



## MEDICAID EXPANSION UNDER ACA FOR AMERICAN INDIANS AND ALASKA NATIVES

*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 comprehensive and affordable health care services.<sup>1</sup> This is achieved, in part, by extending Medicaid coverage to the lowest income Americans, including low-income American Indians and Alaska Natives (AI/AN).<sup>2</sup> To achieve increased enrollment by AI/AN in Medicaid, significant efforts by Indian health programs – and substantial resources from the Federal government – are needed.*

---

### Key Provisions of the Medicaid Expansion under ACA Section 2001:

- Beginning on January 1, 2014, all States participating in Medicaid must cover all persons with family income up to 133 percent of the poverty level who are not over 65 or on Medicare<sup>3, 4</sup>. This new mandatory eligible population primarily consists of low-income adults without dependent children.
- From 2014 to 2019, the Federal government will pay between 100% and 93% of the cost of covering these newly-eligible individuals. After 2019, the Federal Medical Assistance Percentage (FMAP) will be 90 percent for these Medicaid health service costs, with States contributing 10%. The FMAP for AI/AN served by the Indian Health Service (IHS) and Indian tribes and tribal organizations will remain at 100 percent.
- States are required to maintain their pre-2011 Medicaid eligibility levels through December 31, 2013 for all adults and through September 30, 2019 for children under Medicaid and CHIP.

**More AI/AN Will Be Eligible for Medicaid with ACA Implementation:** An estimated 185,000 – 380,000 uninsured AI/AN who report access to Indian health programs providers would be eligible for Medicaid under the expansion.<sup>5</sup> These Medicaid enrollees are in addition to the approximately 437,000 IHS users that are covered by Medicaid or the Children’s Health Insurance Program (CHIP) today.<sup>6</sup> The Medicaid expansion under the ACA is projected to generate new funding to serve AI/AN. A portion of the new Medicaid revenues will flow to Indian health programs and a portion will offset Contract Health Service expenditures.

**Medicaid Expansion under ACA Section 2001 May Provide Narrower Scope of Benefits than Traditional Medicaid:** For individuals covered under the new Medicaid eligibility category, they will receive “benchmark” or “benchmark-equivalent” coverage consistent with the requirements of section 1937 of the Social Security Act.<sup>7</sup> The coverage is to provide at least the “essential benefits” as required for Exchange-offered plans, including prescription drugs and mental health services. But, services not included in typical employer-provided insurance, such as transportation services, may be excluded by a State from the Medicaid benchmark coverage offered under the Medicaid section 2001 expansion.

**Existing Medicaid Protections for AI/AN and I/T/U<sup>8</sup> Apply under Medicaid Expansion:** All rules applicable under the Medicaid program in general apply to this new eligibility group, including rules relating to cost sharing.<sup>9</sup> For example, no Medicaid premiums or cost sharing may be imposed on an AI/AN applicant or an AI/AN receiving services from an I/T/U directly or through referral under Contract Health Services.<sup>10</sup> In addition, AI/AN will continue to be exempt from mandatory managed care enrollment. And as added by section 5006(d) of the Recovery Act, AI/AN enrolled in Medicaid managed care plans have the option of choosing an Indian health care provider as the AI/AN’s primary care provider.<sup>11</sup>

**IHCIA Provisions Prohibit Offsetting of Appropriations:** Under a long-standing provision of the Indian Health Care Improvement Act (IHCIA), section 401(a) directs Congressional appropriators to not consider

the amount of revenues received by Indian health programs from Medicare, Medicaid and CHIP when determining appropriation levels for the Indian health programs.<sup>12</sup> While this provision may not actually bind Congressional appropriators, it does provide a clear indication of the Congressional intent to supplement direct appropriations to Indian health programs with third party revenues, and not substitute third party revenues for direct appropriations. In addition, IHCA section 207 ensures tribes and tribal organizations are able to retain the third-party revenues they generate and prohibits the IHS from offsetting the revenues received by reducing IHS amounts already obligated to the tribe or tribal organization.<sup>13</sup>

**Medicaid Eligibility and Enrollment Streamlined:** The ACA contains several provisions simplifying and streamlining Medicaid eligibility determinations and enrollment. A single (modified adjusted gross income-based) formula will be used for income eligibility calculations nationally. The asset test was eliminated for Medicaid eligibility, except for certain Medicare-related populations.<sup>14</sup> Enrollment for Medicaid, CHIP and subsidized plans through an Exchange may be accessed through a single application form (and Internet portal) to ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or CHIP, the individual is enrolled in the program.<sup>15</sup> The Express Lane eligibility determination option remains available to States, and I/T/U were added to the list of entities that can serve as Express Lane agencies able to determine Medicaid and CHIP eligibility. *But even with these changes in law, in order to achieve expanded enrollment of AI/AN in Medicaid, significant efforts by Indian health programs – and substantial resources from the Federal government – are required.*

**State-based Tribal Consultations:** Tribal consultation is required for State Medicaid Plan amendments. States should work with tribes to assure that the existing Medicaid protections for AI/AN are maintained and that I/T/U providers are included in health plan provider networks under Medicaid (and Exchange-offered) plans.<sup>16</sup>

**States May Expand Medicaid Coverage under ACA Section 2001 prior to 2014:** States may expand Medicaid eligibility under this option as early as April 1, 2010. To date, only the District of Columbia and Connecticut have exercised this option, and these Medicaid expansions were designed to enroll populations previously insured with predominantly state-only funding.<sup>17</sup> Massachusetts, Pennsylvania, Tennessee, Vermont, Washington, and Wisconsin all have state-financed programs as well and may be able to use the early Medicaid expansion option to offset current State expenditures.<sup>18</sup> In the case of States that, prior to 2010, extended Medicaid coverage to adults without dependent children, additional Federal support for covering this population is phased-in so that in 2019 and thereafter, expansion States would receive the same FMAP as other States for this new mandatory eligible Medicaid population.

**Federal Contribution Percentage Greatly Increased under ACA Section 2001 Medicaid Expansion:** The Federal government will cover a much higher percentage of program costs under the ACA section 2001 Medicaid expansion than is generally true today. Under current practice, the Federal contribution (i.e., FMAP rate) ranges from 50% to 76%, and averages 60% across the country.<sup>19</sup> Beginning in 2014 for the new expansion population, 100% of the program costs will be covered by the Federal government. This figure phases down slightly over six years, and the FMAP rate then locks in at 90% for years 2020 and forward.<sup>20</sup> For services provided to AI/AN by IHS and Indian tribes and tribal organizations, the FMAP rate continues at 100%.

**Increased Medicaid Rates for Primary Care Providers:** The ACA requires States to increase Medicaid payment rates to primary care physicians for furnishing primary care services to no less than 100 percent of Medicare payment rates in 2013 and 2014. The Federal government is to provide 100 percent Federal funding for the additional costs to States of meeting this requirement. Other payment mechanisms under Medicaid remain in effect and are not impacted, including the all inclusive rate that is used by many I/T facilities.

---

<sup>1</sup> Reference to the ACA (Public Law 111-5, as amended by Public Law 111-148) also includes reference to the provisions of the Indian Health Care Improvement Act contained in the ACA.

---

<sup>2</sup> Section 2001 of the ACA.

<sup>3</sup> An additional 5 percentage point income disregard is permitted, effectively raising the income threshold to 138% of the Federal poverty level.

<sup>4</sup> Undocumented immigrants and immigrants in the country less than five years are excluded from the Medicaid expansion.

<sup>5</sup> Low end of range cited from CRIHB, November 2010 Report, Appendix B. High end of range cited from “Health Reform Overview: Indian Provisions, Role of Medicaid and Insurance Exchanges,” presentation by Jim Roberts, NW Portland Area Indian Health Board.

<sup>6</sup> Figure cited from “Health Reform Overview: Indian Provisions, Role of Medicaid and Insurance Exchanges,” presentation by Jim Roberts, NW Portland Area Indian Health Board.

<sup>7</sup> ACA Section 2001(a)(2). The benchmark coverage will provide “essential health benefits”, which, by law, will be modeled after what a typical employer currently provides today in the private sector.

<sup>8</sup> “I/T/U” means Indian Health Service, Tribe or Tribal organization, or urban Indian organization.

<sup>9</sup> Center for Medicare and Medicaid Services, Dear State Medicaid Director Letter, SMDL# 10-005, April 9, 2010, page 3. <https://www.cms.gov/smdl/downloads/SMD10005.pdf>

<sup>10</sup> Section 5006(a) of the American Recovery and Reinvestment Act (Public Law 111-5, enacted February 17, 2009; Recovery Act) amended sections 1916 and 1916A of the Social Security Act.

<sup>11</sup> Section 5006(d) of the Recovery Act amended section 1932(h)(1) of the Social Security Act (42 U.S.C. 1396u-2).

<sup>12</sup> Indian Health Care Improvement Act (Public Law 94-437), enacted September 30, 1976, originally included section 401(a) with application solely to title XVIII of the Social Security Act (Medicare).

<sup>13</sup> Section 207(b) reads: “No Offset of Amounts.—The [Indian Health] Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a) [Medicare, Medicaid, CHIP, etc.]”

<sup>14</sup> See ACA section 2002 for a list of exceptions to the new income eligibility rules.

<sup>15</sup> See ACA section 1413 and ACA section 1311(d)(F).

<sup>16</sup> Sec. 5006(e) of the Recovery Act codified in statute, at section 2107(e)(1)(C) of the Social Security Act, the requirement that States seek advice from tribes on a regular and ongoing basis in States where one or more Indian health program or urban Indian organization furnishes health care services.

<sup>17</sup> <http://newsroom.dc.gov/show.aspx/agency/dhcf/section/2/release/20289/year/2010/month/8>;  
<http://newsroom.dc.gov/show.aspx/agency/dhcf/section/42/release/20321/year/2010/month/5>

<sup>18</sup> <http://www.kaiserhealthnews.org/Stories/2010/April/01/States-Hope-New-Funding-From-Health-Law-Will-Bolster-Unique-Programs.aspx>

<sup>19</sup> [http://cmhda.org/go/Portals/0/CMHDA%20Files/Committees/LegComm/0901\\_JAN/0901\\_Leg%20Comm%20Handout\\_Federal%20Medicaid%20match%20rate%20proposalrev%201-09.pdf](http://cmhda.org/go/Portals/0/CMHDA%20Files/Committees/LegComm/0901_JAN/0901_Leg%20Comm%20Handout_Federal%20Medicaid%20match%20rate%20proposalrev%201-09.pdf)

<sup>20</sup> For states that expand Medicaid eligibility under this option between 2010 and 2014, these States will receive the State’s standard Federal Medical Assistance Percentage (FMAP) but will receive the higher Federal contribution beginning in 2014.