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MEDICAID REFORM AND THE INDIAN HEALTH SYSTEM

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One of the highest priorities for the new Congress and President-Elect Trump is to repeal and/or replace the Patient Protection and Affordable Care Act (P.L. 110-148) (ACA)¹ and enact far reaching Medicaid Reform. The Medicaid program is a critical component in the United States' fulfillment of its trust responsibility to provide for the healthcare needs of American Indians and Alaska Natives (AI/ANs). Without continued access to Medicaid resources, the Indian health system will suffer immeasurably.

Medicaid Reform proposals are currently actively being considered and worked on by congressional staff. Some of these proposals would sunset Medicaid Expansion, which has provided desperately needed funding to supplement inadequate Indian Health Service (IHS) budgets in expansion states. Other proposals would cap Federal funding by moving to a block grant or per capita allocation formula, which would reduce Federal Medicaid funding and eliminate the 100% Federal Medical Assistance Percentage (FMAP) for health services provided to American Indians/Alaska Natives. All of these proposals would have significant negative impacts on the Indian health system if they do not account for Indian Country's reliance on the Medicaid program to narrow the gap between the unmet needs of AI/ANs and the chronically underfunded Indian health system.

This paper will explain how Medicaid payments to IHS and Tribal health facilities are grounded in the Federal trust responsibility, how Medicaid is presently structured to benefit the Indian health system and AI/ANs, how these various proposals would take away those benefits, and what strategies tribes might adopt to protect their interests.

The Importance of Medicaid in Carrying Out the Federal Trust Responsibility For Indian Health Care

The United States Constitution gives Congress the power to “regulate Commerce . . . with Indian Tribes.”² The U.S. Supreme Court interprets this Clause as giving Congress the plenary power “to deal with the special problems of Indians.”³ Congress has exercised this power in enacting the Indian Health Care Improvement Act (IHCIA), and declaring in the IHCIA “that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians. . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”⁴

Congress recognized that the Medicaid program is a crucial component in fulfilling the Federal Government's trust responsibility to provide resources for Indian health care. For decades, the Indian health system has been chronically underfunded, leading to a large gap in the health care needs of Indian people. In 2014 for example, the per capita spending for IHS patient services was \$3,107 as compared to \$8,097 per person nationally.⁵ Lack of funding has led to predictable results. AI/ANs continue to have some of the worst health disparities in the Nation.⁶ As Congress recognized in 2010, “the unmet health needs of American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.” 25 U.S.C. § 1601(5).⁷

The Medicaid program is a crucial component in filling the disparity gap created by inadequate IHS funding. In FY 2016, IHS operated facilities received \$808 million in Medicaid funding for services provided to the Medicaid eligible individuals they serve.⁸ This represents 13 percent of the total funds received by IHS facilities in 2016.⁹ Tribally operated facilities received approximately an additional \$1 Billion in Medicaid reimbursements. Medicaid today covers 34 percent of non-elderly AI/ANs and more than half of AI/AN children.¹⁰

In 1976, Congress enacted Title IV of the IHCA which amended the Social Security Act to require Medicare and Medicaid reimbursement for services provided in IHS and tribally operated health care facilities.¹¹ This was intended to help fulfill the federal trust responsibility and bring additional revenue into the Indian health system. The House Report explained that “These 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.”¹² In order to ensure that Medicaid funding was supplemental to IHS funding, Congress enacted a complementary provision that provides that Medicaid reimbursements are not to be considered when determining future appropriations for the IHS.¹³

At the same time, Congress took steps to ensure that IHS access to state Medicaid services not unduly burden the states with what is a federal responsibility. Congress amended Section 1905(b) of the Social Security Act to apply a 100 percent FMAP for services provided to AI/ANs that were received through an IHS or tribally-operated facility.¹⁴ This ensured that Medicaid services provided to AI/ANs through the IHS system would be paid for entirely by the United States, and not individual state Medicaid programs. The House Report explained:

The Committee has made a technical change in the provision for a 100 percent Federal matching rate for State Medicaid expenditures for eligible Indians receiving services in IHS facilities in order to place that provision within title XIX of the Social Security Act. The Committee approved this provision because:

- (1) The Federal government has treaty obligations to provide services to Indians; it has not been a State responsibility;
- (2) Since the 100 percent matching is limited to services in IHS facilities, it is clearly being paid for Indians who are already IHS eligible (and therefore clearly part of the population to which the U.S. Government has an obligation) and who are already eligible for full Federal funding of their services; and
- (3) States with a large IHS eligible Indian population have a limited tax base because so much of the land is public and not taxable; the higher matching rate under Medicaid simply recognizes this.¹⁵

Congress thus viewed Medicaid payments to IHS and tribally operated facilities, reimbursed by the Federal government to states at 100% FMAP, as a critical component in filling the disparity gap created by inadequate IHS funding. On February 26, 2016, CMS revised and expanded its interpretation of the 100 percent FMAP provision to include services provided by outside providers referred by IHS or tribal facilities.¹⁶ This revision was widely hailed by states, as it will further reduce burdens on state governments.¹⁷ As discussed below, it is critical that 100% FMAP be retained.

Congress has amended Medicaid numerous times to accommodate the unique nature of the Indian health system. For example, when Congress provided states with new flexibility to mandate enrollment in managed care systems through State Plan Amendments in 1997, it provided an exception for AI/ANs along with other groups.¹⁸ When it created the Children's Health Insurance Program (CHIP) that same year, Congress expressly required States to describe in their State plans the procedures they will use to assure access for AI/AN children.¹⁹ In 2009, Congress made further amendments to the law to ensure that States are prohibited from imposing any premium or cost-sharing on an Indian for a covered service provided by the IHS, a health program operated by an Indian tribe, tribal organization or urban Indian organization, or through referral under contract health services;²⁰ to ensure that certain trust related property is excluded from income for eligibility determinations;²¹ to impose Medicaid estate recovery protections for AI/ANs;²² and special rules to ensure that Indian healthcare providers are fully reimbursed by the states using Medicaid Managed care systems.²³

Medicaid Reform and the Indian Health System

While Medicaid reform proposals are still being developed, they will likely be based on past proposals involving capped payment systems designed to reduce federal spending levels on the Medicaid program. They will also likely phase out and/or eliminate Medicaid Expansion and eliminate presumptive eligibility periods. They could also include work requirements, as well as premiums and cost sharing requirements that do not provide exceptions for AI/ANs. We provide a brief overview of these systems and summarize several prior proposals that may be the most likely starting points for legislation in the new Congress.

Current Medicaid Funding is Not Capped

The way the Medicaid program is presently structured, the cost of Medicaid is split between the states and the Federal government with the Federal government paying anywhere from 50 to 83 percent of the costs depending on a state's FMAP. Under Federal law, the Federal government is obligated to pay its share of each state's Medicaid costs, whatever those costs turn out to be, so long as the state expenditures meet the requirements of the Medicaid program. There is no cap or ceiling on the amount of Federal funding that is available.

Uncapped Federal financing allows the Medicaid program to guarantee coverage to all eligible individuals because Federal financing will be available on an “as needed” basis. States have considerable discretion to decide who will be eligible for Medicaid in their state, but once states decide on eligibility rules, they must enroll all eligible individuals. The Federal government does not cap funding to states for Medicaid, and states cannot cap or stop enrollment of eligible individuals under Medicaid. Thus, the entitlement feature of the Medicaid program is closely tied to how Medicaid financing is presently structured.

Medicaid Reform Models Would Cap Federal Spending

Recently discussed Medicaid reform proposals share the common element that Federal funding would be subject to a pre-determined limit or ceiling (cap). Under these proposals, FMAP would be eliminated and federal funding for Medicaid would not automatically adjust based on actual costs as is the case now. Instead, federal funding would be set at an amount that would not change.

There are two main models being discussed: the **block grant** approach and the **per capita allotment** approach. Under a **block grant** approach, each state would receive a set amount of federal Medicaid funding per year, based on prior spending, and that amount would be adjusted each year. The states would then supplement that amount with their own funding. In a **per capita allotment** approach, states would receive a total Medicaid amount from the federal government that would be capped at a dollar amount per individual, with the state again responsible for any spending not covered by the federal amount. As discussed below, the FMAP reimbursement model would be eliminated under either approach, and as a result the special 100 percent FMAP rule for AI/ANs would be eliminated as well.

Following are summaries of several prior proposals that are receiving attention and could serve as models or starting points for new Medicaid Reform legislation.

The Ryan Plan – “A Better Way”

House Speaker Paul Ryan (R-WI) and other House Republicans announced a healthcare reform proposal on June 22, 2016 entitled “A Better Way.” It would allow states to accept Federal funding for Medicaid on either a block grant or a per-capita cap designed to cut Federal funding for states by \$1 Trillion over 10 years compared to current law. FMAP funding of a percentage of state costs would be eliminated. The proposal envisions states either electing a block grant or defaulting to a per-capita cap starting in 2019. The proposal would shift substantial costs to states and will likely lead states to cut Medicaid substantially over time.

Under the **per capita** option, a total capped Federal per-capita allotment would be available for each state to draw down. Calculation of the Federal per-capita allotment for each state would be the product of (1) a per-capita allotment for the four major beneficiary categories—aged, blind and disabled, children, and adults—and (2) the

number of enrollees in each of those four categories. The per-capita allotment for each beneficiary category would be determined by each state's average medical assistance and non-benefit expenditures per full-year-equivalent enrollee during the base year (2016) adjusted for inflation. Caps would be adjusted only for general inflation in subsequent years, and thus could squeeze state Medicaid budgets because health care costs have consistently risen significantly faster than the overall inflation rate. Certain payment categories would be excluded from the per-capita allotment and would be calculated through a separate funding stream, such as Federal payments to states for disproportionate share hospitals, Graduate Medical Education payments, and other appropriate exclusions.

The Ryan Plan does not provide any details on how a state's **block grant** amount would initially be set or be adjusted annually under the block grant option. Block grants are often based on a state's historical spending in a base year, adjusted annually for population growth and general inflation.

Speaker Ryan asserts that his plan allows states to compensate for the losses in Federal funding under a per-capita cap or a block grant by cutting costs – allegedly without harming beneficiaries. The Ryan Plan would allow states to make significant fundamental changes in their Medicaid programs:

- (1) Shift Medicaid beneficiaries into individual market plans which, with elimination of ACA market reforms, could restrict benefits and impose substantial deductibles and cost-sharing charges;
- (2) Impose work requirements and terminate coverage for people who do not comply;
- (3) Begin charging premiums for most adults by eliminating current rules that prohibit premiums for individuals with incomes below 150% of the poverty line;
- (4) Use waiting lists or cap enrollment for any group of “optional” Medicaid beneficiaries; and
- (5) Eliminate or restrict benefits for “optional” beneficiaries such as Early Periodic Screening, Diagnostic, and Treatment (EPSDT) for children with incomes above 138 % of the poverty line.

In addition, the Ryan Plan would not allow further expansion of Medicaid by states that had not already done so. However, it would expand Health Savings Accounts and make them available to IHS beneficiaries, and allow the purchase of health insurance across state lines.

Rep. Tom Price's Bill - Empowering Patients First Act (H.R. 2300)

Representative Price's²⁴ bill would repeal the ACA in its entirety. If enacted, it would mean that all of the Medicaid-related provisions in the ACA, along with the IHCA would be repealed. While preserving the IHCA remains the priority for Indian country, the changes to Medicaid would also be substantial. A wholesale repeal of the

ACA would eliminate the following Medicaid-related ACA provisions: Medicaid expansion, funding and authorization for CHIP beyond 2019, increases in the CHIP matching rate, authorization for states to provide for health homes for persons with chronic conditions as well as certain preventative and obesity related services as well as tobacco cessation programs, establishment of the Center for Medicare and Medicaid Innovation (CMMI), Home and Community-Based Services State Plan options, Money Follows the Person Rebalancing Demonstration Grant extensions, transparency and authorization of public notice and comment and tribal consultation requirements for on state waiver proposals, and various Medicaid program integrity measures, among others. The bill would replace the ACA with refundable tax credits for health insurance coverage and expansion and incentives to participate in health savings accounts (HSA). It would allow IHS eligible individuals to contribute to an HSA. The only new language that would affect Medicaid is a provision that would allow Medicaid-eligible individuals to opt-out of Medicaid and receive a tax credit to purchase a personal health plan instead.

Reconciliation Legislation (H.R. 3762)

H.R. 3762 was passed by Congress in early 2016 under budget reconciliation procedures that allow for expedited consideration of certain budget related provisions with limited amendments, limited debate, and no filibusters in the Senate. It was vetoed by President Obama on January 8, 2016. Even though it was not enacted into law, H.R. 3762 is likely to be considered by the Trump Administration as precursor legislation for ACA repeal and Medicaid reform.

H.R. 3762 was not a wholesale repeal of the ACA; nor would it have changed Medicaid to a block grant program. However, if enacted, it would have dismantled implementation of the ACA by repealing the following provisions:

- (1) premium assistance tax credit and cost-sharing provisions;
- (2) the small employer health insurance tax credit;
- (3) the individual tax penalty for failure to maintain minimum essential health coverage known as the individual mandate;
- (4) the shared responsibility payments for large employers known as the employer mandate; and
- (5) Medicaid expansion.

H.R. 3762 would also have eliminated (1) the state option provided by the ACA to expand presumptive eligibility beyond children and pregnant women to include parents and adult individuals who qualify under income guidelines; and (2) 100% FMAP for childless adults and community-based attendant services under the ACA.

Presumptive eligibility determinations are made by “qualified entities” including the IHS and a health program or facility operated by a tribe or tribal organization under the ISDEAA.²⁵ The state must provide Medicaid application forms to qualified entities and inform them how to assist applicants in completing the forms. The ACA and its implementing regulations extend presumptive eligibility to caretaker relatives and other

adults covered by the state's Medicaid program.²⁶ Presumptive eligibility provides patients with immediate access to care and creates the opportunity for the qualified entity to encourage and assist the patient in submitting a full Medicaid or CHIP application.

The Burr, Hatch, Upton Proposal

The Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act proposed by Republican Senators Richard Burr (R-NC) and Orrin Hatch (R-Utah) and Representative Fred Upton (R-MI) on March 24, 2015, would repeal the ACA and put in its place a series of insurance market reforms. Insurance regulation would be returned to the states within a framework under which: (1) no one can be denied coverage or charged higher premiums because of a pre-existing conditions as long as they remain continuously enrolled in a health plan, (2) insurers must allow dependents age 26 and younger to enroll in their parent's insurance plan, and (3) insurers could not charge their oldest enrollees more than five times the premiums charged their youngest enrollees, replacing the ACA's three times rule.

Medicaid would be restructured in two major ways. First, individuals who are eligible for Medicaid could choose a Federal tax credit instead. In states using Medicaid as their default auto-enrollment plan, individuals could use the tax credit to buy private insurance. Second, the FMAP funding system would be eliminated and replaced by a modified block grant approach involving: (1) a health grant based on each patient's health status, age, and life circumstances; and (2) a separate grant to provide low-income elderly and disabled persons long-term care and support services. Importantly, FMAP funding would remain intact for acute-care services to the elderly and disabled.

Waiver Proposals

In recent years, several States, including Indiana and Arizona, have proposed Medicaid waivers that would impose a number of new Medicaid eligibility limits and requirements. The proposals have included, among other things:

- Mandatory enrollment in managed care;
- Premiums and co-pays, along with a requirement to pay into a health savings account;
- Six month lockout period for individuals who do not make premium payments;
- Work referral requirements; and
- Five year time limits for Medicaid eligibility.

Imposing such requirements on AI/AN Medicaid beneficiaries would be inconsistent with the federal trust responsibility²⁷, and to date CMS has not approved Section 1115 waivers that would have done so. Medicaid reform efforts could, however, grant additional flexibility to States to impose such requirements without the need to seek a waiver from CMS. Tribes will need to be vigilant to ensure that to the extent that Medicaid Reform legislation includes such authority, it contains exceptions for AI/ANs. Tribes will also need to ensure that existing waiver authorities that have authorized

Tribal-specific Medicaid waivers such as the uncompensated care waivers approved for IHS and tribal facilities in Arizona, California and Oregon, are maintained.

Strategies for Preserving Existing Benefits for Tribal Health Care Programs and American Indians and Alaska Natives in Medicaid Reform Legislation

The Medicaid Reform proposals discussed above do not contain any of the benefits and protections Congress previously enacted for Indian health programs and AI/AN beneficiaries. As a result, these proposals give rise to two main concerns for IHS, tribal and urban Indian health programs. First, that the Medicaid statute will be amended to allow States the flexibility to impose across the board requirements that will reduce access to Medicaid services for AI/ANs. Second, that Medicaid funding might be changed to eliminate 100% FMAP so that Medicaid funding for AI/ANs would be a state, not a Federal responsibility. This would eliminate longstanding congressional policy that Medicaid funding is provided for AI/ANs as a component of the federal trust responsibility for AI/AN health care. There are several options for Tribes to consider in addressing these concerns.

Preserving Tribal Medicaid Rights

As discussed above, over the years Congress has repeatedly amended the Medicaid law to account for the unique status of the Indian health system and ensure free and continued access to Medicaid programs by AI/ANs. The Medicaid Reform proposals being considered will likely contain across the board changes that will not include the same kind of protections for Indian health programs or Indian people contained in the current law, such as 100% FMAP and exemptions from premiums or cost-sharing requirements.

As a result, at a minimum, Tribes should insist that 100% FMAP and the following Indian specific Medicaid protections be preserved in any federal Medicaid reform proposal:

- Right of Indian health programs to participate in Medicaid on the same basis as other providers;²⁸
- Protections for AI/ANs from premiums and cost-sharing requirements;²⁹
- Tribal presumptive eligibility determinations;
- Use of documents issued by tribes as proof of citizenship for Medicaid enrollment;³⁰
- Protection from mandatory enrollment in managed care plans;³¹
- AI/AN right to see Indian healthcare provider of their choice, even if not a Managed Care provider;
- Right of Indian healthcare provider to be paid by a managed care plan whether or not they are enrolled as a participating provider;³²
- Right of Indian healthcare provider to be promptly paid at the IHS Reimbursement Rate (“OMB Rate”) or a rate set out in State plan;

- Disregard of certain Indian property from resources for Medicaid and CHIP eligibility,³³ and
- Medicaid estate recovery protections.³⁴

As discussed above, Medicaid reform proposals may also include new authorities for States to grant them additional flexibility in administering their Medicaid State plans. In recent years, several States, including Indiana, have proposed Medicaid waivers that required mandatory enrollment in managed care systems, and required individuals to make payments to health savings accounts to pay for premiums and co-pays. These proposals have also included benefit limits and work requirements. Medicaid reform proposals may well include state authority to implement these types of requirements without seeking a waiver from CMS. Tribes will need to be vigilant in assessing such proposals and advocating for exceptions for AI/ANs, and to ensure that Tribes will be able to work with states to continue to take advantage of waiver authorities for tribal facilities.

Full Federal Funding for Medicaid Services Provided to American Indians and Alaska Natives

Restructuring Medicaid as a block grant or per-capita program would eliminate the FMAP reimbursement methodology, including the special 100 percent FMAP rule for services provided to AI/ANs that are received through IHS and tribal health care facilities. Under current law, the United States is responsible for 100 percent of the costs of providing Medicaid services to AI/ANs. Moving to a block grant or per capita funding program would result in the states having to use the same block grant of federal funds to provide services to Indians and non-Indians alike. The current proposals do not contain any carve out that would maintain federal responsibility for the cost of providing Medicaid services to AI/ANs.

This would have several negative consequences. First, the states would have to use a portion of their federal share payment to provide services to AI/ANs. They currently do not. This will likely result in imposing a new burden on many states, and ultimately result in their making fewer services available or restricting eligibility. There are several proposed alternatives tribes can consider:

Option 1 – Keeping the 100% FMAP for Medicaid Services Provided to AI/ANs

To the extent that any Medicaid Reform proposal contains carve outs or exceptions from a general block grant or per capita allocation rule, Indians should be included. For example, the Hatch plan states that acute-care funding for low-income elderly and disabled individuals would continue to be reimbursed through the FMAP formula. The Ryan plan also contains exclusions from the capped per-capita allotment. Due to the unique nature of the Indian health system, funding for services provided to AI/ANs should also be continued to be reimbursed under the current 100 percent FMAP rule. Doing so would be consistent with previous expressions of congressional intent to

shield the States from costs associated with IHS and tribes participating in the Medicaid program.

Option 2 – Tribal Set-Aside – State Administered

If legislation is introduced and moves forward that does not contain any exceptions or carve outs for block grant or per capita allocation funding, then Tribes should consider asking for tribal set asides in state allocation formulas. The funding amounts could be based on historic funding for IHS, tribal and urban facilities in each state, and then that amount would flow to the state to be administered in a separate “federal Indian Medicaid allocation” account. IHS, tribal, and urban programs would bill against the account until funds were exhausted, at which point the state could ask CMS for supplemental funding. In this way, although state amounts would be capped, tribal amounts would not be. This approach is consistent with the federal trust responsibility, and also will not have any material effect on total Medicaid spending. To put it into perspective, total IHS Medicaid spending for 2015 was only 0.15 percent of total Medicaid spending.

Option 3 – Tribal Set-Aside – Federally Administered

This option would separate a Federal Medicaid program for AI/ANs from a block grant or per-capita program for the states. Such a Federal Medicaid program for AI/ANs would be administered by CMS through fiscal intermediaries, such as the Federal Medicare program is now. Under this option, IHS, tribes and urban Indian programs would submit their Medicaid claims directly to the federal fiscal intermediary. While this option is one that many tribes have long sought, it would also require the most significant work to achieve, however.

Conclusion

Medicaid payments to IHS and Tribal health facilities are grounded in the Federal trust responsibility, and it is imperative that 100 percent FMAP reimbursement be retained in any Medicaid reform proposal. The Medicaid program plays a pivotal role in augmenting the chronically underfunded Indian health system. Any version of Medicaid reform is sure to have wide reaching impacts on the provision of health care in Indian Country. It is of vital importance that AI/AN input is considered as Congress and the new Administration develops their plans for reform.

¹ A wholesale repeal of the ACA would pose a significant threat to the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.) (IHCIA), which was enacted as Section 10221 of that law. As a result, preserving the IHCIA will be a priority for Indian Country in any legislation that seeks to repeal/replace the ACA. This paper focuses on a separate threat to federal funding for the Indian health system posed by parallel efforts to reform the Medicaid program.

² Article I, Section 8, Clause 3.

³ *Morton v. Mancari*, 417 U.S. 535, 551-555 (1974).

⁴ 25 U.S.C. § 1602(1).

⁵ The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2017 Budget (May 2015), <http://www.nihb.org/docs/02272015/FY2017National%20Tribal%20BFWG%20Summary%20Recommendations.pdf>.

⁶ As detailed in the National Tribal Formulation Workgroup's Recommendations on the IHS Budget for 2017, "[a]ccording to IHS data, AI/ANs die at higher rates than other Americans from AI/AN people die at higher rates than other Americans from alcoholism (552% higher), diabetes (177% higher), unintentional injuries (138% higher), homicide (82% higher) and suicide (65% higher)." *Id.*

⁷ While the Indian health system has received funding increases in recent years, per capital healthcare spending levels still lag far behind the rest of the United States.

⁸ Samantha Artiga and Anthony Damico, *Medicaid and American Indians and Alaska Natives*, The Henry J. Kaiser Family Foundation (March 7 2016), <http://kff.org/report-section/medicaid-and-american-indians-and-alaska-natives-issue-brief-march-2016-update/>.

⁹ *Id.*

¹⁰ *Id.*

¹¹ 42 U.S.C. § 1395qq (eligibility of IHS/tribal facilities for Medicare payments); 42 U.S.C. § 1396j (eligibility of IHS/tribal facilities for Medicaid payments).

¹² H.R. Rep. No. 94-1026-Part III (May 12, 1976) at 21, reprinted in 1976 U.S. Code Cong. & Admin News at p.2796.

¹³ 25 U.S.C. § 1641(a).

¹⁴ 42 U.S.C. §1396d(b).

¹⁵ H.R. Rep. No. 94-1026-Part III (May 12, 1976) at 21, reprinted in 1976 U.S. Code Cong. & Admin News at p.2796.

¹⁶ Center for Medicare and Medicaid Services, SHO #16-002, Feb. 26, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf>.

¹⁷ Governor Dugaard of South Dakota recently cited CMS's new 100 percent FMAP policy in a letter informing Tribes in the State that he looked forward to working with the Trump Administration to reform Medicaid in a manner that maximized the effect of the policy.

¹⁸ Balanced Budget Act of 1997 (P.L. 105- 33, BBA 97).

¹⁹ 42 U.S.C. § 2103(a)(3)(D).

²⁰ 42 U.S.C. §§ 1396o(j) and 1396o-1(b)(3)(A)(vii), as added by Sec. 5006(a) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009). In recognition of the trust responsibility, Indian children have been exempt from cost-sharing in the CHIP program pursuant to regulation at 42 C.F.R. 457.535.

²¹ 42 U.S.C. §§ 1396a(ff) and 1397gg(e)(1)(H), as added by Sec. 5006(b) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

²² 42 U.S.C. § 1396p(b)(3)(B), as added by Sec. 5006(c) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

²³ 42 U.S.C. § 1396u-2(h), as added by Sec. 5006(d) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

²⁴ President-elect Trump announced that he would appoint Representative Tom Price (R-GA) to be Secretary of Health and Human Services and Ms. Seema Verma to be head of the Center for Medicare and Medicaid Services. As discussed above, Rep. Price's legislation would repeal the entirety of the ACA (including the IHCAA) and replace it with health savings accounts. He has also expressed support for Medicaid block grants. Ms. Verma is a healthcare consultant who has worked on a number of state Medicaid waiver proposals that would have imposed cost-sharing and work requirements and auto-enrolled Indians into managed care.

²⁵ 42 U.S.C. § 1396r-1(b)(2)(D)(iv); 42 U.S.C. 1396r-1a(b)(3)(A)(i)(I).

²⁶ 42 C.F.R. § 435.1103.

²⁷ As discussed below, any requirement that AI/ANs pay premiums and co-pays or be mandatorily enrolled in managed care absent a waiver is inconsistent with existing Medicaid protections for AI/ANs.

²⁸ 42 U.S.C. § 1396j; 25 U.S.C. § 1647a.

²⁹ 42 U.S.C. §§ 1396o(j) and 1396o-1(b)(3)(A)(vii).

³⁰ 42 U.S.C. § 1396b(x)(3)(B)(v).

³¹ 42 U.S.C. § 1396u-2(a)(2)(C).

³² 42 U.S.C. § 1396u-2(h).

³³ 42 U.S.C. §§ 1396a(ff) and 1397gg(e)(1)(H).

³⁴ 42 U.S.C. § 1396p(b)(3)(B).