Health News & Notes

Our Mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

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IT'S TIME TO CHANGE THE STORY ABOUT INDIAN HEALTH

By Mark Trahant

We live in funny times. People have ideas about health that are based on a retelling of stories -- the kind we would tell our friends over coffee -- and then they stick to that story, even when the data says something quite different.

Start with health care reform. The Kaiser Family Foundation reported in February that one in five Americans believe that the Affordable Care Act has already been repealed. Another 26 percent are not sure. In other words just under half are not sure that the Affordable Care Act is the "law of the land." Drew Altman, the president of the Kaiser Family Foundation, put it this way: "I am seldom surprised by our poll findings, but this month's tracking poll produced a doozy."

Or how about this? A Harvard study, Debating Health: Election 2008, found that Americans are not certain where our health care system ranks globally. Forty-five percent believe the U.S. has the best system; 39% believe other countries have better systems; and 15% don't know or don't answer. But this question also reflects an ideological division because nearly seven-in-ten Republicans (or 68%) believe the U.S. health care system is the best in the world, compared to just three in ten (32%) Democrats and four in ten (40%) Independents who feel the same way.

The data is clear. We are nowhere close to offering the best health care in the world. But the story sticks because we ignore the data either because of our own experiences, or our own belief that when the time comes we will get first-rate care. We choose to focus on the very best elements of the US health care system.

There is a double standard at work here. While the narrative about the larger health care system often focuses on its best elements, the story about Indian health shifts to the worst examples. The oft-repeated line "don't get sick after June" defines a broken, poorly funded system that represents the worst in health care delivery.

It's easy to think that way when we compare our health statistics to those of our neighbors -- especially without context. But if we pull back and look at the arc of federal health care delivery over the last couple of decades or fifty years, then the story is one of remarkable success not failure.

The transfer of Indian health services from the Bureau of Indian Affairs to the Indian Health Service is a great example. In 1955

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Our Policy and Legislative Issue Contains:

PUBLIC HEALTH IMPORTANCE TO TRIBES: ANOTHER VIEW

by Joe Finkbonner, NPAIHB Executive Director

Public health is the means of protecting, promoting, and improving the health and well-being of a population within a distinct governmental jurisdiction. How the population is quantified can be defined in multiple ways for tribal governments. The three most common qualifications of populations are enrolled tribal membership, service population of the health system, or those living within the exterior boundaries of the reservation borders or any combination of those just mentioned.

The role of public health is not always construed in the broader context of health policy or tribal sovereignty discussions. The term "public health" has abstract meaning to many who utilize the Indian health system, primarily because many services that are typically classified as "public health" were integrated into the administration of the primary care system that the Indian Health services operated, beginning in 1955. The role of public health is viewed more as a practice rather than a policy issue. Services such as health education, sanitation, and injury prevention have formally been operated out of the "Service Unit" at many tribal and IHS clinics and those that utilize the clinics have never distinguished them as "public health". Many of the improvements in the health status of the American Indian/Alaska Native (AI/AN) have been the result of the implementation of the public health services on the reservation.

The gap in life expectancy narrowed following the transfer of responsibility for health services from the Bureau of Indian Affairs to the IHS in 1955. The construction of clinics and access to primary care and prevention services narrowed the gap from approximately 24 year difference in 1974 (see Trahant article in this issue) to less than 3 years for American Indians and Alaska Natives born today (74.5 years to 76.9 years, respectively; 1999-2001 rates). However, there is still a lot of public health left to do in Indian Country. For example, nearly 12% of AI/AN homes lack adequate water supply compared to 1% for the general population. In fact, the three leading causes of death for AI/AN (health disease, cancer, and accidents) can all be mitigated using effective public health interventions.

I believe we all generally agree that prevention will be the key to further improvements in the health

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THE DEFICIT: WHERE DO INDIAN HEALTH PROGRAMS FIT IN?

by Jim Roberts, NPAIHB Policy Analyst

So far various Congressional members have proposed cutting the pay of federal workers, closing military bases, reducing foreign aid, eliminating earmarks, expanding the payroll tax and cutting Social Security benefits for high earners in order to get a handle on government spending. Those with differing points of view like the National Fiscal Commission on Fiscal Responsibility, the Republican Study Committee, and the President have all agreed that our nation's fiscal path is unsustainable and something must be done to balance the budget.

The Congressional Budget Office's (CBO) January 26, 2011 report, "The Budget and Economic Outlook: Fiscal Years 2011 to 2021," details daunting economic and budgetary challenges and the fact that the economy has struggled to recover from the recent recession. The deficits of $1.4 trillion in 2009 and $1.3 trillion in 2010 are, when measured as a share of gross domestic product (GDP), the largest since 1945—representing 10.0 percent and 8.9 percent of the nation's output, respectively. In 2011, CBO projects that if current laws remain unchanged, the federal deficit will grow to $1.5 trillion, or 9.8 percent of GDP. This has begun face-off between House Republicans, Senate Democrats and the President. Caught in this cross fire is the funding that goes to support health programs in Indian Country.

Over the last four years, the Indian Health Service (IHS) has seen the largest budget increases in the history of the Agency. This in part due to a Democratic controlled Congress and generous budget requests by the Obama Administration. The last year (FY 2001) of the Clinton Administration saw a 10% increase for the IHS. From fiscal years 2002 – 2007, the average budget increase seen by IHS was less than 3%, with the Agency's budget growing by only $421 million. Following 2007, the IHS budget increase has averaged 8.5% annually and grown by over $1 billion in the last four years. These figures get better if the President's proposed increase for FY 2011 is included. Unfortunately, these times may come to an end for Indian health programs.

The President's proposed FY 2011 IHS budget would have continued a positive maintenance of effort for Indian health programs who have suffered a heavy burden of neglect over the last fifteen years. House Republican proposals have focused on rolling back discretionary spending to FY 2008 levels. The President has proposed freezing

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doctors were quitting because the bureaucracy was intolerable and there was no consideration of the needs of people. Indeed the new IHS started with a brilliant move: Investing in sanitation and public health programs. (Something we now take for granted and complain about because it's sometimes a slow process.) But over that first decade the IHS working with tribal governments built more than 400 water and waste disposal systems. The agency reported that "the people themselves have contributed more than one third of the total cost through donated labor, materials and funds." That single idea resulted in an 80 percent reduction in gastrointestinal disease among American Indian and Alaskan Natives since 1973.

Or jump ahead to the enactment of the Indian Health Care Improvement Act. At the Ford White House, Dr. Ted Marrs described the conditions of native people this way: "In 1974 the average age at death of Indians and Alaska Natives was 48.3. For white U.S. citizens the average age of death was 72.3. For others, the average age was 62.7."

Think about that for a second. Life expectancy in 1974 was a little over 48 years old -- compared to more than 72 for white Americans.

And now? The Centers for Disease Control report, "The AI/AN population has a life expectancy at birth that is 2.4 years less than that of all U.S. populations combined." There is not a health care parity with the general population, not by a long shot, partly because of the chronic nature of so many diseases that afflict Indian Country. And the federal funding gap is real (and potentially growing). But nonetheless by one important measure, "closing the existing gap in age at death," has been improving over the four decades.

Why, then, is the narrative about the Indian Health Service so dismal? Because we are telling the wrong story. We need to talk about the elements of the system that are excellent -- and insist on that as goal for every community -- rather than letting real shortcomings define the story.

The other story to tell is about cost. The Indian health system is sustainable, while the rest of the U.S. health care system is not. That one fact is critical to the story we tell.

Dr. Donald Berwick who now heads the Centers for Medicare and Medicaid for the Obama Administration put it this way: "The Indian Health Service can and will be one of the leading prototypes for health care in America. The Indian Health Service is trying to deliver the same or better care with half the funding of other systems in the United States."

Berwick, and virtually every government official, admits that IHS needs more money – but at the same time he says the agency's ability to execute is "stunning." The very nature of the historical underfunding has resulted in a discipline that's "an example for us all."

One part of that story is changing the name of our "system." The Indian Health Service implies a federal government program. That no longer reflects reality. The IHS is now as much of a funding source than a direct health care operation. More than half of the IHS programs are operated by tribes or tribal organizations through self-determination or other contracts.

Across the country -- and certainly across the Northwest -- tribes and organizations are redefining that notion of "system" in ways that ought to inspire communities everywhere. Practical applications of this creativity are being applied from the Couer d'Alene Reservation in Idaho to the Jamestown S'Klallam community in Washington. I would add the Portland Area Indian Health Board to the reason why there's another story to be told. The quality of data, analysis, information sharing, all builds on the idea that an excellent health care system is possible.

But first we need to reject the story about failure. It's time to tell folks about what can be done.

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status of AI/AN population. We need better strategies for preventing obesity, diabetes, cancer, alcohol and substance use and abuse. My continued monologue on the "health" side of "public health" is no surprise nor is it particularly provocative; I know that you have heard some version of this conversation before.

Those of us that are drinking the same Kool-aid will nod our heads in agreement about the value of public health. I just spent the better part of page building a series of justifications for the importance of public health in the context of improving health status and quoting some statistics that would lead you to believe that what I am saying is accurate, now I want to look at public health and the need for tribes to consider accreditation from a slightly different (at least to me) perspective.

An effective public health system establishes the threshold of acceptable criteria for all elements affecting the public's health. These may include the licensing requirements for health practitioners, to the certification and standards needed to serve food at any of the facilities or events on the reservation. Tribes could require facilities to maintain the highest safety standards for the workforce or public accessing the facility. Tribal water purification standards could be set to ensure that only "the highest quality of water" is dispensed from the tap on reservations. Reservation street lights or traffic flow regulators (stop signs or lights) could remarkably decrease the number of traffic accidents on the reservation.

From a policy standpoint, it is the process of developing those standards, regulations and codes that will strengthen tribal sovereignty and, for that matter the democracy of its government. The establishment of public health codes would require public comment, engaging tribal communities to participate in review. Public hearings would allow the community to express their concerns related to the protection of public health, or the standards by which their health is being protected. This engagement will only pay dividends in the future when it comes to the public participation in the implementation of these same regulations.

Having an effective public health system that can protect the public's health requires that the governmental jurisdiction has the ability to work in partnership with other jurisdictions. Particularly in the control of communicable disease outbreaks (disease knows no borders) and having the necessary agreements in place so that roles are clearly defined. Coordination of activities can stop or slow the spread of disease and doing so in a manner that is complementary to adjacent public health jurisdictions increases the likelihood of a more productive outcome.

Another consideration is that tribal jurisdictions that lack public health codes or regulations are subject to the next level of government County, State or Federal that already HAS codes and regulations in place. . The example of having codes for isolation and quarantine comes to mind. If a tribe does not have the necessary laws in place to deal with this, the Federal government in all likelihood would step in severe cases). I know that most tribal elected officials want to determine for their members what jurisdiction has authority over their communities. Ideally, it is the tribe's laws that have precedence.

Effective public health systems are important to protecting the well being of tribal communities. I believe that once tribes understand all that is involved in developing and maintaining an effective public health system, they will see that a fully functional public health system also leads to good health status for "sovereignty" as well.

TRIBAL PLANNING FOR HEALTH INSURANCE EXCHANGES BEGINS NOW


Mim Dixon

by Kris Locke and Mim Dixon

Health Insurance Exchanges are a centerpiece of the recently enacted health care reform legislation (Public Law 111–148), known as the Patient Protection and Affordable Care Act (ACA). Currently most States are planning and designing their health insurance exchanges (Exchanges). If a State decides not to create an Exchange, the federal government will operate one for the residents of that State. The ACA calls for Exchanges to start operations no later than January 1, 2014.

What is a Health Insurance Exchange?

Under health reform, the Exchanges are the primary hub of activities – and the vehicle for securing federal subsidies for premiums and cost sharing.

Exchanges will provide a website where consumers and small businesses can compare health plans with different levels of benefits, and enroll in a plan of their choice. The website will let consumers know if they are eligible for Medicaid, the State Child Health Insurance Program (CHIP), or government subsidies of premiums, and provide a mechanism for enrollment. The Exchange will determine which plans qualify to be listed on the exchange, and will rate the plans using quality measures. Exchanges may also provide grants to organizations for programs to assist consumers enroll.

Exchange Plans Will Offer a New Source of Revenue for Indian Health Care

While the law requires most Americans to acquire health insurance or pay a penalty, AI/AN are exempt from these penalties. Premium subsidies will be available to low-income individuals enrolled in Exchange plans, if their income is below 400 percent of the federal poverty level (FPL). Because there is a high rate of poverty in American Indian communities, premium subsidies would apply to a high percentage of AI/AN.

To access this subsidized health insurance, Tribal health programs may choose to pay the unsubsidized portion of the premium for some of their user population. In fact, the Indian Health Care Improvement Act (IHCIA) allows Tribes to make premium payments on behalf of members using federal funds.

For people who are enrolled in Exchange plans, the IHS, Tribal or Urban (I/T/U) health program would be able to bill the insurance for the services they provide, as well as reduce their Contract Health Services (CHS) expenditures by having the insurance plan pay for the costs of services delivered in the private sector. The law prohibits cost-sharing for AI/AN enrolled in an Exchange plan if the service is provided by an I/T/U health program. This means the I/T/U health program would be able to collect 100 percent reimbursement for services from the Exchange plan for those who are enrolled. Furthermore, AI/AN enrolled in Exchange plans are exempt from cost sharing at all other providers if their income is below 300 percent FPL or if they receive a referral through the health program .

The increased income for Tribal health programs, and the decreased demand on Contract Health Services (CHS) budgets, may more than offset the payments Tribal health programs would make for premiums. Having more patients insured also holds the promise of less reliance on Catastrophic Health Emergency Funds (CHEF), as well as coverage for additional preventive benefits, and some relief from the CHS priority system.

More AI/AN will be Enrolled in Medicaid

The ACA's Medicaid provisions will expand AI/AN eligibility and enrollment in Medicaid. ACA envisions that all individuals with incomes below 133 percent FPL (even childless adults) will qualify for Medicaid. Web portals used by the Exchanges will have a single enrollment form for both Medicaid and Exchange plans. The online site will gather and electronically match information to expedite eligibility determinations for Medicaid. The Exchanges may use data supplied by the Internal Revenue Service (IRS) eliminating the need for applicants

TRIBAL PLANNING FOR HEALTH INSURANCE EXCHANGES BEGINS NOW

to produce income documents for eligibility. The electronic application process will be easier and more convenient than previous Medicaid eligibility determination and enrollment processes. Thus, it is expected that the Health Insurance Exchange will increase the number of AI/AN enrolled in Medicaid.

Tribal Members Can Benefit if Their I/T/U Health Program are Providers in Exchange Plans

I/T/U should be paid by insurance companies for services they deliver to AI/AN enrolled in their plans, regardless of whether the Indian health programs have provider contracts with Exchange plans. Section 206 of IHCIA gives Indian health providers the right to receive reasonable charges, or, if higher, the highest amount an insurance plan would pay for the same care delivered by other providers. Even though we believe Section 206 makes it possible to collect reimbursement without having a provider network contract with an Exchange plan, having such a contract may provide additional benefits to I/T/U health program providers and their patients – such as better access to specialty providers in a health plan's network.

Tribal Action Needed at the State Level

States are currently designing Exchanges and should also be consulting with Tribes; however, Tribes may have to be proactive to ensure on-going consultation. The CMS Center for Consumer Information and Insurance Oversight has alerted States that they have a responsibility to establish a consultation with Tribes.

Right now Tribes should consider making recommendations to State agencies about the following types of issues:

- Require web portals to provide information about AI/AN provisions so informed choices can be made by Tribes and individual AI/AN.
- Require Exchange plans to include I/T/U health programs as Essential Community Providers.
- Require Exchange plans to use contracts with specified modifications for Indian health programs.
- Require plans to pay Indian health programs at the rates specified by law (reasonable charges billed, or, if higher, the highest rate paid to providers in the plan).
- Design computer programs with considerations for Tribes to be able to sponsor AI/AN by paying the premium for plans, enroll on a monthly basis, allow AI/AN to use the address of the Tribal health center for mailings from a plan, and authorize the Indian health center to represent the individual and receive information over the telephone in dealings with the Exchange and plans.
- Because Medicaid, ACA and the IHCIA contain different provisions to protect AI/AN, it will be important to make sure these access provisions are preserved. As States innovate to leverage federal funding, Medicaid and other traditional programs may be obscured by new names and financing combinations.

In addition to being involved in the planning process, Tribes and Tribal organizations will need to advocate for favorable provisions in legislation and regulation at the State level.

Tribal Planning to Prepare for Exchanges Should Begin Now

Tribes should designate an individual or a team to become informed about the Exchange as well as engaged in advocacy on behalf of the Tribe in the development of policies and regulations.

Tribal health programs will need to decide whether they are going to pay the non-subsidized portion of premiums. Although there will be an initial cost outlay for the premiums in the first year, revenues and CHS savings that Tribes receive from billing the insurance companies may be sufficient to pay premiums after the first year. Tribes will need to develop models to estimate the cost of premiums based on the number

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LEGISLATIVE AND JUDICIAL ATTACKS ON THE AFFORDABLE CARE ACT: WHAT THEY COULD MEAN FOR THE INDIAN HEALTH AMENDMENTS

by Carol L. Barbero - Hobbs, Straus, Dean & Walker, LLP

Editor's Note: *This article reports on circumstances as they existed at press time – March 3, 2011. Readers are advised to check the news media for subsequent events involving the Affordable Care Act.*

The historic health care reform law – the Patient Protection and Affordable Care Act (ACA) – signed into law by President Obama on March 23, 2010, seeks to make health insurance more accessible and affordable, especially for the uninsured and small businesses, and to expand Medicaid eligibility within three years. Its enactment also signaled a major leap forward for Indian health through inclusion of several Indian-specific provisions such as long-sought amendments to the Indian Health Care Improvement Act (IHCIA).

But from the day the President signed the ACA, it has been under attack by its opponents: The constitutionality of the law's "individual mandate" feature – which requires most Americans to obtain health insurance or pay a penalty – has been challenged in dozens of court cases, and Republicans in the newly-elected 112th Congress are pursuing several ways to derail the law.

Congressional Attacks.

In January, the House of Representatives voted to repeal the entire ACA – with no exceptions. A repeal vote in the Senate failed, and President Obama has vowed to veto such a bill if one were to reach his desk.

Then, in mid-February, the GOP-led House put several amendments on to H.R. 1 – the bill to finish funding the current (FY11) fiscal year – that would prohibit any funds from being used to implement the ACA. This bill has not yet been debated or voted on by the Democratic-led Senate. The President has vowed to veto a bill that prohibits funding for ACA implementation.

Before March 4, the two chambers are expected to enact a 2-week extension – through March 18 – of funding for FY11 to avoid a government-shut down that would otherwise occur after March 4 when the current "Continuing Resolution" for FY11 funding expires. Such action would put off for 2 weeks a confrontation on GOP efforts to deny funding for ACA implementation.

Court Challenges.

So far, three Federal judges have said that the ACA and its "individual mandate" feature **are** constitutional,[1] and two Federal judges have handed down negative decisions.

One of the negative decisions was issued at the end of January by a Federal judge in Florida in a case brought by 26 states. After declaring one provision – the individual mandate – unconstitutional, the judge then struck down the *entire* ACA.[2] The United States has asked the judge to clarify his ruling, pointing out that many beneficial and clearly constitutional ACA provisions have already been implemented and that "substantial disruption and hardship" would occur if the judge intended his declaratory judgment to become effective immediately. The government asks the judge to say that, pending appeal, the parties to the case are not relieved of rights or obligations under the ACA. The states who brought the case opposed the U.S. motion. On March 3, 2011, the judge agreed to treat the U.S. motion as a request for a "stay" of his decision, but with important conditions attached: that the U.S. to file its anticipated appeal with the 11th Circuit Court of Appeals within 7 days (by March 10), and seek expedited review either in the Court of Appeals or the Supreme Court. He reiterated his prior statement that "the citizens of this country have an interest in having this case resolved as soon as practically possible".

The U.S. has already indicated it will appeal the Florida judge's decision. It has already appealed the decision of a Federal judge in

1. *Thomas More Law Center, et al. v. Obama* (10-CV-11156) (E.D. Mich. Oct. 7, 2010); *Liberty Univ., et al. v. Geithner* (6:10-cv-00015-nkm) (W.D. Va. Nov. 30, 2010); *Mead v. Holder, et al.,* (10-cv-950-GK) (D.D.C. Feb. 22, 2011).

2 *State of Florida, et al. v. U.S. Dept. of Health and Human Services* (No. 3:10-cv-91) (N.D. Fla. Jan. 31, 2011).

LEGISLATIVE AND JUDICIAL ATTACKS ON THE AFFORDABLE CARE ACT: WHAT THEY COULD MEAN FOR THE INDIAN HEALTH AMENDMENTS

the Eastern District of Virginia who also said the individual mandate is not constitutional.[3] In that case, however, the judge let the rest of the law stand.

Impact on Indian health provisions.

So what does all this mean for the Indian health advancements imbedded in the ACA? The short answer is: They could be at risk. Why? Because Congressional leaders who oppose the law want to repeal or deny funding to implement the *entire* ACA, not just the parts they oppose, and the outcome of the Florida case – brought by 26 States – was to invalidate the whole law.

If the entire ACA goes down, some losses to Indian health include -

IHCIA Amendments. The ACA incorporated by reference a bill approved by the Senate Indian Committee in 2009 that makes over 50 changes to the IHCIA, including permanently reauthorizing that law. Indian Country devoted over ten years to the IHCIA revision effort and for the past year implementation of the revisions has proceeded apace. If all these amendments are lost, the IHCIA would revert to its pre-ACA text.

Key Indian Tax Provision. The ACA put a new provision in the Internal Revenue Code to exclude from a tribal member's gross income the value of tribally-provided health benefits. This was needed to overcome the IRS's decision to tax tribal members who receive such benefits. One of the IHCIA amendments allows tribes to use federal funds to purchase insurance coverage for IHS beneficiaries.

Two Indian-specific Medicare Amendments. One of these made permanent the authority of IHS and tribal programs to collect for all Medicare Part B services. The other enhances the ability of IHS, tribal and urban Indian pharmacies to collect reimbursements under the Medicare prescription drug program.

Expansion of Medicaid Coverage. The new law expands Medicaid eligibility to all persons (including childless adults) with incomes under 133% of the Federal Poverty Level in 2014. Some Indian health advocates estimate this expansion could be worth $1 billion to the Indian health system because more Indians will qualify for Medicaid.

What's Next?

In Congress. Republican efforts to derail the ACA will continue. The next key date is March 18 – the day funding for FY11 will expire – presuming the House, Senate and President agree to continue funding the government for the 2-week period of March 4 through March 18. Even if the impasse is avoided or further postponed, the House will continue efforts to de-fund ACA implementation and to repeal or replace major ACA components during 2011.[4]

In the Courts. As noted, the judge in the *Florida v. HHS* case granted a "stay", conditioned on the U.S. filing its appeal by March 10 and seeking an expedited appeal. Many other cases challenging the ACA are still pending in various Federal district courts.

All observers expect that the U.S. Supreme Court will eventually decide whether the individual mandate is constitutional and whether all or some of the ACA will stand. The Virginia Attorney General has formally asked the Supreme Court to accept the cases for review now – without waiting for the appeals courts to weigh in. The Supreme Court has sole discretion whether to agree to an expedited appeal process.

Possible Tribal Involvement.

There is a move to have one or more tribes file "friend of the court" briefs in the appeals courts (or Supreme Court) asking for preservation of the IHCIA amendments and other beneficial Indian provisions – especially those not connected to the individual mandate. No case has

3. *Commonwealth of Virginia v. Sebelius,* (10CV 188-HEH) (E.D. Va. Dec. 13, 2010).

4. Two bills intended to preserve some Indian-specific provisions of the ACA have been introduced in the House by Rep. Don Young (R, AK) – his bill would repeal the full ACA ***except*** for the IHCIA amendments section – and Rep. Tom Cole (R, OK) (whose bill would amend the IHCIA in almost the identical form in which it was amended by the ACA). House leadership did not bring Rep. Young's bill to the floor, preferring to pass the ACA repeal bill that had no exceptions. House leadership has not addressed Rep. Cole's bill.

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HOPE & FEAR IN THE 112TH CONGRESS

By Philip Baker-Shenk

The convening of the 112th Congress on January 3rd elicited a robust range of emotions from Indian Country. Fear and loathing. Cheers and dancing. A full range of feeling from anxious worry to hopeful expectation.

Ninety four new members of Congress were sworn in, the largest number of fresh-mostly-men in nearly 20 years. They were largely from one party -- 85 Republicans and nine Democrats. At least 35 of these newcomers had never before held elected office.

Much of the fear and anxiety came from the unknowns accompanying all this change. The niceties and nuances of Federal Indian law are not taught in most schools or known by most voters. So this wave of new lawmakers set off tsunami warning signals throughout Indian Country.

But scratch a bit below the surface and some bright spots appear. Some of these new Members bring great knowledge of Indian Country from their experience as state legislators. For example, Rep. Jeff Denham (R-CA) brings close ties with Tribes from his days in the California Senate. And Rep. Rick Berg (R-ND) likewise brings the familiarity of an ally of Tribes in North Dakota from his years as Speaker and Majority in the State House.

Others have only the twisted exposure about Indian Country that comes from the occasional national press clip or Hollywood screen. Many are from places in America sometimes referred to as "Former Indian Country" without any Indian Tribes as constituents. One such newcomer is Kentucky's new Senator Rand Paul, the son of perennial presidential candidate Rep. Ron Paul. Sen. Paul, trained as an ophthalmologist, rode the Tea Party movement into his first ever elective office advocating term limits, a balanced budget, cuts in federal spending and taxation, and strict adherence to the U.S. Constitution.

For some unknown reason, within weeks of taking his oath to uphold the U.S. Constitution, Sen. Paul introduced a bill that would override it. His legislation would defund the BIA and IHS on the basis that these agencies perpetuate a relationship he feels should be terminated.

Ironically, even as we see a resurgence of interest and veneration for the U.S. Constitution, Sen. Paul's vision appears to have a huge blind spot when it comes to the legal obligations owed Native American Indians in federal treaties solemnly negotiated and ratified as the "supreme law of the land". Article VI of the Constitution says, of course: "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land... ."

No honest fan of the Constitution can deny that the Founders were referring to treaties with the Indians when they wrote the Constitution. Anyone proposing to terminate or defund the BIA or IHS must, if they are to honor the Constitution, accompany that with a proposal as to how they intend to otherwise carry out the trust obligations of the United States towards Indians and Indian resources. Anything short of that is just another Indian resource grab and swindle that mocks the rule of law. Everybody decries the flexing of the brute strength of despots in northern Africa and the Middle East today. How about here in America, yesterday and today? Ah, aren't the blind spots that accompany self-interest so … annoying? No one can honestly defend the twisted history of paralysis, waste, and inefficiency that is intertwined with the BIA and IHS. But surgery and rehabilitation is the Constitutional answer, not amputation or manslaughter.

Now to some extent, Sen. Paul's argument sounds like the familiar "zero-based budget" approach to cutting federal spending. That approach dates back at least to President Jimmy Carter and his OMB Director Bert Lance in the

HOPE & FEAR IN THE 112TH CONGRESS

late 1970s. That thinking asked which federal agencies or programs had earned a bad reputation for mismanagement and then proposed to simply terminate them because they had failed. It is an approach that says -- let's cut our losses and move on. Whatever its merits generally, when this approach is applied to federal Indian programs, it is entirely in conflict with the trust obligations of the United States for the care and protection of Indians and Indian resources, which obligations originate not from charity but instead from legally-binding agreements in exchange for land and resources.

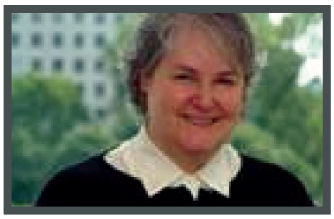
Indian Country can take comfort that the threatening ideas of newcomers like Sen. Paul will run head-on into experienced lawmakers who are strong allies of Indian Country. The Chairman and Vice Chairman of the Committee on Indian Affairs, Senators Daniel Akaka (D-HI) and John Barrasso (R-WY), have both demonstrated their understanding and commitment to Federal Indian policy and to upholding a course of dealings that is fair, honorable, and consistent with treaties and agreements with Indian nations. And there are dozens of other members of the Senate who are likewise committed and knowledgeable. Since most election prognosticators say the 2012 elections will probably shift the Senate to Republican control, it will be all the more important over the next two years for Indian Country to build stronger relationships with Senate Republicans. The fact that, like Senator Tim Johnson (D-SD) in 2002, Sen. Lisa Murkowski (R-AK) owes her re-election last year to the Native vote, is earning Indian Tribes increasing notice from campaigners elsewhere in Indian Country.

On the House side, I cannot remember a time when Indian Country had more friends in high places. Veteran legislator Rep. Don Young (R-AK) now chairs the Subcommittee on Indian and Alaska Native Affairs, and his friend and ally of Indian Country, Rep. Dan Boren (D-OK), serves as its Ranking Member. Young is one of the most senior members of the House and has been a leading advocate for tribal rights and resources for decades. Both Young and Boren will help guide Rep. Doc Hastings (R-WA) and Rep. Ed Markey (D-MA) who are Chair and Ranking Member of the full Committee on Natural Resources. And Rep. Mike Simpson (R-ID) now chairs the powerful appropriations Subcommittee on Interior and Related Agencies, who, with Rep. Jim Moran (D-VA), its Ranking Member, are both active supporters of Indian Country. Other key House Committees are headed by Republican members who have actively contributed to positive advances in Federal Indian policy over the past decade, including Ways and Means Committee chairman Rep. Dave Camp (R-MI) and Education and the Workforce Committee chairman Rep. John Kline (R-MN). The anchor for all of these leaders is appropriations committee member, Rep. Tom Cole (R-OK), who is a member of the Chickasaw Nation and a forceful and articulate advocate for tribal sovereignty, and serves as co-chair of the House Native American Caucus along with long-time supporter Rep. Dale Kildee (D-MI).

Each of these Senators and Representatives has hired veteran staff experienced in Native American Indian matters. Indian Country is in good hands. Our friends, however, may not be able to completely rebuff the strong wave of spending reductions that will likely wash away some federal Indian programs. Survival for Indian Country will necessarily require a fuller recognition by the United States of the sovereign powers of Indian Tribes to regulate and tax commerce in Indian Country to the exclusion of all other governments. Nothing short of a robust sovereignty will suffice.

Philip Baker-Shenk *is a lawyer and partner in the Indian Law Practice Group of Holland & Knight LLP. He has worked on behalf of Indian Tribes since 1976.*

INDIAN HEALTH PROGRAMS AND THE DEPARTMENTS OF VETERANS' AFFAIRS AND DEFENSE



by Myra M. Munson and Samuel E. Ennis - Sonosky, Chambers, Sachse, Miller & Munson LLP

Three sections of the Indian Health Care Improvement Act, Pub. L. 94-437, as amended, ("IHCIA"),[1] address relationships between the Indian Health Service ("IHS") and tribal health programs ("THPs") (collectively "Indian Health Programs" or "IHPs") and the Departments of Veterans' Affairs ("VA") and Defense ("DoD"). These address facility and service sharing arrangements, reimbursement to IHPs by VA and DoD, and collaborative arrangements between VA and IHS.[2]

American Indians and Alaska Natives ("AI/ANs") have the highest rate of military service of any ethnic group in the country. The health needs (including behavioral health) of veterans and military members and their families are tied to their service. After more than a decade of war (and other wars and conflicts stretching back as far as World War II), many AI/AN veterans require treatment and supportive services for physical injuries and emotional damage, including post-traumatic stress disorder.

Indian Health Programs are underfunded and often struggle to meet the most basic needs of their patients. VA facilities and programs are often hundreds of miles away from the AI/AN community where the veteran returned after completing his or her service. Obtaining information about eligibility for VA direct services or approval to receive care elsewhere paid for by VA seems universally challenging for veterans and IHPs.

The amendments to the IHCIA, which became effective March 23, 2010, were intended to address these problems. However, implementation has been slow, at least from the tribal point of view, and despite many requests IHS has not included a tribal representative directly in discussions with VA.

> Reimbursement.—The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

Reimbursement by VA

The amendment of most immediate interest to THPs is found in Section 405(c) (25 U.S.C. 1645(c)):

Tribal leaders have told IHS that they believe Section 405(c) requires VA (and DoD) to reimburse IHPs for any service provided to a veteran who is eligible for VA benefits. This view is reinforced by the new payer of last resort provision enacted in Section 2901 of the ACA (25 U.S.C. 1623(b)). It ends with language making it applicable "notwithstanding any Federal, State, or local law to the contrary."

The delay in implementing the reimbursement requirement obviously has resulted in lost revenue, but there are other concerns, as well. First, is whether tribal leaders concede that IHS has the authority to enter into agreements with VA regarding reimbursement that would be binding on Tribal health programs. Although tribal leaders have been deferential to the IHS process, they have asked to be represented directly, through representatives chosen by tribal health programs, in the negotiations with VA. There are a number of issues about which IHS may not be able to adequately represent the wide range of tribal health programs or in which IHS might make agreements that might

1. The IHCIA was most recently amended by Section 10221 of the Patient Protection and Affordable Care Act, Pub. L. 111-48 ("ACA"), which incorporated by reference S. 1790 as reported by the Senate Committee on Indian Affairs.

2. No implementation activity has begun with DoD so this paper addresses only VA. Similar issues are present with DoD, although there are more veterans than active duty members and while they are in active duty status, they obtain their health care mostly directly from DoD.

INDIAN HEALTH PROGRAMS AND THE DEPARTMENTS OF VETERANS' AFFAIRS AND DEFENSE

be objectionable to or impractical for THPs. Based on comments submitted to IHS, these include eligibility (all veterans eligible for VA direct services), covered services (any service provided by an IHP), payment (the IHS encounter rate published by OMB), coordination (how to facilitate locally), choice of location of care (should be up to the AI/AN veteran), payment for services since the effective date (should be made), how claims may be filed (paper or electronic), etc.

Tribal leaders continue to press this issue. If the results are not satisfactory or there continue to be delays, individual THPs will need to decide whether they should begin to bill VA and take enforcement action if they are not paid. That would be both divisive and expensive, but understandable.

Because payment has not been occurring, the Tribal Technical Advisory Group ("TTAG") to the Centers for Medicare and Medicaid Services ("CMS") have also asked CMS to clarify that neither Medicare or Medicaid will seek to recover for payments they may have made to an IHP for services provided to a veteran for which VA was responsible under the new law. Such payments generally violate the "secondary payer" rules of those programs. At the most recent TTAG meeting, CMS officials indicated that they are taking the position that the secondary payer rules will not apply until IHS completes implementation. CMS has been asked to put that in writing to avoid questions from State Medicaid programs or later audits.

Collaboration and Sharing

The other two amendments specifically address sharing facilities and programs among Indian Programs and VA and DoD, and collaborations, including a Memorandum of Understanding ("MOU") between the IHS and VA. *See*, Sections 405(a), (b), and (d) (codified at 25 U.S.C. 1645(a), (b), and (d)) (sharing) and 407 (codified at 25 U.S.C. 1647) (collaborations, MOU, and funding).

Pursuant to Section 407, the IHS and VA updated and renewed their MOA. After it was signed in November 2010, tribal leaders were given a chance to comment. No summary of the comments or response to them has been provided. Even before the amendments, sharing arrangements have been in place under various VA pilot projects and under agreements between tribes and VA. Some even included limited reimbursement. However, many THPs indicate that they fail to address the most basic issues.

Bottom Line

AI/AN veterans should be entitled to receive health care at either Indian or VA programs and that the veteran should be allowed to exercise the option. VA should make specific expertise about treating service related conditions available to IHPs, if they ask, and should, in turn, obtain information from tribes and THPs about how to provide culturally appropriate care to AI/AN veterans who continue to rely on VA facilities. The VA should make the process of obtaining confirmation of eligibility for veterans simple and make payment to IHPs for the services they provide. VA should pay IHPs for the services they provide to AI/AN veterans.

NCAI March 2011 - Pearl Capoeman-Baller, Quinault Nation, ***Andy Joseph, Jr.***, Colville Tribe, ***Shawna Gavin,*** Umatilla Tribe, ***Jim Roberts,*** NPAIHB Policy Analyst

STATE AND FEDERAL POLICIES TO IMPROVE MATERNAL AND INFANT HEALTH

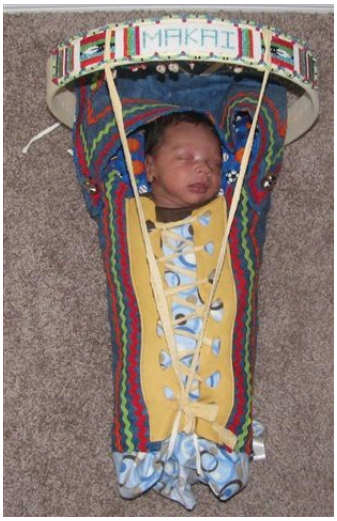

Mim Dixon

by Mim Dixon and Sheryl Lowe

There are tragic disparities in American Indian (AI) maternal and infant health (MIH) in Washington State even though most pregnant women and their children qualify for Medicaid. The infant mortality rate for AI is more than twice that of the population as a whole. Infant deaths due to Sudden Infant Death Syndrome (SIDS) are 3 times greater among AI, injuries cause infant deaths at a rate 5 times higher for AI, and infant deaths due to infectious disease are 3 times higher in the AI population. Many of these deaths are preventable. While the trend in infant mortality has improved for every other population group in Washington State, it has gotten worse for American Indians in the past 12 years.

The American Indian Health Commission for Washington State (AIHC), which represents all 29 tribes and 2 urban Indian programs, developed a Maternal and Infant Health Strategic Plan[1] in 2010 that seeks to eliminate disparities by focusing on the leading causes of infant mortality and the top 6 risk factors for poor pregnancy outcomes. Those risk factors are: mental health; alcohol and/or substance abuse; smoking; threatened pre-term labor; history of prior low birth weight baby, preterm delivery or fetal death; and nutrition and weight. For each of these risk factors, strategies have been identified based on the best available research. Programs and best practices have been identified throughout the country to carry out the strategies. Most of the strategies that have been shown to be effective should be carried out by tribes, because tribal health departments are the most geographically accessible sources of care and the most culturally-competent to deal with the sensitive issues and to provide services within homes.

The Special Supplement Nutrition Program for Women, Infants and Children (WIC) is a federal program designed to improve maternal and infant health. While WIC is funded by the U.S. Department of Agriculture (USDA), the money goes through the State of Washington which contracts with tribes, tribal organizations, and urban Indian programs. The MIH Strategic Plan identified a number of issues and made recommendations for WIC to better serve tribal members. Some of the issues can be resolved at the state level, but other issues require policy changes nationally. For example, tribes are currently not able to receive the federally-approved indirect cost rate in addition to direct costs of providing WIC services. The MIH Strategic Plan recommends that USDA form a national Tribal Technical Advisory Group (TTAG). In November, the National Congress of American Indians (NCAI) passed a resolution endorsing this idea.



Like many states in the country, Washington State is responding to lower tax revenues by cutting expenditures, including eliminating optional Medicaid services. The MIH Strategic Plan developed by AIHC requires investments upfront, but it can actually save the state money in two ways: 1) lowering Medicaid costs by shifting women from expensive C-sections and neonatal intensive care to normal deliveries as a result of reducing risk factors for pregnant women: and 2) shifting the provision of health care services from the private sector to tribal health programs so that the federal government pays 100 percent of the costs under Medicaid.

One of the Medicaid programs that may be eliminated is First Steps Maternity Support Services (MSS), which pays for such things as nutrition counseling, smoking cessation, and home visits for pregnant women. A review of this program showed that it wasn't working very well in Indian Country. In 2009, only one tribe and the Seattle Indian Health

STATE AND FEDERAL POLICIES TO IMPROVE MATERNAL AND INFANT HEALTH

Board were providers of MSS. Over half the tribes had tried to provide these services but discontinued over the years due to issues such as complicated enrollment and billing processes, payment using a fee for service approach with limits based on increments of 15 minutes of service, program requirements that were not culturally appropriate, and staffing shortages. The MIH Strategic Plan shows how the state can make MSS more attractive to tribes, serve more AI women, and save money.

A limiting factor in delivering effective prenatal care is the shortage of health professionals in rural areas. Policy changes are needed to allow greater use of telehealth for nutrition counseling, to increase the number of internships available for people to become registered dieticians, and to provide residency programs in rural areas for primary care providers. While most tribes do not have obstetricians or other doctors who will deliver babies, this may no longer be an obstacle if hospitals in the State of Washington follow the trend of hiring "laborists" to attend deliveries (similar to "hospitalists" who provide care only within the hospital). Tribes could provide the prenatal care and wraparound services. With electronic medical records there can be fairly good continuity of care. To facilitate this process, Medicaid needs to unbundle its rates for prenatal care and deliveries to make it economically feasible for tribes to deliver the prenatal services.

Resources are always an issue for tribes and urban Indian programs, as well as states. Health reform legislation, known as the Patient Protection and Affordable Care Act of 2010, includes many new programs and funding opportunities for states that could improve maternal and infant health. In many states there is a history of bad feelings as a result of state government using health disparity data regarding AI/AN to apply for federal funding, receiving funding, and then not sharing the funding with tribes and urban Indian programs to address the disparities identified in the proposal. States and tribes need to work closely together, often on short timelines, to assure that the new resources are directed to meet the greatest needs and to eliminate the disparities in maternal and infant health for Native Americans.

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Sheryl Lowe *is the Executive Director of the American Indian Health Commission for Washington State. To obtain a copy, please contact Sheryl Lowe at slowe@aihc-wa.com or 360-582-4881.*

LEGISLATIVE AND JUDICIAL ATTACKS ON THE AFFORDABLE CARE ACT: WHAT THEY COULD MEAN FOR THE INDIAN HEALTH AMENDMENTS

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challenged the constitutionality of the IHCIA amendments, the Indian tax exclusion, or the two Indian Medicare provisions, so a tribal brief would argue that the courts have a responsibility to preserve provisions that are constitutional. This is called the "severability" argument; that is, the court should sever only any provision determined to be unconstitutional and let the other provisions stand.

Conclusion.

The ACA enacted a number of statutory provisions that would enormously benefit the Indian health system. But the political and judicial challenges to this landmark law threaten both its controversial and non-controversial components. Expect the Congress and the courts to continue wrestling with ACA issues throughout 2011 – and perhaps into 2012, a Presidential election year.

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GOVERNMENT UNDERPAYMENTS HURT TRIBAL HEALTH CARE

By Lloyd B. Miller

Indian Tribes suffer the worst health status in the Nation, and it doesn't help that funding for Indian health care ranks dead last even behind federal funding for prisoner health. Adding to the burden are recurrent questions about the ability of a mammoth agency like the U.S. Indian Health Service to efficiently administer care in a way that is also flexible and responsive to local needs. Last year's Senate Indian Affairs Committee investigation into IHS only heightened these concerns.

Many tribal governments have taken these challenges head on by stepping in to IHS's shoes and replacing the agency as the local health care provider. These efforts date from the 1975 Indian Self-Determination Act, which empowers tribal governments to force the agency to turn over its operations to local tribal control. Today some Tribes control one or two IHS programs while many other Tribes have entirely replaced IHS and fully manage federal hospitals and clinics on their reservations. Overall, just over half the IHS budget is now controlled by tribal governments, representing over $2.2 billion dollars in health care spending, and employing over 53,000 people.

By every measure, the devolution of federal health care services to tribal control has been a stunning success. Patent satisfaction, accountability, access to care, billing practices, employment and employee morale—all have improved dramatically as a result of the movement toward greater tribal self-determination. All of this work has been accomplished under government contracts which federal law requires IHS to award the Tribes on much the same basis as any other government contract.

In the face of this history, it is nothing short of stunning that the government continues to budget insufficient funds to pay all of its contracts in full. In theory, the law requires that IHS not only pay a tribal contractor all of the health care funding IHS itself has to operate a given program, but to also pay sufficient funds (called contract support costs, or CSCs) for the contractor to actually administer the program. CSCs include funds for insurance, mandatory audits and financial management and procurement systems, and the government itself sets these fixed costs based upon independent audits.

But for several years the government has simply failed to budget sufficient sums to pay them. As a consequence, every year Tribes fully perform their part of the contracts by running IHS clinics and hospitals for a full year, but they usually do not know how much they will actually be paid—or underpaid—until the year is over.

Since the unpaid CSC costs are fixed, Tribes incur them regardless of whether IHS pays them. Generally, that means when IHS fails to pay the CSC costs, tribal contractors are compelled to make up for the difference by reducing their medical care expenditures under the contracts. With the largest share of the controllable medical costs being personnel costs, the result is layoffs or vacant positions left unfilled.

In the President's just-released Budget for the next fiscal year starting October 1st, the agency estimates that CSC underpayments will rise to $153 million nationally. That means a $153 million cut in IHS programs administered by Tribal contractors, in order to make up for the shortfall in the government's payments. Conservatively, that cut will cost over 1,500 medical positions across Indian country. In fact, however, the cut will cost over 2,700 positions because reduced medical services means reduced Medicare, Medicaid and private insurance collections that fund additional medical positions. All of these cuts will be shouldered by tribally-contracted IHS programs alone; none will be borne by IHS and the programs that remain under agency administration.

Insufficient budgets are not new to government contracting. To the contrary, they are routine. What is also routine is how the government typically deals with these situations:

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INDIAN HEALTH AND SMALL PROVIDERS PRESENT IT & MEANINGFUL USE CONCERNS

By Jim Roberts, NPAIHB Policy Analyst

Recent correspondence with various state and federal health departments reveals uncertainty about whether Tribal and urban Indian health programs fall within the definition of federally-qualified health centers (FQHC). Being within the definition of an FQHC carries significant benefits in the context of the electronic health records program (EHR) Medicaid meaningful use incentive payments established under the American Recovery and Reinvestment Act. An accurate interpretation and application of the definition of FQHC is therefore critical to ensure that Tribal and urban providers receive the benefits for which they are entitled under these statutes.

Likewise, small rural health clinics (RHC) and community health centers (CHC) present similar challenges for the Medicaid incentive program. Although meaningful use standards for EHRs should help improve patient care within RHCs and CHC, many barriers remain in place for smaller providers to adopt the technology, according to representatives of these facilities. Michael Lardiere, of the National Association of Community Health Centers, a national membership organization for FQHCs, indicates that meaningful use standards of EHRs could improve patient care within smaller health centers. This is because they have the potential to improve quality, safety, efficiency, reduce healthcare disparities, improve care coordination, improve population and public health and ensure adequate privacy and security protections for personal health information.

However, Lardiere cited funding as an obstacle to incorporating EHRs into FQHCs. "We would recommend that meaningful use funds be provided to FQHCs in the first year, as soon as an FQHC informs the state of its intent to sign an agreement with an EHR vendor, and the funds be available to the FQHC within 30 days of the notice to the state. This would allow the FQHC to move forward with adoption and be on their way to meaningful use. Unless these funds are available, the adoption of EHRs may be stalled."

The Medicaid incentives will be critical in the decision making process for many smaller Tribal programs in determining the feasibility of implementing an EHR. The Indian health system is already severely underfunded and in many instances cannot capitalize the costs to deploy an EHR. The costs associated with EHR software, hardware, and training are simply too much when balancing resources with the level of care that can be provided. Gaining access to the incentive payments will assist in the EHR deployment at many smaller Indian health, RHC, and CHC clinics. It is estimated that the incentive payments can assist to underwrite up to 50-60 percent of the costs in deploying EHR for these smaller types of health systems.

The Centers for Medicare & Medicaid Services (CMS) has advised the States that Tribal health programs do not qualify as FQHCs for the purpose of the Medicaid incentive program if they are billing the OMB encounter rate. It is an important distinction that Tribal health programs be able to participate in the incentive program as FQHCs in order to meet required patient volumes to be eligible for incentives. In order to be eligible for incentive payments, non-hospital based health professionals must have at least a 30% patient volume in the Medicaid program and/or physicians who practice in federally qualified health center or rural health clinic programs must have a Medicaid patient volume of at least 30 percent. FQHCs will be allowed to use the practice or clinic Medicaid patient volume (or needy individual patient volume) and apply it to all eligible providers in their practice. This provides an advantage for FQHCs if they cannot meet the patient volume threshold solely with Medicaid patients alone. Unfortunately, if CMS will not change their decision on this issue, implementation of EHRs may not happen for many smaller Tribal health clinics spread across Indian Country.

The importance of financing these costs is very important, not only for smaller health systems like tribal clinics, but larger sized

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GOVERNMENT UNDERPAYMENTS HURT TRIBAL HEALTH CARE

the agency, the President and Congress work together to secure supplemental appropriations each year to make up for any deficiency. Boeing and General Dynamics are paid in full for services rendered. But strangely when it comes to government contracts between Indian tribes and IHS, the same is not true. Tribes are left with no remedy but to sue the government for breach of contract, a substantial undertaking that only the bravest of Tribes dare undertake.

Two Tribes took on the challenge in the 1990s, the Shoshone Paiute Tribes in Idaho and Nevada, and the Cherokee Nation in Oklahoma. After nearly a decade of litigation and multiple lower court rulings, in 2005 the Supreme Court upheld the Tribes' contracts and authorized an award of damages for the CSC underpayments they had suffered. But the Bush Administration made no effort to comply with the Court's ruling, and it continued to budget insufficient funds to fully pay all of the government's contract obligations.

The Obama Administration has made significant gains in closing the overall shortfall by budgeting increased sums to pay tribal contractors, including over $100 million last year. But the prospect of a $153 million program cut in tribally operated programs next year shows there is still a long way to go before the government honors its contractual obligations to the Tribes.

Until then, the full promise of tribal self-determination will not be realized, jobs in Indian country will suffer, and patient care will remain even more limited than it already is.

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INDIAN HEALTH AND SMALL PROVIDERS PRESENT IT & MEANINGFUL USE CONCERNS

facilities as well. Marty Fattig, CEO of Nemaha County Hospital in Auburn, N.E. explained how EHRs were implemented at his 20-bed critical access hospital six years ago. Although Fattig was proud of the EHR progress at Nemaha County Hospital, he stated that the proposed meaningful use standards surpass the capability of its current system, and by extension, would surpass the capacity of many similar small hospitals and CHCs who have yet to implement EHR technologies. Fattig's primary concern for small hospitals and health centers was the accessibility of technical resources in their service area. Comparably, how can the Indian Health System effectively implement EHRs and achieve meaningful use if they do not have access to resources they are entitled as an FQHC.

The CMS decision flies in the face of authorizing legislation that allows any outpatient health program or facility operated by a tribe or Tribal organization under the Indian Self-Determination Act. An urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act, for the provision of primary health services is an FQHC as that term is defined in both Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. The CMS decision to ignore this statute effectively locks out smaller tribal health programs from the benefits of participation in the Medicaid incentive program.

As the statute is written and must be interpreted, any outpatient health program or facility operated by a tribe or tribal organization under the ISDEAA or by an urban Indian organization receiving funds under title V of the IHCIA for the provision of primary health services is statutorily an FQHC. The NPAIHB Board will be working to address this issue with CMS and the Tribal Technical Advisory Group with the goal of recognizing tribal health programs as FQHC in the Medicaid incentive program.

THE DEFICIT: WHERE DO INDIAN HEALTH PROGRAMS FIT IN?

continued from page 3

certain discretionary program spending for the next five years. The compromise lies somewhere above 2008 and at or below 2010 levels. Recent budget activity indicates that the IHS program may be treated more favorably than other discretionary programs. When the House passed their year-long continuing resolution (CR) for discretionary spending last session, it included a $93 million increase for IHS. While this is $261 million less than the President's request it demonstrates some support to fund Indian health programs. The Senate omnibus recommended the President's request of $354 million for IHS. Fortunately the House bill did not get passed by the Senate and unfortunately the Senate bill died in Congress. When Congress couldn't reach an agreement on 2011 appropriations they passed a CR through March 4, 2011.

Leading up to the March 4th deadline, the House did reach an agreement on a year-long CR that was passed and sent over to the Senate. The measure would have provided an $89 million increase for the IHS ($3 million less than what the House recommended last year) but was publically denounced by the Senate and began frantic negotiations between the two houses. Neither wanted the egg on their face over who would get blamed for a government shut-down if they couldn't reach an agreement. The result is that Congress passed a two week agreement that extended government operations through March 18th, at the 2010 spending levels. Where this leaves IHS and Tribal health programs is anyone's guess. Indications are that the IHS budget will be increased but not at the level needed or supported by the President.

The President's FY 2012 request does hold promise for Tribes and health programs. The 2012 request uses FY 2010 as its baseline, and because of this, increases or decreases may appear better or worse when compared to final Congressional action on the 2011 budget. For example, when the FY 2012 budget is compared to the FY 2010 level, it makes the President's request a $571.4 million (14.1%) increase. The increase for IHS when compared to the pending FY 2011 request is only $217.3 million (4.9%). The FY 2012 request is respectable given the fact that most discretionary funded programs were either cut, flat-lined or given minimal budget increases.

The President's request sends a clear sign that he continues to be supportive of Indian health programs and that he likely calculated the Congressional face-off over appropriations. A 14% increase over 2010 is a tell-tale sign that he anticipated Congress to cut his 2011 request, and he restored it with his 2012 request. So now begins the work with Congress to fight and support funding for our health programs. In the coming months, Tribes will need a focused effort of advocacy with new House members to educate them about Indian health, the federal trust relationship (though they won't want to hear it), and that we as Indian people will not go away. This will be critical for the survival of our health programs and people.

NCAI March 2011 - Andy Joseph, Jr., Colville Tribe, ***Jim Roberts,*** NPAIHB Policy Analyst, Dr. **Yvette Roubideaux** , IHS Director, ***Shawna Gavin,*** Umatilla Tribe, ***Pearl Capoeman-Baller***, Quinault Nation,

A TRIBUTE TO RACHEL JOSEPH

by Jim Roberts, Policy Analyst

It's fitting that we dedicate an article in this policy edition of our newsletter to an individual that has dedicated her life to advancing health care issues of American Indian and Alaska Native (AI/AN) people. I have worked with Rachel Joseph for over fifteen years. In this time, I have come to know her as a caring and compassionate tribal leader with a relentless resolve to get the job done. Her fortitude to continue work on the reauthorization of the Indian Health Care Improvement Act (IHCIA) despite the bill's demise on several occasions speaks for itself. The new IHCIA holds the promise to change lives of Indian people by increasing their access to and quality of health care services.

Rachel is a member of the Lone Pine Pauite-Shoshone Tribe who has also served as the Tribal Chair for many years. She serves on the Board of the Toiyabe Indian Health Project, a consortium of nine Tribes, in Mono and Inyo Counties in central California. Rachel began her career working in California in the early employment and training manpower programs. In time her work progressed to working at the national level including a brief spell as an interim Executive Director of the National Congress of American Indians (NCAI). She is active on Indian education issues working at the state level in California on youth scholarship programs. Rachel has also served on the IHS National Budget Formulation Workgroup since its inception. In 1999, Rachel Joseph was appointed as one of the Co-Chairs of the IHCIA's National Steering Committee (NSC), a position she held until achieving passage of the bill last year.

Rachel's contributions to achieve passage of the IHCIA are truly remarkable when one considers the sacrifices she made over an eleven year period. The reauthorization process began in 1999 and did not end until March 23, 2010. Rachel was there every step of the way beginning with the NSC listening sessions in 1999 and 2000, then developing legislative language in 2001, and finally getting a bill (S. 2526) introduced by Senator Ben Nighthorse Campbell in the 106th Congress. Following introduction of the first IHCIA bill there were a number of objections by either Congress or the Administration. Between 2001 and 2003 the NSC and Rachel worked hard to compromise and reach consensus with members of Congress, the Administration, and Indian Country on a number provisions. Key to this was the leadership of Rachel Joseph and her relentless work ethic to make sure that all parties in the reauthorization process stayed focused and on task.

Important to understand is that serving as the NSC Chair was not a paid position that also required resources. It required a tremendous amount of work and dedication. Rachel's efforts were covered by her Tribe, the Toiyabe Indian Health Project, and the California Rural Indian Health Board (CRIHB). California Tribes financed a significant cost of getting the IHCIA passed through Rachel's leadership on the NSC. Working on the passage on the legislation is not cheap. Our Board understands how significant these costs can be and easily estimate our contribution to the IHCIA was over $1 million. The costs to CRIHB had to be similar if not more. CRIHB is equally a recipient in our accolades to Rachel's work and for their support to get the IHCIA passed.

In 2004, I recall sitting in the hotel lobby of the NCAI winter session with no IHCIA reauthorization bill imminent in the 108th Congress. I was speaking with Tim Martin, Executive Director of the United South and Eastern Tribes, Ed Fox, then Executive Director of our Board, and Rachel Joseph. We were complaining and feeling sorry about how the reauthorization bills in the 107th Congress failed (S. 2526 and H.R. 1662) and it didn't look favorable to get a bill introduced in the 108th session. Rachel pulled us up

A TRIBUTE TO RACHEL JOSEPH

by our boot straps and commanded a meeting to be held at the National Indian Health Board the next day. She instructed each of us to mobilize and collect as many of the NSC members that were in town for NCAI and bring them to the meeting. Where a service area did not have tribal representation, she recruited a Tribal leader from that Area to participate in the meeting. What followed was a series of NSC conference calls with the Administration and Senate Committee on Indian Affairs staff and in time Senator McCain introduced S. 1057. Rachel once again breathed life into a process that seemed dead. This probably would not have happened if it was not for Rachel's tenacity and undying commitment to get the IHCIA reauthorized.

I am sure there are many other stories that people could tell about Rachel's undying resolve. She would fly countless trips to Washington D.C., sometimes at her own expense, to meet with Congressional Committees and members. She would go to D.C. at the drop of a hat for meetings that NIHB or NCAI had set up and needed NSC representation. If CRIHB or NPAIHB needed her in D.C. she was there without question or regard for herself. Rachel isn't one to complain or share her personal health issues. But on many of these trips Rachel was suffering her own health care challenges. She testified countless times before important Committees like Indian Affairs, House Natural Resources, and Senate Finance. She was often put into contentious situations to facilitate disagreements within the National Steering Committee or with the Administration. Never once did I witness Rachel put her personal interests or the needs of the California Tribes above the interests of Indian Country. She was never willing to jeopardize the well-being of the bill. Some of these contentious issues included facilities construction and the infamous "DOJ Whitepaper" leaked by the Administration. She did a remarkable job to maintain consensus among all of Indian Country and to finally achieve passage of the Act.

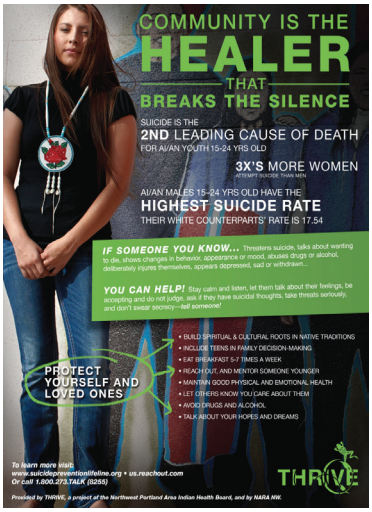
Rachel often brought her mother, Dorothy Joseph, to IHCIA meetings or functions of the NSC. We all got to know Dorothy and that she was synonymous with Rachel's work on the IHCIA. So it was a sad time when she passed. I called Rachel when she lost her mother to pass along my condolences and while she was sad and grieving, she told me (in her auntie tribal leader voice), "... you know Jim, I am truly sad to have lost Mom and she had a wonderful life. But I also know she might have lived longer and had a better life if she had better health care." Rachel went on to explain that her mother's passing had renewed her strength and commitment to get the IHCIA passed, a loss that she drew inspiration from and used to benefit all of Indian Country. Sure enough a couple of weeks later (not months mind you) I saw Rachel and she was right back at work hitting the hill and calling on Congress.

We have our own champions in the Northwest that played a key role in the passage of the IHCIA and those have their own stories. But I believe that most of us involved in working on the IHCIA will agree that we could not have gotten it done without Rachel Joseph!

SUICIDE PREVENTION, POLICY, AND THRIVE

by Colbie Caughlan

No one can deny the link between substance abuse and other behavioral health issues and suicide. Yet the policy framework and funding to address substance abuse and suicide prevention issues has been slow to evolve in the Indian health system. For decades, Tribal leaders have advocated for effective policy and funding to address the onslaught of substance abuse issues and suicide in Indian Country. It isn't until recently that Tribes are now beginning to see new policy initiatives that hold hope for Indian Country to combat these issues. The reauthorization of the Indian Health Care Improvement Act (IHCIA) integrates alcohol and substance abuse with mental health services to take a comprehensive and integrative approach to behavioral health. The IHCIA now provides for both prevention and treatment programs for Indian children, youth, women and elders. The policy changes around the new behavioral health programs will emphasize the interconnectedness of services related to alcohol and substance abuse, child welfare, suicide prevention and social services.

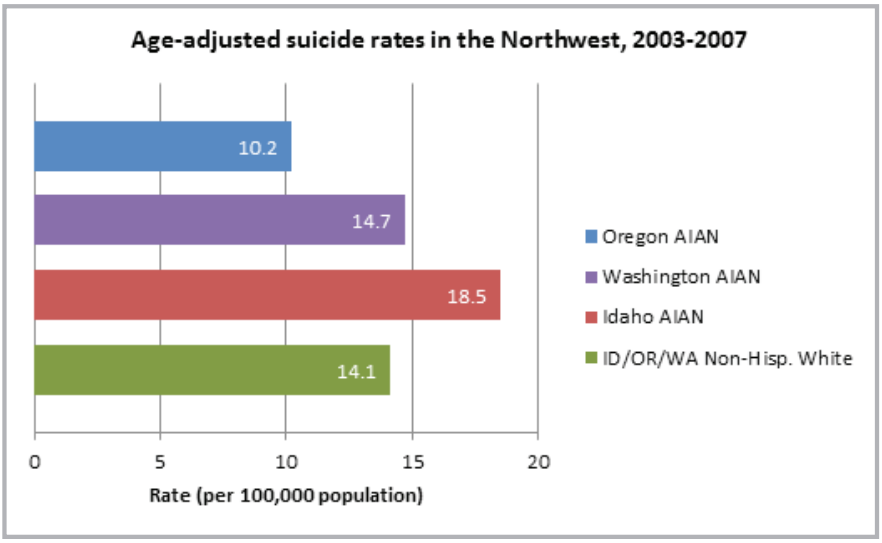


The new IHCIA includes specific provisions to address youth suicide as part of the behavioral health program and in a culturally-appropriate manner. IHS now has authority to award grants for telemental health demonstration projects to provide counseling to Indian youth and health providers, training for Indian community leaders, and the development of culturally-relevant materials. This important policy was developed in response to Congressional hearings and Tribal leader listening sessions on suicide issues in Indian Country. These grant opportunities recognize that suicide prevention for Indian youth is a long-term effort and must be addressed for many multi-factorial causes. Questions such as whether the loss of cultural identity contributes to the youth suicide problem remain unanswered. The IHCIA makes suicide a priority for the IHS research agenda, particularly the identification of various factors that either protect the tribal community or make that community at risk for suicides, and the role the loss of tribal identity plays in suicidal behavior.

Just over one year ago, the Northwest Portland Area Indian Health Board announced new funding from the Indian Health Service (IHS) to provide regional support for the *Methamphetamine and Suicide Prevention Initiative* (MSPI). During this first year the MSPI project staff worked hard alongside G & G Media to develop media materials to not only "brand" the project, but to be among the first to create an AI/AN suicide prevention media campaign in the United States. The project has since been named *THRIVE* (meaning *Tribal Health: Reaching out InVolves Everyone)*, a logo was developed, and a new slogan has been sweeping across the region *Community is the Healer that Breaks the Silence.* THRIVE staff hope to share the media materials that were developed, such as flyers, posters, window clings, t-shirt designs, wallet tip cards, flash drive designs, and other templates, with other Tribes around the United States and collaborate more with other regions to continue creating more AI/AN suicide prevention materials. To view and download these materials please visit our webpage at http://www.npaihb.org/epicenter/project/thrive/.

Policy development and funding for suicide prevention continues to be needed, for example, in the past six to ten months, deaths by suicide have remained in newspaper headlines and on televised news shows. There was the death of the gay male college student, the suicide pact of two teen girls in the Northeast, the couple of AI/AN youth who jumped in front of trains and who took their lives on school campuses among the NW

SUICIDE PREVENTION, POLICY, AND THRIVE



Tribes. The Oregon Partnership (OP) is in charge of the crisis line in the Portland-metro area of Oregon State and in December 2010 they too saw a spike in the need for suicide rescues. With all of the deaths by suicide and increasing number of attempts it is times like these when prevention programs and staff must work even harder to help make communities aware of the impacts of suicide, how to prevent them, and how to engage in postvention (aftermath of a suicide). The NPAIHB and THRIVE continue to support the NW Tribes in any way possible as they all have suicides among their community members.

It is because suicide needs to be discussed more often in Tribal communities, it is because no more lives should be taken by suicide, it is because community members should not have to grieve multiple times per year due to lives taken by suicide, and it is because suicide is 100% preventable that government officials and agencies, prevention programs and staff, and community groups are partnering to educate more and more people on the signs of suicide to save lives in the future! The IHS Behavioral Health Workgroup developed a National Tribal Advisory Council that was tasked to work together in creating a five-year Suicide Prevention Strategic Plan that will address Indian Country fears when it comes to suicide – the fear that suicide will continue to take the lives our young Indian youth at alarming rates. This Plan is in its final draft stages and will be reviewed by the IHS Director by late 2011.

In November 2010, IHS and the Department of Veteran's Affairs (VA) signed a comprehensive Memorandum of Understanding (MOU) targeting the improvement of health status among AI/AN Veterans. This MOU will provide coordination, collaboration, and resource-sharing between the organizations to create more efficient services for populations served by both the VA and IHS. This agreement highlights the importance of Tribal consultation as well as collaboration among leaders from both organizations. A few strategies of the MOU are to: increase service and benefit access, improve the coordination of care, and to improve system efficiency and effectiveness.

The Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of the Interior (DOI), and IHS worked together in the Fall of 2010 to begin Suicide Prevention Listening Sessions across Indian Country. These sessions were very important to hear from tribal members and those who advocate for tribes across the U.S. These listening sessions recently came to a close and ideas, suggestions, and experiences that were shared will be taken into consideration while the three agencies work to organize a National Suicide Prevention Conference. All that was shared at the listening sessions will give IHS, SAMHSA, and the DOI a better grasp of how to effectively support tribal communities and show their continued need for more policies and funding to be put in place to help them combat suicide.

Another step forward regarding suicide prevention in Indian Country has been the development of the AI/AN Task Force for the National Action Alliance for Suicide Prevention. This Task Force, along with the

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FIRST TRIBAL CLINIC NOW ACTIVE ON THE STATE'S BROADBAND TELEHEALTH NETWORK

Siletz Community Health Clinic able to provide better access to health care via the Oregon Health Network

(Portland, Ore.) – The Oregon Health Network announced the addition of its first tribal clinic, Siletz Community Health Clinic, to its growing statewide broadband telehealth network. The clinic, part of the Confederated Tribes of Siletz Indians (CTSI), is one 67 active provider sites being monitored 24/7/365 by OHN's Network Operations Center (NOC).

"Tribes have been hoping for more help from Indian Health Services (IHS) so that tribal populations can have greater access to care, but IHS, state and local budgets face financial limitations," says CTSI Health Director Judy Muschamp. "We would encourage other tribes to take advantage of this opportunity to get funding for the broadband infrastructure and the 85 percent support funding for up to five years."

Siletz Community Health Clinic is one of 166 sites in Oregon participating in the Rural Health Care Pilot Program (RHCPP). Of those, 96 sites have received funding commitment from the Federal Communications Commission and 67 sites have 24-hour monitoring by the NOC. The rural tribal clinic received 85 percent of its installation costs covered through the program with the remaining 15 percent from OHN's matching funds to launch or enhance their broadband infrastructure. Ongoing monthly recurring costs associated with broadband service are paid at 85 percent over the duration of the 5-year program that ends in May 2014. Siletz will pay the remaining 15 percent monthly.

Siletz Community Health Clinic now gains immediate access to the NOC and can connect to a statewide network of providers and health care education sites. The new 100 mbps connection is a tremendous upgrade from the old shared 1.5 mps connection and will expand and improve the clinic's operations, service delivery and referral partnerships.

CTSI is a self-governance tribe with approximately 4,770 enrolled tribal members. One of the programs that CTSI funds and manages is the Siletz Tribal Health Care Program—the delivery of comprehensive health care to the Siletz Indian People and their dependants within their 11-county service area in western Oregon. Services are provided through a combination of direct care, contracts and referral to appropriate agencies. Patients are offered health and wellness, dental, laboratory, radiology, alcohol and drug treatment, mental health, optometry and more.

Oregon providers in rural and underserved areas encounter the challenge of limited availability of funding and information technology expertise. "A lack of quality broadband access, equipment and resources can be a significant barrier for both rural and urban providers," adds Lamb. "Technologies and applications on the forefront of medicine can be challenging to integrate and implement. It is exciting that Siletz now joins a growing number of providers in Oregon who are providing access to care and emerging technology to provide better care for patients."

The FCC awarded Oregon $20.182 million and the state has pledged an additional $3.8 million to be administered by OHN to build Oregon's first telehealth broadband network. OHN's vision is to provide the best access to health care, no matter where a patient lives or a provider works in Oregon.

Oregon Health Network's $20.182 million subsidy was the fifth largest award as part of the FCC's Rural Health Care Pilot Program and provided for full deployment of the critical first phase of the infrastructure necessary to build the first statewide, broadband, telehealth network in the state. Through the RHCPP, OHN is working to bring on as many as 166 eligible hospitals, clinics, community colleges and government facilities onto its managed, high-speed, broadband network.

Nationally, $417 million has been allocated within the FCC RHCPP

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FIRST TRIBAL CLINIC NOW ACTIVE ON THE STATE'S BROADBAND TELEHEALTH NETWORK

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to subsidize hundreds of hospitals, providers and clinics representing 42 states, three territories and more than 6,000 health providers.

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About the Oregon Health Network

Oregon Health Network (OHN) administers a $20.2 million Federal Communications Commission subsidy and more than $3.8 million in state funding to create Oregon's first state-wide broadband telehealth network. OHN is a nonprofit, member organization connecting and serving physicians, allied providers, clinics, health organizations, educators, students, government agencies, and businesses who are critical to improving the quality, access and delivery of health care to Oregonians. OHN provides high-speed, high quality, broadband connectivity for electronic medical records, radiological images, videoconferencing, and distance education applications which will expand the use of telemedicine and telehealth education in Oregon. The network also connects providers to each other, reducing the cost of health care in rural communities by minimizing duplicate efforts and time, obtaining correct patient information, procedure codes and referrals, and much more. Thirty-five providers in Oregon are live on OHN's broadband telehealth network with 24/7 monitoring by the Network Operations Center. Please visit our website for additional information at www.oregonhealthnet.org

CONTACT: Kim Lamb, Executive Director, (503) 344-3742

SUICIDE PREVENTION, POLICY, AND THRIVE

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others newly created (Lesbian, Gay, Bisexualy, and Transgender Task Force and the Military/Veterans Task Force), will work to carryout goals of the National Strategy for Suicide Prevention, engage in data and surveillance, and conduct research. The tasks will help shed more light on these high-risk populations and how to more effectively prevent suicide among them.

Over the past one and a half years, THRIVE staff have also been working to decrease suicide among the NW Tribes. They work hard to carry out goals from the *Northwest Suicide Prevention Tribal Action Plan* and have been successful in providing suicide prevention training and technical assistance, and financial support to the NW Tribes. In April 2010 and October 2010 THRIVE awarded 28 MSPI Cooperative Grants to NW Tribes. The grants amounted to over $176,000 and many prevention activities and events were held throughout Idaho, Washington, and Oregon Tribes.

With the Cooperative Grant funds, tribal communities have already or are planning to: participate in suicide prevention or crisis response team trainings and workshops, organize or expand their crisis response team, disseminate suicide prevention materials at health fairs and community events, provide expert suicide or meth prevention speakers to events, contract with the *Music Mentors Academy* to teach their youth how to express their feelings and the impacts of suicide and drug use in positive ways through song writing and production, and organize a multiple-day youth camp that focused on suicide prevention and what warning signs to look out for with friends and family.

Please contact THRIVE staff at the NPAIHB if you need any technical assistance and/or suicide prevention trainings organized in your tribal community. THRIVE staff are trainers of the *Applied Suicide Skills Intervention Training* (ASIST), *Question Persuade Refer* (QPR), and *SafeTALK*, for more information about these trainings please visit www.qprinstitute.com and www.livingworks.net.

Contact Information: Colbie Caughlan, MPH (503) 416-3284 or ccaughlan@npaihb.org.

BILLY MILLS YOUTH CONFERENCE: A "GOLD"EN SUCCESS

Billy Mills, won the 1964 10,000 meter Olympic gold medal in what has been called the greatest race on the track in Olympic history. However, his trek to that track was anything but golden. "It's the journey, not the destination," Mills told a group of youth ages 12-18

attending a three-day American Indian Youth Prevention Conference at Seven Feathers Casino Resort. "It's the daily challenges you face in life."

Mills, 72, a member of a Lakota Tribe, grew up on the Pine Ridge Indian Reservation in South Dakota. Both of his parents died by the time he was 12 and was raised by his grandmother. He attended the University of Kansas on a track scholarship and earned All-American honors for three years. He won the individual title in the 1960 Big Eight cross-country championships and was a member of the Jayhawks' outdoor track teams that won two national championships. As the sole American Indian on the Jayhawk campus, however, he was barred from joining a fraternity, was asked to step aside from his fellow All-Americans so that a group photo could be taken without him in it, and encountered the many stereotypes American Indians face today such as being labeled alcoholics, drug abusers, and quitters.

After graduating from the University of Kansas with a degree in Physical Education, Mills joined the U.S. Marines where he was able to start his training for the Olympic trials. He finished second at the U.S. Olympic Trials and was virtually unknown coming into Tokyo since he had not won a major race and was overshadowed by favorite and world record holder Ron Clarke of Australia. Clarke set the pace for the 6.2 mile race and at the halfway point, only four runners, including Mills, were still with him. On the final lap, Mills found himself being pushed by Clarke and Mohammed Gammoudi of Tunisia who sprinted into the lead as they rounded the final curve. Mills ran wide into the third lane and passed both Gammoudi and Clarke to win the gold medal in Olympic record time. Mills' time of 28:24.4 was nearly 50 seconds faster than he had ever run. He remains the only American to win the 10,000 meters at the Olympics.

Today, Mills is a businessman, author and national spokesperson for Running Strong for American Indians, an organization that helps support projects that benefit the American Indian people, especially youth. As the spokesperson, he's been able to raise over $120 million for organic gardening opportunities, two dialysis clinics, helping the elderly with emergency heating bills and to build up the infrastructure on the reservations as a means of trying to empower American Indians.

Mills was a large presence during the three day conference that sponsored 50 Tribal youth, their adult chaperones and members of the Cow Creek Health & Wellness Center and Cow Creek Band of Umpqua Tribe of Indians' staff. Youth from the Cow Creek Tribe, Burns Paiute Tribe, Klamath Tribes as well as tribal members from Washington State and California traveled to the event hosted by the Cow Creek Health & Wellness Center, Indian Health Services and Nike. On the agenda were a variety of cultural activities, self-care and nutrition activities, youth suicide prevention training, diabetes prevention, A&D

BILLY MILLS YOUTH CONFERENCE: A "GOLD"EN SUCCESS

prevention, many physical activities, games and much more. Mills made a surprise appearance to the youth and adults after they viewed the movie, Running Brave, a 1984 movie based on his life. He also observed many of the activities, dined with the kids and staff and was the keynote speaker at the 100 person dinner on the final evening of the event. The dinner began with drumming by Thundering Water Drum Group, followed by a welcome from Cow Creek Tribal Administrator, Michael Rondeau and a prayer by Teri Hansen. Cow Creek Tribal Counsel Wayne Shammel introduced Mills who was also presented with a gift and medal of recognition from Tribal Board Member, Robert Van Norman, for Mills' military service with the Marines. "We're trying to provide a positive message in a very troubling time," Tribal Administrator Michael Rondeau said. "For our first event, it was a big success", said Cindy Delay, Outdoor Recreation Coordinator for the Tribe. We had a decathlon of activities to give a good variety for our youth. One that meant a lot to me was to empower and enable our youth to save a life through the QPR training (suicide prevention) taught by Diane Rose, CCH&WC's Behavioral Health Manager. We would like this conference to be an annual event."

Mills' words of wisdom can empower people of all races and walks of life. "The daily decisions you make in life, not the talent you possess, are what choreograph your destiny. Ultimately, it's the pursuit of excellence that takes you to victory. When you find that passion, it allows you to focus. In my American Indian world when you are focused, then the body, the mind, and the spirit all work as one to motivate you to discover and achieve your dream."

TRIBAL PLANNING FOR HEALTH INSURANCE EXCHANGES BEGINS NOW

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of people who will be covered, their estimated income levels, their level of utilization of health services and the cost of the plan premium. Tribal governments will also have to determine the criteria that they will use to pay premiums.

Summary

Health care reform will provide new opportunities for expanded access to health care services for AI/AN and increased I/T/U revenues to provide needed services. Effective Tribal consultation in the development of Health Insurance Exchanges should result in specific positive outcomes to make the Exchanges work effectively for Tribes and AI/AN.

Kris Locke *is a consulting health policy analyst who has worked with Tribes since 1993. Her work has focused on improving access to health care services, State/Tribal relationships and reorganizing health programs to maximize funding. Kris lives in Sequim, Washington.*

***Mim Dixon, PhD**, is a consultant who specializes in policy, research, planning, and facilitating in the field of American Indian and Alaska Native health care. Her work for tribes and tribal organizations has included managing large tribally-operated health care systems, as well as serving as Policy Analyst for the National Indian Health Board. She is the author, co-author or editor of four books and numerous articles.*

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S JANUARY 2011 RESOLUTIONS

RESOLUTION #11-02-01
Change to NPAIHB Resoluion Template

RESOLUTION #11-02-02
NW Tribal Substance Abuse Action Plan

RESOLUTION #11-02-03
Board Approved Program Ops Manual

RESOLUTION #11-02-04
NW Tribal Data Repository

RESOLUTION #11-02-05
Portland Area-wide RPMS Database

RESOLUTION #11-02-06
Sub-recipient to NIHB HITECH REC