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TESTIMONY OF THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD ON THE 20TH ANNUAL U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES BUDGET

March 30, 2018

The Northwest Portland Area Indian Health Board (NPAIHB) thanks the U.S. Department of Health and Human Services (HHS) for the opportunity to provide this testimony on the FY 2020 HHS Budget. NPAIHB is a Public Law 93-638 Tribal organization that advocates on health care issues for the forty-three federally-recognized tribes in the states of Idaho, Oregon, and Washington[1].

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary-Secretary's Minority AIDS Initiative Fund (SMAIF)

SMAIF has been funded at $54 million for the past several years with $3.6 million to the Indian Health Service (IHS) for HIV/HCV prevention, treatment, outreach and education. Every year these funds are in jeopardy of being eliminated. The IHS has done an outstanding job managing the $3.6 million dollar SMAIF funds. SMAIF funding and Minority AIDS Initiative (MAI) funding go directly to federal agencies for dispersal in the form of grants, capacity building, infrastructure, etc. Agencies open to MAI funds include the CDC, HRSA, OMH and SAMHSA (among others). In FY 2017, $3.6 million of SMAIF dollars were allocated to IHS for HIV/AIDS and HCV prevention, treatment, outreach and education. There is no other direct and strategic funding for IHS through the MAI, only SMAIF funds are available to IHS.

Rates of HIV diagnoses increased for American Indians/Alaska Natives (AI/ANs) in the period from 2010 to 2014.[2] A total of 2,273 AI/ANs met the definition of newly diagnosed with HIV from 2005 through 2014, an average annual rate of 15.1 per 100,000 AI/ANs. Most (356/391) IHS health facilities recorded at least 1 new HIV diagnosis. The rate of new HIV diagnoses among males (21.3 per 100,000 AI/ANs) was twice as high as that among females (9.5 per 100,000 AI/ANs; rate ratio = 2.2; 95% confidence interval, 2.1-2.4); by age, rates were highest among those aged 20-54 for males and females. By region, the Southwest region had the highest number (n =1,016) and rate (19.9 per 100,000 AI/ANs) of new HIV diagnoses. Overall annual rates of new HIV diagnoses were stable from 2010 through 2014, although diagnosis rates increased among males ($P < .001$) and those aged 15-19 ($P < .001$), 45-59 ($P < .001$), and 50-54 ($P = .01$).[3] Moreover, AI/ANs are disproportionately affected by Hepatitis C virus and have both the highest rate of acute HCV (Hepatitis C) infection and the highest HCV-related mortality rate of any US racial/ethnic group. The AI/AN HCV-related mortality rate in Idaho, Oregon and Washington is over three times that of non-Hispanic whites.

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[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.l. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

[2] Health Equity Report 2017, available at https://www.hrsa.gov/sites/default/files/hrsa/health-equity/2017-HRSA-health-equity-report.pdf.

[3] Assessing New Diagnoses of HIV Among American Indian/Alaska Natives Served by the Indian Health Service, 2005-2014, available at http://journals.sagepub.com/eprint/BKmUmmb39hZemwFNfNxx/full.

Given this data, any proposed cuts to HCV/HIV funding will have far reaching and harmful impacts on Indian Country's ability to maintain ongoing HIV/HCV prevention, treatment, and outreach efforts. It will also have a devastating impact on the Tribes and Tribal Epidemiology Centers that carry out this important work.

The NPAIHB has several successful SMAIF projects:

National HIV Prevention Capacity Building and Technical Assistance: The capacity-building program has: increased routine HIV, STI and HCV screening in settings where widespread screening has not been previously performed; increased the availability of treatment for people living with HIV/AIDS (PLWHA); increased the availability of treatment for Hepatitis C positive people; carried out outreach activities to engage PLWHA and Hepatitis C people in diagnosis and treatment, especially reaching populations at disproportionate risk; advanced IHS customer service improvements with LGBT individuals, with special emphasis on appropriate services for MSM and transgender; and advanced IHS policy and procedures to address HCV needs of the service population, with special emphasis on services for people co-infected with HIV and HCV.

Most notably, the capacity building made available to IHS via SMAIF dollars has provided technical assistance for IHS to achieve the following in the most recent data: parental HIV Screening - 10,238 of 11,771 prenatal patients tested, for a screening rate of 87 percent; HIV Screening - 218,738 of 449,638 patients for a screening rate of 49.2 percent, (a nine percent increase relative to 2014 in unique persons tested for HIV for the first time); HCV screening of people born from 1945-1965 - 50,196 unique patients born between 1945 and 1965 (45 percent of total), have ever received an HCV test. This represents nearly a 26 percent relative increase over the 2014 screening coverage rate of 37 percent.

HCV-ECHO: The project works closely with I/T/U providers to screen, manage and treat patients infected with HIV/AIDS and hepatitis C virus (HCV) within existing systems I/T/U clinics nation-wide. Project ECHO is a collaborative model of medical education and care management that empowers clinicians to provide better care to more people, right where they live. The ECHO model does not actually "provide" care to patients. Instead, it dramatically increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub. As the ECHO model expands, it is helping to address some of the healthcare system's most intractable problems, including inadequate or disparities in access to care, rising costs, systemic inefficiencies, and unequal or slow diffusion of best practices. The HCV ECHO collaborative, started in February of 2017, has provided recommendations to 62 HIV/HCV patients and connected over 75 providers into the ECHO knowledge-sharing network.

Native Youth HIV Prevention and Outreach: *We R Native* is a comprehensive, multimedia health resource for Native youth, by Native youth. The service includes an interactive website (www.weRnative.org), a text messaging service (Text NATIVE to 97779), a Facebook page, a YouTube channel, Instagram, Twitter, and print marketing materials. Special features include 100+ Youth Ambassadors and an "Ask Auntie" Q&A service. In the last year, the website received over 84,000-page views; a 104% increase from the year before. We R Native's YouTube channel has 620 uploaded videos, with over 270,000 minutes watched. Altogether, *We*

R Native's sexual health messages reached nearly 2.5 million viewers last year, while promoting cultural pride, resilience, and youth empowerment.

Disseminating Effective Interventions**:** The website www.HealthyNativeYouth.org is a one-stop-shop for tribal health advocates to access engaging, age-appropriate sexual health curricula for AI/AN youth. The portal allows users to filter and compare curricula on several dimensions, to determine best fit. Since its launch in August 2016, the site has been accessed in all 50 states. In the last year, the website received over 7,400-page views; a 93% increase from the year before.

> **Recommendation**: We urge continued funding of SMAIF at $54 million OR an appropriation of $3.6 million for the Indian Health Service for HIV/HCV prevention, treatment, outreach and education.

INDIAN HEALTH SERVICE (IHS)

Full Funding for IHS

IHS is significantly underfunded compared to other federal health agencies. We request full funding for IHS and advance appropriations for IHS. At the very minimum, IHS should be receiving increases that address population growth and include medical inflation rate increases. Our tribes rely on annual increases to maintain current services. In addition, there is a long list of unfunded authorizations under the Indian Health Care Improvement Act (IHCIA) that, if funded, would address many of our needs, such as long-term care for our elders. Northwest tribes repeatedly request increases for purchased and referred care (PRC) because we have no hospitals in our area.

> **Recommendation:** Support full funding for IHS pursuant to the recommendation made by the National Tribal Budget Formulation Workgroup[4]; and support advance appropriations for IHS.

Joint Venture and Small Ambulatory Facilities Grants

The 2016 IHS/Tribal Health Care Facilities' Needs Assessment Report to Congress stated that the current priority list will not be complete until 2041 and at the current rate of construction appropriations and the replacement timeline, a new 2016 facility would not be replaced for 400 years. Portland Area Tribes have had to assume substantial debt to build or renovate clinics for Indian people to receive IHS-funded health care. Joint venture funding and small ambulatory facilities grant program are important funding sources to meet the needs of our smaller tribes who cannot compete in the existing new facilities construction priority system.

> **Recommendation:** We ask that IHS change its policy on funding for new facilities construction to ensure funding to all areas. In addition, and until the priority system changes, we request more funding be appropriated to the small ambulatory facilities grant program and joint venture projects.

[4] National Tribal Budget Formulation Recommendation FY 2020, available at https://www.nihb.org/legislative/budget_formulation.php

Expansion of the Community Health Aide Program (CHAP)

Request for Area CHAP Certification Board Pilot Project: NPAIHB and Portland Area Tribes have been positioning for an area level CHAP certification board structure. Area flexibility and area certifications boards will make implementation of CHAP in the lower 48 more relevant to each area, accelerate expansion, and ensure local buy-in for the CHAP program. NPAIHB agrees that there must be some federal baselines standards for services provided by any CHAP program and that IHS must ensure the regional certification boards and CHAP programs have a common baseline structure, curriculum, and standards to ensure consistency in the CHAP professions across all IHS, tribal, and urban Indian programs.

> **Recommendation:** IHS should partner with the NPAIHB to build a pilot program area level certification board in the Portland Area.

Oppose IHS's position on AFA Language for DHATs at Port Gamble S'Klallam

NPIAHB understands that the IHS opposed language in Port Gamble S'Klallam's Annual Funding Agreement (AFA) that would allow inclusion of dental health aide therapists (DHATs). IHCIA does not require that a policy be put in place before a tribe moves forward with a DHAT program. IHS's position is in direct opposition to tribal self-governance and self-determination.

> **Recommendation:** We ask IHS to reconsider its position and approve Port Gamble's AFA to allow the inclusion of DHATs.

Regional Specialty Referral Center in Portland Area

In 2009, the Portland Area Facilities Advisory Board completed a study to evaluate the feasibility of regional specialty referral centers in the Portland Area. Three regional specialty referral centers were proposed. The first one could be constructed as a demonstration project under the authorities in the Indian Health Care Improvement Act (IHCIA). The center would provide services such as medical and surgical specialty care, specialty dental care, audiology, physical and occupational therapy as well as advanced imaging, and outpatient surgery. It is anticipated that this facility could provide services for approximately 50,000 users within the regional service area as well as an additional 20,000 through telemedicine consults.

> **Recommendation:** We ask IHS to support a Regional Specialty Referral Center in the Portland Area.

Permanent Authorization for the Special Diabetes Program for Indians (SDPI)

Our tribes have seen positive outcomes for their people and are strong advocates for renewal of this program. We are appreciative of the inclusion of SDPI funding at $150 million for 2018 and 2019 in the Continuing Resolution (CR). Congress must enact long-term renewal (7 years or more) or permanent authorization of SDPI.

> **Recommendation**: Congress must reauthorize SDPI at $200 million per year with medical inflation rate increases annually.

Fund HCV Treatment

Native people are disproportionately affected by the Hepatitis C virus and have both the highest rate of acute HCV (Hepatitis C) infection and the highest HCV-related mortality rate of any US racial/ethnic group. AI/AN HCV-related mortality rates in Idaho, Oregon and Washington are over three times that of non-Hispanic whites and this disparity has persisted over time, demonstrating the need for enhanced and expanded access to HCV curative therapies. Lack of drug access is the single most important barrier to a scale-up of HCV treatment and liver disease prevention. Despite lower negotiated prices with federal suppliers, cost is a formidable hurdle to treating large numbers of patients and many private insurance companies and state insurance programs have instituted measures that restrict access to treatment. HCV drugs are not on the IHS formulary, so clinicians must spend considerable time mounting often unsuccessful attempts to get third-party payers such as private insurers, Medicaid, and patient-assistance programs to pay for them. There is precedent for HCV funding. Congress has appropriated annual funding to the VA (since 2014) to make these therapies available to veterans. The VA had nearly 200,000 HCV patients compared to IHS' approximate 40,000 patients.

> **Recommendation**: Support HCV Treatment for 40,000 patients at an estimated cost of $600 million –$1.5 billion (dependent on pharmaceutical prices).

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicaid Expansion, 100% FMAP and Affordable Care Act Subsidies (ACA)

The Medicaid program provides critical health coverage for AI/AN people and has also become a very important source of financing for health care for Indian health programs. Because the IHS budget has not received adequate increases to maintain current services, Medicaid provides additional revenue for Indian health care providers. Medicaid resources make up over 50 percent of many tribal health programs total funding. Most of the IHS budget increases are directed toward staffing new facilities and minimally financing inflation and population growth for Indian health programs. The increased coverage and revenue associated with Medicaid expansion has had a very positive effect on Northwest Tribal health programs. It is essential that the federal trust responsibility for Indian health care be honored, and 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS and Tribal facility is preserved. Portland Area Tribes are opposed to any reform proposals (e.g., block grants) that are designed to stop or reduce federal spending on these programs or that eliminate ACA subsidies. ACA subsidies make insurance affordable for some AI/ANs and many tribes have premium sponsorship programs that provide critical services to AI/ANs and bring in critical revenue to tribal clinics.

> **Recommendation:** Support continuation of Medicaid expansion, 100% FMAP for services through an IHS or Tribal facility, and ACA subsidies.

Reimbursement of Dental Health Aide Therapists (DHATs) and other Community Health Aide Providers (CHAP) Services

Portland Area Tribes has taken the lead in the lower 48 on the expansion of the Dental Health Aide Therapist (DHAT) Program. There are two working DHATs in Washington and two working DHATs in Oregon; and ten students in the Alaska DHAT training program from tribes in Washington, Oregon, and Idaho and one urban Indian program. And there are at least four tribes with students applying to the Alaska Dental Therapy Training Program Class of 2020. The

provision of services by DHATs must be supported and reimbursed by CMS. In addition, one tribe in our area is also in the process of developing a behavioral health aide program so reimbursement of other CHAP providers must also be considered.

> **Recommendation:** Given the great progress Portland Area has made, we ask for CMS to work with the NPAIHB and Portland Area Tribes to reimburse for DHAT and other CHAP services. We specifically request approval of Tribal Dental Health Aide Therapist (DHAT) State Plan Amendment (SPA), Washington State Plan Amendment (SPA) Transmittal Number 17-0027.

Exempt AI/ANs from Medicaid Work Requirements

Federally recognized tribes and tribal members have a political status with the United States and CMS should exempt AI/ANs from Medicaid work requirements. Unlike all other Medicaid enrollees, AI/ANs do not have to enroll in Medicaid in order to receive care. They can receive care at IHS or tribal facilities.

> **Recommendation**: CMS should exempt Indians from work requirements. In addition, CMS must honor tribes' request to have a meeting with the Office of Civil Rights.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

Opioid Crisis and Funding

Over 353,000 AI/AN people reside in Idaho, Oregon, and Washington, representing 6.8% of the nation's AI/AN population. This figure includes urban AI/AN people, as well as tribally-enrolled AI/ANs. The 43 federally-recognized tribes in the Pacific Northwest are diverse in terms of their population size, culture, geographic location, infrastructure, and economic and health opportunities.

Opioid prescriptions have risen dramatically over the past 15 to 20 years and the annual incidence of opioid overdose and deaths have also risen nationally. People in rural counties are nearly twice as likely to overdose on prescription painkillers as people in big cities and many tribal communities are located in rural areas. AI/AN communities experience disparities in many health outcomes, including opioid overdose deaths. In 2008, the year for which opioid analgesics accounted for over 40% of all drug poisoning deaths, the drug overdose death rate for AI/ANs was greater than all other races/ethnicities in the U.S. The opioid pain reliever-related overdose death rate for AI/ANs was 6.2 per 100,000 population in 2008. In 2010, the opioid overdose death rate among AI/AN women was 7.3 per 100,000 population, compared with a rate of 5.7 among white women and 4.2 among all U.S. women.

Prescription overdoses impact every family member in tribal communities throughout the Portland IHS Area (Idaho, Oregon, and Washington). Tribal elders are often raising their grandchildren, while fighting to help their child suffering from addiction. In the Portland IHS Area a race-corrected analysis found the age-adjusted drug overdose death rate for AI/ANs for opioid, prescription drug, and all drug overdoses to be twice that of non-Hispanic whites. This disparity in opioid and drug overdoses has persisted in Idaho, Oregon, and Washington since 1997. Drug overdose deaths from opioid misuse are of significant concern to tribal communities. From 2006 to 2012, a total of 10,565 deaths occurred among AI/AN residents in the states of

Idaho, Oregon, and Washington. There were 584,070 deaths among non-Hispanic White (NHW) in the three-state region. Drug overdoses accounted for 4.3% (450) of all deaths among Northwest AI/ANs and 1.7% (9,868) of all deaths among NHWs. Of the drug overdose deaths, 65.3% (294) of AI/AN deaths and 69.3% (6,837) of NHW deaths were from prescription drugs. Of the prescription drug overdose deaths, 77.2% (227) of AI/AN deaths and 75.4% (5,157) of NHW deaths were from opioid overdoses.[5]

Misuse of prescription opioids commonly leads to the use of other drugs, such as heroin in tribal communities. The National Institute of Drug Abuse noted that 21 to 29 percent of patients prescribed opioids for chronic pain misuse them, and 4 to 6 percent who misuse prescription opioids transition to heroin. Furthermore, the death rate for heroin overdoses among AI/ANs have dramatically increased, rising 236 percent from 2010 to 2014.[6]

NPAIHB appreciates the inclusion of $4 billion to fight the opioid crisis in FY 2018, particularly the $50 million set-aside for tribes and tribal organizations in the recently passed Consolidated Appropriations Act of 2018 (H.R.1625). The $5 million in FY 2018 appropriations specifically for tribes under the Medication-Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction program is also crucial for tribal clinics to implement the MAT program and administer the life-saving treatment.

Portland Area Tribes need direct funding and programs to address the opioid epidemic in their communities such as State Targeted Response to Opioid Epidemic grants (STR). Tribes should not have to compete for funding through states. Portland Area tribes request funding for both medicated-assisted treatment (MAT) and prevention; and funding for outreach, education and training on opioid use disorder (OUD), especially pharmacy education. In our area, the Swinomish Tribe has established an opioid addiction treatment center that includes wrap around services and a full continuum of care for patients- MAT, counseling, primary care and oral health services. Other tribes in the Portland Area are interested in establishing similar programs but are in need of funding to do this.

In addition, NPAIHB and our member tribes support the Mitigating Methamphetamine Epidemic and Promoting Tribal Health Act (METH Act) (S.2270), introduced by Senator Steve Daines (R-MT). This legislation would make tribes eligible for direct funding under the 21st Century Cures Act, which provides states with funding for opioid prevention and response. The bill would also allow for the funds to be used for prevention and response to other substances, such as methamphetamines. NPAIHB and our member tribes also support the Tribal Addiction Recovery Act of 2018 (TARA Act) (H.R. 5140). This legislation also makes tribes and tribal organizations eligible for direct funding under the 21st Century Cures Act and extends the use of the funds to also address other addictive substances such as alcohol, heroin and methamphetamine, including by providing mental health services.

> **Recommendation**: Provide direct funding to tribes to address the opioid epidemic, including funding to Tribal Epidemiology Centers.

Behavioral Health Workforce Development

[5] Northwest Portland Area Indian Health Board IDEA-NW Project. 2016. Unpublished death certificate data from Idaho, Oregon, and Washington.
[6] Dan Nolan and Chris Amico, How Bad is the Opioid Epidemic?, PBS.org (Feb. 23, 2016), available at https://www.pbs.org/wgbh/frontline/article/how-bad-is-the-opioid-epidemic/

The Community Health Aide Program (CHA) has been a successful program in Alaska and includes training and certification for behavioral health aides (BHAs). BHAs are selected by and for the community they serve which ensures culturally appropriate services. Lack of behavioral health providers is a significant issue and need in the Portland Area. The NPAIHB and Portland Area Tribes are leading the way in the development of a dental health aide therapy (DHAT) program (modeled after Alaska's program) and are now focusing on a BHA program. A behavioral health organization in Washington has funded the exploration and planning phase of creating a BHA training program in Washington.

Recommendation: SAMHSA must partner with IHS and Portland Area Tribes in our efforts to develop the behavioral health aide work force.