment (MAT) Programs in FY 2021. For FY 2022, we request the following increases for Tribal Specific Programs: increase the Tribal Behavioral Health Grant program to at least $50 million -$25 million for mental health and $25 million for substance abuse - this funding is critically important as we manage the long-term impact of COVID-19; fund the Garrett Lee Smith Suicide Prevention Tribal Set Aside with at least $3.5 million; fund Zero Prevention Initiative with at least $3 million; and fund the National Child Traumatic Stress Initiative Tribal Set Aside with at least $1.5 million.

***Designated Resources for Youth Behavioral Health Programs*.** In order to comprehensively address the need for whole person mental health and substance use disorder services for AI/AN youth, there must be dedicated funding streams for culturally-centered prevention, intervention, treatment, aftercare and transitional living support for youth substance use disorder services. Youth Residential Treatment Centers that provide aftercare and transitional living for both substance use and mental health are a priority for Portland Area Tribes, the current facilities we have do not meet the demand. For FY 2022, we request $25 million in funding for youth-specific outpatient and inpatient mental health and substance use programs.

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Minority HIV/AIDS Fund. The Minority HIV/AIDS Fund is the only HHS funding source that includes funding to IHS for HIV and Hepatitis C (HCV) prevention, treatment, outreach and education. For FY 2022, we recommend that Congress provide at least $60 million for Minority HIV/AIDS Fund with at least $15 million to IHS**.**

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Public Health Infrastructure & Environmental Impacts. COVID-19 has demonstrated the under-investment made by the federal government in public health and medical care infrastructure in the Indian, Tribal, and Urban (I/T/U) health system. The I/T/U system is underfunded, and lacks capacity to respond effectively to public health emergencies like COVID-19. We can no longer allow population density as the primary consideration in the allocation of emergency preparedness resources. In FY 2022, we request that CDC provide at least $1 billion for a Tribal Public Health Emergency Fund established through the Secretary of HHS that tribes can access directly for tribally-declared public health emergencies.

Include Tribes in HIV/HCV Funding Opportunities. CDC HIV/HCV prevention and education generally flows to states via block grants, leaving many tribes with limited or no resources, and forcing tribes to compete with states for funding. For FY 2022, we recommend that CDC set-aside at least $25 million for HIV and HCV prevention in Indian Country.

Fund Good Health and Wellness in Indian Country (GHWIC). The GHWIC initiative supports AI/AN communities in the implementation of holistic and culturally adapted approaches to reduce tobacco use, improve physical activity and nutrition, and increase health literacy. With COVID-19, tribal communities are more focused than ever on the importance of traditional foods and the nutritional and healing qualities of these food in a time of crisis. Additional funding is needed to address food access issues, food insecurity, and support traditional food and local food system initiatives during COVID-19. NPAIHB recommends that the CDC allocate at least $32 million in FY 2022 for Good Health and Wellness in Indian Country.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicaid Legislative Initiative. HHS must work with Congress to pass legislation that creates the authority for states to extend Medicaid eligibility to all AI/AN people with household income up to 138% of the federal poverty level; authorizes Indian Health Care Providers (IHCP) in all states to receive Medicaid reimbursement for health care services delivered to AI/AN people under IHCIA; extends 100% FMAP to states for Medicaid services furnished by urban Indian providers permanently; and removes the limitation on billing by IHCP for services provided outside the four walls of a tribal clinic.

Medicare Telehealth Reimbursement. Because many AI/AN people live in rural areas and do not have access to reliable transportation, telehealth (and supported tribal broadband infrastructure) provide another way to take care of our people. Telehealth capacity and flexibilities must be made permanent at the appropriate OMB encounter rate, and expanded to support telephone-only telehealth visits, direct physician supervision of non-physician providers be provided remotely via telephone, expanded "originating site" locations from which telehealth services can be received, and inclusion of multiple platforms (including FaceTime, Zoom, and Skype).

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Provider Relief Fund Uninsured Program. The Families First Coronavirus Relief Response Act, P.L. 116-127, defines uninsured individual as an individual that is not enrolled in a Federal health care program thereby limiting access by IHCPs. IHS has been chronically underfunded as underscored in the Broken Promises Report. This limitation does not ensure the highest possible health status for AI/AN people by providing all resources necessary. We request that the Subcommittee support a legislative fix to clarify that Indian Health Care Providers can receive funding under any and all uninsured programs administered by HHS.