NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

2121 S.W. Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

SENT VIA ELECTRONIC TRANSMISSION: opioids@finance.senate.gov

February 16, 2018

Chairman Orrin G. Hatch (R-UT)
Ranking Member Ron Wyden (D-OR)
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: **Comments on Senate Finance Committee Opioid Input Solicitation Letter**

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of Northwest Portland Area Indian Health Board (NPAIHB) and Portland Area Tribes, I write to submit comments to the Senate Finance Committee (Committee) on federal health and human services policy recommendations impacting the opioid epidemic, issued in a solicitation letter on February 2, 2018. The 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] The Committee must take into consideration the unique health care system that serves American Indians and Alaska Natives (AI/ANs) as well as health disparities that plague tribal communities.

Background

The United States has a unique legal and political relationship with tribal governments established through and confirmed by 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 and communities, including the provision of healthcare and public health services to AI/ANs.

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. We know that people in rural counties are nearly twice as likely to overdose on prescription painkillers and

[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

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/AN 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.

In the Portland IHS Area (Idaho, Oregon, and Washington) 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 Oregon and Washington since 1997. About 1 in 10 AI/ANs aged 12 or older used prescription painkillers for nonmedical reasons in the past year, compared to 1 in 20 whites and 1 in 30 blacks. AI/AN residents of Oregon also have the highest opioid overdose death rate of any other race/ethnicity in the state. The Oregon Department of Health reported that from 2011-2015, AI/ANs died of drug overdose 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.

AI/ANs face barriers to receiving quality medical and behavioral health care, due in part to chronic underfunding of IHS, tribal, and urban Indian clinics, and stigma associated with accessing behavioral health care in some communities. Limited access to specialized health care services contributes to and exacerbates disparities in nonfatal and fatal opioid overdose among AI/ANs. Indian reservations are often located far from urban centers where specialized health services for opioid addiction treatment are available. Indian reservations span across county and state boundaries. Federally recognized tribes, as sovereign nations, can elect to have IHS provide all health care services for their tribes, including substance abuse treatment and mental health services, or they can choose to take the funding for all or part of these services and deliver health care services themselves. Although the rules governing health care delivery for federally recognized tribes are uniform across the U.S., there is significant heterogeneity within and between IHS Areas regarding services administered by IHS, Tribes, and Urban Indian health clinics. In 2014, there were only eight tribal health facilities with medication assisted treatment (MAT)/ office-based opioid treatment (OBOT) services, and six tribal programs with MAT/OBOT policies and procedures.

Lack of Opioid Funding and Resources for Tribes

There is a drastic need for more funding and resources to address this crisis in tribal communities. Section 10003 of the 21st Century Cures Act provides grant funding for the State response to the opioid abuse crisis, however no grant funding was set-aside for tribes.[2] Therefore, tribes are left out of statewide public health initiatives, such as prevention and intervention efforts created through the state opioid crisis grants. Eligibility for the state targeted response to the opioid crisis grants (STR) was statutorily limited to single state agencies, thus tribes could not apply. The grant

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] Public Law 114-255, December 13, 2016

directed states to identify communities of focus at highest risk for opioid use disorder (OUD). States are also expected to address differences in access, service use and outcomes for their population of focus. Of the 35 states that have federally recognized tribes, 16 states acknowledged tribes as a population of focus and/or specified actions being taken to combat opioids in tribal communities. In the Northwest, no tribal clinics received funds to combat the opioid epidemic in tribal communities and only the state of Washington included tribes as a high-risk population of focus. Northwest Tribes have expressed overwhelming concern with the high costs for providing the actual MAT doses to OUD patients without reimbursement from federal healthcare programs. We request that the Committee consider providing funding for MAT reimbursement to health care providers treating OUD patients. Our tribes need as much financial assistance from federal healthcare programs as well as direct funding and programs to address the opioid epidemic in their communities. Tribes should not have to request or receive funding through states.

The Role of Medicaid and Medicare for Tribes

AI/ANs are among the nation's most vulnerable populations, and yet the IHS remains woefully underfunded. IHS is currently funded at around 60% of need,[3] and average per capita spending for IHS patients is only $3,688 compared with $9,523 nationally.[4] Most of our citizens live in areas of chronic unemployment, which leaves many of them without any form of coverage other than Medicare and Medicaid. Without supplemental Medicaid resources, the Indian health system would not survive. Medicaid is a critically important resource for the Indian health system and provides critical funding to increase access to and reimbursement for inpatient and outpatient treatment services, and expanding access to life saving drugs, such as Naloxone. However, most Medicaid funds to combat the opioid crisis (as well as other federal funds) have gone to state agencies and large urban hospitals, leaving Tribes behind. It is critical that the Committee 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. The Committee must also contemplate the differences for Medicaid beneficiaries who reside in Medicaid expansion states versus non-expansion states. For example, Medicaid expansion has assisted with a lower uninsured rate, but tribal clinics will always take care of uninsured patients who are falling through the cracks.

Policy Recommendations

Opioid use disorder is a devastating and life-threatening chronic medical condition, and the Senate Finance Committee needs to create legislation for tribes to improve access to treatments that support recovery and lifesaving medications to reverse overdoses.

NPAIHB and our member tribes are supportive of an evaluation of how health programs under the Committee's jurisdiction can include the pain management and substance use disorders needs of tribes. The Committee must utilize Northwest tribes as partners and a best practice model while creating legislative language. Tribal clinics in the Northwest serve both native and non-native patients in rural underserved areas in the Northwest.

[3] Indian Health Service, Frequently Asked Questions, https://www.ihs.gov/forpatients/faq/.
[4] Indian Health Service, IHS 2016 Profile, https://www.ihs.gov/newsroom/factsheets/ihsprofile/.

The Committee must take into consideration the unique status of AI/ANs as well as the unique health care system that serves AI/ANs. Legislation must assist in expanding access to integrated services and reach critically underserved AI/AN people. The Committee also must consider that Medicare and Medicaid payment incentives do not work in tribal clinics because of the unique health care system that services AI/ANs, chronic underfunding of the Indian health system, limited health care resources available to tribes, and lack of infrastructure, including outdated electronic health record systems.

The majority of Northwest tribal clinics have limited resources and health care providers; therefore, they do not have their clinics set up to provide MAT services for the opioid use disorder (OUD) and substance use disorder (SUD) patients. It is a significantly expensive venture for tribal programs to provide OUD and SUD services. Tribes are constantly competing for specialized unique population funding. Northwest tribes are heavily dependent on their purchased and referred care (PRC) program funds to refer patients outside of the community, which can take too much time and distance for tribal patients. The general purpose of PRC is for IHS and tribal facilities to purchase services for specialty care services in situations where: 1) no IHS or tribal direct care facility exists; 2) the existing direct care element is incapable of providing required emergency and/or specialty care; 3) utilization in the direct care element exceeds existing staffing; and 4) supplementation of alternate resources (e.g., Medicare, Medicaid, or private insurance) is required to provide comprehensive health care to eligible AI/AN. We recommend that the Committee works to expand reimbursement for MAT services and eliminate current reimbursement and policy restrictions that limit access to MAT, counseling services, inpatient and residential treatment services, and burdensome prior authorizations.

Best Practices

NPAIHB recommends that the Committee investigate tribal best practices to learn more about the success rates and needs of these programs, and encourages the Committee to communicate directly with the Northwest tribes and NPAIHB in order to improve broad awareness, support and secure future funding.

Tribes cannot be limited to the types of services they provide due to the lack of reimbursement for services or financial assistance. There are no actual resources for tribes to provide direct OUD and SUD services, especially with the high costs associated with the capitol construction of an OUD and SUD clinic and no certainty to get reimbursed. Additionally, there is a need for wrap around services and a full continuum of care including daily monitoring of dosages. The Swinomish tribe in Washington, could no longer wait for federal or state entities to assist or supplement OUD and SUD treatment services because in the county the opioid overdose mortality has increased by 42% in the last decade. Swinomish in response to this public health crisis recently developed a treatment model and built a new tribally-financed, tribally-owned, and tribally-managed opiate outpatient treatment facility. The projected service population for the first year is 200 patients, 350 patients in the following years, and will require a minimum of 20-25 staff.

Currently, there are four other Washington tribes that are exploring providing OUD and SUD services in their tribal clinics and therefore the state of Washington should be a potential design-model for other states.

A best practice policy recommendation to be considered for tribal clinics or rural clinics is financial assistance and incentives for an integrated continuum of care for OUD patients. Although, it is difficult to truly integrate our services. Washington tribes have opted for all their Indian Medicaid patients to be opted out of managed care organizations (MCOs) and behavioral health organizations (BHOs), but if patients are in need of more intensive treatment they need to get their patients enrolled in MCOs or BHOs. The Swinomish Tribe utilizes an integrated continuum of care model that is a unique whole-person treatment model with a full-service approach unlike what clinics have traditionally offered. The Swinomish opiate treatment facility offers outpatient treatment services, primary medical care, mental health counseling, medication assisted therapies, shuttle transportation, on-site childcare, as well as case management and referrals. However, none of these services are funded through federal or state funds.

Another best practice for the Committee to consider is the inclusion of funding similar to the Methamphetamine and Suicide Prevention Initiative (MSPI), which began in 2009. The MSPI allows flexibility for organizations and tribes to tailor it to their community needs of prevention-based versus treatment-based.

Non-Pharmaceutical Therapies

Federally funded health care programs should include reimbursement for non-pharmaceutical therapies and alternative methods to treat pain. There are limited types of non-pharmaceutical therapies that are reimbursable, therefore tribes must rely on the ability to use PRC program funds. Physical therapy, oral health services, and acupuncture are examples of additional therapies and services that OUD patients need.

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.

NPAIHB 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 model, a Tribally created and driven system, 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 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.

Prevention, Identification, and Education of Health Professionals

A best practice for prevention and identification is the inclusion of culturally responsive and community relevant prevention, treatment, and aftercare practices for OUD patients (i.e. Methamphetamine and Suicide Prevention Initiative (MSPI) Healing patients in tribal communities must be done through traditional healing and cultural practices along with MAT. However, funding is very limited for the financial support of traditional services to Medicare and Medicaid beneficiaries. AI/ANs do not prefer to seek mental health services through Western models of care due to the lack of cultural sensitivity; furthermore suggesting that AI/ANs are not receiving the services they need to help reduce these alarming statistics

A significant problem that must be addressed 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. Therefore, NPAIHB and the Northwest tribes recommend more outreach, education and training on opioid use disorder (OUD), especially pharmacy education. We recommend that Medicare and Medicaid design prevention and non-pharmaceutical therapy tools for individuals and curtail it towards culture and community. Currently, patients have a misconception that if it is prescribed it is not an issue. Additionally, the Committee must consider including peer support services.

The various federal and state prescription monitoring programs are helpful, but there is a need for more sufficient monitoring programs because of the large number of prescribers who are still over-prescribing.

Data Sharing and Coordination

There is a need to streamline data sharing and reporting. Tribes have limited support and training to do case management through their electronic health record (EHR) and Resource Patient Management System (RPMS). Tribal Epidemiology Centers (TECs) must be included as partners in data sharing and coordination. The Tribal Epidemiology Center (TEC) program was authorized by Congress in 1996. Due to their placement in tribal organizations, TECs, now designated as Public Health Authorities and having research capacity, are uniquely positioned to implement prevention, surveillance, training, research and technical assistance programs with member tribes. Over the past twenty years, the NWTEC has developed innovative strategies to monitor and address the health and wellness needs of AI/AN, many of which are now used nationwide. NPAIHB employees maintain professional partnerships with every state health department in the

Northwest and partnerships with the federal government. In addition, NPAIHB projects work closely with universities and tribal schools in the region, other regional TECs, and other project stakeholders to provide the best possible services to its 43 member tribes.

Conclusion

We thank you for this opportunity to provide comments and policy recommendations and look forward to further engagement with the Senate Finance Committee on legislation impacting the Northwest tribes plagued with the opioid epidemic.

If you have any questions about the information discussed above, please contact Laura Platero, Government Affairs/Policy Director at (503) 407-4082 or by email to lplatero@npaihb.org.