Health News & Notes

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POLICY ISSUE

TRIBAL SPONSORSHIP: LESSONS LEARNED AND CHALLENGES AHEAD

By Mim Dixon

It was five years ago that the Patient Protection and Affordable Care Act (ACA) was signed into law. During the first three years, Northwest Portland Area Health Board (NPAIHB) worked with other Area Health Boards to understand the potential benefits of ACA for Indian health. Models were developed to estimate the costs and benefits of Tribal Sponsorship programs to pay the portion of the health insurance premiums that was not subsidized through tax credits. To create those models, assumptions were made because a lot of key information was unknown at the time, such as the cost of premiums. Now we know a lot more than we knew when those models were developed. We've been through one enrollment cycle in 2014 and we have started on the second cycle in 2015.

According to information presented by the Centers for Medicare and Medicaid Services (CMS) at the Tribal Technical Advisory Group (TTAG) Data Symposium on February 19, 2015, at the end of the open enrollment period for 2015, approximately 24,000 people had enrolled in plans with cost sharing protections for American Indians and Alaska Natives (AI/AN) through the federally-facilitated Marketplace (FFM), including about 20,000 in zero cost sharing plans and 4,000 in limited cost sharing plans. While AI/AN can enroll at any time though out the year, these numbers are lower than expected considering that it includes those who had enrolled in 2014 and re-enrolled the following year.

The combination of exemption from the penalty and access to care through the Indian health system results in little incentive for AI/AN to purchase health insurance. Tribal Sponsorship programs are essential to eliminate the economic barrier to purchasing insurance. In addition, Tribes must find other incentives to get people to enroll and assist them with the enrollment process.

On the positive side, Tribes have found that their Tribal Sponsorship program has cost less than they planned, enrolled fewer people than they projected (because more

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CHAIRMAN'S NOTE

Andy Joseph, Jr
NPAIHB Chairman
Confederated Tribes of Colville Council Member

The beginning of the year always marks a very busy time for us all at the Board. It began with the new 114th Congress coming in a laying out their priorities for the next two years. The President also submitted the FY 2016 budget to the Congress. IHS national budget formulation and the HHS Department-wide budget meetings were also conducted in February. And then in March I testified before the House Interior Appropriations Subcommittee on the IHS budget. Finally, in late January we learned that the IHS director could not remain in an acting role and Dr. Yvette Roubideaux had to step down and was replaced by Robert McSwain as the Acting Director. As you can see, it has been a very busy time, there have been lots of events, and we're only three months into the new Congress.

I continue to co-chair and attend the important IHS Contract Support Costs (CSC) Workgroup meetings. The CSC Workgroup met in Rockville on January 29-30, 2015. The Workgroup continues to work with IHS on strategies to stabilize CSC funding and allocation issues. We do not want the federal government's requirement to pay CSC to compete with IHS program increases. The President's budget proposes to move CSC funding from the discretionary budget and making it an entitlement. This is a positive first step and commitment by the Administration and I hope Congress will support it. The Workgroup is also working on re-establishing the fixed CSC Pilot Project Program which allows Tribal programs that have demonstrated contracting and compacting stability to develop fixed CSC rates over a fixed term. This helps stabilize CSC administrative issues for both the IHS and Tribes. The Workgroup also continues to work on many other CSC issues.

In February I attended the Affiliated Tribes of Northwest Indians (ATNI) winter conference in Lincoln City. The Board continues to do an effective job of conducting the ATNI Health Committee meetings. We shared our 2015 Legislative and Advocacy Plan at ATNI as well as other important health updates. I also testified before the Washington State Legislature on the Tribal Dental Health Aide Therapist (DHAT) bills introduced by Senators John McCoy and David Sawyer. Unfortunately, it does not appear that these bills will not pass in this session. On February 23-25th, I attended the NCAI winter session in Washington D.C., and also made our annual lobbying trips. This was a very important because it allows the Board to start to develop relationships with new members. It also helps to begin to develop relationship with new staff. This all is very important to our work in the legislative process. During our hill visits we presented our legislative plan and FY 2016 IHS budget priorities. Later in the same week I attended the HHS Annual Department-wide budget meetings.

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CHAIRMAN'S NOTE

In March, I attended the HHS Regional Tribal Consultation meetings held in Seattle, Washington. I want to commend Susan Johnson, HHS Region X Administrator; she did a remarkable job of developing the agenda and getting the right folks to the meeting. I thought this year's consultation meetings were very effective. We have already received that consultation report and there are good commitments from the HHS Agencies to respond to the tribal issues presented at that meeting. We'll be sure to monitor this to make sure the commitments are followed through.

On March 24th, I testified before the House Interior Appropriations Subcommittee, in which we presented the Board's Annual Budget Analysis recommendations. Our priorities this year were to fund mandatory costs (inflation and population growth), we cautioned about funding $185 million in construction due to recurring staffing dollars that will follow, more funding for contract health care, and support to make CSC funding mandatory.

The Board also continues to be active to attend and staff the Direct Service Tribes Advisory Committee (DSTAC) meetings. The last meeting was held in Nashville and unfortunately was not well attended since it was an ice storm. I know our delegates Greg Abrahamson from the Spokane Tribe and Janice Clements from the Warm Springs Tribes are very involved in the work of the DSTAC and attend all the meetings for our Portland Area.

I hope you enjoy this edition of the newsletter and we look forward to the next quarter as we continue to work to support all our member Tribes.

Andy Joseph, Jr., Chair
Colville Tribal Council

Northwest Portland Area Indian Health Board

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people had access to other types of health insurance, including Medicaid), and produced better results than anticipated in both revenues to the Tribally-operated clinic and savings for Purchased/Referred Care (PRC). When Tribes can help people enroll in bronze plans, the premiums are much lower than was ever predicted in the early models, often as low as $1 per month.

A few Tribes have been very successful in their Tribal Sponsorship programs and they have been willing to share their experiences with the Tribal Self Governance Advisory Committee (TSGAC) Success Stories project. Consumers have also shared their experiences. While this project is still underway, some preliminary observations are offered here. If your Tribe has not already started a Tribal Sponsorship program consider this advice:

1. Form a multi-disciplinary Tribal Sponsorship Workgroup in your clinic. The workgroup should include leadership from patient registration, Contract Health Services (CHS) or Purchased/ Referred Care (PRC), the billing department, medical services, and others who might be able to help, such as Human Resources.

2. Start small with a pilot project and then expand. The pilot project allows the Tribe to establish its policies and procedures, train staff, and test systems to see how they are working. Modifications can be made before the program is expanded.

3. Integrate Tribal Sponsorship with the PRC program. After the pilot project, successful Tribes have turned from "outreach" to "in-reach." This is done by changing the PRC policies to require people to see if there are alternate resources available, including enrollment in an insurance plan with Tribal Sponsorship, before PRC will pay for care. This is the motivation to get people to enroll, much the same as Medicaid eligibility. To make this work, staff must be trained to do enrollment assistance and the Tribe must be prepared to pay the unsubsidized portion of the premium, as well as any costs to the consumer for tax preparation and additional taxes.

4. Make the consumer experience seamless with PRC. Many consumers who are enrolled in insurance through the Marketplace do not understand the complexities of the system, do not know whether they have zero cost sharing or limited cost sharing plans, and do not want to use their insurance in a way that may cost them additional money. However, they are very familiar with PRC and the process for getting referrals for PRC. A seamless system makes it look to them like they are using PRC, even when their insurance is paying. In places where PRC funding is limited and a priority system limits referrals, consumers with insurance are grateful that they can get care that would not otherwise be authorized.

5. Select one or two insurance plans and work with the insurance companies to pay for all premiums with a single payment each month. The Tribe will likely have to keep a spreadsheet that lists the people covered, their premiums, the portion paid by the Tribe and the months of coverage. If premiums are paid for a year at a time, then this needs to be tracked and the Tribe should be able to apply its Tribal Sponsorship payments to other individuals if a person enrolled in the program dies.

6. Tribal clinics should join the provider networks for the plans they use for Tribal Sponsorship. This is really important for making the consumer experience seamless with PRC. As in-network providers, the referral process (both internal to Indian Health and required by health plans) can implemented without the patient's involvement or action. Both staff and patients feel like they have one system and this creates a feeling of simplicity, rather than being overwhelmed by complexity. PRC has to have the knowledge to manage the complexity "behind the curtain." The payment rate for providers who are in-network may be lower than desired, but it is more likely that the clinic will be paid.

7. Ask people who are enrolled through a Tribal Sponsorship program to authorize a Tribal representative to go on-line to review their account. It is nearly impossible for Tribes to know how much the insurance company has

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spent on behalf of a patient for services provided outside the Tribal clinic, unless they have access to the on-line information that is equivalent to a summary of Explanation of Benefits (EOBs). Access to this information allows the Tribe to get a true picture of the return on their investment in Tribal Sponsorship. This important to communicate to Tribal members and Tribal Leaders to obtain their continuing support for a Tribal Sponsorship program.

In addition to these best practices, we are learning about policies that make the costs of Tribal Sponsorship higher in some states than others. The most obvious one is that people living in states without Medicaid Expansion who would otherwise qualify for Medicaid Expansion are not eligible to receive tax credits for insurance premiums. Another problem that drives up the cost of health insurance for Tribes is that multi-state plans offered through the Marketplaces do not give AI/AN the option of bronze plans. These are often the only policies that offer broad networks for those who live near a state border and seek their care in another state. The federal Office of Personnel Management (OPM) should require issuers to offer bronze plans. Insurance can also be more expensive if states allow plans to charge a higher premium for people who smoke, for example in Idaho. ACA allows states to do this, so Tribes must work at the state level to change this policy.

Acknowledgements: Many thanks to all who shared their experience and advice, including the leadership and staff at Coeur d'Alene Tribe and Citizen Potawatomi Nation.

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CDC Tribal Consultation Advisory Committee with the Senior CDC staff at CDC TCAC quarterly meeting - February 10, 2015

NETWORK ADEQUACY IN INDIAN COUNTRY

By Melissa Gower

Over the past year tribes have discussed the problems with securing contracts with the Marketplace Qualified Health Plans, companies who offer insurance plans on healthcare.gov. During the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group (CMS TTAG) meetings this subject has been a long standing agenda item. CMS has always responded in the same way, that all qualified health plans have certified they have offered a contract to all Indian health care providers in their service area. From the discussions with various tribes, we have known that the response is not in fact what has happening. Therefore, the Tribal Self-Governance Advisory Committee (TSGAC) decided to do a study on "Network Adequacy and Essential Community Provider Inclusion in Indian County". The study began in late fall of last year and has continued. The plan is to have it completed in the next 30 days or so.

The authors of the study decided to select five states to perform a survey with various Indian health care providers, including Indian Health Service and Tribes. One of the states chosen was the State of Oregon. The State of Oregon began their marketplace adventure as a state-based exchange called "Cover Oregon." However, in 2015 Cover Oregon transferred some their functions to the federally-facilitated marketplace. The Affordable Care Act was written to enable the United States population to have affordable access to health care. One of the major pieces of the legislation is Medicaid Expansion for all states. This provision was overturned by the Supreme Court and made Medicaid Expansion optional for states, rather than mandatory. As of March, 2015 there are 29 states that have chosen to expand Medicaid and the State of Oregon was one of those 29 states. This is great news for the Indian health care providers in that area.

Since the state based exchanges passed their own regulations and rules to govern their exchanges some of them included requirements that required all qualified health plans to offer contracts to all Indian health care providers in their area and some did not. The same is true for a requirement to use the CMS Model Indian Addendum. Over the years there have been numerous issues that have become barriers to insurance companies utilizing their standard contracts to contract with Indian health care providers, such as, hours of operation, licensure of health professionals, etc. The CMS Model Indian Addendum ensures those barriers are overcome and allows a smoother contracting process for Indian health care providers. In the State of Oregon's regulations, Cover Oregon does require all qualified health plans to offer contracts to all Indian health care providers, but do not require the use of the CMS Model Indian Addendum.

For the study, we chose the northern part of Oregon, including Jefferson, Polk, and Umatilla counties which has both Indian Health Service and tribally operated health systems included. The Portland Area Indian Health Service covers the states of Washington, Oregon, and Idaho and operates six Federal health facilities in five Tribal communities and one at Chemawa Indian School. Tribes operate health facilities under the authority of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), Titles 1 and V. Twenty-three Tribes have Title V compacts and there are twenty-four Tribes or Tribal organizations that contract under Title 1. Overall, Tribes administer more than 74% of the Portland Area budget authority appropriation through Self-Determination contracts or Self-Governance compacts. In Oregon, the Indian Health Service operates two outpatient health centers, and four (4) Tribes provide outpatient health services.

We chose two tribally operated health centers and one Indian Health Service facility for the study. A survey with 10 or so questions were sent to each of the facilities. The qualified health plans that are offered in the facilities' zip code was obtained as well

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as the provider networks the Indian health care facility participates. Some states have very few qualified health plans and some have a lot of qualified health plans. Oregon has numerous health plans that are offered, which vary by zip code.

A review of the information obtained from the Oregon Indian health care facilities has shown that most of the qualified health plans in the State of Oregon have offered a contract to each of the Indian health care facilities. As a result of these offers to contracts, most of the Indian health care providers do have a contract with the majority of the qualified health plans in their service area. However, for the most part the qualified health plans did not offer to include the CMS Model Indian Addendum as a part of the contract offer. Upon speaking with some of the Indian health care facilities, it was clear they were not aware that the CMS Model Indian Addendum had been finalized and was available for them to use in contracting with the qualified health plans. That is very unfortunate because a lot of the issues and barriers that kept a contract from being finalized with some of the qualified health plans would have easily been solved by using the CMS Model Indian Addendum in the contracting process.

During the last CMS TTAG meeting, Indian Health Service reported that IHS Portland Area had enrolled 6,258 consumers in Medicaid and CHIP programs. They also reported that 653 consumers had been enrolled in a Marketplace plan. A total of 18 in-network contracts were established in 2014 in the IHS Portland Area. I am sure that is due to the large number of qualified health plans in the area and also that the IHS Portland Area spans a three-state area.

An interesting outcome was that the Indian Health Service facility did not pursue or complete any contracts with the qualified health plans. Also, some of the tribally operated health centers reported they have not pursued obtaining contracts with any qualified health plans because they have not chosen to move forward with a Tribal Sponsorship Program.

However, for the most part the regulations to offer a contract to all Indian health care providers in the state were followed in Oregon.

Melissa has been working as a Health Policy Analyst with the Oklahoma City Area Inter-Tribal Health Board over the past year and a half serving tribes in Oklahoma, Kansas, and Texas. One of her objectives has been working on the Special Protections and Provisions for American Indians in the Affordable Care Act.

MEDICAID WAIVERS ISSUES AND OPPORTUNITIES FOR TRIBES

***By Elliott Milhollin, Esq.*[1]**

The Center for Medicare and Medicaid Services (CMS) has broad authority under the Social Security Act to issue waivers that allow states to make fundamental changes to their Medicaid programs. CMS's waiver authority offers both a challenge and an opportunity for tribal health care programs. Ever since the Supreme Court made Medicaid expansion under the Affordable Care Act optional, states have increasingly looked to waivers to revise their Medicaid plans, whether or not they choose to expand Medicaid. All too often, however, states have not accounted for or addressed tribal concerns in their initial waiver proposals to CMS. In many cases, states have sought waivers that would remove, or could have the effect of removing, critically-important Indian Medicaid protections.

As a result, tribes need to be vigilant in monitoring waiver proposals introduced by states. Tribes that have done so successfully have been able to work with states and CMS to modify the waivers in order to protect their rights. In addition, although waivers must be introduced by states, tribes in some cases have been able to work with states to develop waivers specific to the Indian health system. These tribal waivers have already reaped significant benefits for the Indian health systems in the states in which they are operating, and are being looked to by tribes in other states as well.

CMS's waiver authority is rooted in Sections 1115 and 1915(b) and (c) of the Social Security Act. Section 1115 waivers provide the broadest authority, and permit states to redesign their State plans to operate "experimental, pilot, or demonstration project[s]" that the Secretary of Health and Human Services determines are "likely to assist in promoting the objectives" of Medicaid and CHIP.[2] Also referred to as "Demonstration Waivers," Section 1115 waivers allow states to use federal Medicaid funds in ways that would not otherwise be permitted, so long as federal Medicaid expenditures under the program do not exceed the amount that would otherwise be spent. [3] Demonstration waivers are generally granted for a period of five years, but can be extended for periods of up to three years and can be extended multiple times.[4]

In recent years, waiver authorities have been used both by states seeking to expand Medicaid through alternative models as well as by states that have elected not to expand Medicaid but have chosen to make other significant changes to their state plans. In most cases, however, states did not initially take into account the special benefits and protections for AI/ANs and tribal health systems provided for in the Medicaid statute. Some of the most important of these include:

- AI/ANs cannot be forced into participating in mandatory managed care models as a condition of participating in Medicaid. 42 U.S.C. § 1396u-2(a)(2)(C).
- AI/ANs are exempt from Medicaid premiums and cost-sharing when receiving care at an I/T/U[5] or through Contract Health Services (CHS). 42 U.S.C. § 1396o(j).
- AI/ANs have the right to choose their I/T/U as their primary care provider regardless of whether that provider is in a managed care network or not. 42 U.S.C. § 1396u-2(h)(1).
- I/T/Us have the right to be paid by Medicaid managed care entities regardless of whether they are in a managed care network or not. 42 U.S.C. § 1396u-2(h)(2).

Tribes and tribal health programs have been able to successfully invoke their rights to consult with states and CMS on states' waiver proposals

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2 42 U.S.C. § 1315(a). Section 1915(b) and (c) waivers are more limited in scope. Section 1915(b) waivers allow states to implement Medicaid managed care delivery systems or otherwise limit people's choice in the Medicaid program. 42 U.S.C. § 1396n(b). Section 1915(c) waivers authorize States to create long term community care programs in the home or community setting rather than an institutional setting. 42 U.S.C. § 1396n(c). It is important to note, however, that both managed care and long term care can also be accomplished through Section 1115 waivers.

3 42 U.S.C. § 1315(b). The Secretary may approve a waiver "to the extent and for the period he finds necessary to enable such State or States to carry out such project." 42 U.S.C. § 1315(a)(1).

4 42 U.S.C. § 1315(e)(2), (f)(6).

5 Indian Health Service, Tribally operated health program or facility, or Urban Indian health program or facility.

MEDICAID WAIVERS ISSUES AND OPPORTUNITIES FOR TRIBES

to ensure that these critical protections were maintained in a number of recently approved waivers.[6]

For example, tribes have been able to preserve their right not to participate in a managed care model or premium assistance model in Medicaid expansion waivers that were recently approved by CMS in the States of Indiana, Arkansas, and Iowa. In Indiana, for example, the State sought a waiver to expand Medicaid through a mandatory managed care model. The Tribe in that State was able to ensure that AI/ANs would be able to continue to access the Medicaid program through a fee-for-service model under the waiver, and that the Indian health programs would be paid under the new model. Similarly, in Arkansas, the State sought and received a waiver that allowed it to expand Medicaid through a premium assistance model whereby individuals eligible for Medicaid expansion would get coverage under Medicaid by obtaining subsidized coverage on the new Health Insurance Exchange. Several tribes in neighboring Oklahoma with significant populations in Arkansas were successful in obtaining a carve out mechanism that allowed AI/ANs in the State to continue to receive care under a fee-for-service model.

Tribes have also been able to preserve their rights by invoking the consultation process in states seeking non-expansion waivers as well. For example, the State of Kansas recently sought and obtained a waiver to move to managed care, but Tribes in that State successfully invoked their right to consultation to obtain an opt-out process that allows Medicaid-eligible AI-ANs to continue to access Medicaid through fee-for-service. It also requires the new Medicaid managed care entities to offer to enter into provider contracts with the Indian health providers in the State, using an Indian managed care contract addendum developed by the Tribes in that State.

Tribes have also been able to work with states to obtain waivers specific to the Indian health system. For example, tribes in Arizona, California, and Oregon have been able to obtain "uncompensated care" waivers, which reimburse Indian health facilities for services provided to individuals with no other form of coverage. These waivers have provided critically important resources for Indian health facilities in those States. Tribes in a number of other states, primarily non-expansion states, are currently working to develop new waiver models that would authorize Indian health facilities and the beneficiaries they serve to receive additional funding from CMS.

As these summaries illustrate, waivers represent both a challenge and an opportunity for tribes. In order to protect their rights, tribes must remain vigilant, closely monitor state waiver activity, and get involved as early as possible in the waiver development process. The waiver process itself has and can be used by tribes to adapt state proposals to work for the Indian health system, and can also be used to develop waivers specific to the Indian health system.

6 There are three main consultation mechanisms. 42 U.S.C. § 1396a(a)(73) requires states with one or more Indian health program or urban Indian organization to seek advice on a regular ongoing basis with them on state Medicaid plan matters likely to have a direct effect on Indians or Indian health programs. CMS's waiver transparency regulations require states to have consulted with tribes prior to submitting a waiver proposal to CMS. 42 C.F.R. § 431.408(b). Finally, tribes may consult directly with CMS on any waiver that would significantly affect them under CMS's tribal consultation policy. Tribal Consultation Policy, Ctrs. for Medicare & Medicaid Services, at 3 (Nov. 17, 2011), *available at* http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTCP_FINAL_11_17_11.pdf.

MEDICAID CLAIMS DATE FOR 2013 AND 2014

***By Ed Fox, Ph.D**, is a policy analyst and serves as the Tribal Health Director for the Port Gamble S'Klallam Tribe*

(Source: February 16, 2015 Download of ProviderOne Medicaid Payment Data, Washington Health Care Authority)

It is no surprise that Washington Tribes varied in the amount of increased revenue they received in the first year (2014) of full implementation of the Affordable Care Act. Medicaid Claims data are readily available to document the increases and comparisons are possible with the addition of data from other sources.

Explanation for Variation

In order to attempt to explain the variation (from average of 39% and range of a 3% decline and increase of 157%), I rank tribes (25 of 29 WA Tribes) by the percent revenue increase and include their IHS active User Population.

Medicaid Payments for American Indians and Alaska Natives
Rank by Percentage Increase 2013-2014

	2014 User Pop	2014	2013	Increase 2014	% increase
Kalispel	645	$344,350	$134,230	$210,120	157%
Squaxin Island	1,713	$1,946,760	$890,625	$1,056,135	119%
Nisqually	1,794	$853,079	$443,597	$409,482	92%
Muckleshoot	4,790	$3,090,988	$1,639,344	$1,451,644	89%
Quinault	2,563	$1,592,449	$864,355	$728,094	84%
Skokomish	403	$783,589	$434,043	$349,546	81%
Jamestown	530	$255,550	$143,779	$111,771	78%
Swinomish	1,404	$1,594,108	$899,536	$694,572	77%
Shoalwater Bay	87	$180,877	$104,195	$76,682	74%
Quileute	651	$665,619	$394,083	$271,536	69%
Makah	2,374	$1,964,107	$1,211,703	$752,404	62%
Cowlitz	4,031	$3,604,623	$2,325,447	$1,279,176	55%
Suquamish	94	$729,945	$477,673	$252,272	53%
Spokane	670	$1,354,463	$908,735	$445,728	49%
Chehalis	1,120	$692,463	$475,751	$216,712	46%
Lower Elwha	966	$2,213,920	$1,581,034	$632,886	40%
Puyallup	6,633	$7,391,138	$5,462,701	$1,928,437	35%
Port Gamble	1,583	$2,155,202	$1,617,659	$537,543	33%
Nooksack	1,296	$3,898,046	$3,024,863	$873,183	29%
Snoqualmie	811	$914,291	$710,910	$203,381	29%
Yakama	12,632	$3,604,151	$2,791,855	$812,296	29%
Tulalip	5,230	$2,390,000	$1,997,633	$392,367	20%
Lummi	4,337	$5,890,961	$5,310,037	$580,924	11%
Stillaguamish	823	$2,428,740	$2,188,459	$240,281	11%
Colville	8,366	$1,650,296	$1,706,123	-$55,827	-3%
		$52,189,715	$37,738,370	$14,451,345	38%

Variation by Size

A review of this information shows that there is little, if any correlation that the 'size' of the tribe has in relation to how they were able to enroll its patients in Medicaid, as measure by increase in revenue. Of the top four tribes with extremely large increases in revenue of 157%, Kalispel one is one of the smallest tribes, Squaxin Island (119%) and Nisqually (92%) and Quinault (84%) are medium sized tribes and Muckleshoot (89%) is one of the largest. Similarly, with the six lowest ranked tribes, four are very large tribes, Yakama (29%), Tulalip (20%), Lummi (11%), Colville (-3%) and two, Stillaguamish (11%) and Snoqualmie (20%) are small tribes.

IHS vs. Tribal

The next variable to look at is whether IHS operates the tribe or if its own tribe runs it. There are three health programs run by IHS, Spokane, Yakama, and Colville. Spokane was the most successful and produced a 49% increase in revenue. This is 11% higher than the average for Washington tribes. Yakama had moderate success with a 29% increase, only 11% below the average. Colville, however, had a 3% decrease in revenue. It turns out there is a similar level of variation between the IHS tribes as there is for all of the tribes.

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MEDICAID CLAIMS DATE FOR 2013 AND 2014

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Rural vs. Urban

The Third variable that could play a role in the success of a tribe was their location. I compared seven tribes that could easily be recognized as urban or rural.

This comparison gives evidence that *rural* tribes are consistent with their success with implementation. All three rural tribes have shown growth higher than the state average, while the *urban* tribes are wildly inconsistent showing extreme increases at Muckleshoot and relatively small increases in Puyallup, Lummi and Tulalip.

Urban Vs. Rural Tribe Comparison

	Patients	Increase
Urban (metro area)		
Puyallup (Tacoma)	6,633	35%
Tulalip (Everett)	5,230	20%
Muckleshoot (Seattle)	4,790	89%
Lummi (Bellingham)	4,337	11%
Rural (90+ miles from urban area)		
Quinault	2,563	84%
Makah	2,374	62%
Spokane	1,713	49%

Patients Served Within their Own Tribe

What explains the variation between the four large urban tribes? One variable that is available is the percentage of a health program's patients who are from the tribe that operates the health program, that is, the Medicaid patient's are from their 'own tribe.'

	Patients	Increase	% Own Tribe
Urban (metro area)			
Puyallup (Tacoma)	6,633	35%	26%
Tulalip (Everett)	5,230	20%	69%
Muckleshoot (Seattle)	4,790	89%	82%
Lummi (Bellingham)	4,337	11%	69%
Rural (90+ miles from urban area)			
Quinault	2,563	84%	75%
Makah	2,374	62%	84%
Spokane	1,713	49%	60%

From looking at the percentage a tribe is serving its own members compared to their overall increase in revenue, I can judge their relative success by their willingness to work with the people they serve. All three rural tribes have a high percentage of their patients being served come from their own tribe. These tribes also have strong increases in revenue---evidence that 'own tribe' patients may be correlated to success. The two highest increase tribes from urban areas also serve a higher percentage of their own tribal members. However, when looking at the two lowest increase tribes from this comparison there is variation for the percent of its own tribal members served. Puyallup, with only 26% of its patients from its 'own tribe,' reinforces the theory that the more members of your own tribe served the more likely you are to have an increase in revenue, while Tulalip is the outlier from this theory---despite a high percentage of own members, its increase was low.

It is likely that health directors have the best explanation of the reasons for the relative performance of their own programs compared to other tribes.

HONORING TRADITIONS OF HEALTH - eOREGON'S HEALTH INSURANCE MARKETPLACE

Passed five years ago, the Affordable Care Act provides provisions for American Indians and Alaska Natives to get special health benefits. If you get your insurance through the Oregon Health Plan or Heatlhcare.gov, you may qualify for these special benefits.

Special provisions for enrolled Tribal members buying commercial insurance include:

- **Reduced or no-cost sharing.** American Indians and Alaska Natives whose income is at or below a certain range—up to $34,470 for an individual and $118,890 for a family of eight—won't pay for any cost sharing. And there's never any cost sharing for Tribal members who get services from a Tribal or Urban Indian Clinic.
- **Consistent care.** Members can continue to get care from their trusted community providers and may be eligible for financial help to pay for premiums and cost sharing.
- **Flexible enrollment.** American Indians and Alaska Natives have special monthly enrollment periods, which means they can sign up for health coverage or change plans at any time.

Update: Changes to Oregon's marketplace. The Oregon legislature recently passed Senate Bill 1, which transfers the administration of Oregon's state-based health insurance marketplace from Cover Oregon to the Department of Consumer and Business Services (DCBS). The Health Insurance Marketplace Transition Project is a cooperative venture between Cover Oregon and DCBS to implement the bill and ensure a smooth transition of functions and duties.

During the transition, the project team will make sure that customers of Oregon's health insurance marketplace receive the highest quality customer service. The project team will also work with Tribes and stakeholders throughout the project to ensure full transparency and opportunities for input and feedback about the project and the future of Oregon's state-based health insurance marketplace.

What this means for Tribes: The marketplace project team is currently working with Tribes to establish a new consultation process that clearly outlines how policy decisions that impact Tribal members will be discussed with Tribal leadership.

DCBS remains committed to helping American Indians and Alaska Natives throughout Oregon to get the coverage they need. If you have further questions, please contact : Berri LesliX at Berri.L.Leslie@oregon.gov or visit: http://www.oregon.gov/DCBS/health-marketplac

JOHNS HOPKINS FAMILY SPIRIT PROGRAM LAUNCHES NEW WEBSITE

Family Spirit, a transformative home-visiting program for new mothers has a new website with information on the program, its striking results, and how to get involved. Family Spirit is currently used by Colville Confederated Tribes, Confederated Tribes of Siletz Indians, and Confederated Tribes of the Umatilla Indian Reservation and over 40 other tribal communities across the country.

Family Spirit is an evidence-based home-visiting program designed and implemented by the Johns Hopkins Center for American Indian Health in collaboration with Southwestern tribal communities over the past two decades. The program supports young parents from pregnancy until the child›s 3rd birthday, teaching mothers to provide consistent, responsive care for their infants, avoid drug use, and attain life skills to overcome daunting stress in their environments. It harnesses local cultural strengths and uses paraprofessionals for home visits.

Findings published just published in the American Journal of Psychiatry demonstrate positive outcomes for families enrolled in the Family Spirit Program. Participating mothers knew more about parenting, reported fewer depressive symptoms, and were less likely to use drugs. At three years of age, their children had better behavior and emotional outcomes—for example, children were less likely to be distressed or withdrawn, aggressive, or impulsive. These and other factors the program effected predict later childhood substance abuse, educational attainment, and obesity. The benefits to both the mothers and their children have implications across the life course and even on the next generation of American Indians.

Family Spirit can be used in any tribal community to help strengthen the bond between new mothers and their infants and promote health throughout the lifespan.

We are now welcoming new affiliates to join the network. Visit the new website at jhsph.edu/caih/familyspirit to learn more!

AFFORDABLE CARE ACT (ACA) IMPLEMENTATION CHALLENGES

By Jim Roberts, Policy Analyst

Over the last two years, Tribes have been working very hard to take advantage and implement the Affordable Care Act (ACA). While generally, the work and benefits associated with enrollment for Medicaid expansion have been very beneficial in those states that have expanded Medicaid, however there remain a number of ways that the Administration (HHS and CMS) could improve collaboration with tribes to increase enrollment into the insurance exchanges and to address issues associated with the government federal trust responsibility to provide health care to American Indian and Alaska Native (AI/AN) people.

Waive the Employer Mandate for Tribes

One of the most important issues for Tribes is the application of the employer mandate. Tribal governments would prefer that the Administration waive this requirement for Tribes for obvious reasons under the federal trust responsibility. It requires that tribes qualifying as large employers buy insurance for their tribal-member employees or pay significant fines. If tribes do purchase insurance for their tribal-member employees, those employees will no longer be eligible to receive premium assistance through the health care exchanges. Despite the fact Indian people are eligible for health care from the Indian Health Service (IHS) and the United States has a legal and moral obligation to fund and provide health care to Indians through the IHS. Tribes have repeatedly requested administrative relief from the employer mandate. The employer mandate should be waived for tribal employers with regard to employees who qualify for the Indian exemption to the ACA's individual mandate.

Provide Indian-Specific Enrollment Data

Indian-specific data is needed and necessary to gauge AI/AN marketplace enrollment and Medicaid enrollment and to assess outreach and education efforts. Tribes, however, have not been able to obtain Indian-specific enrollment data from CMS despite numerous requests. CMS should make this data available to tribes.

Establish Indian Desk for the FFM National Call Center

This issue is important for Idaho and Oregon Tribes who since both states are federal supported health insurance exchanges (or marketplaces). Tribes have also repeatedly requested that CMS establish an Indian Desk for the National Call Center. Currently, AI/AN callers are frequently being misinformed by call center staff who do not understand the Indian-specific provisions of the ACA. This has created much confusion and frustration as AI/AN consumers seek Indian-specific answers regarding enrollment, plan changes, tax exemptions, and other ACA-related matters.

Fund Indian-Specific Enrollment Assistance

This issue is critical in the FFM but also effects Washington Tribes who have had to absorb much of the state's financial responsibility for outreach and enrollment activities. Funding for enrollment assistance is essential to increasing the low proportion of AI/ANs currently enrolled in health coverage. Navigator grants, however, have not proven to be an effective mechanism for funding Indian-specific enrollment assistance because of their constraints and reporting requirements. Funding is needed, therefore, for enrollment assistance that is tailored to the needs of tribal communities.

Issue Guidance Regarding AI/AN Cost-Sharing Reductions

Some qualified health plans have stated zero-cost-sharing plans are only available to AI/AN enrollees who earn between 100% and 300% of the Federal poverty level (FPL). These plans, therefore, refuse to provide zero-cost sharing to persons earning below 100% of the FPL. Tribes have requested that CMS issue guidance stating that zero-cost-sharing plans are available for American Indians and Alaska Natives earning from 0% to 300% of the FPL, as Congress intended in section 1402 of the ACA.

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AFFORDABLE CARE ACT (ACA) IMPLEMENTATION CHALLENGES

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Northwest Tribes support and embrace the benefits of the ACA. We are already seeing many of its benefits in our health programs, but more can be done to improve ACA implementation. With exception of the employer mandate, the issues presented here are not that difficult to overcome. If the Administration, HHS, and CMS would assist to address some of these issues it would improve the ability of Tribes to help enroll more AI/AN into the insurance exchanges and contribute to a greater success of the ACA.

WELLNESS @ WORK

The Northwest Portland Area Indian Health Board (NPAIHB's) Wellness Committee presented "*Wellness @ Work*" on Monday March 23rd at the 14th Native Women and Men's Wellness Conference in San Diego, CA., sponsored by the American Indian Institute (AII) from the University of Oklahoma. Wellness committee members; Birdie Wermy, Erik Kakuska and Candice Jimenez, presented on the Board's Wellness policy, 2014 accomplishments, 2015 all-staff wellness survey results and goals, provided health and wellness resources and engaged participants in a 30 minute chair workout. Learning objectives included; identifying and observing wellness activities that staff can participate in while at work, chair workout within the workplace, useful and helpful materials including 8 week challenge, workout ideas, and a monthly log to track wellness progress to motivate staff in wellness at work. Overall, we have received positive feedback and there were 60 attendees at this session. We plan to submit another abstract for the 2016 conference

Birdie Wermy, going over the 43 Tribes Wellness Survey administered in 2014.

NPAIHB Wellness Mission: "The Wellness Committee is committed to create & support opportunities for Wellness by promoting a safe & healthy workspace through a respect for ourselves & the organization."

Wellness committee members: Birdie Wermy (Chair), Victoria Warren-Mears (Co-Chair), Candice Jimenez, Colbie Caughlan, Erik Kakuska, Luella Azule, Ryan Swafford, Tam Lutz, Tanya Firemoon & Jacqueline Left Hand Bull.

For more information about Wellness in the workplace please contact Birdie Wermey at 503.416.3252 or bwermey@npaihb.org .

Erik Kakuska leading the chair workout to the wellness conference attendees.

NEW FACES AT THE BOARD

Nora Alexander, Nez Perce tribal member, joined the NPAIHB in January 2015 as the WEAVE Health Educator and Communications Project Specialist. The WEAVE project focuses on best practices that will help our Tribal communities create health policies within their communities. These policies are aimed to reduce the rates of Type II Diabetes, Cardiovascular Disease and promote healthy behaviors such as healthy eating and increased physical activity. Nora will serve as the focal point for all communications with the project, including the development of training programs and coordination of communication with tribal partners.

Nora received her Bachelors in Public Health at Oregon State University and is currently enrolled in the Masters of Public Health (MPH) program at Portland State University. Her focus is in Health Management and Policy.

She has 4 years of experience working as a health educator teaching evidence-based nutrition and fitness curricula to SNAP-eligible families across Multnomah County. Passed partnerships included Native American Youth and Family Services (NAYA), the Native American Rehabilitation Association (NARA), Department of Human Services (DHS), and multiple school districts within the county.

Christina Peters is the Oral Health Project Director tasked with assisting tribes as they explore opportunities to improve oral health access and outcomes in their tribal communities. Christina has come to the Board from the Children's Alliance where she was the Health Policy Director. There she was actively engaged in promoting health equity, the implementation of the Health Benefit Exchange in Washington State, preservation and improvement of Medicaid and CHIP programs, and advocacy for a mid-level dental provider in Washington State. Christina graduated from the University of Washington with a B.A in Economics.

UPCOMING EVENTS

APRIL

April 26-30
2015 Self-Governance Annual Consultation Conference
Reno, NV

MAY

May 4-6
Providers Best Practices & GPRA Measures Continuing Medical Ed.
Sacramento, CA

May 4-6
3rd Annual Tribal Sexual Assault Advocacy Training
Portland, OR

May 12-13
15th Annual Tribal Mental Health Conference
Bow, WA

Save the Date
May 12-13, 2015

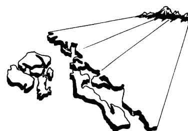
15TH ANNUAL
TRIBAL MENTAL HEALTH CONFERENCE

"Building Strength and Resiliency"

pavel_klimenko/Bigstock.com

At the Skagit Resort, Bow, WA

Presented by the North Sound Mental Health Administration &
the Tribes of the North Sound Region
http://nsmha.org/Tribal/Default.htm



Please Post

May 13-14
IHS Direct Service Tribes Advisory Committee Meeting
Spokane, WA

May 13
Oregon Tribes SB 770 Meeting
Pendleton, OR

May 14
American Indian Health Commission (AIHC) Meeting
Spokane, WA

May 18-21
Affiliated Tribes Northwest Indians (ATNI) Mid-Year Conference
Warm Springs, OR

May 18-19
6th Annual Native American Healthcare Conference
Valley Center, CA

May 20-21
Tribal State & Federal Summit: Protecting & Healing (Sexual Assault)
Pendleton, OR

May 28
Idaho Tribes/State Quarterly Meeting
Ft. Hall, ID

JUNE

June 2-3
Secretary's Tribal Advisory Committee (STAC)
Washington, DC

June 9-10
2015 Tribal Public Health Emergency Preparedness Conference
Ocean Shores, WA

UPCOMING EVENTS

June 22-26
5th Annual Tribal Health-Reaching out Involves Everyone (THRIVE) Conference
Portland, OR

June 28 – July 1
National Congress of American Indian (NCAI) Mid-Year Conference
St. Paul, Minnesota

JULY

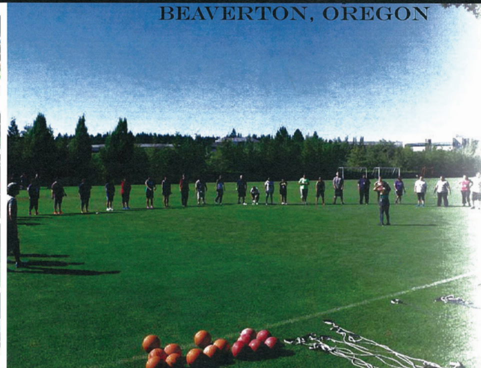
July 4
Independence Day

July 6-10
NPAIHB & CRIHB Joint Quarterly Board Meeting
Thunder Valley, CA

We welcome all comments and Indian health-related
news items. Address to:
Health News & Notes/ Attn: Lisa Griggs or by e-mail at lgriggs@npaihb.org
2121 SW Broadway, Suite 300, Portland, OR 97201
Phone: (503) 228-4185 FAX: (503) 228-8182

For more information on upcoming events please visit www.npaihb.org

NATIVE FITNESS XII
NIKE WORLD HEADQUARTERS
BEAVERTON, OREGON



Why should you attend?
-Receive skills in basic aerobic training
-Learn creative fitness training techniques
-Learn culturally specific approaches to health & wellness
-Certificate of Completion (upon request)

Who Should Attend?
-Diabetes Coordinators
-Tribal Fitness Coordinators
-Community Wellness Trainers
-Youth Coordinators
-Tribal Leaders

SAVE THE DATE
SEPTEMBER 1ST & 2ND, 2015

For Registration Information:
Western Tribal Diabetes Project * Northwest Portland Area Indian Health Board
Toll Free: 1-800-862-5497 * Email: wtdp@npaihb.org

Northwest Portland Area Indian Health Board

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S JANUARY 2015 RESOLUTIONS

RESOLUTION #15-02-01

Washington State University School of Medicine

RESOLUTION #15-02-02

Oregon Tribal Tobacco Cessation Project