

A National Roundtable on the Indian Health System and Medicaid Reform



Northwest Portland Area Indian Health Board



National Roundtable on
the Indian Health System and
Medicaid Reform

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The views expressed in this report are those of the Roundtable participants and do not necessarily reflect the views of the Urban Institute, its board, or its funders.

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National Roundtable on the Indian Health System and Medicaid Reform Summary Report

Major Medicaid cuts now being discussed by policymakers could have serious ramifications for the health and well-being of American Indians and Alaska Natives. Changes in eligibility rules, benefits packages, cost-sharing requirements, provider payment rates, and financing might hinder the ability of Indian health programs to provide essential services to some of the poorest U.S. communities. To respond, the Northwest Portland Area Indian Health Board partnered on August 31, 2005 with the Indian Health Service (IHS), the Kaiser Family Foundation, and the Urban Institute to hold a National Roundtable on the Indian Health System and Medicaid Reform. The Roundtable met at the Urban Institute, in Washington, DC. Urban Institute president Robert Reischauer welcomed program officials, advocates, and health care analysts, remarking that “this Roundtable is occurring at a terribly important juncture in policy history.”



“Change is inevitable,” Reischauer said, and “the direction of that change is not in question.”

The day after the Roundtable, September 1, the Medicaid Commission submitted to Congress recommendations for achieving \$11 billion in savings over the next 5 years through changes in prescription drug reimbursement, in rules on transferring assets for Medicaid eligibility, and in cost-sharing. The Commission now has until the end of next year to make longer-term recommendations on the future of the Medicaid program, with proposals that address such issues as eligibility, benefits design, and delivery.

Roundtable participants expressed concerns that any changes in national Medicaid policy may damage the severely underfunded Indian health system—a broad organizational structure that includes services provided directly by the federal Indian Health Service (“I”), tribally operated programs (“T”), and urban Indian clinics (“U”). This health delivery structure, often referred to as ITU (or I/T/U), is considered “prepaid” with the land ceded by tribes in more than 800 ratified treaties and presidential executive orders. So tribal members using ITU health programs are not charged for services.

This provision of health care to American Indians and Alaska Natives falls under the federal trust responsibility, rooted in the U.S. Constitution, that recognizes the debt owed to Indian tribal governments. With the recognized responsibility to indigenous people has come respect for tribal sovereignty and willingness to work with the tribes on a culturally sound health delivery system. A major shortcoming is chronic underfunding, according to Indian participants at the Roundtable.

Medicaid reimburses IHS for services to Medicaid enrollees. But unlike Medicaid or Medicare, the IHS is not an entitlement program in the federal budget process. Indian health funding, subject to discretionary annual appropriations from Congress, currently meets only about 60 percent of need. Roughly 20 percent of the IHS clinical services budget comes from Medicaid, while less than 0.5 percent of Medicaid expenditures go to Indian health.

The patient must be a descendent of a member of a tribe to qualify for Indian health care services. Approximately 1.8 million American Indians and Alaska Natives meet these standards, and 1.6 million are active users of the Indian health system. At present, there are 562 federally recognized tribes spread across 35 states. The Indian health system is comprised of 49 hospitals, 247 health centers, 5 school health centers, 309 health stations, and 34 urban health clinics, as well as satellite clinics and Alaska community health aide clinics. Access to primary, specialty, and long-term care and emergency services is limited by geographic constraints and by the historic and chronic underfunding of the Indian health system.

Any further cutbacks in Medicaid funding would result in an even greater rationing of services, participants and speakers said. “Because of the small size and relative obscurity of Indian health programs, these negative consequences may go ignored outside Indian health for years,” said Kris Locke, a consultant from Washington State. The general public should be better educated on the issues, many agreed. Although government has supported some health care services to Indian tribes since 1849, the health status of Indians is far below that of the general U.S. population. Factors that contribute to the health disparity in Indian country are the continued underfunding of

the IHS, high rates of poverty, low education levels, poor housing, and inadequate transportation. Many of the diseases that plague Indian populations, including obesity and diabetes, are preventable and treatable. If ignored now, these health problems will become more costly to the federal government as Medicare or disability payments.

More than a dozen areas require special consideration in any Medicaid reform, participants said, including the special “trust” relationship between the federal government and American Indians that provides the legal justification and the moral imperative for the federal provision of health care. A distinct disadvantage of Medicaid, from the Indian perspective, is that it is a state program. As states do not share in the federal government’s trust responsibility, the challenge has been to ensure the funding from the federal government reflects the federal responsibility.

One of the key Roundtable recommendations is to continue the current 100 percent Federal Medical Assistance Percentage (FMAP), the portion of the Medicaid program paid by the Federal government rather than the states, for all Medicaid services provided to American Indian/Alaska Native (AI/AN) enrollees through IHS, tribal, and urban facilities. The federal government’s share of Medicaid normally ranges from 50 percent to 83 percent, with states with lower per capita incomes receiving more federal funds.

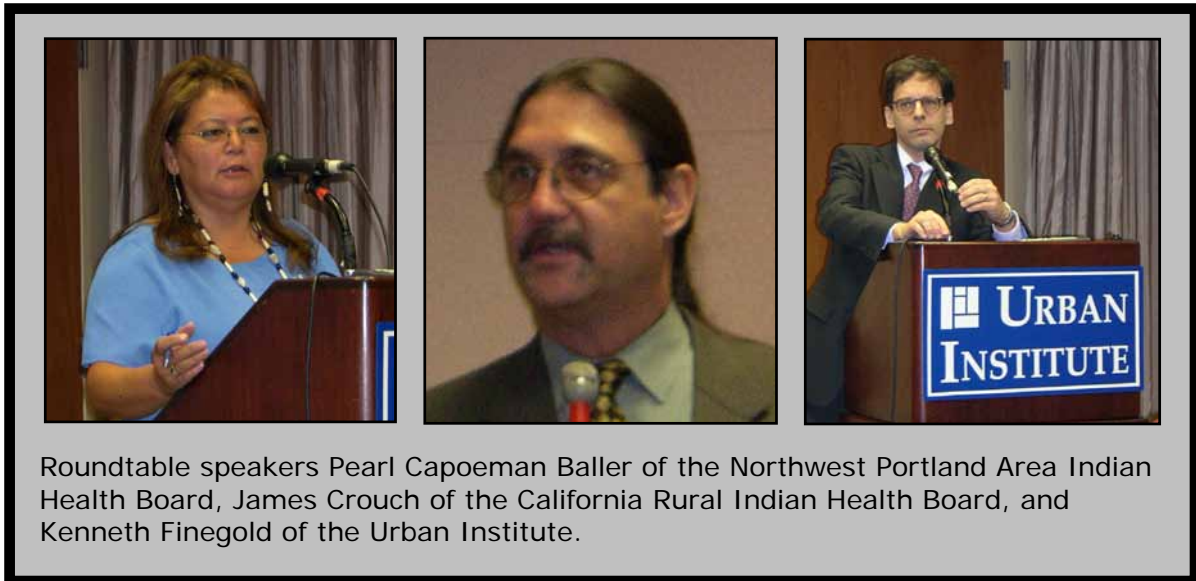


The future of the Indian health system is intrinsically tied to Medicaid as the government’s health program for the poor, despite the federal trust responsibility that predates Medicaid. As Carol Barbero, a partner in the Washington, DC, law offices of Hobbs, Straus, Dean & Walter, explained, “Congress recognized that it had the responsibility for these individuals as IHS beneficiaries, and should have the same responsibility for them as Medicaid beneficiaries.”

Other recommendations included continuing the exemption that many states have requested for AI/AN Medicaid beneficiaries from required premiums, deductibles, copayments, or other cost sharing; and rejecting any waiver without tribal consultation.

The Roundtable audience included a cross section of individuals from the health policy arena, tribal representatives from each of the 12 Indian Health Service areas, and members of the National Indian Health Board and Tribal Technical Advisory Committee. Congressional staff members and representatives from the Medicaid

Commission, health policy foundations, the IHS, and the Centers for Medicare and Medicaid Services (CMS) also attended. Indian health policy and Medicaid experts had prepared policy papers on Medicaid reform issues that served as discussion pieces with the audience.



Why American Indian People Should be Treated Differently in Medicaid

Differential treatment for American Indians and Alaska Natives in Medicaid and other programs is based on a political classification (membership in a tribe) rather than a racial one. This practice has been upheld by the courts and should be affirmed in health policymaking, according to Roundtable participants. Indian tribes are governments that predate the governmental status of the United States. More than two centuries of judicial decisions, statutes, regulations, executive branch directives, and ongoing dealings between the federal government and Indian tribal governments have attempted to define the appropriate manner for treating these indigenous nations. The 1976 Indian Health Care Improvement Act underscored that “any effort to fulfill federal responsibilities to the Indian people must begin with the provision of health services.” The law recognized that it was the federal government’s responsibility to pay the full costs of Medicaid services to American Indians.

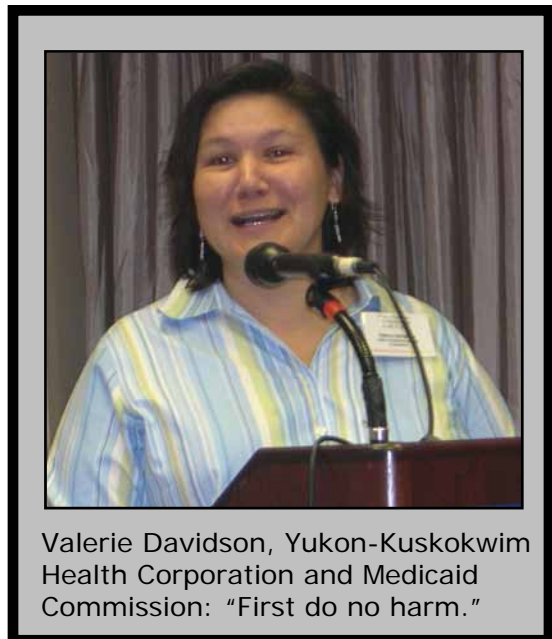
Important cultural distinctions must also be respected. Indian health care advocates feel strongly that the ITU system is *not* an extension of the mainstream health system in America. To the contrary, federal support has built a system designed to serve Indian people. This community-based and culturally appropriate health care approach can accommodate the needs of Indian people and their cultures. It is important not to undo

that system, they say, but to instead build on those programs that tribes, the IHS and other Indian health providers have started. The poor state of health among Indians also requires specialized attention to break the cycle of illness and addiction.

An evolving federal bureaucracy does include an Indian voice, albeit a small one. CMS is now the federal agency responsible for administration of Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP). In 2003, CMS chartered the Tribal Technical Advisory Group (TTAG) to, among other things, honor the federal trust responsibilities and obligations to the tribes, which includes consultation with tribes before enacting new policies. Serving as an advisory body to CMS, the TTAG provides expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for Indians served by Titles XVIII, XIX, and XXI of the Social Security Act. The TTAG is composed of 12 tribal leaders or employees appointed by area directors, with consultation of tribes in each of the 12 IHS geographic areas, and representatives of three national Indian organizations—the National Congress of American Indians, the National Indian Health Board, and the Tribal Self-Governance Advisory Committee.

Pending Policy Changes: The Medicaid Commission

The fundamental policy principle of Indian health providers and policy experts is that the Medicaid Commission must “first do no harm” when it considers ways to cut \$10 billion from what has become the largest source of health care funding for people with limited income. “Sometimes harm isn’t intended, but we all know as tribal people that sometimes in the grand scheme of trying to do the right thing for Indians, if you are not really careful, unintended harm can result,” Valerie J. Davidson, executive vice president of the Yukon-Kuskokwim Health Corporation in Alaska and a nonvoting member of the Commission, told participants.

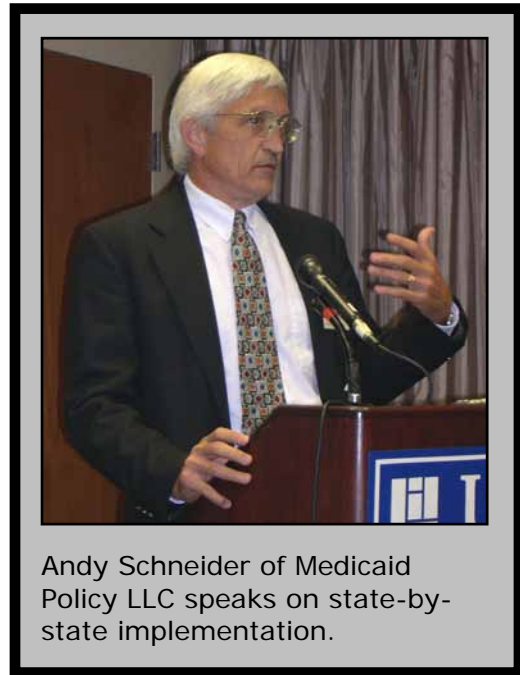


Valerie Davidson, Yukon-Kuskokwim Health Corporation and Medicaid Commission: “First do no harm.”

Many people at Commission meetings with considerable Medicaid knowledge, according to Davidson, know nothing about Indian health programs. They are not aware of the federal trust responsibility to provide health services. As Indian health is a small part of Medicaid, many protections for Indian people could be adopted with little

impact on the federal budget. These protections “could make a huge difference to tribes in Indian health programs,” she said.

Yet, as Andy Schneider, a principal with Medicaid Policy LLC, explained to Roundtable participants, the outcomes from the Commission recommendations will vary from state to state. Many of the Commission recommendations released on September 1 are based on proposals put forth by the National Governors Association. The governors urge that any changes to the federal/state program continue to stress state flexibility. For instance, on the benefits package, governors would prefer that states be given the ability to offer a different level of benefits using SCHIP as a model. Under this plan, states could establish different benefit packages for different populations in different parts of the state. An Indian reservation could be defined as a different part of the state and denied benefits available elsewhere in the state.



By December 31, 2006, the Commission will submit longer-term recommendations to Health and Human Service Secretary Michael O. Leavitt. The more extensive plan on the future of the Medicaid program and its sustainability will address such complicated dilemmas as how to expand the number of people covered with quality care while recognizing budget constraints.

Elders and Behavioral Health

Roundtable participants fear that Medicaid reform might hinder innovation or cut off funding to new endeavors. The Indian health system has been slow to confront pervasive health problems, but is now starting to do so. The Indian population has remained relatively young, but changing demographics have put more emphasis on such costly health issues as long-term care for the elderly.

By 2030, it's estimated that there will be 430,000 American Indian and Alaska Native elders, requiring some creative thinking on the part of the Indian health care system to cope with the elders' very high rates of disability and chronic conditions. Planning for this projected growth should begin immediately, according to Traci L. McClellan,



Traci McClellan, National Indian Council on Aging

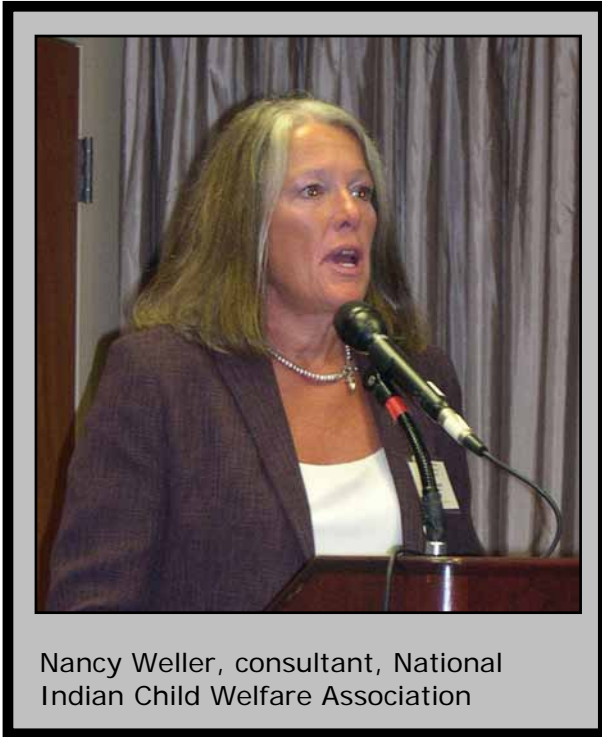
executive director of the National Indian Council on Aging. At this point, there are only 15 long-term care tribal facilities to serve the 562 tribes.

Yet, designing long-term care services for Indian people must be consistent with tribal sovereignty—allowing the tribes to design and plan how they will administer services. In accord with many cultural values of tribal communities, most elders live with their children, grandchildren, or other members of the extended family. As a result, the daily care of those suffering from chronic diseases and disability falls to family members. McClellan suggested developing family counseling programs to support these caregivers.

Costly long-term care insurance is not an option for most financially strapped Indian families. And licensed, certified home health care is not universally available within the Indian health system. However, waivers from the state Medicaid program can allow tribal health programs to serve as a home health agency and receive the reimbursement. Other models to follow include the Program for All-Inclusive Care for the Elderly (PACE). Designed to prevent or delay nursing home admissions, PACE combines a comprehensive package of services using Medicare and Medicaid funding sources.

The concept of behavioral health encompasses both mental health services and drug and alcohol treatment, which practitioners see as intertwined. “Tribal behavioral health, as you all know, has a very different take on health and wellness, and usually it’s from a relational worldview perspective,” explained Holly Echo-Hawk, an independent consultant to the National Indian Child Welfare Association. Many practices that work elsewhere across this country may not work in tribal communities with higher than average rates of suicide, homicide, domestic violence, child abuse, and substance abuse. The geographic isolation of many tribes and the grossly inadequate behavioral health staff and service levels across Indian country are spurring problems to epidemic proportions—for instance, youth suicide and violent death in some Alaska Native villages.

Echo-Hawk said that one area specific to AI/AN people—historical and generational trauma—has finally gotten attention in the last 10 years, with tribes tackling high levels of depression among tribal children and alcoholism. Methamphetamine is also a major problem on the reservations. “I was in a tribal community in Maine and the problem there, needle addiction, has gotten so severe it went through every home, every house on that reservation,” she said.



Yet, there are some signs of hope. Roundtable participants were heartened to hear about the 16 Circle of Care programs across the country designed to support federally recognized tribal governments and urban Indian programs by providing culturally appropriate mental health service models. Some fear that this progress might be squelched in Medicaid reform. The tribes have not yet met the licensing and accreditation required for reimbursement from Medicaid on these new behavioral health models. “To change the program is like pulling the rug out from under their feet,” said Nancy Weller, another consultant to the National Indian Child Welfare Association.

State Innovations

Health care services are thriving among the Northwest tribes, with good facilities, an experienced staff active in national Indian health activities, and an ever-increasing array of services. Edward J. Fox, executive director of the Indian Health Board of Nevada, discussed the progress at the Roundtable. “We say the main reason for the success in these expanding programs is the ability to access Medicaid programs in the states of Washington, Oregon, and Idaho,” he said. While the budget for the Indian Health Service has remained flat over at least the past ten years, Medicaid funding for the Indian health system has risen. He attributed this, in part, to the states meeting with the tribes not less than quarterly to facilitate Indian health programs’ access to Medicaid.

Fox outlined why Medicaid reform could be harmful. “Tribes are fearful that the role of Medicaid is not well understood and that changes to provisions and practices could, however unintentionally, negatively impact our programs.” Currently, the states have provided tribes with the flexibility needed to achieve success. Yet, he said, some proposals discuss allowing states flexibility without any minimal standards, without any strict guidelines for cost-sharing, and without any clear recognition that there is a federal responsibility to provide health care to Indians.

Already, health status among the tribes in the northwest states is stagnating. Disparities are growing between the Indian and white populations in terms of being healthier

longer, mortality, and morbidity. This loss of momentum is yet another call for ensuring a steady flow of funding to the health care services, said Fox.

Innovations in Alaska would also be threatened in any Medicaid cutbacks, participants said. Alaska Natives—Eskimos, Indians, and Aleuts—comprise 40 percent of the state’s Medicaid population. Yet, they don’t make up enough of the population, nor carry enough political clout, to warrant necessary protections. Nancy Weller, who retired last year as tribal health manager for the Alaska Department of Health and Human Services, outlined the collaborations that have occurred despite isolation and poverty.



Edward Fox of the Indian Health Board of Nevada

The Yukon-Kuskokwim Health Corporation (YKHC) received a grant in 1996 to become the first managed care plan under Alaska’s Medicaid program. In designing the plan, YKHC identified its major health concerns: children, behavioral health, and long-term care services. Because travel costs to get patients to health care facilities are exorbitant, the state gave YKHC an additional grant for travel management centers in Anchorage and Bethel, which developed into a full-blown air ambulance service.

Getting more of Alaska’s eligible Native population to enroll in Medicaid has been a major challenge, though persistent efforts—especially to families with children—cut through such barriers as culture and language. Medicaid reform could hurt the administrative match agreements that many states, including Alaska, have negotiated with the tribes. These administrative funds allow the outreach and education eligibility work. If that activity is capped, tribes are going to be increasingly reluctant to expand critical outreach work.

Recommendations

The Roundtable provided a forum for a thorough discussion of Medicaid reform and served as the basis of recommendations in response to Medicaid reform proposals by the Medicaid Commission and National Governors Association. Foremost, policymakers are encouraged to “first do no harm” to the Indian health system in any reforms. To accomplish this, policymakers must protect Indian health programs by including the following provisions in any Medicaid reform legislation and regulations:

1. **Cost sharing.** Eliminate or waive cost-sharing requirements for AI/AN beneficiaries. Legislation and regulation must extend the current SCHIP premium and cost-sharing exemptions to Medicaid.
2. **Federal responsibility for health care services to Indian people.** One-hundred percent FMAP should be applied for all services through Indian health programs.
3. **Benefits flexibility.** States should be prohibited from offering benefit packages to AI/AN Medicaid beneficiaries that are less in amount, duration, or scope than the benefits packages they offer to any other group of Medicaid beneficiaries anywhere in the state. This “most favored nation” rule should apply with respect to all AI/AN Medicaid beneficiaries, regardless of whether they live on or near a reservation.
4. **Estate recovery.** Estate recovery inhibits AI/AN participation in the Medicaid programs, and Indian people will simply not enroll if they are subject to any estate recovery claims in the Medicaid program. AI/AN beneficiaries must be exempt from estate recovery rules.
5. **Traditional practices.** Respect for cultural beliefs requires blending of traditional practices with a modern medical model and emphasizing public health and community outreach. CMS should include access to traditional medicine as part of the services available to AI/AN people and fully recognize traditional medicine as an integral component of the Indian health care delivery system.
6. **Access to CMS program eligibility.** Simplify and improve AI/AN outreach, enrollment, and eligibility determination. Provide funding to Indian health programs for conducting outreach and linkage activities. Simplify the application process by reducing required documents, providing “real time” determination, and allowing self-declaration for residency and income. Allow Tribes the option to provide program enrollment and eligibility determination on site.
7. **Managed care.** If Medicaid reform includes managed care, Indian programs and AI/AN people must have the following flexibility:
 - *Choice.* AI/AN individuals should be allowed to choose an Indian health program or a managed care plan, as they prefer.
 - *Default assignment to Indian health program.* Individual AI/AN must NOT be involuntarily assigned to a non-Indian managed care plan when an Indian health program is available.
 - *Out-of-Plan Service.* Medicaid must require managed care plans or contractors to pay Indian health providers when providing services to AI/AN people who exercise their right to use tribal/IHS programs.

Appendices

A Guide to the Language

Specialists in Indian health, like their counterparts in other policy areas, often use terms that are familiar to them but not to broader audiences. Following are some of the phrases and acronyms used at the Roundtable:

- **American Indians and Alaska Natives (AIAN or AI/AN).** The official federal term for the indigenous peoples of the Americas, used as a racial classification in the Census and other government statistics. Some of the people in this category prefer to be called *Native Americans*.
- **Federal trust responsibility.** The obligation of the U.S. government, recognized in statute and case law, to provide for the health and well-being of American Indians and Alaska Natives. The U.S. accepted the federal trust responsibility in exchange for land under treaties with American Indian tribes. The federal trust responsibility applies to Alaska Natives under the 1867 treaty for cession of Alaska, which provided that Natives would be treated on the same terms as Indians within the existing United States.
- **Indian Health Service (IHS).** The federal agency within the Department of Health and Human Services that is responsible for providing health services to American Indians and Alaska Natives in accord with the federal trust responsibility. For administrative purposes, IHS divides the U.S. into 12 geographic regions, labeled *areas*.
- **Indian health system.** IHS facilities providing direct services to American Indians and Alaska Natives, plus IHS-funded programs run by tribes or tribal organizations and IHS-funded urban Indian health centers. The Indian health system is also referred to as the I/T/U (for Indian Health Service, Tribal, and Urban), or ITU.
- **Medicaid.** The federal program of acute and long-term medical assistance for people with low incomes, established in 1965. States administer Medicaid within constraints set by federal law and regulation and receive partial reimbursement for the costs of the program.
- **Federal Medical Assistance Percentage (FMAP).** The portion of Medicaid costs the federal government reimburses the state, which varies inversely with state per capita income. FMAP normally ranges from 50 to 83 percent, but states can be

reimbursed for 100 percent of the cost of Medicaid services provided by IHS or tribal facilities.

- **State Children’s Health Insurance Program (SCHIP).** The federal program supplying grants to states to provide health coverage for children in families with incomes above Medicaid limits, established in 1997. Some states also use SCHIP funds to cover parents or other adults.
- **Medicare.** The federal program, established in 1965, that provides health coverage for persons who are 65 and older and for some younger people who are disabled. Unlike Medicaid and SCHIP, Medicare is financed and administered by the federal government, with no direct role for the states.
- **Centers for Medicare and Medicaid Services (CMS).** The federal agency within the Department of Health and Human Services that is responsible for SCHIP as well as Medicare and Medicaid. Before 2001, CMS was known as the Health Care Financing Administration (HCFA).

The Federal Trust Responsibility: The Basis for Indian Health Policy

The federal trust responsibility to American Indians and Alaska Natives, including the obligation to provide health care, is rooted in the U.S. Constitution’s Indian Commerce, Treaty, and Supremacy clauses. The parameters of the trust responsibility have evolved over time through judicial pronouncements, treaties, acts of congress, executive orders, regulations, and the ongoing discussions between the federal government and Indian tribal governments. The following are some highlights:

- ***Cherokee Nation v. Georgia, 1831.*** Chief Justice John Marshall established the legal foundation for the trust responsibility by describing Indian tribes as “domestic dependent nations” whose relationship with the United States “resembles that of a ward to his guardian.”
- **The Snyder Act, 1921.** Considered the most significant Indian welfare law of the early 20th century, this act permanently authorized appropriations “for the benefit, care, and assistance of the Indians throughout the United States.”
- **The Johnson-O’Malley Act, 1934.** Congress authorized the secretary of the interior to use federal funds to contract with states and territories for education, medical attention, and other welfare activities for the “relief of distress” of Indians in the states and territories.
- **The Transfer Act, 1954.** Congress transferred responsibility for Indian Health and operation of Indian health facilities to the Public Health Service. What became the Indian Health Service following this transfer now has a \$3 billion annual budget—more than half of which is distributed to Indian tribes and tribal organizations.
- ***Morton v. Mancari, 1974.*** The Supreme Court set out the standard of review for laws that establish special treatment for Indians—the “rational basis” test. In rejecting a challenge that the application of Indian preference in employment at the Bureau of Indian Affairs was racially discriminatory under the civil rights law, the court characterized the preference as political rather than racial.
- **The Indian Self-Determination and Education Assistance Act, 1975.** This act expressly preserves tribal sovereign immunity, affirms the federal trust responsibility, and establishes a national policy of Indian self-determination by

allowing Indian tribes to assume operational control of programs previously administered by federal agencies.

- **The Indian Health Care Improvement Act, 1976.** This comprehensive legislation sought to bring order and direction to health services delivery for Indian people: “The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”

The act made Indian Health Service hospitals eligible to collect Medicare reimbursements. And, it provided eligibility for the IHS facilities to collect reimbursements from Medicaid and to apply a 100 percent Federal Medical Assistance Percentage (FMAP) to Medicaid services provided to an Indian by an IHS facility.

- **State Children’s Health Insurance Program (SCHIP), 1997.** This ambitious new federal/state match program, designed to supply health coverage for low-income children, was required to ensure that child health assistance would be provided to targeted low-income Indian children in the state. A regulation was issued prohibiting states from imposing “premiums, deductibles, coinsurance, copayments, or any other cost-sharing charges on children who are American Indians or Alaska Natives.”
- **The Medicare Prescription Drug, Improvement, and Modernization Act, 2003.** Congress included Indian-specific provisions to ease participation by IHS, tribal, and urban Indian pharmacies, which are often the only pharmacies available in Indian communities. Regulations have been issued to ensure the new Medicare benefits are available to their Indian patients.

Based on the paper Carol L. Barbero presented at the Roundtable, “The Federal Trust Responsibility: Justification for Indian-Specific Health Policy.”

John Holahan on Coming Changes in Medicaid

John Holahan, director of Urban Institute's Health Policy Center, delivered the keynote address, "Coming Changes in Medicaid." Following are some highlights:



- **Medicaid isn't high-cost considering the health problems of those in the program.** Most of the differences in cost between Medicaid and private insurance can be explained by the presence of chronic conditions, disability, and poor health. When simulations ask what would happen if we put a Medicaid population with such conditions in private plans, the answer is that private insurance would cost significantly more.
- **The most prominent reform proposals include changes in the way we pay for prescription drugs.** Drugs are a major driver of cost growth in Medicaid. Alternatives such as charging average manufacturer's prices provided by drug companies, getting larger rebates, and extending those rebates to drugs provided by managed care plans have been discussed.
- **Asset transfers are also getting the spotlight.** When patients turn assets over to their future heirs and then enter nursing homes as a Medicaid patient, nursing home costs are paid by taxpayers rather than the patient's own resources. While transfers get a lot of attention, most observers believe that only a small share of nursing home residents on Medicaid ever had much to transfer. In fact, the administration estimates budget savings from preventing asset transfers at \$1.5 billion over five years, or less than 1 percent of nursing home spending.

- **Another issue is cost-sharing—the idea that people should pay more of their Medicaid costs so they'll use health care services more appropriately.** Cost-sharing may reduce some inappropriate care, but evidence shows some appropriate use of services would also be cut back. Careful design of cost-sharing policies would protect the poorest and sickest, thus limiting the savings.
- **“Benefit package flexibility” is another target.** Many states provide a wide range of acute care benefits—like vision, hearing, dental care, and so forth. Often, these aren't part of the benefit packages for low-income people that have private insurance, so why should they be in Medicaid? However, people on Medicaid are generally poorer than those with private coverage and would find these services unaffordable when needed. Moreover, these optional benefits are not very costly and cutting them would yield relatively little savings.
- **The real savings in Medicaid are going to come only with managing high-cost populations better.** Right now, 4 percent of the Medicaid population accounts for 53 percent of Medicaid spending. Another 3 percent accounts for 12 percent of spending. So 7 percent of the Medicaid population, or about 3 million people, get two-thirds of all Medicaid dollars. These cases represent a lot of potential for savings through better management.

Medicaid Commission Recommendations

The Medicaid Commission, established by charter in May 2005, is charged with recommending “options to achieve \$10 billion in scorable Medicaid savings over 5 years while at the same time mak[ing] progress toward meaningful longer-term program changes to better serve beneficiaries.” The recommendations delivered to Congress by the Medicaid Commission on September 1 include

- **Prescription drug reimbursement formula reform.** Allows states to establish pharmaceutical prices based on average manufacturer price rather than published average wholesale price. *Estimated Savings: \$4.3 billion over five years.*
- **Assets for Medicaid eligibility.*** When assets have apparently been transferred to gain Medicaid eligibility, current law requires a three-year “penalty period” beginning on the date of the transfer, during which Medicaid will not pay for long-term care. The Commission proposes the penalty period be extended to five years, with the date of application for Medicaid or admission to a nursing home (whichever is later) as the start date. *Estimated Savings: \$1.5 billion over five years.*
- **Tiered copayments for prescription drugs.** Current law limits the copayment that can be charged on prescription drugs and exempts some categories of beneficiaries from copayments altogether. The Commission proposes that states be allowed to increase copayments on nonpreferred drugs when a preferred drug is available. *Estimated Savings: \$2 billion over 5 years.*
- **State Taxes on Managed Care Organizations.** States would be required to tax all managed care organizations, not just those with Medicaid contracts. A loophole in current law defines as a separate class of health care services the services of Medicaid managed care organizations and permits states to impose taxes solely on Medicaid. *Estimated Savings: \$1.2 billion*

* Valerie J. Davidson, executive vice president of the Yukon-Kuskokwim Health Corporation in Alaska and a nonvoting member of the Commission, asked that this be considered during discussion of this reform option: *At a minimum, all assets of AI/AN individuals be exempt from Medicaid eligibility calculations and estate recovery provisions.* The Commission did not incorporate this language into its recommendations on assets.

Research Priorities in Indian Health

The Roundtable brought program administrators and advocates together with health policy researchers. Participants suggested that the following research projects would provide valuable information about Indian health policies and needs:

- **Calculating better cost estimates for proposals that would expand Medicaid funding for the Indian health system, or protect American Indians and Alaska Natives from cost-sharing, estate recovery, or other measures to reduce Medicaid spending.** Any such estimates should include the effects on the Indian health system as well as on Medicaid. Participants thought that the Congressional Budget Office (CBO) estimates of these costs are too high, but the CBO methodology is not known, and no alternative source of budget estimates is currently available.
- **Matching Medicaid paid claims data with IHS data on active users to better understand the relationship between Medicaid and the Indian health system.** Using Social Security numbers as identifiers in the two datasets should allow researchers to successfully match many of the individuals who participate in both, but the situation is complicated by state ownership of the Medicaid claims data.
- **Measuring improvements in quality of care and health outcomes from the provision of Medicaid reimbursements to the Indian health system.** Changes in acute and chronic illness, prenatal care, and infant mortality could be analyzed with data available from IHS publications or the IHS web site. The IHS epicenters are currently doing work along these lines.
- Forging partnerships between Indian health organizations and research institutions to build capacity for policy and data analysis by American Indians and Alaska Natives.