Health News & Notes

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

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July 2013

REPORT CARD ON HHS/CCIIO REGULATIONS FOR HEALTH INSURANCE MARKETPLACES

By Jim Roberts and Mim Dixon[1]

President Obama has undertaken the most massive health care reform since the passage of Medicare and Medicaid in the 1960s. In the three years since the Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, an incredible amount of work has been done at the federal level and within many states to set up Exchanges, also called "Marketplaces," where private insurance will be sold primarily over the internet.

The cost of these health insurance policies will be subsidized by tax credits to make premiums affordable for low and middle income people, all the way up to households with income as high as $94,000 for a family of four. There are special provisions in ACA for American Indians and Alaska Natives (AI/AN) to be able to enroll every month and to eliminate most co-pays and deductibles.

The fact that approximately 30% to 37% of AI/ANs are uninsured or lack access to an Indian Health Service (IHS), Tribally-operated, or an urban Indian health program (I/T/U) should make access to health insurance an attractive opportunity.[2] Health reform holds the promise to make significant steps toward improving, maintaining, and financing programs that support the health care needs of many AI/ANs. But this promise will not be fulfilled unless regulations to implement the new law adequately support the Indian health system and encourage AI/ANs to enroll in health insurance sold by insurance marketplaces. To do anything less is an empty promise about the potential benefits of health reform for AI/AN people.

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1 Jim Roberts is Policy Analyst for the Northwest Portland Area Indian Health Board. Mim Dixon is a consultant working with Tribes. Both serve as Technical Advisors to the CMS Tribal Technical Advisory Group (TTAG) and members of the Medicaid and Medicare Policy Committee (MMPC) of the National Indian Health Board.

2 "A Profile of AI/AN and Their Health Coverage," James, Cara, Kaiser Family Foundation, 2009; and "Health Care Reform: Tracking Tribal, Federal, and State Implementation," Ed Fox, by Kauffman & Associates for the Centers for Medicare & Medicaid Services (CMS).

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CHAIRMAN'S NOTE

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

I hope this finds you all having a very nice summer! Fortunately, I have not had to do much traveling this last quarter. This is a good thing. It's given me an opportunity to stay home and focus on local issues and spend valuable time with my family. I am also pleased to announce that I was re-elected for another term to on the Colville Tribal Council and want to thank all of you that supported me. Our work is important and I could not do it without your support. It means a lot to me in my work at home and for the Board.

In April, I traveled to Washington, D.C. to testify before the House Interior Appropriations Subcommittee. This is a very important time for not just Indian health, but all Indian programs. The Congress and Administration are in a face-off over the budget and held hostage is the funding that the United States owes our Indian people under the treaties the U.S. government signed. We have already seen the effect of this with sequestration. The IHS budget was cut $228 million, with over $14 million of this being reduced in the Portland Area. The Board's presence and our testimony at this hearing are very important to remind Congress of the treaty obligations. We need to protect the funding that our programs are entitled to receive. My testimony recommended restoration of the $228 million cut from the IHS budget. We also underscored the importance of Congress to always fund current services and contract support costs.

In April, I attended the Tribal Self-Governance Advisory Committee (TSGAC). The TSGAC conference prioritized work on health reform, budget and legislative priorities, and health program best practices. The impact of sequestration was heavy on our hearts and minds. To know that a budget cut was coming and we could not stop it was not a good thing. The meeting allowed Tribes to develop a strategy to address this and the Board will do its part to advance the message that IHS and BIA programs must be exempt from budget cuts in the future.

I also attended the Affiliated Tribes of Northwest Indians (ATNI) mid-year conference. It was nice to not travel so far and be in Spokane for this meeting. Our ATNI health committee included a legislative and budget report from the Board. We also reviewed Northwest recommendations on the Special Diabetes Funding for Indians anticipating tribal consultation on the FY 2014 funding cycle.

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IHS BUDGET: WILL FY 2014 BE ANOTHER SEQUESTER?

By Jim Roberts, Policy Analyst

Tribes and the rest of America are faced with a long period of political and budget uncertainty as they prepare for the upcoming 2014 fiscal year. For now, there is calm in the sequestration storm as we are all numb over the cuts and make the most to implement what remains of budgets in this fiscal year. Rest assured that the budget debate will inevitably return when this fiscal year ends on September 30, 2013. Tribes were caught off guard in the wake of budget austerity and were not prepared to fend off the FY 2013 sequestration. If this happens again in FY 2014, the amounts may not be as significant but the effects could be much worse.

The Indian Health Service (IHS) budget was reduced by $228 million in FY 2013 due to sequestration. The Portland Area Office budget used to be just over $288 million. For Northwest Tribes in Idaho, Oregon, and Washington their share of sequestration means that there will be $14.2 million less to provide health care. The Portland Area Office budget will be reduced to $274 million in FY 2013. These cuts could go deeper if there is another sequestration in FY 2014. Such cuts become exponential when you factor that your base budget has been seriously eroded and inflation and population growth will be factored on a significantly lower funding base. Accumulate this over time and one can see the impact it will have.

The sequestration prophecy did not play out the way it was supposed to for anyone in the Administration or the Congress. And unfortunately many people including Tribes have been hurt because of it. The expectation was that sequestration would cause alarm and be painful enough to force a compromise in the appropriations and tax policy (revenue) process to summon a compromise. It did not and now Indian programs have to deal with it, despite the United States obligations under the federal trust responsibility. We are one year into a ten year process and Tribes need to begin to deal with this sequestration business. As former White House OMB official, Barry Anderson, involved in the previous sequestration cuts in 1991 explained it, “It’s a diet that gets worse every year” and Tribes need to prepare.

At this writing, a House-Senate-White House deal is required to avert a government shutdown at the end of this fiscal year. House Republicans are also still demanding concessions from the President before they approve an extension to the debt limit. This will further complicate the FY 2014 appropriations process. Many folks around Washington feel that the

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REPORT CARD ON HHS/CCIIO REGULATIONS FOR HEALTH INSURANCE MARKETPLACES

Along with some very talented and dedicated Tribal Leaders and their technical advisors, the Board has been working tirelessly over the past three years to help the federal government understand what has to be done to make these new programs work for AI/AN people and Tribes that provide health care. Together we all have reviewed thousands of pages of draft regulations, submitted detailed comments, participated in teleconferences and meetings, and pleaded for more effective Tribal Consultation. We have met with HHS, CMS, IHS, IRS, OPM, and the White House. Now the regulatory period is coming to an end and government is entering the final phases of implementation before people start enrolling in these new Marketplaces in October.

Our efforts have prevented the worst case scenario. With a new ruling announced recently, there will be no tax penalty for not having private health insurance for AI/AN who are members of federally-recognized Tribes, or use the Indian health programs, or meet the Medicaid definition of AI/AN.

However, we have been unable to achieve the best case scenario. Overall, the federal government has not taken the steps that would make it easiest for our Indian health care systems to benefit from the massive new federal funding for health care.

While Tribal representatives have advised the federal government on hundreds of issues, both large and small, we have chosen to present here a scorecard on nine of the most significant issues for Tribes.

The IRS recently published a rule that will grant a hardship exemption to Indian Health Service beneficiaries from tax penalties if they do not have private health insurance. For the other eight items on the list, we have lost 75 percent of our battles. In the urgency for the Obama Administration to meet the deadlines in the law, Indian health was deemed expendable.

HHS/CCIIO Report Card on Tribal Issues in Federal Regulations to Establish Insurance Exchanges

Tribal Regulation or Issue/Concern	Implemented Tribal Recommendation?
Align ACA definition of Indian with Medicaid definition	No
Use IHS data base in on-line application process	No
Develop Indian Addendum for use with provider contracts	Yes
Require Plans to offer contracts with Indian Addendum to I/T/U	No
Exempt IHS beneficiaries from tax penalty for not having insurance	Yes
Apply Indian cost sharing exemption to all services offered by plans, not just Essential Health Benefits (EHB)	No
Apply Indian cost sharing exemptions to AI/AN over 400% FPL	Yes
Require Exchanges to develop Tribal Sponsorship programs	No
Have Indian-specific funding and training for Navigators, call centers	No

The decision was made to serve a majority of the people and leave the AI/AN minority behind. The Administration decided it was more important to work with insurance companies to keep premiums low and profits high, than to work with Tribes to assure that premiums would be paid on behalf of AI/AN to bring new resources into an underfunded health care system. Despite eloquently worded Tribal Consultation policies, Tribal Consultation was reduced to a series of teleconferences in which federal employees read press releases.

Where do we go from here? First, Tribal Leaders and national advocacy organizations are trying to educate Congress about problems of the definitions of Indian in ACA and urge them to pass legislation to make one consistent definition that is the same for

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NORTHWEST MARKETPLACE (EXCHANGE) PROFILES & TRIBAL ITEMS			
EXCHANGE FUNCTION	**IDAHO**	**OREGON**	**WASHINGTON**
Exchange Name	Idaho Health Insurance Exchange	Cover Oregon	Washington Healthplanfinder
Structure (As described in the legislation)	A quasi-governmental organization, specifically an "independent body corporate and politic."	"A Public Corporation performing governmental functions and exercising governmental powers."	"A quasi-governmental organization, specifically a "self-sustaining public-private partnership separate and distinct from the state."
Legislation	HB 248	SB 91, HB 4164	SB 5445; HB 2319 **Legislation includes Indian provisions**.
Governance	Exchange Board consists of 19 total members, with 17 voting members. The 14 voting members who are not members of the legislature shall be appointed to the board by, and serve at the pleasure of, the governor. The governor appointments must be confirmed by the Senate. ***No Tribal representation.***	Nine Member Board, w/two ex-officio members. Governor appoints 7 members, which are confirmed by Senate; ***No Tribal representation***	Eleven member board, w/two non-voting, ex officio members. Governor appoints 8 voting board members from lists of nominees created by the two largest caucuses in the House and Senate. ***No Tribal representation***
Tribal Consultation Policy	No	Yes	Yes
Tribal Engagement			Yes – Tribal Advisory Workgroup linked to Consultation Policy
Financing		Exchange will impose and collect administrative charges from insurers and state programs participating in the Exchange to cover costs and expenses.	HB 2319 gives the Board explicit authority to assess a surcharge on premiums. The Exchange is required to be self-sustaining without direct state tax subsidies, or else operations can be suspended. Mention current bill being considered for sustainability?
Exchange Establishment Funds	Planning grant $1 million Level I $20.3 million ***No Tribal funding provided yet***	Planning grant $1 million Early Innovator $59 million Level I & II $242 million ***Approximately $350,000 to Tribes***	Planning grant $1 million Level I $~~150.8~~ 22.9million Level II - $127.8 million ***Approximately $480,000 to Tribes***
Contracting w/Plans	HB 248 specifies Exchange will function as a clearinghouse; all carriers, health benefit plans, and stand-alone dental plans will be allowed to participate in the Exchange if in compliance with state and Exchange law. Exchange will us geographic rating areas based on three-digit zip codes with State divided into seven geographic rating areas. Network adequacy standards similar to the standards established by HHS-FFE.	Authorized to act as an active purchaser QHPs. May "limit the number of QHPs as long as the same limit applies to all insurers. Carriers required to offer standard bronze, silver-, and gold-level plan in each of their service areas & option to offer three platinum plans; and /or one catastrophic plan. ***Requires Tribal Addendum when contracting with Tribes.***	Exchange Board approved 19 criteria (all of which were specified in the ACA) to be the framework for health insurers' participation in the Exchange. The OIC is responsible for reviewing nine criteria while the HBE will review the remaining ten. ***Includes requirements for QHP issuers to offer contracts to Tribes and encourages QHP Issuers to use Tribal Addendum when contracting with Tribes***
EHB Design	Idaho has not put forward a EHB recommendation, the state's benchmark EHB plan will default to the largest small-group plan in the state, Blue Cross Blue Shield of Idaho-Preferred Blue PPO.	EHB benchmark is Small Group PacificSource Preferred CoDeduct. CHIP Plan will be pediatric dental benefit. The federal BlueVision "High Plan" package is the pediatric vision benefit.	EHB benchmark is Blue Shield- Regence Innova Plan PPO. CHIP will serve as the pediatric dental supplement. Federal Employee Vision Plan (FEDVIP) as the pediatric vision supplement.
Consumer Outreach & Assistance	Idaho has not announced it plans for consumer outreach and assistance.	Contractor selected to develop marketing campaign. Community Partner Program (CPP) for outreach and engagement. Navigators program in place w/assistance from CPP. **Tribes can be Navigators & carve out of CPP funding.**	Navigator program comprised of Lead Organizations, organized by county service area or target population, that will contract with HBE to build, train, fund, and monitor networks of in-person assisters (IPAs) and Navigators. **Includes carve out of IPA funding for Tribes.**
Tribal Sponsorship	No	Yes – Tribal Portal	Yes – Tribal Agreements
Medicaid Expansion	No	Yes	Yes

WHAT HEALTH REFORM MEANS TO TRIBES IN WASHINGTON STATE

By Sheryl Lowe, Tribal Liaison, Washington Health Benefit Exchange

Many of you may have heard about some of the changes associated with the Affordable Care Act (ACA) and are curious about how health reform in Washington State will affect your tribe and community. A key component of the ACA is the creation of health insurance marketplaces where people can go to easily shop for health plans and gain access to financial assistance from the federal government to help pay for their coverage, depending on their income level.

The Washington Health Benefit Exchange is a quasi-governmental agency created in 2011 to implement an online marketplace in our state. Known as Washington Healthplanfinder, the site will allow residents to compare Qualified Health Plans (QHPs) side by side that meet new standards under the ACA, determine eligibility for federal tax credits, or receive personal assistance enrolling in the right health plan to meet their needs.

An estimated 22,000 American Indians and Alaska Native adults in Washington State will be eligible for health plans and additional benefits through Washington Healthplanfinder when it opens October 1, 2013. The ACA also includes a number of provisions that outline special rules for American Indians and Alaska Native enrollment in state-based Exchanges. These include:

- **A Break on Costs for Certain Income Levels:** American Indians and Alaska Natives with a household income of less than $70,650 for a family of four and $34,470 for an individual will not have copays or deductibles if they obtain insurance through Washington Healthplanfinder.

- **No Costs for Using Indian Health Services:** There are no copays or other costs for American Indians who receive health care services or receive a referral through Indian Health Services, Tribes, Tribal organizations, or Urban Indian organizations.

- **Special Open Enrollment Periods:** American Indians may enroll in or change their health plan on a monthly basis, if they desire.

- **No Federal Mandate**: An additional protection exempts members of Federally-recognized Tribes, Tribal descendants and other Indian Health Service users from the federal mandate requiring all individuals to purchase minimum health care coverage.

Collaborating with the Exchange

Last summer, the American Indian Health Commission for Washington State (AIHC) was awarded an Exchange grant to work with Washington's 29 federally recognized tribes and 2 urban Indian health organizations to identify AI/IN Exchange issues that require attention, provide ideas around outreach and education to tribal populations, and help the Exchange prepare for open enrollment on October 1, 2013. You can find more information about their health reform efforts on their website.

AHIC was also tasked with working with the Exchange and Tribal Leaders to establish a Tribal Consultation Policy that outlines how the Exchange will consult and collaborate with Indian Tribal Governments and tribal programs on policies or decisions that have an impact on Indian people in Washington State. It also ensures that the benefits and protections of tribal populations are protected.

To provide an avenue for input and on-going collaboration, a Tribal Advisory Workgroup has recently been developed. Representatives in this group were appointed through a tribal process, and the workgroup has now been officially sanctioned by the Exchange. The purpose of the Workgroup is to assist, in collaboration with I/T/Us, in the identification of proposed policy or actions that have tribal implications and to satisfy the requirement for WHBE to collaborate with I/T/Us and AIHC on a consistent, on-going basis. These efforts further complement the efforts of Leslie Wosnig of AIHC and the Suquamish Tribe, who serves on the Exchange Advisory Committee, as well as Vicki Lowe of the

WHAT HEALTH REFORM MEANS TO TRIBES IN WASHINGTON STATE

Jamestown S'Klallam Tribe who serves on the Exchange Navigator Technical Advisory Committee.

The Exchange also hired me as the Tribal Liaison on April 1st to further strengthen the relations between Tribes, urban Indian Health programs and the Exchange. My role is to plan, manage and evaluate HBE programs and policies related to I/T/Us, provide advice to Exchange staff, and collaborate with Tribal Leaders, Tribal health programs, the AIHC and other Tribal organizations on Exchange issues that have Tribal implications.

Working with the Exchange

In addition to a streamlined health plan shopping experience and financial assistance, there are several ways that Tribes can access additional benefits through Washington Healthplanfinder. These include:

- **A Tribal In-Person Assistance Network**: Due to the unique characteristics of tribal programs, the Exchange has begun the process of selecting tribes, coalitions of tribes, and/or tribal organizations to provide a tribal in-person assistance network. These organizations will be responsible for providing one-on-one help for tribal members in their local community if they need additional help comparing and enrolling in Qualified Health Plans (QHPs) through Washington Healthplanfinder. These organizations will be announced by the Exchange sometime in July.

- **Premium Sponsorship:** The Exchange is working with tribal leaders to develop a sponsorship program that permits Tribal Entities to pay plan premiums on behalf of designated individuals who enroll in a Qualified Health Plan (QHP) offered through Washington Healthplanfinder. For an overview of this program, please click here.

- **Qualified Health Plan Contracting:** The Exchange has coordinated with the Office of the Insurance Commissioner, Tribes and AIHC, to assure that QHPs are required to offer contracts to all Tribes and urban Indian Health organizations. The OIC is also encouraging carriers to use the Indian Addendum that was approved by HHS this spring. The Addendum describes the most relevant federal Indian laws that plans must abide by when contracting with Tribes.

- **Training for the In-Person Assister Network and the Exchange's Customer Support Center** (Call Center)– The Exchange is working with an AIHC-sponsored, "Tribal Get Covered" Workgroup, to develop an AI/AN Training module that will be included in both the In-Person Assister Training, as well as with Customer Service Representatives on the special provisions and protections afforded to AI/AN. The module will be completed in early July. The Workgroup is also assisting the Exchange in developing education and outreach strategies to reach AI/AN in Washington.

We hope that Washington Healthplanfinder will provide a new way for tribal populations across Washington State to gain access to quality health care coverage and specialty services. If you would like to get involved or need more information, please contact me at 360-688-7749 or sheryl.lowe@wahbexchange.org.

For more information about Washington Healthplanfinder, please visit our Tribal Members page at wahbexchange.org.

TRIBAL LEADER GUIDE TO THE ACA INDIAN DEFINITION ISSUE

What is the Indian Definition Issue?

The ACA includes special protections and benefits for American Indian and Alaska Natives (AI/AN). The U.S. Department of Health and Human Services (HHS) has ruled that in order to be eligible for these special protections and benefits a person must be an enrolled member of a federally- recognized Tribe. This issue is not about determining who is eligible to enroll in a Tribe. It is about making Indian people eligible to receive health benefits in the new health reform law.

Who does the current definition leave out?

The current definition of Indian under ACA will leave out many California Indians, Alaska Natives who are not shareholders in Native corporations under the Alaska Native Claims Settlement Act, Indian children whose Tribes do not enroll people younger than 18 years old, and some descendants of Tribal members who are eligible for IHS health care.

What definition are Tribal advocates supporting?

Tribal advocates support changing the ACA definition of Indian eligibility to be the same as the eligibility rules of the Indian Health Service (IHS) and Medicaid.

Why is fixing the Indian definition issue a good thing?

The current ACA definition will result in inconsistent eligibility determinations for AI/AN special provisions for health care services under the ACA, Medicaid and IHS programs. This will cause confusion and make it harder to manage the programs. Also, it means that some AI/AN will have higher costs for health insurance, while other groups of AI/AN will have free or low cost health insurance. Changing the definition of Indian in ACA will remove this inequality.

Will an expanded Indian definition decrease health services and resources to enrolled members?

No. If people who use Indian health care had insurance under the ACA and qualified for the special protections and benefits, IHS and Tribal programs could bill the insurance companies for the costs of providing services and save valuable CHS dollars, so there will be more resources for everyone who uses IHS, Tribal, and urban Indian programs.

Will the definition issue affect Tribal sovereignty about enrollment in my Tribe?

No. This issue has nothing to do with a Tribe's sovereign authority to determine its membership and enrollment.

Will AI/AN have to pay a tax penalty for not having insurance?

No. Enrolled members of federally-recognized Tribes can receive an "Indian exemption." Individuals who are eligible for the Indian Health Service (IHS) and/or meet the Medicaid definition of Indian can receive a "hardship exemption" from paying the tax penalty for not having private health insurance.

How can I help fix this issue?

The federal government has stated that the only way to fix the ACA Indian definition issue is with legislation. Tribal leaders and advocates should contact their Congressional Members about this issue and recommend passage of legislation developed by the National Indian Health Board to address this issue. Information is available at: www.nihb.org.

MEDICAID INDIAN MANAGED CARE ENTITIES

By Jim Roberts, Policy Analyst

The American Recovery and Reinvestment Act (ARRA) includes protections to ensure that American Indian and Alaska Native (AI/AN) enrollees and their Indian health providers can participate in Medicaid managed care. The legislation amended the Social Security Act to add a new Medicaid statute at section 1932(h) and a new CHIP statue at section 2107(e)(1)(J). These changes will apply consistent rules governing the treatment of AI/ANs, Indian health care providers, and *Indian Managed Care Entities (IMCEs)* in State Medicaid and CHIP managed care programs.

The legislation includes authority at section 1932(h)(3) and 1932(h)(4) for an Indian Health Program or an Urban Indian Organization to function as a "Indian Medicaid managed care entity." The new authority for IMCEs may present a new opportunity amid increasing state and national interest to develop and move to stricter Medicaid managed care models. These new Medicaid models have already started to have an impact on the Indian health system. The states have begun to restructure their managed care programs into units that serve a set geographic population. These units have a responsibility for care coordination and outcomes for the population served. They may transition from fee-for-service reimbursement (FFS) to global budgets, provide payment incentives for performance and quality outcomes, and allow providers to share in the cost savings associated with quality improvements and efficiency.

Almost every state has some form of new care coordination underway including health home initiatives, patient-centered medical homes, Accountable Care Organizations, or other initiative to coordinate physical and behavioral health or to coordinate long-term care and acute care services. States like Oregon's Coordinated Care Organizations (CCOs) are well underway. CMS and states are also working on new models to better align financing of the Medicare and Medicaid programs. These managed care models integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid dual eligibles. Oregon Tribe's experience with the new CCOs has demonstrated that these new Medicaid managed care delivery models are a challenge and may not integrate well with the Indian health system.

The potential of becoming an IMCE may help Tribes to transition into these new Medicaid delivery system reforms. While CMS has issued a State Medicaid Director Letter (SMDL#: 10-001) regarding implementation of the ARRA provisions, it was not detailed enough in its instructions to operationalize and implement the IMCE provisions. CMS describes an IMCE as follows:

> *The term Indian Managed Care Entity (IMCE) means a managed care entity that is controlled by the IHS, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the IHS. The new statutory provision expressly recognizes that an IMCE may restrict its enrollment to Indians in the same manner as Indian health programs may restrict the delivery of services to Indians.*

Aside from the general explanation provided in SMDL #10-001, there is no formal policy or rule that explains how IHS, Tribes or urban Indian health program can become an IMCE. Additional policy guidance is needed from CMS to the states. The CMS-TTAG should also elevate this issue to provide such a framework.

ICD-10 IMPLEMENTATION: "GETTING CLOSER"

by: Jim Roberts, Policy Analyst

The Centers for Medicare & Medicaid Services (CMS) has mandated the replacement of the International Classification of Diseases—9 (ICD-9) code sets used by medical coders and billers to report health care diagnoses and procedures to a set of new ICD-10 codes. Implementation of the new ICD-10 codes was to begin October 1, 2013, however due to several challenges to implement the new code requirements CMS has extended the date to October 1, 2014. The move to ICD-10 is not optional and all Indian Health Service (IHS), tribally-operated, and urban Indian health programs must comply with its requirements.

Why change from ICD-9 to the new ICD-10 code sets? There are four main reasons why the federal government is moving to a new ICD-10 code set standard.[1] The first is that the ICD-9 dates back to 1979 and its functionality has been "exhausted" and does not reflect "new and changing medical advancements." Another is that the outdated ICD-9 code manuals were full, which required putting codes in "topically unrelated chapters," which is burdensome for healthcare providers in a move toward more efficiency.

The third reason CMS states is that ICD-9 was insufficient and did not provide detail opportunities, explaining that, "[I]n an age of electronic health records, it does not make sense to use a coding system that lacks specificity and does not lend itself well to updates, new and emerging health care technologies, and the need for interoperability amid the increase in electronic health records (EHRs) and personal health records (PHRs)."

The final reason is that ICD-9 code manual was no longer supported by the World Health Organization. CMS explained in the rule that, "As we become a global community, it is vital our health care data represent current medical conditions and technologies, and that they are compatible with the international version of ICD-10." The rule further explains that ICD-10 will allow more precise diagnosis and procedure codes for payment purposes and that this is critical to the national and international health care community for mortality reporting, bio-surveillance, treatment of patients, hospital management, and research.

To meet the challenge of implementing ICD-10, IHS has implemented a project planning team that includes ICD-10 implementation through an IHS Steering Committee and Area Coordinators. The Steering Committee is responsible for the delivery of tasks associated with ICD-10 project planning and implementation. It includes clinical, technical and business representatives from I/T/U programs. The Area Coordinators serve as a point of contact for the I/T/U to communicate ICD-10 status, issues and to oversee project activities. The Area Coordinator for the Portland Area is Peggy Olligaard.

It is anticipated that ICD-10 implementation will radically change the way coding is currently done and will require a significant effort to implement. CMS' goal in postponing the transition was to provide health care system stakeholders with an additional twelve months to accomplish the complex tasks associated with implementing ICD-10. Despite this extension of time there are many stakeholders, including the I/T/U, that have expressed confusion and frustration and that they will not be ready by October 1, 2014.

Recent discussion about ICD-10 implementation at a recent meeting of the American Indian Health Commission (AIHC) indicates many Tribal Health Directors (THDs) are concerned about the impact of ICD-10. Tribal health directors do not feel there are inadequate resources for training and implementation, especially for the severely underfunded Indian health care system. Despite preparation by sending staff to ICD-10 training and preparing for implementation, most THDs believe there will be a significant negative

1 Federal Register / Vol. 73, No. 164 / Friday, August 22, 2008 / Proposed Rules: HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards To Adopt ICD-10-CM and ICD-10-PCS; Proposed Rule.

ICD-10 IMPLEMENTATION: "GETTING CLOSER"

impact on their health operations and finances from the transition process. They stated that this will have a negative effect on the level of health care services that can be provide and patient care. They stated that more resources are needed to assist the I/T/U in the conversion process. Some of the THDs do not believe they will be ready in time and will not be able to meet the October 1, 2014 deadline.

Even with the extended deadline, and because of the concerns expressed by Tribes, many feel that another extension is necessary to help meet the implementation requirements. Despite these concerns, CMS as well as many other health organizations support the commitment to stay the course and meet the October 1, 2014 compliance date to switch to the new coding system. Many health care experts feel the ICD-10 change one of the most significant and positive changes by the healthcare industry. They state that medical practices will be better reflected with the new codes, and case management and care coordination will be improved. Thus, the I/T/U should plan to meet the commitment of October 1, 2014 for ICD-10 implementation.

The Board will work to keep you updated on ICD-10 implementation activities. We can also help by coordinating with our IHS ICD-10 Area Coordinator, Peggy Olligaard, to provide you updates at Tribal Health Director Meetings. If you should need to contact Ms. Olligaard, you may call (503) 414-5593 or email Peggy.Ollgaard@ihs.gov.

ICD-10 Resources:

CMS Website:
http://www.cms.gov/Medicare/Coding/ICD10/index.html

IHS Website: http://www.ihs.gov/icd10/index.cfm

Morning wellness

Delegates enjoying the Tulip festival in La Conner, WA

NEW HIV PREVENTION CAMPAIGN FOR NATIVE LGBT2S

The Northwest Portland Area Indian Health Board and the Indian Health Service National HIV/AIDS Program are pleased to announce the availability of new media materials designed to reduce stigma and promote HIV testing among American Indian and Alaska Native LGBT2S (Lesbian, Gay, Bi-sexual, Transgender and Two Spirit) community members. The campaign was developed in collaboration with national partners and Native LGBT2S community members from throughout Indian Country.

The *Native. LGBT2S. Proud.* campaign includes:

- Fact Sheets on– Self Acceptance, Family Acceptance, HIV Prevention, & HIV Screening
- 5 Youth Posters, 1 Family Poster
- 2 Radio PSAs – 1 Youth; 1 Family Acceptance. Please pass these along to your local radio stations!
- An Ad for placement in Tribal Newspapers. Please share this with the editor of your local newspaper!
- Promotional Cards

A limited number of these materials can be ordered free-of-charge from Project Red Talon. We will fill orders as supplies allow.

To order print materials, please contact:
Wendee Gardner
Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300, Portland, OR 97201
ph: (503) 228-4185 fax: (503) 228-8182
Email: wgardner@npaihb.org

IHS BUDGET: WILL FY 2014 BE ANOTHER SEQUESTER?

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partisan divide over sequestration has actually gotten worse among Republicans and Democrats. Some House Republicans are not sure that sequestration will be around the full ten years, but there are some like Rep. Paul Ryan (WI-R) and Rep. Roy Blunt (MO-R) that predict it will be around as long as the Obama Administration.

So what can tribes do to prepare for this political and budget face-off between the Congress and the Administration? Tribes have already begun to document the effect of sequestration on programs and they should continue to do so. Some of these stories are very compelling and they should be shared with our Area Health Board, ATNI, and of course NIHB and NCAI. Share concrete examples of sequestration's effects with your members of Congress, and send them to the local, regional, and national media.

The Board, ATNI, and our national organizations have all unanimously passed resolutions that the United States trust and treaty obligations to Indian Tribes are not subject to sequestration. The Board will continue to address this issue and provide updates as needed. If your Tribe is interested to share its sequestration story, please contact Jim Roberts, at jroberts@npaihb.org.

NARCH PROGRAM

Amanda Skenedore, Navajo. Amanda has been awarded two different NARCH fellowships to help support her education in Public Health at the University of Colorado. Amanda plans to return to school to pursue a phd in a public health-related field. She says she is very grateful to the narch support offered to her by the Board.

Through the NARCH program funded by the Indian Health service and NIH, the Board is able to provide a limited number of scholarships to support research career development in the biomedical sciences. Historically, the NARCH fellowships have supported AI/AN students pursuing MPH degrees, other masters degrees, PhD's in social and biomedical sciences, MD's, and other doctoral-level degrees. Successful candidates will receive monthly stipends to support their studies, and can use the funds as they see fit for career development. Doctoral candidates will receive stipends of 37K per year, and masters level students will receive 28K per year. The scholarships will be awarded on a first come, first served basis as long as the grant support allows. The successful candidates must demonstrate satisfactory progress toward degree completion during the course of their awards.

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

CHAIRMAN'S NOTE

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The month of June had me attending the National Indian Health Board (NIHB) Public Health Summit hosted at the Seminole Tribe. This year's event was well attended and a great success for our national organization. It allowed our programs an opportunity to addresses issues in the field of Tribal public health and to develop a national agenda to address those challenges.

I hope you enjoy this summer edition of Health News and Notes as we provide you important updates about implementation of health reform.

Andy Joseph, Jr.
NPAIHB Chairman

REPORT CARD ON HHS/CCIIO REGULATIONS FOR HEALTH INSURANCE MARKETPLACES

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Medicaid and the Marketplaces. Second, some states with Tribes are operating their own Marketplaces and they have been creating excellent models of Tribal consultation, good policies and workable solutions. We particularly commend Oregon, Washington, and Minnesota for setting a standard that we hope other Marketplaces will follow. Third, we need to track outcomes and let Congress know whether American Indians and Alaska Natives are being helped by the Affordable Care Act.

So often in history Tribes have found themselves frustrated by the inexplicable reluctance of the federal government to do what is in their power to raise the health status of American Indians and Alaska Natives. Tribes have learned that they are on their own to find ways to make complicated regulations work for their people. Once again Tribes will find a way. But the federal government has not made it easy.

The Board would like to welcome Carter Dean Rushing! b
Born June 23,2013. 8lbs, 21 inches. Big stster Finley, Carter and mom Stephanie Craig-Rushing

Upcoming Events

JULY

July 16-17
MMPC/TTAG Face to Face Meeting
Washington, DC

July 22-25
10th Annual Direct Service Tribal National Meeting
Minneapolis, NM

July 29 – August 4
AAIP 42nd Annual Meeting
Santa Clara, CA

July 30-31
Nike Native Fitness
Beaverton, OR

July 31st – August 1st
Tribal contract Support Cost Summit
TBD

AUGUST

August 1-6
Paddle to Quinault
Quinault Indian Nation

August 7-8
Health Reform & Affordable Care Act (ACA) Training
for Oregon Tribes
Portland, OR

August 13-14
Health Reform & Affordable Care Act (ACA) Training
for Idaho Tribes
Boise, ID

August 26-229
NIHB Annual Consumer Conference
Traverse City, MI

SEPTEMBER

September 2
Federal Holiday - Labor Day

September 16-19
ATNI Annual Conference 2013
Coeur d'Alene, ID

September 27
8th Annual Dancing in the Square
American Indian Day Celebration
Portland, OR

OCTOBER

October 7-11
2013 Tribal Environmental Leaders Summit Region 10
Spokane, WA

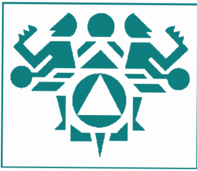
October 13-18
70th Annual Convention & Market Place
Tulsa, OK

October 21-24
NPAIHB Quarterly Board Meeting
hosted by Lummi Nation
Bellingham, WA

October 29-30
IHS Tribal Self-governance Advisory Committee Meeting
Washington, DC

October 29-31
IHS TSGAC & DOI SGAC Meetings
Washington, DC

For more information on any event please visit:
www.npaihb.org



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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S APRIL 2013 RESOLUTIONS

13-03-02
INTERVENTIONS FOR HEALTH PROMOTION & DISEASE PREVENTION IN NATIVE AMERICAN POPULATIONS

13-03-03
NATIVE SEXUAL HEALTH CONTINUUM PROJECT

13-03-04
PARTNERSHIP WITH OHS TO APPLY FOR FUNDING THAT ADDRESSES INDOOR AIR POLLUTION & MITIGATION STRATEGIES

13-03-05
PARTNERSHIP WITH OHSU, PREVENTION RESEARCH CENTER, THE CENTER FOR HEALTHY COMMUNITIES TO APPLY FOR FUNDING TO ADDRESS HEALTH PROMOTION & CHRONIC DISEASE PREVENTION NEEDS AMONG AI/AN COMMUNITIES