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Raven E. Ross

Washington University in St. Louis

Lauren D. Garfield

Washington University in St. Louis

Derek S. Brown

Washington University in St. Louis

Ramesh Raghavan

Washington University School of Medicine in St. Louis

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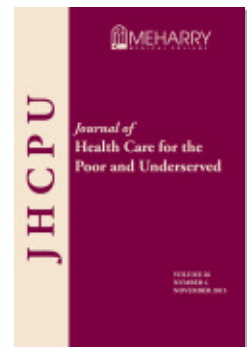
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The Affordable Care Act and Implications for Health Care Services for American Indian and Alaska Native Individuals

Raven E. Ross, MSW
Lauren D. Garfield, PhD
Derek S. Brown, PhD
Ramesh Raghavan, MD, PhD

Abstract: American Indian and Alaska Native (AI/AN) populations report poor physical and mental health outcomes while tribal health providers and the Indian Health Service (IHS) operate in a climate of significant under funding. Understanding how the Patient Protection and Affordable Care Act (ACA) affects Native American tribes and the IHS is critical to addressing the improvement of the overall access, quality, and cost of health care within AI/AN communities. This paper summarizes the ACA provisions that directly and/or indirectly affect the service delivery of health care provided by tribes and the IHS.

Key words: American Indian/Alaska Native, health, Affordable Care Act, services.

The Patient Protection and Affordable Care Act of 2010 (ACA) was passed by the 111th Congress in March 2010 (PL 111-148). The ACA represents progress for the U.S. health care system through expanding access to insurance coverage to millions of people who would otherwise be uninsured. This paper provides a brief overview of the provisions in the ACA that affect the service delivery of health care provided by tribes, urban Indian health programs, and the Indian Health Service (IHS) to American Indian and Alaska Native (AI/AN) citizens of federally recognized tribes.

Health Status of American Indians/Alaska Natives

Health disparities. American Indian and Alaska Native (AI/AN) populations have long experienced poorer health and reported more adverse health outcomes than many other racial and ethnic groups in the U.S.¹ Diseases of the heart, unintentional injuries, and diabetes are leading causes of death in AI/AN individuals; overall life expectancy is 4.2 years less than the overall U.S. all races population (2005–2007 rates). According to the Indian Health Service (IHS), AI/ANs who are citizens of federally recognized tribes die at substantially higher rates than other ethnic and racial groups in the U.S. as

The authors are associated with Washington University, St. Louis, MO. Please address all correspondence to Raven E. Ross, Washington University, St. Louis, Campus Box 1196, St. Louis, MO 63130, by email at raven.ross@wustl.edu, or by phone at 928-853-0258.

a result of many conditions, including chronic liver disease and cirrhosis (368% higher), diabetes (177% higher), unintentional injuries (138% higher), assault/homicide (82% higher), and intentional self-harm/suicide (65% higher).^{2,3,4,5,6,7}

Behavioral health. In addition to disparities in physical health, co-occurring mental health disorders significantly affect the health and quality of life of AI/AN individuals. In a study of youth residing on a reservation, 29% received a diagnosis of at least one psychiatric disorder, 13% met the diagnosis for multiple diagnoses, and 60% diagnosed with any depressive disorder had a substance abuse disorder as well.² In a recent study of patients at an urban Indian health center and a reservation-based program, 74% of the sample reported a lifetime history of depression and/or anxiety.⁸

American Indian and Alaska Native populations also suffer from high rates of alcohol and drug dependence and have high alcohol-related death rates when compared with all other U.S. ethnic groups.^{9,10,11} According to the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) of adults 18 years and older, the prevalence of drinking for AI/ANs was 70.7%, compared with 77.1% for Whites, 60.1% for Blacks, and 60.4% for Hispanics. In addition, AI/AN individuals had the highest prevalence of exceeding the recommended daily and weekly drinking limits (53% and 27.4% of the population exceeding the two limits, respectively) compared with Whites (52.5% and 17.3%, respectively), Blacks (29% and 8.9%), and Hispanics (37.3% and 8.5%).¹²

The Indian Health System

Although the ACA was designed to improve access to health care for all Americans, AI/AN citizens of federally recognized tribes are the only population who have the legal right to receive health care in the U.S.² The Indian Health Care Improvement Act (IHCIA) of 1976 and the Snyder Act of 1921 provide Congress with the legal authority to appropriate funds specifically for the health care of AI/AN individuals who are citizens of federally recognized tribes.¹³ There are currently 566 federally recognized tribes in the U.S. The citizens of these tribes residing on or near reservations are eligible to receive health care from the IHS, a government agency established in 1955 to meet the federal government's commitment and responsibility to provide health care to AI/AN individuals. Currently, the IHS provides services to 2.2 million AI/AN people.¹⁴ The Indian Health System refers to the delivery of health and behavioral health services through the IHS, tribally ran facilities, and urban located facilities; collectively, this system is often referred to as the ITU (IHS/tribal/urban).

The IHS is divided into 12 areas and provides a variety of health care services through a comprehensive network in 35 states that includes hospitals, health centers, Alaska Village clinics, and health stations.¹⁵ These facilities receive 45,907 inpatient admissions and 13,280,745 outpatient visits annually.¹⁶ However, the Agency provides these services in a significantly under-funded environment. For example, in Fiscal-Year (FY) 2014, the IHS has a budget appropriation of 4.4 billion, which resulted in an IHS expenditure on user population of \$2,849 compared with the total U.S. population expenditure of \$7,713.¹⁶

The IHS employs approximately 15,000 Civic Service and federal employees and

United States Public Health Services Commissioned Officers. These employees provide an array of health services such as inpatient, ambulatory, emergency, dental, public health nursing, and preventive care and refer specialty cases to appropriate care outside of the IHS. Less than 40% of the mental health programs and less than 20% of the alcohol and substance abuse programs are IHS-operated (the remaining are tribally operated; see below) and provide prevention, treatment, and aftercare behavioral health services.¹⁶

Tribal Health System

Over the past few decades, tribes have moved towards taking control of their health care delivery system. This is often referred to as the *638 process*, after Public Law 93-638, which regulates self-determination contracts and self-governance compacts.¹⁷ Through this process, a tribe operates health care service sites that are supported by funds allocated from the federal government which are distributed through the IHS and are subject to IHS funding. Both the IHS and tribal system strive to be culturally appropriate and community driven. Currently, over 50% of the mental health programs and over 80% of the alcohol and substance abuse programs that service AI/ANs are tribally operated.¹⁸

Urban Indian Health System

Urban Indian Health Programs (UIHPs) provide services to AI/AN individuals residing off reservations through 34 urban-centered nonprofit organizations at 57 locations. The services provided vary by UIHP and range from ambulatory health care to outreach and referral services, and may include some behavioral health services. Funding for these organizations come from the IHS (Title V of IHCIA) and other federal, state, local, and private sources. Approximately 45% of the UIHPs receive Medicaid reimbursement as Federally Qualified Health Centers (FQHC).¹⁹

Collectively, AI/AN individuals and communities display considerable health burdens, and exhibit great disparities in their physical and mental health status. Given their health vulnerabilities and the structural constraints of dependency on Federal support for health care services, the implementation of the ACA has the potential to greatly affect the health and quality of life of AI/AN individuals.

ACA Provisions with Service Implications for American Indians and Alaska Natives

There are a variety of health provisions within the ACA that have the potential to affect health services for AI/AN individuals, both through general provisions of the law and through measures that are specifically designed to reach AI/AN individuals or health care networks that serve AI/AN populations.²⁰ How these provisions affect the delivery of health services is determined by who the service provider is (IHS, tribal, urban Indian organization), who and where the patient is (does the AI/AN individual reside on a reservation, in an area with an IHS facility, in an area with a tribally ran facility, or in an urban area with no AI/AN specific services provided by a tribe or

the IHS), and what type of health-related service is being sought. Separating out the provisions by the impact on tribal and IHS specific services provides a framework for understanding how the Indian Health System will be affected.

The component of the ACA most tailored to AI/ANs is the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA; P.L. 94-437). The IHCIA was last fully reauthorized in 1992 and since FY 2000 the IHCIA has been subject to yearly appropriations by Congress. The IHCIA, as reauthorized in the ACA, authorizes new programs within the IHS to ensure that the IHS is more equipped to meet its mission. A significant component of the IHCIA (Title VII) authorizes new and expanded programs for mental and behavioral health treatment and prevention. Previously, much of the IHS focus had been on substance abuse. Title VII of the IHCIA calls for a behavioral health plan that focuses on a comprehensive system that provides a framework for prevention, intervention, treatment aftercare, and outpatient services.

The IHCIA authorizes programs that affect how services are delivered, where services are delivered, administrative requirements, and recruitment of staff. In terms of how services are delivered, the IHCIA authorizes the integration of behavioral health into primary care (improving patient care initiative), demonstration projects for innovative health care facility construction, provision of dialysis services, and facilitation of care for AI/AN veterans. These provisions provide additional authority to the IHS on program development and funding. The IHCIA focuses on where services are delivered through long-term care services, including home health care, assisted living and community-based care and new authorities for urban Indian health programs. Urban Indian organizations (Title V) may now apply for contracts or grants for health services in urban areas, specifically in areas outside of the catchment area of previous boundaries. This is especially important as the urban AI/AN population continues to grow; although general funding from AI/AN health care is insufficient to meet the need, urban AI/AN health continues to grow more scarce.²¹

Administratively, the IHCIA improves the Purchased/Referred Care (PRC) program, formally known as the contract health services (CHS) program, which pays for referrals, provides funding of patient travel costs, and asks for the development of health professional shortage demonstration programs. The IHCIA Title I focuses on increasing the number of AI/AN health professionals through scholarship and loan repayment programs, funding for continuing education and advanced training, and expanding the use of community health aids workers at IHS funded facilities.

The ACA should directly increase coverage of AI/AN individuals through the exchanges, both federal and state based, which opened in October 2013. The exchanges provide eligible individuals and small businesses the ability to purchase health insurance coverage.²² AI/AN individuals who purchase health insurance through an exchange do not have to pay co-pays or other cost-sharing (also identified as a cost-sharing exemption) if their incomes do not exceed 300% of the federal poverty level. This is particularly important for those who require additional coverage but are outside the reach of the Indian Health System. Additionally, Section 2901 of the ACA (Exclusion of Health Benefits Provided by Indian tribal Governments), outlines regulations in the event an AI/AN individual covered through an exchange received care from an I/T/U (such as the individual will not be subject to cost-sharing). Additionally, AI/AN indi-

viduals can submit an application for exemption from the individual mandate penalty to the marketplace or claim the exemption on yearly federal tax returns.

Various sections of the ACA specify grant opportunities and proposed set-asides targeted for tribes and tribal organizations application. For example, the Maternal and Child Health Bureau and Administration for Children and Families shall have grants for a needs assessment and evaluation of early childhood home visitation programs with a 3% set-aside of funds for these specific grants. Additionally, Subpart 3-Recruitment and Retention Programs highlights the goal of training and placing qualified health care professionals in underserved areas. This investment in workforce has great potential to address staff shortages within the Indian Health System and improve quality of and access to care. Tribes and UIHPs are also able to purchase coverage in the Federal Employee Health Benefits (FEHB) program for eligible employees which increases access to affordable coverage.

Outside of the IHCA reauthorization, different sections of the ACA affect the Indian Health Care System. Section 2901: Special rules relating to Indians state that there is no cost-sharing for AIs/ANs and programs within the Indian Health System are to be payer-of-last-resort which means that all other funding mechanisms (such as Medicaid or Veterans Affairs) should be used first. Section 2902: Elimination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics; addresses how services within the Indian Health System will be reimbursed by Medicare Part B beginning January 1, 2010. This addresses concerns raised by Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 according to which certain services were going to no longer be covered after December 31, 2009. Section 5104: In order to address access to health care in rural areas of Alaska, the Interagency Task Force to Assess and Improve Access to Health Care in the State of Alaska calls for a membership of agencies, including the IHS, to develop a strategy for the federal government to improve health care delivery to federal beneficiaries in Alaska. Finally, a key part to effective implementation of these provisions and the ACA in general is the productive and inclusionary communication with tribes and UIHPs. Tribal consultation is not only respectful of a government-to-government relationship, but is specified within the ACA as a necessary step prior to the implementation of anything that substantially affects tribes and is presidentially mandated (Executive Order No.13175, 2000).²³

An important part of the ACA included expanded provisions for Medicaid, a long-standing assistance program that supports more than 20 million pregnant women, children, needy families, the blind, the elderly, and the disabled in funding specific services of their health care. As originally written, the ACA expands these areas to include all non-elderly, non-pregnant adults with adjusted gross income at or below 138% of the federal poverty level.^{24,25} However, the Supreme Court found mandated Medicaid expansion within the ACA unconstitutional (*National Federation of Independent Business v. Sebelius*, 2012) and through this decision turned Medicaid expansion into a State option program.²⁶ This decision greatly complicated matters for tribes whose tribal boundaries span more than one state. For example, the Navajo Nation and the IHS Navajo Area fall within the state boundaries of Arizona, New Mexico and Utah. Arizona, New Mexico, and Utah have all adopted varying versions of Medicaid

expansion which will each affect how services are funded for Medicaid eligible Navajo Nation citizens in different ways. Navajo Nation citizens who live in Arizona and receive services in Utah at a non-IHS or non-tribal facility will incur different co-pays and costs to the state depending on their eligibility.

Title IV of the IHClA authorizes a demonstration project to permit tribes and tribal organizations operating under self-determination to directly bill the Centers for Medicare and Medicaid Services for Medicare and Medicaid payments and requires direct billing reimbursements for a facility to be held aside in a fund that will pay for compliance with Medicare and Medicaid requirements and improve health services within that facility. As we look at the future of health care delivery on tribal lands, understanding how services can be billed for in each state will significantly affect what services are offered and funded by a tribe, the IHS, UIHP, and the state.

Conclusion

The ACA is an important reform of the U.S. health care system from which AI/AN individuals, tribes, and the IHS can benefit. As we look toward the implementation of the provisions of the ACA that apply to AI/AN individuals, challenges and barriers will need to be addressed in a systematic way that allows for the entire Indian Health System to adapt together. Whether the provision in the ACA allows for an AI/AN-specific exemption or reauthorizes the IHClA, we are in a time where we can affect the access, quality, and cost of health care services for AI/AN to effectively and efficiently address the long standing poor physical and mental health outcomes.

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