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October 2013 | Issue Brief

Health Coverage and Care for American Indians and Alaska Natives

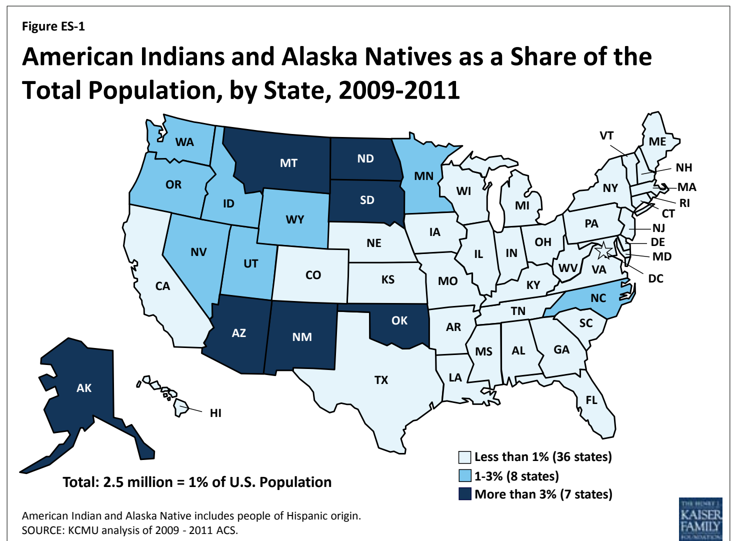
EXECUTIVE SUMMARY

American Indians and Alaska Natives face persistent disparities in health and health care, including high uninsured rates, significant barriers to obtaining care, and poor health status. Treaties and laws establish the federal government's responsibility to provide certain rights, protections, and services to American Indians and Alaska Natives, including health care. The Indian Health Service (IHS) is the primary vehicle through which the federal government provides health services to American Indians and Alaska Natives. However, chronic underfunding for IHS and other barriers limit access to care for the population. The Affordable Care Act (ACA) offers important opportunities to increase health coverage and care for American Indians and Alaska Natives and reduce the longstanding disparities they face. This brief provides an overview of health coverage and care for American Indians and Alaska Natives today and the potential implications of the ACA coverage expansions.

A total of 5.1 million individuals self- identify as American Indian or Alaska Native alone or in combination with some other race, representing 2% of the total population. This includes some 2.5 million individuals who identify solely as American Indian or Alaska Native, making up roughly 1% of the total U.S. population. Some American Indians and Alaska Natives belong to a federally-recognized tribe, some belong to a state-recognized tribe, and others self-identify as American Indian and Alaska Native, but are not enrolled in a tribe. Tribal membership has important implications for access to benefits. Members and descendents of members of federally recognized tribes have broader access to certain federal benefits and services. American Indians and Alaska Natives live across the country but are concentrated in certain states (Figure ES-1). While many American Indians and Alaska Natives live in rural areas, only 22% live on reservations or land trusts. As of 2010, 60% of American Indians and Alaska Natives live in metropolitan areas.

Figure ES-1

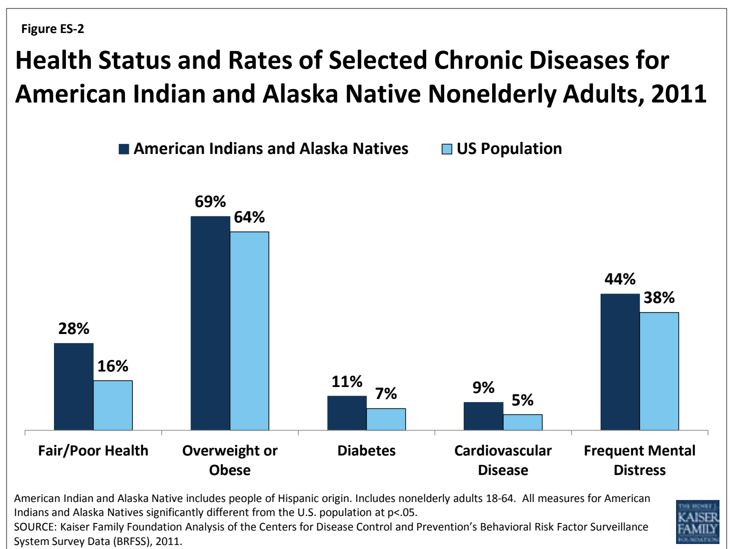
American Indians and Alaska Natives as a Share of the Total Population, by State, 2009-2011



American Indian and Alaska Native includes people of Hispanic origin.
SOURCE: KCMU analysis of 2009 - 2011 ACS.

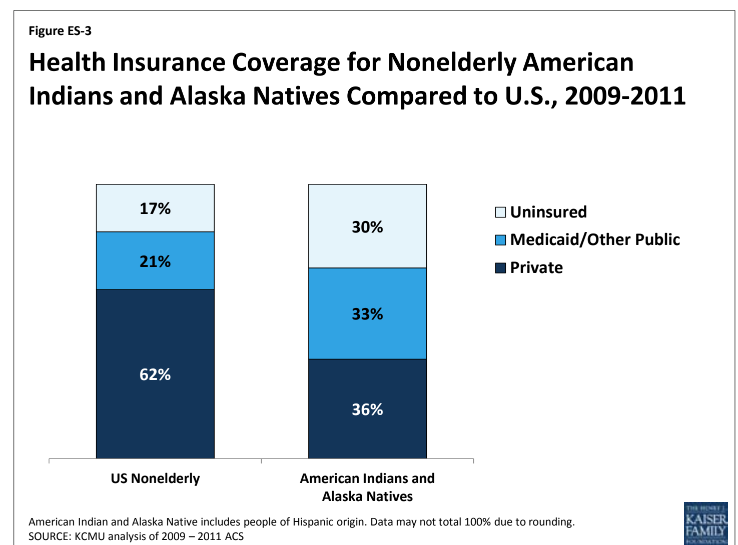
While the majority of American Indians and Alaska Natives are in working families, they have high rates of poverty. Six in ten (63%) nonelderly American Indians and Alaska Natives are in working families, but American Indians and Alaska Natives are less likely than the overall population to be in the workforce and have significantly higher rates of poverty (41% vs. 25%).

American Indians and Alaska Natives face significant physical and mental health problems. Among nonelderly adults, American Indians and Alaska Natives are more likely than the overall population to report being in fair or poor health, being overweight or obese, having diabetes and cardiovascular disease, and experiencing frequent mental distress (Figure ES-2). Moreover, the suicide rate for American Indian and Alaska Native adolescents and young adults is two and half times higher than the national average.

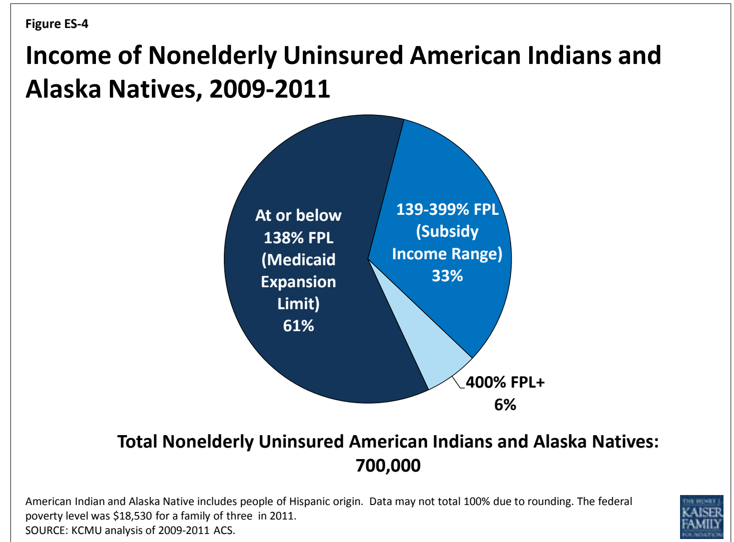


The IHS provides health care and prevention services to roughly 2.2 million American Indians and Alaska Natives, but has historically been underfunded to meet the health care needs of the population. IHS-funded health services are provided through a network of hospitals, clinics, and health stations that are managed directly by IHS, by tribes or tribal organizations, and urban Indian health programs. Some services also are provided through contract with non-Indian providers. In general, services provided through IHS- and tribally-operated facilities are limited to members of and descendants of members of federally recognized tribes that live on or near federal reservations. Urban Indian health programs serve a wider group of American Indians and Alaska Natives, including those who are not able to access IHS- or tribally-operated facilities because they do not meet eligibility criteria or reside outside the service areas. IHS funding is limited and must be appropriated by Congress each fiscal year. In FY2013, total program funding was $5.46 billion. Although the IHS budget has increased over time, funds are not equally distributed across facilities and they remain insufficient to meet health care needs. As such, access to services through IHS varies significantly across locations, and American Indians and Alaska Natives who rely solely on IHS for care often lack access to needed care. Moreover, as a discretionary program IHS funding is subject to the automatic funding cutbacks under the sequester, which further limit access to services.

Nearly one in three American Indians and Alaska Natives is uninsured. Overall, American Indians and Alaska Natives have limited access to employer-sponsored coverage because they have a lower employment rate and tend to be employed in low-wage jobs that typically do not offer health coverage. Less than four in ten (36%) American Indians and Alaska Natives have private coverage, compared to 62% of the overall nonelderly population. (Figure ES-3). Medicaid helps fill this gap, covering one in three non-elderly American Indians and Alaska Natives. Medicaid also provides key financing for IHS providers and has special financing rules and protections for American Indians and Alaska Natives. However, nearly one in three (30%) nonelderly American Indians and Alaska Natives remains uninsured.



The ACA offers opportunities to increase coverage and access to care for American Indians and Alaska Natives. For all Americans, the ACA seeks to reduce the number of uninsured through an expansion of Medicaid and new Health Insurance Marketplaces with tax credits to help purchase coverage. Nine in ten (94%) uninsured American Indians and Alaska Natives have incomes in the range to qualify for these coverage expansions (Figure ES-4). Moreover, the ACA permanently reauthorizes the Indian Health Care Improvement Act, extending and authorizing new programs and services within the IHS.



However, half of poor uninsured adult American Indians and Alaska Natives live in states not moving forward with the Medicaid expansion at this time, and, as such, will continue to face a gap in coverage. The ACA Medicaid expansion was effectively made a state option by the Supreme Court ruling on the ACA. As of September 2013, half of states are moving forward with the expansion to adults with incomes at or below 138% of the federal poverty level (FPL) ($15,856 for an individual in 2013). In these states, many American Indian and Alaska Native adults will become newly eligible for the program. However, in states not expanding Medicaid, many American Indian and Alaska Native adults will continue to face a gap in coverage since they will remain ineligible for Medicaid and those below 100% FPL will not be eligible for the tax credit subsidies for Marketplace coverage. Half of uninsured adult American Indians and Alaska Natives with incomes below 100% FPL live in the 26 states not moving forward with the expansion at this time. Moreover, state Medicaid expansion decisions will create unique equity issues for American Indians and Alaska Natives since some tribal nations extend across states that have made differing expansion decisions, which will drive variations in coverage, access, and health status both within and between tribes.

The Marketplaces provide new coverage options for many American Indians and Alaska Natives, but only members of federally- recognized tribes will receive certain consumer protections. Members of federally-recognized tribes who purchase coverage through the Marketplaces will receive special protections, including the ability to change health plans on a monthly basis and some exemptions from cost-sharing. However, these protections will not apply to the broader group of American Indians and Alaska Natives who are eligible for IHS services and are afforded certain Medicaid protections. This inconsistency will result in many American Indians and Alaska Natives not receiving the special Marketplace protections and likely lead to confusion that may hamper enrollment efforts.

In sum, while the federal government has the responsibility to provide health care to American Indians and Alaska Natives, many face challenges accessing care and the population continues to experience poor health outcomes. Due to limited funding, the IHS is not able to fully meet the need for care. American Indians and Alaska Natives also have limited access to employer-sponsored insurance. While Medicaid helps fill this gap, many remain uninsured. Looking ahead, the ACA provides important opportunities to increase coverage and access to care for American Indians and Alaska Natives, which could help reduce the longstanding health disparities they face. However, significant coverage gaps will remain in states that do not expand Medicaid and decreases in IHS funding may further limit access to IHS services.

INTRODUCTION

American Indians and Alaska Natives face persistent disparities in health and health care, including high uninsured rates, significant barriers to obtaining needed care, and poor health status. While the United States has a unique responsibility to provide health care for American Indians and Alaska Natives, which is primarily carried out through the Indian Health Service (IHS), chronic underfunding and other barriers continue to limit access to care for the population. The Affordable Care Act (ACA) offers important opportunities to increase health coverage and care for American Indians and Alaska Natives, helping to reduce the longstanding disparities they face. This brief provides an overview of health coverage and care for American Indians and Alaska Natives today and the potential implications of the ACA coverage expansions.

KEY CHARACTERISITCS OF AMERICAN INDIANS AND ALASKA NATIVES

A total of 5.1 million individuals self- identify as American Indian or Alaska Native alone or in combination with some other race, representing 2% of the total U.S. population. This includes some 2.5 million individuals who identify solely as American Indian or Alaska Native, making up about 1% of the total U.S. population. American Indians and Alaska Natives live throughout the country, but are concentrated in certain geographic areas. In seven states, American Indians and Alaska Natives comprise over 3% of the total population (Alaska, Arizona, Montana, New Mexico, North Dakota, Oklahoma, and South Dakota) (Figure 1). Moreover, over half (54%) of the total American Indian and Alaska Native population resides in just seven states (Figure 2). American Indian reservations, land trusts, or tribal statistical areas[1] are located in all but 13 states and the District of Columbia with some tribal boundaries extending across more than one state.[2] While many American Indians and Alaska Natives live in rural areas, only 22% currently live on reservations or land trusts and, as of 2010, some 60% lived in metropolitan areas.[3] The share of American Indians and Alaska Natives living away from reservations has grown steadily over time and this demographic shift is expected to continue.[4]

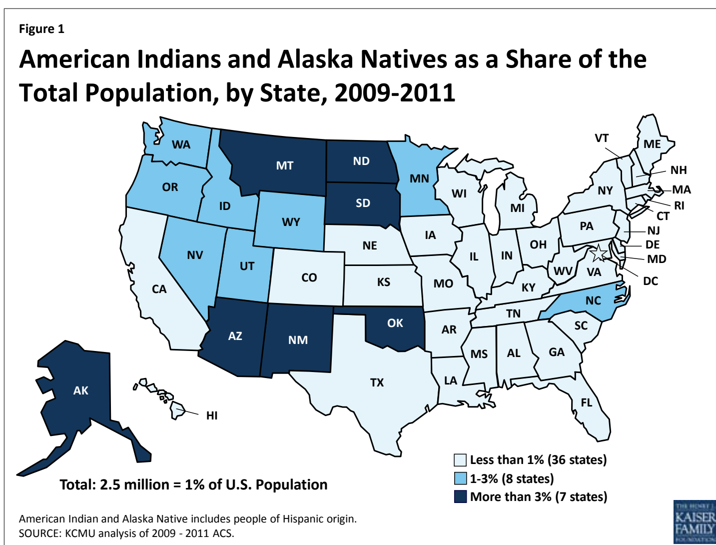


Figure 1

American Indians and Alaska Natives as a Share of the Total Population, by State, 2009-2011

American Indian and Alaska Native includes people of Hispanic origin.
SOURCE: KCMU analysis of 2009 - 2011 ACS.

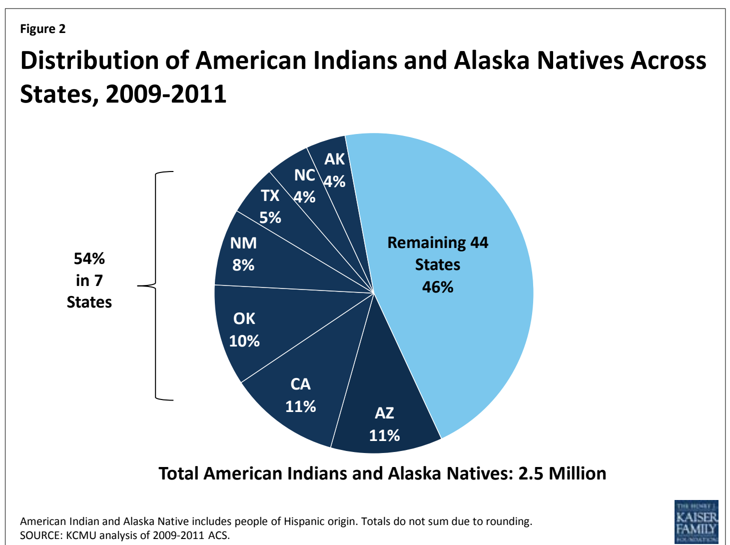


Figure 2

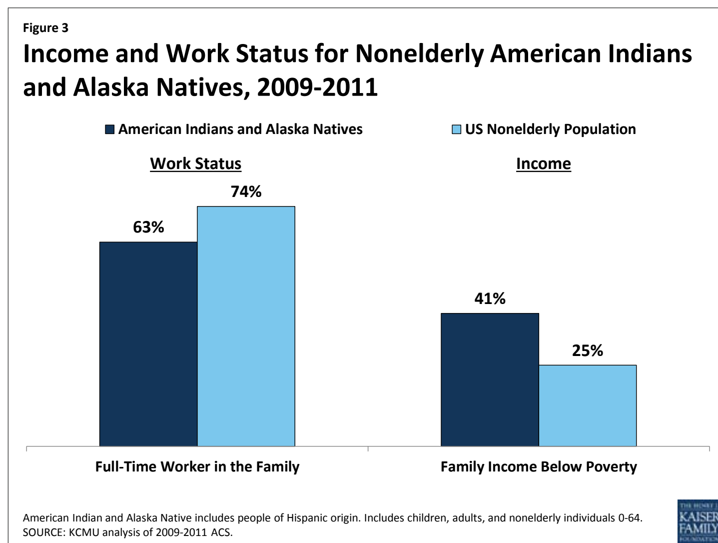
Distribution of American Indians and Alaska Natives Across States, 2009-2011

American Indian and Alaska Native includes people of Hispanic origin. Totals do not sum due to rounding.
SOURCE: KCMU analysis of 2009-2011 ACS.

Some American Indians and Alaska Natives belong to a federally- recognized tribe, some belong to a state- recognized tribe, and others self- identify as American Indian and Alaska Native, but are not enrolled in a tribe. There currently are 566 federally-recognized sovereign tribes[5] and more than 100 state-recognized tribes[6] in the United States. Each tribe has its own eligibility requirements and unique customs and beliefs and more than 200 tribal languages are still spoken. Federally-recognized tribes share a government-to-government relationship with the federal government based around the "Federal Trust Responsibility." Treaties and laws have established the federal government's responsibility to provide members of federally-recognized tribes certain rights, protections, and services, including health care. As such, members of and descendants of members of federally-recognized tribes have broader access to certain federal benefits.

Compared to the U.S. population as a whole, the American Indian and Alaska Native population is younger and has lower education levels. One in three American Indians and Alaska Natives is under age 19 (31%) compared to 26% of the U.S. population, while only 7% of American Indians and Alaska Natives are over the age of 65 compared to 13% of the U.S. population. With regard to educational attainment, four in ten (40%) American Indian and Alaska Native adults have completed at least some college or higher, compared to over half of the overall adult population (54%).[7]

While the majority of nonelderly American Indians and Alaska Natives are in working families, they are less likely than the overall nonelderly population to be in the workforce and have significantly higher poverty rates than the total nonelderly population (Figure 3). Some 63% of nonelderly American Indians and Alaska Natives are in a family with at least one full-time worker, compared to 74% of the U.S. nonelderly population. Reflecting this employment pattern, the poverty rate for American Indians and Alaska Natives (41%) is more than one and half times the overall rate for the nonelderly population (25%).[8] However, despite this overall high rate of poverty, there is variation in economic status among American Indians and Alaska Natives. For example, there has been successful economic development among tribes, not only through gains stemming from casinos and natural resources, but also among tribes with a strong focus on American Indian and Alaska Native entrepreneurship and business development.[9]



American Indians and Alaska Natives have high rates of physical and mental health problems. Among nonelderly adults, American Indians and Alaska Natives are significantly more likely than the overall population to report being in fair or poor health, being overweight or obese, having diabetes or cardiovascular disease, and experiencing frequent mental distress (Figure 4).[10] American Indian and Alaska Native children and adolescents are also at higher risk for health problems than their peers. Nearly four in ten American Indian and Alaska Native children are overweight or obese, and studies have found the overweight and obesity rates among American Indian and Alaska Native children to be higher than any other group.[11] In addition, the suicide rate for American Indian and Alaska Native adolescents and young adults is two and half times higher than the national average, and suicide is the second leading cause of death among American Indian and Alaska Native adolescents and young adults, compared to the eleventh leading cause of death nationally.[12]

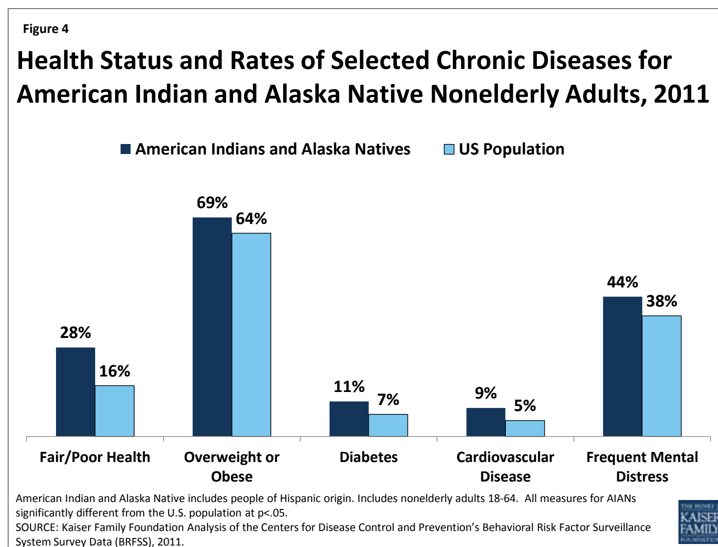


Figure 4

Health Status and Rates of Selected Chronic Diseases for American Indian and Alaska Native Nonelderly Adults, 2011

American Indian and Alaska Native includes people of Hispanic origin. Includes nonelderly adults 18-64. All measures for AIANs significantly different from the U.S. population at p<.05.
SOURCE: Kaiser Family Foundation Analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2011.

HEALTH COVERAGE AND CARE

As noted, the U.S. government has a unique responsibility to provide health care services for American Indians and Alaska Natives that is primarily the responsibility of the IHS. However, the IHS is subject to funding restrictions that limit the provision of care to the population. Given the limitations of IHS, health insurance coverage remains important for providing access to health care for American Indians and Alaska Natives, with Medicaid playing a particularly important role. However, overall, American Indians and Alaska Natives remain significantly more likely to be uninsured than most other groups.

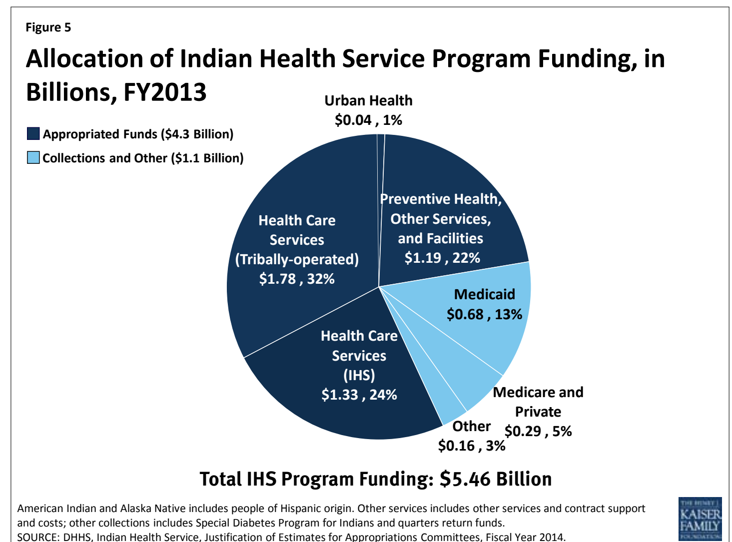
Role of the Indian Health Service

The IHS is responsible for providing health care to American Indians and Alaska Natives. The IHS is the principal federal health care provider for Indian people, and its goal is to raise their health status to the highest possible level.[13] In addition to medical care, the IHS provides a wide range of other services, including sanitation and public health functions. The IHS provides health care and disease prevention services to approximately 2.2 million American Indians and Alaska Natives through a network of hospitals, clinics, and health stations.[14] Health services are provided through facilities that are managed directly by IHS, by tribes or tribal organizations under contract or compact with the IHS, and urban Indian health programs. As of 2013, there are a total of 612 IHS- and tribally-operated facilities located mostly on or near reservations, some 80% of which are operated by tribes.[15] In addition, there are 33 urban Indian programs operating in 40 sites located in cities throughout the U.S.[16] If facilities are unable to provide needed care, the IHS and tribes may contract for health services from private providers through the Contract Health Services (CHS) program. However, urban Indian health organizations do not participate in the CHS program and do not receive CHS funding for additional health services beyond the scope of what they can provide. Overall, the services provided through the IHS consist largely of primary care, but include some ancillary and specialty services. American Indians

and Alaska Natives receiving services through IHS providers are not charged or billed for the cost of their services.

Direct services provided through IHS- and tribally- operated facilities generally are limited to members or descendants of members of federally- recognized tribes, including Alaska Natives and California Indians, who live on or near federal reservations. Moreover, due to limited funding, services through CHS are largely reserved for American Indians and Alaska Natives who reside on reservations or within specific geographic areas nearby and are often rationed based on medical need, such as emergency care for life-threatening illnesses and injuries. Urban Indian health programs serve a wider group of American Indians and Alaska Natives, including those who are not able to access IHS- or tribally-operated facilities because they do not meet eligibility criteria or because they reside outside their service areas. However, funding to urban Indian health programs is very limited and the share of IHS funding going toward urban programs over time has not reflected the overall demographic shift of American Indians and Alaska Natives away from reservations.[17] Individuals who rely solely on IHS for care without any form of health insurance coverage are classified by the U.S. Census as uninsured. Both insured and uninsured American Indians and Alaska Natives may seek care at IHS and tribal facilities.

As a discretionary program, IHS funding is limited and must be appropriated by Congress each fiscal year. The appropriated funds are distributed to IHS facilities across the country and serve as their annual budget. If service demands exceed available funds, services are prioritized or rationed. In FY2013, a total of $4.3 billion was appropriated for IHS services, with $3.1 billion going to health care services and the remaining funds supporting preventive health and other services (Figure 5).[18] Over half (57%) or $1.8 million of the $3.1 million going to direct health services was appropriated to tribally-operated facilities, with the remaining $1.3 million going toward those directly operated by IHS. Only 1% of total program funding was directed toward urban Indian health.



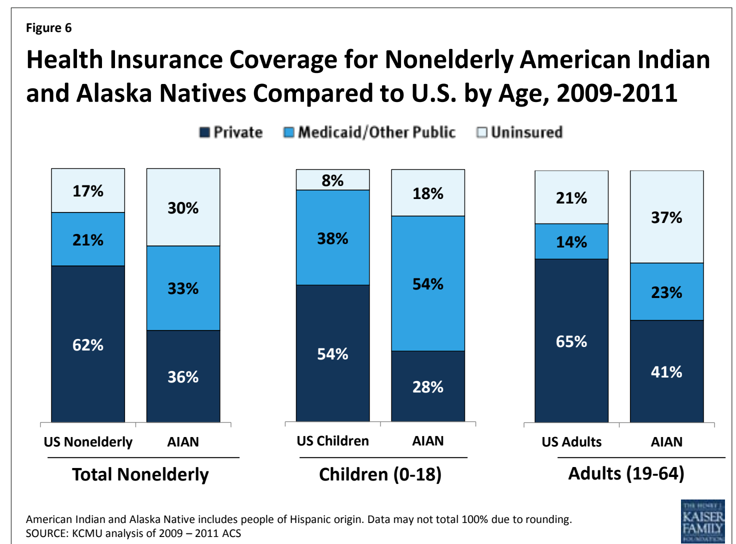
In addition to direct appropriations, revenues from third- party payers are a significant part of IHS funding. Given that appropriations have been insufficient to enable many Indian hospitals and clinics to meet the needs of the populations they serve, they often rely on revenues from third party payers, including Medicare, Medicaid, the Veterans Administration, and private insurance, to help reduce shortfalls between capacity and need. In fact, IHS regulations require that the facilities the IHS operates, as well as those run by tribes or by urban Indian health programs, identify and recover third party resources.[19] A total of $973 million will be collected from third party payers in FY2013. By far the largest third-party payer is Medicaid, which accounts for $683 million or 70% of total third party revenues, and 13% of total IHS program funding for FY2013.[20]

IHS has historically been underfunded to meet the health care needs of American Indians and Alaska Natives. Although the IHS discretionary budget has increased over time, funds are not equally distributed across IHS facilities and remain insufficient to meet health care needs.[21] As such, access to services through IHS varies significantly across locations, and American Indians and Alaska Natives who rely solely on IHS for care often lack access to needed care, including preventive care and early treatment of chronic diseases.[22] Moreover, access to services through CHS is significantly limited with available funding often only able to support "medical priority 1 cases, or those that threaten life or limb."[23]

The Role of Medicaid

While the roughly 700,000 American Indian and Alaska Native Medicaid beneficiaries make up a small portion of total Medicaid beneficiaries, Medicaid is an important source of health insurance coverage for the population.[24] Medicaid helps to fill the large gaps in private coverage for American Indians and Alaska Natives and provides a key source of financing for IHS providers. Moreover, the Medicaid program includes a number special financing rules and consumer protections that apply to American Indians and Alaska Natives.

Medicaid fills gaps in private coverage for nonelderly American Indians and Alaska Natives, but nearly one in three (30%) remains uninsured (Figure 6). American Indians and Alaska Natives have limited access to employer-sponsored coverage because they have a lower employment rate and those working tend to be employed in low-wage jobs and industries that typically do not offer health coverage. Less than four in ten (36%) nonelderly American Indians and Alaska Natives have private health insurance coverage, compared to over six in ten nonelderly in the U.S. (62%). Medicaid helps fill this gap, covering one in three (33%) nonelderly American Indians and Alaska Natives. However, Medicaid does not fully offset the difference, leaving nonelderly American Indians and Alaska Natives significantly more likely to be uninsured than the national average (30% vs. 17%). Medicaid plays a more expansive role for American Indian and Alaska Native children than adults, covering more than half of American Indian and Alaska Native children (54%) versus 23% of nonelderly adults. As such, the uninsured rate for nonelderly American Indian and Alaska Native adults is nearly twice that for children (37% vs. 18%).[25]



Just as with other eligible individuals, American Indians and Alaska Natives who meet state eligibility standards are entitled to Medicaid coverage in the state in which they reside. Medicaid eligibility is determined by states within federal guidelines. As a result, eligibility criteria vary considerably from state to state. Overall, states have significantly expanded eligibility for children, while eligibility levels for parents remain very low in most states. Moreover, until the enactment of the ACA, other non-disabled adults, often referred to as "childless adults," were excluded from the program, regardless of how low their income was. An American Indian or Alaska Native who meets the Medicaid eligibility criteria of the

state in which he or she resides is entitled to Medicaid coverage. This is true whether or not the individual is a member of a federally-recognized tribe, whether or not the individual lives on or off a reservation, and whether or not the individual receives services (or is eligible to receive services) at an IHS- or tribally-operated hospital or clinic. American Indians and Alaska Natives with Medicaid can access care through all providers who accept Medicaid for all benefits covered by the state Medicaid program. As such, they have access to a broader array of services and providers than those who rely solely on IHS services for care.

Many American Indians and Alaska Natives are eligible for Medicaid but remain uninsured due to an array of enrollment barriers. Common barriers to Medicaid enrollment include lack of knowledge about the program, difficulty completing the enrollment process, language and literacy barriers, and geographic and transportation barriers. In addition, there are some barriers specific to the American Indian and Alaska Native population, including mistrust of federal and state governments due to historical conflicts, certain cultural beliefs, a preference for relying on IHS services for care, and the belief that the federal government has the responsibility to provide and fund all needed care through the IHS.[26]

Medicaid has special eligibility rules and provides specific consumer protections to American Indians and Alaska Natives. These include exemptions of certain types of property in determining whether American Indians and Alaska Natives meet income and resource standards for Medicaid eligibility as well as enhanced consumer protections with respect to cost sharing and managed care (See Text Box 1, next page). Consistent with American Indian and Alaska Native eligibility for IHS services, these provisions apply to American Indians and Alaska Natives who are members or descendants of members of federally-recognized tribes, including Alaska Natives, California Indians, and the broader group of American Indians and Alaska Natives eligible for urban Indian programs.[27]

As is the case for other Medicaid providers, federal Medicaid funding is available for covered services provided through IHS facilities, tribally- operated facilities, and urban Indian health programs. Similarly, if an American Indian or Alaska Native enrolled in Medicaid is referred for CHS, Medicaid pays for the covered services. In contrast to IHS funds, which are limited at a fixed amount appropriated per year, Medicaid funds are not subject to annual appropriation limits. In addition, since Medicaid claims are processed throughout the year, IHS facilities receive Medicaid payments on an ongoing basis. As such, Medicaid revenues can help IHS facilities cover needed operational costs, including provider payments and infrastructure developments, supporting their ability to meet demands for care and maintain care capacity.

The federal government covers 100% of the cost of covered Medicaid services provided to American Indian and Alaska Native beneficiaries through IHS- or tribally- operated facilities. Medicaid is a federal-state matching program—the federal government matches the costs states incur in paying for covered services provided to eligible individuals. The rate at which the federal government matches state Medicaid costs varies across states from 50% to 74%, depending on a state's per capita income.[28] However, the federal government matches 100% of a state's costs for services provided to American Indian and Alaska Native beneficiaries through an IHS- or tribally-operated facility.[29] This 100% matching rate reflects a policy judgment that states should not have to contribute state general funds to the cost of care provided by a federal facility, whether operated by the IHS or on its behalf by a tribe. In contrast, a state's regular federal matching rate

applies to the cost of services provided to American Indian and Alaska Native beneficiaries through an urban Indian health program or non-Indian health provider. In addition, there is a special financing rule that applies to tribal and urban Indian providers, which are designated under federal law as federally qualified health centers (FQHCs). Specifically, these providers may elect to either be paid the IHS rate established each year with the Office of Management and Budget or to use the same payment methodology as other FQHCs.[30]

Text Box 1: Medicaid Protections for American Indians and Alaska Natives

States are prohibited from counting certain types of property as resources in determining Medicaid eligibility for American Indians and Alaska Natives. These include lands held in trust by the federal government and items that have unique religious, spiritual, traditional or cultural significance. Similarly, states are prohibited from recovering certain income or property from the estates of deceased Indian beneficiaries to reimburse the Medicaid program for the costs of long-term care services received after age 55. *(Section 1902(ff) and Section 1917(b)(3) of the Social Security Act; State Medicaid Director Letter, ARRA Protections for Indians in Medicaid and CHIP (SMDL #10-001) (January 22, 2010).)*

American Indians and Alaska Natives are exempt from Medicaid premium and cost-sharing requirements. State Medicaid programs have the flexibility to impose copayments and other types of cost-sharing requirements on certain services for certain beneficiaries. However, American Indian and Alaska Native beneficiaries are exempt from all Medicaid cost-sharing if they have ever received a service directly from an IHS or tribally-operated facility, from an urban Indian health program, or through a referral under CHS. Similarly, states may not charge American Indian and Alaska Native beneficiaries premiums for enrolling in Medicaid. This aligns Medicaid policy with IHS policy, under which American Indians and Alaska Natives receiving services at IHS facilities are not expected to contribute toward the cost of the service. *(Sections 1916(j), 1916A(b)(3)(A)(vii), and 1916A(b)(3)(B)(x) of the Social Security Act; State Medicaid Director Letter, ARRA Protections for Indians in Medicaid and CHIP (SMDL #10-001) (January 22,2010).)*

States do not have optional authority to require American Indians and Alaska Natives to enroll in Medicaid managed care organizations (MCOs), unless the MCO is operated by the IHS, a tribe, or an urban Indian health program State Medicaid programs have broad discretion to determine whether beneficiaries will receive covered services on a fee-for-service basis or through risk-based MCOs. In general, states can require most groups of beneficiaries in urban areas to enroll in risk-based managed care so long as the beneficiary has a choice between at least two MCOs that meet federal standards; in rural areas, states may limit beneficiaries to one MCO. However, under federal rules, states do not have the option to require American Indians and Alaska Natives to enroll in Medicaid MCOs unless the MCO is operated by the IHS, a tribe, or an urban Indian health program. However, the Secretary is authorized to waive this protection under certain circumstances. *(Sections 1932(a), 1115 and 1915(b) of the Social Security Act.)*

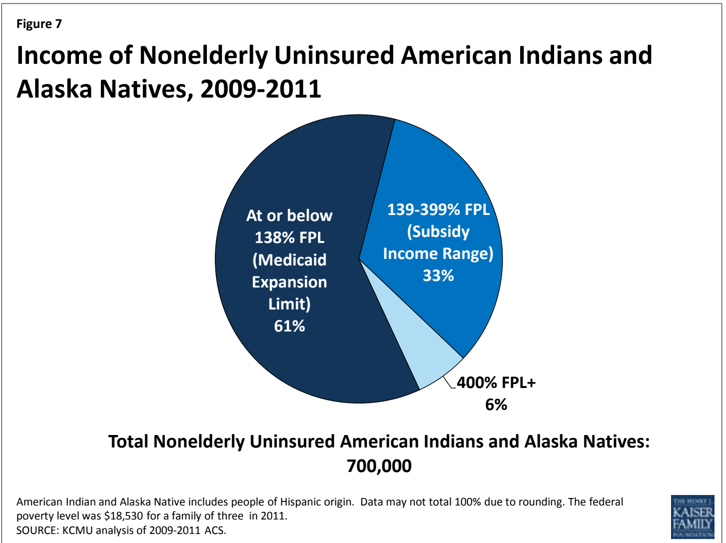
Medicaid also provides special protections for American Indian and Alaska Native beneficiaries who are enrolled in an MCO that is not operated by the IHS, a tribe, or and urban Indian health program. Medicaid MCOs that enroll American Indian and Alaska Native beneficiaries must have a sufficient number of Indian health providers participating in their networks to ensure timely access to care for American Indian and Alaska Native enrollees. The MCO must also allow the beneficiary to select an Indian health provider as his or her primary care provider. In addition, the state must allow an American Indian and Alaska Native beneficiary to go outside the managed network to seek care through an Indian health program or urban Indian organization, and there are requirements to ensure the Indian providers receive payment for services provided. *(Sections 1932(h)(1) and 1932(h)(2)(A)(i) of the Social Security Act; State Medicaid Director Letter, ARRA Protections for Indians in Medicaid and CHIP (SMDL #10-001) (January 22,2010).)*

The 100% federal matching rate for services provided to American Indians and Alaska Natives through IHS- and tribally- operated facilities is limited to services covered by the state Medicaid program. Although state Medicaid programs are required to cover certain benefits, like inpatient hospital and physician services, they have flexibility as to whether to cover other "optional" services like dental care for adults. There is significant variability across states in coverage of these services, and many states have made reductions in optional services in recent years due to funding constraints. Such reductions in Medicaid services limit access to services for American Indians and Alaska Natives. Moreover, IHS and tribal facilities do not receive Medicaid reimbursement for providing these services if they are not covered by the state Medicaid program. However, under waiver authority, the Secretary of Health and Human Services (HHS) has recently approved an approach to enable IHS and tribal facilities to receive uncompensated care payments to help offset costs for services and individuals that are no longer covered by the state Medicaid program (see Appendix A).

States are required to consult with tribes before making changes in their Medicaid programs that affect tribal members. Medicaid is a federal-state program. The formal legal document that mediates the relationship between the federal government and a participating state is the State Medicaid Plan, which sets forth a state's benefits, eligibility, and provider payment policies.[31] Although the federal government recognizes tribes as sovereign nations, they are not a party to the State Medicaid Plan and do not have administrative authority over the Medicaid program at either the federal or state level. The federal government does, however, require that its agencies consult with tribes. In particular, the HHS, which includes both the IHS and the Centers for Medicare & Medicaid Services (CMS), has a formal policy that "before any action is taken that will significantly affect Indian Tribes…to the extent practicable and permitted by law, consultation with Indian Tribes will occur."[32] In implementing this directive, CMS requires that state Medicaid programs consult with federally-recognized tribes, Indian health programs, and/or urban Indian health organizations prior to submitting an application for a Section 1115 demonstration waiver[33] or developing an integrated care model.[34] The federal Medicaid statute also requires that if a State Medicaid program is amending its State Medicaid plan or seeking a waiver or a demonstration project that "is likely to have a direct effect" on Indians, or on facilities operated directly by the IHS facility or by tribes, or on an urban Indian health organization, the State must "solicit advice" from the affected Indian health programs and urban Indian health organizations. The advice must be sought prior to submission of the plan amendment or waiver or demonstration proposal to CMS for review.[35]

THE ACA COVERAGE EXPANSIONS

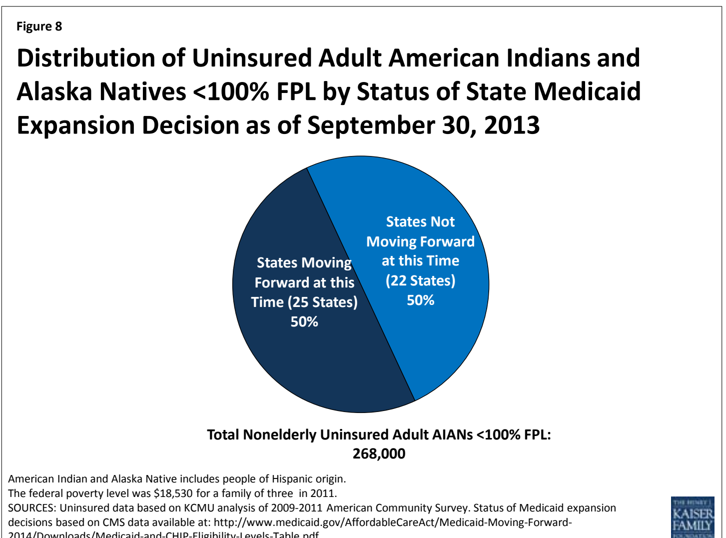
Looking ahead, the ACA offers important opportunities to increase coverage and access to care for American Indians and Alaska Natives. For all Americans, the ACA seeks to reduce the number of uninsured through an expansion of Medicaid and the creation of new Health Insurance Marketplaces with tax credits to help offset the purchase of coverage. Overall, nine in ten (94%) uninsured American Indians and Alaska Natives have incomes in the range to qualify for these coverage expansions (Figure 7 and see Appendix B, Table 1 for data across states). Moreover, the ACA permanently reauthorizes the Indian Health Care Improvement Act, extending and authorizing new programs and services within the IHS.



THE MEDICAID EXPANSION

Under the ACA, Medicaid will expand to adults with incomes at or below 138% of the FPL ($15,856 for an individual in 2013) in states that implement the Medicaid expansion, which was made a state option by the Supreme Court ruling on the ACA. The federal government will cover 100% of the cost for all individuals made newly eligible by the expansion for the first three years, phasing down to 90% over time.[36] Regardless of a state's decision to expand Medicaid, the ACA also streamlines the Medicaid enrollment process by providing a single streamlined application with multiple avenues for individuals to apply, reducing paperwork requirements, utilizing technology to support eligibility determinations, and coordinating with other coverage programs, including new Marketplace coverage.[37]

American Indians and Alaska Natives have a significant stake in state Medicaid expansion decisions. In states that expand Medicaid, many currently uninsured American Indians and Alaska Natives will gain a new coverage option as many parents and adults without dependent children become newly eligible for the program. In contrast, in states that do not expand Medicaid, poor uninsured adults will not gain a coverage option, since those below 100% FPL will not be eligible for the tax credit subsidies for Marketplace coverage. Half of uninsured adult American Indians and Alaska Natives with incomes below 100% FPL live in the 26 states not moving forward with the Medicaid expansion at this time (Figure 8 and see Appendix B, Table 2 for data across states).[38] These adults will not be eligible for Medicaid or the Marketplace subsidies and will likely remain uninsured.



The Medicaid expansion provides the opportunity for increased Medicaid revenues for IHS- and tribally- operated facilities increasing state costs. As noted, Medicaid serves as a key source of revenue for IHS providers, and IHS- and tribally-operated facilities are paid from 100% federal Medicaid matching funds for covered services provided to American Indians and Alaska Natives. This 100% federal matching rate is not tied to the "newly eligible" expansion population and will remain in place when the 100% federal matching rate provided to states for all new eligibles begins to phase down. In states that expand Medicaid, the share of patients served by IHS providers with Medicaid coverage will likely grow, resulting in increased revenues for these facilities that may enhance their capacity to provide services. In contrast, in states that do not expand, IHS providers will not benefit from these increased revenues.

Health Insurance Marketplaces

The ACA creates new Health Insurance Marketplaces in all states that opened for enrollment on October 1, 2013, with coverage beginning on January 1, 2014. These Marketplaces offer a choice of qualified health plans (QHPs) for consumers to compare and select among at different price and benefit levels. In addition, tax credit subsidies are available to help offset costs for moderate-income individuals who do not have access to affordable coverage from their employer.

One in three (33%) uninsured American Indians and Alaska Natives has income in the range to qualify for the tax credit subsidies to purchase a QHP through the new Marketplaces. As such, the Marketplaces and subsidies will provide new affordable coverage options for many American Indians and Alaska Natives. In addition, a Marketplace may allow tribes, tribal organizations, and urban Indian organizations to pay premiums on behalf of American Indians and Alaska Natives. There also are two special protections provided for members of federally-recognized tribes who enroll in a QHP through the new Marketplaces that reflect the federal government's special trust responsibility to American Indians and Alaska Natives. Specifically, members of federally-recognized tribes have the option to change health plans on a monthly, rather than annual, basis and are exempt from cost sharing requirements, such as copayments, coinsurance, and deductibles, if their income is below 300% FPL or they receive direct services or a referral from an IHS provider.[39] However, these protections do not apply to the broader group of American Indians and Alaska Natives who are eligible for IHS services and afforded special Medicaid protections.

Individual Requirement to Have Health Insurance

Along with the coverage expansions, the ACA also establishes a new requirement for most individuals to have health insurance. Specifically, most individuals are required either to have "minimum essential coverage" or to pay a tax penalty. In general, individuals who have coverage through their employer or purchased on the individual market; are covered by public insurance programs like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); or who have certain types of coverage through the veteran's health program will be considered to have met this requirement.[40] In contrast, individuals relying solely on care provided by HIS, without other health coverage, will not be considered to have minimum essential coverage. Under the ACA statute, American Indians and Alaska Natives who are members of federally-recognized tribes are exempt from the requirement to have minimum essential coverage. Recent regulations also added a hardship exemption from the requirement for all individuals eligible for IHS services, which is consistent with the broader group of American Indians and Alaska Natives afforded special Medicaid protections and provisions.[41]

LOOKING AHEAD

Looking ahead there is an array of challenges and opportunities to improve access to care for American Indians and Alaska Natives and help reduce the longstanding health disparities they face:

Access to IHS services will likely become even more limited as a result of automatic federal budget cutbacks under the sequester. IHS is a discretionary program with funding based on annual appropriations by Congress. As a discretionary program, the IHS is subject to the automatic, across-the-board federal budget cuts that were triggered as of March 1, 2013 under the sequester. Overall, the Office of Management and Budget estimates that the IHS will be subject to 5% budget cuts under sequestration. The Office of Management and Budget estimates that the sequester will result in a $220 million budget cut for IHS during the 2013 federal fiscal year which, according to IHS, will lead to 3,000 fewer inpatient and 804,000 fewer outpatient visits each year.[42] These budget cuts directly impact the availability of resources for tribal and urban Indian operated facilities as well. These restrictions will further limit the ability of American Indians and Alaska Natives to access services through the IHS, tribal, and urban Indian providers and, as such, increase the importance of the ACA coverage expansions for the population.

The Medicaid expansion provides a significant opportunity to increase coverage and care for American Indians and Alaska Natives. In states that expand Medicaid, many parents and childless adults will become newly eligible for the program, providing a new coverage option for many currently uninsured American Indians and Alaska Natives. Widespread evidence suggests that obtaining health insurance coverage leads to improved access to care and health care utilization. Individuals who are insured are more likely to get recommended levels of preventive care, higher quality care, and to have better health outcomes. Moreover, for American Indians and Alaska Natives who currently solely rely on IHS services for care, gaining Medicaid coverage may increase access to providers, since they will no longer be limited to care at IHS- or tribally-operated facilities. At the same time, increases in Medicaid coverage may also help expand capacity within IHS- and tribally-operated facilities since their Medicaid revenues will increase if more patients enroll in Medicaid. Overall, the importance of Medicaid as a source of financing for health care for American Indians and Alaska Natives is likely to grow over the next decade as federal budget pressures constrain IHS appropriations at the same time as the Medicaid expansions in the ACA are implemented.

American Indians and Alaska Natives will continue to face significant gaps in coverage and face growing inequities in coverage and care in states that do not expand Medicaid. While the Medicaid expansion offers the opportunity to significantly increase coverage among American Indians and Alaska Natives, as of September 30, 2013, 26 states were not moving forward with the Medicaid expansion at this time. In states that do not expand Medicaid, poor uninsured adults will not gain a coverage option and likely remain uninsured. Similarly, IHS providers in states moving forward with the expansion will likely experience greater revenue gains than those in states not moving forward. Moreover, state Medicaid expansion decisions will create unique equity issues for American Indians and Alaska Natives since there are tribal nations with boundaries that extend across states that have made differing expansion decisions. For example, the Navajo nation extends into Utah, Arizona, and New Mexico. Arizona and New Mexico are moving forward with the expansion, while Utah is not moving forward at this time. As a result, a Navajo tribal member living in Arizona may have access to Medicaid coverage, while a Navajo member (meeting the same income and eligibility requirements) living in the Utah might not. As such, state Medicaid expansion decisions will drive variations in coverage, access, and health status both within and between tribes.

The new Marketplaces also will provide a new coverage option for many American Indians and Alaska Natives, but only members of federally- recognized tribes will receive certain consumer protections. As noted, the new Marketplaces will provide additional protections to members of federally-recognized tribes, including the ability to change health plans on a monthly basis and some exemptions from cost-sharing. However, these Marketplace protections do not apply to the broader group of American Indians and Alaska Natives who are eligible for IHS services, afforded special Medicaid protections, and exempt from the individual requirement to have health insurance. This inconsistency will result in many American Indians and Alaska Natives not receiving these protections. It also will likely contribute to confusion and uncertainty, particularly since the Marketplace and Medicaid application processes will be integrated, which may hamper outreach and enrollment efforts for American Indians and Alaska Natives.

Targeted outreach and enrollment efforts and access to culturally competent providers will be key for translating the coverage expansions into improved care for American Indians and Alaska Natives. Past Medicaid and CHIP experience suggests that targeted outreach and direct one-on-one enrollment assistance provided by trusted individuals within the community will be important to help eligible people enroll in the ACA coverage expansions. Involving tribes, tribal organizations, and urban Indian organizations in outreach and enrollment efforts will be vital for enrolling uninsured American Indians and Alaska Natives in coverage and ensuring they have access to linguistically and culturally appropriate enrollment assistance. The ACA establishes a variety of consumer assistance programs to support enrollment and allows for tribes and tribal organizations to provide assistance, but outreach and enrollment assistance efforts will likely vary widely across states. Beyond supporting enrollment in coverage, it will also be important to connect individuals to providers who can provide linguistically and culturally appropriate care. States are required to work with tribes to ensure that Indian providers are included in provider networks under Medicaid. Marketplace QHPs must meet standards related to including "Essential Community Providers" in their provider networks, which include Indian providers. However, concerns remain about network adequacy and travel times to participating providers, particularly for individuals living in remote areas.

In conclusion, while the federal government has a distinct responsibility to provide health care to American Indians and Alaska Natives, many face challenges accessing needed care and the population continues to experience poor health outcomes, including high rates of chronic disease. The IHS is the primary vehicle through which the federal government provides health care to American Indians and Alaska Natives. However, due to its limited funding, the IHS is not able to fully meet the need for care. Moreover, as individuals increasingly move away from reservations, many cannot access IHS facilities. American Indians and Alaska Natives also have limited access to private health coverage given their low incomes and employment patterns. While Medicaid helps fill this gap, many uninsured adults remain ineligible for the program and some eligible individuals remain uninsured due to enrollment barriers. Looking ahead, American Indians and Alaska Natives continue to face many challenges to accessing care, including further decreases in IHS funding. However, the ACA coverage expansions provide important opportunities to increase their coverage and access to care, which could help reduce the longstanding health disparities they face.

This brief was prepared by Samantha Artiga and Rachel Arguello with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured (KCMU) and Philethea Duckett, formerly with KCMU. The authors thank Andy Schneider, former consultant to KCMU; Kitty Marx, with the Centers for Medicare and Medicaid Services, Geoffrey Roth with the Indian Health Service, Ralph Foquera with the Seattle Indian Health Board, and Doneg McDonough for their helpful review and comments.

APPENDIX A: FEDERAL MEDICAID PAYMENTS FOR UNCOMPENSATED CARE AT IHS FACILITIES IN ARIZONA AND CALIFORNIA

Recently, CMS has approved Section 1115 waivers that include provisions designed to improve the financial viability of IHS- and tribally-operated facilities. Section 1115 of the Social Security Act authorizes the Secretary of HHS, at the request of a state, to waive certain requirements of federal Medicaid law to enable the state to experiment with different approaches to delivering or paying for services. Section 1115 also authorizes the Secretary to provide federal Medicaid matching funds for state costs that would not otherwise be matched under current rules, subject to an overall budget neutrality limit.

As of July 2011, almost half of the roughly 278,000 American Indians and Alaska Natives residing in Arizona were enrolled in the state's Medicaid program.[43] In 2010, Arizona made cutbacks in Medicaid eligibility and benefits to reduce state spending, closing enrollment for childless adults with incomes below 100% of the federal poverty level (FPL) and eliminating coverage of certain optional services such as adult dental care. As a result of these reductions, IHS- and tribally-operated facilities would no longer receive reimbursement for poor childless adults unable to enroll in the program due to the enrollment cap and optional services no longer covered by Medicaid. However, because the federal government pays 100% of the cost of covered services provided to American Indians and Alaska Natives through IHS- or tribally-operated facilities, the state would not realize any savings from the reductions in these services provided by these facilities to American Indians and Alaska Natives

In April 2012, CMS approved an amendment to Arizona's existing section 1115 waiver that enables IHS- and tribally-operated facilities to continue to receive federal Medicaid funds for services provided to these childless adults and for these optional services, even though they are no longer covered by the state Medicaid program. Specifically, under the waiver, the federal government will pay IHS- and tribally-operated facilities for uncompensated care costs that stem from services provided to adults with incomes below 100% FPL who are no longer able to enroll in Medicaid and the provision of optional services that are no longer covered by the program to Medicaid-eligible individuals. According to the waiver approval, this "will enable the State to evaluate how this approach impacts the financial viability of IHS and 638 [tribal] facilities and ensures the continued availability of a robust health care delivery network for current and future beneficiaries."[44]

In April 2013, a similar waiver amendment was approved in California that allows the state Medicaid agency to make supplemental payments to IHS facilities, including tribal facilities, to take into account the burden of providing care to certain uninsured adults and for optional services that are no longer covered by the state Medicaid program. The waiver approval states this will enable the state "to test the effects of the payments on the financial viability of IHS and 638 [tribal] providers and determine if Medicaid funding under the demonstration results in an increase in the volume of primary care services delivered to Medicaid beneficiaries, an increase in the capacity to deliver such services by participating providers."[45]

Appendix B, Table 1
Nonelderly Uninsured American Indians and Alaska Natives (AIANs), 2009-2011

	Total Nonelderly AIANs	Percent Uninsured	Distribution of Uninsured by Income			
			Total Uninsured AIANs	<139% FPL	139-400% FPL	400% FPL +
United States	**2,279,100**	**30%**	**694,300**	**61%**	**33%**	**6%**
Alabama	24,100	20%	4,800	56%	--	--
Alaska	91,400	40%	36,300	59%	33%	8%
Arizona	258,900	31%	80,200	65%	30%	5%
Arkansas	17,400	24%	4,100	49%	--	--
California	253,400	25%	63,500	59%	33%	8%
Colorado	45,000	29%	13,200	64%	31%	--
Connecticut	6,700	13%	--	--	--	--
Delaware	2,500	40%	--	--	--	--
District of Columbia	--	--	--	--	--	--
Florida	57,100	38%	21,800	57%	34%	9%
Georgia	20,900	32%	6,700	68%	31%	--
Hawaii	2,600	9%	--	--	--	--
Idaho	18,400	34%	6,200	69%	27%	--
Illinois	22,300	20%	4,600	67%	--	--
Indiana	12,300	31%	3,800	72%	--	--
Iowa	9,400	24%	2,200	61%	--	--
Kansas	22,200	26%	5,800	72%	27%	--
Kentucky	7,800	20%	1,600	82%	--	--
Louisiana	24,200	30%	7,300	59%	36%	--
Maine	6,900	15%	--	--	--	--
Maryland	15,600	24%	3,700	58%	--	--
Massachusetts	11,400	16%	--	--	--	--
Michigan	48,900	19%	9,100	65%	28%	--
Minnesota	53,100	23%	12,000	57%	32%	--
Mississippi	12,900	36%	4,700	57%	--	--
Missouri	19,300	21%	4,100	60%	--	--
Montana	58,600	47%	27,700	60%	31%	9%
Nebraska	16,100	37%	6,000	69%	28%	--
Nevada	25,200	33%	8,400	62%	31%	--
New Hampshire	2,600	21%	--	--	--	--
New Jersey	19,300	29%	5,600	57%	--	--
New Mexico	175,500	42%	73,600	60%	35%	5%
New York	59,200	23%	13,600	61%	30%	--
North Carolina	99,300	30%	29,700	64%	32%	--
North Dakota	33,200	36%	11,900	72%	22%	--
Ohio	19,500	19%	3,800	56%	--	--
Oklahoma	232,800	32%	74,500	57%	37%	6%
Oregon	46,200	30%	13,900	64%	30%	--
Pennsylvania	14,700	14%	2,100	62%	--	--
Rhode Island	3,900	16%	--	--	--	--
South Carolina	12,700	23%	2,900	69%	--	--
South Dakota	64,800	38%	24,700	73%	23%	--
Tennessee	13,600	30%	4,100	69%	--	--
Texas	116,400	30%	35,300	58%	36%	--
Utah	29,200	35%	10,300	69%	25%	--
Vermont	--	--	--	--	--	--
Virginia	22,500	26%	5,800	53%	--	--
Washington	85,900	26%	22,500	58%	35%	--
West Virginia	2,800	19%	--	--	--	--
Wisconsin	44,600	24%	10,700	57%	39%	--
Wyoming	12,600	32%	4,100	61%	32%	--

"--" = Sample size not sufficient for reliable estimate; totals may not sum to 100% due to rounding and sample size restrictions
American Indian and Alaska Native includes people of Hispanic origin.
Data include noninstituational, civilian nonelderly individuals ages 0-64.
SOURCE: KCMU analysis of the 2009-2011 American Community Survey.

Appendix B, Table 2

Nonelderly Uninsured American Indian and Alaska Native Adults <100% FPL by State, 2009-2011

Grouped by Status of State Medicaid Expansion Decision as of September 30, 2013

	Nonelderly Uninsured Adults <100% FPL	Distribution of Nonelderly Uninsured Adults <100% FPL
UNITED STATES	**268,400**	**100%**
MOVING FORWARD AT THIS TIME		
Arizona	29,100	11%
Arkansas	--	--
California	25,400	9%
Colorado	4,800	2%
Connecticut	--	--
Delaware	--	--
District of Columbia	--	--
Hawaii	--	--
Illinois	2,300	1%
Iowa	--	--
Kentucky	--	--
Maryland	--	--
Massachusetts	--	--
Michigan	3,700	1%
Minnesota	3,900	1%
Nevada	3,400	1%
New Jersey	--	--
New Mexico	30,000	11%
New York	4,500	2%
North Dakota	4,200	2%
Oregon	5,900	2%
Rhode Island	--	--
Vermont	--	--
Washington	9,200	3%
West Virginia	--	--
Total	**135,300**	**50%**
NOT MOVING FORWARD AT THIS TIME		
Alabama	1,800	1%
Alaska	13,300	5%
Florida	7,700	3%
Georgia	3,000	1%
Idaho	2,700	1%
Indiana	--	--
Kansas	2,600	1%
Louisiana	2,500	1%
Maine	--	--
Mississippi	--	--
Missouri	--	--
Montana	9,500	4%
Nebraska	2,600	1%
New Hampshire	--	--
North Carolina	13,800	5%
Ohio	--	--
Oklahoma	26,200	10%
Pennsylvania	--	--
South Carolina	1,700	1%
South Dakota	11,200	4%
Tennessee	2,400	1%
Texas	12,700	5%
Utah	4,800	2%
Virginia	--	--
Wisconsin	4,000	1%
Wyoming	2,000	1%
Total	**133,100**	**50%**

-- = Sample size is not sufficient for a reliable estimate.

American Indian and Alaska Native includes people of Hispanic origin.

Data include noninstituational, civilian nonelderly individuals ages 0-64.

SOURCES: Status of Medicaid expansion decision based on Centers for Medicare and Medicaid Services data available at: http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf. Uninsured data based on KCMU analysis of 2009-2011 American Community Survey.

ENDNOTES

[1] The Bureau of the Census collects data on the major types of American Indian and Alaska Native areas, including: reservations, land trusts, and tribal statistical areas. Reservations are areas that have been set aside for tribes through treaties, statues, or executive order. Within these territories, tribes have primary governmental authority. Tribes also have primary authority over land trusts, land held in trust by the federal government for a tribe. Land trusts may exist within reservations or off-reservation. Statistical areas are used by the Census Bureau to present data on recognized tribes that do not have a reservation (U.S. Census Bureau, "American Indian and Alaska Native Areas," Chapter 5 in *Geographic Areas Reference Manual* (Washington, DC: November 1994), http://www.census.gov/geo/reference/pdfs/GARM/Ch5GARM.pdf).

[2] U.S. Census, *Map: American Indians and Alaska Natives in the United States* (2010), http://www2.census.gov/geo/maps/special/AIANWall2010/AIAN_US_2010.pdf.

[3] Office of Minority Health, *American Indian/Alaska Native Profile*, (September 2012), http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=52.

[4] Ralph Forquera, Seattle Indian Health Board, *Urban Indian Health* (Kaiser Family Foundation, November 2001), http://www.kff.org/disparities-policy/report/urban-indian-health/.

[5] Bureau of Indian Affairs, U.S. Department of the Interior, "Indian Entities Recognized and Eligible to Receive Services From the Bureau of Indian Affairs," *Federal Register* 77, no. 155 (Friday, August 10, 2012), http://www.bia.gov/cs/groups/public/documents/text/idc-020700.pdf. The Shinnecock tribe of New York was added as a federally-recognized tribe since the last Federal Register publication.

[6] Office of Minority Health (September 2012).

[7] Kaiser Commission on Medicaid and the Uninsured analysis of 2009-2011 ACS data.

[8] Ibid.

[9] Charles Harrington, *American Indian Entrepreneurship: A Case For Sustainability,* Journal of Leadership, Management, and Organizational Studies, Volume 2, Issue 1 (2012) http://www.scientificjournals.org/journals2012/articles/1533.pdf and National Indian Gaming Association, *2009 Economic Impact Report* (2009), http://www.indiangaming.org/info/NIGA_2009_Economic_Impact_Report.pdf.

[10] Kaiser Commission on Medicaid and the Uninsured analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2011.

[11] For more information about overweight and obesity among AIAN children and adolescents, please see: Leadership for Healthy Communities, *Overweight and Obesity Among American Indian and Alaska Native Youths* (Robert Wood Johnson Foundation, May 2010), http://www.rwjf.org/en/research-publications/find-rwjf-research/2010/05/overweight-and-obesity-among-american-indian-and-alaska-native-y.html.

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[13] Indian Health Service, "About IHS, " http://www.ihs.gov/aboutihs/.

[14] Department of Health and Human Services, Indian Health Service, Fiscal Year 2014 Justification of Estimates for Appropriations Committees, March 12, 2013, available at: http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf

[15] Indian Health Service, Year 2013 profile, January 2013, available at: http://www.ihs.gov/newsroom/factsheets/ihsyear2013profile/.

[16] Indian Health Service, Office of Urban Indian Health Programs, Program Information, available at: http://www.ihs.gov/newsroom/factsheets/urbanindianhealthprogram/.

[17] Ralph Forquera, (Kaiser Family Foundation, November 2001).

[18] Department of Health and Human Services, *Indian Health Service: Fiscal Year 2014 Justification of Estimates for Appropriations Committees* (March 12, 2013).

[19] 42 CFR 136.61.

[20] Department of Health and Human Services, *Indian Health Service: Fiscal Year 2014* (March 12, 2013).

[21] Edward Fox and Verné Borner, *Health Care Coverage and Income of American Indians and Alaska Natives: A Comparative Analysis of 33 States with Indian Health Service Funded Programs,* for Tribal Affairs: Centers for Medicare and Medicaid Services, (2012), http://www.crihb.org/files/Health_care_coverage_and_income_of_aians.pdf; Ed Fox, *Health Care Reform: Tracking Tribal, Federal, and State Implementation,* Tribal Affairs Group, Centers for Medicare and Medicaid Services, (May, 20, 2011) http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSHealthCareReform5202011.pdf; and Government Accountability Office, *Indian Health Service, Health*

Care Services Are Not Always Available to Native Americans, GAO-05-789 (Washington DC: Government Accountability Office, August 2005), http://www.gao.gov/products/GAO-05-789.

[22] Ibid.

[23] Tribal Leader Letter, *Dr. Roubideaux provides an update on Contract Health Services (CHS) Program increases for referrals for prevention services as a follow-up to the Tribal Leader Letter dated August 2, 2012,* Department of Health and Human Services, Indian Health Service, (January 15, 2013), http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2013_Letters/01-15-2013_DTLL_FollowupCHSPreventionServices.pdf.

[24] Kaiser Commission on Medicaid and the Uninsured Analysis of 2009-2011 American Community Survey data.

[25] Ibid.

[26] Kathryn Langwell, et al., *American Indian and Alaska Native Eligibility and Enrollment in Medicaid, SCHIP, and Medicare, Individual Case Studies for Ten States,* Centers for Medicare and Medicaid Services (December 2003), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/langwell_2003_5.pdf and New Mexico Human Services Department, *Barriers to Obtaining Health Insurance Among Native Americans in New Mexico,* (January 2006), http://www.insurenewmexico.state.nm.us/Inm/Native%20American%20Health%20FINAL%20REPORT%20(2-3-06).pdf.

[27] See 42 CFR 447.50 (b).

[28] Robin Rudowitz, *Financing Medicaid Coverage Under Health Reform: What is in the Law and the New FMAP Rules* (Kaiser Commission on Medicaid and the Uninsured, May 2013), http://www.kff.org/health-reform/issue-brief/financing-medicaid-coverage-under-health-reform-the-role-of-the-federal-government-and-states/.

[29] Section 1905(b) of the Social Security Act (third sentence).

[30] While state Medicaid programs have broad discretion to set payment rates to providers, state Medicaid programs must cover services furnished by FQHCs and they are required to pay for those services using a Prospective Payment System (PPS) methodology (Sections 1902(a)(15) and 1902(bb) of the Social Security Act). Under federal law, tribally-operated clinics are considered FQHCs, as are urban Indian health programs that deliver primary care services (Section 1905(l)(2)(A) of the Social Security Act). Tribal clinics and urban Indian health programs that are designated as FQHCs may elect to be paid at the "all-inclusive rate" (AIR) for outpatient visits throughout the IHS system rather than the PPS rate. The Medicare and Medicaid AIR is negotiated between IHS and CMS and is published annually in the Federal Register. (78 Fed. Reg. 22890-22891 (April 17, 2013)).

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[39] 45 CFR 155.350 and 45 CFR 155.420(d)(8).

[40] Section 5000A(f)(1)(A)(ii) of the Internal Revenue Code, as added by section 1501 of the Patient Protection and Affordable Care Act, P.L. 111-148.

[41] 45 CFR 155.605(g)(6),78 Fed. Reg.39524-39525 (July 1, 2013) http://www.gpo.gov/fdsys/pkg/FR-2013-07-01/pdf/2013-15530.pdf#page=2.

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