Health News & Notes

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

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Policy

The Marketplace Offers Continued "Sponsorship" Opportunities

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"Sponsorship"[1] is a term frequently used to refer to the purchase of health insurance coverage by a Tribe or Tribal health organization (T/THO) on behalf of Tribal members, including dependents of enrolled Tribal members[2]. The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) created expanded opportunities for T/THOs to access federal resources through Sponsorship.

IN THIS ISSUE:

Despite the uncertainty over the ACA emanating from Washington, D.C., T/THOs are increasingly looking to Sponsorship as a means of leveraging capped federal funding in order to secure substantial new health care resources to meet the needs of Tribal citizens. And even under congressional proposals to "repeal" the ACA, Sponsorship opportunities created under the Affordable Care Act are expected to continue, at least through January 2020.

Background

For some time[3], T/THOs have engaged in Sponsorship of Tribal members by paying the health insurance premiums under federal programs, such as Medicare Part B (for physician and other ancillary services) and Medicare Part D (for pharmaceutical coverage).[4] Under Medicare Part B, most enrollees pay 25% of the premium, with the federal government subsidizing the remainder of the cost.[5] The federal government also covers 75% of prescription drug costs for most enrollees under Medicare Part D.[6]

In addition, and particularly for Tribes with members dispersed across the country, some T/THOs have viewed securing health insurance coverage—even if unsubsidized by federal assistance—as the most efficient and effective means of providing timely access to necessary health care services for Tribal members. As a result, some T/THOs have purchased, or provided through a self-insured plan, health insurance coverage through the individual or group insurance market for some or all of their Tribal members.

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Northwest Portland Area Indian Health Board

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Chairman's Notes

By Andrew Joseph, Jr.,
Colville Tribal Council
NPAIHB Chair

Hello,

I wanted to share with everyone that I attended the U.S. Department of Health & Human Services, 19th Annual Tribal Budget and Policy Consultation, on March 30, 2017. Tribal leaders from across Indian country attended the meeting to discuss budget and policy concerns with leadership from several federal agencies, including: HHS Office of Intergovernmental Affairs, HHS Office of Budget, Administration of Children and Families, Administration for Community Living, Administration for Native Americans, Administration on Aging, National Institutes of Health, Centers for Disease Control and Prevention, Substance Abuse Mental Health Services Administration, Centers for Medicare and Medicaid Services, and Indian Health Service.

As a co-Chair of the National Tribal Budget Formulation Workgroup, I made a needs-based budget request to IHS of $32 billion to be phased in over a 12-year period. I also discussed the impact of cuts to the Low Income Home Energy Assistance Program (LIHEA), the Meals on Wheels Program, and the Low Income Student Foods Assistance Program; recent passage of bill in Washington state allowing dental health aide therapists (DHATs) to work in Tribal communities, and need to get DHATs approved for reimbursement under Medicaid; Indian country's oral health disparities, the need for DHATs, and the Indian Health Care Improvement Act's restriction on use of DHATs without state authorization; importance of Headstart; funding for traditional healing and the Tribal Behavioral Health Agenda; and other concerns. For the Colville Tribe, I talked about working with the State on obtaining the inpatient encounter rate for our convalescent center and in-home care and long term care needs.

Tribal leaders also met with HHS Secretary Tom Price. Secretary Price acknowledged the trust responsibility and government-to-government relationship with Tribes. He genuinely seemed interested in our concerns and expressed interest in visiting Tribes. I was able to speak directly with him and reiterate several of the concerns that I expressed to the federal agencies. It was full day!

I am honored to represent my Tribe and the Board at these meetings and always welcome your input and concerns.

Way límˈlímx (Thank you)
Yəx̌ʷyəx̌ʷúɬxn (Badger)

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Impacts on tribal health programs

By Geoffrey D. Strommer,
Partner Hobbs, Straus, Dean & Walker

This article briefly discusses some of critical issues that have arisen during the first 100 days of Congress, along with updates on a number of other developments, including: the status of the ACA "repeal and replace" efforts; Indian Health Service appropriations for FY 2017; the FY 2018 Budget; the Redding Rancheria litigation and proposed CHEF rules; "Section 105(l)" lease proposals under the ISDEAA; and an update on contract support costs developments.

ACA "Repeal and Replace" Efforts on Hold, For Now

Despite an intense push by the White House and Republican congressional leadership over the last several weeks, the effort to repeal and replace the Affordable Care Act (ACA, also known as Obamacare) appears to have stalled—at least for now. Leadership was hoping to deliver on the Republicans' campaign promise to repeal and replace the landmark healthcare law through a budget reconciliation measure, which requires only a simple majority to pass the Senate but limits the subject matter of the legislation to budget-related matters. Draft legislation was unveiled on March 6, 2017 and subsequently amended in attempts to address concerns by both moderate and conservative Republicans in the House of Representatives, but on March 24 a House floor vote was cancelled after Republican leadership failed to muster enough votes for the bill to pass.

Indian Country has been closely monitoring the ACA repeal and replace effort for its potential impact on the Indian health system. Critically, the Indian Health Care Improvement Act (IHCIA) was permanently reauthorized as Section 10221 of the ACA, so a wholesale repeal of the ACA would also repeal the IHCIA. In addition, there are several Indian-specific provisions in the ACA that provide critical resources and protections to American Indians and Alaska Natives and to the IHS and tribal health programs, including: Section 2901 (which makes the IHS and tribal and urban Indian health programs the payor of last resort by statute, enabling them to collect reimbursement from third party sources); Section 2902 (which grants IHS and tribal health programs permanent authority to collect reimbursements for all Medicare Part B services by removing the "sunset" date that had applied to authority to collect for some Part B services previously); and Section 9021 (which ensures that the value of health benefits provided by a tribe to its members are not considered taxable income). In addition, Medicaid Expansion (enacted as part of the ACA) has significantly increased Medicaid reimbursements to the IHS and tribal health programs in expansion states.

The budget reconciliation measure recently proposed by the House Republican leadership would not have impacted the IHCIA, or several of the other key Indian-specific ACA provisions. However, the bill proposed to defund Medicaid Expansion effective in 2020 and would have made other significant changes to the Medicaid program, including a per capita cap on federal Medicaid contributions and a state block grant option. Tribal advocates were successful in their efforts to exclude services received through the IHS and tribal health programs from being included in the proposed cap. However, the cap could still have had a major impact on tribal health programs by forcing states to roll back eligibility and coverage unless they could afford to subsidize the program with additional state funds. Additionally, the bill proposed to replace the existing ACA premium tax credits with less generous portable tax credits and to eliminate the ACA cost sharing protections, including those for American Indians and Alaska Natives now in effect. The bill, though supported by the White House, was widely criticized and ultimately rejected by both conservative Republicans (who felt the bill was too similar to the existing ACA) and more moderate House members (who were concerned that the bill, among other things, would result in a loss of coverage for many of their constituents).

Impacts on tribal health programs

Immediately following cancellation of the House floor vote on March 24, both President Trump and House Speaker Paul Ryan indicated that they would be dropping the effort and moving on to other matters. More recent news reports suggest that there is still some appetite among at least some legislators to pursue healthcare legislation, but it is uncertain as to whether and when such efforts may begin.

In addition to the legislative efforts, administrative efforts are underway to make significant changes in implementation of the ACA and Medicaid. For example, on March 14, 2017, Health and Human Services (HHS) Secretary Tom Price and Seema Verma, the new Administrator for the Centers for Medicare & Medicaid Services (CMS), sent a letter to state governors calling Medicaid expansion a "clear departure" from the mission of the program and outlining possible changes to Medicaid requirements. The letter suggested that CMS might approve new waiver applications submitted by states that would impose work requirements on Medicaid recipients, alluding to innovations that involve "training, employment, and independence," and said that states may want to consider new premium or contribution requirements, cost-sharing models, emergency room co-pays, and waivers of presumptive eligibility and retroactive coverage. In addition, the Administration has indicated it is open to taking steps that would affect Marketplace coverage under the ACA, including waiving fines for not enrolling in coverage; rolling back outreach on marketplace coverage; tightening enrollment and collecting unpaid premiums; and shortening open enrollment periods. These measures could all be adopted without Congressional action. In addition, there is ongoing litigation regarding the Administration's ability to use available appropriations to fund cost sharing subsidies under the ACA, and the new Administration's position in the litigation is not yet clear.

Indian Country will need to monitor these issues closely, and be prepared to work with Congress and the administration to ensure that any changes to the ACA or the Medicaid program do not have a negative impact on Indian country.

Congress Endeavoring to Put Together a FY 2017 Omnibus Appropriations Bill to Fund the Remaining Five Months of the Fiscal Year

With the clock ticking on the FY 2017 Continuing Resolution (CR) – the source of current funding of most federal agencies – Congress is now trying to pull together a FY 2017 omnibus appropriations bill to fund the remaining five months of the fiscal year for all federal agencies for which appropriations bills have not been enacted. The current CR expires midnight of April 28, 2017. Given that Congress will be out for a break April 8-23, that leaves eight legislative days (as of April 3) for the necessary House and Senate consideration of what would be a massive piece of legislation. The House and Senate Appropriations Committees have been negotiating these final bills behind the scenes and reportedly, they are close to being completed. The fact that the first seven months of the fiscal year have been funded via a CR, primarily at pro rata FY 2016 funding levels and conditions, there is some limitation on the changes that can effectively be made at this point in time.

Other than for Military Construction/Veterans Administration, Congress has not enacted any FY 2017 appropriations bills. The FY 2017 Defense bill has been negotiated and introduced and likely will be the vehicle on which to attach an Omnibus Appropriations bill or a CR.

Should an omnibus appropriations bill not be viable, Congress would again need to resort to a CR – either very short term while negotiations continue – or through the end of the fiscal year. Should there be another CR it might contain some differences ("anomalies") from the FY 2016 funding levels. If so, that is an opportunity to obtain some increases over FY 2016.

The House and Senate Appropriations Committees' FY 2017 Interior, Environment and Related Agencies bills differ in some significant ways with regard to the IHS. The House-passed bill recommended significantly more than the Senate for IHS built-in costs, Purchased/

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Policy as a Community Health Tool

By Nora Alexander *(Nez Perce)*
WEAVE-NW Project Specialist
Jenine Dankovchik
WEAVE-NW Biostatistician & Program Evaluation Specialist
Nanette "Star" Yandell
WEAVE-NW Project Director & Epidemiologist

In a fickle political environment, it is easy to feel the uncertainty that may negatively impact our budgets, intervention programs, and public health strategies. How can we plan for the future when the funding for programs may not be available? What ways can we help our communities if resources are finite?

Policies may lead to a more sustainable approach to public health strategies while simultaneously helping your communities.

If policies are defined as a binding fixed document, then it is more difficult to view them as sustainable or having a lasting support to make a change. What if we expand our definition of policy to be inclusive to the cultural and traditional values for the people the policy is written to represent? Expanding the definition of policy to include the unwritten rules within the community through tradition and culture may increase the sustainability and effectiveness of implementation. Tribes are in a unique position to create lasting policy change.

Elders' Wisdom is Policy

A local tribal community wanted to decrease the high consumption of sugar-sweetened beverages during cultural activities on their reservation, especially for youth. The Tribal Council knew that signing and posting a written policy would not necessarily change the drinks that were brought to different gathering areas; they also knew that as soon as an Elder stated a guideline sharing their wisdom, the community listened. An expanded view of policy was that when multiple Elders stated to the youth that sugar drinks were no longer allowed in the public gathering centers, no one questioned these words. In addition, because community members knew the message came from a good place, they told their friends and relative and implementation of this policy could be actively seen within the week.

The story above does not mean that written policies are obsolete, rather it is an example of community culture as a guide when writing a policy. Adhering to traditions, wisdom, and embracing the strategies that already exist bring lasting changes in a time of uncertainty.

The WEAVE-NW (Good Health and Wellness in Indian Country) project, focuses on decreasing chronic disease through upstream approaches that lead to long-term sustainable change. This often includes policies focused on improving access to healthy, safe, and affordable foods for Tribal communities across the Pacific Northwest. WEAVE-NW funds over seven gardens in tribes across Oregon and Washington that include Tribal food sovereignty initiatives. These projects have policies that come in many forms. For example, over the past year policies have been created on Food Handling Protocols, Food Voucher Programs that link Tribal Clinics with their Community Gardens, and community involvement of Tribal Council for support of the gardens beyond the funding years.

It is imperative that community leads the way when making policies. This includes the youth, our future Tribal Leaders. Policy is not created for policy sake, instead community-driven policy leads to sustainable efforts that will exist well beyond the current political climate. Including youth is key to ensuring healthier communities for our future generations.

Listening for the Answer

Another great community health policy success is in a community that wanted to increase walking and bike use on their reservation. They have trails and a bike lending library, and both were underutilized. For their project, Tribal Council asked community members why they were not checking out bikes and what may help them be encouraged to use the trails more. They learned that there were dogs running

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Policy as a Community Health Tool

lose on the reservation throughout the day and in particular, people were afraid of being bitten. Tribal Council unanimously passed an ordinance within a few months requiring dogs to be locked up at their homes or on a leash during the day. Within six months the bike use and trail use increased substantially.

Although the original project aim was to increase physical activity in the community by adding opportunities such as a walking club and other outdoor opportunities, that is not exactly what the community needed. The best way to increase physical activity in this specific community came to light by listening to what the community said were their specific barriers. When it comes to improving the health of our communities it is key to listen to the stories of everyday life to hear the role the environment has on increasing overall health.

Where we live, work, play, and gather all has an impact on our health. Policies that include the culture and traditions of our community including our relationship with the natural and built environment are more likely to address the root of health issues and provide long term sustainable changes. Health truly can be included in all policies!

For more policy information please contact:
weave@npaihb.org

Nez Perce Tribe – Community Overview

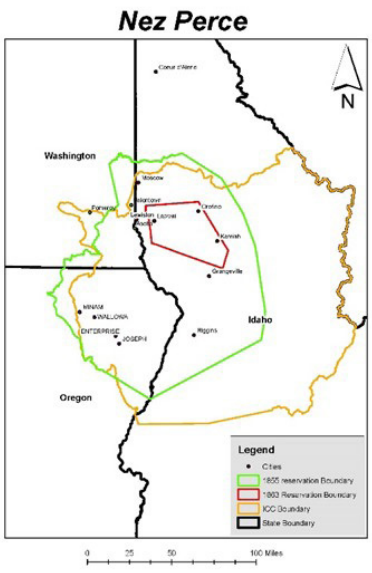
The Nez Perce Tribe is located in North Central Idaho, includes five rural counties: Nez Perce, Clearwater, Lewis and Latah. The reservation encompasses 770,000 acres, primarily thinly-populated agricultural and forest lands, including 107,000 acres owned by the Tribe or tribal members.

The Nez Perce Tribal community is a close net community. As generations grow up in the community, families develop close ties with other families through sports, culture activities, work, sorrow, school activities and community events.

Nez Perce Tribe – Community Overview

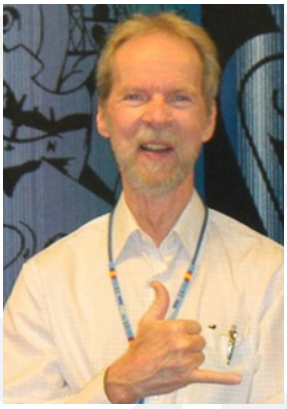
The Nez Perce people who live on the Nez Perce Reservation reside in one of the three main communities. Lapwai is where the Nez Perce Tribal headquarters, Nimiipuu Health, Housing and other Tribal Programs are stationed. In Lapwai there is one school grades K-12, a community building for events and a Grocery Store, Restaurant and gas station. Lapwai has a population of 1,146. Most families travel to Lewiston, which is 16 miles away, for shopping. Orofino is 36 miles up the Clearwater River from Lapwai. This community has a small population of Nez Perce Tribal members. In Orofino there is a small building designated for Community events and meetings and next door the Nez Perce Tribal Fisheries Offices. Kamiah is 60 miles upriver from Lapwai along the Clearwater River. Kamiah's population is 1,320. In Kamiah, there is a school K-12, Community Building and several privately owned businesses.

The Nez Perce Tribe owns and operates two Casinos, on in Kamiah and one at the edge of the Nez Perce Reservation boundary near Lewiston, Idaho. The tribe also has the Appaloosa Express Transportation Department servicing transportation throughout the Nez Perce Reservation and to the Lewiston area. The Appaloosa Club is active and the appaloosa horses are being raised within the Nez Perce Reservation.



Nimiipuu Health is the primary care for most Nez Perce Tribal members within the Nez Perce Reservation. Nimiipuu Health has approximately 4,761 patients.

NW Native American Research Centers for Health (NW NARCH) Fellow Highlights



By Dr. Tom Becker
NW NARCH & Cancer Project Director

Greetings,

The NW Native American Research Centers for Health (NW NARCH) Fellowship Program is very proud of all of our graduates and we wanted to share a snapshot of some of our ground breaking Native professionals. This program is designed to assist full-time students pursuing their research-related degrees and the goal is to increase the number of American Indian/Alaska Native (AI/AN) health professionals who are committed and prepared with the biomedical or social service research skills needed to conduct successful research projects.

The program is funded by the Indian Health Service (IHS) and the National Institutes of Health (NIH) and The Northwest Portland Area Indian Health Board (NPAIHB) administers the grant and is able to provide a limited number of scholarships and fellowships to support research career development and ensure graduates in the field by providing financial assistance, mentorship, and culturally relevant training.

For more information, please contact Dr. Tom Becker, NW NARCH Director tbecker@npaihb.org or Tanya Firemoon, NW NARCH Coordinator tfiremoon@npaihb.org.

Misty Blue (White Earth Nation)
NW NARCH Fellow
Masters of Public Health, Maternal and Child Health Concentration, Evaluation Minor

How did I learn about the NW NARCH Fellowship?
I learned about the NW NARCH Fellowship during my attendance at the American Public Health Association Annual Meeting in 2014. Representatives from NW NARCH were at a poster session that I attended.

Why did I choose my specific degree?
I have always been passionate about health. Growing up, I felt that good health was the first step to being able to accomplish any goal that I had for myself. I continued this interest on a personal level throughout my life. After working at a domestic violence agency, participating in KWESTRONG, and becoming a mother, it became clear that creating ways for women and children to be safe and healthy was the path that I wanted to continue on.

After graduating, what are my career goals and/or educational goals?
I just accepted a job in the applied research and evaluation field. The agency that I work for, Rainbow Research Inc., has a long history and great reputation of using a community-engaged practice. Data is valuable, and I am committed to making meaning out of disjointed data that communities can use.

How did the NW NARCH fellowship help in furthering my education?
NW NARCH fellowship was an incredibly supportive experience. The financial aspect of the fellowship strengthened my resolve to work diligently on my degree, as I did not have to stress about finances. I even finished earlier than anticipated! Also a single mother, having less stress really allowed me to be a better, more present caregiver to my daughter.

The trainings that NW NARCH provided me with were also so energizing. I learned great material, and was able to meet other Natives doing this work in different places across the country. In an MPH program that did not have much diversity, I gained confirmation that I was on the right path and others were beside me.

Finally, having Tanya and Dr. Becker as additional supports during my degree program has been invaluable. Knowing that I have mentors all the way on the west coast who are encouraging, hoped for, and believed in my abilities to succeed was integral to my accomplishment.

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(NW NARCH)

What would you share with others who are seeking financial assistance?
I would urge students who are seeking financial assistance to be proactive and build relationships at every opportunity they encounter. Throughout my entire graduate school experience, I have met so many people who were ready to assist me in any way possible, i.e. letters of recommendations, advice about funding, leads on jobs, etc.

Most people recognize that graduate school is a difficult path with obstacles, but are eager to help each other out. People and programs are available and excited to support native students as they pursue advanced degrees, especially in the health sciences. Now that I have finished and have received so much support from my communities and circles, I feel very grateful and appreciative. And ready to help guide others just beginning their programs.
Year of Graduation:
December 2016

State Medicaid Programs Still Withholding Cure for Hepatitis C

By David Stephens, *BSN, RN*
HCV Clinical Services Manager, NPAIHB

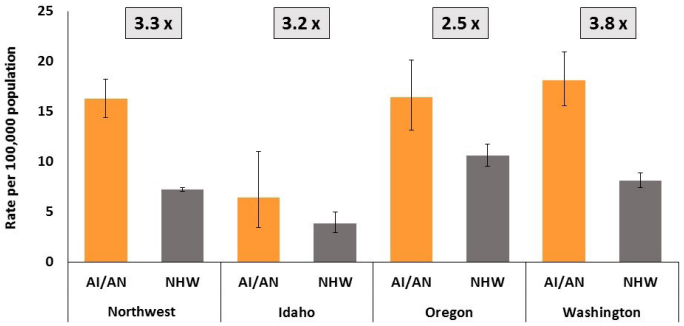
Jessica Leston, *MPH HIV/STI/HCV Clinical Programs Director, NPAIHB*

Sarah Hatcher, *PhD Epi Intelligence Service Officer, CDC, NPAIHB*

Hepatitis C virus (HCV) is a chronic infection and a deadly disease. If HCV is left untreated, the virus slowly destroys the liver. The American Indian/Native Alaska population is disproportionately affected by hepatitis C virus (HCV). The most recent national data show American Indian/Alaska Native people with both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any US racial/ethnic group. In the Northwest from 2006–2012, the American Indian/Alaska Native HCV-related mortality rate was over three times that of non-Hispanic whites. This disparity has persisted over time, demonstrating the need for access to treatment for American Indians and Alaska Natives in the Northwest.

State Medicaids Still Withholding Cure for Hepatitis C

Age-Adjusted Hepatitis C-Related Mortality – Northwest, 2006–2012



About 20,000 persons die from HCV each year, despite the availability of new medications that have a 95 percent success rate and can cure patients in as little as eight weeks. Improvements in new treatment options for HCV could have a major effect on the health of American Indians/Alaska Natives. These new medications have high rates of achieving sustained virologic response with few contradictions or adverse effects. These advances represent a major shift in treatment options for HCV and have the ability to reduce HCV-related deaths.

But because the drugs can be expensive, state Medicaid programs have been restricting access to them to only people in the advanced stages of the liver destroying disease.

Restricting Access
In 2015, there were at least 34 states who had restrictions in place that limited access to treatment, determined by the level of damage to and scarring on the liver.

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State Medicaid Programs Still Withholding Cure for Hepatitis C

Currently in the Northwest:

- **Idaho** – Patients must have advanced liver scarring (referred to as Metavir stage F2-F4), and have no history of alcohol or substance abuse within 6 months prior to treatment. To learn more about Idaho's Medicaid policy and inclusion criteria for HCV medication, visit: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/PrescriptionDrugs/HepatitisCTherapeuticGuidelines.pdf

- **Oregon** – Patients must have advanced liver scarring (Metavir stage F3-F4), and be enrolled in a treatment program under the care of an addiction specialist if they are actively using illicit drugs or abusing alcohol. To learn more about Oregon's Medicaid policy and inclusion criteria for HCV medication: http://www.oregon.gov/oha/healthplan/tools/Oregon%20Medicaid%20PA%20Criteria,%20January%202017.pdf

- **Washington** – Will approve payment for nearly every patient with chronic HCV (as of June 2016), including patients who are actively injecting drugs and/or using alcohol. To learn more about Washington's Medicaid policy and inclusion criteria for HCV medication, visit: https://www.hca.wa.gov/assets/billers-and-providers/WA-Apple-Health-HepatitisC-Clinical-Policy.pdf

As of April 2017, Washington has the most open access to HCV medications for Medicaid patients, but this was not always the case. In 2015, the Washington Health Care Authority (HCA) approved guidelines restricting access to HCV drugs. A class action lawsuit ensued, claiming the restrictions violate federal law.

In response to the class action lawsuit, a federal judge ordered the state Health Care Authority to cover hepatitis C drugs for all patients with HCV, not just those who are sickest. The lawsuit was in response to a policy that restricted Medicaid patient's access to the medications based on the amount of liver scarring that was present.

Only those with the most liver scarring were able to get the curative treatment.

After the federal judge's order, patients with less severe cases of HCV are now also able to access the medications. Unfortunately this is not the case in Oregon or Idaho, mainly due to the cost of the medication.

In March, Health Board staff Jessica Leston and David Stephens went to Oregon's capital advocating for expanded access to HCV medication. Currently, Oregon Medicaid restricts access to medication for only those who with the most liver scarring.

In Oregon, AI/AN reported cases of HCV are more than twice as high, cases of liver cancer are 50% higher, and HCV related deaths are twice as high compared to whites. These are deadly outcomes and expensive as well. Each hospital visit averaged over $25,000 and hospital visits associated with liver cancer averaged over $50,000. This cost could be avoided, but only those Medicaid patients in Oregon or Idaho who have advanced liver scarring, are given access to these curative drugs, and in some cases must be abstinent from alcohol and injection drug use. These criteria are not based on medical evidence, and in fact go against what national medical experts recommend. The American Association for the Study of Liver Diseases and the Infectious Diseases Society of America

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Hepatitis C

recommend HCV treatment as soon as possible rather than waiting for their liver to be heavily damaged.

From a public health perspective, rates of new infection will continue to rise unless a considerable number of people with chronic HCV who continue to inject drugs are treated. Many providers have therefore adopted a treatment-as-prevention approach when treating patients with HCV and finding ways other than getting reimbursed through Medicaid to cover the medications.

Medicaid or private insurance companies may block access to medications with an outright denial. If a patient's medication request is rejected, or a patient simply prefers not to apply for insurance given the ACA's Indian health coverage exemption, patient assistance programs exist for all currently available HCV medications. Medication assistance programs and patient advocacy foundations help patients who are uninsured, underinsured, denied coverage, or need co-pay assistance. The process of acquiring approval for medications, and applying to patient assistance programs can be confusing and time-consuming, but almost all patients can get medication for free or reduced price without any cost to the tribe or medical facility. For an extensive list of programs, and to learn more about the process to acquire direct-acting antivirals for patients, please visit: http://www.hepatitisc.uw.edu/go/evaluation-treatment/cost-access-medications/core-concept/all or contact David Stephens (dstephens@npaihb.org).

For more information about treating HCV in your community, please contact Jessica Leston, 907-244-3888 or jleston@npaihb.org

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Jessica Leston, MPH *HIV/STI/HCV Clinical Programs Director, Northwest Portland Area Indian Health Board*
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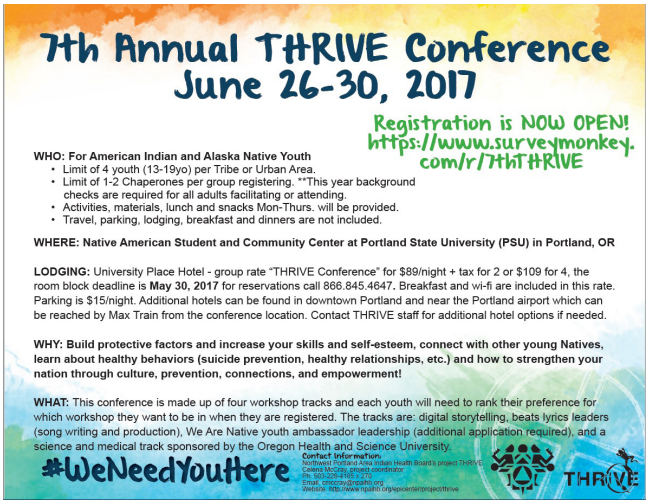

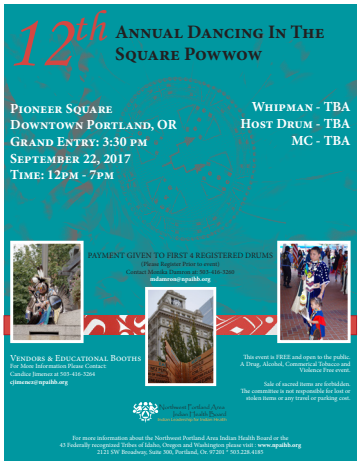

Congrats Nancy Scott! Employee of the Year!

Happy Retirement Leslie Wosnig!

Blue Zones Project success
KTHFS first tribe approved in Pacific Northwest

By JOHANNA BERNHARD
H&N Staff Reporter
February 23, 2017

Klamath Tribal Health and Family Services (KTHFS) became the first tribal organization in the Pacific Northwest to become Blue Zones Project approved on Wednesday.

KTHFS, a primary care health center owned and operated by the Klamath Tribes, is responsible for providing healthcare services to the Native American population living in Klamath County.
On Wednesday afternoon, KTHFS employees, the Klamath Tribal Council and members of the Klamath Falls Blue Zones Project gathered at the tribal headquarters in Chiloquin to recognize the organization's success with a ribbon cutting ceremony.

KTHFS began working to become Blue Zones approved in May 2016, after Tribal Chairman Don Gentry proposed the idea. While the organization already had various health practices in place, it created a wellness committee to promote more healthy choices and well-being for its employees, wellness committee member Martha Decker-Hall said. "We found that it was a good fit as a lot of the best practices we had already adopted as an organization," she said. "It went fast for us because we were already on that path."

From the outset, the wellness committee implemented a series of healthy steps, including standing or walking meetings to encourage movement throughout the day; the installation of equipment offering health benefits, such as standing desks, wireless headsets and exercise balls; and posting positive messages throughout the offices, Director of Health Planning and Education Shawn Jackson said. The 121 KTHFS employees are also given 30 minutes of wellness time every day, which they can use to "do something healthy to energize themselves." Some staff opt to go for a walk on the trail, while others use the weight room, Jackson said. "It feels great that we have been approved," he said. "A healthy employee is a happy employee."

Blue Zones Project Organization Lead Jessie Hecocta, who works closely with KTHFS, recognized the organization's achievements and the wellness committee's future plans before presenting Jackson, the wellness committee team leader, with the Blue Zones Project certificate.

"Klamath Tribal Health and Family Services are working hard at changing some of the risk factors that affect our tribal nations," she said. "What they have realized is they can't help people be well if their employees are not well themselves." Hecocta added that the wellness committee are looking to provide a space for breastfeeding and pumping and will restructure the organization's current fitness policy to make it work around employee's schedules. The Blue Zones Project will also hold an overall well-being assessment of the organization to ensure it stays on track and achieves its healthy goals.

As an enrolled tribal member of the Klamath Tribes and passionate about well-being, Hecocta said she is proud the tribe wants to move in a healthier direction. As the first Blue Zones approved tribal organization in the Pacific Northwest, she said KTHFS has the opportunity to act as a guide for other services across the country.

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The Marketplace Offers Continued "Sponsorship" Opportunities

The ACA provides new opportunities for Sponsorship. Under the ACA, a Health Insurance Marketplace (Marketplace) was established in each state, with new types of federal assistance funneled through the Marketplaces. To date, for roughly 85% of enrollees in health plans through a Marketplace, federal premium tax credits (PTCs) have reduced the health insurance premiums due from the enrollees (or their T/THO "sponsors").[7] And, comprehensive, Indian-specific cost-sharing reductions (CSRs) are available through a Marketplace for American Indians and Alaska Natives (AI/ANs) meeting the definition of "Indian" under the ACA.[8] These cost-sharing protections alone transfer 40% of the average health insurance costs from the enrollee and/or T/THO sponsor to the federal government.

There are threats to continued Marketplace operations—and the opportunities for Sponsorship available through them—but the impact of these potential legislative changes is not likely to occur in the short-term. Under several pending congressional legislative proposals to "repeal and replace" the Affordable Care Act, the current PTCs would be significantly altered, with low- to medium- income households and older enrollees experiencing the greatest increases in premiums.[9] And CSRs would be completely eliminated, both for Indians as well for the general population, under some proposals. But enactment of these proposals is far from certain, and even if enacted, the changes to the PTCs and CSRs would not be fully felt for a number of years. The leading legislative proposal from the House of Representatives, for example, would not make significant modifications to the current PTCs and CSRs until January 1, 2020, more than 2 ½ years in the future.[10]

Likewise, there are administrative threats to the operation of the Marketplaces, but these challenges are manageable if the intention of Congress and the Administration is to maintain access to health insurance coverage during a transition to any new approach, if enacted. Given these dynamics, it is reasonable to anticipate, and beneficial to consider, that the Marketplaces will continue to offer Sponsorship opportunities able to generate substantial new health care resources over the short-term, even if not permanently.

Results of Sponsorship Activities

Over the last decade, T/THOs have established Sponsorship programs that vary greatly. Most programs involve a single Tribe, with modest enrollment levels. Other programs are Service Unit-specific, with eligibility open to all uninsured Tribal members who are Active Users in the Service Unit. At least one program is statewide, involving dozens of T/THOs.

In Table 1 below, the net health insurance costs are shown for Marketplace enrollees living in Multnomah County, Oregon, for the lowest-cost bronze preferred provider organization (PPO) plan. AI/ANs meeting the ACA's definition of Indian who enroll in Marketplace coverage have no cost-sharing, such as deductibles, coinsurance, and co-payments. As such, the premium amounts shown are the entire costs for health insurance coverage for these individuals/families.

TABLE 1: Net Annual Household Contribution for Marketplace Premium for Lowest Cost Bronze Plan: PPO[1, 2]

HH size:	1-p HH	2-p HH	3-p HH	
# enrolled:	1 enrollee	2 enrollees	2 enrollees	Average
FPL	Multnomah County, OR			
140%	$434	$499	$696	$543
150%	$595	$717	$970	$761
175%	$961	$1,209	$1,590	$1,253
200%	$1,396	$1,796	$2,329	$1,840
225%	$1,825	$2,375	$3,057	$2,419
250%	$2,306	$3,024	$3,874	$3,068
Average per HH	$1,253	$1,603	$2,086	$1,647
Average per person	$1,253	$802	$1,043	$1,032

[1] Bridge Span Bronze HDHP 6000 RealValue

[2] PPO = Preferred Provider Organization (broader network of providers)

As shown in Table 1, for instance, a family of three with a household income at 225% of the federal poverty level ($45,360 per year) and two enrollees in the Marketplace would have a total annual household premium of $3,057, or $1,529 per enrollee. For these enrollees, per person health care services received under the plan would average $5,100 per year, with no out-of-pocket costs for the AI/AN enrollees. The net gain in health service resources over the coverage year

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The Marketplace Offers Continued "Sponsorship" Opportunities

for these two previously uninsured individuals would be $7,143 ($10,200 – $3,057).

The example above illustrates the great potential that Sponsorship holds for T/THOs. In one recent case, a Tribe implementing a Sponsorship program in another state found that, for the first 300 enrollees in the program, the federal government contributed an average of $5,278 in PTCs per person and was expected to make an additional $2,100 in average cost-sharing payments on behalf of each enrollee. Taken together, the federal government is projected to finance in excess of 78% of enrollee health insurance costs.

Under another Sponsorship program comprised of a coalition of T/THOs, over the first 15 months of the program, the T/THOs generated more than $6 million in net cash collections (after subtracting program premium and overhead costs), resulting in a return on investment (ROI) of 294%. An additional $1.6 million in payments to non-THO providers was made on behalf of the Sponsored individuals, resulting in substantial savings to the THO Purchased/Referred Care (PRC) programs and increasing the ROI to the T/THOs.

An analysis for T/THOs in South Dakota provides an additional example of the potential of Sponsorship through a Marketplace. Enrolling one-half of the currently uninsured AI/ANs in the state, including the lowest-income AI/ANs who have an income too low to qualify for PTCs, could generate a net increase in health care resources of $48 million per year. This would represent a substantial increase in health care resources over the annual congressional appropriation to South Dakota Tribes for PRC and Hospitals and Clinics funding.

Conclusion

Recent deliberations in Congress create uncertainty over the continuation of the PTCs and CSRs provided under the ACA, as well as the associated value of Sponsorship through a Marketplace. But at least for the near term, the PTCs and CSRs currently accessible through a Marketplace are expected to continue. As such, Sponsorship of Tribal members through a Marketplace—as well as under Medicare—continues to hold promise for T/THOs and their Tribal members.

[1]Sponsorship also is described as "Tribally-sponsored" health insurance coverage or "Tribal Premium Sponsorship."

[2]Tribal members are defined here as persons eligible for services from the Indian Health Service, Indian Tribes and Tribal organizations, or urban Indian organizations.

[3]Section 402 of the Indian Health Care Improvement Act (IHCIA) was modified and clarified by section 152 of the Indian Health Care Improvement Reauthorization and Extension Act, which was contained in the ACA.

[4]See TSGAC, Tribal Sponsorship of Medicare Part B and Part D Premiums (Washington, DC: Nov. 23, 2016) at http://www.tribalselfgov.org/wp-content/uploads/2016/12/TSGAC-Memo-Tribal-Sponsorship-of-Medicare-Part-B-D-Premiums-2016-11-....pdf.

[5]Higher-income Medicare beneficiaries pay a larger share of the Part B premium. See Social Security Administration, Medicare Premiums: Rules for Higher-Income Beneficiaries (Washington, DC: Jan. 2017) at https://www.ssa.gov/pubs/EN-05-10536.pdf.

[6]For 2017, the Part D standard benefit requires enrollees to pay a $400 deductible and 25% coinsurance until they reach a coverage limit of $3,700 in total drug costs, followed by a coverage gap. In the coverage gap, enrollees must pay for a larger share of their total drug costs than in the initial coverage period, until their total out-of-pocket spending reaches $4,950. After enrollees reach the catastrophic coverage threshold, they must pay either 5% of their total drug costs or $3.30/$8.25 for each generic/brand-name drug, respectively. See Kaiser Family Foundation, The Medicare Part D Prescription Drug Benefit (Washington, DC: Sep. 26, 2016) at http://files.kff.org/attachment/Fact-Sheet-The-Medicare-Part-D-Prescription-Drug-Benefit.

[7]The figure is for 2016 in states using the Healthcare.gov platform. See HHS ASPE, Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report (Washington, DC: Mar. 11, 2016) at https://aspe.hhs.gov/system/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf.

[8]The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (i.e., member of an Indian tribe or shareholder in an Alaska Native regional or village corporation).

[9]See TSGAC, Review of Congressional ACA Repeal and Replace Legislation (Washington, DC: Mar. 15, 2017) at http://www.tribalselfgov.org/health-reform/webinars/03152017-tsgac-webinar-acaihcia-outreach-education-webinar/.

[10]The legislation is the American Health Care Act of 2017 (H.R. 1628). See the text of the bill at https://www.congress.gov/115/bills/hr1628/BILLS-115hr1628rh.pdf.

[11]See TSGAC, Next on the Affordable Care Act: Funding for Cost-Sharing Protections and Marketplace Stability Programs (Washington, DC: Mar. 27, 2017) at http://www.tribalselfgov.org/wp-content/uploads/2017/04/TSGAC-Brief-Next-on-ACA-2017-03-27d-2.pdf.

[12]See TSGAC, "Success Stories," accessed on Apr. 10, 2017, http://www.tribalselfgov.org/health-reform/success-stories/.

[13]Premiums for the lowest-cost bronze exclusive provider organization (EPO) plan are lower than those for the PPO plan shown.

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Impacts on tribal health programs

Referred Care and Urban Indian Health. The Senate Committee bill, on the other hand, would provide significantly more than the House for Behavioral Health and would fund a Small Ambulatory Health Facilities program. We do not know how these differences may have been resolved in recent negotiations on an omnibus bill or whether any of these programs might receive an increase by being included as an anomaly in any FY 2017 Continuing Resolution.

We note that on March 27, 2017, the Trump Administration circulated details on their proposal to cut FY 2017 domestic discretionary spending by $18 billion below the spending cap, in part to increase funding for defense and for a down payment on construction of a wall on the southern U.S. border. The response from Congressional appropriators of both parties has been to dismiss it as too late at this point in the process. Included in the recommendations is a $25 million reduction from IHS for "preventive" programs, including the Community Health Representatives program. Democrats in Congress have sent a strong signal that any FY 2017 bill which includes funding for construction of a wall on the southern U.S. border will be met with strong opposition.

FY 2018 Budget

On March 16, 2017 the Trump Administration submitted its proposed FY 2018 Budget Blueprint (Blueprint), a 53-page document which addresses discretionary spending for each federal department. This document is also called the "skinny budget". It lists for each department the proposed overall increase or decrease. Only Defense, Homeland Security and Veterans Affairs are recommended for increases. Interior, for instance, is recommended for a 12 percent decrease and HHS for a 17.9 percent decrease. The proposal has been criticized from both parties as being unrealistic. While targeting some programs for reduction or elimination, it is lacking in detail, and simply notes that funding will be eliminated for "duplicative" or "ineffective" programs.

The Blueprint describes the IHS and Community Health Centers as a "high priority" but provides no numbers. It also states in the Interior Department section that the Administration supports tribal sovereignty and self-determination but also that they will propose reductions for recent demonstration projects and initiatives which serve only a few tribes.

The Trump Administration FY 2018 Blueprint would, by proposing a $54 billion increase for defense and a $54 billion decrease for discretionary domestic spending, would require an amendment to the Budget Control Act.

With regard to scheduling, the House Appropriations Subcommittee on Interior, Environment and Related Agencies has said they would like to schedule a hearing for public witnesses on Indian programs but as of this writing no date has been set. The Administration's detailed proposed FY 2018 budget, including recommendations for both discretionary and mandatory spending, is expected to be available in mid-May.

Update on Redding Rancheria v. Price in the U.S. District Court for the District of Columbia

An oral argument was held before Judge Rosemary Collier on March 24, 2017, in the U.S. District Court for the District of Columbia in Redding Rancheria v. Price, Civ. No. 14-2035 (RMC). The primary issue before the court was whether the Redding Rancheria's self-insured health plan for tribal members is an alternate resource to the IHS Catastrophic Health Emergency Fund (CHEF). The NPAIHB and several Tribes in the Northwest joined an amicus brief that was filed in the case in support of the Redding Rancheria's position.

As background, the CHEF is established in § 202 of the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1621a. CHEF is administered in IHS Headquarters for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses. CHEF reimburses IHS service units and tribal health programs for the cost of treating

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Impacts on tribal health programs

any victim of a catastrophic illness or disaster over a certain threshold amount established by the IHS.

The Redding Rancheria (Rancheria) adopted a self-insured health plan for tribal members (Member Plan) to supplement its compacted Patient Referred Care (PRC) program. Tribal members are generally eligible for both PRC and the Member Plan. In order to take advantage of the PRC program's ability to pay for health care services at Medicare-Like Rates (MLR), the Rancheria adopted a Combined Master Plan Document to coordinate the benefits its PRC program and Member Plan. The Combined Master Plan provides for PRC payment of provider claims for which the provider would accept MLR. Provider claims for which a provider would not accept MLR are paid by the Member Plan. Coordinating the benefits of the PRC program with the Member Plan in this manner allowed the Rancheria get the maximum cost benefit from the PRC program's ability to pay provider claims at MLR.

The IHS refused to process any of the *Rancheria's* requests for CHEF reimbursement under this coordination of benefits arrangement. IHS supported this position by asserting that the Payor of Last Resort provision in § 2901(b) of the Affordable Care Act (ACA), 25 U.S.C. § 1623(b), did not make an exception for tribal member health plans and thus the Rancheria's Member Plan is an alternate resource to PRC and CHEF. This is a radical departure from long-standing IHS policy under the Payor of Last Resort regulation at 42 C.F.R. § 136.61, which does not include tribal health plans in its definition of alternate resources. It also is contrary to the definition of alternate resources in § 1621a(d)(5) of the IHCIA establishing the CHEF.
The IHS, simultaneously with the Redding litigation, published a Notice of Proposed Rulemaking, 81 Fed. Reg. 4239 (Jan. 26, 2016) proposing to make tribal health plans an alternate resource to CHEF. Due to objections by tribes, this regulation is on hold.

The oral argument did not go well for the IHS. The argument opened with the judge indicating that the definition of a "tribal health plan" in the IHCIA included the Rancheria's Member Plan. Thus, the Rancheria's Member Plan was encompassed within the ACA Payor of Last Resort provision. In other words, the ACA Payor of Last Resort provision encompassed both the PRC program and the Rancheria's Member Plan. The Member Plan was thus not an alternate resource to the Rancheria's compacted PRC program.

Having apparently lost her central argument, the Government's attorney then shifted to arguing that nevertheless, the Rancheria was not following CHEF administrative procedures in the IHS Manual, and thus could not access CHEF funds. The judge was not impressed with this argument either, indicating that the IHS Manual is not a legally binding regulation and there was no law against the Rancheria coordinating the benefits of the PRC program and the Member Plan.

Because questions were raised at the hearing about how the Rancheria's coordination of benefits process actually worked, and how it had been changed over time in an attempt to respond to IHS' concerns, the judge asked the Rancheria's attorneys to file a detailed statement addressing these questions. The Government would then have a chance to respond. So the case is not yet ready for the judge to issue an opinion, but the oral argument was very favorable to the Rancheria.

IHS Actively Negotiating New Lease Proposals Under Section 105(l) of the Indian Self-Determination Act

In a set of lawsuits that finally wrapped up in the fall of 2016, the United States District Court for the District of Columbia established in two major rulings that Section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA) and its implementing regulations require the Indian Health Service (IHS) to enter into a fully-compensated lease with a tribe or tribal organization with an ownership, leasehold, or trust interest in a facility used by the tribe or tribal organization for the administration and delivery of services under its ISDEAA contract or compact. The implementing regulations (codified at 25 C.F.R. Part

900, subpart H) set out specific options and elements for lease compensation, and the district court ruled that those options and elements are binding on the IHS—permitting tribes and tribal organizations to negotiate under one of those options for full facility funding. Though the lawsuits were brought against the IHS, the statute and regulations apply equally to the Bureau of Indian Affairs.

The IHS has begun accepting and negotiating new Section 105(l) lease proposals from tribes and tribal organizations that meet the statutory criteria for a lease. Thus far, new proposals have been submitted mainly in Alaska (where the lawsuits originated). There is a steep learning curve for both the IHS and the tribes with respect to implementing the Section 105(l) leasing authority, which until now has been all but ignored. However, the precedent set by these lawsuits and the leases finalized thus far has the potential to dramatically impact the level of facilities funding available for tribal health clinics, hospitals, and other facilities used by tribes and tribal organizations to carry out the ISDEAA, particularly if the IHS effectively leverages its new legal obligations in seeking additional funding from Congress in the upcoming years.

Contract Support Cost Developments

Contract support cost (CSC) issues continue to percolate. After a brief pause during the transition in administrations, IHS has resumed settling past-year CSC claims, with payments issuing from the Treasury Department's Judgment Fund. Beginning in FY 2014, Congress lifted the CSC spending "caps" and has required full payment, so litigation of past-year claims should diminish—but will not disappear entirely. IHS's new CSC policy, approved in October 2016, requires the agency to conduct a "reconciliation" process to ensure each tribe and tribal organization was fully paid but not overpaid. IHS is still in the process of reconciling CSC needs and payments going back to FY 2014 for many tribes. In most cases the reconciliation process should be noncontroversial, but disagreements can be expected. In December, IHS published a CSC distribution report listing all ISDEAA contractors and compactors and how much the agency thinks they were underpaid—or overpaid. The report is available at:
https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/CSC_Report.pdf

Two issues dividing the IHS and tribes—what types of funding generate CSC and how to ensure that CSC does not duplicate Secretarial funding—are currently being litigated in the case Navajo Health Foundation – Sage Memorial Hospital, Inc. v. Burwell. On November 3, 2016, the court held that third-party revenues, such as reimbursements tribes and tribal organizations receive from Medicare, Medicaid and third-party insurance, that are used to provide health care services under an ISDEAA agreement, are to be considered "Secretarial funds" that generate CSC to the same extent as IHS funds appropriated by Congress. In the same decision, the court upheld the tribal position on duplication: that a dollar-for-dollar offset should be applied to administrative costs included in the Secretarial amount. The court rejected the IHS position that duplication is prohibited on a categorical basis (e.g., if the Secretarial amount provides even $1.00 for a certain activity, no additional funding for that activity could be provided as CSC). IHS seems strongly committed to this position, which was incorporated into the new CSC policy. And the ruling on CSC for third-party revenues, if it stands, would greatly expand the agency's annual CSC spending. Not surprisingly, counsel for the hospital recently reported that IHS will appeal the Sage Memorial decision to the Tenth Circuit Court of Appeals.

Upcoming Events

APRIL

April 11-22
weRnative Clothing Line Launch
http://www.wernative.org/gear/team-store
Worldwide, Earth

April 23-27
2017 Tribal Self-Governance Annual Consultation Conference
Spokane, WA

April 24 - May 5
10th Anniversary of the UN Declaration on the Rights of Indigenous People
UN HQ, New York

April 27-29
2017 AISES Leadership Summit
Chandler, AZ

MAY

May 2-4
2017 Tribal Interior Budget Council
Washington, DC

May 2-4
6th Annual HIV/HCV Harm Reduction Summit
Mahnomen, MN

May 14-20
SAMHSA National Prevention Week
Washington, DC

May 23-26
ATNI Mid Year Convention 2017
Portland, Oregon

May 23-24
Oregon Health Authority - SB 770 Quarterly Health & Human Services Cluster Meeting
Coquille Tribe, OR

Upcoming Events

JUNE

June 5-6
Tribal Leaders Diabetes Committee Meeting
Anchorage, AK

June 6-8
Western Tribal Diabetes Project - RPMS/DMS training
Portland, OR

June 6-8
NIHB Public Health Summit
Anchorage, AK

June 9-30
Summer Institute (NARCH)
Portland, OR

June 12-15
NCAI Mid Year Conference and Marketplace
Uncasville, CT

June 16-17
National Alaska Native American Indian Nurses Association (NANAINA) Conference
St Paul, MN

June 26-30
7th Annual THRIVE Conference
Portland, OR

JULY

July 18-20
NPAIHB - CRIHB Joint Quarterly Board Meeting
Cow Creek, OR

July 25-27
IHS Direct Service Tribes Advisory
Committee Quarterly Meeting
Mashpee, MA

We welcome all comments and Indian health-related
news items. Address to:
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RESOLUTION #17-03-01
Supporting Standing Rock

RESOLUTION #17-03-02
Support of CHAP National Exchange

RESOLUTION #17-03-03
Support Engagement of Youth and Development of Youth Track

RESOLUTION #17-03-04
Support Nomination of Dr. Charles W. Grim for Director of the Indian Health Service