

Tribal Technical Advisory Group

American Indian and Alaska Native Strategic Plan 2020-2025



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
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Pursuant to section 5006(e)(1) of ARRA, Pub. L. 111-5, the CMS Tribal Technical Advisory Group (TTAG) was codified in accordance with requirements of the charter dated September 30, 2003 and expanded to include a representative of a national urban Indian health organization and a representative of the Indian Health Service.

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Purpose Statement

Tribal leaders, advocates and technical experts developed this fourth iteration of the *American Indian and Alaska Native Strategic Plan* to ensure that Tribal priorities shape federal health policy and programs impacting American Indian and Alaska Native (AI/AN) people across Indian Country. This strategic plan includes information and direction on a range of issues with a special and specific focus on the Centers for Medicare & Medicaid Service (CMS). Tribal stakeholders put forward this plan to advance the overarching goal of eliminating health disparities for AI/AN people and ensuring access to critical health services.

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Introduction and Executive Summary

Medicare, Medicaid, the Children’s Health Insurance Plan (CHIP), and Exchange Plans play an integral role in ensuring access to health services for American Indian and Alaska Native (AI/ AN) people and provide critically important funding support for the Indian health system overall. In fact, in many places across Indian Country, these Centers for Medicare and Medicaid Services (CMS) programs allow for Indian health system sites to address medical needs that previously went unmet as a result of underfunding of the Indian health system. The role of these CMS programs in Indian Country go beyond advancing general program goals and meeting the needs of individual health care consumers. As an operating division of the United States Department of Health and Human Services (HHS), CMS owes a Trust Responsibility to the Tribes, as that solemn duty runs from the entire federal government to all federally recognized Tribes. For these reasons and others, CMS policy development must include robust, meaningful and consistent engagement with the Tribes and the Tribal Technical Advisory Group (TTAG) to CMS.

Past accomplishments recommend this approach. Establishment of the CMS Tribal Technical Advisory Group (TTAG) in 2003 allowed for regular and improved communication between the Tribes and CMS, which in turn provided valuable information and important Tribal input. The TTAG also served as a means to communicate information and policy back to Indian Country. These activities resulted in improved access to CMS-funded health insurance for AI/AN people, better treatment and health outcomes for Indian people, and increased revenue for Indian health programs within the Indian Health Service, Tribal and Urban Indian health system (I/T/U).

The Strategic Plan operates as a guide, not a checklist, for the work to be done. It includes some essential information about Indian health, the Federal Trust Responsibility for health care, and details about the TTAG. More importantly, it sets out expectations and responsibility for the work of Tribes and CMS, and details a process to achieve the goals of this collaborative endeavor. In defining a process, this plan includes guidance to optimize consultation with Tribes, to proactively identify issues to be addressed, to accurately measure success in meeting objectives, and to thoughtfully evaluate new programs and initiatives, with an eye to Tribal impacts. In sum, this Strategic Plan builds upon an ongoing agenda that seeks to raise the health care status of American Indians and Alaska Natives to the highest level.

Tribal Consultation Required for CMS Programs

The U.S. Constitution, treaties, federal statutes, executive orders, and judicial decisions established the unique legal and political relationship between the United States federal government and American Indian and Alaska Native (AI/AN) Tribal governments. On numerous occasions, Congress reaffirmed this special relationship and the duties of the federal government, declaring 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.”¹

As made explicit in this statement and others outlining the Trust Responsibility, the federal government owes a duty to Tribes which includes responsibility for protecting and improving the health status of Indian Tribes and AI/AN people. This special relationship also includes recognition of Tribes as sovereign nations that retain the inherent right to self-govern. In keeping with federal Indian law and policy, this recognition and acknowledgment of sovereignty calls for a government-to-government level of engagement between Tribes and the United States, elevating Tribal-federal relations beyond interactions seen between the federal government and other actors.

The federal government’s duty to conduct Tribal consultation arises from this array of responsibilities to Tribal Nations, that compels the United States to protect Tribal sovereignty and provide certain services to Tribes and AI/AN people. In that respect, the federal government’s duty to consult with Tribal Nations has a unique foundation that distinguishes it from State government consultations or notice and comment rulemaking.

Tribal consultation is an open and continuous exchange of information that leads to mutual understanding and informed decision making between federal agencies and Tribal governments. In addition, consultation and collaboration must be meaningful. Consultation is meaningful when all parties involved arrive at a complete understanding of all factors and implications of the proposed action and agree on how to move forward. Listening sessions held for the

purpose of soliciting Tribal viewpoints are not Tribal consultation sessions, and cannot substitute for Tribal consultation procedures outlined in Executive Order 13175. Executive Order 13175, “Consultation and Coordination with Indian Tribal Governments” (November 6, 2000).

PROCESS

Tribal consultation should occur at the earliest possible point in the policy formulation process, particularly whenever decisions would significantly impact Tribes, would have a substantial compliance cost, or would result in new or changed policies. Tribes may invoke consultation privileges or raise issues independently. Both the United States Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid (CMS) have Tribal consultation policies. The CMS Tribal Consultation policy calls for an annual review of the policy to update it and make periodic revisions. In addition, the agency coordinates and convenes Tribal advisory bodies to help guide its work. CMS holds Tribal consultations on: CMS proposed rules, sub-regulatory guidance, administrative decisions, implementation of CMS programs and services, and other topics impacting Tribes.

REPORTING OF OUTCOMES

CMS should respond to consultation comments and follow-up on the issues raised in a timely manner. CMS should report on the findings from consultations and the agency’s follow-up work in a timely manner and ensure such reports reach all interested stakeholders across Indian Country. When stakeholders raise issues in official settings, in Tribal Technical Advisory Group meetings, or in communications from Tribes, the Tribal Technical Advisory Group and CMS must track and report back the results of those communications and input.

¹ 25 U.S.C. § 1602(a)(1)

Tribal Technical Advisory Group Advises CMS

The Tribal Technical Advisory Group (TTAG) was started by CMS in 2003 as a policy advisory body. In 2009, ARRA Section 5006(e)(1), P.L. 111-5 established the TTAG in law, added new categories of members, and reaffirmed its status as exempt from the Federal Advisory Committee Act (FACA).

The CMS Tribal Technical Advisory Group (TTAG) is the only Tribal advisory committee to the Centers for Medicare and Medicaid Services that is mandated by federal statute.² The TTAG consists of 17 members, one from each of the 12 Indian Health Service (IHS) service areas, a representative from the IHS, and the following national Tribal Organizations:

- National Indian Health Board;
- National Council for Urban Indian Health;
- National Congress of American Indians; and
- Tribal Self-Governance Advisory Committee.

CMS has implemented some of the TTAG recommendations as CMS regulation and/or policy. In addition, Congress has codified a number of TTAG's recommendations in federal law. While the TTAG has offered its advice to CMS on a wide range of issues, the following list details some of the significant achievements:

- In 2015, the updated CMS Tribal Consultation Policy was adopted and training was provided for CMS employees to implement the policy.
- Native American Contacts (NACs) continue to support CMS.

- CMS held Tribal Consultation Sessions in 2013 and 2014 at NIHB's National Tribal Health Conference. When not consulting on a specific topic, CMS has held regular Listening Sessions in 2016, 2017, 2018, and 2019 at NIHB's National Tribal Health Conference.
- TTAG developed an *Indian Managed Care Addendum*, that was included as part of a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin on December 14, 2016.
- From 2013 to 2015, CMS funded International Classification of Diseases (ICD) 9/10 coding training for third-party business office coordinators and billing office staff.
- CMS and TTAG developed a *Behavioral Health Service Provider Report* in 2019, detailing behavioral health providers who are licensed to bill Medicaid in states that have Indian health care programs.
- In 2015 and 2018, TTAG held National Tribal Data Symposiums.
- The creation and continued maintenance of the CMS Long-Term Services and Supports Technical Assistance Center for AI/ANs.
- CMS and TTAG continue to collaborate, develop, and coordinate trainings and materials to increase enrollment in Medicaid and the Federal Health Insurance Marketplace.

² ARRA section 5006, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/downloads/arra-protections-for-indians-in-medicaid-and-chip-smd.pdf>.

New Developments Require A Strategic Response

The Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) prepared this fourth edition of the *American Indian and Alaska Native Strategic Plan* to help guide the work of CMS and the TTAG. The plan provides a strategic roadmap on how to best work with Tribes to effectively and efficiently improve the Indian health system, and also provides guidance to accomplish this work in a collaborative process. The TTAG issued the first Strategic Plan during the period of 2005-2010; the second during the period of 2010-2015; and the third during the period of 2013-2018, with an addendum issued on February 20, 2014. Significant changes in law, policy and practice since TTAG issued the most recent Strategic Plan, include:

- 1. Engagement on Medicaid Transformation including expansion of Managed Care, Pay for Performance, and value-based purchasing.** Tribes, IHS, and Urban Programs are responding to the next stage of Medicaid Managed Care and the move to cover patients previously not covered by Managed Care including behavioral health patients and patients with chronic diseases and disabilities. This new wave of demonstrations deals with more vulnerable populations and, for Indian health programs, it involves provider types that prove more difficult to recruit and retain and specialty networks that remain difficult to access.
- 2. Continued implementation of the Patient Protection and Affordable Care Act (ACA), P.L. 111-148, March 23, 2010.** The ACA also permanently authorized the Indian Health Care Improvement Act (IHCIA) through Section 10221.³ Enrollment in Exchange Plans began January 2014 and regulations continue to evolve.
- 3. Revision of the CMS Consultation Policy.** CMS issued the most recent policy with an effective date of December 10, 2015.⁴
- 4. SUPPORT for Patients and Communities Act of 2018 (H.R. 6).** Signed into law by President Trump on October 24, 2018, H.R. 6 reauthorized the State Targeted Opioid Response Grants for an additional two years, including a 5% set aside for Tribal Nations. H.R. 6 includes many provisions that can assist Tribal Nations to better respond to the opioid crisis in their communities.
- 5. Payment reform.** CMS has begun to use payments tied to quality measures to promote care coordination, evidence-based practice, and to reward innovations that lower costs while improving quality of care. The CMCS Informational Bulletin, “Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts,” was released on November 2, 2017.⁵ The Bulletin described the states’ ability to implement delivery system and provider payment initiatives under Medicaid Managed Care contracts.
- 6. Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA).** The Quality Payment Program (QPP), established under MACRA, paves the way to quality care through the Merit-Based Incentive Payment System (MIPS) and advanced Alternative Payment Models (APMs).⁶
- 7. Medicaid and CHIP Managed Care Rules.** Issued by CMS on April 25, 2016, the new rules align with those of other health insurance coverage programs and modernize how states purchase managed care for beneficiaries. This final rule constitutes the first major update to Medicaid and CHIP Managed Care regulations in more than a decade.
- 8. Medicaid Work and Community Engagement Requirements.** On January 11, 2018, CMS issued a Dear State Medicaid Director letter outlining the CMS parameters for state proposed 1115 waivers seeking to implement work and community engagement requirements as a

³ Reauthorization and litigation pertaining to the Patient Protection and Affordable Care Act are ongoing.

⁴ CMS, Tribal Consultation (last modified Apr. 4, 2018), <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/ALAN/Consultation.html>.

⁵ CMS, CMCS Informational Bulletin (Nov. 2, 2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf>.

⁶ Indian Health Service, Quality Payment Program, <https://www.ihs.gov/qpp/>.

condition of Medicaid eligibility. On January 17th, 2018, CMS issued a Dear Tribal Leader letter announcing the new policy and acknowledging Tribal requests to CMS for an AI/AN exemption. The letter stated that CMS could not provide that exemption and stated that requiring states to exempt AI / ANs could raise “civil rights issues.” On January 18, 2019, CMS approved Arizona’s 1115 waiver to implement work and community engagement requirements which included an exemption for members of federally recognized Tribes.

9. Implementation of Medicaid Managed Care initiatives. Tribal stakeholders have voiced a range of concerns with managed care initiatives including Managed Care Plan compliance with requirements for timely payment to IHS, Tribal, and Urban providers, among other issues.

10. Medicaid Block Grant / Per Cap Funding Structure. On January 30, 2020, CMS issued a Dear State Medicaid Director letter providing CMS guidance for state proposed 1115 waivers seeking to convert a portion of a state’s Medicaid program into a block grant (aggregate cap) or per cap payment structure. Tribal leaders raised concerns with how this payment structure would interact with the 100% FMAP for beneficiaries receiving services through the Indian health system. Tribal leaders also voiced concerns with operation of the cap should a state reach or approach its funding cap. Tribal leaders want to ensure that operation of the cap will not impact AI /AN beneficiaries nor Indian health system providers.

CMS Programs Must Reduce Health Disparities

Federal funding for Medicaid, Medicaid Expansion, CHIP, Medicare, and Health Insurance Exchanges is intended to reduce health disparities in society. At every stage of their lifespan, AI/ANs experience significantly worse health disparities including higher incidence and prevalence of obesity, diabetes, substance use disorders, tobacco addiction, and cancer.

Available data demonstrate disparities beyond health, and include leading indicators for social determinants of health. According to an analysis by the Office of Minority Health (OMH), educational attainment in AI/AN communities lagged behind other minority groups. More specifically, 82 percent of AI/ANs over age 25 hold at least a high school diploma, compared to 92 percent of non-Hispanic whites. Further, 17 percent of AI/ANs over the age of 25 attained at least a Bachelor's degree compared to 33 percent of the non-Hispanic white population. Economically, AI/ANs' median household income is \$37,353, significantly lower than non-Hispanic whites at \$56,565.⁷ As a result, more than 26 percent of AI/ANs lived in poverty in 2015 — the highest percentage of any racial group.⁸

HEALTH DISPARITIES

OMH notes that AI/AN adults are 2.4 times more likely than white adults to be diagnosed with diabetes, and 2.7 times more likely to be diagnosed with end stage renal disease (ESRD) than non-Hispanic whites. AI/AN men are more than twice as likely to have liver and Inflammatory Bowel Disease (IBD) cancer as non-Hispanic white men; AI/AN women, on the other hand, are 2.5 times more likely to have liver and IBD cancer than non-Hispanic white women. AI/AN men are also 1.6 times more likely to have stomach cancer than non-Hispanic white men and twice as likely to die from stomach cancer.⁹

Infectious disease rates illustrate another area of disparity. Data indicates that certain regions with high concentrations of AI/ANs experience greater rates of infectious disease than the national average. These include areas, such as: Alaska, the Great Plains, Northern Plains, and the Southwest regions of the United States. Factors contributing to these high incidence rates include the remote nature of Indian reservations, difficulty retaining providers, and the lack of adequate sanitation. Correspondingly, incidence rates of fourteen of twenty-six infectious diseases were higher for AI/ANs when compared to non-Hispanic whites.¹⁰

In addition to significant physical health issues, AI/ANs face mental health and substance use disorders that impact Tribal communities at rates higher than other racial minorities. The Centers for Disease Control and Prevention (CDC) states that suicide is a leading cause of death among AI/ANs across all ages. Moreover, the suicide rate among AI/AN adolescents and young adults aged 15 to 34 is 1.5 times higher than the national average in that particular age group.¹¹

Surveys such as the CDC Behavioral Risk Factor Surveillance System (BRFSS) indicate that AI/ANs experience higher risk on behavioral health indicators as well. For example, 'Past month' tobacco usage for AI/AN was 40.1 percent, which was higher than all rates for all other ethnic groups.¹² Additionally, AI/AN adolescents are 30 percent more likely than non-Hispanic whites to be obese while adults are 50 percent more likely than non-Hispanic whites to be obese.

7 Office of Minority Health. 2018. Profile: American Indian/Alaska Native. Retrieved from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62>

8 Centers for Disease Control and Prevention. 2017 Indian Country and CDC Working Together. Retrieved from <https://www.cdc.gov/chronicdisease/pdf/CDC-indian-country.pdf>

9 Office of Minority Health. 2018. Profile: American Indian/Alaska Native. Retrieved from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62>

10 Centers for Disease Control and Prevention. 2017. Indian Country and CDC Working Together. Retrieved from <https://www.cdc.gov/chronicdisease/pdf/CDC-indian-country.pdf>

11 Centers for Disease Control and Prevention. 2015. Suicide: Facts at a Glance. Retrieved from <https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf>

12 Substance Abuse and Mental Health Services Administration. SAMHSA American Indian/Alaska Native Data. Retrieved from https://www.samhsa.gov/sites/default/files/topics/tribal_affairs/ai-an-data-handout.pdf

FIGURE 1 ¹³

MORTALITY DISPARITY RATES

American Indians and Alaska Natives (AI/AN) in the IHS Service Area
 2009-2011 and U.S. All Races 2010
 (Age-adjusted mortality rates per 100,000 population)

	AI/AN Rate 2009-2011	U.S. All Races Rate - 2010	Ratio: AI/AN to U.S. All Races
ALL CAUSES	999.1	747.0	1.3
Diseases of the heart (Heart Disease)	194.7	179.1	1.1
Malignant neoplasm (cancer)	178.4	172.8	1.0
Accidents (unintentional injuries)*	93.7	38.0	2.5
Diabetes mellitus (diabetes)	66.0	20.8	3.2
Alcohol-induced	50.0	7.6	6.6
Chronic lower respiratory diseases	46.6	42.2	1.1
Cerebrovascular diseases (stroke)	43.6	39.1	1.1
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Influenza and pneumonia	26.6	15.1	1.8
Drug-induced	23.4	15.3	1.5
Nephritis, nephrotic syndrome (kidney disease)	22.4	15.3	1.5
Intentional self-harm (suicide)	20.4	12.1	1.7
Alzheimer's disease	18.3	25.1	0.7
Septicemia	17.3	10.6	1.6
Assault (homicide)	11.4	5.4	2.1
Essential hypertension diseases	9.0	8.0	1.1
* Unintentional injuries include motor vehicle crashes.			

13 Indian Health Service. 2018. Disparities. Retrieved on October 17, 2019 from <https://www.ihs.gov/newsroom/factsheets/disparities/?mobileFormat=0;%20Indian%20Health%20Service,%20Indian%20Health%20Disparities>

CONTRIBUTING FACTORS

A number of factors contribute to persistent disparities in the health status of AI/ANs.

Historical trauma, often leading to ongoing contemporary trauma, has profoundly and negatively impacted Tribal Nations and people. AI/ANs continue to experience trauma from damaging federal policies, including those of forced removal, boarding schools, and taking of Tribal lands. Contemporary threats to culture, language, and lifeways and reduced access to traditional foods continue to damage the health and wellness of Indian Country.

AI/ANs experience the highest rates of poverty in America, with the following contributing factors: high jobless rates, lower education levels, poor housing, lack of transportation, and geographic isolation. AI/ANs also have a relatively high uninsured rate and face considerable barriers in obtaining comprehensive health care. AI/ANs primarily access health services through the Indian Health Service (IHS), Tribally-operated programs, or Urban Indian organizations – collectively referred to as the I/T/U system. Unfortunately, historic and persistent under-funding for the Indian healthcare system results in problems with access to care, and limits the ability of the Indian healthcare system to provide the full range of medications and services that could help prevent or reduce the complications of chronic diseases.

Collaborating with CMS has been one avenue to alleviate these concerns. Medicare covers about 11 percent of the patients of Indian health programs.¹⁴ Medicaid provides health insurance coverage for approximately 33 percent¹⁵ of all AI/AN adults, and half of AI/AN children.¹⁶ As mentioned previously, AI/AN families experience poverty at higher than average rates, however Medicaid aids in lowering the systemic barriers to receiving adequate health services. Medicaid expansion in states with significant AI/AN populations not only brought coverage to more individual AI/ANs,¹⁷ but also increased revenue for IHS and Tribally-operated facilities.¹⁸ A recent Government Accountability Office (GAO) report highlighted these promising developments, finding that Medicaid expansion and other health reforms (including enrolling in health insurance)

significantly improved health coverage and expanded access to care for AI/ANs.¹⁹

CMS, IHS, and Tribes must work together to eliminate existing health inequalities. Together, these stakeholders can and must strengthen the ability of Indian health programs to serve as the medical home for AI/ANs, offering culturally competent care with a public health focus, while fulfilling their important role as essential providers for Medicaid, Medicare, Children's Health Insurance programs and Health Insurance Exchange plans. This plan continues its original goal to give CMS and TTAG a roadmap for making that happen.

¹⁹ Id.

¹⁴ Government Accountability Office Report. September 2019. Retrieved from <https://www.gao.gov/assets/710/701133.pdf>

¹⁵ Id.

¹⁶ Id.

¹⁷ Id.

¹⁸ Id.

The Indian Health System is Unique

The Indian health system has been developed through a very complex and comprehensive set of federal Indian policy that draws upon treaties between Tribal Nations and the United States, Indian-specific provisions in the U.S. Constitution, a host of federal laws and regulations, United States Supreme Court cases and other case law.

While federal Indian policy has shifted significantly throughout U.S. history, there are three basic legal principles that have remained constant and continue to guide the administration of federal Indian health programs: the federal Trust Responsibility; the government-to-government relationship; and Tribal sovereignty.

The federal governmental responsibility to provide health services to Indian Tribes flows from treaties and executive orders made between the United States and Tribes. In exchange for Indian land and peace, the federal government promised health care, material resources and other services in hundreds of individually negotiated treaties. What initially started as varied and individual implementations of those promises eventually grew into a more comprehensive and uniform system of federally-provided health care to American Indian and Alaska Native (AI/AN).

The federal government's earliest goals for this more systematic approach focused on preventing infectious disease and forcing Indians to assimilate into the general population by fostering dependence on Western medicine and discouraging (or prohibiting) the practice of traditional medicine.

In 1921, the Snyder Act of 1921 (P.L. 67–85, Act) provided the basis for the modern Indian health care delivery system. The Act directed the federal government to provide appropriations “. . . for the benefit, care and assistance . . . [and] for the relief of distress and the conservation of health . . . for Indian Tribes throughout the United States.” This provided the first formal Congressional authority for the federal provision of health services to Tribes.

The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638, ISDEAA) fundamentally changed the Indian health care delivery system by allowing Tribes to

assume authority and responsibility for administering their own health programs.

The Indian Health Care Improvement Act of 1976 (P.L. 94-437), made permanent by the 2010 Affordable Care Act,²⁰ acts as the key federal law authorizing appropriations for the provision of health care to AI/AN people. It establishes the basic structure for the delivery of health services to Indian people and authorizes the construction and maintenance of health care and sanitation facilities. In recent budgets, Congress has appropriated \$8.5 billion to IHS to support direct medical and specialty care services to eligible AI/AN people. Along with ambulatory primary care services, IHS provides dental care, mental health care, vision care, and substance abuse treatment programs. Additionally, IHS provides the primary source of funding for Tribal and Urban Indian health programs.

Because Congress consistently fails to fully fund IHS, including the IHS Purchased and Referred Care (PRC) program, the Indian Health System cannot meet the level of patient need in providing services. As a result of these funding shortfalls, IHS uses special rules to determine how to allocate available PRC resources, including provision of services (using a priority scheme), eligibility requirements, and provider payments. Federal rules require a very stringent eligibility system for PRC services and patients must exhaust all alternate resources before qualifying for eligibility. These rules also use a medical priority system in order to determine priorities for purchasing services, and require Medicare providers to accept Medicare-Like Rates for any PRC referral, or risk their participation in the Medicare program. Effective management of the PRC program requires ongoing coordination and careful integration of Medicaid, Medicare, CHIP and federal and state insurance exchange plans.

In order to address IHS funding shortfalls, Tribes have aggressively sought third party payment strategies. All of the Tribes operating Tribal health clinics and all IHS health programs have contracted with state Medicaid agencies to be providers in order to access Medicaid financing to help provide

20 The Indian Health Care Improvement Act was amended and permanently reauthorized by Section 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010), 25 U.S.C. § 1601

health services to Tribal members. Between 500,000 and 650,000 IHS active users have Medicaid Coverage.²¹ Most Indian health programs also receive Medicare payments for the estimated 160,000 active users with Medicare coverage (estimate is for Part A, no estimate for Part B or Part C). An October 2019 GAO report noted increases of 50 percent in both Medicare and Medicaid Payments to federally operated programs from 2013 to 2018 (GAO 2019).²²

TTAG notes promising developments and many accomplishments in their work to ensure Medicaid requirements reflect the unique status of Indian health programs. At the same time, TTAG also recognizes the need for more engagement and focus on Medicare and health exchange plans, to ensure those resources more fully support the Indian health system and are in accordance with the special protections and benefits for Tribes and AI/AN people. Ensuring regular and meaningful consultation in the implementation of Medicare and Exchange plans will improve the current situation where many who are eligible for Medicare-paid services instead rely on Indian health program-paid services. Including provisions similar to those TTAG recommended for Medicaid (like provisions to ensure an AI/AN patient can choose their own Indian health program for services), will address less than optimal utilization of the Medicare program and health exchange plans.

THE INDIAN HEALTH CARE SYSTEM

Three types of Indian health care programs make up the core of the Indian health system. These include IHS, Tribal and Urban programs, collectively referred to as the I/T/U. IHS operates clinics and hospitals; IHS employees are federal employees. Tribes operate Indian health care programs under the authorization of ISDEAA (PL 93-638). A Tribe utilizes a 638 compact to completely takeover all IHS program/functions; it utilizes a 638 contract to takeover operations of one or more IHS programs. Tribes frequently elect to operate certain programs and functions, such as behavioral health programs, even if they otherwise rely upon IHS to deliver services to their populations. There are over 15,000 federal employees in the Indian Health Service operating 24 hospitals, 50 Health Centers, 24 Health Stations, and 7 Youth Regional Treatment Centers (YRTC's). Tribes operate 5 YRTC's, 127 Alaska Village Clinics, 54 Health Stations, 285 Health Centers, and 22 Hospitals. The total number of

Tribal employees is unknown, but likely exceeds 15,000 since over 60 percent of the IHS budget go to 638 compacts and contracts. Hospitals range in size from 4 beds to 133 beds.

Urban Indian health programs serve over 75,000 AI/ANs in 41 Urban Indian Organizations (501(c) (3) nonprofits), and work to provide comprehensive health care services to AI/ANs living off Tribal lands.²³

A SYSTEM UNDER STRESS

Recent reports, including the GAO report on the impact of the Affordable Care Act (ACA) on IHS and the December 2018 report of the US Commission on Civil Rights *Broken Promises*,²⁴ document the chronic underfunding of the Indian health system. GAO rated IHS a high-risk federal program, despite the positive developments resulting from the ACA and Medicaid expansion. *Broken Promises* goes into great detail on the funding crises and resulting poor health outcomes in its report.²⁵ These reports and other data and findings illustrate the need for sustained, meaningful and robust Tribal engagement in every part of the federal government and especially with CMS and IHS, two federal agencies with tremendous potential to help advance the health and wellness of AI/AN people across the nation.

23 IHS, Office of Urban Indian Health Programs, Strategic Plan, 2017 to 2021.

24 *Broken Promises: Continuing Federal Funding Shortfall for Native Americans*, Briefing Report, December 2018. 25 *Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections*, GAO-19-612, September, 2019.

21 The American Community Survey (which is a point in time estimate) estimate is 500,000 (2017) and the IHS estimate is 675,000 for 2018, but IHS includes many who are no longer enrolled in Medicaid.

22 Government Accountability Office Report. September 2019. Retrieved from <https://www.gao.gov/assets/710/701133.pdf>

Organization of the AI/AN Strategic Plan

This plan is organized to provide a focus on the goals and objectives. Supporting documentation is provided in the appendices. There are four overarching goals in this plan that apply to all CMS programs, including Medicare, Medicaid, CHIP, and Health Insurance Exchanges. These are:

Goal 1: CMS TTAG will develop policy relevant to the Indian health system.

Goal 2: CMS TTAG will apply policy relevant to the Indian health system.

Goal 3: CMS TTAG will evaluate policy relevant to the Indian health system.

Goal 4: CMS TTAG will keep policy responsive

For each goal, a number of objectives are listed with tasks identified that are necessary to achieve each objective. These goals and objectives were developed over the course of a year where members of the TTAG and their technical advisors provided recommendation and input on priority items and objectives for the TTAG and CMS for the next five-year period (2020-2025). As the Strategic Plan developed, it became apparent that the objectives and tasks could be sorted into four major categories related to policy activities, including development, application, evaluation, and flexibility.

While this shift in organization for the Strategic Plan departs from previous iterations, this new organization is meant to provide more streamlined implementation and greater ability to measure progress to ensure success for CMS, TTAG and the Tribes.

TTAG Strategic Plan: Goals, Objectives, and Tasks

GOAL 1:

CMS TTAG will develop policy relevant to the Indian Health System

OBJECTIVE 1A –

CMS must fully engage with Tribes through regular, meaningful consultation and listening sessions

Task 1: CMS will provide funding for technical assistance and support for Tribal leaders and their representatives at Tribal Consultations and Listening Sessions.

Task 2: CMS will provide timely notice of activities and biannual reports of the outcomes of Tribal Consultations and Listening Sessions.

OBJECTIVE 1B –

CMS must fully engage with Tribes to expand and enhance review of CMS' proposed policies

Task 1: CMS will collaborate and consult with TTAG and Tribes before the policy development process begins, where Tribes have requested to be involved or where such policies have Tribal implications.

Task 2: TTAG will continue to conduct timely monitoring, comprehensive review and final comments to CMS on regulations, guidance and other documents issued by CMS that have Tribal implications.

Task 3: CMS will support activity to catalogue information submitted by TTAG and affiliated Tribal organizations in response to its requests for comments; provide TTAG with a summary of TTAG and Tribal recommendations quarterly; clearly list CMS' response to each of the TTAG's recommendations; and note any action items that will be discussed at the TTAG meeting immediately following. Tracking will include letters from TTAG, white papers, data reports, and regulatory comments.

Task 4: CMS will support a process to provide a schedule to TTAG that outlines CMS' timeline for conducting regulatory impact analysis on Indian Country for proposed policies that will notify TTAG of the opportunity to engage in the analysis, whether by providing documentation or by any other means.

Task 5: CMS will conduct periodic regulatory impact analysis of CMS' proposed policies on Indian Country and share this information with TTAG as frequently as necessary to ensure TTAG has the most current and updated information.

OBJECTIVE 1C –

CMS must fully engage with Tribes to develop the capacity to collect data, in a manner that is informed by Tribal best practices

Task 1: CMS will support work to establish capacity to access and link data to Tribal citizens and other IHS eligible individuals across the IHS National Data Warehouse and CMS Medicare and Medicaid databases.

Task 2: CMS will support TTAG's goals by promulgating policies for Tribal Access to CMS programs data.

Task 3: CMS will support and provide access for compilation and analysis of CMS program data in collaboration with Tribal data sources.

Task 4: CMS will support work to evaluate, use, and inform States on how the use of state plan amendments (SPA), 1115 waivers, or other demonstrations can improve access for Tribal citizens and other IHS-eligible individuals to timely health care services.

Task 5: CMS will work with TTAG, in collaboration with Tribes, to develop best practices for data collections.

Task 6: CMS will work with TTAG to identify gaps in data for policy development and plans for collection of data measures that address the social determinants of health.

Task 7: CMS will support the development of data reports around maternal and child health, elders, and young adults and other Tribal priorities as identified by TTAG.

OBJECTIVE 1D –

CMS will prepare Tribes through the TTAG to take advantage of emerging opportunities for funding and policy changes that arise due to a changed focus of the non-Indian health system

Task 1: CMS will provide TTAG quarterly updates on emerging issues and funding opportunities.

Task 2: Whenever legislation is being proposed, adopted or implemented, that will have an impact on AI/AN and IHS, CMS will provide timely information to TTAG.

OBJECTIVE 1E –

CMS and the TTAG will work together to assure that AI/ANs continue to receive needed services and the I/T/U continues to receive payment for those services

Task 1: When States reform Medicaid through State Plan Amendments (SPAs) or through waivers, CMS will take all steps available and permissible to ensure continued services for AI/AN from I/T/U, and payment for those services.

Task 2: CMS will ensure compliance with Medicaid managed care regulations at 42 CFR 438.14 for payment to Indian health care providers.

Task 3: CMS will engage the TTAG on emerging payment approaches (such as managed care and value based programs), analyze how those approaches may affect the I/T/U, and share that information.

Task 4: All CMS programs will review their payment policies to assure that the I/T/U can be reimbursed for telehealth services delivered to AI/AN, to the extent authorized by regulations and Medicare or Medicaid policy. CMS shall address barriers that may be preventing permissible payments.

Task 5: Value-based payments will include either funding for reporting requirements and IT infrastructure or exemptions from certain requirements that exceed the capacity of the Indian health providers.

OBJECTIVE 1F –

CMS will improve and expand the development of Long-Term Services and Supports (LTSS) throughout Indian communities

Task 1: CMS will continue to work with the Administration for Community Living (ACL) and IHS to maintain a website that will serve as an AI/AN LTSS Portal.

Task 2: CMS will work with the TTAG, IHS, and ACL to develop technical assistance materials for the I/T/U.

Task 3: CMS will collaborate with Tribes on creating best practices to build LTSS in Indian communities.

Task 4: CMS will collaborate with Tribes to identify barriers to implementing LTSS programs.

Task 5: CMS and TTAG will work collaboratively to educate Tribal leaders and Tribal stakeholders about long term care program planning and implementation, particularly with regard to the growing need for services that address the needs of elders, veterans, and persons with disabilities. This includes community-based services and other options to allow AI/AN elders to age in place.

OBJECTIVE 1G –

CMS will engage with the TTAG and Tribes as it develops its rural health strategy

Task 1: CMS will work with Tribes to ensure tribes are included in any current or future programs and policies of the Rural Health Initiative.

Task 2: CMS will provide technical assistance to Indian health care providers to help them comply with policies, and implement CMS policies and initiatives to transform their practice.

Task 3: CMS and Tribes will identify and accelerate promising and evidence-based practices to improve access to services and providers across Indian Country.

Task 4: TTAG will explore opportunities within existing CMMI demonstrations that could cover certain transportation services in Indian Country and work with CMS to improve rural patients' care which includes certain telehealth flexibilities to bring care to rural locations or Indian Health Care Providers (IHCP).

OBJECTIVE 1H –

CMS will reduce unnecessary burden on Indian health care providers, increase efficiency, and improve the AI/AN beneficiary experience

Task 1: CMS and TTAG will review current quality measures across the CMS programs to ensure that measures are streamlined, outcome based, and meaningful to Indian health care providers and AI/AN.

Task 2: CMS will provide information and education to the Office of Inspector General to advance the goal of including new safe harbors for Indian health care providers that would create parity with existing safe harbors for Federally Qualified Health Centers.

GOAL 2:

CMS TTAG will apply policy relevant to the Indian Health System

OBJECTIVE 2A –

Ensure Tribes are provided the information they need to implement new and existing policies and programs

Task 1: CMS will provide technical assistance to the CMS TTAG and IHCPs necessary to understand, ensure compliance and take full advantage of new policies that are the result of legislation or regulatory action.

Task 2: CMS will seek out and compile Tribal and state level examples of successful policies and programs. This includes best practices on enrollment in CMS health insurance, in the implementation of new benefits, and the compliance requirements of CMS programs.

OBJECTIVE 2B –

Ensure Tribes maximize health benefit programs enrollment and utilize the revenue to build health services capacity

Task 1: TTAG will identify and build relationships with key partners and stakeholders such as the National Association of Medicaid Directors, the National Congress of State Legislators, the National Governors Association, and the Association of State and Territorial Health Officials to educate them on the I/T/U system and the critical role that Medicaid plays.

Task 2: CMS will develop materials and training capacity through staff or contractors to assist Tribes' efforts to maximize enrollment in CMS health insurance programs.

Task 3: TTAG will provide the I/T/U programs with information (obtained from Tribes, States Medicaid Programs, and CMS) on the ways to build service capacity using funding from revenues.

OBJECTIVE 2C –

Share information about grant opportunities and provide technical support

Task 1: CMS will ensure that I/T/U and ancillary programs are aware of grant funding opportunities by providing timely notice and ongoing communications.

Task 2: CMS will support a dedicated clearinghouse and data resource center so Tribes, Tribal organizations, and urban Indian health organizations can easily access required grant information and data about AI/AN populations, income, education, and health insurance status.

Task 3: CMS will support creation of a toolkit and support technical assistance that will aid Tribes, Tribal organizations, and urban Indian organizations in the grant application process to connect them with new and existing resources.

Task 4: CMS will support the development of data gathering capacity and the creation of useful information on health, income, education, housing, and insurance coverage for grant applications.

OBJECTIVE 2D –

CMS will work with the TTAG to develop a universal approach to health benefit reimbursement assistance for all CMS programs

Task 1: CMS will identify and address barriers which restrict health benefit reimbursements.

Task 2: CMS will work with TTAG to identify and remove barriers to I/T/U, ancillary programs, and others paying premiums for enrollment in federally-funded programs.

Task 3: CMS will create and deliver trainings on I/T/U program billing to help maximize reimbursements.

OBJECTIVE 2E –

CMS will work with the TTAG and Tribes to recruit and retain AI/ANs into the CMS workforce

Task 1: CMS will actively recruit American Indians and Alaska Natives to hire for key policy positions, including those who are responsible for the administration of, technical assistance for, and outreach regarding health benefit programs.

Task 2: In coordination with TTAG leadership, CMS will develop a succession plan to preserve institutional knowledge and minimize impacts to Agency operations when staff turnover occurs.

Task 3: In coordination with TTAG leadership, CMS will develop a transition plan when there are changes in the Administration.

OBJECTIVE 2F –

CMS will work with the TTAG to produce and market I/T/U enrollment trainings for the Marketplace, Medicare, Medicaid, and CHIP programs

Task 1: CMS will hold 13-16 regional trainings annually to promote AI/AN enrollment in healthcare programs.

Task 2: CMS will target regional trainings based on the latest data around enrollment in CMS programs.

GOAL 3:

CMS TTAG shall support activities to evaluate policy relevant to the Indian Health System

OBJECTIVE 3A –

Monitor American Indian and Alaska Native participation in CMS Programs; Provide Outreach and Education to Promote Enrollment; Evaluate Efforts and Policy to Identify Areas for Improvement

Task 1: CMS will provide an annual report on Medicaid enrollment, Medicare enrollment, and Marketplace enrollment using administrative data, the American Community Survey, and other relevant data resources.

Task 2: Using data reports, TTAG will identify barriers impeding enrollment and make recommendations to CMS for policy or regulatory changes to address these problems.

Task 3: CMS and TTAG will use lessons learned and/or evaluations to develop and improve outreach and education materials and programs.

Task 4: CMS will provide focused reports on how to access CMS programs for new and emerging areas of concern, including LTSS and Substance Use Disorder.

Task 5: Reports will link its research, findings, and recommendations to the Strategic Plan.

OBJECTIVE 3B –

Evaluation activities shall be conducted collaboratively between entities likely to be impacted, including CMS, IHS, Tribes, Tribal Organizations and Urban Indian Organizations

Task 1: CMS will maintain up-to-date contact list of representatives by their role and participation on TTAG and its subcommittees.

OBJECTIVE 3C –

CMS shall, whenever feasible and practicable provide access to CMS resources and technical expertise in support of the TTAG's work

Task 1: Annually, CMS will host TTAG members to attend meetings and trainings at the CMS headquarters in Baltimore, MD.

GOAL 4:

TTAG will respond to changing needs and priorities of the Indian Health System and CMS

OBJECTIVE 4A –

Develop Annual List of Priorities

Task 1: TTAG will annually analyze the progress in meeting the goals of the TTAG Strategic Plan and make recommendations for priority areas for the succeeding year.

Task 2: TTAG will conduct an annual review of outstanding issues and categorize these issues into those that need a legislative solution, a regulatory solution, policy solution, or enhanced outreach and education.

– Appendix A –

Legal Basis for Special CMS Provisions for American Indians and Alaska Natives

I. INTRODUCTION

The United States has a unique trust responsibility toward Indian people regarding health care, and unique Constitutional authority to fulfill that responsibility that is recognized by the courts. The Constitution's Indian affairs powers and the trust responsibility serve as the legal justification and moral foundation for health policy-making specific to American Indians and Alaska Natives (AI/AN).

The obligation to carry out the trust responsibility to Indians applies to all agencies of the federal government – including the Centers for Medicare & Medicaid Services (CMS).²⁵ Federal law assigns comprehensive duties to the Secretary of the Department of Health and Human Services (HHS) in order to achieve the goals and objectives established by Congress for Indian health. The Constitution's Indian affairs power and the trust responsibility, and laws enacted pursuant thereto, provide ample authority for the Secretary – whether acting through the Indian Health Service (IHS), CMS, or other agency of HHS – to take proactive efforts to achieve the Indian health objectives Congress has articulated.

HHS and CMS both acknowledge the unique political and legal relationship that Indian tribes have with the federal government in their tribal consultation policies:

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government. This relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race. This special

relationship is affirmed in statutes and various Presidential Executive Orders ...²⁶

While CMS often looks to the Social Security Act for authority, the historic and complex body of federal Indian law and case law applies to all agencies throughout the federal government, including CMS. The intent of this Appendix is to provide a brief summary of federal Indian law that is most relevant to current and future regulations, guidance, and decision-making regarding participation of Indians and the Indian health system in Medicare, Medicaid, Child Health Insurance Programs, and health insurance exchanges.

II. THE UNITED STATES HAS A TRUST RESPONSIBILITY TO INDIANS

A. ORIGINS OF THE TRUST RESPONSIBILITY TO INDIANS

The federal trust responsibility to Indians, and the related power to exercise control over Indian affairs in aid of that responsibility, is rooted in the United States Constitution – most significantly the Indian Commerce Clause, the Treaty Clause, and the exercise of the Supremacy Clause.²⁷ The parameters of the trust responsibility have evolved over time through judicial pronouncements, treaties, Acts of Congress, Executive Orders, regulations, and the ongoing course of

²⁵ See, e.g., Exec. Order No. 13175, *Consultation and Coordination With Indian Tribal Governments*, 65 Fed. Reg. 67249 (Nov. 6, 2000) reprinted in 2000 U.S.C.A.N. at B77; White House Memorandum for the Heads of Executive Departments and Agencies (Nov. 5, 2009); HHS Tribal Consultation Policy (Dec. 14, 2010); CMS Tribal Consultation Policy (Dec. 10, 2015); *Cramer v. United States*, 261 U.S. 219 (1923).

²⁶ HHS Tribal Consultation Policy (Dec. 14, 2010), at 1; CMS Tribal Consultation Policy (Nov. 17, 2011), at 1.

²⁷ *Morton v. Mancari*, 417 U.S. 535, 551-552 (1974) (“The plenary power of Congress to deal with the special problems of Indians is drawn both explicitly and implicitly from the Constitution itself.”); *McClanahan v. State Tax Comm'n of Arizona*, 411 U.S. 164, 172, n.7 (1973); see also TASK FORCE No. 9, VOL. 1, AMERICAN INDIAN POLICY REVIEW COMM'N 31 (1976) (explaining the origins of Constitutional power to regulate Indian affairs as flowing from Congress's treaty making powers, powers to regulate commerce with Indian tribes, and its authority to withhold appropriations); FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 418-423 (2005); Reid Payton Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213, 1215-1220 (1975).

dealings between the federal government and Indian tribal governments.

Indian tribes are political, sovereign entities whose status stems from the inherent sovereignty they possess as self-governing people predating the founding of the United States,²⁸ and since its founding the United States has recognized them as such.²⁹ As the Supreme Court explained in 1876, “from the commencement of its existence [and following the practice of Great Britain before the revolution], the United States has negotiated with the Indians in their tribal condition as nations.”³⁰ The United States entered into the first treaty with an Indian tribe in 1778.³¹ Once the Constitution was ratified, President George Washington worked with the Senate to ratify treaties in the late 1780s, thereby establishing that treaties with Indian tribes would utilize the same political process that treaties with foreign nations must go through.³²

From the United States’ perspective, treaty objectives were essentially two-fold: cessation of hostilities to achieve and maintain public peace, and acquisition of land and resources occupied by tribal members. Tribes doubtless had a peacemaking motive as well, but in return for the vast tracts of land they relinquished to the more powerful federal government, tribes also obtained the promise – expressed or implied – of support for the social, educational, and welfare needs of their people, including health care. Thus, through the cession of lands and resources, Indian tribes and their citizens pre-paid for the provision of services, including health care services, by the United States. Although treaty making with Indian tribes formally ended in 1871, the federal government has continued to interact with Indian tribes as political entities through statutes and administrative actions.

In the landmark case of *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831), Chief Justice John Marshall established the legal foundation for the trust responsibility by describing Indian tribes as “domestic dependent nations” whose relationship with the United States “resembles that of a ward to his guardian.” *Id.* at 17. Through nearly two centuries of case law, the courts have extensively examined the parameters of the trust responsibility to Indians, frequently in the context of whether the federal government has the authority to perform an action and whether there are limitations on the exercise of Congressional power over Indian affairs. While Congress has authority over Indian matters through the Constitution, the “guardian-ward” relationship articulated by Chief Justice Marshall requires that federal actions be beneficial, or at least not harmful, to Indian welfare. Over the years, Congress has

enacted Indian-specific laws on a wide variety of topics³³ and included Indian-specific provisions in laws of general applicability to address Indian participation in federal programs.³⁴

B. “INDIAN” AS A POLITICAL RATHER THAN A RACIAL CLASSIFICATION: INDIAN-SPECIFIC LAWMAKING AND THE “RATIONALLY RELATED” STANDARD OF REVIEW

CMS has ample legal authority to single out IHS beneficiaries for special treatment in administering the statutes under its jurisdiction if doing so is rationally related to its unique trust responsibility to Indians. Under familiar principles of Indian law, such actions are political in nature, and as a result do not constitute prohibited race based classifications. This principle has been recognized and repeatedly reaffirmed by the Supreme Court and every Circuit Court of Appeals that has considered it, and has been extended to the actions of administrative agencies like the HHS. HHS regulations implementing Title VI of the Civil Rights Act recognize and implement this principle with respect to the Indian health system.³⁵

In 1974, the Supreme Court in *Morton v. Mancari* held that the federal government could lawfully treat Indians and Indian tribes differently from other groups in carrying out the trust responsibility without running afoul of United States Constitution’s equal protection clause.³⁶ The Court explained that such treatment is not directed at a suspect racial classification but rather at a unique and non-suspect

33 See, e.g., Indian Health Care Improvement Act, 25 U.S.C. § 1601, *et seq.*; Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 5301, *et seq.*; Indian Education Act, 20 U.S.C. § 7401, *et seq.*; Tribally Controlled Schools Act, 25 U.S.C. § 2501, *et seq.*; Tribally Controlled Colleges and Universities Assistance Act, 25 U.S.C. § 1801, *et seq.*; Native American Housing Assistance and Self-Determination Act, 25 U.S.C. § 4101, *et seq.*; Indian Child Welfare Act, 25 U.S.C. § 1901, *et seq.*; Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. § 3201, *et seq.*; Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. § 3401, *et seq.*

34 See, e.g., 42 U.S.C. § 1395qq (eligibility of IHS/tribal facilities for Medicare payments); 42 U.S.C. § 1396j (eligibility of IHS/tribal facilities for Medicaid payments); 42 U.S.C. § 1397bb(b)(3)(D) (assurance of CHIP services to eligible low-income Indian children); Elementary and Secondary Education Act, as amended, 20 U.S.C. § 6301, *et seq.* (funding set-asides throughout this law for the benefit of children enrolled in the Bureau of Indian Affairs school system); Impact Aid Program, 20 U.S.C. § 7701, *et seq.* (federal aid to public school districts for Indian children living on Indian lands); Carl D. Perkins Vocational and Applied Technology Education Act, 20 U.S.C. §§ 2326, 2327 (funding set-aside for Indian vocational education programs and tribal vocational Institutions); Higher Education Act, 20 U.S.C. § 1059c (funding for tribally-controlled higher education institutions); Individuals with Disabilities Education Act, 20 U.S.C. § 1411(h) (funding set-aside for Bureau of Indian Affairs schools); Head Start Act, 42 U.S.C. § 9801, *et seq.* (includes funding allocation for Indian tribal programs and special criteria for program eligibility); Federal Highway Act, 23 U.S.C. § 101, *et seq.* (1998, 2005, 2008 and 2012 amendments include funding set-asides for Indian reservation roads programs and direct development of regulations through Negotiated Rulemaking with tribes); American Recovery and Reinvestment Act of 2009, Pub. L. 111-5 (Feb. 17, 2009) (ARRA) (§5006 making amendments to the Social Security Act to provide various protections for Indians under Medicaid and CHIP, discussed below); Patient Protection and Affordable Care Act, Pub. L. 111-148 (Mar. 23, 2010) (various Indian specific provisions, discussed below).

35 45 C.F.R. § 80.3(d).

36 417 U.S. 535 (1974). This memorandum focuses on the federal government’s different treatment of Indians and Indian tribes. However, courts have made clear that state action implementing federal law aimed at furthering the federal government’s trust responsibility is subject to the same rational basis equal protection test. See, e.g., *Washington v. Confederated Bands & Tribes of the Yakima Indian Nation*, 439 U.S. 463 (1979).

28 See *Worcester v. State of Ga.*, 31 U.S. 515 (1832).

29 See *Morton v. Mancari*, 417 U.S. 535 (1974).

30 *United States v. Forty-Three Gallons of Whiskey*, 93 U.S. 188, 196 (1876).

31 Delaware-U.S. Treaty of Fort Pitt, 7 Stat. 13 (Sept. 17, 1778).

32 COHEN’S HANDBOOK OF FEDERAL INDIAN LAW 31–32 (Nell Jessup Newton et al. eds., 2012 ed.); see also *Marks v. United States*, 161 U.S. 297, 302 (1896).

class that is based on a political relationship with tribal entities recognized as separate sovereigns in the Constitution.³⁷ The Court noted that “there is no other group of people favored in this manner.”³⁸ Thus, while the Supreme Court’s civil rights jurisprudence has generally applied strict scrutiny when reviewing classifications based on race, color, or national origin,³⁹ the Court in *Mancari* held that the strict scrutiny test was not appropriate when reviewing the Indian employment preference law at issue in that case.⁴⁰ The Court explained that the analysis instead “turns on the unique legal status of Indian tribes under federal law and upon the plenary power of Congress [drawn from the Constitution], based on a history of treaties and the assumption of a ‘guardian-ward’ status, to legislate on behalf of federally recognized Indian tribes.”⁴¹ The Court went on to mandate that, “[a]s long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress’ unique obligation toward the Indians, such legislative judgments will not be disturbed.”⁴²

Following *Morton v. Mancari*, the Supreme Court has explained that the federal government is not acting on behalf of a “racial group consisting of Indians,” but instead the different treatment is “rooted in the unique status of Indians as a separate people with their own political institutions” and in Indian tribes’ status as “quasi-sovereign tribal entities.”⁴³ As former Supreme Court Justice Antonin Scalia acknowledged in an opinion he authored for the United States Court of Appeals for the D.C. Circuit, Indians and Indian tribes do not qualify as a suspect classification for purposes of an equal protection analysis because the “Constitution itself establishes the rationality of the present classification” through its “provi[sion of] a separate federal power which reaches only the present group.”⁴⁴ And in *Washington v. Washington State Commercial Passenger Fishing Vessel Assoc.*, the Supreme Court held that the “peculiar semisovereign and constitutionally recognized status of Indians justifies special treatment on their behalf.”⁴⁵

In its decision in *United States v. Antelope*, the Supreme Court summarized its jurisprudence in this area:

37 *Id.* at 553–55.

38 *Id.* at 554.

39 The Supreme Court has interpreted Title VI of the Civil Rights Act, 42 U.S.C. § 2000d, *et seq.*, to allow racial and ethnic classifications only if those classifications are permissible under the equal protection clause. *Regents of Univ. of California v. Bakke*, 438 U.S. 265, 287 (1978). The Court has stated that “all racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny. In other words, such classifications are constitutional only if they are narrowly tailored measures that further compelling governmental interests.” *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 227 (1995).

40 417 U.S. at 553–55.

41 *Id.* at 551.

42 *Id.* at 555.

43 *United States v. Antelope*, 430 U.S. 641, 645–46 (1977) (omitting internal quotations).

44 *United States v. Cohen*, 733 F.2d 128, 139 (D.C. Cir. 1984) (citing *United States v. Antelope*, 430 U.S. 641, 649 n.11 (1977)).

45 443 U.S. 658, 673 n. 20 (1979).

The decisions of this Court leave no doubt that federal legislation with respect to Indian tribes, although relating to Indians as such, is not based upon impermissible racial classifications. Quite the contrary, classifications expressly singling out Indian tribes as subjects of legislation are expressly provided for in the Constitution and supported by the ensuing history of the Federal Government’s relations with Indians.⁴⁶

Since *Mancari*, Courts have continuously upheld the principle that federal actions that single Indians and Indian tribes out do not unconstitutionally target a racial classification, including actions other than the Indian hiring preference at issue in *Mancari*. The Supreme Court has done so many times,⁴⁷ every United States Circuit Court of Appeals that has discussed the issue has affirmed this principle,⁴⁸ courts continue to employ it today,⁴⁹ and courts have confirmed that applies equally in the context of agency action.⁵⁰

46 430 U.S. at 645.

47 See, e.g., *Washington v. Washington State Commercial Passenger Fishing Vessel Ass’n*, 443 U.S. 658, 673 n.20 (1979); *Confederated Bands & Tribes of Yakima Indian Nation*, 439 U.S. at 500–01; *Delaware Tribal Bus. Comm. v. Weeks*, 430 U.S. 73, 84–85 (1977); *United States v. Antelope*, 430 U.S. at 645–46; *Moe v. Confederated Salish & Kootenai Tribes of Flathead Reservation*, 425 U.S. 463, 479–80 (1976); *Fisher v. Dist. Court of Sixteenth Judicial Dist. of Montana, in & for Rosebud Cty.*, 424 U.S. 382, 390–91 (1976).

48 See, e.g., *KG Urban Enterprises, LLC v. Patrick*, 693 F.3d 1, 17–20 (1st Cir. 2012); *United States v. Wilgus*, 638 F.3d 1274, 1286–87 (10th Cir. 2011); *Means v. Navajo Nation*, 432 F.3d 924, 932–35 (9th Cir. 2005); *Am. Fed’n of Gov’t Employees, AFL-CIO v. United States*, 330 F.3d 513, 520–23 (D.C. Cir. 2003); *Peyote Way Church of God, Inc. v. Thornburgh*, 922 F.2d 1210, 1214–16 (5th Cir. 1991); *Bordeaux v. Hunt*, 621 F. Supp. 637, 653 (D.S.D. 1985) *aff’d sub nom.*, 809 F.2d 1317 (8th Cir. 1987); *United States v. State of Mich.*, 471 F. Supp. 192, 271 (W.D. Mich. 1979) *aff’d in part*, 653 F.2d 277 (6th Cir. 1981), *cert. denied*, 454 U.S. 1124 (1981)).

49 Even within this decade, many courts have applied the principle. See, e.g., *E.E.O.C. v. Peabody W. Coal Co.*, 773 F.3d 977, 987–88 (9th Cir. 2014); *KG Urban Enterprises, LLC v. Patrick*, 693 F.3d at 17–20; *United States v. Wilgus*, 638 F.3d at 1286–87. In August of this year, the Fifth Circuit in *Brackeen v. Bernhardt* confirmed the continuing validity of the *Morton v. Mancari* equal protection principle and its application to the Indian Child Welfare Act. 937 F.3d 406, 425–430 (5th Cir. 2019). The Fifth Circuit in its decision held that the Act’s application to Indian children not formally enrolled members of federally recognized tribes is not a race-based classification. *Id.* at 428.

50 See, e.g., *E.E.O.C. v. Peabody W. Coal Co.*, 773 F.3d at 982–89 (upholding federal agency approval of company’s lease to mine coal on Indian tribes’ reservations that included hiring preference for tribal members); *United States v. Decker*, 600 F.2d 733, 740–41 (9th Cir.1979) (upholding federal agency regulation enacted to implement tribes’ treaty fishing rights and international treaty); *Paravano v. Babbitt*, 861 F.Supp. 914, 926–28(N.D. Cal. 1994), *aff’d*, 70 F.3d 539 (9th Cir. 1995) (upholding federal agency authorization via regulation of fish harvest for tribal members); see also *United States v. State of Mich.*, 471 F. Supp. at 270–71 (finding state compliance with federal agency regulation protecting Indians’ treaty rights would not violate equal protection clause).

III. CONGRESS'S IMPLEMENTATION OF THE FEDERAL TRUST RESPONSIBILITY IN HEALTH LAWS

Congress initially provided for the health care of Indians through the ratification of treaties that specifically obligated the United States to provide care for Indians, including health care, and through discretionary appropriations. By 1871, when Congress ceased treaty making and instead dealt with Tribes through statute, at least 22 treaties had obligated the United States to provide for some type of medical service.⁵¹ Congress continued to address Indian health through a patchwork of appropriations and statutory authority, and in 1921 enacted the Snyder Act, which authorized the Bureau of Indian Affairs to carry out programs “[f]or relief of distress and conservation of health” among Indians.⁵² In 1954, Congress enacted legislation that transferred responsibility for Indian health to the Public Health Service.⁵³

Since the early part of the 20th century, Congress has enacted a number of laws that authorize, direct, and fund the provision of health care services to Indian people. Here we focus on the most significant legislative enactments intended to ensure access of Indian people to federally-assisted health care programs, and to enhance the viability of IHS and tribal programs that serve the Indian population.

A. THE INDIAN HEALTH CARE IMPROVEMENT ACT

The Indian Health Care Improvement Act (IHCIA)⁵⁴ was originally enacted in 1976 as Public Law 94-437. It brought statutory order and direction to the delivery of federal health services to Indian people. Its legislative history catalogued the deplorable conditions of Indian health that demanded legislative attention: inadequate and under-staffed health facilities; improper or non-existent sanitation facilities; prevalence of disease; poor health status; inadequate funding;⁵⁵ low enrollment of Indians in Medicare, Medicaid, and Social Security; serious shortage of health professionals, including Indian health professionals; and the need for health care for Indian people who had moved from reservations to urban areas. The legislation addressed each of these deficiencies through focused titles: Manpower; Health Services; Health

Facilities (including sanitation facilities); Access to Medicare and Medicaid; Urban Indian Health; and a feasibility study for establishing an American Indian School of Medicine.⁵⁶

The IHCIA has been periodically reauthorized and amended since 1976. In 2010, the law was comprehensively amended and authorized through the Patient Protection and Affordable Care Act, Pub. L. 111-148 (ACA).⁵⁷ Section 10221 of the ACA incorporated by reference and enacted into law an existing bill, S.1790 which contained over 270 pages of amendments to the IHCIA. Although the IHCIA was enacted by reference in the ACA, it had a separate legislative genesis and purpose than the remainder of the ACA.

Throughout its history, the IHCIA has contained an unequivocal recognition of the United States' responsibility to improve the health of Indian people, to provide federal health services to this population, and to foster maximum Indian participation in health care program management. The 2010 amendments reiterated and reinforced these federal commitments through the following provisions:

Congressional Findings

The Congress finds the following:

1. Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.
2. A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.
3. A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.
4. Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.
5. Despite such services, the unmet health needs of American Indian people are severe and the health status

51 U.S. Pub. Health Serv., *Health Services for American Indians* 86 (1957).

52 25 U.S.C. § 13.

53 Pub. L. 83-568, c. 658, §1, 68 Stat. 674 (codified as amended at 42 U.S.C. § 2001).

54 25 U.S.C. § 1601, *et seq.* The Indian Health Care Improvement Act was amended and permanently reauthorized by Section 10221 of the ACA.

55 The House Interior and Insular Affairs Committee noted that per capita spending on Indian health in 1976 was 25 percent less than the average American per capita amount. H.R. Rep. No. 94-1026-Part I at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2655. According to the U.S. Commission on Civil Rights, IHS per capita spending for Indian medical care in 2003 was 62 percent lower than the U.S. per capita amount. U.S. Comm'n on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Sept. 2004), at 98.

56 The IHCIA was later amended to include formal establishment of the IHS as an agency of HHS. Pub. L. 100- 713 (1988). The IHS establishment is codified at 25 U.S.C. § 1661.

57 Sec. 10221 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (Mar. 23, 2010).

of the Indians is far below that of the general population of the United States.⁵⁸

Declaration of National Indian Health Policy

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians –

1. to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
2. to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
3. to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
4. to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
5. to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
6. to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
7. to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.⁵⁹

It is important to note that these expressions of policy, obligation, and objectives apply to the federal government as a whole. The Act reposes responsibility for their implementation in the Secretary of Health and Human Services. While the IHS has first-line responsibility for administering the Indian health system, the Secretary of HHS remains the official with ultimate responsibility to see that programs are performed as directed and the objectives established by Congress are achieved. Thus, the obligation to exercise the trust responsibility for Indian health, to implement the expressed policies, and to achieve the stated goals extend to CMS, as an agency of HHS.

⁵⁸ 25 U.S.C. § 1601.

⁵⁹ 25 U.S.C. § 1602.

B. INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT

In 1976 Congress also enacted the Indian Self-Determination and Education Assistance Act (ISDEAA), which authorizes Tribes to take over federal programs for Indians, including health programs, by contracting with the federal government.⁶⁰ In 1988, Congress expanded the program by enacting the Tribal Self-Governance Demonstration Project, which provided tribes greater flexibility in the administration of programs under the Act.⁶¹ That authority was made permanent as to the IHS in 2000.⁶²

C. STATUTORY AUTHORITY FOR PARTICIPATION IN MEDICARE AND MEDICAID

In the 1976 IHCA Congress amended the Social Security Act to extend to Indian health facilities the authority to collect Medicare and Medicaid reimbursements. Prior to these amendments, the IHS as a federal agency, was not permitted to claim reimbursements from Medicare and Medicaid.

- Sec. 1880⁶³ made IHS hospitals (including those operated by Indian tribes⁶⁴) eligible to collect Medicare reimbursement.
- Sec. 1911⁶⁵ made IHS and tribal facilities eligible to collect reimbursements from Medicaid
- An amendment to Sec. 1905(b)⁶⁶ applied a 100 percent federal medical assistance percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Sections 1880 and 1911 were intended to bring additional revenue into the Indian health system in order to address the deplorable condition of Indian health facilities, many of which were in such a poor state they were unable to achieve accreditation. The House Report explained that “These Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian. . . .”⁶⁷ In order to ensure that Medicaid funding was supplemental to IHS funding, Congress enacted a complementary provision that provides that Medicaid reimbursements are not to be considered when determining future appropriations for the IHS.⁶⁸

⁶⁰ 25 U.S.C. § 5301, *et seq.* (formerly 25 U.S.C. § 450, *et seq.*).

⁶¹ Pub. L. 100-472 § 209, 102 Stat. 2285.

⁶² Pub. L. 106-260 § 4, 114 Stat. 713 (codified at 25 U.S.C. § 5381, *et seq.*).

⁶³ 42 U.S.C. § 1395qq.

⁶⁴ Tribes and tribal organizations are authorized to operate IHS-funded hospitals and clinics through contracts and compacts issued pursuant to the ISDEAA, 25 U.S.C. § 5301, *et seq.* (formerly 25 U.S.C. § 450, *et seq.*).

⁶⁵ 42 U.S.C. § 1396j.

⁶⁶ 42 U.S.C. § 1396d(b).

⁶⁷ H.R. Rep. No. 94-1026-Part III at 21 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2796.

⁶⁸ 25 U.S.C. § 1641(a).

At the same time, Congress took steps to ensure that IHS access to State Medicaid services not unduly burden the States with what is a federal responsibility. Congress amended Section 1905(b) of the Social Security Act to apply a 100 percent federal matching rate (FMAP) for services provided to AI/ANs that were received through an IHS or tribally-operated facility.⁶⁹ This ensured that Medicaid services provided to AI/ANs through the IHS system would be paid for entirely by the United States, and not individual State Medicaid programs. The House Report explained:

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

1. The Federal government has treaty obligations to provide services to Indians; it has not been a State responsibility;
2. Since the 100 percent matching is limited to services in IHS facilities, it is clearly being paid for Indians who are already IHS eligible (and therefore clearly part of the population to which the U.S. Government has an obligation) and who are already eligible for full Federal funding of their services; and
3. States with a large IHS eligible Indian population have a limited tax base because so much of the land is public and not taxable; the higher matching rate under Medicaid simply recognizes this.⁷⁰

Congress viewed 100% FMAP as a critical component in filling the disparity gap created by inadequate IHS funding. The application of a 100% FMAP to the Medicaid-covered services provided by these facilities was made in express recognition of the federal government's treaty obligations for Indian health. The Committee of jurisdiction observed that since the United States already had an obligation to pay for health services to Indians as *IHS beneficiaries*, it was appropriate for the U.S. to pay the full cost of their care as *Medicaid beneficiaries*.⁷¹ This action is consistent with the status of AI/ANs as a *political* designation.

Through amendments to Sec. 1880 made in 2000, 2003 and 2010, IHS and tribal hospitals and clinics are authorized to collect reimbursements for all Medicare Part A and Part B services. As health care providers, IHS and tribal health

programs are authorized to collect reimbursements under Medicare Parts C and D, as well.⁷²

D. STATUTORY AUTHORITY FOR PARTICIPATION IN CHIP

IHS and tribal health providers are authorized to collect payments when providing services to individuals enrolled in the Children's Health Insurance Program (CHIP).⁷³ To assure that low- income Indian children who are CHIP-eligible are not overlooked, Congress, when creating the program in 1997, expressly required States to describe in their State plans the procedures they will use to assure access for these children.⁷⁴

E. INDIAN-SPECIFIC PROVISIONS DESIGNED TO ENSURE INDIAN ACCESS TO MEDICAID AND CHIP

Since early 2009, Congress has added several significant provisions to Titles XIX and XXI of the Social Security Act that give voice to the federal government's unique responsibility to Indian people and the need to remove barriers to their participation in Medicaid and CHIP, especially when AI/ANs eligible for those programs receive services from Indian health providers. We highlight these actions below.

- *Proof of Citizenship for Medicaid Enrollment.* In the Deficit Reduction Act of 2005 (DRA), Congress directed that on and after July 1, 2006, persons who apply to enroll or renew enrollment in Medicaid must provide documentary proof of identity and U.S. citizenship, and identified the types of documents that would be acceptable proof. Indian health advocates feared – correctly, as it turns out – that many AI/ANs would not possess sanctioned documentation of their status as U.S. citizens. Recognizing the barrier this presented for Indian access to Medicaid and CHIP, in 2009 Congress amended these requirements to designate documents issued by a federally-recognized Indian tribe evidencing an individual's membership, enrollment in, or affiliation with such tribe as satisfactory evidence of U.S. citizenship.⁷⁵ Significantly, Congress gave tribal documentation “tier I” status – the same as a U.S. passport. Individuals presenting tribal

⁷² In fact, Congress expressly authorized the Secretary of HHS to issue standards to assure access by pharmacies operated by the I/T/Us to the Medicare Part D prescription drug benefit (42 U.S.C. §1395w-104(b)(1)(C)(iv)), and required the Secretary to establish procedures (including authority to waive requirements) to assure participation by these pharmacies in the transitional assistance feature of the temporary discount drug program. 42 U.S.C. §1395w-141(g)(5)(B). Congress added language in the ACA to allow Indian patients to qualify for the catastrophic coverage phase of the Part D program. 42 U.S.C. §1395w-102(b)(4)(C).

⁷³ 42 U.S.C. § 1397ee(c)(6)(B); see also 25 U.S.C. §1647a.

⁷⁴ 42 U.S.C. § 1397bb(a)(3)(D).

⁷⁵ 42 U.S.C. § 1396b(x)(3)(B), as added by Sec. 211 of the CHIP Reauthorization Act of 2009 (Pub. L. 111-3) (Feb. 4, 2009).

⁶⁹ 42 U.S.C. § 1396d(b).

⁷⁰ H.R. Rep. No. 94-1026-Part III at 21 (1976), reprinted in 1976 U.S.C.C.A.N. 2796.

⁷¹ *Id.*

affiliation documentation would not be required to present any additional identity documentation.

This legislative action recognizes not only the historic reality that Indian people were the original occupants of the North American continent, it also implements in the clearest possible way the policy of maintaining a government-to-government relationship with Indian tribes. It also demonstrates respect for the sovereignty of tribes both to determine tribal membership and to issue legal documents. As a practical matter, amending the law to order acceptance of tribal documentation underscores Congress's recognition of its continued responsibility to enact Indian-specific legislation when needed to assure full access to federal programs.

- *Medicaid Premium and Cost-Sharing Protections.* Pursuant to an amendment to Medicaid made in 2009, States are prohibited from imposing any premium or cost-sharing on an Indian for a covered service provided by the IHS, a health program operated by an Indian tribe, tribal organization or urban Indian organization, or through referral under contract health services.⁷⁶
- *Disregard of Certain Indian Property from Resources for Medicaid and CHIP Eligibility.* In 2009, Congress amended the Medicaid and CHIP laws to exempt from the resources calculation certain enumerated types of Indian property. Primarily, the excluded property is of a type that flows to an individual Indian by virtue of his/her membership in a tribe.⁷⁷
- *Medicaid Estate Recovery Protections.* In an express endorsement of a provision in the CMS State Medicaid Manual, in 2009 Congress statutorily exempted certain Indian-related income, resources, and property held by a deceased Indian from the Medicaid estate recovery requirement.⁷⁸ The objective of the Manual and statutory protection was to remove a disincentive to enrollment for Indian people eligible for Medicaid.
- *Special Indian-Specific Rules for Medicaid Managed Care.* In 2009, Congress removed several barriers to full and fair participation of Indian people and Indian health providers in Medicaid programs operated through managed care entities. It required State contracts with managed care entities to allow Indian Medicaid managed care enrollees the option to select an Indian health program as his/her primary care provider.⁷⁹ Congress also required State managed care contracts to ensure that managed care entities

promptly pay Indian health providers (I/T/Us) at negotiated rates or at a rate not less than that of the managed care entity's network provider rate.⁸⁰ It also required managed care entities to guarantee a sufficient number of in-network Indian health providers and to pay Indian health care providers, whether they are enrolled as a network provider or not.⁸¹ In addition, to the extent the managed care entity does not pay the Indian health provider at the rate set out in the State Plan, the law requires the State to make a wrap-around payment to ensure Indian health care providers are paid the full amount they are entitled to.⁸²

In addition, when Congress enacted legislation authorizing States to move to managed care arrangements through State Plan Amendments, it prohibited States from mandating Indians into enrolling in managed care.⁸³ It also authorized Indian tribes and tribal organizations to create Indian Managed Care Entities (IMCEs) that are authorized to restrict enrollment to IHS eligible individuals.⁸⁴

- *Tribal Innovation Center Models*—In 2009, Congress enacted Section 1115a of the Social Security Act, which established the CMS Innovation Center. The CMS Innovation Center tests models of health care delivery to reduce program costs and improve the coordination, quality, and efficiency of health care services for Medicare and Medicaid. Congress identified an enumerated list of models for the Secretary to test, and it specifically included in this list IHS/tribal facilities using telehealth services to treat behavioral health issues and stroke and to improve the capacity of non-medical providers and non-specialized providers to provide services to treat complex health conditions.⁸⁵ This inclusion recognized the innovative work IHS/tribal facilities have long been engaged in to maximize federal dollars and improve patient care.

F. REQUIREMENTS FOR STATE TO ENGAGE WITH INDIAN HEALTH PROGRAMS

In recognition of the need to assure that impacts on the unique Indian health system by proposed changes in Medicare, Medicaid, and CHIP are fully evaluated, Congress placed in the Social Security Act a requirement for prior notice and solicitation of input from I/T/Us. On the federal level, this requirement is to be carried out by CMS

76 42 U.S.C. §§ 1396o(j) and 1396o-1(b)(3)(A)(vii), as added by Sec. 5006(a) of the ARRA. In recognition of the trust responsibility, Indian children have been exempt from cost-sharing in the CHIP program pursuant to regulation at 42 C.F.R. § 457.535.

77 42 U.S.C. §§ 1396a(ff) and 1397gg(e)(1)(K), as added by Sec. 5006(b) of the ARRA.

78 42 U.S.C. § 1396p(b)(3)(B), as added by Sec. 5006(c) of the ARRA.

79 42 U.S.C. § 1396u-2(h), as added by Sec. 5006(d) of the ARRA.

80 *Id.*

81 *Id.*

82 *Id.* IHS and tribal providers are generally reimbursed for most services by Medicaid at either the IHS OMB rate that is published annually in the Federal Register, or at an FQHC rate if they elect to bill as FQHCs. Managed care entities may pay their in-network providers at rates that are lower than these rates. If they do, this provision requires the State to make up the difference between the two rates in a wrap-around payment to the Indian health provider.

83 42 U.S.C. § 1396u-2(a)(2)(C)

84 *Id.*

85 42 U.S.C. 1315a(b)(2)(B)(xix).

through maintenance of the TTAG originally chartered by the agency in 2003.⁸⁶

Congress has also required States to solicit advice from IHS and tribal health programs and urban Indian organizations within their borders prior to submission of any state plan amendments, waiver requests and demonstration projects to CMS.⁸⁷

In addition, Congress required HHS to encourage States to enter into agreements with tribes to increase outreach and enrollment of Indians living on or near reservations in order to help them get access to benefits under Medicaid and CHIP.⁸⁸ Congress also directed the Secretary of HHS to facilitate agreements between tribes and states to increase access to services by Indians under the Medicaid and CHIP programs.⁸⁹

G. CAP ON RATES CHARGED FOR PURCHASED/REFERRED CARE SERVICES.

Modeling on the Medicare Provider Agreement provision that caps the amount a hospital can charge for services purchased by the Department of Veterans Affairs, in 2003 Congress enacted a similar limitation on the amount a Medicare participating hospital may charge for services purchased by Indian health programs operated by the IHS, tribes and tribal organizations, and urban Indian organizations (I/T/Us). As a condition for participation in Medicare, such hospitals must accept patients referred by I/T/Us in accordance with the admission practices, payment methodology, and payment rates set forth in Secretarial regulations, and may accept no more than the payment rates set by the Secretary.⁹⁰ This statutory rate cap is often referred to by the shorthand “Medicare-like rates.” In regulations issued by IHS and CMS in 2007, the maximum amount a Medicare hospital is permitted to accept for a service purchased by an I/T/U is the applicable Medicare rate.⁹¹ These statutory and regulatory actions are intended to enable I/T/Us to achieve greater economies for the services they must purchase for their Indian patients with funds appropriated for contract health services.

H. INDIAN-SPECIFIC PROVISIONS DESIGNED TO ENSURE INDIAN ACCESS TO THE HEALTH INSURANCE EXCHANGES

The ACA was enacted by Congress in 2010 in order to reform the health insurance market and make health insurance more accessible and affordable for all Americans. It imposes a responsibility on most Americans to acquire or maintain health insurance coverage, and contains a number of provisions intended to strengthen health insurance consumer protections and enhance the health care workforce. Congress included a number of provisions designed to ensure that Indians could take advantage of the new reforms. We highlight several of these below.

- *Exemption from Penalty for Failure to Comply with the Individual Mandate.* Although Congress designed the ACA to make nearly all Americans responsible for acquiring or maintaining acceptable levels of health insurance coverage, Congress specifically exempted members of Indian tribes from the tax penalty for failure to obtain acceptable coverage.⁹² This provision is based on the theory that the United States is responsible for providing health care to Indians, but it has failed to supply an acceptable package of benefits through the IHS. Having failed in that responsibility, it would violate the trust responsibility to require Indians to pay for non-IHS coverage or be assessed a tax penalty for failing to do so. We note that Congress has since effectively eliminated the individual mandate by zeroing out the penalties for non-compliance in the Tax Cuts and Jobs Act of 2017.⁹³
- *Cost-Sharing Protections for Indians Enrolled in a Health Insurance Exchange Plan.* The ACA prohibits assessment of any cost-sharing for any service provided by an Indian health provider to an AI/AN enrolled in an Exchange plan. Furthermore, no cost sharing may be assessed by non-Indian health providers to an AI/AN enrolled in such a plan if the individual receives services through an Indian health provider or through contract health services. Indians with income below 300 percent of the Federal Poverty Level do not have cost sharing in the private sector even if they do not have a referral from an Indian health provider. The Secretary of HHS is responsible for paying the Exchange plan the additional actuarial cost that results from these cost-sharing protections.⁹⁴
- *Special enrollment periods for AI/AN.* The ACA provides special enrollment periods for AI/ANs for health insurance exchanges. This is another measure to provide access to this important source of funding for the I/T/U.

⁸⁶ 42 U.S.C. §1320b-24, as added by Sec. 5006(e)(1) of the ARRA. The maintenance of the TTAG does not substitute for government-to-government consultation with tribes.

⁸⁷ 42 U.S.C. §§ 1396a(a)(73) and 1397gg(e)(1)(C), as added by Sec. 5006(e)(2) of the ARRA.

⁸⁸ 42 U.S.C. § 1320b-9(1).

⁸⁹ *Id.*

⁹⁰ 42 U.S.C. § 1395cc(a)(1)(U), as added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173 (Dec. 8, 2003) (MMA).

⁹¹ 72 Fed. Reg. 30706 (June 4, 2007), adding Subpt. D to 42 C.F.R. Part 136, and adding §489.29 to 42 C.F.R. Part 489. These regulations became effective on July 5, 2007.

⁹² 26 U.S.C. § 5000A(e)(3).

⁹³ Pub. L. 115-97 (Dec. 22, 2017).

⁹⁴ 42 U.S.C. § 18071(d).

These provisions are designed to reduce the costs for AI/ANs to access the Exchange plans and to provide incentives for them to do so, as well as to increase the likelihood that I/T/Us will receive payments from health insurance exchange plans for services they provide to AI/ANs.

IV. EXECUTIVE BRANCH

RECOGNITION OF THE FEDERAL TRUST RESPONSIBILITY IN ADMINISTERING FEDERAL HEALTH PROGRAMS

A. EXECUTIVE BRANCH ADMINISTRATION OF THE TRUST RESPONSIBILITY

The Executive Branch is responsible for carrying out the federal trust responsibility to provide health care to Indians. The federal government's general trust duty to provide social services and its duty as a trustee to protect and manage Indian trust property are different types of duties and thus are treated differently by the courts.⁹⁵ Courts have generally been reluctant to impose liability for the federal government's failure to provide social services under the general trust relationship.⁹⁶ One notable exception is the case of *Morton v. Ruiz*⁹⁷ where the Supreme Court said the Bureau of Indian Affairs (BIA) erred in refusing to provide welfare benefits to unemployed Indians who lived off, but near, their reservation. The Court reiterated that the "overriding duty of our Federal Government [is] to deal fairly with Indians wherever located", and that BIA's failure to publish eligibility criteria through Administrative Procedure Act regulations was not consistent with the "distinctive obligation of trust incumbent upon the Government in its dealings" with Indians.⁹⁸

The IHClA policy statements quoted above expressly recognize a trust responsibility to maintain and improve the health of Indians, establish a national policy to assure the highest possible health status to Indians, and provide all resources necessary to effect that policy. They establish the goals which the Executive Branch – particularly the HHS – must strive to achieve as it implements federal law. In fact, they justify – indeed, require – the Executive Branch to be proactive and use its resources "to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." 25 U.S.C. §1602(1). The

Executive Branch has a dual duty – to carry out the policy established by Congress in federal law, and to perform the United States' trust responsibility to Indians in accord with the Congressionally-established standard.

Indian people take the United States at its word when reading the policy statement in the IHClA, and have a right to expect its trustee to achieve the goal of assuring them the highest possible health status. As stated by Justice Black in his lament over the U.S. breaking faith with Indians, "Great nations, like great men, should keep their word."⁹⁹

B. CMS ADMINISTRATION OF THE TRUST RESPONSIBILITY

As part of HHS, and as an agency required to implement statutory provisions intended to benefit Indian health, CMS should affirmatively advance policy objectives set out by Congress in the IHClA when making Indian-related decisions in the Medicare and Medicaid programs. The trust responsibility and the federal laws enacted to carry it out not only permit CMS to treat AI/ANs served by the Indian health system as unique Medicare and Medicaid consumers entitled to special treatment, they require it.

CMS shares the responsibility to carry out the policy goals established by Congress in the IHClA. Both the HHS and CMS tribal consultation policies recognize "the unique government to government" relationship between the United States and Tribes, as well as the trust responsibility "defined and established" by "the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders."¹⁰⁰ One manifestation of this trust responsibility is CMS's recognition that "CMS and Indian Tribes share the goals of eliminating health disparities for American Indians and Alaska Natives (AI/AN) and of ensuring that access to Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Exchanges is maximized."¹⁰¹ Though its consultation policy, CMS has committed to consulting with Indian tribes when developing policy that may affect Indians.

Over the years, CMS has taken numerous executive actions to administer federal health care programs and interpret statutes and regulations within its jurisdiction in a manner that ensures access by Indian people and full participation by the Indian health system. In recent years, CMS (previously HClA) has taken concrete steps to carry out the federal trust responsibility in administering Medicare, Medicaid and CHIP. CMS has accommodated the unique needs of

⁹⁵ *Seminole Nation v. United States*, 316 U.S. 286, 297 (1942).

⁹⁶ See, e.g., *Gila River Pima-Maricopa Indian Community v. U.S.*, 427 F.2d 1194 (Ct. Cl. 1970), cert. denied. 400 U.S. 819 (1970).

⁹⁷ 415 U.S. 199 (1974).

⁹⁸ *Id.*

⁹⁹ *Federal Power Comm'n v. Tuscarora Indian Nation*, 362 U.S. 99, 142 (1960) (Black, J., dissenting).

¹⁰⁰ CMS Tribal Consultation Policy (Dec. 10, 2015), at 1; HHS Tribal Consultation Policy (Dec. 14, 2010), at 1.

¹⁰¹ CMS Tribal Consultation Policy (Nov. 17, 2011), at 2.

the Indian health system, through numerous regulations, guidance, policy, State Medicaid Director Letters, and its consideration of State Plan Amendments and Section 1915 and 1115 Demonstration Waivers.

A summary of these actions follows:

- *Authority for Tribal Facilities to Bill Medicaid at the Same Rate as IHS Facilities.* In 1996, through a Memorandum of Agreement with IHS, HCFA re-interpreted the term “facility of the Indian Health Service” in Section 1911 (Medicaid) to allow a tribally-owned facility operated under an ISDEAA agreement to elect designation as a “facility of the Indian Health Service.” Previously, HCFA had interpreted the term “facility of the Indian Health Service” to include only facilities actually owned or leased by IHS. The MOA enabled these tribally-owned facilities to bill Medicaid at the annually-established Medicaid billing rates for IHS facilities and applied the 100% FMAP to Medicaid services provided by such facilities.
- *Exemption of IHS and Tribal Clinics from the Outpatient Prospective Payment System.* In 2002, the Director of the Center for Medicare agreed to continue the exemption of IHS and tribal clinics from the Outpatient Prospective Payment System.
- *CMS has Broadly Defined the Hospital Services that are Subject to the Medicare-like Rates Cap.* In 2007, CMS issued regulations implementing Section 506 of the MMA to require all Medicare-participating hospitals to accept Medicare-like rates when providing services to I/T/U beneficiaries. The final regulations broadly defined hospital and critical access hospital services subject to the rule to include inpatient, outpatient, skilled nursing facilities, and any other service or component of a hospital. 42 C.F.R. § 136.30; 42 C.F.R. § 489.29.
- *IHS and Tribal Facility Participation in Medicaid.* The 1996 IHS/HCFA MOA incorporated the regulatory policy that states must accept as Medicaid providers IHS facilities that meet state requirements, but these facilities are not required to obtain a state license. 42 C.F.R. § 431.110. Thus, it applied this regulatory policy to tribally-owned facilities. Congress converted this policy into law for all federally-funded health programs serving AI/ANs in the 2010 amendments to the IHCA.¹⁰²
- *Cost-Sharing Protections for Indian Children in CHIP.* In 1999, HCFA issued guidance, followed by a proposed rule, that prohibits states from imposing any cost-sharing on AI/AN children under CHIP, citing the unique federal relationship with Indian tribes. This rule was subsequently promulgated in final form. 42 C.F.R. § 457.535.

This HCFA regulation reflects the agency’s interpretation of how best to carry out the statutory provision requiring states to demonstrate how they will assure CHIP access for eligible Indian children. 42 U.S.C. § 1397bb(b)(3)(D). In 2000, HCFA announced that the policy prohibiting cost sharing for Indian children under CHIP would be extended to Section 1115 Medicaid demonstration projects and stated the agency would no longer approve Section 1115 projects that impose such cost-sharing. 66 Fed. Reg. 2490, 2526 (Jan. 11, 2001).

- *State-Tribal Consultation on Medicaid Programs.* In 2001, CMS issued a policy statement that requires states to consult with tribes within their borders on Medicaid waiver proposals and waiver renewals before submitting them to CMS.¹⁰³ Congress subsequently made this consultation requirement statutory, adding State Plan Amendments and demonstration projects as requisite subjects of tribal consultation.¹⁰⁴ CMS informed the States of this consultation requirement on several occasions and codified the 2001 policy statement.¹⁰⁵ In May of 2012, CMS announced that it would not accept the waiver applications submitted by New Mexico and Kansas until they met the tribal consultation requirements.
- *CMS Tribal Technical Advisory Group.* In 2003, CMS chartered a Tribal Technical Advisory Group (TTAG) comprised of tribal officials and tribal employees to advise the agency on Medicare, Medicaid, and CHIP issues that impact Indian health programs. CMS’s foresight was met with approval by Congress, which granted the TTAG explicit statutory status in 2009 and added representatives of the IHS and urban Indian organizations to the TTAG’s membership. 42 U.S.C. § 1320b-24.
- *Indian Health Addendum Required for Medicare Part D Pharmacy Contracts.* When implementing the Medicare Part D drug benefit, CMS recognized that special terms and conditions in pharmacy contracts would be needed to assure that I/T/Us pharmacies would be able to participate in the Part D program. The agency requires Part D plans to include the CMS-approved text of an Indian Health addendum in contracts offered to those pharmacies. 42 C.F.R. § 423.120(a)(6). The addendum addresses several aspects of federal law and regulations applicable to those pharmacies, such as Federal Tort Claims Act (FTCA)

¹⁰³ Letter from Health Care Fin. Admin. to State Medicaid Directors (July 17, 2001), <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd071701.pdf>.

¹⁰⁴ 42 U.S.C. §§ 1396a(a)(73) and 1397gg(e)(1)(C), as added by Sec. 5006(e)(2) of the ARRA.

¹⁰⁵ Letter from CMS to State Medical Directors, SMD#09-003 (June 17, 2009), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD061709.pdf>; Letter from CMS to State Medical Directors, SMDL#10-001 (Jan. 22, 2010), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/downloads/arra-protections-for-indians-in-medicaid-and-chip-smd.pdf>; 77 Fed. Reg. 11678 (Feb. 27, 2012).

¹⁰² 25 U.S.C. § 1647a.

coverage (obviating the need for privately-purchased professional liability insurance).¹⁰⁶

- *Approval of Indian-Specific Section 1115 Demonstration Waiver.* In April of 2012, CMS approved an Arizona Medicaid waiver request through which several optional Medicaid services can continue to be covered at IHS and tribal facilities although they are otherwise discontinued from coverage in the State's plan. When these services are provided to Indian patients at IHS and tribal facilities, the 100% FMAP continues to apply. This action is a significant acknowledgement by CMS that it has the authority and the obligation to carry out its trust responsibility for Indian health. CMS subsequently approved similar waivers submitted by California and Oregon.
- *Approval of Indian-Specific Exemptions to Section 1115 Demonstration Waivers.* Just as it has approved Indian-specific demonstration waivers, CMS has also approved Indian-specific exemptions to State demonstration waivers of general applicability. In January 2019, CMS approved a demonstration waiver submitted by the State of Arizona that would impose a series of community engagement requirements as a condition of Medicaid participation, but which exempted members of federally recognized tribes.¹⁰⁷
- *Indian-specific provisions must be implemented by Medicaid managed care plans.* In 2016, CMS published a final rule on managed care in Medicaid and CHIP, codifying a range of Indian managed care protections. The rule includes required standards for contracting with Indians, Indian health care providers, and IMCEs. 42 C.F.R. § 438.14 and 457.1209. The final rule clarified that Indian enrolled in an MCO do not have to get a second referral from an in-network provider if their Indian health care provider is not an enrolled provider. CMS subsequently issued, after tribal consultation, a model Medicaid and CHIP managed care addendum.

Carrying out the trust responsibility to Indians in these and other ways coincides with and complements CMS's stated program objectives.

V. THE UNIQUE NATURE OF THE INDIAN HEALTH SYSTEM

The IHS-funded system for providing health services to AI/ANs is one-of-a-kind; it is unlike any other mainstream health delivery system. In fact, the federal government created and designed the system in use today for the specific purpose of serving Indian people in the communities in which they live. Overall, the Indian health programs have a community-based approach and seek to provide culturally-appropriate services. As demonstrated in this Plan, the IHS system was created for Indian people as a political class, not as a racial group. These circumstances require unique rules and policies from CMS to enable IHS-funded programs to fully access Medicare, Medicaid, and CHIP and to achieve the agency's health disparities elimination objective.

We outline below some of the unique circumstances of this health system and of Indian tribes that have been established or recognized by federal law and regulations:

- *Limited service population.* The IHS health care system is not open to the public. It is established to serve AI/AN beneficiaries who fall within the eligibility criteria established by the IHS. See 42 C.F.R. § 136.12.¹⁰⁸ The IHS estimates the service population served by IHS and tribally-operated programs in more than 30 states is approximately 2.1 million AI/ANs.
- *No cost assessed to patients.* IHS serves AI/AN beneficiaries without cost. For several years, Congress reinforced this policy with language in the annual IHS appropriations act that prohibited the agency to charge for services without Congressional consent.¹⁰⁹ IHS services at no cost to the Indian patient remains IHS policy today. Some members of Congress have described the IHS as a pre-paid health plan – pre-paid with land ceded by tribes to the U.S. government.
- *Indian preference in employment.* Indian preference in hiring applies to the IHS. 42 C.F.R. § 136.41-.43.¹¹⁰ Such preference also applies to tribally-operated programs through the requirement that, to the greatest extent feasible, preference for training and employment must be given to Indians in connection with administration of any contract or grant authorized by any federal law to Indian organizations or for the benefit of Indians. 25 U.S.C. § 5307.

¹⁰⁶ The text of the Addendum is included in the Medicare program's solicitation for applications for new cost plan sponsors. See, e.g., "Medicare Prescription Drug Benefit, Solicitation for Applications for New Cost Plan Sponsors, 2012 Contract Year," at 131, https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/2013applicationfornewcostplanfinal_01182012.pdf.

¹⁰⁷ See FN 88, *infra*.

¹⁰⁸ Under certain circumstances non-Indians connected with an Indian beneficiary (such as minor children and spouses) can receive services as beneficiaries. Other non-Indians may receive services in carefully defined circumstances, but are liable for payment. See 25 U.S.C. § 1680c.

¹⁰⁹ See, e.g., Pub. L. 104-134, 110 Stat. 1321-190 (April 26, 1996).

¹¹⁰ See also *Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984) (upholding the IHS's Indian employment preference).

- *Only tribes have rights under ISDEAA.* Indian tribes (and tribal organizations sanctioned by one/more tribes) – and only those entities – can elect to directly operate an IHS-funded program through a contract or compact from the IHS issued pursuant to the ISDEAA. 25 U.S.C. § 5301, *et seq.* The tribal operator receives the program funds the IHS would have used and additional funding for administrative costs. A tribal operator directly hires its staff and has the authority to re-design the program(s) it offers.
- *Federal Tort Claims Act coverage.* Pursuant to federal law, tribal health programs and their employees are covered by the FTCA. 25 U.S.C. § 5321. For this reason, it is often unnecessary for tribes to purchase liability insurance for the health services they operate with federal funding.
- *Use of HHS personnel.* To help staff their programs, tribes and tribal organizations are authorized by law to utilize employees of HHS under Intergovernmental Personnel Act assignments and commissioned officers of HHS under Memoranda of Agreement. 25 U.S.C. § 5323.
- *Creation of specific health care providers.* Federal law has created health care delivery providers found only in the Indian health care system. *See* Community Health Representative Program, 25 U.S.C. § 1616; Community Health Aide Program (CHAP) for Alaska, 25 U.S.C. § 1616*l*. The Alaska Medicaid Plan reimburses Indian health programs for covered services provided by CHAPs in Alaska. Through a 2010 amendment to the IHCA, the Secretary is authorized to implement a CHAP program for tribes in the lower 48 states.
- *IHS as payer of last resort.* A longstanding IHS regulation makes IHS programs the payer of last resort for eligible Indian beneficiaries, notwithstanding any state or local law to the contrary. 42 C.F.R. § 136.61. Congress has made this payer of last resort status a statutory requirement for I/T/Us.¹¹¹
- *IHS-specific Medicare, Medicaid reimbursement rates.* On an annual basis, the IHS (in consultation with CMS) establishes the rates at which Medicare outpatient and Medicaid inpatient and outpatient services provided to eligible Indians shall be reimbursed to IHS facilities. *See, e.g.,* 77 Fed. Reg. 33470 (June 6, 2012). This is an all-inclusive encounter rate which is unique to Indian health care. Tribal clinics may instead elect to bill for services as a Federally Qualified Health Center (FQHC).
- *100 Percent Federal Medical Assistance Percentage.* The cost of Medicaid covered services provided to AI/ANs in IHS and tribal facilities are reimbursed to the States at 100% FMAP in recognition that the responsibility for Indian health care is a federal obligation. Sec. 1905(b) of the Social Security Act; 42 U.S.C. § 1396d(b).
- *No U.S. right of recovery from tribes.* If an Indian tribe (or a tribal organization sanctioned by one/more tribes) has a self-insured health plan for its employees, the United States is prohibited by law from recovering from that plan the cost of services provided unless the sponsoring tribe/tribal organization expressly authorizes such recovery. 25 U.S.C. § 1621e(f).
- *Indian tribes are governments.* Upon achieving federal recognition, an Indian tribe is acknowledged to be and is treated as a *government* by the United States. The U.S. deals with Indian tribes on a government-to-government basis that is recognized in Executive Orders and consultation policies adopted by federal agencies.¹¹² Indian tribes determine their own governmental structure. They are not required to follow the U.S. model of separate legislative, executive, and judicial branches.
- *State law does not apply.* By virtue of the Supremacy Clause, state laws generally do not apply to the IHS system. The Supreme Court has recognized that Indian tribal governments are not subject to state laws, including tax laws, unless those laws are made expressly applicable by federal law. *See, e.g., McClanahan v. State Tax Comm'n of Arizona*, 411 U.S. 164 (1973). Indian tribal governments are not political subdivisions of states. Tribal facilities are not required to hold state licenses so long as they meet the criteria for licensure,¹¹³ and tribal health professionals working in an IHS or tribal facility are not required to be licensed in the state in which the facility is located so long as they hold a state license.¹¹⁴
- *Federal trust responsibility.* The United States has a trust responsibility to Indian tribes (described above).
- *Tribal sovereign immunity.* Indian tribal governments enjoy sovereign immunity except vis-à-vis the United States Federal Government, the superior sovereign. *See, e.g., United States v. United States Fidelity & Guaranty Co.*, 309 U.S. 506 (1940).

In sum, an Indian tribe that has elected to directly operate its health care program can simultaneously serve in several capacities: as a sovereign government; as beneficiary of IHS-funded health care; as a direct provider of health care (including the right of recovery from third party payers); as administrator of a health program with responsibilities for advising its patients about eligibility for Medicare,

¹¹² *See* FN 1, *supra*.

¹¹³ 25 U.S.C. § 1647a.

¹¹⁴ 25 U.S.C. § 1621t.

¹¹¹ 25 U.S.C. § 1623(b), as added by Sec. 2901(b) of the ACA.

Medicaid, and CHIP; and as a sponsor of a health insurance plan for its employees (and the payor under such a plan if it is a self-insured plan). CMS must take these multiple roles into account and fashion special policies to effectively implement Medicare, Medicaid, and CHIP in Indian Country in ways that assure full access by Indian beneficiaries and IHS/tribal providers.

VI. CMS'S OBLIGATIONS TO INDIAN COUNTRY WHEN CONSIDERING NEW POLICY AND HEALTH REFORM PROPOSALS

CMS has an obligation to uphold the federal trust responsibility as it implements federal laws and policies and when it makes decisions regarding State proposals. CMS does so informally when it weighs in on Department-wide policies and initiatives or issues guidance in the form of Informational Bulletins, State Medicaid Director Letters or otherwise. CMS also does so formally, as when it promulgates regulations and when it considers State Plan Amendments and State Demonstration Waiver proposals.

The Indian health system is unique. System-wide policy and program changes to Medicare, Medicaid and CHIP programs that may not affect access for other users can create significant access challenges for Indian health care providers and the AI/AN beneficiaries they serve. Congress authorized the Indian health system to access Medicare, Medicaid, and CHIP resources in order to help fund the chronically underfunded Indian health system.¹¹⁵ AI/ANs must be able to enroll in those programs and maintain coverage so that Indian health providers can bill for the services they provide. CMS has an obligation to ensure that the policies and decisions it makes to effectuate national or state policy goals do not have the unintended effect of erecting barriers to Medicare, Medicaid, and CHIP for the Indian health beneficiaries and Indian health providers.

The Indian health system has several unique characteristics that create access challenges in Medicare, Medicaid and CHIP. First, IHS beneficiaries have a right to receive care through the Indian health care system at no cost to them. As discussed, above, the IHS system has been described as a pre-paid health system that grants IHS beneficiaries a right to access to IHS care at no cost. This can create challenges in convincing IHS-eligible individuals of the need to enroll in Medicaid, Medicare, or CHIP. Yet enrollment is essential in order for AI/ANs to gain the increased choice and access to coverage those programs provide and for the IHS system

to bill those programs in the manner intended by Congress. Both Congress and CMS have worked to lower barriers to access to care for AI/ANs. Congress has exempted AI/ANs from premiums, co-pays and cost sharing of any kind in the Medicaid program, for example. CMS has engaged and funded substantial outreach and enrollment efforts. But many barriers remain. In Medicare, for example, AI/ANs are not exempt from co-pays, and many AI/ANs who live a subsistence lifestyle may not qualify for Medicare. In Medicaid, the more complicated the conditions of enrollment are, the less likely AI/ANs with a right to IHS care will be to enroll.

Second, with regard to Medicaid, Congress has mandated that the United States be responsible for 100 percent of the cost of services to AI/ANs that are received through IHS and tribally operated facilities. As states consider options to cap or control costs through a variety of mechanisms, CMS should take into account that Congress intended the United States to fully reimburse states for the cost of Medicaid services for AI/ANs received through the IHS system.

In recent years, CMS has had occasion to consider a number of different policy initiatives designed to streamline access to services, lower costs, incent individuals to engage in healthy behaviors and become less dependent on CMS programs. In considering such initiatives, CMS has an obligation to ensure they do not have an adverse impact on AI/AN access to Medicare, Medicaid, and CHIP, and the ability of Indian health providers to access resources from those programs.

For example, States have proposed imposing enrollment caps in the Medicaid program for certain populations or wait lists on access to providers in an effort to contain State Medicaid costs. States have also sought to impose per capita spending caps, caps on the total annual amount that can be provided for any service (such as annual caps on dental services) and other payment reforms and limitations. CMS has both the obligation and the authority to consider how such broad stroke reimbursement caps would impact the Indian health system. As discussed above, Congress mandated that the United States pay for 100 percent of the cost of care received through IHS and tribal providers in the Medicaid program,¹¹⁶ and a State imposed cap would be inconsistent with that requirement with regard to Indian health. State caps, whether imposed through block grants, per capita caps, or otherwise could eliminate 100 percent federal reimbursement for services received through IHS and tribes. If the State receives only the amounts based on the caps, they will likely have to use those funds to provide services to Indians and non-Indians alike. This may result in a reduction in available services or eligibility restrictions. CMS has a duty in considering such proposals to ensure that full federal

¹¹⁵ 42 U.S.C. § 1395qq; 42 U.S.C. §1396j; 42 U.S.C. § 1397ee(c)(6)(B).

¹¹⁶ 42 U.S.C. § 1396d(b).

funding for the Indian health system is maintained notwithstanding any state caps or limitations.

CMS has an equal obligation to ensure that state proposals to impose new conditions of eligibility do not create barriers of access unique to AI/ANs. CMS had recent occasion to do so when considering whether to include State-proposed exemptions to new community engagement requirements in a number of State demonstration waiver proposals. In January of 2019, CMS approved a waiver proposed by the State of Arizona that imposed community engagement requirements on the new adult population.¹¹⁷ CMS also approved an exemption from those requirements for members of federally-recognized tribes.¹¹⁸ This was an important decision because work requirements would have created an insurmountable barrier to Medicaid access for many IHS eligible Medicaid enrollees. Many AI/ANs live in rural areas where there are no jobs and/or participate in subsistence economies that work requirement proposals do not recognize as qualifying work. In addition, many AI/ANs participate in tribal work and community programs, and would not participate in State programs as well simply to maintain access to Medicaid.

CMS has also exercised its authority to consider how State managed care proposals may adversely affect AI/AN access to the Indian health system. As discussed above, Congress has prohibited States from mandating AI/ANs into managed care when implementing managed care through a State Plan Amendment,¹¹⁹ and imposed a series of structural reforms to the Social Security Act designed to ensure AI/ANs can maintain access to the Indian health care provider of their choice, and that Indian health care providers will be paid at the rates they are entitled to receive.¹²⁰ CMS implemented these protections in its most recent revisions to the managed care rules.¹²¹ Yet even with these protections, Indian health care providers still routinely experience challenges working with managed care plans that do not understand the Indian health system. CMS has not approved of any State plan or waiver that mandates AI/ANs into managed care for health care services, and has created a subcommittee of the TTAG to examine managed care issues for Indian health care providers whose members have elected to opt-in to managed care.

CMS's Tribal Consultation Plan requires it to engage in "open, continuous and meaningful consultation" with tribes when considering policies and decisions that might impact the Indian health system.¹²² This means that when CMS is considering or formulating policies or decisions that have tribal implications, it must first encourage tribes to develop their own policies to address the issue, and where possible, defer to tribes to develop their own standards.¹²³ When considering whether to establish federal standards, CMS must ask tribes whether such standards are needed or whether tribes should be exempt from such standards.¹²⁴ CMS must also consult with tribes when promulgating regulations.¹²⁵

CMS has an equal obligation to ensure that States meet their own obligation to consult with tribes on matters that may adversely affect tribal health programs and the beneficiaries they serve. CMS's Tribal Consultation Policy requires CMS to ensure states consult with tribes before submitting SPAs and waivers, and that CMS will not consider an application complete if states have not consulted with tribes.¹²⁶ CMS also requires States to consult with tribes about any changes to a SPA or waiver before they are approved.¹²⁷

117 <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-appvd-demo-01182019.pdf>. The TTAG welcomed this approval as consistent with CMS's obligation to fulfill the trust responsibility in administering and approving State Medicaid programs and demonstration waivers. The TTAG maintains, however, that CMS has the authority to extend the exemption not just to members of federally-recognized tribes, but to all IHS eligible Medicaid enrollees.

118 *Id.*

119 *See* n. 57, *supra*.

120 *See* n. 55, 56, *supra*.

121 42 C.F.R. § 438.14.

122 CMS Tribal Consultation Policy at 5.1 (Dec. 10, 2015).

123 *Id.* at 5.6.

124 *Id.*

125 *Id.* at 5.7.

126 *Id.* at 8.2.1.

127 *Id.* at 8.2.1.

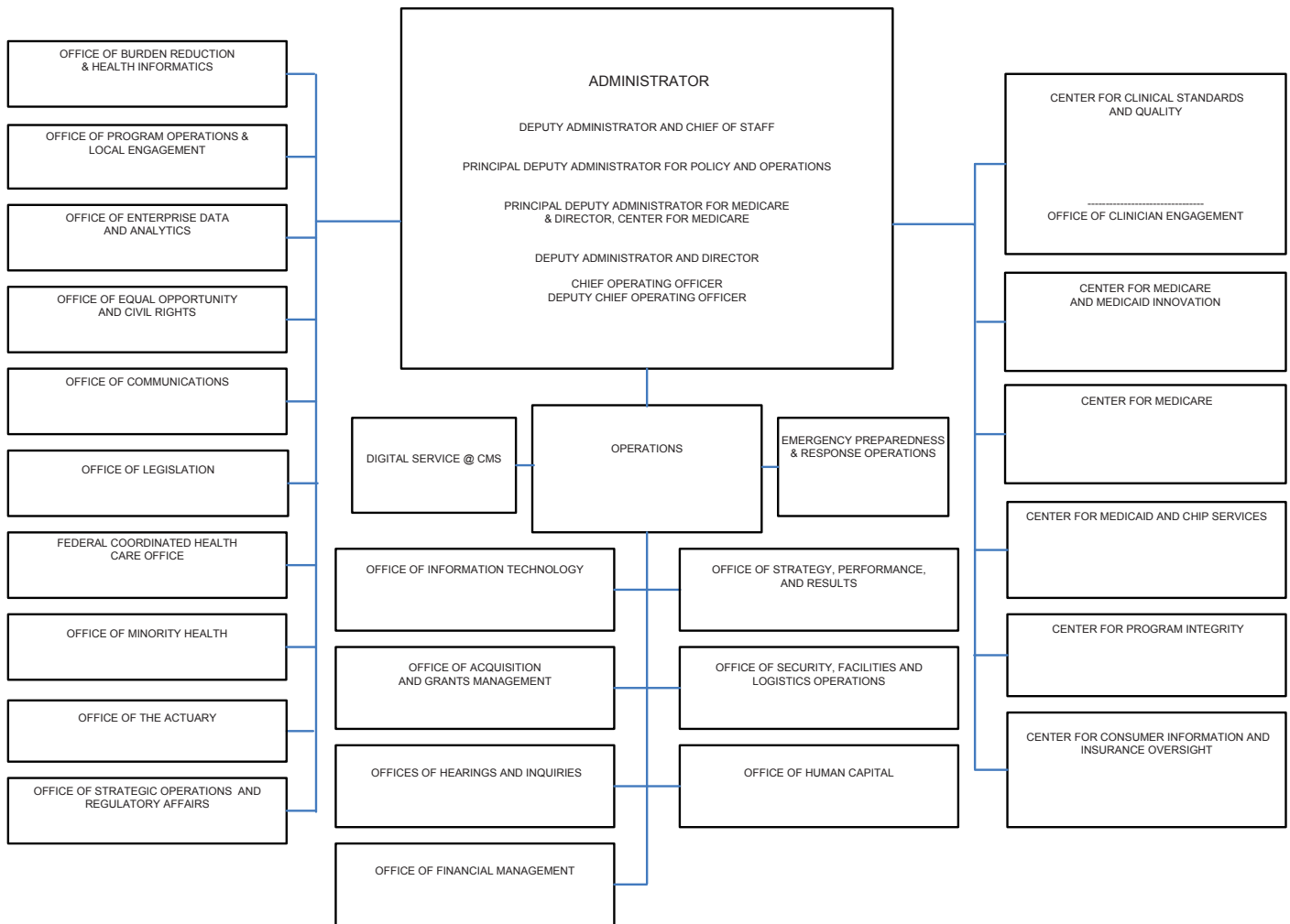
- Appendix B -

CMS Organizational Chart

Org Chart Text Version

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED



Common Terms & Acronyms

(Agencies referenced are in CMS unless otherwise indicated*)

ACA	Patient Protection and Affordable Care Act (P.L. 111-148)	IHCIA	Indian Health Care Improvement Act (P.L. 94- 437)
AI/AN	American Indians and Alaska Natives	IHCP	Indian Health Care Providers
ACL	Administration for Community Living* (in HHS)	IHS	Indian Health Service* (federal agency in HHS)
ARRA	American Recovery and Reinvestment Act of 2009 (P.L. 111-5)	LTSS	Long Term Services and Support
CCIO	Center for Consumer Information and Insurance Oversight	MA	Medicare Advantage (managed care plan)
CHIP	Child Health Insurance Program	MAM	Medicaid Administrative Match
CHIPRA	Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3)	MOA	Memorandum of Agreement
CMCS	Center for Medicaid and CHIP Services	NAC	Native American Contact in CMS Regional Offices
CMM	Center for Medicare Management	NIHB	National Indian Health Board
CMMI	Center for Medicare and Medicaid Innovation	OGC	Office of General Counsel
CMS	Centers for Medicare & Medicaid Services	Part A	Medicare inpatient coverage
CMSO	Center for Medicaid and State Operations	Part B	Medicare outpatient coverage
DSRIP	Delivery System Reform Incentive Payments	Part C	Medicare managed care plans, also called Medicare Advantage
FFE	Federally-facilitated Exchange	Part D	Medicare prescription drug benefit
FMAP	Federal Medical Assistance Percentage (for Medicaid)	PRC	Purchased/Referred Care (IHS program to purchase services)
FQHC	Federally Qualified Health Centers	TAG	CMS Tribal Affairs Group
HHS	U.S. Department of Health and Human Services*	TTAG	Tribal Technical Advisory Group to CMS
I/T/U	Health care services operated by the IHS, Tribes and Urban Indian clinics	Title XVIII	Medicare, Social Security Act
		Title XIX	Medicaid, Social Security Act
		Title XXI	Children’s Health Insurance Program, Social Security Act

Acknowledgments

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Notes

