National Indian Health Board

January 31, 2025

The Honorable Mike Johnson
Speaker of the House
H-232 U.S. Capitol Bldg.
Washington, D.C., 20515

The Honorable John Thune
Senate Majority Leader
S-230 U.S. Capital Bldg.
Washington, D.C., 20510

The Honorable Hakeem Jeffries
Minority Leader
H-204 U.S. Capitol Bldg.
Washington, D.C., 20515

The Honorable Charles E. Schumer
Senate Minority Leader
S-221 U.S. Capitol Bldg.
Washington, D.C., 20510

RE: Preserve Medicaid Resources for the Indian Health System in Medicaid Reform Legislation

Dear Majority Leader Thune, Minority Leader Schumer, Speaker Johnson, Minority Leader Jeffries:

On behalf of the National Indian Health Board (NIHB) and the 574+ Tribal Nations, we request your leadership to protect the Medicaid program that is pivotal to the Indian health system. Medicaid resources are critically important to supplementing the underfunded Indian health system, and their availability is a critical consideration for Tribes deciding whether to take over Indian Health Programs under the Indian Self-Determination and Education Assistance Act (ISDEAA). Reducing access to Medicaid resources will disincentivize Tribes from electing to take over programs from the IHS and reduce access to much needed supplemental resources for existing Tribal, IHS and Urban Indian programs.

As discussed below, in any Medicaid reform legislation, Congress should preserve full federal funding for Medicaid services provided to American Indians and Alaska Natives (AI/ANs) by exempting them for counting towards per capita caps as it did previously in the American Health Care Act (AHCA) of 2017[1] and the Better Care Reconciliation Act (BCRA) of 2017.

Congress should also exempt AI/ANs from any mandatory work requirements, which also has previous precedent. For example, when CMS approved Healthy Adults Opportunities Section 1115 Demonstration Waivers in a number of states, they included exemptions from work requirements for AI/ANs. Congress should also preserve access to Medicaid resources for Indian health care providers in Medicaid expansion states.

[1]H.R. 1628, *American Health Care Act of 2017*. 115th Congress. Section 121 of the AHCA would have created a new Section 1903A of the Social Security Act, and Section 1903A(e)(1)(b) would have exempted IHS eligible individuals from the definition of Section 1903A enrollees used to calculate per capita caps. Section 133 of BCRA adopted the same approach.

Total Medicaid reimbursements to the IHS in FY2025 represent only 0.213 percent of total federal medical assistance payment forecasted in FY 2025. As a result, preserving access to the Medicaid program for Indian health care providers in the manner recommended below will not have any material effect on eliminating total Medicaid costs to the federal government. But it is essential for preserving access to needed care throughout Indian Country, particularly as more and more Tribes elect to provide those services themselves through self-determination or self-governance.

As Congress prepares for its budget reconciliation work, we request Congress protect the Indian health system with the following considerations:

I. Ensure Budget Reconciliation or Medicaid Changes Uphold the Federal Responsibility for Indian Health Care

Congress should ensure that any reform efforts maintain the federal responsibility for Indian health care. The trust and treaty obligations owed to Tribal Nations lie solely with the federal government, and their responsibility may not be delegated to the states. Our unique government-to-government relationship with the United States and the trust and treaty obligations it owes Tribal Nations require the federal government maintain responsibility for ensuring the delivery of healthcare to Tribal Nations and our communities.

In 1976, Congress amended Section 1905(b) of the Social Security Act (SSA) to provide 100 percent Federal Medical Assistance Percentage (FMAP) for Medicaid. Congress took the view that it would be unfair and inequitable to burden State Medicaid programs with the costs of serving AI/AN people since that was a federal responsibility. This also helps to protect State Medicaid budgets, preserves eligibility and maintains optional levels of service.

In 2017, the AHCA exempted reimbursements to States for services received through IHS and Tribal healthcare facilities in the calculation for per-capita allotment caps and exempted services received through the IHS and Tribal healthcare facilities from optional block-granting. If Congress considers similar policy proposals during reconciliation, it should include similar exemptions again.

II. Exempt Medicaid Reimbursements for Services Received Through IHS/Tribal Facilities from Eligibility or Services Limitations Resulting from Caps

Medicaid is an important tool through which the federal government works to fulfill its trust and treaty responsibility to provide for Indian health care. Exempting services received through an IHS or Tribal facility from statewide caps or block grants is critically important, but not enough to protect IHS and Tribal programs from state limitations on eligibility or services that may result from capping Medicaid funds. The United States funds Medicaid reimbursements to states at 100 percent FMAP for AI/AN beneficiaries, and capping Medicaid services for AI/ANs for any reason is fundamentally inconsistent

with the federal trust and treaty responsibilities and Congress' intent in authorizing the Indian health system to access Medicaid resources.

III. Exempt AI/AN from Any Mandatory Work Requirements

Tribal governments support full employment for their citizens, but mandating work requirements through the Medicaid program will not increase employment in Indian Country. Unlike other Medicaid enrollees, AI/ANs have a right to access IHS services and payer of last resort statutes and regulations require AI/ANs to enroll in Medicaid before receiving services from an IHS or Tribal health provider. AI/ANs would not need to meet mandatory work requirements to obtain coverage and may instead simply elect not to enroll in Medicaid. This will deprive IHS and Tribal facilities of a critically important source of funding.

To the extent Congress considers imposing Medicaid work requirements, Congress should exempt AI/ANs from any work requirements. Establishing mandatory work requirements as a condition of Medicaid eligibility will not work in Indian Country because the incentive structures and economic conditions for job opportunity are completely different because AI/ANs face unique structural barriers that make compliance with the red tape and paperwork necessary to meet work requirements very difficult. Many AI/ANs live in frontier communities where they may not have post addresses to receive mail and little-to-no access to email or broadband, making communication with State Medicaid agencies to demonstrate compliance with a work requirement or satisfaction of an exception a real challenge. In addition, many AI/ANs who work in rural communities may have jobs involving Tribal trust resources that are exempt from taxation or Medicaid income eligibility for which documentation is nonexistent or difficult to provide As a result, rather than encouraging job seeking or saving program costs, mandatory work requirements may result in many AI/ANs being disenrolled from Medicaid not because they do not work or meet an exception, but because of the challenges in proving they comply with the requirement. We recently saw this occur during the Medicaid unwinding process when AI/ANs were procedurally disenrolled at very high rates as a result of these barriers

Tribes fully support work programs and employment, but we believe such programs should be voluntary so as not to provide a barrier to accessing Medicaid for our citizens. For example, exemptions for AI/AN beneficiaries was approved in Arizona's Healthy Adult Opportunities Section 1115 demonstration waivers that imposed work requirements on the state's Medicaid program but exempted AI/ANs. CMS approved Section 1115 demonstration waivers in Arizona, Indiana, South Carolina, and Utah that all exempted AI/ANs from work requirements. Again, this is consistent with over 45 years of Medicaid policy for Indian Country.

IV. Preserve Medicaid Expansion

Medicaid expansion has provided critical third-party revenues to the Indian health system, greatly expanding the care available to AI/ANs. The additional revenue created by Medicaid expansion has allowed Tribal health programs to increase and expand

services and access to care, which has been critical considering the significant health disparities that persist in Tribal communities. Congress must preserve expansion as an option for states. Medicaid expansion has been critically important to Tribes throughout the country. The increased resources which Medicaid expansion provides has led many Tribes, that have never considered taking over IHS programs, to consider self-governance in health care for the first time. If Congress eliminates Medicaid expansion it will disincentivize those Tribes from taking that step, and reduce funding for existing Tribal, IHS, and urban Indian programs.

Conclusion

Any type of Medicaid changes brought through the budget reconciliation process must ensure that the Indian health system does not experience significant funding shortfalls and must continue to preserve and protect current law for AI/ANs participants in Medicaid. We respectfully ask that Congress make decisive steps that fulfill the United States Federal trust responsibility to Tribal governments and protect the fragile financing of the Indian health system.

Sincerely,

William Smith, Valdez Native Tribe
Chairman
National Indian Health Board

CC: Senate Finance Committee; House Energy and Commerce Committee; House Ways and Means Committee