State Health Reform Assistance Network
Charting the Road to Coverage

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Medicaid and the Indian Health Service: States to Receive Additional Federal Funds

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Introduction

States with a significant American Indian and Alaskan Native (AI/AN) population will want to pay special attention to plans recently announced by the Centers for Medicare & Medicaid Services (CMS) to increase the range of Medicaid services furnished by Indian Health Services (IHS) eligible for 100 percent federal match. Where Medicaid-eligible AI/ANs receive services through an IHS facility, the federal matching rate is 100 percent and the state pays no share of the cost. Accordingly, as discussed below, CMS' proposal will effectively reduce states' cost for Medicaid expansion and buffer the impending decrease in the federal matching rate for newly eligible adults after 2016.

This report is the fifth in a series prepared by the Robert Wood Johnson Foundation's *State Health Reform Assistance Network* exploring the fiscal implications of Medicaid expansion. The first two reports explored state budget savings and revenue gains associated with expansion;[1] the third reviewed the impact on uncompensated care spending and related state budget implications;[2] and the fourth considered the ways in which Medicaid expansion may reduce states' criminal justice costs. This paper examines proposed rules that offer states additional federal funding for Medicaid services to American Indians and Alaskan Natives.

Federal funding in the Medicaid program

Under the Affordable Care Act (ACA), states that determine to expand their Medicaid programs to all adults with incomes below 138 percent of the federal poverty level receive 100 percent matching funds (FMAP) through 2016 for these newly eligible adults. In 2017, the matching rate decreases to 95 percent, decreasing further over time and leveling off at 90 percent in 2020 and thereafter.

However, for American Indians and Alaskan Natives within the newly eligible group,[3] the federal government covers 100 percent of the costs for certain Medicaid services received through the Indian Health Service.[4] Eligible IHS facilities include those operated directly by the IHS as well as those operated by an Indian Tribe or Tribal Organization.

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State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org.*

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Notably, the full federal match rate applies to IHS services for both the expansion and pre-expansion Medicaid populations and does not decrease over time. Thus, the proposal to expand the AI/AN services for which states may claim 100 percent federal funding will provide an economic benefit to states with respect to both newly eligible adults as well as previously eligible populations.

Proposed changes: federal government to fully fund additional services for American Indians and Alaskan Natives

Under current rules, the 100 percent federal match rate only applies to "facility services," meaning the set of services that are (or could be) furnished *directly* by an IHS facility. CMS issued a Request for Comment[5] in October 2015 stating that the agency is "strongly considering" significant changes to the funding rules that would further shift IHS-related Medicaid costs from states to the federal government.

Under the proposed rule, the 100 percent federal match rate would apply to *any service* that an IHS facility is authorized to provide under the state Medicaid plan. This definition includes several non-facility services that were not previously eligible, most notably transportation services. Emergency and non-emergency transportation is vital in ensuring access to needed services,[6] particularly in the remote areas where many American Indians and Alaskan Natives live.

The services eligible for the 100 percent federal match can be offered by the facility itself, by its employees, or by a contractual agent, as long as the Medicaid beneficiary is served as a patient of the IHS facility.[7] Urban Indian Health Programs may participate as contractual agents of an IHS facility, even though they are not directly eligible for the full match for their direct services.

As a result of these changes, IHS facilities may contract with third parties to provide services that are covered by the state plan but are not offered by the IHS facility. Examples include personal care, home health, and certain waiver services. Where the services provided are not within the facility's IHS benefit, the services will be paid at state plan rates rather than at the IHS facility rate, but in either case the state will receive 100 percent federal match.

Finally, noting that the current CMS policy was designed for Medicaid fee-for-service, CMS proposes to permit states to claim 100 percent federal match for the portion of the capitation payment representing services provided to AI/ANs through an IHS facility.

Conclusion

As a result of the proposed federal rule, states will be able to maintain or increase Medicaid services to American Indians and Alaskan Natives at no additional cost. States that expand their Medicaid programs will enjoy full federal matching for this subset of beneficiaries, even as the federal match declines for the general population starting in 2016. By funding the full cost of IHS services, the federal government supports two vulnerable populations at once: states can better meet the needs of American Indians and Alaskan Natives, while also relying on federal support to expand their Medicaid programs for the benefit of all their low-income residents.

STATES WITH LARGE AMERICAN INDIAN AND ALASKAN NATIVE POPULATIONS WILL REAP THE LARGEST BENEFIT

The increased federal funding is particularly helpful in states with a large number of Medicaid-eligible American Indian and Alaskan Native (AI/AN) people. The table below lists the 15 states where the nonelderly population (ages 0 to 64) has the highest proportion of AI/AN individuals. Under Medicaid expansion, nonelderly people are eligible if their income falls below 138 percent of the federal poverty level.

State	% AI/AN
Alaska	14.6%
New Mexico	10.1%
South Dakota	9.1%
Oklahoma	7.3%
Montana	6.9%
North Dakota	5.3%
Arizona	4.6%
Wyoming	2.5%
Washington	1.5%
Oregon	1.4%
Idaho	1.3%
North Carolina	1.2%
Utah	1.1%
Minnesota	1.1%
Nevada	1.1%

(States highlighted in red have not yet expanded their Medicaid programs)

End notes

[1] Bachrach D, Boozang P, Glanz D, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains: Early Data Shows Consistent Economic Benefits Across Expansion States" (Princeton: Robert Wood Johnson Foundation, 2015), accessed November 2, 2015, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf419097; Bachrach D, Boozang P, Glanz D, "States Expanding Medicaid See Significant Budget Savings and Revenue Gains: Early Data From Two States Shows More Than $1 Billion in Savings" (Princeton: Robert Wood Johnson Foundation, 2015), accessed November 2, 2015, http://statenetwork.org/wp-content/uploads/2015/03/Medicaid-Expansion-States-See-Significant-Budget-Savings-and-Revenue-Gai....pdf.

[2] Bachrach D, Boozang P, Lipson M, "The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States" (Princeton: Robert Wood Johnson Foundation, 2015), accessed November 2, 2015, http://statenetwork.org/wp-content/uploads/2015/06/State-Network-Manatt-Impact-of-Medicaid-Expansion-on-Uncompensated-Care-Costs-June-2015.pdf.

[3] Indian Health Service eligibility also includes other groups, such as Indians of Canadian or Mexican origin, as well as non-Indians with certain Indian familial relationships. For full details, see "Indian Health Manual," Section 2-1.2, (Washington, D.C.: Indian Health Service), accessed October 27, 2015, http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p2c1#2-1.2.

[4] 42 U.S.C. § 1396d(b).

[5] CMS & CMCS, *Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment* (Washington, D.C.: U.S. Department of Health & Human Services, 2015), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/downloads/tribal-white-paper.pdf.

[6] "Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community" (National Conference of State Legislatures, 2015), accessed November 2, 2015, http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx.

[7] CMS & CMCS, *Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment* (Washington, D.C.: U.S. Department of Health & Human Services, 2015), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/downloads/tribal-white-paper.pdf. The Request for Comment specifies that "[t]he IHS/Tribal facility would need to retain responsibility for the provision of services, meaning that the IHS/Tribal facility must retain control of the medical records, including updating medical records with information from care provided by contractual agents and providing care coordination for the AI/AN individual."