Seattle Indian Health Board
For the Love of Native People
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Testimony of Esther Lucero, MPP
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Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
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Chair DeLauro, Ranking Member Cole, and members of the House Committee on Appropriations – Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, my name is Esther Lucero. I am Diné, of Latino descent, and third generation in my family living outside of our reservation, I strongly identify as an urban Indian. I serve as the President & CEO of the Seattle Indian Health Board (SIHB), one of 41 Urban Indian Organizations (UIO) nationwide. I have had the privilege of serving SIHB for six years and have been providing congressional testimonials for the past four years. I am honored to have the opportunity to submit my testimony today requesting: the permanent authorization of 100% Federal Medical Assistance Percentage (FMAP) for UIOs; encouraging behavioral health parity and integration through workforce development initiatives across the U.S. Department of Health and Human Services (HHS) and Health Resource and Services Administration (HRSA); modifying the Substance Abuse and Mental Health Services Administration (SAMHSA) Government Performance and Results Act (GPRA) tool; increasing access to traditional health services through the Centers for Medicare and Medicaid Services (CMS); and increasing administrative time under the Indian Health Service (IHS) Loan Repayment Program. Addressing these key issues can advance the health of urban American Indian and Alaska Native (AI/AN) population.

SIHB is an Indian Health Service (IHS)-designated UIO and a HRSA 330 Federally Qualified Health Center, which serves nearly 5,000 AI/AN living in the Greater Seattle Area in Washington state. Nationwide, UIOs operate 74 health facilities in 22 states and offer services to over 5.4 million AI/AN people in select urban areas. As a culturally attuned service provider, we offer direct medical, dental, traditional health, behavioral health services, and a variety of social support services on issues of gender-based violence, youth development, and homelessness. We are part of the Indian healthcare system and honor our responsibilities to work with our Tribal partners to serve all Tribal people, wherever they may reside.

We are home to a Tribal public health authority, Urban Indian Health Institute (UIHI), 1 of 12 Tribal Epidemiology Centers (TEC) in the country and the only TEC with a national purview- serving both rural and urban AI/AN's. For over 20 years, UIHI has managed public health information systems, managed disease prevention and control programs, communicated vital health information and resources, responded to public health emergencies, and coordinate these activities with other public health authorities and UIO's nationwide. Due to a lack of access to disease surveillance data, UIHI released the

only AI/AN *COVID-19 Data Dashboard,*[1] providing critical disease surveillance data to the 45 UIO service areas ensuring AI/AN communities have access to culturally informed data collection, research, and evaluation.

Extend 100% Federal Medical Assistance Percentage (FMAP)
The American Rescue Plan Act of 2021 temporarily extended 100% Federal Medical Assistance Percentage (FMAP) to UIOs. For Washington state, the two-year temporary extension has resulted in $18 million in federal cost savings that will be captured in the Indian Health Improvement Reinvestment Account. The investment account will be able to expand its funding to activities, programming, and initiatives that improve the health of AI/AN people across the state of Washington.

The permanent extension of 100% FMAP to UIOs upholds the political status of Tribal citizens to ensure federal dollars provide Medicaid-coverage to urban AI/AN Medicaid beneficiaries. Permanent extension of 100% FMAP reduces state Medicaid expenditures, honors federal trust and treaty responsibility to AI/AN people and creates innovative healthcare delivery and systems changes to address social determinants of health experienced in AI/AN communities.

Encourage Behavioral Health Parity and Integration
We request HHS improve partnerships and invest resources with the Indian healthcare system to support recruitment and retention of health care professionals to support health integration, consumer demand, and identify need. A HRSA report found significant shortages of psychiatrists, psychologists, social workers, school counselors, and therapists across the country resulting in severe workforce deficits for Indian County.[2] For Washington state, HRSA has identified our area as having a Mental Health Professional Shortage Area, with only16.8% of mental health needs being met.[3]

We ask that HHS encourage behavioral health parity and integration by supporting initiatives to dual credential our providers to support vacancies. We request HHS mirror the Veterans Benefits Administration (VBA) dual certification process to support our providers. As AI/AN people are disproportionately represented in poor behavioral health outcomes, including higher rates of behavioral health conditions such as mental health, substance use, or suicide,[4] it is necessary for HHS to invest in behavioral health parity through workforce developments for Indian healthcare clinics.

To address the workforce shortage of the Indian healthcare system as a whole, we support the National Tribal Budget Formulation Workgroup Recommendations, which includes $1 billion to the Indian healthcare workforce development program to recruit and retain health professionals to address chronic and pervasive health care provider

[1] Urban Indian Health Institute (April 2022) COVID-1 Data Dashboard. Retrieved from: https://www.uihi.org/covid-19-data-dashboard/
[2] U.S. Department of Health and Human Services – Health Resources and Services Administration. (2016). National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025. Retrieved from: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf
[3] KFF. (2021). Mental Health Care Health Professional Shortage Areas (HPSA). Retrieved from: https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[4] U.S. Department of Health and Human Services – Office of Minority Health. (2021). Mental and Behavioral Health – American Indians/Alaska Natives. Retrieved from: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=39

shortages. In addition, we ask that HHS advocate for, prioritize, and support workforce development incentives at IHS, SAMHSA, and HRSA.

Increase Partnerships and Resources to Address Provider Shortages
As previously mentioned, we recommend HRSA support investments into the Indian healthcare system through workforce development and supporting dual credentialing of providers to address our workforce deficits and meet the needs of Indian Country.

In order to ameliorate the significant vacancy rates for the Indian healthcare system, and address challenges to filling the vacancies in our facilities, SIHB has a strong workforce development program which includes 6 family medicine residents, 6 public health interns, and 4 Master of Social Work program students. Of our 6 family residents, 4 identify as AI/AN and recent graduation rates show 80% of our previous residents go on to work in communities of color and 50% go on to work in Native communities. These types of training programs increase AI/AN representation in provider positions.

As we develop the next generation of Indian Health Care Providers, we must ensure that barriers for American Indian and Alaska Native providers are eliminated, and we must increase leadership and management opportunities for all Indian Health Care Providers in the LRP program. We recommend that IHS modify LRP program requirements to allow providers additional administrative time. Additionally, HRSA investments can support vacancies, salary comparison, incentives, training programs, and dual credentialing needed to support recruitment and retention of AI/AN representation in the healthcare workforce.

Mandate CMS Reimbursement for Traditional Health Services
We request CMS support the integration of Traditional health services as reimbursable services to improve access to quality health services for AI/AN populations. Improved access to Traditional health services support equity-based health care initiatives that are outcome-oriented, patient-centered, and support primary and preventative healthcare services.

In 2021, SIHB secured a SAMHSA grant to launch a Traditional Indian Medicine (TIM) pilot that will code Traditional health services into our Electronic Health Records (EHR) system and will replicate reimbursable services. UIHI will provide evaluation on the pilot to document the health benefits of integrating Traditional Practitioners as part of our wraparound services. SIHB has uniquely integrated our Traditional Practitioners into our clinical and social services teams to provide over 39,000 encounters through assessments, counseling, hospital visits, and group services. In March 2023, SIHB will release a report documenting our methods to credential Traditional Practitioners, code Traditional health services into EHR, replicate reimbursable billing, and health outcomes from this pilot.

The pilot will demonstrate how integrating traditional services in relatives' (patients) primary and preventative care can support and improve health outcomes of our relatives. Traditional health services can complement Western healthcare to support

culturally attuned care for AI/AN people and BIPOC communities across the nation. We will utilize our success story to advocate for Traditional health services being a standard practice across healthcare systems in the nation to advance health equity by supporting outcome-oriented, patient-centered, and primary and preventative healthcare services.

Modify the GPRA Tools for Low-Barrier and Culturally Attuned Services

The GPRA Modernization Act of 2010 modified the GPRA tool to better serve the needs of providers. Twelve years later, we desperately need the GPRA tool to be remodified to meet the modern needs of providers. The Administration, Congress, and local elected officials have all announced their efforts to address rising Substance Use Disorder (SUD) rates. However, the GPRA tool continues to be a burden to SUD access and treatment for our relatives due to the trauma triggering questionnaire. Additionally, the GPRA tool places a strain on our providers to meet required quotas. To ensure continued funding for our critical services, providers must commit their time and resources to fulling the requirements of the GPRA tool despite it not informing multidisciplinary teams of local clinics.

Today, the GPRA performance tool is burdensome to patients and providers. From providers in the Indian healthcare system, we have heard the GPRA tool is trauma triggering for patients, time intensive for patients and providers, and collects data that is solely beneficial for the federal government. The GPRA tool must be modified to be patient-centric, consider the time of our patients and providers, and avoid collecting unnecessary data that does not benefit local clinics. For example, UIHI and our medical division, are recipients of GRPA funds and certain questions related to behavioral health do not benefit our clinical team or research division.

We request HHS and SAMHSA modify the GPRA tool to be culturally attuned and low barrier to support the needs of our relatives. Additionally, we request HHS and SAMHSA modify the tool with the input of providers, patients, and Native experts to shorten the screening tool, ensure it is patient-centered, holds validity, administratively considerate, and informs providers of the immediate and long-term care of relatives.

Increase Administrative Time under the IHS Loan Repayment Program (LRP)

IHS has notified me amending the Loan Repayment Program (LRP) structure is a legislative fix that must be addressed by Congress. As the Indian healthcare system is severely understaffed, we must continue to implement unique initiatives to support our providers, which includes amending the IHS LPR to increase administrative time.

Under the current IHS LPR structure, medical providers are limited to 20 percent of FTE allocated to administrative time. While direct clinical care training is essential to the development of healthcare providers, we must acknowledge that administrative time is an opportunity to develop skillsets in leadership and operations management. I believe this amendment will support providers in the Indian healthcare system.