RESOLUTION # 19-04-07
NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

RESOLUTION # 339-08-19
CALIFORNIA RURAL INDIAN
HEALTH BOARD

JOINT RESOLUTION

SUPPORT OF ENACTING LEGISLATION TO ENSURE MEDICAID FULFILLS FEDERAL TRUST RESPONSIBILITY TO AMERICAN INDIANS/ALASKA NATIVES

WHEREAS, the Northwest Portland Area Indian Health Board (NPAIHB) is a Tribal organization under P.L. 93-638 that represents 43 federally-recognized Indian Tribes in Oregon, Washington, and Idaho and is dedicated to assisting and promoting the health needs and concerns of American Indian/Alaska Native (AI/AN) people in the Northwest; **AND**

WHEREAS, the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California, is a Tribal organization under P.L. 93-638 that represents 52 federally-recognized Tribes through its membership of 16 Tribal Health Programs in California and is committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California; **AND**

WHEREAS, the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of AI/AN people; **AND**

WHEREAS, the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member tribes; **AND**

WHEREAS, Tribes have a unique government-to-government relationship with the federal government, and it is required that the federal government consult with Tribes on any policy or action that will significantly impact Tribal governments; **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 (U.S.), and since its founding, the U.S. has recognized Tribal Nations as such and have 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 regular, meaningful, and collaborative; **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, 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 U.S., resulting in an average life expectancy for AI/ANs to be 4.5 years less than that for the 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 Fiscal Year 2017, the congressional appropriations for IHS was only $3,332 per person,[4] as compared to average per capita spending nationally for personal health care services of $9,207[5] and $12,744 for Medicare spending per capita[6]; **AND**

WHEREAS, the IHS continues to be significantly underfunded by Congress—even when considering government health insurance resources—leading to rationed care and worse health outcomes for AI/ANs;[7] **AND**

WHEREAS, the federal Medicaid program generates significant resources that are critical to the ability of Tribal Nations to meet the health care needs of Tribal citizens, 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 U.S. 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, 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;

---

[4] 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.

[5] 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.

[6] Honoring The Federal Trust Responsibility: A New Partnership to Provide Quality Healthcare to America's First Citizens: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2019 Budget, March 2017, p. 14, https://www.nihb.org/docs/04032017/TBFWG%20Testimony%20FY%202019%20FINAL.pdf

[7] "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.

authorize Indian Health Care Providers in all states to receive Medicaid reimbursement for mandatory and optional health care services authorized under federal Medicaid law, as well as select services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible 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 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; **AND**

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.

THEREFORE BE IT RESOLVED, that the NPAIHB and CRIHB support the enactment of legislation to ensure Medicaid advances the federal government's trust responsibility to AI/AN Tribal governments, including:

- Creates authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level;
- Authorizes Indian Health Care Providers in all states to receive Medicaid reimbursement for mandatory and optional health care services authorized under federal Medicaid law, as well as select services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible AI/ANs;
- Extends 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;
- Clarifies that state Medicaid programs are not permitted to override Indian-specific Medicaid provisions in federal law through state waivers;
- Removes the limitation on billing by Indian health care providers for services provided outside the four walls of a clinic facility.

CERTIFICATION

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of NPAIHB and CRIHB (***NPAIHB*** *vote 26 For and 0 Against and* 0 *Abstain;* ***CRIHB*** *vote --- For and* 0 *Against and 2 Abstain*) held this 18th day of July 2019, in Lincoln, CA and shall remain in full force and effect until rescinded.

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD
2121 SW Broadway, Suite 300
Portland, OR 97201
(503) 228-4185

Chairperson of the Board

Attest

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.
1020 Sundown Way
Roseville, CA 95661
(916) 929-9761

Chairperson of the Board

Attest