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.

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.

National Indian Health Board

TALKING POINTS

Medicaid funding is critical to meeting Tribal community health care needs.

- Discretionary appropriations for IHS are woefully underfunded and consistently fall short of meeting health care needs. Medicaid provides the Indian health system with much needed funding to provide basic healthcare services to AI/ANs. Medicaid reimbursements supplement IHS appropriations to assist in meeting health care needs.
- The Medicaid program provides important resources that allow the I/T/U system to maintain or expand access to care, make facility improvements, hire health care professionals, and meet accreditation and quality requirements.
    - In FY 2023, Medicaid reimbursements at just IHS-operated facilities were $1.2 billion, which was equal to 24% of the IHS Services budget in FY 2023.
- **For many IHS and Tribal facilities, Medicaid represents approximately 30-60% of operating budgets.** Any changes to Medicaid that would reduce services or eligibility for AI/ANs would be devastating to the Indian health care system.

Preserving full federal Medicaid funding for Indian health care providers does not prevent Congress from controlling federal Medicaid costs.

- **Preserving 100% FMAP for services received by or through the Indian health providers is needed to avoid shifting hundreds of millions in Medicaid costs from the federal government to the States.**
    - **IHS Medicaid spending in FY2025 represents only 0.213 percent of total federal medical assistance payment forecasted in FY 2025.**[2] Preserving full federal funding for Medicaid services received through the Indian health system will not adversely affect the overall effort to cap and control federal Medicaid spending. Medicaid serves as a key source of revenue for I/T/U providers.

2. FY 2025 Medicaid Assistance payments are estimated to be $604.1 billion. See FY 2025 CMS Congressional Justification, page 5, accessed on January 21, 2025. Also see FY 2025 IHS Congressional Justification, page 143, accessed January 29, 2025.

National Indian Health Board

TALKING POINTS (CONTINUED)

IHS and Tribal programs should be exempt from any state limitations on eligibility or services that Congress or States may impose due to per capita caps or block grants.

- States may feel the need to reduce eligibility or reduce optional services because they would have fewer dollars to spend under per capita cap or block grant funding mechanisms.
- States that have expanded Medicaid should maintain Medicaid expansion.
- States should also exempt AI/ANs from any eligibility or service limitations the State may otherwise want or need to impose.

100% FMAP Acknowledges the Federal Government's Responsibility toward Tribal Nations.

- For over 40 years, the federal government has reimbursed States for 100% of the cost of providing Medicaid services to AI/AN beneficiaries.
  - **100% FMAP ensures that IHS access to state Medicaid services does not burden the states with what is a federal responsibility.** Eliminating 100% FMAP for services received through Indian health care providers would shift hundreds of millions in costs to the states.
- The reimbursement by the federal government to states for Medicaid payments to IHS and Tribally operated facilities is critical in filling the gap created by inadequate IHS funding.
- Any plan to change the manner in which State Medicaid costs are reimbursed by the federal government must include a carve out for services provided to AI/ANs so that the federal government's trust responsibility is maintained, and **costs are not shifted to the States.**
- The last time Congress considered Medicaid reform in the American Health Care Act of 2017 and the Better Care Reconciliation Act of 2017 it exempted reimbursement for services received through Indian health care providers from counting towards per capita caps. Congress must do the same in any new legislation.
- Any reforms to how state governments receive Medicaid should not impact Indian Health Service (IHS), Tribal, or urban Indian (I/T/U) providers.