

# National Indian Health Board



## I/T/U Are Essential Community Providers

A central goal of the Patient Protection and Affordable Care Act (ACA) is to ensure that all Americans, regardless of income or location, have access to a sufficient choice of health care providers. This is achieved, in part, by requiring “essential community providers... that serve predominantly low-income, medically-underserved individuals” to be included in the networks of all health plans offered through the to-be-established health insurance exchanges.<sup>1</sup>

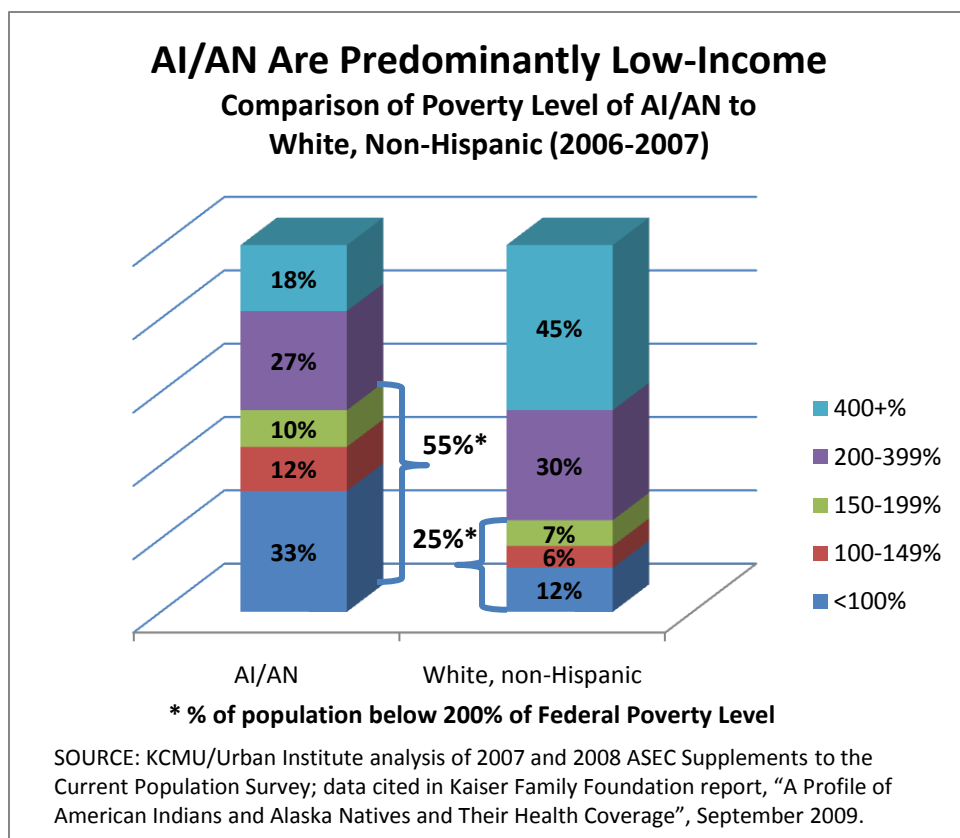
**I/T/U Are Essential Community Providers:** Over successive generations, the Indian Health Service, Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as “I/T/U”) have worked to develop the capacity to serve the traditionally medically-underserved communities of American Indians and Alaska Natives (AI/AN). *As such, I/T/U have long-been considered “essential” providers by the AI/AN communities they serve.* Many provide health care in the most remote locations in the United States where, without an Indian health program, no services would be available. Furthermore, the unique cultural requirements of Indian people require providers who understand their language, community and special health needs. *And, I/T/U meet the statutory definition of “essential community providers” (ECP) under Section 1311(c)(1)(C) of the ACA as they serve predominantly low-income, medically-underserved individuals.*<sup>2</sup>

**AI/AN Individuals and Communities Are Predominantly Low-Income:** One-third of AI/AN are in families with incomes below the federal poverty line. In fact, “[the AI/AN] poverty rate is higher than any other racial or ethnic group and about twice as high as the poverty rate of the overall nonelderly population.”<sup>3</sup> Further, “[AI/AN] remain at the bottom in almost every measurable economic category and earn only about half of that earned by the average American... On Indian reservations, poverty levels for [AI/AN] are significantly worse. Among the Navajo, for example, over 50 percent live below the poverty level and almost 50 percent are unemployed.”<sup>4</sup>

**AI/AN Individuals and Communities Are Predominantly Medically-Underserved:** A clear indication that AI/AN individuals and communities are predominantly medically-underserved is the determination by the Health Resources and Services Administration (HRSA) to --

- Automatically designate Indian communities as Health Profession Shortage Areas (HPSAs); and
- Automatically designate as HPSAs outpatient health programs or facilities operated by a Tribe or Tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.<sup>5</sup>

The infant mortality rate is a key measure of a population being medically-underserved and is used by HRSA in designating Medically-Underserved Areas or Populations.<sup>6</sup> AI/AN have 1.5 times the infant mortality rate as non-Hispanic whites (8.3 versus 6.9 deaths per 1,000 live births). AI/AN infants are 3.5 times as likely as non-Hispanic white infants to have mothers who began prenatal care in the 3rd trimester or did not receive prenatal



care at all.<sup>7</sup> “Beyond disturbingly high mortality rates, [AI/AN] also suffer a significantly lower health status and disproportionate rates of disease compared with all other Americans.”<sup>8</sup>

**I/T/U Serve AI/AN Individuals and Communities:** I/T/U are the three components of the Indian health system. “The IHS [including contracting and compacting Tribes] strives for... meeting the health needs of its service population, who live mainly on or near reservations and in rural communities in 35 states, mostly in the western United States and Alaska.”<sup>9</sup> The IHS and Tribally-operated programs supply essential personal health services to 1.9 million AI/AN<sup>10</sup> on/near reservations. An additional 46,000 AI/AN receive medical and public health services from 34 urban Indian organizations supported by Federal funds.<sup>11</sup>

**I/T/U Fit Examples of ECP Provided in Law:** The ACA identifies FQHCs and providers eligible to obtain discounted drugs under the 340B program as examples of entities that should be designated as essential community providers. Tribally-operated outpatient clinics and urban Indian organization clinics are defined as FQHCs in both the Medicare and Medicaid laws.<sup>12</sup> I/T/U providers are also eligible to obtain pharmaceutical products from Federal discount drug programs and do so through either the 340B program or the Federal Supply Schedule prime vendor program administered by the Department of Veterans Affairs.

**ECP Designation Will Help Integrate Health Care Services for AI/AN:** Congress previously recognized the imperative for ensuring access to I/T/U providers and integrating I/T/U providers into broader networks when it required States to include in their Medicaid managed care contracts a requirement to admit I/T/U.<sup>13</sup> States, such as Minnesota, have instituted similar policies, designating Indian health providers as ECP and requiring all health plans licensed in the State to contract with the ECP. For similar reasons, CMS requires Medicare Part D plan sponsors to offer network contracts to all I/T/U pharmacies in its service area and to contract with the I/T/U pharmacies using the standard terms and conditions contained in the model Indian Health Addendum provided by CMS.

Thus, through both the statutory descriptors (providers "that serve predominately low-income, medically-underserved individuals") and the statutory examples (FQHCs and covered entities in the 340B program), I/T/U – the Indian health system providers – qualify as ECP and should be designated as such in the ACA regulations.

---

<sup>1</sup> Section 1311(c)(1)(C) of the ACA reads, in part: “(1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum... (C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8...”

<sup>2</sup> See NIHB Oct. 4 and Dec. 17, 2010 letters to HHS/OCIIO in response to request for comments on Exchange standards.

<sup>3</sup> Kaiser Family Foundation, “Race, Ethnicity and Health Care, A Profile of American Indians and Alaska Natives and Their Health Coverage”, September 2009, page 6.

<sup>4</sup> U.S. Civil Rights Commission, “Broken Promises: Evaluating the Native American Health Care System,” September 2004, page 38.

<sup>5</sup> HRSA Website reads: “Members of Indian Tribes as defined in section 4(d) of PL 94-437 are automatically designated as population HPSAs; outpatient health programs or facilities operated by a Tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act are considered Federally Qualified Health Centers and so automatically designated HPSAs.” <http://www.hrsa.gov/publichealth/community/indianhealth/shortage.html>, viewed Feb. 6, 2011.

<sup>6</sup> The three other criteria used by HRSA in designating MUA or MUP are: Ratio of primary care physicians per 1,000 population; percentage of population with incomes below poverty level; and percentage of population 65 and over.

<sup>7</sup> <http://minorityhealth.hhs.gov/templates/content.aspx?ID=3038>, viewed Feb.6, 2010.

<sup>8</sup> U.S. Civil Rights Commission, “Broken Promises: Evaluating the Native American Health Care System,” September 2004, page ii.

<sup>9</sup> IHS; <http://info.ihs.gov/Disparities.asp>, accessed February 1, 2011.

<sup>10</sup> Indian Health Service, *Fiscal Year 2011 Budget Justifications*, at CJ-57.

<sup>11</sup> Indian Health Service, *Fiscal Year 2011 Budget Justifications*, at CJ-123.

<sup>12</sup> Secs. 1861(aa)(4) [Medicare] and 1905(l)(2)(B) of the Social Security Act.

<sup>13</sup> Sec. 1932(h) of the Social Security Act [42 USC §1396u-2(h)], enacted by Sec. 5006(d) of the ARRA.