



**Statement of the National Indian Health Board  
to the United States House Committee on Energy and Commerce, Subcommittee on Health  
Combating the Opioid Crisis:  
Improving the Ability of Medicare and Medicaid to Provide Care For Patients  
For the Record of the United States Congress  
April 11, 2018**

**Introduction**

The National Indian Health Board (NIHB) would first like to thank Chairman Burgess for holding the hearing, “Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care For Patients” on April 11, 2018. NIHB is a 501(c)3, not for profit, national Tribal organization founded by the Tribes in 1972 to serve as the unified, national voice for American Indian and Alaska Native (AI/AN) health in the policy-making arena. Our Board of Directors is comprised of distinguished and highly respected Tribal leaders in AI/AN health. They are elected by the Tribes in each region to be the voice of all 573 Tribes at the national level.

Since 1972, NIHB has advised the U.S. Congress, Indian Health Service (IHS), and other federal agencies about health disparities and service issues experienced in Indian Country. As such, the current opioid epidemic represents one of the most pressing public health crises affecting Tribal communities. While this epidemic is affecting many communities throughout America, it has disproportionately impacted Tribes and has further strained the limited public health and healthcare resources available to Tribes. The federal government must take concrete action to ensure Indian Country has the tools it needs to address opioid abuse and heal Tribal communities. Medicare and Medicaid are vital components of the Indian health system and the unique needs of Indian Country should be taken seriously when considering legislation.

**Trust Responsibility**

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation’s obligations to the Tribes and the special trust relationship between the United States and Tribes. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace.<sup>1</sup> In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the federal government to American Indians and Alaska Natives (AI/ANs), declaring that “it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians – to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”<sup>2</sup>

The Indian Health Service is the primary agency by which the federal government meets the trust responsibility. IHS provides services in a variety of ways: directly, through agency-operated programs

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<sup>1</sup> The Snyder Act of 1921 (25 U.S.C. 13) legislatively affirmed this trust responsibility.

<sup>2</sup> 25 U.S.C. 1602

and through Tribally-contracted and operated health programs; and indirectly through services purchased from private providers. IHS also provides limited funding for urban Indian health programs that serve AI/ANs living outside of reservations. Tribes may choose to receive services directly from IHS, run their own programs through contracting or compacting agreements, or they may combine these options based on their needs and preferences.

Today the Indian healthcare system includes 46 Indian hospitals (1/3 of which are Tribally operated) and nearly 630 Indian health centers, clinics, and health stations (80 percent of which are Tribally operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 34 urban programs offer services ranging from community health to comprehensive primary care. To ensure accountability and provide greater access for Tribal input, IHS is divided into 12 geographic Service Areas, each serving the Tribes within the Area.

It is important to note that Congress has funded IHS at a level far below patient need since the agency's creation in 1955. In FY 2017, national health spending was \$9,207 per capita while IHS spending was only \$3,332 per patient.

### **The Opioid Epidemic in Indian Country**

The national opioid epidemic represents one of the great public health challenges of the modern era. The Centers for Disease Control and Prevention (CDC) noted over 64,000 drug overdose deaths in 2016 alone, largely driven by prescription and illicit opioids.<sup>3</sup> Among AI/ANs, the rate of drug overdose deaths is twice that of the general population, according to the IHS. Deaths from prescription opioid overdoses increased four-fold from 1999 to 2013 among AI/ANs.<sup>4</sup> The CDC reported that AI/ANs consistently had the highest drug overdose death rate by race every year from 2008-2015, and the highest percentage increase in drug overdose deaths from 1999-2015 at 519%.<sup>5</sup>

Regional data trends further demonstrate the high burden of the opioid epidemic within Tribal communities. According to the State of Alaska Epidemiology Center, AI/ANs had the highest overdose death rate by race from 2009-2014 at 20.2 deaths per 100,000 population. In Minnesota, the Department of Human Services reported that the age-adjusted death rate due to drug poisoning is four times higher among AI/ANs compared to Whites. Further, despite representing roughly 1.1% of the population for the state, AI/ANs accounted for 15.8% of those who entered treatment for opioid use disorder. Similarly, the Washington State Department of Health reported that from 2011-2015, the opioid overdose death rate was highest among AI/ANs at a rate of 29 deaths per 100,000 compared to 12 deaths per 100,000 for Whites. These statistics illuminate the critical need for more comprehensive interventions in Tribal communities to improve prevention and treatment measures.

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<sup>3</sup> National Institute on Drug Abuse. 2017. Overdose Death Rates. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

<sup>4</sup> Indian Health Service. New effort targets drug overdoses in Indian Country. Retrieved from <https://www.ihs.gov/newsroom/pressreleases/2015pressreleases/new-effort-targets-drug-overdoses-in-indian-country/>

<sup>5</sup> Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. *MMWR Surveill Summ* 2017;66(No. SS-19):1–12.

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Addressing the opioid epidemic is a nationwide priority; however, access to critical opioid prevention and treatment dollars are not reaching many of the Tribal communities that are in serious need of these funds. As sovereigns, Tribes are not systematically included within statewide public health initiatives such as the recent prevention and intervention efforts created through the new opioid crisis grants found in the 21<sup>st</sup> Century CURES Act.

### **Medicare and Medicaid's Role in Tribal Health**

The IHS by law is the payer of last resort for Tribal members receiving health care. If AI/AN members are enrolled in Medicare or Medicaid (or employer or private insurance) those are billed first for reimbursement of services.

In authorizing IHS to bill Medicaid, Congress also took steps to ensure that the Federal government did not shift responsibility for Indian health care to the States. Congress amended the SSA to provide for 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS or Tribal facility. This provision ensures that all Medicaid services provided to AI/ANs that are received through an IHS or Tribal facility are reimbursed to the States at a 100% match by the United States. It was an express recognition of the federal government's treaty obligations for Indian health. The House Committee Report stated that since the United States already had an obligation to pay for health services to Indians as IHS beneficiaries, it was appropriate for the United States to pay the full cost of their care as Medicaid beneficiaries.<sup>6</sup>

Congress intended that Medicaid funding be supplemental to IHS funding, and not replace it. As a result, Congress enacted a provision of law that ensures that Congress must not take into account collections from Medicare, Medicaid (and later, CHIP) in determining IHS appropriations.<sup>7</sup>

Medicaid has proven to be a critically important resource for IHS and Tribal health systems. The funding it has provided has helped extend scarce IHS discretionary appropriations, including Purchased/Referred Care (PRC) funding. PRC funding is used to cover the cost of care by providers outside the IHS system when an IHS or Tribal facility cannot provide the service itself. Medicaid helps extend PRC funding, which otherwise routinely runs out before the end of the year. ou

### **Medicaid and Medicare's Role in Tribal Responses to the Opioid Crisis**

In Tribal communities, specialty care is often deferred or delayed due to lack of funds at the Indian Health Service. For example, the FY 2018 IHS Congressional Budget Justification noted that the FY 2016 budget denied an estimated \$371.5 million for an estimated 80,000 in services. As a result of these denials, patients are often forced to utilize prescription opioids instead of getting needed surgeries. This leads to increased dependency on opioids and little incentives to change the problem. However, if a patient is Medicare or Medicaid eligible, they have more options for obtaining needed surgery.

Congress should ensure that Medicare and Medicaid patients are better tracked to limit "pharmacy shopping." Patients are currently able to fill their opioid prescriptions at any pharmacy, and can travel from one to another in order to obtain prescription opioids, with some patients even traveling across state

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<sup>6</sup> H.R. REP. NO. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

<sup>7</sup> 25 U.S.C. § 1641(a).

lines if they live in a border town. When patients travel across state lines it makes it harder to track them through the prescription drug monitoring program (PDMP) system, given that most, if not all, states lack data sharing agreements or ban data sharing altogether. Additionally, CMS should establish additional training for all providers –*including those working in the Indian health system* – to provide guidelines for prescribing non-cancer pain management and treatment. Those trainings should be specific to cultural needs in Tribal communities and be grounded in the role of traditional medicine. In Oregon, for example, the state banned prescribing opioids for spinal injuries and other forms of back pain. National standards – with appropriate engagement from stakeholders, including Tribes – should be created and disseminated to reduce risks provided by prescription pain management.

In 2017, the Office of Inspector General (OIG) within the United States Department of Health and Human Services (HHS) released a report stating that roughly 33% of Medicare Part D beneficiaries received an opioid prescription in 2016, amounting to roughly \$4.1 billion in spending. Moreover, the OIG reported that roughly half a million Part D beneficiaries received an average dosage of greater than 120mg a day for at least 3 months, despite the fact that the 2016 CDC guidelines for opioid prescribing for chronic pain recommended no more than 90mg a day. To put that in context, 120mg is the equivalent of 16 tablets of 5mg Percocet per day.

CMS updated a Medicare Part D Opioid Drug Mapping Tool in late 2017 that allows the public to investigate provider opioid prescribing practices across the country. The data includes the providers name, zip code, state, opioid prescription count, and prescribing rate. Although this is an important resource, it does not include information about where and when the prescriptions were filled, how many (if any) refills were provided, the dosage, and demographics of the patient. In addition, the information does not include the provider’s place of employment, making it difficult to determine if there are any notable differences in prescribing rates between Tribal and IHS providers and other providers. In addition, it was not clear how CMS was intending to utilize the tool – whether it be to launch investigations into unscrupulous prescribing practices, or to identify providers who required additional training.

It is noteworthy to point out that physicians are required under the Drug Addiction Treatment Act (DATA) of 2000 to complete trainings and obtain a waiver to administer MAT drugs like buprenorphine, while no such trainings are mandated as a precondition for prescribing opioids which can lead to opioid use disorder (OUD).

The NIHB recommends that CMS work with the Drug Enforcement Agency (DEA) – which has jurisdiction over DATA 2000 waivers – and the Substance Abuse and Mental Health Services Administration (SAMHSA) – which has been largely responsible for administering MAT trainings and grants – to establish and require routine prescription opioid and substance use trainings for all Medicare and Medicaid billing providers as a precondition for renewing their license and retaining the authority to prescribe opioids.

The NIHB also recommends that the CMS Part D Opioid Drug Mapping Tool collect employment information so that the IHS and Tribes are able to track if providers on their payroll are engaging in suspicious or risky prescribing practices.

### **Improving Medicare and Medicaid's Data Sharing in Tribal Health Settings**

Data is the backbone of public health. However, for many Tribal health departments and epidemiology centers, access to timely, accurate and complete datasets are far from the norm. The 2010 permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) provided states with a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid services rendered to AI/ANs, and solidified a direct relationship between the Centers for Medicare and Medicaid Services (CMS) and the IHS that was further ensured by amendments to the Social Security Act.

Compounding the issue is the high probability of a Tribal member being racially misclassified on their health records. As previously cited, due to racial misclassification on death certificate data, the actual opioid death count among AI/ANs may be underestimated by as much as 35%. Without timely and accurate access to patient health data, it is close to impossible for a Tribe or Tribal epidemiology center to maintain accurate records of vital statistics, to quantify disparities in health outcomes between AI/ANs and other populations, or to ultimately make assessments of need.

Tribal health systems need improved access to national health surveillance systems that have been disaggregated by race and ethnicity. This is particularly important given that existing data collection systems such as Prescription Drug Monitoring Programs (PDMPs) do not collect patient race or ethnicity information or the patient's medical condition. In addition, only the state of Alaska has explicitly authorized IHS prescribers and dispensers to access PDMP data. Although the IHS has taken steps to both train and require their providers to utilize the PDMP system, it is a critical issue that only one state has decreed special access for IHS providers despite their being federal-recognized Tribes in 36 states across the country.

The current PDMP system is state-based, meaning that each state has outlined its own regulations around surveillance, data reporting and data sharing. For instance, only a handful of states have authorized data sharing across state lines, while most states either restrict data sharing or have simply not engaged other states in data sharing agreements. In addition, states have different reporting guidelines meaning that while in one state providers are required to update the system with any new prescriptions within 24 hours, other states allow providers to take as long as a month to update the system. Establishing a system that streamlines and standardizes PDMPs would improve the overall effectiveness of the program by eliminating inconsistencies in how data is collected, analyzed and accessed.

The NIHB recommends that Congress find a solution to the current PDMP model that prioritizes efficiency, accountability and timeliness in data reporting and access, while also improving surveillance of AI/AN health conditions, including opioid overdoses and dependence rates. This will help ensure that Tribes have the necessary data to make decisions and identify needs.

### **Support Needed for Tribal Solutions**

Behavioral health initiatives in Tribal communities have the most potential for success when the program integrates traditional healing practices with Western models of care such as MAT and mental health counseling. For instance, the Port Gamble S’Klallam Tribe of Washington developed the Tribal Healing Opioid Response (THOR) initiative. The THOR program integrates evidence-based best practices such as expansion of access to MAT and naloxone with culturally-appropriate wellness activities such as powwows, youth and elder social events, and traditional games and community activities.

The program is designed to meet three overarching goals: to prevent opioid misuse and abuse; expand access to opioid use disorder treatment; and prevent deaths from overdose. The program utilizes an integrated approach that involves every sector of government and the community including the Tribal council, police force, health services divisions, youth workers, wellness staff, and community advocates and leaders. By employing an integrated approach, the THOR project is able to foster stronger community support and buy-in, diversify its stakeholders, and reach a wider net of at-risk populations.

The program’s broad reach and holistic approach have gained the support of powerful stakeholders, which will help ensure the long-term effectiveness and uptake of the program. Some immediate outcomes include established partnerships with the Washington State Department of Health and the Olympic Community of Health, which brings together county and Tribal health officials to improve interagency coordination of addiction and overdose response efforts. In addition, the Port Gamble S’Klallam Tribal Council recently approved the adoption of the Washington State Good Samaritan Law, which provides civil and criminal protection for individuals who provide assistance to anyone experiencing an overdose.

Another Tribally developed program with great promise is the Chickasaw Nation of Oklahoma “Define Your Direction” campaign which encourages youth to make healthy choices and be positive role models when it comes to resisting prescription drug misuse and underage drinking in their communities. The program materials include videos, online and social media communications, and information on local behavioral health resources. The program has received support and funding from SAMHSA and the Southern Plains Tribal Health Board. The program has focused on youth not only to bolster primary prevention activities, but also because Chickasaw youth have been particularly impacted by the opioid crisis. For instance, American Indians living on Chickasaw Nation reported a statistically significant higher rate of prescription opioid misuse within the past 30 days compared to non-Natives living in Chickasaw, while 54% of youth who stated that they used prescription opioids in the past 30 days to get high shared that they obtained those drugs from friends or family.

Although these programs highlight the positive work being done in Tribal communities to address the opioid epidemic, many more resources are needed to develop a compendium of Tribal best practices to address behavioral health issues such as high rates of OUDs and substance use disorder (SUD). Nevertheless, examples of effective models that have been developed to treat other health conditions can and should be adapted to address behavioral health priorities. One nationwide example includes the Special Diabetes Program for Indians (SDPI). SDPI has been responsible for A1C levels among AI/ANs nationwide going down by an entire percentage point. In addition, rates of End Stage Renal Disease – one of the biggest contributors to Medicare costs – have decreased by 54%. Moreover, SDPI demonstrates a real life example of Western medicine working in tandem with traditional healing practices to create

major, positive gains in treating and preventing disease in Tribal communities. Medicare and Medicaid programs should embrace models like this for behavioral health.

NIHB also supports the expansion – and commensurate Medicaid and Medicare reimbursement – of the Community Health Aide Program (CHAP) to Tribes outside of Alaska. CHAP is an excellent example of reform that was developed in response to a need for providers in Alaska. CHAP, a Tribally created and driven model, was developed in response to unique Tribal communities’ needs. CHAP trains local residents to provide basic health care, assuring that health services are available in the local community from culturally competent providers who speak the Native language. For more than 50 years, CHAP has proven as an effective method for diminishing the health disparities of Alaska Natives. Community based, culturally-informed providers are desperately needed in the Indian health system. Behavioral Health aides (which are part of the CHAP program in Alaska) are a potential solution to fill this need in Indian Country. However, in order for them to be effective and provide quality care, they must be trained, not just on treatment, but also prevention, aftercare, and post-vention. As IHS works to expand the CHAP in the coming year, it is critical that both Medicare and Medicaid allow reimbursements for these types of providers.

The NIHB recommends that the Subcommittee investigate Tribal best practices to learn more about the high success rates of these programs, and encourages the Subcommittee to communicate directly with these and other successful Tribally-based initiatives in order to improve broad awareness, support and secure future funding. Programs like Medicare and Medicaid provide vital support to the Indian health system, and Congress should ensure that the Tribal community programs able to bill for third party reimbursement can incorporate traditional healing practices. Tribes have demonstrated their ability to counter OUD and SUD when given the resources and flexibility they need to ensure these programs are effective.

### **Conclusion**

NIHB and the Tribes stand ready to work with the House Subcommittee on Health to develop new or improve existing regulations, programs, and funding streams that will assist Tribal Nations in addressing the opioid epidemic. We thank Chairman Burgess for this opportunity to provide our comments and recommendations for how Medicare and Medicaid can better work to reduce the scourge of opioid related deaths and dependence rates and look forward to further engagement with the Subcommittee on curbing the opioid epidemic within Tribal communities.

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