National Indian Health Board

Submitted via email to: opioids@finance.senate.gov

February 16, 2018

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: United States Senate Committee on Finance: Request for Comments on the Role of Medicare and Medicaid in Addressing the National Opioid Epidemic

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the National Indian Health Board (NIHB), I write to submit recommendations on workable solutions to current Medicare and Medicaid regulations and programs as they relate to addressing the national opioid epidemic.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care and public health to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area directly with the NIHB. Whether Tribes operate their healthcare program through contracts or compacts with the Indian Health Service (IHS) under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

The opioid epidemic is one of the most pressing public health emergencies facing the United States today, and has been especially devastating to Tribal Nations across the United States. As you know, Medicare and Medicaid are significant sources of health coverage for AI/ANs, while also providing a substantial degree of third-party revenue for the IHS. We urge the Finance Committee to ensure that any proposed changes to the regulatory framework of Medicare and Medicaid, as it relates to addressing the opioid epidemic, lead to a reduction in overdose deaths and improved health outcomes for all AI/AN communities.

Background

The United States has a unique legal and political relationship with Tribal Nations founded upon the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions.

Central to this relationship is the federal government's trust responsibility to protect the interests of Indian Tribes, including the provision of healthcare and public health services to AI/ANs.

Despite the trust responsibility, Tribes were largely excluded from many of the government's initiatives to build the country's public health infrastructure. Today, Tribes remain underfunded and have fewer resources with which to support Tribal public health systems, activities, and the public health workforce. These obstacles have made it particularly difficult for Tribal communities to assemble a coordinated and comprehensive response to major health emergencies, including the opioid epidemic.

According to the Centers for Disease Control and Prevention (CDC), in 2014 the opioid-related death rate for AI/ANs was 8.4 per 100,000 – tied with non-Hispanic Whites for the highest rate by race in the country. In a CDC Morbidity and Mortality Weekly Report (MMWR) from October, 2017, AI/ANs were reported to have the highest drug overdose death rate by race in 2015, and the highest percentage increase in drug overdose deaths from 1999-2015 at 519%. Moreover, the 2015 National Survey on Drug Use and Health reported that AI/ANs over the age of 12 had the highest rate of misuse of prescription drugs by race, and were tied with non-Hispanic Whites in reporting the highest rate of prescription drug usage within the past year. Even more striking, the CDC reported that due to high rates of racial misclassification on death certificate data, that the actual overdose death count among AI/ANs may be underestimated by as much as 35%.

Regional statistics further demonstrate the extent of the epidemic within AI/AN communities. The Oregon Department of Health reported that from 2011-2015, AI/ANs died of drug overdoses at a rate of 12.4 per 100,000, compared to a rate of 8.2 per 100,000 for Whites and 8.4 per 100,000 for Blacks. In the state of Utah, the opioid death rate among AI/ANs from 2010-2014 was 13.4 per 100,000, second only to non-Hispanic Whites. Similar statistics in the states of Nevada, Michigan, Colorado and Washington identify AI/ANs as having either the highest or second highest opioid overdose death rates by race. Despite the alarmingly high drug overdose and dependence rates within AI/AN communities, past and current appropriations have not answered the level of need.

The Role of Medicare and Medicaid

Medicare and Medicaid services, including Medicaid expansion, have provided needed support to many Tribal communities by reducing the uninsured rate, increasing access to and reimbursement for inpatient and outpatient treatment services, and expanding access to life saving drugs such as Naloxone. Medicaid, especially, is a critical part of how the federal government fulfills its trust responsibility to AI/ANs. However, most Medicaid funds to combat the opioid crisis (as well as other federal funds) have gone to state agencies, leaving Tribes behind. It is critical that Congress consider the unique challenges and opportunities in the Indian health system as it looks to make reforms to Medicare and Medicaid as it relates to the opioid crisis.

Below, the NIHB has provided comments and recommendations based on the questions outlined in the Finance Committee's letter.

1. ***How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDs?***

No national "gold standard" exists to guide physicians on the proper duration or dosage of prescription opioid treatment for non-cancer related pain. Further compounding the problem is the limited availability of trainings for providers on proper prescribing, and limited provider education on substance use prevention and treatment protocols and procedures. For instance, a report by Pacira Pharmaceuticals in 2017 indicated that 90% of patients who undergo a surgical procedure are subsequently prescribed opioids, typically averaging around 85 pills. Many of these pills are then diverted, given that studies have shown between 67 and 92 percent of patients have opioid pills left over after common surgical procedures. According to Pacira, that equates to roughly 3.3 billion pills per year left unused by patients who've undergone surgery. This is critical as 55% of people who misuse prescription opioids are obtaining them from friends or family, according to the 2015 National Survey on Drug use and Health. More importantly, Pacira indicated that so much as a 10% reduction in postsurgical opioid prescriptions could lead to 332 million fewer unused pills per year flooding communities, 300,000 fewer people each year becoming persistent opioid users, and $830 million in annual savings in drug costs alone.

As more and more reports are released that illuminate the controversial tactics of pharmaceutical companies in promoting prescribing of opioid medications, the attention must now be turned to educating and incentivizing providers to build their knowledge of substance use disorder (SUD) and opioid use disorder (OUD) and the proper prevention and treatment protocols. For instance, prior authorization for prescribing buprenorphine is currently in place in 48 Medicaid programs. The American Medical Association (AMA) has called for prior authorization to be removed for medication-assisted treatment (MAT), as the requirement to obtain prior authorization can potentially serve as a disincentive to physicians to administer MAT. Other barriers include fail first protocols that require physicians to exhaust all other treatment options prior to prescribing MAT. Modern medical science acknowledges MAT as the best evidence-based practice available to treat SUDs and OUDs. In order to address the crisis, it is imperative that regulatory barriers in prescribing MAT be eliminated. Finally, much more needs to be done to address the stigmatization of SUDs and OUDs by providers and communities. This persistent stigma can serve as a disincentive to physicians to treat patients with SUD or OUD.

Currently, every state Medicaid program covers at least one out of the three primary types of medication-assisted treatments (MAT), with a significant portion of state Medicaid programs covering all three. As reported by the Kaiser Family Foundation, states that opted to expand Medicaid had a higher percentage of their spending on buprenorphine financed by Medicaid compared to states that did not expand Medicaid (average 29% versus 15%). An analysis by Wen et al. (2017) on the impact of Medicaid expansion on utilization of buprenorphine demonstrated that state expansion was associated with a 70% increase in buprenorphine prescriptions, and a 50% increase in Medicaid spending on the drug. This is significant for two reasons. One, buprenorphine is one of the most effective forms of MAT currently available for treating OUD and SUD; and

two, buprenorphine is a relatively expensive drug with an average price tag of $4,000 to $5,000 per year per patient who is on a daily regimen.

There are several issues with the way MAT and behavioral health services overall are currently administered by state Medicaid agencies that can pose challenges.

One, there is no national gold standard on the appropriate duration of MAT treatment, as reported by the Medicaid and CHIP Payment and Access Commission (MACPAC). This has led to a great deal of variability in duration of MAT treatment, which is not only an ineffective approach in treating OUDs or SUDs, but can also be dangerous and counterproductive.

Two, states differ in their coverage of behavioral health services. For instance, as of 2015, only 21 state Medicaid programs covered some form of intensive outpatient services, and only 26 states covered some form of non-detoxification related inpatient care, such as residential facilities. Current clinical guidelines suggest that MAT services be supported by mental health counseling, case management and other forms of behavioral health services in order to support a whole-person health and wellness approach.

Three, there are currently 11 state Medicaid programs that have imposed lifetime limits on the use of buprenorphine. This is inconsistent with clinical best practices as they relate to MAT treatment. It also contradicts modern medical pedagogy, which advocates for treating substance addiction as a chronic disease.

Four, although the Comprehensive Addiction Treatment and Recovery Act (CARA) authorized nurse practitioners and physician assistants to apply for a buprenorphine waiver, restrictive laws in 28 states have limited nurses' scope of practice. For instance, some states require nurse practitioners to be working alongside a physician who has a federal buprenorphine license, while other states explicitly prohibit nurse practitioners from prescribing buprenorphine regardless of whether or not a physician works alongside them. This is particularly challenging in rural and Tribal communities that may have highly limited access to physicians.

Tribal communities face even larger obstacles. According to the IHS Division of Behavioral Health, there are currently no IHS facilities that operate MAT programs, and only eight Tribally-run MAT programs across Indian Country. In addition, according to data from the Substance Abuse and Mental Health Services Administration (SAMHSA), there are 46,525 providers nationwide who are currently certified to administer MAT, amounting to roughly 930 providers per state. In comparison, only 28 providers throughout the entire Indian Health system – which spans the IHS, Tribal, and Urban clinics and hospitals – are certified to administer MAT. This is a tremendous gap that restricts Tribes from delivering the services their communities need, especially given that drug overdose and dependence rates are on average much higher in Tribal communities.

The NIHB recommends that CMS work with SAMHSA, IHS and DEA to expand reimbursement for MAT services, increase provider education and training in MAT, and eliminate current reimbursement and policy restrictions that limit access to MAT, counseling services, inpatient and residential treatment services, and burdensome prior authorizations.

2. ***What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?***

Healing patients in Tribal communities when it comes to Opioid or Substance Abuse Disorders must be done as a combination of both Traditional healing methods and Western Medicine therapies like MAT. However, there is little funding available for the financial support of these services through Medicare and Medicaid programs. Research demonstrates that AI/ANs do not prefer to seek mental health services through Western models of care due to the lack of cultural sensitivity; suggesting that AI/ANs are not receiving the services they need to help reduce these alarming statistics.[1]

We recommend embracing the reimbursement of traditional healers and other traditional medicine practices to help heal the whole person, not just treat medical needs. For example, the Special Diabetes Program for Indians (SDPI) was created over 20 years ago to target the high rates of type 2 diabetes in AI/AN populations. This innovative program uses a combination of clinical and traditional healing methods to reduce the risk and complications of type 2 diabetes. It has worked. A1C levels among AI/ANs nationwide are down by an entire percentage point and End Stage Renal Disease – one of the biggest contributors to Medicare costs – has decreased by 54%. SDPI demonstrates that using a combination of Western medicine and traditional healing practices can make major, positive gains when it comes to treating and preventing disease in Tribal communities.

NIHB also supports the expansion – and commensurate Medicaid and Medicare reimbursement – of the Community Health Aide Program (CHAP) to Tribes outside of Alaska. The Community Health Aide Program (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.

Additionally, NIHB supports S. 1879 which would allow Medicare reimbursement for marriage and family therapist services and mental health counselor services under Medicare, exclude such

[1] Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. American Journal of Psychiatry, 162, 1723-1732.

services from the skilled nursing facility prospective payment system, and authorize marriage and family therapists and mental health counselors to develop discharge plans for post-hospital services. Again, this would help provide reimbursement for these professionals who can provide a lifeline for those struggling with OUD or SUD.

3. **How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives for beneficiaries to access evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?**

The NIHB recommends that CMS incentives Certified Electronic Health Record Technology (CEHRT) and Certified Addiction Rehabilitation Facility (CARF) accreditation. Certified Electronic Health Record Technology (CEHRT) could be used to track best practice outcome related incentives; CMS could establish criteria to capture relevant clinical data including screening at each visit and in instances of self-reported use or abuse, conduct initial assessments to demonstrate need for referral to appropriate treatment centers. Providers reporting screening, assessment and referral could receive enhanced reimbursement for intervention efforts for fee for service. There should be no caps on fee for service including the frequency and type of service for Opioid Use Disorder (OUD) and Substance Use Disorder (SUD) diagnosis codes (DSM-IV and ICD-10).

Utilizing CEHRT, criteria focused on advancing clinical outcomes could be expanded upon the Stage 1 set for physician groups, to include criteria captured at the treatment center level, including clinical outcomes. Clinical indicators would be achieved based on best practice outcome criteria, using evidenced based approaches. Treatment Centers could be incentivized to attain best practice status, using evidenced based treatment modality through Certified Addiction Rehabilitation Facility (CARF) accreditation. CARF accreditation requires evidenced based treatment, quality assurance measures and patient monitoring. Enhanced reimbursement fee for service could be attached to CARF accreditation. Additional incentives could be included for treatment centers that share relevant Opioid Use Disorder (OUD) and Substance Use Disorder (SUD) patient data with referring providers. Using CEHRT, clinical outcomes could be tracked, including patient treatment milestones, wrap around supportive services access, relapse incidence and patient monitoring. Enhanced reimbursement could be attached to clinical outcomes.

4. **Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?**

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 even patients traveling across state 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 made to reduce risks provided by prescription pain management.

5. **How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?**

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 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.

6. **What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?**

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.

In addition, section 130 of IHCIA included a provision establishing Tribal epidemiology centers (TECs) as public health authorities under the Health Insurance Portability and Accountability Act (HIPAA).

This authority grants TECs access to protected health information "…*for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions*."[i]

Nevertheless, misinterpretation of the HIPAA privacy rule in addition to restrictive state and local laws have imposed limitations in TEC access to vital AI/AN health data. In addition, many TECs report a lengthy and time-consuming process for establishing data-sharing agreements with state and local governments, and also cite expensive fee requirements as further barriers in timely and complete access to AI/AN health information.

These setbacks have impacted the Tribal response to the opioid epidemic. For instance, some services rendered to AI/ANs are under the IHS Purchased/Referred Care (PRC) program. These services are medical or dental care services that are provided outside of the I/T/U system. Unfortunately, there is no federal requirement for non-I/T/U providers to return the PRC data to the Tribe. This is particularly challenging because of common scenarios such as when a Tribal member is transported by ambulance off of a reservation to receive health services for an overdose at a county hospital or clinic. Unless the Tribe has a data-sharing agreement established with that hospital or clinic, the data related to that encounter would not return to the Tribe.

Further 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.

7. **What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?**

Treatment centers should be supported in efforts to attain Certified Addiction Rehabilitation Facility (CARF) accreditation and to improve existing accredited facility capacity to provide evidence based treatment. The effort could be supported by individual grants to facilities and entities such as Tribal and state governments to establish or improve facilities, and enhanced reimbursement for facility fee for service. In addition, wrap around services (social, nutritional, counseling and medical services) focused on patient centered care, enhanced medication access such as buprenorphine for acute instances and step-therapies using a nurse manager model could be supported by the Medicare payment system. Patients in treatment abuse specialty programs would be assisted to attain primary care providers, social services and outpatient treatment, with community based nursing service following a case managed model. This approach enhances assessment of home related factors that influence relapse, incorporating a preventative approach to patient centered care.

8. **What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?**

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.

Although the program is still in its initial stages, its 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 SUDs. Nevertheless, examples of effective models that have been developed to treat other health conditions can and should be adapted to address behavioral health priorities. Examples include the SDPI program and the CHAP program. As previously mentioned, the SDPI program 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.

The NIHB recommends that the Committee investigate Tribal best practices to learn more about the high success rates of these programs, and encourages the Committee to communicate directly with these and other successful Tribally-based initiatives in order to improve broad awareness, support and secure future funding.

The NIHB also recommends that the Congress work to establish a Special Behavioral Health Program for Indians that is based on the SDPI model. The incredible success of SDPI can and should be duplicated in other arenas to continue building the capacity of Tribes to address health issues in a manner consistent with Tribal values and best practices. NIHB and the Tribes stand ready to work with the Senate Committee on Finance to develop new or improve existing regulations, programs and funding streams that will assist Tribal Nations in addressing the opioid epidemic. We thank you 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 Committee on curbing the opioid epidemic within Tribal communities.

Please contact NIHB Congressional Relations Director Caitrin McCarron Shuy at cshuy@nihb.org with any questions or comments.

Sincerely,

Vinton Hawley,
Chairman, National Indian Health Board

[i] Id. § 164.512(b)(1)(i).