

Reforming American Indian/Alaska Native Health Care Financing: The Role of Medicaid

Chronic underfunding of American Indian and Alaska Native (AIAN) health care by the federal government has weakened the capacity of the Indian Health Service, tribal governments, and the urban Indian health delivery system to meet the health care needs of the AIAN population.

I describe the current role of Medicaid in financing health care services for American Indians/Alaska Natives and offer 3 suggestions for reforming Medicaid financing of AIAN health care: (1) apply a 100% federal matching rate to the cost of Medicaid services furnished by urban Indian health programs; (2) apply a 100% federal matching rate to the cost of Medicaid services furnished by referral to AIAN patients of hospitals or clinics operated by the Indian Health Service, tribes, tribal organizations, or urban Indian health programs; and (3) exempt AIAN Medicaid beneficiaries who receive services from such hospitals or clinics from state reductions in Medicaid eligibility and benefits. (*Am J Public Health*. 2005;95:766–768. doi:10.2105/AJPH.2004.061317)

Andy Schneider, JD

THE FINANCING OF AMERICAN Indian and Alaska Native (AIAN) health care is broken and needs to be fixed. As Dixon et al. observed, the financing of AIAN health care has been broken for many years.¹ Chronic underfunding of AIAN health care by the federal government, meticulously documented by the Federal Disparity Index Work Group,² has undercut the capacity of the Indian Health Service (IHS), tribal, and urban Indian health delivery system to meet the health care needs of the AIAN population, whether on or near reservations or in urban areas. The result has been health disparities as persistent as they are indefensible.

Reforming the financing of AIAN health care will not in and of itself raise the health status of the AIAN population. However, if the financing of AIAN health care is not reformed, there is very little chance that the health status of the AIAN population will improve significantly. Financing reform is not a sufficient condition for the reduction or elimination of health disparities, but it is a necessary condition.

Medicaid is a key element of AIAN health care financing reform. Congress has increasingly relied on federal and state revenues from Medicaid to finance the provision of services to eligible American Indians/Alaska Natives through the IHS. Medicaid is the nation's largest health care program and the federal government's second largest health care spending program. In FY 2004,

Medicaid revenues were projected to account for 16% of the IHS budget for clinical services.³ At the same time, the growth in appropriated funding for clinical services is not sufficient to keep pace with the growth in the AIAN population and the cost of furnishing needed health care services. The appropriation for IHS clinical services increased by only 2.3% between fiscal year 2003 and fiscal year 2004.³ If AIAN health care financing is to be reformed, Medicaid revenues will need to play a larger and more effective role.

In an ideal world, the reform of AIAN health care financing would not depend in part on a means-tested program administered on a day-to-day basis by the states. The legal and moral foundation for national AIAN health policy is the trust relationship between the federal government and Indian tribes. This relationship is based on treaties, the US Constitution, and federal statutes, not on the deplorable poverty rates found among American Indians/Alaska Natives. However, it is the high incidence of poverty that makes many American Indians/Alaska Natives eligible for basic health benefits under Medicaid, a program that by definition limits its coverage to certain categories of low-income people.

Unfortunately, we find ourselves in a world that is far from ideal. Medicaid does not make its benefits available to American Indians/Alaska Natives based on their tribal membership or cultural heritage. Further, Medicaid

also has the distinct disadvantage, from the AIAN perspective, of being administered largely by states, which do not share in the federal government's trust responsibility to tribes. The challenge for AIAN health care financing reform is to expand and more effectively channel the federal funds that flow through Medicaid to the IHS, tribal, and urban Indian health delivery system.

CURRENT MEDICAID POLICY

Medicaid pays for health care and long-term care services furnished to individuals who fall into certain categories (e.g., children younger than 21 years, pregnant women, individuals with disabilities, the elderly) and who have limited income and assets. Medicaid is administered by states within broad federal guidelines. States have used their discretion to fashion programs that vary greatly in eligibility standards, enrollment procedures, types of services covered, and methods of provider payment. The Medicaid program in North Dakota differs considerably from that in neighboring Minnesota, and the Medicaid program in Arizona varies substantially from that in neighboring New Mexico.

The cost of Medicaid is shared by the federal government and the states. In general, the federal government's share ranges from 50% to 77%, depending on a state's per capita income (the poorer the state, the higher the federal share).⁴ States with rela-

tively high percentages of American Indians/Alaska Natives—Alaska, Arizona, Minnesota, Montana, Nebraska, North Carolina, North Dakota, New Mexico, Oklahoma, South Dakota, Washington, and Wyoming—tend to have federal matching rates at 60% or more. This means that for every \$2.50 their Medicaid programs spend to purchase a covered service, the federal government pays \$1.50 and the state governments pay \$1.00. Examined another way, for every \$1.00 of its own funds that a state with a 60% federal matching rate spends, it draws down \$1.50. This is a 150% return on investment, which compares quite favorably with other potential uses of state funds. However, this return is available only if the state has the \$1.00 of its own funds available to invest.

Many states, including those with relatively large AIAN populations, are under revenue pressures that limit their ability or willingness to fund their Medicaid programs. On average, state revenues are not growing as rapidly as Medicaid costs. Because the federal government is not filling in the gap, states must either increase the portion of their revenues each year that they allocate to their Medicaid programs (at the expense of other state programs such as education), reduce the amount they spend on Medicaid, or both. States vary in their policy preferences, but in the past year, all states undertook at least 1 Medicaid cost containment measure.⁵ These measures included reductions in eligibility and benefits as well as cuts or freezes in provider payments.

When states tighten Medicaid eligibility or benefits, they not only reduce their own spending but also lose the federal match-

ing funds that accompany their spending. Providers that do not receive payment for services and populations that Medicaid no longer covers lose both the federal and state matching funds. For example, in a state with a federal matching rate of 60%, to save \$1.00 in state funds, it must reduce its Medicaid spending by \$2.50. The state saves \$1.00, the federal government saves \$1.50, and the provider loses \$2.50.

For IHS and tribally run facilities, this effect is magnified because an enhanced federal matching rate of 100% applies when Medicaid patients receive covered services through these facilities. (This 100% matching rate does not apply to covered services provided through urban Indian health programs). For example, if a state reduces eligibility for pregnant women from 185% of the federal poverty level to the federal minimum of 133% of the federal poverty level, all AIAN pregnant women in this income range will lose Medicaid eligibility along with all pregnant women who are not American Indians/Alaska Natives. For those being treated at IHS or tribal facilities, the facilities will no longer be able to bill Medicaid for their services. Similarly, if a state decides to reduce or eliminate an optional service such as adult dental care, the IHS or tribal facilities that provide such services to Medicaid beneficiaries will no longer be able to bill the state Medicaid program for these services. In both cases, the state does not save any of its own funds by cutting off payment to the IHS or tribal facilities, because 100% of the Medicaid costs of these services would be paid by the federal government. However, the IHS or tribal facilities will lose the federal Medicaid revenues.

In short, under current Medicaid financing arrangements, policy decisions that states make to limit the growth in state spending can have a major impact on the amount of federal Medicaid funds received by IHS or tribal providers that serve large numbers of Medicaid beneficiaries. Because state fiscal conditions and policy preferences vary, the flow of federal Medicaid funds can vary greatly among IHS or tribal providers in different states, even though the federal government has a trust responsibility to all federally recognized tribes regardless of the state in which they are located. In those states in which the flow of federal Medicaid funds is significantly constrained, the facilities must absorb more service costs with the limited IHS appropriations allocated to them each year. Existing IHS or tribal hospitals and clinics may be forced to reduce services or staffing, and new ventures, such as tribally controlled clinics or managed care plans, may have great difficulty launching operations.

REFORMING MEDICAID FINANCING

Financing of AIAN health care is only 1 of the many aspects of Medicaid that could be improved. For example, the matching formula does not provide sufficient federal assistance when state revenues decline because of economic downturns, and the categorical eligibility limits bar federal matching for the health care costs of poor working age adults who are not disabled and who do not have dependent children. Nonetheless, it is possible to reform Medicaid financing of AIAN health care without reforming all of Medicaid financ-

ing—a considerably more complex and expensive proposition on which there is far from a national consensus.⁶ At a minimum, reform of Medicaid financing of AIAN health care would have the following elements: urban programs, referrals, and protection from cutbacks.

Urban Programs

The 100% federal matching rate should be extended to the cost of covered services furnished by urban Indian health programs to AIAN Medicaid beneficiaries. Currently, only the costs of Medicaid services provided through IHS and tribal providers qualify for 100% federal matching. The costs of Medicaid services provided through urban Indian health programs are matched at a state's regular matching rate. This policy change will require a change in the federal Medicaid statute.

Referrals

The 100% federal matching rate should be extended to the cost of covered services furnished to AIAN Medicaid patients either directly by IHS, tribal, and urban Indian health facilities or by referral to other providers by those facilities. Under current administrative interpretation, the 100% federal matching rate applies only to the cost of Medicaid services furnished directly by an IHS or tribal facility on site. If an IHS or tribal facility must refer an AIAN Medicaid beneficiary to a non-IHS, tribal, or urban Indian health delivery provider because the facility does not have the capacity to offer the needed service, the federal government pays only its regular share of the cost in that state, not 100%. The federal government's administrative interpretation is currently under

challenge by some states in federal court.^{7,8} Regardless of the outcome of the litigation, the federal Medicaid statute would benefit from clarification on this point.

Protection From Cutbacks

AIAN Medicaid beneficiaries receiving services directly or by referral from IHS, tribal, and urban Indian health facilities should be exempted from state eligibility or benefits reductions, whether these reductions are achieved through optional state Medicaid plan changes or through waivers. Several states have unsuccessfully requested permission from the Secretary of Health and Human Services to exempt AIAN Medicaid beneficiaries from eligibility or benefits reductions in the context of section 1115 waivers.⁹ A change in the federal Medicaid statute is required to achieve this policy change.

DISCUSSION

These 3 reforms would be of considerable value to IHS, tribal, and urban Indian health providers and their Medicaid and non-Medicaid patients alike. By making additional federal Medicaid matching funds available for the costs of care of Medicaid beneficiaries, these reforms would release limited IHS appropriations for the care of non-Medicaid patients. These reforms also articulate the principle that, in a federal–state program, certain costs should be borne entirely by the federal government rather than by individual states. Just as the cost of treating individuals eligible for Social Security who have end-stage renal disease is assumed by the federal Medicare program, and just as the cost of treating low-income Americans with HIV should be assumed by the federal govern-

ment rather than the states in which those individuals are clustered,¹⁰ the cost of fulfilling the federal trust obligation should be assumed by the federal government rather than the states in which the tribes are located.

These 3 reforms, although significant, are relatively limited in scope. They do not resolve all of the shortfalls in Medicaid financing policy that affect AIAN health. In particular, they do not specify a minimum eligibility standard for American Indians/Alaska Natives separate from the minimum eligibility standards that apply under federal Medicaid law to all states for children, pregnant women, parents, and elderly and disabled individuals. Nor do they specify a minimum benefit package to which American Indians/Alaska Natives would be entitled; again, the national Medicaid benefits standards would continue to apply. Thus, the variation in state Medicaid program eligibility and benefits rules would continue to affect the flow of federal Medicaid funds to IHS, tribal, and urban Indian health providers. Moreover, these recommendations would not fully federalize the cost of caring for AIAN Medicaid beneficiaries, because the states would continue to pay their share of the costs of treating such beneficiaries when they do not receive covered services through or on referral from an IHS, tribal, and urban Indian health provider.

To fully federalize the cost of health care and long-term care services for low-income American Indians/Alaska Natives, more far-reaching reforms are necessary. For example, federal Medicaid payments might be channeled directly through IHS to providers in the IHS, tribal, and urban Indian health delivery

system to fund the delivery of a uniform national benefit package to all low-income American Indians/Alaska Natives who meet a specified national income standard. Changes of this magnitude are simply unachievable in the current political context.

Admittedly, the far more limited reforms I suggest here also face significant opposition. In addition, as noted, they will not fully solve the financing problems that confront the IHS, tribal, and urban Indian health delivery system and the AIAN population that relies on it for care. Yet these incremental Medicaid reforms would substantially improve the flow of federal funds to IHS, tribal, and urban Indian health delivery providers. For IHS, tribal, and urban Indian hospitals and clinics that serve large numbers of low-income patients, these additional revenues could enable them to significantly improve the scope and quality of the services they offer. Of course, achievement of these reforms is by no means certain. What is certain, however, is that in the absence of these reforms, the ability of the IHS, tribal, and urban Indian health delivery system to address the health disparities facing AIAN populations will continue to erode. ■

About the Author

Andy Schneider, JD, is with Medicaid Policy, LLC.

Requests for reprints should be sent to Andy Schneider, JD, Medicaid Policy, LLC, 3948 Garrison Street, NW, Washington, DC 20016 (e-mail: medicaidpolicy@aol.com).

This article was accepted August 25, 2004.

Acknowledgments

Partial support for the preparation of this article was provided by the Kaiser Family Foundation.

The author gratefully acknowledges the comments of Marsha Lillie-Blanton,

DrPH, Vice President, Kaiser Family Foundation, and James Crouch, MPH, Executive Director, California Rural Indian Health Board.

Human Participant Protection

No approval from the human participation board was required.

References

- Dixon M, Mather DT, Shelton BL, Roubideaux Y. Organizational and economic changes in Indian health care systems. Dixon M, Roubideaux Y, eds. *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century*. Washington, DC: American Public Health Association; 2001:89–117.
- Federal Disparity Index Workgroup letter to Dr. Trujillo, Director, Indian Health Service, March 26, 2001. Available at: <http://www.ihs.gov/nonmedicalprograms/lmf/IHCIF2002/TucsonLetter.pdf>. Accessed December 15, 2004.
- US Department of Health and Human Services, *Budget in Brief FY 2005*. Washington, DC, US Government Printing Office; 2005. Available at: <http://www.hhs.gov/budget/05budget/fy2005bibfinal.pdf>. Accessed January 25, 2005.
- Miller V, Schneider A. *The Medicaid Matching Formula: Policy Considerations and Options for Modification*. Washington, DC: AARP Public Policy Institute; 2004.
- Smith V, Ramesh R, Gifford K, Ellis E, Rudowitz R, O'Malley M. *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2004.
- Wachino V, Schneider A, Rousseau D. *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2004.
- Ellenbecker v Centers for Medicare and Medicaid Services*, CIV 02–3042 (D SD September 30, 2003).
- State of North Dakota ex rel. Olson v Centers for Medicare and Medicaid Services*, Case No. A1–03–028, (D ND October 1, 2003).
- Roberts J, Johnston B. American Indian access to Medicaid and civil rights concerns. *National Indian Health Board Health Reporter*. 2004;10(2):1.
- Committee on Public Financing and Delivery of HIV Care, Institute of Medicine. *Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White*. Washington, DC: National Academy of Sciences Press; 2004.