National Indian Health Board

ENSURE MEDICAID REFORM UPHOLDS FULL FEDERAL FUNDING FOR INDIAN HEALTH CARE

As Congress deliberates budget reconciliation proposals that will reform the Medicaid program, it must preserve full federal funding for Medicaid services received through Indian health care system and avoid unintentionally shifting those costs to the States. When Congress last developed per capita cap funding models for the Medicaid program in the American Health Care Act of 2017 and the Better Care Reconciliation Act of 2017, it exempted costs associated with Indian health care services from counting towards per capita caps. This exemption was needed to preserve full federal funding for Indian health care in the Medicaid program and avoid shifting hundreds of millions in costs from the federal government to the States.

Request: Use the models provided in the American Health Care Act of 2017 and the Better Care Reconciliation Act of 2017 to exempt costs associated with providing services to Medicaid beneficiaries eligible for services received through Indian Health Care Providers from counting towards per capita caps or block grants and preserve 100% federal medical assistance percentage (FMAP) reimbursement rate for Medicaid services provided to American Indian and Alaska Natives (AI/ANs) received by or through the Indian health care system.

Issue: The United States has a trust and treaty responsibility to fully fund Indian health in all the programs it administers, including the Medicaid program. Since 1976, Congress has required CMS to reimburse States at 100% FMAP for services provided by or through Indian health care providers.[1] Unless there is an exception for services received through Indian health care providers, moving to per capita caps or block grant funding would eliminate the 100% FMAP rule for Indian health and result in hundreds of millions in costs being shifted to the States. The American Health Care Act of 2017 preserved full federal funding for Indian health care through Section 121, Section 1903A(e)(1)(b) which exempted IHS eligible individuals from the definition of Section 1903A enrollees used to calculate per capita caps. Section 133, Section 1903A(e)(1)(b) of the Better Health Care Reconciliation Act of 2017 took the same approach. Congress should follow this model if it decides to pursue per capita cap limitations once more.

REFERENCE:

1. 42 U.S.C. 1396d(b). Congress authorized the Indian health system to bill the Medicaid program because "[t]hese Medicaid payments are viewed as a much needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian." H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.