Health News & Notes

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Indian Leadership for Indian Health

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MAKING CONTRACT SUPPORT COSTS (CSC) OBLIGATIONS AN ENTITLEMENT

Jim Roberts, Policy Analyst

Tribal leaders have begun to advocate for a change in the manner in which contract support costs (CSC) are appropriated now that the U.S. Supreme Court has affirmed the payment of CSCs under the Indian Self-Determination and Education Assistance Act (ISDEAA) are a legal and binding obligation owed to Tribes carrying out ISDEAA contracts and compacts. The Indian Health Service (IHS) and Bureau of Indian Affairs (BIA) have also begun to pay full CSC payments beginning in FY 2014. The agencies have requested similar action in the President's FY 2015 budget request. Despite the mandatory nature of CSC obligations they are currently paid from annual discretionary appropriations.

Tribal leaders, Indian health advocates and even some Congressional members assert that CSC obligations should be made an entitlement and not funded from discretionary appropriations. The result of CSC obligations in the appropriations process has caused decades of conflict over the underfunding of CSC payments to Tribes. This has resulted in numerous lawsuits between the federal government and Indian Tribes. There are over 1,500 past year's claims filed by Tribes over CSC underfunding that total over one billion dollars. To put this into perspective, the damages that are owed to Tribal governments for unpaid contract support costs are comparable to the recent landmark settlements of the *Cobell, Nez Perce* and *Keepseagle* court cases.

A proposal supported by a growing number of Tribal leaders to address the fundamental disconnect between the legal binding CSC requirements of the ISDEAA and the appropriations process would be for Congress to pass a simple statutory amendment that would appropriate contract support costs on a permanent, indefinite basis like other legal entitlements. Contract support costs would no longer be pitted against funding for Indian programs and services in the annual budgeting process. It would also help to alleviate the difficulties associated with predicting CSC needs as tribes expand or reduce the scope of their contracts and as indirect cost rates change.

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POLICY

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Northwest Portland Area Indian Health Board

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CHAIRMAN'S NOTE

Andy Joseph, Jr., NPAIHB Chair, Confederated Tribes of Colville Tribe

This past quarter has been extremely busy for us all at the Board. In February, Steve Kutz, Cowlitz Tribe, and I attended the IHS Budget Formulation meeting in Washington, D.C. This budget formulation session was very interesting as it followed IHS decision to fully fund contract support costs (CSC) and made for some interesting discussion with the IHS Director and others in attendance. The Board continues to take a leadership role in CSC issues and much of discussion was related to issues that our Tribes have already discussed and taken positions. The workgroup agreed to submit a budget to HHS that recommends an increase of $779 million for the Indian Health Service.

February proved to be a very busy month as I also attended the Affiliated Tribes of Northwest Indians conference hosted by the Lummi Nation on February 17-20. The health committee topics included an update on the dental health therapist legislation in the Washington State legislature, insurance exchange updates, Genomic research and data usage issues, and IHS budget and policy updates.

On February 24-25, Fawn Sharp, President of Quinault Nation, and I attended a meeting of the IHS Contract Support Cost Workgroup. This very important meeting addressed a number of issues associated with IHS and BIA now paying 100% of Tribe's contract support cost payments. One the first issues we addressed was the allocation of the FY 2014 payments and what needed to be done for IHS to make those payments as soon as possible. President Sharp and I have sent out routine updates to Northwest Tribal leaders about this work. The issues are too complicated to describe in this update, but if you have any questions about the work of the CSC Workgroup I encourage you to contact Jim Roberts at the Board. Hopefully you all will receive your FY 2014 CSC payments very soon.

In March I attended the HHS Department-wide Budget Consultation meetings and the NCAI Winter Session. Our hill visits included meetings with Senate staff of Jeff Merkley, Patty Murray, Ron Wyden, and Mike Crapo. On the House side we visited with staff of Representatives Cathy McMorris Rogers, Mike Simpson, Dave Reichert, and Doc Hastings. We also met with Darren Benjamin who staffs the IHS portfolio at the House Interior Appropriations Subcommittee. All were very positive meetings and provided us the opportunity to address important issues to our Tribes.

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MAKING CONTRACT SUPPORT COSTS (CSC) OBLIGATIONS AN ENTITLEMENT

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Tribal leaders and other Indian health advocates support changing the contract support cost appropriations process to be into line with the entitlement required in the ISDEAA. Congress recently called for "long-term accounting, budget, and legislative strategies" to address the challenge of full contract support cost funding. This proposal would not solve all of these challenges but it would represent a major step forward to address such issues.

In order to explain this issue to Tribal leaders, health directors, and other Indian health advocates a white paper titled, "Proposal to Enact Permanent Mandatory Appropriations for Contract Support Costs Under the Indian Self-Determination and Education Assistance Act" has been developed by the law firm Hobbs, Straus, Dean and Walker, LLP. The paper provides a summary of the Supreme Court cases on contract support costs, the recent Congressional directives on CSC issues which are contained in the FY 2014 Interior Appropriations bill, and explains why the solution to funding CSC payments in the future should be to appropriate funding for legally obligated contract support costs on a permanent, mandatory basis.

Appropriations for entitlements are normally made on a mandatory basis and are not subject to the discretionary annual appropriations process. The Congressional Budget Office defines "Entitlement" as follows:

> *A legal obligation of the federal government to make payments to a person, group of people, business, unit of government, or similar entity that meets the eligibility criteria set in law and for which the budget authority is not provided in advance in an appropriation act. Spending for entitlement programs is controlled through those programs' eligibility criteria and benefit or payment rules.*

The Congressional Research Service has similarly stated: "Entitlements are programs that require payments to persons, state or local governments, or other entities if specific eligibility criteria established in the authorizing law are met. Entitlement payments are legal obligations of the federal government, and eligible beneficiaries may have legal recourse if full payment under the law is not provided."

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Northwest Portland Area Indian Health Board

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IHS TO FULLY FUND CONTRACT SUPPORT COST PAYMENTS

Jim Roberts, Policy Analyst

This past year has seen momentous developments in the area of contract support cost policy. We have seen a complete shift in the position of the Administration, the Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS) with respect to paying CSC payments to Tribes. Following the U.S. Supreme Court decision in *Salazar v. Ramah Navajo Chapter*, in which the highest court in land ruled that the federal government must pay contract support costs to tribes that enter into agreements to manage federal programs, the Administration and its federal agencies continued to resist paying Tribes full CSC funding.

Justice Sonia Sotomayor writing the opinion for the majority noted the Supreme Court's 2005 decision in Cherokee Nation v. Leavitt, another self-determination case, in which the court "stressed that the government's obligation to pay contract support costs should be treated as an ordinary contract promise, noting that [Indian Self-Determination and Education Assistance Act] 'uses the word 'contract' 426 times to describe the nature of the Government's promise'" and further stating that, "Consistent with longstanding principles of government contracting law, we hold that the government must pay each tribe's contract support costs in full," Justice Sonia Sotomayor wrote for the majority.

Finally, the IHS and BIA spending plans for FY 2014 revealed for the first time ever the federal government will pay Tribes their full CSC payments. Many in Congress feel that this puts to rest this controversial policy issue in which the federal government did not feel obligated to pay Tribes what they were owed. "This ought to put this issue to rest now," said Rep. Tom Cole (R-Okla.), one of two Native Americans in Congress. Congressman Cole further added that this "should have never happened in the first place." The Obama administration's decision is a dramatic reversal from its proposed 2014 budget, which called for placing spending caps on individual contracts. Under the caps, tribes would again have been paid millions of dollars less than what they say they are owed and millions less than the agencies' estimates of the payments due. The spending caps also would have been a step toward limiting payments in the future.

The decision to fully fund CSC payments to tribes increases the CSC budget line item from last year's appropriation by over $139 million, which is a significant 31% increase. This marks the second time in the last five years in which the Administration and Congress will direct over $100 million to fund CSC payments to Tribes. Tribes are cautious about the treatment of CSC payments and other policy issues. While for the time being, the Administration, IHS, and the BIA have requested funding to fully pay CSC payments in the FY 2015 budget, tribes are suspicious this could change based on actions of the federal government. There are also outstanding issues associated with settling past year's claims and it is clear that the federal government and their agencies are doing everything they can to mitigate their liability for settling past year's claims (see IHS Workgoup Update). For now, it is welcome news for Tribes to be able to be paid what they are due. Almost every tribe in the United States has a contract to perform some BIA or IHS function and is owed CSC payments. CSC payments are used to cover the administrative cost associated with managing programs. The federal government receives

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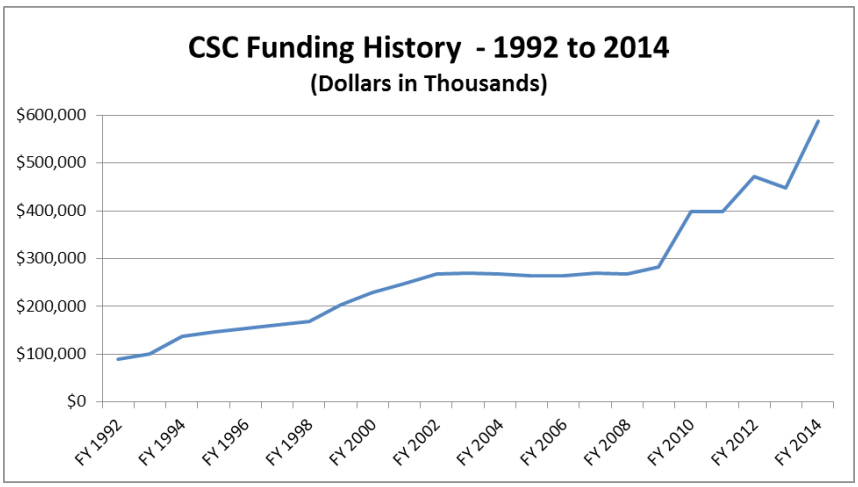

TRANSITIONING TO MODIFIED ADJUSTED GROSS INCOME – WHAT AMERICAN INDIANS AND ALASKA NATIVES NEED TO KNOW

By Samuel E. Ennis - Sonosky, Chambers, Sachse, Endreson & Perry, LLP[1]

In order to make it faster, easier, and more accurate for individuals to apply for health insurance and Medicaid, the Patient Protection and Affordable Care Act (ACA) created a new formula called "modified adjusted gross income" (MAGI). MAGI is now used to determine eligibility for Medicaid and the Children's Health Insurance Program (CHIP),[2] as well as eligibility for advance premium tax credits (APTCs) and certain cost-sharing protections for American Indians and Alaska Natives (AI/ANs) for health insurance plans purchased through the Marketplaces established by the ACA. Participation in any of these programs will require general familiarity with how MAGI works.

In order to calculate your MAGI, the Internal Revenue Service (IRS) first determines your adjusted gross income, which is basically the amount of income you report on your federal income tax return. If you do not fill out an annual tax return, the Marketplace applications will help you determine your adjusted gross income. This calculation is made automatically through the Marketplace, which is required by law to determine your eligibility for both private insurance and Medicaid through the same application.[3]

Next, the IRS adds back in certain tax deductions that you might have claimed on your tax return for (1) foreign income and housing costs, (2) tax-exempt interest, and (3) Social Security and railroad retirement benefits (to whatever extent those deductions applied to you). The resulting amount is called your "modified adjusted gross income." 26 U.S.C. § 36B(d)(2)(B)

If you are an AI/AN, though, there are additional categories of income that are further excluded from your MAGI. 42 C.F.R. § 435.603(e)(3). This makes it easier for you to qualify for Medicaid, CHIP, and the Marketplace health plan protections: any income received from an exempt source will not count toward your MAGI calculation, no matter how much the amount. The Marketplace applications will specifically ask you about this income to make sure you deduct it from your MAGI.

Below is a list of the general categories of exempt AI/AN income. But the AI/AN MAGI exclusions work slightly differently depending on the context. When you are calculating MAGI for the purposes of determining eligibility for APTCs or AI/AN cost-sharing protections, AI/AN income is only exempt from MAGI if it is *also* exempt from federal income taxation. In practice, this means that the AI/AN income is *usually* also excluded from MAGI, but might count in certain circumstances. When you are calculating MAGI for Medicaid or CHIP purposes, *all* of the income falling within *any* of the categories below is excluded, even if it is taxable.[4] These rules make it a little bit easier for AI/ANs to qualify for Medicaid and CHIP than for tax credits or cost-sharing protections.

The following are the general categories of AI/AN MAGI-exempt income (with some specific examples):

- **Distributions from Alaska Native Claims Settlement Act (ANCSA) Corporations and Settlement Trusts.**
  - Cash distributions
  - Stock or bonds issued by an ANCSA Corporation
  - A partnership interest and distributions
  - Land or an interest in land

- **Distributions from trust/reservation property**
  - Rents from any such lands and any structures on the land (housing, retail facilities, etc.)

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1. Sam Ennis is an associate in the San Diego office of Sonosky, Chambers, Sachse, Endreson & Perry, LLP. His firm specializes in representing Native American interests nationwide.
2. The MAGI calculation applies to children, pregnant women, and, in states that expand Medicaid eligibility under the ACA, parents and the adults enrolled under the ACA's new adult eligibility group. It does not apply to individuals age 65 and older and individuals who qualify for Medicaid based on disability. These individuals' Medicaid eligibility is determined by their State's pre-ACA eligibility asset and income tests. 42 C.F.R. § 435.603(g).
3. State Medicaid agencies will do the same for individuals applying directly for Medicaid through the agency.
4. The AI/AN income exemptions for MAGI under Medicaid are identical to the AI/AN income exemptions under the pre-ACA assets and resources tests.

TRANSITIONING TO MODIFIED ADJUSTED GROSS INCOME – WHAT AMERICAN INDIANS AND ALASKA NATIVES NEED TO KNOW

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  - Royalties or other compensation received from oil and gas production, mineral extraction, timber harvesting, and similar activities
  - Profits or revenues derived from economic activity on the land, operation of motels, retail outlets, etc.

- **Income from property and rights related to hunting, fishing, and natural resources**
  - Profits from the sale, lease, or harvest of mineral, timber, and other such resources
  - Income derived from hunting, fishing, gathering, and harvesting fish, wildlife, and plant resources pursuant to Federally-protected rights, including off-reservation rights

- **Income from the sale and use of cultural/ subsistence property.**
  - Property sold for use in healing or spiritual ceremonies, such as sage or sweetgrass
  - Sales of artwork, pottery or jewelry with cultural or religious significance, such as traditional American Indian and Alaska Native crafts
  - Handicrafts made by Alaska Natives from fish and wildlife resources taken for personal or family consumption
  - Proceeds of sales of subsistence fish and game

- **Student financial assistance provided by the Bureau of Indian Affairs**

- **Any other income that the IRS exempts from taxation (either currently or in the future)**
  - Judgment Funds distributions
  - Income excluded under the General Welfare Doctrine
  - Payments from the *Cobell* settlement

One final point to remember is that gaming per capita payments are *always* included in your MAGI.

How does this work in practice? On the Medicaid side, prior to the passage of the ACA, Medicaid eligibility was determined on a state-by-state basis under some version of an "assets and resources" test. State Medicaid Agencies have replaced those tests with new, MAGI-based eligibility standards that are far less administratively burdensome for both the State and the individual applicant.

Within the Marketplace, one of the requirements for APTC eligibility is a household income between 100% and 400% of the federal poverty level (FPL). Enrolled Tribal members and ANCSA shareholders with an individual or household income below 300% of the FPL are also exempt from any cost-sharing otherwise required by a Marketplace health plan.[5] In both cases, your FPL is determined using your MAGI.

The transition to MAGI is an important tool for expanding AI/AN access to Medicaid, ATPCs, and cost-sharing protections. The MAGI calculation generally exempts significant categories of AI/AN income from the overall consideration and greatly simplified the Medicaid application process. It is a very positive development for AI/ANs.

5. For the purposes of this protection, "cost sharing" includes deductibles, copays, coinsurance, and similar obligations. It does not include premium costs.

THE FEDERALLY FACILITATED EXCHANGE AND *YOUR HEALTH IDAHO*: AMERICAN INDIANS AND ALASKA NATIVES

By Melissa Gower with Contributions from Jim Roberts

The Idaho health insurance exchange, or "Your Health Idaho", was established by the Idaho legislature (H.B. 248) in 2013 to provide an online marketplace where Idaho families and small businesses can go to compare and purchase health insurance. *Your Health Idaho* is governed by a 19-member Board authorized by the Idaho Legislature to set the rules and regulations for Idaho's state-based health insurance exchange. Stephen Weeg of Pocatello, a retired executive director of Health West, serves as chairman of the Board. Amy Dowd serves as the Executive Director and has over 20 years of experience in the health insurance and utilities industries.

Initially, Idaho received the a $20.3 million dollar grant from the U.S. Department of Health and Human Services to support the establishment of Idaho's own state-based health insurance Exchange. One key issues that the *Your Health Idaho* faced early on was how to build the complex application and data technology that is required to connect individuals to insurers' plans and financial assistance such premium assistance or reduced cost-sharing programs; a process that can take between 12 – 24 months. Because Idaho got such a late start and had a short amount of time to create their exchange and meet required deadlines, the State elected to utilize the Federal Facilitated Marketplace (exchange) for the information technology requirements of the exchange.

The aspects that Your Health Idaho is responsible for include managing key functions that include plan management, a staffed consumer resource center, the consumer assistance, and development of the exchange website. Qualified Health Plans (QHPs) that are sold on the Idaho Health Insurance Exchange have been certified by the Idaho Department of Insurance that they meet certification requirements. The Idaho exchange will establish a consumer resource center located here in Idaho that will be staffed by Idahoans to field questions about the Exchange. Your Health Idaho is also working with non-profits and community organizations to train staff to be in-person assisters who help people navigate the exchange website.

As we enter into the sixth month of the Health Insurance Exchanges being operational there are a number of outstanding issues that affect American Indian and Alaska Native people. Because Idaho is supported by the Federal Facilitated Marketplace (FFM), we are focusing on a few of these outstanding issues with the FFM that Tribes in Idaho may encounter as they work to enroll members in their communities into Your Health Idaho plans.

Verification Process for American Indians and Alaska Natives

One of the themes brought up time after time during informational calls on the Affordable Care Act and Health Insurance Exchanges is the issue of tribal membership verification. This is a very important issue as being a member of a federal recognized tribe can mean you are eligible for special protections and provisions, such as special enrollment periods, reduction of cost-sharing protections, and exemption from tax penalty. According to the marketplace application, there are two ways to submit documentation to verify you are a member of a federally recognized tribe. The first is that you can upload and submit these documents on www.healthcare.gov; however individuals are reporting that 80% of the time they are actually not able to upload their tribal documents. The second is to mail your required documents into the marketplace for processing. After hearing no response for several weeks, members are calling the call center and are being told that their documents have not been received. Also, there were numerous identified individuals that mailed their Indian Exemption Application with required tribal documents on January 9, 2014 and as of this date they have had no response.

This brings forward the need even more to have this process be performed electronically. The electronic process would be a real-time verification to determine eligibility and to do so in a manner that is accurate and is efficient, and that increases the number of eligible persons who actually receive the benefit. Applicants would also continue to have the option of providing

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THE FEDERALLY FACILITATED EXCHANGE AND *YOUR HEALTH IDAHO*: AMERICAN INDIANS AND ALASKA NATIVES

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paper documentation, when needed, for verification purposes. This is currently possible through the IHS National Data Warehouse. This data warehouse will indicate who has been determined eligible for IHS services as an Indian, and the data set would be made accessible to the appropriate Federal and state government agencies for use in the real-time verification of Indian status.

As the advocacy for this effort continues, it is imperative that tribal participation is involved in the development and approval of this verification process.

Qualified Health Plans (zero and limited cost sharing plans) not including some Essential Health Benefits and Qualified Health Plans not offering American Indian Tribes or Alaska Native Corporations contracts with Indian Addendum

In numerous states around the country the "American Indian Zero & Limited" Qualified Health Plans that are listed on healthcare.gov are showing that Hospitalization Benefits are not included in the plan. These plans are shown in the application process that you are eligible for; but when going to enroll into the specific zero & limited plans the post enrollment summary screen pops up and shows that there is no Inpatient Hospital coverage. This issue was subsequently brought to the attention of the Insurance carrier and CMS and we have now been told that this typographical error has been fixed. If plans, states, or citizens are experiencing these issues, they need to submit a similar request. We do know that after several enrollees went ahead and selected those plans, once they received their actual policy from the insurer, the plan did include hospitalization. There is no question that inpatient hospital services must be covered by all insurance companies offering coverage, both inside and outside of marketplaces, under the Affordable Care Act as "Hospitalization" is designated as an Essential Health Benefit.

For a tribal health system to be reimbursed at the best rate, the health systems need to be considered an in-network provider in the plan. To be an in-network provider the health system must have a contract with the plan. There are many issues in the contracts that make tribal health care systems not eligible. To remedy this situation, CMS along with tribes developed an Indian Addendum that can be used with plan contracts for tribal health systems, however, there are many plans throughout Indian Country that refuse to offer a contract with the Indian Addendum. Up to date, CMS has only recommended the use of the Indian Addendum. The only remedy is for CMS to require, not recommend, that the plans offer contracts with the Indian Addendum to tribal health care systems.

Reporting American Indian or Alaska Native Income

There is some confusion about the Marketplace Application and where and how to report the various types of American Indian or Alaska Native Income. There are two places on the Marketplace Application which asks the applicant to provide income information, one is the specific Indian income and the other is the Total Income.

On the Marketplace application under the "Indian specific income" section they ask you to list Medicaid-exempt income, but they only include the following types of Indian income:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

However, the application excludes certain categories, particularly the Alaska Native Claims Settlement Act

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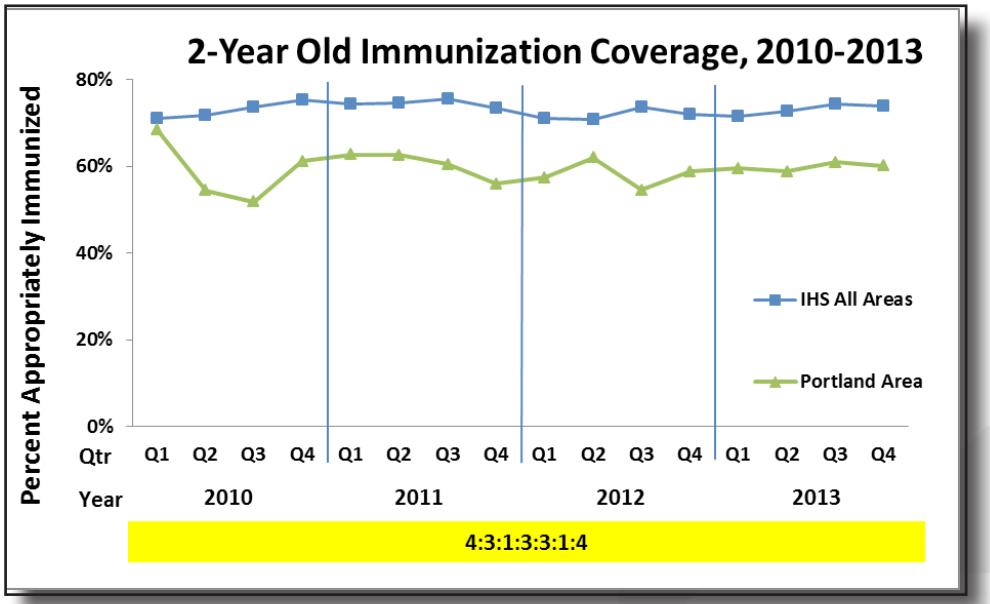
IMMUNIZATIONS EDUCATION NEEDED

CAPT. Thomas Weiser, MD, MPH Medical Epidemiologist, Portland Area IHS

In 2012-13, the Portland Area Immunizations Program and the NW Tribal Epidemiology Center conducted a study to understand the attitudes and practices of NW AI/AN community members and healthcare providers regarding childhood immunizations. Prior to conducting the study, there was growing concern that Immunization levels had fallen well below the 80% goal for two-year olds to have received all doses of recommended vaccines (Figure 1). We wanted to know why these rates had fallen and stayed so low. Was it because of a "data" problem? Were children vaccinated but not being counted in our reports? Or was it because parents had concerns about vaccines that weren't being addressed? We also wanted to know where community members and providers learned about vaccines- where did they get their information? How did they determine which sources were reliable and which were not?

Figure 1. Two-year old complete immunization coverage, IHS and Portland Area, 2010-2013



4:3:1:3:3:1:4 is 4 doses DTAP, 3 doses IPV, 1 dose MMR, 3 doses HIB, 3 doses Hep B, 1 dose varicella and 4 doses pneumococcal vaccines.

We sent web-based surveys out to healthcare providers in ID and OR, conducted phone interviews with healthcare providers in all three states and held focus groups with community members in OR and WA. There were 25 responses from the surveys, 33 healthcare providers interviewed and 36 community members in the three focus groups.

Here's what we found out:

Surveys: 48% of respondents were nurses, 16% were physicians, 12% were nurse practitioners. Most respondents (98%) get their information about immunizations from the US Centers for Disease Control and Prevention (CDC). When parents asked about an alternative to the recommended schedule of vaccines because of concerns about too many shots, or overwhelming the immune system, two-thirds of providers said they encouraged parents to follow the CDC recommended immunization schedule; 43% offered an alternative schedule and 29% warned parents of the risks of following an alternative vaccine schedule.

Interviews: From the 33 interviews conducted with providers (which included 6 primary care providers, 10 nurses/immunization coordinators, 3 pharmacists ad 14 "other/missing"), we identified barriers and facilitators of children receiving immunizations (Table 1.). One of the most commonly identified barriers was the lack of knowledge of the importance of immunizations. While providers said that they did try to provide education during clinic visits and give handouts with information about vaccines, it was not clear how this information was received by the parents of children attending the clinic. Issues related to poverty such as inability to afford transportation and instability of housing are also important barriers that make

IMMUNIZATIONS EDUCATION NEEDED

Table 1. Perceived barriers and facilitators of routine childhood immunizations by healthcare providers from NW IHS/Tribal clinics

Barriers	Facilitators
Parents lack of knowledge or understanding of the importance of children receiving vaccines on time	Using EHR- improves forecasting, better tracking of immunizations, clinical reminders, reports and automatic letters to patients/families
Lack of transportation, finances to pay for gas	State Immunization Information Systems (IIS)
Household instability, frequent changes in living arrangements	Internet access to immunization information
Inaccurate contact information	Use a standardized (CDC) immunization schedules for routine and catch-up immunizations
	Standing orders
	Providing transportation to the clinic
	Dedicated well child clinics, with reminder letters sent out inviting those families with children not up to date to attend
	Add extra immunization clinics/venues

it difficult for parents to bring their children to the clinics on time for immunization services. Providers pointed to several ways their clinics are working to improve immunization services- by making better use of Information Technology, expanding services and use of standardized immunizations schedules with standing orders that nursing staff can follow without the medical provider issuing specific vaccine orders.

Focus Groups: The three focus groups also identified a number of issues that contribute to keep children from being fully immunized and ways to improve this (Table 2.). In many ways, the community members' perceptions mirrored those of healthcare providers. One exception to this was mistrust and fear of the government in general and of vaccines in particular. Providers did not identify these as important barriers, but among community members, these were the most commonly identified and perhaps had the strongest impact on parents' vaccine acceptance. The need for educational materials that were easy to read and used plain language was highlighted by community members. Ensuring that providers had time to explain the importance of vaccines and give thoughtful answers to their questions was also mentioned as a way to address parents' concerns and alleviate their fears.

Table 2. NW AI/AN community member identified barriers and facilitators of routine childhood immunizations

Barriers	Facilitators
Mistrust/Fear of government	Making information understandable
Inadequate information about vaccines, especially safety	Providers having the time/ability to educate in plain language
Fear of vaccines	Advertising, newsletters, handouts
Inability to take time off to bring children to clinic	Community support and trust
Poor clinic reputation	Personal Experience-having had the disease or a child with the disease
Not having adequate transportation or money to pay for transportation	Having pediatricians on staff was perceived as increasing confidence and acceptance of immunizations
Belief in natural immunity/natural lifestyle	

Conclusions: Parental education that addresses parental fears and concerns about vaccines was identified as an important and much-needed service to improve the acceptance of childhood immunizations in NW AI/AN communities. Our next step is to work with community members, clinical providers and IHS patient education experts to develop better written materials and multi-media materials for use in IHS and Tribal clinics. We also hope to work with clinical staff at all levels to help improve their ability to clearly communicate the benefits of on-time, routine childhood immunizations.

MAKING CONTRACT SUPPORT COSTS (CSC) OBLIGATIONS AN ENTITLEMENT

continued from page 3

As the Supreme Court has ruled in the 2005 *Cherokee* case and now the recent *Ramah* decision, contract support costs owed under the ISDEAA are "legal obligation[s] of the federal government to make payments" to ISDEAA tribal contractors. As affirmed by the Supreme Court, tribal contractors "have legal recourse if full payment under the law is not provided." Accordingly, contract support costs are an existing entitlement under substantive law.

The appropriation process has failed to reflect the status of contract support costs as such, however, and that failure is ultimately at the root of the persistent funding problems that have loomed over the otherwise largely successful efforts to diminish "federal domination of Indian service programs" under bold new self-determination and self-governance initiatives. Since contract support costs are already an entitlement under substantive law, Congress should align the appropriation process with the authorizing statute and the *Cherokee* and *Ramah* decisions by appropriating funding for contract support costs on a mandatory basis. Tribal leaders believe this would be a simple and straightforward way to achieve that goal that addresses historical obstacles to full funding of contract support costs with no overall effect on federal spending levels.

CHAIRMAN'S NOTE

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At the end of March I also attended the National Indian Health Board's Tribal Public Health Summit held in Billings, Montana.

Finally, on April 8th I was accompanied by Jim Roberts our Policy Analyst, to testify before the House Interior Appropriations subcommittee. Our recommendations to the Subcommittee stress the need to restore the lost funding from sequestration. We also recommended at least $250 million be provided to maintain current services in FY 2015. I underscored the importance of the Subcommittee to continue to work with Tribes in the oversight of IHS to fully fund contract support costs. We are at the inception of the federal government's decision to fund CSC payments to Tribes. We do not want to lose any ground on the government's implementation. And finally I addressed health facilities issues and the need for IHS to continue to work on a fair construction system. The proposal in the President's request under the "Opportunity, Growth, and Security Initiative" to fund only projects on the priority list is simply not fair for Indian Country. If Congress funds this initiative the funding should be put to fund maintenance and improvement projects so that all Tribes can benefit. Not just one or two construction projects.

The Board through the work of our staff on the TTAG, SAMHSA, and CDC Tribal workgroups continues to be active on a number of priorities for our Tribes. I commend them for their hard work and dedication. Thank you Board Delegates for all your support and advice during our quarterly board meetings to raise the level of awareness on Indian health issues.

Andy Joseph, Jr.

WHAT'S TRENDING NOW: THE NORTHWEST TRIBAL EPI CENTER ASSISTS WITH COMMUNICABLE DISEASE SURVEILLANCE EFFORTS

Jessica Marcinkevage, EIS Officer

Over the past several months, there's been no lack of headlines on the most recent "outbreak" to hit our beloved Pacific Northwest, from foodborne pathogens to sexually transmitted diseases, influenza to norovirus. Just how these outbreaks are detected stems from the cornerstone of public health: disease surveillance. As Dr. David Satcher, former U.S. Surgeon General, once said, "*In public health, we can't do anything without surveillance. That's where public health begins.*" Since these newsworthy conditions most definitely affect our tribal populations, NPAIHB's own Northwest Tribal Epidemiology Center (NWTEC) has been actively assisting local health jurisdictions with data collection, analysis, interpretation and dissemination for public health action – the true definition of public health surveillance.

When news of the recent (and not yet expired) gonorrhea outbreak in Washington state made headlines, personnel from the NWTEC and Portland Area IHS worked with public health nurses and medical officers from several Washington counties to identify how residents of tribal lands were affected, and the areas of greatest burden. These activities led to guidance for clinicians on increased screening practices, and public service announcements for members of the hardest hit communities. Even though there have been fewer reported cases over the past few months, the NWTEC continues to monitor gonorrhea and other sexually transmitted disease trends for the state, and remain in communication with state and local partners.

Although rates of tuberculosis (TB) have declined significantly over the past 20 years, the disease continues to be a greater burden in AI/AN populations than for other race/ethnicities. We at the NWTEC are reminded of this after a recent call from one community, requesting assistance with its TB surveillance and data management. Working with personnel at the clinic, county and state levels, the NWTEC is helping to identify risk factors for TB within the community and make recommendations for screening practices.

The Epi Center's role in disease surveillance does not end with these isolated examples. In coordination with the Portland Area IHS, the NWTEC continually monitors influenza activity in federal, tribal and urban clinics of Idaho, Oregon and Washington via weekly reporting from the IHS Influenza Awareness System. Additionally, the NWTEC is working with IHS and State partners to test the validity of IHS' National Data Warehouse for use in surveillance of a multitude of communicable diseases. So what's trending now? A tribal epidemiology center, working to put public health surveillance into action.

IHS TO FULLY FUND CONTRACT SUPPORT COST PAYMENTS

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100% of their administrative costs which are covered by various operatives within the federal government like the Office of Personnel Management, the General Services Administration, Department of Justice, and other agencies that perform administrative functions. Historically, Tribes have had to absorb these costs by cutting services or using other Tribal resources to the disadvantage to the Tribe and their members. Fully funding CSC payments will now help Tribes to maintain services.

FETAL ALCOHOL SPECTRUM DISORDERS (FASD) WEBINARS

Jacqueline Left Hand Bull

Two New Fetal Alcohol Spectrum Disorders (FASD) Webinars to be available.

Through its contract with the University of Washington's Fetal Alcohol and Drug Unit (FADU), the NPAIHB project has added two more webinars to this year's planned activities, as well as another in- person training for tribal leaders and practitioners.

The webinars are "Preventing FASD: Creating a Circle of Hope" on **May 28th, 10-11 PDT**, to be presented by Kathleen Mitchell and Daphne Colacion, and "FASD and Addiction: Improving Treatment Outcomes" on **June 18th, 10-11 PDT,** presented by Dan Dubovsky and Michael McDonell. Both of the webinars are being made available by the Tribal Behavioral Health Center for Excellence, as a service of the Indian Health Service – Headquarters Division of Behavioral Health, and are open to any interested person.

The call-in process is simple.
1. Go to: http://ihs.adobeconnect.com/dbh
2. Select "Enter as a Guest"
3. Enter your name (First and Last) in the name field.
4. Enter the room passcode: **dbh**
5. Press the "Enter Room" Button

For technical assistance, contact: Alaina George alaina.george@ihs.gov 505-248-4531

The in-person training event will focus on understanding diagnosis. It will be held the third in September, in Seattle. More information will be available in the July issue of Heath News and Notes.

THE FEDERALLY FACILITATED EXCHANGE AND YOUR HEALTH IDAHO: AMERICAN INDIANS AND ALASKA NATIVES

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distributions, which could be significant for Alaska Natives or BIA educational program income, both of which are included in the exact same Modified Adjusted Gross Income (MAGI) regulatory exclusions as the listed income.

There have been numerous questions to CMS about how to list other exempt income. CMS has said that any exempt Indian income not specifically listed in the applications are tax exempt, and therefore already exempt from the Modified Adjusted Gross Income (MAGI), and therefore CMS didn't feel the need to list it again. The problem with this response is that neither the application nor its instructions make this clear. Because of this confusion, applicants and assisters need clear instructions on where and how to report Indian income on the Marketplace application.

Even though you try to shop and enroll in insurance on the marketplace, you may have problems uploading your tribal documents for verification of your Indian identity, or it may be unclear whether the plan you prefer includes all the Essential Health Benefits, or you may not clearly understand where or how to report all your Income, it is to your advantage to shop and enroll in the marketplace if you don't have any health coverage, as there are many benefits for American Indians and Alaska Natives.

These are just a few of the issues that are being debated nationally between tribal representatives and CMS, however, we are sure that there are many more. We are and will continually work and advocate on your behalf to resolve these issues.

If you have a specific issue that needs attention, please feel free to contact Lisa Griggs at (503) 228-4185.

UPCOMING EVENTS

MAY

May 4-8
2014 Tribal Self-Governance Consultation
Arlington VA

May 6-7
Synergy "Addressing the Impact of Domestic Violence on Children"
Portland, OR

May 7-8
Historical Trauma Training
Grand Ronde, OR

May 14-15
IHS Direct Service Tribes Advisory Committee Meeting
Rockville, MD

May 16
8th Annual Medical Update Conference
Shelton, WA

May 19 - 21
Providers Best Practices & GPRA Measures Continuing Medical Education
Sacramento, CA

May 20-21
(CMS) Indian, Tribal and Urban Outreach and Education
Auburn, WA

May 20-21
Tribal Sexual Assault Advocacy Skills Training
Centralia, WA

May 26
Memorial Day

May 28-29
Risky Business 2014
Portland, OR

JUNE

June 1-5
26th Annual Native Health Research Conference
Phoenix, AZ

June 8-11
NCAI Mid-Year Conference
Anchorage, AK

June 16-20
National Nurse Leaders in Native Care [NLiNC]
Online

June 16
Administration for Children and Families Consultation
Arlington, VA

June 17-18
2014 Tribal Public Health Emergency Preparedness Conference
Portland, OR

June 23
NPAIHB Tribal Health Directors Meeting
Ocean Shores, WA

June 24-26
NPAIHB Quarterly Board Meeting
Ocean Shores, WA

We welcome all comments and Indian health-related news items.
Address to: Health News & Notes
2121 SW Broadway, Suite 300, Portland, OR 97201
Phone: (503) 228-4185 FAX: (503) 228-8182
Website: www.npaihb.org

UPCOMING EVENTS

Northwest Diabetes Management System Training

Northwest Portland Area Indian Health Board
2121 SE Broadway, Suite 300, Portland, OR 97201
Attention diabetes coordinators, CHRs nutritionists, health care providers, and data entry personnel!

You are invited by the Northwest Portland Area Indian Health Board to our Northwest Diabetes Management System Training! : Participants will receive hands-on instruction in the Diabetes Management System package for RPMS (BDM) in both the "roll and scroll" interface and the Visual DMS graphical user interface (GUI). Topics include building and maintaining diabetes and pre-diabetes registers, editing patient information, and running register and quality assurance reports. Additional topics include using QMAN for custom searches to meet needs that commonly arise for diabetes programs, creating panels of patients in iCare, and performing the annual IHS Diabetes Audit with WebAudit. Instruction is hands-on using a training server with mock patient data.

Please check the box beside the training you are interested in attending. Or click here to register online.

- ☐ March 11 - 13, 2014
- ☐ June 3 - 5, 2014
- ☐ September 23 - 25, 2014
- ☐ December 2 - 4, 2014

Day 1- 8:30 AM - 4:00 PM
Day 2- 8:30 AM - 4:00 PM
Day 3- 8:30 AM - 11:30 AM

Please fax registration to: (503)228-4801
you may also email your registration to: wtdp@npaihb.org

You must have registrations and/or cancellations submitted at least TWO weeks prior to training. Please contact: Western Tribal Diabetes Project (800) 862-5497, to confirm training time, attendance, and registration.

Registration for RPMS DMS Training

Name:_____ Title:_____
Organization:_____
Address:_____
City:_____ State:___ Zip:_____
Phone:_____ Fax:_____
E-mail:_____

REGISTRATION OPEN FOR 4TH ANNUAL THRIVE CONFERENCE

FOR AMERICAN INDIAN AND ALASKA NATIVE YOUTH

- Ages 13 - 19. Limit 4 youth per Tribe or Urban Area.
- 1-2 Chaperones per group registering.
- Registration is free and ends on June 13th!
- Activities, materials, and most meals will be provided.
- Travel, parking, and lodging are not included.

REGISTER AT - https://www.surveymonkey.com/s/2014ThriveConference

JUNE 23 - 27, 2014
LLOYD CENTER DOUBLETREE HOTEL, PORTLAND, OR

Youth workshop tracks & activities:

- We R Native Youth Ambassadors (NEW Leadership workshop! Application required.)
- Digital Storytelling
- Film Production
- Song Writing & Production
- Dancing and cultural sharing

WHY THIS CONFERENCE?

- Building protective factors, i.e. the workshop tracks, for youth can help reduce the chances of engaging in risky behaviors and increase self-esteem and confidence.
- Protective factors focused on: connectedness to friends and culture, engaging in activities, support, encouragement, and more!

DoubleTree Lloyd Center Hotel rates are $113 - $123/night for up to 4 in a room, use group "Annual THRIVE Conference" or register ONLINE using group code "TH6". Call 1-800-996-0510 for reservations.
Deadline to reserve: June 9, 2014

Contact Information
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
THRIVE and PRT Staff:
Colbie Caughlan until 4/15/14 and after 6/15/14
Phone: 503.416.3284
Email: ccaughlan@npaihb.org
Tommy Ghost Dog from 4/16/14 till 6/14/14
Phone: 503.416.3259
Email: tghostdog@npaihb.org
Web: www.npaihb.org

COME SHOW HOW YOU STRENGTHEN YOUR NATION!

I STRENGTHEN MY NATION
THRIVE

NATIVE FITNESS XI

NIKE WORLD HEADQUARTERS
BEAVERTON, OREGON

Who Should Attend?

- *-Diabetes Coordinators*
- *-Tribal Fitness Coordinators*
- *-Community Wellness Trainers*
- *-Youth Coordinators*
- *-Tribal Leaders*

Why Should You Attend?

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

SAVE THE DATE

JULY 29 & 30, 2014

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

Native American Fitness Council
Northwest Portland Area Indian Health Board

For more information about upcoming events please visit: http://www.npaihb.org/

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Resolution #14-02-01
Support to Expand Medicare-like Rates to Non-Hospital Based Services

Resolutions #14-02-02
OS-PAW-14-001 Mobilization for Health: National Prevention Partnership Awards

Resolution #14-02-03
NPAIHB Program Operations Manual Revisions

Resolution #14-02-04
Support for Legislation for Tribal Dental Aides and Dental Health Aide Therapists in Washington Legislature