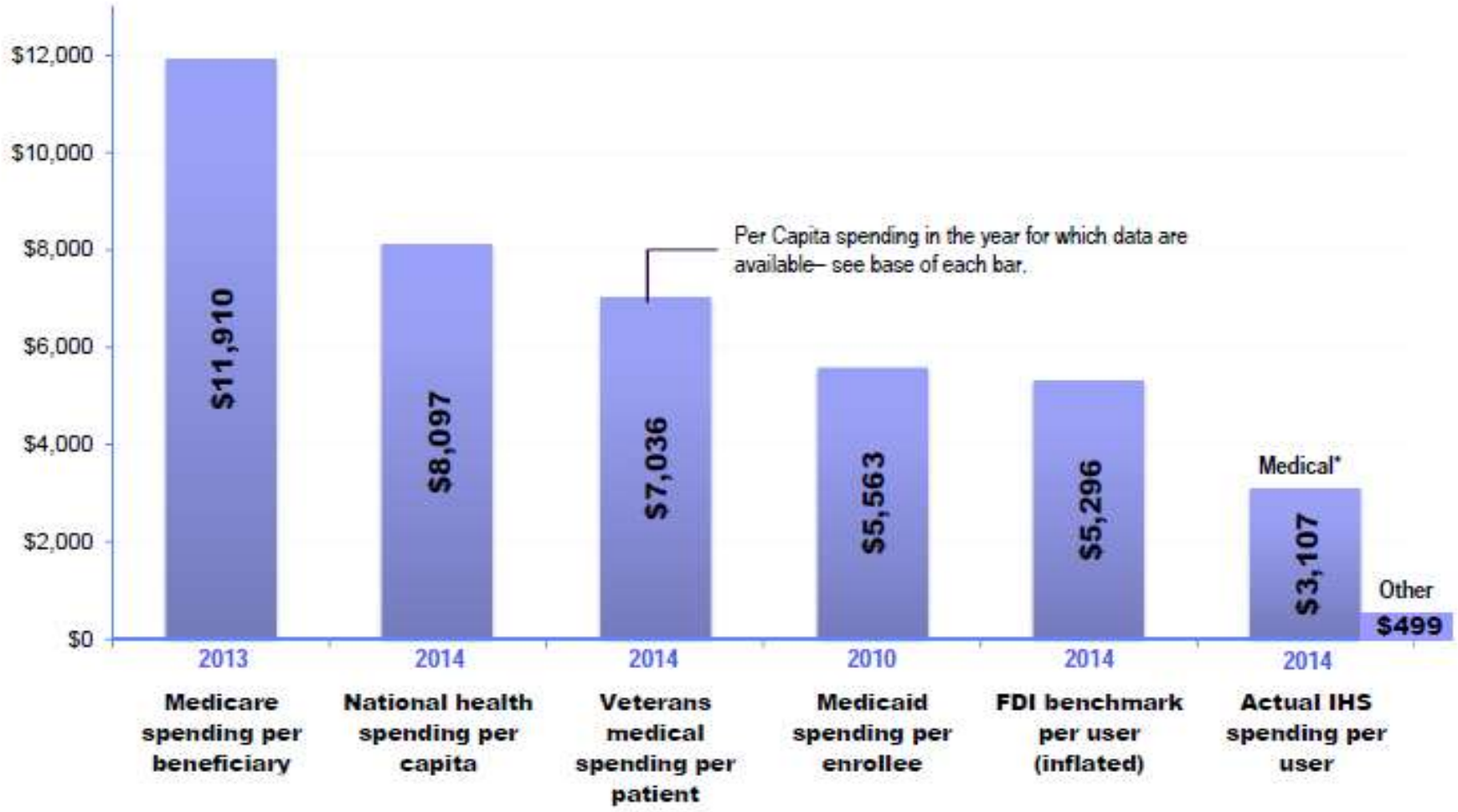
Medicaid, the ACA and the Indian Health System

ELLIOTT MILHOLLIN

HOBBS, STRAUS, DEAN & WALKER LLP

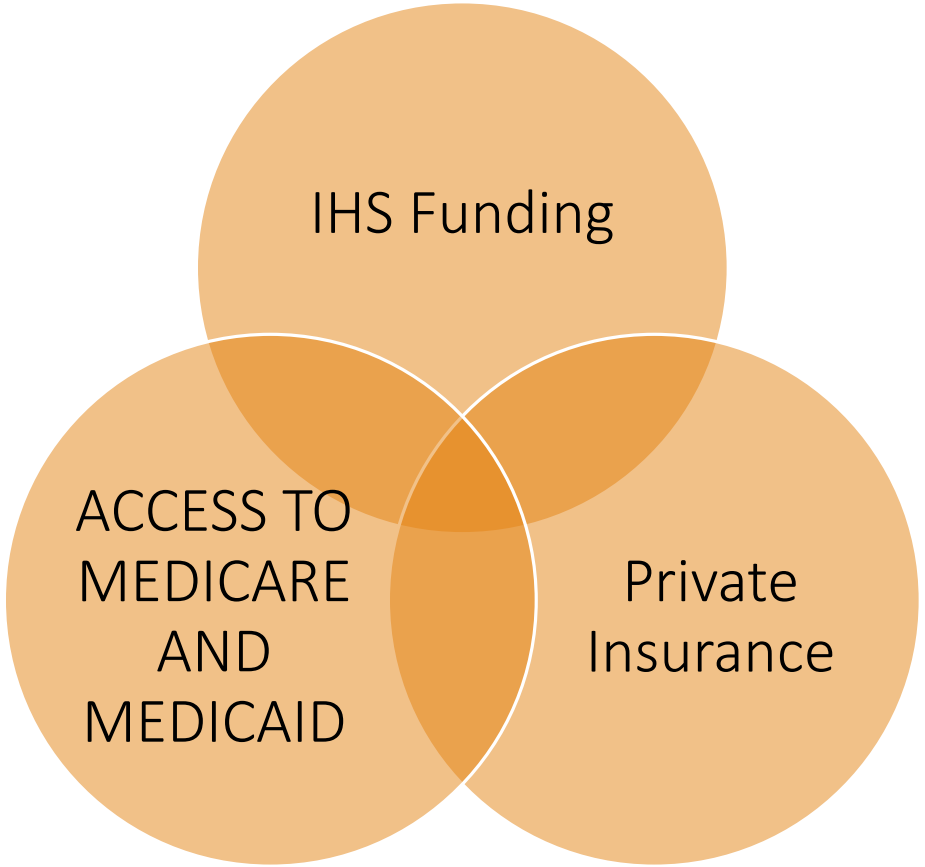
2014 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



*See page 2 notes on reverse for data. *The extent of payments by other sources for medical services provided to AI/ANs outside IHS is unknown.*

2/13/2015

Third Party Resources | A Critical Component



ACA | Health Reform for Indian Country

- Medicaid Expansion
- Access to Federal Insurance
- Indian provisions in federal insurance marketplace exchanges
- Improvement to ability to access private insurance

IHS Access | Medicare and Medicaid

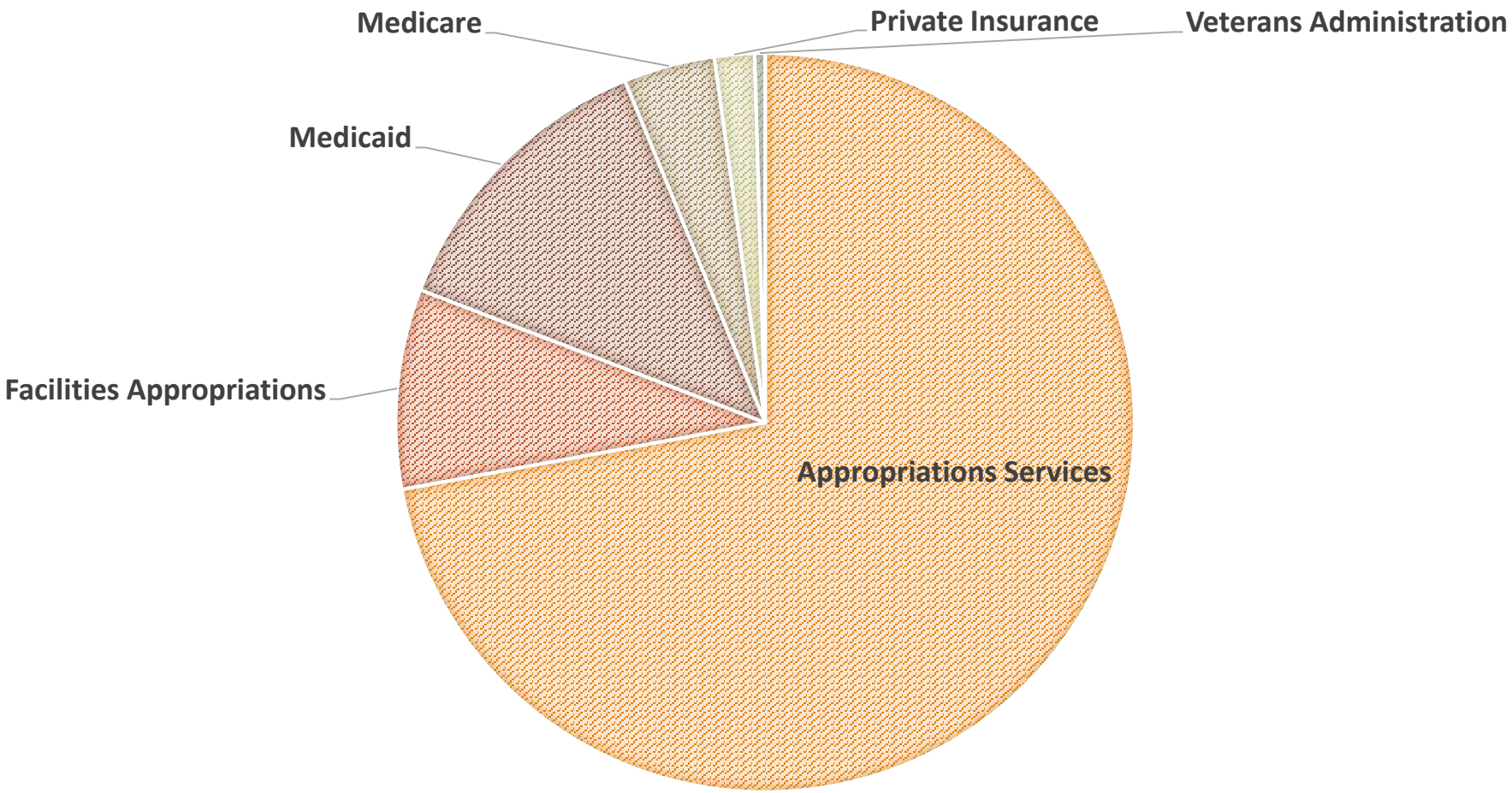
- Section 1880 of the Social Security Act, 42 U.S.C. 1395qq
  - Access to Medicare for IHS and tribal Hospitals and skilled nursing facilities
- Section 1911 of the Social Security Act, 42 U.S.C. §1396j
  - Access to Medicaid for IHS and tribal health facilities
- Section 1905(b) of the Social Security Act, 42 U.S.C. §1396d(b)
  - 100 percent FMAP for services received through IHS and tribal facilities
- Section 401(d) of the IHCIA, 25 U.S.C. § 1641(d)
  - Authority for tribal health programs to directly bill for Medicare and Medicaid services
- Section 401(a) of the IHCIA, 25 U.S.C. § 1641(d)
  - Medicare and Medicaid funding to supplement IHS funding

Congress | Medicaid to Supplement IHS Funding

- Access to Medicaid is intended to act "as a much-needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian."
- Medicaid authorization was provided by Congress "to enable Medicaid funds to flow into IHS institutions."

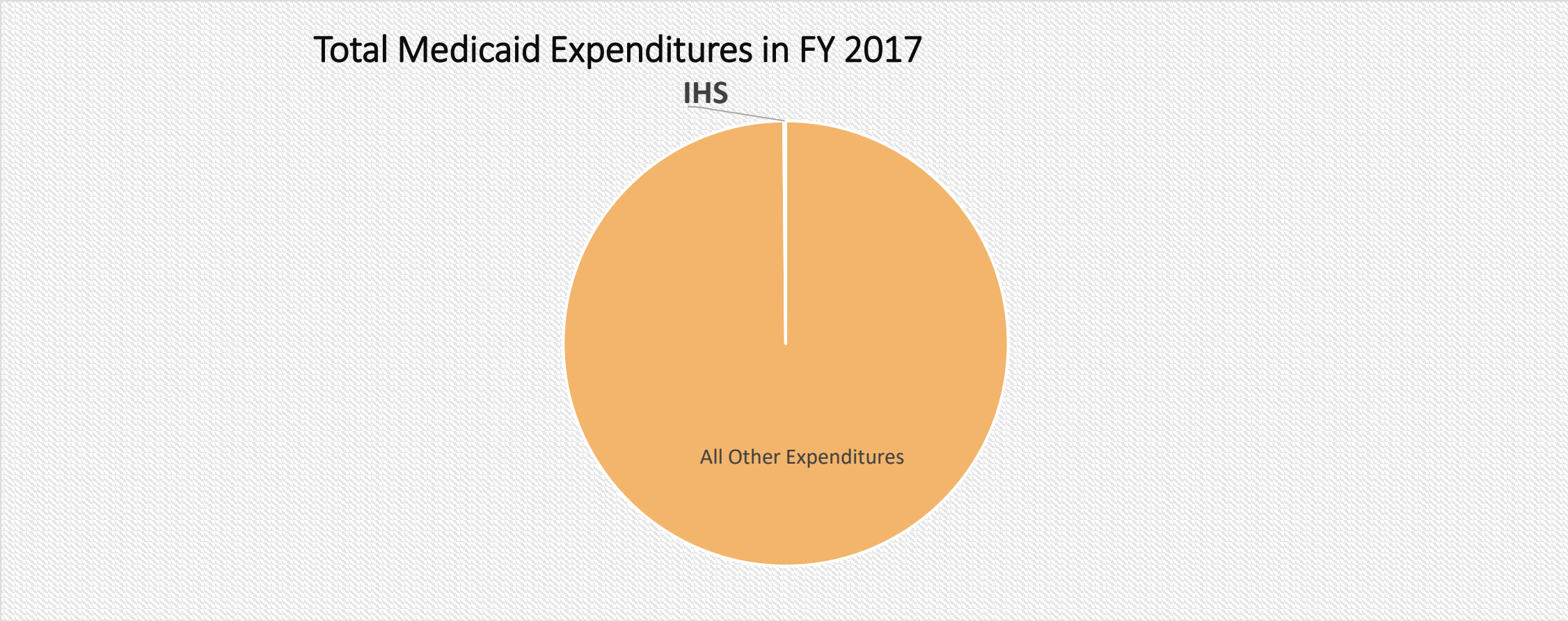
H.R. REP. NO. 94-1026, pt. III at 21 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2782, 2796

IHS Funding Breakdown| 2017



- Medicaid collections provided for nearly $808 million of the $6.3 billion IHS budget in FY 2017, which is approximately 12.69% of the agency's annual operating budget.

Medicaid Funding for IHS Programs | 0.14% of Total Medicaid Spending



IHS collections account for just 0.14% of Medicaid's annual expenditures of approximately $574.567 billion.

2009 American Recovery and Reinvestment Act

- An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider or through referral under Contract Health Services (CHS) is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under CHS. SSA § 1916(j)(1)(A); 42 U.S.C. § 1396o(j)(1)(A).
- Payment to I/T/U providers cannot be reduced by the absence of copays or premiums from an AI/AN patient. SSA § 1916(j)(1)(B); 42 U.S.C. § 1396o(j)(1)(B).
- A state is prohibited from classifying trust land and items of cultural, religious or traditional significance as "resources" for purposes of determining Medicaid eligibility for AI/ANs. SSA 1902(ff)(1)-(4); 42 U.S.C. § 1396a(ff)(1)-(4).

2009 American Recovery and Reinvestment Act (cont.)

- Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery. SSA § 1917(b)(3)(B); 42 U.S.C. § 1396p(b)(3)(B).
- If an AI/AN elects to enroll in an MCO, they are allowed to designate an Indian health care provider as their primary care provider if in-network. SSA § 1932(h)(1); 42 U.S.C. § 1396u-2(h)(1).
- An Indian health care provider must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider. SSA § 1932(h)(2)(A)-(C); 42 U.S.C. § 1396u-2(h)(2)(A)-(C).
- If the MCO pays the Indian health care provider less than what the Indian health care provider would be paid under the State plan (the encounter rate), then the State must make up the difference in a wraparound payment to the Indian health care provider. SSA § 1932(h)(2)(C)(ii); 42 U.S.C. § 1396u-2(h)(2)(C)(ii).

ACA Medicaid Expansion

- Medicaid eligibility varies state by state
- The ACA was intended to equalize Medicaid eligibility levels across the board to 138 Percent of Federal Poverty Levels, but the Supreme Court made Medicaid Expansion optional. *National Federation of Independent Business v. Sebelius,* 156 U.S. ___ (2012).
- 34 States (and DC) have expanded; 17 have not. Several are considering.

Section 1115 Demonstration Waivers

Section 1115 of the Social Security Act, 42 U.S.C. 1315 permits the Secretary of HHS to waive certain Medicaid and CHIP requirements.

Section 1115 Waivers are the most flexible waiver authorities in Medicaid and CHIP.

Waivers allow states to operate "experimental, pilot, or demonstration project[s]" that are likely to promote the objectives of Medicaid and CHIP.

They may be authorized and extended at Secretary's discretion. Usually 5 years in length, but may be extended thereafter.

1115 Provides Two Distinct Waiver Authorities

Expenditure Authority: Section 1115(a)(2) authorizes the Secretary to treat expenditures not described in Section 1903 as if they were made in accordance with an approved State plan. Section 1903 defines the types of expenditures States may make.

Waiver authority: Section 1115(a)(1) authorizes the Secretary to waive almost any requirement in Section 1902 of the Social Security Act (comparability, state-wideness, etc.) so long as the waiver continues to meet the requirements of the Medicaid program.

Waivers Can Also Be A Tool for Tribes

Only States may submit a waiver to CMS

But Tribes can work with States to develop waivers that increase access to the Medicaid program for American Indians and Alaska Natives and reduce administrative burdens on State programs

UNCOMPENSATED CARE MODEL

- Arizona waiver amendment approved April 2012
  - Allows the Indian health care facilities in that State to offer Medicaid benefits the State no longer covered in its State Medicaid plan.
- California waiver amendment approved March 2013
  - Allows Indian health care providers to be reimbursed for benefits no longer covered by the State plan and to be reimbursed for individuals up to 138% of the FPL as if Medicaid Expansion had occurred
- Oregon waiver amendment approved December 2013
  - I/T/U facilities reimbursed for primary care services no longer covered by State plan when provided to adult beneficiaries who are enrolled in Medicaid or who are not enrolled in Medicaid up to 133% of FPL.

Other Potential Waiver Models

Premium Assistance Facility Based Model

- Premium assistance qualifies as medical assistance for purposes of the SSA
- Concept approved in Arkansas Expansion

Indian Managed Care Model

- Self-governance model for Medicaid
- Tribes contract with State to cover Medicaid reimbursement for care provided through I/T/Us
- Tribes design eligibility and reimbursement to match AI/AN Medicaid rights and not tied to State requirements

Health Insurance Marketplaces

ACA creates Health Insurance Marketplaces to make it easier for individuals to comply with the individual mandate.

The federal government provides significant subsidies for lower income people to buy insurance on a sliding scale from 100% to 400% of the Federal Poverty Level (FPL)

INDIAN-SPECIFIC MARKETPLACE RULES

No Cost-Sharing for Indians receiving services from an IHS or Tribal provider or through CHS, ACA 1402(d)

No Cost-Sharing for Indians with incomes up to 300% FPL who receive services outside of the Indian health system

- 300% FPL for family of 4: $72,750

Month to month enrollment allowed, ACA 1311

Premium Assistance Model

Section 402 of IHCIA allows Tribal and urban Indian health programs to use their federal health care dollars to purchase insurance for their beneficiaries

Value of premiums not considered income, ACA 9021

Some tribes have created Premium Assistance programs where they pay for the unsubsidized portion of the premium for their members, obtaining coverage at a fraction of the cost

Elliott Milhollin is a partner in the Washington D.C. office of Hobbs, Straus, Dean and Walker LLP. He represents individual tribes and tribal health care programs as well as national and regional tribal organizations on Health Care issues involving Medicare, Medicaid, CHIP, the Indian Health Care Improvement Act, the Affordable Care Act and the Indian Self-Determination and Education Assistance Act.

Elliott Milhollin
Hobbs, Straus, Dean & Walker LLP
2120 L Street, NW
Washington, D.C. 20037
(202) 822-8282
emilhollin@hobbsstraus.com