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Ensuring Sovereignty in Healthcare: A Comparison of Tribal Healthcare Compacts and Medicaid

ABSTRACT. This Note examines federal-state and federal-tribe relationships through a comparison of Medicaid and the Indian Health Service (IHS). Analysis of tribal contracting and compacting documents and Medicaid state plans reflects the history of each program: Medicaid is a product of trusting federal-state collaboration, while the IHS reflects a history of distrust between tribes and executive-branch agencies in particular. This finding suggests that IHS compacting and contracting practices have significant lessons for Medicaid as the latter program negotiates with a hostile federal government.

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INTRODUCTION

For twelve hours, Cory Booker and Hakeem Jeffries sat on the steps of the Capitol. Part political stunt, part policy discussion, their sit-in was a plea to protect Medicaid and other federal programs.[1] Congressional Republicans had introduced a bill that threatened to cut $800 billion from Medicaid—a significant portion of the program's federal budget.[2] Booker and Jeffries hosted policy experts, other members of Congress, and passersby to talk about the importance of Medicaid and similar programs. Despite their best efforts, the massive Medicaid cuts passed and were signed by President Trump as part of the One Big Beautiful Bill Act (OBBBA) on July 4, 2025.[3] As enacted, this cut is the largest in the program's history and will reduce coverage under a program that has been providing healthcare for those in poverty since 1965.[4]

Threats to Medicaid are not exactly new. The program has faced opposition almost since inception; experts have theorized that the program was only passed into law on Medicare's coattails,[5] and proposals to block grant Medicaid or

1. *See* Edward Helmore, *Hakeem Jeffries and Cory Booker Hold 12-Hour Sit-in Against GOP Funding Plan*, GUARDIAN (Apr. 28, 2025, 8:57 AM ET), https://www.theguardian.com/us-news/2025/apr/27/hakeem-jeffries-cory-booker-livestream-protest-republican-funding-bill [https://perma.cc/K9MN-8HLZ].

2. *See* One Big Beautiful Bill Act, Pub. L. No. 119-21, §§ 71103, 71104, 139 Stat. 72, 291-94 (2025) (increasing requirements for confirming eligibility, which will likely lower overall program enrollment); *id.* § 71114, 139 Stat. at 301 (sunsetting the increased Federal Medical Assistance Percentage (FMAP) initiative for Medicaid recipients made eligible by the Affordable Care Act); *id.* § 71115, 139 Stat. at 301-02 (reducing states' ability to tax Medicaid providers, reducing state income); *see also* Kody Kinsley & Dan Rusyniak, *Medicaid Cuts Proposed by Congress Will Shift Costs to States, Reduce Benefits, and Hurt Families*, COMMONWEALTH FUND (June 20, 2025), https://www.commonwealthfund.org/blog/2025/medicaid-cuts-proposed-congress-will-shift-costs-states-reduce-benefits-and-hurt-families [https://perma.cc/8UAF-B5QB] (explaining the One Big Beautiful Bill Act's impact on red tape, coverage, and rural communities).

3. *See* One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72 (2025). For more on the legislative history of the Act, see Sarah Kliff & Margot Sanger-Katz, *The Senate Wants Billions More in Medicaid Cuts, Pinching States and Infuriating Hospitals*, N.Y. TIMES (June 17, 2025), https://www.nytimes.com/2025/06/17/upshot/medicaid-cuts-republicans-senate.html [https://perma.cc/34LY-SHCW].

4. *See supra* note 2 and accompanying text; Health Insurance for the Aged Act, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343-52 (1965).

5. *See* Julian E. Zelizer, *The Contentious Origins of Medicare and Medicaid*, *in* MEDICARE AND MEDICAID AT 50: AMERICA'S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE 3, 16-17 (Alan B. Cohen, David C. Colby, Keith A. Wailoo & Julian E. Zelizer eds., 2015).

impose work requirements have been common throughout the program's history.[6] Yet despite these ongoing threats, Medicaid has mostly existed quietly in the background, providing mandatory state and federal funding to care for some of the nation's most vulnerable patients.[7] Medicaid is one of the nation's largest sources of insurance coverage and one of the largest line items in state budgets.[8] The One Big Beautiful Bill Act that Booker and Jeffries protested will shock state budgets, deal a damaging blow to doctors and hospitals, and, most importantly, disrupt healthcare for millions of Americans. For the first time, Medicaid is facing a truly existential threat.

For the Indian Health Service (IHS), however, underfunding has long been a daily reality. Per capita, the IHS spends about half of what Medicaid spends and less than half of what the Department of Veterans Affairs spends.[9] At oral argument in *Becerra v. San Carlos Apache Tribe*, a recent Supreme Court case concerning disputed IHS funding, Justice Sotomayor generously described the IHS's spending: "It's not as if all of this money is bringing us a luxury healthcare spa."[10] At that same argument, the Biden Administration acknowledged that solely providing the tribes with contract-support costs—not even fully funding all necessary healthcare services—would increase the IHS's spending from

6. *See generally* Madeline Guth & MaryBeth Musumeci, *An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?*, Kaiser Fam. Found. (May 3, 2022), https://www.kff.org/medicaid/issue-brief/an-overview-of-medicaid-work-requirements-what-happened-under-the-trump-and-biden-administrations [https://perma.cc/G24U-4EWU] (describing some of the history of work-requirement proposals); Jeanne M. Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 Milbank Q. 41 (2005) (discussing the history of Medicaid block-grant proposals).

7. *See generally Policy Basics: Introduction to Medicaid*, Ctr. on Budget & Pol'y Priorities (June 10, 2025), https://www.cbpp.org/research/health/introduction-to-medicaid [https://perma.cc/4ZNS-BEEW] (explaining the mechanics and the importance of Medicaid); Jill Quadagno, *The Transformation of Medicaid from Poor Law Legacy to Middle-Class Entitlement*, *in* Medicare and Medicaid at 50, *supra* note 5, at 77 (describing Medicaid's evolution into a program relied upon by many).

8. *See Policy Basics: Introduction to Medicaid*, *supra* note 7 (noting that 70 million people are enrolled in Medicaid and stating that the program is "states' single largest source of federal funds").

9. *See* U.S. Gov't Accountability Off., GAO-19-74R, Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs 5 (2018) (listing Medicaid per capita spending as $8,109, Veterans Health Administration per capita spending as $10,692, and Indian Health Service (IHS) per capita spending as $4,078 in 2017).

10. Transcript of Oral Argument at 20, Becerra v. San Carlos Apache Tribe, 602 U.S. 222 (2024) (No. 23-250).

anywhere between $800 million to $2 billion per year.[11] Most recently, the Trump Administration has also proposed cutting IHS funding by up to $900 million in fiscal year 2026.[12] For the IHS, a hostile lack of funding is nothing new.

While the IHS's chronic underfunding has created access-to-care problems in Indian country, the IHS has still managed to succeed. The IHS is not an entitlement program, meaning that the agency lacks a set array of guaranteed services and often runs out of funding for needed services toward the end of the year.[13] Furthermore, the IHS primarily consists of a collection of clinics that provide limited services to tribal members and a fund that can pay for needed external care.[14] However, the IHS has had success in improving the population health of tribes.[15] Through contracts (also called Title I contracts) and more flexible

11. *Id.* at 17. Contract-support costs refer to the additional costs that tribes incur by entering into partnership with the federal government and taking over administration of their IHS programs. The federal government does not have to pay such costs when administering the same program due to the federal government's existing infrastructure. For example, the government is effectively self-insured through the Federal Tort Claims Act, but tribes may need to buy general insurance or malpractice insurance for their facilities and providers. *See Indian Health Manual Part 6, Chapter 3: Manual Exhibit 6-3-G*, INDIAN HEALTH SERV. (Aug. 6, 2019), https://www.ihs.gov/ihm/pc/part-6/p6c3-ex-g [https://perma.cc/4GB9-MU8R].

12. *See* Neely Bardwell, *Trump FY 2026 Budget Aims to Slash $900 Million from Indian Health Service*, NATIVE NEWS ONLINE (Apr. 19, 2025), https://nativenewsonline.net/health/trump-fy-2026-budget-aims-to-slash-30-to-indian-health-service [https://perma.cc/NXE7-GBTW] ("The proposal would slash nearly 30% from the IHS base funding, end advance appropriations, halt funding for health care and sanitation facility construction, restrict Tribal self-governance opportunities, and cut nearly $900 million in critical services and facility support in FY 2026.").

13. *See Purchased/Referred Care (PRC) Users Guide*, CONFEDERATED TRIBES OF SILETZ INDIANS (2025), https://ctsi.nsn.us/purchased-referred-care-prc-users-guide [https://perma.cc/CJ66-DKS3] ("The availability of funds determines the level of care provided. Towards the end of the fiscal year, funding may be limited."); Holly E. Cerasano, *The Indian Health Service: Barriers to Health Care and Strategies for Improvement*, 24 GEO. J. ON POVERTY L. & POL'Y 421, 435-36 (2017).

14. *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 9, at 2-3 ("Specifically, IHS and VHA provide health care services directly to eligible beneficiaries. Both programs provide care through agency-administered hospitals and other health care facilities, though IHS funds also pay for care provided by tribally operated facilities . . . . In contrast, Medicare and Medicaid act as public insurers for their beneficiaries . . . .").

15. *See* Gina Kruse, Victor A. Lopez-Carmen, Anpotowin Jensen, Lakotah Hardie & Thomas D. Sequist, *The Indian Health Service and American Indian/Alaska Native Health Outcomes*, 43 ANN. REV. PUB. HEALTH 559, 565-66 (2022) (describing improvements in health disparities); *see also* Tamara Perkins et al., *Healing of the Canoe: Preliminary Suicide Prevention Outcomes Among Participating and Non-Participating Youth*, 26 PREVENTION SCI. 740, 744-48 (2025) (detailing the effectiveness of culturally sensitive treatment for suicide prevention); Kamilla L. Venner

self-governance compacts (Title V compacts), tribes have partnered with the federal government to manage tribal health services and facilities.[16] In addition to operating traditional brick-and-mortar clinics, the IHS runs creative public-health programs that fill gaps and maximize its limited funding.[17]

Given the passage of the OBBBA, the Medicaid program faces an uncertain future and a new, potentially hostile relationship with the federal government.[18] As a result, state Medicaid programs may have much to learn from the IHS as they struggle to navigate an uncertain federal landscape. And beyond the current federal political shift, the IHS and Medicaid care for similarly vulnerable populations and face similar challenges in care and coverage. For example, Medicaid is dealing with significant problems in rural health, including provider and funding shortfalls in remote areas of the country;[19] the IHS has been dealing with the same problems for much longer.[20] Any solutions for the IHS would also support Medicaid program goals, and vice versa.

This Note compares the IHS to Medicaid, an analysis that is novel in the legal literature.[21] The Note undertakes this analysis for a few reasons. First, as

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et al., *Culturally Tailored Evidence-Based Substance Use Disorder Treatments Are Efficacious with an American Indian Southwest Tribe: An Open-Label Pilot-Feasibility Randomized Controlled Trial*, 116 ADDICTION 949, 949-50 (2020) (describing the development of culturally sensitive treatment for substance-use disorder).

16. *See infra* Section I.A.

17. *See* Off. of Quality, *IHS Innovation Projects Address Social Factors in Health*, INDIAN HEALTH SERV. (2022), https://www.ihs.gov/office-of-quality/ipc/impacts-and-outcomes/innovation-projects [https://perma.cc/T7FN-J8VY]; Mark Carroll et al., *Innovation in Indian Healthcare: Using Health Information Technology to Achieve Health Equity for American Indian and Alaska Native Populations*, PERSPS. HEALTH INFO. MGMT. art. no. 1d, at 1-6 (Winter 2011).

18. *See supra* notes 1-8 and accompanying text.

19. *See* Julia Foutz, Samantha Artiga & Rachel Garfield, *The Role of Medicaid in Rural America*, KAISER FAM. FOUND. (Apr. 25, 2017), https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america [https://perma.cc/G82Z-YV5Z]; Zachary Levinson, Jamie Godwin & Scott Hulver, *Rural Hospitals Face Renewed Financial Challenges, Especially in States That Have Not Expanded Medicaid*, KAISER FAM. FOUND. (Feb. 23, 2023), https://www.kff.org/health-costs/issue-brief/rural-hospitals-face-renewed-financial-challenges-especially-in-states-that-have-not-expanded-medicaid [https://perma.cc/SEJ3-TEAW].

20. *See* Cerasano, *supra* note 13, at 431; Laura-Mae Baldwin et al., *Access to Specialty Health Care for Rural American Indians in Two States*, 24 J. RURAL HEALTH 269, 276 (2008).

21. Academic literature explores how the IHS intersects with population-health concerns and how the IHS represents repeated failures of the federal government to meet its responsibilities to the tribes, but does not compare the IHS to Medicare or Medicaid extensively. For more on how the IHS intersects with public health, see generally Cerasano, *supra* note 13, which documents IHS actions in the realm of public health; Lucas Trout, Corina Kramer & Lois Fischer, *Social Medicine in Practice: Realizing the American Indian and Alaska Native Right to Health*, 20

noted above, the IHS and Medicaid provide care to very similar populations, and lessons from one are instructive to the other. Medicaid provides insurance coverage for those experiencing poverty, with coverage historically limited to the elderly, pregnant woman, people with disabilities, and families with children.[22] The IHS provides medical care and coverage for enrolled tribal citizens.[23] Though the populations are different, each has poor population health and low levels of trust in medicine due to historically problematic treatment.[24] Second, the IHS and Medicaid both involve partnerships between the federal government and a sovereign entity (i.e., a state or a tribe) to provide healthcare services to a set population. The legal relationships that tribes and states have with the federal government are very different, and Medicaid and the IHS are very different. However, the differences in the legal relationships and the healthcare programs formed are related; each healthcare program reflects its underlying history and legal relationship. Medicaid and IHS compacting each evolved based on a unique relationship between two sovereigns. A comparison of the two programs

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HEALTH & HUM. RTS. J. 19 (2018), which describes the role of the IHS in Alaska Native healthcare; Richard H. Levin, *The Indian Health Service Medical Care Program: A Guide for Advocates*, 10 CLEARINGHOUSE REV. 681 (1976), which describes strategies for utilizing the IHS to promote health; and Danika Elizabeth Watson, *Healthcare Self-Governance*, 10 AM. INDIAN L.J. 1 (2022), which discusses the general intersection between the IHS and public health. For more on the IHS and the trust doctrine, see generally Mark J. Connot, Blue Legs v. United States Bureau of Indian Affairs*: An Expansion of BIA Duties Under the Snyder Act*, 36 S.D. L. REV. 382 (1991), which discusses obligations imposed by the trust responsibility; and Lauren E. Schneider, Comment, *Trust Betrayed: The Reluctance to Recognize Judicially Enforceable Trust Obligations Under the Indian Health Care Improvement Act (IHCIA)*, 52 LOY. U. CHI. L.J. 1099 (2021), which describes judicial approaches to enforcing trust obligations in regards to tribal health.

22. *See* 42 U.S.C. § 1396-1 (2024) (describing the purpose of Medicaid appropriations); *see also Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels*, MEDICAID (2023), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels [https://perma.cc/9UHL-6C97] (providing eligibility levels in each state for key coverage groups).

23. *See* 25 U.S.C. § 1603(13) (2024) (defining "Indian" for the purposes of the IHS subchapter); *see also Eligibility*, INDIAN HEALTH SERV., https://www.ihs.gov/aboutihs/eligibility [https://perma.cc/5S2P-R9FA] (explaining how and where to find the rules, standards, and procedures that determine whether someone can get care from the IHS).

24. *See infra* notes 36-39 and accompanying text; Manatt, Phelps & Phillips, LLP, *Medicaid's Role in Addressing Social Determinants of Health*, ROBERT WOOD JOHNSON FOUND. (Feb. 1, 2019), https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html [https://perma.cc/HR4J-FVGT]. Both programs serve populations that are disproportionately ethnic and/or racial minorities and are lower income. Both of these characteristics are correlated with lower trust in medicine and the medical system. *See* Jessica Greene & Sharon K. Long, *Racial, Ethnic, and Income-Based Disparities in Health Care-Related Trust*, 36 J. GEN. INTERN. MED. 1126, 1126 (2021).

demonstrates how a different legal and historical relationship has impacted the resulting services and programs created under federal-state or federal-tribe partnerships.

Finally, the two programs' structural differences can shed light on policy proposals for each. The Biden Administration proposed to fund the IHS fully,[25] a promise that has at times been echoed by the Trump Administration,[26] which would make it look more like Medicaid. As mentioned above, the OBBBA's cuts to Medicaid funding will lead to some of the same challenges around underfunding that the IHS has dealt with since its inception. Particularly, the IHS's history of negotiating with a recalcitrant federal government may provide valuable insight for a new era of Medicaid.

This Note discusses both programs, including their statutory and contracting structures, and makes recommendations for the future of Medicaid. Part I explores the background of each program, including the programs' history, current structure, and challenges for the future. These histories illustrate how the IHS's current structure, which creates a federal-tribal partnership for tribal administration of the IHS, grew out of significant distrust between the tribes and the federal government. Part I also demonstrates that, conversely, Medicaid has a history of trust: state Medicaid agencies have been able to rely on federal executive-branch partners. Part II examines the programs' structures in more detail, focusing on how the federal government contracts with tribes and states to offer the IHS and Medicaid. An analysis of contract formation and contract language shows that the federal government treats Medicaid and the IHS differently and details how the tribes have used different contracting and compacting structures to protect their interests and promote tribal sovereignty. Part III proceeds to outline prescriptive lessons that the IHS's self-governance program has for Medicaid. When dealing with fickle federal partners and uncertain funding, state Medicaid agencies may want to consider how best to communicate about their efforts, negotiate with the federal government, and secure their programs effectively — similarly to the IHS's current approach and structure. Tribes and states are not the same, and Medicaid and the IHS differ significantly, but a comparison

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25. *See supra* notes 10-11 and accompanying text; *Fact Sheet: President Biden Touts Historic Support for Indian Country and Transformation of the Nation-to-Nation Relationship with Tribal Nations*, WHITE HOUSE (Oct. 24, 2024), https://bidenwhitehouse.archives.gov/briefing-room/statements-releases/2024/10/24/fact-sheet-president-biden-touts-historic-support-for-indian-country-and-transformation-of-the-nation-to-nation-relationship-with-tribal-nations [https://perma.cc/5LTX-D8DN].

26. *See* Em Luetkemeyer, *Lawmakers Say Trump's Budget Would Put Health Care for Native Americans at Risk*, NOTUS (June 5, 2025), https://www.notus.org/congress/trump-budget-proposal-indian-health-services-advance-funds [https://perma.cc/9DZN-V72Y] ("Trump's budget wishlist would fund IHS at $7.9 billion . . . .").

of the two offers a new path forward to promote public health in uncertain times.

I. HISTORY OF THE IHS AND MEDICAID

Medicaid programs and the IHS have divergent histories and structures. These differences reflect the historical federal-state and federal-tribe relationships that formed each program. The IHS grew out of treaty obligations and was initially administered by the federal government. The program's dual-sovereign structure originated with the creation of IHS contracting and compacting, which allowed tribes to partner with the federal government to manage federal government programs. Medicaid, on the other hand, grew out of individual state programs for indigent care. Medicaid became a partnership between the states and the federal government when the federal government passed legislation offering funding in exchange for program standards. These histories — Medicaid's continuous state administration and the IHS's transition from federal program to federal-tribe partnership — are reflected in their modern structures. Despite these differences, Medicaid and the IHS have similarities remarkably ripe for comparison: both operate under sovereign-to-sovereign relationships and provide care in diverse, often rural communities struggling with population health.

This Part lays out the history of both programs and then discusses some of the key ways in which they overlap to provide care for tribal populations. Understanding this history is crucial — it undergirds much of the analysis in Part II, as the history of the IHS and Medicaid helped develop the documents that currently govern them. The IHS's history includes a difficult beginning rooted in the federal government's colonialist attitude toward tribes and treaty obligations, an attitude still reflected in some of the program's documents. The IHS still does not have the resources to provide all needed care, but it has become successful given its circumstances — a model of how creative leaders can effectively advocate to promote sovereignty and public health. Medicaid's history conversely reflects a consistent federal-state partnership with mandatory federal funding, which is one source of its current vulnerability.

A. The Indian Health Service

The IHS began with the federal government's treaty obligations to the tribes; in these treaties, the federal government agreed to provide for the safety and health of tribal members as partial consideration for tribal land.[27] These treaties created a number of federal obligations to the tribes, including the healthcare

27. Robert Onders, Comment, *Medicaid: Can Federal Responsibilities, State Authorities, and Tribal Sovereignty Be Reconciled?*, 15 WYO. L. REV. 165, 171 (2015).

obligation that was the foundation of the IHS, and are broadly cited as the source of the federal trust obligation to the tribes.[28] The trust obligation purports to require the federal government to provide certain services to tribes in good faith, making them mandatory. However, the extent to which tribal healthcare programs are bound by these trust responsibilities is uncertain.[29] This historical background is the foundation of the IHS's financial precarity. While the federal government should be required to provide adequate healthcare to tribes as a treaty obligation, later decisions by Congress and the courts to distinguish healthcare from the trust responsibility mean that the federal government is not required to fund and staff the IHS adequately. Today's IHS, administered in partnership with many tribes, reflects the hard work and ingenuity of many who made it their life's work to improve the IHS and shape it into a shining example of tribal sovereignty. Yet the IHS still reflects its flawed, colonialist beginnings.

Programs to provide healthcare for tribes began with a congressional appropriation to purchase and administer the smallpox vaccine in 1832 and programs to provide physician services pursuant to treaty obligations in 1836.[30] The federal government gave more systematic attention to Indian health as a whole in the early 1900s, leading to the inclusion of provisions on tribal healthcare in the

28. The trust relationship between the federal government and the tribes grew out of language in treaties from the early period of colonization; this language was reinforced by courts. *See* Reid Peyton Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213, 1213 n.1 (1975). Notably, the trust relationship, while it purports to ensure that the federal government deals in the utmost good faith with the tribes, has proven hard to enforce. *See* ROBERT T. ANDERSON, SARAH A. KRAKOFF & BETHANY BERGER, AMERICAN INDIAN LAW: CASES AND COMMENTARY 232, 242 (2020). It does not map perfectly onto the common-law understanding of a trustee relationship, although courts have at times used that area of the law as an analogy or example. *See id.* at 232-33, 241-42.

29. Courts have delivered mixed results regarding how healthcare is covered by the trust responsibility and the extent to which the trust responsibility's healthcare aspect is enforceable. *See* Schneider, *supra* note 21, at 1142-46 (discussing both Rosebud Sioux Tribe v. United States, 450 F. Supp. 3d 986 (D.S.D. 2020), and Lincoln v. Vigil, 508 U.S. 182 (1993), which took different approaches to recognizing a federal trust responsibility regarding Indian healthcare).

30. *See* Caryn Trombino, *Changing the Borders of the Federal Trust Obligation: The Urban Indian Health Care Crisis*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 129, 133 n.28 (2004) (describing the first federal appropriation for smallpox vaccines for tribes in 1832). Notably, the first tribal health program coincided with *Worcester v. Georgia*, 31 U.S. (6 Pet.) 515 (1832). The last in the infamous Marshall trilogy, *Worcester* was one of the earliest Supreme Court cases discussing tribes and reflected the Court's early view of tribes as dependent. *See Worcester*, 31 U.S. (6 Pet.) at 555 ("The Indian nations were, from their situation, necessarily dependent on some foreign potentate for the supply of their essential wants, and for their protection from lawless and injurious intrusions into their country.").

Snyder Act of 1921.[31] The Snyder Act gave legislative authority to the early Indian Health Service, which was originally housed in the Bureau of Indian Affairs (BIA).[32] The BIA was "ill-equipped" to fulfill the healthcare aspects of its mandate under the Snyder Act, and tribal healthcare commitments continued to be underfunded.[33] In 1954, the IHS was transitioned to the Department of Health, Education, and Welfare, a precursor to the current Department of Health and Human Services.[34] Through this shift, the IHS was able to expand the services offered to tribal members.[35]

Despite federal efforts at improvement, the IHS has been mired in challenges ranging from financial limitations to institutional racism. The program's underfunding has led to care rationing and inadequate facilities and equipment.[36] However, funding was not the IHS's only problem. To say that the IHS in the 1970s did not provide culturally competent care is an understatement—the program conducted large-scale efforts to stop the birth of native children at all costs. IHS doctors conducted forced or coerced sterilizations that impacted between 25% and 50% of all Native people with the capacity for pregnancy, and they administered experimental contraceptives on Native people (and continued to administer one even after it was denied FDA approval).[37] Unethical medical

31. *See The First 50 Years of the Indian Health Service: Caring and Serving*, INDIAN HEALTH SERV. 8 (2005), https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/GOLD_BOOK_part1.pdf [https://perma.cc/S4MT-N7TE]; Act of Nov. 2, 1921, ch. 115, 42 Stat. 208, 208-09.

32. *See* Schneider, *supra* note 21, at 1123-24.

33. *Id.* at 1124 n.116 (quoting Robert McCarthy, *The Bureau of Indian Affairs and the Federal Trust Obligation to American Indians*, 19 BYU J. PUB. L. 1, 120-21 (2004)).

34. *Id.* at 1124.

35. *Id.* at 1124 & nn.119-20.

36. Mark N. Trahant, *The Story of Indian Health Is Complicated by History, Shortages & Bouts of Excellence*, 147 DAEDALUS 116, 117 (2018) ("Currently, the vacancy rate for Indian Health Service doctors, dentists, and physician assistants is roughly 30 percent. The backlog of facilities maintenance at IHS hospitals is over half a billion dollars, and according to the agency's own budget documents, the average age of its facilities is roughly four times that of its private sector counterparts." (quoting *Review of the FY2018 Budget Request for the Indian Health Service: Hearing Before the Subcomm. on Interior, Env't & Related Agencies of the S. Comm. on Appropriations*, 115th Cong. 2 (2017) (statement of Sen. Lisa Murkowski, Chair, S. Subcomm. on Interior, Env't & Related Agencies of the S. Comm. on Appropriations))); Jennie R. Joe, *The Rationing of Healthcare and Health Disparity for the American Indians/Alaska Natives*, *in* UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 528, 530 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003).

37. *See* Brianna Theobald, *A 1970 Law Led to the Mass Sterilization of Native American Women. That History Still Matters*, TIME (Nov. 28, 2019, 11:47 AM ET), https://time.com/5737080/native-american-sterilization-history [https://perma.cc/7AR3-8R4X]; HARRIET A. WASHINGTON,

research was also conducted in tribal communities, ranging from medical experiments conducted in Indian boarding schools to the Havasupai diabetes project (which first began in 1989 and continued unethically using blood samples—which have cultural and spiritual significance to the Havasupai—until this issue was raised in a dissertation defense in 2003).[38] Under the federal government's management, the IHS failed tribal populations repeatedly and created a legacy of medical mistrust that lingers and contributes to health disparities in tribal populations today.[39]

The 1975 passage of the Indian Self-Determination and Education Assistance Act (ISDEAA) was an important win for tribal sovereignty, even as the legislation faced significant challenges from a recalcitrant federal executive branch. The ISDEAA allowed tribes to partner with the federal government to provide IHS services themselves for the first time.[40] This new opportunity for tribal sovereignty in healthcare was a significant accomplishment. The ISDEAA was passed only a couple of decades after tribal termination had been the official policy of the U.S. federal government; in this context, a program to allow tribal self-government was novel.[41] The original ISDEAA allowed tribes to enter into contracts, now called Title I contracts, to administer programs or parts of programs through the IHS.[42] This change was an important step forward, allowing tribes to take over administration of the programs that provided basic services on tribal

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Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present 198-99 (2006); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 Am. Indian Q. 400, 400 (2000); *Despite Ban, American Indians Given Depo-Provera as Contraceptive*, Wash. Post (Aug. 10, 1987), https://www.washingtonpost.com/archive/lifestyle/wellness/1987/08/11/despite-ban-american-indians-given-depo-provera-as-contraceptive/94cbb91d-6497-4b95-abcf-oddb7ffd5c7b [https://perma.cc/64H8-DUY5].

38. *See* Christina M. Pacheco et al., *Moving Forward: Breaking the Cycle of Mistrust Between American Indians and Researchers*, 103 Am. J. Pub. Health 2152, 2153-54 (2013); Jamie E. Ehrenpreis & Eli D. Ehrenpreis, *A Historical Perspective of Healthcare Disparity and Infectious Disease in the Native American Population*, 363 Am. J. Med. Scis. 288, 291 (2022).

39. *See* B. Ashleigh Guadagnolo et al., *Medical Mistrust and Less Satisfaction with Health Care Among Native Americans Presenting for Cancer Treatment*, 20 J. Health Care for Poor & Underserved 210, 211 (2009); Michael C. Harding & Quinn D. Bott, Letter to the Editor, *Earning Trust Among Native American Populations*, 94 Acad. Med. 460, 460 (2019).

40. S. Bobo Dean & Joseph H. Webster, *Contract Support Funding and the Federal Policy of Indian Tribal Self-Determination*, 36 Tulsa L.J. 349, 350-52 (2000); 25 U.S.C. § 450f (1980).

41. *See* S. Res. 156, 119th Cong. (2025) (enacted) (describing how the Indian Self-Determination and Education Assistance Act was passed five years after President Nixon gave a speech "reject[ing] the misguided policies of termination and paternalism").

42. *Indian Health Service Tribal Self-Governance Program*, Off. Tribal Self-Governance 10-11 (Oct. 2022), https://www.tribalselfgov.org/wp-content/uploads/2022/11/IHS_OTSG_Brochure.pdf [https://perma.cc/D8GG-LKC2].

lands, such as schools and IHS clinics.[43] However, these new partnerships were met with significant resistance from the BIA and other executive-branch agencies. Through rulemaking and contract negotiations, the agencies dragged their feet, resisting tribal ownership of programs and projects that the agencies were (at the time) running.[44] As a later House Report noted,

> Since the Act was passed, tribes have encountered many problems in their contracts with the Federal agencies. Generally, tribes have complained that because of Federal contracting requirements and bureaucratic regulations that are too rigid and burdensome, they have not been able to implement their own priorities and agenda for tribal self-determination.[45]

The tribes deemed initial drafts of regulations implementing the program unworkable because the BIA and the IHS retained too much control, while federal reports determined, to the contrary, that the agencies did not retain enough.[46] Ultimately, the program stalled in its implementation due to bureaucratic opposition.[47]

Exasperated by the federal executive agencies' history of foot-dragging, tribes advocated together for changes to the ISDEAA programs that would allow the full realization of the 1975 legislation.[48] Congress, sharing tribal concern about the implementation of its Act, passed new legislation in 1988 to support the ISDEAA's implementation.[49] This new legislation set out requirements for agency oversight and made it mandatory for the federal government to grant

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43. *See* Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance Under the Indian Self-Determination and Education Assistance Act*, 39 AM. INDIAN L. REV. 1, 21-26 (2014).

44. *See* H.R. REP. NO. 100-393, at 4 (1987); *see also* 25 U.S.C. § 5321 (2024) (creating a procedure for a "refusal of request to contract" and establishing that the Secretary has the burden of proof of demonstrating why they opted not to contract).

45. H.R. REP. NO. 100-393, at 4.

46. *See* Strommer & Osborne, *supra* note 43, at 26-27.

47. *Id.* at 29; *The 30th Anniversary of Tribal Self-Governance: Successes in Self-Governance and an Outlook for the Next 30 Years: Hearing Before the S. Comm. on Indian Affs.*, 115th Cong. 2 (2018) [hereinafter *30th Anniversary of Tribal Self-Governance*] (statement of Sen. John Hoeven, Chairman, S. Comm on Indian Affs.) ("[T]hough the law made many positive changes, inflexible bureaucracy and Federal inefficiencies restricted implementation of the 1975 Act. As a result, an alliance of tribes and tribal organizations joined forces to develop legislative proposals addressing these issues.").

48. *See 30th Anniversary of Tribal Self-Governance*, *supra* note 47, at 2.

49. *See* Strommer & Osborne, *supra* note 43, at 30.

tribal contracts when tribes met the specified criteria.[50] These changes allowed more complete implementation of Title I and aimed to ensure that tribes were respected as unique partners instead of intrusive government contractors.[51] The 1988 amendments further expanded tribal self-governance by introducing a demonstration project testing compacting, a new form of partnership between tribes and the federal government.[52] These compacts, called Title III compacts, allowed tribes to take more complete ownership of programs by running them more independently and for an indeterminate period of time, only renegotiating funding annually.[53] Much of the evolution of tribal compacting and contracting under the ISDEAA took the form of Congress stepping in to affirm the partnerships and expand tribal sovereignty in the face of executive-branch resistance.[54] In 1992, the compact demonstration project implemented in 1988 was expanded to allow tribes to enter into agreements to provide IHS services under compact, giving them more comprehensive authority and autonomy when providing healthcare services to tribal members.[55]

While both compacts and Title I contracts are options for promoting tribal sovereignty and improved healthcare provision, compacts give tribes more

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50. Indian Self-Determination Amendments of 1987, Pub. L. No. 100-472, § 201, 102 Stat. 2285, 2288 (1988) (codified at 25 U.S.C. § 5321) ("The Secretary is directed, upon the request of any Indian tribe by tribal resolution, to enter into a self-determination contract . . . . Whenever the Secretary declines to enter into a self-determination contract or contracts . . . the Secretary shall . . . (1) state any objections in writing . . . ."); *id.* § 104, 102 Stat. at 2287 (specifying limited audit materials).

51. *See* H.R. Rep. No. 100-393, at 4 (1987) ("The bill . . . amends the Act so as to give the tribes more of a voice in determining policies affecting the various Federal programs being contracted.").

52. Indian Self-Determination Amendments of 1987, § 209, 102 Stat. at 2296.

53. *Id.*, 102 Stat. at 2296-97. Title III compacts were a predecessor to Title V compacts, which are the primary compacts operating today. *See infra* note 61 and accompanying text.

54. *See* Strommer & Osborne, *supra* note 43, at 30, 35, 42-43 (describing successive amendments); *30th Anniversary of Tribal Self-Governance*, *supra* note 47, at 5 (statement of Hon. Melanie Benjamin, Chief Exec., Mille Lacs Tribe of Ojibwe) ("We faced many battles in those early years. Many Federal employees opposed self-governance which they saw as a threat to their authority, budgets and jobs. We could not get complete budgetary information from the BIA and some officials were actually hiding money."); *Implementation of the Tribal Self-Governance Demonstration Project: Hearing Before the S. Comm. on Indian Affs.*, 103d Cong. 11 (1993) (statement of William Ron Allen, Chairman, Jamestown Band of S'Klallam Indians) ("There has been a great deal of frustration over the past—and you have heard it through countless hearings—over paternal guardianship or the ward relationship with the tribal governments. We get quite frustrated with the bureaucracy of the tentacles of the regulatory system surrounding us and hindering us or obstructing our abilities to [carry out] our responsibilities. This initiative would remove those obstacles.").

55. *See* Indian Health Amendments of 1992, Pub. L. No. 102-573, § 814, 106 Stat. 4526, 4590.

flexibility to allocate and control the dollars spent without direct IHS approval.[56] As an example, Title I contracts are often fairly specific, telling the tribes which programs to run, specifying staffing levels, and only guaranteeing tribal control for a few years at a time.[57] Compacts, by contrast, allow tribes to take over programs indefinitely and provide significantly greater discretion in the use of funds to implement programs as the tribes see fit.[58] Through compacts, tribes have taken over long-term management of hospitals and local public-health programs and have been able to design new and innovative public-health initiatives based on local needs.[59] Compacting, initially enacted as a time-limited experimental program, was extended in 1994.[60] In 2000, Title III demonstration authority was extended into its own independent Title V authority, further signaling the permanence of tribal-federal partnerships in administering IHS programs.[61] The Affordable Care Act permanently extended Title V in 2010.[62] As of 2020, 65% of

56. 25 U.S.C. §§ 5381-5399 (2024); MARIEL J. MURRAY, CONG. RSCH. SERV., IF11877, INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT (ISDEAA) AND THE BUREAU OF INDIAN AFFAIRS 1 (2021).

57. *See* Strommer & Osborne, *supra* note 43, at 20-26; *see also* Complaint, Exhibit A at 1, Fort Defiance Indian Hosp. Bd. v. Becerra, No. 24-cv-00606 (D.N.M. June 14, 2024) (describing a three-year contract from 2015 through 2018); Notice of Filing Administrative Record at 14, Council of Athabascan Tribal Gov'ts v. United States, 693 F. Supp. 2d 116 (D.D.C. 2010) (No. 07-1270) [hereinafter Council of Athabascan Tribal Governments Contract] ("To provide health services with regard to the Yukon Flats Health Center, Health Development & Support Services programs for the Alaska Natives/American Indians residine [sic] within Arctic Village, Beaver, Birch Creek, Chalyitsik, Circle, Fort Yukon, Stevens Village, Venetie."); Council of Athabascan Tribal Governments Contract, *supra*, at 27 (describing a limited contract period of performance).

58. *See* Strommer & Osborne, *supra* note 43, at 30-31, 33 (describing the Title III self-governance demonstration that initially established tribal compacting); Joint Appendix at 37, Swinomish Indian Tribal Cmty. v. Becerra, 993 F.3d 917 (D.C. Cir. 2021) (No. 19-5299) [hereinafter Swinomish Tribal Compact and CY 2010-2014 Funding Agreement]; Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra*, at 43 (describing an extended term and flexible tribal governance).

59. *See* Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra* note 58, at 43 ("In accordance with Section 506(e) of Title V, the tribe may redesign or consolidate [programs, services, functions, and activities (PSFAs)] (or portions thereof) included in a [funding agreement] and reallocate or redirect funds for such PSFAs (or portions thereof) in any manner which the tribe deems to be in the best interest of the health and welfare of the Indian community being served . . . ."); *see also supra* note 17 and accompanying text (describing the success of the IHS in improving the population health of tribes through creative public-health programs).

60. *See* Act of Nov. 2, 1994, Pub. L. No. 103-435, § 22, 108 Stat. 4566, 4575.

61. *See* Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, § 4, 114 Stat. 711, 713; *30th Anniversary of Tribal Self-Governance*, *supra* note 47, at 3.

62. Cerasano, *supra* note 13, at 430.

the federally recognized tribes participated in self-governance compacts with the IHS under Title V, and these programs made up about half of the IHS budget.[63]

The IHS's compacting has improved the program significantly, but the IHS still lacks significant and needed financial support from the federal government.[64] The IHS, including services provided under both Title I contracts and Title V compacts, is funded with discretionary, rather than mandatory, appropriations.[65] This means that the IHS does not provide every service needed by its beneficiaries, or even a set benefits package[66]—instead, IHS services are provided until annual appropriations run out. IHS services are also limited by budget interruptions, like government shutdowns or other lapses in funding.[67] The limits on IHS funding are most acutely felt by beneficiaries in need of the IHS's externally contracted services. These services, which are purchased by the IHS on behalf of IHS beneficiaries but are delivered by private providers, represent the most uncertain and uneven portion of IHS budget allocations.[68] This

63. *Expansion of Tribal Self-Governance Within the Department of Health and Human Services*, Rocky Mountain Tribal Leaders Council 1 (2022), https://www.rmtlc.org/wp-content/uploads/2022/01/Expansion-of-Tribal-Self-Governance-at-HHS-White-Paper-1-3.pdf [https://perma.cc/AN5S-CM7P]; Cassandria Dortch, Elayne J. Heisler & Mariel J. Murray, Cong. Rsch. Serv., R48256, Tribal Self-Determination Authorities: Overview and Issues for Congress 1 (2025).

64. In addition to the funding issues noted here, the IHS also struggles to recruit and retain providers and offer services in very rural areas. *See* U.S. Gov't Accountability Off., GAO-18-580, Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies 17-18 (2018). These issues, especially geographic barriers to care, cannot be fully solved with additional funding. However, additional funding would go a long way towards ameliorating them.

65. Cerasano, *supra* note 13, at 435.

66. *Frequently Asked Questions*, Indian Health Serv., https://www.ihs.gov/forpatients/faq [https://perma.cc/8S5Q-VXG8] ("The Indian Health Service is not an entitlement program, such as Medicare or Medicaid. The Indian Health Service is not an insurance program. The Indian Health Service is not an established benefits package . . . . [Purchased/Referred Care] payments are authorized based on clearly defined guidelines and are subject to availability of funds.").

67. *See* Elayne J. Heisler & Kate P. McClanahan, Cong. Rsch. Serv., R46265, Advance Appropriations for the Indian Health Service: Issues and Options for Congress 1 (2020).

68. The Indian Health Service provides much of its care in-house at IHS facilities with IHS providers who work for the system. When there is a need for a healthcare service that cannot be provided internally, the IHS contracts out to private providers through the Purchased/Referred Care (PRC) program. PRC funding is limited and is provided only in specific situations where a service does not exist at an IHS facility or the facility does not have the capacity to provide the care when it is needed. The PRC program has restricted funding, meaning that it cannot provide all the care that is needed, and has strict requirements for individuals who qualify for its use. *See History*, Indian Health Serv., https://www.ihs.gov/prc/history

shortfall in funding often leads to rationing and the inaccessibility of certain services.[69]

Despite chronic funding woes, the IHS's self-determination programs have shown significant innovation and ingenuity, reflecting the results of effective advocacy.[70] Tribes have developed models of care that are culturally competent and work with limited resources to deliver unique and high-quality services.[71] Tribal compacts have important lessons to offer the broader health system on how to consider and address population health on a meager budget. With adequate funding, the IHS could be a best-in-class model of single-payer rural-healthcare delivery; even without adequate funding, tribal accomplishments in the face of sometimes hostile federal partnership have been significant. The work of tribal leaders in developing, debating, and implementing ISDEAA programs

[https://perma.cc/9YBC-6Y2C]. To qualify for services through the PRC program, in addition to meeting the medical need and access criteria described above, individuals must demonstrate that they reside within a geographic area served by the PRC program (or are subject to an exception); receive a referral from their provider and authorization based on that referral from the program; have no alternate sources of insurance, such as Medicare or Medicaid, that could cover the costs of the services needed; and are seeking services that are listed on the program's medical priorities list. *See Requirements: Eligibility*, INDIAN HEALTH SERV., https://www.ihs.gov/prc/eligibility/requirements-eligibility [https://perma.cc/J5PJ-XE4V]. Regulations authorize tribes participating in the PRC program to restrict providers to charging only "Medicare-like rate[s]" for services provided through the PRC program. *Purchased/Referred Care Rates*, OFF. RES. ACCESS & P'SHIPS (Jan. 18, 2017), https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/prcri/PRC-Rates-Presentation-Webinar-1-18-17.pdf [https://perma.cc/4NW6-DRZ3]; *see* 42 C.F.R. § 136.30 (2025). Providers participating in Medicare are required to provide care at these rates but are not required to accept referrals. Tribes can opt into this program, which ensures providers cannot overcharge tribes, by adding some language to their contracts or compacts. *See Purchased/Referred Care Rates*, *supra* (describing 42 C.F.R. § 136.30 as allowing tribes to "opt-in to the rule and implement immediately or when they are able to fully implement the rule, provided that they have agreed in their contract/compact to adopt"). Tribes that opt in to these regulations still have some flexibility to negotiate lower or higher rates (which may be of interest in ensuring access—as noted above, providers have a lot of negotiating power given general access issues and may simply opt not to take patients if their tribe does not pay enough). *See Purchased/Referred Care Rates FAQs*, INDIAN HEALTH SERV. 1 (2017), https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/prcri/Purchased_Referred_Care_Rates_FAQ.pdf [https://perma.cc/TAF7-R65C]. Negotiated rates are usually based on a most-favored-customer rate—meaning that the rate negotiated generally has to be around the lowest rate that a provider will charge for that particular service. *See id.*

69. *See* HEISLER & MCCLANAHAN, *supra* note 67, at 1-2; U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 9, at 18-20 (2018).

70. Trahant, *supra* note 36, at 121-22 (describing the development by the Southcentral Foundation of new models to prioritize the satisfaction and care of "customer-owners"—their term for patients, emphasizing focus on the individual as the leader of their care team).

71. *Id.*; *see also supra* notes 15-17 and accompanying text (describing the successes of the IHS in the face of funding limitations).

demonstrates an exemplary method of building successful partnerships in an uncertain relationship with the federal government.

B. Medicaid

Like the IHS, Medicaid grew out of modest program beginnings—but unlike the IHS, Medicaid has never been administered by the federal government. Medicaid has its origins in state programs for indigent care. Prior to 1935, medical care was provided by states and localities under their welfare programs on an ad hoc and erratic basis.[72] The provision of public assistance through these welfare programs often tracked the idea of the "deserving" poor—those who were aged, blind, or disabled. These categories grew into Social Security's original eligibility categories, and later into Medicaid's eligibility categories.[73]

Medicaid almost looked significantly more like the IHS, with clinics dedicated to population health and public provision of care. In the early twentieth century, before Medicaid was created, public ownership of hospitals and clinics was fairly common.[74] The federal government made significant investments in medical infrastructure through the early Hill-Burton program, which provided funding for the construction of hospitals.[75] Professor Paul Starr describes a large network of healthcare clinics created through a government effort called the Regional Medical Programs.[76] Through various sources of federal funding, these clinics were built across the country, and were initially intended to be the primary source of care for vulnerable populations, especially in rural areas.[77] In addition to healthcare services, many of these programs offered other health-supportive services, like food distributions.[78] However, these programs did not experience the massive growth and resulting staying power that Medicaid did by virtue of its compatibility with powerful institutions.[79] While these clinical

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72. Robert Stevens & Rosemary Stevens, Welfare Medicine in America: A Case Study of Medicaid 5 (1974).

73. *Id.* ("Such assistance was typically given grudgingly by the towns and counties . . . . In this context the proper role of assistance was seen to be to provide minimal help in unattractive circumstances, lest those on relief corrupt both themselves and ultimately other members of society.").

74. *Id.* at 15-17.

75. Edward Berkowitz, *Medicare and Medicaid: The Past as Prologue*, 27 Health Care Fin. Rev. 11, 19 (2005); Paul Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry 363 (1982).

76. Starr, *supra* note 75, at 370.

77. *Id.* at 371.

78. *Id.*

79. *Id.* at 372.

programs provided an important set of wraparound services for communities, Medicaid supported private providers and allowed hospital systems to write off bad debt.[80]

The fate of these community centers is a passing anecdote in the history of public provision of care for the poor, but it provides interesting parallels with the IHS. These public clinics eventually failed at least in part because they were not politically expedient for powerful stakeholders.[81] The IHS does not have a powerful healthcare lobby like the American Hospital Association advocating for it. But IHS compacting has the tribes, which have effectively advocated on behalf of the IHS in front of Congress to get repeated program improvements over time.[82] Outside of the IHS, much of the healthcare provided for vulnerable populations is supported in part because it provides profit for powerful stakeholders.[83] Yet the advocacy that is most effective, both for the IHS and for Medicaid, is advocacy that comes from leaders representing patients — tribal leaders for the IHS, or public advocates for Medicaid.[84] Leaving Medicaid advocacy to corporate interests may not result in a program that provides optimal patient care or that can effectively weather hostile political environments.

A series of legislative proposals in the 1950s represented the first efforts by the federal government to fund privately provided healthcare services for the poor.[85] These early programs, including the Kerr-Mills program enacted in 1960, were almost entirely state run, despite federal funding.[86] Because these programs served the narrow policy goal of providing restricted help to only those deeply in need, their uptake was somewhat limited and they were

80. *Id.*

81. *Id.* ("Medicaid simply had the advantage of institutional compatibility.").

82. *See* Strommer & Osborne, *supra* note 43, at 31-32. *See generally 30th Anniversary of Tribal Self-Governance*, *supra* note 47 (including testimony from tribal leaders); *Implementation of the Tribal Self-Governance Demonstration Project*, *supra* note 54 (same).

83. *See* Matthew B. Lawrence, *Super-Groups: Legal Empowerment and "Public Law*," 100 IND. L.J. 1179, 1241-45 (2025) (discussing the impact on reimbursement of legally empowered interest groups like the American Heart Association and the American Medical Association); Timothy Callaghan & Lawrence R. Jacobs, *Interest Group Conflict over Medicaid Expansion: The Surprising Impact of Public Advocates*, 106 AM. J. PUB. HEALTH 308, 309 (2016) (discussing how both public-interest advocates and business and professional lobbyists impacted Medicaid expansion decisions).

84. For a discussion of the work of tribal advocates, see *infra* note 283 and accompanying text. For more on the power of public-interest advocates in Medicaid, see generally Callaghan & Jacobs, *supra* note 83, which explains how public-interest advocates affected Medicaid expansion.

85. Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, 27 HEALTH CARE FIN. REV. 45, 45-46 (2005).

86. Berkowitz, *supra* note 75, at 17.

underfunded.[87] The structure of Kerr-Mills, which was expanded to become the foundation of the modern Medicaid program, intertwined the program inextricably with public assistance in a way that would have long-term costs for the program's popularity.[88] Ultimately, Medicaid was passed in 1965 in the shadow of Medicare, its more popular social-insurance counterpart.[89] Kerr-Mills was developed because Congress recognized a need for healthcare for the poor, but before Medicare, there was not the political will for a program as fulsome as Medicaid.

Today, Medicaid is the healthcare program in the United States that provides coverage to the largest number of people.[90] The structure of Medicaid programs is not dissimilar to an IHS Title V compact. Medicaid is a federal-state partnership but is primarily run by the states. While there are federal requirements to receive federal funding, each state decides the structure of its program and the benefits it will provide.[91] States can also apply for waivers, which can further reduce federal requirements and allow states to experiment with changes in the provision of coverage and benefits.[92] Medicaid's waiver programs, which have a few different statutory bases,[93] allow states to implement programs that are unique to the state based on a plan submitted to and approved by the federal government.[94] States have used Medicaid waivers to expand or adjust services

87. LaShyra T. Nolen, Adam L. Beckman & Emma Sandoe, *How Foundational Moments in Medicaid's History Reinforced Rather than Eliminated Racial Health Disparities*, HEALTH AFFS. (Sep. 1, 2020), https://www.healthaffairs.org/content/forefront/foundational-moments-medicaid-s-history-reinforced-rather-than-eliminated-racial-health [https://perma.cc/Y8K6-VDQ4].

88. Moore & Smith, *supra* note 85, at 46.

89. Zelizer, *supra* note 5, at 2, 16-17.

90. *July 2025 Medicaid & CHIP Enrollment Data Highlights*, MEDICAID (Nov. 17, 2025), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html [https://perma.cc/Z48K-KN2H] (showing enrollment of about 70.3 million). By comparison, Medicare has an enrollment of 69.3 million. *See Medicare Enrollment Dashboard*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Aug. 2025), https://data.cms.gov/tools/medicare-enrollment-dashboard [https://perma.cc/Y3PA-EG69].

91. *See* 42 U.S.C. § 1396a(a)(10)(A) (2024) (mandating that states operating Medicaid make "medical assistance available, including *at least* the care and services listed" in various sections throughout the title (emphasis added)); *id.* § 1396a(b) (listing the three reasons for which the Secretary can reject a state's Medicaid plan).

92. *See Waivers*, MEDICAID & CHIP PAYMENT ACCESS COMM'N, https://www.macpac.gov/medicaid-101/waivers [https://perma.cc/C6XY-X454].

93. *See, e.g.*, 42 U.S.C. § 1315 (2024) (describing Section 1115 waivers, which are focused on research or experimental pilot programs); *id.* § 1396n (describing Section 1915(b) and 1915(c) waivers, which allow for noninstitutional care of those with disabilities).

94. *See State Waivers List*, MEDICAID (2025), https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list [https://perma.cc/B4B8-UHCB].

provided to those with disabilities, cover new experimental healthcare programs, and even adjust the basic Medicaid program to impose work requirements on beneficiaries.[95]

Each state must turn its state plan over to the Centers for Medicare and Medicaid Services (CMS) to receive federal approval for its program.[96] The state plan provides information about what the state covers and the eligibility criteria for its enrollees.[97] The federal government provides funding that matches state expenditures for Medicaid services—this funding is mandatory and varies based on the per capita income in that state.[98] The minimum Federal Medical Assistance Percentage (FMAP) is 50%, which means that the federal government covers at minimum 50% of a state's Medicaid costs.[99] Mississippi, which has a low average per capita income, has the highest FMAP of any state Medicaid program—76.9%.[100] States that have comparatively high per capita incomes, like Maryland and Massachusetts, receive the minimum FMAP of 50%.[101]

Unlike an IHS Title V compact or other IHS services, most Medicaid services are not publicly provided. Medicaid provides reimbursement either to private medical providers on a fee-for-service basis[102] or to insurance companies under a managed-care contract.[103] Providers offering services on a fee-for-service basis

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95. *See, e.g.*, *1915(b) Waivers*, MEDICAID & CHIP PAYMENT ACCESS COMM'N (May 9, 2022), https://www.macpac.gov/subtopic/1915b-waivers [https://perma.cc/VXQ6-CCEL]; *AL HCBS Living at Home Waiver for Persons with Intellectual Disabilities (LAH) Waiver (0391.R04.00)*, MEDICAID (2020), https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/80901 [https://perma.cc/3QYN-HFDU]; *Arkansas Waiver: Arkansas Works*, MEDICAID & CHIP PAYMENT ACCESS COMM'N (Mar. 2020), https://www.macpac.gov/wp-content/uploads/2020/03/Arkansas-Waiver-Arkansas-Works.pdf [https://perma.cc/YD4H-3NFT]; *Testing New Program Features Through Section 1115 Waivers*, MEDICAID & CHIP PAYMENT ACCESS COMM'N (June 2020), https://www.macpac.gov/publication/testing-new-program-features-through-section-1115-waivers [https://perma.cc/3E97-RJA3]; *Florida Medicaid Family Planning Waiver*, MEDICAID (1998), https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81301 [https://perma.cc/V97H-KYKX].

96. 42 C.F.R. § 457.160 (2025).

97. 42 U.S.C. § 1396a (2024).

98. *See id.* § 1396b (describing all of the federal funding provided for the Medicaid program); *id.* § 1396b(d) (detailing how the federal matching funds vary in federal matching based on per capita income).

99. *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, KAISER FAM. FOUND. (2025), https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier [https://perma.cc/325C-AG8F].

100. *Id.*

101. *Id.*

102. 42 U.S.C. § 1396a(a)(13) (2024).

103. *Id.* § 1396b(m).

can choose whether or not they are interested in serving Medicaid patients, and those who want to participate enroll with the state's program and then bill for services provided.[104] Each state has federal provider-enrollment requirements it must follow,[105] but states have discretion above and beyond these requirements to set the terms and conditions for provider participation.[106] States determine the rate that they pay participating providers and other contractors for services.[107] States also have discretion regarding the rates and structure of the contracts they enter with managed-care providers, although there are federal requirements about the services provided and access to providers.[108]

Despite its important role, Medicaid faced significant challenges even before the OBBBA's massive budget cuts. Proposals have threatened to turn Medicaid into a block-grant program rather than an entitlement, which would force states to either shoulder the burden of additional coverage or ration care.[109] The first Trump Administration allowed a few states to move forward with Section 1115 demonstration waivers implementing work requirements, which limit who is eligible for Medicaid enrollment.[110] In addition, the frequently raised proposals to repeal Obamacare would also repeal the Affordable Care Act's Medicaid expansion, rolling back coverage for many formerly uninsured adults who did not

104. *See* 42 C.F.R. § 455.410 (2025) (setting out requirements for state provider enrollment); *Provider Enrollment*, Md. Dep't of Health, https://health.maryland.gov/mmcp/provider/Pages/enrollment.aspx [https://perma.cc/48SW-NC9T].

105. *See generally* Ctr. for Program Integrity, *Medicaid Provider Enrollment Compendium (MPEC)*, Ctrs. for Medicare & Medicaid Servs. (2021), https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf [https://perma.cc/H732-GSQ9] (laying out regulatory guidance around provider-enrollment requirements).

106. *See* 42 U.S.C. § 1396a(kk)(9) (2024).

107. *E.g.*, *Medicaid Hospital Reimbursement*, Conn. Soc. Servs. (2025), https://portal.ct.gov/dss/health-and-home-care/medicaid-hospital-reimbursement/medicaid-hospital-reimbursement/fees [https://perma.cc/EC55-PJND]; *Rate Review and Rate Guides*, Medicaid (Aug. 2025), https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html [https://perma.cc/Z63M-N3PC].

108. *See Key Federal Program Accountability Requirements in Medicaid Managed Care*, Medicaid & CHIP Payment & Access Comm'n (July 23, 2020), https://www.macpac.gov/subtopic/key-federal-program-accountability-requirements-in-medicaid-managed-care [https://perma.cc/Q8QA-6SBT].

109. *See supra* note 6 and accompanying text.

110. *See Medicaid's Role in Health Care for American Indians and Alaska Natives*, Medicaid & CHIP Payment & Access Comm'n 7 (Feb. 2021), https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf [https://perma.cc/D3SL-F7VF]. Tribes sought an exception for American Indian and Alaska Native People, but the Trump Administration did not grant one. *Id.*

meet categorical eligibility criteria.[111] Many of these proposals are advanced on political grounds by state governments that benefit from the additional Medicaid funding.[112]

Medicaid's current vulnerability stems in part from its uncertain political support. Tribes fought to build the existing ISDEAA compacting and contracting; states' Medicaid advocacy is conflicted at best.[113] Medicaid was a grant of federal funding to enhance existing state programs, while IHS compacting required that tribes assert their sovereignty over the objections of federal agencies that wanted to maintain control of the IHS.[114] In this context, the OBBBA's cuts were passed in part by exploiting one of Medicaid's weaknesses — states were not and are not advocating for full state control over Medicaid programs, but instead for conflicting visions of a federal-state program. This means that each individual state does not have full autonomy to run its Medicaid program without federal input. By contrast, tribal advocacy has worked to ensure that tribes can administer their own services under deliberately limited oversight. As a result, IHS compacting is insulated from burdensome federal oversight in a way that Medicaid is not.

C. Program Overlap: Medicaid and the IHS

Medicaid and the IHS are structurally intertwined in a few ways. Most importantly, there is significant overlap in enrollment between the IHS and Medicaid: Medicaid provides coverage for one-third of the American Indian and Alaska Native population.[115] Through this enrollment, Medicaid provides a key source of revenue for IHS facilities and providers. Tribal members who meet eligibility qualifications for both Medicaid and the IHS can enroll in both

111. *See* John Holahan, *How Undoing the Affordable Care Act Would Affect Americans' Health Care*, COMMONWEALTH FUND (Sep. 5, 2024), https://www.commonwealthfund.org/publications/explainer/2024/sep/how-undoing-aca-would-affect-health-care [https://perma.cc/694L-PHWM]; Elizabeth Williams, Alice Burns, Rhiannon Euhus & Robin Rudowitz, *Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates*, KAISER FAM. FOUND. (Feb. 13, 2025), https://www.kff.org/medicaid/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates [https://perma.cc/6TMC-6ZWR].

112. As an example, many states (especially Republican states) resisted the Medicaid expansion and fought against it in court, while others adopted the expansion. *See* Jennifer Tolbert, Clea Bell & Robin Rudowitz, *Medicaid Expansion Is a Red and Blue State Issue*, KAISER FAM. FOUND. (Nov. 27, 2024), https://www.kff.org/medicaid/medicaid-expansion-is-a-red-and-blue-state-issue [https://perma.cc/CS5E-HBRY]; California v. Texas, 593 U.S. 659, 666 (2021).

113. For more on the IHS and tribal advocacy, see *supra* notes 40-55 and accompanying text. For more on states' conflicting Medicaid advocacy, see *supra* note 112 and accompanying text.

114. *See supra* notes 44-47, 85-89 and accompanying text.

115. *See Medicaid's Role in Health Care for American Indians and Alaska Natives*, *supra* note 110, at 1.

programs; for a person who qualifies for both, Medicaid will provide payment for services.[116] As a result, if a tribal member visits an IHS facility with IHS and Medicaid coverage, the IHS facility can bill Medicaid for the care, and the federal government will pay for the service.[117] In FY 2019, IHS facilities received over $800 million in Medicaid reimbursements, the strong majority of total third-party billing revenue for IHS facilities.[118] This funding is all federal, because the federal government provides 100% of the Medicaid funds for care given to American Indian and Alaska Native populations in IHS facilities (compared to the shared federal-state funding for other Medicaid recipients or for tribal citizens outside IHS facilities).[119] A tribal member with both types of coverage living away from IHS facilities could visit providers as any other Medicaid member could, and both programs might provide some payment for services, with Medicaid paying first.[120]

Given this significant overlap between the two programs, Medicaid often consults tribes when implementing policies that impact tribal populations.[121] As indicated in Table 2 of the Appendix, several states have explicit language in their Medicaid plans referring to consultations with "tribal partners."[122] This language stems from federal requirements that state Medicaid programs consult with tribal partners and consider the impact of program changes on tribal

116. Letter from Vikki Wachino, Medicaid Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Offs. 2 (Feb. 26, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf [https://perma.cc/JB6X-VQAV].

117. *Id.*

118. *See Medicaid's Role in Health Care for American Indians and Alaska Natives*, *supra* note 110, at 5.

119. *See* 42 U.S.C. § 1396d(b) (2024) ("Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization . . . ."). In 1976, the Indian Health Care Improvement Act was passed, and it expressed a federal policy of increased funding and commitment to Indian health. The new law allowed for Medicare and Medicaid billing for services provided by the IHS at a federal matching percentage of 100% and expanded IHS services and programs offered. *See* Schneider, *supra* note 21, at 1126.

120. *See* Letter from Vikki Wachino, *supra* note 116, at 5.

121. *Tribal Consultation*, Ctrs. for Medicaid & Medicare Servs. (June 23, 2025, 9:46 AM), https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/tribal-consultation [https://perma.cc/XT8J-JT3M].

122. Trudel Pare, *Ensuring Sovereignty in Healthcare: A Comparison of Tribal Healthcare Compacts and Medicaid: Appendix*, Yale L.J. 2 tbl. 2 (Jan. 2026) [hereinafter *Appendix*], https://yalelawjournal.org/files/o1KDK04DYJGCDZEPD19134ESQX.pdf [https://perma.cc/JP9V-DSPC].

populations.[123] Tribal consultations, which happen at both the federal and state levels, do not always result in the policies preferred by tribal leaders; for example, Medicaid will still not fully reimburse for IHS services provided outside the four walls of an IHS clinic, which limits the ability of tribes to use Medicaid dollars to pay for certain public-health programs.[124] However, tribal members and trust property are not subject to certain Medicaid rules—like income requirements and estate recovery—in recognition of tribes' unique structure and financial situation.[125]

As a result of the interconnectedness of Medicaid and the IHS, many of the challenges threatening Medicaid threaten tribal populations and IHS funding as well. IHS facilities and providers rely on Medicaid and other third-party funding when the federal allocations for IHS services run out or another extenuating circumstance interrupts federal funding.[126] Any proposal to block grant Medicaid would limit the availability of these reimbursement funds, threatening the long-term viability of IHS services.[127] Work requirements or other proposals to roll back coverage would also limit this reimbursement funding, again exacerbating the issue of underfunding in IHS facilities.[128] In many ways, these two programs are intertwined as they already exist, and together they provide care to a uniquely vulnerable population. Considering and evaluating these programs together provides lessons for Medicaid as it faces significant new challenges with budget cuts and a recalcitrant federal government partner.

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123. *See, e.g.*, *Medicaid Administration*, NEV. DEP'T HEALTH & HUM. SERVS. 9 (May 11, 2015) [hereinafter Nevada State Plan], https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSP/CompleteSPAPages.pdf [https://perma.cc/5KEU-K6HP]; *State Plan Under Title XIX of the Social Security Act*, OKLA. HEALTH CARE AUTH. 47 (May 1, 2025) [hereinafter Oklahoma State Plan], https://oklahoma.gov/content/dam/ok/en/okhca/docs/research/title-xix-state-plans/2025/State%20Plan%2005.01.2025.pdf [https://perma.cc/RPU8-CR4R].

124. *See Medicaid's Role in Health Care for American Indians and Alaska Natives*, *supra* note 110, at 8.

125. *See id.* at 6.

126. U.S. GOV'T ACCOUNTABILITY OFF., GAO-22-104742, INDIAN HEALTH SERVICE: INFORMATION ON THIRD-PARTY COLLECTIONS AND PROCESSES TO PROCURE SUPPLIES AND SERVICES 2 (2022); *see also* Matthew B. Lawrence, *Congress Should Insulate the Indian Health Service from the Next Government Shutdown*, PETRIE-FLOM CTR. (June 3, 2021), https://petrieflom.law.harvard.edu/2021/06/03/indian-health-service-biden-congress [https://perma.cc/U22C-3873] (detailing how the differences in IHS and Medicaid funding result in inequities during a government shutdown).

127. *See* Jazmin Orozco Rodriguez, *Tribal Health Leaders Say Medicaid Cuts Would Decimate Health Programs*, KFF HEALTH NEWS (Mar. 19, 2025), https://kffhealthnews.org/news/article/tribal-indian-health-service-ihs-medicaid-cuts-underfunding-fallout [https://perma.cc/UJT7-WQC7].

128. *See Medicaid's Role in Health Care for American Indians and Alaska Natives*, *supra* note 110, at 7-8.

II. CONTRACTING

This Part analyzes Medicaid and IHS partnerships by comparing Medicaid state plans (the documents memorializing Medicaid programs' arrangements with the federal government) with Title V compacts (which allow tribal governments to administer IHS programs). These documents, both of which represent government-to-government relationships, demonstrate the differences between the federal-state relationship and the federal-tribe relationship. The differences follow a number of themes discussed in literature on the IHS — the federal government's failure to uphold its trust responsibilities to tribes,[129] an attempt by the federal government and tribes to promote a particular version of self-government,[130] and a struggle by the IHS to support the population health of a historically marginalized group.[131]

However, an evaluation of the formation and language of these different kinds of documents[132] displays a key, stark difference discussed in Part I. While the federal government and the tribes have a government-to-government relationship now, this partnership was hard-won.[133] Tribes have advocated continually for partnerships that promote their sovereignty and protect their ability to provide services for their citizens.[134] This is different from Medicaid, which was built on an established federal-state relationship grounded in hundreds of years of trust — after all, the federal government is ultimately a creature of the states'

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129. *See supra* notes 27-29 and accompanying text.

130. *See* Philip P. Frickey, *(Native) American Exceptionalism in Federal Public Law*, 119 HARV. L. REV. 431, 483-85 (2005) ("Every victory was bittersweet from the broader perspective of promoting more tribal self-governance in the longer term, for each ratified the tribes' subordination to Congress."); STEPHEN CORNELL, THE RETURN OF THE NATIVE: AMERICAN INDIAN POLITICAL RESURGENCE 93-94 (1988) ("The institutions provided for through the IRA were Euro-American in origin, applied more or less uniformly to a hugely varied mosaic of cultures and in widely divergent local situations.").

131. *See supra* notes 37-39 and accompanying text.

132. The word "document" refers to all of the federal-state and federal-tribe partnerships discussed in this Note, including Medicaid state plans, Title I contracts, and tribal compacts. Where the word "contract" is used, it is referring to a Title I contract, and the word "agreement" refers to an annual funding agreement pursuant to a Title I contract or Title III, IV, or V compact.

133. *See, e.g.*, *30th Anniversary of Tribal Self-Governance*, *supra* note 47, at 5-6; Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1, 17 (1831) (describing tribes as "domestic dependent nations"); Johnson v. M'Intosh, 21 U.S. (8 Wheat.) 543, 567 (1823); Worcester v. Georgia, 31 U.S. (6 Pet.) 515, 552 (1832).

134. *See supra* notes 48-53 and accompanying text.

construction.[135] This Part builds upon Part I to show how present-day IHS and Medicaid agreements reflect the history and structure of each program.

Contrasts between Medicaid programs and IHS tribal compacts demonstrate key differences between federal-state and federal-tribe relationships. While the federal-state relationship is a long-established partnership that provides a comprehensive suite of Medicaid services, the federal-tribe relationship is still marked by the challenges that once plagued the interactions between the federal government (particularly the executive branch) and tribes. This Part includes an analysis of eleven tribal compacts and ten corresponding Medicaid state plans.[136] While Title I contracts are different, and so are less apt comparisons to Medicaid state plans, nine Title I contracts are included in this analysis as well.[137] This Part also analyzes the text of the programs' enacting legislation—both ISDEAA Title V and the Medicare and Medicaid Act. These analyses trace the following: first,

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135. *See* U.S. CONST. art. VII (outlining the ratification process for states to adopt the U.S. Constitution).

136. Tribal compacts analyzed here include a 2010 Alaskan Tribal Health Compact, a 1995 Duck Valley Shoshone-Paiute Tribes Compact, a 1994 Cherokee Nation Compact, a 1995 Chippewa-Cree Indian Tribe Compact, a 1995 Duckwater Shoshone Compact, a 2016 Fort McDermitt Paiute and Shoshone Tribe Compact, a 2019 Jamestown S'klallam Indian Tribe Compact, a 2016 Little River Band of Ottawa Indians Compact, a 1990 Quinault Indian Nation Compact, a 2011 Redding Rancheria Compact, and a 2002 Swinomish Indian Tribal Community Compact. For additional details regarding each of these compacts, see *Appendix*, *supra* note 122, at 1 tbl. 1. Many of these compacts are Title V compacts for IHS services specifically, but some are grounded in other authority and cover different tribal self-governance services. All of these compacts (and the Title I contracts referred to below) were sourced either from publicly available litigation documents (and are cited accordingly), or from the resources available on the Tribal Self-Governance website. *See Document Library*, TRIBAL SELF-GOVERNANCE, https://www.tribalselfgov.org/resources/document-library [https://perma.cc/9Y8A-HAXX].

Medicaid state plans analyzed here are from Arizona, Michigan, Nevada, Oklahoma, Oregon, Washington, Wisconsin, California, New Mexico, and Montana. For additional details on the analysis and these specific plans, see *Appendix*, *supra* note 122, at 2 tbl. 2. I have tried to collect here either Medicaid state plans representing the same geographic region where most of the contracted or compacted facilities are, or the state plans for neighboring states (if the state plan for the primary state is unavailable online or difficult to navigate). This is to ensure that the analysis is relatively similar—both tribal compacting/contracting and Medicaid program administration involve different administrative choices and concerns based on the provider landscape and population served, which will be most similar in similar geographic regions. These Medicaid plans were all sourced from state websites.

137. Tribal contracts analyzed here include a 1994 Council of Athabascan Tribal Governments contract; a 2015 Fort Defiance Indian Hospital Board contract; three Menominee Tribe of Wisconsin contracts from 1995, 1996, and 1999; a 2010 Navajo Nation Council contract; a 2011 San Carlos Apache Tribe contract; a 2016 Northern Arapaho Business Council contract; and a 2000 Seneca Nation of Indians contract. For additional details regarding these contracts, see *Appendix*, *supra* note 122, at 3-4 tbl. 3. As noted above, these contracts are all sourced from litigation documents.

how all of these documents are formed; second, the language of the documents that guides implementation; and third, the elements of each document that govern dispute resolution.[138] By examining the life cycle of these agreements, this Part demonstrates that the IHS compacting and contracting process was designed by tribes to protect themselves, while Medicaid state plans demonstrate no such goal.

A. Program Formation as of Right

Pre-partnership requirements for tribes and states differ markedly. A Title V compact is a culmination of numerous requirements. First, tribes must conduct a "planning phase" during which they conduct "legal and budgetary research" and "organizational preparation relating to the administration of health care programs."[139] The Title V statute also states that "[t]he planning phase shall be conducted to the satisfaction of the Indian tribe."[140] The statute requires that tribes meet a fiscal-responsibility standard for three years prior to entering into a compact.[141]

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138. There are a few crucial limitations to this analysis that could present opportunities for future study. First, all tribal compacts and contracts included here are sourced from litigation documents. This means that they are an incomplete view into tribal contracts and compacts; they may not even be fully representative of any individual tribe's health compacting history, as litigation documents only show a snapshot of a tribe's documents and materials relevant at one time, for one particular case. In addition, since all of these documents are from litigation materials or public sources, they may represent some selection bias. Subsequent study that contains a broader set of tribal documents will likely provide a more fulsome picture of tribal contracting and compacting.

This analysis is also primarily focused on contracting documents and Medicaid state plans, not ancillary documents, and did not include any fieldwork. As a result, while it is clear from the documents what detailed Medicaid plans cover, it is not entirely clear what tribal compacted services look like. There is some literature describing the tribal IHS programs generally and providing statistics, but an in-depth study conducting interviews of providers and tribal leaders would be a helpful contribution to the knowledge in this area.

Finally, this project was qualitatively coded by the author alone. Each column in the tables in the Appendix was created by reviewing documents and coding based on the language included. For example, the column with the heading of "Self-Governance Language" was based on a review of the compacts and contracts for language that spoke about the importance of tribal sovereignty, the role of tribal governments in the family of governments, or a general "whereas" section or tribal resolution. *See Appendix*, *supra* note 122. The Medicaid state plans, which are significantly longer, were coded using a keyword search for particular terms. Given the possibility for human error in these methods, a more thorough review could impact the results.

139. 25 U.S.C. § 5383 (2024).

140. *Id.* § 5383(d).

141. *Id.* § 5383(c).

Medicaid contains fewer explicit requirements. The section of the U.S. Code authorizing Medicaid does not include anything about a planning phase for states entering the program.[142] It includes a provision for the required elements of a state plan[143] and a section detailing the consequences for a state that does not comply with its state plan.[144] The federal government certainly provides technical support, guidance, and requirements for states operating Medicaid programs,[145] but there is no similar requirement that states demonstrate financial stability before entering into a Medicaid state plan. The statute authorizing state plans only requires that states "provide for financial participation by the State."[146] Separately, other federal contracting relationships — even those completed under Title I with tribes[147] — do not have these requirements, although they do have other mandatory audits.

The difference reflects history. Partner federal agencies wanted to encourage states to establish and expand Medicaid; federal partners did not, at first, want tribes entering partnerships to compact for the IHS. The tribes' IHS compacting moved the administration of IHS programs and services from the federal government to tribes. When Title V was passed in 2000, it followed a history of executive-branch (specifically, IHS) resistance to tribal compacting to provide healthcare services.[148] This resistance existed because the tribes' sovereignty would limit or end federal agencies' oversight of those programs or services.[149] The committee report on the bill noted these federal-agency issues and expressly laid out the limits of the financial examination that tribes would undergo in the

142. *See* 42 U.S.C. § 1396a (2024).

143. *Id.* § 1396a(a).

144. *Id.* § 1396c.

145. *See Technical Assistance: Medicaid Managed Care — Individualized Technical Assistance for States*, MEDICAID, https://www.medicaid.gov/medicaid/managed-care/technical-assistance/index.html [https://perma.cc/D3RY-CV9R].

146. 42 U.S.C. § 1396a(a)(2) (2024).

147. 25 U.S.C. § 5321 (2024).

148. *See* Strommer & Osborne, *supra* note 43, at 33-34, 41; S. REP. NO. 106-221, at 9 (1999) ("The Committee is concerned with the reluctance of the Indian Health Service to include all available federal health funding in self governance funding agreements.").

149. *See 30th Anniversary of Tribal Self-Governance*, *supra* note 47, at 8, 10 (statement of Hon. Melanie Benjamin, Chief Exec., Mille Lacs Tribe of Ojibwe) ("It should come as no surprise that tensions arise when a tribe seeks to assume a program, function, service or activity previously carried out by a federal agency office . . . . Most of the challenges we encountered in our negotiations with IHS mirrored our experience with the BIA; except that our federal counterparts on the IHS negotiating team kept showing up in military dress . . . . Given our history with the federal cavalry, we could not help being rather underwhelmed by that negotiation maneuver.").

planning phase.[150] In addition, the report language and the legislation noted that three years of audits without issue should be "conclusive evidence of the required stability."[151] This element of the legislation was designed by tribal advocates to be protective of their right to compact.[152] By contrast, the federal government never administered Medicaid. Medicaid has no need for such requirements. Since the federal government primarily acts as a funding source and support mechanism to Medicaid, the program did not evolve through the same tensions as IHS compacting.

A comparison between Title I ISDEAA contracts and Title V compacts further demonstrates how this planning phase was used by tribes to create more space for sovereignty. As noted above, there is no planning phase required for Title I contracts.[153] Title I contracts allow tribes to run many of the same kinds of programs as Title V compacts. For example, Sage Memorial Hospital, a full-service Native American-operated hospital in Ganado, Arizona, is operated under a Title I contract instead of a Title V compact.[154] Title I contracts were also hard-won, requiring congressional intervention to ensure that federal agencies did not impose burdensome oversight on the tribes.

But in Title I, the tribes and the federal agencies struck a slightly different balance. Title I contracts are based upon a model agreement included in legislation. Title I contracts contain more requirements for federal review of proposed changes to the programs being administered and are usually only awarded for a few years at a time.[155] Title I involves more oversight and less flexibility for tribes

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150. S. REP. NO. 106-221, at 7 ("Proof of no material audit exceptions in the tribe's self determination contracts or Self Governance funding agreements is conclusive proof of such qualification . . . . The bill has been deliberately crafted to make clear that a tribe's activities in other economic endeavors are not to be the subject of the Section 503(c) examination.").

151. *Id.* at 42; 25 U.S.C. § 5361 (2024).

152. *See Hearing on S. 979 Before the S. Comm. on Indian Affs.*, 106th Cong. 69 (1999) (statement of Stephanie Rainwater-Sande, President, Ketchikan Indian Corp.) ("The whole point of self-governance is for the tribe to determine how a program will be administered within the limits of any applicable statutory restriction."); *id.* at 80 (statement of Henry Cagey, Lummi Indian Nation) ("Tribes, cognizant that so-called 'good' ideas of previous laws and reforms had produced some unexpected disastrous results, opted to proceed cautiously.").

153. 25 U.S.C. § 5321 (2024).

154. *See* Indian Self-Determination Act Contract Between Navajo Health Foundation/Sage Memorial Hospital and the Secretary of the Department of Health and Human Services at 14, Navajo Health Found. v. Burwell, 256 F. Supp. 3d 1186 (D.N.M. Oct. 26, 2015) (No. 14-00958), Dkt. No. 21-1 [hereinafter Navajo Contract].

155. *See supra* notes 56-57 and accompanying text.

than Title IV or V but also requires less upfront assurance of stability and capacity for self-governance.[156]

Tribes advocated for and negotiated these changes to IHS compacting—they worked together to design legislation, testify in front of Congress, and legislate to pass these updates to the self-governance program.[157] Facing a hostile federal-agency system, tribal members built these balances to guarantee that those tribes that demonstrated their ability to administer key programs for their members were not turned away due to the skepticism of their federal partner.[158] Medicaid has been iterated on, certainly, but it does not require the same level of negotiation because its federal-agency partner, CMS, was never designed to run its programs. In building Medicaid, the federal government did not have to hand over a program that it was already running to state governments; instead, the states received additional resources to support programs *they* were already running. As a result, the foundation of IHS compacting required additional security, and Medicaid did not.

B. Program Administration

After the completion of a "planning phase" for Title V compacts, or after the approval of a Title I contract or Medicaid state plan, a tribe or state operates the program according to the agreement with the federal government. This Section focuses on the actual documents that emerge from these formation processes. As noted above, this Section analyzes eleven tribal Title V compacts and ten Medicaid state plans, as well as nine Title I contracts. In this analysis, three themes emerge.

First, continuing a theme from the partnership-formation phase described in Section II.A, the tribal compacts include a great deal of language focused on the goal of tribal self-governance and the promise of tribal independence. This language, focused on the parties' nation-to-nation relationship, promotes tribal sovereignty and federal-tribal partnership. In conjunction with the other contractual elements, this language seems designed also to articulate tribal policy and rally support for a project that involves significant planning and risk in partnership with a federal government that has not always been friendly.

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156. *See supra* notes 56-57 and accompanying text. Title IV is another compacting provision, which allows for federal-tribal partnerships to administer programs housed in the Department of the Interior. Titles IV and V together made the original Title III compacting demonstration project permanent. *See* Strommer & Osborne, *supra* note 43, at 33-35.

157. *See supra* Section I.A. *See generally* Strommer & Osborne, *supra* note 43 (describing tribal advocacy efforts).

158. *See supra* notes 148-152 and accompanying text.

Second, the tribal compacts and contracts are significantly less specific than parallel Medicaid state plans. This reflects the history and evolution of each of these programs: Medicaid, as a mandatory-funding program, needs to show its federal partners what it will cover, while the IHS, as a discretionary program focused on promoting tribal sovereignty, aims to provide maximum flexibility with limited resources.

Finally, the structure of the Title I contracts and Title V compacts, with an overarching contract or compact separate from a funding agreement, offers several provisions designed specifically to protect tribes against partnership breakdown and a loss of funding.

1. The Language of Self-Governance: Messaging Sovereignty

The first notable difference between Medicaid and ISDEAA documents is that ISDEAA documents, especially Title V compacts, include self-governance language articulating tribal interest in sovereignty and self-governance. Each Title V tribal compact begins with "Purpose" and "Authority" sections, which explicitly state a self-governance purpose for the compacts. For example, the Swinomish Compact describes its purpose as "to enable the Swinomish Tribal Community to . . . enhance the effectiveness and long term financial stability of its tribal government" and "promote[] the autonomy of the Tribe."[159] The compact also describes the relationship between the federal government and the tribe by claiming the compact will "strengthen the Government-to-Government Relationship"; "enable the United States to maintain and improve its unique and continuing relationship with and responsibility to the Swinomish"; and "permit an orderly transition from federal domination of programs and services to allow Indian tribes meaningful authority to plan, conduct, and administer those programs."[160] All compacts included in this analysis contain some version of this self-governance language.[161] In addition, four of the compacts contain a section,

159. Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra* note 58, at 37.

160. *Id.* at 37-38.

161. Joint Appendix, Volume I at 69, Cherokee Nation v. Leavitt, 543 U.S. 631 (2004) (No. 02-1472) [hereinafter Duck Valley Shoshone Paiute Compact]; Joint Appendix, Volume I at 172, *Cherokee Nation*, 543 U.S. 631 (No. 02-1472) [hereinafter Cherokee Nation Compact]; Plaintiff's Exhibit B at 2, Maniilaq Ass'n v. Burwell, 170 F. Supp. 3d 243 (D.D.C. 2016) (No. 13-cv-380) [hereinafter Alaska Compact]; Plaintiff's Exhibit G in Support of Motion for Summary Judgment at 4, *Maniilaq Ass'n*, 170 F. Supp. 3d 243 (No. 13-cv-380) [hereinafter Maniilaq Funding Agreement]; Compact of Self-Governance Between the Chippewa Cree Indian Tribe and the United States of America (Oct. 1, 1995) [hereinafter Chippewa Cree Compact], *reprinted by* TRIBAL SELF-GOVERNANCE, https://tribalselfgov.org/wp-content/uploads/2021/04/Chippewa-Cree-Compact-_-DOI.pdf [https://perma.cc/5DP9-HVQN]; Compact of

usually before the "Purpose" and "Authority" sections, which seems to function as a preamble to the compacts and contains more extended self-governance language.[162] This language is often a tribal resolution, as the legislation enacting Title V expressly requires that participating tribes have a resolution indicating interest in taking on self-governance programs.[163]

However, this self-governance language is not ubiquitous. Most of the Title I contracts analyzed, many of which were drafted and implemented at the same time, do not include this language. For example, the Navajo Contract, which was implemented in 2010,[164] does not include much description of self-governance principles. The Navajo Contract's Purpose section states that the Contract is designed to "carry out a meaningful self-determination policy . . . which will permit an orderly transition from the federal domination of programs."[165] This section is longer and more descriptive in Title V compacts but occupies only one paragraph in the Navajo Contract. After this paragraph, the contract returns to discussing details of the agreement at hand—in this case, running a hospital.

The varying self-governance language across ISDEAA documents indicates both the different aims of compacts and contracts and the rising interest in asserting self-governance through tribal healthcare programs. It is unsurprising that Title V compacts include self-governance language that Title I contracts do

Self-Governance Between the Duckwater Shoshone Tribe and the United States of America (1995), *reprinted by* TRIBAL SELF-GOVERNANCE, https://tribalselfgov.org/wp-content/uploads/2021/05/293wb10059.pdf [https://perma.cc/MKL4-35M3]; Administrative Record at 4, Fort McDermitt Paiute & Shoshone Tribe v. Becerra, 6 F.4th 6 (D.C. Cir. 2021) (No. 19-5336) [hereinafter Paiute and Shoshone Tribe Compact]; Plaintiff's Exhibit B at 2, Jamestown S'Klallam Tribe v. Azar, 486 F. Supp. 3d 83 (D.D.C. 2020) (No. 19-2665) [hereinafter S'Klallam Tribe Compact]; Compact of Self-Governance Between the Little River Band of Ottawa Indians and the United States of America (2016) [hereinafter Little River Band of Ottawa Indians Compact], *reprinted by* TRIBAL SELF-GOVERNANCE, https://tribalselfgov.org/wp-content/uploads/2021/05/Compact-Little-River-Band_-DOI.pdf [https://perma.cc/TVN4-UX36]; Compact of Self-Governance Between the Quinault Indian Nation and the United States of America (June 27, 1990) [hereinafter Quinault Compact], *reprinted by* TRIBAL SELF-GOVERNANCE, https://tribalselfgov.org/wp-content/uploads/2021/04/Quinault-COmpact.pdf [https://perma.cc/YX3E-4MZ9]; Joint Appendix, Part 1 at 3, Redding Rancheria v. Burwell, No. 14-02035 (D.D.C. May 27, 2016) [hereinafter Redding Rancheria Compact]. In lieu of citing all compacts again, this piece will instead reference this footnote and the tables in the Appendix.

162. *See* Alaska Compact, *supra* note 161, at 1-6; Duck Valley Shoshone Paiute Compact, *supra* note 161, at 72-76; Paiute and Shoshone Tribe Compact, *supra* note 161, at 4-6; Little River Band of Ottawa Indians Compact, *supra* note 161, at 1-2.

163. *See, e.g.*, Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra* note 58, at 48-50.

164. This is the same year that the Alaska Compact was amended and restated with self-governance language included. *See* Alaska Compact, *supra* note 161, at 1.

165. *See* Navajo Contract, *supra* note 154, at 1.

not—compacting grew out of earlier contracting, which was less focused on the language of self-governance.[166] But Title V compacts have variable self-governance language as well. Most of the earliest tribal health compacts (some of them actually Title III compacts) did not include the long preamble section included in many of the later tribal health compacts, for example.[167] Some of the earliest compacts also included language describing compacting as an "experiment" or "unprecedented."[168] By contrast, the only tribal health compact initially drafted and negotiated during the 2010s that does not include this preamble is the Redding Rancheria Compact, initially completed in 2011.[169] This suggests that interest in adding self-governance language increased over time as the programs' success and tribal interest in self-governance grew.[170]

Much of this language was drafted by the tribes to promote the advantages of self-governance. As noted above, many of the "whereas" sections with self-governance language are actually tribal resolutions, designed to indicate the tribe's own policy in favor of self-governance as required for compacting.[171] In the Alaska Compact specifically, this language reflected an interest by the drafters in increasing buy-in from the diverse tribal communities that would be covered by the new compacting partnership.[172] These sections were, in effect, an effort

166. *See supra* Section I.A.

167. *See* Quinault Compact, *supra* note 161, at 1; Chippewa Cree Compact, *supra* note 161, at 1; Cherokee Nation Compact, *supra* note 161, at 6.

168. *See* Quinault Compact, *supra* note 161, at 1; Chippewa Cree Compact, *supra* note 161, at 1; Cherokee Nation Compact, *supra* note 161, at 76.

169. *See* Redding Rancheria Compact, *supra* note 161, at 7.

170. Tribal interest in compacting was initially limited due to concerns about the program implications. *See Hearing on S. 979 Before the S. Comm. on Indian Affs.*, *supra* note 152, at 74-75 (statement of Henry Cagey, Chairman, Self-Governance Tribal Advisory Task Force) ("[T]he fear that a lot of tribes ha[ve] is the fear of termination, you know, that we're taking on responsibilities and functions of the government, where, you know, some tribes see it as the responsibility of the United States as a trust responsibility . . . . There is [an] education and communication project that allows the tribes to further communicate what is going on with self-governance . . . .").

171. *See supra* note 163 and accompanying text.

172. Alaska's healthcare compact is a collaboration between many tribes in Alaska and forms government-to-government relationships with the federal government and between the tribes. *See* Alaska Compact, *supra* note 161, at 10. Over time, tribes have joined this compact. *See Hearing on S. 979 Before the S. Comm. on Indian Affs.*, *supra* note 152, at 73 (statement of H. Sally Smith, Chairman, Alaska Native Health Bd.) (describing the growth of the Alaska Tribal Health Compact). The preamble language in the Alaska Tribal Health Compact is signed by each participating tribe (or is adopted by tribal resolution). *See* Alaska Compact, *supra* note 161, at 9. This language thus functions both as a record of the tribes' agreement and as a way of promoting self-governance to tribes that may have been hesitant to join. *See* Brief for Cook

by the tribes themselves to internally promote the project of self-governance, and to externally signal an interest in compacting.[173] This language promoted compacting by providing a unified vision for tribes embarking on the project of coaxing a reticent federal agency to partner with them.

Medicaid state plans do not include any of this language. Oregon's state plan, for example, is just a copy of the state's submission on CMS's website. It contains only technical information about the program's operations and benefits.[174] Nevada's state plan is similar—a technical document with no mention of sovereignty or the state's ability to manage itself.[175] None of the state plans analyzed here involve any language relating to self-governance at all, and the only mentions of a trust responsibility are in relation to Medicaid programs geared towards tribal members.[176] The Medicaid program does not have a statutory goal

Inlet Region, Inc. as Amicus Curiae in Support of Petitioners at 16, Yellen v. Confederated Tribes, 594 U.S. 338 (2021) (No. 20-544) (detailing the work done by early advocates of self-determination to broaden the scope of compacting); *see also* Email from Lloyd B. Miller, Partner, Sonosky, Chambers, Sachse, Miller & Monkman, LLP, to author (Aug. 31, 2025, 3:00 PM) (on file with author) (indicating that language in the Alaska Compact demonstrated drafters' interest in tribal buy-in); *Hearing on S. 979 Before the S. Comm. on Indian Affs.*, *supra* note 152, at 73 (statement of Buford Rolin, Chairman, Nat'l Indian Health Bd.) ("During our annual meeting held in Anchorage, AK, in October 1998, we received resolutions from five areas that included a total of 331 tribes that supported the H.R. 1833. We understood that four areas had chosen not to endorse this concept . . . ."); Watson, *supra* note 21, at 8-9 (providing background on the scope and unique nature of compacting in Alaska).

173. Title V requires that a tribe pass a tribal resolution before entering a compact. *See* 25 U.S.C. § 5383 (2024) (describing that a tribe "may elect to participate in self-governance under this title under existing authority as reflected in tribal resolution").

174. *State Plan Under Title XIX of the Social Security Act Medical Assistance Program*, OR. HEALTH AUTH. 1 (Nov. 22, 2023) [hereinafter Oregon State Plan], https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf [https://perma.cc/4LHT-249F].

175. Nevada State Plan, *supra* note 123, at 1.

176. *See* Oregon State Plan, *supra* note 174, at 260; Nevada State Plan, *supra* note 123, at 112; *Medicaid State Plan*, MICH. DEP'T OF HEALTH & HUM. SERVS. 273 (July 1, 2025) [hereinafter Michigan State Plan], https://www.mdch.state.mi.us/dch-medicaid/manuals/MichiganStatePlan/MichiganStatePlan.pdf [https://perma.cc/L8CV-GCNA]; *State Plan for Medicaid*, ARIZ. HEALTH CARE COST CONTAINMENT SYS. 1 (2025) [hereinafter Arizona State Plan], https://www.azahcccs.gov/Resources/StatePlans/indexedstateplan.html [https://perma.cc/8FGH-LNG8]; Oklahoma State Plan, *supra* note 123, at 1-14; *Medicaid (Title XIX) State Plan*, WASH. STATE HEALTH CARE AUTH. 80 (2024) [hereinafter Washington State Plan], https://www.hca.wa.gov/assets/program/SP-Numbered-Pages-General-Program-Administration.pdf [https://perma.cc/XY5A-MEJC]; *Medicaid and CHIP State Plan and Waiver Amendment Public Notices*, MONT. DEP'T PUB. HEALTH & HUM. SERVS. (2024), https://dphhs.mt.gov/MontanaHealthcarePrograms/MedicaidStatePlanAmendmentPublicNotices [https://perma.cc/535J-X3SY] (it should however be noted that the structure of Montana's state plan makes performing an exhaustive search thereof nearly impossible); *New Mexico Medicaid State Plan*,

of enhancing state sovereignty, but this does not fully explain the difference. Furthermore, the federal government has a clear interest in the management of Medicaid programs, as it invests in efforts to reduce fraud and offers states technical assistance.[177] Yet nowhere in the Medicaid state plans does the state include language about the importance of the state's place in the "family of governments."[178] Despite the fact that many of the Medicaid state-plan documents date to the early decades of the program, none of them describe Medicaid as an "experiment."[179]

The historical and comparative context demonstrates that states and tribes approached the genesis of IHS compacting and Medicaid implementation differently. By the time legislation to create Medicaid was passed, the states had decades of experience administering care in their precursor programs, and the federal government was the new partner in those arrangements.[180] In IHS compacting, tribes wrested healthcare programs from a federal government that had been administering them.[181] The self-governance language played an important role in establishing the tribes' status and interest in taking on governance of their own programs, while states did not need this language — they were running the programs already, and the federal government was showing up to offer funding in exchange for the states meeting its requirements. In addition, the broader contexts of federal-state and federal-tribe relationships differ significantly, warranting the tribal compacts' inclusion of this language to remind federal partners of the significance of their role in their own governance.

2. *The Option to Innovate*

The second difference between Medicaid and ISDEAA documents is the level of specificity included. Medicaid plans are long and highly specific, reflecting a less flexible partnership and mandatory funding, while ISDEAA documents give tribes more flexibility to implement programs with variable funding. Generally,

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N.M. Health Care Auth., https://www.hca.nm.gov/new-mexico-medicaid-state-plan [https://perma.cc/UV4K-HWXC]; *Medicaid State Plan Documents*, Wis. Dep't Health Servs. (Jan. 1, 2023), https://www.dhs.wisconsin.gov/mandatoryreports/mastateplan/plan.htm [https://perma.cc/M83M-E63Q]; *California State Plan*, Cal. Dep't Health Care Servs. (2025), https://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx [https://perma.cc/CVS7-FB42].

177. *See supra* note 145 and accompanying text.

178. *See* Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra* note 58, at 37.

179. *Appendix*, *supra* note 122, at 2 tbl. 2; *cf. supra* text accompanying note 168 (noting this language in older ISDEAA documents).

180. *See supra* notes 85-89 and accompanying text.

181. *See supra* Section I.A.

both Title I contracts and Title V compacts contain two elements: the overarching contract or compact and an associated funding agreement.[182] The funding agreement is updated periodically and provides details about the programs that the tribes will run and the amount of funding allocated to the contract or compact for that year.[183] The compacts, by contrast, are typically evergreen,[184] only updated or amended as changes come up that the parties want to accommodate. Medicaid state plans are structured like annual funding agreements and Title V compacts combined—they include details on eligibility, operations, and the benefits available (like a funding agreement), but they are evergreen and represent an ongoing partnership (like a compact). Medicaid state plans can be amended like a compact (and frequently are, based on changing state priorities).[185] Medicaid state plans do not have annual funding agreements because Medicaid is an entitlement program. The funding for Medicaid benefits is mandatory; under the current statute, the federal government cannot decline to pay the federal share for approved benefits.[186] This does not mean that the federal government cannot cut Medicaid funding or services; as demonstrated by the recently passed OBBBA, Congress can revise Medicaid's structure or benefits at any time.[187] But these changes require an act of Congress, not simply a federal administrative action.

Funding agreements under both Title I contracts and Title V compacts provide some details about the operations and maintenance of the program. Both types of funding agreement generally include a list of services that the tribe should provide; resources that the government will make available to the tribe, such as phones, cars, or clinics and other real-property facilities; and the amount of money to be paid for that year. But these specifications remain fairly general. For example, the Annual Funding Agreement to the Title V compact for the Duck Valley Shoshone-Paiute Tribes dated October 1, 1995, includes a list of services that contains "Outpatient Clinical Services."[188] The main specification for this category is that "[t]he outpatient clinic will provide a comprehensive range of

182. *See* 25 U.S.C. §§ 5384-5385 (2024); Off. of Tribal Self-Governance, *Frequently Asked Questions*, Indian Health Serv., https://www.ihs.gov/selfgovernance/faq/#12 [https://perma.cc/QZK6-2YCU].

183. 25 U.S.C. § 5385 (2024).

184. *See supra* note 53 and accompanying text.

185. *See Medicaid State Plan Amendments*, Medicaid (2025), https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html [https://perma.cc/8W4Z-KMUP].

186. *Policy Basics: Introduction to Medicaid*, *supra* note 7 ("[S]tates have guaranteed federal financial support for part of the cost of their Medicaid programs.").

187. *See* One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72 (2025); *supra* note 3 and accompanying text.

188. *See* Duck Valley Shoshone Paiute Compact, *supra* note 161, at 109.

services including diagnosis and treatment of illness or injury; preventive care, including well baby care; periodic check-ups and routine immunizations; laboratory tests and radiological examinations."[189] The Annual Funding Agreement from 2009 for the Alaska Compact is similarly general, describing under the "Patient Care Services" subsection that the tribe should provide "acute patient care" and "licensed physician . . . coverage."[190] The subsequent "Ancillary Services" subsection is even more vague, requiring only that "[a]ncillary services will be maintained at levels sufficient to support medical diagnosis."[191] All compact annual funding agreements reviewed include some description of the services to be covered and some detail about the level of service required.

Title I contract annual funding agreements are similar, with a few more details. Many Title I contract annual funding agreements include a Scope of Work attachment that details a specific list of services to be provided.[192] In addition, some annual funding agreements include requirements for specific staffing levels. The Menominee annual funding agreements, for example, include a term requiring a certain number of pharmacists to staff the program and note the particular level of qualification or license the staff needs to have.[193] These provisions are more specific than compact funding agreements' general provisions that the tribes provide "a comprehensive range of services."[194] In addition, perhaps as a result of their specificity, most Title I contract annual funding agreements do not include details about which programs were reserved (i.e., not to be operated by the tribe).[195] Most compact annual funding agreements did not include these

189. *Id.*

190. *See* Maniilaq Funding Agreement, *supra* note 161, at 8.

191. *Id.* at 9.

192. *See* Complaint, Exhibit B at 1, Fort Defiance Indian Hosp. Bd. v. Becerra, No. 24-cv-00606 (D.N.M. June 14, 2024) [hereinafter Fort Defiance Funding Agreement]; Complaint, Exhibit E, Pt. A at 31, Seneca Nation of Indians v. HHS, 945 F. Supp. 2d 135 (D.D.C. 2013) (No. 12-1494); Complaint, Exhibit E, Pt. B at 30, *Seneca Nation of Indians*, 945 F. Supp. 2d 135 (No. 12-1494) [hereinafter FY 2010 Seneca Nation Annual Funding Agreement]; Joint Appendix at 86, Becerra v. San Carlos Apache Tribe, 602 U.S. 222 (2024) (Nos. 23-250, 23-253) [hereinafter 2012 San Carlos Apache Funding Agreement]; Joint Appendix at 92, *San Carlos Apache Tribe*, 602 U.S. 222 (Nos. 23-250, 23-253) [hereinafter 2013 San Carlos Apache Funding Agreement]; Joint Appendix at 141, *San Carlos Apache Tribe*, 602 U.S. 222 (Nos. 23-250, 23-253) [hereinafter 2016 Northern Arapaho Funding Agreement].

193. *See, e.g.*, Plaintiff's Exhibit E at 24, Menominee Indian Tribe v. United States, 614 F.3d 519 (D.C. Cir. 2010) (No. 09-5005).

194. *See* Duck Valley Shoshone Paiute Compact, *supra* note 161, at 109.

195. *See, e.g.*, Fort Defiance Funding Agreement, *supra* note 192; FY 2010 Seneca Nation Annual Funding Agreement, *supra* note 192; 2012 San Carlos Apache Funding Agreement, *supra* note 192; 2013 San Carlos Apache Funding Agreement, *supra* note 192; *see also Appendix*, *supra* note 122, at 3-4 tbl. 3 (listing various funding agreements).

details, splitting the program operation between the tribe and the BIA/IHS at a higher level than healthcare specialty.[196]

By comparison, Medicaid state plans are incredibly specific. Like a tribe with a Title V compact would, states administer their Medicaid programs almost wholly independently (with federal funding, training, and support).[197] Yet their state plans include a very different level of detail. Arizona had the shortest Medicaid state plan studied here, and it was still 933 pages long.[198] Nevada's state plan (951 pages long) begins with a detailed description of the state agency's organization and structure and contains an organizational chart.[199] Then, the plan describes all of the groups eligible for coverage, including updates (as Medicaid coverage has expanded a few times since the program's initial approval).[200] Under Medicaid, states do not provide services directly but instead contract with private providers[201] — so the state plans do not include requirements for hours of operation like the ISDEAA documents do.[202] With that caveat, the state plans are much more detailed in describing the services Medicaid provides than the compacts or contracts. A Medicaid state-plan description of physical-therapy services provided in an outpatient setting is over a page long and includes sections on what "[p]hysical therapy means," "Physical Therapy Evaluations and Treatments," "Maintenance Therapy," and "Provider Qualifications."[203] The plan also has descriptions of occupational-therapy services, rehabilitative services, and

196. *See, e.g.*, Maniilaq Funding Agreement, *supra* note 161, at 5; Joint Appendix, Volume I at 185, Cherokee Nation v. Leavitt, 543 U.S. 631 (2004) (No. 02-1472); Administrative Record at 23, Fort McDermitt Paiute & Shoshone Tribe v. Becerra, 6 F.4th 6 (D.C. Cir. 2021) (No. 19-5336); Plaintiff's Exhibit G at 2, Jamestown S'Klallam Tribe v. Azar, 486 F. Supp. 3d 83 (D.D.C. 2020) (No. 19-2665); Joint Appendix at 22, Redding Rancheria v. Burwell, No. 14-02035 (D.D.C. May 27, 2016).

197. *See* 42 C.F.R. § 431.10(b)(1) (2025) (requiring that a state plan must "[s]pecify a single State agency established or designated to administer or supervise the administration of the plan").

198. *See* Arizona State Plan, *supra* note 176.

199. *See* Nevada State Plan, *supra* note 123, at 8.

200. *Id.* at 20-69.

201. *See Provider Payment and Delivery Systems*, MEDICAID & CHIP PAYMENT ACCESS COMM'N, https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems [https://perma.cc/J47B-J2B5] ("States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both.").

202. *See* Annual Funding Agreement Between Navajo Health Foundation/Sage Memorial Hospital and the Secretary of the Department of Health and Human Services, Fiscal Year 2013 at 9-11, Navajo Health Found. v. Burwell, No. 14-00958 (D.N.M. Jan. 13, 2015), Dkt. No. 21-1 [hereinafter Navajo Funding Agreement]; Duck Valley Shoshone Paiute Compact, *supra* note 161, at 109.

203. *See* Nevada State Plan, *supra* note 123, at 242-43.

doula services.[204] In addition, in order to change a state plan, states need to draft the change and submit it to the federal government for approval by CMS.[205]

The specificity of Medicaid state plans does not imply that the federal government does not trust the states to act as good partners—indeed, Medicaid is a significant federal priority and a huge line item for both the federal and state governments.[206] In addition, the states are the primary decision-makers on issues of administration, coverage, and waivers. States only have to meet federal requirements; otherwise, program administration is left to their discretion in alignment with the state plan.[207] It is unlikely the federal government would entrust a state with this level of responsibility in a high-priority area if there was not some level of trust and partnership, and the federal government has also acknowledged such partnerships explicitly.[208]

If Medicaid state-plan specificity does not imply a lack of trust, it might instead suggest a particular type of sovereign-to-sovereign partnership. These documents provide details on how to administer every aspect of the Medicaid program, and they are long, detailed, and frequently revised.[209] The details indicate that both state and federal governments take the program seriously and want to ensure mutual understanding and partnership between governments. The state trusts the federal government enough to provide long and detailed accounts of its benefits and programs and historically has not had concerns that the federal government will try to stall or otherwise limit its administration of Medicaid programs by requesting additional information or requiring further

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204. *See id.* at 243-44, 256-85.

205. 42 C.F.R. § 430.12 (2025).

206. *See HHS Takes Additional Actions to Help People Stay Covered During Medicaid and CHIP Renewals*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 28, 2024), https://www.cms.gov/newsroom/press-releases/hhs-takes-additional-actions-help-people-stay-covered-during-medicaid-and-chip-renewals [https://perma.cc/2HNU-UHHH] (quoting Secretary Xavier Becerra as saying, "HHS is committed to ensuring Medicaid and CHIP coverage for all who are eligible"). Medicaid and CHIP alone make up about 10% of the federal budget. *See Medicaid Spending in Context*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (July 20, 2020), https://www.macpac.gov/subtopic/medicaid-spending-in-context [https://perma.cc/5E6D-4JMF].

207. *See supra* notes 91-95 and accompanying text.

208. *See* Letter from Xavier Becerra, Sec'y, U.S. Dep't of Health & Hum. Servs., to U.S. Governors (June 12, 2023), https://www.hhs.gov/about/news/2023/06/12/letter-us-governors-from-hhs-secretary-xavier-becerra-medicaid-redeterminations.html [https://perma.cc/7LWA-2WEH] ("Our partnership is critical in making this a reality, and I urge every state to go above and beyond to keep eligible people covered. My team stands ready to help. Thank you for your continued partnership.").

209. *See supra* notes 197-205 and accompanying text.

state action. This general understanding holds on both sides of the Medicaid program.[210]

The lack of specificity inherent in Title V compacts between the federal government and states reflects a historically different relationship and a different structure. Medicaid is structured differently than an IHS provider—Medicaid is a payor and does not deliver services. Additionally, IHS compacts were not initially given freely by federal executive agencies, and tribes and Congress iterated on the program to put in place guidelines that pushed the relevant federal agencies to enter into contracts and compacts with good faith.[211] Legislation specifically limited how and why the executive branch could deny tribal compacting requests to ensure that tribes could take on self-governance roles.[212] It is therefore telling that the beginning third of each Title V compact is a long narrative about the importance of tribal sovereignty and federal support for tribal independence, but the compacts do not include much detail about the programs themselves—the point was to provide tribal sovereignty to implement the program flexibly and with limited federal oversight.[213]

Another nonspecific element of Title I contracts and Title V compacts underscores tribes' and states' differing federal relationships: the audit and report sections. In Medicaid, auditing is a joint federal-state process. The federal government conducts Medicaid auditing activities, but these audits are targeted primarily at providers while states are viewed as partners to federal audit contractors.[214] By contrast, the Alaska Compact includes in "Section 6—Audits" a requirement for "an annual single organization-wide audit . . . . A copy of this audit will be sent simultaneously to the Indian Health Service Area Office, the

210. *See supra* note 208 and accompanying text; *see also* Kathy Hochul, *State of the State 2024: Our New York, Our Future*, N.Y. GOVERNOR (Jan. 2024), https://www.governor.ny.gov/sites/default/files/2024-01/2024-SOTS-Book-Online.pdf [https://perma.cc/2R7S-V7XW] (mentioning Medicaid 53 times); Mara Silvers, *What Montana's Candidates for Governor Have to Say About Renewing Medicaid Expansion*, MONT. FREE PRESS (May 10, 2024), https://montanafreepress.org/2024/05/10/where-montanans-governor-candidates-stand-on-medicaid-expansion [https://perma.cc/TAE6-2NY7] (quoting incumbent Governor Greg Gianforte as saying, "The safety net of Medicaid should be there for those who truly need it").

211. *See supra* Section I.A.

212. *See supra* note 50 and accompanying text.

213. Even in the Navajo Contract, which is generally less focused on self-governance than its peer documents, a detailed list of services to be provided and other operational parameters were not included in either the contract or the funding agreement—they were buried in Attachment A. *See* Navajo Funding Agreement, *supra* note 202, at 9.

214. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., PUB. NO. 100-15, MEDICAID PROGRAM INTEGRITY MANUAL (2024) (including a chapter on "Collaboration with States" and a chapter on "Medicaid Investigations & Audits").

cognizant agency, and the Federal Audit Clearinghouse."[215] The Swinomish Compact contains a similar requirement to provide the federal government with an annual audit.[216] The Nevada state Medicaid plan, by contrast, only includes language attesting that the state will maintain an auditing contractor and require audits from its providers.[217]

This difference could be because the tribes are operating facilities, and the Medicaid programs are effectively a pass-through for payments to providers. But the Medicaid programs operate with a massive budget and more federal money than IHS programs do.[218] If the goal were specifically safeguarding federal dollars while expending the least effort, requiring states to conduct an audit of Medicaid programs and report back to the federal government would make significant sense. Yet instead of asking states for annual audits of their programs, the federal government partners with them to conduct audits of external parties. The federal government does require that Medicaid programs provide reporting to the government, but this requirement is not framed as an audit of the Medicaid program, and the data are used for numerous purposes that are not related to monitoring state activity. The federal government asks Medicaid for more data than it does the IHS, but outside of an audit framework.[219]

Out of context, these differences seem odd. But IHS compacting and the Medicaid program have different structures that warrant a different type of review. And these auditing systems grew out of the different relationships underlying each of these programs. In the early days of ISDEAA implementation, the federal agencies' oversight of self-governance programs was burdensome—so Congress edited this oversight back to one audit annually.[220] By contrast, the federal government and state Medicaid programs partner to identify fraud issues and share data because the federal government provides support, training, and

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215. *See* Alaska Compact, *supra* note 161, at 13.

216. *See* Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra* note 58, at 39.

217. *See* Nevada State Plan, *supra* note 123, at 321, 491.

218. *See* Elizabeth Williams, Anna Mudumala, Robin Rudowitz & Alice Burns, *Medicaid Financing: The Basics*, KAISER FAM. FOUND. (Jan. 29, 2025), https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics [https://perma.cc/5V38-X7H9] (detailing federal spending as 69% of $880 billion in federal fiscal year 2023, or about $606 billion); Luetkemeyer, *supra* note 26 (noting a requested expanded IHS budget of about $8 billion).

219. *See Encounter Data*, MEDICAID, https://www.medicaid.gov/medicaid/managed-care/guidance/encounter-data [https://perma.cc/N8K7-7JJK]. The encounter-data audits mentioned on this page are audits by the state of their managed-care private partners—i.e., not audits of the state itself but of the insurance providers who contract with the state. *See* 42 C.F.R. § 438.602(e) (2025).

220. *See supra* note 50 and accompanying text.

funding aligned with the data submitted.[221] This difference has some structural reasons: for Medicaid, the state and federal governments are both providing funding and are interested in ensuring program integrity on a claim-by-claim basis, while tribal governments are both administrator and provider of services and receive a large lump sum annually.[222] As a result, the auditing provision of IHS compacting reflects the program's structure, but it is also a legacy of the federal government's long history of less-than-optimal management of tribal resources, property, and the IHS itself.[223]

3. Structured to Survive

Title V compacts and Title I contracts are both structured to anticipate bad outcomes and protect tribes from funding shortfalls, while Medicaid plans do not contemplate negative outcomes. First, both contracts and compacts are, as previously noted, structured so the contract or compact is one document and the funding and services to be provided are a separate document.[224] This is necessary for funding reasons but can create uncertainty and requires an unavoidable level of federal control on an ongoing basis, even as Title V is set up to encourage tribal sovereignty. Once a tribe signs a compact, the tribe has agreed to a federal-tribal partnership where they administer and operate health facilities, often including large hospitals, indefinitely but without assurance of annual funding. Because these facilities receive federal funding on an annual, as-available basis, federal agencies could manipulate annual funding negotiations—they could cut or eliminate funding to influence a tribe's administration of healthcare.

The solution to this problem is an excellent example of how the tribes advocated and implemented protective measures in IHS compacting partnerships. First, tribes and advocates have effectively raised the problem to Congress. In the committee reports discussing the Self-Governance Amendments of 2000 (the legislation implementing Title V), Congress expressed concern at federal

221. *See supra* notes 102-108 and accompanying text.

222. For details on Medicaid's funding structure, see *supra* notes 98-101 and accompanying text. For details on the IHS compact funding structure, see *supra* notes 65-69 and accompanying text.

223. *See, e.g.*, Rebecca Hersher, *U.S. Government to Pay $492 Million to 17 American Indian Tribes*, NAT'L PUB. RADIO (Sep. 27, 2016), https://www.npr.org/sections/thetwo-way/2016/09/27/495627997/u-s-government-to-pay-492-million-to-17-american-indian-tribes [https://perma.cc/K75Q-UMMS]; WatchBlog, *Improving Federal Administration of Programs that Serve the American Indian Population*, U.S. GOV'T ACCOUNTABILITY OFF. (Dec. 12, 2017), https://www.gao.gov/blog/2017/12/12/improving-federal-administration-of-programs-that-serve-the-american-indian-population [https://perma.cc/X5J9-3ER5].

224. *See supra* notes 182-184 and accompanying text.

agencies' behavior in annual-funding-agreement negotiations and put additional safeguards in place to prevent the IHS from withholding funds or using annual-funding-agreement negotiations as leverage.[225]

Next, drafters put significant work into structuring compacts, contracts, and funding agreements to protect tribes. A compact or contract may be the overarching agreement, but much of the operational substance of the federal-tribal agreement on funding, services to be provided, and crucial program management is in the funding agreements. Title I contracts and Title V compacts regularly mention their accompanying funding agreements. The Alaska Compact, discussing funding for the compact, states that "the Secretary shall provide the total amounts specified in the Funding Agreements."[226] Furthermore, the Compact is active only "provided the Co-Signer has a Funding Agreement in effect."[227] Subsections describing "Property Management" and "Compact Programs" also reference the funding agreement for a list of the actual properties or programs at issue.[228] The Swinomish Compact has parallel references to its funding agreement in the "Funding Amount" and "Tribal Programs" sections.[229]

In comparison to other federal contracts, these terms are unusual, but necessary. The federal government frequently enters into multiyear contracts with federal contractors in other programs, and the standard procedure is to include a cancellation procedure if the funds needed to fulfill the contract are not available in subsequent years.[230] With these agreements, there is no need to negotiate on an ongoing basis with the contractor after awarding the contract.[231] There is also no parallel procedure in Medicaid — although, as noted above, Medicaid is an entitlement program, so the federal government is obligated to match the state's funding.[232] The design of the IHS documents — nonspecific in the compact, more specific in the annual funding agreements — ensures an evergreen

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225. *See* H. Rep. No. 106-477, at 21 (1999) ("The Committee is concerned with the reluctance of the IHS to include all available federal health funding in self-governance funding agreements . . . . This section is intended to directly remedy this situation."); S. Rep. No. 106-221, at 7 (1999) ("Accordingly, this section is to be interpreted broadly by affording a presumption in favor of including in a tribe's self-governance funding agreement any federal funding administered by that Agency.").

226. *See* Alaska Compact, *supra* note 161, at 12.

227. *Id.* at 11-12.

228. *Id.* at 14, 17.

229. *See* Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra* note 58, at 38, 43.

230. 48 C.F.R. § 17.106-1 (2025).

231. *Id.*

232. *See supra* note 186 and accompanying text. Notably, none of the Medicaid state plans surveyed include retrocession or termination language. *See Appendix*, *supra* note 122, at 2 tbl. 2.

partnership with the federal government without contractually committing the tribe to specific tasks or projects without associated funding. So one problematic annual funding agreement may limit services for a year but will not undermine the broader compact.

IHS documents also include explicit provisions that avoid leaving the tribes financially responsible for care that ought to be federally funded. First, all of the compacts contain some version of the following sentence: "Each Co-Signer shall not be obligated to continue performance that requires an expenditure of funds in excess of funds awarded under the Funding Agreement."[233] Most of the compacts and contracts contain a specific "Limitation of Costs" provision, which provides some detail as to what happens if IHS funding falls short of what the tribe needs to operate its program.[234] Given this language, if the funding ran out, the tribe would not be required to continue providing services using their own revenue — they would simply have to "provide reasonable notice to the Secretary."[235]

These provisions do involve one wrinkle: the tribe often cannot opt to consolidate or redesign its services in such a way as to "have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable federal law."[236] This means that if a tribe is given limited funding, it cannot change the overall eligibility requirements of the program — which Medicaid programs can do with a state plan amendment. The tribe is bound to reduce services for everyone if it reduces them at all.

Yet despite the eligibility requirement, the limitation-of-cost provisions ensure tribes are not responsible for costs if the federal government halts funding. This design protects the tribes in a situation in which the federal government acts as a fickle partner, as partly played out with Sage Memorial Hospital, which was run pursuant to the Title I contract between the federal government and the Navajo.[237] The IHS effectively shut down Sage Memorial in the middle of the COVID-19 pandemic after unclear communication with tribal leaders about the process for renewing the Navajo Nation's contract to operate the facility.[238]

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233. *See, e.g.*, Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra* note 58, at 43; Alaska Compact, *supra* note 161, at 16; Duck Valley Shoshone Paiute Compact, *supra* note 161, at 79.

234. *See, e.g.*, Paiute and Shoshone Tribe Compact, *supra* note 161, at 16; S'Klallam Tribe Compact, *supra* note 161, at 8.

235. *See* Paiute and Shoshone Tribe Compact, *supra* note 161, at 79-80.

236. Alaska Compact, *supra* note 161, at 17; *see also Appendix*, *supra* note 122, at 1 tbl. 1 ("Baseline Measures/Maintenance of Services" column).

237. *See* Emma Whitford, *Hospital on Navajo Nation Sues IHS to Keep Gov't Contract*, Law360 (Nov. 16, 2020, 3:41 PM EST), https://www.law360.com/articles/1329098 [https://perma.cc/MP67-HMTY].

238. *Id.*

When asked about this shutdown, the IHS commented that the tribal resolution authorizing contracting had expired.[239] Any funding issue a tribe might have with its healthcare program—ranging from a government shutdown to a federal agency holding fast to a minor bureaucratic requirement (as was the case with Sage Memorial)—could stop the tribe from providing services.[240] Then, the funding agreement would effectively be almost void, but the contract or compact would still be in place.[241] The tribe would be required to reduce or shut down its services but would still have the option to resume them if funding were restored. And the tribe would not be liable for spending outlays it could not support.[242] Under these agreements, the federal government effectively cannot create a compact without federal funding. If funding is cut, the tribe can opt to discontinue unfunded services.

As noted above, the disparity in bargaining power is particularly acute in negotiating successor annual funding agreements—where the tribes have signed evergreen compacts and need funding to keep the programs running. A lack of funding means a hospital or clinic could close and needed care could be delayed. Here again, the tribes advocated for protection and Congress stepped in to force the executive agencies' hand.[243] Every single contract and compact references the renegotiation of funding agreements. The compacts often contain language requiring the federal government to provide the tribe "with a written list of the retained programs, activities, functions, and services relevant to Native health care in [the tribe's service area] for the upcoming fiscal year" at least 120 days prior to the end of each fiscal year.[244] From this language, it is unclear whether the federal government could unilaterally make decisions about which programs

239. *Id.*

240. *Id.*; *see also* Cindy Yurth, *Nez Vetoes Sage's Tribal Contract*, NAVAJO TIMES (Oct. 8, 2020), https://navajotimes.com/reznews/nez-vetoes-sages-tribal-contract [https://perma.cc/R4HF-KPNL] (quoting Christi El-Meligi, the CEO of Sage Memorial, who stated that "[t]he funds Sage currently has in its savings [are] to be used to build the new hospital. If it has no IHS funding and is forced to use these funds to run its operations[,] [t]his funding will last three years at most").

241. *See, e.g.*, Alaska Compact, *supra* note 161, at 16 ("In accordance with section 508(k), if, at any time the Co-Signer has reason to believe that the total amount required for performance of a Funding Agreement . . . would be greater than the amount of funds awarded under the Funding Agreement, the Co-Signer shall provide reasonable notice to the Indian Health Service and affected tribes and tribal organizations. If the Indian Health Service does not . . . increase the amount of funds awarded under the Funding Agreement, the Co-Signer may suspend performance of the Funding Agreement . . . .").

242. *See supra* notes 233-236 and accompanying text.

243. *See supra* note 225 and accompanying text.

244. *See, e.g.*, Alaska Compact, *supra* note 161, at 18; S'Klallam Tribe Compact, *supra* note 161, at 10.

to retain or cut, but the underlying legislation clarifies that the Secretary has limited discretion to decline to compact.[245]

Many compacts also note that negotiations for a new funding agreement must begin no later than 120 days "in advance of the conclusion of the preceding Funding Agreement."[246] These provisions likely stem from tribes' historical difficulty bringing the federal government to the negotiating table and Congress's efforts to ensure fair dealing on the part of the executive branch. Parties negotiating ISDEAA documents may still have significant information and power asymmetries going into negotiations, as the federal agency controls the budget, but these provisions and the underlying legislation work to limit a tribe's disadvantage in negotiations.

The only contract and compact provision more universal than that specifying the procedure for negotiating annual funding agreements is a provision detailing the procedure for modifications, which protects against uncertainty in the program's structure and funding.[247] Modifications could happen for a number of reasons (many of them positive, like additional funding), and Medicaid state plans also contain provisions providing a procedure for state-plan amendments (including a process for tribal consultation).[248] However, documents for compacts and contracts demonstrate that the modification process is used frequently—sometimes multiple times a year—and often to adjust funding. For example, the Menominee Tribe's 2000 funding-agreement documents show multiple successive modifications.[249] While these changes may ultimately be positive, they reinforce the uncertainty and lack of leverage that tribes have in operating their programs. Each time the tribe runs out of money, it relies upon the whims of the federal government for a budget adjustment that might not

245. *See* 25 U.S.C. § 5387(b)-(d) (2024) (describing the process for accepting or declining final offers and specifying that the Secretary has the burden of proof of demonstrating why the offer was not accepted). Once compacts are entered, the term is usually indefinite. *Cf. id.* § 5384(d) (stating that compacts "shall remain in effect for so long as permitted by Federal law or until terminated by mutual written agreement, retrocession, or reassumption").

246. *See, e.g.*, Alaska Compact, *supra* note 161, at 14; Cherokee Nation Compact, *supra* note 161, at 180; Little River Band of Ottawa Indians Compact, *supra* note 161, at 3. The Shoshone Paiute Compact and the Redding Rancheria Compact provide a slightly longer time horizon of 150 days. Duck Valley Shoshone Paiute Compact, *supra* note 161, at 86; Redding Rancheria Compact, *supra* note 161, at 10.

247. *See Appendix*, *supra* note 122, at 1 tbl. 1 ("Modifications" column).

248. *See* Nevada State Plan, *supra* note 123, at 14; Oklahoma State Plan, *supra* note 123, at 821; Washington State Plan, *supra* note 176, at 159.

249. *See, e.g.*, Defendant's Motion to Dismiss or, in the Alternative, for Summary Judgment, Exhibit F at 13, 17, Menominee Indian Tribe v. United States, 614 F.3d 519 (D.C. Cir. 2010) (No. 09-5005).

come through.[250] However, these provisions guard against these situations. If a tribe runs out of funding, it may modify or adjust its programs to account for the shortfall.

Finally, most compacts expressly plan for complete failure. All but one or two reference retrocession, in which a tribe returns a program to the federal government.[251] Several early compacts describe their programs as experimental, suggesting that they might fail.[252] One of the annual funding agreements contains a provision referring to the memorialization of disputes — not simply a dispute-resolution provision, but a provision to track and monitor disputes that arise and cannot be resolved.[253] This provision seems to expect that the tribes and the federal government may have longstanding, unresolved issues.

The Medicaid plans do not even mention what would happen if the state shuttered its Medicaid program or refused to offer core services.[254] Moreover, none of the Medicaid state plans describe the program as an experiment.[255] Medicaid is the nation's largest public insurance program by enrollment.[256] Medicaid has been implemented and provides coverage in every state,[257] even as some states opt to provide fewer services to fewer beneficiaries than others.[258] So even though almost every single tribal compact and contract references a trust responsibility to the tribes,[259] only the Medicaid programs confer the promise that they cannot be shut down or retroceded without an act of Congress.

These provisions protect tribes. The historic uneasiness of relationships between tribes and federal agencies warrants these provisions, which offer an

250. Many annual funding agreements suggest that adjustments are not uncommon. *See, e.g.*, Joint Appendix at 113-16, *Menominee Indian Tribe*, 614 F.3d 519 (No. 1409-510), 2015 WL 5169178 (presenting a "Model/Annual Funding Agreement Modification"). In addition, disputes between the federal government and tribes have limited funding to IHS compacts and contracts. *See supra* notes 237-240 and accompanying text (describing a dispute over contracting impacting funding for Sage Memorial Hospital).

251. *See Appendix*, *supra* note 122, at 1 tbl. 1.

252. *See supra* note 168 and accompanying text.

253. *See* FY 2010 Seneca Nation Annual Funding Agreement, *supra* note 192, at 32; *see also Appendix*, *supra* note 122, at 3 tbl. 3 (showing that the Seneca Nation funding agreement was the only agreement with a "Memorialization of Disputes" clause).

254. *See Appendix*, *supra* note 122, at 2 tbl. 2 ("Retrocession/Termination" column).

255. *Id.* ("Experiment" column).

256. *See supra* note 90 and accompanying text.

257. *See Program History and Prior Initiatives*, MEDICAID, https://www.medicaid.gov/about-us/program-history [https://perma.cc/R2UN-DG4N].

258. *See Status of State Medicaid Expansion Decisions*, KAISER FAM. FOUND. (May 9, 2025), https://www.kff.org/status-of-state-medicaid-expansion-decisions [https://perma.cc/65L4-ZR5A].

259. *See Appendix*, *supra* note 122, at 1 tbl. 1.

escape hatch for tribes if programs do not work or are otherwise difficult to maintain. Medicaid has never needed this kind of security, and its statutory structure does not require planning for funding shortfalls or large-scale program failure.[260] Considering more recent, sustained attacks on Medicaid, this faith seems quaint.[261] Without a mechanism for unraveling, Medicaid state plans would be left holding the bag if federal funding fell through. Based on the IHS Title V compacts, tribes have a backup plan, albeit a devastating one.

C. Dispute Resolution: ICRA and Due Process

Finally, both Medicaid and ISDEAA documents generally contain provisions about dispute resolution or appeals, which echo many of the themes discussed in this Part. For contracts and compacts, the dispute-resolution provision specifically mentions the Indian Civil Rights Act (ICRA). For example, Section 13 of the Navajo Contract provides: "Pursuant to the Indian Civil Rights Act of 1968 (25 U.S.C. § 1301 et seq.), policies and procedures of Sage shall provide for administrative due process."[262] As noted in Table 1 of the Appendix, this provision is a common one in tribal health contracts and compacts.[263] These provisions govern disputes not between the contracts' parties but between the tribe and its members.

The ICRA provision is problematic for a few reasons, perhaps evidenced by the fact that it is not universally included in the compacts and contracts studied here. ICRA imposes protections for civil liberties akin to the Bill of Rights on tribal governments in their interactions with their members.[264] ICRA is highly controversial; Congress has used its plenary power to limit tribal jurisdiction and ability to govern, but ICRA represents a particularly glaring intrusion of the federal government between tribes and their members.[265] Protecting civil

260. *See supra* notes 98-101 and accompanying text.

261. *See supra* Introduction. For discussion of the One Big Beautiful Bill Act, which cuts Medicaid funding indirectly in significant ways, see *supra* notes 1-8, 18, 187 and accompanying text; and *infra* notes 292-297 and accompanying text.

262. *See* Navajo Contract, *supra* note 154, at 19.

263. *See Appendix*, *supra* note 122, at 1 tbl. 1 ("ICRA Provision" column).

264. *See* 25 U.S.C. § 1302 (2024).

265. *See Developments in the Law—Indian Law*, 129 HARV. L. REV. 1652, 1715-19 (2016); *cf.* Santa Clara Pueblo v. Martinez, 436 U.S. 49, 58-59 (1978) (resolving the tension between individual rights granted by the Indian Civil Rights Act of 1968 and tribal sovereign immunity by determining that tribal members cannot sue tribes in federal courts under the statute). While *Santa Clara Pueblo* vindicated the goal of self-governance by declining federal jurisdiction, it also proceeded with the expectation that tribal courts would adjudicate issues based on ICRA, an ongoing intrusion into tribal law. *Santa Clara Pueblo*, 436 U.S. at 65-66.

liberties is not inherently a self-governance issue, but forcing a specific dispute-resolution mechanism upon tribes and their members undermines the project of self-governance that the contract or compact aims to advance.[266] ICRA itself was passed in a phase of the federal government's approach to self-governance that was significantly more paternalistic than what exists today.[267] These vestigial contract and compact provisions are a reminder of this period in self-governance history, but they are also binding contractual language.

While the requirements for Medicaid and IHS-compacting-program appeals are not dissimilar, the histories leading to this result demonstrate different levels of sovereign input. Incorporating ICRA by contract or compact is a reminder of an era when the federal government was less than respectful of tribes' role in their own self-governance. ICRA already applies to all tribes "exercising powers of self-government," so the reference is not necessary.[268] The apparent purpose of this provision is a reminder that if a tribe administering healthcare programs violates administrative due process, the federal government (or a tribal member) has statutory and contractual causes of action against the tribe.[269] The fact that this provision does not appear in some of the compacts (especially the Alaska Compact, which was renegotiated in 2010) indicates that it may have been a point of negotiation for the tribes. Its presence in these contracts signifies the legacy of a federal government interested in oversight, not partnership.

Medicaid state plans often have a similar appeals requirement, albeit with different context.[270] Medicaid programs explicitly and uniformly require an appeals procedure (which needs to comply with the administrative-due-process requirements described with respect to ISDEAA documents above).[271] But the

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266. *See Developments in the Law—Indian Law*, *supra* note 265, at 1724-26.

267. *See* Strommer & Osborne, *supra* note 43, at 16 ("Despite this favorable shift away from termination, President Johnson's definition of self-determination was viewed by some critics as more of a paternalistic image than of beneficial substance.").

268. 25 U.S.C. § 1302 (2024).

269. This cause of action allows tribal members to sue as third-party intended beneficiaries of the compact or contract. *See* Glass v. United States, 258 F.3d 1349, 1354 (Fed. Cir. 2001) ("In order to prove third party beneficiary status, a party must demonstrate that the contract not only reflects the express or implied intention to benefit the party, but that it reflects an intention to benefit the party directly.").

270. 42 U.S.C. § 1396a(a) (2024) ("A State plan for medical assistance must . . . provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness . . . .").

271. *See Appendix*, *supra* note 122, at 2 tbl. 2 (showing universal adoption of an appeals-process requirement in the Medicaid state plans surveyed); *supra* notes 262-263 and accompanying text (describing administrative-due-process requirements in the ISDEAA context). For

states' requirement to implement due process is the result of a historical relationship with more state input. Twelve states had the opportunity to provide input at the Constitutional Convention, and others adopted these requirements when they entered the Union at various times.[272] States also have procedural protections in the Constitution.[273] In other words, due process is a requirement that states chose when selecting their form of federal governance. Tribes did not have this option. Their due-process requirement was implemented with a notable lack of due process,[274] and certainly without explicit focus on tribal self-governance.

III. LESSONS FOR MEDICAID

The previous Parts have described the history of Medicaid and the IHS and analyzed the agreements governing the sovereign-to-sovereign relationship that each program represents. Analysis of these documents illustrates a key observation: these programs are the result of their history and of very different federal-state and federal-tribe relationships. The federal-state relationship has historically been a relatively trusting one;[275] the federal-tribe relationship has not

example, Michigan's Medicaid state plan requires that its Medicaid agency "ha[ve] a system of hearings that meets the requirements of 42 C.F.R. Part 431, Subpart E." *See* Michigan State Plan, *supra* note 176, at 33. This provision creates procedural requirements for a Medicaid hearing and appeals process. *See* 42 C.F.R. § 431.200 (2025).

272. *See* Richard R. Beeman, *The Constitutional Convention of 1787: A Revolution in Government*, NAT'L CONST. CTR., https://constitutioncenter.org/the-constitution/white-papers/the-constitutional-convention-of-1787-a-revolution-in-government [https://perma.cc/GU6L-8HZR].

273. *See* U.S. CONST. amend. XI.

274. ICRA was enacted, over the objections of tribal leaders, during a period when tribes and the federal government did not have the partnership they have today. *See, e.g.*, Matthew L.M. Fletcher, *Fletcher on Monteau on the Indian Civil Rights Act*, TURTLE TALK BLOG (July 10, 2012), https://turtletalk.blog/2012/07/10/fletcher-on-monteau-on-the-indian-civil-rights-act [https://perma.cc/8Y47-NQAA]; *see also supra* notes 265-266 and accompanying text (observing how Congress has limited tribal self-governance); ANDERSON ET AL., *supra* note 28, at 340 (describing how ICRA was enacted over the protests of tribal leaders).

275. The operative word here is "relatively." For example, the states created the federal government and were understandably wary of (and acted to limit) its power. *See* U.S CONST. pmbl. ("We the People of the United States . . . do ordain and establish this Constitution . . . ."); THE FEDERALIST NO. 51, at 322 (James Madison) (Clinton Rossiter ed., 1961) ("A dependence on the people is, no doubt, the primary control on the government; but experience has taught mankind the necessity of auxiliary precautions."). However, at the same time, the states and the federal government were actively colonizing tribal land and at war with tribes. *See generally* ROXANNE DUNBAR-ORTIZ, AN INDIGENOUS PEOPLES' HISTORY OF AMERICA (2014) (detailing U.S. policies of territorial expansion and violent dispossession of tribal land). The conflicts between states and the federal government are different in kind from the federal

always been as trusting as it has grown to be. IHS compacting grew up in hostile political environments and has adapted to promote tribal sovereignty while also providing incredible public-health results on a shoestring budget.[276]

In a piece establishing a comparison, it is typical to find lessons for both parties. Here, I focus primarily on lessons for Medicaid. Medicaid's lessons for the IHS—the importance of mandatory funding, improving rural health infrastructure, and addressing staffing shortcomings—have been explored elsewhere.[277] But the IHS offers several important lessons for Medicaid as the latter program faces an uncertain future. This Part covers four of these lessons: building a document structure that prizes flexibility, messaging about the program's importance and success, planning for difficult outcomes, and designing creative solutions that do more with less. This Part focuses on solutions that states can likely implement administratively, with minimal regulatory or legislative changes.

A. Less Can Be More

Right now, Medicaid state plans and IHS compacts have a high-level difference: Medicaid state plans are incredibly long and detailed, while IHS compacts have few detailed descriptions of their covered programs.[278] This is due mainly to each program's history, evolution, and current legislative and regulatory structure. Medicaid was created out of primarily state-run programs and currently requires states to submit detailed state-plan updates to the federal government in order to ensure funding and program changes.[279] IHS compacts were developed as a way for tribes to take over existing federal programs, and the legislation creating these programs sets explicit limits on federal oversight and monitoring.[280] As a result, IHS-compacted programs are significantly more flexible in implementation than state Medicaid plans.

This difference carries an important lesson for Medicaid. In an uncertain funding environment, state Medicaid agencies may need to adjust quickly. These circumstances may require states to take action not authorized in their state plans. As the program is set up currently, those actions would violate the

government's policy of tribal termination and erasure. *See* Haaland v. Brackeen, 599 U.S. 255, 298-303 (2023) (Gorsuch, J., concurring) (detailing the history of the federal government's policies to destroy Native families and steal children).

276. *See supra* notes 70-71 and accompanying text.

277. *See supra* notes 13-14, 36 and accompanying text.

278. *See supra* Section II.B.2.

279. *See supra* note 86 and accompanying text; 42 C.F.R. 457.606 (2025).

280. *See supra* Section I.A.

structure of the state plan and possibly federal law.[281] To avoid this issue, state Medicaid agencies may want to take the approach that tribes took with IHS compacting: less is more. If Medicaid ceases to be an entitlement plan or is reformed as an unfunded mandate, broader descriptions of services to be provided and more explicit flexibility would suit the program. Drastic and obvious changes to Medicaid's funding (making it an unfunded mandate, for example) require conspicuous federal legislation and are unlikely. Changes like the OBBBA are more likely—slow, strategic moves that cut funding gradually over time to starve the program. States, observing slow legislative movement to defund the program, may want to implement provisions in their state plans relating to modification and reduction of services to prevent catastrophic impact to state budgets. States could make these changes over time through the current state-plan amendment process. If Medicaid continues to be defunded, a structure much more like IHS compacting would serve states well.

B. Program Documents as Messaging

Much of the language regarding self-governance in IHS tribal compacts is drafted by tribes.[282] As the Alaska Compact exemplifies, this kind of messaging around a program can help sway public opinion and create alignment on the program's goals.[283] Medicaid does very little of this. In fact, many states are more invested in allowing beneficiaries to hide that they are on Medicaid than in promoting the program. As a result of alternative names for Medicaid programs (e.g., Medi-Cal, TennCare, and Husky Health), many people do not know the full reach of the Medicaid program.[284] In fact, some Medicaid beneficiaries are not even aware of the true benefactor of their care.[285]

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281. *See* 42 U.S.C. § 1396c (2024) (authorizing the Secretary to withhold funding from a state deviating too far from its approved state plan).

282. *See supra* notes 171-173 and accompanying text.

283. As discussed above, Alaskan tribal leaders' work resulted in the expansion of IHS compacting from an initial thirteen tribes to cover almost all Alaska Native populations in the state. *See supra* note 172 and accompanying text; *Hearing on S. 979 Before the S. Comm. on Indian Affs.*, *supra* note 152, at 91 (statement of H. Sally Smith, Chairman, Alaska Native Health Bd.). To date, the Alaska Tribal Health Compact is the only group compact covering multiple tribes. *See* Watson, *supra* note 21, at 8.

284. *See* Anna Claire Vollers, *A Fifth of Americans Are on Medicaid. Some of Them Have No Idea*, STATELINE (Apr. 9, 2025, 5:00 AM), https://stateline.org/2025/04/09/a-fifth-of-americans-are-on-medicaid-some-of-them-have-no-idea [https://perma.cc/JG3L-9CR6]; Janna Herron, *Medicaid Goes by Many Names. Will Americans Realize if It Gets Cut?*, YAHOO FIN. (Mar. 10, 2025), https://finance.yahoo.com/news/medicaid-goes-by-many-names-will-americans-realize-if-it-gets-cut-100005873.html [https://perma.cc/4EEE-KL4A].

285. *See* Vollers, *supra* note 284.

In a political environment in which Medicaid is threatened, the program needs to rethink its messaging. IHS compacts provide a blueprint. Tribal resolutions and introductions provide a clear focus for the program and emphasize shared values like self-sufficiency, tribal empowerment, and tribal autonomy.[286] When rethinking how to talk about Medicaid, state leaders could opt to use Medicaid documents to promote unity using similar messaging. Medicaid provides very important services; in some states, half of all childbirths are paid for by Medicaid, and Medicaid provides crucial care for families with developmentally disabled or medically fragile children.[287] Medicaid also provides an important safety net for rural hospitals and nursing homes.[288] All of these are near-universal goods, and Medicaid could be louder about the importance of these goals and the role it plays in making them a reality. Without a shared understanding of what Medicaid does or is meant to do, it is hard to support the program. By following the path set out by tribes in their approach to developing compacting language, Medicaid could use state plans, Medicaid cards, and annual mailings to emphasize the centrality of the program. These changes would be easy to implement—changing marketing campaigns or ID-card design would likely not require regulation or legislation. While fairly small, this change could have far-reaching impacts on the public's understanding and appreciation of Medicaid.

C. Plan for the Worst

Right now, Medicaid state plans do not plan for disaster. As noted above, state Medicaid plans do not anticipate funding shortfalls or budget cuts; they contain no provisions specifying what to do if the program has to limit benefits

286. *See, e.g.*, Swinomish Tribal Compact and CY 2010-2014 Funding Agreement, *supra* note 58, at 37; Alaska Compact, *supra* note 161, at 2.

287. *See* Usha Ranji, Alina Salganicoff, Jennifer Tolbert, Brittni Frederiksen & Ivette Gomez, *5 Key Facts About Medicaid and Pregnancy*, KAISER FAM. FOUND. (May 29, 2025), https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-pregnancy [https://perma.cc/G3UV-3ELS]; Elizabeth Williams, *5 Key Facts About Children with Special Health Care Needs and Medicaid*, KAISER FAM. FOUND. (Apr. 18, 2025), https://www.kff.org/medicaid/issue-brief/5-key-facts-about-children-with-special-health-care-needs-and-medicaid [https://perma.cc/ZFR3-BHBE].

288. *See* Michelle Mills & Kevin J. Bennett, *Critical Condition: How Medicaid Cuts Would Reshape Rural Health Care Landscapes*, NAT'L RURAL HEALTH ASS'N (Apr. 8, 2025), https://www.ruralhealth.us/blogs/2025/04/critical-condition-how-medicaid-cuts-would-reshape-rural-health-care-landscapes [https://perma.cc/QVC4-PMTL]; *Rural Hospitals at Risk: Cuts to Medicaid Would Further Threaten Access*, AM. HOSP. ASS'N (June 2025), https://www.aha.org/system/files/media/file/2025/06/Rural-Hospitals-at-Risk-Cuts-to-Medicaid-Would-Further-Threaten-Access.pdf [https://perma.cc/UUQ5-9NFF].

or shut down.[289] Editing a Medicaid plan involves approval from the federal government, and this process does not have the same procedural safeguards as IHS compact modifications.[290] IHS compacts, by contrast, have retrocession clauses and provisions that specify how to roll back or limit benefits if funding falls short.[291] IHS-compacted programs can often be modified by the tribe without any involvement of the federal government, and where federal input is needed, the Secretary's ability to refuse the modification is somewhat limited.

Many of these differences, as noted above, are a result of statutory structure—funding shortfalls can happen in IHS compacts, for example, because the IHS is subject to discretionary funding. Medicaid does not plan for funding shortfalls because the program currently receives mandatory funding: a shortfall is grounds for a federal lawsuit, not a reduction in services. While the recently passed OBBBA modifies this relationship by limiting federal funding for certain things, it does not end mandatory federal funding for Medicaid.[292] Instead, it uses mechanisms like barring the state-provider tax and imposing paperwork requirements on beneficiaries to reduce states' ability to enroll members and draw down federal dollars.[293] But even these limited changes put some states in the uncomfortable position of choosing how to adjust their programs and benefits while also dealing with the immediate fallout of a budget cut. The IHS's compacting structure could provide a path forward—Medicaid will need to plan for funding shortfalls, make cuts, and move forward creatively to provide care.

D. Build Creative Solutions

As a result of the flexibility found in IHS compacts, tribal IHS programs have been able to innovate in rural healthcare provision. The IHS runs programs outside its brick-and-mortar facilities, sponsors culturally competent care, and works within its own communities to promote better health outcomes.[294] Medicaid has some of this flexibility, but Medicaid is a payer working within the existing healthcare infrastructure and has regulatory limits on the speed and

289. *See supra* notes 254-259 and accompanying text.

290. *Compare* 42 U.S.C. § 1315(d) (2024) (specifying that the Secretary should promulgate regulations relating to Medicaid Section 1115 waivers), *with* 25 U.S.C. § 458aaa-7(d) (2024) (prohibiting the Secretary from taking certain actions related to IHS funding).

291. *See supra* notes 251-253 and accompanying text.

292. *See* One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72, 290-319 (2025) (containing no provision ending Medicaid federal matching).

293. *See supra* note 2 and accompanying text.

294. *See supra* notes 15, 17, 70 and accompanying text.

processes with which it can implement waivers.[295] As a result, Medicaid programs are typically more unwieldy than IHS compacts, limiting their ability to implement flexible local solutions. Medicaid programs also currently spend about twice as much per capita as comparable IHS compacting.[296]

The IHS's funding levels could become reality for state Medicaid programs. In this case, Medicaid would no longer be an entitlement program, and states would need to think about how to promote population health with less money. This may be a reality for states that want to maintain their current level of benefits in the wake of the OBBBA.[297] Programs with the most effective return on investment—for example, primary care and public-health interventions[298]—would need to become prioritized care. Medicaid programs may also need to think about how to ration care if funding is unavailable. In these circumstances, Medicaid can borrow ideas directly from the IHS. IHS compacting deals with similar populations—many of their beneficiaries also qualify for Medicaid—and programs that tribes have implemented successfully could be models for new Medicaid demonstration programs. This recommendation is likely the heaviest administrative lift of these proposals, as it may require regulatory or even legislative changes to adjust how Medicaid funding is used. The IHS's underfunding is not a model to emulate, but where underfunding exists, state Medicaid leaders can look to IHS tribal demonstration projects and research.

CONCLUSION

Medicaid and the IHS are parallel programs that have much to learn from each other. Comparing Medicaid to IHS tribal compacts and contracts makes apparent that they were built out of different relationships with the federal government. In Medicaid, the state and federal government have an extended, trusting partnership. In IHS compacts and contracts, the executive branch and tribes

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295. *See, e.g.*, 42 C.F.R. § 431.408 (2025) (providing for public notice); *id.* § 431.412 (describing the application process); *id.* § 431.416 (detailing the federal approval process).

296. *See supra* note 9 and accompanying text.

297. While the OBBBA does not end federal matching for Medicaid services, it does implement provisions to limit enrollment and state funding sources that will reduce the federal funds drawn down by the states. *See supra* notes 292–293 and accompanying text. States that want to keep enrollment eligibility as it was before the Act or want to avoid cutting services and programs will have fewer resources to implement those benefits.

298. *See* Leiyu Shi, *The Impact of Primary Care: A Focused Review*, SCIENTIFICA art. no. 432892, at 1 (2012) (describing the value of primary care); Rebecca Masters, Elspeth Anwar, Brendan Collins, Richard Cookson & Simon Capewell, *Return on Investment of Public Health Interventions: A Systematic Review*, 71 J. EPIDEMIOL. & CMTY. HEALTH 827, 831-33 (2017) (detailing the value of public-health interventions).

have historically been at odds. The current partnership structure contains vestiges of these fights.

In an uncertain federal environment, Medicaid has crucial lessons to learn from the IHS. While Medicaid grew up as a federal-state partnership, tribes had to advocate for the opportunity to administer healthcare programs for their own citizens against significant resistance. IHS compacts therefore demonstrate how a sovereign interacting with the federal government should act when funding and friendship are uncertain.

IHS self-governance agreements' history and structure in a fraught federal landscape have much to teach Medicaid in a new era with less funding and more challenges. Medicaid programs facing an uncertain future will need to think about how to better message Medicaid. Taking a lesson from tribes, Medicaid programs could use their documents and projects to better advertise the importance of Medicaid. Next, IHS self-governance agreements can teach Medicaid how to contract strategically and plan for the worst, building safeguards into the program's structure. Finally, Medicaid can learn from tribes' creative population-health solutions on how to do more with less. These lessons can support the health of people who rely on both programs for basic healthcare in the face of federal budget cuts.