

**Tribal Options in those States not implementing Medicaid Expansion**  
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**Executive Summary**

The Patient Protection and Affordable Care Act (ACA) expands the Medicaid program by increasing the national eligibility limits up to 133% (138% with a 5% income disregard) of the federal poverty level (FPL). This will open Medicaid coverage to adults without dependent children, many of them uninsured. This is a category of the population currently not typically served by Medicaid, and includes many American Indians and Alaska Natives (AI/ANs). It is estimated that there are approximately 1.2 million AI/AN people that do not have health insurance.<sup>1</sup> Of this number, there are approximately 530,000 individuals with incomes below 138% of the FPL that would qualify for Medicaid expansion. If all states expand Medicaid, the percentage of uninsured AI/ANs could be cut nearly in half.

Because implementation of Medicaid expansion is at a state's option, it will leave out many uninsured people in those states that do not expand their Medicaid program. This poses serious health coverage issues for AI/ANs located in states that will not expand Medicaid. It will result in many AI/ANs not being able to take advantage of the full range of health benefits and protections that many Americans will enjoy under the Affordable Care Act.

This paper explores two options for states and the Centers for Medicare & Medicaid Services (CMS) to use in order to expand Medicaid coverage for AI/ANs in those states that do not implement Medicaid expansion.

**Background**

Initially, when the ACA was passed it required all states to expand Medicaid eligibility up to 133% FPL. When the Supreme Court reviewed the Act and upheld the ACA, the Court's decision limited the federal government's ability to enforce Medicaid expansion, leaving Medicaid expansion optional for states. For those states that expand Medicaid, the federal government will fund the vast majority of the costs of the expansion. Those states that do not expand Medicaid will see large coverage gaps since individuals below 100% FPL will not be in Medicaid nor will they be eligible for subsidies to purchase insurance on the new health insurance exchanges. This will have an adverse impact on AI/ANs since many would have been eligible for the Medicaid expansion and will not qualify for a subsidy to purchase insurance through an exchange.

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<sup>1</sup> "Medicaid Expansion Could Cut Native Americans' Uninsurance Rate by Half", Center for Budget Policy and Priorities, November 19, 2012. <http://www.cbpp.org/files/medicaid-expansion-and-native-americans-fs.pdf>

Congress fully intended that Indian health programs be able to supplement their funding with Medicare and Medicaid reimbursements. The Social Security Act expressly authorizes Indian health facilities to collect Medicare and Medicaid reimbursements in order to bring additional resources into the Indian health system and address the deteriorating condition of Indian health facilities. Congress also protected the states by allowing them to benefit from a 100 percent Federal Medical Assistance Percentage (FMAP) for payments made to Indian health facilities for Medicaid-covered services provided by them to AI/ANs. This level of federal commitment is provided in express recognition of the federal government's special trust responsibility for Indian health. The Committee of jurisdiction observed that since the United States already had an obligation to pay for health services to Indians as IHS beneficiaries, it was appropriate for the U.S. to pay the full cost of their care as Medicaid beneficiaries.<sup>2</sup> This action is consistent with the status of AI/ANs as a political designation. There are considerable health coverage and financing opportunities for AI/ANs and the Indian health system that serves them under Medicaid expansion. But only to the extent that states exercise their option to expand their Medicaid program.

Currently there are only 28 states that have indicated their intent to expand their Medicaid programs, and two other states weighing their options.<sup>3</sup> There are 20 states in which either the governor, legislature or both have indicated opposition toward implementing Medicaid expansion, and 15 of these states have AI/AN tribes located in them.<sup>4</sup> This means that over 42% of Indian Country will not be covered under Medicaid expansion, at least at the outset. Expanding Medicaid to include more AI/AN people up to 138% FPL and offering additional services would allow the Indian health system to more effectively serve AI/ANs and increase their individual access to health care. It would also allow IHS, Tribes and urban Indian health programs to address severe health disparities. This is critical for those AI/ANs that rely on the Indian health system for their care since it is chronically underfunded. Thus, strategies must be developed by CMS, states and Tribes to cover more AI/AN people in the states that will not implement Medicaid expansion. The following provides two possible strategies to make this happen.

### **The Arkansas Option**

CMS recently announced that it would entertain a limited number of applications from States to implement Medicaid Expansion by using Medicaid dollars to buy insurance for individuals on the new Health Insurance Marketplaces, rather than expanding their existing Medicaid programs. This option is generally referred to as the Arkansas option because the State of Arkansas was the first to propose it. Ohio is reportedly considering a similar proposal, as are several other States.

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<sup>2</sup> H.R. REPT. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

<sup>3</sup> "State Decisions on Health Insurance Exchanges and the Medicaid Expansion, as of May 9, 2013", Kaiser Family Foundation, May 9, 2013. Available at: <http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/>

<sup>4</sup> Fifteen states that oppose implementing Medicaid expansion: Alabama, Alaska, Idaho, Iowa, Louisiana, Maine, Mississippi, Nebraska, North Carolina, Oklahoma, South Carolina, Texas, Utah, Wisconsin, and Wyoming,

Reports indicate that this option is being looked at favorably in States in which a private insurance model may be more politically palatable than the expansion of Medicaid, a government program.<sup>5</sup>

Under the Arkansas option, States would implement Medicaid Expansion through the use of a relatively obscure provision of the Social Security Act, Section 1905a, which allows States to use Medicaid dollars to provide "Premium Assistance" to low income individuals to purchase private insurance, rather than take part in traditional Medicaid programs. The Arkansas option would provide Premium Assistance for low income individuals in the State to purchase insurance on the new Health Insurance Marketplaces, also known as Exchanges.

CMS recently released a Q & A on this option, which states that the Agency is likely to approve such proposals if they seek to cover individuals who would otherwise be covered through Medicaid Expansion. The Q & A sets out the broad parameters for the Arkansas option. One key point is that any proposal must demonstrate that it will be cost-effective, which means that the State must demonstrate that this option will not cost more than traditional Medicaid Expansion. This may be difficult for many States to achieve, as the Congressional Budget Office and others have estimated that the cost of Medicaid Expansion is likely to be significantly less than the cost of purchasing insurance on the Health Insurance Marketplaces. However, CMS has indicated that States have some flexibility in demonstrating cost-effectiveness.

There are several key points for Tribes to consider in States that may be considering this option. First, although this option would be implemented by purchasing insurance on the Exchanges, it would remain a form of Medicaid. As a result, it is the Medicaid rules for Indians that will apply (unless explicitly waived), and not those for the Exchanges. This is important because AI/ANs are exempt from paying any premiums or cost-sharing through Medicaid, but only have cost-sharing protections through the Exchanges. Similarly, the Medicaid rules are more inclusive than the Exchange rules may be with regard to who qualifies as an Indian eligible for cost-sharing protections.

Any Arkansas-model option is likely to be implemented by a State asking CMS to issue a Section 1115 demonstration project waiver. Under a demonstration, a state may ask to waive cost-sharing protections otherwise available to Medicaid enrollees, such as the protections provided to AI/ANs that was provided under Section 5006 of the the American Recovery and Reinvestment Act. Tribes and Tribal Organization are entitled to be consulted on any such waiver request. As a result, Tribes in States seeking to implement the Arkansas option should seek to consult with CMS and, if possible, the State regarding how implementation will occur to ensure that the option is exercised in a manner that does not undermine the application of Medicaid protections for AI/ANs.

## **1115 Waiver Authority**

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<sup>5</sup> In reality, most states currently cover their non-elderly and non-disabled Medicaid populations through private health plans, so the "Medicaid" approach and the "Exchange" approach may be more similar than is sometimes portrayed.

Section 1115 of the Social Security Act provides demonstration authority for the HHS Secretary to permit a state to use federal Medicaid matching funds to pay for expenditures that would otherwise not be allowable under the Medicaid statute. On April 6, 2012, CMS approved a waiver request from Arizona to amend its 1115 demonstration known as the Arizona Health Care Cost Containment System (AHCCCS), which allows the State to offer uncompensated care payments to Indian Health Service and tribally-operated facilities. Under the amended demonstration, IHS and Tribal facilities can begin to claim payments for uncompensated care costs associated with services furnished to individuals with income up to 100 percent of the FPL.

In March 2013, CMS also granted permission for the State of California to amend its section 1115(a) demonstration (11-W-00193/9), entitled the California Bridge to Reform Demonstration, allowing supplemental payments to support participating IHS and Tribal facilities for services furnished to uninsured individuals with incomes up to 133% of FPL and for uncompensated services that had been covered, but are no longer covered, under Medi-Cal as of January 1, 2009. In a letter to California, CMS stated that, “it shares the state's goal of maintaining the financial viability of IHS and tribal facilities to ensure the continued availability of their health care service delivery for current and future Medicaid beneficiaries.”

A key question is whether the Arizona and California waivers that allow CMS, States and Tribes to expand Medicaid eligibility and services for AI/ANs in those states create a precedence, for implementation post-January 1, 2014, to expand coverage to AI/ANs in states that will not implement Medicaid expansion. This can now be done under 1115 demonstration waiver authority. Both Arizona and California waivers allow reimbursement of optional services (uncompensated care) that have been eliminated. California’s waiver expands eligibility up to 133% of FPL. These same strategies may be available for use by Tribes in states that will not expand Medicaid, however the viability of these models after January 1, 2014, when states had the option to expand Medicaid, is not as clear as we would like. At least two critical questions come to mind:

- 1) If existing demonstration waivers expire in a state as of January 1, 2014, as CMS has indicated, what will be the mechanism to demonstrate cost-neutrality for the AI/AN-specific waivers, as excess cost-savings under preexisting waivers were used to offset the costs of the AI/AN-specific expansions in California and Arizona; and
- 2) will the “all or nothing” position currently taken by HHS with regard to expanding coverage to persons under 138% FPL post-January 1, 2014 be an impediment to expanding coverage and/or services to AI/ANs under 138 % FPL?

A new demonstration waiver in a state that does not expand Medicaid could negate the need to address these questions. Under a post-Medicaid expansion demonstration, we believe CMS could allow Medicaid coverage for all eligible individuals, services and provider types that a State is permitted under Title XIX of the Social Security Act to include in a Medicaid program and could be provided to all individuals at or below 133% of the FPL. The waiver would be limited to services be delivered through the federal IHS and Tribally-operated health programs operated under the ISDEAA.

The demonstration project could provide that payments would be made for services provided by IHS and tribal health programs operating under the ISDEAA to any individuals the IHS or tribal health program serves under its eligibility policies, including non-IHS beneficiaries, if approved under Section 813 of the IHCA. Services provided to a non-IHS beneficiary would need to be tracked by IHS or the Tribal health program. These services would be eligible for payment as long as the individual meets the demonstration requirements.

The FMAP for the state, under such a demonstration, would continue to be 100 percent for payments made for services provided to IHS-eligible individuals and the state's usual FMAP would apply to services provided to the non-IHS beneficiaries. If a state is not willing to cover the non-federal share of the Medicaid match, then the following process could be implemented under the demonstration: for services to non-IHS eligibles, tribally-operated health program or IHS would provide the state Medicaid share to the state through Certified Public Expenditures (CPE).

For all services provided under these waiver demonstrations, a third party administrator may be required to validate the CPE claiming protocol that would be administered by IHS and Tribal health programs. Generally, the process would require IHS and Tribes to submit certified claims through an encounter-based claiming protocol and submitted to the state. The state would reimburse IHS and tribal health programs for the claims. Claiming protocols will be developed during the forthcoming consultation process with CMS.

This model Indian health demonstration would allow the federal government to continue to use the Medicaid program to fulfill its special trust responsibility without undermining each state's decision making authority with regard Medicaid expansion for its larger population.