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Medicaid: Can Federal Responsibilities, State Authorities, and Tribal Sovereignty Be Reconciled

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COMMENT

**Medicaid: Can Federal Responsibilities, State Authorities,
and Tribal Sovereignty be Reconciled?**

*Robert Onders, M.D.**

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I. INTRODUCTION

Health care reforms are occurring at both the national and state levels as a consequence of growing costs and the failure of a market system to allocate resources optimally. The Patient Protection and Affordable Care Act (ACA) enacted in 2010, and its subsequent optional expansion of Medicaid, highlighted numerous critical intergovernmental issues related to the health care delivery and payment. An issue currently in the national spotlight is the role of federal and state governments in determining Medicaid eligibility requirements. Although it has not received the same degree of national attention, the Medicaid expansion also involves the intergovernmental relationships between the federal government, states, and American Indian and Alaska Native Tribes. The federal government has a unique government-to-government relationship with American Indians and Alaska Native Tribes based on the U.S. Constitution, treaties, court decisions,

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statutes, and regulations.¹ This unique relationship permeates the delivery of health care to American Indians and Alaska Natives. Health care for American Indians and Alaska Natives is provided pursuant to the organization of hundreds of treaties, which include medical services, the services of physicians, or for hospitals for the care of Indian people, into law.²

The decisions made by state governments related to Medicaid funding of American Indian and Alaska Native health care is not consistent with either the federal responsibility or the unique government-to-government relationship the Tribes have with the federal government. The United States Supreme Court's recent decision allowing optional Medicaid expansion for states further emphasizes how state authority in Medicaid implementation decisions impacts federally funded care delivered to American Indians and Alaska Natives.³ American Indians and Alaska Natives are disproportionately impacted in states not expanding Medicaid.⁴

The medical assistance provided to American Indians and Alaska Natives through the Medicaid program should be reformed to appropriately reflect federal responsibilities, state authorities in Medicaid program decisions, and Tribal sovereignty. This comment first reviews the Medicaid program as it relates to health care for American Indians and Alaskan Natives.⁵ Second, it reviews the Medicaid program in the context of the federal responsibility to provide health care for American Indians and Alaskan Natives, state authority in Medicaid decisions, and Tribal sovereignty.⁶ Third, this comment analyzes two current

¹ See, e.g., WILLIAM C. CANBY, JR., *AMERICAN INDIAN LAW IN A NUT SHELL* 1 (5th ed. 2009). This work discusses the doctrinal bases of Indian Law as follows:

First, the tribes are independent entities with inherent powers of self-government. Second, the independence of the tribes is subject to exceptionally great powers of Congress to regulate and modify the status of the tribes. Third, the power to deal with and regulate the tribes is wholly federal; the states are excluded unless Congress delegates power to them. Fourth, the federal government has a responsibility for the protection of the tribes and their properties, including protection from encroachments by the states and their citizens.

Id.; see also CENTERS FOR MEDICAID AND CHIP SERVICES, *Indian Health and Medicaid*, <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Indian-Health-and-Medicaid/Indian-Health-Medicaid.html> (last visited Sept. 1, 2014).

² *Indian Health and Medicaid*, *supra* note 1; see also, e.g., Fort Bridger Treaty art. 10, July 3, 1868, 15 Stat. 673; Treaty of Fort Laramie art. 8, Apr. 29, 1868, 15 Stat. 635; Treaty of Cession art. 3, June 20, 1867, 15 Stat. 539. The U.S. government entered into hundreds of treaties with American Indians prior to the end of treaty-making with the Indian Appropriations Act of 1871. The Fort Bridger Treaty and Treaty of Fort Laramie are two examples where physician's services were partial consideration for Tribal land cessions while the 1867 Treaty of Cession provided that Alaska Natives would be treated the same as aboriginal peoples in the rest of the United States.

³ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

⁴ See *infra* notes 32–45 and accompanying text.

⁵ See *infra* notes 9–45 and accompanying text.

⁶ See *infra* notes 46–111 and accompanying text.

practices which attempt to reconcile the federal responsibility in light of federal, state, and Tribal roles in Medicaid: Tribal consultation and Section 1115 waivers.⁷ Finally, the analysis examines two potential solutions—Tribal Medicaid Agencies and a change to the Indian Health Service budget—that would provide a true Tribal government-to-Federal government relationship.⁸

II. BACKGROUND

A. *The Medicaid Program*

Medicaid is an optional joint federal-state program authorized under Title XIX of the 1965 Social Security Act.⁹ Today, all fifty states participate.¹⁰ Currently, Medicaid is administered by the Center for Medicare and Medicaid Services (CMS) and insures sixty-eight million people or one in every five Americans.¹¹ Prior to the optional expansion allowed by the ACA in 2014, eligibility for Medicaid included mandatory eligibility groups under federal Medicaid law: pregnant women, children, low income families, people with disabilities, and low income seniors.¹² Federal law requires each state to insure these groups and grants flexibility to cover other optional eligibility groups.¹³ States set income level eligibility criteria within federally specified parameters for the mandatory and optional eligibility groups.¹⁴ Additionally, states may apply to CMS for a waiver of federal law to expand health coverage beyond federal eligibility groups, benefits, or test approaches in Medicaid that differ from federal rules.¹⁵

⁷ See *infra* notes 121–155 and accompanying text.

⁸ See *infra* notes 156–178 and accompanying text.

⁹ 42 U.S.C. §§ 1396–1396(w) (2012).

¹⁰ KAISER FAMILY FOUNDATION, *Medicaid: A Timeline of Key Developments*, <http://kaiserfamilyfoundation.files.wordpress.com/2008/04/5-02-13-medicaid-timeline.pdf> (last visited Sept. 1, 2014) (Arizona was the last state to join the program in 1982).

¹¹ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Medicaid and CHIP: August 2014 Monthly Applications, Eligibility Determinations and Enrollment Report 2* (Oct. 17, 2014), <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/August-2014-Enrollment-Report.pdf>.

¹² CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Eligibility*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html> (last visited Oct. 19, 2014).

¹³ 42 U.S.C. § 1396(a)(10)(A) (2012).

¹⁴ *Id.* § 1396(a).

¹⁵ *Id.* § 1315; CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Waivers*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html> (last visited Oct. 19, 2014); Robin Rudowitz, Samantha Artiga, & MaryBeth Musumeci, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers* (Nov. 24, 2014), <http://kff.org/medicaid/issue-brief/the-aca-and-recent-section-1115-medicaid-demonstration-waivers/>.

Medicaid program decisions regarding eligibility criteria, optional groups, and waivers result in program variances from state to state.¹⁶ As of January 2013, nineteen states covered children up to at least 150% of the federal poverty level (FPL)—\$29,295 for a family of three in 2013.¹⁷ Adult eligibility for Medicaid is significantly limited. Nationwide, the median eligibility level for working parents is sixty-three percent of poverty, ranging from seventeen percent in Arkansas to 215% in Minnesota.¹⁸ Historically, non-disabled adults without dependent children (“childless adults”) have been excluded from Medicaid. Federal parameters and state decisions led to the current composition of the Medicaid population. Nearly half of all Medicaid enrollees are children.¹⁹ Non-elderly adults (mostly working parents) make up another quarter.²⁰ Seniors and people with disabilities account for the remaining quarter.²¹

Additional Medicaid program variability is created by states’ choices of the medical assistance services or benefits provided through Medicaid. States must provide a core set of benefits, but have flexibility in coverage of optional benefits.²² States also have options in determining the amount, duration, and scope of the benefit.²³ As with eligibility, state determinations of optional benefits result in a great deal of variation in medical assistance services provided in state Medicaid programs.²⁴

In addition to sharing decision-making power related to eligibility requirements and services provided, the federal government and states share Medicaid administrative and medical assistance costs.²⁵ The federal government matches state Medicaid medical assistance spending according to the federal match rate, known as the Federal Medical Assistance Percentage (FMAP), which varies based on per capita income in each state.²⁶ Roughly fifty-seven percent of

¹⁶ KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *Medicaid Moving Forward* (June 17, 2014), <http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/>.

¹⁷ *Id.*; see also 42 U.S.C. § 9902(2) (2012) (defining the federal “poverty line”).

¹⁸ KAISER COMMISSION, *supra* note 16.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² 42 U.S.C. § 1396(a) (2012); CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Medicaid Benefits*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html> (last visited Oct. 19, 2014).

²³ *Medicaid Benefits*, *supra* note 22; Laura Snyder et al., *Why Does Medicaid Spending Vary Across States: A Chart Book of Factors Driving State Spending* 20 (November 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8378.pdf>.

²⁴ Snyder, *supra* note 23, at 21.

²⁵ 42 U.S.C. § 1396(b) (2012).

²⁶ *Id.* § 1396(d) (2012).

all Medicaid costs flow from federal funds.²⁷ There is an exception to this general formula for federal Medicaid medical assistance spending on American Indians and Alaska Natives. If medical assistance to an American Indian or Alaska Native is provided through an Indian Health Service (IHS) or Tribally operated facility,²⁸ the federal government pays 100% of a state's costs for services covered by the state Medicaid program.²⁹

The extensive intergovernmental relationships associated with both the operation of the Medicaid program and its funding have been present since the program began.³⁰ The recent optional expansion of the Medicaid program, and the significant role Medicaid plays in state budgets, has drawn these relationships in the national spotlight.³¹

B. Medicaid and the Patient Protection and Affordable Care Act

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA), which encompasses ten titles and spans over 900 pages.³² It focuses on provisions to expand public and private health care insurance coverage, control health care costs, and improve the health care delivery system.³³ Medicaid eligibility expansion is an important component of expanding health care insurance coverage to individuals.³⁴ The Act establishes a minimum eligibility level of 133% of the FPL for nearly all Americans under age sixty-five.³⁵

The Medicaid eligibility expansion includes a change to federal cost sharing to reduce the burden on state budgets. The ACA substantially raised the federal

²⁷ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Financing and Reimbursement*, <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html> (last visited Oct. 19, 2014).

²⁸ Indian Self-Determination Act, Pub. L. No. 93-638 (1975) (allowing services previously provided by IHS to be administered by Tribes: frequently referred to as 638 facilities).

²⁹ 42 U.S.C. § 1396(d) (2012).

³⁰ *Id.* §§ 1396–1396(w) (2012).

³¹ NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS, *Healthcare and Medicaid*, <http://www.nasbo.org/budget-topics/healthcare-medicare> (last visited Nov. 7, 2014) (finding Medicaid issues “create enormous financial and policy challenges for states and it is estimated that Medicaid comprised 23.6 percent of total state expenditures in 2011”).

³² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

³³ DEPARTMENT OF HEALTH AND HUMAN SERVICES, *About the Law*, <http://www.hhs.gov/health-care/rights/> (last visited Oct. 19, 2014); KAISER FAMILY FOUNDATION, *Summary of the Affordable Care Act* (Apr. 25, 2013), <http://kff.org/health-reform/fact-sheet/summary-of-new-health-reform-law/>.

³⁴ *About the Law*, *supra* note 33; KAISER FAMILY, *supra* note 33 (additional provisions to expand health care coverage include requiring individuals to have insurance coverage and requiring certain employers to offer insurance to their employees).

³⁵ *Eligibility*, *supra* note 12 (Sometimes 138% of FPL will be used because the way Medicaid eligibility is calculated, it is effectively 138% of the FPL.).

share of the costs for newly eligible enrollees; those costs will be paid entirely by the federal government from 2014 through 2016.³⁶ This federal share will gradually decrease beginning in 2017 until it reaches ninety percent in 2020, where it will remain for all subsequent years.³⁷ The federal matching rate for American Indians and Alaska Natives receiving services at IHS and Tribally operated facilities will remain at 100% for newly eligible population.³⁸

On June 28, 2012, the United States Supreme Court issued an opinion on a combination of actions related to the ACA in *National Federation of Independent Business v. Sebelius*.³⁹ The Court upheld the individual mandate for health insurance coverage as a constitutional exercise of Congressional authority to tax, but held the Medicaid expansion requirement exceeded Congressional authority under the Spending Clause.⁴⁰ This decision bars the U.S. Department of Health and Human Services (HHS) Secretary from revoking or withholding Medicaid funding to states that choose not to expand their Medicaid programs.⁴¹ Functionally, the decision allows individual states to decide whether or not to expand state Medicaid programs to cover low-income adults up to 133% of the FPL.⁴²

The optional expansion of Medicaid to a minimum of 133% FPL leads to greater program variation between states that have expanded coverage and those that have not.⁴³ American Indians and Alaska Natives' increased poverty level results in a higher proportion qualifying for Medicaid.⁴⁴ Consequently, state decisions on Medicaid eligibility requirements and services provided have a significant impact on American Indians and Alaska Natives.⁴⁵

³⁶ 42 U.S.C. § 1396(d)(y)(1) (2012); Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010, 42 C.F.R. § 433 (2013).

³⁷ Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010, 42 C.F.R. § 433 (2013).

³⁸ Samantha Artiga, Rachel Arguello, & Philethea Duckett, *Health Coverage and Care for American Indians and Alaska Natives* 9–10 (Oct. 7, 2013), <http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-american-indians-and-alaska-natives/>.

³⁹ Nat'l. Fed. Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

⁴⁰ *Id.* at 2608.

⁴¹ *Id.* at 2607.

⁴² *Id.* at 2608.

⁴³ Stan Dorn et al., *What is the Result of States not Expanding Medicaid?*, URBAN INST. (2014), available at <http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid.pdf> (one finding showing the number of uninsured in expanding states fell by thirty-eight percent since September 2013 while nonexpanding states experienced a decline of just nine percent); see *supra* notes 9–31 and accompanying text.

⁴⁴ *Health Coverage*, *supra* note 38, at 8–9; UNITED STATES CENSUS BUREAU, *American Fact-Finder – Results*, <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited June 21, 2014).

⁴⁵ See *infra* notes 85–104 and accompanying text.

C. *Health Care for American Indians and Alaskan Natives*

1. *Federal Responsibility to American Indians and Alaska Natives*

The federal government's provision of health care services results from treaty obligations where over 400 million acres of Tribal lands were ceded to the United States.⁴⁶ In partial consideration for the land cessions, Tribes were promised health care services.⁴⁷ The Snyder Act of 1921 provided the legislative authorization for these federal health care responsibilities promised in prior treaties.⁴⁸ The Snyder Act empowers the Bureau of Indian Affairs (BIA) to "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States" for purposes including "relief of distress and conservation of health[.]" and assistance with property, employment, and "administration of Indian affairs."⁴⁹

The agency tasked with providing health care to American Indians and Alaska Natives under the federal responsibility has changed multiple times. In 1803 the Office of Indian Affairs, in the War Department, assumed direction of Indian health matters.⁵⁰ This responsibility transferred to the BIA in the Department of Interior in 1849.⁵¹ The 1954 Transfer Act shifted the duty to the Public Health Service, a division of the Department of Health, Education, and Welfare.⁵² The IHS was established in 1955 under the Public Health Service and is now within the Department of Health and Human Services (HHS).⁵³ The 1975 Indian Self-Determination Act provides a mechanism to transfer programs traditionally administered by the BIA and the IHS to Tribal governments.⁵⁴ Tribal organizations are currently able to provide the health care services previously delivered only by IHS prior to the Act.⁵⁵ The Act recognized the importance of Tribal decision-making in Tribal affairs and the nation-to-

⁴⁶ See *supra* note 2 and accompanying text; U.S. COMMISSION ON CIVIL RIGHTS, *Broken Promises: Evaluating the Native American Health Care System* 47 (2004), available at <http://www.usccr.gov/pubs/nahealth/nabroken.pdf>.

⁴⁷ *Broken Promises*, *supra* note 46, at 47.

⁴⁸ 25 U.S.C. § 13 (1998).

⁴⁹ *Id.*

⁵⁰ Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 214–15 (1997).

⁵¹ *Id.* at 215.

⁵² Indian Facilities Act, 68 Stat. 674 (1954).

⁵³ INDIAN HEALTH SERVICES, IHS GOLD BOOK 8 (2005), available at <http://www.ihs.gov/newsroom/factsheets/>.

⁵⁴ Indian Self-Determination Act, Pub. L. No. 93-638 (1975) (Facilities administered by Tribes are frequently referred to as 638 facilities.).

⁵⁵ *Id.*

nation relationship between the United States and Tribes.⁵⁶ As will be discussed in greater detail below, the current funding and decision-making authorities in the Medicaid program strain this relationship.⁵⁷

Although the federal government is responsible for providing health care to American Indians and Alaska Natives, appropriations have been insufficient to facilitate the performance of this federal trust responsibility.⁵⁸ The inadequacy of appropriations was clearly noted in Meriam Report in 1928 and continues today.⁵⁹ The federal government spends less on American Indian and Alaska Native health care per capita than on prisoners, veterans, federal employees, or military personnel.⁶⁰ IHS spends sixty percent less on its beneficiaries compared to the nationwide average per person health care expenditure.⁶¹ To counteract these shortfalls, IHS and Tribal facilities rely on third party revenues from Medicare, Medicaid, the Veterans Administration, and private insurance.⁶²

The 1976 Indian Health Care Improvement Act (IHCIA) attempted to correct some of the identified deficiencies in care and funding. IHCIA reaffirmed the federal responsibility for health care and provided the goal of elevating the health status of American Indian and Alaska Native people to a level equal to the general population.⁶³ In order to meet this goal, and in recognition of the underfunding of IHS, Section 402 of IHCIA amended the Social Security Act, allowing IHS to bill Medicaid for services provided to American Indians and Alaska Natives.⁶⁴ When IHS bills Medicaid, it is reimbursed at 100% FMAP if the “services [were] received through an Indian Health Service facility.”⁶⁵ From 1976

⁵⁶ Office of Tribal Self-Governance, *What is the Tribal Self-Governance Program?*, INDIAN HEALTH SERVICE, http://www.ihs.gov/SelfGovernance/index.cfm?module=dsp_otsg_about (last visited Sept. 19, 2014).

⁵⁷ See *infra* notes 112–178 and accompanying text.

⁵⁸ *Broken Promises*, *supra* note 46, at 87–120; *Health Coverage*, *supra* note 38, at 7.

⁵⁹ LEWIS MERIAM ET AL., THE PROBLEM OF INDIAN ADMINISTRATION: REPORT OF A SURVEY MADE AT THE REQUEST OF HONORABLE HUBERT WORK, SECRETARY OF THE INTERIOR 9 (1928) (presenting a two-year study of the Indian Bureau examining Indian policy’s impact on life of Indians and finding “the inadequacy of appropriations has prevented the development of an adequate system of public health administration and medical relief work for the Indians”); *Broken Promises*, *supra* note 46, at 87–120.

⁶⁰ *Broken Promises*, *supra* note 46, at 98 fig.4.

⁶¹ *Broken Promises*, *supra* note 46, at 87.

⁶² *Health Coverage*, *supra* note 38, at 7.

⁶³ Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976); see *infra* notes 85–104 and accompanying text (discussing current health status of American Indians and Alaska Natives compared to the general population).

⁶⁴ Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976) (amending Social Security Act of 1935, 42 U.S.C. §§ 1396(d), 1396(j), 1905(b), 1911 (2000)).

⁶⁵ *Id.*

to 1996, Center for Medicare and Medicaid Services (CMS) narrowly construed Section 402 of IHCA and only IHS-owned facilities were reimbursed at the 100% FMAP rate.⁶⁶ The 1994 Indian Self-Determination Contract Reform Act eventually allowed services at Tribe-operated facilities to receive 100% FMAP.⁶⁷ IHCA was reauthorized “permanently and indefinitely” in March 2010 with the passage of the ACA.⁶⁸

Considered together, these acts re-affirm the nation-to-nation relationship based on treaty obligations between the United States and Tribes in the provision of health care.⁶⁹ The acts also recognize the intention of Medicaid funding to help meet the federal responsibilities of providing health care to American Indians and Alaska Natives as there is no required state contribution.⁷⁰ The 100% FMAP provision of IHCA recognizes states merely provide the Medicaid agency to pass through payment on behalf of the federal government.⁷¹

2. *Medicaid Eligibility and Expansion*

American Indians and Alaska Natives are eligible for services under Medicaid.⁷² American Indians and Alaska Natives’ increased poverty level results in higher Medicaid eligibility rate.⁷³ Twenty-nine percent of single-race American Indians

⁶⁶ *Ellenbecker v. Ctrs. for Medicare & Medicaid Servs.*, 335 F. Supp. 2d 999, 1003 (2003) (quoting letter from CMS to State Medicaid Directors (Jan. 3, 1997) announcing a modification to CMS policy in regards to reimbursement of Medicaid services provided to Medicaid-eligible American Indian and Alaskan Native individuals).

⁶⁷ 25 U.S.C. § 450(j)(1) (2012).

⁶⁸ See Patient Protection and Affordable Care Act, § 10221 (enacting the Indian Health Care Improvement and Reauthorization Act).

⁶⁹ H.R. REP. 94-1026, 108 (1976), stating as follows:

The Senate Finance Committee justified the 100% reimbursement method by noting that with respect to matters relating to Indians, the Federal Government has traditionally assumed major responsibility. The Committee wishes to assure that a State’s election to participate in the Medicaid program will not result in a lessening of Federal support of health care services for this population group, or that the effect of Medicaid coverage be to shift to States a financial burden previously borne by the Federal Government.

⁷⁰ H.R. Rep. 94-1026(III), 21 (1976) (finding Committee approval of the 100% FMAP because “the Federal government has treaty obligations to provide services to Indians; it has not been a State responsibility”).

⁷¹ *Id.*

⁷² DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, *Memorandum of Agreement: Provision of Medical Services to Indians and Other Native Americans* ¶ 27,222 (Jan. 7, 1975) (finding American Indians and Alaska Natives are entitled to equal access to state, local, and federal programs under the Constitution and the Civil Rights Act of 1964).

⁷³ UNITED STATES CENSUS BUREAU, *American FactFinder – Results*, <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited June 21, 2014).

and Alaska Natives were considered impoverished in 2012, the highest rate of any racial group.⁷⁴ For the nation as a whole, the poverty rate was sixteen percent.⁷⁵ Medicaid Program eligibility and service choices affect a larger percentage of the total American Indians and Alaskan Natives compared to the general population because of their higher eligibility rates.

If a state does not opt to expand Medicaid under the ACA, American Indians and Alaska Natives are disproportionately impacted.⁷⁶ Many uninsured American Indian and Alaska Native parents, as well as adults without dependent children, will obtain health care coverage in states expanding Medicaid.⁷⁷ Unfortunately, sixty percent of those American Indians and Alaska Natives below 139% of the federal poverty level live in the twenty-six states currently without expansion.⁷⁸ Based on their income, they would be eligible for Medicaid under the ACA eligibility expansion provision.⁷⁹ The results of a state's decision not to expand Medicaid are especially apparent in states with a high percentage of American Indians and Alaska Natives such as Alaska (19.6%), Oklahoma (13.4%), South Dakota (10.0%), and Montana (8.1%).⁸⁰ For example, for those who would gain eligibility if Alaska expanded Medicaid, 14,000, or thirty-seven percent, are American Indians or Alaska Natives.⁸¹ In states not expanding Medicaid sixty-one percent of uninsured American Indians and Alaska Natives would be eligible under the optional expansion.⁸² Leaving American Indians and Alaska Natives without Medicaid coverage impacts their health by both making access to health care resources unavailable and contributing to the underfunding of IHS and Tribal health care facilities.⁸³

Current state decisions in Medicaid implementation lead to program variability in eligibility and services. These decisions can also lessen the impact

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Matthew Buettgens & Christopher Hildebrand, *Medicaid in Alaska Under the ACA* 7 (Feb. 1, 2013), available at <http://www.urban.org/publications/412748.html>.

⁷⁷ *Health Coverage*, *supra* note 38, at 8–9.

⁷⁸ UNITED STATES CENSUS BUREAU, *American FactFinder – Results*, <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited June 21, 2014); 42 U.S.C. § 9902(2) (2012) (defining “poverty line”) (Because of the way FPL is calculated for Medicaid eligibility, it's effectively 138% of the FPL.).

⁷⁹ *Eligibility*, *supra* note 12.

⁸⁰ UNITED STATES CENSUS BUREAU, *supra* note 78.

⁸¹ Matthew Buettgens & Christopher Hildebrand, *Medicaid in Alaska Under the ACA*, URBAN INST. 7 (2013), available at <http://www.urban.org/publications/412748.html>.

⁸² *Health Coverage*, *supra* note 38, App.B tbl.1.

⁸³ *Field Hearing on the Indian Health Service: Ensuring the IHS is Living up to its Trust Responsibility Before the Senate Committee on Indian Affairs* (2014) (testimony of multiple Tribal leaders on the need to prioritize care delivered based on funding available); *Broken Promises*, *supra* note 46, at 87–120; *Health Coverage*, *supra* note 38.

that the 100% FMAP Medicaid funding stream has in compensating for shortfalls in the annually appropriated IHS budget. Funding shortfalls harm people who need chronic and preventative services because the funding is spent first on emergent or urgent needs.⁸⁴

3. *Health and Medicaid*

American Indian and Alaska Natives have higher rates of physical and mental health conditions per capita.⁸⁵ An analysis of Behavioral Risk Factor Surveillance System Survey Data in 2011 revealed non-elderly, adult American Indians and Alaska Natives were more likely than the overall population to report being in fair or poor health, being overweight or obese, having diabetes and cardiovascular disease, and experiencing frequent mental distress.⁸⁶ A comparison of 2002–2004 American Indian and Alaska Native death rate to the 2003 U.S. all races death rate reveals further disparities: tuberculosis, 750% greater; alcoholism, 524% greater; motor vehicle crashes, 234.6% greater; diabetes mellitus, 193% greater; unintentional injuries, 153% greater; homicide, 103.3% greater; suicide, 66% greater; pneumonia and influenza, 47% greater; and firearm injury, 8% greater.⁸⁷ In Montana, the disparities result in white males living nineteen years longer than American Indian men, and white females living twenty years longer than American Indian women.⁸⁸ The gap is even larger in Wyoming, where American Indians' life expectancy in fifty-three years, while that of the general population is seventy-nine.⁸⁹

Medicaid expansion of services and eligibility to Tribal members, and the associated funding of care, may be one way of addressing these health disparities. A recent study compared three states (New York, Maine, and Arizona) that substantially expanded adult Medicaid eligibility beginning in 2000. Researchers found the expansions were associated with reduced mortality, improved access to care, and better self-reported health.⁹⁰ In another study, Medicaid coverage

⁸⁴ *Field Hearing*, *supra* note 83.

⁸⁵ INDIAN HEALTH SERVICE, TRENDS IN INDIAN HEALTH 2002–2003 EDITION (2009), available at http://www.ihs.gov/dps/files/Trends_02-03_Entire%20Book%20%28508%29.pdf.

⁸⁶ *Health Coverage*, *supra* note 38; CENTERS FOR DISEASE CONTROL AND PREVENTION, *Behavioral Risk Factor Surveillance System*, http://www.cdc.gov/brfss/about/about_brfss.htm (last visited Feb. 6, 2015) (health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services).

⁸⁷ INDIAN HEALTH SERVICE, *supra* note 85.

⁸⁸ MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, THE STATE OF THE STATE'S HEALTH 11 (2013).

⁸⁹ Gregory Nickerson, '*Medicaid expansion still very important*' on reservation, WYOFILE (July 29, 2014), http://wyofile.com/gregory_nickerson/medicaid-expansion-still-important-reservation/#sthash.1xXgrGgX.dpuf.

⁹⁰ Benjamin D. Sommers et al., *Mortality and Access to Care among Adults after State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (2012).

resulted in an absolute decrease in the rate of depression by 9.15 percentage points, representing a relative reduction of thirty percent.⁹¹

The national shortage of primary care physicians and staff further strains the American Indians and Alaska Native health care system.⁹² Twenty percent of IHS physician positions are vacant.⁹³ The ability to recruit and retain competent health care providers directly impacts the quality of care at a health care facility.⁹⁴ Research demonstrates better health exists in areas with a greater number of primary care physicians, and people who receive care from primary care physicians are healthier.⁹⁵ For example, continuity of care with a primary care provider is associated with better glucose control among patients with type 2 diabetes, a disease with a 193% higher mortality rate in American Indians and Alaska Natives.⁹⁶ Other studies demonstrate increased rates of preventative screening and immunizations with increased continuity in health care.⁹⁷ Conversely, greater severity of hypertension correlates to the absence of a relationship with a primary care provider.⁹⁸ Access to primary care, regardless of income level, has been shown to prevent worsening of conditions that can be treated outside the hospital, such as asthma in children.⁹⁹ These statistics emphasize the need to adequately recruit and retain qualified health care providers in order to improve health in American Indians and Alaska Natives.

Health disparities in American Indians and Alaska Natives, and the evidence that adequate health care can improve health, makes the 1928 Meriam Report's

⁹¹ Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713 (2013).

⁹² See generally HEALTH RESOURCES AND SERVICES ADMINISTRATION, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020* (2013), available at <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf>.

⁹³ Yvette Roubideaux, *Statement of Acting Director Indian Health Service before the Senate Committee on Homeland Security and Government Affairs Subcommittee on the Efficiency and Effectiveness of Federal Programs and the Federal Workforce 3* (May 23, 2013), <http://www.hsgac.senate.gov/download/?id=584550c8-b1a7-4dab-ab00-b9347f6ad1f7> (noting that vacancy rates are calculated based on the number of positions available but not filled).

⁹⁴ *Broken Promises*, *supra* note 46, at 77; *Field Hearing*, *supra* note 83 (including testimony of multiple Tribal leaders on the impact of staffing levels on care delivered).

⁹⁵ Barbara Starfield et al., *Contribution of Primary Care to Health Systems and Health*, 83 MILBANK Q. 457 (2005).

⁹⁶ Michael Parchman et al., *Continuity of Care, Self-management Behaviors, and Glucose Control in Patients with Type 2 Diabetes*, 40 MED. CARE 137 (2002).

⁹⁷ Ann O'Malley, *Current Evidence on the Impact of Continuity of Care*, 16 CURRENT OPINION IN PEDIATRICS 693 (2004).

⁹⁸ Steven Shea et al., *Predisposing Factors for Severe, Uncontrolled Hypertension in an Inner-city Minority Population*, 37 NEW ENG. J. MED. 776 (1992).

⁹⁹ Carmen Casanova & Barbara Starfield, *Hospitalizations of Children and Access to Primary Care: A Cross-national Comparison*, 25 INT'L. J. HEALTH SERV. 283 (1995).

conclusion as true today as when it was first published: “The chief explanation of the deficiency in this work lies in the fact that the government has not appropriated enough funds to permit the Indian Service to employ an adequate personnel properly qualified for the task before it.”¹⁰⁰ Although “[m]any factors contribute to these disparities, . . . the failure of the federal government to adequately fund the Indian Health Service for the provision of care to the 1.8 million patients it is supposed to serve means that the promises of treaties signed in the 1800s have never been fulfilled.”¹⁰¹ Medicaid funding plays a critical role in funding health care to American Indians and Alaska Natives.¹⁰² Increased funding is necessary to assist the IHS and Tribes in meeting the substantial staffing shortages.¹⁰³ Provider shortages directly affect the timeliness and quality of care.¹⁰⁴ Increased eligibility or services through Medicaid expansion would likely help address these issues impacting the health care of American Indians and Alaska Natives.

4. *Economic benefits*

Not only could Medicaid expansion directly impact the health of American Indians and Alaska Natives, the secondary economic benefits of expansion may also impact their health.¹⁰⁵ Recent reports on Medicaid expansion in Alaska and Montana focus on the potential derivative benefits to the economy.¹⁰⁶ Higher Medicaid spending results in increased employment, labor income, and tax revenues.¹⁰⁷ In Alaska, it is estimated that each \$1 million in State spending could generate approximately \$28 million in additional economic activity.¹⁰⁸ This increased activity results from leveraging of the federal Medicaid expenditures

¹⁰⁰ Lewis Meriam et al., *The Problem of Indian Administration: Report of a Survey Made at the Request of Honorable Hubert Work, Secretary of the Interior* 8 (1928); *Broken Promises*, *supra* note 46, at 87–120.

¹⁰¹ Yvette Roubideaux, *Beyond Red Lake—The Persistent Crisis in American Indian Health Care*, 353 *NEW ENG. J. MED.* 1881–83 (2005).

¹⁰² See *infra* note 152 and accompanying text.

¹⁰³ *Broken Promises*, *supra* note 46, at 77–79.

¹⁰⁴ *Id.*

¹⁰⁵ RICHARD G. WILKINSON & M.G. MARMOT, *SOCIAL DETERMINANTS OF HEALTH: THE SOLID FACTS* 20–21 (2nd ed. 2003).

¹⁰⁶ UNIVERSITY OF MONTANA, BUREAU OF BUSINESS AND ECONOMIC RESEARCH, *An Estimate of the Economic Ramifications Attributable to the Potential Medicaid Expansion on the Montana Economy* (2013), available at http://csi.mt.gov/health/media/BBER_MedicaidExpansion.pdf; NORTHERN ECONOMICS, INC., *Fiscal and Economic Impacts of Medicaid Expansion in Alaska* (2013), available at <http://www.anthctoday.org/news/Final%20Report-Fiscal%20and%20Economic%20Impacts%20of%20Medicaid%20ExpansioninAlaska.pdf>.

¹⁰⁷ UNIVERSITY OF MONTANA, *supra* note 106; NORTHERN ECONOMICS, INC., *supra* note 106.

¹⁰⁸ UNIVERSITY OF MONTANA, *supra* note 106; NORTHERN ECONOMICS, INC., *supra* note 106.

and the multiplier effects in the State's economy.¹⁰⁹ In 2012, American Indians and Alaska Natives had the lowest employment to population ratio of any race nationwide.¹¹⁰ Unemployed adults had poorer mental and physical health than employed adults, a pattern found for insured and uninsured adults across all ethnic backgrounds.¹¹¹ For American Indians and Alaska Natives the secondary economic benefits of expansion may result in employment opportunities that directly benefit their health.

III. ANALYSIS

It is challenging to reconcile federal trust responsibilities and Tribal sovereignty in light of state authorities in the Medicaid program. The Commerce Clause of the Constitution expressly includes Indian Tribes together with two other sovereigns—foreign nations and the states.¹¹² The history of the adoption of the Indian Commerce Clause, and its elimination of two provisions in the Articles of Confederation reserving some state authority in Indian affairs, strongly suggests Indian affairs should be managed through a direct Federal-Tribal relationship.¹¹³ This direct relationship has been affirmed by the United States Supreme Court and is critical when analyzing the roles the federal government, state government, and Tribes play in Medicaid.¹¹⁴

Medicaid is a large program, jointly managed and funded by federal and state governments.¹¹⁵ IHS and Tribal facilities rely on congressionally directed Medicaid funding to counteract funding shortfalls.¹¹⁶ This funding is critical to reaching the goal of elevating the health status of American Indian and Alaska Native people to a level equal to the general population.¹¹⁷

¹⁰⁹ UNIVERSITY OF MONTANA, *supra* note 106; NORTHERN ECONOMICS, INC., *supra* note 106 (noting that the multiplier effect refers to the increase in final activity arising from any new injection of spending).

¹¹⁰ UNITED STATES BUREAU OF LABOR STATISTICS, *Labor Force Characteristics by Race and Ethnicity* (2013), available at <http://www.bls.gov/cps/cpsrace2012.pdf>.

¹¹¹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *National Center for Health Statistics-Data Briefs-Number 83* (2012), available at <http://www.cdc.gov/nchs/data/databriefs/db83.htm#findings>.

¹¹² U.S. CONST. art. I, § 8, cl. 3.

¹¹³ Robert N. Clinton, *There is No Federal Supremacy Clause for Indian Tribes*, 34 ARIZ. ST. L.J. 113, 128–33 (2002) (providing supporting documentation from JOURNALS OF THE CONTINENTAL CONGRESS 1774–1789, at 457–59 (1936)).

¹¹⁴ See, e.g., *Worcester v. Georgia*, 31 U.S. 515, 561 (1832).

¹¹⁵ See *supra* notes 9–31 and accompanying text; see *infra* notes 121–136 and accompanying text.

¹¹⁶ *Health Coverage*, *supra* note 38, at 7.

¹¹⁷ See Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976); see *supra* notes 85–104 and accompanying text (discussing current health status of American Indians and Alaska Natives compared to the general population).

The 100% Federal Medical Assistance Percentage (FMAP) funding recognizes Medicaid's role in the federal trust responsibility to American Indians and Alaska Natives.¹¹⁸ This provision, along with other provisions of Indian Health Care Improvement Act (IHCIA), was intended to reduce health disparities by increasing funding for American Indian and Alaska Native health care.¹¹⁹ However, there was no Congressional intent to transfer authority of Tribal healthcare to the states.¹²⁰ The analysis focuses on possible solutions reconciling the goal of providing Medicaid funding to IHS and Tribal health care facilities to reduce health disparities with state decision authority in Medicaid programs. First, two current practices, Tribal consultation and Section 1115 waivers, will be discussed. Next, this analysis discusses two comprehensive solutions: the creation of Tribal Medicaid agencies and a change in the IHS budget.

A. Tribal Consultation

Tribal consultation on Medicaid decisions is one way to recognize the Tribes' connection with the federal government. The unique government-to-government relationship between Tribes and the federal government creates the basis for Tribal consultation.¹²¹ The relationship is based on the political and legal aspects of Tribal sovereignty, not on race.¹²² In recognition of the unique government-to-government connection between Tribes and the Federal Government, the Center for Medicare and Medicaid Services (CMS) developed a formal Tribal Consultation Policy in 2011.¹²³ The policy was developed based on Executive Order 13175 (2000), Executive Memorandum on Tribal Consultation (2009), HHS Tribal Consultation Policy (2010) along with input from Tribes and CMS regional offices.¹²⁴ President Clinton's Executive Order 13175 states "[e]ach agency shall have an accountable process to ensure meaningful and timely input by tribal officials in the development of regulatory policies that have tribal

¹¹⁸ See *supra* notes 69–70 and accompanying text.

¹¹⁹ Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976) (The act also increased direct appropriations to IHS, allowed IHS to also bill Medicare, and in the "findings" section of the act, Congress noted: "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian People. . . . A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level.").

¹²⁰ See *supra* notes 69–70 and accompanying text.

¹²¹ See *supra* note 1 and accompanying text.

¹²² See *Morton v. Mancari*, 417 U.S. 535, 553–54 (1974) (holding that Indians constitute a political rather than racial category and therefore are not subject to the same type of equal protection analysis used by courts to protect the rights of other minority groups).

¹²³ CENTERS FOR MEDICAID AND MEDICAID SERVICES, *Tribal Consultation Policy* (2011), http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTCP_FINAL_11_17_11.pdf.

¹²⁴ *Id.*

implications.”¹²⁵ President Obama’s 2009 memorandum to the heads of executive departments and agencies identified consultation as a “critical ingredient of a sound and productive Federal-[T]ribal relationship,” and set in motion a process for complete and consistent implementation of Executive Order 13175.¹²⁶

Under the CMS Tribal Consultation Policy, any agency action significantly affecting Tribes triggers consultation.¹²⁷ The goal is to obtain Tribal input prior to taking any actions that have the potential to affect federally recognized Tribes.¹²⁸ The policy recognizes the importance of consultation in developing culturally appropriate approaches to improve access to CMS programs, enhance health care payment and resources to IHS and Tribal health providers, and contribute to overall improved health outcomes.¹²⁹

Requirements for Tribal consultation have a statutory basis as well. Section 5006 of the 2009 American Recovery and Reinvestment Act (ARRA) codified the requirement that the Secretary of Health and Human Services maintain a Tribal Technical Advisory Group (TTAG) within CMS.¹³⁰ TTAG was established in 2004 by CMS to seek input and advice on policies and programs affecting delivery of health services and to increase American Indians’ and Alaska Natives’ access to CMS programs.¹³¹ The group consists of one elected tribal leader, or appointed representative from each of the twelve IHS service areas along with representation from IHS and four Washington, DC-based advocacy organizations: Tribal Self Governance Advisory Committee, National Indian Health Board, National Congress of American Indians, and National Council of Urban Indian Health.¹³² The group and its subject-specific subcommittees meet frequently on issues related to Medicare, Medicaid, and CHIP policies affecting American Indians and Alaska Natives.¹³³

ARRA and Medicaid Section 1115 waivers also require Tribal consultation for decisions related to Medicaid state plans for medical assistance.¹³⁴ The

¹²⁵ Exec. Order No. 13175, 65 Fed. Reg. 67,249, 67,250 (Nov. 9, 2000).

¹²⁶ Memorandum on Tribal Consultation, 74 Fed. Reg. 57,881, 57,881 (Nov. 9, 2009).

¹²⁷ *Tribal Consultation Policy*, *supra* note 123.

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ American Recovery and Reinvestment Act (ARRA), Title V, § 5006(e)(1) (2009) (codified at 42 U.S.C. § 1320(b)(24) (2012)).

¹³¹ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Tribal Technical Advisory Group*, <http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/TTAG/index.html> (last visited Oct. 25, 2014).

¹³² *Id.*

¹³³ *Id.*

¹³⁴ American Recovery and Reinvestment Act, Pub. L. No. 111-5 Div. B, Title V, § 5006(e)(2) (2009); 42 U.S.C. § 1396(a) (2012); 42 C.F.R. § 431.408(b).

statutes require states to seek advice from designees of Indian health programs and urban Indian organizations when Medicaid decisions are likely to have a direct effect on those populations.¹³⁵ The consultation provisions are critically important to keeping Tribes involved in the decision-making process at the state level, though states make the final decision. This final decision-making authority gives states wide latitude in designing Medicaid programs in terms of eligibility, services covered, payment methodology, and claims processing.¹³⁶ Allowing Tribes consultation rights only, while the states have the final decision making authority, is not consistent with the government-to-government relationship the Tribes share with the federal government. Thus Tribal consultation alone is inadequate to protect the Federal-Tribal relationship.

B. Section 1115 Waivers

Section 1115 of the Social Security Act may provide a mechanism to reconcile Federal responsibility and State authority with Tribal sovereignty. Section 1115 grants states the ability to seek waiver of federal requirements for all programs authorized under the Social Security Act.¹³⁷ The HHS Secretary can authorize experimental, pilot, or demonstration projects where Medicaid state plan requirements are waived.¹³⁸ The waiver allows states to experiment with new approaches that promote the objectives of Medicaid.¹³⁹ Demonstration projects give states additional flexibility to design and improve their programs through a variety of approaches such as expanding eligibility to additional individuals, providing services not typically covered, or using innovative service delivery systems.¹⁴⁰ States submit waiver applications to CMS and the application is subject to state and federal public notice and comment requirements.¹⁴¹ Section 1115 demonstrations are generally initially approved for a five-year period and can be renewed.¹⁴² Projects must be budget neutral to the federal government, meaning that during the course of the project federal Medicaid expenditures will not be greater than federal spending without the waiver.¹⁴³ During the course of the demonstration federal Medicaid expenditures must not increase.¹⁴⁴

¹³⁵ American Recovery and Reinvestment Act, Pub. L. No. 111-5 Div. B, Title V, § 5006(e)(2) (2009); 42 U.S.C. § 1396(a) (2012); 42 C.F.R. § 431.408(b).

¹³⁶ *Medicaid Benefits*, *supra* note 22 (providing list of mandatory and optional benefits).

¹³⁷ Social Security Act, § 1115 (referencing 42 U.S.C. § 1315).

¹³⁸ *Id.*

¹³⁹ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Section 1115 Demonstrations*, <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html> (last visited Oct. 25, 2014).

¹⁴⁰ *Id.*

¹⁴¹ 42 C.F.R. §§ 431.408, 431.416 (2014).

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Id.*

In 2012, Arizona amended its previous section 1115 waiver to include specific provisions for IHS and Tribal health care providers.¹⁴⁵ The amended demonstration allowed IHS and Tribal facilities to receive payments for health care costs associated with services to individuals with family income up to 100% of the Federal Poverty Level (FPL) who are no longer covered under the current state Medicaid plan.¹⁴⁶ Arizona requested an extension on the project in August of 2014 after an analysis of the program clearly demonstrated the critical role payment play in supporting IHS and Tribal facilities meeting the needs of Medicaid beneficiaries.¹⁴⁷

In March of 2013, California similarly amended its section 1115 demonstration. The California Bridge to Reform Demonstration allows payment to IHS and Tribal facilities for uncompensated services when provided to uninsured individuals with incomes up to 133% of the FPL.¹⁴⁸ Both state amendments help IHS and Tribal health care providers receive compensation for providing health care services, allow the provision of services they otherwise would be unable to provide, and financially support the underfunded facilities.¹⁴⁹

Wyoming has a total of seven active and approved section 1115 waivers although none of the current waivers are Tribal specific.¹⁵⁰ Wyoming House Bill 80, titled Medicaid waiver-tribal health programs-2, was sponsored by the Select Committee on Tribal Relations in February 2014.¹⁵¹ It would have created an exception to the legislature's ban on the health department investigating a section 1115 waiver for those eligible for services delivered by IHS.¹⁵² The bill failed to win enough votes to be introduced during a budget session.¹⁵³

Tribal specific section 1115 waivers have the potential to help the federal government meet its obligation to provide health care to American Indians and Alaska Natives. The waivers enable states to provide federally funded services to

¹⁴⁵ C.M.S. Waiver Letter. (April 6, 2012) (granting request to amend Arizona's Medicaid Section 1115 Demonstration, the Arizona Health Care Cost Containment Demonstration).

¹⁴⁶ *Id.*

¹⁴⁷ Letter from Monica H. Coury, Assistant Director Office of Intergovernmental Relations, Arizona Health Care Cost Containment System, to Wakina Scott, Division of State Demonstrations and Waivers, CMS (Aug. 29, 2014), *available at* <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa-tribal-uncompensated-care-pool.pdf>.

¹⁴⁸ California Department of Health Care Services Memorandum (January 24, 2013) (providing notice of proposed change to the Medi-Cal program).

¹⁴⁹ Letter from Monica H. Coury, *supra* note 147; California Department of Health Care Services, *supra* note 147 (providing notice of proposed change to the Medi-Cal program).

¹⁵⁰ *Waivers, supra* note 15.

¹⁵¹ H.B. 80, Wyoming 2014 Budget Session (Wyo. 2014).

¹⁵² *Id.*

¹⁵³ *Id.*

American Indians and Alaska Natives, which states might not provide if required to share costs of providing those services. It is also a solution that is currently available and has been shown as beneficial.¹⁵⁴ The proposition is still less than ideal, however, because section 1115 waivers are created through a combination of state and federal authority. This process does not recognize the unique government-to-government relationship Tribes share with the federal government.¹⁵⁵ A more comprehensive Medicaid solution is required to reconcile federal responsibility, state authority, and Tribal sovereignty.

C. Tribal Medicaid Agencies

Independent Tribal Medicaid Agencies are an alternative solution that would recognize the unique government-to-government relationship between Tribes and the federal government. The Navajo Nation is exploring this option. Navajo Nation covers over 27,000 square miles and extends into the states of Arizona, New Mexico, and Utah.¹⁵⁶ It has a population over 250,000.¹⁵⁷ Navajo Nation faces a unique problem because it spans three states with different Medicaid rules. Residents of the Navajo Nation may be eligible for the Arizona, New Mexico, or Utah Medicaid program depending on their location on the reservation.¹⁵⁸ In addition, IHS and Tribal health providers face significant additional complexities by dealing with three different Medicaid agencies.¹⁵⁹

The ACA contains a provision to study the feasibility of establishing a Navajo Nation Medicaid agency.¹⁶⁰ The study, released in May of 2014, suggests it could be feasible and would have little economic impact on the three surrounding states.¹⁶¹ The report recognized creating this agency would face challenges in terms of costs and administrative work needed to design, implement, and manage the Medicaid Agency.¹⁶² Design and implementation of the agency was estimated to take five years.¹⁶³

¹⁵⁴ See *supra* note 147 and accompanying text.

¹⁵⁵ See *Worcester v. State of Georgia*, 31 U.S. 515, 561 (1832).

¹⁵⁶ NAVAJO NATION GOVERNMENT, <http://www.navajo-nsn.gov/index.htm> (last visited Sept. 28, 2009).

¹⁵⁷ *Id.*

¹⁵⁸ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Report to Congress on Feasibility of a Navajo Nation Medicaid Agency* (2014), available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Downloads/Navajo-Nation-Medicaid-Agency-Feasibility-Report-to-Congress.pdf>.

¹⁵⁹ *Id.*

¹⁶⁰ 25 U.S.C. § 1647(d) (2012).

¹⁶¹ *Report to Congress*, *supra* note 158.

¹⁶² *Id.*

¹⁶³ *Id.*

A Navajo Nation Medicaid agency would not only allow for a direct relationship with the federal government, it would also address the unique issues the Tribe faces. A Navajo Nation Medicaid agency would create a single set of eligibility provisions and services. It would also have the potential to promote Tribal sovereignty in the administration of Medicaid while lessening the challenges related to working with three state Medicaid agencies.¹⁶⁴

The report looked at many factors in considering the feasibility of the agency. These factors included costs, availability of professional and management staff, contracting for a Medicaid Management Information System, legal and regulatory issues, provider network and payment issues, and outreach and education needs.¹⁶⁵ These feasibility considerations and federal requirements make the solution appropriate in the case of Navajo Nation, but may prevent smaller Tribes from implementing an independent Medicaid program.¹⁶⁶

D. Indian Health Service Budget Changes

The final potential solution proposes changing the formulation of the IHS budget to allow IHS Tribal facilities to receive Medicaid funding in a direct government-to-government fashion. IHS and Tribal health care facilities serve 2.2 million American Indians and Alaska Natives nationwide.¹⁶⁷ The 2014 annual appropriation to IHS was 4.4 billion dollars.¹⁶⁸ This funding results in an IHS health care expenditure of \$2000 per capita at IHS facilities compared with U.S. population per capita health care expenditure of \$7713.¹⁶⁹ To compensate for this shortfall in funding, IHS and Tribal facilities rely on billing third party health insurance programs.¹⁷⁰ The largest alternate third party health insurance providing funding for IHS and Tribal facilities is the Medicaid program, run jointly by the state and federal government.¹⁷¹ In 2006, Medicaid payments to IHS health care service providers for American Indian and Alaska Native Medicaid enrollees were estimated at \$2.05 billion.¹⁷² This funding is 100% federal dollars based on the exception to Federal Medical Assistance Percentage (FMAP) for IHS and Tribal

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ See 42 U.S.C. § 1396(a) (listing requirements for state plans for medical assistance).

¹⁶⁷ INDIAN HEALTH SERVICES, *IHS Year 2014 Profile*, <http://www.ihs.gov/newsroom/factsheets/ihsyear2014profile/> (last visited Oct. 25, 2014).

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Health Coverage*, *supra* note 38, at 7.

¹⁷¹ California Rural Indian Health Board, *Analysis of Medicaid Payments for American Indians and Alaska Natives* i (2012), available at http://www.crihb.org/files/0.Medicaid_Report_FINAL_1_9_13.pdf.

¹⁷² *Id.* at ii.

facilities.¹⁷³ The federal Medicaid funding provided for services delivered at IHS and Tribal facilities is subject to individual state Medicaid decisions related to eligibility and services provided.¹⁷⁴ This arrangement results from decisions to increase funding to IHS and Tribal funding through Medicaid, but it indirectly gives states decision-making authority over the provision of Tribal health care.¹⁷⁵

Moving the non-discretionary Medicaid funding for qualified Tribal members receiving services through IHS or Tribal facilities directly into the IHS budget is a potential solution to this issue. Currently, the IHS budget, unlike Medicaid and Medicare, is contained within the small portion of the Health and Human Services' discretionary budget and is subject to annual appropriations.¹⁷⁶ Annual appropriations cause IHS and Tribal health administrators to wonder if, when, and how much of their budgets will be funded each time Congress passes a continuing resolution.¹⁷⁷ A change in budgeting would provide IHS and Tribal facilities more control over non-discretionary funding for Medicaid-eligible American Indian and Alaska Natives. Federal Medicaid funding would then go directly to Tribes and allow the Tribes, not states, to determine eligibility and service parameters within federal guidelines.

The eligibility and services provided could be set for each of the twelve IHS regions.¹⁷⁸ Section 1115 waivers would still play an important role, but instead of the application coming from the states to CMS it would come from the Tribes in the twelve IHS regions. Existing IHS and Tribal staff and facilities could determine eligibility and submit claims to the federal government without having to create independent Tribal Medicaid agencies. The facilities already receive annually-appropriated funds from IHS. Under this approach they would also receive non-discretionary funding for medical assistance from IHS rather than through state agencies.

¹⁷³ 42 U.S.C. § 1396(d) (2012).

¹⁷⁴ See *supra* notes 32–45 and accompanying text.

¹⁷⁵ See *supra* notes 32–45 and accompanying text.

¹⁷⁶ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Fiscal Year 2015 Budget in Brief* (2014), available at <http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf> (Eight percent of the projected 2015 HHS budget is discretionary.).

¹⁷⁷ NATIONAL INDIAN HEALTH BOARD, *Advance Appropriations for IHS*, http://www.nihb.org/legislative/advance_appropriations.php (last visited Sept. 1, 2014).

¹⁷⁸ INDIAN HEALTH SERVICE, *Locations*, <http://www.ihs.gov/locations/> (last visited Nov. 7, 2014) (noting that Indian Health Service is divided into twelve physical areas of the United States; Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland, and Tucson).

IV. CONCLUSION

Medicaid is a large program, jointly managed by federal and state governments.¹⁷⁹ IHS and Tribal facilities rely on congressionally directed Medicaid funding to counteract funding shortfalls.¹⁸⁰ The funding is critical to reaching the goal of elevating the health status of American Indians and Alaska Natives to the level of the general population.¹⁸¹ There are potential solutions, which recognize federal trust responsibilities and Tribal sovereignty in light of state Medicaid authorities.

State proposed and federally approved Tribal-specific section 1115 waivers recognize the federal responsibility and increase needed funding for health care provision to American Indians and Alaska Natives.¹⁸² Tribal Medicaid agencies provide the potential to recognize the unique Federal-Tribal intergovernmental relationship, while also meeting the federal responsibility for providing health services, which has not been fulfilled. Yet, these solutions are still less than ideal. States submit section 1115 waivers to the federal government for approval, thereby becoming the intermediary in what is supposed to be a Tribal-Federal government-to-government relationship. Independent Tribal Medicaid Agencies recognize the unique government-to-government relationship of Tribes and the Federal government, but may be limited in application because of the many requirements and costs of setting up the agencies.¹⁸³ Allowing IHS and Tribal facilities direct compensation from a federal, nondiscretionary budget for services provided to Medicaid-eligible American Indians and Alaska Natives may be the best solution, bringing federal responsibility and Tribal sovereignty related to health care into alignment.¹⁸⁴ This budget change could help correct the long-term underfunding of IHS and Tribal health and bring the health care of American Indians and Alaskan Natives in line with federal trust responsibilities and treaty obligations.

¹⁷⁹ See *supra* notes 9–31, 121–136 and accompanying text.

¹⁸⁰ See *supra* notes 69–70 and accompanying text; *Health Coverage*, *supra* note 38, at 7.

¹⁸¹ Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976); see *supra* notes 85–104 and accompanying text (discussing current health status of American Indians and Alaska Natives compared to the general population).

¹⁸² See *supra* notes 137–155 and accompanying text.

¹⁸³ See *supra* notes 156–166 and accompanying text.

¹⁸⁴ See *supra* notes 167–178 and accompanying text.