NATIONAL COUNCIL OF URBAN INDIAN HEALTH CARE RESOLUTION IN SUPPORT OF ENACTING LEGISLATION TO ENSURE MEDICAID FULFILLS THE FEDERAL TRUST RESPONSIBILITY TO AMERICAN INDIANS/ALASKA NATIVES

WHEREAS, the National Council of Urban Indian Health (NCUIH) was founded to support the development of quality, accessible, and culturally sensitive health care programs for American Indians/Alaska Natives (AI/AN)s living in urban communities; and

WHEREAS, NCUIH envisions a nation where comprehensive, culturally competent personal and public health services are available and accessible to AI/ANs living in urban communities throughout the United States; and

WHEREAS, NCUIH strives to improve the health of the over 70 percent of the AI/AN population living in urban settings, supported by quality, accessible health care centers; and

WHEREAS, the United States has a unique trust obligation for the provision of health care to AI/ANs, which dates back to early treaties between the U.S. and Tribes and has been reinforced for hundreds of years through law; and

WHEREAS, the trust responsibility applies to all federal agencies and all AI/AN people regardless of their current place of residence; and

WHEREAS, Tribal Nations are political, sovereign entities whose status stems from the inherent sovereignty they possess as self-governing people predating the founding of the United States, and since its founding the United States has recognized them as such and entered into treaties with them on that basis; and

WHEREAS, Executive Order 13175 sets forth clear definitions and frameworks for consultation, policymaking and accountability to ensure that consultation with Indian Tribes is meaningful; and

WHEREAS, in 24 U.S.C. § 1602(a)(1) Congress declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy"; and

WHEREAS, it has been longstanding United States policy to fulfill this obligation to AI/ANs through federal executive and legislative actions; and

WHEREAS, in 1955, Congress created the Indian Health Service (IHS) in order to help fulfill its trust responsibility for health care to Tribes; and

WHEREAS, the unmet health needs of AI/ANs are severe and the health status of AI/ANs is far below that of the general population of the United States, resulting in an average life expectancy for AI/ANs 4.5 years less than that for the overall U.S. population; and

WHEREAS, in 1976, Congress noted that Medicaid payments were a "needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian" (H.R. Rep. No. 94-1026-Part III); and

WHEREAS, in 1976, Congress established the authority for the IHS, Tribal Nations, and Tribal health organizations, to seek reimbursement under the federal Medicaid program in order to help fulfill its trust responsibility for health care to the Tribes; and

WHEREAS, in FY 2017, the congressional appropriations for IHS was only $3,026 per person,[1] as compared to average per capita spending nationally for personal health care services of $9,207;[2] and

WHEREAS, the IHS continues to be funded by Congress at less than half of expected need—even when considering available government health insurance resources—leading to rationed care and worse health outcomes for AI/ANs;[3] and

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[1] The figure on congressional appropriations for IHS includes funding for health care delivery as well as sanitation, facilities and environmental health. Per capita IHS appropriation was calculated from $4,957,856,000 in total appropriations divided by 1,638,687 Active Users. Source: *2017 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita,*" February 26, 2018, available at: https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/2017_IHS_Expenditures.pdf, last accessed 10/15/2018.

[2] NHE Projections 2016-2025 –Tables, Table 5 Personal Health Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2016-2025; Per Capita Amount; Projected; available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[3] "FY2017 Indian Health Service Level of Need Funded (LNF) Calculation" (shown at https://www.ihs.gov/ihcif/includes/themes/responsive2017/display_objects/documents/2018/FY_2017_LevelofNeedFunded_(LNF)_Table.pdf) indicates an LNF funding percentage of 46.6%. A preliminary LNF figure for FY 2018 of 48.6% was calculated by IHS, which includes consideration of third-party coverage made available through the Affordable Care Act.

WHEREAS, Medicaid is a critical health program for AI/ANs, with one in three nonelderly adults, half of children, and 40% of urban AI/AN UIHP patients enrolled in Medicaid; and

WHEREAS, the federal Medicaid program generates significant resources that are critical to the ability of Tribal Nations and UIHPs to meet the health care needs of AI/AN people, but there are significant gaps in access to quality health care services under the federal Medicaid program for low- and moderate-income AI/ANs, depending upon state of residence; and

WHEREAS, AI/ANs across the United States have substantially different eligibility and access to services under the federal Medicaid program based on their state of residence; and

WHEREAS, state governments are not reimbursed for the costs of care provided by urban Indian health care providers to AI/ANs to the same degree that state governments are reimbursed for care to AI/ANs provided by IHS and Tribal health care providers; and

WHEREAS, the federal Medicaid program provides insufficient flexibility to Tribes and UIHPs to design and implement health service delivery approaches that meet the often times unique circumstances in Indian country; and

WHEREAS, Tribal Nations have developed a legislative proposal to address these gaps in access to quality health care services which will create authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level; authorize Indian Health Care Providers in all states to receive Medicaid reimbursement for health care services authorized under the Indian Health Care Improvement Act and delivered to AI/ANs; extend full federal funding (through 100% FMAP) to states for Medicaid services furnished by urban Indian providers to AI/ANs, in addition to services furnished by IHS/Tribal providers to AI/ANs; clarify that state Medicaid programs are authorized to implement Indian-specific policies and are not permitted to override Indian-specific Medicaid provisions in federal law through state waivers; and removes the limitation on billing by Indian health care providers for services provided outside the four walls of a clinic facility.

WHEREAS, these provisions, if enacted, will improve access to quality health care services for AI/ANs across all states, and thereby advance the Federal government's trust responsibility to AI/ANs and Tribal governments; and

THEREFORE BE IT RESOLVED, that the National Council of Urban Indian Health supports the enactment of legislation to ensure Medicaid advances the Federal government's trust responsibility to AI/AN Tribal governments; and

CERTIFICATION

The foregoing resolution was adopted by NCUIH on December 11, 2018 with a quorum present.

Maureen Rosette, President

Linda Son-Stone, Secretary